APPLICATION COVER SHEET
Applicant Information – RFA # 3402

Applicant Name: **DCIPA, LLC – dba Umpqua Health Alliance**

Form of Legal Entity: **Limited Liability Company**

State of domicile: **Oregon**

Primary Contact Person: **Robert Dannenhoffer MD** Title: **Board Chair**

Address: **1813 W Harvard – Suite 448**

City, State, Zip: **Roseburg OR 97471**

Telephone: **541-464-4491** Fax: _____

E-mail Address: **rdannenhoffer@dcipa.com**

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

Name: **Robert Dannenhoffer MD** Title: **Board Chair, Umpqua Health Alliance**

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

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

Signature: _____ Title: **Board Chair** Date: 04/26/2012
(Authorized to Bind Applicant)

DCIPA, LLC – dba Umpqua Health Alliance

1813 W Harvard – Suite 448 | Roseburg OR 97471
Phone: 541-464-4491

Application
Coordinated Care Organization
RFA 3402

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ATTESTATIONS, ASSURANCES AND REPRESENTATIONS

Applicant Name: **DCIPA, LLC – dba Umpqua Health Alliance**

Attestations for Appendix A – CCO Criteria

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
Attestation A-1. Applicant will have an individual accountable for each of the following operational functions:				
• Contract administration	X			
• Outcomes and evaluation	X			
• Performance measurement	X			
• Health management and care coordination activities	X			
• System coordination and shared accountability between DHS Medicaid-funded LTC system and CCO	X			
• Mental health and addictions coordination and system management	X			
• Communications management to providers and Members	X			
• Provider relations and network management, including credentialing	X			
• Health information technology and medical records	X			
• Privacy officer	X			
• Compliance officer	X			
Attestation A-1. Applicant will participate in the learning collaborative required by ORS 442.210.	X			
Attestation A-3. Applicant will collect, maintain and analyze race, ethnicity, and primary language data for all Members on an ongoing basis in accordance with standards jointly established by OHA and DHS in order to identify and track the elimination of health inequities.	X			

Attestations for Appendix B – Provider Participation and Operations Questionnaire

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
Attestation B-1. Applicant will, as demonstrated with policies and procedures, (i) authorize the provision of a drug requested by the Primary Care Physician (PCP) or referral Provider, if the approved prescriber certifies medical necessity for the drug such as: the formulary's equivalent has been ineffective in the treatment or the formulary's drug causes or is reasonably expected to cause adverse or harmful reactions to the Member and (ii) reimburse providers for dispensing a 72-hour supply of a drug that requires prior authorization in accordance with OAR 410-141-0070.	X			
Attestation B-2. Applicant will comply with all applicable provider requirements of Medicaid law under 42 CFR Part 438, including provider certification requirements, anti-discrimination requirements, provider participation and consultation requirements, the prohibition on interference with provider advice, limits on provider indemnification, rules governing payments to providers, and limits on physician incentive plans.	X			
Attestation B-3. Applicant will assure that all provider and supplier contracts or agreements contain the required contract provisions that are described in the Contract.	X			
Attestation B-4. Applicant will have executed provider, facility, and supplier contracts in place to demonstrate adequate access and availability of Covered Services throughout the requested service area.	X			
Attestation B-5. Applicant will have all provider contracts or agreements available upon request.	X			
Attestation B-6. As Applicant implements, acquires, or upgrades health information technology (HIT) systems, where available, the HIT systems and products will meet standards and implementation specifications adopted under section 3004 of the Public Health Services Act as added by section 13101 of the American Recovery and Reinvestment Act of 2009, P.L. 111-5.	X			
Attestation B-7. Applicant's contracts for administrative and management services will contain the OHA required contract provisions.	X			
Attestation B-8. Applicant will establish, maintain, and monitor the performance of a comprehensive network of providers to assure sufficient access to Medicaid Covered Services as well as supplemental services offered by the CCO in accordance with written policies, procedures, and standards for participation established by the CCO. Participation status will be revalidated at appropriate intervals as required by OHA regulations and guidelines.	X			

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
Attestation B-9. Applicant will have executed written agreements with providers (first tier, downstream, or related entity instruments) structured in compliance with OHA regulations and guidelines.	X			
Attestation B-10. Applicant, through its contracted or deemed Participating Provider network, along with other specialists outside the network, community resources or social services within the CCO's service area, will provide ongoing primary care and specialty care as needed and guarantee the continuity of care and the integration of services through:				
• Prompt, convenient, and appropriate access to Covered Services by enrollees 24 hours a day, 7 days a week;	X			
• The coordination of the individual care needs of enrollees in accordance with policies and procedures as established by the Applicant;	X			
• Enrollee involvement in decisions regarding treatment, proper education on treatment options, and the coordination of follow-up care;	X			
• Effectively addressing and overcoming barriers to enrollee compliance with prescribed treatments and regimens; and	X			
• Addressing diverse patient populations in a culturally competent manner.	X			
Attestation B-11. Applicant will establish policies, procedures, and standards that:				
• Assure and facilitate the availability, convenient, and timely access to all Medicaid Covered Services as well as any supplemental services offered by the CCO,	X			
• Ensure access to medically necessary care and the development of medically necessary individualized care plans for enrollees;	X			
• Promptly and efficiently coordinate and facilitate access to clinical information by all providers involved in delivering the individualized care plan of the enrollee;	X			
• Communicate and enforce compliance by providers with medical necessity determinations; and	X			
• Do not discriminate against Medicaid enrollees, including providing services to individuals with disabilities in the most integrated setting appropriate to the needs of those individuals.	X			
Attestation B-12. Applicant will have verified that contracted providers included in the CCO Facility Table are Medicaid certified and the Applicant certifies that it will only contract with Medicaid certified providers in the future.	X			

Attestation B-13. Applicant will provide all services covered by Medicaid and comply with OHA coverage determinations.	X			
Attestation B-14. Applicant, Applicant staff and its affiliated companies, subsidiaries or subcontractors (first tier, downstream, and related entities), and subcontractor staff will be bound by 2 CFR 376 and attest that they are not excluded by the Department of Health and Human Services 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			
Attestation B-15. Neither the state nor federal government has brought any past or pending investigations, legal actions, administrative actions, or matters subject to arbitration involving the Applicant (and Applicant's parent corporation if applicable) or its subcontractors, including key management or executive staff, or major shareholders over the past three years on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services.	X			

Medicaid Assurances for Appendix B – Provider Participation and Operations Questionnaire

Assurance	Yes	No	Yes, Qualified	Explanation if No or Qualified
Assurance B-1. Emergency and Urgent Care Services. Applicant will have written policies and procedures and monitoring systems that provide for emergency and urgent services for all Members on a 24-hour, 7-days-a-week basis: The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. (See 42 CFR 438.114 and OAR 410-141-3140]	X			
Assurance B-2. Continuity of Care. Applicant will have written policies and procedures that ensure a system for the coordination of care and the arrangement, tracking and documentation of all referrals and prior authorizations to other providers. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.208 and OAR 410-141-3160]	X			

Assurance	Yes	No	Yes, Qualified	Explanation if No or Qualified
Assurance B-3. Applicant will have written policies and procedures that ensure maintenance of a record keeping system that includes maintaining the privacy and security of records as required by the Health Insurance Portability and Accountability Act (HIPAA), 42 USC § 1320-d et seq., and the federal regulations implementing the Act, and complete Clinical Records that document the care received by Members from the Applicant's primary care and referral providers. Applicants will communicate these policies and procedures to Participating Providers, regularly monitor Participating Providers' compliance with these policies and procedures and take any Corrective Action necessary to ensure Participating Provider compliance. Applicants will document all monitoring and Corrective Action activities. Such policies and procedures will ensure that records are secured, safeguarded and stored in accordance with applicable Law. [See 45 CFR Parts 160 – 164, 42 CFR 438.242, ORS 414.679 and OAR 410-141-3180]	X			
Assurance B-4. Applicant will have an ongoing quality performance improvement program for the services it furnishes to its Members. The program will include an internal Quality Improvement program based on written policies, standards and procedures that are designed to achieve through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas and that are expected to have a favorable effect on health outcomes and Member satisfaction. The improvement program will track outcomes by race, ethnicity and language. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.200 and 438.240; OAR 410-141-0200]	X			
Assurance B-5. Applicant will make Coordinated Care Services accessible to enrolled Members. The Applicant will not discriminate between Members and non-Members as it relates to benefits to which they are both entitled. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.206 to 438.210; and OAR 410-141-3220]	X			

Assurance	Yes	No	Yes, Qualified	Explanation if No or Qualified
Assurance B-6. Applicant will have written procedures approved in writing by OHA for accepting, processing, and responding to all complaints and Appeals from Members or their Representatives that are consistent with Exhibit I of the Appendix G "Core Contract". The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.228, 438.400 – 438.424; and OAR 410-141-3260 to 410-141-3266]	X			
Assurance B-7. Applicant will develop and distribute informational materials to potential Members that meet the language and alternative format requirements of potential Members. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.10; OAR 410-141-3280]	X			
Assurance B-8. Applicant will have an on-going process of Member education and information sharing that includes appropriate orientation to the Applicant, Member handbook, health education, availability of intensive care coordination for Members who are aged, blind and/or disabled and appropriate use of emergency facilities and urgent care. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.10; and OAR 410-141-3300]	X			
Assurance B-9. Applicant will have written policies and procedures to ensure Members are treated with the same dignity and respect as other patients who receive services from the Applicant that are consistent with Attachment 4, Core Contract. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.100, ORS 414.635 and OAR 410-141-3320]	X			
Assurance B-10. Applicant will provide Intensive Care Coordination (otherwise known as Exceptional Needs Care Coordination or ENCC) to Members who are Aged, Blind or Disabled. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.208 and OAR 410-141-3405]	X			

Assurance	Yes	No	Yes, Qualified	Explanation if No or Qualified
Assurance B-11. Applicant will maintain an efficient and accurate billing and payment process based on written policies, standards, and procedures that are in accordance with accepted professional standards, OHP Administrative Rules and OHA Provider Guides. The Applicant and its providers will not hold Members responsible for the Applicants or providers debt if the entity becomes insolvent. The Applicant will have monitoring systems in operation and review the operations of these systems on a regular basis. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 447.46 and OAR 410-141-0420]	X			
Assurance B-12. Applicant will participate as a trading partner of the OHA in order to timely and accurately conduct electronic transactions in accordance with the HIPAA electronic transactions and security standards. Applicant has executed necessary trading partner agreements and conducted business-to-business testing that are in accordance with accepted professional standards, OHP Administrative Rules and OHA Provider Guides. The Applicant will have monitoring systems in operation and review the operations of these systems on a regular basis. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 45 CFR Part 162; OAR 943-120-0100 to 943-120-0200]	X			
Assurance B-13. Applicant will maintain an efficient and accurate system for capturing encounter data, timely reporting the encounter data to OHA, and validating that encounter data based on written policies, standards, and procedures that are in accordance with accepted professional standards, CCO and OHP Administrative Rules and OHA Provider Guides. The Applicant will have monitoring systems in operation and review the operations of these systems on a regular basis. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.242; and the Contract]	X			

Assurance	Yes	No	Yes, Qualified	Explanation if No or Qualified
Assurance B-14. Applicant will maintain an efficient and accurate process that can be used to validate Member Enrollment and Disenrollment based on written policies, standards, and procedures that are in accordance with accepted professional standards, OHP Administrative Rules and OHA Provider Guides. The Applicant will have monitoring systems in operation and review the operations of these systems on a regular basis. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.242 and 438.604; and Contract]	X			

Informational Representations for Appendix B – Provider Participation and Operations Questionnaire

Informational Representation	Yes	No	Yes, Qualified	Explanation if No or Qualified
Representation B-1. Applicant will have contracts with related entities, contractors and subcontractors to perform, implement or operate any aspect of the CCO operations for the CCO Contract.	X			
Representation B-2. Applicant has an administrative or management contract with a delegated entity to manage/handle all staffing needs with regards to the operation of all or a portion of the CCO program.	X			
Representation B-3. Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the systems or information technology to operate the CCO program for Applicant.	X			
Representation B-4. Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the claims administration, processing and/or adjudication functions.	X			
Representation B-5. Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the Enrollment, Disenrollment and membership functions.	X			
Representation B-6. Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the credentialing functions.	X			
Representation B-7. Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the utilization operations management.	X			

Assurance	Yes	No	Yes, Qualified	Explanation if No or Qualified
Representation B-8. Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the Quality Improvement operations.	X			
Representation B-9. Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of its call center operations.	X			
Representation B-10. Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the financial services.	X			
Representation B-11. Applicant will have an administrative or management contract with a delegated entity to delegate all or a portion of other services that are not listed.	X			

Signature: RH D/L Title: Board Chair – Umpqua Health Alliance Date: 04/27/2012

Robert Dannenhoffer, M.D.
(Applicant Authorized Officer)

APPLICATION CHECKLISTS

1. Technical Application, Mandatory Submission Materials

☒ **a.** Application Cover Sheet

☒ b. Attestations, Assurances and Representations

☒ c. This Technical Application Checklist

☒ d. Letters of Support from Key Community Stakeholders

☒ e. Résumés for Key Leadership Personnel

☒ f. Organizational Chart

☒ g. Services Area Request

☒ h. Questionnaires

☒ (1) CCO Criteria Questionnaire (Appendix A)

☒ (2) Provider Participation and Operations Questionnaire (Appendix B)

☒ (3) Accountability Questionnaire (Appendix C)

☒ • Services Area Table

☒ • Publicly Funded Health Care and Service Programs Table

☒ (4) Medicare/Medicaid Alignment Demonstration Questionnaire (Appendix D)

2. Technical Application, Optional Submission Materials

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

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

LETTERS OF SUPPORT FROM KEY COMMUNITY STAKEHOLDERS

Adapt

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

P.O. Box 1121
Roseburg, OR 97470

(541) 672-02691
Fax (541) 673-5642

www.adaptoregon.org

April 26, 2012

Robert Dannenhoffer, M.D.
Chief Executive Officer
Douglas County Independent Practice Association
1813 W. Harvard #448
Roseburg, Oregon 97471

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

Dear Gentlemen:

Adapt is a Federally Qualified Health Center, with a 40 year history of providing behavioral health services and conducting NIH sponsored clinical research. Our services in Douglas County focus on delivering integrated behavioral health services. In addition to our Community Health Center and continuum of outpatient CD services, residents have since 1982 relied upon our adult and adolescent regional residential services.

We have been pleased to be included from the beginning in the development of the Coordinated Care Organization in Douglas County, in partnership with DCIPA and other community partners. We look forward to continuing our participation as an at-risk partner, as a major component of the health care delivery system, and as part of the CCO governance.

We have a particular interest in delivering behavioral health services as an embedded feature of *private practice* primary care. Our experience using this model over the past 7 years has demonstrated increased patient access, satisfaction, and noteworthy cost-savings. CCO implementation will create new opportunity to extend these outcomes.

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

Sincerely,

Bruce Piper
CEO

Advantage Dental Services, LLC
The Advantage Community

April 24, 2012

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

Re: Non-Binding Letter of Support for DCIPA, LLC dba Umpqua Health Alliance's Application

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

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

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

www.AdvantageDental.com
442 SW Umatilla Ave, Ste. 200 Redmond, OR 97756

Advantage Dental Services, LLC
The Advantage Community

Advantage is excited to be part of this challenging and important work. We look forward to working with DCIPA, LLC dba Umpqua Health Alliance in the formation of the CCOs and coordinating care for its community members.

Sincerely,

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

www.AdvantageDental.com
442 SW Umatilla Ave. Ste. 200 Redmond, OR 97756

ATRIO
HEALTH PLANS
Get Greater Value From Medicare

April 26, 2012

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

Re: Non-Binding Letter of Support of CCO Application for DCIPA, LLC dba Umpqua Health Alliance

Dear Ms. Hurst:

As President and CEO of ATRIO Health Plans, Inc., I am writing this letter to express support of Umpqua Health Alliance's application with the Oregon Health Authority to become a Coordinated Care Organization (CCO). ATRIO has extensive relationships with the organizations that have come together to form Umpqua Health Alliance. We believe strongly in the purpose of the CCO to bring about the comprehensive health care delivery system envisioned by Oregon's legislators.

We believe that Umpqua Health Alliance has brought together the experience and expertise necessary to operate as a highly successful CCO. The participants in the Alliance are already positioned to support the models of care proposed in the CCO guidelines to achieve the Triple Aim of better health, better care and lower costs for the population it serves

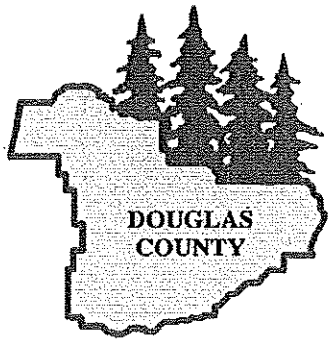
We share the State's goal of providing high-quality health care in a cost efficient manner, and believe that the CCO's efforts will have a profound impact on the quality and cost of health care in Douglas County. ATRIO fully supports the efforts of Umpqua Health Alliance as it seeks to become a Coordinated Care Organization.

Sincerely,

Ruth A. Rogers Bauman
CEO

cc: DCIPA, LLC dba Umpqua Health Alliance

2270 NW AVIATION DRIVE • SUITE 3 • ROSEBURG, OR 97470 • 541.672.8620 • FAX 541.672.8670 • TOLL FREE 877.672.8620



BOARD OF COMMISSIONERS

DOUG ROBERTSON JOSEPH LAURANCE SUSAN MORGAN

1036 S.E. Douglas Ave., Room 217 • Roseburg, Oregon 97470 • (541) 440-4201

April 27, 2012

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

RE: Non-Binding Letter of Support for DCIPA LLC CCO Application

Please accept this letter of support for the application that DCIPA is submitting to form a CCO for Douglas County with the exception of our coastal region.

Douglas County provides mental health services to Medicaid eligible residents through our Health and Social Services Department. We have benefitted greatly from our relationship with Greater Oregon Behavioral Health. We have also benefitted from collaborating for a number of years with our community partners to provide efficient and effective mental and physical health treatment and improve outcomes for our citizens.

We are looking forward to growing and enriching our collaborative relationships across mental, physical and oral health, and growing our CCO structure into one of collaborative ownership.

Sincerely,

Susan Morgan, Chair
Douglas County Commission

GOVERNMENT

OFFICES

2371

NE STEPHENS

STREET

SUITE 100

ROSEBURG

OREGON

97470

(541) 672-9405

FAX NUMBER

(541) 673-0432

April 26, 2012

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

Please accept The Cow Creek Band of Umpqua Tribe of Indians strong letter of support and commitment to DCIPA, LLC dba Umpqua Health Alliances (UHA) application to become the Coordinated Care Organization (CCO) here in Douglas County. We are excited to partner and assist them in succeeding in this process and hope to join them in assuring Douglas County residents are provided comprehensive, wrap-around healthcare which will result in positive health outcomes.

We believe DCIPA, LLC dba Umpqua Health Alliance will be a strong entity and will be able to manage the healthcare of its members in a way that will ensure quality yet affordable healthcare (part of the triple aim) and meet the transformation benchmarks Oregon has set forth. We believe the organization and previous work of the DCIPA partnerships has proven to be one of strong partnerships in regards to prevention and risk reduction program models. Together we will be able to provide evidence linking organizational structure and performance to health outcomes. This important work will allow us to build upon previous translational efforts and, in the future, to develop prescriptive organizational-level interventions to facilitate organizational capacity to successfully implement evidence-based health interventions in real world medical and public health settings.

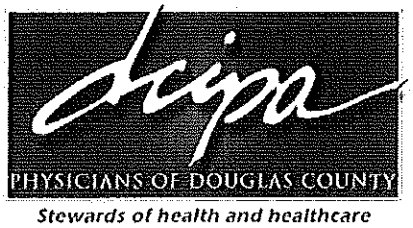
Working together, along with other community partners, promises to be an incredibly valuable opportunity for all of us. The Cow Creek Band of Umpqua Tribe of Indians and the Indian Health Service has been in the business of a "CCO" model of healthcare delivery for over 50 years and we look forward to the opportunity to assist them in achieving medical, dental and social service best practices via referrals and other opportunities to contract healthcare services.

This letter confirms the Cow Creek Band of Umpqua Tribe of Indians commitment to support and partner with DCIPA, LLC dba Umpqua Health Alliance and to assure they are a successful Coordinated Care Organization. No doubt lessons will be learned and progression of CCO's will continue to be developed and together we hope we can assure the health of all Americans benefit from the hard work completed here in Douglas County, Oregon.

Sincerely,

Dan Courtney, RN
Chairman, Cow Creek Band of Umpqua Tribe of Indians

Sharon Stanphill, DrPH, RD
Health Director, Cow Creek Band of Umpqua Tribe of Indians



April 24, 2012

RE: Letter of Support of DCIPA, LLC – dba Umpqua Health Alliance

It is with great pleasure that the Douglas County Individual Practice Association, Inc. (DCIPA) heartily supports DCIPA, LLC's – dba Umpqua Health Alliance (DCIPA LLC) – application to operate a coordinated care organization ("CCO") in Douglas County, Oregon.

DCIPA is a physician organization of over 100 community physicians in Douglas County, representing nearly all of our community doctors. In addition to serving our member physicians, DCIPA also serves as the Medicaid contractor for the Medicaid population in our county. As stewards of health and healthcare in our community, DCIPA has partnered with GOBHI/Douglas County Behavioral Health and Advantage Dental, along with Adapt, Umpqua Community Health Center, and ATRIO Health Plans to form the new CCO.

Douglas County is a poor and rural county in Southern Oregon. As our county is known as the timber capital of the nation, we have been especially negatively impacted by the downturn in new house construction and have suffered unemployment rates of more than 15%.

In its role as patient advocate and as a Medicaid contractor and as the collective voice of physicians in the community, we believe that the application from DCIPA, LLC – dba Umpqua Health Alliance – and its selection will be a very positive and important for our OHP members, fellow citizens, and for our medical community. I would be happy to talk with you further in support of this application.

Sincerely,

Laurence M. Sharp, DO, Chair
Douglas County Individual Practice Association, Inc.

/srp

1813 W. Harvard, Suite 206 Roseburg, Oregon 97471 www.dcipa.com
Serving the needs of physicians and their patients in Douglas County.

CATHOLIC HEALTH INITIATIVES®

Mercy Medical Center

April 27, 2012

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

Re: Letter of Support for DCIPA, LLC dba Umpqua Health Alliance

I would like to take this opportunity to offer Mercy Medical Center's support for the application submitted by DCIPA, LLC dba Umpqua Health Alliance to operate a coordinated care organization in Douglas County, Oregon.

Mercy Medical Center is a sophisticated 174-bed hospital located in Roseburg, Oregon and has upgraded our technology and expanded our services to ensure Douglas County residents access to state-of-the-art healthcare without having to leave the community. Mercy, in partnership with the medical community has created a regional healthcare delivery system that ranks in the top quartile nationally for quality. Mercy provides inpatient and outpatient medical care locally and coordinates specialized care with a relentless focus on clinical excellence.

Mercy is proud to be a part of DCIPA, LLC dba Umpqua Health Alliance and is looking forward to working together with our partners to provide coordinated high quality efficient care in our community.

Sincerely,

Kelly C. Morgan
President and CEO

A ministry of healing since 1909

2700 Stewart Parkway Roseburg, Oregon 97471 541.673.0611

UMPQUA COMMUNITY
HEALTH CENTER

Caring for the community on a personal level

April 26, 2012

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

Re: Non-Binding Letter of Support for DCIPA, LLC dba Umpqua Health Alliance's CCO Application

Dear Ms. Hurst,

As the CEO of Umpqua Community Health Center (UCHC), I am pleased to provide this "Letter of Support" for the CCO application to the Oregon Health Authority submitted by DCIPA, LLC dba Umpqua Health Alliance.

UCHC, a Federally Qualified Health Center provides primary medical, dental and mental health services from five clinic locations, including two School Based Health Centers, located throughout Douglas County. UCHC has been working toward serving as the Patient Centered Primary Care Medical Home for some time. In 2011 UCHC served over 8,000 unduplicated patients of which nearly 40% are Oregon Health Plan recipients. We are fully committed to achieving the triple aim of providing quality care, while improving efficiencies, by coordinating the care of our patients, resulting in cost containment.

DCIPA, LLC dba Umpqua Health Alliance has been working with local community leaders across the spectrum of the health care delivery system for multiple years. Most recently this group has been very successful in collaboratively focusing on developing a local CCO that will best serve the patients in Douglas County. The level of collaboration demonstrated by this group of diverse interests has been remarkable. DCIPA, LLC dba Umpqua Health Alliance has taken a leading role in successfully developing trust relationships between all the members and is in the position to best serve as the CCO for the Oregon Health Plan patients in Douglas County.

UCHC is looking forward to working with DCIPA, LLC dba Umpqua Health Alliance, along with all the community partners that are coming together to develop a CCO that will provide appropriate high quality health care, that is coordinated and best suited to individual patients, while resulting in better utilization of limited resources.

Sincerely,

Linda Mullins

Linda Mullins, CEO

Roseburg	Drain	Glide	Myrtle Creek
Administration • Dental • Medical	Medical	Medical	Medical
(541) 672-9596 Office	(541) 836-7155 Office	(541) 496-3504 Office	(541) 860-4070 Office
(541) 464-3519 Fax	(541) 836-7157 Fax	(541) 496-3489 Fax	(541) 860-5032 Fax
160 Kenneth Ford Drive	316 West A Avenue	20170 N. Umpqua Hwy.	790 South Main Street
Roseburg, OR 97470	Drain, OR 97435	Glide, OR 97443	Myrtle Creek, OR 97457

www.umpquachc.org

RESUMES FOR KEY LEADERSHIP PERSONNEL

255 Dawson Road
Roseburg, Oregon 97470
Phone : 541.672.3585
E-mail : annieandbob@earthlink.net

Robert Dannenhoffer, MD

Education

1980	BS, Rensselaer Polytechnic Institute Troy, New York
1980	MD, Albany Medical College Albany, New York
1980 – 83	Resident in Pediatrics, Massachusetts General Hospital Boston, Massachusetts
1983 – 84	Chief Resident in Pediatrics, Massachusetts General Hospital Boston, Massachusetts

Professional Experience

1983 – 84	Associate in Pediatrics, Massachusetts General Hospital Boston, Massachusetts
1984 – 1986	Pediatrician, Bethesda Naval Hospital Bethesda, Maryland
1986 – 1988	Pediatrician, Naval Hospital Okinawa, Japan
1988 – 1989	Pediatrician, Naval Hospital Bethesda, Maryland
1989 – Present	Pediatrician Roseburg, Oregon
1994 – 2001	Medical Director, Douglas County IPA Roseburg, Oregon
2001 – 2010	Vice President for Clinical Effectiveness, Mercy Medical Center Roseburg, Oregon
2010 – Present	CEO, DCIPA, the Physicians of Douglas County Roseburg, Oregon

Additional

Professional Activities

1993	Chief of Staff, Douglas Community Hospital
1994-2001	Medical Director, Douglas County IPA
2001 – Present	Board Member, Douglas County IPA
2002 – Present	Member, Douglas County Immunization Coalition
2002 – 2008	Director, Umpqua Community Health Center
2002 – Present	Director, Cobb Street Children's Learning Center
2001 – Present	Board Member, Oregon Immunization ALERT
2002 – 2003	Vice President, Oregon Medical Association
2003 – 2004	President Elect, Oregon Medical Association
2005 – 2006	President, Oregon Medical Association
2006 – Present	Immediate Past President, Oregon Medical Association
2006 – Present	Alternate Delegate, American Medical Association
2006 – Present	Chair, Patient Safety Committee, Oregon Medical Association

Professional Memberships

Medical Staff, Mercy Medical Center

Oregon Medical Association

American Medical Association

Fellow, American Academy of Pediatrics

Publications

Nephrotic syndrome associated with Kimura's disease. Whelan TV,Maher JF Kragel P, Dysart N, Dannenhoffer, R, Prager L. Am J Kidney Disease, 1988 Apr;11(4):353-6

Accreditations

Board Certified in Pediatrics

BRENT A. EICHMAN, MBA, CHFP

655 Cross Creek Dr • Roseburg, OR • (541) 680-0801 • brent_eichman@yahoo.com

PROFESSIONAL PROFILE

Results-oriented, innovative, and versatile professional offering a rich mixture of experience and success in healthcare leadership. Recognized for exceptional achievement and the ability to motivate others on all levels in the pursuit of individual and organizational goals. Effective communicator well versed in board and community level interactions. Currently seeking a dynamic and challenging career opportunity in the field of Health Care Finance and Administration.

AREAS OF EFFECTIVENESS / QUALIFICATIONS SUMMARY

• Strategic Planning	• Contract Negotiation	• Risk Analysis
• Financial Analysis/Forecasting	• Analytics Development	• C&O Budgeting
• Business Development	• Service Line Analysis	• Project Management

WORK HISTORY

DCIPA, Roseburg, OR, January 2006 to present

VP Finance, Chief Financial Officer – $115M Integrated Delivery Network (IDN) providing medical care throughout southern Oregon. DCIPA, together with its subsidiaries, operates a managed Medicaid health plan, a Medicare Advantage health plan, a medical group practice consisting of 39 employed providers, and other vertically integrated medical service companies.

- Grew top line revenues from $52M to $115M over 5 year period through a combination of vertical integration, acquisition, and core business growth
- Delivered 5 year stock return of 177%
- Lead all corporate finance activities including capital/operational budgeting, auditing, financial control systems, risk management, investments, and financial statement reporting
- Effectively interacted with Board of Directors in reporting financial and operational performance at the enterprise and business unit level
- Successfully managed business units including administrative staff, health plan operations, medical clinics, patient financial services, and information technology representing 168 employees
- Led strategic planning, opportunity analysis teams, and business development on an enterprise and business unit level
- Successfully interacted with shareholders, the board of directors, stakeholders, and community physicians in a wide variety of medical community activities related to health care delivery change and physician alignment
- Provided financial oversight to health plan operations consisting of 14,000 Medicaid and 5,000 Medicare covered beneficiaries
- Managed all external vendor relationships including claims processing, medical management/care coordination systems, compliance, audit, contracting, and other specialized vendors
- Developed talent within the organization to ensure a positive work environment and recruited, mentored, and coached the skills necessary to execute corporate strategies and initiatives

Notable Organizational Achievements:

- Led the acquisition of a 25 member multi-specialty medical group
- Led the creation of a Rural Health Clinic(RHC) to meet the concurrent organizational goals of maximizing system revenue while creating access for the increasing medical service needs of Medicaid and Medicare clients
- Created a professional medical billing company serving employed, community-based, and hospital-employed physicians which increased practice revenues by 10%
- Interfaced with community healthcare leaders and State legislators in the improvement of local healthcare delivery systems as it pertains to State and National policy development
- Managed the implementation of an interoperable community-wide single chart electronic records system (EMR) in collaboration with local healthcare providers including physicians, hospital service lines, labs, imaging centers, and community health centers
- Well versed in strategic health care policy considerations including Medical Homes, ACO's, HIT standards development, and National health care reform implications
- Developed corporate-wide financial and clinical analytics systems to enable operational efficiencies and create distributed reporting capability

Allina Hospitals & Clinics, Minneapolis, MN, November 2004 to January 2006
Finance Director, Payer Relations & Contracting, Healthcare system comprised of hospitals, clinics, and other specialized services, providing care throughout Minnesota and western Wisconsin.

- Assisted in the oversight of system wide reimbursement for all contracted patient services representing 11 hospitals, 43 primary care clinics, 26 hospital based specialty clinics, 500 employed physicians, and a variety of specialty operations
- Directed all finance related activities pertaining to contract negotiation, contract administration, issues resolution, and special settlements representing over $1.5 Billion in annual revenue
- Oversaw vendor relationships and systems related to contract modeling, reimbursement, and revenue cycle management
- Supervised staff of six hospital and physician analysts who support facility and system office finance functions by providing financial and data analysis
- Led and participated in system wide stakeholder initiatives to improve the quality of patient care while improving the financial performance of the organization
- Initiated and led the development of complex revenue modeling systems which allow impact analysis on payer specific rate changes and external industry factors
- Hired and trained staff in the areas of financial analysis, decision support functions, data management, and financial reporting

Southwest Washington Medical Center, Vancouver, WA, November 2002 to November 2004
Senior Decision Support Analyst, 442-bed hospital and medical center offering a full range of outpatient and inpatient diagnostic, medical, and surgical services.

- Developed customized financial modeling application for Capital and Operational Budgeting and implemented on a hospital wide-basis
- Supported the organizational administration of Capitated (risk) contract relationships with Managed Medicare/Medicaid payors
- Developed and implemented automated claims auditing process that identified over $300,000 in recoverable reimbursement in the first year

- Participated in cross-functional teams from Decision Support, Budgeting, Business Development, and Strategic Planning in the generation of Service Line level Business Plans
- Extracted, codified, analyzed, and interpreted patient and population level health care information from disparate systems in the support of financial, clinical, and quality improvement initiatives
- Interacted regularly with the executive team in support of overarching organizational goals and strategic initiatives

WellMed / WebMD, Portland, OR, October 1999 to November 2001
Senior Manager, Business Development, WellMed, Inc., Health and Disease Management Company serving Health Care Organizations, Fortune 500 Corporations, and Pharmaceutical Companies by delivering personal health information to end-users through web-based technology

- Provided strategic guidance and business development services to web-based health and disease management company specializing in leveraging technology to deliver personalized health information and content
- Engineered strategic business relationships with health insurance companies and hospitals generating over $5 Million in revenue
- Secured distributor relationship with HCA (formerly Columbia HCA) in providing customized web based health management tools to 1800 hospitals nationwide
- Managed strategic relationship with Aetna-US Healthcare/Intelihealth-Developed health content delivery and disease management programs for 19 Million Aetna health plan members
- Negotiated complex contracts involving all internal groups (Sales, Customization, Development, Implementation, Operations, Legal) to deliver on new business opportunities
- Led cross-functional teams to guide the technical delivery of customized web-based applications

SOFT SKILLS / PERSONAL CHARACTERISTICS

- Unwavering ethics, character, and integrity
- A team player with a "can do" attitude
- Ability to deal with people and problems effectively and respond professionally in all situations
- Ability to perform effectively under the high stress of continual demands and competing priorities and deadlines
- Proficient in prioritizing and managing concurrent tasks subject to frequent change
- Ability to gather, analyze, evaluate and present data in an effective and understandable format
- Proficient in exercising sound judgment, seeking advice where appropriate
- Skilled in taking initiative, organizing work, and leading teams

EDUCATION

BBA Finance, University of Iowa, graduated with honors
MBA, HCA, REGIS University, graduated with honors
CHFP, Healthcare Financial Management Association

GOVERNANCE / DIRECTORSHIPS / ADVISORY BOARDS / APPOINTMENTS

Umpqua Community College Foundation – Board Member

SOASTC – Southern Oregon Adolescent Treatment Center- Board Member Emeritus

Oregon State HIO Executive Panel – Advisory Board Member

Gubernatorial Appointment – Global Budget Transformation Workgroup

TECHNICAL EXPERTISE

Decision Support/CRM/SFA: Cognos Impromptu, Crystal Reports, MicroJ, Maximizer, Actl, SQL Reporting Services, Pathways Decision Support, Inteligenz

Healthcare Systems: Mckesson (Trendstar, Star, HBI), NextGen, Outcomes Advisor, Cerner Lab, Cascade, MediPac, Epic, GE Centricity, HCC, GuidingCare Pathways

Revenue Cycle Management: IMaCS, RCMS

Budgeting/Productivity/Payroll Systems/GL: Lawson, ReportSmith (query), SRC, QuickBooks, ADP (payroll), Mas90

LAURENCE M. SHARP, DO

Experience

2004 – Present Douglas County IPA Roseburg, OR
South Ridge, SC
Chairman of the Board of Directors
- Supervise and coordinate activities of the Board, represent DCIPA at various functions in and out of Douglas County while becoming a spokesperson for the medical community.

2005 - Present Sharp Family Medicine Roseburg, OR
Private Practice: Family Physician
- Provide full service family medical care, excluding obstetrics.
- Provide full inpatient care, including ICU, CCU and neonatal care..

1987 – 2005 Sutherlin Family Medicine Sutherlin, OR
South Ridge, SC
Private Practice: Family Physician
- Provided full service family medical care, excluding obstetrics.
- Provided full inpatient care, including ICU, CCU and neonatal care.
- Served as preceptor for PA students.

1999 – 2001 Mercy Medical Center Roseburg, OR
Vice-Chief of Medical Staff
- Represented medical staff, advanced ideas and provided effective interface between staff and administration.
- Ensured medical staff cooperation in achieving hospital's mission and duty: to provide quality and dignity in delivering patient care.

1997-1998 Douglas County IPA Roseburg, OR
Medical Director
- Educated physicians, instituted care plans, defined "best practices", developed incentive payment methodology and profiled physicians.
- Interfaced with health insurance companies and negotiated contracts..

1996 - 1997 Douglas County IPA Roseburg, OR
South Ridge, SC
Chairman of the Board of Directors
- Supervised and coordinated activities of the Board, represent DCIPA at various functions in and out of Douglas County, served on Boards of SureCare Health Plans and CompCare – Chairman of CompCare.
- Assisted with obtaining licensure for CompCare.

- Participated in presentations to other IPA's and organizations, helping to expand managed care model of Oregon Health Plan throughout State.
- Instrumental in separating DCIPA and SureCare and hiring new CEO

1995 - 1999 Mercy Medical Center Roseburg, OR
Chair, Utilization Management
- Monitored and educated physicians in their utilization and advised regarding specific cases.
- Developed (or caused to be developed) various care tracks and protocols, while being responsible for implementation.
- Supervised "swing bed" program while monitoring its utilization.
- Reduced Mercy Medical Center's average length of stay to below statewide averages.

1994 -1996 Columbia Douglas Medical Center Roseburg, OR
Medical Executive Committee

1992 -1993 Columbia Douglas Medical Center Roseburg, OR

Physicians Quality Improvement Committee

1992 CDMC & Mercy Medical Center Roseburg, OR
Chair, Division of Family Practice

1984 -1987 United States Army Indianapolis, IN
Flight Surgeon and Family Physician

1977 - 1978 Utah State University Logan, UT
Mathematics Instructor

1976 -1977 International Business Machines Rochester, MN
Design Programmer

Education

1981 -1984 DeWitt Army Hospital Fort Belvior, VA
Family Practice Residency
Diplomat, American Board of Family Practice: 1984, 1991, 1998, 2005
Fellow, American Academy of Family Practice: 1984

1978 -1981 Oklahoma State University, COM Tulsa, OK
Doctor of Osteopathic Medicine

1975 -1976 Utah State University Logan, UT
Masters of Mathematics, cum laude

1971 -1975 Utah State University Logan, UT
Bachelors of Science: Mathematics & Physics, cum laude

Interests

Physician influence over health care delivery, church service, the arts, bicycling and hiking, photography and grandchildren

SHARP FAMILY MEDICINE, 1813 W. Harvard Ave, Suite 426, Roseburg, OR 97471
PHONE 541.459.1611/fax 541.459.5741

ORGANIZATIONAL CHART

CCO Criteria Questionnaire – A.I.r.

CCO Criteria Questionnaire

Part I: Background Information about the Applicant

A.I.a. DCIPA, LLC – dba Umpqua Health Alliance (UHA), hereinafter referred to as **Applicant**, an Oregon corporation (Registry No. 312689-98, is domiciled at 1813 W. Harvard – Suite 206, Roseburg, Oregon 97471. This is its primary office and administration address.

A.I.b. Applicant is an integrated delivery network and includes a panel of physicians, ATRIO Health Plans, and Mercy Medical Center – an acute care hospital, an electronic health record and information system, a technology support service, a physician billing service, medical and case management services, and claims management working in collaboration with Adapt, Advantage Dental, Douglas County Mental Health, Greater Oregon Behavioral Health, Inc., and Umpqua Community Health Center.

A.I.c. Applicant's intended effective date for serving Medicaid populations is August 1, 2012.

A.I.d. Applicant is not invoking alternative dispute resolution with respect to any provider.

A.I.e. Applicant does not request changes or desire to negotiate any terms and conditions in the Core Contract, other than those mandated by Medicaid or Medicare.

A.I.f. Applicant desires to provide care to all people in Douglas County, including zip codes 97410, 97417, 97428, 97429, 97432, 97435, 97436, 97442, 97443, 97447, 97455, 97457, 97462, 97469, 97470, 97471, 97473, 97479, 97481, 97484, 97485, 97486, 97494, 97495, 97496, 97499, and 97731, and excluding those zip codes in the coastal Douglas County area, as members in that geographic area have traditionally been part of the medical community in Coos Bay, which excludes 97441, 97442, 97457, 97467, and 97473.

A.I.g. The address of Applicant's primary office and administration is 1813 W. Harvard – Suite 206, Roseburg, OR 97471.

A.I.h. Applicant's service area includes Douglas County. It is anticipated that a member of the Douglas County Board of Commissioners will serve on the CCO board and will work to establish written agreements required.

A.I.i. Applicant is contracted with Division of Medical Assistance Programs (DMAP) to provide healthcare to Medicaid insured in Douglas County, as a Fully Capitated Health Plan (contract number: 132339 between the State of Oregon, Oregon Health Authority and DCIPA, LLC).

A.I.j. Applicant is the identical organization with a current MCO contract (Registry No. 312689-98).

A.I.k. Applicant includes itself, Umpqua Community Health Clinic a Federally Qualified Health Center (FCHP), and by contract, Mercy Medical Center – an acute care hospital, GOBHI – a Mental Health Organization (MHO), and Advantage Dental – Dental Care Organization (DCO).

A.I.l. The current MCO, DCIPA LLC, makes this Application for the identical Service Area that is the subject of the current MCO's contract with OHA. We do not propose any change in the current Service Areas.

A.I.m. Applicant has experience as an MCO, but no other experience as an OHA contractor.

A.I.n. Applicant's parent corporation, DCIPA Inc., is an owner in ATRIO Health Plans, Inc., a Medicare Advantage contractor with a current Medicare Advantage contract servicing Douglas, Klamath, Marion and Polk counties in Oregon.

A.I.o. Applicant does not hold a current certificate of insurance from the State of Oregon Department of Consumer and Business Services, Insurance Division.

A.I.p. **(1)** DCIPA, LLC and its community partners have had long experience with providing dental, mental health and physical health service to Oregon Health Plan members. DCIPA has been at the forefront in its use of alternative payment methodologies including:

- Very early adoption (since the mid-1990s) of primary care case management fees. We believe that these case management fees are a forerunner to a robust PCPCH system.
- Use of hospital capitation as a primary method of hospital payment. We believe that hospital capitation may be a step towards development of global budgets.
- Dental capitation payments focus on preventive care.
- Use of salaried specialists to deliver high intensity services to high risk members. We have hired a gerontologist to consult on most of our members in LTC, hopefully increasing the level of expertise and availability of care.
- Paying for detailed risk assessments of our most vulnerable dual eligible members.
- Investing in community activities that improve the health of the community including the "I can prevent Diabetes program," "Shots for Tots" and "LiveWell Douglas County." Previously, such expenses were not considered as medical expenses in our actuarial accounting and we are thrilled to have the opportunity to expand these services.

(2) In our small community, the leaders of mental, dental and physical health have a long history of working together to solve problems, as evidenced by the composition of our board of directors. Examples of specific programs include:

- Placement of a social worker in our medical clinics to deal with behavioral and chemical dependency issues as they arise. This program was highlighted during the governor's visit to the clinic.
- A collaborative program between the county and DCIPA, LLC to provide comprehensive prenatal care, with attention to issues of poverty and substance abuse. This program has had fabulous experience in decreasing the rate of low birth weight in those using the clinic.
- A program with our partners at ATRIO and DCIPA to improve transitions of care and management of our fragile high needs members.
- Collaborative programs between medical and dental providers, to improve referral patterns and to decrease the need for total mouth restorations in our pediatric population.

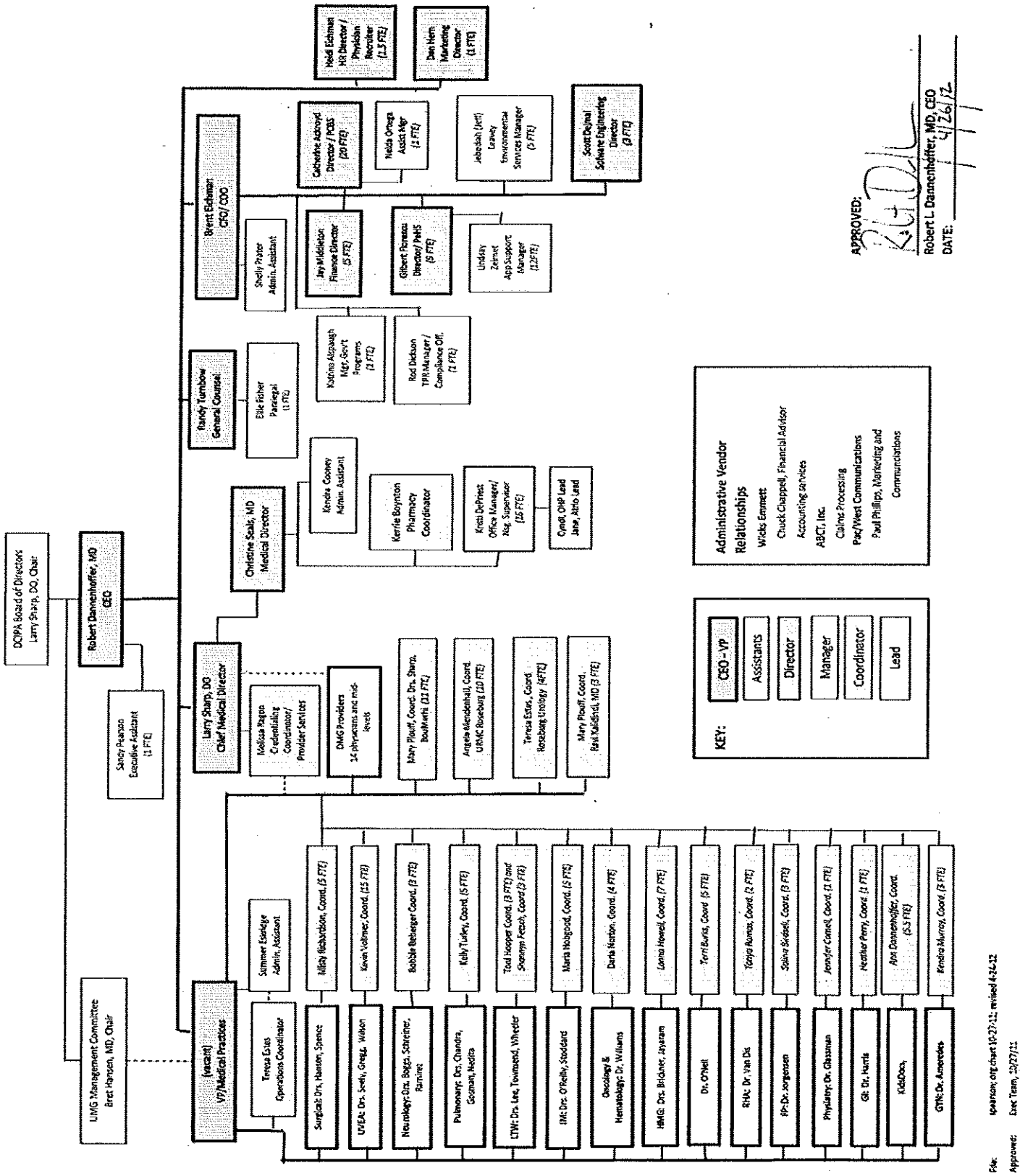
(3) Our community and providers are already highly engaged in the move towards coordinated care. We have communicated the move towards coordinated care through

newspaper, radio and TV stories and, in conjunction with the OHA, a very well attended community meeting. In addition, a large group of providers have met to discuss the move to coordinated care. The issues of health status are in the public mind, with the recent release of the county health rankings that showed disappointing results for Douglas County. These disappointing results were discussed with the community in a radio program involving members of Umpqua Health Alliance and in newspaper articles that quoted UHA board members. We have outlined a robust community advisory panel to identify barriers to care and health disparities. In addition, DCIPA has worked with Director of Healthcare Disparities at the American Medical Association for advice and technical assistance on identifying and reducing disparities.

A.I.q. DCIPA, LLC's key leadership personnel are listed below. Their respective resumes are included in application beginning on Page 22.

- CEO: Robert L. Dannenhoffer, MD
- CFO/COO/CIO: Brent A. Eichman
- CMO: Laurence M. Sharp, DO

A.I.r. DCIPA, LLC's organizational chart is as follows:



A.I.s. Applicant is not deferring submission of any supporting documents, tables, or data that are part of its Technical Application.

Part II: Community Engagement in Development of Application

Section 1 - Governance and Organizational Relationships

A.1.1. Governance

A.1.1.a. Applicant will have a governing board that will be composed of community members and the major health providers in Douglas County. The governance structure includes:

- **Adapt**, an alcohol and drug treatment provider and provider of primary care services;
- **Advantage Dental**, a dental care provider and one of the current dental care providers for our service area;
- **ATRIO** Health Plans, a Medicare advantage provider, currently serving most of the dual eligible patients in our service area;
- **Douglas County Mental Health**, the county provider of mental health services;
- **DCIPA, LLC** an independent practice association consisting of over 100 physicians, a subsidiary of which (DCIPA, LLC) has had a long history of contracting as an Fully Capitated Health Plan (FCHP);
- **Greater Oregon Behavioral Health, Inc., (GOBHI)**, a mental health managed care organization that currently serves as the mental health contractor for Douglas County;
- **Mercy Medical Center**, our community hospital;
- **Umpqua Community Health Center**, our local Federally Qualified Health Center (FGHC);
- A member of the Douglas County Board of Commissioners representing the community at large; and
- The Chair of the Community Advisory Council (CAC).

We anticipate this group will contain a licensed physician, a licensed dentist, a mental health provider, and an alcohol and drug treatment provider.

A.1.1.b. We anticipate a robust CAC representing the needs of special populations and representing the various geographical regions in our service as detailed in our draft procedure for this council – ATTACHMENT A.1.1.b.

A.1.1.c. We anticipate that the chair of the CAC will serve on the board of directors for UHA and that several UHA board members will attend the CAC meetings to gather community input and ensure transparency and accountability.

A.1.1.d. As the administrator of the Douglas County Mental Health Department, a county commissioner and GOBHI are on the UHA board of Directors, we anticipate that those with mental illness will be well represented by the Governing Board. As the county liaison with the Area Agency on Aging (AAA) and the CEO of the Medicare Advantage plan are on the board, we anticipate that the needs of those in long term care will be represented. Although members of the CAC are not yet chosen, our procedure calls for selection of members with expertise in each of those areas.

A.1.2. Clinical Advisory Panel

A.1.2.a. DCIPA, LLC has a Quality Improvement Utilization management Committee made up of participating (Network) providers. The committee has functioned for over 14 years, providing oversight of clinical guidelines, policies and procedures and best practices. This committee would become the Clinical Advisory Panel (CAP) with the addition of providers from mental and dental health.

A.1.2.b. Not applicable

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

A.1.3.a. Currently the agencies that constitute our Coordinated Care Organization (CCO) either include or have pre-existing relationships and/or partnerships with both the local Type B Area Agency on Aging (AAA) (Douglas County Senior Services) and Aging and People with Disabilities (APD). Preliminary discussions regarding a Memorandum of Understanding (MOU) have begun and are ongoing between agencies. All parties have agreed to discuss key elements of the agreement. Key elements include, but are not limited to, strategies for coordinating long term care (LTC) services in residential care facilities, nursing homes, in home support services, other living settings available to individuals, and with other appropriate non-traditional health care workers. The goal will be to assure coordination between the two systems (CCO and LTC), to align incentives to produce the best health and functional outcomes for individuals and to prevent escalation of cost for both systems.

A.1.3.b. The MOU will address the prioritization of high needs members, the development of individual care plans, transitional care practices, member engagement and preference and establishing member care teams. Specific goals that will be addressed in the development of the MOU will include:

1. Creating a better experience for the individual
2. preventing/avoiding cost shifting
3. Providing better care and services
4. Creating better health outcomes
5. Lowering costs
6. Pursuing innovative and transformational approaches to care

The development of the MOU will build the foundation of existing relationships and partnerships and will focus on formalizing processes. It is our intent that the MOU will assure the ability to assess whether or not the MOU is meeting its established goals, the ability to revise or amend, as needed, and agreed upon methods for resolving disputes and solve problems are included.

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

A.1.4.a. The Local Mental Health Authority and Community Mental Health Programs, represented by Commissioner Susan Morgan and Peggy Madison, respectively, have participated in the development of the local CCO. The Mental Health Authority intends to continue to ensure members have access to the draft CCO contractual obligations for mandated Mental Health services for all eligible members of the community.

A.1.4.b. The Community Mental Health program intends to work with long-term psychiatric care programs in a collaborative process to ensure appropriate mutually agreeable discharges within five working days of receiving notification of discharge readiness. The care coordination model developed by GOBHI will ensure that all services are integrated from the first point of contact.

A.1.4.c. The local Community Mental Health program already works closely with Community Emergency Services Agencies to promote appropriate response to members experiencing a mental health crisis and intends to maintain and improve those relationships to meet the needs of people in mental health crisis. GOBHI will provide the analysis of utilization data in order to provide the platform for creating hot spot teams. These teams wrap services around those members who have both a mental health/substance abuse disorder and one or more physical health disorder.

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

A.1.5.a. Applicant partners are fortunate to have well established working relationships with the listed agencies (see chart following this section) to meet the increasing needs of our community. Coordination of care occurs on a regular basis with all of the listed providers for addictions, mental health and public health providers. The physical and dental health care organizations also have working relationships with many of the listed organizations. Applicant, together with partner organizations, will utilize these connections to increase coordination with the physical health, dental health, and mental health and addiction providers.

As the model of care coordination develops, the existing relationships will be expanded to include more of the partner organizations with the social and support services organizations to meet the care coordination needs of our members thereby supporting the goals of Triple Aim.

