Applicant Information

Applicant Name: Yamhill County Care Organization

Form of Legal Entity: Yamhill County Care Organization is established as an Oregon nonprofit public benefit corporation having 501(c)3 status, with Mid-Valley Behavioral Care Network and CareOregon as its affiliates.

State of Domicile: Oregon

Primary Contacts: Silas Halloran-Steiner

Address: 627 Evans St

City, State, Zip: McMinnville, OR 97128

Telephone: (503) 434-7523

Fax: (503) 434-9846

E-mail Address: halloras@co.yamhill.or.us

Name and title of the person(s) authorized to represent the Applicant in any negotiations and sign any Contract that may result: Silas Halloran-Steiner - Director, Yamhill County Health and Human Services Department

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

1. Applicant does not discriminate in its employment practices with regard to race, creed, age, religious affiliation, sex, disability, sexual orientation or national origin, nor has Applicant or will Applicant discriminate against a subcontractor in the awarding of a subcontract because the subcontractor is a minority, women or emerging small business enterprise certified under ORS 200.055.

2. Information and costs included in this Application will remain valid for 180 days after the Application due date or until a Contract is approved, whichever comes first.

3. The statements contained in this Application are true and, so far as is relevant to the Application, complete. Applicant accepts as a condition of the Contract, the obligation to comply with the applicable state and federal requirements, policies, standards, and regulations.

4. The undersigned recognizes that this is a public document and will become open to public inspection, except as described in Section 7.8.

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

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

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

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

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

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

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

[signature], YAMHILL COUNTY HHS DIRECTOR

ATTACHMENT 6 – ATTESTATIONS, ASSURANCES AND REPRESENTATIONS

Applicant Name: **Yamhill County Care Organization** (Affiliates include CareOregon and Mid Valley Behavioral Care Network)

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

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

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

Attestations for Appendix A – CCO Criteria

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

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

Attestations for Appendix B – Provider Participation and Operations Questionnaire

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

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
payments to providers, and limits on physician incentive plans.				
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			To ensure adequate access to Covered Services, YCCO will contract with Mid-Valley Behavioral Care Network. To the extent possible, YCCO will utilize CareOregon's network for services provided outside the service area.
Attestation B-5. Applicant will have all provider contracts or agreements available upon request.	X			
Attestation B-6. As Applicant implements, acquires, or upgrades health information technology (HIT) systems, where available, the HIT systems and products will meet standards and implementation specifications adopted under section 3004 of the Public Health Services Act as added by section 13101 of the American Recovery and Reinvestment Act of 2009, P.L. 111-5.	X			
Attestation B-7. Applicant's contracts for administrative and management services will contain the OHA required contract provisions.	X			
Attestation B-8. Applicant will establish, maintain, and monitor the performance of a comprehensive network of providers to assure sufficient access to Medicaid Covered Services as well as supplemental services offered by the CCO in accordance with written policies, procedures, and standards for participation established by the CCO. Participation status will be revalidated at appropriate intervals as required by OHA regulations and guidelines.	X			
Attestation B-9. Applicant will have executed written agreements with				See Attestation B-4.

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

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
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 B-1. Emergency and Urgent Care Services. Applicant will have written policies and procedures and monitoring systems that provide for emergency and urgent services for all Members on a 24-hour, 7-days-a-week basis. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. (See 42 CFR 438.114 and OAR 410-141-3140]	X			

Assurance B-2. Continuity of Care. Applicant will have written policies and procedures that ensure a system for the coordination of care and the arrangement, tracking and documentation of all referrals and prior authorizations to other providers. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.208 and OAR 410-141-3160]	X			
Assurance B-3. Applicant will have written policies and procedures that ensure maintenance of a record keeping system that includes maintaining the privacy and security of records as required by the Health Insurance 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 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	X			

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]				
Assurance B-10. Applicants will provide Intensive Care Coordination (otherwise known as Exceptional Needs Care Coordination or ENCC) to Members who are Aged, Blind or Disabled. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.208 and OAR 410-141-3405]	X			
Assurance B-11. Applicant will maintain an efficient and accurate billing 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 B-14. Applicant will maintain an efficient and accurate process that can be used to validate Member Enrollment and Disenrollment based on written policies, standards, and procedures that are in accordance with accepted professional standards, OHP Administrative Rules and OHA Provider Guides. The Applicant will have monitoring systems in operation and review the operations of these systems on a regular basis. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.242 and 438.604; and Contract]	X			

Informational Representations for Appendix B – Provider Participation and Operations Questionnaire

Informational Representation	Yes	No	Yes, Qualified	Explanation
Representation B-1. Applicant will have contracts with related entities, contractors and subcontractors to perform, implement or operate any aspect of the CCO operations for the CCO Contract.	X			YCCO will contract with CareOregon and Mid-Valley Behavioral Care Network to perform CCO operations.
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			YCCO will contract with CareOregon and Mid-Valley Behavioral Care Network to manage all staffing needs for the CCO.
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			YCCO will contract with CareOregon to perform most CCO system functions; with sub-contracts as needed for back-up and other IS functions.
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			YCCO will contract with CareOregon and Mid-Valley Behavioral Care Network to perform all CCO claims administration functions.
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			YCCO will contract with CareOregon and Mid-Valley Behavioral Care Network to perform all CCO enrollment and membership functions.

Informational Representation	Yes	No	Yes, Qualified	Explanation
Representation B-1. Applicant will have contracts with related entities, contractors and subcontractors to perform, implement or operate any aspect of the CCO operations for the CCO Contract.	X			YCCO will contract with CareOregon and Mid-Valley Behavioral Care Network to perform CCO operations.
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			YCCO will contract with CareOregon and Mid-Valley Behavioral Care Network to perform most CCO credentialing. CareOregon does sub-delegate some credentialing to entities that qualify, such as PrimeCare.
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			YCCO will contract with CareOregon and Mid-Valley Behavioral Care Network to perform all CCO utilization management functions.
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			YCCO will contract with CareOregon and Mid-Valley Behavioral Care Network to perform all CCO quality improvement activities.
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			YCCO will contract with CareOregon and Mid-Valley Behavioral Care Network to perform all CCO call center operations.

Informational Representation	Yes	No	Yes, Qualified	Explanation
Representation B-1. Applicant will have contracts with related entities, contractors and subcontractors to perform, implement or operate any aspect of the CCO operations for the CCO Contract.	X			YCCO will contract with CareOregon and Mid-Valley Behavioral Care Network to perform CCO operations.
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			YCCO will contract with CareOregon to perform all CCO financial services, contracting with actuaries and auditors as needed to meet CCO requirements.
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			YCCO's affiliates CareOregon and Mid-Valley Behavioral Care Network will contract with other entities if needed to perform all other services necessary under this CCO contract. For example, CareOregon will contract with a pharmacy benefit manager (PBM) to perform administrative services related to prescription drugs.

(Applicant Authorized Officer)
Signature: _____ Title: YCHHS DIRECTOR Date: 7/31/12

Informational Representation	Yes	No	Yes, Qualified	Explanation
Representation B-1. Applicant will have contracts with related entities, contractors and subcontractors to perform, implement or operate any aspect of the CCO operations for the CCO Contract.	X			YCCO will contract with CareOregon and Mid-Valley Behavioral Care Network to perform CCO operations.
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			YCCO will contract with CareOregon to perform all CCO financial services, contracting with actuaries and auditors as needed to meet CCO requirements.
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			YCCO's affiliates CareOregon and Mid-Valley Behavioral Care Network will contract with other entities if needed to perform all other services necessary under this CCO contract. For example, CareOregon will contract with a pharmacy benefit manager (PBM) to perform administrative services related to prescription drugs.

(Applicant Authorized Officer)
Signature: _____ Title: YCHHS DIRECTOR Date: 7/31/12

ATTACHMENT 7 –APPLICATION CHECKLISTS

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

1. **Technical Application, Mandatory Submission Materials**

- ☒ a. Application Cover Sheet (Attachment 1)
- ☒ b. Attestations, Assurances and Representations (Attachment 6).
- ☒ c. This Technical Application Checklist
- ☒ d. Letters of Support from Key Community Stakeholders.
- ☒ e. Résumés for Key Leadership Personnel.
- ☒ f. Organizational Chart.
- ☒ g. Services Area Request (Appendix B).
- h. Questionnaires
  - ☒ (1) CCO Criteria Questionnaire (Appendix A).
  - ☒ (2) Provider Participation and Operations Questionnaire (Appendix B).
  - ☒ (3) Accountability Questionnaire (Appendix C)
    - Services Area Table.
    - Publicly Funded Health Care and Service Programs Table
  - ☒ (4) Medicare/Medicaid Alignment Demonstration Questionnaire (Appendix D).[§]

Responsive ✓
Responsible ✓
5-1-12

2. **Technical Application, Optional Submission Materials**

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

- ☐ a. Transformation Scope Elements (Appendix H).
- ☐ b. Applicant's Designation of Confidential Materials (Attachment 2).

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

July 26, 2012

Re: Letter of Support for Yamhill County Care Organization

To Whom It May Concern:

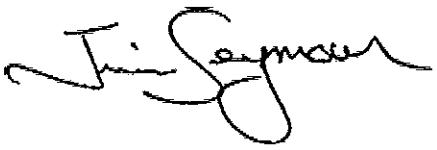
This letter is in support of the formation of Yamhill County Care Organization (YCCO) as a Coordinated Care Organization (CCO). Through coordinated efforts across the county and with partnerships with Care Oregon and Mid-Valley Behavioral Care Network, YCCO has drafted a strong plan to integrate physical, behavioral, and dental health services in our community.

YCCO's goals are in line with the Governor Kitzhaber's policy initiatives to achieve optimum population health, improve health care and realize needed cost-savings. This will initially be accomplished by focusing on quality primary care services and coordinating with systems that provide integrated health services across a spectrum of areas including long-term care. Community health improvement goals will be met by focused intervention and investment in changing social determinants of health and improving health equity across the county.

Most importantly, the providers and community leaders that have been involved in the planning of this CCO have demonstrated a commitment to the health and well-being of the residents of Yamhill County. Although still in its nascent stages, YCCO is a community-owned and community-led organization; all policies and care models will be developed overtime with input from consumers, providers, residents and elected officials at the local level.

The undersigned support the collective efforts and goals of YCCO and are excited to play an active role in the transformation of healthcare delivery models, as well as the entire health system, in Yamhill County.

Sincerely,



Jim Seymour
Executive Director
Catholic Community Services

GEORGE FOX UNIVERSITY

Graduate Department of Clinical Psychology
414 N. Meridian St. V104, Newberg, OR 97132
503.554.2370

July 25, 2012

Re: Letter of Support for Yamhill County Care Organization

To Whom It May Concern:

This letter is in support of the formation of Yamhill County Care Organization (YCCO) as a Coordinated Care Organization (CCO). Through coordinated efforts across the county and with partnerships with CareOregon and Mid-Valley Behavioral Care Network, YCCO has drafted a strong plan to integrate physical, behavioral, and dental health services in our community.

YCCO's goals are in line with the Governor Kitzhaber's policy initiatives to achieve optimum population health, improve health care and realize needed cost-savings. This will initially be accomplished by focusing on quality primary care services and coordinating with systems that provide integrated health services across a spectrum of areas including long-term care. Community health improvement goals will be met by focused intervention and investment in changing social determinants of health and improving health equity across the county.

Most importantly, the providers and community leaders that have been involved in the planning of this CCO have demonstrated a commitment to the health and well being of the residents of Yamhill County. Although still in its nascent stages, YCCO is a community-owned and community-led organization; all policies and care models will be developed overtime with input from consumers, providers, residents and elected officials at the local level.

The undersigned support the collective efforts and goals of YCCO and are excited to play an active role in the transformation of healthcare delivery models, as well as the entire health system, in Yamhill County.

Sincerely,

Mary Peterson

Mary Peterson, PhD, ABPP/CL
George Fox University
Graduate Department of Clinical Psychology
414 N. Meridian St, V104
Newberg, OR 97132
mpeterso@georgefox.edu

PROVIDENCE
Newberg
Medical Center

July 25, 2012

Re: Letter of Support for Yamhill County Care Organization

To Whom It May Concern:

I'm writing to you today to express our support for the formation of Yamhill County Care Organization (YCCO) as a Coordinated Care Organization (CCO). Through coordinated efforts across our county and with partnerships with CareOregon and Mid-Valley Behavioral Care Network; YCCO has drafted a strong plan to integrate physical, behavioral, and dental health services in our community.

I feel the goals of YCCO echo those of Governor Kitzhaber's policy initiatives to achieve optimum population health, improve health care and realize needed cost-savings. This will initially be accomplished by focusing on quality primary care services and coordinating with systems that provide integrated health services across a spectrum of areas including long-term care. Community health improvement goals will be met by focused intervention and investment in changing social determinants of health and improving health equity across the county.

The one thing that makes me proud is that the providers and area leaders that have been involved in the planning of this CCO have demonstrated a commitment to the health and well being of everyone in Yamhill County. While still new, YCCO is a community-owned and community-led organization; all policies and care models will be developed overtime with input from consumers, providers, residents and elected officials at the local level.

Providence is in support of the efforts and goals of YCCO and is excited to play an active role in the transformation of health care delivery models, as well as the entire health system, in Yamhill County.

Sincerely,

Alan C. Olive
Chief Executive
Providence Newberg Medical Center

NWSDS

NorthWest Senior & Disability Services

Formerly Mid-Willamette Valley Senior Services Agency

3410 Cherry Avenue NE • Salem, OR 97303
Mailing Address: PO Box 12189 • Salem, OR 97309-0189
Phone: 503.304.3400 • Fax: 503.304.3434
www.nwsds.org

July 30, 2012

Re: Letter of Support for Yamhill County Care Organization

To Whom It May Concern:

This letter is in support of the formation of Yamhill County Care Organization (YCCO) as a Coordinated Care Organization (CCO).

YCCO's goals are in line with the Governor Kitzhaber's policy initiatives to achieve optimum population health, improve health care and realize needed cost-savings. This will initially be accomplished by focusing on quality primary care services and coordinating with systems that provide integrated health services across a spectrum of areas including long-term care. Community health improvement goals will be met by focused intervention and investment in changing social determinants of health and improving health equity across the county.

Most importantly, the providers and community leaders that have been involved in the planning of this CCO have demonstrated a commitment to the health and well being of the residents of Yamhill County. Although still in its nascent stages, YCCO is a community-owned and community-led organization; all policies and care models will be developed overtime with input from consumers, providers, residents and elected officials at the local level.

The undersigned support the collective efforts and goals of YCCO and are excited to play an active role in the transformation of healthcare delivery models, as well as the entire health system, in Yamhill County.

Sincerely,

Melinda Compton
Executive Director (Program)

Rodney Schroeder
Executive Director (Operations)

WILLAMETTE VALLEY
MEDICAL CENTER

July 25, 2012

Re: Letter of Support for Yamhill County Care Organization

To Whom It May Concern:

This letter is in support of the formation of Yamhill County Care Organization (YCCO) as a Coordinated Care Organization (CCO). Through coordinated efforts across the county and with partnerships with CareOregon and Mid-Valley Behavioral Care Network, YCCO has drafted a strong plan to integrate physical, behavioral, and dental health services in our community.

YCCO's goals are in line with the Governor Kitzhaber's policy initiatives to achieve optimum population health, improve health care and realize needed cost-savings. This will initially be accomplished by focusing on quality primary care services and coordinating with systems that provide integrated health services across a spectrum of areas including long-term care. Community health improvement goals will be met by focused intervention and investment in changing social determinants of health and improving health equity across the county.

Most importantly, the providers and community leaders that have been involved in the planning of this CCO have demonstrated a commitment to the health and well being of the residents of Yamhill County. Although still in its nascent stages, YCCO is a community-owned and community-led organization; all policies and care models will be developed over time with input from consumers, providers, residents and elected officials at the local level.

The undersigned support the collective efforts and goals of YCCO and are excited to play an active role in the transformation of healthcare delivery model, as well as the entire health system, in Yamhill County.

Sincerely,

2700 SE Stratus Avenue McMinnville, Oregon 97128 (P) 503-472-6131 (F) 503-472-8691 www.wvmcweb.com

Advantage Dental Services, LLC
The Advantage Community

July 27, 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 Yamhill County Care Organization'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 Yamhill County Care Organization.

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 Yamhill County Care Organization. Advantage believes that it will best serve the residents of its individual communities through collaborative efforts in developing a CCO. Advantage supports the formation of CCOs to achieve the triple aim and through efficiency and quality improvements reduce medical cost inflation and coordinate health care for each community member by providing the right care, at the right time, in the right place.

Advantage Dental Services, LLC
The Advantage Community

Advantage is excited to be part of this challenging and important work. We look forward to working with Yamhill County Care Organization 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

Capitol Dental Care, Inc.

3000 Market Street Plaza NE, Suite 129 • Salem, OR 97301-1806 • (503) 585-5205 • Fax: (503) 581-0043

July 27, 2012

Tammy L. Hurst, Contract Specialist
Office of Contracts and Procurement
Oregon Health Authority

Dear Mrs. Hurst,

Capitol Dental Care, Inc. (CDC) supports Yamhill County Care Organization (YCCO) as a Coordinated Care Organization serving Yamhill County. We believe that they will be well positioned to support the Triple Aim goals of improved health, enhanced patient care and reduced costs.

We have observed the community support and cooperation of medical, mental health and dental providers at YCCO's organizational meetings. We are impressed with their efforts and the progress that has been made in a short period of time.

CDC has been engaged with providing dental care to Oregon Health Plan members in this area for many years. We remain committed to these members and look forward to working closely with YCCO to enhance their overall health through better coordination of dental care.

Sincerely,

Hart Laws

President

CHURCH ON THE HILL

Jerry Moen, Lead Pastor
Phone: 503.472.8476 / Ext. 227
E-mail: jmoen@hillchurch.com

July 23, 2012

CCO Proposal

To Silas Halloran-Steiner:

We at Church on the Hill and Hope on the Hill (HOTH is our 501 C-3 that deals with purely social outreach issues), have come to understand Yamhill County is in the process of developing a CCO and we have the interest and, we believe, the resources to partner with you. We are a faith based organization that has a long history of meeting the needs of people in Yamhill County and we are poised to greatly expand what we do for our community.

With what we have learned of your pending needs, and as we have analyzed what we currently do and could do in the future, we would like to offer you a good faith gesture to provide any of the following services you would deem helpful to your efforts to be a fully functioning CCO.

IMMEDIATE SERVICES we currently offer and which you could access immediately.

- **Celebrate Recovery.** This is a nationally acclaimed program that helps people get free from a variety of substance & behavioral addictions.
- **The Landing.** This is the Teen Version of Celebrate Recovery.
- **E.D.G.E.** This is a life skills course we have offered for years in this county.
- **Food Pantry.** We feed thousands of people each year, open every week for an integrity filled experience for the hungry in our county.
- **Professional Counseling.** We provide low cost counseling from licensed counselors for those who don't have insurance or can't afford their own counseling in the market place.
- **Computer classes for transitional age youth and adults.** We currently offer computer classes to enhance the life skills we teach in the E.D.G.E. program.
- **Financial Management Courses.** We teach the Financial Peace University (by Dave Ramsey) course regularly to youth, transitional youth, and adults.
- **Mental Health Screenings.** We have multiple licensed counselors who offer mental health screenings and we can open this up to a larger portion of the public.
- **Mentoring Program.** Our congregation has mentors serving in various capacities in this county and we would like to expand the number of our people serving in the county's mentoring program.
- **Children's Wellness Programs.** With our indoor playground, outdoor playground, full gymnasium, climbing wall and play fields, we have all the resources necessary to help kids get, and stay, fit. We offer CrossFit for kids and have experienced martial arts instructors who can add that element for kids as well.

SHORT TERM SERVICES are programs we could create and have operating by the fall of 2012.

- **Youth Housing.** We could collaborate with, or mirror the 'Youth Outreach Housing Program.'
- **Wellness programs for families and/or Children.**
  - **Let's Move program**
  - **We Can program**
  - **Modify our Food Pantry into a faith based grocery store**
  - **Provide counseling groups for kids**
    - Anger management
    - Dialectical Behavior Therapy
    - Art Therapy
    - Anti Pornography groups
    - Personal care / Hygiene groups
    - Grief groups for children / families
  - **Classes for Transitional Age Youth**
    - Meal preparation & Nutrition
    - Personal Financial Management
    - Life & Computer Skills
    - College / Career Planning
  - **Provide CCO Health Navigators**
  - **Parish Nursing program**

LONGER TERM SERVICES are programs we could create and have operating in 6 – 12 months.

- **Crisis Respite.** We have the facilities and the qualified personnel to provide this, as soon as the system can approve us for this service.
- **The Maslow Project.** We have already made contact with the team in Medford OR to start the process of opening up a sister program right here in McMinnville.

We do hope you will contact us in the near future and let us know if any of these services would be a help to you, as you put together this new CCO. This list is by no means exhaustive so if you have a different service you are in need of, please bring it to our attention. If it falls within the vision for our future, and if we believe we can provide it with the excellence (like we believe we can do with everything included in this letter) it deserves, we will tackle it for you.

I look forward to your response and if it would be a help to you, please feel free to call, write or email, with any questions you may have. To be of further service to you, I'll call you in a few days to make sure you received this letter.

Sincerely looking forward to serving you,

Jerry Moen

Pastor Jerry Moen

THE ODS COMPANIES
FOR INSURANCE & BUSINESS SERVICES

July 25, 2012

Re: Letter of Support for Yamhill County Care Organization

To Whom It May Concern:

This letter is in support of the formation of Yamhill County Care Organization (YCCO) as a Coordinated Care Organization (CCO). Through coordinated efforts across the county and with partnerships with CareOregon and Mid-Valley Behavioral Care Network, YCCO has drafted a strong plan to integrate physical, behavioral, and dental health services in our community.

YCCO's goals are in line with the Governor Kitzhaber's policy initiatives to achieve optimum population health, improve health care and realize needed cost-savings. This will initially be accomplished by focusing on quality primary care services and coordinating with systems that provide integrated health services across a spectrum of areas including long-term care. Community health improvement goals will be met by focused intervention and investment in changing social determinants of health and improving health equity across the county.

Most importantly, the providers and community leaders that have been involved in the planning of this CCO have demonstrated a commitment to the health and well being of the residents of Yamhill County. Although still in its nascent stages, YCCO is a community-owned and community-led organization; all policies and care models will be developed overtime with input from consumers, providers, residents and elected officials at the local level.

The undersigned support the collective efforts and goals of YCCO and are excited to play an active role in the transformation of healthcare delivery models, as well as the entire health system, in Yamhill County.

Sincerely,

William S. Ten Pas
Sr. VP and President ODS

Oregon Dental Service Dental Insurance
–
ODS Health Plan, Inc. Medical Insurance
–
Dentists Benefits Insurance Company Insurance And Risk Management For Dentists
–
Dentists Benefits Corporation Insurance Solutions For Dentists
–
DAISY (Dentists Management Corporation) Dental Practice Management Software And Business Services
–
BenefitHelp Solutions Benefits Administration
–
The ODS Companies
ODS Tower
601 S.W. Second Ave.
Portland, OR 97204-3156
Phone 503.22[illegible]8402
www.odscompanies.com

BOARD OF COUNTY COMMISSIONERS

KATHY GEORGE • LESLIE LEWIS • MARY P. STERN

535 NE Fifth Street • McMinnville, OR 97128-4523
(503) 434-7501 • Fax (503) 434-7553
TTY (800) 735-2900 • www. co.yamhill.or.us

June 27, 2012

Re: Second Revised CCO Letter of Intent to Apply for Yamhill County Region

Dear Sir/Madam:

The undersigned hereby express their intent to form a Coordinated Care Organization pursuant to HB 3650, SB 1580 and applicable Oregon Revised Statute. This letter constitutes the "CCO Letter of Intent to Apply" as described in Request for Applications for Continuing Care Organizations #3402 as issued by the Oregon Health Authority on March 19, 2012 ("RFA #3402").

1. ***What is Applicant's Legal Entity name, Oregon headquarters location, and key contact person?***

The legal entity for Applicant's CCO has not yet been formed but is in the planning stages. The current working name of the Applicant is "Yamhill County Care Organization" (referred to herein as "YCCO"), to be headquartered in Yamhill County, Oregon. For purposes of this Letter of Intent to Apply the key contact person is Silas Halloran-Steiner, Yamhill County Health and Human Services Director. Contact information:

627 NE Evans
McMinnville, OR 97128
Phone: (503) 434-7523
halloras@co.yamhill.or.us

2. *What is the Applicant's desired service area by county or zip code?*

YCCO service areas will include all cities and zip codes within Yamhill County, and include the surrounding communities where clients typically seek services within Yamhill County. These include the following: 97101, 97111, 97114, 97115, 97119, 97127, 97123, 97128, 97132, 97137, 97140, 97148, 97304, 97347, 97371, 97378, 97338, 97071, 97002, 97026 and 97396.

3. *Who are the Applicant's key potential Affiliates or sponsoring organizations, if known?*

Any existing Fully Capitated Health Plan (FCHP), Mental Health Organization (MHO) and Dental Care Organization (DCO) with members in the YCCO service areas will be considered as collaborative partners and possibly affiliate organizations. Additionally, YCCO anticipates working closely with the State's Division of Medical Assistance Programs (DMAP) on strategies to immediately enroll all Open Card members, as well as any other FCHP & MHO members into the YCCO. DCO members will be enrolled when required under HB 3650 and SB 1580 or sooner if mutually agreed upon by YCCO and any affiliate DCO.

Named partner, infrastructure or provider agencies and individuals are listed immediately below. Note: Signature by Applicant's sponsor at the end of this document indicates full consent and plan to participate in the YCCO by these named partners and provider agencies:

Advantage Dental: Mike Shirtcliff
Capitol Dental: Hart Laws
CareOregon: Dave Ford
Catholic Community Services: Jim Seymour
Chehalem Medical Clinic: Dr. William Bailey
Chehalem Youth and Family Services: Deborah Cathers-Seymour
George Fox University: Mary Peterson
Lutheran Community Services NorthWest: Jordan Robinson
McMinnville Physicians Organization: Dr. Michael Jaczko
Mid-Valley Behavioral Care Network: Jim Russell
NorthWest Senior and Disability Services: Rodney Schroeder
Physicians Medical Center: Dennis Gray
Providence Health Plan: Stephanie Dreyfuss, or designee
Providence Newberg Medical Center and Medical Staff: Alan Olive
Virginia Garcia Memorial Health Center: Gil Munoz
Willamette Valley Medical Center: Daniel Ordyna
Willamette Valley Provider Health Authority & Marion Polk Community Health Plan: Dean Andretta
Yamhill County Dental Society: Dr. Mark Miller
Yamhill County Health and Human Services: Silas Halloran Steiner
Yamhill County Elected Officials & Citizens

4. ***What is the Applicant's desired member capacity? If the Applicant desires to have no limit on capacity, so state.***

YCCO desires to have no limit on member capacity.

5. ***Does the Applicant or an Affiliate or intended subcontractor of the Applicant have a contract with the Oregon Health Authority as a Medicaid managed care organization (MCO)? If so, does Applicant expect that contract to be terminated immediately before the effective date of Applicant's CCO Contract?***

YCCO expects to terminate the Mental Health Organization (MHO) and Fully Capitated Health Plan (FCHP) contracts for all persons enrolled in YCCO immediately before the effective date of YCCO's contract.

6. ***Is the Applicant, or an Affiliate or intended subcontractor of the Applicant, licensed or expected to be licensed as an insurer (including health care service contractor) with the Oregon Insurance Division?***

One or more of the possible affiliates has a license as an insurer with the Oregon Insurance Division.

7. ***Does the Applicant, or an Affiliate or an intended subcontractor of the Applicant, have or expect to have a contract as a Medicare Advantage Plan with the Center for Medicare and Medicaid Services (CMS)?***

Several of the potential affiliates operate Medicare Advantage Plans. YCCO intends to work with these affiliates to achieve Medicare coverage in Yamhill County.

8. ***Which of the four possible Application deadlines described in RFA #3402, Attachment 3, does the Applicant elect for submitting its Technical and Financial Applications? Choose one pair.***

YCCO indicated in our original April 2, 2012 LOI its intent to submit the Technical Application by August 1, 2012 and the Financial Application by August 8, 2012. The YCCO Steering Committee met on May 21, 2012 and decided to move to Wave 3. A formal amendment was submitted effective 5/25/12. As of this date, YCCO is amending the LOI to move us back to Wave 4 and using the dates as follows: Technical Application by August 1, 2012 and Financial Application by August 8, 2012.

9. ***Does the Applicant intend to submit a Medicare Notice of Intent to Apply to CMS? If so, please provide a copy to CMS.***

Yes. However, YCCO may also choose to partner with one of our affiliates who has also submitted a Medicare Notice of Intent to Apply to CMS.

The Applicant acknowledges that this Letter of Intent to Apply is non-binding, except that OHA will consider this Letter of Intent to Apply will remain in effect and OHA may rely on it until the Applicant changes or withdraws it in accordance with the RFA. The Applicant will submit Technical and Financial Applications on the dates set forth in this Letter of Intent to Apply, unless Applicant submits to OHA changes to this Letter of Intent to Apply. The Applicant understands this Letter of Intent to Apply will be made public.

YAMHILL COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES

Silas Halloran-Steiner, Director

July 25, 2012

Re: Letter of Support for Yamhill County Care Organization

To Whom It May Concern:

This letter is in support of the formation of Yamhill County Care Organization (YCCO) as a Coordinated Care Organization (CCO). Through coordinated efforts across the county and with partnerships with CareOregon and Mid-Valley Behavioral Care Network, YCCO has drafted a strong plan to integrate physical, behavioral, and dental health services in our community.

YCCO's goals are in line with the Governor Kitzhaber's policy initiatives to achieve optimum population health, improve health care and realize needed cost-savings. This will initially be accomplished by focusing on quality primary care services and coordinating with systems that provide integrated health services across a spectrum of areas including long-term care. Community health improvement goals will be met by focused intervention and investment in changing social determinants of health and improving health equity across the county.

Most importantly, the providers and community leaders that have been involved in the planning of this CCO have demonstrated a commitment to the health and well being of the residents of Yamhill County. Although still in its nascent stages, YCCO is a community-owned and community-led organization; all policies and care models will be developed overtime with input from consumers, providers, residents and elected officials at the local level.

The undersigned support the collective efforts and goals of YCCO and are excited to play an active role in the transformation of healthcare delivery models, as well as the entire health system, in Yamhill County.

Sincerely,

Lin Hollan Lim, Yamhill County HHS Director
Capitol Dental Care, Inc.
for Jim Russell, Mid-Valley Behavioral Care Network
, Virginia Garcia Memorial Health Center
Providence Medical Group, Oregon
Physicians Medical Center PC
, Yamhill County Commissioner
, Providence Newberg Medical Center
, McMinnville Physicians Organization
Advantage Dental, for Letters of Support, MD
Yamhill Co. HHS Provider Relations

Lutheran Community Services
Northwest
Health • Justice • Hope

617 NE Davis St.
McMinnville, OR 97128
Phone: 503) 472-4020
Fax: (503) 472-8630

July 25, 2012

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The undersigned support the collective efforts and goals of YCCO and are excited to play an active role in the transformation of healthcare delivery models, as well as the entire health system, in Yamhill County.

Sincerely,

Jordan Robinson, MSW
Community Director
Lutheran Community Services

SILAS J. HALLORAN-STEINER

17504 SW Masonville Rd, McMinnville, OR 97128 // 503.435.7572 // halloras@co.yamhill.or.us

EDUCATION & CERTIFICATIONS

M.S.W.	Yeshiva University, NY
B.A. in Cultural Studies & Education	New School University, NY
Certified Alcohol and Drug Counselor III	ACCBO*, OR
Public Health Leadership Certificate	University of North Carolina, NC

PROFESSIONAL EXPERIENCE

Director, Health and Human Services — **Yamhill County**
6/2010 – present — McMinnville, OR

- Serve as Community Mental Health Program Director and Public Health Administrator.
- Administer fiscal and program operations for an approximately $20,000,000 annual budget.
- Lead a team of nine division managers with supervisory authority over 163 full time equivalent (FTE) staff.
- Oversee the development of intergovernmental agreements and departmental contracts.
- Work closely with internal and external collaborative partners and community members.
- Obtain grants from appropriate funding sources and manage grant expenditures.
- Review and interpret pending legislation, statutes and administrative rules.
- Manage the recruitment, training and retention of department staff.
- Perform public relations activities to provide information to the community.

Program Supervisor — **Yamhill Co. Corrections**
3/2007 – 5/2010 — McMinnville, OR

- Supervised a staff of 13 adult Parole and Probation Officers in an office of nearly 40 FTE.
- Worked as a certified Parole and Probation Officer when covering for staff.
- Charged with implementation of program services, evaluation and training.
- Developed procedures and policies.
- Led criminal justice system evidence-based practices program development.
- Collaborated with local stakeholders, county and state agencies to ensure positive outcomes.
- Monitored contracts with treatment providers and other contracted services.
- Administered collaborative grants.

Program Director — **Cascadia Behavioral Healthcare**
9/2005 – 3/2007 — Portland, OR

- Directed multiple community-based programs for adults who committed crimes and pled Guilty Except for Insanity and were discharged from the Oregon State Hospital under the jurisdiction of the Psychiatric Security Review Board (PSRB).
- Prepared and monitored an annual fiscal budget of approximately $3,000,000.
- Managed 40 FTE in a variety of clinical and administrative capacities.
- Developed recovery-oriented programs and evaluated progress towards goals.
- Utilized a continuum of services in order to effectively meet the needs of individual clients.
- Complied with Oregon Administrative Rules; audits for residential and outpatient licensure.
- Designed and implemented an innovative intensive case management program.
- Worked closely with diverse stakeholders, concerned citizens and consumers to site services.

*Addiction Counselor Certification Board of Oregon (ACCBO)

Program Manager II — **Cascadia Behavioral Healthcare**
8/2004 – 9/2005 — Portland, OR

- Oversaw clinical and program development for a ten bed mental health and addictions treatment facility called Residential Integrated Treatment Services (RITS).
- Managed the Corrections Services Program, a sixty person intensive outpatient program serving high need adults with mental health, addictions and developmental disabilities issues.
- Collaborated with Department of Community Justice administrators to ensure compliance with contractual requirements and effective service delivery.
- Prepared an annual budget of $750,000 and monitored revenue and expenditures.

Program Supervisor — **Cascadia Behavioral Healthcare**
1/2004 – 8/2004 — Portland, OR

- Guided onsite clinical and program operations for the RITS program.
- Provided clinical and administrative supervision of employees and training to improve knowledge, skills and attitudes among the direct service providers.

Mental Health Case Coordinator — **Cascadia Behavioral Healthcare**
8/2003 – 1/2004 — Portland, OR

- Provided case management services for high need severe and persistently mentally ill adults with chemical dependency issues, developmental disabilities and traumatic brain injuries.
- Completed biopsychosocial assessments, intake paperwork, progress notes, treatment plans, and discharge summaries to address goals, strengths, diagnoses and track progress.

Lead Wilderness Guide & Chemical Dependency Counselor — **Catherine Freer Wilderness Therapy Expeditions**
6/1998 – 6/2003 — Albany, OR

- Expedition leader and counselor for a state-licensed and Joint Commission on the Accreditation for Healthcare Organizations certified treatment program for 13 to 18 year-olds who participate in 21-day wilderness treks year round in the Pacific Northwest.
- Led individual and group therapy sessions, facilitated psycho-educational groups, implemented detailed treatment plans and completed behavioral health assessments with American Society for Addiction Medicine Patient Placement Criteria (2nd edition revised).

Men's Basketball Coach & After-School Athletic Coordinator — **Academy for Peace and Justice El Puente Community Center**
9/1996 – 5/1998 — Brooklyn, NY

- Developed programming within an after-school athletic program for a public alternative high school for African American, Caribbean American and Latin American youth.
- Coached young people of diverse ethnic, cultural and familial backgrounds towards success.

HONORS

- Faculty Award for Outstanding Scholarship: Yeshiva University, NY
- Samuel L. Golding M.S.W. Fellowship Recipient: Yeshiva University, NY
- Dr. Ernest M. Ogard Jr. Award for Outstanding Scholastic Achievement: DPSST, OR**
- Award for Outstanding Health and Fitness: DPSST, OR

**Department of Public Safety Standards and Training (DPSST)

James D. Russell
1046 Judson Street SE
Salem, Oregon 97302
(503) 588-7170

PROFESSIONAL EXPERIENCE

EXECUTIVE MANAGER

Mid-Valley Behavioral Care Network -- September 1997 to present
1660 Oak Street SE, Suite #230, Salem, Oregon 97301

I provide executive leadership for the Mid Valley Behavioral Care Network, a five county, public / private network of behavioral healthcare providers that contracts for managed care services. I am responsible for strategic and business planning, marketing and business relationships, oversight of operations and staff, preparation and oversight of $70M budget, and the service quality performance of contracting organizations. Chair of Board of Directors: Kathy George (Yamhill County Commissioner)

DEVELOPMENT AND CONTRACTS COORDINATOR

Marion County Health Department -- July 1994 to September 1997
3180 Center Street NE, Salem, Oregon 97301-4592

I provided technical support for the Mid Valley Behavioral Care Network, then a four county, public / private network of behavioral healthcare providers that contracted for managed care services.

As Contracts Coordinator I coordinated the contracting of services provided by other agencies under contract with the MCHD: writing Requests for Proposals, participating in contractor selection, negotiating fiscal and performance requirements, drafting contract language, developing protocols for and conducting on site evaluation of contractors' administrative rule compliance and program performance and providing technical assistance for program development and quality improvement. Supervisor: Ruth Johnson

PROGRAM SUPERVISOR

Marion County Health Department -- December 1990 through June 1994

I led the adult mental health programs (approximately 40 staff and a $3 M budget) and oversaw the contracted services (residential and in-patient, $2 M budget); led the development of new programs, wrote and administered program procedures and policies, managed daily operations through the supervision of clinical supervisors, and evaluated program performance information. Supervisor: Margaret Nallia

MENTAL HEALTH MANAGER

Polk County Mental Health Program -- September 1988 to December 1990
182 S.W. Academy Street, Dallas, Oregon 97338

As Mental Health Manager I directed mental health, chemical dependency and developmental disability case management services. I wrote biennial plans (describing community service needs, proposing service priorities and objectives) for state division approval and funding for these services. I directly hired and supervised the clinical and support staff. I recruited and staffed a Mental Health Advisory Committee. I prepared a $3 M annual budget and guided it through the county Budget Committee approval process. Supervisor: Donna Middleton

COMMUNITY TREATMENT TEAM LEADER

Larimer County Mental Health Center -- June 1982 to September 1988
525 West Oak Street, Fort Collins, Colorado 80521

I developed and administered a comprehensive program for adults with serious and persistent mental illness. I supervised twenty people who provided psychotherapeutic, vocational and residential services. I directly provided clinical individual and group services, at the mental health clinic and on the inpatient unit of the local hospital. Supervisors: Harold Frontz, Jack Reid

GERIATRIC TEAM LEADER

Larimer County Mental Health Center -- September 1980 to June 1982, Fort Collins, Colorado

I developed and conducted a community mental health program for older adults including a peer counseling program and a volunteer Outreach to the Isolated Elderly program. I provided ongoing training and support for these volunteers and supervised the peer counselors. I directly provided individual and group counseling at the clinic, in nursing homes and at an inpatient hospital unit. Supervisor: Jack Reid

SOCIAL SERVICE SUPERVISOR

Larimer County Department of Social Services -- March 1970 to January 1972 and November 1977 to July 1979, Fort Collins, Colorado

As a Social Service Supervisor I directed child welfare services including protective services, in-home parent support, foster care and adoptive home placement and supervision. Supervisor: Kathleen Winder

EDUCATION

Irondequoit High School Diploma
Irondequoit, New York – June 1963

Bachelor of Science, Electrical Engineering
Purdue University - West Lafayette, Indiana – June 1967

Master of Social Work
University of Michigan - Ann Arbor, Michigan – May 1969

Patrick J. Curran
(503) 416-1421
curranp@careoregon.org

EXPERIENCE

Director of Business Integration and Medicare – CareOregon (2006 - Present)

Responsible for the following functional areas: provider relations and contracting, communications, sales and marketing, business development, and activities related to operation of Medicare Advantage program. Serve as leader of senior management meetings, as well as involvement in the annual business planning process. Work with CareOregon departments to coordinate operations, member satisfaction, and compliance with state and federal requirements. For the Medicare Advantage program, led the team to add a new benefit plan, expand the service area, grow the plan 40%, and pass a CMS audit, while attaining profitability in each of the plan's first six years (2006-11).

Provider Services Director – CareOregon (2003 – 2006)

Responsible for team that performed all contracting and service-related activities for more than 4,000 providers in statewide Medicaid health plan serving more than 100,000 enrollees. Participated in senior management team that is responsible for strategic planning. Developed provider satisfaction survey to measure team performance, and deployed enhanced online resources. Designed, implemented, and managed grant program for provider-based projects that encourage health system innovation. Responsible for all provider agreement contract language and financial analysis.

President – Physician Resource Northwest, LLC (2001 – 2003)

Managed all activities for health care service company with revenue of $600,000. Wrote the business plan that created PRN and led company through significant transition in 2001-2002 while maintaining profitability. Managed teams in diverse areas such as claims and customer service, information technology, regulatory compliance, web development, and financial analysis. Developed a program that measures customer satisfaction and tied results to the staff incentive plan.

Vice President, Provider Services – Pacific Medical Group (1999-2001)

Performed senior management duties for management services organization (MSO). Administered all contractual relationships with health plans, MSO customers, vendors, and physicians. Led several departments: information resources, healthcare analysis, utilization management, provider affairs, customer service, and claims.

Director of Contracting – MedPartners NW Region (1996-99)

Coordinated plan and provider contracting in a four-state area (OR, ID, WA, CA) on behalf of multiple medical groups and IPAs. Duties focused on financial analysis of complex risk arrangements, contract language review, and direct negotiations. Educated affiliated medical groups in all aspects of managed care, government program compliance and regulations, and clinic financial performance.

Director/Senior Coordinator of Provider Relations – MedPartners (1994-96)

Participated in and then led the Provider Relations team that was responsible for provider network contracting and IPA operations in the northern California region. Worked closely with physician-led regional committees to implement effective reimbursement and risk arrangements. Increased network from 800 to over 1,900 providers and grew managed care enrollment from 30,000 to more than 50,000 enrollees.

Independent Consulting, Menlo Park, CA (1993-94)

Developed managed care outpatient rehabilitation programs throughout northern California for TheraCare, Inc.

Corporate Networks Manager – Community Care Network (1990-92)
Established provider networks in ten states over a two-year period. Duties emphasized employee hiring and training, coordinating physician recruitment, budgeting, and negotiating contracts. Also served as company lead for physician reimbursement and contract issues.

Physician Services Coordinator – Community Care Network (1988-90)
Led a team that developed and managed a preferred physician network throughout California. Performed all fee schedule analysis and implemented local physician credential committees. Also marketed program to employer groups and business coalitions.

Planning and Development Coordinator – San Diego Foundation for Medical Care (1986-88)
Developed and operated two programs for this provider-based preferred provider organization: (1) the first fully capitated IPA in San Diego County; and (2) a Champus referral network for military dependents throughout California.

DEGREES

UNIVERSITY OF SANTA CLARA, Santa Clara, CA 1980-84
Bachelor of Science in Combined Science, June 1984

SAN DIEGO STATE UNIVERSITY, San Diego, CA 1984-86
Master of Public Health in Health Services Administration, May 1986
Thesis Subject: The Effect of Prepaid Revenue on Medical Group Income Distribution

SELECTED PUBLICATIONS

- Curran P, "*Financial risk for physicians: what's next?*" Aon Healthline 2003 July: 7-8.
- Curran P, "*Quick tip: Build a solid foundation to improve performance and achieve organizational change*," MGMA e-Connexion 2002 December.
- Curran P, "*Give and take: negotiation in health plan contracting*," MGMA Connexion 2002 Sept: 50-53.
- Curran P, "*Don't be demoralized...analyze: examine revenue to improve your health plan contracting efforts*," MGMA Connexion 2002 April: 40-43.
- Curran P, "*The ABCs of RVUs: what you need to know about today's payment methodology*," MGMA Connexion 2001 Sept: 53-59.
- Curran P, "*Defined contribution programs: how physicians and medical groups can prepare now for their impact*," MGM Journal 2001 Jul-Aug: 14-22. *(*Note: Selected as a semi-finalist for the 2001 Article of the Year Award.)*
- Williams SJ et al, "*Epidemiologists in the United States: an assessment of the current supply and the anticipated need*," American Journal of Preventive Medicine 1988 Jul-Aug: 231-8. Served as co-author.

ACTIVITIES/PERSONAL

- Board Member, Association of Community Affiliated Plans (ACAP)
- Volunteer, Oregon Food Bank
- Member, Clackamas County Community Health Council (2005-2008)
- Member, Oregon Masters Swimming
- Volunteer coach, soccer and basketball

DENNIS D. GRAY
254 NE Norton Ln
McMinnville OR 97128
(503) 435-2905 (Home)
(503) 434-8285 (Office)

PROFESSIONAL EXPERIENCE

PHYSICIANS MEDICAL CENTER, McMinnville, Oregon 2001-Current

Administrator

Responsible for the Clinical, Operational, and Financial success of a 15 physician multispecialty group practice. Plan, develop, and implement all phases of operations, finance, accounting, and marketing involving Family Practice, Internal Medicine, Pediatrics, and General Surgery

SOUTHWEST HEALTH SYSTEMS, Cortez, Colorado 1997- 2001

Director of Physician and Ambulatory Services

Responsible for the coordination of Orthopedic Clinic, Rural Health Physician Practice, Physical Therapy, Occupational Therapy, Speech Therapy, Audiology, Medical Imaging, Laboratory, Owned Clinics, Cardio Pulmonary, and Cardiac Rehabilitation Departments. Worked towards developing an Outpatient team focus in preparation for APC's

Executive Director, MSO

Responsible for the development of a hospital owned MSO and operation of 6 hospital owned medical clinics. Coordinated the operations of an Orthopedic, Urological, Internal Medicine, and Family Practice offices through the creation of an MSO focusing on operational and billing efficiencies. Experience with rural health clinics and 24-hour emergency services.

EMERGICARE MEDICAL CENTERS, Colorado Springs, Colorado 1991 - 1997

Administrator

Responsible for the operation of 4 (four) medical clinics and 2 (two) Physical Therapy Clinics in Colorado Springs and Pueblo Colorados. Planned, developed, and implemented all phases of operations, finance, and marketing in the following areas: Family Practice, Occupational Medicine, Urgent Care, Physical/Occupational Therapy centers, psychological Counseling, Neurological and Orthopedic specialists, and Chiropractic.

UNIVERSITY OF PHOENIX, Colorado Springs & Portland

Instructor 1996 - 2010

NATIONAL AMERICAN UNIVERSITY, Colorado Springs, Colorado

Instructor 1991 - 1997

EDUCATION

CMPE – Board Certified Medical Group Manager – American College of Medical Practice Exec. 2002
M.B.A. Business Administration, University of Wyoming, Laramie, Wyoming 1990
B.S. Management Information Systems, University of Northern Colorado, Greeley Colorado 1987

Continuing Education

JCAHO Ambulatory Accreditation	1998
Issues in Cost Accounting - University of Colorado	1995
Outcomes Measurement - MGMA	1994
Cost Management - MGMA	1994
Issues For Small Group Practices - MGMA	1993
The Dale Carnegie Course	1992

Professional/Community Involvement

Junior Achievement, Project Business Consultant
President, Graduate Business Council
Medical Group Managers Association
Select Provider Advisory Council - Colorado Compensation Insurance Authority
Cub Master - Boy Scouts of America

James S. Rickards, MD
1266 NW Countryside Ct. McMinnville, OR 97128
773-793-8074 rickards33@yahoo.com

Employment

2008- Current	**Managing Partner - Physician Radiologist** McMinnville Imaging Associates Willamette Valley Medical Center	McMinnville, OR

Professional Service Organizations

2012	**McMinnville Physician Organization** Trustee	

Education

2012- Present	**Oregon Health Sciences/Portland State University** Health Care MBA	Portland, OR
2007-2008	**Rush Medical University** MRI Predominant Body Imaging Fellowship	Chicago, IL
2003- 2007	**Cook County Hospital, John H. Stroger, Jr.** *Chief Resident* Diagnostic Radiology Residency	Chicago, IL
2002-2003	**Swedish Covenant Hospital** Transitional Year Internship	Chicago, IL
1998-2002	**Indiana University School of Medicine** Doctor of Medicine	Indianapolis, IN
1993-1997	**Indiana University** *Magna Cum Laude*, Bachelor of Science Biology	Bloomington, IN

Board Certifications & Medical Licenses
American Board of Radiology - Board Certified 2007
Indiana State Medical Board Licensed Physician
Oregon State Medical Board Licensed Physician
Michigan State Medical Board Licensed Physician
Nevada State Medical Board Licensed Physician

Academic Appointments

2007-2008	**Rush Medical University** Clinical Instructor of Radiology	Chicago, IL
2010- Current	**Western University of Health Sciences** Clinical Assistant Professor of Radiology	McMinnville, OR

Professional Organizations

American College of Radiology - Member
American Roentgen Ray Society - Member
Radiology Society of North America - Member
Radiology Business Management Association - Member

Hospital Committees

2010	Trauma Committee - Willamette Valley Medical Center
2008-10	Cancer Center Committee - Willamette Valley Medical Center
2010 -12	Professional Practice Evaluation Committee - Willamette Valley Medical
2011-12	Quality Council - Willamette Valley Medical Center
2011-12	Health Information Management - Willamette Valley Medical Center

Gil M. Muñoz, M.P.A.

P.O. Box 568
Cornelius, OR 97113
(503) 359-8503
gmunoz@vgmhc.org

WORK EXPERIENCE

VIRGINIA GARCIA MEMORIAL HEALTH CENTER, Cornelius, OR

Chief Executive Officer: Current Position 4/01 to Present

- Work with the Board of Directors to develop and carry out Center's mission and goals;
- Serve as the Center's Chief Executive Officer;
- Develop and promote relationships with other health providers, community and government agencies, private funding organizations, and the community at large.

Highlights:

Over 17 years experience in management of Federally Qualified Health Centers.
Successful program development to include: Dental Program, 1997
Successfully managed 4,400 sqft. facility development for Dental/Vision program. 1999
Successful development of VG Healthy Start OB program in Hillsboro, 1999
Successful new access point development primary care in Hillsboro, 2002
Successful new access point development primary care in Beaverton, 2004
Development of Behavioral Health Integration with Primary Care, 2005
New facility expansion in Hillsboro and McMinnville Clinics, 2006
Successful development of VG Pharmacy, 2003 currently expanded to four sites, 2007
New facility expansion in Cornelius Clinic – Wellness Center, 2011

Associations:

Oregon Primary Care Association, Past Board President
CareOregon Board of Directors, Member
Oregon Community Health Information Network Board of Directors, Member
Oregon Health Council, Member (2001-2003)
Tuality Hospital Board Member
Northwest Regional Primary Care Association, Board President
Virginia Garcia Memorial Foundation, Board Member
Quality and Transparency Work Group, Subcommittee of Oregon Health Fund Board, 2008

EDUCATION

LEWIS & CLARK COLLEGE, Portland, Oregon

- Masters in Public Administration August 95

- State & Local Govt.
- Administration in Government
- Administrative Law
- Research Methodology
- Policy Analysis
- Library/Research Skills
- Grantwriting
- Organizational Development
- Nonprofit Administration

UNIVERSITY OF MARYLAND

- B.A. Economics December 1984

Other Work Experience:

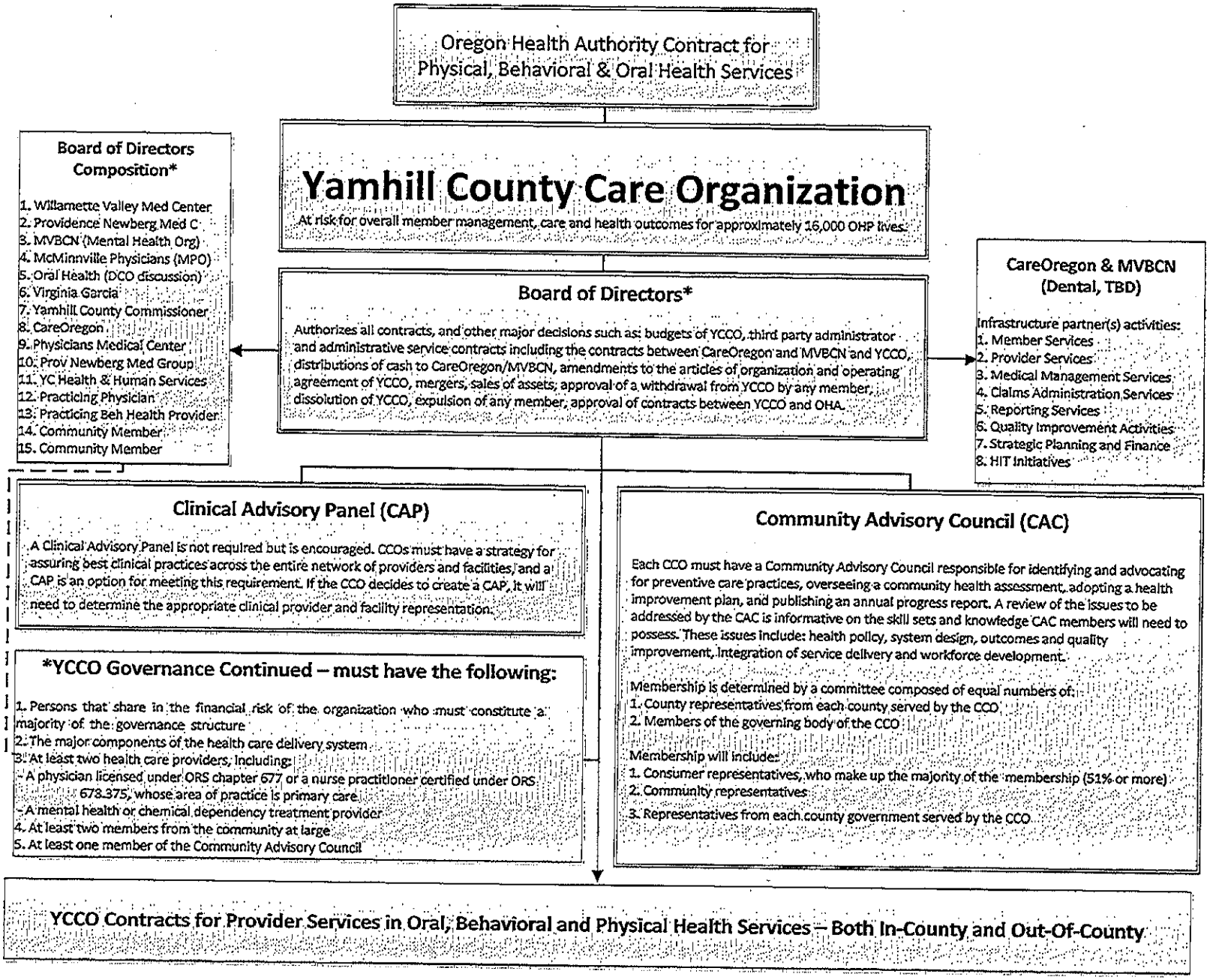
POLICY ALTERNATIVES FOR CARIBBEAN AND CENTRAL AMERICA (PACCA)
Washington, D.C. February 1990 to December 1990