Community Engagement for Coordination of Care	
Meetings / Partnership	**Organizations / Purpose**
Coordination of Oral Health -- the education, screening and fluoride varnish for WIC children and those enrolled in home visit programs	Douglas County Public Health (WIC, Baby Smiles), Advantage Dental in Advantage is also coordinating care with Mental Health
Baby Smiles -- research, education, information and referral for identified eligible women for project design	Douglas County Public Health, Klamath County and University Washington
Community Resource Meeting – Resource information sharing meeting.	Department of Human Services (DHS), UCAN, BPA, Mental Health, Public Health, and many more.
Chronic Disease and Self-Management	YMCA, MMC, ATRIO, UCHC, UCAN, Prescription Asst. Program, Family Care Givers Support, Cow Creek Tribe, Community Granges, UCC, and Douglas County Public Health
Prenatal Program -- Partnership and coordination of prenatal care for women in Douglas County	Douglas County Public Health, DCIPA, Douglas County Mental Health, ADAPT, and Mercy Medical Center.
Douglas County Early Childhood Planning Coalition (DCECPC) – Advisory to Commission on Children and Families on Early Childhood	Douglas County Public and Mental Health, Commission on Children and Families, Douglas ESD, Mercy Medical Center, Umpqua Community College, UCAN Headstart, Phoenix School, Family Development Center, Department of Human Services, Advantage Dental.
Birth to Eight Support Systems Team (Birth to 5)	Douglas Educational Services District, DHS Child Welfare, Douglas CARES, Options Counseling, Commission on Children and Families, Family Development Center, Head Start
Douglas County Early Learning Council: Local sub-group of DCECPC that has developed a matrix identifying staffing and tools that are utilized in early childhood screenings and assessments. Continues work in progress in the development of local early childhood plan	Douglas County CCF, PHD, ESD/EI, FDC, UCAN – Head Start, and UCC.
Douglas County Child Multi-disciplinary Team	DHS- Child Welfare, Local Law Enforcement – Roseburg Police Department, Oregon State Police, Douglas County Sheriff's Office, Winston Police Department, Sutherlin Police Department, Douglas CARES, Douglas County Public Health and Mental Health, Douglas County District Attorney's Office, Douglas County Juvenile Department
Douglas County Adult Multi-disciplinary Team	Local Law Enforcement , Douglas County Mental Health and Developmental Disabilities, Douglas County District Attorney's Office, Adult and Public with Disabilities programs, Court watchers

Community Engagement for Coordination of Care	
Meetings / Partnership	**Organizations / Purpose**
Douglas County Child Fatality Review Team	DHS- Child Welfare, Local Law Enforcement – Roseburg Police Department, Oregon State Police, Douglas County Sheriff's Office, Winston Police Department, Sutherlin Police Department, Douglas CARES, Douglas County Public Health and Mental Health, Douglas County District Attorney's Office, Douglas County Juvenile Department, ODOT, Douglas County Medical Examiner's Office.
Live Well Douglas County and Health Communities Plan —chronic disease	Douglas County Public Health, Douglas County IPA, Healthy Start, Mercy Medical Center, Cow Creek Tribe, Umpqua Community Health Center, UCAN, AHEC, School Districts, Ford Family Foundation, Douglas ESD, DHS- Self Sufficiency, Child Welfare, Senior Services, Battered Persons Advocacy, Options Counseling, Local CCF, United Way, Umpqua Community College, Douglas County Mental Health, Douglas County Clerk's Office, News Review, Umpqua Partners, Advantage Dental.
Living Well with Chronic Conditions Workshops	UCAN, Umpqua Community Health Center, Rogue Council of Governments, Live Well Douglas County, Community Volunteers
Early Intervention Council -- Members provide input to help set goals to improve the services provided by Early Intervention and Early Childhood Special Ed. Programs.	Douglas ESD, Early Intervention, UCAN Headstart, Umpqua Community Health Center, Douglas County Public Health, and Parent Volunteers.
Tobacco Free Housing -- education, assessment, planning and implementation	Public Health and Mental Health and numerous community partners, Housing Authority, Neighbor Works, UCAN Housing and other affordable housing partners, landlords
Residential Treatment & alternative housing	Public Health Home Visiting programs, Mental Health, Crossroads/ Safe Haven/Casa de Belen
Mercy Foundation Children's Healthcare Fund – This committee reviews and recommends funds to help ease the financial burden on families of expenses like special equipment, medications and transportation.	Douglas County Public Health, Mercy Foundation, Mercy Medical Center, Douglas ESD, and Community Volunteers.
Special Needs Children -- Coordination of services for children with special health care needs.	Douglas County Public Health, CaCoon Program and Nurse Delegation, School Districts in Douglas County, and Douglas ESD.
Family Decision Meetings	DHS-Child Welfare, Self-sufficiency, Court systems, children and families attorneys, and PHD nurses who have families that are involved in the juvenile or drug court system
Corrections – Jail, Parole and Probation Prenatal care and home visits	Public Health Coordinates with Corrections, Jail, Parole & Probation
Management of Special Health Care Needs children	Douglas County Public Health , OHSU/CDR

Community Engagement for Coordination of Care	
Meetings / Partnership	**Organizations / Purpose**
Douglas County Child Abuse Prevention Coalition-- Assessment, training, and planning for community response to prevent abuse in Douglas County	Mercy Foundation, Douglas County Sheriff's Office, Roseburg Police Department, Battered Person's Advocacy, SART, Douglas County Juvenile Program, CASA, Veterans Affairs, UCAN Head Start, Family Development Center, Healthy Start, Douglas County Commission on Children and Families, Douglas County Early Childhood Planning Coalition, Douglas County Health and Social Services (Public Health & Mental Health), Department of Human Services Child Welfare Program, Douglas County Homeless Youth Coalition, ADAPT, True North Start Ministries, Phoenix School, Douglas County Foster Parent Association, Douglas CARES, Umpqua Community Health Center, Options Counseling, Douglas ESD, Umpqua Valley Boys and Girls Club, Cow Creek Tribe., Advantage Dental, DCIPA, District Attorney's office, Foster Parent's Association, CAPP
Interdisciplinary Care Team (IDCT)— coordination of care	DCIPA, ATRIO, DHS, DSO, Mental Health, PCP's, and care providers
Coordination of Oral Health Care	Advantage Dental, Child Welfare and Department of Human Services
Coordination of Oral Health Care	Advantage Dental, UCAN (Umpqua Community Action Network), UCAN Head Start, UCAN Homeless Coalition
Coordination of Oral Health Care	Advantage Dental, Umpqua Community Health Clinic, Mercy Foundation, School-Based Health Clinics, Schools
Coordination of Oral Health Care	Advantage Dental & Shots for Tots
Children's Oral Health Initiative	Umpqua Community Health Center, Mercy Foundation, UCAN Head Start, Family Development Center, UCAN Summer Lunch Program, Housing Authority of Douglas County, Ford Family Foundation, Cow Creek Foundation, United Way, School Districts county wide , UCAN AmeriCorps, Boys and Girls Club of Douglas County, Oregon Community Foundation, UCC Dental Hygiene Program, Parent Volunteers
Douglas County Cancer Services	Community Cancer Center, Umpqua Community Health Center, Camp Millennium, Community Volunteers
School-Based Health Centers	Douglas County Public Health, Umpqua Community Health Center, Roseburg High School, Winston-Dillard School District
340B Prescription Drug Program	Umpqua Community Health Center, Hometown Drugs
UCC Dental Hygiene Program	Umpqua Community Health Center, Umpqua Community College, Lane Community College, Advantage Dental
Prescription Drug Voucher Program	FISH, Umpqua Community Health Center, Hometown Drugs; referrals from multiple agencies

Community Engagement for Coordination of Care	
Meetings / Partnership	**Organizations / Purpose**
Day of Sharing-Services for Homeless	Douglas County Housing & Homeless Coalition, UCAN, VA, Umpqua Community Health Center, Housing Authority of Douglas County, St. Joseph's Catholic Church, community volunteers
Umpqua Valley Disaster Readiness Health Care Coalition	Red Cross, Community Cancer Center, Douglas County IPA, Dept of Human Services, EMS, VA, Health Department Preparedness Coordinator, Public Health, Mercy Medical Center, AHEC, Evergreen Family Medicine , City of Roseburg, EOC
HICS for Healthcare Managers	VA, Douglas County IPA, ABCT, Umpqua Medical Group, Dept of Human Services, Mercy Medical Center
Hazard Vulnerability Analysis	Roseburg City Police, Douglas County Sheriff's Office, Mercy Medical Center, Douglas County Health & Social Services & numerous responders in the community
EMS & MMC Forum	RFD#2, Winston-Dillard Fire District, Glendale Ambulance Services, North County Ambulance Service, Mercy Medical Center, Emergency Room Physician
Emergency Medical Services Advisory Committee	Douglas County Health Department, Paramedic, Fire Department, Community Members, Emergency Room Physician, Law Enforcement Officer, Hospital Administrator, Emergency Room RN
Douglas County Senior Resource Coalition	Mercy Foundation, RSVP, ATRIO, Mercy Home Health, Amedisys, Senior Services (APD), Senior Companion, Douglas County Health Department Senior Services, UCAN, Foster Home Association, and many more
HSAC	DHS, Mercy Foundation, UCAN Headstart, Umpqua Valley Dental Society, DCIPA, Commission on Children and Families
Umpqua Partners – For a drug-free future	Mercy Foundation, Boys and Girls Club, DCIPA, Cow Creek Tribe, ATRIO, Adapt, Douglas ESD, Roseburg School District, Douglas County Public Health, Douglas County Sheriff's Office, Roseburg Police Department, Myrtle Creek Police Department, and many more
Funders Forum	Mercy Foundation, Ford Family Foundation, Oregon Community Foundation, United Way, Whipple Fund, Douglas Community Fund, Crane Creek Foundation, Commission on Children and Families, and many more
Non-Profit Coalition	Mercy Foundation, UCAN, United Way, Boys and Girls Club, CASA, Douglas Cares, Community Cancer Center, Wild Life Safari, UCC Foundation, and many more
Build our Kids	Commission on Children and Families, Mercy Foundation, Phoenix School, All School Districts, Boys and Girls Club, YMCA, United Way, and many more
Douglas County Leave A Legacy	Mercy Foundation, United Way, UCAN, Boys and Girls Club, Family Development Center, YMCA

Community Engagement for Coordination of Care	
Meetings / Partnership	**Organizations / Purpose**
Community Restraint	Mercy Medical Center, Douglas County Mental Health, Douglas County Sheriff's Office, Roseburg Police Department
Patient Family Advisory Council	Mercy Medical Center, Community Members
Commission on Children and Families Reception	Douglas ESD, Douglas County Schools, Douglas County Juvenile Department, DHS Child Welfare, Douglas County Homeless Youth Coalition, Options Counseling, Family Development Center, Douglas County Early Childhood Planning Coalition, CASA, UCAN
Juvenile Staffing/Residential Determination Committee	Adapt, Mental Health, CASA, School Districts, Juvenile Department, DHS Child Welfare, ESD
CWP/Mental Health Collaboration Meeting	Mental Health, DHS Child Welfare
ESD/Mental Health Collaboration Meetings	Mental Health, Douglas ESD
Douglas County Juvenile Department/Mental Health Collaboration Meetings	Adapt, Douglas County Juvenile Department, Mental Health
MH Community Resource Team Meetings	Pastors, School personnel, Child Welfare, Foster Home Parents, Juvenile Department, CASA, Private Counselors.
Community Care Coordination Committee	Douglas County Schools, Douglas County Juvenile Department, DHS Child Welfare, Commission on Children and Families, UCAN, Douglas ESD, CASA, Family Development Center.
Integration Planning and Implementation Meetings	Umpqua Community Health Clinic Primary Care Providers, GOBHI, Douglas County Mental Health
Health Care Innovation Grant Planning	Adapt, Umpqua Community Health Clinic, Advantage Dental, GOBHI, Mental Health, Public Health.
University of Mass Certificate Program in Primary Care Behavioral Health Workshops	Umpqua Community Health Clinic, Primary Care Providers, DCIPA Administrators, Nurse Case managers. Mental Health
Integration/ Co-Staffing	Umpqua Community Health Clinic Primary Care providers and Mental Health LMP
Medical Management Staff Meeting and Pain Management Committee	Douglas County IPA, Community Primary Care Providers, Mental Health
Integration Dunes Family/Mental Health	Dunes Family Health Care Primary Care providers, Douglas County Mental Health LMP,
PHASE project	Juvenile Department, Probation and Parole Officers, Douglas County Mental Health., Oregon Youth Authority
Family Resource Center (Reedsport)	Community Based social service agencies, Mental Health
South Coast Hospice Coordination	South Coast Hospice, Mental Health, Primary Care Providers, Senior and People with Disabilities.

Community Engagement for Coordination of Care	
Meetings / Partnership	**Organizations / Purpose**
Community Resource Team Meetings	Mental Health, Specific School representative, Treatment Foster Care Providers, Juvenile Department, DHS Child Welfare, Residential Treatment Facility, Hospital Staff, AMH Staff, GOBHI, MHO providers
Deer Creek Substance Abuse Treatment	ADAPT, Mental Health, Primary Care Providers, School Staff, Hospital Staff
Health Fair Committee	Umpqua Community College Nursing Program, Umpqua Community Health Dental Van, Dream Center, Oregon State University Extension Office, Mental Health
Adult Foster Home Coordination	Mental Health, Foster Home Providers, AMH, Community Partners
370 (Aids and Assist) Program	AMH, Oregon State Hospital, Mental Health, Jail Medical Team, Local Law Enforcement, Jail Staff, Public Defenders, District Attorneys, Private Mental Health Evaluators, Foster Home providers
Probation and Parole collaboration	Mental Health, Jail, Probation and Parole Department
Mediation Courts Collaboration	Oregon Association of Family Courts Services, Douglas County Mediation, Douglas County Mental Health
Adult Mental Health Initiative	Foster Home Providers, Residential Care providers, Oregon State Hospital, GOBHI, Public Guardians, Courts, Acute Care Hospitals, Mental Health
Mental Health First Aide	Local Law Enforcement, Juvenile Department, Public Health, Mental Health, Community members at will.
NAMI	Mental Health, Community members, local Law Enforcement officers, Primary Care Providers
Supported Employment Program	Voc Rehab, Employment Agencies, Community Business members, Mental Health
Mercy Medical Seclusion and Restraint Committee	Mercy medical Center ED Director, Mercy Security Admin, Douglas County Sheriff, Douglas County Jail's Medical Unit, Mental Health
Involuntarily Held Patients	VAMC Psychiatrists, Family Members, Community Collaterals, Mental Health

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

A.1.6.a. Applicant has been actively working with community partners in gathering various agency health assessments. An example is the extensive community collaboration that occurred in developing the Douglas County Healthy Communities Assessment and Plan (LiveWell Douglas County). Douglas County Public Health and the Cow Creek Band of Umpqua Tribe of Indians have worked together over the past 24 months with 25 active participants, representing the tribe, hospital, mental health, seniors, and members from our outlying communities.

The CAC and the UHA board of directors will undertake a community health assessment, building upon the updated needs assessment currently in process by Mercy Medical Center (completion date scheduled for June 30, 2012), the work already done by LiveWell Douglas County and the County Health Rankings prepared by the University of Wisconsin.

Mercy Medical Center's 2012 Physician Development Plan is currently being updated with an expected completion date of September. The 2009 Physician Development Plan is attached – ATTACHMENT A.1.6.a.

Mercy Medical Center's 2005 Community Health Access Assessment Local Community Report, LiveWell Douglas County Report and County Health Rankings Report are as follows:

Mercy Medical Center – 2005 Community Health Access Assessment

Community Health Access Assessment
Local Community Report

Submitted by:

Hospital Name: Mercy Medical Center

City, State: Roseburg, Oregon

Chief Executive Officer: Victor J. Fresolone, FACHE

Date: June 3, 2005

INTRODUCTION

This report summarizes the key findings of five focus groups conducted on February 2nd and 3rd 2005, that addressed the important issue of improving health care access in our community. The participants included sixteen (16) consumer representatives, eighteen (18) health care providers, eight (8) business and industry representatives, and twelve (12) clergy and religious leaders.

HEALTH CARE ACCESS

Focus group participants were asked to identify those segments of the community that do not have ready access to health care services; the types of services they have difficulty accessing; the root causes behind these access issues; and gaps in the services available in our area that could be addressed to better meet these access needs.

1. Who in our community does not have ready access to healthcare services?
   - The uninsured
   - Non-English speaking people
   - People without transportation (especially rural people and seniors)
   - The illiterate
   - Unemployed or underemployed

2. What key services are these people missing?
   - Preventative care
   - Dental care & prevention
   - Pre-natal care
   - Vision care
   - Prescriptions

3. What are some of the underlying reasons?
   - Lack of knowledge of available services
   - Lack of reliable alternative transportation
   - Lack of regional facilities
   - High unemployment rate
   - Shame, embarrassment or fear

4. What programs already exist in the community?
   - Umpqua Community Health Center
   - Home Health & Hospice
   - County Health Department
   - Shots for Tots
   - Free Dental Day program

5. How could we build on these existing programs?
   - Centralized, coordinated source for information about services
   - Concentrate on prevention/developing good habits
   - Better networking between the various groups
   - Improve public transportation & attitudes about it
   - Educated the community

6. Realistically, what else can we do?
   - Expand volunteer programs
   - Emphasize prevention through education & communication
   - Talk about patient fears upfront in a non-threatening way
   - Have more community health centers
   - Set up a website for healthcare in the county

7. What would it take to put these solutions in place?
   - Community commitment and awareness
   - Lower the risks for doctors (malpractice/liability)
   - Make good/simple information readily available
   - Use retired nurses to man the program
   - A leader – someone to spearhead this

8. Anything else to add?
   - There will be a Health Fair on September 11, 2005, at the Fairgrounds.
   - Mercy should provide clergy parking spaces
   - Facility for homeless youth is opening

9. What is your #1 priority?
   - Improve basic education about health – break the cycle with education
   - Capitalize on retired providers to increase access
   - A directory of services
   - Eliminate misuse and overload of the ER
   - Expand patient advocacy for pre-hospital and after-care issues

IMPACT OF NATIONAL POLICY ISSUE ON LOCAL COMMUNITY

In addition to the issue of health care access, the discussion addressed a national health policy issue *<Indicate which health policy topic was addressed>* and its implications for our own community.

- ☐ A. **Affordable health care coverage.**
- ☐ B. **Provide care equitably to all.**
- ☐ C. **Health as a shared responsibility.**
- ☐ D. **Better stewardship of limited resources**
- ☐ E. **Financed to meet long term responsibilities.**
- ☐ F. **Emphasize wellness; center on preventive and primary care**
- ☐ G. **Deliver high quality, evidence-based care.**
- ☐ H. **Structured to provide more coordinated continuity of care.**
- ☒ I. **A health system that is simple and easy to understand and navigate.**
- ☐ J. **Transparent in sharing information with consumers and clinicians.**

Interpretation

A health system that is simple and easy to understand and navigate. How user friendly is Mercy Medical Center?

- Routine care is very user friendly, but the wait period in the ER is much too long.
- Need patient advocates to help people through the maze of paper work especially the billing. There is a gap between the efficiency of service and the quagmire of bureaucracies.
- The computer systems are not user friendly to the physicians.
- There is a community bias because there is no competition for Mercy and because it is a Catholic institution.
- Mercy gives quality, compassionate service. The community is lucky to have this hospital.

Next Steps for Our Communities

<Describe participants' key suggestions for actions that can be taken at the local level to address this health policy issue.>

- Itemize bills that go to patients and provide someone to explain them.
- Take a second look at the computer systems.
- Send "Thank You" letters to the consumers that say "we care about you."
- Ask employers to urge their employees to take an active part in the service and the billing.
- Do something about the long waiting times in the ER.

Differences by Segment

<Identify any key distinctions, concerns, or differences by participant segment with respect to how this health policy issue is understood, and with respect to suggested actions.>

- Consumers: Mercy does a wonderful job – very efficient, but the wait time in ER is too long and the bills are too complicated.
- Clinicians: Mercy is the best hospital these patients were ever in. Waiting times are much longer in other places.
- Business leaders: Mercy is very user-friendly except for all the unnecessary paperwork the patient and the nurses have to put up with.
- Religious leaders: Regular admittance is superb, but the flow of parking, waiting and seeing a parishioner in the ER is very frustrating.

Most Important Finding

<Identify the single most important finding or implication of the discussion on this health policy topic.>

- We need to provide itemized, easily understood billing to our patients as well as the insurance companies, and we need to appoint volunteer advocates to assist these people in understanding them.

CONCLUSION

<Conclude with next steps, e.g., convening a task force to select key priorities and develop an action plan, or other next steps.>

- Convene task force to select key priorities an develop an action plan.

LiveWell Douglas County Summary Report

LiveWell Douglas County

information + action

"All people in Douglas County live, work, play and learn in communities that support health and optimal quality of life."
A vision for Douglas County

LiveWell Douglas County is an alliance of individuals and organizations that are working to advance policies, systems, and environments that promote health and prevent and manage chronic disease.

What We're Doing to Promote Healthy Communities

- **Smokefree Environments** – advancing safe, healthy and tobacco-free workplaces, schools, health systems, and outdoor places and spaces.
- **Chronic Disease Prevention and Self-Management** – supporting local efforts to increase access and referral to classes and resources to prevent and manage chronic conditions.
- **Wellness at Work** – working to promote employee health through physical activity, healthy eating, tobacco cessation, and chronic disease prevention and self-management.
- **Active Community Environments** – promoting community environments where physical activity and healthy eating are accessible and affordable for everyone.
- **Promotion of Existing Community Resources** – supporting local efforts to promote healthy lifestyles and healthy communities.
- **School Community Support** – supporting school communities to promote tobacco-free school environments, safe biking and walking routes, healthy food choices, and physical activity.
- **Community Assessment & Grant Support**– support of Healthy Communities assessment, grantwriting and grant partnerships, and broad-based communication network to share information and opportunities.

How You Can Help Create a Healthier Douglas County

Contact us to find out how you can get involved with local efforts to create a healthier Douglas County.

Public Health Division
Douglas County Health & Social Services
541-440-3563 | mjcarter@co.douglas.or.us

LiveWell Douglas County participants have dedicated time and expertise to the completion of a local Healthy Communities assessment, and have championed a number of policy initiatives.

Tobacco-Free Policies & Initiatives

- City of Roseburg Parks System
- Douglas County Fair
- Umpqua Community College
- Lower Umpqua Hospital
- Mercy Medical Center
- Harvard Medical Park
- Adapt Outpatient Addiction
- SouthRiver Medical Center
- Umpqua Community Health Center
- Family Development Center & Head Start
- United Community Action Network Campus
- NeighborWorks Umpqua Housing Properties
- Tobacco Cessation CME for Professioals

Chronic Disease Prevention & Management

- Colorectal Cancer Screening Campaign
- Promotion of Living Well with Chronic Conditions
- Diabetes Prevention Program Project support in cooperation with OHSU Schnitzer Diabetes Center, YMCA, ATRIO Health Plans, DHS-SDA 6
- Arthritis Foundation Exercise Program leader training and promotion
- Development and distribution of Chronic Disease Prevention & Self-Management Resource Directory
- LiveWell Douglas County Fair Booth in cooperation with DCIPA-The Physicians of Douglas County, Mercy Medical Center, Cow Creek Band of Umpqua Tribe of Indians and many others
- Participation on statewide planning and leadership committees for chronic disease prevention

Physical Activity & Nutrition

- Support of local Bike & Pedestrian Coalition work to increase opportunities for active transportation
- Successful WIC Breastfeeding grant (2012)
- Promotion and adoption of Breastfeeding Friendly Worksite policies
- Promotion of Wellness@Work Inititive
- Partner and technical support to School Garden, Sustainable Local Foods, USDA summer food grants and initiatives
- Partner and technical support to local Safe Routes to School, National Parks & Recreation ACHIEVE grants and initiatives
- Community networking to promote learning and funding opportunities.

Douglas County Health Rankings 2012

	Douglas County	Error Margin	National Benchmark*	Oregon		Rank (of 33)
Health Outcomes					**32**	
Mortality					29	
Premature death	8,702	8,029-9,375	5,466	6,343		
Morbidity					32	
Poor or fair health	22%	19-25%	10%	14%		
Poor physical health days	4.9	4.2-5.6	2.6	3.7		
Poor mental health days	3.9	3.2-4.5	2.3	3.3		
Low birthweight	6.5%	6.0-7.1%	6.0%	6.0%		
Health Factors					**31**	
Health Behaviors					31	
Adult smoking	26%	22-29%	14%	18%		
Adult obesity	31%	27-35%	25%	26%		
Physical inactivity	22%	19-26%	21%	18%		
Excessive drinking	15%	12-18%	8%	16%		
Motor vehicle crash death rate	25	21-29	12	14		
Sexually transmitted infections	179		84	303		
Teen birth rate	44	41-46	22	35		
Clinical Care					18	
Uninsured	20%	18-22%	11%	19%		
Primary care physicians	1,310:1		631:1	739:1		
Preventable hospital stays	46	43-50	49	42		
Diabetic screening	85%	81-90%	89%	85%		
Mammography screening	72%	67-76%	74%	68%		
Social & Economic Factors					28	
High school graduation	67%			66%		
Some college	52%	48-56%	68%	64%		
Unemployment	14.6%		5.4%	10.8%		
Children in poverty	31%	24-37%	13%	22%		
Inadequate social support	16%	13-20%	14%	16%		
Children in single-parent households	34%	29-38%	20%	30%		
Violent crime rate	118		73	271		
Physical Environment					22	
Air pollution-particulate matter days	13		0	12		
Air pollution-ozone days	0		0	1		
Access to recreational facilities	10		16	12		
Limited access to healthy foods	3%		0%	6%		
Fast food restaurants	49%		25%	43%		

* 90th percentile, i.e., only 10% are better

Note: Blank values reflect unreliable or missing data

We will draw upon the excellent resources of the OHA and develop a community process including the OHA, Mercy Medical Center, Douglas County Public Health, our local mental health authority, and the Type B AAA to develop a comprehensive health needs assessment. Applicant will use the comprehensive needs assessment to guide our work to and to implement CHANGE/MAPP processes to identify objectives for moving forward in a shared health improvement plan that will coordinate care, encourage prevention and lead to a healthier community. We will review and update the assessment as needed, but not less than every two years.

The draft CAC procedure calls for the inclusion of diverse populations, including representation of those in long term care (LTC) and those with severe mental illness. (Draft attached – noted in A.1.1.b.)

Section 2 - Member Engagement and Activation

A.2.1. Member and Family Partnerships

A.2.1.a. We will develop policies and training opportunities into our case management programs that will incorporate best practices for engaging members in their health care choices at a high and frequent level. This might include training of our Exceptional Needs Care Coordinator (ENCC) nurses on health coaching for members. Likewise, we will be sure to appropriately address engagement of authorized representatives for the member including family members and support network participants. Frequent outreach will be made from the CCO that will seek to actively involve members, their caregivers and loved ones in appropriate quality improvement programs, such as check lists for routine check-ups and screenings or invitations to comprehensive medication review clinics.

A.2.1.b. We plan to create a comprehensive communication campaign informing all members about the CCO. This will describe what members should come to know and expect from the CCO and include pieces designed to educate our members on how to access care and the multitude of community resources and partnerships that being part of the CCO plugs the member into. Several other communication pieces will be developed which will be aimed at prevention and healthy living. These pieces might include calendars in which each month has a new educational piece geared toward a specific preventive service or perhaps a "checklist of check-ups" that will help the member be proactively engaged in managing the many screenings and vaccinations they might need throughout the year. Where appropriate, our content developers will involve cultural experts and translation services to ensure member communications are created in a culturally competent manner.

Our communications strategies will teach members about our nurse case managers and how the member can think of their nurse case manager as a virtual care system navigator. Here we will educate members on how to access a nurse case manager who is there to assist the member in understanding how important coordination of care is and how to successfully navigate the healthcare system in our community. A vital part of these communications will be to inform our members about their appeals rights and responsibilities in taking ownership of their health and how to navigate the CCO's rules and benefits. This would be an ideal type of communication to also educate the members about the Community Advisory Council (CAC) and

its purpose. Not only do we want to let members know about the CAC but how vital the CAC is to the overall improvement of the healthcare system in our community.

Section 3 - Transforming Models of Care

A.3.1. Patient-Centered Primary Care Homes

A.3.1.a. DCIPA supports the Patient-Centered Primary Care Home (PCPCH) model of care. We developed a networked Electronic Medical Record (EMR) made up of providers on a system called UmpquaOneChart. This allows our providers to coordinate care, communicate and view records on a single system. We subsidize and manage the technology necessary to keep the system functioning and up to date. We have policies and procedures for managing providers concerns through an EMR steering committee made up of providers. The EMR has built in decision making tools and population disease management tools are being developed. Our network of providers is culturally diverse. Their special skills are matched to our member's needs. Our provider network already uses the EMR for coordination of care and communication. Most of our providers have qualified for meaningful use. This puts our providers in a good position to become PCPCHs.

Following is the breakdown of points required to meet each tier level for Patient Centered Primary Care Homes:

PCPCH

Except for the 10 Must-Pass measures, each measure is assigned a point value corresponding to the Tier. For a o practice to be recognized as a PCPCH, it must meet the following point allocation criteria:

- Tier 1: 30 – 60 points and all 10 Must-Pass Measures
- Tier 2: 65 – 125 points and all 10 Must-Pass Measures
- Tier 3: 130 points or more and all 10 Must-Pass Measures

Must pass (A-attest/D-data)

1. Continuous Phone **access**- A
    a. Most clinics do
2. **Track** one quality Metric- A
    a. Stars or hedis
3. **Offer** full range of Care- A
    a. Acute
    b. Chronic
    c. Procedures
    d. Diagnostics
    e. Education
4. **Document** screening strategy for- A
    a. Mental and substance use
    b. Developmental
    c. Referral Resources
5. **Report** % patients assigned clinician- D
6. **Report** % visits with assigned clinician- D
7. **Maintain** health record …. **EMR**- A
8. **Care** for **hospital** patient, or written agreement to hospitalist- A
9. Process to offer or coordinate **Hospice**
10. **Document/offer** language options- A

Additional points to make Tier 1-3

- **Survey** CAHPS (minimum 30 patients) – 5-15 pts
- After-hours **access** – 5 pts
- **Track measures** and improve – 10-15 pts
- Offer **preventative services** (90%) – 5 pts
- **Collaborate** with **mental health** providers – **10-15 pts**
- Comprehensive health assessments and intervention (3 risks) – 5 pts
- Meet benchmarks for **% patients assigned** clinic and provider – 15 pts
- Share clinical info **ELECTRONICALLY-EHI** – 15 PTS
- Have an **EHR** and meet **meaningful use – 15 pts**
- **Data manage** patient populations – 5 pts
- **Data manage** sub populations – 5 pts
- **Assign care coordinator** and tell family (describe and demonstrate) – 5-10 pts
- Track tests – 5 pts
- Track referrals – 5 or 15 pts
- Manage SNF or coc – 5 pts
- Create **CARE PLANS – 10 pts**
- Document **patient education and prevention** – 10 pts
- **Survey** CAHPS and meet benchmark – 5-15 pts

A.3.1.b. The key to the PCPCH is the relationship between the member and their provider. We ensure that every member has a primary care provider. We have been supporting our primary care providers by coordinating care and case managing our members for many years, in addition to paying case management fees for each primary care patients. We plan to expand our management and the current Interdisciplinary Team meetings, by developing individualized care plans with the cooperation of the primary care providers. We see ourselves as a support system to meet the members' needs. With every phone call and interaction we will "sell" health and motivate our members.

A.3.1.c. We have a strong network of providers. Our two largest clinics likely meet criteria for PCPCH and are in the process of Attesting. The combination of Umpqua Regional Medical Center (URMC) - the DCIPA owned rural clinic which cares for 23% and Umpqua Community Health Clinic (UCHC) -the local FQHC which cares for 19% of our OHP members, 42% of our members are already being cared for in PCPCHs. Many of the other local clinics will meet tier one within the year. We expect our clinics to be able to move to tier 2 and 3 with the development of population based disease management tools we are developing.

Our EMR, the UmpquaOneChart, provides the ability to communicate and coordinate care amongst providers on the system. We are able to communicate with the provider and track real time the comprehensive case management needed to make a difference.

A.3.1.d. Our nurse case managers, coordinate transitions of care from hospitalization to LTC facilities. The majority of our members in LTC facilities are managed by a single provider, contracted with us to provide oversight. The nurse case managers and primary care providers coordinate care with this physician via the EMR.

A.3.1.e. Several rural health clinics (Evergreen Family Medicine and Umpqua Regional Medical Center) are valued providers. We also work cooperatively with our local Federally Qualified Health Center (FQHC), Umpqua Community Health Clinic (UCHC), which has school based clinics and clinics in some or our most rural locations. We expect these clinics to be patient centered primary care homes and will be working closely with our network of providers to qualify.

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

A.3.2.a. We plan to follow state guidelines and focus on PCPCH.

A.3.3. Access

A.3.3. Access

A.3.3.a. Our current network of providers is diverse and geographically appropriate to meet needs of our community. We contract with our local FQHC (UCHC), which has clinics in Glide, Drain, Myrtle Creek and Roseburg. We own our own rural clinic URMC, with the ability to expand to whatever our member needs may be.

Our Mental Health Providers are located at three locations in Roseburg; Reedsport, Drain, and Canyonville county offices; nine schools throughout the county; and in two therapeutic learning classrooms (Riddle and Yoncalla elementary schools).

We will employ a triage system including 27/7 access and screening to ensure that members will receive the right level of care at the right time. Utilization data will be utilized to trigger outreach and engagement by care coordinators to those members who are not receiving recommended treatment.

Our Dental Health has 43 dental providers within the service area and one clinic in Winston, operated by Oregon Community Dental Care - dba Winston Community Dental Clinic, which will be utilized to serve the dental needs of the Applicant's Members.

Attached is DCIPA's Policy & Procedure – ATTACHMENT A.3.3., demonstrating our goal to maintain network of providers adequate to serve Members' health care and service needs.

A.3.3.b. We are designated a provider and mental health provider shortage area. We work with our local hospital to establish our community needs, and we collaborate in recruiting the providers needed. We meet our current member needs through contracts with our local providers and through our own rural clinic. We have the ability to expand, and our only barrier will be getting state licensing for new providers in a timely fashion.

A.3.3.c. We reach our members through the news media, letter campaigns, member services, member newsletters and our website. In addition, all communication with our members will be consistent.

A.3.4. Provider Network Development and Contracts

A.3.4.a. Applicant has a contracted provider network, through DCIPA, LLC, sufficient to successfully deliver medical benefits under the existing Oregon Health Plan benefit. DCIPA, LLC will use credentialed healthcare professionals and advanced Information Systems to coordinate care across all provider types and care settings, regardless of geographic location. Applicant will be actively involved in the Health Information Technology Oversight Council (HITOC) health information organization (HIO) executive panel and anticipates being one of the pioneering organizations with regard to Health Information Exchange (HIE) with tertiary healthcare facilities. Applicant will endeavor to expand both its Information Systems and its provider network to the extent it will aid in coordinating care and accommodating member needs.

Douglas County Mental Health provides coordinated care with a variety of provider networks including eight children's treatment foster homes and six adult foster homes in Douglas County, nine children treatment foster homes and residential facilities, eight adult treatment facilities, and seven residential treatment facilities outside the county. Care plans are coordinated for each Member in these facilities to meet the mental health treatment plan goals of the members and connect the members to appropriate primary care services.

A.3.4.b. Applicant will build upon partnerships that have already been formed within the community in order to address inpatient utilization for children and adults. Through the partnership of the CCO, members will utilize existing strategies such as the utilization of hold rooms at Mercy Hospital, Crisis Team Response, officers trained via the Crisis Intervention

Training (CIT), foster homes, Mental Health First Aid, Early Assessment and Support Alliance (EASA), treatment foster homes, and community wrap around approaches. Over the last six months, the community has begun the process of hot spotting cases to ensure that patients utilizing the highest level of care or with complex medical conditions are staffed and a wrap around plan completed. Additionally, through the lessons learned from both the Children's Change Initiative and Adult Mental Health Initiative (AMHI), members have consistently demonstrated their ability to manage these high end level cases.

Douglas County Mental Health and Adapt have developed an extensive continuum of outpatient and residential care, succeeding in dramatically lowering inpatient utilization over the past three years. This includes, for both adults and adolescents, evidence-based and medication assisted outpatient treatment, intensive outpatient therapy, gender specific services, short and long term residential, targeted case management, behaviorally integrated primary care, recovery coaches, and outpatient and residential treatment for parenting women.

Further, Advantage Dental will work with Applicant and existing partners in a joint effort to decrease the utilization of emergency rooms and operating rooms for dental services and increase prevention so fewer children contract the dental infection disease.

A.3.4.c. Applicant intends to utilize its existing behavioral health network of providers and the existing network of support within the community to assist members in being maintained to the extent possible in our community in the least restrictive setting. This includes the partnership between the behavioral health provider and housing resources which include Umpqua Community Action Network (UCAN) and other housing providers in the community. In addition, Applicant will provide wraparound support and case management services to the level necessary to help members maintain their independence. Through the use of flexible funds and a non-traditional approach to service delivery, the goal will be to assist members in creating a care management plan that addresses the complexity of their needs. Through the use of the Community Health Assessment and Community Improvement Plan, gaps and areas needing further development will be explored.

An extensive network currently exists, linking County Mental Health, Adapt, South River Community Health Center, Umpqua Community Health Center, Douglas Medical Group, Umpqua Regional Medical Center, UCAN, and two other housing/poverty needs providers. Adapt and County Mental Health have collaborated with UCAN on the building of four housing complexes, specifically for clients with chemical dependency or mental illness. Additional local projects have created independent living units for clients with developmental disabilities. Where clients are shared, case management functions coordinate to avoid duplication, which will be significantly enhanced once the CCO is operational.

A.3.5. Coordination, Transition and Care Management

A.3.5.a. Information and documentation will be in the community wide Electronic Health Record. Access is available to providers in the community as well as CCO staff. This facilitates direct communication between the CCO care coordinators and the providers.

A.3.5.b. Exceptional Needs Care Coordinator (ENCC) nurses and support staff will continue to work with the Interdisciplinary Care Team (IDCT) to manage member needs. IDCT consists of Primary Care Providers (PCP), social services and mental health professionals. Additional IDCT

members are invited based on need identified. We plan to work with our affiliates to expand and further develop community prevention and self-management programs based on the needs of our population. Currently crisis management is available from our community partner Douglas County Mental Health.

A.3.5.c. Educational materials will be developed for distribution with member enrollment packets. The population of Douglas County is homogeneous with less than 1% of our population being non English speaking. (CAHPS 2007) Letters will be sent to members and providers with information about how to get alternate formats. Our website will be updated, as well as provider and member handbooks to include this information. Where appropriate, our ENCCs will involve cultural experts and translation services to ensure member care plans are created in a culturally competent manner.

A.3.5.d. See response to A.3.5.b. As a small rural community our PCPs are the gatekeepers of members care. We will continue to work closely with them and the rest of the IDCT to manage members. It is through the ENCCs that the appropriate community resources are leveraged for member care plans. The Douglas County Developmental Disabilities (DD) program works the local brokerage and DD providers to develop case plans for Members and will coordinate those plans with primary care providers.

A.3.5.e. We will be working with our local mental health department, Douglas County Mental Health. They have extensive programs available for community based services. We will continue our program with our geriatrician to manage members in the local LTC facilities. Again, our model seeks to utilize the ENCC's expertise to ensure the member's care is coordinated across the provider network and community resources.

A.3.5.f. It is our goal to evaluate technology vendors or industry consultants who have expertise in developing innovative solutions for integrating community resource and provider network coordination. This could either be enhancing our current EMR system or to contract with a vendor who has a track record of disseminating innovative strategies across a community with resources and demographics similar to ours.

A.3.5.g. All members will be assigned a Primary care provider when they become enrolled with our CCO. Our local providers have contracts that define the timeliness of access required. This information is available to the member and provider in the member and provider handbook. Our team of ENCCs will be the "hub" in coordinating services to ensure the member and the member's PCP are linked to appropriate IDCT members and resources.

A.3.5.h. Our provider network is culturally diverse with highly skilled providers to asses member health needs. Our ENCC nurses are available to help coordinate care and support these providers and members with their needs. Where appropriate, our ENCCs will involve cultural experts and translation services to ensure member care plans are created in a culturally competent manner.

A.3.5.i. Transitions will be addressed on an individual case need. When notified of a transition, each case will be reviewed for services or additional assistance needed. Coordination with

mental health, dental health and physical health providers will be facilitated by the ENCC to maintain an appropriate plan of care.

A.3.5.j. This care will be managed by our Geriatrician on staff. Type B AAA and/or ADP case managers will regularly be part of our IDCT meetings to address any issues or concerns and to assist with any transitions the ENCC may need assistance with.

A.3.5.k. Commercially available software programs will be evaluated for use in tracking this process. Also, there are opportunities we want to explore with our hospital partner to develop processes for early identification of transitions and coordination with our ENCCs for discharge planning.

A.3.5.l. Policy and procedures will be developed that require care plans for any members identified as needing intensive care coordination. Our mental health partners will continue to share their plans with our ENCCs for members with persistent mental illness receiving services. We also plan to evaluate case management software solutions that will help risk stratify our population to identify those who may need intensive care coordination from an ENCC.

A.3.5.m. The Disability Services Office (DSO) will continue to use the continuity of care referral form for care coordination when members apply for the plan. Dual members will continue to receive a yearly HRA from our local Medicare Advantage plan for evaluation. This will be shared with the community partners and used by our care coordinators to coordinate care plans between agencies. Additional needs assessment surveys will be determined by the ENCC or IDCT members with the assistance of technology services.

A.3.5.n. (See above) – We will continue to review the form and work with our local social service agency (DHS, DSO). Communication will be through the usual channels (telephonic, secure email) with the ENCC coordinating relevant information from these sources in generating member care plans.

A.3.5.o. At the time of a transition the IDCT or ENCC care manager will facilitate to address any higher level needs. Care plans are considered living and fluid documents that will be updated with any changes to ensure members receive the right care and resources at the right time, based on their changing health needs and goals completion.

A.3.5.p. Channels will be developed for exchange of information in an appropriately confidential manner. Secure email is the current option available to all. There may be opportunities to enhance current technologies to incorporate real-time information sharing across these settings, such as a secure web portal or a "cloud" where vital documents necessary to care plan development can be exchanged.

A.3.6. Care Integration - Mental Health and Chemical Dependency Services and Supports

A.3.6a. Applicant will utilize the existing behavioral health provider network, available through Douglas County Mental Health (DCMH) and Adapt, to meet the behavioral health needs of the community. DCMH and Adapt both have a long history of providing mental health and addiction

services to the community and are currently licensed by the State to provide both Outpatient services. Additionally, DCMH, through the Intensive Treatment Services (ITS), provides services to children through two therapeutic learning classrooms. As part of the GOBHI (Greater Oregon Behavioral Health, Inc.) provider network, DCMH has developed a service delivery array and provider network to meet the needs of the covered members. Adapt complements and extends this continuum with gender specific intensive residential services for adolescents, adults, and parenting women.

A.3.6.b. Applicant will utilize DCMH and Adapt, with the expertise of GOBHI, to ensure that members receive the level of care coordination and behavior health services. Both DCMH and GOBHI have established protocols and processes in place for the coordination of members needing to access and transition back from higher levels of care. GOBHI was the leader in the development of the array of services for children and implemented Family Care Coordinators to ensure that all children and families needing higher levels of care have a thorough Care Coordination plan that involves and is directed by the family. Both DCMH and GOBHI have also established a network of Exceptional Needs Care Coordinators (ENCC) for those members needing both hospital and inpatient levels of care. The ENCCs ensure that care is coordinated and in direct communication with the providers network of residential and hospital facilities.

Adapt likewise coordinates care with DCMH, and also works with South River Community Health Clinic, Umpqua Community Health Clinic and DCIPA Clinics to integrate and coordinate addiction services with primary care.

A.3.6.c. Applicant will utilize DCMH and Adapt as the providers of screening and access to mental health and addiction services. Through the process of development of the CCO, it is anticipated that access to behavioral health will continue to evolve through the use of primary health homes to ensure that member behavioral health needs are met in conjunction with their physical health needs. Through the utilization of screening process, Applicant will work to ensure that members will gain access to the appropriate level of behavioral health services. Applicant will utilize the four quadrant model to assist in the facilitation of this process. Additionally, multiple staff members from the Applicant provider network are already engaged in training on the provision of integrated care, through the University of Massachusetts.

Douglas County through its relationship with GOBHI provides integrated care and service delivery by proactively "identifying" members utilizing various modalities: patient registry/"hot spotting", ER and hospital referral, behavioral health referral, schools, Department of Human Services, community programs and the various legal systems/entities. DCMH and GOBHI arrange and facilitate the provision/coordination of care through Community Based Client Care Teams, which include some of the following components: care management, peer delivered services, home visits, family involvement, wrap around services, safe and drug free housing, employment/education support, child care, telemedicine, Skype, P2/NOCCS, ICTS and Self Help. Adapt has embedded integrated care Licensed Clinical Social Workers into South River Community Health Clinic and DCIPA Clinics, as well as both their adult and adolescent residential facilities. Later this year, we will go live with telemedicine screening and limited treatment in four rural school districts.

A.3.6.d. Applicant will utilize DCMH and Adapt for the provision of mental health and addiction services. As stated, DCMH and Adapt have a long history of providing coordinated

behavioral health services and are licensed by the State. Over the course of the last five years, DCMH has gone through a transformation in providing a service delivery model that incorporates evidence based practices, is strength based focused and is culturally competent. DCMH has also taken great strides in the provision of services that are community-based with the emphasis on wrap around principles and resiliency to keep people in the community. DCMH has engaged in several outcome studies that demonstrate their success in this process. As stated above, through the partnership of the UHA, primary care and behavioral health services are being integrated and will continue to evolve as the CCO develops. Similarly, Adapt has been providing integrated substance abuse/primary care services for seven years, has a nationally recognized research center conducting NIH clinical trials in evidence-based practices, is a Federally Qualified Health Center with telemedicine capability, and is currently one of 10 organizations chosen by the National Council For Community Behavioral Healthcare as a participant in their Co-Occurring Disorder Learning Community.

A.3.6. Care Integration – Oral Health

A.3.6.e. Applicant will include oral health as part of its delivery system when Applicant enters into a contract with OHA. Applicant is currently in the process of developing a contractual arrangement with Advantage Dental Services, LLC for oral health services. Currently, Advantage Dental Services, LLC provides dental services for 18,250 OHA members in Douglas County. On or before August 1, 2012, Applicant and Advantage Dental Services, LLC will have a contractual relationship to include oral health as part of the delivery system and Advantage Dental Services, LLC will have a position on the governing board of Applicant.
A.3.6.f. Applicant will contract with Advantage Dental Services, LLC (Advantage Dental) for the delivery of oral health care to Members in Douglas County. Advantage Dental has been working to enhance dental care in Pacific Northwest communities since its formation of Advantage Dental Services, LLC in 1995. Advantage Dental has operated as a DCO for 16 years and currently provides dental services to over 185,000 OHP Members throughout Oregon. In Douglas County, Advantage Dental has 43 dental providers and manages a dental clinic in Winston, in the Riverside Health Center, operating under the name Oregon Community Dental Care - dba Winston Community Dental Clinic, to meet the oral health needs of Members. Advantage will continue to work with the two Federally Qualified Health Centers toward their goal for patient centered health homes. Along with its providers and clinic, Advantage Dental has a 24/7 after-hours on-call system to meet the emergency and urgency needs of its patients.

Advantage Dental will continue its prevention and general oral health care by having dental hygienists screen children in schools, the Head Start program, and Women Infants and Children (WIC) programs for cavities and by applying fluoride varnish to the children's teeth. Cavities are caused by an infection disease with a behavioral overlay. Advantage is working to medically manage the caries in those recipients that are chronically infected. Advantage Dental will coordinate care with behavioral health, physical health and the hospital to reduce the use of emergency rooms, operating rooms and medications by diverting patients at the right time, to the right place, and for the right care.

A.3.6. Care Integration – Hospital and Specialty Services

A.3.6.g. Applicant will endeavor to have agreements and information systems with its hospital and specialty care providers to coordinate patient-centered primary care on a community-wide

basis. Primary care, specialty care, and hospital based providers will all share access to a single electronic patient record delivering the right information, at the right place, at the right time, to ensure efficient, informed, and timely coordination of care.

PCPCH or primary care providers will utilize DCIPA, LLC's Care Management team and related information systems to coordinate and provide access to specialty physician and hospital-based inpatient and outpatient services. All referral and care coordination services offered by DCIPA, LLC will utilize community resources leveraging an effective blend of technology and local relationships to efficiently process and refer members/patients to timely and appropriate care.

Because DCIPA, LLC has an integrated Medical Care Management team and shared information systems inclusive of primary, specialty, and hospital-based care, all member services are highly coordinated across the continuum of care. The sharing of medical records for hospital and specialty treatments, at the time of hospital admission or discharge, for after-hospital follow up appointments, and other care transitions will be enabled throughout the DCIPA, LLC provider network, and includes patient consent, Medical Care Management team coordination, and direct provider engagement.

Because DCIPA, LLC has an integrated Medical Care Management team and shared information systems inclusive of primary, specialty, and hospital-based care, all member services are highly coordinated across the continuum of care. PCPCH or primary care providers will have access to member care plans, transitions of care plans, and other member and population health management tools and plans to help facilitate efficient provider interactions and improved health outcomes.

A.3.7. DHS Medicaid-funded Long Term Care Services

A.3.7.a. The Team approach will be used as our model for coordinating these services. Each member who experiences a transition to a setting where Medicaid-funded long term care services will be utilized, will be assigned a nurse case manager (NCM). Once alerted of a transition the NCM will begin reaching out to the member and draft a care plan. This care plan will be developed with the assistance of an interdisciplinary care team that will include the NCM, the member, the member's PCP, necessary specialist provider(s), case managers from the APD office and other appropriate non-traditional healthcare workers. This will allow best practices to be shared amongst the care team to ensure the member's care is coordinated across transitions.

The care plan may contain, and is not limited to, both medical and non-medical information (e.g., a current problem list, medication regimen, allergies, advance directives, baseline physical and cognitive function, benefit information, contact information for professional care providers or practitioners and informal care providers). The care plan will include long term and/or short term goals that take into account the patients' goals and preferences, identifies barriers to meeting their goals or complying with the care plan, and has a process to assess progress against case management plans.

A.3.8. Utilization management

A.3.8.a. We will continue to use our current prior authorization process, as we have extensive policies and procedures written to ensure emergent or acute issues are cared for in a timely fashion. We already case manage our exceptional needs members and will continue to do so to

ensure their diverse needs are met. We will coordinate all health care (physical, mental, oral and Developmental Disabilities Program) to ensure access and management as appropriate. Attached is OHP Staff Process – ENCC Responsibilities – ATTACHMENT A.3.8.a.

We have been tracking, trending and managing over-utilization for many years. We will continue to track measures considered markers of over-utilization, such as Emergency room utilization, MRIs and narcotics. We have always focused on specific areas of under-utilization, such as immunizations and mental health services. We will continue our current programs for improvement as well as develop ongoing plans for population management of each area, including working with oral health to reduce the utilization of the emergency room for dental related emergencies.

Section 4 - Health Equity and Eliminating Health Disparities

A.4.1. Umpqua Health Alliance (Applicant) is a collaboration of most of the providers in our county. Our deep community involvement and long tenure in the county will help us to deliver culturally competent care, but we look forward to working with OHA to continually improve.

A.4.2. Applicant is fortunate to have most of our patients enrolled in a community wide electronic health record and is further fortunate to have advanced data support that will allow us to track and report measures by many demographic, diagnostic and care characteristics.

Section 5 - Payment Methodologies that Support the Triple Aim

A.5.1. The OHP managed care contractors in Douglas County have a long history of innovative payment practices that support the triple aim, including but not limited to:

- Primary care case management fees paid by DCIPA since the mid 90's are a precursor to Patient Centered Primary Care homes. We anticipate further expansion of our PCPCH model with the goal of high tier PCPCH in many of our practices.
- DCIPA has contracted with a geriatrician to provide the bulk of nursing home services to our dual eligible providers in LTC.
- Hospital capitation payments focus on the provision of quality care rather than volume of services.
- Risk pools in hospital contracts focus on outcomes rather than volume of services.
- Risk pools in mental health contracts focus on outcomes.
- Dental capitation payments focus on preventive dental care.
- Extra payments to providers for performing comprehensive assessments of those who are dual eligible.
- Special programs to align financial incentives for those who work with the Medicare Advantage STARS program.

Under the CCO model, we anticipate that we will be able to better share information and pool dollars across mental, dental and physical health. Projects under discussion include:

- Decrease ED utilization for acute dental pain and mental health issues
- Decrease OR utilization for extensive dental reconstructions in children
- A quality project between mental and physical health to share medical and drug utilization

Section 6 - Health Information Technology

A.6.1. Health Information Technology (HIT), Electronic Health Record Systems (EHRs) and Health Information Exchange (HIE)

A.6.1.a. Currently, there are over 100 providers that regularly access our EMR and, if one includes the ancillary support staff, DCIPA has 678 registered users. There is no limit regarding the number of unique patients whose records are housed in DCIPA's EMR; our current number exceeds 200,000.

Two committees meet weekly to improve HIT data analytics and form development. The latter includes patient portal and provider decision tools. As referenced in A.3.4.a., Applicant will be actively involved in the HITOC and HIO executive panel and anticipates being one of the pioneering organizations with regard to Health Information Exchange (HIE) with tertiary healthcare facilities.

A.6.1.b. UmpquaOneChart, running on Centricity EMR, is a community-wide, single-chart model, robust EMR in which physicians and other providers have been directive in forms development, decision tools, QA/UM activities, and recruiting non-participating providers for adoption. It is federally ONC certified. Each provider in our network is encouraged to adopt this resource and has been financially incentivized to do so.

A.6.1.c. Providers using UmpquaOneChart have access to all of the Phase I meaningful use subsidies from CMS or the state through the use of forms developed for this purpose within the system.

Robust and elegant interfaces have been developed and implemented for all of the area's laboratories and radiology facilities. Co-developed with Mercy Medical Center, interfaces exist that actively feed information from hospital transcription services, cardiovascular PACS, radiology PACS, Emergency Department, and other areas without delay.

Although our current system was not conceived to answer affirmatively to the above challenge, our management team and informatics committee have recognized the importance of such an interface to all network providers. We are already in the process of developing a web-based interface to our data warehouse and its tools. These tools include: disease and case management, population disease management, interfaces to our mental and dental health colleagues for sharing clinical and management information, and special needs and transitions of care.

Advantage Dental through its affiliated Not for Profit, Advanced Dental Information Network, provides technology that allows dental providers to interface with certified EHR systems that will enhance care coordination and allow dentists to be part of the primary care team and patient centered care coordination by sharing patient charts and information.

Provider Participation and Operations Questionnaire

Section 1 - Service Area and Capacity

DCIPA LLC is applying for all service areas listed by zip code below, with the intent to place no limit on the maximum number of assigned/accepted members.

Service Area Table

Attached – ATTACHMENT B.1

Section 2 - Standards Related to Provider Participation

Standard #1 – Provision of Coordinated Care Services

DCIPA, LLC will have the delivery system network to provide comprehensive, integrated, and coordinated care management across both the Medicaid and dually eligible membership that will encompass all categories of services. Whether this network is through direct contracting or collaboration, DCIPA LLC intends to focus on prevention, improving quality, accountability, eliminating health disparities and lowering costs. Please refer to our submitted Participating Provider Table (Table B-1).

Table B-1 (Participating Provider Table)

Standard #2 – Providers for Members with Special Health Care Needs

All of our local providers in primary care fields, physicians and midlevel providers are licensed to provide care for members with an array of medical illnesses including those that the state would consider "special needs." All members with special needs are assigned to a provider who best meets their needs and have access to the specialists necessary to meet any of their individual needs either through the contracted provider network or through allowance of referrals to non-contracted providers. See Table B-1 – ATTACHMENT B.2.

All of Advantage Dental's local providers are licensed dentists that are capable and willing to provide the necessary dental care for members including those members with special health care needs and children. When a primary care dental provider is not able to provide the required dental services for whatever reason, the primary care dental provider is able to refer the member to a specialist dental care provider that will be able to provide the needed dental services. See Table B-1 – ATTACHMENT B.2.

Standard #3 – Publicly funded public health and community mental health services

Publicly Funded Health Care and Service Programs Table – ATTACHMENT B.2.3.

(a) Umpqua Health Alliance (Applicant) includes in its community partners a County Commissioner representing the Mental Health and Public Health Authority, the Health Administrator for the Mental Health/Developmental Disabilities, and Public Health Divisions of the Health Department and the CEO of Adapt (the local chemical dependency treatment provider).

(b) Currently the contract for public health point of contact services is with DCIPA, the mental health contract is with GOBHI and the addictions contract is with DCIPA. Future public health, mental health and addictions contracts with Umpqua Health Alliance are under discussion and negotiations. Applicant understands that these contracts will need to be in place prior to the state issuing the CCO contract.
(c) Planning and discussions are in process at this time and contracts are expected to be in place as required.