- Project Coordinator, Guatemala Internal Refugee Research Project
- Coordinator of educational projects
- Production of briefing packets on Central American issues for editorial staff

CASA ALIANZA PROGRAMS DE LA CIUDAD DE GUATEMALA
Guatemala City, October 1987 to October 1989

- Counselor/Educator
- Street Outreach staff
- Program development/design
- Presenter to community groups on needs of homeless youth

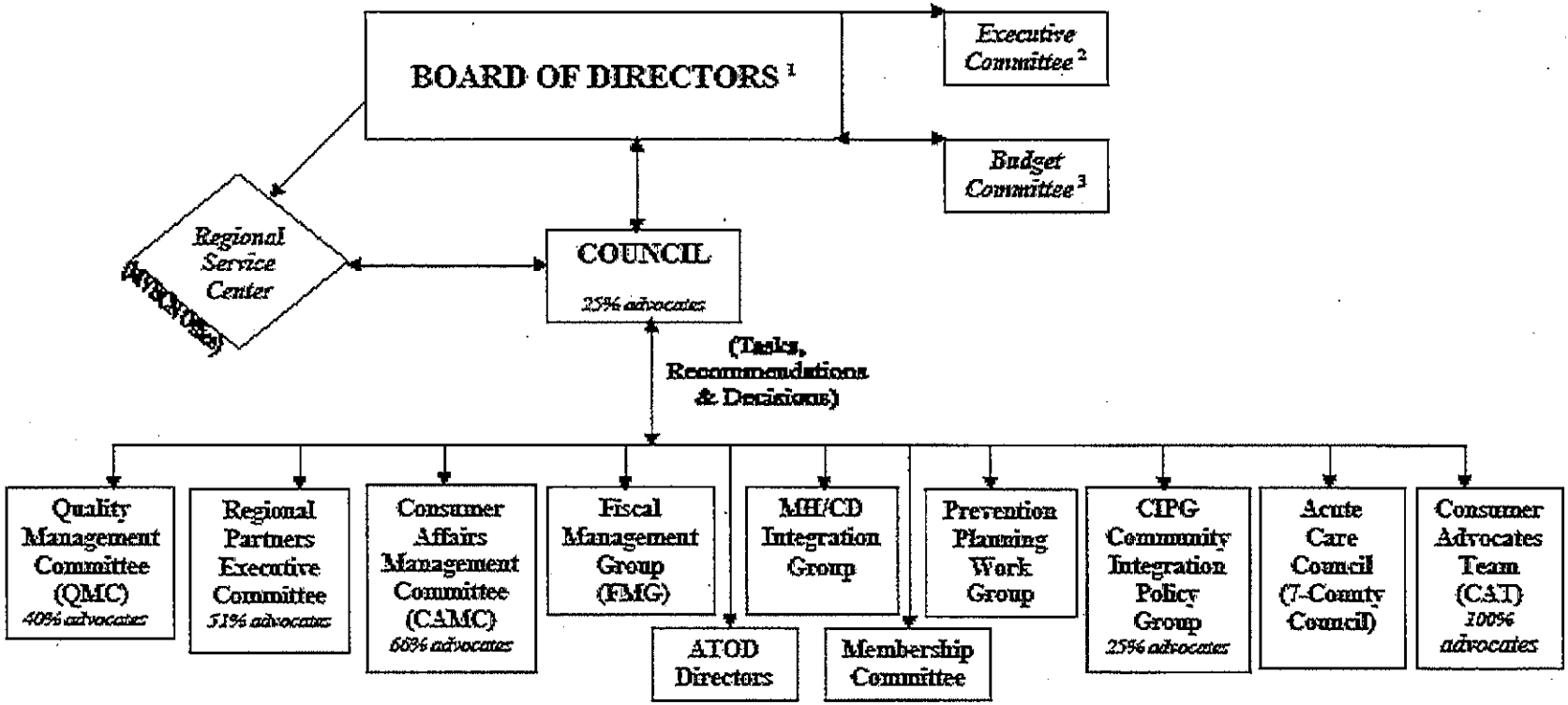
Developed literacy and outreach programs for street youth in Guatemala City.


Oregon Health Authority Contract for Physical, Behavioral & Oral Health Services
Yamhill County Care Organization
At risk for overall member management, care and health outcomes for approximately 16,000 OHP lives.
Board of Directors Composition*
1. Willamette Valley Med Center
2. Providence Newberg Med C
3. MVBCN (Mental Health Org)
4. McMinnville Physicians (MPO)
5. Oral Health (DCO discussion)
6. Virginia Garcia
7. Yamhill County Commissioner
8. CareOregon
9. Physicians Medical Center
10. Prov Newberg Med Group
11. YC Health & Human Services
12. Practicing Physician
13. Practicing Beh Health Provider
14. Community Member
15. Community Member
Board of Directors*
Authorizes all contracts, and other major decisions such as: budgets of YCCO, third party administrator and administrative service contracts including the contracts between CareOregon and MVBCN and YCCO, distributions of cash to CareOregon/MVBCN, amendments to the articles of organization and operating agreement of YCCO, mergers, sales of assets, approval of a withdrawal from YCCO by any member, dissolution of YCCO, expulsion of any member, approval of contracts between YCCO and OHA.
CareOregon & MVBCN (Dental, TBD)
Infrastructure partner(s) activities:
1. Member Services
2. Provider Services
3. Medical Management Services
4. Claims Administration Services
5. Reporting Services
6. Quality Improvement Activities
7. Strategic Planning and Finance
8. HIT Initiatives
Clinical Advisory Panel (CAP)
A Clinical Advisory Panel is not required but is encouraged. CCOs must have a strategy for assuring best clinical practices across the entire network of providers and facilities, and a CAP is an option for meeting this requirement. If the CCO decides to create a CAP, it will need to determine the appropriate clinical provider and facility representation.
Community Advisory Council (CAC)
Each CCO must have a Community Advisory Council responsible for identifying and advocating for preventive care practices, overseeing a community health assessment, adopting a health improvement plan, and publishing an annual progress report. A review of the issues to be addressed by the CAC is informative on the skill sets and knowledge CAC members will need to possess. These issues include: health policy, system design, outcomes and quality improvement, integration of service delivery and workforce development.
Membership is determined by a committee composed of equal numbers of:
1. County representatives from each county served by the CCO
2. Members of the governing body of the CCO
Membership will include:
1. Consumer representatives, who make up the majority of the membership (51% or more)
2. Community representatives
3. Representatives from each county government served by the CCO
*YCCO Governance Continued – must have the following:
1. Persons that share in the financial risk of the organization who must constitute a majority of the governance structure
2. The major components of the health care delivery system
3. At least two health care providers, including:
- A physician licensed under ORS chapter 677 or a nurse practitioner certified under ORS 678.375, whose area of practice is primary care
- A mental health or chemical dependency treatment provider
4. At least two members from the community at large
5. At least one member of the Community Advisory Council
YCCO Contracts for Provider Services in Oral, Behavioral and Physical Health Services – Both In-County and Out-Of-County

Mid-Valley Behavioral Care Network

Committee Organizational Chart

An intergovernmental organization formed under ORS Chapter 190. It is domiciled in OR; the FEIN is 41-2198963. It is not a licensed insurer.

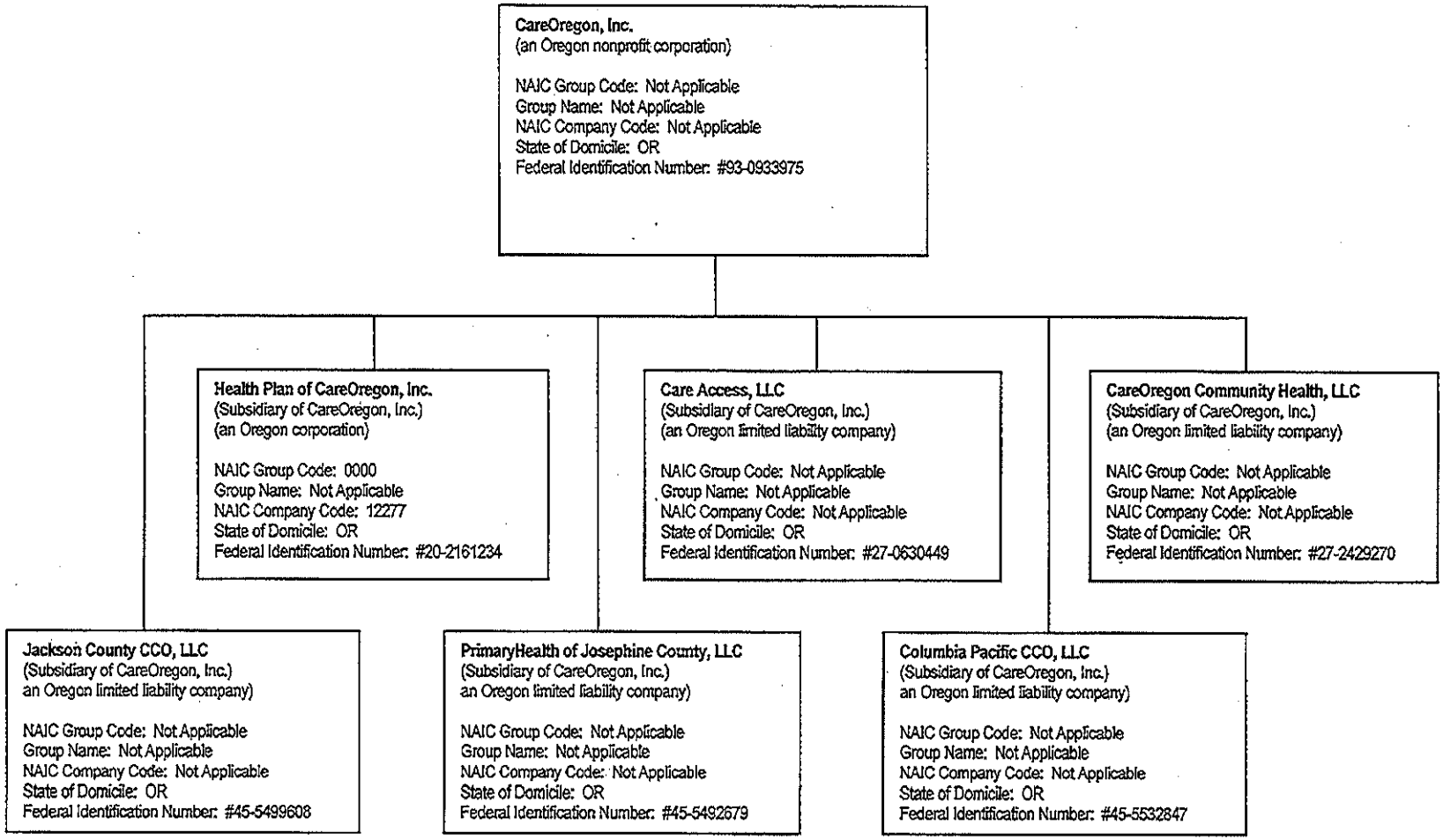


[1] The Board of Directors is made up of the 3 elected County Commissioners from each of the five member counties: Linn, Marion, Polk, Tillamook, & Yamhill.
[2] The Executive Committee is made up of 1 Commissioner from each of the five counties, and meets regularly in place of the full Board to provide policy direction and authorize contracts with MVBCN.
[3] The Budget Committee convenes annually in May to review the budget proposal for the upcoming fiscal year and to recommend a budget to the full Board of Directors.
[4] The term "advocates" includes consumers of behavioral health services, family members, and other persons representing different perspectives of the advocacy community.
NOTE: The results from many projects created through MVBCN committees are monitored by QMC and are found in the Annual Quality Plan.

H:\BHS Admin\ADMIN\MGD_CARE\CCO Development\RFA Document\Copies of application questions\Appendix E attachments\BCN Org Chart - Main- 7-12 - Copy.doc

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY
PART 1 – ORGANIZATION CHART

CareOregon, Inc.
Legal Organization Chart



Applicant Name: Yamhill County Care Organization		
Service Area Table		
Appendix B - Section 1		
Zip Code	**Service Area Description**	**Maximum # of Members - Capacity level**
YCCO Service area including all of Yamhill County		
97101	Yamhill - All	550
97111	Yamhill - All	462
97114	Yamhill - All	913
97115	Yamhill - All	437
97127	Yamhill - All	858
97128	Yamhill - All	7,518
97132	Yamhill - All	3,539
97378	Yamhill - All	1,344
97396	Yamhill - All	539
97148	Yamhill - All	407
Sub Total		16,567
Contiguous Service Areas adjoining Yamhill County		
97071	Clackamas	81
97002	Marion	285
97026	Marion	
97137	Marion	
97347	Polk	400
97304	Polk	
97338	Polk	
97371	Polk	
97304	Polk	
97119	Washington	231
97123	Washington	
97140	Washington	

Yamhill County Care Organization
Appendix A – CCO Criteria Questionnaire

A.I – Background Information

A.I.a The Applicant is Yamhill County Care Organization (hereinafter YCCO), an Oregon nonprofit public benefit corporation that has no members. The management of the corporation shall be vested in a board of directors. The manner of electing or appointing the board of directors, their terms of office, voting rights, etc. are all set forth in the YCCO's bylaws. YCCO is in the process of applying for a 501c3 designation as a not for profit organization. See attachment "Articles of Incorporation YCCO"

A.I.b CareOregon, Inc. (hereinafter CareOregon) is the primary Affiliate associated with this entity's application. Mid Valley Behavioral Care Network (hereinafter MVBCN) will subcontract behavioral health services from YCCO.

A.I.c YCCO intends to begin serving the Medicaid population effective November 1, 2012.

A.I.d In accordance with HB 3650 Section 8(4), a health care entity may not unreasonably refuse to contract with an organization seeking to form a coordinated care organization if the participation of the entity is necessary for the organization to qualify as a coordinated care organization. The Applicant is not invoking alternative dispute resolution with respect to any provider.

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

A.I.f The proposed service area includes all of Yamhill County including the following zip codes: 97396, 97378, 97101, 97132, 97111, 97114, 97115, 97127, 97128, 97148
YCCO also agrees to serve OHP members from adjoining zip codes: 97002, 97026, 97071, 97137, 97338, 97371, 97304, 97140, 97123, 97119, 97347

A.I.g The Applicant's primary office has not been established. We have offers from a partner agency to use space if needed for start up. YCCO will establish an office prior to the contract effective date within the Yamhill County area. In the interim, please use the address on the application cover sheet.

A.I.h YCCO expects to serve primarily Yamhill County. Historically there is movement by OHP members between counties for access purposes and we intend to serve interested members. For this reason, we have included, adjoining areas zip codes: 97002, 97026, 97071, 97137, 97338, 97371, 97304, 97140, 97123, 97119, and 97347.
YCCO has had active participation by Yamhill County Commissioners and staff representing County Mental Health, Public Health, Substance Abuse and Developmental Disabilities programs. See 1.3a for more detail.

A.I.i NO - YCCO was not formerly known by OHA as a managed care organization, however it's two affiliate partners, CareOregon and Mid Valley Behavioral Care Network, did have a contract as of 10/1/2011. It is our intention to file as a converting organization.

A.I.j YCCO is not an identical organization nor does this entity have a current MCO contract.

A.I.k YCCO's affiliates, CareOregon and MidValley Behavioral Care Netwrok, currently have a contract with OHA as a Medicaid Managed Care Organization. CareOregon expects that their current contract with OHA will terminate as it currently applies to the Yamhill County service areas immediately before the effective date of the YCCO's CCO contract.
MVBCN, as an YCCO affiliate, brings a history as one of the original MHOs selected under OHP. MVBCN's current leadership has over 15 years of managed care experience in Oregon. YCCO steering committee partners include Capital Dental and Advantage Dental. These DCO organizations collectively represent about 90 of Yamhill County OHP members.

A.I.l No. YCCO does not make this application for an identical Service Area, although all of the partner MCOs currently have membership in Yamhill County.

A.I.m YCCO's affiliate, CareOregon, is not currently licensed as an insurer with the Oregon Insurance Division to serve any of the listed programs. MVBCN holds the AMHI contract for Yamhill and will continue to provide leadership in this program.

A.I.n YCCO's affiliate, CareOregon, has had a Medicare contract with the federal government since 2006 through Health Plan of CareOregon, a wholly-owned subsidiary. It operates two plans; one is a dual-eligible Special Needs Plan (D-SNP) for people with Medicare and Medicaid, and the other is for people with Medicare only. The service area for these plans covers nine counties throughout Oregon Yamhill County is not within the currently approved CMS service area, but CareOregon would apply to CMS to add the specific YCCO service area to its CMS contract effective January 1, 2014.

A.I.o YCCO's affiliate, CareOregon, through its wholly-owned subsidiary Health Plan of CareOregon, has a current certificate of insurance as a licensed Health Care Services Contractor through the Department of Consumer and Business Services Insurance Division (NAIC number 12277).

A.I.p YCCO's affiliate, CareOregon and our community partners have demonstrated experience in the following areas:
(1) In 2005, CareOregon developed a program called CareSupport and System Innovation (CSSI) which has funded project-based payments of more than $3 million per year with the specific goals of achieving the Triple Aim and addressing the six aims of the Institute of Medicine: equitability, safe, effective, efficient, timely, and patient-centered care. CareOregon has also introduced outcome and Member experience-based payments to its primary care and hospital contracts based on improving safety, health outcomes as measured by HEDIS, and Member experience as measured by CAHPS. We plan to expand and update these alternative payment arrangements in collaboration with the Yamhill County community.
(2) YCCO partners such as Yamhill County, MVBCN and CareOregon have a long history with the delivery of chemical dependency services, and are actively working with and to develop an integration strategy that both enhances coordination and care and is not disruptive to the CCO

Members. CareOregon also has experience in several programs of co-location and integrating physical and behavioral health, and will be working with YCCO partners to develop a comprehensive strategy to integrate dental services for the entire CCO Membership. CareOregon has developed a pilot program in conjunction with the state for long-term care services which uses a team approach led by a nurse practitioner and focuses on home-bound patients. This experience will help YCCO develop a partnership with the local Area Agencies on Aging and other community-based long-term care providers. Integration initiatives among community partners in Yamhill County include cooperative agreements between MVBCN (via Yamhill County Mental Health) and Virginia Garcia (FQHC) in the county to provide psychiatric care and behavioral health interventions in community health clinics. Yamhill County mental health and addictions providers work closely together and have established a co-occurring disorders group to staff cases, address system problems, coordinate care and promote workforce development towards joint competencies in both chemical dependency and mental health treatment. YCCO sees this as an area for continued impact because of the severe health disparities seen for people who have major mental health and substance use challenges.
(3) YCCO has already begun discussions as part of the YCCO clinical committee to identify specific areas of community need and opportunity. This included providers serving Yamhill County's Medicaid population and included hospitals, physicians, clinics, mental health providers and chemical dependency providers with the goal to identify methods to share health care data and identify areas for a collective effort to reduce costs and enhance care. Members of this group are working with OHP claims data and CareOregon to identify high-cost, high-needs members and deploy community health workers, who will be linked to others in similar positions throughout the state. This group also provides a forum to integrate health care needs identified through hospital and public health community needs assessments. The data indicates some patterns of care and health care use. Certain aspects of illegal drug use and patterns of emergency room use require specific strategies that will be unique to this county and will build on previous community efforts to address these issues. YCCO will work closely with the Yamhill County Health Department which will have a role in creating the CAP for the CCO.

A.I.q YCCO is in the process of electing its officers of the Board of Directors. We have included the résumés for key leaders who have been active in the development of the organization. These individuals and their roles are further identified in the organizational charts listed later in the application. Please see attached resumes in document **1e. Resumes - YCCO**

A.I.r Please see attached document **1f. Organizational Charts – YCCO, CareOregon, MVBCN.**

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

Part II - Community Engagement

Section 1 – Governance and Relationships

A.1.1 – Governance

A.1.1.a YCCO's proposed Governing Board will include representatives from the following:

- Willamette Valley Medical Center
- Providence Newberg Medical Center

- Mid-Valley Behavioral Care Network (MVBCN)
- McMinnville Physicians Organization
- Oral Health
- Virginia Garcia Memorial Health Center
- Kathy George, Yamhill County Commissioner
- CareOregon
- Physicians Medical Center
- Providence Newberg Medical Group
- Yamhill County Health and Human Services
- Local practicing physician
- Practicing behavioral health provider
- Community Member Chair of the Community Advisory Council
- Community Member

Most of the members of the YCCO Steering Committee will transition to serve as board members of the CCO. We will provide the final names of Governing Board Members at the time of the Readiness Review. Through the collaborative effort of YCCO and its members such as CareOregon, MVBCN, both Yamhill County hospitals, physician organizations, and the many of the participating providers who will be sharing in financial risk (including capitation or other risk mechanisms), we believe that this structure meets the intent of the CCO legislation and also emphasizes diverse community involvement.

A.1.1.b The Community Advisory Council will be convened in accordance with the statute to include at least 51% participation of YCCCO CCO members. Membership will also include community stakeholders important to serving the OHP population. The Chair of the CAC will be a voting member of the governing board and will present any report from the CAC to the board. Two members of the CAC will serve on the Clinical Advisory Panel. YCCO will solicit applications of interest in participating in the CAC from the membership and a subcommittee of the governing body will select the members in accordance with the CCO regulations. The CAC charter is attached and member roster will be available at readiness review.

A.1.1.c The Governing Board will include at least one CAC Member, who will report on CAC activities and take the lead in certain areas, such developing and presenting the health improvement plan. We expect board meeting to be open to CAC members and will invite CAC members to participate in any community-based board initiatives or committees. The CAC will also be involved in soliciting projects and receiving updates on those projects that are initiated through the transformation fund.

A.1.1.d Yamhill County individuals and families receiving mental health services are very active in advisory roles at both MVBCN and YCHHS, and will be offered the opportunity to apply for participation in the Community Advisory Council. Staff representing Yamhill County Mental Health programs will serve on the Governing Board and the CAP. . MVBCN and Yamhill County HSS also have processes in place to solicit and obtain input from individuals and caregivers of Members with severe and persistent mental illness, and board members from those organizations can inform the board about those issues.

A.1.2 – Clinical Advisory Panel

A.1.2.a We will establish a Clinical Advisory Panel (CAP) whose role will be to oversee the provision and policy of physical health, behavioral health, and the oral health of our members. The Governance Board will appoint members of the CAP and ensure that practitioners from key parts of the delivery system are represented. Two members of the Community Advisory Committee will be members of the CAP. The CAP will report and be responsible to the governance Board. We anticipate having the CAP charter and membership available at the time of Readiness Review.

A.1.2.b We will establish a CAP.

A.1.3 – Type B Area Agencies on Aging

A.1.3.a YCCO is currently in discussions with AAA/APD to finalize standard memoranda of understanding with Yamhill County Medicaid LTC agencies. A MOU has been drafted and outlines requisite roles, responsibilities and scopes of work. This document will be fully executed at the time of the Readiness Review once YCCO has elected officers. The YCCO steering committee has had active representation from NorthWest Senior and Disability Services. A copy of the draft MOU is included as attachment: **A.MOU-LTC-YCCO**

A.1.3.b A MOU has been drafted and outlines requisite roles, responsibilities and scopes of work. This document will be fully executed at the time of the Readiness Review once YCCO has elected officers. A copy of the draft MOU is included as attachment: **A.MOU-LTC-YCCO** .YCCO has obtained MOUs with local agencies and is included with this application.

A.1.4 – Mental Health Authorities

A.1.4.a YCCO is fortunate in that its founding steering committee members include the County health and human services director, the local mental health and addiction service providers, and MVBCN which has been the local MHO for many years. These organizations have a long history of collaborative efforts and are already working together to further integrate services and improve care. The YCCO will facilitate and support the acceleration of new resources. In addition, these are the same organizations which will continue to provide mental health services not initially included in the global budget, which will make transition of those services into the CCO as seamless as possible.

YCCO's steering committee has drafted a MOU with YCCO and the LMHA/CMHP and LPHA and outlines requisite roles, responsibilities and scopes of work. This document will be fully executed at the time of the Readiness Review once YCCO has elected officers. A copy of the draft MOU is included as attachment **A.MOU-LMHA-LPHA-YCCO**

A.1.4.b Yamhill County's mental health services will be the core of what YCCO offers to extended care OHP Members. Yamhill County has a long history of providing supported housing and other evidence-based practices to support individuals with serious mental illness. MVBCN and Yamhill County MH will continue to facilitate and coordinate transitions from extended or long-term care, including participating in IDT meetings at OSH and organizing and distributing clinical packets to potential providers of community and residential services. The current standard of practice consistent with the CMHP co-management contracts requires that MHOs and CMHPs arrange placements within 30 days, after which financial penalties apply. The 5 day goal

referenced in the RFA is challenging because clinical packets are not always provided by OSH at the time an individual is determined to be ready to transition. Once packets are distributed it can take up to 2 weeks for CMHP and residential providers to review the material and interview prospective residents for appropriateness for the placement. This timeframe also allows for consumer and guardian input and choice regarding community placement. MVBCN will continue to work with all stakeholders to improve and expedite this process, and looks forward to OSH becoming able to provide electronic access to the patient's clinical information.

A.1.4.c YCHHS has extensive partnerships with Community Emergency Service Agencies, which will continue and be included in the MOU described in A.1.4. Services have been designed and implemented based on available funding in compliance with Oregon Health Authority contractual mandates and community needs.

A Community Crisis Response Team (CCRT) was implemented in 2008 to promote partnership amongst providers in the community who often interface with individuals in psychiatric crisis. The team consisted of representatives from our two local hospital emergency departments, sheriff's office, local police departments, corrections department, developmental disabilities department and adult mental health crisis assessment team as well as civil commitment investigators. The CCRT team was based on early crisis intervention teams in Memphis Tennessee and Florida and on the Sequential Intercept model. The CCRT goal is to provide a forum to build understanding of each provider's primary mission, and address challenges based on the premise that there are critical intercept points in the community when an individual in psychiatric crisis could be engaged in mental health services. Our goal is that the community works together to maximize response in these situations to best serve the individual presenting a risk to self or others.

A Memorandum of understanding was implemented in 2010 which outlines the partnership between key partners in serving people in psychiatric crisis in the community.

In 2010 a special needs task force was coordinated with the Courts, Corrections, Sheriff's Office, Police departments, hospitals and mental health department to identify community based needs in diverting individuals with serious mental illness in psychiatric crisis who are committing crimes from being incarcerated by engaging them in mental health services.

YCHHS leadership has participated in a long standing weekly strategic planning meeting with The District Attorney, Presiding Judge, Juvenile Corrections Director, Corrections Services Director and manager, Jail Commander and Department of Human Services Child Welfare Office Supervisor.