Standard #4 – Services for the American Indian/Alaska Native Population (AI/AN)
(a) Umpqua Community Health Center, an FQHC with 5 locations in Douglas County, provides primary medical, dental, and limited mental health services to over 8,000 unduplicated patients annually. It is our practice to meet each individual patient where they are and travel with them in their journey to better health. This requires a sensitivity and respect for all human attributes and challenges. The Cow Creek Band of the Umpqua Tribe of Indians does not have reservation lands and have generally integrated their lifestyle into that of mainstream Douglas County. As a sovereign tribe, they are responsible for providing government services for the Indian people under their jurisdiction. UCHC does provide care to a small number of patients who identify themselves as American Indian. These patients, as with all UCHC primary care patients are empanelled with a primary care provider team which includes a medical assistant, patient care coordinator, and receptionist. Based on individual patient needs, in-house referrals provided to our mental health nurse practitioner and the dental department. Referrals to other services outside the organization are also provided to any number of resources, including those that may be available to Native Americans. Should assistance be necessary in how to access or better understand these resources, UCHC has a patient advocate who provides this assistance for our patients.

Standard #5 – Indian Health Services (HIS) and Tribal 638 facilities
(a) The Cow Creek Band of the Umpqua Tribe of Indians, a sovereign tribe with the responsibility of providing government services for the Indian people under its jurisdiction. The Cow Creek Band has expanded this responsibility to the provision of a robust system of health care provided through their local clinic, including medical, dental and behavioral health as well as education and assistance for smoking cessation, nutrition and diabetes education. Hospitalization and specialty care is provided to the tribe members on a referral basis for any health care services not provided by the tribe.

Standard #6 – Integrated Service Array (ISA) for children and adolescents
Applicant will include every one of the 5 local board certified pediatricians and the only two board certified child psychiatrists, as well as the county mental health department to meet the needs of those with severe mental and emotional disorders. Our county mental health department already has in place an ISA system as described.

Each GOBHI county will provide community based treatment services to all children, adolescents, and their families, who qualify for Intensive Community-based Treatment and Support Services. Presently, GOBHI providers offer a full range of services to this population, which are coordinated by trained Family Care Coordinators (FCCs), with leadership provided by the GOBHI Regional Youth Program. Because research indicates that children who experience early neglect and/or trauma do not usually respond to conventional "talk" therapy, GOBHI has

developed a variety of flexible encounter codes to expand services that focus on addressing sensory integration, self-regulation, relational and cognitive health. GOBHI plans to continue to expand on these existing efforts by developing additional Therapeutic Foster Care homes, as one entity that will aid in serving children and adolescents with severe mental or emotional needs in their communities. We will also focus on utilizing "family finding" services for children receiving ISA and at risk of becoming Child Welfare charges.

In addition, as part of our CCO development, GOBHI plans to invest our efforts on the assessment and treatment of infant mental health. This will include early identification of attachment and attunement between caregivers and their infants. Services will focus on trainings in Child-Parent Psychotherapy, Parent-Child Interaction Therapy, and Neurosequential Model of Therapeutics for "first responders" (pediatricians, PCPs, nurse practitioners) and mental health clinicians. GOBHI also plans to create parent support partners and mental health specialists that can provide education and support to at-risk caregivers and their infants.

(a) Through the use of the provider network established by DCMH, Applicant will build upon and identify any gaps in the services array for children and adolescents. Currently, DCMH has built a service array in the community that utilizes family therapy, groups, skill building, crisis services, medication management, family care coordination, case management, skill building, mentoring, therapeutic learning classroom and treatment foster homes. Through the utilization of wrap around principals and the Intensive Community Based Treatment (ICTS) array, DCMH has been able to bend the cost curve and keep children that would have otherwise been placed in residential or state hospital in the community.

(b) The service array created above has only been possible through the coordination and support with other partners in the community including juvenile justice, child welfare, the schools and other community partners. For example, the Therapeutic Learning Classroom utilizes braided funds between the Douglas Education Service District (ESD) and DCMH to provide two day treatment level classrooms in the county; a third classroom is funded in a braided effort between the Roseburg School District and DCMH. The child serving providers in Douglas County have a long history of working together and coming to the table formally (various venues, meetings, and committees) and informally to support the needs of children in our community. It is anticipated that the Umpqua Health Alliance (UHA) will build upon these relationships and bring the partnership further in its evolution that now includes physical and dental health.

Community Resource Teams (CRT's) are established for each child enrolled in Intensive Community Treatment Services (ICTS). These teams are comprised of relevant child serving systems representatives as well as family members and other persons important to the child/youth. The teams are the locus of decision making in which the child and family are supported by participants collaborating to achieve optimal outcomes. GOBHI is also a licensed child placing agency and directly recruits, trains, and certifies therapeutic foster homes throughout its service area.

(c) Applicant intends to utilize and expand upon the existing service delivery model for children and families. Through the use of the feedback of members, providers and community partners, Applicant will identify any gaps in the service delivery model for children and families to ensure that the goals of the ISA are being met. Current evaluation of the ISA has to date shown a marked increase in the number of services provided to children and families, more children and families being served and a cost shift in reducing the number of high-end services provided (hospitalization, residential treatment). The gains made through the development of the

ISA for children will be expanded in the UHA to include further emphasis and development for coordination with primary care to ensure that children continue to be treated in a service delivery model that supports the decisions of the family and is in the least restrictive level of care possible.

The CRT is the key to assuring that the ISA meets all appropriate contemporary standards, and is the forum in which family members can guide professionals in the provision of services that have a basis in the strengths of the child and family. The CRT also helps to recognize the unique attributes the family brings to the treatment process. The job of the CRT is to then deploy and/or develop those services/approaches designed to meet the needs of the child and family in their community.

Standard #7A – Mental Illness Services

(a) Applicant will utilize its existing network of mental health services as provided by DCMH. Mental Health services have been and will continue to be focused on the provision of these services in the community. As described in previous sections, DCMH has a history and is licensed to provide mental health services in Douglas County and has an established network of providers as well as continuum of services to meet the member needs. Additionally, Applicant will comply and coordinate with the necessary providers to ensure that the conditions of the 1915(I) plan will be met.

(b) Applicant will build upon existing practices for the screening of mental illness to ensure that members have access and receive the appropriate level of treatment. Currently through a coordinated effort of Applicant partners, members enrolled in the Prenatal Clinic receive immediate access to mental health staff for coordination and follow through. It is anticipated the Applicant will expand upon this successful practice to ensure that a warm handoff is given to each member and that a system will be developed through a coordinated EMR system that will ensure follow through and referrals are tracked and monitored. Applicant will also expand and build upon current coordination meetings that identify and track utilization. Currently, a project is under way to examine all data from DMAP to look at utilization and outcomes for members with chronic health conditions. It is anticipated that once this research is completed, its findings will inform the development of practice standards.

Standard #7B – Chemical Dependency Services

(a) Adapt has an extensive local continuum of outpatient and residential care for both adults and adolescents, including evidence-based and medication-assisted outpatient treatment, intensive outpatient therapy, gender specific services, short and long term residential, behaviorally integrated primary care, recovery coaches, and outpatient and residential treatment for parenting women. Child care is provided for women needing to participate in outpatient treatment, and transitional and permanent drug-free housing is available.

(b) Same day chemical dependency screening is currently available. Further, some Adapt counselors are embedded in several primary care clinics, and as-needed in the County pre-natal clinic. Embedded counselors receive "warm hand-offs" and average a little over 2000 patient contacts per year, including screens, early intervention, assessment, and referral. Patients evidencing a history of substance abuse or mental illness are referred specifically to the embedded counselor, to County Mental Health, or Adapt outpatient services.

Standard #8 – Pharmacy Services and Medication Management

(a) DCIPA collaborates with MedImpact Healthcare Systems, a pharmacy benefits manager (PBM), to administer DCIPA's formulary and ensure that pharmacy claims process according to DCIPA's formulary and benefit design. DCIPA follows the Oregon Administrative Rules in providing the prescription drug benefit for covered conditions.

(b) DCIPA maintains a formulary containing over 27,000 prescription and non-prescription medications. Prior authorization, step edits, and quantity limits are edits within the formulary as a process to allow patients and prescribers access to medications while ensuring that medications are safe, effective, and affordable.

Medication guidelines and changes to the formulary are reviewed and approved by DCIPA's quality improvement utilization management committee. Information regarding new FDA drugs to the market is provided by MedImpact Healthcare Systems, Inc.

The formulary is developed and reviewed with the quality improvement utilization management committee based upon data and research from MedImpact Healthcare Systems, Inc.

(c) DCIPA provides national and custom pharmacy network administration that includes retail chains and independently owned pharmacies. Members, prescribers, and pharmacies receive notifications. Notifications are via mail, the electronic medical record, or the on-line pharmacy benefits manager system.

(d) DCIPA contracts with MedImpact Healthcare Systems, Inc. to process pharmacy claims. Their proprietary system (MedAccess) provides an online processing and adjudication system interface. MedImpact uses standard National Council for Prescription Drug Programs (NCPDP) logic to conform to regulations.

(e) Prior authorization requests are received in-house and processed according to time frame regulations. Requests after hours and on holidays are processed through MedImpact Healthcare Systems, Inc.

(f) The contractual agreements are the following: Brand AWP-17%, Generic AWP-17% or Maximum Allowable Cost (MAC). Generic effective rate is the Guarantee AWP-75%. MedImpact Healthcare Systems, Inc. pays 75% of all rebates recovered to DCIPA.

The dispensing fee is $1.85 or usual and customary.

The management fee is $1.445 for each claim submitted electronically.

(g) DCIPA is working with Umpqua Community Health Center a federally qualified health center to develop a program.

(h) DCIPA will either develop a program internally or utilize a vendor to provide Medication Therapy Management (MTM).

(i) DCIPA providers have access to an electronic medical record that allows prescribers to electronically send prescriptions to a pharmacy or print the prescription out and hand it to a member.

Standard #9 – Hospital Services

(a) Mercy Medical Center is a not-for-profit hospital and is the only facility in central Douglas County. As part of its mission and charitable purpose, Mercy provides equal access to care to all service area residents including Medicare, Medicaid and uninsured patients regardless of their ability to pay.

Mercy Medical Center is a community hospital and thus tertiary and sub-specialty services are not provided locally. Examples include advanced trauma and burns, cardiac surgery, neurosurgery, transplant services, pediatric subspecialties, neonatal intensive care, etc. For

patients that present at the hospital, Mercy has robust relationships with tertiary providers that allow us to seamlessly transfer patients to the appropriate level of care. Community physicians also have referral relationships with specialists and subspecialists affiliated with larger facilities to accommodate the needs of Members that need services unavailable locally.

Applicant will utilize DCIPA LLC's Care Management team and related information systems to coordinate and provide access to hospital-based inpatient and outpatient services. All referral and care coordination services offered by DCIPA LLC will utilize community resources leveraging an effective blend of technology and local relationships to efficiently process and refer members/patients to timely and appropriate care.

(b) Because DCIPA, LLC has an integrated Medical Care Management team and shared information systems inclusive of primary, specialty, and hospital-based care, all member services are highly coordinated across the continuum of care. The Medical Care Management Team will utilize data and reports from the shared information systems to monitor inappropriate use of high-intensity resources by Members. These reports will enable Case Managers to identify "high utilizers" and educate them on appropriate use of healthcare resources through phone calls, letters and in-person counseling.

(c) Adverse Events – We contractually hold our providers to the policies and procedures of our organization. We have in place the "Adverse Event Reporting and Investigation" policy and procedure, as follows: In accordance with Oregon Administrative Rules, we will notify health care providers of identified potential adverse events and request information from the those providers in order to perform reviews. All findings from investigations will be shared with the providers in order to create opportunities for improvement. We will track adverse event frequency for all members. Policy attached – ATTACHMENT B.2.9.

Our Quality Improvement staff will conduct reviews of all identified occurrences of potential adverse events such as those listed below. The Quality Improvement Coordinator and the Chief Medical Officer will review the clinical information. All findings will be shared with the health care organization(s) where the potential adverse event occurred. Recommendations for corrective action plans will be provided as appropriate. We follow Medicare and Medicaid guidelines regarding adjudication of claims.

Hospital Acquired Conditions – HAC are identified in the coding on inpatient claims. The hospital has monthly reporting in place to track these events as they occur. These reports are widely available in the hospital's information systems and are utilized to design and drive initiatives to reduce their incidence. DCIPA's claim adjudication system will also have the ability to identify claims that include an HAC. We follow Medicare and Medicaid guidelines regarding adjudication of claims.

(d) Decreasing hospital readmission rates is a focus of our Quality Improvement and Case management programs. We collaborate and strategize with our providers to find focused areas for improvement. We invested in and developed a robust Transitions of Care Program, for our Medicare population, this includes monitoring our progress and outcomes. As this program is becoming a success, we expect to expand this process to our Medicaid population.

We are developing risk stratification techniques to identify high risk members for hospital admission and readmissions, and will be utilizing members focused case management to improve outcomes.

(e) The Medical Care Management team can leverage data in the shared information systems to proactively identify Members that utilize hospital services inappropriately and assign case managers to work with them. Similarly, patients with chronic diseases can be monitored closely

to trigger a timely intervention by the PCPH to avoid hospitalization. . Please see section A.3.5 for additional case management description.

Section 3 - Assurances of Compliance with Medicaid Regulations and Requirements

Applicant is a managed care organization and has directly operated a FCHP under a contract with the State of Oregon since 2005, and has done so through a predecessor entity since 1994. It complies with all applicable Medicaid regulations. In addition, its proposed mental and dental health care subcontractors (GOHBI and the Advantage Dental family of companies) comply with those regulations. The policies and procedures of all three organizations have been validated or approved by a number of audits and similar processes. We anticipate continued compliance by all three parties by continuing use of existing policies and procedures, with continual improvements and updating in the ordinary course of business and to accommodate specific requirements applicable to Coordinated Care Organizations. In particular, all three entities have the following procedures, policies, and/or staff, either directly or through contracts with third-party administrators.

1. Fraud and abuse, ethics, and other compliance policies, procedures, and staff.
2. HIPAA policies and privacy officers.
3. Provider credentialing policies, procedures, and staff.
4. Detailed written provider policies and contracts that, among other things, protect member rights and provide access to care.
5. Provider education and communication programs.
6. Medical Management and Quality Improvement systems that track provider performance, quality and continuity of care, protection of member rights, and recordkeeping.
7. Emergency and Urgent Care services, including call procedures.
8. Medical records policies and procedures. Please note that Applicant, through a related entity, provides a community electronic health records system to providers and intends to expand use of that system.
9. Panels of contracted providers, provider assignment procedures, and data tracking systems designed to monitor and assure access. Please note that Applicant also maintains a number of clinics and employed providers, in part to assure access.
10. Grievance and appeals policies, procedures, and staff.
11. Member information, education, and services.
12. Standardized prior authorization, referral, and billing policies and procedures.
13. Data compilation, reporting, and validation policies and procedures meeting all current standards.
14. Electronic communications policies, procedures, and protocols currently acceptable to all electronic trading partners (although we continue to accept paper claims and other transactions).

Additional and more detailed information is available upon request.

Accountability Questionnaire

Section 1 - Accountability Standards

C.1.1. Background Information

C.1.1.a. We currently participate in multiple performance measurements. We collect data, create reports and analyze results for State required measurements such as the Asthma Project and the Ambulatory Care performance Measure. We have the technology to pull any claims data needed to report to any agency necessary, and have done so annually to HEDIS. In addition, Advantage Dental pulls performance measures for ever-enrolled and continuously enrolled which measures preventative services for all members. Attached is our Policies & Procedures / Quality and Performance Improvement Practice Guidelines – ATTACHMENT C.1.1.

C.1.1.b. We currently participate in HEDIS reporting and all federal required reporting for our Medicare line of business ATRIO.

C.1.1.c. Our providers and contractors are held to a professional standard of care, outlined in our provider manual, and agreed to contractually.

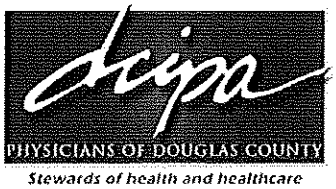
C.1.1.d . The Quality Improvement committee oversees the providers and contractors performance. Communication with providers regarding their performance is done through written and verbal communication. Currently provider specific utilization information is shared through generated reports. Our plan for population based performance measures is to develop an interface for providers to view their reported data. Advantage Dental currently provides the reports described above and currently has the interface for dental providers to view their reported data.

C.1.1.e. When communicating with members, we utilize letters written at a 5th grade level. Performance information will be member specific, clearly defined and with a clear plan. Much of our communication is verbal (by phone), supportive, encouraging and specific member's needs. Advantage Dental provides members with materials in different languages and interpreter services. In addition, Advantage Dental has internal staff to provide interpreter services through video conferencing in the operatory during the patient visit.

C.1.1.f. We have current incentives in place but we are developing a performance methodology for incentivizing providers to become PCPCH's and will be selecting measures to monitor. Advantage Dental has measurements in place to monitor utilization and each provider has a goal to provide dental services to a specific percentage of pregnant women and children.

C.1.1.g. We have the technology and experience to report any claims data measures. We can capture and report on discrete clinical data (e.g., smoking status, cholesterol, hgaic) utilizing our EMR database.

Following is our 2011 Quality Assessment & Performance Improvement Evaluation:



2011
QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT EVALUATION
DCIPA, LLC

INTRODUCTION

DCIPA, LLC (DCIPA) is currently comprised of over 200 local physicians serving the needs of Oregon Health Plan members in Douglas County.
Membership has increased from an average of 13,276 in 2010 to an average of 15,720 for 2011 YTD.
DCIPA is currently working with the Douglas County Health & Social Services to coordinate care for our high need members in anticipation of the Coordinated Care Organization model being implemented. This coordination of care will benefit the members by allowing open communication between the members care providers.
DCIPA has successfully contracted with the local hospital and is currently working on an Emergency Department Deferred Care program utilizing a Triage Coordinator to help members facilitate care with their Primary Care Provider.

QUALITY ASSURANCE

COMPLIANCE WITH REGULATORY OVERSIGHT

DCIPA is contracted with the Division of Medical Assistance Programs (DMAP). As such, DCIPA must comply with all regulations, as well as successfully pass annual evaluations.

DMAP ANNUAL EVALUATION

The Annual Quality Improvement Evaluation (QIE) took place in September 2010. Over all DCIPA did well on this evaluation. DCIPA received the results of the evaluation, which indicated that the Plan had a few areas to address with a response. These areas have been included on DCIPA's Quality Improvement Work Plan.

DMAP contracted health plans are required to participate in the External Quality Review program. The last site visit was performed September of 2010. Information Systems Capabilities Assessment (ISCA) was reviewed in January of 2011. The External Quality Review, Collaborative Performance Improvement Project (PIP), and Asthma Performance Improvement Project (PIP) were reviewed by Acumentra Health in March of 2011. Overall the plan met the compliance requirements for ISCA. The PIP's that were reviewed have since been retired. However, the recommendations will be considered with the development of our current PIP's.

DMAP PROJECT PREVENTION

All Fully Capitated Health Plans (FCHPs) are required to participate in Project Prevention, a sustained performance improvement project related to prevention and coordinated by DMAP.

Tobacco Cessation:

DCIPA offers a FREE Quit Smoking Class to its members. The program is held at the ***Active Life Fitness Center***. Members receive lots of helpful information that assist to keep members motivated as they leave are quitting tobacco use. The class is called, "Freedom From Smoking", an excellent, positive course endorsed by the American Lung Association. DCIPA also offers medications to help quit including both nicotine patches and Chantix. In order to obtain treatment with NRT or Chantix, patients will be required to sign a **Letter of Intent to Attend Smoking Cessation Classes.**

ECCP:

Currently this is not a reportable measure. Our Medical Director is working with UCHC and Mercy Foundation on increasing awareness and usage in the community. Mercy Foundation has a grant and is using the dental van and nurses to teach in classroom.

PERFORMANCE MEASURES

Ambulatory Care: Outpatient Visits and Emergency Visits:

DCIPA will calculate denominators, numerators, and rates using HEDIS 2011 Technical Specifications Volume 2 for the 2010 measurement year and HEDIS 2012 Technical Specifications Volume 2 for the 2011 measurement year. DCIPA will note and specify when methods of calculations vary from the HEDIS Technical Specifications.

Childhood Immunizations:

This measure is calculated by DMAP and the ALERT Immunization registry. Results for 2011 will be calculated in the autumn of 2011 using an assessment date of March 1, 2011.

PERFORMANCE IMPROVEMENT PROJECTS

ABCD III Performance Improvement Project (PIP)

DCIPA is currently working in cooperation with OPIP and DMAP on this Performance Improvement Project. The PIP goals are as follows: **Goal 1** - ***Early identification*** of at-risk children for developmental, behavioral or social delays; **Goal 2** - Children who are identified at-risk for developmental, behavioral delays and or with developmental disabilities are ***referred*** to Early Intervention; **Goal 3** - Children at-risk or with disabilities ***receive*** Early Intervention services or other community-based services and **Goal 4** - ***Care coordination*** between the primary care provider/primary care sector and community-based services.
DCIPA has identified five areas for improvement. DCIPA plans to improve the referral process by working with EI to create a referral form in the EMR that is modeled after the universal referral form, improve the screening tool within the EMR, improve the exchange of information with EI and getting access to EMR, and to improve health literacy.

Collaborative PIP with Douglas County Mental Health

Our goal is to establish a relationship with Douglas County Mental Health (DCMH) and create an ongoing project that will benefit our members. At this time we are currently in talks with DCMH about what study topic we would jointly like to pursue that would achieve that goal.

ACCESS

Membership has increased from an average of 13,276 in 2010 to an average of 15,720 for 2011 YTD. The expectation is that all new members will be assigned to a Primary Care Provider within 30 days of enrollment. ABCT is DCIPA's outsource partner. ABCT is tasked with assigning PCPs to members. Members are immediately auto assigned to a PCP if they did not make a PCP selection upon enrollment on the Oregon Health Plan.

APPEALS AND GRIEVANCES

Grievance and appeal reports are presented to the Quality Improvement Utilization Management (QIUM) Committee quarterly. Managed Care Organizations are required to complete the processing of member appeals within 16 days, and grievances within 5 days (up to 30 calendar days if an extension is needed).

DMAP requires that all appeals, except expedited requests, be filed in writing. Administrative Hearing Rights and an Administrative Hearing Request are included with the Notice of Action sent to members.

Over the past year, DCIPA has noted an increase of appeals with the Standard population, this increase parallels with the increase in the numbers of Standard members. The numbers for the Plus population have remained stable.

PROVIDER MEDICAL RECORDS REVIEW

DCIPA performed medical record reviews of 10 contracted providers within Douglas Medical Group. These reviews ensure that providers maintain a medical record-keeping system that is compliant with State and Federal regulations, and is mindful of professional standards. Providers are reviewed every 3 years in accordance with their re-credentialing cycle.

EXCEPTIONAL NEEDS CARE COORDINATION (ENCC) / CASE MANAGEMENT

DCIPA provides coordination of services with DCIPA's OHP members who are elderly, blind, disabled, or children with special needs. We provide cost effective management of health care resources to meet the individual member's health care needs and promote positive health outcomes. Case Managers act as a member advocate and liaison between providers, agencies, and members and/or their personal representative.
Case Managers strive for early identification of DCIPA OHP members that have disabilities or complex medical needs. Once identification is made, Case Managers try to assist medical providers in coordination of medical services and discharge planning; coordinate and communicate with community support and social service systems, as necessary, to link their services to delivery of medical care. ENCC activity is logged and maintained in Plexis. Phone calls are documented on an Excel spreadsheet.

SATISFACTION SURVEYS

The Medicaid CAHPS (Consumer Assessment of Health Plans Survey) assess consumer satisfaction with the member's health plan. The most recent CAHPS survey was completed in 2011.

MEMBER EDUCATION

Member education is performed in a number of ways. DCIPA newsletters are mailed on an approximately quarterly basis with the change of seasons, i.e., Spring, Summer, Fall and Winter. DCIPA mails approximately 8,714 newsletters to members quarterly. The newsletters cover many topics including ENCC services, tobacco cessation assistance, heart disease (including risk factors, symptoms, treatment and smoking and coronary artery disease), health and sleep, etc. The information varies depending on the season. DCIPA will continue to send this newsletter out quarterly as well as in all new member packets.

Member education is also available on-line, as www.dcipa.com. On-line healthcare information includes, but is not limited to, colon cancer screening, diabetes prevention, preventing eye diseases, and skin cancer. Videos are on-line concerning obesity with exercise tips, smoking cessation, healthy habits, immunizations and blood pressure.

Additionally, each week on KPIC News, there is a session of Spotlight on Health which covers various health concerns such as eye health, prescription drug abuse, senior health, colon cancer screening, women's health and nutrition, breast cancer, childhood obesity, flu season and much more. There are also education segments regarding Medicaid, Medicare, Clinics and Electronic Health Records, Shots for Tots, Children's Dental Month, Healthy Kids Outreach, Walk and Bike to School Day, urgent care clinics, and much more.
At the 2011 Douglas County fair, DCIPA partnered with Cow Creek Health & Wellness, Douglas County Public Health Promotion, Mercy Medical Center, Mercy Foundation and Umpqua Partners to offer health screening, education and awareness activities. Our alliance, ***Live Well Douglas County***, provided fairgoers with the opportunity to participate in a free passport to health screening. Physicians, clinicians and other healthcare professionals were on hand to talk to fairgoers and provide suggestions that promote healthy lifestyles. During the five days of the fair, we had approximately 1500 visitors through the booth.

MEMBER HANDBOOK

Member handbooks are updated annually, as well as throughout the year as information changes and updates. Member handbooks are posted on the DCIPA website, www.dcipa.com, and are also mailed to each new member in the new member packet as they come on the plan. Members are also provided a member handbook upon request.

PROVIDER HANDBOOK

Provider handbooks are updated annually, as well as throughout the year as information changes and updates. Provider handbooks are posted on the DCIPA website, www.dcipa.com, and are also mailed to each new provider in the new provider packet as they join DCIPA. Providers are also provided a provider handbook upon request.

UTILIZATION MANAGEMENT

PAY-FOR –PERFORMANCE / QUALITY AWARDS PROGRAM

DCIPA is involved with a pay-for –performance program for Primary Care Providers. This provides a financial incentive of an additional $5.00 per member when the provider has over 150 OHP patients. In 2011/2012 the pay-for-performance program will be reviewed.

PHARMACY UTILIZATION REPORTS

DCIPA is contracted with Med Impact Healthcare Systems, Inc. as the pharmacy benefit manager for pharmacy claims adjudication. In addition, DCIPA defers to Med Impact's quarterly pharmacy and therapeutics committee meetings. The DCIPA medical directors along with the pharmacy coordinator add/remove, place quantity limits, and add prior authorization to medications to the formulary on a weekly basis with a focus on cost and quality of care. The data from the second quarter of 2011 compared to the first quarter of 2011 reveal the following performance trends:

- ***Pharmacy Performance Trends***

	Current Quarter	Previous Quarter	% Change
$PMPM (Per Member Per Month)	$31.46	$31.90	-1.38%
Average Membership/Month	16,706	16,455	1.53%
Prescription Utilization (Rx PMPM)	0.93	0.97	-4.12%
Average Cost/Rx	$33.85	$33.07	2.38%
Generic Utilization	83%	83%	--
Multi-Source Brand Utilization	0%	0%	--
Formulary Compliance	99%	99%	--

- ***Top 5 Therapeutic Categories by Amount Paid***

Current Quarter	Previous Quarter
Asthma	Asthma
Diabetes	Diabetes
Pain Management-Analgesics	Pain Management-Analgesics
Infectious Disease-Bacterial	Infectious Disease-Bacterial
Cardiovascular DZ-Hypertension	Cardiovascular DZ-Lipid Irregularity

DCIPA's current focus as it relates to pharmacy management is on increasing generic utilization through communications with providers and hard-stops at the pharmacy claim level to encourage a trial of generic products prior to higher cost generic and brand name medications.

SUMMARY

The 2011 Quality Assessment & Performance Improvement Evaluation offers an overview of DCIPA's Quality Improvement Program. DCIPA has a positive attitude about its QI Program. We look forward to continuing our efforts in developing a robust QI Program.

DCIPA received recommendations from the 2010 Final EQR Report regarding ISCA and PIP's. We look forward to examining ways to implement these in the future. In addition, we have noted some other areas for improvement, and have incorporated these into our Annual Quality Improvement Work Plan.

DCIPA has been successfully collaborating with Early Intervention, OPIP, and DMAP regarding the ABCD III PIP. We are eager to move forward with our efforts and work toward accomplishing our five outlined goals.

Section 2 - Quality Improvement Program

C.2.1. Quality Assurance and Performance Improvement (QAPI)

C.2.1.a. Our QI Program consists of a Committee made up of Physicians, Nurses and the Medical Director; Work Plans and Performance Improvement Projects. Ongoing evaluation of Grievances and Appeals are used to determine areas of interest and follow up. DCIPA's Quality Program will expand with the inclusion of our Community Partners, Douglas County Mental Health and Mercy Medical Center. They have comprehensive programs to which all would be part of.

C.2.1.b. The QI Committee is made up of eleven members. Included in this group are eight local providers representing eight different health care clinics, DCIPA's Medical Director, DCIPA's Medical Management Nursing Supervisor, and DCIPA's Pharmacy Coordinator. The Committee Members themselves have various specialties in their practices: Primary Care Providers, Newborns, Obstetrics, Pediatrics, Surgery, Orthopedics, Internal Medicine, Family Practice, and Ophthalmology. The Committee Members represent our local providers with a much more extensive list of various specialties. They also speak various languages: English, Arabic, Chinese, French, German, Indian, Lebanese, Hindi, Mandarin Chinese, Filipino, Romanian, Spanish, Sign Language and Telugu. Our providers also come from varying cultural back grounds. The Committee Members represent DCIPA's clinics located throughout Douglas County making care to our members more convenient: Myrtle Creek, Sutherlin, Roseburg, Glide, Canyonville, Winston, Winchester, Drain, etc. The Quality Improvement Committee meets on a monthly basis to discuss various items: contested denials; complaints received from providers, vendors and members; development of Policies & Procedures; the Pain Management Committee; etc...Information is presented, issues are addressed, resolutions are discussed and communication to appropriate party or action needed is followed through with. The structure will evolve with the addition of Community Partners and incorporate best practices among the entities in order to develop a central committee. (CCO QI Committee)

C.2.1.c. On a yearly basis, DCIPA develops a Quality Improvement Work Plan. The following year Policies & Procedures, Processes, Guidelines, and Projects are put in place to improve the areas specified.

On a monthly basis accountability is brought to the Work Plan established via updates to the Quality Improvement Committee. The Committee develops the steps to obtain perceived goals and discusses their progress, reviews drafts of policies and processes to be initiated and approves implementation. On a daily basis the Support Staff, Nurse Case Managers and the DCIPA Medical Director put into action adjustments by the QI Committee. Performance Improvement Projects are also utilized to review data in certain aspects of our health plan. This process would expand to include our Community Partners. Each entity would be integrating their own plan with other entities resulting in common goals and areas of concern being incorporated.

C.2.1.d. Members and providers have the right to submit complaints regarding the service they eceived from DCIPA, providers, vendors, facilities, etc. These are reviewed by the QI Committee. These complaints contribute to what is developed in the aspects of planning, design and implementation of DCIPA's QI Program. Our members also have access to our Customer Service Representatives where they can express their specific questions and concerns by phone. A Monthly Phone Report is generated and reviewed by our Medical Director. Providers can express their viewpoints directly to our staff via phone, email or letter. In many cases, this results in reconsideration of a requested service. Our DCIPA website keeps members and providers informed of the development of our health plan.

C.2.1.e. The QI program utilizes the QI Committee's review of health care requests to address health care in general, health outcome inequities, care coordination and transitions between care settings. This review incorporates the needs of the member with current evidence based medicine. The Committee and Medical Management are available to assist the Primary Care Provider with providing appropriate care for the member. Suggestions for improvement to the member plan are made within the Committee and communicated to the provider and member both telephonically and in a formal resolution letter. The QI Program will provide a complete benefit package of OHP health services with the Exceptional Needs Care Coordinator acting as the hub in assisting with these more complex, medical and/or special needs members.

C.2.1.f. As stated in DCIPA's Provider Handbook (ATTACHMENT C.2.1.f.), the Quality Improvement Committee will manage issues involving providers or provider's staff and can result in the provider's termination as a participating provider for DCIPA. In the medication arena, DCIPA will utilize the ability to block payment of prescriptions written by providers proven to be prescribing inappropriately. Compliance will be monitored by our grievance log and when identified, trends will be reviewed and addressed. Corrective action plans will be implemented based on the decision of the QI Committee.

C.2.1.g. In general other 'Relevant Resources' which include Affiliate Contract, Policies and Procedures provide for procedural detail on various Member and Enrollee Rights. It is the practice of DCIPA to include detail information specific to applicable Rights within the Member handbook and inform affiliate providers in the form of contractual agreements, access to the Provider Handbook, the DCIPA website as well as periodic Newsletter publications. We

monitor member rights through our grievance process and periodic surveys as determined by our Quality Improvement Department. Also see answer C.2.1.F.

Our Fraud & Abuse Department purposes to outline and define the scope, responsibilities and operational guidelines, controls and activities to assist in the identification and reporting of potential member or provider fraud and abuse occurrences. This Plan is established in accordance with the terms and conditions of applicable state and federal statutes and regulations. DCIPA expects all its employees, contractors, providers, officers, and Board members (personnel) and community partners to act with the highest degree of integrity at all times, and to comply with this Plan and all applicable law.

DCIPA will continue to use evidenced-based clinical practice guidelines that are based on valid and reliable clinical evidence or on a consensus of Health Care Professionals. DCIPA's Practice Guidelines will also take into account the Guidelines and Oregon Administration Rules as set by DMAP. DCIPA will ensure that the needs of its members are taken into consideration when developing guidelines. Dissemination of guidelines will be accomplished through approved channels: the Provider Handbook, DCIPA's website, and notification of change letters.

QAPI current process will continue and include our community partners.

C.2.2. Clinical Advisory Panel

C.2.2.a. Our Current Quality Improvement Utilization Management Committee made up of Providers from our Community would become the CAP.

C.2.2.b. We would add Dental and Mental Health representation and would make sure to have representation on the Governing Board.

C.2.3. Continuity of Care/Outcomes/Quality Measures/Costs

C.2.3.a. Care guidelines are developed with emerging best practices and in conjunction with the QIUM committee. They are used to manage member out comes as well maintain appropriate care for members.

C.2.3.b. We have two performance improvement projects under way – 1) deals with connecting children with Early Intervention and promoting screening, and 2) developing improved communication between the PCP and Mental Health providers. Both of these projects are in the spot light for health care on the national and state levels. We continue to improve in immunization measures, focus on Emergency room utilization and ambulatory care measures. We collect reports on and address all Hedis measures.

C.2.3.c. We have an active wellness program for our staff, supporting healthy meals, exercise, and weight loss. We speak out in our local TV station with "Spotlights" on health, and in our local paper with articles on wellness topics. We have educational materials available on our website and in our EMR for members. We use our Member Newsletters to focus on specific health topics.

C.2.3.d. DCIPA has been a managed care organization for over 10 years. We have extensive experience with collecting data, managing staff and creating policy and procedure. We have the technology to pull reports from our claims data and our Electronic medical record.

C.2.3.e. The already implemented Electronic Medical Record has cut down on duplications and improved coordination and increased communication between providers. We are working on the physical and mental health coordination of health information and services.

C.2.3.f. We have access to the Electronic medical record for almost all of our patients. Such access improves our ability to identify continuity of care needs, and to coordinate care amongst providers.

We have an electronic tracking system for our referrals and authorizations and policies and procedures that ensure continuity of care.

Medicare/Medicaid Alignment Questionnaire

Section 1 - Background Information – Inclusion of Dually Eligible Individuals in CCOs

Not applicable – based on OHA's decision to implement the dual eligible capitation integration demonstration in 2014, rather than 2013.

Section 2 – Ability to Serve Dually Eligible Individuals

D.2.1. Our organization will contract with our affiliate, ATRIO Health Plans, to administer the Medicare benefits in our service area. ATRIO Health Plans is a Medicare Advantage Organization and an affiliate of the CCO Applicant. ATRIO already has applied and has been awarded CMS contracts for 2012 services. Through the coming Bid process ATRIO fully expects to be granted a renewal from CMS to continue as a Medicare Advantage Organization in 2013 and into 2014, continuing to serve the full dual members of the CCO.

ATRIO currently administers the following CMS contracts:

- H3814: a local Coordinated Care Plan, local HMO, MA-PD and MA-Only
  - This contract is approved for a Full-Benefit Dual Eligible Special Needs Plan in Douglas and Klamath (partial: 97601, 97602, 97603, 97604, 97621, 97622, 97623, 97624, 97625, 97626, 97627, 97632, 97633, 97634 and 97639.) Counties in Oregon.
- H6743: a local Coordinated Care Plan, local HMO, MA-PD and MA-Only
  - This contract is approved for the service area of Douglas and Klamath (partial: 97601, 97602, 97603, 97604, 97621, 97622, 97623, 97624, 97625, 97626, 97627, 97632, 97633, 97634 and 97639.) Counties in Oregon.

D.2.2.a. Our CCO will be able to continue to provide the Medicaid benefits to dually eligible Members through our existing resources with DCIPA who has managed the OHP benefit as a Fully Capitated Health Plan since 1994. Along with the other community partners and affiliates of our CCO we are certain that we can offer Medicaid benefits in a timely and accurate manner. We have the access, staff and resources to continue administering the Medicaid Benefits in our service area and place no limits to the number of members that may be enrolled.

To coordinate the Medicare benefits for the dually eligible Members we will be contracting with ATRIO Health Plans who has been serving the Medicare Advantage Full Dual Eligible Special Needs Plan population since 2006. ATRIO's experience with managing the full dual population is extensive. ATRIO already has the access, processes, staff and resources in place to ensure Medicare benefits are provided to the full dual beneficiaries enrolled in t CCO.

D.2.2.b. ATRIO already has applied and has been awarded CMS contracts for 2012 services. Through the coming Bid process ATRIO fully expects to be granted a renewal from CMS to continue as a Medicare Advantage Organization in 2013 and into 2014, continuing to serve the full dual members of the CCO. Additionally, to meet the MIPPA requirements ATRIO is in contract negotiations with State and our OHP partners to ensure that ATRIO has the required fully integrated SNP contract in place and submitted to CMS by 7/1/2012 to continue operations as a SNP into 2013 and beyond.

Key milestones that ATRIO is prepared to meet include (but are not limited to):

- Formulary Submission – ATRIO has submitted the required formularies to CMS for many years and will continue to have the processes in place for timely submission in 2014.
- Transition Fill Policy submission – The transition fill policy currently in use by ATRIO meets the CMS requirements. The current transition policy will be updated as appropriate or as required by CMS or OHA for the 2014 plan year.
- Medication Therapy Managed Program (MTMP) submission – The MTMP currently in use by ATRIO meets the CMS requirements. The current MTMP will be updated as appropriate or as required by CMS or OHA for the 2014 plan year.
- Bid Submission – ATRIO stands ready to prepare all necessary Bid documentation and submission items by the 2014 Bid deadlines and ensure appropriate coordination with our CCO.
- Enrollment – ATRIO has a well-established Enrollment department and stands ready to meet all CMS required pre and post enrollment activities for the 2014 plan year as well as respond to any future updates to enrollment requirements.
- Member materials – ATRIO has a history of creating and distributing all CMS required member materials. ATRIO stands ready to meet all timeframes for required member materials
- Readiness Checklist – Each fall CMS sends out to all Medicare Advantage Organizations a Readiness Checklist for important operational items that need to be in place for successful operations into the coming plan year. ATRIO stands ready to have all operational areas ready to meet the standards for all 2014 Readiness Checklist items.
- Compliance – ATRIO has robust compliance resources and continuously monitors all state and federal regulations that affect operations. ATRIO has the staff and resources needed to stay current on all state and federal requirements. Additionally, ATRIO will be able to respond to any updates or new requirements CMS or OHA may develop between now and 2014.

D.2.2.c. Our CCO will facilitate all applicable requirements regarding dual eligible Medicare Benefits are accomplished through our contracted affiliate ATRIO Health Plans who has been a Medicare Advantage Organization serving dual eligible Members since 2006.

ATTACHMENT A.1.1.b. – CAC Draft Procedure

Umpqua Health Alliance Advisory Council
CHARTER

NAME

The Umpqua Health Alliance Board officially established an advisory council to be known as the Umpqua Health Alliance Advisory Council. The Umpqua Health Alliance Board is responsible for the development of the Charter of the Community Advisory Council (CAC) and for any and all revisions of the Charter.

PURPOSE AND RESPONSIBILITIES

1. Purpose and Objectives

The purpose of this Advisory Council is to advise the Umpqua Alliance in matters regarding the health care needs of the consumers and the community. The Advisory Council ensures the opportunity for involvement of consumers in advising the Umpqua Health Alliance Board.

2. Responsibilities

The Advisory Council will establish procedures for the internal operation of the Advisory Council to include electing officers of the Advisory Council, conducting regular meetings for the purpose of carrying out the responsibilities of the Advisory Council, and reporting to the Umpqua Health Alliance Board of Directors.

The duties of the Advisory Council include:

- Advise the Board on health care needs of consumers and the community.
- Advise the Board on issues of access to health care and ease of navigation of the health care system.
- Advise the Board on Quality of care issues.
- Identify and advocate for preventive care practices.
- Oversee a community health assessment and adopt a community health improvement plan to serve as a strategic population health and health care system service plan for the community served by the Umpqua Health Alliance.
- Publish annually a report on the progress of the community health improvement plan.

In order to advise the Umpqua Health Alliance Board on areas identified in the responsibilities listed above, the Advisory Council may develop an annual work plan. The work plan may (1) identify information, and data needed to develop recommendations to the Umpqua Health Alliance; 2) define methods to collect and analyze that information including timelines and responsible parties; 3) describe the format for recommendation reporting. The information collection phase may include but is not limited to: consumer surveys, conducting public meetings and other methods of collecting comments and recommendations from consumers regarding issues affecting their health care.

MEMBERSHIP AND VOTING

1. **Membership**

A. Members of the Advisory Council will be broadly representative of the community with a balance of age, sex, ethnic, socioeconomic, geographic, professional, and consumer interests represented. Members will be residents of Douglas County.

B. The Advisory Council will consist of not more than fifteen (15) regular members appointed by the Umpqua Health Alliance Board and one (1) Ex-officio non-voting member of the Umpqua Health Alliance Board. At least eight members will represent consumers of health services under the responsibility of the Umpqua Health Alliance in Douglas County.

C. Membership may represent the following geographic areas of Douglas County as established by the Umpqua Health Alliance:

Position #1	North & East Douglas County (areas north and east of Winchester/Roseburg)
Position #2	West Douglas County (areas west of Roseburg/Green)
Position #3	South Douglas County (areas south of Roseburg/Green)
Position #4	Central Douglas County (Roseburg, Green, Winchester)
Position #5	Central Douglas County (Roseburg, Green, Winchester)

The following positions may be filled by consumers of services or community members with special interest or knowledge in the following:

Position #6	Seniors & People with Disabilities
Position #7	Mental Health & Addictions
Position #8	Health/Medical
Position #9	Dental
Position #10	Education
Position #11	Local Government
Position #12	Children
Position #13	Tribe
Position #14	Housing
Position #15	Faith Community
Position #16	Ex-officio member of the Umpqua Health Alliance Board of Directors

2. **Appointments**

The Umpqua Health Alliance Board may seek qualified candidates through an application process. The Umpqua Health Alliance Board will review applications received and appoint members to the Advisory Council.

3. **Term of Membership**

The term of office for Advisory Council regular members will be two years. Terms of the appointments will be designated by the Board. No regular member may serve more than three (3) consecutive two-year terms, exclusive of appointment to fill unexpired

terms. The Umpqua Health Alliance will stagger the terms of office for the first appointees as follows:

Position #1	2 years	Position #9	2 years
Position #2	1 year	Position #10	1 year
Position #3	2 years	Position #11	2 years
Position #4	1 year	Position #12	1 year
Position #5	2 years	Position #13	2 years
Position #6	1 year	Position #14	1 year
Position #7	2 years	Position #15	2 years
Position #8	1 year	Position #16	1 year

4. Absence
An Advisory Council member who fails to attend three (3) consecutive meetings without notifying the Chairperson may be removed by a vote of the Umpqua Health Alliance Board of Directors.

5. Resignation
A member may resign by written notice to the Chairperson. Automatic resignation from the Advisory Council occurs when a member moves from Douglas County.

OFFICERS AND DUTIES

1. Officers
The officers of the Advisory Council will be a Chairperson and a Vice-Chairperson. The Chairperson will be appointed by the Umpqua Health Alliance Board from the public directors on the Umpqua Health Alliance Board. The Vice-Chairperson will be elected by the Advisory Council. The Umpqua Health Alliance Board may provide staff to the Advisory Council to take and produce the minutes of the meetings.

2. Term of Office
Officers may hold office for a period of one (1) year.

3. Elections of Officers
Election of the Vice-Chairperson may be held at a regular meeting of the Advisory Council.

4. Duties
The chairperson may preside at each regular and special meeting of the Advisory Council and perform other duties necessary for the proper function of the Advisory Council. In the absence of the Chairperson, the Vice-Chairperson may perform the duties of the Chairperson for the Advisory Council.

MEETINGS

1. Regular Meetings
Regular meetings of the Advisory Council may be held quarterly in the months of at a date, time, and place designated by the Chairperson.

2. Special Meetings
Special meetings may be called by the Chairperson upon request of five (5) members of the Advisory Council, at the request of the Chairperson, or the request of the Umpqua Health Alliance Board.

3. Notice of Meetings
Members will have written notice five (5) days in advance of each regular and special meeting of the Advisory Council.

4. Quorum
A quorum will consist of a simple majority of the Advisory Council present at the meeting.

5. Action
Each regular member of the Advisory Council will have one (1) vote on all business presented at regular and special meetings at which the member is present. The action of a simple majority of the members present and voting at regular and special meetings of the Advisory Council will constitute the action of the Advisory Council.

COMMITTEES

1. Executive Committee
The Executive Committee may act on behalf of the Advisory Council in the oversight of all Advisory Council affairs. The Executive Committee consists of the Chairperson, Vice Chairperson and one member of the Advisory Council selected by vote of the Advisory Council. Specific responsibilities of the Executive Committee will be delegated by the Umpqua Health Alliance Board.

2. Standing Committees
By majority vote of the members of the Advisory Council, standing committees may be established. The function of standing committees and the number of members may be prescribed by the Advisory Council, who will also determine the committee's business, and appoint the committee chairperson and members. At least 50% of the members must be members of the Advisory Council.

3. Special Committees
By majority vote of the members of the Advisory Council, special committees may be established. Special Committees of the Advisory Council are to be appointed by the Advisory Council. The function of special committees and the number of members

therein may be prescribed by the Advisory Council, who may also determine the committee's business, and appoint the committee chairperson and members. At least 50% of the members must be members of the Advisory Council.

4. Liaison Assignments

Members may be appointed by a vote of the Umpqua Health Alliance Board as official liaison person(s) to facilitate communications with other advisory committees, commissions or organizations.

Adopted: March 14, 2012

ATTACHMENT A.3.3

PHYSICIANS OF DOUGLAS COUNTY
Stewards of health and healthcare

Policy & Procedure

Title: Availability of Services

Approved by: DCIPA's Quality Improvement Committee

Date Approved: 3/18/09

Reference: OAR 410-141-0220; CFR §438.207(b)(3)

BACKGROUND:

The purpose of this policy is to demonstrate DCIPA's goal to maintain an appropriate network of providers adequate to meet the needs of its members.

APPLICABILITY:

This policy is used by quality improvement, medical management, member services and the Medical Director.

DEFINITIONS:

Contract -- The written agreement between the State of Oregon and DCIPA.

Covered Services -- Are Medically Appropriate health services that are funded by the Legislature and described in ORS 414.705 to 414.750; OAR 410-120-1210; 410-141-0120; 410-141-0520; and 410-141-0480; except as excluded or limited under OAR 410-141-0500 and rules in chapter 410, division 120.

Fee-for-Service (FFS) Health Care Providers -- Health care providers who bill for each service provided and are paid by DMAP for services as described in DMAP provider rules.

Medicaid -- A federal and state funded portion of the Medical Assistance Program established by Title XIX of the Social Security Act, as amended, and administered in Oregon by DHS.

Participating Provider -- An individual, facility, corporate entity, or other organization which supplies medical, dental, chemical dependency services, or mental health services or medical and dental items and that has agreed to provide those services or items to DMAP Members under an agreement or contract with a PHP and to bill in accordance with the signed agreement or contract with a PHP.

Rural -- A geographic area 10 or more map miles from a population center of 30,000 people or less.

POLICY:

This policy ensures that DCIPA maintains and monitors a network of appropriate providers whom are supported by written agreements. The network will be sufficient to provide adequate access to all services covered under the contract by anticipating Medicaid enrollment, and utilization of services, taking into account the number of network providers who are not accepting new Medicaid patients. Additionally, it is DCIPA policy to maintain a network of providers within the geographic location of members, and provide that any member requesting a second opinion may have another opinion free of charge from a provider either inside or outside the network. DCIPA ensures that for 90% of our Members, routine travel time or distance to the location of the PCP does not exceed the Community Standard for accessing health care. The travel time or distance to PCPs shall not exceed 60 miles, 60 minutes or the Community Standard, whichever is greater.

Further, DCIPA will coordinate with out-of-network providers so that payments and costs of services to the enrollee are no greater than it would be if the services were furnished within the network.

The timing of services will follow the standards provided by DMAP and take into account the urgency of need for services. The providers will offer hours of operations comparable to commercial enrollee or Medicaid fee-for-services enrollees. When medically necessary, services will be available 24 hours a day, 7 days a week. Providers will comply with the following standards regarding Member appointments:

- Emergency Care - member shall be seen immediately or referred to an emergency department depending on the Member's condition.
- Urgent Care - The Member shall be seen within 48 hours
- Well Care - The Member shall be seen within 4 weeks or within the community Standard.
- Routine Care – The Member shall be seen within an average of 8 weeks and within 12 weekds or the community standard, whichever is less.

DCIPA will make every effort to promote delivery of services and interpreter services in a culturally competent manner to all enrollees.

DCIPA will monitor Providers for compliance with ADA requirements.

PROCEDURE:

Weekly enrollment reports are provided by Member Services.

DCIPA provides incentives to PCPs to provide access for Oregon Health Plan members by paying a case management fee and monitors the patient access to PCPS on a weekly basis.

All specialists are open to Oregon Health Plan members.

DCIPA refer members to specialists and to out-of-area physicians for second opinions , and when required services are unavailable in Douglas County. These services are free of cost to the member.

DCIPA has written agreements with all in-area and some out-of-area providers and allows referrals to non-contracted providers.

DCIPA monitors compliance regarding timing of services through the Complaint and Appeal process, DMAP termination reports, and DMAP Member Surveys.

ATTACHMENT A.3.8.a.

PHYSICIANS OF DOUGLAS COUNTY

Stewards of health and healthcare

OHP STAFF PROCESS
DCIPA, LLC

ENCC RESPONSIBILITIES

Of DCIPA, LLC

Approved by: **Quality Improvement Committee**

Approved: _____

Christine M. Seals, MD, Medical Director of DCIPA, LLC **Date**

Purpose:

To assure there is always coverage for the ENCC during regular business hours Monday to Friday 8:00 am to 5:00 pm., all DCIPA OHP Nurse Case Managers are trained to assist members with special needs.

The following process should be followed by the ENCC.

1. The nurse should verify the caller's ID per HIPAA guidelines by asking for the member's date of birth, OHP ID number etc. The member's eligibility should also be checked before the conversation begins.

    a. Incoming calls regarding a special needs member may come from a member's representative, specialist, caseworker, DME supplier, pharmacist, hospital discharge planner, skilled nursing facilities or foster home's care provider, the ENCC from another plan, or a DMAP representative etc.

2. Documentation of the call should be included in the demographic screen in Plexis with the date and time of the call, the caller's name and the purpose of the call.

    a. A note capturing the call will also be made in the "ENCC Log" for the purpose of tracking the request to resolution. Be clear as to how the issue was resolved or what the plan of action will be.

    b. If the issue is left unresolved it should be discussed with the ENCC upon their return.

3. Appeal or complaint calls regarding special needs members should be directed to the Appeal and Grievance Coordinator. A note should be made in Plexis as to how the call was handled.

   a. If the member wants to file a complaint, the call can be transferred to Member Service and a representative will mail the paperwork.

4. Use all available resources to meet the member's needs.

   a. The member's case worker may be of assistance.

   b. Other agencies may be able to meet needs that are not covered by OHP such as meals on wheels, Senior Services, ADAPT, CRAFT, Batter Women's, Advocacy, the Salvation Army etc.