Lastly, the County has developed Emergency Response Policies and Procedures to address a community emergency/disaster utilizing the incident command system addressing vulnerable populations while partnering with allied agencies.

A.1.5. – Social and Support Services

A.1.5.a YCCO intends to continue maintaining and building on those relationships which are already in place among Affiliate entities. Examples of current relationships among social and support services in YCCO's service area are:

1. "Community Partners" is a team that convenes at least one time per month to discuss service needs for difficult to serve youth. Participating partners include representatives from Yamhill Family and Youth, Developmental Disability Services, Juvenile Justice, Residential Providers, DHS Child Welfare, School District personnel, Oregon Youth Authority, family members and others.

The team works at solving barriers to services for children and youth in the Yamhill County service area.

2. "Adult Multi-Disciplinary Team" for vulnerable adult populations. This is a team of community partners comprised of; Yamhill County Developmental Disability Services, Adult Mental Health, Northwest Senior and Disability Services, Law Enforcement, District Attorney and other community partners with interest in the protection of vulnerable adult populations (individuals with developmental disabilities, mental health diagnoses, seniors and persons with physical disabilities).
3. "Court Coordinated Services" (CCS) is a partnership among the justice system, Mental Health and Developmental Disability Services. The focus is to provide an opportunity for diversion for our enrolled clients from the criminal justice system. CCS participants who successfully complete the yearlong program will have their criminal charges dismissed.

YCCO partners have a long history of collaborative efforts to meet the special housing needs of high risk OHP members. Collaborative efforts with our local Housing Authority and YCCO partners are illustrated in existed supportive housing programs such as Bridges, Homeport, Sunnyside, Reflections and others where stable drug free housing is a foundational component to living independently.

A.1.6 – Community Health Assessment

A.1.6.a The YCCO will utilize the public health's 2011 Community Health Assessment as the starting point for developing the community health strategy, engaging behavioral health and hospital systems which also perform community health assessments. The updated health assessment will be a compilation of the current work being done by each of those entities and will build toward a comprehensive community health assessment that will occur every five years. As the work in assessment evolves the Community Advisory Council (CAC) will take on the role of facilitator and ensure the engagement of diverse populations as well as individuals receiving Medicaid-funded LTC and individuals with severe and persistent mental illness.

The CAC will utilize the results of the Community Health Assessment (CHA) to develop a county-wide health improvement plan and make recommendations to the CCO board. Data will be used to move policy and practice toward improved health outcomes, decreased cost and increased quality of care.

Section 2 – Member Engagement

A.2.1 – Member and Family Partnerships

A.2.1.a Members and their families will be recruited to participate in the Community Advisory Council, with CAC members also serving on the Clinical Advisory Panel. Input from these committees will be incorporated into YCCO decision making around quality initiatives and customer service improvement initiatives. Surveys of members, families and support networks regarding the quality of services received will be administered annually. YCCO plans to participate in and use data from any survey OHA deploys, or use another nationally recognized survey measure. As we develop PCPCH capacity, will emphasize the role of the medical team to engage members in the

interventions are that will result in better outcomes. YCCO will encourage tailoring of individual messages about gaps in care or care needs to specifics of the patient's situation (5 A's around smoking to a member with gum disease). YCCO will encourage consistent use of after visit summaries in all areas of service (not just medical). YCCO will use PCPCH and nontraditional care workers to address questions around care plan to improve patients' understanding of desired outcomes. YCCO will support, via technical assistance and policy development, use of the Patient Activation Measure and coaching/motivational interviewing consistent with the Member's needs as a common practice tool.

A.2.1.b YCCO Affiliate CareOregon has many of experience working with its members and the state to develop plain language written materials, and will work with YCCO to develop materials for CCO members. YCCO will ensure comprehensive communication to engage and provide all Members, not just those Members accessing services or involved in committees, with appropriate information related to benefits and accessing physical health, behavioral health and oral health services via the following:

• Provide annual Member handbooks written in plain language outlining:

- Rights and responsibilities
- Benefits and services
- How to access customer support
- How to access providers
- How to navigate coordinated care
- How they can participate in improvement efforts or peer-to-peer support
- Information about preventive care and non-traditional services
- Privacy rights

• Provide the option of receiving handbooks and preauthorization information in languages other than English

• Provide interpretation services for all languages

• Provide a website (with a translation function) that includes service and benefit information, customer support, health education, provider access, formulary options, and Member engagement information and opportunities

• Provide a periodic newsletter to all Members

• Provide social media opportunities that support sharing late breaking news and opportunities, as well as feedback and peer-to-peer opportunities

• Solicit feedback and involvement through newsletters, handbook, web site, surveys

• Participate in PSA opportunities through TV and radio to encourage better nutrition and exercise, as well as preventive care, among target audiences (families, individuals, parents)

• Engage the CAC in the development, deployment, and analysis of the annual CAHPS survey and other measures of member experience, such as focus groups, primary care-based surveys, engagement rates in care management programs, and customer service statistics.

• Provide targeted communications to Members regarding preventive care, immunizations, and screenings and testing services

In addition, Members will be offered opportunities to learn more through group orientation sessions, one on one interaction with non-traditional health care workers, or at introductory visit with PCP. Introductory sessions in any setting will be structured to include information about empanelment, PCPCH, wellness and prevention services, and the importance of taking charge of one's care. YCCO/CareOregon will, as well, develop mechanisms to identify the individuals who want or need to get this information one-on one and those who need cultural and language specific attention. Non traditional healthcare workers will participate in design of introductory sessions. Sessions will be designed for different audiences to reflect the different subpopulations served by the YCCO.

Section 3 – Transforming Models of Care

A.3.1. – PCPCH

A.3.1.a CareOregon/YCCO will prioritize assigning families together to a PCPCH. YCCO/CareOregon will facilitate PCP participation in learning collaborative to grow the capacity for medical homes in the county. There will be a Clinical Advisory Panel which reviews performance data, selects improvement initiatives, and designs communication and technical assistance strategies to engage practitioners. The CAP will also bring provider concerns to the governing body. YCCO will have staff assigned to the CAP. YCCO administrative data will be shared in such a way to allow the best coordination of care, such that the medical home is aware of all services an assigned member is receiving. Coordination tools in the form of reports designed to show services needed and received will be developed by the CareOregon/YCCO.YCCO Affiliate CareOregon has been involved in primary care home development since 2006, forming collaboratives and providing support and training. YCCO will build on that experience, as well the PCPCH initiative through the state. YCCO clinics will benefit from technical assistance and tools for coordination from both CareOregon and the state. In CareOregon's program, there are tools available to regularly monitor provider and member satisfaction with team-based care and patient engagement. There are also tools to assist clinics in mining data to measure progress on measures, including HEDIS process and outcome measures. YCCO will develop the PCPCH program to fit the needs of the community, building on existing programs and tools, but ensuring that the CAP plays a critical role in development of the CAP, as well as ongoing monitoring of member outcomes.

The YCCO will inventory the cultural competencies of the practices within the contracted providers. The information will be used to allow patients to choose their provider. We do have systems (VGMHC, Providence practices) with expertise within the two major communities of McMinnville and Newberg and we will facilitate learning opportunities among the provider groups.

A.3.1.b The YCCO response to A.2.1.b described the specific tools YCCO will use to engage members, such as written materials, web site, translation, individual meetings, and other opportunities, such as the use of social media, which CareOrgon is using through both Facebook and Twitter.

Specifically for the transformation to a truly patient-centered primary care home, YCCO will use existing survey tools to assess member satisfaction, as well as member focus groups. For example, CareOregon used its Member Advisory Committee to develop materials to help members with their clinic visit, including a list of things to bring to the visit, and questions to ask before completing the appointment. These materials were developed by members and initiated by members, based on experiences that they deemed important. Within YCCO the Community

Advisory Council will play a similar role in determining what how materials and approaches can be shaped to be most effective for Members.

A.3.1.c YCCO is fortunate to have the participation and engagement of all the major physician entities in the community, including the McMinnville Physician Organization, Providence Medical Group, and Virginia Garcia Memorial Health Center.
YCCO anticipates having adequate PCP capacity for OHP Yamhill County members on Nov. 1, with capacity within practices at PCPCH Level 1 or higher for 75% of members. The strategy for assigning patients for primary care will be based on these principles:

1. Engage all willing PCPs in serving the OHP population and participating in health care transformation
2. Support patient choice and continuity of care
3. Enroll family members in the same PCPCH
4. Match cultural and language needs of the members with clinic capacity
5. Consider partnerships between physicians and long-term care providers when assigning triple eligible members

YCCO's target is to assign at least 90% of members to a practice at Tier 1 by January 2014. The learning collaborative will lay out targets and benchmarks to get all practices to level three within the contractually-required timeline. Processes for communication and care coordination will be included in the learning collaborative.

A.3.1.d The goal of YCCO is to better integrate services by initiating real-time notification to PCP and other key players such as LTC providers when needed. Methods may include phone, fax, or secure email of important treatment related transitions for members including a member's living situation. This notification process will be part of MOU between YCCO and LTC providers. YCCO clinical committee has scheduled an August training for August 2012 as a possible addition to the above methods.
Long term care needs and natural partnerships are considered in PCP assignment decisions. The PCP will know which of their patients are involved in long term care and the PCPCH Care manager or for small practices through notification from LTC agencies. The YCCO outreach worker (non-traditional health workers) will be assigned to certain high-need members to assure coordination of care between primary care home and long term care case manager.

A.3.1.e YCCO currently has Virginia Garcia Memorial Health Center (VGMHC), a FQHC, as a key part of our proposed network. VGMHC has a long history in Yamhill County and currently serves many low income and agricultural workers in this community .YCCO has two School Based Health Clinics in place and we will contract with these providers in order to assure adequate access for its members to the extent this is desired by each local community.

A.3.2. – Other models of PCPCH

A.3.2.a We do not anticipate any PCPH model that is not completely consistent with the state's PCPCH development. YCCO will use its best efforts to assign 90% of members to a practice at Tier 1 by January 2014. The learning collaborative will lay out targets and benchmarks to get all practices

to level three within the contractually-required timeline. Processes for communication and care coordination will be included in the learning collaborative.

A.3.2.b YCCO intends to:

- Build off of existing primary care medical homes by engaging the Medicaid population in building a relationship with primary care medical homes.
- Coordinate relationships with essential community resources for targeted members.
- Continue to provide health education, chronic care management and literacy initiatives through members' assigned health team.
- Coordinate services for members in a similar fashion as the team based models that currently exist in local NCAQ Tier 3 primary care medical homes.

At the center of this system will be a coordinated network of community health workers to coordinate care, provide critical outreach for the engagement of patient population. CareOregon through engagement of the patients' assigned primary care medical home will work with YCCO to develop a regional 'hot spot' program similar to other coordinated care efforts currently implemented across the state. The objectives of this program are to move YCCO toward successful achievement of triple aim objectives reducing ED utilization, hospital readmissions, over utilization of system and improve patient experience and overall health outcomes.

A.3.2.c Electronic health records and the secure, efficient communication between YCCO providers are imperative for successful and effective two-way communication that can positively impact patient health and experience. The YCCO plan is to build upon existing EHR systems across the network that will enable outreach workers, providers and care managers to develop a comprehensive picture of the various service providers that are involved with each patient, and work to make these relationships coordinated and effective.

A.3.2.d Continuing with current practices of facilitating strong, coordinated care for DHS Medicaid-funded LTC members, YCCO, as a patient centered primary health care delivery system, will ensure that:

- LTC members are empanelled to ensure continuity of care.
- PCPCH teams are trained for coordinated care efforts that ensure access to all services needed (dental, mental health, specialty services, tertiary care etc).
- Continued adherence and implementation of policies and procedures for coordinated care.
- Continue current QI and QA processes that align PCPCH efforts with patient centered goals.

Create a linkage agreement that creates guidelines for coordination of care between LTC and the PCPCH team.

A.3.3 – Access

A.3.3.a YCCO partners are actively planning, training and engaging health navigators and community health workers. These non-traditional health workers will build on current initiatives and programs to ensure geographically convenient access to coordinated care efforts through initiatives such as home visits, school based health centers, establishing relationships with employers for work visits such as those in nurseries, farms and wineries with enhanced efforts

for underserved populations and those with language, cultural and other significant barriers to care. Certified health care interpreters will be used when bilingual staff is not available. Guidelines, agreements and mechanisms about how and when to share information will be created. Yamhill County Mental Health is working with Virginia Garcia clinic to bring primary care services into the mental health clinic for individuals with serious mental illness. CCO care coordination systems will allow for improved communication between behavioral health and physical health providers, and all will be using Patient Activation Measure-based health coaching tools to assist individual to improve their capacity to improve their own health.

A.3.3.b The primary potential barrier to sufficient access is the current situation in which more than 60% of the OHP beneficiaries in Yamhill County are enrolled through DMAP FFS, and therefore have no current PCP assignment other than through the PCCM program. With the recent commitment of the local primary care physicians to work with YCCO, we believe that we will be able to successfully enroll Members with primary care clinics. The ability to appropriately assign individuals to a PCPCH in a short period may be challenging given the limited time to evaluate the individual member and family needs. We will review our drafted plan for assigning members to PCPCH by the Readiness Review and have full plan in place by contract signature.

A.3.3.c YCCO will ensure comprehensive communication to engage and provide all Members, not just those Members accessing services or involved in committees, with appropriate information related to benefits and accessing physical health, behavioral health and oral health services. The key to PCPCH success in member engagement will be the goal of contacting all new members who choose the specific PCHCH within 90 days of joining the practice so the clinic can identify the needs of the member and family, including obtaining advised preventive services.
In addition, we will use the CAP and CAC to provide input from members and clinicians regarding effective engagement strategies.

A.3.4. – Provider Development/Contacts

A.3.4.a The existing, actively participating provider network includes the following primary care practices: Federally Qualified Health Centers (Virginia Garcia), largest primary medical group in McMinnville (Physicians Medical Center), and Newberg (Providence Medical Group) and Yamhill County Health and Human Services and committed private practice providers who have applied for designation as PCPCH.
In addition to primary care, the proposed YCCO also has: two regional medical centers (Willamette Valley Medical Center and Providence Medical Center-Newberg); an oral health network of providers represented by Capitol Dental, Advantage Dental, Yamhill Dental Society and the YC Oral Health Coalition.
We are currently providing some services to target high-risk populations including a) emergency room consultation and referral to the most appropriate level of care, and b) provision of services in primary care environments for high utilizing patients with chronic medical illness and behavioral health needs. These groups have previously established contractual relationships, including policies and procedures that ensure coordination of care from initial contact through follow-up. These models will be expanded to address currently unmet needs.
Our plan is to build on existing providing networks by

1. Developing policies and partnerships to ensure the coordinated care for out-of-network providers.
2. Further developing services and strategies for target high-risk populations including
    a. High utilized Emergency room services (adults, children and adolescents)
    b. High outpatient medical utilization for adults with behavioral health needs and medical needs.
    c. Drug-seeking adults and those with chemical dependency treatment needs.
    d. Adults in extended care (with serious medical or behavioral health needs)

Increased efforts to move our primary care services to PCPCH Tier designation.

A.3.4.b MVBCN has successful strategies for screening, diversion and utilization management of inpatient care for both adults and children. Strategies include use of person-centered crisis plans, crisis/respite placements, and a mental health supported detoxification option when the presenting need is a substance-use disorder rather than a primary mental health problem. A medically managed detoxification program within a residential chemical dependency treatment center provides an alternative to hospital-based detoxification. Children and adults at the highest level of care are provided with individual and family driven team-based care management focused on increasing ability to achieve personal goals. Available supports include a wide array of in-home and community-based services and family and peer mentors. Teams work closely with residential facilities to ensure that treatment plans address the skills needed for success in the community. We anticipate that teams will participate as needed with the YCCO care coordination processes for members with significant health challenges.

A.3.4.c YCHHS will be the primary provider of behavioral health services, and will continue to provide the full array of outpatient and intensive supports as they have been enhanced during membership in the MVBCN. MVBCN will continue to contract with psychiatric hospitals and providers of intensive services for children for YCCO members. Lutheran Community Services will provide outpatient services for children and preventive services including parent training and a post-partum depression program. HHS Supported Housing program provides an array of housing supports based on level of need.

A.3.5 – Coordination, Transition, and CM

A.3.5.a Yamhill County Adult Mental Health has a long and effective history of collaboration with LTC providers which will continue and be the basis for YCCO supports for this population. YCCO policies and procedures that address information sharing requirements across all programs will include links between LTC and mental health. Eventually secure information sharing between Electronic Health record systems will be implemented. Health registries may be developed and treatment team meetings may take place in with treatment team providers to coordinate care. We intend that Electronic prescribing systems will be implemented as well as avenues to share lab results electronically. We intend to honor existing relationships between primary care providers and LTC facilities as we assign Members to a PCPCH.

A.3.5.b YCCO will develop criteria for referrals to social and support services developed from both administrative perspective and PCP perspective. YCCO will ensure PCP practices are aware of community resources. We are interested in implementing the Pathways model to enlist and

coordinate the work of community social service providers with medical and behavioral health care managers and nontraditional health workers.
Crisis management: YCCO will work with County Mental health services to develop a telephonic crisis response team with referral and triage criteria. YCCO will develop Behavioral Health Consultants and Non-Traditional Health Workers to work with PCPCH clinics so that enhanced crisis response resources are available within the medical team. YCCO will develop a strategy for centralized itinerant staff to make this resource available to even small clinics. The goal will be to identify at-risk individuals and apply resources to them early.

A.3.5.c YCCO will build on existing processes, which include translation services, to ensure access for members with linguistic needs. YCCO affiliate organizations each bring tools regarding cultural competency and can access state resources as well. For example, CareOregon has initiated training for its staff regarding the needs of various constituent groups, including recent immigrant individuals with disabilities. Virginia Garcia has expertise and skill with individuals who work in migrant or temporary labor situations, and may be recent immigrants. To the extent it is available, YCCO will share member preferred language from OHP enrollment data with PCP clinic. YCCO will enable cultural sensitivity training opportunities using resources already available in the community (e.g. Providence and Virginia Garcia) and promote sharing of already-developed tools. The non-traditional health workers that engage clients in care coordination will develop educational tools to use with clients that are culturally and linguistically appropriate.

A.3.5.d There are multiple methods to coordinate care with a Member's primary health home. Currently the Community Developmental Disability Program (CDDP) Service Coordinator identifies for a single client all of the service providers, including physical and mental health, working toward supporting wellness for the individual in the Individual Support Plan (ISP). YCCO intends to coordinate efforts to identify/clarify core responsibilities of YCCO and other entities such as the CDDP Service Coordinator in order to avoid duplicative efforts and align services for those members involved with multiple healthcare systems.
One example of efforts planned for consideration would be a Member questionnaires that could capture health management needs that are either currently unmet, unaddressed or that are being coordinated by a primary care or other service provider.
In addition to those programs, YCCO providers in both physical and mental health may use the following screening processes to identify individuals whose care is delivered in multiple settings:
1. Routine screens will be administered across YCCO providers for medical and behavioral health conditions such as:

- SBIRT = Screening, Brief Intervention, and Referral to Treatment Tool, PhQ-2, EASA Early Psychosis screen, dementia and others.
- Asthma, diabetes, tobacco use,
- Metabolic screening for all individuals taking second generation antipsychotic medications: waist circumference, lipids, weight, blood pressure, glucose level, etc.

2. The contract will address required screening and assessment for medical conditions, mental health and substance abuse, and will implement linkage agreements across providers including acute and long-term care. Referral agreements and guidelines will be identified. Clinical guidelines/EBP will be established across organizations

Information technology will be used to maximize service planning and bring together strands of services into a single plan for achieving an individual's health and wellness.
3. Registries and EHR data sharing will be implemented across YCCO providers to routinely share information to best coordinate and provide holistic integrated and coordinated healthcare. Including the following,

- Tracking a member's PAM scores and self-management goals.
- The impact of the care and supports provided.

4. Policies will be developed regarding treatment provider review of prescribed medications and alerts will be sent to treating providers re any new or discontinued medications, hospitalizations, urgent care service or significant procedures/changes in service plan.
5. Data sharing strategies will be identified for implementation across YCCO participating organizations, including patients (and family members) in care planning and information sharing. Virtual treatment team meetings may be used to coordinate care for the highest users of costly care. If medical home is integrated in one place of business, meetings will happen on site in person.
6. Pharmacy services and lab work will be implemented electronically and tracked. Alert system will be put in place. Medication service policies and procedures will be developed with client contracts.
7. Standards will be set for timely access to care.
8. We will utilize the 4 Quadrant Clinical Integration Model of Care to outline strategies for integrating care within the mental health clinic and PCPCH to address the needs of populations with differing levels of mental health and physical health needs.

A.3.5.e Yamhill County HHS has a long and successful history of providing community support services to individuals with serious mental illness in our community and a sophisticated understanding of how to match braided funding to meet the complex needs of this population. (Appendix B Standard 7 offers more details about the existing service array). The 1915(i) SPA offers a much needed opportunity for individuals with a serious mental illness who present with complex MH and physical health needs. Because YCHHS has partnered for many years with Northwest Seniors and Disabilities Services and OHA to provide enhanced care, enhanced outreach and residential support to OHP members, YCCO is well positioned to support the SPMI population. YCCO is in the process of implementing a MOU amongst ASO partners to ensure critical communication and coordination of services. YCCO will continue to work through these organizations to support and expand this existing multidisciplinary team approach. YCHHS has successfully trained a group of staff who are poised to provide behavior coaching support to LTC entities to promote continuous community integration, wellness, and decreased use of Emergency department and inpatient psychiatric care services.

A.3.5.f All members will be assigned to a primary care provider. YCCO will ensure there is a central team of nontraditional health workers (community health workers) accessible to the primary care clinics. Identification of members in need of these services will be through administrative processes (such as utilization review) as well as identification by any of the service providers. The YCCO clinical advisory panel will review the criteria CareOregon uses to enroll members in additional care support/case management services and adopt or adapt these practices for YCCO. The Pathways model may provide a central hub through which a PCP can make a referral to other case management supports available in community agencies.

A.3.5.g CareOregon assigns all Members to a Primary Care Provider within 30 days of enrollment and relevant PCP contact information is provided to the Member upon assignment. Members are assigned based on prior history with a primary care provider, Member preference, or provider availability in terms of capacity or geography. The PCP also has access to an assigned roster 24/7 through an online portal so that the provider can accommodate patient requests upon initial contact. Member education materials encourage the establishment of care immediately upon attaining benefit eligibility Future Member assignments may be based on performance measures.

A.3.5.h YCCO will use several strategies to ensure that all services are culturally and linguistically appropriate, with the predominant need in our community being for Spanish-speaking members. First, we have PCPCH capacity for bilingual and bicultural staff to work with Latino families who will be assigned to them. Secondly, we will include *promotoras* who can serve as liaison between the member and family and the medical system. A key focus will be on ensuring that preventive and transition services for this population are consistent with expected practice. Thirdly, we will ensure access to interpreters as needed. We will also create a process in which those medical practices with expertise in serving specific cultural groups teach their strategies to other partners within the CCO.

A.3.5.i YCCO will ensure systems in place for real time communication of admissions and discharges from one care setting to another to the PCP. Hospital discharge planning social workers will decide with PCP on follow-up plan in new setting. Practice care manager or non-traditional health worker will carry out the plan formulated. A home visit will usually be an important first step. YCCO will work with existing community resources devoted to transitions of care to ensure (or develop its own resource) to assure adequate resources for home visits after each appropriate discharge from a care setting. The CAP will be a key resource to develop and implement transitions of care processes.

Newberg Providence's ethics committee evaluates needs of patients being discharged and YCCO will build on that model. MVBCN has care management teams for children (New Solutions) and Adults (Community Integration Initiative) within each county which manage transitions between levels of mental health care. These teams will link with medical providers for members with intensive mental health needs who also experience significant health challenges.

A.3.5.j The current level of transitional care coordinated by the APD (Aged and People with Disabilities) staff for Medicaid long-term care individuals include communication between long-term care facilities, hospital discharge planners, primary care providers, adult mental health and family members.

To achieve the goal of better overall health and reduced hospital re-admission, reduced ED utilization for non-emergent conditions and better chronic disease care the following will be implemented.

1. YCCO staff will lead an inter-disciplinary team to coordinate services, identify and problem-solve barriers to care, connect with patients and families to optimize care.
2. The YCCO will monitor outcomes including health care utilization, maximal quality of life as defined by the individual and successful transition for individuals including correct medication reconciliation, linkages and support from post acute-care service network.

The Long Term Care Program began as a joint venture with CareOregon, a large medical group in the Portland area, and Seniors and People with Disabilities (SPD). The program utilizes a Nurse Practitioner (NP) to perform home visits on chronically ill CareOregon Members, living in their home or in an adult foster home, who need additional support to access care/treatment, or are having difficulty working within the regular medical system. The NP works directly with the Member's Primary Care Providers (PCP) and SPD case managers. The focus is to improve the quality of health care services, coordinate chronic disease treatment, streamline access, avoid over use of the ER, assure safe transitions, and avoid unnecessary hospitalizations for these Members. Once the Member is stabilized, the NP may release them back to the sole care of the PCP, or in some cases, follow the patient for a longer period of time. CareOregon works with the NP and PCP to discuss currently enrolled Members and barriers they have to receiving care. CareOregon and the NP work together to assure that Member needs are met while coordinating services and appropriate payments within the benefit structure. YCCO will support the deployment of the CareOregon Long Term Care Program in Yamhill County.

A.3.5.k YCCO's affiliate, CareOregon, currently has a transitional tracking system in place. Transitions work in concurrent review includes the CR RN working actively with discharge planners and CareSupport staff while the Member is in the inpatient setting. The CR RN works to facilitate a safe and effective discharge plan. Work begins with CareSupport early in the Member's hospital stay in order to proactively assist the Member during the transition process. CareOregon has a CR RN that reviews all SNF stays. In addition to the review work for level of care, she will also visit SNFs to participate in Care Conferences on specific Members. She additionally visits Members and, if available, their families to discuss transitions to other care settings.
Transition work continues after discharge with CareSupport and the Hot Spot program. CareSupport utilizes daily census reports from an electronic system which identifies Members at admission and includes all inpatient, SNF, and Home Health admissions for the past year. They additionally utilize another report from the system which identifies that a Member has been discharged from the inpatient or SNF setting. They follow the Member for 30 days; work with the Member on their plan of care, and document contact with the Member and the Member's family in the electronic system.
In the above cases, YCCO would be adding on to existing programs and document management systems within its affiliate, CareOregon. We would need to develop programs in the area for palliative care, as CareOregon has done in the Portland area. YCCO would also need to expand presence in Adult Foster Care Facilities.
Please refer to CareOregon's Utilization Management Program description and QI description in attached document **2c. CareOregon QI Program - YCCO** for further information.
The current system of coordination with psychiatric residential treatment providers and state hospitals used by partners will continue to be used to coordinate discharge planning and develop transitional care plans for individuals with serious mental illness. At the county, the AMHI coordinator (adults) and the ISA Coordinator (children) participate in hospital discharge planning meetings and develop a community plan for transition back into the community, including a range of transitional and community supports for children and adults including intensive case management, skills training, medication oversight, benefits management, supported housing and supported employment. An individual care coordinator will be assigned for each AMHI client and will coordinate primary care, habilitative supports (funded with the 1915i SPA), mental health treatment supports, residential services, state hospital services,

community corrections, developmental disabilities programs, Aging and Disability Services and additional recovery needs and commitments.
In addition to specific programs and personnel-driven coordination efforts, development of population-based information systems will significantly improve coordination. Utilization management databases and middleware for physical health and behavioral health will be integrated to minimize redundant efforts and maximize return on investment in benefits management.