5. The Medical Director is available if additional assistance is needed.

Originated: 6/18/2008
Reviewed: *
Revised: 9/16/2009

ATTACHMENT B.1

Appendix B Section 1 - Service Area and Capacity Service Area Table		
Service Area Description	**Zip Codes(s)**	**Maximum Number of Members – Capacity Level**
Azalea	97410	759
Camas Valley	97416	937
Canyonville	97417	2439
Curtin	97428	209
Days Creek	97429	684
Dillard	97432	included in 97496
Drain	97435	2349
Elkton	97436	838
Glendale	97442	2112
Glide	97443	2368
Idleyld Park	97447	887
Myrtle Creek	97457	9884
Oakland	97462	4002
Riddle	97469	2782
Roseburg	97470	40060
Roseburg	97471	
Sutherlin	97479	9505
Tenmile	97481	682
Tiller	97484	336
Umpqua	97486	652
Wilbur	97494	included in 97495
Winchester	97495	1745
Winston	97496	17603
Yoncalla	97499	2031
		Total: 102864

ATTACHMENT B.2

CONTRACTOR NAME	LAST NAME	FIRST NAME	BUSINESS/PRACTICE ADDRESS	BUSINESS/PRACTICE CITY	BUSINESS/PRACTICE ZIP	BUSINESS COUNTY	PROVIDER TYPE	SPECIALTY	NPI	PCP IDENTIFIER	# MEMBERS ASSIGNED	ADDITIONAL MEMBERS CAN BE	CREDENTIAL VERIFICATION	SANCTION HISTORY	CONTRACT START DATE	CONTRACT END DATE
DCIPA	ABRIO	HENNIE	2700 STEWART PARKWAY	ROSEBURG	97471-1281	DOUGLAS	34	262	1891925129	N	0	0	07/16/10	NOT APPLICABLE	06/30/09	99/99/99
DCIPA	ACOSTA	BONITA	115 SW PINE STREET	CANYONVILLE	97417-0000	DOUGLAS	42	364	1295882512	N	See Gregory Falk, MD	See Gregory Falk, MD	06/09/09	NOT APPLICABLE	03/17/06	99/99/99
DCIPA	ADAPT		548 SE JACKSON ST	ROSEBURG	97470-4983	DOUGLAS	03	004	1720010549	N	0	0	04/28/09	NOT APPLICABLE	01/01/00	99/99/99
DCIPA	ADAPT DBA SOUTHRIVER MEDICAL CLINIC		671 SW MAIN	WINSTON	97496-9660	DOUGLAS	15	091	1912061755	N	561	CLOSED	Providers associated with this facility are credentialed individually. Please refer to all providers at this address.	NOT APPLICABLE	12/01/06	99/99/99
DCIPA	AGARWAL	DIWAKER	1813 W HARVARD STE 432	ROSEBURG	97471-8705	DOUGLAS	34	246	1770573057	N	0	0	12/13/11	NOT APPLICABLE	07/01/04	99/99/99
DCIPA	AGSTEN	SARAH	2579 NW EDENBOWER BLVD	ROSEBURG	97471-6220	DOUGLAS	34	249	1104803691	Y	565	CLOSED	09/17/09	NOT APPLICABLE	07/01/98	99/99/99
DCIPA	ALLEN	SHARI	115 SW PINE STREET	CANYONVILLE	97417-0000	DOUGLAS	42	364	1679620967	N	See Gregory Falk, MD	See Gregory Falk, MD	04/20/10	NOT APPLICABLE	01/01/01	99/99/99
DCIPA	AMEREDES	FAYE	2460 STEWART PARKWAY STE 230	ROSEBURG	97471-1516	DOUGLAS	34	276	1811066822	N	0	0	07/12/11	NOT APPLICABLE	10/01/00	99/99/99
DCIPA	ANDREWS	TYLER	1813 W HARVARD STE 432	ROSEBURG	97471-0000	DOUGLAS	34	246	1528284361	N	0	0	07/01/11	NOT APPLICABLE	07/01/11	99/99/99
DCIPA	BAKER	ROLA	2282 NW TROOST ST STE 102	ROSEBURG	97471-6072	DOUGLAS	34	249	1750444972	N	109	CLOSED	04/20/10	NOT APPLICABLE	01/01/94	99/99/99
DCIPA	BANCROFT	CLYDE	2570 NW EDENBOW	ROSEBURG	97471-	DOUGLAS	46	395	1841397742	Y	see facilit	see facility	04/20/10	NOT APPLICA	01/12/10	99/99/99

			ER BLVD STE 100		6214						y w/same address	w/same address		BLE		
DCIPA	BEERY	HEIDI	150 KENNETH FORD DR	ROSEBURG	97470-1042	DOUGLAS	34	249	1164627667	Y	see facility w/same address	see facility w/same address	09/13/11	NOT APPLICABLE	07/16/10	99/99/99
DCIPA	BENEDETTI	PHILIP	1813 W HARVARD STE 432	ROSEBURG	97470-0000	DOUGLAS	34	246	1811959620	N	0	0	02/08/11	NOT APPLICABLE	02/08/11	99/99/99
DCIPA	BENNETT	ROBERT	1813 W HARVARD STE 432	ROSEBURG	97471-8705	DOUGLAS	34	246	1982694386	N	0	0	05/13/10	NOT APPLICABLE	01/01/94	99/99/99
DCIPA	BITTER	DOUGLAS	171 MEDICAL LOOP STE 160	ROSEBURG	97471-1694	DOUGLAS	34	290	1568448959	N	0	0	04/20/10	NOT APPLICABLE	01/01/94	99/99/99
DCIPA	BLACK	FREDERICK	2282 NW TROOST ST STE 103	ROSEBURG	97471-6072	DOUGLAS	34	249	1942343074	Y	1721	309	09/17/09	NOT APPLICABLE	01/01/94	99/99/99
DCIPA	BLACK	JOSEPH	2570 NW EDENBOWER BLVD STE 100	ROSEBURG	97471-6214	DOUGLAS	34	249	1578524377	Y	0	0	03/16/10	NOT APPLICABLE	05/01/05	99/99/99
DCIPA	BLACK	JOSEPH	115 SW PINE STREET	CANYONVILLE	97417-0000	DOUGLAS	34	249	1578524377	N	0	0	03/16/10	NOT APPLICABLE	05/01/05	99/99/99
DCIPA	BLACK	JOSEPH	2700 STEWART PARKWAY	ROSEBURG	97471-1281	DOUGLAS	34	249	1578524377	N	0	0	03/16/10	NOT APPLICABLE	05/01/05	99/99/99
DCIPA	BLACK	JOSEPH	3019 NW STEWART PKWY	ROSEBURG	97471-1612	DOUGLAS	34	249	1578524377	N	0	0	03/16/10	NOT APPLICABLE	05/01/05	99/99/99
DCIPA	BOGGS	JERRY	2510 NW EDENBOWER BLVD STE 152	ROSEBURG	97471-8899	DOUGLAS	34	268	1003890153	N	0	0	03/16/10	NOT APPLICABLE	08/15/99	99/99/99
DCIPA	BOLDUC	DIANE	340 MEDICAL LOOP	ROSEBURG	97471-1645	DOUGLAS	34	249	1174537047	N	276	CLOSED	08/09/11	NOT APPLICABLE	01/02/02	99/99/99
DCIPA	BOU MERHI	GABRIEL	1813 W HARVARD AVE STE 422	ROSEBURG	97471-8705	DOUGLAS	34	262	1518943687	Y	24	CLOSED	06/10/10	NOT APPLICABLE	08/01/03	99/99/99

DCIPA	BRICKNER	KURT	1813 W HARVARD STE 241	ROSEBURG	97471-8708	DOUGLAS	34	262	1023092178	N	30	CLOSED	09/16/10	NOT APPLICABLE	04/01/01	99/99/99
DCIPA	BRICKNER	KURT	2700 STEWART PARKWAY	ROSEBURG	97471-1281	DOUGLAS	34	262	1023092178	N	0	0	09/16/10	NOT APPLICABLE	04/01/01	99/99/99
DCIPA	BRITTAIN	SHELLEY	2570 NW EDENBOWER BLVD STE 100	ROSEBURG	97471-6214	DOUGLAS	34	262	1114995735	Y	200	CLOSED	12/13/11	NOT APPLICABLE	07/02/08	99/99/99
DCIPA	BRONSTEIN	GARY	2700 STEWART PARKWAY	ROSEBURG	97471-1281	DOUGLAS	34	234	1932284528	N	0	0	09/16/10	NOT APPLICABLE	09/01/07	99/99/99
DCIPA	BRONSTEIN	GARY	2801 NW MERCY DR STE 300	ROSEBURG	97471-2348	DOUGLAS	34	234	1932284528	N	0	0	09/16/10	NOT APPLICABLE	09/01/07	99/99/99
DCIPA	BRUNS	BART	2801 NW STEWART PARKWAY, STE 200	ROSEBURG	97471-1281	DOUGLAS	34	228	1881620839	N	0	0	02/14/12	NOT APPLICABLE	04/01/99	99/99/99
DCIPA	CALDWELL	ANN	2700 STEWART PARKWAY	ROSEBURG	97471-1281	DOUGLAS	34	228	1689600660	N	0	0	03/10/11	NOT APPLICABLE	04/17/06	99/99/99
DCIPA	CALDWELL	ANN	2801 MERCY DRIVE	ROSEBURG	97471-2348	DOUGLAS	34	228	1689600660	N	0	0	03/10/11	NOT APPLICABLE	04/17/06	99/99/99
DCIPA	CHANDRA	ALPANA	2460 STEWART PARKWAY STE 103	ROSEBURG	97471-1516	DOUGLAS	34	295	1033212923	N	0	0	11/10/09	NOT APPLICABLE	11/01/08	99/99/99
DCIPA	CHEN	WEN	2460 STEWART PARKWAY STE 100	ROSEBURG	97471-5545	DOUGLAS	42	366	1538357587	N	0	0	01/19/10	NOT APPLICABLE	02/05/09	99/99/99
DCIPA	CHIOU	REI-KWEN	2460 STEWART PARKWAY STE 100	ROSEBURG	97471-5545	DOUGLAS	34	304	1548374978	N	0	0	12/09/10	NOT APPLICABLE	02/05/09	99/99/99
DCIPA	CHOU	ALICE	1813 W HARVARD STE 220	ROSEBURG	97471-2755	DOUGLAS	34	223	1508802521	N	0	0	11/16/10	NOT APPLICABLE	10/01/96	99/99/99
DCIPA	COLLINS	SAMUEL	2801 MERCY DRIVE, SUITE 200	ROSEBURG	97471-000	DOUGLAS	46	395	1225107089	N	0	0	05/10/11	NOT APPLICABLE	05/10/11	99/99/99
DCIPA	COMMUNITY CANCER CENTER		2880 NW STEWART PARKWAY STE 100	ROSEBURG	97471-1203	DOUGLAS	09	056	1457351991	N	0	0	04/28/09	NOT APPLICABLE	01/01/94	99/99/99

DCIPA	COOKSLEY	RICHARD	115 SW PINE STREET	CANYONVILLE	97417-0000	DOUGLAS	46	395	1942271192	N	See Gregory Falk, MD	See Gregory Falk, MD	07/23/09	NOT APPLICABLE	01/01/97	99/99/99
DCIPA	CUDNEY	ERIN	150 KENNETH FORD DR	ROSEBURG	97470-1042	DOUGLAS	42	362	1831409150	Y	see facility w/same address	see facility w/same address	11/18/10	NOT APPLICABLE	11/18/10	99/99/99
DCIPA	DANDY	GARY	2570 NW EDENBOWER BLVD STE 100	ROSEBURG	97471-6214	DOUGLAS	34	249	1184697401	Y	0	0	03/16/10	NOT APPLICABLE	07/09/01	99/99/99
DCIPA	DANNENHOFFER	ROBERT	2460 NW STEWART PKWY STE 104	ROSEBURG	97471-1516	DOUGLAS	34	283	1306873393	Y	296	CLOSED	12/13/11	NOT APPLICABLE	01/01/94	99/99/99
DCIPA	DANSON	LAURENCE	780 NW GARDEN VALLEY 50B1	ROSEBURG	97471-6528	DOUGLAS	43	380	1679797666	N	0	0	05/13/10	NOT APPLICABLE	11/01/95	99/99/99
DCIPA	DASKALOS	JAMES	2570 NW EDENBOWER BLVD STE 100	ROSEBURG	97471-6214	DOUGLAS	34	247	1164428017	Y	0	0	08/09/11	NOT APPLICABLE	04/08/08	99/99/99
DCIPA	DAUTERMAN	JOHN	2700 STEWART PARKWAY	ROSEBURG	97471-1281	DOUGLAS	34	282	1861463044	N	0	0	02/16/10	NOT APPLICABLE	07/01/01	99/99/99
DCIPA	DAVOL	PATRICK	2460 STEWART PARKWAY, STE 100	ROSEBURG	97471-0000	DOUGLAS	34	304	1003025875	N	0	0	08/01/11	NOT APPLICABLE	08/01/11	99/99/99
DCIPA	DELOHERY-HART	MALIA P.	671 SW MAIN	WINSTON	97496-9660	DOUGLAS	69	545	1083741946	N	see provider w/same address	see provider w/same address	02/29/12	NOT APPLICABLE	02/29/12	99/99/99
DCIPA	DOUGLAS MEDICAL EQUIPMENT SUPPLY		1813 W HARVARD, STE 212	ROSEBURG	97471-0000	DOUGLAS	36	315	1457520041	N	0	0	05/31/11	NOT APPLICABLE	12/19/08	99/99/99
DCIPA	DOUGLAS MEDICAL GROUP DBA BOU MERHI		1813 W HARVARD STE 422	ROSEBURG	97471-8705	DOUGLAS	09	056	1346578861	Y	See Gabriel Bou	See Gabriel Bou Merhi,	Providers associated with this facility are credentialed	NOT APPLICABLE	08/01/03	99/99/99

											Merhi, MD	MD	individually. Please refer to all providers at this address.			
DCIPA	DOUGLAS MEDICAL GROUP DBA DOUGLAS COUNTY INTERNAL MEDICINE		1813 W HARVARD STE 426	ROSEBURG	97471-8712	DOUGLAS	09	056	1346578861	Y	109	59	Providers associated with this facility are credentialed individually. Please refer to all providers at this address.	NOT APPLICABLE	06/23/07	99/99/99
DCIPA	DOUGLAS MEDICAL GROUP DBA SHARP FAMILY MEDICINE		1813 W HARVARD STE 426	ROSEBURG	97471-8712	DOUGLAS	09	056	1346578861	Y	490	994	Providers associated with this facility are credentialed individually. Please refer to all providers at this address.	NOT APPLICABLE	11/01/07	99/99/99
DCIPA	DRIVER	MATTHEW	2570 NW EDENBOWER BLVD STE 100	ROSEBURG	97471-6214	DOUGLAS	34	252	1689647927	Y	0	0	04/20/10	NOT APPLICABLE	06/18/01	99/99/99
DCIPA	EDSON	STEVEN	1813 W HARVARD AVE STE 432	ROSEBURG	97471-8705	DOUGLAS	34	246	1881656692	N	0	0	05/13/10	NOT APPLICABLE	07/23/09	99/99/99
DCIPA	ENGSTROM	GERALD	2801 NW MERCY DR STE 340	ROSEBURG	97471-2348	DOUGLAS	34	250	1609851898	N	0	0	09/16/10	NOT APPLICABLE	01/01/94	99/99/99
DCIPA	EPPS	KIMBRA	2569 NW EDENBOWER BLVD.	ROSEBURG	97471-0000	DOUGLAS	42	364	1154406064	N	see facility w/same address	see facility w/same address	07/01/11	NOT APPLICABLE	07/01/11	99/99/99
DCIPA	EVERGREEN DIAGNOSTICS, LLC		2570 NW EDENBOWER BLVD STE 100	ROSEBURG	97470-6214	DOUGLAS	29	190	1568434025	Y	0	0	04/28/09	NOT APPLICABLE	05/01/05	99/99/99
DCIPA	FALK	GREGORY	115 SW PINE STREET	CANYONVILLE	97417-0000	DOUGLAS	34	249	1144377433	N	202	CLOSED	05/13/10	NOT APPLICABLE	01/01/94	99/99/99
DCIPA	FELDMAN	HOWARD	2801 NW MERCY DRIVE STUITE 300	ROSEBURG	97471-2348	DOUGLAS	34	232	1548287022	N	0	0	09/17/09	NOT APPLICABLE	11/01/06	99/99/99
DCIPA	FIEBER	PAUL	2570 NW EDENBOWER BLVD STE 100	ROSEBURG	97471-6214	DOUGLAS	46	395	1043371305	N	see provider w/sa	see provider w/sam	06/10/10	NOT APPLICABLE	08/01/02	99/99/99

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DCI PA	GADE	JAY	2440 NW EDENBOW ER BLVD	ROSEBUR G	9747 1- 8847	DOUGL AS	3 4	24 2	1447222 724	N	0	0	11/16/10	NOT APPLICA BLE	07/01/ 99	99/99/ 99
DCI PA	GAFFIELD	KELLI R.	150 KENNETH FORD DR	ROSEBUR G	9747 0- 1042	DOUGL AS	4 2	36 4	1245509 090	Y	see provid er w/sa me addre ss	see provid er w/sam e addres s	02/29/12	NOT APPLICA BLE	02/29/ 12	99/99/ 99
DCI PA	GAMBILL	JON	2570 NW EDENBOW ER BLVD STE 100	ROSEBUR G	9747 1- 6214	DOUGL AS	4 6	39 5	1073586 319	Y	see provid er w/sa me addre ss	see provid er w/sam e addres s	01/19/10	NOT APPLICA BLE	04/01/ 04	99/99/ 99
DCI PA	GARDIN II	JOHN	671 SW MAIN	WINSTON	9749 6- 9660	DOUGL AS	5 3	43 5	1760407 100	N	0	0	09/13/11	NOT APPLICA BLE	08/20/ 10	99/99/ 99
DCI PA	GAUER	BONNIE	2995 NW EDENBOW ER BLVD	ROSEBUR G	9747 0- 3959	DOUGL AS	4 3	38 0	1164401 634	N	0	0	05/13/10	NOT APPLICA BLE	05/13/ 08	99/99/ 99
DCI PA	GEE	MATTHEW	2440 EDENBOW ER BLVD	ROSEBUR G	9747 1- 8847	DOUGL AS	3 4	24 2	1306835 764	N	0	0	10/14/10	NOT APPLICA BLE	10/23/ 09	99/99/ 99
DCI PA	GLADDING	TIMOTHY	2700 STEWART PARKWAY	ROSEBUR G	9747 1- 1281	DOUGL AS	3 4	28 2	1659342 830	N	0	0	09/13/11	NOT APPLICA BLE	02/01/ 99	99/99/ 99
DCI PA	GLASSMAN	ANTHONY	1813 W HARVARD STE 230	ROSEBUR G	9747 1- 2755	DOUGL AS	3 4	29 1	1801841 259	N	0	0	07/23/09	NOT APPLICA BLE	08/01/ 96	99/99/ 99
DCI PA	GOODWIN	ALLEN	1740 NW GOETZ ST	ROSEBUR G	9747 1- 1613	DOUGL AS	3 4	29 1	1043378 920	N	0	0	06/09/09	NOT APPLICA BLE	01/01/ -94	99/99/ 99
DCI PA	GOODWIN	LYNN	425 N MAIN	MYRTLE CREEK	9745 7- 0000	DOUGL AS	4 3	38 0	1407968 472	N	0	0	05/13/10	NOT APPLICA BLE	01/01/ 94	99/99/ 99
DCI PA	GOSLINE	SYLVIA K.	2880 NW STEWART PARKWAY STE 100	ROSEBUR G	9747 1- 1281	DOUGL AS	3 4	27 8	1194716 456	N	0	0	04/20/10	NOT APPLICA BLE	10/24/ 00	99/99/ 99
DCI PA	GOSMAN	RAZVAN	2460 NW STEWART PKWY STE 103	ROSEBUR G	9747 1- 1516	DOUGL AS	3 4	29 5	1407832 868	N	0	0	06/10/10	NOT APPLICA BLE	08/01/ 03	99/99/ 99

DCIPA	GRADY	CONNIE	2700 NW STEWART PARKWAY	ROSEBURG	97471-0000	DOUGLAS	34	262	1740266816	N	0	0	04/19/11	NOT APPLICABLE	04/16/11	99/99/99
DCIPA	GRAY	ANDREA	2995 NW EDENBOWER BLVD	ROSEBURG	97471-6220	DOUGLAS	34	274	1104818020	N	0	0	09/13/11	NOT APPLICABLE	08/01/-99	99/99/99
DCIPA	GRAY	JASON	2700 STEWART PARKWAY	ROSEBURG	97471-1281	DOUGLAS	34	228	1174565972	N	0	0	02/14/12	NOT APPLICABLE	07/01/00	99/99/99
DCIPA	GREGG	PATRICK	341 MEDICAL LOOP STE 120	ROSEBURG	97471-5546	DOUGLAS	34	274	1346224201	N	0	0	06/10/10	NOT APPLICABLE	08/04/03	99/99/99
DCIPA	GROSHONG	ARIC	1813 W HARVARD STE 140	ROSEBURG	97471-2743	DOUGLAS	34	283	1619078110	Y	353	CLOSED	12/13/11	NOT APPLICABLE	08/01/95	99/99/99
DCIPA	GROSHONG	JACQUELYN	2460 NW STEWART PKWY STE 104	ROSEBURG	97471-1516	DOUGLAS	34	283	1700893674	Y	465	CLOSED	12/13/11	NOT APPLICABLE	08/01/95	99/99/99
DCIPA	GUTIERREZ	WILSON	2700 STEWART PARKWAY	ROSEBURG	97471-1281	DOUGLAS	34	262	1962694802	N	0	0	07/23/09	NOT APPLICABLE	09/16/08	99/99/99
DCIPA	HAINES	GREGORY	2700 STEWART PARKWAY	ROSEBURG	97471-1281	DOUGLAS	34	228	1629004676	N	0	0	10/14/10	NOT APPLICABLE	03/25/04	99/99/99
DCIPA	HALL	LARRY	2010 OPPORTUNITY LN	GLIDE	97443-9779	DOUGLAS	34	283	1225207202	N	11	CLOSED	03/16/10	NOT APPLICABLE	01/01/94	99/99/99
DCIPA	HANSEN	BRET	2801 MERCY DRIVE STE 330	ROSEBURG	97471-2348	DOUGLAS	34	300	1164406211	N	0	0	07/12/11	NOT APPLICABLE	06/19/02	99/99/99
DCIPA	HANSEN	AIMEE	2282 NW TROOST ST STE 103	ROSEBURG	97471-6072	DOUGLAS	42	364	1376527788	Y	See Fred Black, MD	See Fred Black, MD	04/20/10	NOT APPLICABLE	02/01/02	99/99/99
DCIPA	HARRINGTON	KERRY	2570 NW EDENBOWER BLVD STE 100	ROSEBURG	97471-6214	DOUGLAS	46	395	1760473060	Y	see provider w/same address	see provider w/same address	03/16/10	NOT APPLICABLE	02/27/07	99/99/99
DCIPA	HARRIS	KEITH	2564 NW EDENBOWER BLVD	ROSEBURG	97471-8854	DOUGLAS	34	250	1538235726	N	0	0	12/09/10	NOT APPLICABLE	12/09/10	99/99/99
DCIPA	HARTER	PHYLLIS J.	1813 W HARVARD STE 426	ROSEBURG	97471-1645	DOUGLAS	42	364	1619086816	N	see provider	see provider	03/01/12	NOT APPLICABLE	03/01/12	99/99/99

											w/same address	w/same address				
DCIPA	HAWES	VIRGINIA	2570 NW EDENBOWER BLVD STE 100	ROSEBURG	97471-6214	DOUGLAS	34	262	1306819651	Y	see provider w/same address	see provider w/same address	01/13/11	NOT APPLICABLE	06/01/03	99/99/99
DCIPA	HERSCHER	FRED	781 W CENTRAL AVENUE	SUTHERLIN	97479-9472	DOUGLAS	34	249	1619974235	N	316	CLOSED	12/09/10	NOT APPLICABLE	01/01/94	99/99/99
DCIPA	HERSCHER	MARK	145 NE BROADWAY	MYRTLE CREEK	97457-9665	DOUGLAS	34	249	1598856122	N	129	CLOSED	04/20/10	NOT APPLICABLE	01/01/94	99/99/99
DCIPA	HINSHAW	CHERYL	2460 NW STEWART PKWY STE 240	ROSEBURG	97471-1516	DOUGLAS	42	363	1982642542	N	0	0	10/14/10	NOT APPLICABLE	08/10/05	99/99/99
DCIPA	HOLLANDER	WILLIAM	1813 W HARVARD STE 436	ROSEBURG	97471-8705	DOUGLAS	34	276	1902964315	N	0	0	08/09/11	NOT APPLICABLE	01/01/94	99/99/99
DCIPA	HOYNE	JAMES	1813 W HARVARD AVE STE 201	ROSEBURG	97471-2754	DOUGLAS	34	249	1831250133	Y	see facility w/same address	see facility w/same address	04/20/10	NOT APPLICABLE	09/01/94	99/99/99
DCIPA	HUNDLEY	CHARLES	2570 NW EDENBOWER BLVD STE 100	ROSEBURG	97471-6214	DOUGLAS	34	249	1881667145	Y	195	CLOSED	04/19/11	NOT APPLICABLE	06/18/01	99/99/99
DCIPA	JACOBSON	BARBARA	150 KENNETH FORD DR	ROSEBURG	97470-1042	DOUGLAS	42	364	1689804239	Y	see facility w/same address	see facility w/same address	10/14/10	NOT APPLICABLE	10/13/09	99/99/99
DCIPA	JAWORSKI	GERALD	2282 NW TROOST STE 101	ROSEBURG	97471-6072	DOUGLAS	34	249	1043272099	N	65	CLOSED	12/13/11	NOT APPLICABLE	01/01/94	99/99/99
DCIPA	JAYARAM	ARUNA	1813 W HARVARD SUITE 241	ROSEBURG	97471-2754	DOUGLAS	34	262	1720308620	N	135	0	08/09/11	NOT APPLICABLE	08/01/10	99/99/99
DCIPA	JONES	MICHELLE	150 KENNETH	ROSEBURG	97470-	DOUGLAS	42	364	1225264153	Y	see facilit	see facility	07/16/10	NOT APPLICA	08/13/09	99/99/99

			FORD DR		1042						y w/same address	w/same address		BLE		
DCIPA	JORDAN	ELENA	2700 STEWART PARKWAY	ROSEBURG	97471-1281	DOUGLAS	34	228	1861428773	N	0	0	02/16/10	NOT APPLICABLE	01/01/94	99/99/99
DCIPA	JORGENSEN	LAYNE	2569 NW EDENBOWER BLVD	ROSEBURG	97471-6220	DOUGLAS	34	249	1477698173	Y	1045	501	01/19/10	NOT APPLICABLE	06/01/97	99/99/99
DCIPA	JUETT	JARED	1813 W HARVARD SUITE 201	ROSEBURG	97471-2754	DOUGLAS	69	545	1528286143	Y	see facility w/same address	see facility w/same address	10/14/10	NOT APPLICABLE	05/01/09	99/99/99
DCIPA	KALIDINDI	RAVI	320 MEDICAL LOOP	ROSEBURG	97471-0000	DOUGLAS	34	249	1285969618	Y	89	OPEN	12/13/11	NOT APPLICABLE	10/10/11	99/99/99
DCIPA	KELLY	CHRISTOPHER	425 N. MAIN STREET	MYRTLE CREEK	97457-4934	DOUGLAS	43	380	1801827266	N	0	0	05/13/10	NOT APPLICABLE	07/01/08	99/99/99
DCIPA	KEYS	CLYDE	340 MEDICAL LOOP RD	ROSEBURG	97471-1645	DOUGLAS	34	249	1952300881	N	264	0	02/14/12	NOT APPLICABLE	01/01/94	99/99/99
DCIPA	KEYS	CYNTHIA	340 MEDICAL LOOP RD	ROSEBURG	97471-1645	DOUGLAS	46	395	1851431597	N	see Clyde Keys, MD	see Clyde Keys, MD	02/14/12	NOT APPLICABLE	09/01/98	99/99/99
DCIPA	KITCHENS	REBECCA	2930 W. HARVARD AVENUE	ROSEBURG	97471-2610	DOUGLAS	43	380	1750477360	N	0	0	05/13/10	NOT APPLICABLE	01/01/09	99/99/99
DCIPA	KLOEPPER	ROBERT	277 MEDICAL LOOP DRIVE	ROSEBURG	97471-0000	DOUGLAS	34	279	1295705481	N	0	0	01/13/11	NOT APPLICABLE	01/13/11	99/99/99
DCIPA	KOVACHEVICH	MOSHE	2700 STEWART PARKWAY	ROSEBURG	97471-1281	DOUGLAS	34	262	1861657975	N	0	0	07/23/09	NOT APPLICABLE	09/16/08	99/99/99
DCIPA	KRAMER	EDITH	2460 NW STEWART PKWY STE 240	ROSEBURG	97471-1516	DOUGLAS	42	367	1861435455	N	0	0	11/16/10	NOT APPLICABLE	07/01/99	99/99/99
DCIPA	KREMSER	PAUL	489 CHEROKEE AVE	ROSEBURG	97471-9534	DOUGLAS	34	300	1457327058	N	0	0	04/20/10	NOT APPLICABLE	01/01/94	99/99/99
DCIPA	KRNACIK	MICHAEL	277 MEDICAL	ROSEBURG	97471-	DOUGLAS	34	279	1902880024	N	0	0	08/09/11	NOT APPLICA	08/30/02	99/99/99

			LOOP DRIVE		1644									BLE		
DCIPA	KUMAR	NEIL	2510 EDENBOWER BLVD STE 176	ROSEBURG	97471-8899	DOUGLAS	34	269	1003813015	N	0	0	11/16/10	NOT APPLICABLE	06/01/02	99/99/99
DCIPA	KUSLER	CYNTHIA	1813 W HARVARD AVE STE 201	ROSEBURG	97471-2754	DOUGLAS	42	364	1578725982	Y	see facility w/same address	see facility w/same address	07/16/10	NOT APPLICABLE	06/01/02	99/99/99
DCIPA	LEE	JOEL	1813 W HARVARD STE 423	ROSEBURG	97471-8712	DOUGLAS	34	262	1790768877	N	19	CLOSED	04/20/10	NOT APPLICABLE	01/01/94	99/99/99
DCIPA	LEE	JOEL	2700 STEWART PARKWAY	ROSEBURG	97471-1281	DOUGLAS	34	262	1790768877	N	0	0	04/20/10	NOT APPLICABLE	01/01/94	99/99/99
DCIPA	LEECH	THOMAS	2282 NW TROOST ST STE 104	ROSEBURG	97471-6072	DOUGLAS	43	380	1952378945	N	0	0	05/13/10	NOT APPLICABLE	09/01/94	99/99/99
DCIPA	LINDEN	KENNETH	1813 W HARVARD STE 432	ROSEBURG	97471-8705	DOUGLAS	34	246	1598755878	N	0	0	04/20/10	NOT APPLICABLE	01/01/94	99/99/99
DCIPA	LUNDY	THERESA	150 KENNETH FORD DR	ROSEBURG	97470-1042	DOUGLAS	34	262	1578654661	Y	see facility w/same address	see facility w/same address	02/14/12	NOT APPLICABLE	11/01/10	99/99/99
DCIPA	MANI	KARTIK	2801 NW MERCY DRIVE SUITE 300	ROSEBURG	97471-2348	DOUGLAS	34	232	1689869885	N	0	0	11/20/09	NOT APPLICABLE	11/11/08	99/99/99
DCIPA	MAUCH	CARLY	1813 W HARVARD AVE STE 310	ROSEBURG	97471-2756	DOUGLAS	46	395	1679758700	N	0	0	06/10/10	NOT APPLICABLE	07/23/09	99/99/99
DCIPA	MAY	SUNNY	2460 NW STEWART PKWY STE 240	ROSEBURG	97471-1516	DOUGLAS	42	367	1053354647	N	0	0	12/22/09	NOT APPLICABLE	09/01/96	99/99/99
DCIPA	MAYNES	CYNTHIA	2570 NW EDENBOWER BLVD STE 100	ROSEBURG	97471-6214	DOUGLAS	42	364	1447223714	Y	see provider w/same addre	see provider w/same addres	11/20/09	NOT APPLICABLE	06/18/01	99/99/99

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DCIPA	MCCANN	DEIDRE	2700 STEWART PARKWAY	ROSEBURG	97471-1281	DOUGLAS	34	228	1821031618	N	0	0	01/13/11	NOT APPLICABLE	03/01/02	99/99/99
DCIPA	MCCANN	DEIDRE	2801 MERCY DRIVE	ROSEBURG	97471-2348	DOUGLAS	34	228	1821031618	N	0	0	01/13/11	NOT APPLICABLE	03/01/02	99/99/99
DCIPA	MCCASKILL	CHENELLE	2570 NW EDENBOWER BLVD STE 100	ROSEBURG	97471-6214	DOUGLAS	46	395	1497751515	Y	see provider w/same address	see provider w/same address	05/31/11	NOT APPLICABLE	02/01/06	99/99/99
DCIPA	MCNUTT	BRYAN	790 S MAIN ST	MYRTLE CREEK	97457-9303	DOUGLAS	42	366	1144293648	Y	see facility w/same address	see facility w/same address	03/16/10	NOT APPLICABLE	10/05/01	99/99/99
DCIPA	MERCY MEDICAL CENTER HOME HEALTH AGENCY		2400 STEWART PARKWAY STE 200	ROSEBURG	97471-1281	DOUGLAS	27	175	1609811181	N	0	0	05/31/11	NOT APPLICABLE	01/01/94	99/99/99
DCIPA	MERCY MEDICAL CENTER HOSPICE		2400 STEWART PARKWAY STE 200	ROSEBURG	97471-1281	DOUGLAS	27	175	1649208802	N	0	0	05/31/11	NOT APPLICABLE	01/01/94	99/99/99
DCIPA	MERCY MEDICAL CENTER, ROSEBURG		2700 STEWART PARKWAY	ROSEBURG	97471-1281	DOUGLAS	26	168	1477590198	N	0	0	05/31/11	NOT APPLICABLE	01/01/94	99/99/99
DCIPA	MERRITT	JULIE	2282 NW TROOST ST STE 103	ROSEBURG	97471-6072	DOUGLAS	42	364	1942459425	N	See Fred Black, MD	See Fred Black, MD	10/11/11	NOT APPLICABLE	07/19/10	99/99/99
DCIPA	MICEK	JENNIFER	150 KENNETH FORD DR	ROSEBURG	97470-1042	DOUGLAS	34	249	1063485423	Y	see facility w/same address	see facility w/same address	05/13/10	NOT APPLICABLE	07/29/05	99/99/99
DCIPA	MICEK	JENNIFER	790 S MAIN ST	MYRTLE CREEK	97457-9303	DOUGLAS	34	249	1063485423	Y	see facility	see facility w/sam	05/13/10	NOT APPLICABLE	07/29/05	99/99/99

											w/same address	e address				
DCIPA	MIDDLEKAUFF	GEORGE	2700 STEWART PARKWAY	ROSEBURG	97471-1281	DOUGLAS	34	227	1598797664	N	0	0	08/09/11	NOT APPLICABLE	01/01/08	99/99/99
DCIPA	MOORE	RANDY	2880 NW STEWART PARKWAY STE 100	ROSEBURG	97471-1203	DOUGLAS	34	231	1508813817	N	0	0	02/14/12	NOT APPLICABLE	08/14/06	99/99/99
DCIPA	MOORE	MELISSA	2570 NW EDENBOWER BLVD STE 100	ROSEBURG	97471-6214	DOUGLAS	46	395	1851481725	Y	see provider w/same address	see provider w/same address	03/16/10	NOT APPLICABLE	12/08/08	99/99/99
DCIPA	MOORE	SCOTT	2880 NW STEWART PARKWAY STE 100	ROSEBURG	97471-1203	DOUGLAS	46	395	1174613053	N	0	0	02/14/12	NOT APPLICABLE	09/19/08	99/99/99
DCIPA	MUSGRAVE	CHARLES	2570 NW EDENBOWER BLVD STE 100	ROSEBURG	97471-6214	DOUGLAS	46	395	1386617520	Y	see provider w/same address	see provider w/same address	05/13/10	NOT APPLICABLE	02/01/01	99/99/99
DCIPA	NEDITA	LUANA	2460 NW STEWART PKWY STE 103	ROSEBURG	97471-1516	DOUGLAS	34	295	1629054085	N	0	0	07/23/09	NOT APPLICABLE	08/01/04	99/99/99
DCIPA	ONEIL	MICHAEL	2880 NW STEWART PARKWAY STE 301	ROSEBURG	97471-1206	DOUGLAS	34	278	1134103252	N	0	0	12/22/09	NOT APPLICABLE	01/01/94	99/99/99
DCIPA	OREILLY	SIOBHAN	272 MEDICAL LOOP STE B	ROSEBURG	97471-5545	DOUGLAS	34	262	1053395160	N	42	CLOSED	05/13/10	NOT APPLICABLE	08/01/96	99/99/99
DCIPA	OSTRANDER	TIMOTHY	2700 STEWART PARKWAY	ROSEBURG	97471-1281	DOUGLAS	46	395	1427076751	N	0	0	06/10/10	NOT APPLICABLE	11/01/96	99/99/99
DCIPA	OTTENHEIMER	EDWARD	2880 NW STEWART PARKWAY STE 200	ROSEBURG	97471-1204	DOUGLAS	34	262	1881787547	N	38	CLOSED	10/14/10	NOT APPLICABLE	02/01/97	99/99/99
DCIPA	PALM	TOBY	145 MYRTLE	SUTHERLIN	97479-	DOUGLAS	43	380	1366430936	N	0	0	05/13/10	NOT APPLICA	10/01/06	99/99/99

			ST SUITE 108		9113									BLE		
DCIPA	PAYNE	SANDY	2282 NW TROOST ST STE 104	ROSEBURG	97471-6072	DOUGLAS	43	380	1477680544	N	0	0	05/13/10	NOT APPLICABLE	03/01/09	99/99/99
DCIPA	PEARSON	JILL	1813 W HARVARD STE 140	ROSEBURG	97471-2743	DOUGLAS	34	283	1760584536	Y	406	CLOSED	10/14/10	NOT APPLICABLE	07/16/99	99/99/99
DCIPA	PETERSON	JOHN M.	150 KENNETH FORD DR	ROSEBURG	97470-1042	DOUGLAS	34	283	1245396662	Y	see provider w/same address	see provider w/same address	02/01/12	NOT APPLICABLE	02/01/12	99/99/99
DCIPA	PHILLIPS	MARK	860 N MYRTLE RD	MYRTLE CREEK	97457-9626	DOUGLAS	34	249	1275568735	N	62	CLOSED	12/13/11	NOT APPLICABLE	11/01/94	99/99/99
DCIPA	POWELL	JOHN	2570 NW EDENBOWER BLVD STE 100	ROSEBURG	97471-6214	DOUGLAS	34	249	1811960883	Y	230	CLOSED	09/17/09	NOT APPLICABLE	06/18/01	99/99/99
DCIPA	POWELL	MARY	1813 W HARVARD AVE, STE 436	ROSEBURG	97471-0000	DOUGLAS	34	276	1487727988	N	0	0	12/13/11	NOT APPLICABLE	04/16/11	99/99/99
DCIPA	POWELL	TIMOTHY	2570 NW EDENBOWER BLVD STE 100	ROSEBURG	97471-6214	DOUGLAS	34	249	1689647844	Y	204	CLOSED	12/22/09	NOT APPLICABLE	06/18/01	99/99/99
DCIPA	RAJENDRAN	RANGANATHAN	3369 NE STEPHENS SUITE A	ROSEBURG	97470-1259	DOUGLAS	34	262	1861577371	N	109	CLOSED	05/31/11	NOT APPLICABLE	04/20/04	99/99/99
DCIPA	RAMIREZ	MARK	2510 NW EDENBOWER BLVD STE 152	ROSEBURG	97471-8899	DOUGLAS	34	268	1245400209	N	0	0	03/10/11	NOT APPLICABLE	07/01/08	99/99/99
DCIPA	REICHERTER	PAUL	1813 W HARVARD AVE STE 310	ROSEBURG	97471-2756	DOUGLAS	34	242	1053379826	N	0	0	08/09/11	NOT APPLICABLE	07/10/02	99/99/99
DCIPA	RICE	ERIN	2801 MERCY DRIVE, SUITE 300	ROSEBURG	97470-0000	DOUGLAS	42	364	1043401201	N	0	0	06/23/11	NOT APPLICABLE	07/16/10	99/99/99
DCIPA	ROBERSON	KAREN	1813 W HARVARD STE 436	ROSEBURG	97471-8705	DOUGLAS	42	367	1376504225	N	0	0	09/16/10	NOT APPLICABLE	08/01/06	99/99/99
DCIPA	ROBINSON	BRAD	2550 NW EDENBOW	ROSEBURG	97471-	DOUGLAS	34	260	1972688828	N	0	0	09/17/09	NOT APPLICA	01/01/03	99/99/99

			ER BLVD STE 104		8829								BLE		
DCI PA	ROHR	CANDICE	1813 W HARVARD STE 220	ROSEBURG	97471-2755	DOUGLAS	34	223	1326084344	N	0	0	07/23/09	NOT APPLICABLE	01/01/94	99/99/99
DCI PA	ROSEBURG AUDIOLOGY CENTER		1367 HARVARD	ROSEBURG	97471-2838	DOUGLAS	09	057	1003009325	N	0	0	04/28/09	NOT APPLICABLE	01/01/00	99/99/99
DCI PA	RUNDLE	SUSAN M.	1813 W HARVARD STE 201	ROSEBURG	97471-2753	DOUGLAS	42	364	1578654232	Y	see provider w/same address	see provider w/same address	02/01/12	NOT APPLICABLE	02/01/12	99/99/99
DCI PA	RUSSO	SAM	1813 W HARVARD AVE STE 201	ROSEBURG	97471-2753	DOUGLAS	34	247	1962510636	Y	see facility w/same address	see facility w/same address	01/13/11	NOT APPLICABLE	01/01/94	99/99/99
DCI PA	SATHIANATHAN	JARIUS	2700 STEWART PARKWAY	ROSEBURG	97471-1281	DOUGLAS	34	262	1548226582	N	0	0	05/13/10	NOT APPLICABLE	07/01/05	99/99/99
DCI PA	SCHALAU	DAPHNE	1813 W HARVARD STE 542	ROSEBURG	97471-2779	DOUGLAS	34	276	1497759112	N	0	0	05/13/10	NOT APPLICABLE	09/01/96	99/99/99
DCI PA	SCHMID	TANDRA	150 KENNETH FORD DR	ROSEBURG	97471-0000	DOUGLAS	42	366	1598056087	Y	see facility w/same address	see facility w/same address	05/31/11	NOT APPLICABLE	05/31/11	99/99/99
DCI PA	SCHNEIDER	DEVON	1813 W HARVARD STE 426	ROSEBURG	97471-8712	DOUGLAS	42	364	1891070207	Y	see facility w/same address	see facility w/same address	11/03/11	NOT APPLICABLE	11/03/11	99/99/99
DCI PA	SCHREINER	CARL	2801 MERCY DRIVE STE 330	ROSEBURG	97471-2348	DOUGLAS	34	280	1710969175	N	0	0	02/14/12	NOT APPLICABLE	05/01/99	99/99/99
DCI PA	SCHREINER	MIA	2510 NW EDENBOWER BLVD STE 152	ROSEBURG	97471-8899	DOUGLAS	34	268	1275517310	N	0	0	05/13/10	NOT APPLICABLE	07/05/05	99/99/99

DCIPA	SEALS	CHRISTINE	2504 NW MEDICAL PARK DR	ROSEBURG	97471-5510	DOUGLAS	34	249	1164412755	N	224	CLOSED	07/23/09	NOT APPLICABLE	10/02/00	99/99/99
DCIPA	SEAMANS	YANCY	150 KENNETH FORD DR	ROSEBURG	97470-1042	DOUGLAS	42	364	1568771517	Y	see facility w/same address	see facility w/same address	02/14/12	NOT APPLICABLE	10/29/10	99/99/99
DCIPA	SEELY	BRADLEY	341 MEDICAL LOOP STE 120	ROSEBURG	97471-5546	DOUGLAS	34	274	1487636825	N	0	0	07/12/11	NOT APPLICABLE	01/01/94	99/99/99
DCIPA	SEGAL	SCOTT	2570 NW EDENBOWER BLVD STE 100	ROSEBURG	97471-6214	DOUGLAS	34	249	1538149794	Y	208	CLOSED	09/16/10	NOT APPLICABLE	11/01/07	99/99/99
DCIPA	SEIBEL	DAVID	1813 W. HARVARD AVE., STE 432	ROSEBURG	97471-8705	DOUGLAS	34	246	1023009180	N	0	0	03/16/10	NOT APPLICABLE	11/01/07	99/99/99
DCIPA	SEPULVADO	POLLY	573 NE STEPHENS	ROSEBURG	97470-3150	DOUGLAS	34	262	1366433781	N	13	CLOSED	02/14/12	NOT APPLICABLE	01/01/94	99/99/99
DCIPA	SERRANZANA	JAIME	925 NW PACIFIC HWY	MYRTLE CREEK	97457-0000	DOUGLAS	34	249	1164516365	N	27	CLOSED	02/16/10	NOT APPLICABLE	01/01/94	99/99/99
DCIPA	SEWELL	LINDA	2564 NW EDENBOWER BLVD STE 134	ROSEBURG	97471-8854	DOUGLAS	34	276	1609880368	N	0	0	10/11/11	NOT APPLICABLE	08/01/06	99/99/99
DCIPA	SHARP	LAURENCE	1813 W HARVARD STE 426	ROSEBURG	97471-8712	DOUGLAS	34	249	1780677146	Y	0	CLOSED	05/31/11	NOT APPLICABLE	01/01/94	99/99/99
DCIPA	SHEMEL	HOWARD	1813 W HARVARD STE 201	ROSEBURG	97470-0000	DOUGLAS	42	364	1225333776	Y	see facility w/same address	see facility w/same address	02/01/11	NOT APPLICABLE	02/01/11	99/99/99
DCIPA	SIEPERT	KASH	2300 STEWART PARKWAY	ROSEBURG	97471-1597	DOUGLAS	19	130	1689677031	N	0	0	11/16/10	NOT APPLICABLE	11/01/95	99/99/99
DCIPA	SMITH	CORDELL	2300 STEWART PARKWAY	ROSEBURG	97471-1597	DOUGLAS	19	130	1437333945	N	0	0	08/09/11	NOT APPLICABLE	07/01/10	99/99/99
DCIPA	SODER	ERIC	2570 NW EDENBOW	ROSEBURG	97471-	DOUGLAS	34	300	1992887103	N	0	0	10/14/10	NOT APPLICA	07/12/01	99/99/99

			ER STE 101		6214									BLE		
DCIPA	SON	DON	2570 NW EDENBOWER BLVD STE 100	ROSEBURG	97471-6214	DOUGLAS	34	249	1558564898	Y	197	CLOSED	06/10/10	NOT APPLICABLE	08/13/09	99/99/99
DCIPA	SPENCE	CHRISTOPHER	2801 NW MERCY DRIVE STE 330	ROSEBURG	97471-2348	DOUGLAS	34	300	1649252008	N	0	0	05/13/10	NOT APPLICABLE	07/01/05	99/99/99
DCIPA	STANLEY	SCOTT	371 NE GARDEN VALLEY BLVD	ROSEBURG	97470-2039	DOUGLAS	43	380	1023009610	N	0	0	05/13/10	NOT APPLICABLE	08/01/02	99/99/99
DCIPA	STODDARD	DONALD	272 MEDICAL LOOP STE B	ROSEBURG	97471-5545	DOUGLAS	34	262	1205818663	N	82	CLOSED	09/16/10	NOT APPLICABLE	08/01/96	99/99/99
DCIPA	STONE	CLAIRE	2700 NW STEWART PARKWAY	ROSEBURG	97471-0000	DOUGLAS	34	282	1205818663	N	0	0	08/01/11	NOT APPLICABLE	08/01/11	99/99/99
DCIPA	THOMPSON	THOMAS	2508 MEDICAL PARK DR	ROSEBURG	97471-5510	DOUGLAS	34	279	1538118799	N	0	0	07/23/09	NOT APPLICABLE	01/01/94	99/99/99
DCIPA	TIWARI	ANANDITA	115 SW PINE STREET	CANYONVILLE	97417-0000	DOUGLAS	34	262	1992775092	N	See Gregory Falk, MD	See Gregory Falk, MD	05/31/11	NOT APPLICABLE	05/16/06	99/99/99
DCIPA	TOTOIAN	DORU	2550 NW EDENBOWER BLVD STE 104	ROSEBURG	97471-8829	DOUGLAS	34	262	1457444119	N	83	CLOSED	10/14/10	NOT APPLICABLE	08/11/03	99/99/99
DCIPA	TOWNSEND	WILLIAM	1813 W HARVARD STE 423	ROSEBURG	97471-8712	DOUGLAS	34	262	1619959061	N	11	CLOSED	10/11/11	NOT APPLICABLE	07/01/01	99/99/99
DCIPA	TRONNES	STEVEN	2435 NW KLINE ST	ROSEBURG	97471-1690	DOUGLAS	43	380	1528065356	N	0	0	05/13/10	NOT APPLICABLE	01/01/01	99/99/99
DCIPA	TSUCHIYA	MELINDA	150 KENNETH FORD DR	ROSEBURG	97470-1042	DOUGLAS	42	362	1982672499	Y	see facility w/same address	see facility w/same address	10/14/10	NOT APPLICABLE	09/01/07	99/99/99
DCIPA	UMPQUA COMMUNITY HEALTH CLINIC		316 W A AVENUE	DRAIN	97435-0000	DOUGLAS	15	097	1396751772	Y	127	2200	Providers associated with this facility are credentialed	NOT APPLICABLE	01/08/07	99/99/99

													individually. Please refer to all providers at this address.			
DCIPA	UMPQUA COMMUNITY HEALTH CLINIC		20170 N UMPQUA HWY	GLIDE	97443-0000	DOUGLAS	15	097	1396751772	Y	216	2200	Providers associated with this facility are credentialed individually. Please refer to all providers at this address.	NOT APPLICABLE	09/01/01	99/99/99
DCIPA	UMPQUA COMMUNITY HEALTH CLINIC		150 KENNETH FORD DR	ROSEBURG	97470-1042	DOUGLAS	15	097	1396751772	Y	2089	35400	Providers associated with this facility are credentialed individually. Please refer to all providers at this address.	NOT APPLICABLE	09/01/01	99/99/99
DCIPA	UMPQUA COMMUNITY HEALTH CLINIC		790 S MAIN ST	MYRTLE CREEK	97457-9303	DOUGLAS	15	097	1508018946	Y	788	9000	Providers associated with this facility are credentialed individually. Please refer to all providers at this address.	NOT APPLICABLE	12/01/08	99/99/99
DCIPA	UMPQUA REGIONAL MEDICAL CENTER		1813 W HARVARD AVE STE 201	ROSEBURG	97471-2754	DOUGLAS	14	086	1659519171	Y	3806	35500	Providers associated with this facility are credentialed individually. Please refer to all providers at this address.	NOT APPLICABLE	05/01/09	99/99/99
DCIPA	VALLEY OPTICIANS INC		780 NW GARDEN VALLEY 50B1	ROSEBURG	97471-6528	DOUGLAS	44	385	1235110446	N	0	0	05/13/2010	NOT APPLICABLE	10100	99/99/99
DCIPA	VAN ANROOY	MICHAEL	277 MEDICAL LOOP DRIVE	ROSEBURG	97471-1644	DOUGLAS	34	279	1598748360	N	0	0	02/14/12	NOT APPLICABLE	08/01/98	99/99/99
DCIPA	VANDIS	FREDERIC	2700 STEWART PARKWAY STE 200	ROSEBURG	97471-1281	DOUGLAS	34	232	1093786261	N	0	0	07/23/09	NOT APPLICABLE	09/30/02	99/99/99
DCIPA	VANNUCCI	SUSAN	2423 NW TROOST	ROSEBURG	97471-1706	DOUGLAS	34	276	1255346938	N	0	0	12/13/11	NOT APPLICABLE	07/01/99	99/99/99
DCIPA	VILLANUEVA	MICHAEL R.	837 ALDER CREEK DRIVE	MEDFORD	97504-8911	JACKSON	33	209	1063522860	N	0	0	01/13/11	NOT APPLICABLE	07/01/99	99/99/99

DCIPA	VU	VANESSA	2801 NW MERCY DRIVE STE 200	ROSEBURG	97471-0000	DOUGLAS	34	228	1083697163	N	0	0	12/13/11	NOT APPLICABLE	01/01/94	99/99/99
DCIPA	WARREN	JERRY	1813 W HARVARD STE 432	ROSEBURG	97471-8705	DOUGLAS	34	246	1437140043	N	0	0	07/23/09	NOT APPLICABLE	01/01/94	99/99/99
DCIPA	WESTERMAN	DREWRY	671 SW MAIN	WINSTON	97496-9660	DOUGLAS	42	364	1851696769	N	see facility w/same address	see facility w/same address	03/14/11	NOT APPLICABLE	03/14/11	99/99/99
DCIPA	WESTON	JON	2435 NW KLINE ST	ROSEBURG	97471-1690	DOUGLAS	34	274	1629072053	N	0	0	09/17/09	NOT APPLICABLE	01/01/94	99/99/99
DCIPA	WHEELER	GARY	1813 W HARVARD STE 423	ROSEBURG	97471-8712	DOUGLAS	34	262	1790767234	N	70	CLOSED	10/11/11	NOT APPLICABLE	01/01/94	99/99/99
DCIPA	WHEELER	GARY	2700 STEWART PARKWAY	ROSEBURG	97471-1281	DOUGLAS	34	262	1790767234	N	0	0	10/11/11	NOT APPLICABLE	01/01/94	99/99/99
DCIPA	WILKS	GORDON	2564 NW EDENBOWER STE 142B	ROSEBURG	97471-8854	DOUGLAS	19	130	1316006539	N	0	0	04/19/11	NOT APPLICABLE	12/01/99	99/99/99
DCIPA	WILLIAMS	STEPHEN	2880 NW STEWART PARKWAY STE 300	ROSEBURG	97471-1205	DOUGLAS	34	278	1437370947	N	0	0	06/10/10	NOT APPLICABLE	09/04/07	99/99/99
DCIPA	WILLIAMS	SUSAN	277 MEDICAL LOOP DRIVE	ROSEBURG	97471-1644	DOUGLAS	34	279	1558395053	N	0	0	06/10/10	NOT APPLICABLE	09/04/07	99/99/99
DCIPA	WILSON JR	STEWART	341 MEDICAL LOOP STE 120	ROSEBURG	97471-5546	DOUGLAS	34	274	1467434969	N	0	0	12/22/09	NOT APPLICABLE	01/01/94	99/99/99
DCIPA	WONDERLY	DONALD	2460 STEWART PKWY STE 240	ROSEBURG	97471-1516	DOUGLAS	34	276	1417990003	N	0	0	11/16/10	NOT APPLICABLE	08/01/99	99/99/99
DCIPA	WOODRUFF	SCOTT	371 NE GARDEN VALLEY BLVD	ROSEBURG	97470-2039	DOUGLAS	43	380	1235105461	N	0	0	05/13/10	NOT APPLICABLE	01/01/94	99/99/99
DCIPA	XU	HONGSHI	2700 NW STEWART PARKWAY	ROSEBURG	97470-0000	DOUGLAS	34	262	1396902862	N	0	0	01/13/11	NOT APPLICABLE	01/13/11	99/99/99

DCIPA	YOUNG	SANDRA	671 SW MAIN	WINSTON	97496-9660	DOUGLAS	42	364	1598758146	N	see facility w/same address	see facility w/same address	11/10/11	NOT APPLICABLE	11/10/11	99/99/99
DCIPA	YUN	JAMES	2801 NW MERCY DRIVE STE 330	ROSEBURG	97471-2348	DOUGLAS	34	280	1144273566	N	0	0	08/09/11	NOT APPLICABLE	08/01/06	99/99/99
DCIPA	ZASTROW	ARLAN	1813 W HARVARD STE 426	ROSEBURG	97471-1645	DOUGLAS	34	249	1114928058	Y	0	0	08/09/11	NOT APPLICABLE	01/01/94	99/99/99
DCIPA	ZYZNIEWSKI	WENDY	2570 NW EDENBOWER BLVD STE 100	ROSEBURG	97471-6214	DOUGLAS	42	364	1609070531	Y	see provider w/same address	see provider w/same address	11/16/10	NOT APPLICABLE	08/01/07	99/99/99

CONTRACTOR NAME	LAST NAME	FIRST NAME	BUSINESS/PRACTICE ADDRESS	BUSINESS/ PRACTICE CITY	BUSINESS / PRACTICE ZIP	BUSINESS COUNTY	PROVIDER TYPE	SPECIALTY	NPI	STATUS INDICATOR	# MEMBERS ASSIGNED	# OF ADDITIONAL MEMBERS CAN BE ASSIGNED	CREDENTIAL VERIFICATION	SANCTION HISTORY	CONTRACT START DATE	CONTRACT END DATE
DCIPA	Briseno	Robert	114 Molly Street	Glendale	97442	Douglas	09	053	1851517353	N	0	0	01/11/11	N/A	08/01/05	12/31/99
DCIPA	McAdoo	Scott	130 Wild Thyme Ln	Glide	97443	Douglas	17	112	1376536979	N	0	0	12/30/10	N/A	03/02/09	12/31/99
DCIPA	Lawson	James	434 NE 2nd Street	Myrtle Creek	97457	Douglas	09	053	1255480786	Y	2500	2497	11/11/10	N/A	12/13/94	12/31/99
DCIPA	Adams	Brannick	1539 W Harvard Ave	Roseburg	97471-2873	Douglas	17	112	1376577700	N	0	0	02/22/12	N/A	06/02/10	12/31/99
DCIPA	Allen	Michael	1813 W Harvard Ave Ste 240	Roseburg	97471-8708	Douglas	17	111	1689851636	N	0	0	01/06/12	N/A	02/23/09	12/31/99
DCIPA	Allender	Brian	1813 W Harvard Ave Ste 211	Roseburg	97470-2755	Douglas	17	115	1386667434	N	0	0	02/03/12	N/A	01/14/10	12/31/99
DCIPA	Bettis	William	1729 W Harvard Ave Ste 2	Roseburg	97470-2795	Douglas	17	112	1407988397	Y	2750	247	01/11/11	N/A	02/01/06	12/31/99
DCIPA	Bratland	Michael	1333 W Harvard Ave	Roseburg	97471-2838	Douglas	09	053	1235128745	N	0	0	01/09/12	N/A	04/01/07	12/31/99
DCIPA	Bratland	Michael	2530 NW Medical Park Dr	Roseburg	97471-5510	Douglas	09	053	1235128745	Y	3000	233	01/09/12	N/A	07/01/11	12/31/99
DCIPA	Drechsel	Liann	1741 W Harvard Ave	Roseburg	97471-2716	Douglas	09	053	1720192958	Y	3750	1328	08/15/11	N/A	01/01/07	12/31/99
DCIPA	Driver	Jennifer	150 NE Kenneth Ford Dr	Roseburg	97470-1042	Douglas	09	053	1144452004	N	0	0	10/06/11	N/A	12/01/10	12/31/99
DCIPA	Driver	Jennifer	1741 W Harvard Ave	Roseburg	97471-2716	Douglas	09	053	1144452004	N	0	0	10/06/11	N/A	10/04/10	12/31/99