A.3.5.l These components of risk assessment and stratification exist in some entities in the current system and YCCO will engage in a process of determining a common system for interdisciplinary care planning. Individualized care plans are currently developed by the mental health provider for adults and children needing intensive community based services, including those in foster care. There is a process in place to determine a level of need and screen individuals for admission to intensive levels of care. Individuals are reassessed based on clinical need.

A.3.5.m Upon enrollment, all YCCO Members will be mailed a health assessment survey as part of their Welcome Packet. Returned surveys will be screened by the Care Coordination team and follow-up will occur as appropriate. Certain eligibility categories of YCCO Members will be automatically referred for intensive care coordination. In addition, YCCO Members may also be identified for intensive care coordination services upon enrollment via Self-Reported Health Risk Assessments, self-referral, from a PCP, agency caseworker, a representative, other health care or social services agencies and through claims-based or diagnosis-driven trigger lists throughout eligibility with YCCO. Intensive care coordination services will also be available to coordinate covered services for Members who exhibit inappropriate, disruptive or threatening behavior in a practitioner's office. Information about services available through intensive care coordination is communicated to the eligible Member according to the most appropriate communication method including accommodations for impaired, disabled, alternative language or other cultural differences. PCPCH development will emphasize the PCPCH role in preventive and chronic disease screenings (mammograms, colonoscopy, pap, A1c, etc.), behavioral health screenings (SBIRT, PHQ2, etc), and the Patient Activation Measure. Claims data will provide a method for tracking the consistency of targeted screenings by each provider.

A.3.5.n YCCO is currently in discussions with AAA/APD to finalize standard memoranda of understanding with local Medicaid LTC agencies. MOUs will outline requisite roles, responsibilities and scopes of work.

A.3.5.o Individualized care plans developed for adults and children needing intensive community based services will be re-assessed every ninety (90) days or as needed by care managers. Upon review, individualized care plans will be modified as necessary. Re-assessments are not limited to changes in clinical status only, but may be triggered by changes in overall health factors, environmental factors (housing), patient activation and identification of barriers to social services and other programs. Community health workers and care management staff are particularly adept at identifying these re-assessment triggers. The YCCO process will be built upon CareOregon's CareSupport program and adapted to meet the needs of Yamhill County.

A.3.5.p The current level of transitional care coordinated by the APD (Aged and People with Disabilities) staff for Medicaid long-term care individuals include communication between long-term care facilities, hospital discharge planners, primary care providers, adult mental health and family members.

To achieve the goal of better overall health and reduced hospital re-admission, reduced ED utilization for non-emergent conditions and better chronic disease care the following will be implemented.

1. YCCO staff will lead an inter-disciplinary team to coordinate services, identify and problem-solve barriers to care, connect with patients and families to optimize care.
2. The YCCO will monitor outcomes including health care utilization, maximal quality of life as defined by the individual and successful transition for individuals including correct medication reconciliation, linkages and support from post acute-care service network.

As we adapt the Long Term Care Project for Yamhill County, we will address the operational details describing how care plans are coordinated between medical and these other community providers.

A.3.6 – Care Integration

A.3.6.a YCCO has the participation of all the major provider groups and organizations throughout Yamhill County. These organizations are already very adept at delivering services in a culturally competent manner. The goal of the CCO will be to build on this expertise and spread throughout the network. For example, Virginia Garcia Memorial Health Center can help all clinics understand the cultural and health needs of the migrant population. Virginia Garcia clinic is already providing culturally appropriate mental health services for Latinos, and Yamhill County's chemical dependency treatment program includes bi-lingual and bi-cultural staff. Lutheran Family Services uses bi-lingual and bi-cultural staff to provide parent training and post-partum depression prevention services. APD and YCHHS both have experience working with individuals who live with disabilities and can train YCCO providers.

A.3.6.b YCHHS will provide the majority of behavioral health care, utilizing their expertise and wide range of services which address the needs of this population. YCHHS has a long history of emphasizing community-based supports for adults with mental illness, with especially strong partnerships which have created a range of supportive housing options. YCHHS and MVBCN will maintain their current systems and practices to manage hospital and residential services and transitions for this population consistent with the Adult Mental Health Initiative and incorporating multiple relevant evidence-based practices. The Early Assessment and Support Alliance program will continue to serve young people with emerging psychotic disorders. The care coordination mechanisms developed by the YCCO will enable improved partnerships with the medical community to ensure appropriate medical care including preventive services.

A.3.6.c Identification of members with significant mental illness and referral to care happens at all points of contact with the health system, and all of these mechanisms will be enhanced as we are able to link electronically. Currently all hospital emergency departments link with mental health screeners for immediate response in high needs situations. YCHHS has placed a behavioral health consultant in one clinic, and there is behavioral health staff embedded in clinical teams at Virginia Garcia. We anticipate making these staff available to all PCPCH clinics

as part of our initial transformation strategies. Assistance with referrals for specialty behavioral health treatment will be one of the services offered by these staff. ENCC staff will partner closely with the mental health system to assist members needing help with system navigation. SBIRT has been implemented within YCHHS to improve screening for chemical dependency, and we will train ED and PCPCH staff in use of this tool. Use of SBIRT will be monitored as one of the CCO metrics.

A.3.6.d YCHHS will be the primary provider of behavioral health services, and will continue to provide the full array of outpatient and intensive supports as they have been enhanced during membership in the MVBCN. MVBCN will continue to contract with psychiatric hospitals and providers of intensive services for children for YCCO members. Lutheran Community Services will provide outpatient services for children and its existing spectrum of prevention services including programs such as Mothers and Babies/Postpartum depression prevention, Making Parenting a pleasure, The Incredible years, The Strengthening Families Program, and Parenting Traumatized Children. YCCO treatment providers offer family-focused and strengths-based care with 24 hour crisis and respite services. YCCO existing evidence-based practices include trauma-informed care, full-fidelity wrap around, early psychosis intervention (EASA), Collaborative Problem Solving, Parent-Child Interaction Therapy, Assertive Community Treatment, Supported Housing, Education and Employment, Medication Support, Motivational Interviewing and peer delivered services. Bio-psychosocial service needs will be assessed and individualized service and support plans will be developed with CCO members. Supports will be coordinated to increase member's wellness and successful community integration and tenure, using intensive community based wrap around support with trans-disciplinary teams as needed. Services are in place to meet CCO member's residential needs including scattered site housing, supported housing, adult foster care, Residential treatment Facility and Secure Residential treatment facility. Primary healthcare may be developed on site for members with serious mental illness through reverse integration.

YCCO's goal will be to improve the psychiatric and physical health status of adults with serious mental illnesses (SMI) who have or are at risk for co-occurring primary care conditions and chronic diseases. We are in the planning stage of becoming (in partnership with Virginia Garcia Clinic through reverse integration) a medical home for individuals with serious mental illness as defined by SAMHSA and the Oregon Health Authority. Treatment will include:

On- site screening, treatment and coordination of care of these physical conditions among persons with mental illnesses;
Comprehensive care management
Care coordination and health promotion
Comprehensive transitional care from inpatient to other settings, including appropriate follow-up
Individual and family support, which includes authorized representatives
Referral to community and social support services, including appropriate follow-up
Electronic submission of prescriptions (as allowable given state-specific laws regarding the use of e-prescriptions for controlled substances);
On- site metabolic testing and tracking
Ability to Receive structured lab results electronically;

Share a standard continuity of care record between behavioral health providers and physical health providers.
Health home program, where different services are offered to different categories of clients according to the severity of the condition/risk factors.
Wellness programs (e.g., tobacco cessation, nutrition consultation, health education and literacy, self-help/management programs) will be developed and available as primary as well as secondary preventive interventions that involve preventive screening and assessment tools, incorporating recovery principles and peer leadership and support.
Services will be provided in an integrated fashion addressing, mental health, substance use, physical health and oral health conditions with the development of a coordinated person centered service plan utilizing the member's strengths in promoting wellness.

A.3.6.e YCCO is fortunate to have the two main DCO providers, Capitol Dental and Advantage Dental, involved in its steering committee. Viewing the early engagement of dental as an important component of health care transformation, YCCO has included DCOs and the Yamhill Dental Society as a part of the CCO conversation throughout its development. YCCO's goal is to have dental contracts in place to serve OHP members on or before July 1, 2014. Additionally, we have plans to incorporate dental into the CAP and consider dental initiatives as part of transformation funding.

A.3.6.f The YCCO currently has one partner agency with integrated dental services: Virginia Garcia Memorial Health Center (VGMHC). YCHHS houses the county Oral Health Coalition (YC-OHC) which includes stakeholders such as VGMHC and the Yamhill County Dental Society. The two area DCO's, Capitol Dental and Advantage Dental are also members of the coalition and participate regularly. The coalition has provided the foundation for medical and dental providers to work together to ensure adequate dental coverage for emergencies; they are working on an Emergency Department Redirect program to reduce the number of dental patients seen in the emergency rooms of our local hospitals. The coalition is working with the Dental Society and the local school districts to provide education, sealants and fluoride varnish to children. The YC-OHC is currently completing an action plan to be used by all YC-OHC agency members, including dental providers, advance practice hygienists and both DCOs. The YCCO Clinical Advisory Panel will have a designated position for a dental health provider to ensure dental health is a part of the overall wellness discussion for our community. By working together YCCO is confident in its ability to improve oral health, and overall general health for those we serve.

A.3.6.g YCCO is committed to adequate, timely and appropriate access to hospital and specialty services for its Members. The goal is to ensure coordination and communication, but not place barriers to care. Initially, YCCO will build upon existing processes in place at its affiliate, CareOregon, which has policies and procedures in place which require the following:

- CareOregon's Medical Benefits Assurance Unit notifies a member's primary care provider of an authorized request for services at the time of authorization, and again upon admission to an in-patient setting or to certain specialty care and ancillary services.
- CareOregon's CareSupport department notifies a Member's PCP of hospital discharge by fax; this occurs for select high-risk OHP members.
- CareOregon's Medical Benefits Assurance Unit accepts requests for service authorizations for inpatient procedures which require authorization. No authorization is required for urgent or

emergent admissions. CareOregon Concurrent Review RNs work with hospital staff during the Member's stay in the hospital

- CareOregon's CareSupport Case Managers encourage and receive referrals from primary care providers for coordination of care for their complex patients. CareOregon's website offers a referral template that can be used by primary care providers to request assistance for care coordination; referrals also occur by telephone either via our Member Services Department or directly to our CareSupport telephone queue.
- CareOregon's Medical Benefits Assurance Unit's notification to providers of an inpatient admission includes a request to share the Member's plan of care with the facility.
- CareOregon CareSupport Case Managers work telephonically with members upon discharge from the hospital or skilled nursing facility to ensure their self-management success and timely follow-up with their primary care provider.

A.3.7 – Medicaid LTC Services

A.3.7.a YCCO's affiliate, CareOregon, has a Long Term Care project which began as a joint venture with CareOregon, a large contracted medical group in the Portland area, and Seniors and People with Disabilities (SPD). The project utilizes a Nurse Practitioner (NP) who performs home visits on chronically ill CareOregon Members, living in their home or in an adult foster home, who need additional support to access care/treatment, or are having difficulty working within the regular medical system. The NP works directly with the Member's Primary Care Providers (PCP) and SPD case managers. The focus is to improve the quality of health care services, coordinate chronic disease treatment, streamline access, avoid over use of the ER, assure safe transitions, and avoid unnecessary hospitalizations for these CareOregon Members. Once the Member is stabilized, the NP may release them back to the sole care of the PCP, or in some cases, follow the patient for a longer period of time. CareOregon staff works with the NP and PCP to discuss currently enrolled Members and barriers they have to receiving care. CareOregon and the NP work together to assure that Member needs are met while coordinating services and appropriate payments within the benefit structure.
YCCO would expand this program model and utilize existing document management systems currently in place. We are targeting January 2013 as the implementation date of the initial pilot, and sooner if feasible.

A.3.8 – Utilization Management

A.3.8.a YCCO's affiliate, CareOregon, makes utilization management decisions for physical health needs by considering each Member's unique needs and diversity. As described above, they have established a program that creates collaboration between SPD, Member PCP, and CareOregon for Member enrolled in LTC services. YCCO would expand that for Members with special health care needs (including the ENCC populations, Members with intellectual disability and developmental disability, serious mental illness, and serious emotional disturbance.) CareOregon maintains a no-authorization required list for ambulatory services so access is not a barrier to their Members. This list can be found on their web site at www.careoregon.org . They do require notification of acute admission, in order to work with Members, Member's family and providers in order to ensure a safe transition, and avoid readmission. CareOregon monitors and analyzes utilization data on an ongoing basis in order to identify potential or actual incidents of over /under utilization. Thresholds are determined for each of the selected areas. If

trends/patterns are recognized necessary steps are taken to investigate and address these variances. Behavioral Health is included in the monitoring process which is performed at least annually. Data is selected from HEDIS measures relevant to the population (Medicare/Medicaid).

- Frequency of selected procedures (HEDIS) Medicare and Medicaid
- Behavioral Health Measure (HEDIS): Initiation and Engagement of AOD

Thresholds are established using external, nationally-recognized sources whenever possible. Reporting and analysis is incorporated into the annual evaluation for reporting purposes. Over- and under-utilization is incorporated into the quality and utilization program descriptions.

YCCO will expand this program model and utilize existing document management systems currently in place.

Outpatient mental health and chemical dependency service needs are assessed and treatment plans developed by the clinician with the client and family based on recognized level of care instruments. Intensive services for children are authorized and paid by the MVBCN based on recommendations from the child's wrap around team in consultation with the local multi-agency Care Coordination Committee. Hospital services are authorized and paid by MVBCN based on recommendations from the local mental health screener.

Section 4 – Health Equity and Disparities

A.4.1 YCCO will identify continuing education opportunities and provide a forum for these opportunities. YCCO will solicit requests from providers of training desired. CAC and CAP will be places where best practices can be shared. YCCO will create and maintain a forum/committee to address complex social and medical issues that lead to disparities (look to Providence model ethics committee). The CAP will look at data from different practices to identify where disparities are minimized and see if best practice can be identified and shared.

A.4.2 YCCO will build on current resources and tools to not only improve outcomes but also as a mechanism to identify opportunities for improvement. Currently CareOregon utilizes a software program called CareAnalyzer which provides the ability to track and report on quality measures. These reports also include demographic information about each Member, allowing for a holistic approach to health improvement. For example, CareAnalyzer can identify prescription drug usage for diabetics and then staff and committees can use this information to track and trend diabetic care for different ethnic groups, addressing the question of whether Latino individuals have different outcomes than Caucasians. CareAnalyzer is updated monthly which gives the ability to generate reports for a variety of HEDIS measures, including ones that involve mental health and substance abuse. Currently HEDIS measures being tracked and monitored for mental health and substance abuse are:

- Follow up After Hospitalization for Mental Illness(Medicare)
- Initiation and Engagement of Alcohol and other Drug Dependence Treatment
- Follow up Care for Children Prescribed ADHD Medication

YCCO intends to implement the SBIRT across service settings.

Section 5 – Payment Methodologies

A.5.1 The development of alternative payment arrangements is a critical component to CCO design and operation. YCCO will fully engage the Governing Board, CAP, and CAC before implementing major changes. These changes will include targets for all aspects of the Triple Aim, not simply cost and utilization targets.

Though YCCO will not implement major payment changes prior to local engagement and approval, we will build on existing programs and payment methods already in place, such as the following: CareOregon currently complies with the state requirement to use DRG and APC payment methodology with hospitals. In addition, the payment also includes incentives for Member experience (hospital CAHPS scores) and Member outcomes (Oregon Patient Safety Commission reporting), as well as project-based funding through its CSSI program to encourage provider connectivity and sharing of electronic health record data in Yamhill County.

CareOregon's primary care payment model is one that has several components: (1) fee for service, (2) CSSI project-based funding to improve health outcomes and engage in PCPCH development, (3) an incentive plan that has several elements related to Member experience and health outcomes. The primary care incentive payment will be based on the PCPCH criteria to ensure that clinics are not duplicating efforts and focus on patient care and not plan reporting. The YCCO board will ultimately decide what incentive payment methods to incorporate for YCCO providers.

Section 6 – Health Information Technology

A.6.1.a YCCO's affiliate, CareOregon, currently houses application systems that efficiently maintain and process:

- Member enrollment
- provider configuration
- customer service call tracking
- contracts
- plan benefits
- case management
- claims adjudication
- utilization management, including web-based tools that support provider practices and have the capacity to be expanded to include personal health records, EHR and medical home functionality)

The current web functionality includes capability to send and receive secure communications between the plan and providers.

CareOregon also maintains data systems and a data warehouse populated with claims, Member enrollment, providers, pharmacy claims, lab results, ALERT data, etc used for a variety of analytical purposes including financial, contractual, program evaluation, hot-spotting, clinic, and whole system analysis.

Additionally, YCCO's largest partner providers, Yamhill County HHS, WVMC, Providence, and Virginia Garcia currently have strong electronic health record systems. This provides a good foundation to develop an interface with CareOregon's data warehouse abilities to meet our care

coordination goals. YCCO's steering committee has scheduled a demonstration of CareAccord for consideration as an Email notification option.

A.6.1.b YCCO's affiliate, CareOregon, is actively involved with the provider community through their Primary Care Renewal program, which them to actively support and encourage use of certified EHRs. They have a regular provider survey and verification process that can be enhanced to include gathering information on EHR status, and enable appropriate follow-up. As mentioned above, the current web functionality can be enhanced to include a certified EHR that can be made available to providers.

A.6.1.c CareOregon has a regular provider survey and information verification process that can be enhanced to include gathering information on meaningful use and HIE status, and enable appropriate follow-up to assist providers with accessing these network tools

Applicant Name: Yamhill County Care Organization		
Service Area Table		
Appendix B - Section 1		
Zip Code	**Service Area Description**	**Maximum # of Members - Capacity level**
YCCO Service area including all of Yamhill County		
97101	Yamhill - All	
97111	Yamhill - All	
97114	Yamhill - All	
97115	Yamhill - All	
97127	Yamhill - All	
97128	Yamhill - All	
97132	Yamhill - All	
97378	Yamhill - All	
97396	Yamhill - All	
97148	Yamhill - All	
Sub Total		16,567
Contiguous Service Areas adjoining Yamhill County		
97071	Clackamas	81
97002	Marion	285
97026	Marion	
97137	Marion	
97347	Polk	400
97304	Polk	
97338	Polk	
97371	Polk	
97304	Polk	
97119	Washington	231
97123	Washington	
97140	Washington	
Sub Total		997
Total		17,564

Applicant Name: Yamhill County Care Organization
Publicly Funded Health Care and Service Programs Table
Appendix B Standard 3 Table.

Name of publicly funded program	Type of public program	County in which Program Provides Service	Specialty/Sub-Specialty Codes
Virginia Garcia Health Clinic	FQHC	Yamhill County	097 - Federal Qualified Health Cntr. (FQHC) 110, 112, 205, 231, 247, 262, 291, 360, 364, 367, 400
Yamhill County Chemical Dependency Program	CMHP	Yamhill County	016 - A&D Outpatient Treatment Program 018 - A&D Residential Treatment Program - Rehab
Yamhill County Court Coordinated Services	CMHP	Yamhill County	092 - Community Mental Health Program
Yamhill County Developmental Disabilities Program	CMHP	Yamhill County	517 - TCM - DDSD/ICFMR Waiver
Yamhill County Family & Youth Program	CMHP	Yamhill County	093 - Community MH Center, Adolescent/Children
Yamhill County Mental Health	CMHP	Yamhill County	092 - Community Mental Health Program 370 - Psychiatric Residential Treatment Facility
NorthWest Senior and Disability Services	(AAA)/(APD)	Yamhill County	
Yamhill County Public Health Services	Public Health	Yamhill County	509 - TCM Babies First/CaCoon
Willamina High School	School Based Health Center	Yamhill County	
Yamhill-Carlton High School	School Based Health Center	Yamhill County	

Yamhill County Care Organization
Appendix B – Provider Participation & Operations Questionnaire

Section 1 – Service Area and Capacity

See attached **B.1 Services Area Table - YCCO**

Section 2 Provider Participation

Standard 1 YCCO, through its affiliate partners CareOregon, MVBCN, DCO's and partner providers, has a comprehensive and integrated network of physical health, mental health, oral health and addictions delivery system that serves Medicaid members in the categories of service and types of providers listed in RFA Standard 1. The YCCO panel of providers will build on the existing participating provider lists of CareOregon (physical health and addictions) and MVBCN (mental health) as part of its MCO and MHO contracts. After initial implementation, YCCO plans to include dental providers as part of our patient centered care delivery services. YCCO will submit details of these providers at readiness review as our **Table B-1- Participating Providers**. We have a comprehensive list of providers that meet current DMAP access standards and the YCCO clinical committee is engaging all community providers regarding CCO participation.
According to the most current Comprehensive Community Health Assessment performed by Yamhill County Public Health and key stakeholders in 2011-12, common areas of concern identified included: obesity, nutrition, physical activity, chronic disease, the un-insured or underinsured, health care access, women's health, infant and children's health, physical abuse, older population care, poverty, homelessness, unemployment, substance abuse and dental care. Surveys, interviews and health forums were conducted across diverse community partnerships and are considered representative of the Yamhill County community. This resource will be one of several used by YCCO to establish priorities
YCCO plans to establish the use of non-traditional health workers within the YCCO service area, some potentially employed by YCCO, others employed and stationed in provider facilities. Coordination of care will be facilitated using the Community Care Coordination Pathways HUB model of integration. Training, supervision and integration of non-traditional health workers will also follow the Pathways methodology for newly hired staff. For stakeholder employees who fill the role of Community Health Worker, Peer Wellness Specialist or other 'navigators' will have training provided to align them with the Pathways HUB model. YCCO is also aware of local educational facilities that provide certification programs for non-traditional health workers and will engage those institutions to assist in recruiting and training workers.

For care management in our network, we may build on the existing models of CareOregon and others. For example, the current CareOregon CareSupport program works with primary care, addictions treatment, and specialty providers throughout the state and may be adapted for Yamhill County. Upon this platform YCCO will extend these transitional services to include a long-term care pilot beginning January 2013.

Standard 2 For members with multiple chronic conditions, YCCO will use current CareOregon care management (CareSupport) staff to engage members in ongoing care coordination. CareSupport uses a behavioral interviewing model that is patient-centered and identifies potential for improvement and engagement by the member. At readiness review, we will identify providers

and specialties in our table **(B-1 Participating Provider Table)**
As a current mental health organization, MVBCN has Adult Exceptional Needs Care Coordinators (ENCC) who works with and on behalf of members with serious mental illness, which by virtue of the severity, chronicity, and acuity of their conditions requires special services including long term out-of-home placements. In accord with AMH's Adult Mental Health Initiative (AMHI) the ENCC, in collaboration with providers and staff, assists in member tracking, placement determination, needs and resource identification, and the facilitation of safe transitions for members to lower levels of care.
Our next step during CCO implementation is to accomplish two main structural changes during the first year of the CCO:

1. Better incorporate local organizations, such as the local APD and AAA offices, schools, and child welfare, into CCO medical care management activities at a local level. The partnerships between these systems and behavioral health are well established.

2. Integrate care management activities of MVBCN and CareOregon so that it is seamless to the member and provider community, ensuring that data and information is transitioned efficiently and effectively while ensuring CCO member confidentiality and rights under HIPAA and Oregon state law.

Standard 3 See attachment **B.3.Publicly Funded Programs – YCCO.** YCCO Publicly Funded Health Care and Service Programs Table. YCCO will have contracts in place by November 1, 1012 where necessary with these providers. Most of the organizations listed sit on the Steering Committee for YCCO. Also, see attached MOU with **A.MOU-LMHA-LPHA-YCCO.**

3.a Yamhill County's efforts to develop a CCO have included all major publicly funded entities since Steering Committee inception, and continue their input throughout the process of YCCO development. Yamhill County Health and Services (HHS) has taken the lead and provided Steering Committee facilitation. Other public partners actively engaged on the YCCO steering committee include: Virginia Garcia Clinic (our FQHC); HHS's Division staff representing Public Health, Mental Health, Substance Abuse and Developmental Disability programs; NW Senior and Disabled Services. Additionally, our Transformation Committee includes foster care providers, Lutheran Community Services, Catholic Community Services, Chehalem Youth and Family Services.

3.b YCCO and affiliates CareOregon, MVBCN and provider partners collectively have extensive and positive experience in coordinating services and contracting with the Yamhill County Health and Human Services Department (YCHHS) and do not anticipate any barriers. In fact, YCHHS has taken one of the key roles in developing this CCO and has the support of the Board of Commissioners. The YCCO contracts will be based on local capacities, considering County provided public health; other publicly funded services and non-publicly funded health related resources. In general, YCCO's contracts with local health departments (and public providers) cover public health programs and services. We will ensure that these contracts, on behalf of YCCO, cover the following:
1. **Community Health Assessment and Health Action Plan.** Local health department involvement in these efforts is critical and described further in A.1.6 of this application.
2. **Point of contact services.** Per ORS 414.153, local health departments will be reimbursed for immunizations, sexually transmitted disease, and other communicable disease clinical services.

3. **School-based health centers.** Yamhill County hosts 2 SBHC's and these are currently operated by the County Health Department but are likely be contracted to local providers in the future. Payment mechanisms for these centers will be consistent with how YCCO treats other publicly funded health care centers (such as federally qualified health centers).
4. **Wraparound and other preventive services.** YCCO will facilitate discussions with local health departments, clinical providers, and appropriate community organizations to determine the best locus for provision of services such as maternity case management, high-risk infant tracking and monitoring, prenatal care, child care, and health-related services provided in schools and early childhood development programs. When appropriate, some or all of these services may be included in the contract with local health departments.
5. **Community-based prevention services.** Following decisions made through the Community Health Assessment and Action Plan (A.1.6), YCCO will facilitate discussions with local health departments, clinical providers, and appropriate community organizations to determine the best locus for providing community-based preventive interventions. When appropriate, some or all of these services may be included in the contract with local health departments.

For mental health services, YCCO will have a capitated, delegated agreement with MVBCN and they will manage most of the current mental health and chemical dependency functions required by YCCO. As mentioned elsewhere in this document, CareOregon and MVBCN will jointly develop a plan of action for integrating administrative services over the first year of the CCO.
As part of its agreement with YCCO, MVBCN will provide comprehensive outpatient mental health treatment services through its existing contracted providers, including psychiatric care, crisis intervention and support, community based services and supports for adults and children with intensive treatment needs. This also includes the provision of transition services for adults and children moving in and out of state hospital and residential treatment. OHP outpatient chemical dependency treatment services will also be included in this agreement.

3.c YCCO plans to establish a written agreement between YCCO and YCHHS to govern MH and Developmental Disability related services to OHP members. YCCO is currently working through provisions related to mental health services, including an agreement with MVBCN, and fully expect to have signed agreements by the implementation date for OHP members.

Standard 4 - Services for AI/AN

4.a YCCO affiliate CareOregon has worked with AI/AN members throughout the state, especially in Portland, coordinating care and access throughout its network and in particular through NARA. Other YCCO partners including affiliate MVBCN and the county have experience working with AI/AN members who seek care throughout the community, and coordinating care and services with the Grande Ronde Health and Wellness Center. YCCO will expand that relationship to obtain training and support from Grand Ronde and other community providers about culturally relevant care for all AI/AN members in the CCO.