DCIPA	Durst	Larry	645 SE Kane St	Roseburg	97470-4906	Douglas	09	053	1467513945	Y	25	21	01/11/11	N/A	01/01/80	12/31/99
DCIPA	Eichman	David	150 NE Kenneth Ford Dr.	Roseburg	97470-1042	Douglas	09	053	1295746410	N	0	0	06/13/11	N/A	06/16/11	12/31/99
DCIPA	Gauthier	Thomas	1333 W Harvard Ave	Roseburg	97471-2838	Douglas	09	053	1376672105	N	0	0	07/18/11	N/A	07/01/11	12/31/99
DCIPA	Gauthier	Thomas	2530 NW Medical Park Dr	Roseburg	97471-5510	Douglas	09	053	1376672105	N	0	0	07/18/11	N/A	07/01/11	12/31/99
DCIPA	Gilday	Damion	1539 W Harvard Ave	Roseburg	97471-2873	Douglas	09	053	1386856524	N	0	0	01/18/12	N/A	05/03/10	12/31/99
DCIPA	Hamm	Mark	1313 W Harvard Ave	Roseburg	97471-2838	Douglas	09	053	1225035207	Y	3500	250	01/19/12	N/A	04/01/94	12/31/99
DCIPA	Hammon	C. Kipp	1813 W Harvard Ave Ste 211	Roseburg	97471-2755	Douglas	09	053	1427071661	N	0	0	04/05/11	N/A	01/14/10	12/31/99
DCIPA	Hein	James	150 NE Kenneth Ford Dr	Roseburg	97470-1042	Douglas	09	053	1568771194	N	0	0	09/28/10	N/A	12/01/10	12/31/99
DCIPA	Hessong	Robert	2530 NW Medical Park Dr	Roseburg	97471-5510	Douglas	09	053	1649363052	N	0	0	01/19/11	N/A	07/01/11	12/31/99
DCIPA	Jensen	Lon	150 NE Kenneth Ford Dr	Roseburg	97470-1042	Douglas	09	053	1740506096	N	0	0	09/28/10	N/A	12/01/10	12/31/99
DCIPA	Kobernik	Jeffrey	1600 NW Hughwood Ct	Roseburg	97471-8844	Douglas	09	053	1598852303	N	0	0	11/11/10	N/A	03/02/09	12/31/99
DCIPA	Laspe	William	1729 W Harvard Ave Ste 4	Roseburg	97471-2795	Douglas	09	053	1477545135	Y	200	97	01/24/12	N/A	12/13/94	12/31/99
DCIPA	Lawson	James	2510 NW Edenbower Blvd Ste 110	Roseburg	97471-8899	Douglas	09	053	1255480786	Y	2000	6	11/11/10	N/A	12/13/94	12/31/99
DCIPA	Lee	Mike	1813 W Harvard Ave Ste 221	Roseburg	97471-8704	Douglas	09	053	1962572859	Y	2	1	01/11/11	N/A	01/01/80	12/31/99

DCIPA	May	Jerry	1539 W Harvard Ave	Roseburg	97471-2873	Douglas	17	112	1104131978	N	0	0	01/04/12	N/A	07/18/11	12/31/99
DCIPA	May	Jerry	2530 NW Medical Park Dr	Roseburg	97471-5510	Douglas	17	112	1104131978	N	0	0	01/04/12	N/A	01/04/12	12/31/99
DCIPA	Norman	Jed	1813 W Harvard Ave Ste 221	Roseburg	97471-8704	Douglas	17	112	1184663718	Y	15	5	01/10/11	N/A	01/01/07	12/31/99
DCIPA	Olson	Daniel	2510 NW Medical Park Dr	Roseburg	97471-5510	Douglas	17	115	1821162595	N	0	0	01/27/12	N/A	08/01/05	12/31/99
DCIPA	Orr	Robert	150 NE Kenneth Ford Dr	Roseburg	97470-1042	Douglas	17	112	1851348437	Y	1500	223	01/27/12	N/A	12/01/10	12/31/99
DCIPA	Riechers	Sara	1539 W Harvard Ave	Roseburg	97471-2873	Douglas	17	112	1083892889	N	0	0	12/28/10	N/A	08/04/10	12/31/99
DCIPA	Roman	Bruce	500 SE Douglas Ave	Roseburg	97470-3120	Douglas	17	113	1669519237	N	0	0	01/30/12	N/A	05/01/01	12/31/99
DCIPA	Schmutz	Jared	1683 W Harvard Ave	Roseburg	97471-2812	Douglas	17	112	1205030244	N	0	0	08/12/11	N/A	05/01/11	12/31/99
DCIPA	Schuyler	Bill	1741 W Harvard Ave	Roseburg	97471-2716	Douglas	17	118	1679569313	N	0	0	01/30/12	N/A	01/31/96	12/31/99
DCIPA	Schwam	Stephen	150 NE Kenneth Ford Dr	Roseburg	97470-1042	Douglas	17	112	1740444207	N	0	0	09/28/10	N/A	12/01/10	12/31/99
DCIPA	Sharp	J. Lee	1683 W Harvard Ave	Roseburg	97470-2812	Douglas	17	112	1841283470	Y	25	7	02/03/12	N/A	12/13/94	12/31/99
DCIPA	Soder	David	1739 W Harvard Ave	Roseburg	97471-2716	Douglas	17	117	1194827840	N	0	0	01/31/12	N/A	12/13/94	12/31/99
DCIPA	Stark	Geoffrey	1602 NW Hughwood Ct	Roseburg	97471-8844	Douglas	17	112	1326131970	N	0	0	03/02/12	N/A	07/28/94	12/31/99
DCIPA	Townsend	Cameron	1813 W Harvard Ave Ste 240	ROSEBURG	97471-8708	Douglas	17	111	1598852188	N	0	0	03/03/11	N/A	06/01/09	12/31/99
DCIPA	Tucker	Todd	1813 W Harvard	Roseburg	97470-	Douglas	17	115	1619981859	N	0	0	09/22/10	N/A	01/14/10	12/31/99

			Ave Ste 211		2755											
DCIPA	Varner	Robert	1729 W Harvard Ave	Roseburg	97471-2788	Douglas	15	082	1619108966	N	0	0	02/01/12	N/A	01/01/80	12/31/99
DCIPA	Washburn	David	150 NE Kenneth Ford Dr	Roseburg	97470-1042	Douglas	17	112	1336278357	N	0	0	09/28/10	N/A	12/01/10	12/31/99
DCIPA	Bullock	Luther	2530 NW Medical Park Dr	Roseburg	97471-5510	Douglas	09	053	1063584530	N	0	0	10/07/11	N/A	09/28/11	12/31/99
DCIPA	Montgomery	Monte	115 N State St	Sutherlin	97479-9807	Douglas	17	112	1164572665	N	0	0	01/25/12	N/A	05/01/07	12/31/99
DCIPA	Hall	Harold	351 Main St	Winston	97496-9503	Douglas	09	053	1609868082	N	0	0	01/11/11	N/A	08/01/05	12/31/99
DCIPA	Oregon Community Dental Care		671 SW Main St.	Winston	97496-6571	Douglas	17	112	1629343140	Y	5000	2580	03/16/12	N/A	03/16/12	12/31/99
DCIPA	Tribble	Ron	90 NW Glenhart Ave	Winston	97496	Douglas	17	112	1184610123	N	0	0	02/01/12	N/A	08/01/05	12/31/99

CONTRACTOR NAME	LAST NAME	FIRST NAME	BUSINESS/PRACTICE ADDRESS	BUSINESS / PRACTICE CITY	BUSINESS/PRACTICE ZIP	BUSINESS COUNTY	PROVIDER TYPE	SPECIALTY	NPI	STATUS INDICATOR	# MEMBERS ASSIGNED	# OF ADDITIONAL MEMBERS	CREDENTIAL VERIFICATION	SANCTION HISTORY	CONTRACT START DATE	CONTRACT END DATE

												SCANBEASSIGNED				
DCIPA	Briseno	Robert	114 Molly Street	Glendale	97442	Douglas	09	053	1851517353	N	0	0	01/11/11	N/A	08/01/05	12/31/99
DCIPA	McAdoo	Scott	130 Wild Thyme Ln	Glide	97443	Douglas	17	112	1376536979	N	0	0	12/30/10	N/A	03/02/09	12/31/99
DCIPA	Lawson	James	434 NE 2nd Street	Myrtle Creek	97457	Douglas	09	053	1255480786	Y	2500	2497	11/11/10	N/A	12/13/94	12/31/99
DCIPA	Adams	Brannick	1539 W Harvard Ave	Roseburg	97471-2873	Douglas	17	112	1376577700	N	0	0	02/22/12	N/A	06/02/10	12/31/99
DCIPA	Allen	Michael	1813 W Harvard Ave Ste 240	Roseburg	97471-8708	Douglas	17	111	1689851636	N	0	0	01/06/12	N/A	02/23/09	12/31/99
DCIPA	Allender	Brian	1813 W Harvard Ave Ste 211	Roseburg	97470-2755	Douglas	17	115	1386667434	N	0	0	02/03/12	N/A	01/14/10	12/31/99
DCIPA	Bettis	William	1729 W Harvard Ave Ste 2	Roseburg	97470-2795	Douglas	17	112	1407988397	Y	2750	247	01/11/11	N/A	02/01/06	12/31/99
DCIPA	Bratland	Michael	1333 W Harvard Ave	Roseburg	97471-2838	Douglas	09	053	1235128745	N	0	0	01/09/12	N/A	04/01/07	12/31/99
DCIPA	Bratland	Michael	2530 NW Medical	Roseburg	47 1-	Douglas	09	053	1235128745	Y	3000	233	01/09/12	N/A	07/01/11	12/31/99

			Park Dr		55 10 97												
DCIPA	Drechsel	Liann	1741 W Harvard Ave	Roseburg	47 1-27 16 97	Douglas	09	053	172019 2958	Y	3750	13 28	08/15/11	N/A	01/01/07	12/31/99	
DCIPA	Driver	Jennifer	150 NE Kenneth Ford Dr	Roseburg	47 0-10 42 97	Douglas	09	053	114445 2004	N	0	0	10/06/11	N/A	12/01/10	12/31/99	
DCIPA	Driver	Jennifer	1741 W Harvard Ave	Roseburg	47 1-27 16 97	Douglas	09	053	114445 2004	N	0	0	10/06/11	N/A	10/04/10	12/31/99	
DCIPA	Durst	Larry	645 SE Kane St	Roseburg	47 0-49 06 97	Douglas	09	053	146751 3945	Y	25	21	01/11/11	N/A	01/01/80	12/31/99	
DCIPA	Eichman	David	150 NE Kenneth Ford Dr.	Roseburg	47 0-10 42 97	Douglas	09	053	129574 6410	N	0	0	06/13/11	N/A	06/16/11	12/31/99	
DCIPA	Gauthier	Thomas	1333 W Harvard Ave	Roseburg	47 1-28 38 97	Douglas	09	053	137667 2105	N	0	0	07/18/11	N/A	07/01/11	12/31/99	
DCIPA	Gauthier	Thomas	2530 NW Medical Park Dr	Roseburg	47 1-55 10 97	Douglas	09	053	137667 2105	N	0	0	07/18/11	N/A	07/01/11	12/31/99	
DCIPA	Gilday	Damion	1539 W Harvard Ave	Roseburg	47 1-28 73 97	Douglas	09	053	138685 6524	N	0	0	01/18/12	N/A	05/03/10	12/31/99	
DCIPA	Hamm	Mark	1313 W Harvard Ave	Roseburg	47 1-28 38 97	Douglas	09	053	122503 5207	Y	3500	25 0	01/19/12	N/A	04/01/94	12/31/99	
DCIPA	Hammon	C. Kipp	1813 W Harvard Ave Ste	Roseburg	47 1-	Douglas	09	053	142707 1661	N	0	0	04/05/11	N/A	01/14/10	12/31/99	

DCIPA	Hein	James	211 150 NE Kenneth Ford Dr	Roseburg	27 55 97 47 0-10 42 97	Douglas	09	053	156877 1194	N	0	0	09/28/10	N/A	12/01/10	12/31/99
DCIPA	Hessong	Robert	2530 NW Medical Park Dr	Roseburg	47 1-55 10 97	Douglas	09	053	164936 3052	N	0	0	01/19/11	N/A	07/01/11	12/31/99
DCIPA	Jensen	Lon	150 NE Kenneth Ford Dr	Roseburg	47 0-10 42 97	Douglas	09	053	174050 6096	N	0	0	09/28/10	N/A	12/01/10	12/31/99
DCIPA	Kobernik	Jeffrey	1600 NW Hughwood Ct	Roseburg	47 1-88 44 97	Douglas	09	053	159885 2303	N	0	0	11/11/10	N/A	03/02/09	12/31/99
DCIPA	Laspe	William	1729 W Harvard Ave Ste 4	Roseburg	47 1-27 95 97	Douglas	09	053	147754 5135	Y	200	97	01/24/12	N/A	12/13/94	12/31/99
DCIPA	Lawson	James	2510 NW Edenbower Blvd Ste 110	Roseburg	47 1-88 99 97	Douglas	09	053	125548 0786	Y	2000	6	11/11/10	N/A	12/13/94	12/31/99
DCIPA	Lee	Mike	1813 W Harvard Ave Ste 221	Roseburg	47 1-87 04 97	Douglas	09	053	196257 2859	Y	2	1	01/11/11	N/A	01/01/80	12/31/99
DCIPA	May	Jerry	1539 W Harvard Ave	Roseburg	47 1-28 73 97	Douglas	17	112	110413 1978	N	0	0	01/04/12	N/A	07/18/11	12/31/99
DCIPA	May	Jerry	2530 NW Medical Park Dr	Roseburg	47 1-55 10 97	Douglas	17	112	110413 1978	N	0	0	01/04/12	N/A	01/04/12	12/31/99
DCIPA	Norman	Jed	1813 W Harvard Ave Ste	Roseburg	47 1-	Douglas	17	112	118466 3718	Y	15	5	01/10/11	N/A	01/01/07	12/31/99

DCIPA	Olson	Daniel	221 2510 NW Medical Park Dr	Roseburg	87 04 97 47 1-55 10 97	Douglas	17	115	182116 2595	N	0	0	01/27/12	N/A	08/01/05	12/31/99
DCIPA	Orr	Robert	150 NE Kenneth Ford Dr	Roseburg	47 0-10 42 97	Douglas	17	112	185134 8437	Y	1500	223	01/27/12	N/A	12/01/10	12/31/99
DCIPA	Riechers	Sara	1539 W Harvard Ave	Roseburg	47 1-28 73 97	Douglas	17	112	108389 2889	N	0	0	12/28/10	N/A	08/04/10	12/31/99
DCIPA	Roman	Bruce	500 SE Douglas Ave	Roseburg	47 0-31 20 97	Douglas	17	113	166951 9237	N	0	0	01/30/12	N/A	05/01/01	12/31/99
DCIPA	Schmutz	Jared	1683 W Harvard Ave	Roseburg	47 1-28 12 97	Douglas	17	112	120503 0244	N	0	0	08/12/11	N/A	05/01/11	12/31/99
DCIPA	Schuyler	Bill	1741 W Harvard Ave	Roseburg	47 1-27 16 97	Douglas	17	118	167956 9313	N	0	0	01/30/12	N/A	01/31/96	12/31/99
DCIPA	Schwam	Stephen	150 NE Kenneth Ford Dr	Roseburg	47 0-10 42 97	Douglas	17	112	174044 4207	N	0	0	09/28/10	N/A	12/01/10	12/31/99
DCIPA	Sharp	J. Lee	1683 W Harvard Ave	Roseburg	47 0-28 12 97	Douglas	17	112	184128 3470	Y	25	7	02/03/12	N/A	12/13/94	12/31/99
DCIPA	Soder	David	1739 W Harvard Ave	Roseburg	47 1-27 16 97	Douglas	17	117	119482 7840	N	0	0	01/31/12	N/A	12/13/94	12/31/99
DCIPA	Stark	Geoffrey	1602 NW Hughwo	Roseburg	47 1-	Douglas	17	112	132613 1970	N	0	0	03/02/12	N/A	07/28/94	12/31/99

			od Ct		88 44 97													
DCIPA	Townsend	Cameron	1813 W Harvard Ave Ste 240	ROSEBURG	47 1-87 08 97	Douglas	17	111	1598852188	N	0	0	03/03/11	N/A	06/01/09	12/31/99		
DCIPA	Tucker	Todd	1813 W Harvard Ave Ste 211	Roseburg	47 0-27 55 97	Douglas	17	115	1619981859	N	0	0	09/22/10	N/A	01/14/10	12/31/99		
DCIPA	Varner	Robert	1729 W Harvard Ave	Roseburg	47 1-27 88 97	Douglas	15	082	1619108966	N	0	0	02/01/12	N/A	01/01/80	12/31/99		
DCIPA	Washburn	David	150 NE Kenneth Ford Dr	Roseburg	47 0-10 42 97	Douglas	17	112	1336278357	N	0	0	09/28/10	N/A	12/01/10	12/31/99		
DCIPA	Bullock	Luther	2530 NW Medical Park Dr	Roseburg	47 1-55 10 97	Douglas	09	053	1063584530	N	0	0	10/07/11	N/A	09/28/11	12/31/99		
DCIPA	Montgomery	Monte	115 N State St	Sutherlin	47 9-98 07 97	Douglas	17	112	1164572665	N	0	0	01/25/12	N/A	05/01/07	12/31/99		
DCIPA	Hall	Harold	351 Main St	Winston	49 6-95 03 97	Douglas	09	053	1609868082	N	0	0	01/11/11	N/A	08/01/05	12/31/99		
DCIPA	Oregon Community Dental Care		671 SW Main St.	Winston	49 6-65 71 97	Douglas	17	112	1629343140	Y	5000	25 80	03/16/12	N/A	03/16/12	12/31/99		
DCIPA	Tribble	Ron	90 NW Glenhart Ave	Winston	49 6	Douglas	17	112	1184610123	N	0	0	02/01/12	N/A	08/01/05	12/31/99		

PUBLIC FUNDED			
NAME	TYPE	COUNTY	DESCRIPTION OF SERVICES
Douglas County Health Department	County Health Department	DOUGLAS	The County Health Department provides
			immunizations and prenatal care to our members.
Douglas County Mental Health	County Mental Health	DOUGLAS	Mental Health Case Management & Coordination

ATTACHMENT B.2.3. – Publicly Funded Health Care and Service Programs Table

Name of Publicly Funded Program	Type of Public Program	County in Which Program Provides Service	Specialty/Sub-Specialty Codes
STD/HIV	Public Health	Douglas County	Community Prevention Services, Health Education, Community Health Workers, Navigators
Immunizations	Public Health	Douglas County	Community Prevention Services, Health Education, Community Health Workers, Navigators
Maternity Case Management	Public Health	Douglas County	Intensive Case Management, Community Prevention Services, Health Education, Community Health Workers, Navigators
Prenatal Clinic	Public Health	Douglas County	Intensive Case Management, Community Prevention Services, Health Education, Community Health Workers, Navigators
Family Planning	Public Health	Douglas County	Community Prevention Services, Health Education, Community Health Workers, Navigators
SBHC	Public Health	Douglas County	School Based Health Centers
Youth and Family Out Patient Services	Mental Health	Douglas County	Health Education, Intensive Case Management, Mental Health Providers, Navigators, Peer Specialist
Intensive Community Treatment	Mental Health	Douglas County	Health Education, Intensive Case Management, Mental Health providers, Navigators, Peer Specialist
Therapeutic Treatment Classroom	Mental Health	Douglas County	Health Education, Intensive Case Management, Mental Health providers, Navigators, Peer Specialist
School Based Therapy	Mental Health	Douglas County	Health Education, Intensive Case Management, Mental Health providers, Navigators, Peer Specialist
Neurosequential Model of Therapeutics Training	Mental Health	Douglas County	Health Education, Intensive Case Management, Mental Health providers, Navigators, Peer Specialist
EASA	Mental Health	Douglas County	Health Education, Intensive Case Management, Mental Health providers, Navigators, Peer Specialist
Young Adult in Transition	Mental Health	Douglas County	Health Education, Intensive Case Management, Mental Health providers, Navigators, Peer Specialist
Supported Employment: EB/BP	Mental Health	Douglas County	Health Education, Intensive Case Management, Mental Health providers, Navigators, Peer Specialist
Aid and Assist Program (370)	Mental Health	Douglas County	Health Education, Intensive Case Management, Mental Health providers, Navigators, Peer Specialist
Adult Mental Health Initiative Treatment and Coordination	Mental Health	Douglas County	Health Education, Intensive Case Management, Mental Health providers, Navigators, Peer Specialist
Adult Foster Care Services Coordination and Referral	Mental Health	Douglas County	Health Education, Intensive Case Management, Mental Health providers,, Navigators, Peer Specialist
Therapeutic Foster Home Referral and Support	Mental Health	Douglas County	Health Education, Intensive Case Management, Mental Health providers,, Navigators, Peer Specialist
Probation and Parole Program	Mental Health	Douglas County	Health Education, Intensive Case Management, Mental Health providers, Navigators, Peer Specialist
Personal Care Assistant 20	Mental Health	Douglas County	Health Education, Intensive Case Management, Mental Health providers, Navigators, Peer Specialist
Group Therapy and Psycho education	Mental Health	Douglas County	Health Education, Intensive Case Management, Mental Health providers, Navigators, Peer Specialist

Name of Publicly Funded Program	Type of Public Program	County in Which Program Provides Service	Specialty/Sub-Specialty Codes
Individual Therapy, Skills Training and Psycho education	Mental Health	Douglas County	Health Education, Intensive Case Management, Mental Health providers, Navigators, Peer Specialist
Medication Management	Mental Health	Douglas County	Health Education, Intensive Case Management, Mental Health providers, Navigators, Peer Specialist
Individual Case Management	Mental Health	Douglas County	Health Education, Intensive Case Management, Mental Health providers, Navigators, Peer Specialist
Community Consultation	Mental Health	Douglas County	Health Education, Intensive Case Management, Mental Health providers, Navigators, Peer Specialist
Assessments and Referrals	Mental Health	Douglas County	Health Education, Intensive Case Management, Mental Health providers, Navigators, Peer Specialist
Crisis	Mental Health	Douglas County	Mental Health Providers

ATTACHMENT B.2.9. – Adverse Event Reporting

PHYSICIANS OF DOUGLAS COUNTY
Stewards of health and healthcare

POLICY and PROCEDURE

Adverse Event Reporting and Investigation

Approved by: Quality Improvement Committee

Approval Date: 4/20/2011

Medical Director's Signature:_____
JOEL R. DAVEN, MD Date

Background:
When an adverse event occurs in a health care organization, appropriate individuals must be made aware of the event, investigate and understand the causes that underlie the event and make appropriate changes to reduce the probability of recurrence.

Definition:

- An adverse event is any unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. The phrase "or the risk thereof" includes any event for which a recurrence would carry a significant chance of a serious adverse outcome.

Examples of Adverse Events:

- Death of a member with a non-terminal diagnosis
- Outpatient procedure resulting in inpatient stay
- Unintended complication resulting in prolonged hospital stay
- Unanticipated death of full term infant
- Unplanned return to surgery
- Severe medication reaction requiring additional treatment
- Emergency transfer to ER from provider's office
- Miscommunication between providers resulting in potential harm to patient
- Any other event deemed adverse by nursing or physician judgment

Goals:

- To facilitate safe patient care for all DCIPA members
- To be aware of occurrence rate of adverse events and to take action on any disparities
- To have a positive impact in improving patient care by encouraging root cause analysis of adverse events
- To encourage and support providers' efforts to develop risk reduction strategies

Policy:

In accordance with Oregon Administrative Rules, DCIPA will notify health care providers of identified potential adverse events and request information from the those providers in order to perform reviews. All findings from investigations will be shared with the providers in order to create opportunities for improvement. DCIPA will track adverse event frequency for all members.

DCIPA's Quality Improvement staff will conduct reviews of all identified occurrences of potential adverse events such as those listed below. The Quality Improvement Coordinator and the Chief Medical Officer will review the clinical information. All findings will be shared with the health care organization(s) where the potential adverse event occurred. Recommendations for corrective action plans will be provided as appropriate.

Procedure:

Identification of Adverse Events:

- Nurse Case Manager Reviews
  Office notes
  Prior authorizations
  Referrals
- Review of emergency room visits
- Review of all out-of-area emergency room visits and hospital admissions
- Patient complaints
- Review of all malpractice claims, Board of Medical Examiner actions, and Credentials Committee actions

Quality Improvement Manager's responsibility:

- Document the event in PLEXIS in patient folder.
- Reviews the event and requests appropriate medical records
- Assures that all documentation is present and complete
- Completes an adverse event review form
- Gives review file to the Chief Medical Officer
- A summary of adverse event activity will be included in the annual Quality Improvement report.

Chief Medical Officer's Responsibility:

- Participates in review provided by Quality Improvement Manager

- Seeks clarification of issues from the Quality Improvement staff, hospital, provider or member as needed
- Reviews for system issues and process failures
- Refers to Quality Improvement or Peer Review Committee if appropriate
- Develops corrective action plan as needed
- Communicates with provider regarding recommendations
- Monitors implementation of corrective action plan
- Documents all deliberations and actions
- Obtains legal counsel when necessary
- Refers to Credentials Committee or Regulatory Agencies as needed

Originated: 3/18/2009
Reviewed: 8/2008; 3/18/2009; 4/19/2011
Revised: 4/19/2011

ATTACHMENT C.1.1.

PHYSICIANS OF DOUGLAS COUNTY
Stewards of health and healthcare

Policies & Procedures

Title: **Quality and Performance Improvement Practice Guidelines**

Approved by: **DCIPA's Quality Improvement Committee**

Date Approved: **October 21, 2009**

Reference: **2009 FCHP Contract, Exhibit B Part III p 39, OAR 410-141-0200; 42 CFR 438.236 (a)(b)(c)(d)**

Background:

To ensure that DCIPA's Practice Guidelines are based on valid and reliable clinical evidence or on a consensus of health care professionals in the particular field; that the guidelines consider the needs of DCIPA Members; the guidelines are adopted in consultation with contracting health care professionals; and are reviewed and updated periodically as appropriate. To ensure that DCIPA's Practice Guidelines are disseminated according to this Policy. To ensure that decisions for utilization management are consistent with DCIPA's Practice Guidelines.

Applicability:
Medical Management
Medical Directors
Quality Improvement Committee

Definitions:
Division of Medical Assistance Programs (DMAP) - The Office of DHS responsible for coordinating Medical Assistance Programs, including the OHP Medicaid Demonstration, in Oregon and CHIP. DMAP writes and administers the state Medicaid rules for medical services, contracts with Providers, maintains records of client eligibility and processes and pays DMAP providers.

DCIPA Member – An OHP Client enrolled with DCIPA.

Health Care Professionals - Persons with current and appropriate licensure, certification, or accreditation in a medical, mental health or dental profession, which include but are not limited to: Medical Doctors (including Psychiatrists), Dentists, Osteopathic Physicians, Psychologists, Registered Nurses, Nurse Practitioners, Licensed Practical Nurses, Certified Medical Assistants, Licensed Physicians Assistants, Qualified Mental Health Professionals (QMHPs), and Qualified Mental Health Associates (QMHAs), Dental Hygienists, Denturists, and Certified Dental Assistants. These professionals may conduct health, mental health or dental assessments of

DMAP Members and provide Screening Services to OHP Clients within their scope of practice, licensure or certification

Quality Improvement Committee – Committee comprised of practicing doctors and other health care experts. The Committee meets once a month to discuss Grievances and to monitor and improve the care given to members.

Policy:

DCIPA will adopt evidenced-based clinical practice guidelines that are based on valid and reliable clinical evidence or on a consensus of Health Care Professionals. DCIPA's Practice Guidelines will also take into account the Guidelines and Oregon Administration Rules as set by DMAP. DCIPA will ensure that the needs of its members are taken into consideration when developing guidelines.

DCIPA's Practice Guidelines will take into consideration the needs of its members. The guidelines will be reviewed and updated as appropriate, but not less than every two years. The guidelines will be disseminated to all DCIPA Providers and upon request, to DMAP, DCIPA members or potential members.

Decisions for utilization management and coverage of services shall be consistent with DCIPA's Practice Guidelines and Oregon Administrative Rules. DCIPA shall ensure consistency through an inter-rator reliability audit.

Procedure:

- When the need for a new practice guideline is noted, DCIPA's Chief Medical Officer will research clinical evidence, Oregon Administrative Rules, and the needs of our member population. All gathered information will be taken to DCIPA's Quality Improvement Committee for review, input, and approval.

- Once DCIPA's Quality Improvement Committee has approved a guideline the guideline will be disseminated to all DCIPA Providers via the DCIPA Provider Newsletter and the Provider Handbook on the DCIPA Website.

- As guidelines are updated and changed they are disseminated according to the above procedure.

- DCIPA Practice Guidelines are available any time upon request and are frequently provided as part of the prior authorization process.

ATTACHMENT C.2.1.f. – Provider Handbook

PHYSICIANS OF DOUGLAS COUNTY

dcipa

Stewards of Health and Healthcare

Provider Handbook 2010

"Serving the needs of physicians and their patients in Douglas County."

Provider Handbook 2010v3

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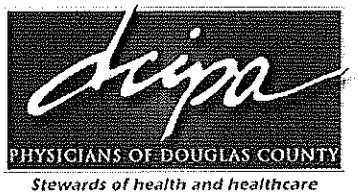

March 2010

DCIPA The Physicians of Douglas County are pleased to present you with a copy of the updated DCIPA Provider Handbook. This handbook outlines policies, procedures, resources and other important information that will assist you and your staff in delivering benefits and services to our community.

As the stewards of health and healthcare, The Physicians of Douglas County and their staff are the most important part of our healthcare delivery system. We pride ourselves on being a physician-driven organization that's committed to providing high quality, affordable healthcare to all residents.

Since its inception 15 years ago, DCIPA has accomplished many goals and demonstrated leadership in the healthcare industry. One of the achievements we're particularly proud of is the creation and implementation of our electronic medical records system, UmpquaOne Chart. This is just one example of how we continuously strive to improve patient care.

We remain committed to ensuring patient and provider satisfaction, increasing access to care for low-income Oregonians, recruiting physicians and specialists to our area, and providing services to enhance the overall health of our community in the most cost-effective manner possible. We appreciate your ongoing dedication and look forward to working with you this year.

The DCIPA Web site, www.dcipa.com, contains additional information, as well as an electronic version of the DCIPA Provider Handbook. If you have questions or comments about the information in this handbook, please contact Sandra Wright at 541-464-4063.

Sincerely,

Ron Preston

Ronald R. Preston, CEO
DCIPA, The Physicians of Douglas County

PROVIDER HANDBOOK
INTRODUCTION

This policy, procedure, and standards handbook has been compiled by Douglas County Individual Practice Association (DCIPA) for the use of providers rendering medical care to all the members covered by our health plan.

This handbook is intended to answer common questions providers and their staff may have while administering care to DCIPA's members.

As policies and procedures contained in this handbook change, revisions will be made available to you for update to enhance its usefulness.

If you have comments or recommendations for future changes, please let us know.

CONFIDENTIALITY

DCIPA employees and providers shall maintain the confidentiality of a member's medical record information and release such information only in accordance with the Health Insurance Portability and Accountability Act (HIPAA), and related regulations, as set forth at 42 CFR 431, subpart F.

DCIPA staff and providers shall not discuss information about a member's condition, health status, personal affairs, claims history, or any other information (except to those responsible for patient care and treatment), without full consent of the member, unless compelled to do so by law.

Access to the member's medical records is reserved to only those persons involved with the member's direct medical care, i.e., the PCP, the referral specialist, and relevant DCIPA employees.

Any request by a member to see their medical records currently in DCIPA's possession will be reviewed by the Privacy Officer. The Privacy Officer will release records according to DCIPA's HIPAA Privacy Policies.

As a general rule, to release information to any source other than the Division of Medical Assistance Programs (DMAP), an Authorization for Release of Health Information must be signed by the member.

DCIPA is considered a covered entity under HIPAA. Providers are allowed to send protected health information for treatment, payment, and/or health care operations by fax, US mail, or courier.

MONITORING AND ENFORCEMENT

Any breach of confidentiality by a DCIPA employee is considered a major offense and will require immediate disciplinary action in the form of suspension from work or termination.

Confidentiality issues involving providers or provider's office staff will be managed by the Quality Improvement Committee and could result in the provider's termination as a participating provider for DCIPA.

Questions involving confidentiality issues by DCIPA's staff or providers shall be directed to the Chief Executive Officer or the Medical Director.

FRAUD & ABUSE POLICY

Policy

Douglas County Individual Practice Association, Inc., (DCIPA) cannot knowingly tolerate fraud and abuse among its Providers or within programs and plans it sponsors or participates in. Under the direction of DCIPA's Board of Directors and Chief Executive Officer (CEO), DCIPA's Corporate Compliance Officer operates and monitors DCIPA's fraud and abuse program. DCIPA expects all its Providers to act with the highest degree of integrity at all times, and to comply with DCIPA's Fraud and Abuse Identification and Reporting Plan (the Plan) and all applicable law. Providers shall immediately alert DCIPA of any personal interest they may have which relates to DCIPA's business, including any DCIPA business that may benefit them, their business, their family members, or friends.

Definitions

- ***Abuse (of Member by Provider).*** Intentional infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault.
- ***Abuse (by Provider).*** Incidents or practices that are inconsistent with accepted sound medical, business, or fiscal practices, which may directly or indirectly result in unnecessary costs to the program, improper payment, or payment for services that fail to meet professionally recognized standards of care, or that are medically unnecessary. Abuse may also involve payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly intentionally misrepresented the facts to obtain payment.
- ***Fraud.*** An intentional deception or misrepresentation which an individual makes knowing that deception could result in some unauthorized benefit to himself/herself or another.

Referrals

DCIPA promptly refers suspected cases of fraud and abuse, including fraud by its personnel and subcontractors, to Division of Medical Assistance Programs (DMAP's) Medicaid Fraud Control Unit (MFCU), and where applicable, Centers for Medicare and Medicaid Services (CMS). In determining whether to make referrals, DCIPA considers the following examples of fraud and abuse:

- Providers who demonstrate a pattern of intentionally reporting encounters or services that did not occur. A pattern is evident when 20 percent or more of audited services are not supported by documentation in the clinical records.
- Providers who demonstrate a pattern of intentionally reporting overstated or up-coded levels of service. A pattern is evident when 20 percent or more of audited services are billed at a higher-level procedure code than is documented in the clinical records.
- Any suspected case where a Provider intentionally or recklessly billed DCIPA more than the usual charge to non-Medicaid recipients or other insurance programs.
- Any suspected case where a Provider purposefully altered, falsified, or destroyed clinical record documentation for the purpose of artificially inflating or obscuring his/her compliance rating or collecting Medicaid payments otherwise not due, including any deliberate misrepresentation or omission of fact material to determining whether benefits are payable,

or whether services are covered or should be rendered; i.e., dates of service, charges or reimbursements from other sources, or the identity of the patient or Provider.

- Providers who intentionally or recklessly make false statements about the credentials of persons rendering care to DMAP Members.
- Primary Care Physicians who intentionally misrepresent medical information to justify referrals to other networks or out-of-network Providers when they are obligated to provide the care themselves.
- Providers who intentionally fail to render Medically Appropriate Covered Services that they are under a contractual and regulatory obligation to provide.
- Providers who knowingly charge DMAP Members for Covered Services or intentionally balance-bill a DMAP member the difference between the total fee-for-service charge and DCIPA's payment to the Provider, in violation of DMAP rules.
- Providers who intentionally submit a claim for payment that already has been paid by DMAP or DCIPA, or for which payment has been made by another source without the amount paid by the other source clearly reflected on the claim form, when receipt of payment is known to the Provider.
- Any theft, embezzlement, or misappropriation of Title XIX or Title XXI program funds.
- Evidence of corruption in the Enrollment and Disenrollment process, including efforts of state personnel or contractors to skew the risk of unhealthy patients toward or away from one of the DMAP contractors.
- Attempts by any individual, including personnel and elected officials of the state, to solicit kickbacks or bribes, such as a bribe or kickback in connection with placing a DMAP Member into a carved out program, or for performing any service that the agent or personnel is required to provide under the terms of his employment.
- Any Provider who hits, slaps, kicks, or otherwise physically abuses any patient.
- Any Provider who sexually abuses any patient.
- Any Provider who intentionally fails to render Medically Appropriate care, as defined by the Fully Capitated Health Plan Contract between DCIPA and DMAP (FCHP Contract), by the OHP Administrative Rules and the standard of care within the community in which the Provider practices.
- Providers who deliberately neglect their obligation to provide care or supervision of vulnerable DMAP Members (children, the elderly, developmentally disabled).

Fraud and Abuse Reporting Procedure

- Reports. All potential fraud and abuse is to be reported to the Corporate Compliance Officer immediately upon discovery. Failure to do so is itself a violation of the Plan subject to discipline. Providers should complete and submit a Personnel Incident Report Form to the Corporate Compliance Officer.
- Investigation. Upon receipt of a Personnel Incident Report Form or other similar communication, the Corporate Compliance Officer will investigate the allegations and, if circumstances and data warrant referral, forward to the MFCU, CMS, or other applicable regulatory state and federal agencies as appropriate. Providers are required to cooperate with the MFCU and Department investigator during any investigation of fraud or abuse. DCIPA will take reasonable steps to protect the anonymity of persons reporting suspected fraud and abuse.
- ***Disciplinary Options.*** Where violations are found, offenders will be subject to discipline such as oral or written reprimands, or suspension or termination of employment or contract.

Discipline imposed will depend upon the circumstances of the violation, the offender's prior history of violations, the offender's motivation, and the nature and degree of the current and any prior violations. All violations will be documented and retained in the offender's file.

- ***Retaliation.*** Retaliation for reporting suspected violations or participating in investigations is strictly prohibited and is itself a violation of the Plan. Retaliation should be reported immediately to the Corporate Compliance Officer. If the Corporate Compliance Officer is involved in the retaliation, the victim should instead report to DCIPA's CEO. If the Corporate Compliance Officer and CEO are involved in the retaliation, the victim should report to the Board of Directors.

FRAUD & ABUSE INCIDENT REPORT **Confidential Information**

INCIDENT REPORT
(PERSONNEL)

Name: _____ (unless you wish to remain anonymous)

Home Phone: _____ Work Phone: _____

Employer: _____

Position: _____ Supervisor: _____

1. Description of possible violation: _____

_____

2. When did this occur? _____

3. Person(s) involved? _____

4. How did you learn of the incident/practice described above? _____

_____

5. Do you have any evidence to prove the above allegations? If yes, please describe: _____

_____

6. Have you discussed the above allegations with anyone else? If yes, who? _____

_____

7. Do you have any further information to provide or any suggestions for verifying the allegations described above?

_____

8. Are you aware of any other individuals who may be able to provide further information regarding the above allegations?

_____

NOTE: This report should be given to DCIPA's Corporate Compliance Officer. However, if the Coordinator is the subject of the report, it should be given to a member of DCIPA's Board of Directors. DCIPA will ensure confidentiality of the above information to the fullest extent possible. Furthermore, nothing in the report will be used adversely against you by DCIPA.

Or Mail to:
Corporate Compliance Officer
DCIPA
500 SE Case Ave, Mailbox 210
Roseburg, OR 97470

FRAUD & ABUSE APPLICABLE LAWS & REGULATIONS

The chart below summarizes some of the laws and regulations impacting DCIPA and its associated Providers. Providers are obligated to avoid any conduct in violation of the listed laws and to immediately report activities they observe that violate the listed laws.

Statute	Prohibited Conduct	Penalties
Criminal Offenses		
Federal False Claims Act 31 USC §§ 3729-3733	(1) Knowing submission of any false or fraudulent claim for payment to the United States; (2) knowing use of a false record or statement to obtain payment of a false or fraudulent claim; or (3) any conspiracy to defraud the United States through false or fraudulent claims.	Up to 5 years in prison, repayment of all ill-gotten gains, and fines up to $25,000.
Bribery, Perjury and related offenses ORS 162.015-ORS 162.119	(1) Offering or accepting any benefit to influence any public official; (2) any sworn or written false statements if made to a public official.	Up to 10 years in prison, repayment of all ill-gotten gains, and fines up to $250,000.
Theft Related Crimes ORS 164.015-ORS 164.174	(1) Taking property from its lawful owner; (2) keeping property of another mistakenly left or lost; (3) obtaining money through extortion or deception; (4) receiving and keeping property knowing that the property was the subject of theft; (5) obtaining services without payment knowing that the services were offered only in exchange for compensation; (6) participating in laundering of unlawfully obtained monies.	Up to 10 years in prison, repayment of all ill-gotten gains, and fines up to $250,000.
Fraud or Deception ORS 165.002-ORS 165.042 ORS 165.075-ORS 165.080 ORS 165.100-ORS 165.107	Forgery, which includes (1) the intent to injure or defraud, making, completing, or altering any document, or passing to another a document knowing it is forged; (2) possessing forged documents knowing they are forged; (3) with the intent to injure or defraud, obtaining the signature of another person by misrepresenting any fact; (4) with the intent to defraud, falsifying, altering, erasing, deleting or otherwise failing to make correct entries in any business record; (5) with the intent to defraud, knowingly stating in writing the financial condition of any person or business with any material inaccuracy.	Up to 10 years in prison, repayment of all ill-gotten gains, and fines up to $250,000.
Making False Claims for Healthcare Payments ORS 165.690-ORS 165.698	(1) Making any claim for payment for healthcare services when the claim contains false statements of any material fact; (2) knowingly concealing any information from a healthcare payor with the intent to obtain a healthcare payment to which the person is not entitled.	Up to 5 years in prison, repayment of all ill-gotten gains, and fines up to $125,000.
Civil and Criminal Racketeering ORS 166.715-ORS 166.735	Using ill-gotten gains resulting from a pattern of racketeering activity to invest in real property or a business enterprise or to control any real property or business, or for any person associated with such business to participate in the business enterprise through a pattern of racketeering activity.	Up to 25 years in prison, repayment of all ill-gotten gains, and fines up to $500,000. Additional penalties: fines up to three times the value gained illegally.

Civil Offenses		
Federal False Claims Act Title 31, Chapter 38 of the United States Code	(1) Knowing submission of any false or fraudulent claim for payment to the United States; (2) knowing use of a false record or statement to obtain payment of false or fraudulent claim; or (3) any conspiracy to defraud the United States through false or fraudulent claims.	Fines between $5,500 and $11,000 per claim filed, plus three times the lost value resulting from the false or fraudulent claim.
False Claims for Public Assistance ORS 411.670-ORS 411.690	(1) Knowingly submitting false claims for public assistance benefits of any kind; (2) knowingly submitting claims for public assistance which have previously been paid or submitted without clearly indicating they are duplicates; (3) knowingly accepting any payment for public assistance which was not actually provided.	Repayment of up to three times the amount of wrongfully received assistance.
Unlawful Trade Practices ORS 646.605-ORS 646.652	(1) Any unconscionable tactics in connection with the sale of any goods or services; (2) failing to deliver any goods or services as promised; or (3) upon request, failing to return or refund any money received from a customer for the purchase of undelivered goods or services. Further, the unlawful trade practice act prohibits virtually any attempt to deceive or misrepresent goods or services offered for sale.	Violations may be prosecuted by a District Attorney but are usually pursued by individual civil actions with penalties including the greater of $200 or actual damages, plus attorney fees and court costs.
Common Law Fraud	Benefiting from any deceitful or fraudulent activity.	Penalties are the amount of actual damages suffered and court costs.
Common Law Claims of Money Had and Received or Money Paid by Mistake or False Pretenses	Benefiting from receipt of money to which the person is not entitled.	Penalties are the amount of actual damages suffered and court costs.
OMAP Program Integrity Requirements OAR 410-120-1395 thru OAR 410-120-1510	Regulations (1) prohibit providers from receiving any state funds to which the provider is not entitled; (2) provide mechanisms to permit the state to recover those funds from the provider; (3) require all providers to submit true, accurate, and complete claims; (4) permit OMAP to refuse to pay claims under numerous circumstances including failure to provide service in according with OMAP requirements, failing to meet quality of care criteria, and medical inappropriateness.	Repayment or refund of monies to which the provider was not entitled for any reason; excluding or suspending the provider from participating in OMAP; imposing discretionary sanctions including monetary or disciplinary sanctions; permitting OMAP to audit provider medical records and claims.

Web Resources

The full text of the Federal False Claims Act (31 U.S.C. 3729-3731) is available on the US Code web site at http://uscode.house.gov/pdf/2005/2005usc31.pdf

GLOSSARY

ABCT
The management company responsible for claims processing, enrollment, and Member Services for DCIPA.

ADA (Americans with Disabilities Act)

AFDC (Aid to Families with Dependent Children)
A federal program coordinated by Adlt & Family Services Division a Department of Human Resources that provides assistance to families.

AFS (Adult and Family Services Division)
A division of the Department of Human Resources.

Aged
Individuals who meet eligibility criteria established by the Senior and Disabled Services Division for receipt of medical assistance because of age.

AIS (Automated Informational System)
Automated computer voice response system that maintains current records of clients and provides information regarding the eligibility to medical providers over the telephone.

ALERT
The Oregon Immunization Registry is an electronic repository that contains children's immunization records, regardless of where they received their shots. It is available to health care providers statewide.

Ancillary Services
Covered services that are medically appropriate to support a diagnosis and/or treatment plan. These may include physical therapy, occupational therapy, home health, hospice, and other treatment services.

For the Oregon Health Plan, ancillary services are those medical services not identified in the definition of a condition/treatment pair under the OHP Benefit Package, but are medically appropriate to support a service covered under the OHP Benefit Package. A list of ancillary services and limitation is identified in OAR 410-141-520, Prioritized List of Health Services.

Blind
Individuals who meet eligibility criteria established by the Senior and Disabled Services Division for receipt of medical assistance because of a condition or disease that causes or has caused blindness.

Capitation
A reimbursement system in which providers are paid a set amount for a defined set of services on a per member per month basis.

Capitated Services
All medically necessary services and supplies rendered or furnished by a provider for a capitation payment.

Capitation Payment
A predetermined monthly payment to a provider by DCIPA for covered services for each member assigned to that provider.

Case Management
Specialized coordination of care services provided by DCIPA and its providers for severe or complex health care problems or for care not available locally.

Chemical Dependency
The addictive relationship with a drug or alcohol characterized by either a physical and/or psychological relationship that interferes with the individual's social, psychological, or physical adjustment to common problems on a recurring basis. For purposes of this definition, chemical dependency does not include addiction to or dependency of tobacco, tobacco products or foods.

CHIP (Children's Health Insurance Program)
Title XXI of the Social Security Act funds are used to expand the existing efforts of the Oregon Health Plan to provide health insurance coverage for low-income families.

COB (Coordination of Benefits)
A method of determining who has primary responsibility when there is more than one payor available to pay benefits for incurred services.

Comfort Care
The provision of medical services or items that give comfort and/or pain relief to an individual who has a terminal illness. Comfort care includes the combination of medical services designed to make it possible for an individual with a terminal illness to die with dignity and respect, and with as much comfort as possible given the nature of the illness.

Community Standard
Serves as the basis for expectations of the health care delivery system in the member's community.

Co-morbid Condition
A medical condition/diagnosis (i.e. illness, disease, and/or disability) coexisting with one or more conditions/diagnoses in the same patient.

Complaint/Appeal
A member or physician's expression of dissatisfaction and identified as a complaint to be addressed by DCIPA. Complaints must address issues that are part of DCIPA's contractual responsibility.

Condition/Treatment Pair
Conditions described in the International Classification of Diseases Clinical Modification, 9th Revision (ICD-9-CM) and treatments described in the Current Procedural Terminology, 4th Edition CPT-4) or American Dental Association Codes (CD-1) which, when paired by the Health Services Commission, constitute the line items in the Prioritized List of Health Services. Condition/Treatment Pairs may contain many diagnoses and treatments. The Condition/Treatment Pairs are listed in OAR 410-141-0520, Prioritized List of Health services.

Covered Services
All medically necessary services and supplies rendered or furnished by a Health Care Provider to members that are benefits under the Oregon Health plan benefit agreements or benefits covered by DCIPA's contract.

DCIPA (Douglas County Individual Practice Association)
A health care services contractor providing health care services to members under the terms of its contract with DMAP.

Diagnostic Services
Those services required to diagnose a condition, including but not limited to, radiology, ultrasound, other diagnostic imaging, EKG's, laboratory, pathology, examinations, and physician or other professional diagnostic/ evaluative services.

Disabled
Individuals with impairment of functional performance and activity defined by the "International Classification of Impairments, Disabilities, and Handicaps" from the World Health Organization. For OHP, these are individuals who meet eligibility criteria established by the Senior and Disabled Services Division for receipt of Medical Assistance because of disability.

Durable Medical Equipment
Crutches, wheelchairs, hospital beds, or other therapeutic equipment which stand repeated use, are medically necessary and are not merely for comfort or convenience of the member or provider. The equipment must be related to the covered medical condition of the member.

EHR (Electronic Health Records)
A software program to help practices manage clinical and administrative data.

ENCC (Exceptional Needs Care Coordination)
A specialized case management service provided by DCIPA to OHP members who are aged, blind or disabled, consistent with OAR 410-141-0405, Oregon Health Plan Prepaid Health Plan Exceptional Needs Care Coordinator.
Services include the following:

- Early identification of those aged, blind or disabled members that have disabilities or complex medical needs,

- Assistance to ensure timely access to physicians and capitated services,
- Coordination with providers to ensure consideration is given to unique needs in treatment planning,

- Assistance to providers with coordination of capitated services and discharge planning,
- And aid with coordinating community support and social services linkage with medical care systems as deemed necessary and appropriate.

EOB (Explanation of Benefits)
A form included with a reimbursement check from DCIPA that explains benefits paid and/or charges that were denied.

FCHP (Fully Capitated Health Plan)
A plan which provides a full range of medical services including physician, inpatient, outpatient, pharmacy, and ancillary services to OHP members.

Fee for Service
A reimbursement system in which a provider bills DCIPA for each service after the service has been provided.

HCFA (Health Care Finance Administration)
A federal agency with the Department Health & Human Services (DHS) responsible for Medicare and Medicaid programs.

HIPAA (Health Insurance Portability and Accountability Act) "Under Title II, subtitle F of HIPAA gives HHS the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information."

HMO (Health Maintenance Organization)
Fully capitated health plans which are covered by the HMO Act of 1973 and regulated by Health Care Finance Administration.

Hospice Service
A public agency or private organization or subdivision of either which is primarily engaged in providing care to terminally ill individuals. Certified for Medicare and/or accredited by the Oregon Hospice Association and listed in the Hospice Program Registry with a valid provider agreement.

ITSS (Information Technology Services and Support)

Managed Care
A system of care where a company contracts with the State of Oregon (DMAP) to provide care under guidelines for members assigned.

Medically Necessary

Those services or supplies which are required for prevention, diagnosis, treatment for sickness or injury, and necessary for symptoms, diagnosis or treatment of an illness/disease, accidental bodily injury, or a condition harmful or threatening to the member's life or health.

- Received in the most cost effective, medically appropriate setting that can be used safely.
- The most effective of the alternative levels of service or medical supplies which can be safely provided to a member.
- Appropriate with regard to widely accepted standards of practice in the State of Oregon and could not have been omitted without adversely affecting the member's condition or the quality of care the member received as determined by DCIPA's established review mechanisms.
- Not primarily for the member's, provider's, hospital's, or any other person's convenience.

The fact that a provider may prescribe order, recommend or approve a service or supply does not, of itself, make the service or supply medically necessary. DCIPA may consult with professional consultants, peer review committees, and/or other appropriate sources for recommendations regarding the medical necessity of the services or supplies received by members.

Member
A person entitled to receive benefits under a policy or contract issued, arranged, or administered by DCIPA.

Mental Health
Conditions meeting the diagnostic criteria defined as mental disorders in the ICD-9-CM and Diagnostic Manual of Mental Disorders (DSM IV-R) published by the American Psychiatric Association.

Non-Participating Provider
A physician who has not signed a contract with DCIPA.

Non-Covered Services
Health care services or items for which members are not entitled to receive from DCIPA according to the Health Care Benefit as outlined in the Oregon Health Plan Benefit Contract. Services may be covered under the Oregon Medical Assistance Program, but not covered under the Oregon Health Plan. Non-covered services for the Oregon Health Plan are identified in OAR 410-141-0050 (excluded services and limitations for OHP clients) and OAR 410-120-1200 (the individual physician guides).

DMAP (Department of Medical Assistance Programs)
A division of the Department of Human Resources responsible for the administration for the Federal/State Medicaid Program and the Oregon Health Plan Medicaid Demonstration Project (OHP).

Open Card
A person who has coverage through the State of Oregon but has not been assigned to a managed care plan.

Oregon Health Plan (OHP)

The Medicaid demonstration project which expands Medicaid eligibility to low income residents and to children and pregnant women up to 185% of the federal poverty level. The OHP relies substantially upon prioritization of health services and managed care to achieve the public policy objectives of access, cost containment, efficacy, and cost effectiveness in the allocation of health resources.

Oregon Health Plan Client
An individual found eligible by DHR division to receive services under the OHP. The individual may or may not be enrolled with DCIPA.

Participating Physician
A physician who has signed a contract with DCIPA.

PCP (Primary Care Provider)

PLM (Poverty Level Medical Program)

Preventive Services
Those medical examinations, laboratory tests, imaging studies, immunizations, and medicines that will prevent or decrease the likelihood or severity of illness or injury. The U.S. Prevention Services Guidelines will be used for accepted preventive services. For OHP, those services are defined under "Expanded Definition of Preventive Services" for OHP members in OAR 410-141-0480, the Oregon Health Plan Benefit Package of Covered Services and OAR 410-141-0520, Prioritized List of Health Services.

Primary Care Provider
A physician or health care provider who specializes in Internal Medicine, General/Family Practice, Pediatrics, or a Family, Adult, or Pediatric Nurse Practitioner who has agreed to function as a PCP under the terms of a contract with DCIPA. PCP's provide primary care services and coordinate care for their patients.

Primary Hospital
The hospital who has signed a contact with DCIPA to provide covered hospital services for its membership. Capitation payment may be the method of reimbursement for the hospital.

Prior Authorization
Process of obtaining authorization from DCIPA for procedures, admissions, or services before the services are provided.

Prioritized List of Health Services
The listing of condition and treatment pairs developed by the Health Service Commission for the purpose of implementing the OHP. See OAR 410-141-0520, Prioritized List of Health Services for the listing of condition/treatment pairs.

QI (Quality Improvement)
A process that assures that health care received by members meets accepted community standards of care.

Quality Improvement Committee
A committee of DCIPA providers and appropriate DCIPA staff charged with conducting quality improvement activities for DCIPA.

Representative
A person who can make OHP related decisions for OHP members who are not able to make such decisions themselves. A representative may, in the following order of priority, be a person who is designated as the OHP Client's Health Care representative.

- A court appointed guardian
- A spouse or other family member designated by the OHP client
- The Individual Service Plan Team (for developmentally disabled members)
- A DHR case manager designated by the OHP client

Spouse
An individual who is legally married or a legally recognized, filed domestic partner.

Terminal Illness
An illness or injury that is forecasted to result in the death of the patient for which treatment directed toward cure is no longer believed appropriate or effective.

TPR (Third Party Resource)
A medical or financial resource that under law is available and applicable to pay for medical services and items for a medical assistance client.

Unassigned
DCIPA members who have not chosen or been assigned a PCP.

UR (Utilization Review)

Urgent
Any injury or illness that does not immediately threaten life or limbs but must be treated as soon as reasonably possible within 16 to 24 hours.

Urgent Care Services
Covered services required in order to prevent a serious deterioration of a member's health that results from an unforeseen illness, injury, or covered dental service required to alleviate severe pain. Services that can be foreseen are not considered urgent services.

UCR (Usual, Customary, and Reasonable Charges)
Charges as determined by DCIPA for a service area based on the following criteria:

- Usual - An amount a physician usually charges for a given service.
- Customary - An amount which falls within the same range of usual charges for a given service rendered by most physicians in the same locality who have similar training and experience.
- Reasonable - An amount which is usual and customary or which would not be considered excessive in a particular case because of unusual circumstances.

Utilization Management
Ongoing review of an institution or a provider's provision of health care services to assure high quality member care and effective use of services.

Women's Health Care Provider
An obstetrician, gynecologist, physician assistant or advanced registered nurse practitioner specializing in women's health, or a certified nurse midwife practicing within the applicable lawful scope of practice.

Worker
A person who works for the Department of Human Resources who is assigned to help OHP clients regarding questions or problems with their coverage. The OHP members ID card will show their office name, phone number, and worker's code.

DCIPA BOARD OF DIRECTORS

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DCIPA STAFF & DUTIES 1813 W Harvard Suite 404, Roseburg, OR 97471 **Phone:** 1-541-672-1685 or 1-800-676-7735 **Fax:** 1-541-677-6015	
Health Care Services Director	Karen
Health Care Services/Member issues Member eligibility, PCP assignments, in-area referrals, claims status, billing issues	Raquel, Supervisor Mary, Kelcey, Amy
Electronic File Submission	Angie, Claims Analyst, Naomi, Claims Analyst
Eligibility List on Disk/printouts	N/A
Health Care Services	Raquel, Mary, Kelcey, Amy
Enrollment/Capitation	Raquel/Angie
DCIPA Medical Management Team 1813 W Harvard Suite 206, Roseburg, OR 97471 **Phone:** 1-541-672-1685 **Fax:** 1-541-677-5881	
Chief Medical Officer	Joel Daven, MD
Medical Director	Larry Sharp, DO
Office Manager/Nursing Supervisor	Micki, NP
Quality Improvement Coordinator, OHP Appeal & Grievance Coordinator	Jennie, RN
ATRIO NCM, Facility Liaison	Kristi, RN, Team Leader
ATRIO NCM	Jane, RN
OHP NCM, Exceptional Needs Care Coordinator (ENCC), Transplant & Interpreter Coordination	Cyndi, RN, Team Leader
OHP NCM –ENCC	Mary, RN
OHP NCM –ENCC	Carolyn, RN
Healthcare Associate/Grievance Backup	Heather, LPN
Sr. Administrative Assistant, HIPAA Privacy Officer, Provider Relations Coordinator	Sandra
Third Party Recovery, MVA	Rod, Megan
Government Programs Manager	Johanna
Credentialing Coordinator	Melissa
Staff Support – OHP Authorization Data Input	Whitney, Shelly, Robbie
Reception, Record Management	Tina

EXCEPTIONAL NEEDS CARE COORDINATOR

DCIPA has an Exceptional Needs Care Coordinator (ENCC) that is available Monday through Friday 8:00 a.m. to 5:00 p.m. to assist members who have complex medical needs and/or special needs. This program is designed to help coordinate health care services for persons who are 65 or older, blind, disabled, or children with special needs. Members who need assistance with medical supplies, equipment, scheduling appointment, or other health care needs can contact DCIPA's ENCC. Providers, caseworkers, care providers, or family members can also let us know if someone is in need of assistance. Contact DCIPA's Health Care Services at 1-541-672-1685 or 1-800-676-7735 or TTY 541-440-6304 or 1-888-877-6304, a representative will take a message for the ENCC to call you back at her earliest possible convenience.

PUBLICATION LIST

FEDERAL REGISTER
US GOVERNMENT PRINTING OFFICE – NEW ORDERS
SUPERINTENDENT OF DOCUMENTS
PO BOX 979050
ST. LOUIS, MO 63197-9000
1-202-512-1800
FAX: 1-202-512-2104

APT & ICD-9 CODING
AMERICAN MEDICAL ASSOCIATION
515 N. STATE STREET
CHICAGO, IL 60610
1-800-621-8335

OHP ADMINISTRATIVE RULES & HCFA BILLING GUIDE
DMAP MEDICAL AFFAIRS PROGRAM
PHYSICIAN RELATIONS
500 SUMMER ST NE, E37
SALEM, OR 98301-1079
1-503-378-2263
1-800-527-5772

MEMBER IDENTIFICATION

DCIPA members will be issued a medical ID card by DHS once a member becomes eligible for coverage under the Oregon Health Plan Medicaid Demonstration Project (OHP) and is assigned to DCIPA.

- This ID card tells you that the patient is enrolled with DCIPA and the period of time the member is eligible.

- DCIPA recommends that you make a copy of the member's medical ID card and keep it in the patient's chart.

Have the patients bring their medical ID card with them to their appointments and check the member's eligibility before each visit.

The member's eligibility can be verified on line, MMIS web portal at www.oregon-medicaid.gov, or by telephone 866-692-3864, or by calling Health Care Services at 541-672-1685 or 1-800- 676-7735.

MEMBER IDENTIFICATION

DCIPA members will be issued a medical ID card by DHS once a member becomes eligible for coverage under the Oregon Health Plan Medicaid Demonstration Project (OHP) and is assigned to DCIPA.

- This ID card tells you the member's name and ID number. This ID card does NOT guarantee medical coverage.

- DCIPA recommends that you make a copy of the member's medical ID card and keep it in the patient's chart.

Have the patients bring their medical ID card with them to their appointments and check the member's eligibility before each visit.

The member's eligibility can be verified

- Online with DCIPA at https://edi.abct.com
- By calling DCIPA's Health Care Services at 541-672-1685 or 1-800- 676-7735.
- MMIS web portal at www.oregon-medicaid.gov
- Or by calling the MMIS AVR (Automated Voice Response) at 866-692-3864

MEMBER ELIGIBILITY LIST

Primary care physicians can download their eligibility list from DCIPA. For ease of member identification theses lists include the following information:

- Member name
- Member ID number
- Birth date

- Sex
- Effective date of eligibility
- PCP number
- PCP name

HOW TO RETRIEVE FILES ONLINE

This electronic eligibility verification system is available 24 hours a day. This service makes it possible to view a single member's eligibility or to generate a list of eligible members that are assigned to a provider. To establish a user name and password, e-mail edi@abct.com.

- Go to https://edi.abct.com.
- Enter in Username and Password
- Click on Login
  - If this is the first time logging into website, you will be prompted to change your password using criteria listed on web page.
  - Type in Old Password
  - Type in New Password
  - Retype in New Password
  - Click Submit
- Click on Prospector. You will be given 2 options:

1. Check the Eligibility by a Single Member
- Enter in 2 of the following 3 items using format shown on screen
  - Member ID
  - Member SSN
  - Birth (DOB)
- Enter Date of Service to Check using format shown on screen. **Note: Field is preset with today's date. Do not check future dates as DMAP can terminate member eligibility at any time. Retro dates of service can also be changed by DMAP at any time.**
- Click in Eligibility Check
  Individual member data will display on screen. This eligibility check shows more information than the list such as member address, phone#, COB information, etc. Page is printable.

2. Generate a list of Eligible OHP Members (NOTE: This option is for Primary Care Provider use only)
- Select Lines per Page (field is preset with 50 lines)
  - Select List Format
    - Plain Text
    - Table (HTML)
    - Excel Format
- Select Date of Report using format shown on screen. **Note: Field is preset with today's date. Do not check future dates as DMAP can terminate member eligibility at any time. Retro dates of service can also be changed by DMAP at any time.**
- Click on Eligibility Report

List will display members that are assigned to Primary Care Provider. If more than one Primary Care Provider is within the facility, all members assigned to each of the Primary Care Providers will display. List is also printable.

****For HIPAA and security reasons, you need to click on Logout to leave the website.****

DISCLAIMER: Every reasonable effort is made to assure the most up-to-date information. ABCT does not assume responsibility for actions taken based on the information provided.

Your questions should be directed to DCIPA's Health Care Services at 541-672-1685.

BENEFITS

DCIPA has contracted with the Department of Human Services (DHS) to provide benefits to OHP clients who are eligible under the Senate Bill 27 Medicaid Expansion/Basic Benefit Package. This program is called the Oregon Health Plan (OHP). DCIPA defines a benefit package using a priority process emphasizing primary care, preventive care, managed care, reduced cost-shifting, and monitoring the purchase and use of expensive medical technology.

Senate Bill 27 requires all third party payers that contract with DMAP for the OHP to offer a defined benefit package based on the Prioritized List of Health Services developed by the Oregon Health Services Commission. The Commission held many public meetings throughout Oregon to find out what health issues were important to Oregonians.

The Health Service Commission ranked all health care procedures in order of importance and created the Prioritized List of Health Services. The Commission consists of an eleven member board that was appointed by the Governor. It is made up of doctors, nurses, and other interested parties concerned about health care issues. As of January 1, 2006 services for condition/treatment pairs line one through 530 of 710 lines are covered services for OHP members. The prioritized list is amended from time to time according to the available budget and the approval of CMS.

The Commission prioritized the services using condition/treatment pairs. Condition/treatment pairs are defined by corresponding CPT procedure codes and ICD-9-CM diagnosis codes. A complete prioritized list of the condition/treatment pairs can be obtained by contacting the following:

Department of Human Services
HRB - 3rd Floor 500 Summer Street NE
Salem, OR 97310
(503) 945-6738
Or HTTP://egov.oregon.gov/DAS/OHPPR/HSC/index.shtml

Senate Bill 27 requires all third party payers that contract with DMAP for the OHP to offer a defined benefit package based on the Prioritized List of Health Services developed by the Oregon Health Services Commission.

SUMMARY OF BENEFITS/PLUS POPULATION

- Medically necessary diagnostic services for **all** medical conditions on the prioritized list.
- Primary care provider services
- Preventive services
  1. Aged-based preventive health exams
  2. Routine immunizations for children and adults
  3. Routine mammography
  4. Routine women's health exams, once yearly
- Specialty services
  1. Physical therapy
  2. Occupational therapy
  3. Speech therapy
- Obstetrical care
- Lab and x-ray services
- Hospital services
- Emergency transportation
- Durable medical equipment
- Prescription medications
- Medication management
- Services at county health departments
- Family planning, contraception medications, and devices
- Voluntary sterilization
- Vision exam and hardware
- Acute inpatient detox
- Outpatient chemical dependency
- Outpatient mental health

SUMMARY OF BENEFITS/STANDARD POPULATION

- Provider services
- Prescription drugs - emergency/urgent hospital services
- Lab and x-ray services
- Out-patient mental health
- Out-patient chemical dependency
- Emergency transportation - ambulance
- Hospice care
- Some medical equipment and supplies limited to:
  1. Diabetic supplies - including blood glucose monitors
  2. Respirator equipment - CPAP, BiPAP
  3. Oxygen equipment - concentrators, humidifiers
  4. Ventilators
  5. Suction pumps
  6. Tracheotomy supplies
  7. Urology and ostomy supplies
- Emergency dental services

- Services at county health departments

NON-FUNDED TREATMENT PAIRS

Understanding the complete implication for the treatment pairs that fall below the funded line is important. These principles needed to be kept in mind:

- Condition/treatment pairs are defined by specific CPT and ICD-9-CM diagnosis codes.
- All claims must have accurate CPT and ICD-9-CM coding in order to be a covered treatment pair. ICD-9-CM codes should be coded to the greatest degree of specificity (4^{th} or 5^{th} digit).
- Diagnostic services may be covered until a diagnosis is reached.
- Non-funded treatments may be provided at the member's expense as long as arrangements have been made prior to treatment.

PUBICLY FUNDED HEALTH CARE SERVICES

DCIPA affirms the value of partnerships between publicly supported programs such as county health departments and community health clinics.

- Douglas County Health Department (DCHD) is contracted for the following services. PA is not required.
  1. Immunizations
  2. Sexually transmitted diseases (STD)
  3. Communicable diseases
  4. Family planning
  5. Well-child care
  6. Women's annual exam
- DCHD is required by contract to provide a record of immunizations, prenatal care, family planning, and well-child care to DCIPA with the claim.
- All immunizations provided by the DCHD are registered with ALERT.

COORDINATION OF BENEFITS

Current federal regulations require that Medicaid pay for health care only after an individual's other health care resources have been exhausted. In other words, Medicaid is viewed as the payer of last resort. The requirement that the private insurer pays first is called Medicaid "third party liability" (TPL).

In guidelines issued by CMS, TPL's are defined as individuals, entities, or programs that may be liable to pay all or part of the expenditures for medical assistance provided under a state Medicaid plan. Third parties include private health insurance (i.e., commercial insurers, self-funded plans, or profit or non-profit pre-paid plans), Medicare, Champus, automobile insurance, state worker's compensation, and other federal programs.

Indian health services facilities and tribal facilities operating under a 638 agreement are payers of last resort and are not considered an alternate resource of third party resources.

If you encounter any of the following circumstance or have any questions regarding third party liability, direct them to DCIPA's TPR Investigator at 541-677-3446.

- Member has other insurance which is not listed on their DMAP Medical Identification form.
- Member is pursuing a settlement for an injury or illness.
- Member is in police custody at the time treatment is rendered.
- Member has permanently moved from Douglas County.

REFUND REQUESTS

On occasion, DCIPA's Claims Department will issue "refund requests" to providers. Typically, these requests are generated because a member is covered by other insurance or had their DCIPA eligibility retroactively terminated by DMAP. It is DCIPA's policy that providers forward the requested reimbursement within 30 days of the receipt of the request. Reimbursement not received within 30 days may result in a deduction from the providers' future claim payments for the requested amount.

PROVIDER CREDENTIALING

DCIPA is committed to continuously improving the quality of patient care and serving the community in an efficient and cost-effective manner. In order to promote and ensure high quality and cost-effective care, expert credentialing and recredentialing processes that follow National Committee for Quality Assurance (NCQA) standards and guidelines are necessary. Providers are credentialed and re-credentialed according to DCIPA's Credentialing Policies and Procedures. Recredentialing shall take place at least every two years. Completion for the credentialing review is required prior to providing care for DCIPA members. Temporary participation as a provider may be granted on a case-by-case basis by the Chairman of the Credentialing Committee or Chief Medical Officer.

Items that DCIPA will collect and verify as part of the credentialing process include:

- State License - current and unrestricted
- Clinical Privileges - at a participating hospital
- 24 Hour Call-Share - see call-share for guidance
- Professional Liability Insurance
- Malpractice History
- Adequate and Proper Education - Board Certified or eligible preferred
- DEA Certificate
- Work History
- Signed Authorization and Release Form
- Professional Questions and Attestation Form
- National Practitioner Data Bank Report
- Federation of State Medical Boards Report
- Additional information may be requested depending on the provider's area of practice.

To ease the burden of completing numerous credentialing/recredentialing applications, DCIPA has contracted with Mercy Medical Center's Credentialing Department. If you are interested in additional information or want to inquire about providers' credentialing rights, call DCIPA and ask to speak to the Credentialing Coordinator.

PRIMARY CARE PROVIDERS

Members must select a Primary Care Provider (PCP) at the time of enrollment in DCIPA. PCP's are listed in the Provider Directory that also lists participating physicians who specialize in internal medicine, family practice, and pediatrics. Each individual family member may choose the same family PCP or a different PCP. The PCP's will receive a monthly list of names of all members who have selected them as their PCP. Once selected, this provider is responsible for managing the member's needs.

The PCP shall:

- Provide all of the member's primary services.
- Provide coverage 24 hours a day, seven days a week. Members are instructed to contact their PCP before seeking care, except in life-threatening emergencies. Members requiring care for emergencies are instructed to notify their PCP within 24 hours of emergent treatment. An explanation should be given to the member indicating that emergency department visits obtained without contacting the PCP or on-call provider, may result in the visit charges being denied.
- In-area referrals do not require prior authorization except for podiatry, dermatology and ENT. Out-of-area referrals require prior authorization.
- Accept eligible members as determined or required by DCIPA to assure the members have access to primary care services.
- Refer to participating providers for lab and x-ray services in accordance with DCIPA policies.
- Initiate PA for elective inpatient hospital or skilled nursing facility admissions and home. **Facilities are required to notify the PCP within 24 hours of an emergency admission.**
- Order outpatient surgical services when ever medically appropriate.
- Maintain medical records in accordance with the standards established by DCIPA. See **Medical Records.**
- Train and educate all individuals working within their medical practice to assure that the procedures for DCIPA's managed care delivery system are followed correctly. **Representatives from the Medical Management Team are available to assist in staff training which may include referral procedures, prior authorization procedures, billing procedures, and the grievance process.**

Specialty Physicians Shall:

- Check for an approved referral before each office visit. Exceptions include emergencies or referrals from the Emergency Department within five days of ER visit. This is required for the visit to be eligible for reimbursement and should be initiated by the PCP.
- Advise the PCP when follow-up care is necessary so a referral can be initiated.
- Treat as necessary within the parameters of the referral from the PCP including ordering any appropriate routine diagnostic testing, surgical procedures, hospitalizations, or ancillary services. If the member requires a procedure for which PA is required, the specialty physician is responsible for calling DCIPA and obtaining PA.
- Ensure that services provided are documented and incorporated into the member's primary care medical record:
- Educate and train all individuals working within their medical practice so that procedures for DCIPA's managed care delivery system are followed correctly.

BE AN ADVOCATE

Provider may, without any constraint from DCIPA, advise or advocate on behalf of an enrollee who is his or her patient, for the following:

- The enrollee's health status, medical care or treatment options, including any alternative treatment that may be self-administered
- Any information the enrollee needs in order to decide among all relevant treatment options.
- The risks, benefits, and consequences of treatment or non-treatment
- The enrollee'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
- (Such contract provisions would not be allowed unless DCIPA has cited a moral or religious objection to counseling for a particular service or services and has provided written information to the State Medicaid agency.)

AVAILABILITY

DCIPA's participating providers agree to provide 24 hour day coverage, seven days a week for all members. The provider or call share provider will be available to provide care or to direct members to the most appropriate treatment setting at all times.

The provider must return a telephone call from a member within a reasonable length of time. The length of time should be appropriate to the member's stated condition. Telephone calls from other providers requesting approval to treat a member must be evaluated to determine appropriate action.

Participating providers agree to provide appropriate back-up as a component of the triage system. When possible, back-up should be provided by a participating provider with the same level of training and specialty.

Minimum credentials for a person who screens calls includes: certified nurse midwife, registered nurse, nurse practitioner, licensed practical nurse, or physician assistant.

Call-Share for Participating Physicians
Primary Care Providers (PCP's) shall agree to make arrangements for other provider's coverage when they are unavailable. A referral for those services is not necessary. In order to avoid the need for a referral, a call-share group listing must be in place with DCIPA. Notify Services of the physician(s) who regularly takes call-share with you. The listing authorizes the call-share physician(s) to provide services to your patients and to receive payment for these services. DCIPA cannot retroactively change call-share arrangements, so Health Care Services should be notified in advance of any changes.

To ensure continuity of care, the call-share provider shall document and transmit information to the member's primary care medical record.

Call-Share for Non-Participating Physicians

In some cases, it is necessary for a participating provider to call share with a non-participating provider. It is the responsibility of the participating provider to provide the following information to all non-participating providers. Non-participating call-share providers shall be fully credentialed by DCIPA prior to seeing DCIPA's members. DCIPA reserves the right to deny non-participating call share status to any provider whose credentials do not meet DCIPA's requirements. Non-participating call share providers shall agree to accept DCIPA's payment for participating providers as payment in full and agree not to bill the member for balances other than co-payment. Non-participating call share providers shall agree to use only participating hospitals and facilities for DCIPA's members unless services are not available. Non-participating call share providers shall agree to follow DCIPA's referral and PA requirements.

LOCUM TENENS PROVIDERS

When participating providers require coverage by a Locum Tenens provider, your office should notify Health Care Services of the arrangements. If the Locum Tenens provider is not currently part of your existing call-share, your office should notify DCIPA's Credentialing Coordinator. Also, let the coordinator know if they will not be continuing to provide coverage for you, so they can be removed from your call-share list.

Call Share with a Participating Provider and a Non-Participating Locum Tenens Provider.

When the Locum Tenens is a non-participating provider and will be covering for your office for **less than 90 days**, you will need to notify DCIPA's Credentialing Coordinator. A copy of the state license and DEA certificate, current malpractice face sheet, and a completed Attestation form (part of the Oregon Practitioners' Credentialing application packet) will need to be provided. If the Locum Tenens provider will be covering for **more than 90 days**, the entire Oregon Practitioners' Credentialing application will need to be submitted.
Locum Tenens providers shall agree to:
Accept DCIPA's payment for participating providers and not bill the member for balances other than co-payments,

- Use participating providers and contracted facilities when available, and
- Follow DCIPA's referral and PA procedures.

TELEPHONE STANDARDS

- DCIPA shall provide telephone access to DCIPA's members during regular business hours, Monday through Friday 8 a.m. to 5 p.m. Providers shall provide telephone access to their assigned DCIPA members, 24-hours per day, seven days a week. All telephone contacts with members shall be recorded and entered into the member's medical record.

During Regular Office Hours:

- Office staff shall communicate member calls to the PCP or an appropriate professional within the practice.

- The PCP or an appropriate professional within the practice shall immediately respond to emergent calls from members. Urgent calls from members shall be responded to within four hours.
- Other calls from members shall be responded to by the end of that working day.

After Regular Office Hours:

- The PCP shall provide call-share or shall have an approved plan to receive after hours call.
- Emergent calls from emergency departments or other providers shall be responded to immediately. Urgent calls should be responded to within one hour.
- The PCP shall assess the nature of the medical complaint and authorize treatment as medically indicated.
- In the rare event that a provider or the call-share fails or is unable to return a call to a member, DCIPA shall document the failure to respond and authorize any services necessitated by the failure. This situation should be referred to the Medical Director for follow-up.
- After hours call information shall be recorded on an "on call" record that includes the following information.

Date	Time	Name of Physician
Members Name	Age	Allergies
Subjective Assessment Plan SOAP		Signature of Care Provider

- The form should be forwarded to the member's PCP by the call-share provider for inclusion into the member's medical record.

Answering Service Machine/Voice Messaging Information:

- When the PCP is not available, there shall be an answering service or voice messaging service in place to provide information to members calling the PCP's office.
- If an answering service is utilized, the person answering the call should be able to provide the following information:
  - When the physician will return to the office and/or
  - The name and telephone number of the covering physician.
- The following should be identified:
  - When a member should be referred to the emergency department
  - When the PCP or call share provider shall be notified, and
  - When a member may leave a message for the provider's office to return the call.
- If an answering machine or voice messaging service is utilized, the message should contain the following information:
  - Office hours,
  - When the office is closed, (i.e. vacation, holiday) and when it will reopen,
  - When and how often the office is checking its messages,

- The telephone number to call or page to contact the PCP, call-share provider or answering service, and
- Different contacts and/or phone numbers for after hours and weekends.

The following is a sample message that contains the above information:

> Hello, you have reached the office of Dr. Sally Smith. If this is an emergency, please call 911 or go directly to the emergency department. Our regular office hours are Monday through Friday, 8:00 a.m. to 12:00 p.m. and 2:00 p.m. to 5:30 p.m. Our office will be closed from December 23rd to January 5th due to the Christmas holidays. If you need to speak with someone, you may call the provider on call, Dr. Sam Smart, at **answering service #, pager #, or # of the provider on call.** Thank you.

OFFICE VISIT ACCESSIBILITY

DCIPA recommends the following office visit access standards for member seeking medical services from participating providers.

Non-urgent, routine care	Symptomatic within 7 days Asymptomatic within 30 days
Urgent care	Schedule as medically appropriate
Emergent care	Immediate assessment and referral or treatment
Wait time in office for scheduled appointment	Not to exceed 45 minutes without an explanation
Wait time in office for walk in appointment **if these are offered by the clinic**	2 hours
Access to advice nurse on the telephone	2 hours
Return telephone calls from physician's office	Routine by close of business day Urgent within 4 hours

The member shall be informed when the provider is not able to see the member at the scheduled appointment time due to an emergency. The member shall be offered an opportunity to reschedule the appointment at another time.

SCHEDULING APPOINTMENTS

Missed Appointments:
If the provider should experience any problems with members who fail to show for appointments, this information should be relayed to Health Care Services. DCIPA will assist in educating the member about the need to cancel or reschedule appointments prior to the time of the appointment. The member's medical record must contain documentation regarding missed

appointments and all recall efforts made by the provider, either by mail or telephone. This information shall be clearly documented in the medical record. Providers offices shall have written policies on the minimum number of missed appointments prior to requesting that a member choose or be reassigned to another PCP. OHP members cannot be billed for missed appointments.

- Members shall be allowed, at a minimum, three failed appointments before the PCP may request that the member choose or be reassigned to another PCP.
- Members are informed of the penalties for failed appointments in the Member Handbook.
- When a member fails to keep a scheduled appointment with a PCP or with an arranged visit to a specialist, the member shall be sent a copy of the Failed Appointment form letter by the PCP's office; attempts shall be made to reschedule the appointment as deemed medically necessary and; documentation shall be maintained in the member's medical record of the failed appointment(s) and recall efforts, regardless of the reason for the appointment.
- A monthly report shall be submitted to DCIPA by the provider's office, listing all members failing to keep an appointment.
- The member shall be referred to Health Care Services if the PCP is unsuccessful in rescheduling the appointment or the member has a persistent record of failed appointments. The information shall be passed on to a nurse case manager who will counsel the member. The nurse case manager shall contact the member to assist with rescheduling and emphasize the importance of keeping appointments.
- The following situations shall be referred to Health Care Services for follow up:
  - Pregnant women who fail to show for one appointment for prenatal care,
  - Adult members who miss more than two appointments for preventive services, and
  - Members whose children miss more than one appointment for preventive services.

Walk-In Appointments:
Members who present to the provider's office shall be evaluated immediately to determine the emergent nature of the condition and treatment shall be scheduled accordingly.

ACCESS FOR SPECIAL NEEDS MEMBERS

DCIPA shall ensure that both the information and services provided are accessible to the members.

- DCIPA's providers are required by contract to comply with provisions of the American Disabilities Act (ADA). Providers shall provide for physical access to their offices. DCIPA staff may conduct an annual site review to determine the accessibility of each of the participating provider's office. As a practitioner, you must ensure the following provisions: street level access or accessible ramp into the facility, wheelchair access to the lavatory, corridor railings, and elevators operable from a wheelchair when appropriate.
- In addition, facilities and personnel shall be prepared to meet the special needs for members who are visually and/or hearing impaired. Providers shall request sign interpreter services to be arranged by DCIPA's ENCC when needed.
- In the event that a PCP is unable to meet the unique needs of a DCIPA member because of a specific disability, the PCP shall notify the ENCC of the member's physical

limitations and services that may be required. The ENCC shall secure the appropriate medical services or assist the member in selecting a different participating provider, arranging for a home visit, or secure services from a non-participating provider. If a non-participating provider is selected to provide needed medical services to the member, the ENCC will initiate the required PA forms. Policies pertinent to the processing of referrals shall apply. The member's PCP shall be notified of any necessary changes. Efforts to locate a provider shall be documented in the member's file.

INTERPRETATIVE SERVICES

- DCIPA will assures that all Member Handbooks and all other printed information intended for widespread distribution to members, including member satisfaction surveys and grievance/complaint information, is available in the primary language of each substantial population of non-English speaking members.
  - Substantial is defined as 35 non-English speaking households that share the same primary language.
  - DCIPA's Provider Directory lists all PCP offices with bilingual capability and the language(s) spoken.
  - During business hours, the ENCC can make arrangements to provide qualified interpreters who can interpret in the primary language of each substantial population of non-English speaking members. The interpreters shall be capable of communication in English, the primary language of the member, and translate medical information effectively. **See Interpreter Prior Authorization form.**
  - There is no fee to the provider or to the member for translation services.
  - When given prior notice, PCP's and other participating providers, such as specialists and hospitals, shall be prepared to meet the special needs of visually and/or hearing impaired members.
  - PCP's offices shall have signs in the primary language of each substantial population of non-English speaking members in their practices.

MEDICAL RECORD KEEPING

Minimum Standards for Provider's Office Records
Each medical professional who contracts with DCIPA shall maintain a medical record keeping system that fully discloses and documents the extent of services arranged for and provided to DCIPA's members. The records shall promote a consistent basis for quality of care.
Providers shall maintain a record keeping system that conforms to professional medical practice, permits internal and external audit, permits encounter claim review, and facilitates an adequate system for follow-up treatment. All medical records shall be maintained for at least seven years after the date of medical services for which claims are made or for such length of time as may be dictated by the generally accepted standards for record keeping.

Each provider shall maintain the confidentiality of the medical record information, assuring that the contents of the medical record shall be released to authorized personnel only. This includes DCIPA's designee or persons, as authorized by the member in the Release of Information form. The provider shall cooperate with DCIPA and their representatives for the purpose of audits and the inspection and examination of medical records. Medical record information can be released to DCIPA by the provider without a HIPAA Authorization form signed by the member, according to HIPAA regulations, if the disclosure is for treatment, payment, and/or operations (TPO).

Confidentiality of medical records and information shall be maintained as required by state law including HIV, mental health, chemical dependency, and genetic testing.

The PCP is responsible for maintenance of each member's integrated medical record that documents all types of services delivered, both during and after office hours.

Participating providers shall include the following in the medical record for all DCIPA members' medical records:

- The medical record shall include the following data: preventive visits according to established protocols, basis of the diagnostic impression, member's primary complaint sufficient to justify any further diagnostic procedures, and treatment or recommendations for return visits and referrals.
- The medical record shall be complete and legible. Each entry shall be dated, have a handwritten legible signature/initial, and all pages identified with the member's name. This includes chart notes, nurses' notes, vital signs, medications, immunizations, and telephone message entries. This excludes problems on the problem list, prominent allergy notations, and biographical or business information.
- Medical records shall be organized, uniform, detailed, current, and contain the securely attached record of one member in each chart.

Baseline Data

- Personal and biographical data shall be recorded including name, sex, date of birth, address, telephone number (home and work, if applicable), insurance coverage, occupation, employer, marital status, next of kin, spouse, legal guardian, custodial, or responsible party.

- Past medical history should be recorded including serious accidents, operations, illnesses, symptoms, plus family and mental health history. For members age 18 and under, the past medical history should include prenatal care, birth, operations, and childhood diseases. For children age 14 and over, there should be documentation concerning use of tobacco, alcohol, and substance abuse.
- Physical examinations shall be recorded. The record shall include age, weight, height, vital signs, and pertinent physical findings.
- Periodic preventative screening appropriate for age of the member shall be recorded.
- Current medications and drug allergies shall be prominently displayed. "NKA" shall be recorded if there are no known allergies.
- Complete immunization records for children age 18 and under shall be recorded.
- "Advance Directives" executed by the member shall be documented in the chart.
- Competed problem list stating significant illnesses and medical conditions shall be recorded.

Visit Data

- All entries shall be dated, signed or electronically authenticated and the individual making the entry shall be identified.
- Chief complaint or purpose of visit shall be recorded.
- Pertinent history with subjective and objective reasons for presenting problems and physical exam findings shall be recorded.
- Differential and/or working diagnoses shall be listed. This includes signs, symptoms, or clinical impression.
- Diagnostic work-up and plan of treatment shall be recorded.
- Appropriate follow-up shall be recorded indicating specific time to return or call, (i.e. weeks, months, PRN). This shall include documentation of immunization follow-up, when appropriate.
- Unresolved problems from previous visits shall be addressed when appropriate.
- Health maintenance education and social services provided to members shall be documented.
- Member phone calls and responses shall be documented. Appointments missed and follow-up efforts made shall be documented.
- The Obstetric Flow Sheet shall be used for all pregnancies.

Referrals and Ancillary Services

- All hospitalization records are reviewed and pertinent ones placed in the office medical record. Discharge summary or physician's notes summarizing the outcome of each hospitalization shall be in the record.
- Known emergency encounters shall be recorded.
- All medically necessary referrals for consultation shall be documented and the results of those consultations included.
- All laboratory, x-ray, and other diagnostic test results shall be placed in the chart with documentation that physician has reviewed the results of the tests. Abnormal lab and imaging study results shall have notation in the chart of follow-up plans.

- The results of any therapeutic services ordered by a provider shall be noted. This includes physical, occupational, speech therapy, respiratory therapy, chemotherapy, and/or radiation therapy.
- Medical goods or supplies dispensed or prescribed shall be recorded.
- Referrals, PA's, and other forms shall be included.
- Medical providers contracting with DCIPA shall ensure the maintenance of the confidentiality for the member's medical record and may release such information only to the extent permitted by DCIPA's contract with DMAP, under Federal Regulation 42 CFR 431 Subpart F and by Oregon Revised Statutes.

Baseline Data
The provider is responsible for outpatient chemical dependency screening. DMAP and the Oregon Office of Alcohol and Drug Abuse Programs have devised an alcohol and drug screening card (CAGE) as defined at the end of this section. There shall be a notation in the medical record that the screening has been done.

MEMBER QUESTIONS REGARDING DCIPA MATERIALS

If members have questions regarding materials sent to them my DCIPA, those members should be referred back to DCIPA at 541.672.1685 or 1.800.676.7735 or TTY 541.440.6304 or TTY 1.800.877.6304.

RED FLAGS FOR ALCOHOL/DRUG ABUSE

Observable

1. Tremor/perspiring/tachycardia
2. Evidence of current intoxication
3. Prescription drug seeking behavior
4. Frequent falls; unexplained bruises
5. Diabetes, elevated BP, ulcers; non-responsive to treatment
6. Frequent hospitalizations
7. Inflamed, eroded nasal septum
8. Dilated pupils
9. Track marks/injection sites
10. Gunshot/knife wound
11. Suicide talk/attempt; depression
12. Pregnancy (screen only)

Laboratory

1. MCV - over 95
2. MCH - high
3. GTT - high
4. SGOT - high
5. Bilirubin - high
6. Triglycerides - high
7. Anemia
8. Positive UA for illicit drugs

Questions to Ask Patient

1. Have you ever felt you should c*ut down* on your drinking or drug use?
2. Have people *annoyed* you by criticizing or complaining about your drinking?
3. Have you ever *felt bad* or *guilty* about your drinking or drug use?
4. Have you ever had a drink or drug in the morning (e*ye opener)* to steady your nerves or to get rid of a hangover?
5. Do you use any drugs other than those prescribed by a physician?
6. Has a physician ever told you to *cut down* or *quit* use of alcohol or drugs?
7. Has your drinking/drug use caused family, job, or legal problems?
8. When drinking/using drugs have you ever had a memory loss (*blackout)*?

RED FLAGS FOR ADOLESCENT ALCOHOL/DRUG ABUSE

Observables

1. Physical injuries: MVA, gunshot/knife wound, unexplained or repeated injuries.
2. Evidence of current use, e.g., dilated/pinpoint pupils, tremors, perspiring, tachycardia, slurred/rapid speech
3. Persistent cough (cigarette smoking is a risk factor)
4. Engages in risky behavior, e.g., unprotected sex
5. Marked fall in academic/extracurricular performance
6. Suicide talk/attempt, depression
7. Inflamed, eroded nasal septum
8. Track marks, injection sites
9. Sexually transmitted diseases
10. Staph infection on face, arms, legs
11. Unexplained weight loss
12. Pregnancy (screen all)

Laboratory

1. Positive UA for illicit drugs
2. Hepatitis A-B-C
3. GGT - high
4. SGOT - high
5. Bilirubin - high

Questions to Ask Parents

1. When did you first use alcohol/drugs on your on your own, away from family/ caregivers?
2. How often do you use alcohol/drugs? Last use?
3. How often have you been drunk or high?
4. Has your alcohol/drug use caused problems with your friendships, family, or school community? Have your grades slipped?
5. Have you had problems with the law?
6. Have you ever tried to quit/cut down? What happened?
7. Are you concerned about your alcohol/drug use?

Questions for Parent/Caregiver

1. Do you know/suspect your child is using alcohol/other drugs?
2. Has you child's behavior changed significantly in the past six months – sneaky, secretive, isolative, assaultive, aggressive, and/or hostile?
3. Has school, community, or the legal system talked to you about your child?
4. Has there been a marked fall in academic/extracurricular performance?
5. Do you believe an alcohol/other drug assessment might be helpful?

Note: Parental/caregiver request for a urine drug screen for the child may be sufficient reason to make a referral for substance abuse assessment.

RED FLAGS FOR PREGNANT WOMEN

Observables

1. High medical risk pregnancy
2. Evidence of current intoxication
3. Frequent hospitalizations
4. Frequent falls and unexplained bruises
5. Prescription drug-seeking behaviors
6. Tremor/perspiring/tachycardia
7. Dilated pupils
8. Track marks/injection sites
9. Diabetes/elevated BP/ulcers are non-responsive to treatment
10. Extreme tooth decay/dental problems
11. Weight loss or no weight gain
12. Prenatal care begun in third trimester
13. Cigarette smoking by mother or in household

Question to Ask Mother-to-be

1. Prior to pregnancy, did you use alcohol or other drugs?
2. Are you drinking now? How much?
3. Do you use any drugs other than those prescribed by a physician?
4. Have you ever felt you should cut down on your drinking or drug use?
5. Have people annoyed you by criticizing or complaining about your drinking or drug use?
6. Have you ever felt bad or guilty about your drinking or drug use?
7. Have you ever had a drink or drug in the morning to steady your nerves or to get rid of a hangover?
8. Do you have a history depression or current concerns such as feeling being generally overloaded?
9. Has drinking or drug use caused family, job, or legal problems?

For more information, contact Therese Hutchinson at the Office of Alcohol and Drug Abuse Programs, 1-503-945-5765.

REFERRALS

Most services received by a DCIPA member must be provided by or authorized through the PCP. An exception would include emergencies or certain self-referral care that members are allowed such as prenatal care. When a member requires the services of a specialty provider, the PCP is responsible for requesting PA from DCIPA's Medical Management Team. All referrals are entered into the computerized data base for purposes of utilization review, quality improvement, physician profiling, and claim's payment and tracking. Every attempt should be made to obtain prior authorization for medically necessary services. If needed, DCIPA's Health Care Services department can assist in this process.

PCP REFERRAL RESPONSIBILITY

- The PCP shall refer the member to the specialty provider by following the outlined referral protocol.
- The PCP shall maintain documentation of the referral in the member's chart.

SPECIALIST RESPONSIBILITY

- The specialist shall provide specialty care when a referral is made by the PCP as outlined in the referral protocol.
- The specialist may treat as necessary for the referral period, including appropriate diagnostic testing, surgical procedures, and ancillary services.
- The specialist is responsible for submitting to the Medical Management Team the proper request for treatment and procedures (including hospitalization) that require PA.
- The specialist shall ensure that services provided are documented in the member's primary medical record.
- If no referral has been made by the PCP, the specialist shall inform the member that he/she may be responsible for payment of the services. A waiver can be filled out and signed by the member if he/she elects to see the specialist without a referral from the PCP. A copy of the waiver needs to be attached to the claim if submitted to DCIPA.

REFERRAL PROTOCOL

- The PCP's office shall complete a Referral Request form and fax it to DCIPA when a referral is needed. The Referral Request form may be obtained at our website www.dcipa.com and then by clicking on the link Referrals & PA Forms. When the Referral Request is processed, it will be faxed back to the provider's office with the referral authorization number if approved.
- Upon obtaining the referral number, the PCP's office shall contact the specialist's office to schedule an appointment and provide them with the authorization number.
- Once the referral is authorized and the referral number assigned, the PCP's office shall advise the member that a specialist referral has been approved.
- The PCP's office shall send any pertinent chart notes, lab, or x-ray reports to the specialist prior to the scheduled appointment. A copy of the Referral Request form is to be filed in the member's chart.

- It is the specialist's office responsibility to verify with DCIPA that a valid referral is in place before seeing the referred member.
- If the specialist office does not receive an approval that has a current authorization number, they should contact Health Care Services to see if a referral is in place. The referral number should be in place at least 24 hours prior to a non-urgent appointment for all DCIPA members.
- If the member schedules the appointment, the specialist's office shall ask if the member has seen his/her PCP and has been referred for the visit. If not, the member shall be referred back to the PCP for the referral process to be started.
- If the referral has not been authorized and there isn't an authorization number in place, the specialist's office shall contact the PCP's office to discuss the referral. The specialist should be prepared to discuss the reason for the visit.
- Retroactive referrals shall not be given after two days from the date of service. The specialist's office should be prepared to provide the PCP and DCIPA with information as to why the visit was needed and the member was seen without PA.

WHEN ADDITIONAL VISITS ARE REQUIRED

- Should the specialist determine that additional visits are needed for treatment and/or on-going procedures, the specialist shall contact the PCP's office for a referral for additional visits. The specialist shall be prepared to discuss the reason additional visits are required.
- If the PCP determines if additional visits are required, the PCP shall fax a Referral Request form to DCIPA for approval of additional visits. A copy of the request for additional visits shall be filed in the member's chart. When approval is received, the PCP shall notify the specialist so their office staff may then set-up the appropriate appointment(s) for the member. Remember, the specialist office must have a Referral Request form that indicates approval for additional visits and has an authorization number.
- If the PCP denies additional visits, he/she should inform the specialist of the reason and note the reason for denial in the member's chart.

SPECIALIST TO SPECIALIST REFERALS

- Specialist to specialist referral is to be authorized though the PCP referral process.

PCP REFERRALS TO AN OUT-OF-AREA SPECIALIST OR NON-PARTICIPATING PROVIDER

- The PCP shall complete the Referral Request form, attach supporting chart notes with explanation of the reason for the referral and fax the request to the Medical Management Team.
- The request is reviewed by a nurse case manager and presented to the Medical Director.
- The PCP shall be notified as to denial or approval by return fax. It is then the responsibility of the PCP to notify the physician regarding the decision.
- The Medical Management Team will notify the member by mail if the request is denied. Notification of their appeal rights will be included in the letter.

FIVE-DAY RULE/REFERRALS TO SPECIALISTS FROM ED AND URGENT CARE FACILITIES

- Non-emergent specialty referrals for OHP require prior authorization.
- The exception is for follow-ups from the ED and Urgent Care seen within five business days of their ED or Urgent Care visit. To ensure payment please follow one of these three methodologies:

    1. See patient, then send chart notes with the claim documenting that patient was seen within five business days **OR**
    2. Call PCP to send in referral **OR**
    3. Call DCIPA's Health Care Services directly for referral.

SERVICES THAT DO NOT REQUIRE REFERRAL

These services must be provided by a DCIPA provider:

- Annual diabetic dilated eye exam.
- Annual women's exam.
- Prenatal care.
- ADAPT - services for drug and alcohol treatment.
- Childhood immunizations provided by the Douglas County Health Department or your child's PCP.
- Publicly funded health care services.

REFERRAL FORM

dcipa
PHYSICIANS OF DOUGLAS COUNTY
Stewards of health and healthcare

Print Form

DCIPA REFERRAL FORM

Referrals: 541-673-1462; fax 541-677-5881 Referral #:

Date of Request:		Date of Birth:	
Patient Name:		Eligibility Dates:	
ID Number:		Insurance Co.:	
Primary Physician:		Referred to:	
Referred by:		Specialty:	
Contact:		Address:	
Telephone:			
Fax:		Telephone:	

ICD-9 Code:		Line:	
Description:			
ICD-9 Code:		Line:	
Description:			
ICD-9 Code:		Line:	
Description:			

REFERRAL SERVICES REQUEST

Diagnosed Previously? ☐ Yes ☐ No

Number of Visits:

Comments:

PLEASE NOTE
REFERRAL DOES NOT ASSURE INSURANCE PAYMENT. PAYMENT OF BENEFITS IS CONTINGENT UPON ELIGIBILITY, PRIOR AUTHORIZATION REQUIREMENTS, FINAL DIAGNOSIS FROM THE PHYSICIAN, EXCLUSIONS AND LIMITATIONS OF COVERAGE, PROVIDER CONTRACT REQUIREMENTS AND OTHER FACTORS.

PCP's, please keep a copy for your chart. Send this information via mail or fax. Specialists, you will be notified by the PCP of approved referrals and number of visits authorized. By accepting this referral, you agree to accept payment rates of OMAP for services rendered.

FOR DCIPA'S USE ONLY

Effective Date		AUTHORIZATION	
Expiration Date		☐ Approved	☐ Denied
Date		Medical Director or Designee:	

PRIOR AUTHORIZATION REVIEW PROCESS

Providers shall consult DCIPA's prior authorization (PA) guidelines for services which require authorization. If the planned service is included in these guidelines, the following instructions should be followed to allow for a timely and complete review of the PA request.

If possible, PA's should be received by DCIPA at least two weeks before a planned service is scheduled. This allows time for DCIPA to process the PA and review pertinent medical record information. A copy of the member's chart notes, lab and or x-ray tests, and any other pertinent information should accompany the original request. This assures the process begins when the request is received and additional time is not spent waiting for information from the provider's office.

General PA requests and referrals will be reviewed by the Medical Review Committee and a decision will be made within 14 calendar days. Medication requests will be reviewed by the Medical Review Committee and a decision made within 3 calendar days. If your request is urgent (i.e. member's life, health and the ability to function is at serious risk), the request will be processed in an appropriate time frame.

In order for DCIPA to process your PA request, your office should fill out the form completely and submit the needed documentation. If documentation is not received with the PA request, the request may be denied for lack of information. The Provider will be notified via fax whether the PA is approved or denied. If denied, DCIPA sends the member a denial letter with a notification of their appeal rights. Emergent surgeries, admissions, tests, referrals, and supplies **do not** require PA but will be retrospectively reviewed. When DCIPA is the secondary insurance (payer), PA is **not** required if the primary health insurance authorization guidelines are met.

Decision making, which includes medical/surgical services, pharmacy and chemical dependency, is based only on appropriate care, coverage guidelines and Oregon Health Plan rules. DCIPA does not reward staff for denying authorization requests and we do not use financial incentives to reward underutilization.

PRIOR AUTHORIZATION DRUG FORM

Print Form

DCIPA'S OHP Prior Authorization Drug Form
DCIPA OHP FAX 541-677-5881

PA #

Patient | Physician
ID# | Completed by | Phone
Date of Birth | Dx Description | Fax
Diagnosis Code | Phone / Ext | Pharmacy

Drug Class	PA Required	Rationale	Criteria
Antiemetic	☐ Aloxi ☐ Anzemet ☐ Cesamet ☐ Emend ☐ ondansetron/Zofran ☐ Others		Exceptions Allowed ☐ Refractory N/V in chemotherapy & radiation patients ☐ Pregnancy with failure of traditional antiemetics & documented need for IV rehydration
Antiviral	☐ acyclovir / Zovirax ☐ famciclovir / Famvir ☐ valacyclovir / Valtrex ☐ Others (Generics not currently available.)	Most uncomplicated viral infections such as chickenpox and herpes simplex 1 are not covered on OHP.	Exceptions Allowed ☐ Complicated viral infection ☐ Ophthalmic herpes ☐ Herpes zoster ☐ Immuno-compromised patient
Antifungals Systemic	☐ fluconazole* / Diflucan ☐ terbinafine hcl 250mg/Lamisil ☐ Sporanox ☐ Others	Fungal skin & nail infections are generally not covered on OHP. *5 doses in 30 days, no PA required.	Exceptions Allowed ☐ Covered conditions such as systemic fungal infections ☐ Immuno-compromised patient due to AIDS or transplant ☐ Two dose therapy / vaginal candidiasis
Antihistamines Non-sedative	☐ Allegra ☐ desloratadine / Clarinex ☐ cetirizine / Zyrtec ☐ Others	Allergic rhinitis is not covered on OHP.	Exceptions Allowed ☐ Covered condition for which these drugs are specifically indicated
Cholinesterase Inhibitors	☐ Aricept ☐ Exelon ☐ galantamine / Razadyne		Guidelines ☐ Not covered for a Mini Mental State of <12
Compounded Medications			Guidelines ☐ Use PA form. List ingredients & cost of Rx
Dermatologicals	☐ desonide / Elocon ☐ clotrimazole / Lotrimin ☐ fluocinonide / Lidex ☐ Others	Atopic dermatitis, stage I & II psoriasis, fungal skin or nail infections are generally not covered on OHP.	Exceptions Allowed ☐ Ultra high potency medicines required an above-the-line condition or significant co-morbid condition.
Enuresis	☐ desmopressin / DDAVP tabs & nasal spray	Enuresis is not covered for treatment on OHP.	Exceptions Allowed ☐ Co-morbid condition such as diabetes insipidus
Muscle Relaxants	☐ baclofen / Lioresal ☐ methocarbamol / Robaxin ☐ Others		Exceptions Allowed ☐ Above-the-line diagnosis or a significant co-morbid condition.
Migraines	☐ Amerge 9 tabs/pkg/mo ☐ Axert 6 tabs/pkg/mo ☐ Frova 9 tabs/pkg/mo ☐ Treximet 9 doses/pkg ☐ sumatriptan (Imitrex) 9 tabs/pkg/mo 6 injs/pkg/mo 2 vial NS/pkg/mo	☐ Maxalt 9 tabs/pkg/mo ☐ Relpax 6 tabs/pkg/mo ☐ Zomig 6 tabs/pkg/mo ☐ Zomig NS 6 tabs/pkg/mo ☐ butorphanol / Stadol NS	Patients requiring more than the limited amounts may need consideration for maintenance medications.

DOCUMENTATION IS REQUIRED FOR ALL DRUGS THAT NEED PRIOR AUTHORIZATION. Side 1 - 2010
Please do not write in the space below; it is needed for documentation.

APPROVED/DENIED_____ DATE_____

Patient				Physician	
ID#		Completed by		Phone	
Date of Birth		Dx Description		Fax	
Diagnosis Code		Phone/Ext		Pharmacy	

Drug Class	PA Required	Rationale	Criteria
Nasal Steriods	☐ Flonase ☐ flunisolide / Nasarel ☐ Rhinocort ☐ Others	Allergic rhinitis is not covered on OHP.	Exceptions Allowed ☐ Chronic sinusitis
NSAID's	☐ misoprostol/diclofenac/Arthrotec ☐ oxaprozin / Daypro ☐ etodolac / Lodine ☐ meloxicam / Mobic ☐ ketoprofen / Orudis ☐ nabumetone / Relafen ☐ ketorolac/Toradol	Generic non-steroidals available without PA including ibuprofen, piroxicam, diclofenac, (except SR), salsalate, indomethacin, flurbiprofen & sulindac.	Exceptions Allowed ☐ On case-by-case basis
Nutritional Supplements	☐ Boost ☐ Casec Powder ☐ Ensure ☐ Jevity ☐ Neutren ☐ Pro Med ☐ Others	Not covered for supplemental feedings that could be provided by blending food.	Guidelines ☐ Documented weight loss of 10% body weight AND specific co-morbid conditions
H2 Blockers		Generic cimetidine, ranitidine & famotidine are available without PA.	Exceptions Allowed ☐ Documented failure of generic products
Proton Pump Inhibitors	☐ Nexium ☐ Prilosec OTC ☐ Prevacid ☐ pantoprazole / Protonix ☐ rabeprazole / Aciphex ☐ omeprazole OTC	This class of drugs is indicated primarily for documented GE reflux & failure of H2 blockers. Prilcsec OTC is the preferred drug.	Exceptions Allowed ☐ Documented GE reflux AND failure of H2 blockers ☐ Short-term therapy for H-pylori ☐ Zollinger-Ellison Syndrome
Sedatives	☐ zolpidem tartrate /Ambien ☐ trizolam / Halcion ☐ Lunesta ☐ temazepam / Restoril ☐ Rozerem ☐ zaleplon / Sonata ☐ Others	Insomnia is not covered on OHF.	Exceptions Allowed ☐ Post-op ☐ Significant co-morbid conditions with above-the-line diagnosis
Smoking Cessation Products	☐ nicotine patches ☐ 21 mg ☐ 14 mg ☐ 7 mg ☐ Chantix	Nicotine Patches & Chantix are both available as first line therapy with a PA.	Exceptions Allowed Must sign Letter of Intent to Attend a Smoking Cessation Class
Statins	☐ Crestor ☐ pravastatin / Pravachol ☐ Lipitor ☐ lovastatin / Mevacor ☐ simvastatin / Zocor	PA required if quantity limits are exceeded.	Guidelines Quantity limits are set in MedImpact. See DCIPA's guidelines for statins. Pill splitters available at pharmacies/no PA required.
Stimulants	☐ amphetamine salts ☐ Concerta ☐ Metadate ☐ Methylin ☐ methylphenidate ☐ Others	PA row required for specific classes of medication and age groups. Short-acting stimulants are available for children ages 6-18 without PA.	Guidelines ☐ See DCIPA's guidelines for stimulant medications.
Other medications / PA required for all injectables as well as all prescriptions that cost over $750.		List medications here	

DOCUMENTATION IS REQUIRED FOR ALL DRUGS THAT NEED PRIOR AUTHORIZATION. Side 2 - 2010
Please do not write in the space below; it is needed for documentation.

APPROVED/DENIED _____ DATE _____

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MEDICATION GUIDELINES

ANTIMETICS/5-HT3 Antagonists

Aloxi **Cesamet** **Kytril/granisetron**
Emend **Zofran/ondansetron** **Others**

- Prior authorization is required.
- The documentation should include:
  1. Patient's diagnosis is above the OHP coverage line, AND
  2. Patient has a chemotherapy or radiation regimen more frequent than 7 days, AND
  3. Patient has refractory nausea and failed, is tolerant of, or is contraindicated for 2 first line agents (Reglan/methoclopramide, Compazine/ proclorperazine, Phenergan/ promethazine), **OR**
  4. Pregnancy with failure of traditional anti-emetics and documented need for IV rehydration.

References:
1. DrugPoints® System (www.statref.com) Thomson Micromedex, Greenwood Village, CO. Updated periodically.
2. AHFS Drug Information® with AHFSfirstReleases®. (www.statref.com), American Society Of Health-System Pharmacists®,Bethesda, MD. Updated periodically.
3. DRUGDEX® System [Internet database]. Greenwood Village, Colo: Thomson Micromedex. Updated periodically.
4. Drug Facts and Comparisons on-line. (www.drugfacts.com), Wolters Kluwer Health, St. Louis, MO. Updated periodically.
5. PDR® Electronic Library™ [Internet database]. Greenwood Village, Colo: Thomson Micromedex. Updated periodically.
6. Emend Prescribing Information. Merck. Whitehouse Station, NJ, March 2003.
7. Transderm-Scop Prescribing Information. Novartis, Summit, NJ, August 2003.
8. ASHP Therapeutic Guidelines on the Pharmacologic Management of Nausea and Vomiting in Adult and Pediatric Patients Receiving Chemotherapy or Radiation Therapy or Undergoing Surgery. 1999;56:730-64

ANTIFUNGAL – Systemic

Diflucan/fluconazole **Sporanox/itraconazole** **Others**
Nizoral/ketoconazole

- Prior authorization is **NOT** required for 5 **tablets** of Diflucan/fluconazole per month for candidal vaginitis.
- All other oral and topical antifungals require prior authorization and chart notes documenting an above-the-line condition or a significant co-morbid condition including immunosuppression.
- Conditions not covered include fungal nail infections, and oral candidiasis.