Standard 5 - HIS and Tribal Facilities

5.a Currently within CareOregon individuals from American Indian or Alaskan Native populations are given the opportunity to self-identify at treatment intake and may be offered referral to Indian Health services upon request. Identified individuals in the community and regional tribal offices are contacted as necessary to coordinate care and offer consultation and assistance. YCCO leadership has reached out to the Grande Ronde Tribe, and they sent a representative to the July 18 community meeting. At this point they have not determined in what form they will relate to YCCO. YCCO expects to work closely with the Grande Ronde Health and Wellness Center in Grande Ronde. YCCO, or its affiliate or partners, will not discriminate in contract payments to these agencies. Members are free to request services from one of these designated agencies, or any other network provider that meets Medicaid standards. Therefore, Alaska Natives and American Indians have access and regularly use physical and mental health services within the system.

Standard 6 - ISA for Children

6.a MVBCN's New Solutions program provides an Integrated Services Array for children and youth with severe mental or emotional disorders. We have invested in training, coaching and monitoring to achieve full-fidelity wrap around services based on system of care principles, with a team creating a family-driven plan for each child in partnership with other child-serving systems. Youth and Family Support Partners have been added to the teams to better engage and support families dealing with challenging children. We have reduced the percentage of children needing residential care, shortened the length of stay, and created a menu of community-based supports that enable children to be maintained in permanent homes in the community. MVBCN provides the largest of the 3 pilot sites for the Children's Wraparound Demonstration Project; YCCO intends to continue that program with local leadership from Yamhill County's Family and Youth Program's.

6.b In implementing the Children's System Change Initiative, MVBCN in partnership with Yamhill County providers, created regional and county oversight structures that include schools, ESDs, OYA, developmental disability programs, OFSN, and DHS. The full-fidelity wraparound EBP model enlists families, other child-serving systems and natural supports to create an individualized team and plan for each child. MVBCN has expanded these services in partnership with DHS for the wrap around pilot demonstration. YCCO will continue these partnerships.

6.c MVBCN's implementation of wrap around has been measured using a nationally-recognized instrument (Wraparound Fidelity Index) and scores above the national average for fidelity in implementing these principles. YCCO will use this instrument to assess continued fidelity implementation of wrap around service delivery.

Standard 7 - Mental Illness Services

7.a YCHHS will be the primary provider of behavioral health services, and will continue to provide the full array of outpatient and intensive supports as they have been enhanced during membership in the MVBCN. MVBCN will continue to contract with psychiatric hospitals and providers of intensive services for children for YCCO members. Lutheran Community Services will provide outpatient services for children and preventive services including parent training and a post-partum depression program.

THE YCCO YCHHS Adult Behavioral Health Programs will provide a comprehensive, integrated array of community based mental health services based on medical necessity. Bio-psychosocial service needs will be assessed and individualized service and support plans will be developed with CCO members. Supports will be coordinated to increase member's wellness and successful community integration and tenure. Services will be evidenced based utilizing the following Community Based Treatment models: Supported Housing, Assertive Community Treatment, Peer Delivered Services, Supported Employment, Supported Education, Early Assessment & Support Alliance and Medication Support – all models that require intensive community based wrap around support using trans-disciplinary teams. Services are in place to meet CCO members' residential needs including scattered site housing, supported housing, adult foster care, residential treatment facility and secure residential treatment facility.
YCCO goal will be to improve the psychiatric and physical health status of adults with serious mental illnesses (SMI) who have or are at risk for co-occurring primary care conditions and chronic diseases. We are in the planning stage of becoming (in partnership with Virginia Garcia Clinic) a medical home for individuals with serious mental illness as defined by SAMHSA and the Oregon Health Authority.

7.b Validated screening tools, such as Patient Health Questionnaire-2 (PHQ-2), will be made available and promoted for use by all primary care clinics in YCCO. This process is consistent with the state's PCPCH initiative. Using this tool, primary care clinic teams will identify a wide range of behavioral health problems (mood, thought and behavior disorders), and integrate that information into the electronic medical record for immediate use by the care team. In addition, Lutheran Community Services provides post-partum depression groups in both English and Spanish for mothers of OHP children, with screening and referrals coming from health and social service providers in the community.
Future goals include the consistent use of the above screenings for all patients in all PCPCH settings and ensuring that patients are directed to the most appropriate level of care.

Standard 7B - Chemical Dependency

7B.a YCCO partners have a long-standing history of providing community-based chemical dependency services. Yamhill County Chemical Dependency Program is part of HHS and will provide services such as:
Level 1 and 2.1 services for adults and adolescents including Spanish speaking and culturally sensitive services, problem gambling services, gender specific services, gender specific and trauma informed services, co-occurring disorders services, intoxicated driver services, high risk offender drug court services, Level 3.1 transitional residential services for women and their children, and referral to social and medical detoxification programs as well as to Level 3.3. and 3.5 residential services. Mutual referral protocols will also continue with community Recovery Support Services organizations (RSS) as well. RSS organizations provide post-discharge recovery supports following treatment. YCCO CD clinical staff will be Certified Alcohol/Drug Counselors (CADCs) and/or Certified Recovery Mentors (CRMs).
YCCO will ensure compliance with confidentiality rules and laws to allow sharing of information to coordinate care across medical home providers. Services will be coordinated with Primary Care, Mental Health care providers, CD residential care providers and urgent or emergent care providers for high users of such services, with client authorization at intake per state statue and when seen by urgent or emergent service provider. For individuals with co-occurring disorders

who have a history of frequent use of emergency departments with law enforcement interface, a medical data base release of information will be discussed with the CCO member.
Intake procedures will include routine requests for release of authorization forms to healthcare team providers, as well as to APD/AAA staff to encourage care is rendered in a setting that promotes independence and community-based services.

7B.b Some PCPs have piloted the screening of some patients with SAMHSA's Screening, Brief Intervention, and Referral to Treatment (SBIRT) program. These data are entered into the electronic medical record for immediate use by the PCP. YCMH has incorporated SBIRT screenings into mental health assessment. YCCO will encourage all primary care clinics to use the SBIRT screening tool.
Future goals include the consistent use of the universal screening for chemical dependency in primary care and emergency departments and ensuring that these patients are directed to the most appropriate level of care.

Standard 8 - Rx Services and MM

8.a YCCO's affiliate, CareOregon, has extensive experience providing prescription drug benefits following the OHP Condition/Treatment pair guidelines, and is committed to continuing to provide this benefit.

8.b YCCO affiliate CareOregon has a restrictive Medicaid formulary that has FDA-approved drug products in each therapeutic class in addition to including over-the-counter medications. The formulary includes at least one FDA-approved drug for each therapeutic class. Access to products not on the formulary is managed through a formulary exception process.

8.c Utilization tools such as prior-authorization, step-therapy, quantity limits, age and drug interaction edits and other quality interventions are used and updated regularly, based on reviews by physician and non-physicians specialists of the latest research. Providers can access information on how to submit a prior authorization (PA) request, including the PA form, online or by calling a Pharmacy technician. YCCO will utilize this CareOregon staff for prior authorization and formulary development, in consultation with the CAP.

8.d YCCO will use CareOregon's pharmacy benefit manager, Express Scripts, to process pharmacy claims, providing real-time inquiry and updated access. This system captures the relevant clinical and historical data required for claims payment and includes appropriate coordination of benefits application. Pharmacy provider reimbursement is tracked and coordinated from the claims processor regularly.

8.e YCCO will use CareOregon's prior authorization services, which are done in-house and accepted via fax 24/7. CareOregon is open 8 a.m. to 5 p.m., Monday through Friday, and Express Scripts covers after-hours for urgent requests and phone calls from pharmacies or providers. In addition, Express Scripts and CareOregon staff will provide emergency supplies of medication to assist when necessary to provide immediate coverage for urgent medications.

8.f YCCO's affiliate, CareOregon, has negotiated rates that are confidential and do not exceed -15% of the Average Wholesale Price (AWP) for either retail brand or generic drugs. Mail order rates

do not exceed -20% AWP. All rebates are handled according to State and Federal regulations, or as agreed upon and stipulated by the contract. Dispensing fees do not exceed $2.00 for either brand name or generic drugs. Generally, mail order prescriptions do not have a dispensing fee.

8.g YCCO's affiliate, CareOregon, currently has contracts with nearly all 340B pharmacies associated with 340B-qualified entities serving the YCCO population, including Virginia Garcia Memorial Health Center. CareOregon is already exploring potential projects with pharmacists representing 340B pharmacies, including Virginia Garcia clinics, to optimize 340B utilization, increase member use of pharmacies eligible to process 340B, and expand best practices in clinical pharmacy services with 340B revenue.

8.h Medication Therapy Management (MTM) is an integral part of CareOregon's services and will be used by YCCO. CareOregon has many years of experience with MTM through both OHP and Medicare, and has incorporated pharmacists into its team-based CareSupport teams. Current projects include evaluation and policies/procedures for effective Hepatitis C medication treatment. CareOregon medical directors and pharmacists will work with the CAP and other clinical committees to initiate projects and improve care management for members with high prescription use.

8.i CareOregon provides e-prescribing for providers to utilize with their EMR systems. Providers can access eligibility, formulary information and patient history through the tool, called epocrates.

Standard 9 - Hospital Services

9.a Both Willamette Valley Medical Center and Providence Newberg Medical Center CEOs fully participate in the YCCO Steering Committee and are devoting much time and energy to the success of YCCO. Both hospitals accept all OHP patients and are committed to serving the community.
Certain sub-specialty care services, such as major trauma, are not provided within the service area. Most specialized services are referred to Portland and Salem. YCCO will use CareOregon's provider contracts to access care outside the service area, and the CAP and other clinical committees will evaluate and monitor access to hospital care. MVBCN contracts for acute psychiatric hospital services with Salem Hospital and Good Samaritan Medical Center in Corvallis.

9.b YCCO hospitals and physicians are already exploring ways to decrease inappropriate emergency room use, and YCCO will explore various options that may include ER navigators, enhanced primary care access, and community outreach workers.
Currently CareOregon's CareSupport Department receives a daily emergency department census from some hospitals. CareSupport staff then follows up with members on the ED visits and provides education to members on ED use. This program will be adopted by YCCO. YCCO will develop reporting capabilities and relationships in the community, which would allow timely access to information regarding ambulance, ED or urgent care use.

9.c CareOregon Claims Department has a process in place to monitor and adjudicate claims for HACs. Their claims payment system, QNXT, has the ability to automatically adjudicate claims based on applicable indicators. They currently have a program in place which stops claims with a Present on Admission indicator, and the claim is sent to an examiner for review.

9.d Current hospital readmission policies at both YCCO hospitals require monitoring of readmissions and extensive discharge planning. Future development would target post-discharge transitions, including home visits within 24 hours for follow up and support and creation of a support plan that enlists ancillary community support services needed. Quality improvement and data tracking systems are in place in local hospitals and we will be implementing data sharing processes across the CCO.

9.e Unnecessary hospital utilization is related to unnecessary testing and ED Utilization. Refer to B9b for Emergency Departments. Unnecessary testing would improve with guidelines and policies for physicians to follow and specified prior authorizations. The CAP will create consistent guidelines for utilization of hospital based and high cost testing and determine which need preauthorization.

YCCO will build on current CareOregon programs to reduce unnecessary inpatient hospital and emergency room use, such as the use of community health workers. YCCO will evaluate OHP FFS data using CareOregon criteria for potential intervention of community outreach workers. Engagement of high-cost and high-needs members can decrease inappropriate ER use and hospital readmissions. YCCO will work with the CAP to evaluate implementing a transitions program, which involves intensive care management for all inpatient discharged members with certain diagnoses at risk for readmission, such as congestive heart failure. YCCO affiliate CareOregon has readmission rates at less than 10% statewide, so applying these strategies to the currently unmanaged YCCO members should yield significant savings.

Section 3 - Compliance with Medicaid

For purposes of implementing this CCO and the readiness review, YCCO will rely primarily on CareOregon policies and procedures for the Medicaid assurances in Attachment 6. CareOregon has met the requirements for the following programs:

- NCQA
- CMS
- DMAP

Each of these entities reviews policies and procedures related to member access, quality improvement, care management, HIPAA, record keeping, billing and payment, and member education. In addition, CareOregon has been an existing trading partner with DMAP since program inception, meeting system requirements for capitation receipt, quality reporting, financial reporting, HIPAA electronic transactions, and encounter reporting.

See Attachment 1.B. Attestations-Assurances-Representations-YCCO

Yamhill County Care Organization
Appendix C – Accountability Questionnaire

Section 1 – Accountability Standards

C.1.1. Background Information

C.1.1.a MVBCN's Quality Management Committee (40% of members are advocates) develops and monitors an extensive annual quality plan, with public data reporting and other mechanisms to hold providers accountable for performance. An annual consumer satisfaction survey obtains member feedback related to specific quality initiatives and allows for comparison of performance across provider agencies. YCHHS will continue to participate in the MVBCN quality improvement structure and link this with the YCCO quality processes. Dental outcomes and disease prevention are expected to be included in quality improvement and reporting measures.

YCCO affiliate Care Oregon's ability to collect and report on the quality measures surrounding accountability is robust and has the internal structure for integrating data from a variety of sources. CareOregon has produced a full spectrum of HEDIS measures for several years, many of which crosswalk to the quality measures found in **RFA Table C-1 - YCCO**. Understanding the member experience has been a focus for CareOregon and is deeply embedded in its Quality Improvement (QI) Program. An annual CAHPS survey is conducted for both Medicaid and Medicare as one way to gain insight into the member experience. Historically, CareOregon has also conducted Clinic-Based CAHPS surveys in order to produce results that are more actionable for both providers and CareOregon. In addition, CareOregon, through its affiliated Medicare plan, currently reports more than 50 outcome and member experience measures to CMS as part of the Star rating program, and has the policies and procedures in place to gather this information, validate it, and submit to CMS, having achieved a 3.5 Star plan rating and 100% compliance with CMS data validation standards.

C.1.1.b At a minimum, YCCO will use the following HEDIS measures as a way to monitor both compliance and performance. These measures are directly linked to YCCO affiliate CareOregon's NCQA Accreditation as a health plan.

- Annual Monitoring for Patients on Persistent Medications (Total Rate)
- Antidepressant Medication Management (Both Rates)
- Appropriate Testing for Children With Pharyngitis
- Appropriate Treatment for Children With Upper Respiratory Infection
- Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis
- Breast Cancer Screening
- Cervical Cancer Screening
- Childhood Immunization Status (Combination 2)
- Chlamydia Screening in Women (Total rate)
- Cholesterol Management for Patients With Cardiovascular Conditions (LDL-C Screening Only)
- Colorectal Cancer Screening
- Comprehensive Diabetes Care (Eye Exam, LDL-C Screening, HbA1c Testing, Medical Attention for Nephropathy)
- Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)

- Controlling High Blood Pressure
- Flu Shots for Adults (Ages 50–64)
- Flu Shots for Older Adults
- Follow-Up After Hospitalization for Mental Illness (7-Day Rate Only)
- Follow-Up for Children Prescribed ADHD Medication (Both Rates)
- Glaucoma Screening in Older Adults
- Medical Assistance With Smoking and Tobacco Use Cessation (Advising Smokers and Tobacco Users to Quit Only)
- Osteoporosis Management in Women Who Had a Fracture
- Persistence of Beta-Blocker Treatment After a Heart Attack
- Pneumonia Vaccination Status for Older Adults
- Prenatal and Postpartum Care (Both Rates)
- Use of Appropriate Medications for People With Asthma (Total Rate)
- Use of High-Risk Medications in the Elderly (Both Rates)
- Use of Imaging Studies for Low Back Pain
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD

C.1.1.c YCCO's performance expectation for HEDIS measures will be to attain the 75th percentile nationally. This is based on the NCQA Quality Compass benchmarks which are produced annually.
Ongoing dialogue with providers concerning HEDIS results will be accomplished through a team approach of YCCO staff members sharing results, identifying best practices and supporting clinics in their improvements efforts. Having the ability to analyze data in a variety of venues will give YCCO additional insight to provide quality improvement activities incorporating cultural and linguistic components. MVBCN uses a peer accountability process that has been very successful in creating powerful and transparent mechanisms for moving a multi-provider system forward. The CAP will consider creating a similar process of graduated information, work plans and sanctions for managing providers who are not achieving quality standards.

C.1.1.d Most primary care providers in the service area have the ability to assess, measure, and track performance through the use of electronic health records with tools such as dashboards, benchmarks, scorecards and other health metrics. YCCO will work to standardize this process and implement across the service area to ensure quality improvement. The YCCO CAP will meet regularly to assess quality assurance and develop and monitor targeted improvement strategies.

C.1.1.e It is important that YCCO members understand that quality of the health plan is a priority. The Community Advisory Committee will review performance information. Members will be informed of the plan's performance on quality metrics via member communications, such a mailings or the YCCO website. Members will also receive information about the goals of the CCO in response to the community needs assessment. All mailings and information will be reviewed and approved in order to meet OHA standards, and for readability and cultural sensitivity. Documents will be translated for prominent sub-populations, if requested.

C.1.1.f YCCO affiliate CareOregon has already implemented incentive-based payment tied to quality and improvement. For example, hospital contracts have incentives related to improve patient safety reporting and hospital patient satisfaction scores (HCAHPS). Primary care medical home payment has incentives that complement the PCPCH incentives developed by the state, which

are also based on HEDIS measures. The YCCO board will evaluate these and other possible incentives that may apply to CCO providers.

C.1.1.g YCCO, through the support of its affiliate CareOregon and MVBCN, has experience with data collection and analysis. CareOregon has six full time Healthcare Analysts on staff skilled at collecting and analyzing healthcare data. In addition, CareOregon's QI Program is staffed by three QI Coordinators, a Health Education Coordinator, an Accreditation Coordinator and a QI Nurse Manager who have experience working with member and healthcare data. CareOregon has had experience with producing member survey data such as CAHPS by working with external vendors. Their experience with the HEDIS process including the hybrid portion has given them the skill set to produce this type of data collection for future endeavors. YCCO will meet data and reporting requirements as required in the CCO contract.

Section 2 Quality Improvement Program

C.2.1 QAPI

C.2.1.a YCCO is affiliated with CareOregon has a Quality Improvement Program that has been reviewed and approved by the National Committee for Quality Assurance (NCQA). Please see attached document **C.2. CareOregon QI Program - YCCO** for a comprehensive description of CareOregon's Quality Improvement Program. YCCO will build upon the existing structure of CareOregon's Quality Improvement Program in developing its own QI Program, which will be centered in a Clinical Advisory Panel with links (including cross-membership) to other CareOregon QI structures. MVBCN's quality program (described in C1.1.a) will continue as a regional effort serving 3 CCOs and bringing advantages of scale to behavioral health system improvement. YCCO's Clinical Advisory Panel will incorporate local behavioral health leadership who will link integration initiatives with MVBCN strategies.

C.2.1.b The Clinical Advisory Panel will include representation from all areas of the service delivery system (outpatient, inpatient, mental health, physical health, oral health etc) as well as representatives from the Community Advisory Committee. CareOregon, MVBCN, and partner agency staff will provide staff support for QI processes.
The QI Program will strive to continuously improve the quality of care and service provided to YCCO members. The following Quality Committees are currently in place at CareOregon.
<u>Quality Improvement Management Committee</u>
• Develops and provides oversight and direction for the implementation of Quality related initiatives in the CareOregon strategic plan. Reviews and recommends approval of the annual Quality Improvement and Utilization Management evaluations and program descriptions
• Establishes and monitors plan-wide quality metrics
• Provides oversight and direction to the various QI committees by assessing committee specific information
• Makes final de-delegation decisions for specific delegated entities
• Meets and exceeds regulatory and accreditation agency standards
<u>Credentialing Committee</u>
• Evaluates healthcare professionals' initial credentialing applications based on established criteria
• Evaluates organization/facility initial credentialing applications based on established criteria

• Evaluates healthcare professionals' recredentialing applications based on established criteria
• Evaluates organization/facility recredentialing applications based on established criteria
• Approves credentialing and recredentialing applications with and without exceptions
• Approves organization/facility credentialing and recredentialing applications with and without exceptions
• Makes recommendations to the Network & Quality Committee of the Board of Directors regarding healthcare professionals' and facilities' participation on the CareOregon panel in the event of an adverse action for applicants
• Reviews and approves policies and procedures that directly relate to the credentialing decision-making process
• Reviews results of internal audits on a regular basis

Delegations Oversight Committee

• Reviews pre-delegation assessments for contracted entities and has the authority to make the following determinations: - Approve assessment
- Request corrective plan from delegate
- Make recommendation to QIMC regarding denial of delegation
• Reviews and approves documents related to delegation oversight
• Makes on-going delegation decisions for delegates based on review of annual reports and audits and has the authority to make the following determinations: - Approve assessment
- Request corrective action plan from delegate
- Make recommendation to QIMC regarding denial of delegation
• Establishes de-delegation and performance thresholds for delegated entities
• Identifies opportunities for improvement
• Defines and implements corrective action plans when warranted
• Ensures adequate resources are available to provide delegation oversight
• Makes policy recommendations regarding delegation oversight

Pharmacy & Therapeutics Committee

• Develops, regularly reviews and revises the CareOregon drug formulary to be consistent with evidence-based clinical practice and requirements of the Oregon Health Plan
• Develops, regularly reviews and revises the Health Plan of CareOregon drug formulary to be consistent with evidence-based clinical practice and requirements of CMS
• Assists with development and appraisal of drug utilization review (DUR) programs
• Assists with development and appraisal of the Medication Therapy Management Program
• Develops, regularly reviews and revises prior authorization, step-edit, quantity limit and other clinical edits to ensure that they are clinically appropriate
• Reviews pharmacy utilization; identifies trends and recommends and monitors improvement projects as appropriate

Peer Review Committee

• Reviews aggregate provider-specific complaints and takes action as appropriate
• Reviews provider-specific performance information (such as sentinel events and adverse outcomes)
• Reviews results of office site assessments done as a result of member complaints and makes recommendations
• Defines and implements provider-specific corrective action plans
• Monitors progress against provider-specific corrective action plans
• Recommends de-credentialing of specific providers to the Credentialing Committee

Quality Improvement Committee

• Reviews population analysis and establishes priorities for projects involving clinical aspects of care to ensure that they address high risk/high volume areas
• Decision-making authority for CareOregon medical policies relating to benefit management
• Decision-making authority to review new technology assessments and new uses of established technologies and make recommendations regarding coverage of the technology
• Reviews utilization data including but not limited to referrals, authorizations, inpatient utilization, appeals and identifying trends
• Establishes performance standards
• Reviews and analyzes data as it pertains to quality improvement initiatives including: -
Preventive health initiatives
- Health education programs
- Programs for members with chronic conditions
- Initiatives that focus on patient safety, health disparities, cultural competency, and health literacy
• Makes recommendations for change or interventions based on results of data
• Monitors for the effectiveness of changes
• Reviews and approves practice guidelines
Service Quality Committee
• Reviews and analyzes data from multiple sources including but not limited to: - **Consumer Assessment Health Plan Survey (CAHPS)**
- Aggregate member complaint reports
- Focus groups
- Aggregate appeals reports
- Provider satisfaction surveys
- Aggregate provider complaint reports
- Member Focus Groups
- Member Surveys
• Identifies areas for improvement and testing
• Monitors results against established targets
• Implements and monitors a systematic and ongoing process to obtain member input
• Recommends improvements to the QIMC
Each YCCO Quality Committee will include members of the Yamhill County provider community and will reflect the diversity of membership in the service area. The Quality Committees will interact with and inform the work of the YCCO Community Advisory Council and Clinical Advisory Panel, respectively.

C.2.1.c The YCCO quality plan will be developed by the Clinical Advisory Panel and approved by Governing Board with quarterly reports on key measures.

C.2.1.d The Community Advisory Committee will name two of their members to serve on the Clinical Advisory Panel, will make recommendations to the CAP regarding how to best pursue quality improvements for each community, and will receive regular reports on quality matters. The CAP will engage professionals from across the delivery system to pursue quality improvements. Under YCCO, a diverse group of providers and consumers will be represented on the CAC, and all will have the opportunity to plan and design the QI program as the community's needs are identified and addressed. Consumers will have a vote on the CAC.

C.2.1.e The QI Program will evaluate outcomes through data and metrics that are reported in a way that allows analysis of health and outcome inequities, particularly racial and ethnic disparities. The CAC will address these specifically in the community health improvement plan.

C.2.1.f The CAP will identify priority performance measures and develop a process for creating progressive performance improvement plans where needed.
Providers will be monitored for compliance with contractual responsibilities regularly through the use of performance measures and the grievance system. If concerning trends are revealed through analysis of grievance reports or other utilization data, providers will be counseled and put on corrective action plans. Those corrective action plans will be reviewed by the CAP or other committee delegated for that activity by the YCCO board.

C.2.1.g YCCO will build on the existing processes of both CareOregon and MVBCN to establish CCO-specific member protections and satisfaction, working closely with the CAC and CAP.
MVBCN will continue to provide leadership across 4 counties to identify, pursue and monitor improvements in mental health and chemical dependency treatment practice. Metrics and initiatives will be shared with the YCCO CAP and vice versa.
YCCO's affiliate, CareOregon, has a well defined process for managing member grievances (complaints) which are seen as one way to respond to customer satisfaction. Three of the established quality committees exist to respond to these issues. These committees are Peer Review, Quality Improvement and Service Quality. They deal with individual clinics/providers (Peer Review) as well as addressing trends and patterns (Quality Improvement/Service Quality). Issues of fraud and abuse can be identified through the grievance process and are managed according to the CareOregon fraud and abuse program.

C.2.2 Clinical Advisory Panel

C.2.2.a Yes

C.2.2.b Not applicable

C.2.3 Outcomes/Quality Measures/Costs

C.2.3.a Several YCCO affiliate organizations have policies and procedures to improve member's outcomes.
1. Willamette Valley Medical Center providers are currently evaluated by national quality organizations. Inpatient & outpatient follows policies and processes that are driven by or use national quality organizations such as HCAPHS, SCIPS, PQRS, CORE Measures etc. Key quality measures currently in place are consistent with existing state and national quality measures, and will be used to determine progress towards improved outcomes. A robust peer review protocol may include outside review. Additionally, our CAP will look at comparative data across providers to improve the quality of care we intend to use the Patient Activation Measure (PAM) across our system of care to assess Members' capacity to engage in self care and to match coaching strategies to their activation level.

2. YCHHS has implemented 80% of its behavioral health service array utilizing evidenced based practices in compliance with SB 267. Patient centered, strength based, culturally sensitive, trauma sensitive service planning including collaborative documentation are required by Oregon Health Authority Integrated Services and Support Rule. YCHHS has developed and implemented correlating policies and procedures ensuring that evidenced based practices are used as medically appropriate. We have developed and implemented a quality improvement process that includes quality goals and objectives that are consistent with these mandates. Outcomes are addressed through the quality improvement process, utilization review process, and by state licensing authorities.
3.CareOregon has achieved commendable NCQA status due to its programs and policies to measure and improve member outcomes. It has achieved a 3.5 Medicare Star rating, and has several initiatives in place to improve member outcome and satisfaction. Its primary care medical home collaborative (PC3) has member engagement and activation at its core. Team members are trained in motivational interviewing and use of PAM measures and scores to best assist members to achieve their health goals.