References:
1. Oregon Administrative Rule 410-141-0070
2. Oregon Administrative Rule 410-120-1200
3. Oregon Administrative Rule 410-141-0480
4. Oregon Administrative Rule 410-141-0500
5. Oregon Administrative Rule 410-141-0520

ANTIFUNGAL – Topicals

Lotrimin/clotrimazole **Monistat/miconazole** **Others**

- Prior authorization is required with chart notes that document an above-the-line condition or a significant co-morbid condition such as immunosuppression.
- Conditions that are below-the-line include fungal nail infections and oral candidiasis.

References:
1. DrugPoints® System (www.statref.com) Thomson Micromedex, Greenwood Village, CO. Updated periodically.
2. AHFS Drug Information® with AHFSfirstReleases®. (www.statref.com), American Society Of Health-System Pharmacists®, Bethesda, MD. Updated periodically.
3. DRUGDEX® System [Internet database]. Greenwood Village, Colo: Thomson Micromedex. Updated periodically.
4. Drug Facts and Comparisons on-line. (www.drugfacts.com), Wolters Kluwer Health, St. Louis, MO. Updated periodically.
5. PDR® Electronic Library™ [Internet database]. Greenwood Village, Colo: Thomson Micromedex. Updated periodically.
6. van de Kerkhof PCM, Pasch MC, Scer PK, et al. Brittle nail syndrome: A pathogenesis-based approach with a proposed grading system. J Am Acad Dermatol 2005;53:644-51.
7. Gupta Ak and Tu LQ. Dermatophytes, diagnosis and treatment. J Am Acad Dermatol 2006;54:1050-5.

ANTIVIRALS

Famvir/famciclovir Valtrex/valacyclovir Zovirax/acyclovir Others

- Prior authorization is required with chart notes documenting an above-the-line condition or a co-morbid condition.
- Most uncomplicated viral infections (e.g., chicken pox, herpes simplex, Type I) are not covered conditions on OHP.
- Exceptions allowed are complicated viral infections, immunosuppression, ophthalmic herpes, herpes zoster, and genital herpes.

References:
1. Famvir internet site accessed 05-17-04 at http://www.famvir.com/hcp/tools/resources/pi.jsp.
2. Product Information, Famvir tablets, Novartis Pharmaceuticals, East Hanover, NJ, February 2002.
3. DrugPoints® System (www.statref.com) Thomson Micromedex, Greenwood Village, CO. Updated periodically.
4. AHFS Drug Information® with AHFSfirstReleases®. (www.statref.com), American Society Of Health-System Pharmacists®, Bethesda, MD. Updated periodically.
5. DRUGDEX® System [Internet database]. Greenwood Village, Colo: Thomson Micromedex. Updated periodically.
6. Drug Facts and Comparisons on-line. (www.drugfacts.com), Wolters Kluwer Health, St. Louis, MO. Updated periodically.
7. PDR® Electronic Library™ [Internet database]. Greenwood Village, Colo: Thomson Micromedex. Updated periodically.
8. Sexually Transmitted Diseases: Treatment Guidelines 2002 accessed at: http://www.cdc.gov/std/treatment/2-2002/TG.htm#GenitalHerpes
9. New anti-herpes drugs tested http://www.genomenewsnetwork.org/articles/04_02/herpes.shtml
10. Kimberlin D. W., Rouse D. J. Genital Herpes. N Engl J Med. 2004; 350:1970-7.
11. Crumpacker CS. Use of Antiviral Drugs to Prevent Herpesvirus Transmission, N Engl J Med 2004; 350:67-68, Jan 1, 2004.
12. Global epidemiology of genital herpes and the interaction of herpes simplex virus with HIV. In: Corey L, ed. HERPES: the Journal of the IFHM. 2004;11(Suppl 1).
13. Lawrence Corey, MD, Clinical Tools for Preventing Sexual Transmission of Genital Herpes; Medscape Infectious Diseases 6(1), 2004
14. Zovirax internet site accessed 05-17-04 at http://www.gsk.com/products/zovirax_us.htm
15. Denavir internet site accessed 05-17-04 at http://www.denavir.com/html/index-about.htm
16. Product Information, Denavir cream, Novartis Pharmaceuticals, East Hanover, NJ, October 2003.
17. Product Information, Zovirax ointment, GlaxoSmithKline, Research Triangle Park, NC, May 2001
18. The Medical Letter. Drugs for Non-HIV Viral Infections. Vol. 44, February 4, 2002
19. Evans, T, et. al, Double-Blind, Randomized, Placebo-controlled Study of Topical 5% Acyclovir-1% Hydrocortisone Cream (ME-609) for Treatment of UV Radiation-induced Herpes Labialis. Antimicrob Agents Chemother 2002; 46:1870-4
20. Chen X, et. al, A comparison of topical application of penciclovir 1% cream with acyclovir 3% cream for treatment of genital herpes: a randomized, double-blind, multicentre trial. Int J STD AIDS 2000; 11:568-73
21. Sexually Transmitted Diseases Treatment Guidelines, 2006 accessed 8-13-06 at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5511a1.htm
22. Update to CDCs Sexually Transmitted Diseases Treatment Guidelines 2006: Fluoroquinolones no longer recommended for treatment of gonococcal infections: accessed at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5614a3.htm

BRAND NAME DRUGS

- The following medications can be prescribed as "brand named medically necessary" without prior authorization.

Armour Thyroid	**Coumadin**	**Dilantin**	**Levoxyl**
Mysoline	**Premarin**	**Tegretol**	

- All other requests for brand named medication, when a generic is available, will require prior authorization.

- When the prescribing physician wishes to prescribe a brand name medication because of an adverse reaction to a generic medicine, a MedWatch report will need to be filed with the FDA for documentation. The report can be sent via the internet – www.fda.gov/medwatch/SAFETY/3500.pdf/ or a copy of the form can be found in the Provider Handbook.
- A copy of the MedWatch report should be included with the prior authorization.

References:
1. Oregon Administrative Rule 410-141-0070
2. Oregon Administrative Rule 410-120-1200

BYETTA
- Prior authorization is required.
- Patient has been diagnosed with type 2 diabetes mellitus.
- Patient has not achieved optimal glycemic control on oral hypoglycemics.
- Patient has documented failure of treatment of at least three classes of oral agents, or documented contraindication to using them.
- Patient has documented contraindication to treatment with insulin.

CHOLINESTERASE INHIBITORS
Aricept Cognex Exelon Razadyne/galantamine
- Cholinesterase Inhibitor therapy should not be initiated in patients with severe dementia (MMSE<12)*
- Therapy should be discontinued if there is evidence of:
  a. Poor compliance
  b. Persistent side effects
  c. Mutual agreement between caregiver and provider
- Tapered discontinuation is recommended in patients when there is clinical evidence of progression to severe dementia or MMSE*<12
- Therapy may be re-instituted where there is evidence of rapid decline upon discontinuation of therapy. There is insufficient evidence to support switching between cholinesterase inhibitors due to lack of efficacy.
  * Mini Mental State Exam

COMPOUNDED MEDICATIONS
- Pharmaceutical compounding requires prior authorization. Detailed chart notes should accompany the request stating the reason for the requested compounding i.e., failure of traditional pharmacological therapy.
- All prior authorization will be reviewed by the Medical Director and approved or denied on a case-by-case basis.
- Cost for compounding is required on the PA and will be approved or denied during the review process.
- **Northwest Compounding Pharmacy (NCP)**
  - The provider will generate a request on DCIPA's Prior Authorization Form.
  - The PA should be faxed to Northwest Compounding Pharmacy (NCP) for completion.
  - NCP should be entered with the appropriate "J"code, list of ingredients, and the total cost for the compounded medication.

- The PA should be faxed to DCIPA and loaded into Plexis.
- The Medical Director will review the request. Approval or denial will be faxed back to the provider and NCP.
- NCP is responsible for filling out the CMS 1500 Form, which can then be submitted to DCIPA for payment.

COX-II INHIBITOR

Celebrex

- Prior authorization is required with documentation, by x-ray or lab tests, of osteoarthritis or rheumatoid arthritis **PLUS**
- History of GI bleed or gastritis, or concurrent treatment with steroids or Coumadin.

DDAVP/desmopressin

Enuresis

- Prior authorization is required.
- Enuresis is not covered for treatment on OHP. An exception would be an existing co-morbid condition such as diabetes insipidus.

DERMATOLOGICALS

- Prior authorization is required for all dermatological creams, ointments, gels, etc. Generic forms should be requested when available.
- Chart notes should document an above-the-line condition or a significant co-morbid condition.

EPOGEN/PROCRIT/ARANESP

- Indicated for anemia (Hgb < 10 gm/dl or Hct <30%) induced by cancer chemotherapy, **OR** in the setting of myelodysplasia, **OR** chronic renal failure with or without dialysis.
  1. Reassessment should be made between 4-8 weeks of treatment. If no response, treatment should be discontinued. If response is demonstrated, the medication should be titrated to maintain a hemoglobin level between 10-12.
  2. Discontinuation and continued monitoring is recommended with Hgb ≥12 and/or Hct ≥ 36.
- Indicated for anemia (Hgb <10 gm/dl or Hct <30%) associated with HIV/AIDS.
  1. An endogenous erythropoietin < 500 iu/l is required for treatment, and patient may not be receiving zidovudine (AZT) > 4200 mg per week.
  2. Reassessment should be made after 8 weeks. If response is demonstrated.

H-2 BLOCKERS

Axid/nizatidine

- **No** prior authorization is required for generic **ranitidine, cimetidine,** and **famotidine.**
- Prior authorization is required for the above H-2 blockers for above-the-line conditions.
- The following must be documented in the chart notes:
  1. Side effects from cimetidine, ranitidine or famotidine.
  2. History of drug interactions.
  3. History of previous failure of cimetidine, ranitidine or famotidine.

- Prescriptions filled on an emergency basis will be supplied for 3 days. A prior authorization must be request within that time for further medication to be received.

HOME ENTERAL NUTRITION

- Prior authorization is required for all oral supplements and chart notes documenting the following criteria:

Clients age 6 or older:

1. **Must have a nutritional deficiency identified by one of the following:**
   a. Recent low serum protein levels **OR**
   b. Recent Registered Dietician assessment shows sufficient caloric/protein intake is not obtainable through regular liquefied or pureed foods.
   c. The clinical exception to the requirement of (a and b) must meet the following:
      - Prolonged history (i.e. years) of malnutrition, and diagnosis or symptoms of cachexia, and
      - Client residence in home, nursing facility, or chronic home care facility, and where (a and b) would be futile and invasive.
2. **AND have a recent unplanned weight loss of at least 10%, plus one of the following:**
   a. Increased metabolic need resulting from severe trauma; **or**
   b. Malabsorption difficulties (i.e. short-gut syndrome, fistula, cystic fibrosis, renal dialysis); **or**
   c. Ongoing cancer treatment, advanced AIDS or pulmonary insufficiency.

***Weight loss criteria may be waived if body weight is being maintained by supplements due to patient's medical condition (i.e. renal failure, AIDS)

Clients under age 6:

1. Diagnosis of "failure to thrive;"
2. Must meet same criteria as above, with the exception of % of weight loss.

HPV VACCINE

- Prior authorization is required.
- Routine HPV vaccination is recommended for girls 11 and 12 years old.
- Girls as younger as age 9 years can receive HPV vaccine.
- HPV vaccination is also recommended for teenaged girls 13 to 18 years old to catch up on missed vaccine or to complete the vaccination series.
- In Oregon the vaccine is covered through the Vaccines for Children Program (HPV) for girls age 18 and under. DCIPA covers dispensing fees.
- The evidence is insufficient to recommend for or against universal vaccination of women 19-26 years old, although DCIPA will cover vaccination in this age group.
- HPV vaccination is not currently recommended for women older than 26 years or for males.

INJECTABLE MEDICATIONS

- Prior authorization is required by the prescribing provider with the exception of Heparin & glucogon emergency kit.

- The medication will be reviewed according to existing guidelines and the category the medication is in.
- The diagnosis should be above-the-line condition. Co-morbid conditions will be considered.

INJECTABLE VITAMINS

- Documentation is required for one of the following conditions:
  1. History of specific vitamin deficiency.
  2. Medical indication during infancy, fertile periods, or breast-feeding.

INTERFERON A-Hepatitis C

- Prior authorization is required for the use of Interferon A and will be reviewed by the Medial Director and/or the Quality Improvement Committee.
- Interferon A will be allowed only within the Manufacturer's Guidelines.
- The patient must have the following:
  1. Persistently abnormal ALT **AND**
  2. Positive HCV RNA **AND**
  3. Liver biopsy with evidence of septal fibrosis and/or moderate to severe necroinflammatory changes.
  4. Non-1 genotyping.
- Initial treatment will be for a period of 3 months only; if the ALT level remains abnormal or viral RNA continues to be present, the treatment will be discontinued.

LEVEMIR INSULIN

- Prior authorization is required.
- Must fail to achieve adequate control, or be intolerant of Lantus Insulin.

MARINOL

- Prior authorization is required.
- Documentation should include the following:
  1. Anorexia associated with weight loss in patients with HIV/AIDS who are unresponsive to conventional treatment.
  2. Nausea and emesis in patients receiving cancer chemotherapy who have failed conventional antiemetic treatment.
  3. Nausea and emesis in patients undergoing radiation treatment who have failed conventional antiemetics.

References:

1. Wells B, DiPiro J, Schwinghammer T, Hamilton C. Pharmacotherapy Handbook. New York: Mc-Graw Hill; 2006.
2. Kris MG et al. American Society of Clinical Oncology guideline for antiemetics in oncology: update 2006. J Clin Oncol. 2006 Jun 20; 24(18):2932-4
3. Longstreth GF, Hesketh PJ. Characteristics of antiemetic drugs. UpToDate Online, accessed 6/26/2007.
4. Hesketh, PJ. Prevention and treatment of chemotherapy-induced nausea and vomiting. UpToDate Online, accessed 6/26/2007.
5. induced nausea and vomiting: results of a meta-analysis of randomized controlled trials. Cancer. 2000 Dec 1; 89(11): 2301-8.
6. Product Information: Marinol®, dronabinol. Solvay Pharmaceuticals, Inc., Marietta, GA, 2006.
7. Product Information: Cesamet®, nabilone. Valeant Pharmaceuticals, Intl., Costa Mesa, CA. May 2006.
8. Funai, Edmund. Hyperemesis gravidarum. Up To Date Online, accessed 4/3/2008.
9. Product Information: Sancuso®, granisetron transdermal system. ProStraken, Inc. Bedminster, NJ: August 2008.

MIGRAINE MEDICATIONS updated 10/07

- Limits set on amounts received per month. If the member is requiring more, they should be considered for maintenance mediations.

Axert	1 pkg/6 tabs	Maxalt	1 pkg/9 tabs
Amerge	1 pkg/9 tabs	Migranol NS	1 pkg/6 sprays
Frova	1 pkg/9 tabs	Relpax/eletipan	1 pkg/6 tabs
Imitrex tabs	1 pkg/9 tabs	Treximet	1 pkg/9 tabs
Imitrex NS	1 pkg/6 units	Zomig	1 pkg/6 tabs
Imitrex SQ	3 pkgs/6 injections		

- Prior authorization is required with chart notes documenting migraine headaches.
- The set amount will be dispensed for a 30-day period.

MUSCLE RELAXANTS

Lioresal/baclofen **Zanaflex/tizanidine**

- Prior authorization is required with chart notes that document increased muscle tone associated with spasicity.

Others

Dantrium/dantrolene na	**Robaxin**/methocarbamol
Skelaxin/metaxalone	**Parafon Forte**/chlorzoxazone
Others	

- Prior authorization is required for all the above muscle relaxants.
- Chart notes should include documentation of an above-the-line condition or a significant co-morbid condition.
- Muscle strains, sprains, lumbago, and neck pain without radiculopathy are below-the-line conditions.

NASAL STEROIDS

Flonase **Nasocort** **Nasonex** **Rhinocort** **Vancenase** **Others**

- Prior authorization is required with chart notes that document an above-the-line condition or a significant co-morbid condition.

NRT Patches / Chantix/ Quit Form

NRT Patches:

- A Quit Form is no longer required.
- NRT with patches is available with PA.
- Additional authorization is not required for dosage titration if it is within 30 days of the initial authorization.
- After failed treatment with nicotine patches, a six month waiting period is required before approval for re-treatment with nicotine replacement therapy.

Chantix:

- Chantix is available as first line treatment with prior authorization. It will be approved for a maximum of 3 months.
- After failed treatment with Chantix, a six month waiting period is required before approval for re-treatment with Chantix.

In order to obtain treatment with NRT or Chantix, patients will be required to sign the following Letter of Intent to Attend Smoking Cessation Classes. The provider's office will need to give a copy of the letter to the patient, and send a copy to DCIPA with the prior authorization request form.

References:
1. Smoking Cessation. Ann Arbor (MI): University of Michigan Health System; 2006 Aug
2. Chantix (package insert). New York, NY: Pfizer, Inc.; May 2006
3. Effectiveness of smoking cessation therapies: A systematic review and Meta analysis. BMC Public Health. 2006; 6: 300
4. Varenicline-Guidance for Health Professionals on a new prescription-only stop smoking medication. ASH, London, November 2006
5. Quitting smoking: What are the best ways? HealthAtoZ. www.healthAtoZ.com Accessed 5/3/2007

NSAID's / Non-Steroidal Anti-Inflammatory Drugs

- The following NSAID's will process without prior authorization.
  1. ibuprofen/Motrin
  2. piroxicam/Feldene
  3. diclofenac/Voltaren
  4. naproxen/Naprosyn
  5. salsalate/Disalcid
  6. indomethacin/Indocin
  7. flurbiprofen/Ansaid
  8. sulindac/Clinoril
- A minimum of two of the above NSAID's will need to be tried before obtaining approval NSAID's that require prior authorization.
- The following NSAID's will require prior authorization:
  1. ketorolac/Toradol
  2. oxaprozin/Daypro
  3. etodolac/Lodine
  4. ketoprofen/Orudis
  5. nabumetone/Relafen
  6. diclofenac/misoprostol/Arthrotec
  7. meloxicam/Mobic
- **Please see separate guideline for COX-2 inhibitors.**

OTC MEDICATIONS

- Prior authorization is **NOT** required for the following medications. A written prescription is required and the prescription will be filled with selected over-the-counter NDC's for the following medications:

acetaminophen	ibuprofen
aspirin plain & EC	naproxen
diphenhydramine tabs & liq	select vitamins (plain & with iron minerals)
famotadine	senna
ferrous sul tabs & feosol liq	sudafed
guaifenesin	Tums
hydroxyzine pamoate	various forms of vitamins with fluoride for children

- All other OTC medications require prior authorization.
- Some OTC's are on the "all inclusive" list for members in skilled nursing facilities.

- The diagnosis should be for above-the-line conditions. Co-morbid conditions should be included in the documentation.

PROTON PUMP INHIBITORS

Aciphex	**Nexium**	**Prilosec OTC& omeprazole OTC**
Prevacid	**Protonix**	

- Prior authorization is required with chart notes that document one of the following conditions:
  1. GE reflux **AND** failure of H-2 Blockers.
  2. Short-term therapy for H-pylori.
  3. Zollinger-Ellison Syndrome.
- Dyspepsia is not a covered condition. Cimetidine, ranitidine and famotidine **DO NOT** require prior authorization.
- Prilosec OTC and omeprazole OTC are the preferred PPIs.

REVIA/naltrexone

- Usage is contraindicated in patients with abuse of cocaine or marijuana.
- Prior authorization is required and chart notes with documentation of alcohol and opiate dependence.
- Patient must be in a formal alcohol and/or drug treatment program.
- Total usage of the drug will be limited to 32 days. Requests for further fills will require a prior authorization with chart notes. They will be reviewed by the Medical Director and/or the Quality Improvement Committee.
- The prescription can be written by the provider or the Medical Director of an alcohol and drug program.

SEDATIVES

Ambien	Halcion/triazolam	Restoril/temazepam
Dalmane/flurazepam	Lunesta	Sonata
Rozerem	Others	

- Insomnia is a below-the-line condition and generally **NOT** covered for treatment.
- Prior authorization is required for use of all sedatives. Chart notes should accompany all requests with documentation of an above-the-line condition or a significant co-morbid condition.
- Post-op is an allowed exception.

SEIZURE MEDICATIONS

Gabitril	Lyrica
Topamax	Neurontin - gabapentin
Trileptal/oxcarbazepine	

- Prior authorization is required with documentation of above-the-line diagnosis and medical appropriateness.

***Neurologists are exempt from PA process for seizure medications.

SEIZURE & NEUROPATHIC PAIN MEDICATIONS
gabapentin & Lyrcia

Gabapentin **and Lyrcia** require prior authorization and will be approved:

1. When prescribed for seizures **or**
2. When prescribed for neuropathic pain
   - When patient has documented neuropathy or post-herpetic neuralgia **and**
   - When there is documentation of failure, intolerance, or a contraindication to a trial of tricyclic antidepressants

STADOL NASAL SPRAY

- Prior authorization is required for Stadol Nasal Spray.

STATINS - Quantity limits for the following statins.

Crestor	5 mg – 15/mo	Lipitor 10 mg – 15/mo	Zocor 10 mg – 15/mo
	10 mg – 15/mo	20 mg – 15/mo	20 mg – 15/mo
	20 mg – 15/mo	40 mg – 15/mo	40 mg – 15/mo
	40 mg –30/mo	80 mg – 30/mo	80 mg – 30/mo
pravastatin	10 mg – 15/mo	lovastatin 10 mg – 15/mo	
	20 mg – 15/mo	20 mg – 15/mo	
	40 mg – 15/mo	40 mg – 30/mo	
	80 mg – 30/mo		

STIMULANT MEDICATIONS
Adults

- Prior authorization is required for stimulant medications for all patients over 18 years of age
- Those adult patients already taking stimulant medications will be required to change to short-acting formulations
- All new prescriptions for stimulant medications in adults will require written documentation of:
  1. Diagnosis of narcolepsy/fatigue in multiple sclerosis **OR**
  2. Diagnosis of Adult Attention Deficit Disorder **AND**

Children

- Short-acting stimulant medication for children between 6-18 years of age will be available without PA
- All stimulant medication for children under 6 years of age will require PA
- Those children already on long-acting formulations may continue with PA. However, all new prescriptions for long-acting stimulants will require documentation of failure on two different short-acting stimulants given at a BID dosage

SYNAGIS

- Prior authorization is required with documentation.
- All requests for Synagis need to be reviewed by the Medical Director and/or the Quality Improvement Committee.
- Indications:
  1. Children under 2 years of age with chronic lung disease.
  2. Prematurity (28 weeks gestation, or less) up to one year of age.

3. Children 29-32 weeks gestation, up to 6 months of age.
4. Children with congenital heart disease will be considered on a case-by-case basis.

TESTOSTERONE – in males

- Prior authorization is required.
- Testosterone will be allowed only within the manufacturer's guidelines.
- Patients should have hypogonadism secondary to documented pituitary or testicular disease.
- Testosterone is not indicated for treatment of sexual dysfunction, mood disorders, or complications of chronic opioid therapy.

WEIGHT REDUCTION MEDICATIONS

Meridia Xenical Others

- Weight reduction medications are a specifically excluded benefit.

XOLAIR

- All of these requirements must be met:
  1. Prior authorization is required.
  2. Age ≥12.
  3. The patient must be a non-smoker.
  4. Documentation of failure of environmental controls.
  5. Positive skin prick test or RAST test to a perennial aeroallergen.
  6. Total serum IgE level ≥ 30iu/ml and ≤ 700 iu/ml.
  7. Documented poor control of asthma symptoms after 3 months of therapy with continued high-dose inhaled steroids and long-acting Beta-2 agonists.
  8. Must be prescribed by a physician specializing in allergy or pulmonary medicine.

***Please note: February 2007, an FDA Safety Alert was issued. It is recommended that patients be observed for at least two hours after Xolair is given due to the reported occurrence of anaphylaxis.

XOPENEX

- PA required.
- Approval will be determined on a case-by-case basis.

EMERGENCY REFILLS THROUGH MEDIMPACT

Emergency (after hour, weekend) Overrides

Procedure: MedImpact staff will forward override requests to the Customer Service Supervisor or the Customer Service Technical Lead for review. The CSS or CST person may use their discretion and authorize up to a three day supply of the medication, by entering a prior authorization after review of the situation. If the medication cannot be broken down due to packaging, the CSS or CST person may use their discretion and allow the entire quantity of the medication to be filled.

Policy – Notification by MedImpact to DCIPA of Potential Drug Abuser

Procedure: If a concern is raised regarding a member's drug use, a CSS or CST Lead will notify Sharon Preston RN at the plan. The notification will be made via e-mail to spreston@dcipa.com.

PROVIDER PRIOR AUTHORIZATION GUIDE

Procedure	PCP	In-Panel Provider	Out-of-Panel Provider
Allergy Shots	PA	PA	PA
Allergy Testing	PA	PA	PA
Bone Density	PA	PA	PA
Bone Scan	No PA	No PA w/ referral	PA
Breast Biopsy	No PA	No PA w/ referral	PA
Cervical Biopsy	No PA	No PA w/ referral	PA
Colposcopy	No PA	No PA w/ referral	PA
Conization of Cervix	No PA	No PA w/ referral	PA
Contact Lenses	PA	PA	PA
Diabetic Supplies – allowed Qty	No PA	No PA	PA
Diabetic Teaching			
6 or less visits per year	No PA	No PA w/ referral	PA
>6 visits per year	PA	PA	PA
Dialysis	PA	PA	PA
Dilation &/or Curettage			
Spontaneous	No PA	No PA	PA
Durable Medical Equipment	PA	PA	PA
Provided in Orthopedic Office <$200	No PA	No PA	PA
1 month crutch rental	No PA	No PA w/ referral	PA
Batteries Hearing Aid < $10 pair	No PA	No PA	PA
Genetic Testing	PA	PA	PA
Implanon Insertion &Removal	PA	PA	PA
Medical Supplies Provided			
In providers office <$200	PA	No PA w/ referral	PA
Nerve Conduction Studies	PA	PA (Except in area neurologists)	PA
Non-Emergent Surgical Procedures			
Performed outside providers office	PA	PA	PA
Out-of-area provider services		PA	PA
Prostate Biopsy	No PA	No PA w/ referral	PA
Removal of suspicious skin lesions	No PA	No PA w/ referral	PA
Therapeutic vitamin injections	PA	PA	PA
Tubal Ligation – signed OHP Consent	No PA	No PA	No PA
Ultrasounds – except for OB	No PA	No PA w/ referral	PA
1st OB ultrasound	No PA	No PA w/ referral	PA
2nd or more OB ultrasound	PA	PA	PA
Vasectomy – signed OHP consent	No PA	No PA	No PA

OUT-PATIENT FACILITY PRIOR AUTHORIZATION GUIDE

PROCEDURE	Mercy Medical Center Roseburg OR	Other Facilities
Amniocentesis	No PA w/ referral	PA
Barium Enema	No PA w/ referral	PA
Bone Density	PA	PA
Bone Scan	No PA w/ referral	PA
Breast Biopsy	No PA w/ referral	PA
Bronchoscopy	No PA w/ referral	PA
Cardiac Catheterization	No PA w/ referral	PA
CT Scan – Limited Sinus	No PA w/ referral	PA
CT Scan – Others	PA	PA
Cervical Biopsy	No PA w/ referral	PA
Colposcopy	No PA w/ referral	PA
Conization of Cervix	No PA w/ referral	PA
Diabetic Teaching		
6 or less visits per year	No PA	PA
> 6 visits per year	PA	PA
Diagnostic Nuclear Medicine	No PA w/ referral	PA
Dialysis	PA	PA
Dilation &/or Currettage-spontaneous	No PA w/ referral	PA
Durable Medical Equipment	PA	PA
Diabetic supplies > Qty Limits	PA	PA
Batteries Hearing Aid < $10/pair	No PA	PA
1 month crutch rental	No PA	PA
Echocardiogram	No PA w/ referral	PA
EEG	No PA w/ referral	PA
Exercise Stress Test	No PA w/ referral	PA
Gastric Endoscopy/ upper & lower w/wo biopsy	No PA w/ referral	PA
Genetic Testing	PA	PA
Holter Monitors	No PA w/ referral	PA
Home Health/Hospice	PA	PA
Inpatient Rehab Services	PA	PA
Lab & X-Ray Services <$200	No PA	No PA w/ referral
DNA not included	PA	PA
Mammogram/ preventive guidelines	No PA w/ referral	PA
MRI	PA	PA
Out-of-area/inside OR		
Lab & x-ray <$200	No PA w/ referral	No PA w/ referral
Other services	PA	PA
Out-Patient Rehab Services		
Physical Therapy	PA	PA
Occupational Therapy	PA	PA
Speech Therapy	PA	PA

PROCEDURE	Mercy Medical Center Roseburg OR	Other Facilities
Cardiac	No PA w/ referral	PA
Pacemaker Check	No PA w/ referral	PA
PET Scan	PA	PA
Sigmoidoscopy	No PA w/ referral	PA
Skilled Nursing Facility Admission	PA	PA
Sleep Studies	PA	PA
Ultrasound	No PA w/ referral	PA
1st OB US	No PA	PA
2nd OB US or more	PA	PA
Upper GI	No PA w/ referral	PA
Vascular Studies	No PA w/ referral	PA

PROCEDURE GUIDELINES 2/2010

1. Anaphylaxis
2. Bariatric - surgery covered starting 1/1/08
3. Blepharoplasty
4. Bone Density Studies/Dexa Scan
5. Cataract Removal
6. Cystocele/Uterine Prolapse
7. Dysmenorrhea/Dyspareunia
8. Endrometroisis and Adenomyosis
9. Enhanced External Counter Pulsation
10. Epidural injections – Back pain
11. Imaging
12. Imaging Chronic Neck Pain
13. Imaging MRI of the Spine
14. Immunotherapy
15. Laparoscopy – Diagnosis
16. Manometry Study
17. Mammoplasty – Reduction
18. Menstrual Bleeding Disorders
19. Neuropsychological Testing
20. Oophorectomy
21. Otitis Media, Chronic
22. Pelvic Pain Syndrome
23. PET Scan
24. Physical Therapy
25. Sinusitis
26. Tonsillectomy and Adenoidectomy
27. Uterine Leiomyoma/Total Hysterectomy or Myomectomy
28. Vagus Nerve Stimulator

PROCEDURE GUIDELINES

AMBULATORY THERAPY CLINIC

- All services provided require prior authorization.
- Outpatient IV services are available.

ANAPHYLAXIS

- NO prior authorization is required for treatment of an acute anaphylactic reaction.
- Prior authorization is required for **allergy testing** and **immunotherapy** on patients who have demonstrated a prior systemic reaction to a stinging insect. This is defined as more severe than an enlarged local reaction.

BARIATRIC SURGERY Jan 08

Bariatric surgery for obesity is covered under the following criteria. (Covered by OHP starting 1/08, criteria adopted from OHP's criteria line 33.)

1. Age ≥ 18.
2. BMI ≥ 35 with co-morbid type II diabetes.
3. Undergo a six month evaluation period, starting with the date the patient is first evaluated by a licensed bariatric surgeon in section 4C below. During this evaluation period, the patient will have periodic visits with staff of the qualified bariatric surgery program and the licensed bariatric surgeon to verify that the patient meets the Bariatric Surgery Center of Excellence program criteria for bariatric surgery. If the patient is found to no longer be an appropriate candidate for surgery for any reason listed in these criteria during the six-month observation period, a new six-month observation period will be required to precede surgery once surgical candidacy has been re-established.
4. Participate in the following four evaluations and meet criteria as described.
    a. Psychosocial evaluation: (Conducted by a licensed mental health professional)
        i. Evaluation to assess compliance with post-operative requirements.
        ii. No current abuse of or dependence on alcohol. Must remain free of abuse of or dependence on alcohol during a six-month observation period immediately preceding surgery. No current use of nicotine or illicit drugs and must remain abstinent from their use during the six-month observation period. Testing, at a minimum, will be conducted within one month of the surgery to confirm abstinence from nicotine and illicit drugs.
        iii. No mental or behavioral disorder that may interfere with postoperative outcomes.[1]
        iv. Patient with previous psychiatric illness must be stable for at least 6 months.
    b. Medical evaluation: (Conducted by OHP primary care provider)
        i. Pre-operative physical condition and mortality risk assessed with patient found to be an appropriate candidate.
        ii. Optimize medical control of diabetes, hypertension, or other co-morbid conditions.
        iii. Female patient not currently pregnant with no plans for pregnancy for at least 2 years post-surgery. Contraception methods reviewed with patient agreement to use effective contraception through 2nd year post-surgery.

c. Surgical evaluation: (Conducted by a licensed bariatric surgeon associated with program[2]
   i. Patient found to be an appropriate candidate for surgery at initial evaluation and throughout a six-month observation period while continuously enrolled on OHP.
   ii. Received counseling by a credentialed expert on the team regarding risks and benefits of the procedure[3] and understands the many potential complications of the surgery (including death) and the realistic expectations of post-surgical outcomes.

d. Dietician evaluation: (Conducted by licensed dietician)
   i. Evaluation of adequacy of prior dietary efforts to lose weight. If no or inadequate prior to dietary effort to lose weight, must undergo six-month medically supervised weight reduction program.
   ii. Counseling in dietary lifestyle changes.

5. Participate in additional evaluations:
   A. Post-surgical attention to lifestyle, and exercise program and dietary changes and understands the need for post-surgical follow-up with all applicable professionals (e.g. nutritionist, psychologist/psychiatrist, exercise physiologist or physical therapist, support group participation, regularly scheduled physician follow-up visits).

[1] Many patients (>50%) have depression as a co-morbid diagnosis that, if treated, would not preclude their participation in the bariatric surgery program.
[2] All surgical services including evaluation are to be performed at a center of excellence for bariatric surgery (OHSU or Legacy Emanuel) as recognized by Medicare.
[3] Only Roux-en-Y gastric bypass and laparoscopic adjustable gastric banding are approved for inclusion.

BLEPHAROPLASTY

Blepharoplasty or levator resection of the upper lid may be considered medically necessary when significant impairment of vision is documented. For bilateral blepharoplasty or levator resection to be medically necessary, one eye must meet the criteria for impaired vision. Blepharoplasty or levator resection of the upper lid is considered medically necessary for reconstructive purposes when **ALL** of the following criteria are met:

- Visual field is limited to 20 degrees or less superiorly, or limited to 10 to 15 degrees or less laterally.
- Any related disease process such as myasthenia gravis or thyroid condition is documented as stable.
- Blepharoplasty of the lower lids for excessive skin and brow ptosis repair are considered cosmetic and are not covered benefits.
- Preauthorization of blepharoplasty and levator resection is required. The following information is requested.
  1. Visual fields, including physician interpretation.
  2. Letter of medical necessity regarding signs and symptoms of decreased vision.
  3. Physician's notes.
  4. Lateral and full face photographs.
- DCIPA reserves the right to request a second opinion from an ophthalmologist.

BONE DENSITY STUDIES

Bone density studies will be allowed **every two years** with a prior authorization for the following reasons:

- Age greater than 65.
- Age less than 65, post menopausal, and one or more risk factors.
  1. History of fracture as an adult.
  2. History of osteoporotic fracture in a first degree relative.
  3. Low body weight (BMI less than 20).
  4. Estrogen deficient (no prior replacement and unable to take estrogen).
  5. Premature menopause (less than 40 years of age).
  6. History of ongoing tobacco abuse.
- Predisposing endocrine disorders with increased risk:
  1. Cushing's syndrome.
  2. Hyperparathyroidism.
  3. Hyperthyroidism.
  4. Chronic renal failure.
- Chronic steroid usage.
- Prolonged heparin therapy.
- Bones unexpectedly osteoporotic on plain x-rays.
- Male hypogonadism

Bone density studies will be allowed more frequently than every 2 years for monitoring of patients with documented osteoporosis who are being treated with FDA approved drug therapy.

CATARACT REMOVAL

- Vision should be 20/50 or less.
- Loss of vision effects life style or work.
- Expectation of improved vision.
- Should not be used when the diagnosis is macular degeneration or glaucoma.

CYSTOCELE - Uterine Prolapse

- Prior authorization is required for surgical treatment. Hysterectomy for pelvic organ prolapse may be indicated when all of the following are documented (1-5):
  1. Patient history of symptoms of pelvic prolapse such as:
     - Complaints of the pelvic organs prolapsing at least to the introitus.
     - Low back discomfort or pelvic pressure.
     - Difficulty defecating.
     - Difficulty voiding.
  2. Nonmalignant cervical cytology, if the cervix is present.
  3. Assessment for absence of endometrial malignancy in the presence of abnormal bleeding.
  4. Physical examination is consistent with patient's symptoms of pelvic support defects indicating either symptomatic prolapse of the cervix, enterocele, cystocele, rectocele, or prolapse of the vaginal vault.
  5. Negative preoperative pregnancy test unless the patient is postmenopausal or has been previously sterilized.

DYSMENORRHEA - & DYSPAREUNIA - Pelvic Pain Syndrome

- Prior authorization is required. Hysterectomy for chronic pelvic pain in the absence of significant pathology may be indicated when all of the following are documented (1-7).
  1. Patient has a history of:
     a. No remediable pathology found on laparoscopic examination AND
     b. Pain for > 6 months with a negative effect on the patient's quality of life.
  2. Failure of a 6 month therapeutic trial of both of the following (a&b), unless there are contraindications to use:
     a. Hormonal therapy (1 or 2):
        1) Oral contraceptives.
        2) Agents for inducing amenorrhea (e.g., GnRH analogs or Danazol).
     b. NSAID's.
  3. Evaluation of the following systems as possible sources of pelvic pain:
     a. Urinary.
     b. Gastrointestinal.
     c. Musculoskeletal.
  4. Evaluation of the patient's psychologic and psychosexual status for nonsomatic causes.
  5. Nonmalignant cervical cytology, if cervix is present.
  6. Assessment for absence of endometrial malignancy in the presence of abnormal bleeding.
  7. Negative preoperative pregnancy test unless patient is postmenopausal or has been previously sterilized.
     a. Myometrial echogenicity or presence of small myometrial cysts
     b. MRI showing thickening of the junctional zone > 12mm

ENDOMETROISIS / ADENOMYOSIS

- Hysterectomy, with or without adnexectomy, for endometriosis may be appropriate when all of the following are documented (1-4):
  1. Patient history of (a and b):
     a. Prior detailed operative description or histologic diagnosis of endometriosis
     b. Presence of pain for more than 6 months with negative effect on patient's quality of life.
  2. Failure of a 3 month therapeutic trial with both of the following (a and b), unless there are contraindications to use:
     a. Hormonal therapy (1 or 2):
        1) Oral contraceptives
        2) Agents for inducing amenorrhea (e.g., GnRH analogs or Danazol)
     b. Non steroidal anti-inflammatory drugs
  3. Nonmalignant cervical cytology, if cervix is present
  4. Negative preoperative pregnancy test result unless patient is postmenopausal or has been previously sterilized.
- Hysterectomy, with or without adnexectomy, for adenomyosis may be appropriate when all of the following are documented (1-6):
  1. Patient history of dysmenorrhea, pelvic pain or abnormal uterine bleeding for more than 6 months with a negative effect on her quality of life.
  2. Failure of a 6 month therapeutic trial with both of the following (a and b), unless there are contraindications to use:

a. Hormonal therapy (1 or 2):
   1) Oral contraceptives
   2) Agents for inducing amenorrhea (e.g., GnRH analogs or danazol)
b. Nonsterodial anti-inflammatory drugs

3. Age > 30 years
4. One of the following (a or b):
   a. Endovaginal ultrasound suspicious for adenomyosis (presence of abnormal hypoechoic myometrial echogenicity or presence of small myometrialcysts:
   b. MRI showing thickening of the junctional zone > 12mm.
5. Nonmalignant cervical cytology, if cervix is present.
6. Negative preoperative pregnancy test unless patient is postmenopausal or has been previously sterilized.

ENHANCED EXTERNAL COUNTER PULSATION

- Prior authorization is required.

EPIDURAL INJECTIONS - Back Pain

- Prior authorization is required for epidural injections for back pain.
- The diagnosis must be an above-the-line condition **AND** radiculopathy or uncontrolled pain included in the documentation.

IMAGING

- CT's and MRI's require prior authorization.
- CT scans and MRI's are done at Mercy Medical Center and at Mercy Harvard Lab and X-ray. All in-area CAT scans and MRI's should be loaded to Mercy Diagnostic (2083).
- CT of the sinus using the codes (70486 and 76380) **DO NOT** require prior authorization.
- Prior authorization is required for all other types of high-tech imaging. If the request is for a routine scheduled test, it works best if the test is scheduled after the office receives the approval.
- Chart notes documenting the reasons for the imaging should accompany all the requests.
- All requests for high-tech imaging will be reviewed by the Medical Director and/or the Quality Improvement Committee.
- Open MRI's are available at:
  1. Open Advance MRI in Eugene 1 (800) 946-1728.
  2. Oregon Open MRI in Salem 1 (503) 763-7300.

IMAGING - Chronic Neck Pain

- Initial evaluation – x-ray (3 views) available without PA
  1. Chronic neck pain with or without a history of remote trauma.
  2. History of malignancy.
  3. History of remote neck surgery.
- Normal radiographs and no neurological signs/symptoms need no further imaging.

IMAGING MRI - Spine

- Normal radiographs PLUS neurological signs symptoms.
  1. CT can be ordered if there are contraindications to MRI such as pacemaker or severe claustrophobia.
- Radiographic evidence of cervical spondylosis or of previous trauma AND neurological signs/symptoms.
  1. Radiographic evidence of cervical spondylosis or previous trauma without neurological signs/symptoms does not usually require further imaging.
- Radiographic evidence of bone or disc margin destruction.
  1. If an epidural abscess is suspected, the exam should be preformed with IV contrast.
  2. If an MRI cannot be done, a CT is recommended.

IMMUNOTHERAPY

- Prior authorization for treatment of asthma with immunotherapy is required.
- Documentation should include the following:
  1. Asthma that requires daily medication therapy for a minimum of 2 months and documentation of patient compliance.
  2. Patient with asthma that has required the use of oral steroids for more than 2 consecutive weeks within the past year.
- Authorization for allergy testing will be given if 1 and 2 are met.
- Authorization will be given for immunotherapy if the allergy tests are positive.
- Annual review and prior authorization is required. Chart notes should be sent with the prior authorization when requesting continuation of immunotherapy.

LAPAROSCOPY - Diagnosis

- Indications for use of diagnostic laparoscopy for chronic pelvic pain:
- **Normal pelvic examination** - At least one or more trials of the following with documented failure:
  1. Birth control therapy for 2 months.
  2. Antiprostaglandin therapy for 2 months (Motrin, Anaprox, Ansaid).
  3. Antibiotics if medically indicated.
  4. Antidepressant therapy for 2 months if there is a secondary diagnosis of depression.
- **Abnormal pelvic examination** - should show documentation of one of the following:
  1. Solid or mixed ectogenic mass on ovary or adnexa.
  2. Fibroids.
  3. Nodularity in the cul-de-sac or uterosacral ligament.

MAMMOPLASTY – Reduction

- Prior authorization is required. Chart notes should include patient's height and weight PLUS documentation of 1 and 2.
  1. Removal of 500 grams or more of breast tissue for each breast AND
  2. Increasing difficulty with activities of daily living PLUS one of the following:
     - Substantial documentation of severe symptoms of neck, back or shoulder pain.
     - Shoulder grooving.

- Excoriation or ulceration due to breast size.

- The Medical Director and/or the Quality Improvement Committee will review each request.

MANOMETRY STUDY

- Prior authorization is required with documentation of necessity.
- The tests are done at Sacred Heart Hospital in Eugene.

MENSTRAL BLEEDING DISORDERS

Endometrial ablation or hysterectomy for abnormal uterine bleeding in premenopausal women may be indicated when all of the following are documented.

- Patient history of (1-5):
  1. Excessive uterine bleeding evidence by (a & b):
     a. Profuse bleeding lasting more than 7 days and repetitive periods at <21day intervals.
     b. Anemia due to acute or chronic blood loss (hgb<10).
  2. Failure of hormonal treatment for a 6 month trial period or contraindication to hormone use.
  3. No current medication use that may cause bleeding, or contraindication to stopping those medications.
  4. Endometrial sampling performed.
  5. No evidence of remedial pathology by sonohysterography or hysteroscopy or hysterosalpingogram.
- Negative preoperative pregnancy test result unless patient is postmenopausal or has been previously sterilized.
- Nonmalignant cervical cytology, if cervix is present.

NEURO-PSYCOLOGIC TESTING

- Prior authorization is required with documentation.

OOPHORECTOMY – Elective

- Prior authorization is required. Documentation should include first degree relative with ovarian cancer and patient desires procedure.

OTITIS MEDIA - Chronic

Treatment: Observation or antibiotic therapy are treatment options for children with effusion that has been present less than 4 to 6 months and at any time in children without a 20-decible hearing threshold level or worse in the better hearing ear.

For the child who has had bilateral effusion for a total of 3 months and who has a bilateral hearing deficiency (defined as 20-decibel hearing threshold level or worse in the better hearing ear), bilateral myringotomy with tube insertion becomes an additional treatment option. Placement of tympanostomy tubes is recommended after a total of 4 to 6 months of bilateral effusion with a bilateral hearing deficit.

*** This information is from the Health Services Commission dated 2/22/01.
Interim modification to the 10/01/99 prioritized list of Health Services.

PELVIC PAIN SYNDROME

- Diagnostic MRI may be indicated for evaluation of pelvic pain to assess for adenomyosis and to assist in the management of these challenging patients when all of the following are documented:
  1. Patient history of dysmenorrheal, pelvic pain or abnormal uterine bleeding for more than six months with a negative effect on her quality of life.
  2. Failure of a six-month therapeutic trial with both of the following (1 and 2), unless there are contrandications to use:
     a. Hormonal therapy (1 and 2):
        1. Oral contraceptives of Depro-Provera
        2. Agents for inducing amenorrhea (e.g., GnRH analogs or Danazol)
     b. Nonsteroidal anti-inflammatory drugs
  3. Age › 30 years
  4. An endovaginal ultrasound within the past 12 months that shows no other suspected gynecological pathology if diagnostic MRI shows › 12mm thickening of the junctional zone, the presumptive diagnosis of adenomyosis is fulfilled. See guidelines for adenomyosis.
- Hysterectomy for chronic pelvic pain in the absence of significant pathology may be indicated when all of the following are documented (1-7).
  1. Patient history of:
     a. No remediable pathology found on laporoscopic examination
     b. Pain for more than 6 months with negative effect on patient's quality of life
  2. Failure of a 6 month therapeutic trial with both of the following (a and b), unless there are contraindications to use:
     a. Hormonal therapy (1 or 2):
        1) Oral contraceptives
        2) Agents for inducing amenorrhea (e.g., GnRH analogs or danazol)
     b. Nonsteroidal anti-inflammatory drugs
  3. Evaluation of the following systems as possible sources of pelvic pain:
     a. Urinary
     b. Gastrointestional
     c. Musculoskeletal
  4. Evaluation of the patient's psychologic and psychosexual status for nonsomatic cause of symptoms
  5. Nonmalignant cervical cytology, if cervix is present
  6. Assessment for absence of endometrial malignancy in the presence of abnormal bleeding
  7. Negative preoperative pregnancy test unless patient is postmenopausal or has been previously sterilized

PET SCAN

PET scans are indicated for diagnosis and staging of the following cancers:

- Solitary pulmonary nodules and non-small cell lung cancer
- Lymphoma
- Melanoma

For diagnosis, PET is covered only when it will avoid an invasive diagnostic procedure, or will assist in determining the optimal anatomic location to perform an invasive diagnostic procedure.
For staging, PET is covered in the following situations:

- The stage of the cancer remains in doubt after standard diagnostic work-up
  OR
- PET replaces one or more conventional imaging studies when they are insufficient for clinical management of the patient **AND**
- Clinical management of the patient will differ depending on the stage of the cancer identified.

***PET Scans are not indicated for routine follow-up of cancer treatment.

PHYSICAL THERAPY

- Prior authorization is required for all physical therapy services. The request should include documentation of an above-the-line diagnosis. All requests will be reviewed by the Chief Medical Officer and/or the Quality Improvement Committee.
- Physical therapy may be approved for above the line diagnosis as follows:
  1. 90/90 traction at home for one month.
  2. Therapeutic exercise training for (4) 15 minute visits.
  3. Instruction in body mechanics/strengthening for one visit.
- Additional physical therapy needs to be prior authorized. Documentation of the treatment plan should be sent with the prior authorization request.
- Requests for physical therapy for below-the-line diagnosis will be reviewed on a case-by-case basis.

SINUSITIS

Acute Sinusitis - Referrals will be given to a specialist upon request by the PCP.

- If the specialist requests immunotherapy for this condition, each case will be reviewed individually by the Chief Medical Officer and/or the Quality Improvement Committee.

Chronic Sinusitis

- Antibiotic therapy prescribed by the PCP will be covered.
- Prior authorization will be required for additional therapy and/or allergy testing.
- Requests will be reviewed by the Chief Medical Officer and/or the Quality Improvement Committee.

***CT of the sinus does not require prior authorization when using these codes: (70486 or 76380).

TONSILLECTOMY AND ADENOIDECTOMY

- Acute or chronic tonsillitis other than beta-streptococcal disease is a below-the- line condition.
- Tonsillectomy is an appropriate treatment in a case with:
  1. Three documented attacks of strep tonsillitis in a year with a positive culture screen, and where 10 days of continuous antibiotic therapy has been completed;
  2. Second occurrence of peritonsillar abscess, or if first abscess, has to be drained under general anesthesia;
  3. Airway obstruction with presence of right ventricular hypertrophy or cor-pulmonale; and/or,
  4. 4+ tonsils, which result in obstruction of breathing, swallowing, and/or speech.

TRANSPLANT & TRANSPLANT EVALUATION

- Prior authorization is required.
- Guidelines set by OAR 410-124-0000 thru 410-124-0160 must be met, as applicable.
- Both the transplant center and the specialist's evaluations must recommend that the transplant be authorized.
- The ICD-9 diagnosis code and the CPT transplant code are paired on the same currently funded line on the Prioritized List of Health Services.
- The patient must also be tobacco free for at least a period three months as indicated by both patient history and nicotine screen.

References:
Oregon Administrative Rule 410-124-0000 thru 410-124-0160

UTERINE LEIOMYOMA - Total Hysterectomy or Myomectomy

Hysterectomy for leiomyomata may be indicated when all of the following bullets are documented.

- One of the following (1 or 2).
  1. Patient history of (2) of the following (a b & c):
     a. Leiomyomata enlarging the uterus to a size of 12 wks or > gestation.
     b. Pelvic discomfort caused by myomata (one of the following):
        - Chronic lower abdominal, pelvic or low back pressure.
        - Bladder dysfunction not due to urinary tract disorder or disease.
        - Rectal pressure and bowel dysfunction not related to bowel disorder or disease.
     c. Rapid enlargement causing concern for sarcomatous changes of malignancy.
  2. Leiomyomata as probable cause of excessive uterine bleeding evidenced by all the following.
     a. Profuse bleeding lasting more than 7 days or repetitive periods at < 21 day intervals
     b. Anemia due to acute or chronic blood loss (hgb<10).
     c. Documentation of mass by sonography.
- Nonmalignant cervical cytology, if cervix is present.
- Assessment for absence of endometrial malignancy in the presence of abnormal bleeding.
- Negative preoperative pregnancy test result unless patient is postmenopausal or has been previously sterilized.

VAGUS NERVE STIMULATOR

- Prior authorization is required.
- Documentation of medically refractory partial onset seizures.
  Definition: A partial onset seizure has a focal onset in one area of the brain and may or may not involve a loss of motor control or alteration of consciousness. Partial onset seizures may be simple, complex, or complex partial seizures secondarily generalized.
- Surgery is not recommended or has failed.

***Vagus nerve stimulation is not covered for patients with other types of seizures which are medically refractory and for whom surgery is not recommended or for whom surgery has failed.

EMERGENCY CARE SERVICES

DCIPA defines a medical emergency as a sudden and unexpected onset of a condition requiring medical or surgical care immediately after the onset, or as soon as it can be made available. Care received later than 24-hours after the onset of the condition is not consider emergent. Chest pains, poisoning, loss of consciousness or respiration, convulsions, severe bleeding, broken bones, and accidental injuries are some examples of medical emergencies.

Some conditions should **not** be treated in an emergency setting. Emergency departments or urgent care facilities should be used for delivery of emergency care or urgent care respectively. Please do not refer your members to the emergency department or urgent care facility for routine care. Routine care provided in a hospital emergency department or urgent care facility is **not** a covered benefit. Members will be responsible for services rendered in a hospital emergency department or urgent care facility for services that do not qualify for emergent or urgent care benefits.

Members are instructed to receive emergency care at their primary hospital if possible. Some examples of services that may not qualify for emergent or urgent care benefits are:

- Colds or slight fevers
- Sore throats
- Medication refills
- Nausea
- Influenza follow-up care for any condition
- Routine treatment for chronic conditions
- Routine physical exam
- Headaches

EMERGENCY CARE SERVICES OUT-OF-AREA

Coverage of out-of-area emergencies is provided only for true emergency situations. DCIPA will cover out-of-area emergency expenses only if the following guidelines are met:

- The need for emergency services could not have been anticipated prior to the member's departure.
- Delay in obtaining emergency services until the member's return to the service area would endanger the member's life or health.
- The PCP is notified within 24-hours of the out-of-area emergency. DCIPA determines that the emergency services were medically necessary.

Members are instructed to seek care at the nearest appropriate facility such as a clinic, urgent care facility, or hospital emergency department.

When a member requires emergency services from a hospital other than Mercy Medical Center and necessary services are provided, DCIPA may pay for the services upon retrospective review. If the member is admitted to the hospital, DCIPA's Hospital Services Coordinator, Medical Director, the member's PCP will work together to arrange a transfer to Mercy Medical Center if and when it is deemed medically appropriate to transfer the member.

OUT-OF-AREA/NON EMERGENT ED VISITS

The out-of-area emergency department should determine if the member is in need of emergent treatment. If not, the PCP or call-share physician should be contacted. If it is agreed that any treatment is necessary, the PCP or call-share physician should initiate the PA process. The member may need to be sent to MMC for treatment or further services. MMC's emergency department can also be contacted to determine if the member should go there for any treatment or service that does **not** require a PA. DCIPA's Medical Management can be contacted for assistance during office hours (8:00 a.m. to 5:00 p.m. Monday through Friday).

PCP RESPONSIBILITY

The PCP is expected to monitor the member's condition and arrange for appropriate care when notified of an out-of-area emergency that will require follow-up or has resulted in an inpatient admission. The physician should determine whether the member can be safely transferred to a participating hospital and contact DCIPA's Hospital Services Coordinator.

HOSPITAL SERVICES

Hospitals are asked to authorize a member's admission for a non-emergent inpatient admission or elective surgery prior to the scheduled admission. Maternity admissions **do not** require a PA unless the length of stay exceeds two days from the date of admission for vaginal delivery and four days from the date of admission for cesarean section.

Hospitals are asked to report emergency inpatient admissions to the PCP and DCIPA by noon of the day following the admission. DCIPA's Hospital Services Coordinator will follow the member's hospitalization on a daily basis.