YCCO's affiliate partner MVBCN has been recognized as Oregon's most innovative MHO, and is experienced in strategies to select, implement and sustain evidence-based practices. Successful clinical improvement has included integration of mental health and chemical dependency services, wellness supports, trauma-informed care, full fidelity wrap around, early psychosis intervention, Collaborative Problem Solving with adults, Parent-Child Interaction Therapy, and peer delivered services. MVBCN uses a quality improvement process motivated by a spirit of collaborative innovation, driven by face-to-face discussion and decision making with all impacted parties. MVBCN has been recognized by AMH for its "outstanding family/youth/consumer involvement in systems work.....reflected not only in the number of advocates involved [40 in multiple committees], but in the depth and breadth of that participation." It brings together clinical leaders, member and family advocates and MHO staff to analyze needs and identify, implement and monitor practice improvements.

C.2.3.b See C. 2.3a.
The YCCO CAP will evaluate outcomes in care through evaluation of core and transformational measures, HEDIS measures, and evaluation of the Quality Strategy. This will include outcomes for disparities and outcomes achieved individually by PCPCHs within the provider panel, using the state PCPCH measures as the framework. At the point dental benefits are included under YCCO, the evaluation will include oral health measures consistent with existing state and national levels i.e. Healthy People 2020 goals.

YCCO will build on the NCQA national benchmark standards already being measured through CareOregon. The CAC will work towards health equities among members to alleviate disparities, and both the CAC and CAP will evaluate additional measures.

C.2.3.c YCHHS, as part of MVBCN, has several years experience with wellness initiatives addressing tobacco use, weight management and metabolic syndrome. We will train clinicians and care managers across our system to provide patients with coaching and educational materials and wellness opportunities commensurate with their PAM scores and individual needs and motivation.

YCCO affiliate CareOregon has implemented a robust member education component to their website which has a strong focus on wellness. Tobacco cessation materials, flu promotion and prenatal information including "Text4Baby" are other examples of CareOregon's ability to reach out to members.

The text below represents an excerpt from the website where members have access to Healthwise®

Resources for Staying Healthy:

- Healthwise® Knowledgebase health conditions, shared decision-making, diseases, and medical tests and procedures.
- Healthwise – Health Topics
- Healthwise – Medical Tests
- Healthwise – Medications
- Healthwise – Symptom Checker
- Healthwise – Interactive Tools
- Interactive Tool: What Health Screenings Do I Need?
- Interactive Tool: Are You Ready to Quit Smoking?
- Health Topic: Healthy Eating
- Health Topic: Asthma

Also available through Healthwise®:

- Healthwise Online Spanish Health Guide

More Resources for Healthy Living

- CareOregon Health Topics: Diabetes

C.2.3.d YCCO, through its founding partners, has the experience, systems and capability to record, monitor and report required data. The programs, methods, and processes have been addressed in prior sections of this C.2.3. YCCO, through CareOregon, already has in place payment incentives with primary care providers and hospitals that align with improved health outcomes and member experience.

C.2.3.e Due to the large migration of FFS members into the CCO, there is tremendous opportunity to more closely coordinate care for members and more efficiently use health care resources. For example, initial welcome calls may identify potential non-clinical services in the community to assist members. A robust PCPCH can proactively identify preventive services to benefit the CCO member. Close coordination among mental health, AAA and APD, primary care, and hospital discharge planning can improve post-discharge outcomes and reduce hospital readmissions. In addition, YCCO will move towards a community-wide HIT network that will help providers access information that will reduce duplication of services. Patient-Centered Primary Care Medical Home development will focus on strategies that may be used by providers to monitor and create improved outcomes in primary care. YCCO will monitor prior authorization policies and use case managers to review requests for services and ensure that they are medically necessary and not duplicative.

C.2.3.f YCCO will draw upon the experience of its affiliate, CareOregon, in managing the coordination of care and the arrangement, tracking and documentation of all referrals and prior authorizations. CareOregon has policies and procedures in place that are designed to ensure continuity of care for members who are accessing different facets of the healthcare system.

CareOregon also has a robust electronic system for tracking, documenting and responding to prior authorization requests. For example, in one pilot program, all members who are admitted with a diagnosis of congestive heart failure (CHF) are assigned a case manager for at least 30 days following discharge to reduce readmissions.

Table C-1
Year 1 CCO Accountability Metrics
(transparency metrics also listed)

Note: CCOs' accountability in Year 1 is for reporting only - reporting encounter data or reporting on measures under the second heading below. Because accountability is for reporting only, measures are not categorized into "core" or "transformational." The OHA Metrics & Scoring Committee (established by SB 1580) will advise the Authority on development of benchmarks, accountability structure, and incentive design for future years. Measures to be collected by OHA and CCOs **1. Reduction of disparities - report all other metrics by race and ethnicity** *Data collection responsibility*: OHA collection of race and ethnicity at enrollment; responsibility for reporting by race and ethnicity depends on specific measure *Measure also collected or required by*: n/a Measures to be reported by OHA or contractor, validated with CCOs **1. Member/patient Experience of care (CAHPS tool or similar)^*** *Data collection responsibility:* OHA *Measure also collected or required by:* Medicaid (Adult Core and CHIPRA Core); Medicare Advantage and ACOs; OR PCPCH; others **2. Health and Functional Status among CCO enrollees^*** *Data collection responsibility:* OHA, at enrollment and reauthorization or via member survey *Measure also collected or required by:* n/a **3. Rate of tobacco use among CCO enrollees^*** *Data collection responsibility:* OHA, at enrollment and reauthorization or via member survey *Measure also collected or required by:* n/a **4. Obesity rate among CCO enrollees^*** *Data collection responsibility:* OHA collection of height, weight via member survey *Measure also collected or required by:* n/a **5. Outpatient and ED utilization^*** *Data collection responsibility: OHA or contractor via encounter data* *Measure also collected or required by: Medicaid (CHIPRA Core)* **6. Potentially avoidable ED visits^*** *Data collection responsibility:* OHA or contractor via encounter data *Measure also collected or required by:* QCorp	**Transparency Measures – Collected/reported by OHA for public reporting, evaluation, etc.** CMS Medicaid Adult Core Measures including: · Flu shots for adults 50-64 · Breast & cervical cancer screening · Chlamydia screening · Elective delivery & antenatal steroids, prenatal and post-partum care · Annual HIV visits · Controlling high BP, comprehensive diabetes care · Antidepressant and antipsychotic medication management or adherence · Annual monitoring and for patients on persistent medications · Transition of care record CMS CHIPRA Core Measures including: · Childhood & adolescent immunizations · Well child visits · Appropriate treatment for children with pharyngitis and otitis media · Annual HbA1C testing · Utilization of dental, ED care (including ED visits for asthma) · Pediatric CLABSI · Follow up for children prescribed ADHD medications SAMSHA National Outcome Measures including: · Improvement in housing (adults)

7. **Ambulatory care sensitive hospital admissions (PQIs)^***
   Data collection responsibility: OHA or contractor via encounter data
   Measure also collected or required by: Medicaid (Adult Core); Medicare ACOs; Q-Corp

8. **Medication reconciliation post discharge^***
   Data collection responsibility: OHA or contractor via encounter data (use measure administrative specifications)
   Measure also collected or required by: Medicaid (CHIPRA Core)

9. **All-cause readmissions^***
   Data collection responsibility: OHA or contractor via encounter data
   Measure also collected or required by: Medicaid (Adult Core); Medicare ACOs; Q-Corp

10. **Alcohol misuse – screening, brief intervention, and referral for treatment^**
    Data collection responsibility: OHA or contractor via encounter data
    Measure also collected or required by: Medicaid (Adult Core); Meaningful Use, OR PCPCH

11. **Initiation & engagement in alcohol and drug treatment^**
    Data collection responsibility: OHA or contractor via encounter data
    Measure also collected or required by: Medicaid (Adult Core); Meaningful Use, OR PCPCH

12. **Mental health assessment for children in DHS custody**
    Data collection responsibility: OHA via encounter and administrative data
    Measure also collected or required by: Current MHO performance measure/ DHS wraparound initiative

13. **Follow-up after hospitalization for mental illness^**
    Data collection responsibility: OHA or contractor via encounter data
    Measure also collected or required by: Medicaid (Adult Core)

14. **Effective contraceptive use among women who do not desire pregnancy***
    Data collection responsibility: OHA via member survey
    Measure also collected or required by: Medicaid (Adult Core)

15. **Low birth weight**
    Data collection responsibility: OHA or contractor via encounter or vital statistics data
    Measure also collected or required by: Medicaid (CHIPRA Core)

16. **Developmental Screening by 36 months**
    Data collection responsibility: OHA or contractor via encounter data, (use measure administrative specifications)
    Measure also collected or required by: Medicaid (CHIPRA Core)

- Improvement in employment (adults)
- Improvement in school attendance (youth)
- Decrease in criminal justice involvement (youth)

Others TBD, for example:

- Time from enrollment to first encounter and type of first encounter (urgent or non-urgent, physical, mental, etc.
- Initiation and engagement of mental health treatment

Measures to be collected by CCOs or EQRO

1. **Planning for end of life care (documentation of wishes for members 65+)**
   Data collection responsibility: CCOs or via EQRO; could be sample- rather than population-based
   Measure also collected or required by: n/a

2. **Screening for clinical depression and follow-up^**
   Data collection responsibility: CCOs or via EQRO; could be sample- rather than population-based
   Measure also collected or required by: Medicaid (Adult Core); Medicare ACOs

3. **Timely transmission of transition record^**
   Data collection responsibility: CCOs or via EQRO; could be sample- rather than population-based
   Measure also collected or required by: Medicaid (Adult Core, Health Homes Core); AMA-PCPI

4. **Care plan for members with Medicaid-funded long-term care benefits**
   Data collection responsibility: CCOs or via EQRO; could be sample- rather than population-based
   Measure also collected or required by: n/a – to promote coordination with long-term care services

* Report separately for members with severe and persistent mental illness

^ Report separately for individuals with Medicaid-funded Long-Term Care (LTC) – These measures may be used to promote shared accountability between CCO and LTC systems.

CareOregon
315 SW Fifth Avenue, Suite 900
Portland, Oregon 97204
503-416-4100 or 800-224-4840
800-735-2900 (TTY/TDD)
www.careoregon.org

Quality Improvement Program

2012

Quality Improvement Program

CareOregon's Mission: *Be a Community Benefit organization to assure Oregon's vulnerable populations receive access to high quality healthcare from a stable network by a well managed, financially sound organization.*

CareOregon is a not for profit organization committed to improving and protecting the health of low income and vulnerable Oregonians. The CareOregon Quality Improvement Program is inclusive of both Medicaid and Medicare. Our current Medicare structure includes a Special Needs Plan (based on the dual eligible membership) and the commercial plan which was developed to ensure low income individuals had an option for coverage. The service area includes 15 counties in Oregon for the Medicaid membership and 7 counties for the Medicare members.

CareOregon recognizes the complexity of the population we serve which includes poverty, low literacy and multiple co-morbid conditions (behavioral and medical).This is especially evident in our Medicare membership with over 55% of the population being under 65 years of age. This non-traditional Medicare plan includes numerous individuals who have achieved Medicare eligibility due to the nature of their mental illness/disability. In order to effectively serve this population, it is essential that CareOregon have a highly integrated quality improvement program.

CareOregon has embraced three key objectives termed the "Triple Aim" which was originally coined by IHI (Institute for HealthCare Improvement). CareOregon has embraced the Institute for Healthcare Improvement's (IHI) Triple Aim as a key driver for much of its quality improvement and business strategy. It is CareOregon's belief that focusing on these concepts will lead us to the integration of quality improvement that will most benefit our members. The key objectives are:

- Improve the health of the population
- Enhance the member experience of care (including quality, access, and reliability)
- Reduce , or at least control, the per capita cost of care

Product Name	Product Type	Enrollees	Date of Operation
CareOregon	Medicaid HMO	155,659	1994
CareOregon Advantage Plus	Medicare Advantage-Special Needs Plan	6967	2006
CareOregon Advantage Star	Medicare Commercial	867	2009
	Total	163,493	

The practitioners that serve our members consist of 950 primary care providers, 3,000 specialists, 33 hospitals throughout the state of Oregon and 14 Public Health Departments. Primary Care Practitioners are defined as family practice practitioners, general medicine practitioners, pediatricians, internists, nurse practitioners and obstetricians. Organizational contracts include home care agencies, skilled nursing facilities, acute care facilities (hospitals), free standing surgical centers, clinical laboratories, comprehensive outpatient rehabilitation facilities, end stage renal disease services provider, rural health clinics and federally qualified health centers. Chemical dependency services are available (and managed) through the CareOregon benefit and provides for substance abuse assessment/evaluation and treatment. Currently there are 120 chemical dependency providers available for our members.

It is important to understand the composition of the Medicaid system in Oregon due to the unique construction of the program. During 1994 the State of Oregon made the decision to provide Medicaid coverage to thousands of individuals that previously did not qualify. Originally the Oregon Health Plan (OHP) began as a Medicaid demonstration project. This is important since the OHP consisted of two key tenets:

- Medicaid benefits were made available to most people living in poverty regardless of age, disability or family status
- Benefits were based on a priority list of health care conditions and treatments.

Currently the OHP offers two benefit packages that were developed to help control costs as well as reduce the number of low income, uninsured Oregonians. The following categories represent the two benefit packages available:

- OHP PLUS: Aged, Blind and Disabled, under the age 19, pregnant or receiving Temporary Assistance for Needy Families
- Standard: Oregon residents with limited income, over the age of 19 and do not qualify for the traditional Medicaid (Standard benefit is limited in scope)

The development of Oregon's unique Medicaid delivery system created a multi-pronged approach for the State to make services available. Currently OHP contracts with three separate organizations to provide services to the Medicaid population. :

- Managed Care Organization (MCO): Manage benefits for physical health including pharmacy(except mental health drugs are not covered) and chemical dependency
- Dental Care Organization (DCO): Manages dental services for the population served under the Medicaid program
- Mental Health Organization: (MHO) Manages the behavioral health services

With the ending of 2011 the State of Oregon was entering into an entirely new dimension of health care delivery for the Medicaid population; Coordinated Care Organizations (CCO). The intent of the CCO model is to ensure that services are provided to this vulnerable population efficiently, effectively and economically. Given that the CCO model is regional in nature CareOregon will be making decisions as to our level of participation in the various counties.

Our Medicare plans provide mental health coverage to members; originally through a contract with United Behavioral Health Care (UBH). The decision was made to transition the mental health benefit from UBH to be managed by CareOregon. This transition was fully executed September 1, 2011.

An analysis of the CareOregon population continues to reflect that diabetes and depression are the most prevalent chronic conditions across the plans. For this reason, CareOregon made the decision to offer disease management services to our members through forming external relationships (delegation). The original source of the disease management services was offered through a NCQA accredited organization, Health Integrated. This decision was made in part since Health Integrated's program (Synergy) is based on a non- traditional approach to disease management. The Synergy program uses the diagnoses of diabetes and depression only as indicators for potential participation while their services are holistic in nature. As of 2011 specific clinics (Primary Care Renewal Clinics) are now delegated to offer the same/similar service to their clients.

Member Demographics

It is important (essential) that CareOregon fully appreciate and understand our members of both health plans in order to identify barriers and unique needs that can improve the experience with the health care system. Over 80% of our

Medicaid/Medicare membership is located in the tri-county area (Multnomah, Washington, Clackamas) which includes the metropolitan Portland area. Approximately 50% of our members are assigned to Federally Qualified Health Centers (safety net) clinics. Approximately (30%) of our members are in clinics that have or are in the process of transforming to patient centered medical homes.

Understanding how best to communicate to our members includes being able to identify their primary language preferences.

We have the advantage that cultural and language preference information is included in the enrollment file that we receive from the state. Since the majority of our Medicare members also have CareOregon for their Medicaid coverage, the information we have available is quite complete.

Medicaid	Medicare
English-71%	English-89.5%
Spanish-21%	Spanish-2%
Russian-3%	Combination: 8.5%

A population analysis is done on an annual basis. This provides us with the opportunity to better understand who our members are both in terms of diagnoses, but also in terms of age, ethnicity, and primary language. This information helps guide the development of quality activities and member communication.

- 57% of our Medicaid members are children (0 to 17); decrease from previous analysis of 6%
- Women represent 56 % of the membership
- Only 5% of our Medicaid adults are over age 65
- 55% of Medicare membership is under the age of 65 years of age. Thus we have a high number of disabled members many of whom have chronic, severe mental illness as their disability.

Scope

The Quality Improvement (QI) program consists of a broad range of clinical and service initiatives relevant to our membership and covers all Medicaid and Medicare products. The program's scope is determined following an annual analysis of the population and its demographic and clinical characteristics. It includes the monitoring and evaluation of high volume, high risk, problem prone,

clinical, and service issues. Performance goals and thresholds are established for all measures, and are trended over time.

The scope includes specific clinical and service areas in which to focus resources to improve performance. At a minimum, the QI program monitors and evaluates major primary care services, management of chronic care, use of preventive services, behavioral care services, the availability and accessibility of services and member satisfaction. A comprehensive summary of clinical and service measures and the specific objectives describing areas selected for focused improvement is located in the QI Work Plan.

Program Goals and Objectives

The overarching goal for the QI program is to meet Triple Aim goals of improved health outcomes, improved experience, and lower cost while using the criteria articulated by the Institute of Medicine's (IOM) "call to action to improve the American health care delivery system" (Crossing the Quality Chasm: A New Health System for the 21st Century 2001) Program goals are based on the following parameters:

- **Safe** – avoiding injuries to patients from the care that is intended to help them.
- **Effective** – providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit.
- **Patient-centered** – providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- **Timely** – reducing waits and sometimes-harmful delays for both those who receive and those who give care.
- **Efficient** – avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Equitable** – providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

CareOregon uses a multi pronged approach to address these elements which includes integration of services internally (Care Support/Medical Benefits Assurance/Pharmacy/Quality Improvement) and externally. CareOregon supports a strategy for addressing cultural and linguistic needs of our members through a

process referred to as the Diversity Committee. The focus of this group is to ensure that culturally appropriate communication is embedded throughout our communication with members.
We have developed a program called Care Support and System Integration (CSSI). Through this mechanism we invest significant money and resources in training and guiding clinics, hospitals, and other community organizations as they undertake quality improvement projects that are consistent with both our strategic business goals and the IOM's stated objectives. As an example, this program has been used to fund our Primary Care Renewal program which focuses on the development of primary care medical homes.

The following program goals support the specific objectives found in the work plan. These include:

1. Implement scientifically-based clinical practice guidelines and disease management programs which improve process and outcomes of clinical care for the most prevalent chronic conditions in the population

2. Improve the use of high volume, high risk preventive health services

3. Work collaboratively with behavioral care services to monitor, evaluate and improve process and outcomes of behavioral care, and coordination between behavioral care and general medical care

4. Support implementation of activities to improve patient safety in care delivery settings

5. Achieve high member satisfaction with health care delivery to ensure it is customer driven, patient centered and community centric through monitoring and evaluation and interventions where appropriate

6. Achieve high functioning alliances with providers by working in partnership with practitioners who are responsible for providing clinical care services in the selection, design and implementation of strategies to improve process and outcomes.

7. Monitor, and improve when necessary, accessibility and availability of clinical care services

8. Maintain a system for monitoring, investigating and evaluating episodes of poor quality of care

9. Maintain an ongoing, up-to-date credentialing and recredentialing process of providers and organizations.

10. Provide oversight of the utilization management program and its impact on members and providers.

11. Provide appropriate oversight of all delegated relationships.

12. Support, or be synergistic with other quality improvement efforts by provider groups, community groups, other health plans and State Medicaid agency

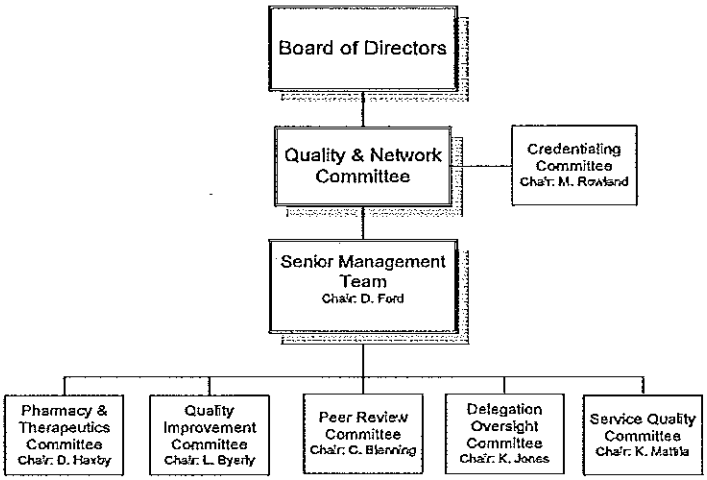
13. Focus on areas that have a significant impact on a population that has exceptional needs and those individuals at risk for poor outcomes

14. Provide services and information to our members in a manner that is both culturally and linguistically appropriate

Quality Improvement Program Structure

CareOregon's Chief Medical Officer is directly responsible for implementation and ongoing efforts of the QI program. The QI program strives to continuously improve the quality of care and service provided to our members. It is implemented through a series of committees that address various aspects of quality of care and service. The Board of Directors has delegated authority for the oversight of CareOregon's quality improvement program to the Board's Quality and Network Subcommittee. The Quality and Network Subcommittee utilizes the Senior Management Committee to oversee the quality improvement program.

CareOregon Quality Committee Structure 2012



Each committee reviews data relevant to its area of accountability and recommends implementation of improvement projects using PDSA (Plan-Do-Study-Act) methodology.

Annually, each committee conducts an evaluation of its work and recommends changes to existing programs and new projects to the Senior Management Committee (SMC) for review. The SMC evaluates the committee recommendations and thereby participates in the creation of the overall QI work plan.

The following sections briefly describe each Quality Improvement Program committee. For information on each committee, see the various committee charters in Addendum A. The committee charters list the committee's responsibilities, membership, and meeting frequency.

Senior Management Committee (SMT)

The Senior Management Team (SMT) is composed largely of senior executives that have general oversight over CareOregon's management, policies, and personnel. This committee oversees the organization's quality improvement program through the reporting of the various quality improvement committees. SMC is accountable for ensuring the focus and direction of the quality program toward achieving the "Triple Aim".

The Senior Management team meets weekly and consists of all CareOregon executives and directors. At CareOregon our business plan, in addition to operational and financial objectives, has a lot of strategic focus on the Triple Aim and on improving provider relations. Consequently, much of the work of the team was duplicating that of QIMC and the decision was made to consolidate the two groups.

The following quality program committees report directly to the SMC:

- Pharmacy and Therapeutics Committee
- Quality Improvement Committee
- Delegation Oversight Committee
- Peer Review Committee
- Service Quality Committee

Pharmacy and Therapeutics Committee (P&TC)

The Pharmacy and Therapeutics Committee (P&TC) is composed of internal staff and contracted physicians and pharmacists. It is accountable for the oversight of the CareOregon Pharmacy program, the development and maintenance of the CareOregon formulary, and programs that impact pharmacy utilization.

Quality Improvement Committee (QIC)

The Quality Improvement Committee (QIC) is a committee of internal staff, contracted providers, and QI specialists from contracted medical and chemical dependency groups. This is an advisory committee that provides oversight and direction for CareOregon initiatives impacting the quality of care for our members. Participation includes physical health and behavioral health providers. The QIC also provides oversight to the CareOregon Utilization Management Program

including approval of medical policies and new technology assessments. Utilization trends are reviewed through the use of standardized reports.

Credentialing Committee

The purpose of the Credentialing Committee is to ensure a high quality health care provider panel for our members. This is accomplished through the review of credentialing and recredentialing provider applications against recognized, consistent standards. Additionally, the Credentialing Committee ensures that the processes used by the CareOregon credentialing staff are consistent with regulatory standards. Credentialing Committee reports directly to the Quality and Network Committee (sub-committee of the Board).

Delegation Oversight Committee (DOC)

The Delegation Oversight Committee is comprised of internal staff involved with the delegation agreements. The Committee provides consistency and structure for review of annual and ongoing oversight and recommendations related to the delegation arrangements.

Peer Review Committee (PRC)

The Peer Review Committee (PRC) is a committee of internal staff and contracted providers. It is accountable for monitoring and ensuring the quality of care and service provided by contracted providers.

Service Quality Committee (SQC)

The Service Quality Committee (SQC) is a committee of internal staff. It is accountable for the identification of issues impacting the satisfaction of our members through the analysis and integration of information from multiple sources. Opportunities for improvement are identified, interventions are recommended and results monitored.

Organizational Structure

Each of the areas (Managers) described in the QI program are responsible for managing the implementation, assessment and evaluation aspects of their

respective accountabilities. The Quality Improvement (QI) Unit is responsible for coordinating the efforts of the QI program as well as monitoring of the QI work plan. Unless otherwise noted this document is inclusive of both Medicare and Medicaid plans.

The QI Unit includes:

- QI Coordinators (2 nurses; 1 medical assistant = 3 FTEs)
- Health Outcome Supervisor (1 FTE)
- Grievance Coordinator (2 FTEs)
- Health Education Coordinator (1 FTE)
- Accreditation Coordinator (1 FTE)
- Administrative Assistant (1 FTE)
- Credentialing Specialists (3 FTEs)
- Records Coordinator (1 FTE)
- QI Nurse Manager (1 FTE)

Responsibilities include:

- Provision of staff support to QI, Peer Review and Credentialing committees;
- Analysis of quality efforts identifying barriers, proposed interventions, intervention timelines; as well as identifying disparities that may exist
- Oversight of the adverse event process as a mechanism to address patient safety issues;
- Oversight of delegation specific to disease management and credentialing, including conducting an initial evaluation of potential delegates, reviewing and evaluating delegates' reports, and communicating an annual assessment of the delegated functions;
- Formulation of scheduled reports for external review agencies;
- Analysis of "Over and Under utilization;"
- Population analysis performed annually;
- Identify and address member communication needs to increase the likelihood of member understanding (language, communication style, etc);
- Facilitate implementation of the QI work plan across the organization;
- Complete research for the adoption of practice guidelines and health management programs for submission to the QIC;

- Manage the member grievance process. Trended reports of aggregate member complaints are reported quarterly to the QIC; and
- Work collaboratively with and oversee the work of Health Integrated and Primary Care Renewal Clinics that provide disease management services.

Pharmacy Unit

The Pharmacy unit is responsible for development and administration of the formulary with the assistance from the Pharmacy Benefits Manager (PBM) and the Pharmacy and Therapeutics Committee. Details of the P&T Committee can be found in the Utilization Management Program description. The Pharmacy Unit is also responsible for the oversight of the Medication Therapy Management Program; currently conducted by the PBM for the Medicare population. Quality Assurance and Retrospective Drug Utilization is conducted through this avenue, as well. The Pharmacy Unit includes:

- Pharmacy Technicians (6 FTEs)
- Pharmacy Technician Lead (1 FTE)
- Clinical Pharmacists (1.8 FTEs)
- Clinical Pharmacist Coordinator (1 FTE)
- Associate Pharmacy Director (1 FTE)
- Pharmacy Director (0.5 FTE)

Medical Benefits Assurance Unit (MBA)

The Medical Benefits Assurance unit is responsible for the development of the UM Program as it relates to the administration of the medical benefits through the prior authorization process, concurrent review, and management of appeals. The scope of MBA also includes the identification and reporting of "Adverse Events" and staff work collaboratively with the QI unit to ensure timely and accurate reporting. The MBA unit provides quarterly reports of timeliness of decision-making, denial rates as well as appeals by type and outcomes to the QIC. MBA works closely with the CareSupport Unit to assist members in managing transitions. Additionally, the MBA Staff identify and refer members appropriate for internal and external programs including the following:

- Health Integrated (Disease Management)
- Palliative Care
- CareSupport (Complex Members)

The Medical Benefits Assurance Unit includes:

- Prior Authorization Nurses (4 FTEs)
- Concurrent Review Nurses (6 FTEs)
- Durable Medical Equipment Specialists (3 FTEs)
- Appeals Coordinators (2 FTEs)
- Medical Benefits Assistants (9 FTEs)
- Administrative Assistant (1 FTE)
- Records Coordinator (.6 FTE)
- Nurse Supervisor (2 FTEs)
- Nurse Manager (1 FTE)
- Associate Medical Directors – who also act as resource to CareSupport and support the post payment reconsiderations (0.6 FTE).