HOSPITAL SERVICES NOT AVAILABLE LOCALLY

Not all medically necessary services are available at MMC. DCIPA requires a PA for **all** requested services to be performed in other participating and non-participating facilities. Members and their physicians are encouraged to utilize MMC for all services available, however, under certain circumstances DCIPA may grant authorization for services to be performed at other facilities.

ELECTIVE OUTPATIENT SURGICAL PROCEDURES

Members may use MMC or another participating facility for most elective out- patient surgical procedures. All procedures require a PA for use of other facilities.

PRIOR AUTHORIZATION GUIDELINES

DCIPA has PA guidelines that have been approved by the Quality Improvement Committee. Services listed in these guidelines always require a PA. Please feel free to contact DCIPA's Medical Management Team for any questions pertaining to the guidelines.

All emergency department claims are subject to retrospective review by DCIPA.

HOSPITAL SERVICES PROVIDED BY MMC

- Cardiac/pulmonary rehabilitation services (outpatient)
- EEG, electroencephalogram services (outpatient)
- EKG, electrocardiogram services (outpatient)
- Emergency department services including all emergent and urgent medical treatments
- Home health care services
- Hospice care services
- Imaging services (outpatient), CT and MRI
- Inpatient hospital services (all)
- Nutritional diabetic education
- Treatment room services **except** when delivered as a component of outpatient treatment
- Occupational therapy (outpatient) at Mercy Institute of Rehabilitation
- Other diagnostic services
- Other therapeutic services
- Physical therapy (outpatient) at Mercy Institute of Rehabilitation
- Pulmonary function services (outpatient)
- Respiratory services (outpatient)
- Sleep studies
- Speech/language pathology (outpatient) at Mercy Institute of Rehabilitation)

HOSPITAL SERVICES PROVIDED BY A PARTICIPATING PROVIDER

- Ambulance and other medically necessary transportation
- Durable medical equipment and supplies
- Mental health and chemical dependency treatment provided by Jefferson Behavioral Health and ADAPT.
- Lithotripsy
- Peritoneal dialysis (outpatient and at home)
- Radiation therapy
- Renal dialysis (outpatient)
- Skilled nursing facility

BILLING AND CLAIMS PAYMENT

All providers and facilities should submit their professional claims in HIPAA 837P or CMS 1500 format (replaces HCFA 1500). These claims should be submitted within 30 days of the date-of-service to facilitate collection of encounter data and provide effective utilization management. Types of services include: office visits by professional provider, hospital visits by professional provider, durable medical equipment, transportation, private duty nursing, physical therapy, occupational therapy and/or speech therapy, and vision services, etc.

Contracted provider claims will be rejected if received more than 90 days from the date-of-service. Non-contracted provider claims will be rejected if received more than 120 days from the date-of-service. Exceptions to these time guidelines for claims submissions are: pregnancy related diagnosis, when DCIPA is secondary to Medicare or another third party resource, and eligibility issues. Payment for all claims is subject to DCIPA's referral and PA requirements.

PAPER CLAIMS

DCIPA follows requirements set forth by Medicare and DMAP for the processing of paper CMS 1500 claims. The paper claims are converted to an electronic image by scanning. The scanned claims then go through an optical character recognition (OCR) process. The following is required in order to properly identify each claim's data:

- CMS 1500 claim forms with red ink that can be scanned should be used. The claim is to be machine printed with dark black ink. Photocopies, faxes, or hand written claims cannot be used. Light ink or dot matrix printed claims may not have characters that are recognized correctly.

- Align the claim form so all information is contained within the appropriate fields. Each piece of data must have a space between it and the next piece of data. For example, the procedure code must have a space between it and any modifier (88305 26 rather than 8830526).

- When multiple claim forms are sent, they should each be accompanied by their own EOB, chart notes, and other attachments as needed. **Do not** send multiple claim forms with only one EOB.

- Each EOB or attachment must be on standard 8½ by 11 white paper with black print. Half sheets or strips of paper will rip or become separated from the claim in the scanning process. Attachments should not be stapled to the claim.

- The billing or performing provider's NPI 24J number should be placed in box 33A. Box 33B enter DMAP Provider Number. Payment will be made to this provider. **Do not** use the same clinic number for all providers or to identify certain lab or x-ray services versus professional services.

- Additional comments can be made on a standard white sheet of paper and submit with the claim. Handwriting on the claim will not be picked up during the OCR process.

- Highlighting is not necessary and cannot be seen once the claim is scanned. Use only a yellow highlighter if highlighting is necessary; other colors will scan as black and will not be seen as highlighted material.

Failure to follow these requirements may result in claims being returned to the provider unprocessed. Refer to the attached image of CMS 1500.

Send paper claims to:

DCIPA's Claims Department
PO Box 1047
Roseburg, OR 97471

ELECTRONIC CLAIMS

HIPAA 837P claims may be submitted to DCIPA. These are DCIPA primary and do not contain prior payer information or electronic attachments. EDI claims processing is faster and more cost effective than paper billing. The online software program, "Claim Jumper", will pre-process the claim file checking for common billing errors that require immediate attention before the file can be accepted. A printable receipt is produced when the claim upload is successful. There is also a 997 functional acknowledgement file available for download when each CDI file is submitted. Most requirements for paper claims also apply to EDI claims.

- The performing provider's NPI 24J number should be in Box 3B. **Do not** use same clinic number for all providers or to identify certain lab or x-ray services versus professional services.

If you wish to be set up to send EDI claims online, you may contact the DCIPA's Claim Department at 541-672-1685 or 1-800-676-7735 ext. 2277 or e-mail EDI@abct.com.

COMPLETE ALL FIELDS OF CLAIM AS SHOWN

The following information should be present on the claim. The numbers listed below correspond directly to the boxes on the CMS 1500.
R (required fields)

1A. Patient's DMAP recipient ID number (8 digit alpha numeric) from their member identification card. **R**
2. Patient's full name as it appears on their member identification card. **R**
3. Patient's date of birth and sex. **R**
5. Patient's address. **R**
9. A-D The insurance information if another carrier is primary to DCIPA coverage. Attach a copy of primary EOB or insurance card. **R**
10. A-D If the claim is for services rendered for an injury or an accident, indicate by marking the appropriate box (member's employment and MVA or other type of accident). **R**
17. Name of referring provider. **R**
17A. Referring provider's DMAP
17B. Enter NPI number

21. Diagnosis code from a current ICD-9 CM manual. More than one diagnosis code may be included if appropriate. Code to the highest specificity. R
23. DCIPA's 15 digit PA referral number if applicable. Use only one referral number per claim. R
24A. Date-of-service must be numeric. DME suppliers should bill for rental equipment using from and to dates. R
24B. Place of service. (Use standard CMS Place of Service Codes.) R
24C. EMG - yes or no
24D. Procedure code using CPT and HCPCS. HCPCS are required for any supply item. Use appropriate modifier if required. R
24E. Diagnostic code pointers that correspond to the services rendered for the diagnosis listed in Box 21. R
24F. Charges or the normal fee for each service. R
24G. Day or units (1,2,3, etc). This number should match the number of days in field 24-A. DME suppliers, please note that one month rental equals one unit of service unless otherwise specified. R
24J. Enter DMAP provider number followed by the NPI of the provider who rendered the service.
25. Enter a 9-digit federal tax ID number. R
26. Member's account number at your facility for your ease of identification.
28. Total charges for all listed services. R
29. Amount paid by primary insurance. A copy of the EOB from the primary carrier is required for claims processing. Do not enter any co-pay taken or estimated insurance payment. R
30. Balance due from DCIPA.
31. Name of performing provider; signature is not required.
32. Name and address of facility where the services were rendered if different from the office or home. R
33. Billing provider's name, address, and phone number. Pin number should be the group or individual NPI and 6-digit DMAP provider ID. R

UBO4 PAPER CLAIM GUIDELINES

DCIPA is using Optical Character Recognition (OCR) equipment to scan and image paper claims into the claims processing system. To assure expedited claims processing follow these submission requirements for UB04 claims forms.

Optimal Requirements:

- **Forms**
  Only the red and white UB04 forms are accepted by the OCR processing. the appropriate forms can be obtained from the US Government Printing Office at the following address:

  Assistant Superintendent
  Department of Accounting - Rep Division
  USGPO Room C-830
  Washington, D.C. 20401

- **Ink**
  The forms must be completed with black ink. The OCR equipment may not interpret forms that are completed in any other color. DO NOT use red on claim to print.

- **Font**
  The font used to complete these forms should be Courier 10 or 12 point. Handwritten forms are not allowed.

- **Alignment**
  Information in each box should be aligned appropriately so it does not get scanned into the next field.

- **Printers**
  Laser or ink jet printers should be used to complete the forms. Dot matrix printers cause "breaks" in the letters and makes it difficult for the OCR equipment to interpret.

- **Dates**
  All dates must be in MMDDYY format. Please do not submit dashes, spaces, or slashes.

HOSPITAL CLAIMS

All inpatient and outpatient services provided by hospitals should be submitted on form UB 04.

Claims for outpatient lab and x-ray services must use both the revenue center code and the CPT procedure code or HCPC code(s) for services provided. Use the DMAP Hospital Service Guide for reference.

All emergency services shall be reviewed for appropriateness of service by the Medical Director.

Claims for outpatient surgery must have current CPT codes for the procedure(s) performed.

UB 04 PAPER CLAIM GUIDELINES - R(required fields)

1. **Provider Identification** R - Enter provider name, mailing address and zip code.

3. **Patient's Control Number** - The number you assigned to the account.
   This is optional. If you enter the patient's account number here, DCIPA will print this information (up to 15 characters) on your "remittance advice".

4. **Type of Bill** - Enter the appropriate numeric code identified in the DMAP Hospital Service Guide. The following types of billing codes are accepted by DCIPA: R
   111 - Inpatient - use for most inpatient billings, including members with Medicare Part A coverage only

121 - Inpatient - use for inpatient billings for members with Medicare Part B coverage only
131 - Outpatient
141 - Outpatient - referenced diagnostic services
721 - Independent - end-stage renal dialysis facility
831 - Hospital based - ambulatory surgery

6. **Statement Covers Period R** - Use MMDDYY (month, day, and year) numeric format. Example (091521)

   Inpatient - "From" date is the date of admission. "Through" date is the date of discharge, transfer, or expiration.
   Total days in this field must equal the number of accommodation days in Form Locator FL46. Do not count the day of discharge when calculating the number of accommodation days. Refer to the current DMAP Hospital Service Guide; revenue codes marked with a pound (#) sign are codes which count as days.

   Outpatient - "From" date is the date services began. "Through" date is the last date services were provided.
   Member must be eligible on all dates on which services were provided. If you bill for more than one service for a series of services, make certain the member was eligible during the entire time for which you are billing. This is required on both inpatient and outpatient claims.

8. **Member's Name** – Enter the member's name as it appears on the Medical Identification Card.

10. **Birthdate** – Use MMDDYY format.

12. **Admission Date R** - Use MMDDYY format. Enter the actual admission date, even if the member was not eligible on that date.

13. **Admission Hour** – Enter the hour of admission, using numbers from 00 to 24. (01 = 1 a.m., 10 = 10 a.m., 13 = 1 p.m., 23 = 11 p.m., etc.)

14. **Type of Admission or Service** – Use the following codes.
    - 1 – Emergent
    - 2 – Urgent
    - 3 – Elective
    - 4 – Newborn

16. **Discharge Hour** – Use numbers from 00 to 24 (as in line 13 above).

17. **Patient Status** (required on inpatient claims only) – Enter one of the following codes.
    - 01 – Discharged to home or self care (routine charge).

- 02 – Discharged or transferred to another acute care hospital.
- 03 – Discharged or transferred to skilled nursing facility (SNF).
- 04 – Discharged or transferred to an intermediate care facility (ICF).
- 05– Discharged or transferred to another type of institution (not another acute care hospital).
- 06– Discharged or transferred to home under care of home health service organization.
- 07 – Left against medical advice.
- 08–Discharged to home under care of Home Enteral/Parentral Provider.
- 20 – Expired.

31-35. **Occurrence Codes and Dates of Occurrence** – Enter one of the appropriate codes and dates of occurrence.

- 01 – Auto Accident.
- 04 – Employment-related accident.

39-41. **Value Codes** – use these field locators to report the following information to DMAP. do not put more than one entry in each field.
Family Planning Percentage – When family planning services are part of the claim, enter Value Code "XO," followed by an estimate of the total charges related to family planning. Report the percentage in the cents area of the amount field. Round to the nearest whole percent (e.g. 100% as 1.00, 45% as 0.45).
Medicare Coinsurance and Deductible – When Medicare is the primary payer, enter the appropriate Value Code(s), followed by the dollars and cents money amount being reported. A1 (Deductible Payer A) – for the Part A or Part B deductible amount. A2 (Coinsurance Payer A) – For Part A or Part B coinsurance amounts.

Note: When Medicare coverage is present, it will normally be reported as "Payer A" on the UB. However, in situations where Medicare is "Payer B," use Value codes "B1" and "B2" to report Medicare coinsurance and deductible. Failure to correctly report the Part A deductible may result in incorrect payment.

42. **Revenue Codes R** - On each line of the claim, enter the revenue code that most accurately describes the service provided. Use an accommodation day revenue code if the member was admitted and discharged, transferred, or expired on the same day. **Revenue codes that count as accommodation days are designed by a pound sign (#) to the right of the revenue code in the Revenue Code Table in the DMAP Hospital Service Guide.**

The same revenue code may not appear on more than one line of an inpatient claim. You may report the same revenue codes on multiple lines of an outpatient claim, as long as the lines are distinguishable by different HCPCS/CPT codes in Form Locator 44 and/or different dates of service in Form Locator 45.

Outpatient laboratory, diagnostic, and therapeutic radiology, etc., require billing for technical component (use the appropriate revenue code) and professional component (use the appropriate revenue code from Revenue Codes 971 through 979).

Bill the technical component using revenue codes 300X, 310X, 32X, 33X, 34X, 35X, 40X, 61X.

Bill the technical component using revenue codes 971, 972, 973, and 974.

44. **HCPCS/Rates**
Inpatient - no entry required.
Outpatients - HCPCS/CPT's are required for most services. Revenue codes requiring HCPCS/CPT's are listed in the DMAP Hospital Service Guide.
Enter the five-digit code. Type of service modifiers are no longer required on electronic or hard copy UB-92 claims. When using unlisted HCPCS codes, a description is required for pricing.

45. **Service Date**
Inpatient - not required.
Outpatient - enter in MMSSYY format that is applicable. Service dates in Form Locator 45 are to be encompassed within from and through dates in FL6.
There are two acceptable methods for billing of outpatient services.

Method 1 You may list each date of service in Form Locator 45.
Example - Outpatient physical therapy services provided from March 1st through March 31st. Three separate services were provided.

Date of service: 01/01/02 - 03/31/02 - Form Locator

FL42	FL45	FL46	FL47
420	030391	1	53.00
420	031591	1	40.00
420	032891	1	40.00

Method 2 When the procedure is the same, you may submit "from" and "through" dates on one detail line if the days are consecutive. The quality Form Locator 45 requires a match. If there is a break in service for more than one day, separate dates of service on detail lines are required.

46. **Units of Service R** - Enter total units of service or accommodation days. Revenue codes marked with a pound (#) sign count as accommodation days on inpatient claims. A "leave of absence day(s)" also counts as an accommodation day.

The total number of accommodation days must equal the number of days in Form Locator 7. The day of discharge ("through" date in Form Locator 6) is not counted by our computer as a day. However, you should bill charges incurred on the day of discharge.

For example: Member admitted on March 1st and discharged on March 5th.
Form Locator 6 = From - 0301, Through - 0305
Form Locator 46 = Units of Service - 4

For outpatient services provided over a period of time, you may bill for more than one service on a single claim form. The "from" and "through" dates (Form Locator 6) must reflect the range of dates on which services were provided. The number of units of service for each revenue code should appear in Form Locator 46. For services that require PA, such

as physical therapy or occupational therapy, the units of services should not exceed the number of services authorized for that time period. **See previous examples.**

47. **Total Charges** - Enter the total charges. At the bottom of Form Locator 42, enter revenue code 001. At the bottom of Form Locator 47, enter the total charges. **Do not** include charges for non-covered services in this column.

48. **Non-Covered Charges** – Enter charges for non-covered services for each line item. Do not total these charges in line 23 of this field and do NOT include these charges in the total charges appearing in item 47.

50. **A,B,C - Payer Identification R** - Identify by name up to three payer organizations from which the physician might expect some payment for the bill. This information is required. Form Locators 50 through 66 have lines marked A, B, and C. Line A is for the primary payer, line B is for a secondary payer, and line C is for an additional secondary payer. When billing DCIPA, reserve one line for Medicaid information. **Medicaid is secondary to all other insurances except Indian Health Services and certain pedestrian/motor vehicle accidents. For further clarification, contact DCIPA's TPR Coordinator.**

    If Medicaid is the only payer entered DCIPA or Oregon Medicaid on Form Locator 50, line A. If there is a primary payer other than DCIPA, such as Medicare, enter that insurer's name on line A and enter DCIPA on line B (or on line C if there is more than one payer primary to DCIPA).

51. **A,B,C - Physician Number** - Enter your DMAP provider number on line A,B, or C, which corresponds to the line you used to identify DMAP in Form Locator 50. Your DMAP physician number is required. DMAP does not require that you report your physician number for other payers listed in Form Locator 50.

52. **Release of Information (for crossover claims to Medicare)** – Enter a "Y" in this field on the line that corresponds to the line used for DMAP in field 50.

53. **Assignment of Benefits (for crossover claims to Medicare)** – Enter a "Y" in this field on the lien that corresponds to the line used for DMAP in field 50.

54. **A,B,C - Prior Payments** - Enter the actual amount of any payments you have received from a third party resource such as Medicare Part A, Part B, or other insurance on the line which corresponds to that payer's line on Form Locator 50. **Third party EOB is required to be attached to the claim.**

56. **NPI R** - Enter your 10-digit National Provider Identifier.

57. **Other Provider ID R** – Enter your six-digit DMAP number, on the line that corresponds to the line used for DMAP in field 50.

58. **Insured's Name (for crossover claims to Medicare)** – On the line that corresponds to the line used for DMAP in field 50, enter the patient's name as shown on the patient's Medical Care Identification.

59. **Patient's Relationship to Insured (crossover claims to Medicare)** – On the line that corresponds to the line used for DMAP in field 50, enter the appropriate code
    - 01 – Spouse
    - 18 – Self
    - 19 – Child
    - 21 – Unknown
    - 39 – Organ Donor
    - 53 – Life Partner
    - G8 – Other Relationship

60. **Insured's Unique ID R** – On the line that corresponds to the line used for DMAP in FL 50, enter the patient's Client ID number as it appears on the client's Medical Care Identification.

63. **A,B,C - Treatment Authorization Codes** - For services which have been prior authorized by DCIPA, enter the authorization number on line A, B, or C (this should correspond to the DCIPA's identification in Form Locator 50).

67. **Principal Diagnosis Codes R** - Enter the ICD-9-CM diagnosis code best describing the principal discharge diagnosis (the condition responsible for admission of the member to the hospital). **Always code to the highest level of specificity available.**

68-71. **Other Diagnosis Codes** - Enter the ICD-9-CM diagnosis codes (up to four) for conditions that co-exist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. **Do not** enter diagnoses that relate to an earlier episode which have no bearing on the current hospital stay. "Other diagnoses" are conditions that affect patient care in terms of requiring clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, increased nursing care, and/or monitoring. This may affect the DRG assignment on inpatient stays.

74. **Principal Procedure** – Enter the ICD-9-CM procedure code which best identifies the procedure completed. The principal procedure is performed for definitive treatment rather than for diagnostic or exploratory purposes, or to treat a complication, or the procedure most related to the principal diagnosis.

74a-b. **Other Procedure Codes and Dates (required on inpatient claims only, when applicable** – Enter ICD-9-CM codes (up to two) for other procedures performed and the date on which the principal procedure was performed.

76. Enter the complete ICD-9-CM code - Enter the admitting diagnosis as stated by the physician at the time of admission.

78. **Other Physician ID** – Enter the NPI, DMAP number, and name of the physician who rendered service. This information is required on all claims **except for** outpatient Medicare/Medicaid "crossover" claims received by DMAP directly from Medicare.
To enter NPI: Enter the 10-digit NPI of the physician who rendered service.
To enter DMAP provider number: Enter the six-digit DMAP provider number or UPIN of the physician.

For patients referred by a PCM or PCO: Enter the PCM's DMAP provider number.

80. **Remarks** – Enter additional information to help process this claim.
Third Party Resource (TPR) codes: If the patient has Medicare Part B, but the service is not covered by Medicare, enter "NC" (Not covered). Using more than one TPR code on a claim can delay processing.
Other Information – Itemization of services provided under Revenue Center Code 512. Description of "unlisted" laboratory or radiology HCPCS codes for manual pricing.

When you have important information about a claim, it is best to submit a hard copy claim with explanations attached.

PHARMACY CLAIMS PAYMENT

Pharmacy services are provided by MedImpact Healthcare Systems. Local pharmacies can contract with MedImpact if they wish to provide services to DCIPA's members. Pharmacy billings are done electronically.

Questions for MedImpact's procedures can be answered by the Help Desk (1-800-788-2949). Business hours are 24 hours a day, seven days a week including holidays.

MedImpact
10680 Treena St, Suite 500
San Diego CA 92131

Member's medication questions should be referred to DCIPA's Health Care Services at 1-541-672-1685 or 1-800-676-7735.

PLACE OF SERVICE CODES FOR PROFESSIONAL CLAIMS

Database (last updated September 10, 2007)

Listed below are place of service codes and descriptions. These codes should be used on professional claims to specify the entity where service(s) were rendered. Check with individual payers (e.g., Medicare, Medicaid, other private insurance) for reimbursement policies regarding these codes. If you would like to comment on a code(s) or description(s), please send your request to posinfo@cms.hhs.gov.

Place of Service Code(s)	Place of Service Name	Place of Service Description
01	Pharmacy**	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
02	Unassigned	N/A
03	School	A facility whose primary purpose is education.

04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
05	Indian Health Service Free-standing Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service Provider-based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or tinder the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Free-standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 Provider-based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members admitted as inpatients or outpatients
09	Prison-Correctional Facility***	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders. (effective *7/1/06)*
10	Unassigned	N/A
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group Home*	A residence, with shared living areas, where clients receive supervision and other services such as social

		and/or behavioral services, custodial service, and minimal services (e.g., medication administration).
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16	Temporary Lodging	A short term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code. (Effective 04/01/08.)
17-19	Unassigned	N/A
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient Hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room — Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of new born infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
27-30	Unassigned	N/A
31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial

		care to other than mentally retarded individuals.
33	Custodial Care Facility	A facility which provides room, board and other personal assistance services, 2enerally on a lon2-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35-40	Unassigned	N/A
41	Ambulance - Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance — Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
48	Unassigned	N/A
49	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only. (effective 10/1/03)
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care tinder the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hotir basis, by or tinder the supervision of a physician.
52	Psychiatric Facility-Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community Mental Health Center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate Care Facility/Mentally Retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.

55	Residential Substance Abuse Treatment Facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing. (effective 10/1/03)
58-59	Unassigned	N/A
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or usin2 the roster billin2 method. This 2enerally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services tinder the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services tinder the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63-64	Unassigned	N/A
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66-70	Unassigned	N/A
71	Public Health Clinic	A facility maintained by either State or local health departments that provide ambulatory primary medical care tinder the general direction of a physician. (effective 10/1/03)
72	Rural Health Clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care tinder the general direction of a physician.

73-80	Unassigned	N/A
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82-98	Unassigned	N/A
99	Other Place of Service	Other place of service not identified above.

* Revised, effective April 1, 2004.
* * Revised, effective October 1, 2005
* * * Revised, effective July 1, 2006

MEMBERS' RESPONSIBILITIES

a. To choose your provider or clinic once enrolled.

b. To treat all plan providers and personnel with respect.

c. To be on time for appointments made with providers and to call in advance either to cancel, if unable to keep the appointment or to let them know you are going to be late.

d. To seek periodic health exams and preventive service from your (PCP) or clinic.

e. To obtain services consistently from your PCP (except in an emergency) or through plan providers upon referral from your PCP.

f. To obtain a referral to a specialist from your PCP or clinic before seeking care from a specialist.

g. To use urgent and emergent care appropriately and notify the plan or PCP within 72-hours of an emergency.

h. To give accurate information to be included in the clinical record.

i. To help the provider or clinic obtain clinical records from other providers which may include signing a release of information.

j. To ask questions about conditions, treatment and other issues related to your care that is not understood.

k. To use information to make informed decisions about treatment before it is given.

l. To help in the creation of a treatment plan with the provider.

m. To follow prescribed agreed upon treatment plans.

n. To tell the provider that your health care is covered under the Oregon Health Plan before services are received and, if requested, to show the provider the DMAP Medical Identification form.

o. To tell the DHS case worker if someone in the family becomes pregnant and to notify the DHS case worker of the birth of a child.

p. To tell the DNS case worker if any family members move in or out of the household.

q. To tell the DHS case worker if there is any other insurance available.

s. To pay for non-covered services.

t. To pay the monthly OHP premium on time, if so required.

u. To assist the plan in pursuing any third party resources available and to pay the Plan the amount of benefits it paid for an injury or any recovery received.

v. To bring issues or complaints to the attention of the Plan.

w. To sign a release so that DHS and the Plan can get information which is pertinent and needed to respond to an "Administrative Hearing" request in an effective and efficient manner.

x. Contact DCIPA immediately if the member suspects any fraud or abuse.

MEMBER RIGHTS

a. To be treated with dignity and respect.

b. To be treated by providers the same as other people seeking health care benefits to which you are entitled.

c. To select or change your PCP.

d. To obtain mental health, chemical dependency, or family planning services without referral.

e. To have a friend, family member, or advocate present during appointments and at other times as needed within clinical guidelines.

f. To be actively involved in the development of your treatment plan.

g. To be given information about your condition and covered and non-covered services to allow an informed decision about proposed treatment(s).

h. To consent to treatment or refuse services and be told the consequences of that decision, except for court ordered services.

i. To receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency.

j. To have written materials explained in a manner which is understandable.

k. To receive necessary and reasonable services to diagnose the presenting conditions.

l. To receive covered services under the Oregon Health Plan which meet generally accepted standards of practice and are medically appropriate.

m. To obtain covered preventive services.

n. To have access to urgent and emergency services 24-hours a day, 7-days a week.

o. To receive a referral to specialty practitioners for medically appropriate covered services.

p. To have a clinical record maintained which document conditions, services received, and referrals made.

q. To have access to ones own confidential clinical records, unless restricted by statute, and may request that they be corrected or amended.

r. To transfer a copy of your medical records to another provider.

s. To make a statement of wishes for treatment and obtain a power of attorney for health care.

t. To receive written notice before a denial of or change in a benefit or service level is made, unless such notice is not required by federal or state regulations.

u. To know how to make a complaint with the health care plan and receive a response from the plan.

v. To request an "Administrative Hearing" with the Department of Human Resources.

w. To request and receive free interpreter services.

x. To receive a notice of an appointment cancellation in a timely manner.

y. To ensure members are free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

ADVANCED DIRECTIVES

In order to comply with the Federal "Patient Self-Determination Act" (section 4751 of OBRA 1991) and Oregon Laws ORS 127.650 and ORA 97.050, DCIPA requires that PCP's document in the member's medical record the existence of an "Advanced Directive".

DCIPA's Health Care Services will provide Oregon's Power of Attorney for Health Care with instructions upon request. When a member presents the physician with an Advanced Directive, it must be documented in the member's medical record and a copy of the document made a part of the chart. (Refer to medical record keeping).

DCIPA encourages PCPs, as part of the member education and registration process, to annually ask if the member has executed an Advanced Directive. If so, a copy should be put in the medical record.

COMPLAINT AND APPEALS PROCEDURE

All complaints/appeals received are handled in a confidential manner. If a member does not indicate satisfaction, the provider or staff person shall advise the member that they should contact DCIPA's Health Care Services by phone or in writing. DCIPA's Grievance Coordinator will look into all concerns both medical and non-medical. The member needs to give written consent to allow DCIPA to investigate the grievance if additional information is needed.

Definitions:

- **Complaints:** DMAP member or representative's expression of dissatisfaction about any matter other than an action.
- **Appeal:** Request by a DMAP member or representative to review an action.
- **Action:** Denial or limited authorization of a requested covered service, reduction, suspension or termination of a previously authorized service, denial of payment for service, failure to provide service in a timely manner; failure of the Health Plan to act within timeframes; denial of request to obtain services outside of the Health Plan's participating provider panel.

DCIPA will respond to a complaint within 5 days but may need up to 30 days to make a decision. If the time is not adequate, DCIPA will notify the member why the investigation is taking longer.

All members have 45 days from the date on the Notice of Action to file an appeal or request an administrative hearing through DMAP. Once the appeal is received DCIPA will review the appeal and make a decision within 16 days. Oral appeals must be followed up by a written and signed statement within that 16 days. If the time is not adequate to resolve the appeal DCIPA may take an additional 14 days for resolution and notify the member why the investigation is taking longer. If the member filed an administrative hearing with DMAP prior to appealing the denial with DCIPA, DMAP will ask DCIPA to review the appeal within the 16 days as

previously mentioned. Postage paid envelopes are sent to the member with the following address:

DCIPA
1813 West Harvard, Suite 206
Roseburg, OR 97471

If the member is not satisfied with DCIPA's decision on the Notice of Appeal Resolution, the member has the right to request an Administrative Hearing from DMAP. Paperwork is enclosed with the Notice of Appeal Resolution letter.

Expedited appeals and hearings can be requested by the member if they feel their life, health, or ability to function is at serious risk.

The member can receive assistance in filling out the appropriate forms by contacting their caseworker. The member should contact the ENCC if interpretive services are needed by calling 541-672-1685 or 1-800-676-7735/TTY 541-440-6304 or 1-888-877-6304.

INTERNAL REVIEW PROCEDURES

DCIPA's Chief Medical Officer reviews all complaints/appeals as they are received. They are then taken to a Quality Improvement Committee Meeting which is usually held twice a month. This Committee can overturn denials or determine if any corrective action needs to be taken. Issues involving providers are referred to an appointed PEER Review Committee.

All complaints/appeals received by DCIPA's Grievance Coordinator are entered into a log. The log identifies the member, date of the grievance, nature of the complaint/appeal, the resolution, and date of the resolution. The log information is sent to DMAP on a quarterly basis with any trends noted.

All grievance records are kept in a special file with documentation of the complaint/appeal, reviews, investigative process, and resolution. Complaint files are retained for the term of the DMAP Demonstration Project plus two years to permit evaluation.

The Quality Improvement Committee is responsible for internal review with the authority to make the final decision at the Health Plan level.

STERILIZATION CONSENT FORMS

Tubaligations and vasectomies need a valid consent form that must be completed at least 30 days before the procedure, but not more that 180 days before the procedure is performed.

In the case of premature vaginal delivery or cesarean section, the consent must have been signed at least 72 hours before the sterilization is performed and not more than 30 days before the expected date of confinement.

All blanks on the consent form must be completed. The physician statement must be signed on the date of the procedure or a date following the procedure.

A copy of the complete consent form must be submitted with the claim in order for the claim to be paid.

The original consent form must be kept in the patient's chart and a copy should accompany the claim.

Hysterectomy Consent Form

A properly completed Hysterectomy Consent Form must be completed prior to surgery and submitted with the claim form at the time of billing.

In cases where a woman is capable of bearing children prior to the surgery, the person securing authorization must inform the woman and her representative that the hysterectomy will render her permanently incapable of reproducing. The woman must sign the consent acknowledging that she has received the information.

In cases where a woman is sterile prior to the hysterectomy, the physician who performs the hysterectomy must certify in writing that the woman was already sterile prior to the hysterectomy and state the cause of sterility.

In cases where the hysterectomy is required because of a life-threatening emergency situation the physician performing the hysterectomy must certify in writing that the hysterectomy was performed under a life-threatening emergency situation in which he/she determined that prior acknowledgment was not possible. The nature of the emergency must also be described.

Claims will not be paid until a fully completed consent form is on file with the DCIPA's Claim Department.

TIPS FOR QUITTING SMOKING

Based on American Cancer Society Guidelines

- Don't carry a lighter or matches; hide all ashtrays.

- When the urge to smoke hits, take a deep breath. Hold it for 10 seconds and then release it slowly. Taking deep, rhythmic breaths is similar to smoking; only you'll inhale clean air, not poisonous gas.

- Spend your free time in places where smoking is prohibited, such as a library, theater, or museum. Go to lunch with friends who are also trying to quit smoking and sit in the "no smoking" section.

- Eat low-calorie, high-nutrition foods instead of smoking. Choose fresh fruit, raisins, and crisp, crunchy vegetables. Or substitute sugarless gum for a cigarette. Other substitutes to try: lemon drops, cloves, beef jerky, apple slices, celery sticks, or popcorn (not buttered).

- Exercise to help relieve tension. Climb stars rather than take the elevator, or get off the bus before your destination and walk the rest of the way.

- Drink liquids - - and lots of them. Water, herbal teas, fruit juices, and certain decaffeinated soft drinks are good choices. Pass up coffee, soft drinks containing caffeine, and alcohol, as they all can increase your urge to smoke.

- Keep your hands occupied. Try doodling, knitting, or working with a calculator (figure out the money you'll save by quitting cigarettes).

- Change your habits connected with smoking. If you always had cigarette on your office break, opt for a low-calorie snack and juice or tea instead.

- Wrap a cigarette in a sheet of paper and then put a rubber band around it. If you must reach for a cigarette, you'll have more difficulty getting to one and you will be aware of your action. Rewrap cigarettes afterward.

- Tell all your friends that you are definitely quitting smoking. Ask them to help keep you from backsliding. Ask your family and co-workers who smoke not to do so around you.

- Treat your body and soul with kindness. Indulge in a bath or massage, or take a nap. Listen to your favorite music or go see a movie. Enjoying these activities in the absence of smoking will help you realize that you don't need a cigarette to have a good time.

TOBACCO CESSATION

The 5 A's adapted from the National Cancer Institute, National Institute for Health

Step 1 **ASK**

Ask every patient age 14 or over about tobacco use at each visit.

Step 2 **ADVISE**

For former tobacco users affirm non-use of tobacco products and encourage prevention of relapse.
For tobacco users advise to quit smoking.

Step 3 **ASSESS**

Ask about current willingness to make a quit attempt.
Even if not ready to quit, hand out appropriate educational materials.

Step 4 **ASSIST**

If willing to make a quit attempt, have the member sign the DCIPA's Quit Smoking Form and set a quit date, discuss the use of appropriate smoking cessation products covered by DCIPA and encourage the attendance of a free tobacco cessation program.

Step 5 **ARRANGE**

Arrange to have the member call in every two weeks to verify that they have stayed quit and provide encouragement to the member to continue to participate in a local tobacco cessation program.

Intent to Attend Tobacco Cessation Program

I _____, intend to make a good faith effort to attend one of the
(print first and last name)
tobacco cessation programs listed below to help me in my effort to become tobacco free. I understand that if I do not make an effort to attend a program I may not be able to get a refill of my nicotine patches or Chantix.

_____ _____
Signature **Date**

The following programs are available to all DCIPA Members free of charge:

Type of Program	Location	Contact Information
Freedom From Smoking	Douglas Health & Wellness	541-464-2812
Be Well	Community Cancer Center	541-673-2267
Stop Smoking Clinic	Seventh Day Adventist Better Living Center	541-672-1542
Cessation Services for Veterans	Roseburg VA Health Care System	541-440-1000 press #1, then enter extension #41312

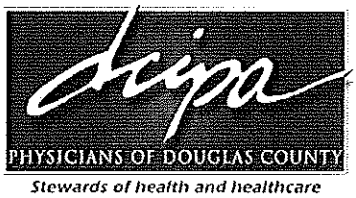
Online Resources:

American Cancer Society	www.cancer.org
Become an Ex: Relearn life without cigarettes	www.becomeanex.org
Freedom from Smoking	www.ffsonline.org
You Can Quit Smoking Now	www.smokefree.gov
Quittobacco.org	www.quittobacco.org

PAIN MANAGEMENT

In accordance with the Intractable Pain Act passed by the Oregon Legislative Assembly in 1995, all patients who are taking controlled substances for chronic non-malignant pain must execute a signed consent form. A sample consent form is provided for you.

Even though it is not required, DCIPA urges providers, who have patients on high dosages of narcotics for non-malignant pain, to have their patients sign a medication agreement stipulating that there will be only one prescribing provider, and only one pharmacy used to administer the medications. A sample medication agreement form is also provided. Please notify DCIPA if an agreement has been signed so that we can enforce the one-provider/one-pharmacy rule.



March 2008

Dear Colleague:

The purpose of this letter is to introduce DCIPA's pain management program. Unfortunately, we continue to see escalating use of opioid medication in the setting of chronic non-malignant pain. For some patients this may be appropriate, especially in today's climate of heightened sensitivity to the plight of patients suffering with pain from any cause. However, when reviewing office records, documentation for such usage sometimes reveals disappointingly incomplete information. At times, information regarding patients' pain problems and treatment are not even mentioned in progress notes.

Various national and state organizations are demanding more detailed documentation. They are also providing various tools to satisfy legal requirements and help providers manage these difficult patients. DCIPA's Peer Review Committee has developed this "tool kit" and recommends it for your use. It contains the following:

- Pain Assessment Form
- Physician Progress Report
- Office Checklist
- Sample Patient Diary
- Material Risk Notice (required by Oregon Statute)
- Sample Medication Agreement (not legally required, but highly recommended)

Please send a copy of any medication agreement on our members to DCIPA or scan it into the EMR so that we can enforce them through our pharmacy benefits manager. Prescriptions for chronic opioids will not be filled unless written by a participating provider or clinic and filled at a single designated pharmacy.

DCIPA recognizes that even with these tools, this population will still be challenging to treat. Regrettably, pain management services are not a funded benefit of the Oregon Health Plan. However, we have arranged for a pain specialist to be available on a limited basis, to consult with providers and do chart reviews with our Peer Review Committee. Your busy schedule is always respected and this opportunity will be available to you without being punitive.

Please contact Sandra Wright at DCIPA, 541-673-1462, if you have any cases that you would like to present at the next meeting. Thank you again for all your efforts for Oregon Health Plan patients in Douglas County.

Sincerely,

Lavry Sharp

Laurence Sharp, D.O
QI Medical Director

LS/slw

PAIN ASSESSMENT FORM—PATIENT PORTION

1. What does the pain feel like?
2. Is it always there, or does it come and go?
3. Where does it hurt? (Mark the body drawing to show where it hurts.)

4. What activities at home or work are difficult for you because of pain?
   For example: sitting, standing, walking, reaching overhead, climbing stairs.

   Activity
   #1 _____
   #2 _____
   #3 _____

5. How long does the pain last?
6. What makes it ease off or get better?
7. What makes it worse?
8. How many hours did you work:
   Last week? The week before?
9. Describe any changes in these 3 activities since the last medical visit.
   Be specific. (For example: "Can walk 8 blocks now. The last time I saw Dr. Smith I could only walk one block")

   Activity
   #1 _____
   #2 _____
   #3 _____

10. On average, please rate your pain:

Name: _____ Patient Signature: _____

Physician Progress Report

Patient's Name:	Date:

1. For what diagnosis are you prescribing opioids?

2. Current pain medications and dosages:

3. Please estimate your patient's level of function.

   (a) Functional level at this visit (circle your numerical estimate)

   0 1 2 3 4 5 6 7 8 9 10

   (b) Function level at previous visit _____

   0 = returned to normal level of function 10 = severe impact on function at home or at work

4. Potential Aberrant Drug-Related Behavior

   - ☐ Over-sedation
   - ☐ Appears intoxicated
   - ☐ Increasingly unkempt or impaired
   - ☐ Requests frequent early renewals
   - ☐ Reports lost or stolen prescriptions
   - ☐ Uses pain medication in response to situational stressor
   - ☐ Abusing alcohol or illicit drugs
   - ☐ Other

5. Has there been overall improvement in the patient's pain and function since opioids were first used to treat the patient's chronic pain? (In terms of daily living or work activities.) (check one box)

   - ☐ Yes
   - ☐ No. Opioids will be discontinued, see my treatment plan below.
   - ☐ No. A consultation has been scheduled for __/__/__
   - ☐ No. See modified treatment plan in question
   - ☐ No. Patient reached max. medical improvement
   - ☐ Rate or refer for Disability Evaluation

6. Have you considered:

   - ☐ NSAIDS
   - ☐ Anti-Depressants
   - ☐ Non-Pharmacological Therapy

7. Treatment plan to improve the patient's function:

8. Have any consultations been scheduled? Where: When:
   ☐ Yes ☐ No

9. Is there any concern about:
   ☐ misuse of medications ☐ tolerance ☐ dependence ☐ toxicity (check all that apply)

10. I have reviewed details of the treatment agreement with the patient. ☐ Yes ☐ No

Physician Signature Date / /

Checklist for Long-Term Opioid Therapy

Patient name:_____

Workup	Date	Outcome
Complete medical history		
Complete physical examination		
Assessment of the pain		
Effect of pain on physical and psychological function		
History of substance abuse		
Coexisting diseases or conditions		
Recognized medical indication for the use of a controlled substance		
Risks and benefits communicated		
Written agreement (optional, if high risk or history of substance abuse)		
Periodic review of goals		
Monitor compliance		
Consultation as necessary for additional evaluation and treatment		
Accurate and complete records to include medical history, physical examinations, evaluations, consultations, treatment plan objectives, informed consent, treatments, medications, and agreements with patient		

Adapted from: Medical Board of California Services for Consumers. Guidelines for Prescribing Controlled Substances for Intractable Pain. Adopted July 29, 1994. www.medbd.ca.gov/consumerguidelines.htm

A7012-AF-IW

MATERIAL RISK NOTICE

This will confirm that you, _____, have been diagnosis with the following condition(s) causing you chronic intractable pain:

_____

_____

I have recommended treating your condition with the following controlled substance(s):

_____

_____

In addition to significant reduction in your pain, your personal goals from therapy are:

_____

_____

Alternatives to this therapy are:

_____

_____

Additional therapies that may be necessary to assist you in reaching your goals are:

_____

_____

Notice of Risk

The use of controlled substances may be associated with certain risks such as, but not limited to,

- **Central Nervous System:** Sleepiness, decreased mental ability, and confusion. Avoid alcohol while taking these medications and use care when driving and operating machinery. Your ability to make decisions may be impaired.
- **Respiratory:** Depression (slowing) of respiration and the possibility of inducing bronchospasm (wheezing) causing difficulty in catching your breath or shortness of breath in susceptible individuals.
- **Gastrointestinal:** Constipation is common and may be severe. Nausea and vomiting may occur as well.
- **Dermatological:** Rash and itching.
- **Urinary:** Urinary retention (difficulty urinating).
- **Pregnancy:** Newborn may be dependent on opioids and suffer withdrawal symptoms after birth.
- **Drug Interaction** with or altering the effect of other medications cannot be reliably predicted.
- **Tolerance:** Increasing doses of drug may be needed over time to achieve the same (pain relieving) effect.
- **Physical dependence and withdrawal:** Physical dependence develops within 3-4 weeks in most patients receiving daily doses of these drugs. If your medications are abruptly stopped, symptoms of withdrawal may occur. These include nausea, vomiting, sweating, general malaise (flu-like symptoms), abdominal cramps, palpitations (abnormal heartbeats). All controlled substances (narcotics) need be slowly weaned (tapered off) under the direction of your physician.
- **Addiction (Abuse):** This refers to abnormal behavior directed towards acquiring or using drugs in a non-medically supervised manner. Patients with a history of alcohol and/or drug potential for addiction

• **Allergic Reaction:** Are possible with any medication. This usually occurs early after initiation of the medication. Most side effects are transient and can be controlled by continued therapy or the use of other medications.

This confirms that we discussed and you understand the above. I asked you if you wanted a more detailed explanation of the proposed treatment, the alternatives and the material risks, and you (check one):

_____ Are satisfied with that explanation and desire no further information.
_____ Requested and received, in substantial detail, further explanation of the treatment, alternatives and material risks.

_____ Date: _____
Patient Signature

Explained by me and signed in my presence:

_____ Date: _____
Provider Signature

MEDICATION AGREEMENT

I, _____, _____ agree to the following rules
Patient Name OHP Patient ID Number

and conditions regarding refills of prescribed medications.

The medication(s) covered by the agreement include:

Medication	Dose	Directions	Quantity per Month

1. I will limit my dose of medication(s) to the dose prescribed. I will discuss any necessary changes in my dose with my provider.

2. I am responsible for my medication(s). Lost, misplaced, or stolen prescriptions will not be replaced.

3. Refills will be made only at the prescribed level. No early refills will be authorized.

4. No refills will be authorized after hours, on holidays, or on weekends.

5. I will obtain all refills for the medication(s) only at _____ Pharmacy.
_____ _____
Pharmacy Phone Number Location

6. I will request all refills through my primary care provider (PCP), _____

7. I will agree to random laboratory diagnostic testing as ordered by my provider.

8. I understand that my provider may stop prescribing opioids or change the treatment plan if I do not show any improvement with the medication(s).

9. Other: _____
_____

10. I understand that failure to comply with any of these conditions or failure to make regular follow-up appointments with my PCP may result in termination of prescriptions for the medication(s) listed above.

Signature: _____ Date: _____

Provider: _____ Date: _____

DCIPA'S
INTERPRETER PRIOR AUTHORIZATION FORM

To be filled out by the office staff and faxed to DCIPA. **1-541- 677-5881**

Patient name: _____ DOB: _____

Insurance ID #: _____ Patient's phone #: _____

PCP: _____

Referring doctor, if not the PCP: _____

ICD-9 Code: _____

Foreign language requested: _____

Signing requested: _____

Appointment date, time, and location: _____

Interpreter/signer requested if one has been used in the past. _____

----------*DCIPA will fax back the following information:*

Interpreter's name: _____

Interpreter's phone #: _____

Appointment confirmed by: _____ Date: _____

Please notify the above interpreter/signer if the appointment date or time is changed.

DMAP APPROVED MEMBER LETTERS

WELCOME TO DCIPA HEALTH PLAN

We at DCIPA (The Physicians of Douglas County) are pleased to help you with your health care needs. Through DCIPA, you will have access to our wide selection of providers who offer excellent health care services. You can also get highly specialized treatment for other health problems.

Packet Contents:

- A Member Handbook with a brief description of the features and advantages of DCIPA's Health Plan and how to use the plan.
- A Primary Care Provider Directory to help you easily choose a participating Primary Care Provider (PCP).
- Emergency care instructions.
- A Primary Care Provider Selection Card (postage paid) to return to DCIPA.
- Notice of "Privacy Practices".

Information on making health care decisions called "Advanced Directives" for end-of-life care is available on request. This is described in the Member Handbook.

The more clearly you understand DCIPA's benefits, the more you will get from the plan. At the same time, you will ensure that you and your family receive the highest quality care.

Thank you for choosing the DCIPA Health Plan.

Date

Dear Member,

We received a letter from your Primary Care Provider (PCP). _____ will only treat you for emergencies until _____. You will need to find another PCP.

We are sending you a PCP list and a PCP Selection Card. Those doctors with an asterisk before their names are open to new patients. Choose another provider, mark your choice on the form and send it back. If you need help filling out the form, call Member Services at 541-672-1685 or 1-800-676-7735 or TTY 541-440-6304 / TTY 1-888-877-6304. DCIPA's Member Services Department is open Monday to Friday from 8:00 a.m. to 5:00 p.m.

If you do not choose a new PCP, one will be chosen for you.

Sincerely,

Member Services Department
DCIPA Medical Management

Date

Dear Member:

The Oregon Medical Assistance Program has informed the DCIPA that you are pregnant. We would like to encourage you to see your primary care provider (PCP) for medical care as soon as possible. You also have the option of choosing an obstetrician to care for you during your pregnancy.

It is important that you choose a PCP who will attend to your baby in the hospital and after delivery. We would like to encourage you to make this choice now, before you enter the hospital, so that your baby's PCP will be available after your delivery. Once your child has been born and you have notified your caseworker of the birth, contact Member Services to let us know who will be your child's PCP.

Call your doctor(s) soon. If you do not have a PCP or need help selecting one for your baby, call DCIPA's Member Services at 541.672.1685 or 1.800.676.7735 / or TTY 541.440.6304 or TTY 1-888-877-6304.

Sincerely,

Member Services Department
DCIPA Medical Management

Date

Dear Member:

A Primary Provider Selection Card is being returned to you for the following reason (s):

Additional information is needed to process your selection. Complete the highlighted areas and return the card to Member Services.

The Primary Care Provider (PCP) you have chosen is not a participating provider with DCIPA. Please choose another PCP and contact their office to be sure they are accepting new patients.

The PCP (Primary Care Provider) you have chosen is not accepting new patients at this time. Please refer to your Provider Directory and select another PCP. Contact their office to be sure that they are accepting new patients.

You have chosen a specialist for you PCP (Primary Care Provider). Refer to your Provider Directory and select another PCP.

Other: _____

Please complete the enclosed Primary Care Provider Selection Card and return it as soon as possible or call us at 541.672.1685 or 1.800.676.7735 or TTY 1.541.957.0377 or TTY 1.888.877.6304 if you have any questions or need assistance.

Thank You,

Member Services Department
DCIPA Medical Management

Date

Dear Member:

The Oregon Health Plan (OHP) has provided you with a complete benefit package of OHP health services. The DCIPA Member Services Department is here to help you with questions about your coverage, selecting a primary care physician or how to access care and services.

An Exceptional Needs Care Coordinator (ENCC) is available to help you with more complex medical or special needs. Simply let the Member Service representative know that you need to speak with the ENCC. Your phone call will be returned.

Member Services can be reached by calling 541.672.1685 or 1.800. 676.6635 / TTY 541.957.0377 or TTY 1.888.877.6304 between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday.

Sincerely,

Member Services Department
DCIPA Medical Management

EMERGENCY CARE 3/08

What should you do in an emergency?
Go to the hospital emergency department or call **911** if you have a serious health problem or an accident.

What is considered an emergency?
A serious health crisis that must be treated immediately such as a serious accident or any of the following:

- Heart attack or stroke
- Severe shortness of breath or chest pain
- Drug overdose
- Poisoning
- Severe burn
- Bleeding that does not stop
- Broken bones
- Gunshot wound
- Any other injury or illness that could put your health in serious danger or cause permanent disability if you do not get immediate medical attention

What is **NOT** an emergency?
Conditions that are not considered emergencies are listed below. For non-emergencies, call you primary care provider (PCP).

- Cold or flu
- Cough or sore throat
- Rash
- Vomiting or diarrhea that last less than one day
- Back pain or tooth pain
- Chronic headaches
- Prescription refills

Important:
Your PCP can help you with the medical care 24-hours a day, 7-days a week. You should call your PCP for advice and they will send you to the right place for care.

If you are sent to the emergency department or urgent care facility by your PCP, be sure to take your DCIPA identification card with you. Your PCP will take care of any follow-up care that you need. Call your PCP's office to make an appointment for follow-up care right away.

DO NOT go to the emergency department for care that can be given by your PCP in their office. If you do, you may be held responsible for the emergency department's bill.

DCIPA Medical Management

Date

Dear Member:

Welcome to DCIPA. In making sure that your health care needs will be taken care of, we have chosen a Primary Care Provider (PCP) for you. We have chosen a PCP as close to your area as possible.

The provider for you will be:

Your PCP will manage your health care for you. Your PCP is interested in keeping you healthy as well as treating you when you are sick. Contact your PCP for all your health care needs. If you go to another doctor or a hospital on your own, you may have to pay the bill.

IF YOU WANT TO CHOOSE ANOTHER PCP, YOU MUST CALL OR WRITE TO US WITHIN 30 DAYS OF THE DATE OF THIS LETTER.

Read your Member Handbook for more information about a PCP and information about your Health Plan. If you have any questions, call DCIPA's Member Services Department at 541.672.1685 or 1.800.676.7735 / TTY 541.440.6304 or TTY 1.888.877.6304.

Sincerely,

Member Services Department
DCIPA Medical Management

DENTAL REFERRAL FORM

Date: _____

Patient Name: _____

DOB: _____

Patient Social Security: _____

Patient Prime ID: _____

Patient Phone Number: _____

DCO Referred to: _____

If client has an open medical/dental card, referred to DMAP? Yes No (circle one)

(If client has an open card, fax this information to DMAP's Dental Program Coordinator)

Medical Plan: _____

Requesting Physician: _____

Physician's Fax Number: _____

Physician Comments and Findings: _____

_____

_____

Does the physician request a response? Yes No (circle one)

Attending Dentist Name: _____

Attending Dentist Phone Number: _____

Dentist Comments and Findings: _____

_____

_____

OHP PREVENTION PROGRAMS

Childhood Immunization

This program promotes childhood immunizations to all infants and children.

- Childhood immunizations are an OHP benefit. In Douglas County they are provided to the members through the Douglas County Health Department's Immunization Clinic or the provider's office.
- All of Douglas County's immunizations are now registered through ALERT, a national registry.
- **Resources:**
  - Oregon's Immunization Alert – www.immalert.org

Diabetes Prevention

This program includes prevention, early detection, and close monitoring to prevent side effects from diabetes.

- Diabetic dietary education is provided by Mercy Medical Center.
- Glucometers, lancets, and test strips are provided to members with a doctor's prescription through DMES (Douglas Medical Equipment & Supply) or Rick's Medical Supply.
- A free exercise program is available at Senior Services locations throughout Douglas County.
- Mercy Medical Center's continuing education has information on the local Diabetic Support Groups.
- **Resources:**
  - 2008 Oregon Progress Report on Diabetes available online - http://www.oregon.gov/DHS/ph/diabetes/figures.shtml
  - 2008 Oregon population-Based Guidelines for Diabetes Mellitus available online –
  - http://www.oregon.gov/DHS/ph/diabetes/guidelines.shtml
  - Living Well with Chronic Conditions –http://oregon.gov/DHS/ph/livingwell/index.shtml
  - National Diabetes Education Program – www.ndep.nih.gov
  - NIH, National Institute of Diabetes, Digestive, & Kidney Diseases (NIDDK) – www.niddk.nih.gov
  - American Diabetes Association – www.diabetes.org
  - Oregon Diabetes Program – www.healthoregon.org/diabetes

Tobacco Cessation – Tobacco cessation products are a benefit of Oregon Health Plan

Information to obtain these products is included in the PA section of the manual. Tobacco cessation classes are provided by Seventh Day Adventist Center for Living at no charge to the patient.

Early Childhood Caries Prevention

Providers are encouraged to assess the oral cavity of infants and young children and make appropriate dental referrals. The member's Dental Care Organization (DCO) is listed on the DMAP ID card. (Pregnant women with dental issues should also be evaluated and referred.)

- Notations should be made in the member's chart to reflect the findings.

- Dental referrals can be made by the PCP's office staff or the member/parent can call the dental care organization noted on the members ID card. If assistance in arranging the appointment is needed, call DCIPA's Health Care Services at 672-1685.
- Resources:
  - CDC Division of Oral Health – www.cdc.gov/OralHealth

Asthma

Please see the pages following this outline for additional information on asthma.

- **Resources:**
  - The 2006 Oregon Asthma Surveillance Summary Report can be obtained by e-mailing Asthma.ohd@state.or.us. The Oregon asthma network also has a web site - www.healthoregon.org/asthma
  - Oregon Asthma Resource Bank –www.oregon.gov/dhs/ph/resource/index.shtml .
  - Living well with chronic conditions and information on adult management programs, American Lung Association in Oregon, www.lungoregon.org.

Heart Disease and Stroke Prevention and Care

The Oregon Statewide Plan for Heart Disease and Stroke Prevention and Care was developed by a special council in 2005.

- **Resources:**
  - Heart Disease and Stroke Prevention Resource - www.oregon.gov/dhs/ph/hdsp/