Clinical Claims Review Unit

The Clinical Claims Review Unit is responsible for pre and post-payment of targeted claims. Post-payment reviews are reviews of hospital inpatient services after care has been received and the hospital providers of care has billed and been reimbursed by CareOregon. Claims are reviewed for documented medically necessary services, appropriate levels of care coding, and nationally recognized billing standards. The goals of pre and post payment claims review is to:

- Enforce contracts with provider of service
- Ensure payments are made consistent with medical policy
- Ensure billing and documentation accuracy

Additionally, the Clinical Claims Unit reviews emergency room claims for either payment at a contract or an assessment rate.

The Clinical Claims Review Unit includes:

- Medical Coding Specialist (1 FTE)
- Clinical Claims Review Unit Assistant (2 FTEs)

- Clinical Claims Review Nurse (1 FTE)
- Clinical Claims Review Nurse Manager (1 FTE)

CareSupport Department

The CareSupport (CS) program serves those whose health care is compromised by complex medical, behavioral, and/or social conditions. The conditions addressed include chronic illness, multiple co-morbidities, level-of-care transitions, chemical dependency, resistance to change, and limited access to resources or inappropriate use of resources. A set of five domains of concern were developed (which are considered to be determinants of health) that each identified member is assessed against in order to identify modifiable risk factors. A separate Care Support program description is included as a supplement to the QI program document

Five Care Domains and Examples of CareSupport Interventions

The five care domains included in each member's assessment are:

1) Health Trajectory: What are the underlying physiological/health status and history of the member? How are co-morbidities impacting the member's status? What has contributed to the member's treatment history? What is the prognosis of the member? What are the risks that may be modified through better or different medical management and/or more optimal monitoring?

2) Medical Home Relationship: How is the member's quality of relationship with his/her primary care provider? How can we facilitate a more productive interaction between the member and his/her medical home? What are the barriers to optimizing this relationship and how can we reduce or eliminate these barriers?

3) Medical Services Access: Are there any barriers the member has to key prescribed treatment and preventative services, referrals, and/or equipment that put the member at risk? Barriers may include:
   - Access to services
   - Transportation
   - Benefit limitations.

4) Self Management Capability/Willingness: Are there self-management behavioral deficits that create a barrier to optimum self management or put the

member at risk either in the near future or over the next year? These deficits may include:

- Knowledge deficit regarding diagnosis/treatment/life planning
- Cognitive impairment/mental illness
- Motivation/engagement level
- Denial
- Inadequate skills development.

5) Social Support System: Are there missing social supports that put the member at risk? Missing supports might include:
   - Basic needs such as appropriate food, safe and adequate housing
   - Available benefits and financial resources
   - Inability to perform activities of daily living (ADL/IADL)
   - Disability support or advocacy
   - Caregiver resources and their involvement in the care plan

Care Support targets members who are identified as being high risk in one of the following areas:

- Functional health decline or health care utilization which represents the top 6-12% utilization of total membership;
- Exceptional/complex health needs; and
- Difficult transitions; such as from hospital to home

Care Support Case Management Program utilizes a multidisciplinary team approach in providing case management services for members with "modifiable" risk factors and who are willing to participate. An integrated relationship exists between Medical Benefits Assurance, Pharmacy, Quality Improvement and Clinical Claims to support the identification, outreach management of our members.

The Leadership and Management of Care Support Department was transitioned as of June 2012. The Chief Medical Officer has direct accountability for this department now.

- Nurse Manager (Manager of Medical Benefits Assurance = 1 FTE)
- Supervisors – (1 Nurse, 1 Social Worker = 2 FTEs)
- Program Coordinator (1 FTE)
- Behavioral Health Specialists (5 FTEs)

- Registered Nurses (8 FTEs)
- Health Care Coordinators (11 FTEs)

INNOVATIVE AND/OR TRANSFORMATIVE PROGRAMS

In addition to the internal processes that are in place to support and promote the quality program's goals CareOregon has created provider based programs to strengthen quality efforts. These are the CareSupport and System Innovation Program, Primary Care Renewal, Long Term Care, and Palliative Care programs.

Care Support and System Innovation Program (CSSI)

CSSI was developed in 2005 as a way to foster a culture of evidence based practice and continuous improvement in CareOregon provider organizations. The CSSI program provides 3 million dollars annually for training, coaching, and technical assistance to hospitals and provider clinics for selected improvement projects. A conference is held at the end of each funding season at which each participant presents their project and outcome. One of the overarching goals is to develop strategic partnerships with providers who share CareOregon's mission of serving the underserved. Projects are funded annually to support providers in developing or enhancing renewal/medical home practice and projects that support our organizational strategic goals.

Primary Care Renewal Program (PCR)

In March 2007 CareOregon and 5 of its partner primary care organizations began a collaborative initiative to test and spread a "patient centered medical home" model that had been demonstrated to be effective by the South Central Foundation in Anchorage, Alaska. The goal of the project, called "Primary Care Renewal," has been to the improve the reliability of delivery of evidence based medical services to practice patients and to enhance the supports to patients with chronic and complex conditions to help them have the best possible health outcomes.

The key elements of the new practice model are:

1. Team based care with multi professional teams of clinicians, care managers, behaviorist, medical assistants and team assistants,
2. Patient centeredness based on ongoing direct assessment of individual and collective patient wants and needs,

3. Integrated behavioral health using a trained "behaviorist" working alongside medical clinicians on the team,
4. Empanelment of patients to a specific team to optimize partnership and population oversight, and
5. Enhanced access not only by open access to clinic visits but also by removing barriers to phone and other methods of team/patient communication and support. All those participating in the PCR initiative have received formal training in process improvement (Model for Improvement/PDSA techniques) through the CareOregon Learning Commons and staff.

Currently there are 18 clinics participating with over 65 individual clinician teams. Throughout the initiative, clinics have been required to report clinical (e.g. HEDIS based), access (next available) and satisfaction measures (PCR designed survey) and encouraged to share "best practices" in improving these outcomes.

In 2009, a pilot PCR quality bonus program was instituted to incentivize improvement of these metrics; lessons learned from the incentive pilot resulted in a 2010 redesign of the bonus program which has a broader set of reportable metrics and a much more rigorous set of data definitions arrived at through an extensive co-design process with the clinics. The goal of the bonus program is not only to learn how to align incentives toward better primary care population outcomes but also to build clinic measurement capacity to guide the work done by the teams in real time and to give feedback to the clinics and their organizations about their overall effectiveness of care.

Long Term Care Program

During late 2010 CareOregon launched a home based Long Term (LTC) Care Pilot in collaboration with the State's Senior and People's with Disabilities (SPD) division. Oregon has a history of providing long term care services to people in non-institutional settings. However even though CareOregon and SPD serve the same clients, the benefits and services have not been coordinated historically. We also know that many of our members receiving LTC services often do not adequately access physician services and tend to over utilize hospital and ED services. This collaborative project offers the opportunity to provide integrated services with the goal of meeting all three arms of the Triple Aim. Program staff consist of a CareOregon Nurse Practitioner and two SPD case workers. Most of the recipients of this program to date are assigned to a Virginia Garcia clinic (one of our Primary Care Renewal clinic systems) or to a CareOregon Community

Clinic. It is anticipated that the details of this will evolve as we gain experience in this area.

Palliative Care

In late 2009 CareOregon implemented a community based palliative care program for members with complex terminal conditions not yet eligible for or interested in participation in a hospice program. This program assists with symptom management, advanced care planning, and meeting social and spiritual needs. The goals of the program include improving end-of-life decision making and reducing the use of futile health care services. We are aiming for improved health outcomes in terms of improved symptom management, enhanced family and patient satisfaction with the health care system, and decreased costs through meeting members' needs at home rather than through ED or inpatient care. In 2010 we added a second agency to this program as a way to broaden the service area reached. In 2011 we were able to focus on standardizing referral criteria and participated in a program which focused on training and mentoring primary care providers in conversations about end of life decision making.

Releasing Time to Care

In 2010, CareOregon launched *Releasing Time to Care* together with four Oregon hospitals, the Oregon Nurses' Association, the Oregon Association of Hospitals and Healthcare Systems, and others. *Releasing Time to Care* is an improvement methodology based on Lean principles that was designed by and for nurses. Its purpose is to free up time of front line hospital nursing staff so that nurses can devote more time to direct patient care, thereby improving patients' experience of care and patient outcomes. Through observation and tracking, teams identify waste that can be removed from daily processes, and they develop quality measures for their units that are displayed so that patients, visitors, and hospital staff can see their progress. *Releasing Time to Care* is rolled out unit by unit within a hospital, preserving the culture of a particular unit while standardizing many processes throughout the hospital. CareOregon will continue to partner with hospitals statewide and beyond to provide the training

CareOregon's Community Care Program

CareOregon has developed a program that is directed at reducing the cost of care including hospital and ED utilization for a unique group of members. This group of individuals are those who have experienced "potentially avoidable" healthcare

services. The program uses experienced community outreach workers hired by CareOregon and embedded in primary care and specialty clinics that serve a high propensity of CareOregon Medicaid or Dually Eligible members meeting the above criteria. The main objectives of the program include:

(1) Engage targeted members in an optimal relationship with a primary health home (physical and behavioral if appropriate), one in which the member actively participates in a culturally appropriate, trusting and respectful partnership with a care team that knows him/her
(2) Facilitate the connection of targeted members to beneficial community resources including peer specialists, and advocate for critical social services
(3) Educate and coach targeted members to improve health literacy, condition-specific self- management skills, and activation in wellness
(4) Coordinate services and communication between various providers of services on behalf of members including specialty health services

CareOregon Community Clinics

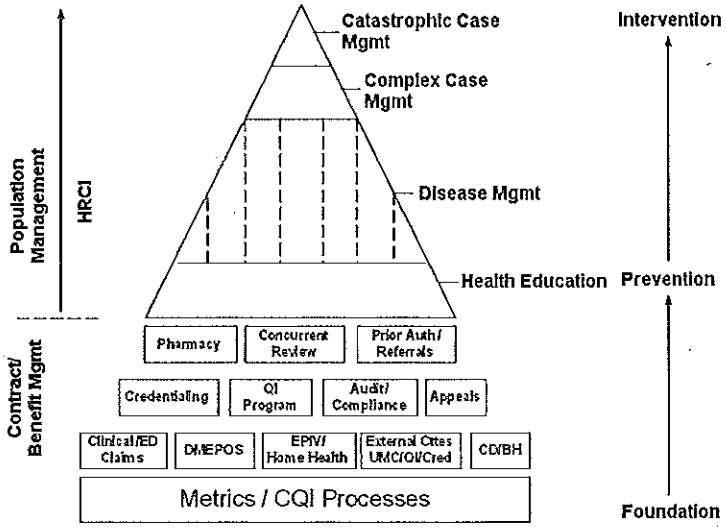
Access issues became increasingly challenging for our members during 2009/2010. This was evidenced by the fact that as many as 16% of our members were unassigned at any given time. Consequently, CareOregon became involved in trying to improve access not only by encouraging clinics to accept new members and continuing work with the PCR clinics around access but notably also by purchasing and renovating clinic space for our largest contracted medical group and by opening our own clinics.

Three clinics (Neighborhood Health Clinics, previously known as CareOregon Community Clinics) were opened in areas of highest need and staffed in ways appropriate for the cultural and language needs of the neighborhood in which they are located. A fourth clinic has recently opened in another high needs area. While the clinics are open to all, the majority of patients being seen are CareOregon members. Since opening the clinics we have seen our rate of unassigned members drop to <0.5%

Another access issue that we are addressing through this mechanism stems from our chronic pain population. Many of these members are so demanding and challenging to care for that many of our contracted providers will no longer take them on as patients. Consequently, we have opened a multidisciplinary pain management clinic at one of our clinic sites.

During 2011 we have hired a dentist and plan to start offering dental services to the patients in these clinics.

The pyramid below depicts the approach that CareOregon has embraced in managing our populations.



Quality of Service

CareOregon collects information about the quality of its service and that of its contracted providers through a variety of mechanisms, including but not limited to:

- Member satisfaction survey, Consumer Assessment of Health Plan Survey (CAHPS)
- Visit Based Member Surveys (VBMS)
- Provider surveys
- Internal Medical Record Review
- Aggregate complaint data
- Assessment of member access data

Quality of Care

CareOregon collects information about the quality of care through a variety of mechanisms, including but not limited to:

- The IS department generates population analysis reports based on age, sex, culture, language, and diagnoses that are severity case-mix adjusted
- Disease registries
- DMAP comparative health plan reports
- Appeals aggregate and provider-specific data
- Measurement programs, such as HEDIS, that indicate the quality of CareOregon's programs
- Adverse event reviews
- Member complaint data

In developing potential interventions based on the findings of the results consideration is given to the cultural and linguistic needs of our members. Materials are offered in languages other than English, as appropriate. Additionally, the messaging is considered from a cultural perspective. The development of a Member Advisory Council has provided CareOregon an avenue for gathering input on member issues and input into initiatives that are member focused.

The following represents the active and current quality activities and the population of focus.		
Activity	***Population***	***Aim***
Breast Cancer Screening	Medicare and Medicaid members	Increase the % of women who receive mammograms
Cervical Cancer Screening	Medicaid members	Increase the % of women who receive cervical cancer screening
Childhood Immunizations	Medicaid members*	Increase the % of children that receive all appropriate immunizations
Colorectal Cancer Screening	Medicare Members	Increase the % of members that receive screening for colon cancer
Early Childhood Cavities Prevention	Medicaid members	Improve oral health for pregnant women and children by increasing the % that receive dental services
Asthma	Medicare and Medicaid members	Reduce the frequency of ED visits Increase the follow up visits after ED Increase the % of members that utilize appropriate medications (HEDIS)

Diabetes	Medicare and Medicaid members	Increase the % of members who receive evidence based services (HEDIS)
CareMoms	Medicaid members	Increase the % of new moms and infants who have timely follow up after delivery (HEDIS-Post Partum)
Tobacco Cessation	Medicare and Medicaid	Increase the% of members that stop smoking and are offered smoking cessation information, treatment and counseling
Mental/Physical Health Collaborative	Medicaid members*	Improve the access and integration with mental health and physical health
Chemical Dependency	Medicare and Medicaid*	Increase the % of members screened for substance abuse
PCP/Specialist Follow up Visits After ED visits	Medicare and Medicaid	Increase the % of members that are seen by Provider within 7 days following ED visit
ABCDIII: Developmental Screening	Medicaid*	Increase the % of children screened for developmental delays Increase the % of children referred for early intervention

Comment [msr1]: This is very vague – can you make it more specific?

Transition of Care (one setting to another)	Medicare (SNP)	Increase % of members who have an outpatient follow up visit within 30 days. Decrease the readmission rate

*Medicaid Contract deliverable

Document Approval

Quality Improvement Committee Chair	Approval Date
Senior Management Committee Chair	Approval Date
Quality & Network Committee Chair	Approval Date

CareOregon

CareSupport
Case Management Program Description
January 1, 2012 – December 31, 2012

CareSupport Scope

Populations Served:
The CareSupport (CS) program serves those members whose health status is compromised by complex medical, behavioral, and/or social conditions. The conditions and circumstances addressed include chronic medical illnesses, socio-economic challenges, site-of-care transitions, chemical dependency and substance abuse, resistance to health behavior change, and limited access to resources or inappropriate use of resources.

More specifically, CareSupport's programs attempt to identify and target members who are currently experiencing, or who are at high risk for experiencing, any or all of the following:

1) Functional health decline,
2) Exceptional needs,
3) Difficult transitions, especially from hospital or skilled nursing facility (SNF) to home, and
4) High hospital and/or emergency department (ED) utilization.

Overlaying these criteria is the expectation that we enroll members who have *modifiable* risk factors and who agree to participate in our programs and receive ongoing case management assistance. We have developed a set of five domains of concern (which we think of as CareSupport determinants of health) that each identified member is assessed against in order to identify modifiable risk factors.

The five domains are:

1) Health trajectory,
2) Medical home relationship,
3) Medical services access,
4) Self-management capability/willingness, and
5) Social support system.

When we assess each member, we determine whether there are opportunities for improvement in each of these areas.

If opportunities exist, our primarily telephonic interventions are tailored toward improving the member's improvement in the domain(s) that are of concern. Refer to *Appendix A* for more details of the five care domains and for examples of CareSupport interventions related to each of the five care domains.

Through our contract with the State of Oregon Division of Medical Assistance Programs (DMAP) we place a special emphasis on meeting the exceptional health care access and coordination needs of our Medicaid-eligible members who meet DMAP-defined high-risk eligibility codes (i.e., aged, blind, and disabled). This population-based contracted service is referred to by DMAP as Exceptional Needs Care Coordination (ENCC), and numerous CareOregon departments, including CareSupport, are responsible for meeting the State's ENCC regulatory requirements. CareSupport meets these regulatory requirements by responding directly to member referrals made by DMAP to our case managers and by responding to inquiries made by ENCC-eligible members themselves or their advocates. These member inquiries are usually generated following ENCC outreach letters that CareOregon sends to the members that are identified and flagged by DMAP as being eligible for ENCC services.

Population Approach:
We have largely declined to internally develop strictly disease-specific programs and enrollment criteria because we believe that a holistic, person-centered approach to our high-risk population yields greater member and provider satisfaction and more effective assessment and intervention. It is also true that the majority of members who are enrolled in a CareSupport program do not have a single disease. Instead they have multiple co-morbid conditions and are experiencing additional socio-environmental morbidity, thus a comprehensive approach makes clinical sense as well. In spite of this overall philosophy, all CareSupport case managers adhere to evidence-based clinical guidelines when providing disease-specific education or coaching. Our member-centric, strengths-based coaching approach has the overall goal of maximizing patients' activation in meeting their own personal health goals.

To most effectively implement our holistic approach with members, CareSupport case managers possess multi-disciplinary competencies and licensure/certification. Registered nurses, social workers, chemical dependency-certified staff, and health care coordinators (para-professional, non-licensed) work collaboratively with support from pharmacy technicians, clinical pharmacists, and physician medical directors. In order to ensure that our services are well integrated and supplemental (but not duplicative) with the members' primary care provider's services, we have assigned our case management teams to specific primary care practices; this also fosters an effective relationship between these practices and our case managers.

CareSupport (CS) services do not duplicate or replace the direct provision of health care services provided by the members' primary care providers (PCPs), specialists and their office staff, or assistance provided by the members' State caseworkers.

CS services are meant to complement, coordinate, and integrate these services, which may include education, support, and referral to disease management programs, palliative or hospice care programs, and/or to community resources, as appropriate.

Program Goals:
The goals of any CareSupport service or program intervention are to:

- Enhance the quality of life for the member through: (1) improved or stabilized functional health status, (2) reduction or stabilization of the adverse effects of bio-psycho-social challenges, and/or (3) assistance during site-of- care transitions.
- Increase the use and effectiveness of a person-centered primary care home in order to reduce the inappropriate or unnecessary utilization of costly health care resources.

Although these goals have been difficult for us to measure on a population basis, they are operationalized through a robust set of assessment tools, care planning guides, program protocols, and numerous policies and procedures. On a monthly basis, team supervisors conduct random chart audits which are useful in determining for individual cases whether these operational tools are being used effectively and whether departmental policies and procedures are being followed when CareSupport services are provided to members.

CareSupport Functions and Specific Programs

Brief Interventions/Care Coordination:
Some members' needs are identified and easily remedied with one or two phone calls or information and referral. We do not formally enroll such members into ongoing case management because the documentation necessary for this formal enrollment takes significant time and is not warranted when members' needs are so temporal. Members who receive brief interventions do not have a formal care plan developed. Examples of these brief interventions or care coordination services are: (1) mailing out a Healthwise Handbook which provides written instructions for a variety of non-acute health issues, or (2) arranging for transportation to a medical appointment. These brief interventions are documented in our Call Tracking QNXT portal or in a Case Management Candidate Record rather than a Case Management Case Record.

On-going (long-term) Case Management:
On-going case management is defined as case management services that require more than a couple phone calls to resolve, stabilize, or improve a member's health-related issues. Members are eligible for on-going case management if they are determined to have at least one modifiable risk factor within at least one of the five CareSupport domains.

All members who are enrolled into on-going case management must have a comprehensive member assessment and plan developed and it must be updated on a regular basis.

The member assessment, plan, and all interactions with the member or others involved in the member's care are documented within a QNXT case management record. On-going case management will be provided primarily telephonically, but may involve making face-to-face visits with the member and/or family/caregiver, and may involve participation in regular multi-disciplinary meetings (MDT) with additional health care providers and/or community based organizations serving the member.

Complex Case Management:
A small subset of members meets the criteria to be enrolled in complex case management. A CareSupport member is eligible for complex case management if they:

- Have at least one modifiable risk factor within at least one of the five CareSupport domains, **and**
- Are dually-eligible for Medicare/Medicaid (CareOregon Advantage); **or**
- Are Medicaid-only (Oregon Health Plan) and have an Adjusted Clinical Groups-Predictive Model (ACG-PM) score greater than 0.5 at the time of their enrollment into the case management program.

In addition to a formal member assessment and care plan, members who are enrolled in complex case management are monitored on a more frequent basis and their care plans are updated with more regularity. The rationale for this increased scrutiny is an assumption that these members are more fragile and vulnerable to rapid changes in their health care status.

Transitional Care Program:
CareOregon has developed a robust intervention program to support members when they are experiencing site-of-care transitions. Members are enrolled into this program if they have been recently discharged home following an unscheduled hospital admission. Members are also eligible for this program after being discharged home following a stay in a skilled nursing facility (SNF). The CareSupport transitional care program was originally developed to exclusively provide services to dually-eligible CareOregon members who were enrolled in our CareOregon Advantage (COA) line of business. In 2011 this program was expanded to provide services to high-risk CareOregon (Medicaid-only) members as well. The goal of this program, which is rooted in Eric Coleman's evidence-based Transitional Care Model, is to support members and their caregivers as they return to their home following a hospital or facility stay, thereby reducing unnecessary readmissions or emergency department (ED) visits and improving member safety and health outcomes. The evidence-based program components are: (1) education on red-flag symptoms, (2) timely primary care follow-up, (3) medication reconciliation and adherence, and (4) patient activation and self-advocacy.

In general, this program provides these specific transition-stabilizing interventions for a period up to 30 days post discharge. These members may be referred to CareSupport's ongoing case management program if they are expected to have continued modifiable risks following the 30-day transition intervention period.

High ED Utilizer Alert Pilot

In April of 2011 one of the ongoing case management teams noticed an increase in the number of provider requests for patient ED alerts. An ED alert is an information exchange and care planning tool authored and approved by a patient's primary care provider. It conveys to the ED specific information about the patient's condition(s) and gives the ED the provider's recommendations and treatment preferences based on their knowledge of the patient. In most instances, an ED can embed the information contained in the alert into the EMR (electronic medical record) so that all care providers in the ED can view it. The increase in requests for ED alerts occurred concurrently to the implementation of the community-wide opiate prescribing standards, and may have been related.

This case management team developed a tracking mechanism and a standard process for implementing the ED alerts in collaboration with providers. As a part of this new process they attempt to contact all members whose PCPs are requesting ED alerts in order to assess whether there are any modifiable needs and/or case management assistance that might be provided. If the member cannot be contacted the case managers continue to collaborate with the PCP and monitor the patient's ED utilization subsequent to the ED alert being implemented.

Currently this pilot is still running. Initial outcomes are reported in the 2011 CareSupport Annual Evaluation.

Program Integration

CareOregon members who are eligible for palliative care are referred to those programs where they are available. CareSupport and other CareOregon staff work together with the palliative care staff to make the member's experience a positive one that affords the member the opportunity to receive safe care in their own home. Specific palliative-care eligibility criteria have been developed by our contracted community-based palliative care programs.

CareSupport staff also regularly make referrals to the Recuperative Care Program (RCP), which provides a room with clinical and social support for homeless CareOregon members who are discharged from the hospital. RCP is a 30-day program which is funded by CareOregon to improve the outcomes for discharged members who otherwise would lack safe housing in which to recover. An analysis was done in 2009/2010 which provided evidence of decreased claims costs for members who have participated in the RCP program. Although there are not strict eligibility criteria for enrollment into RCP, there are well-recognized conditions that must be met for a member to be considered for this program. Examples of these conditions are:

- Must be 18 yrs or older
- Must be currently experiencing homelessness
- Must have primary coverage with CareOregon
- Must be nearly or completely independent with ADLs

- Must have an acute condition (or acute exacerbation of a chronic condition) which has a reasonable chance to stabilize within 30 days, but that is severe enough to produce a high risk of functional health decline without these supports.

A CO medical director makes the final eligibility determination for this service.

CareOregon members with diabetes and/or depression who may benefit from ongoing support and coaching but who do not require complex case management, are referred to either the Synergy program or one of the delegated Primary Care Renewal (PCR) disease management programs. Synergy is a contracted (delegated) service through Health Integrated (HI), which offers our members with diabetes and/or depression another source of ongoing member-centric coaching. Primary Care Renewal is a comprehensive medial home primary care model that is operating at five major metropolitan health centers. As part of this medical home model, disease management for diabetes and depression is occurring. Care Coordination meetings are held monthly between the staff of Health Integrated and CareOregon (CO) and as needed between the PCR clinics and CareOregon to allow for an integrated, seamless approach for managing or co-managing members.

In addition, weekly meetings are held between the HI Outreach Coordinator and a CS supervisor to share updated contact information and pertinent member information for the purpose of coordinating care.

Members whose needs are primarily in the realm of behavioral health, mental health, and/or chemical dependency are assigned to behavioral health specialists (BHSs) for assessment and case management interventions, as appropriate. Direct mental health services for Medicaid (OHP) members are managed by a separate Mental Health Organization within each county and mental health services are provided by and large by community mental health agencies. CareSupport does provide care coordination for OHP members who have mental health conditions, and attempts to integrate these members' mental health and physical health services. CareSupport also provides direct chemical dependency case management services for these members, and arranges for chemical dependency treatment services within the community.

In contrast, CareOregon's dually-eligible members enrolled in CareOregon's Special Needs Plan (SNP) receive management of their mental health services and benefits through CareOregon. In prior years CareOregon had a delegation agreement with Optum Health but as of September 1, 2011 CareOregon terminated its contract with Optum Health and began providing the benefit management of mental health services for our dually-eligible members internally. A focused MH team comprised of a Psychiatric Associate Medical Director, a CareSupport BHS, a specially trained CareSupport HCC who has a QMHA (qualified mental health assistant) certification, a Concurrent Review RN, a clinical pharmacist, and pharmacy technician has been convened to support this new function.

Finally, in August of 2011 a new CareOregon program was launched. CareOregon's Community Care Program (aka 'hot spot program') was developed in collaboration with our primary care network and serves members who meet the following criteria:
(1) 2+ non-obstetric (OB) hospital admissions or
(2) 1 non-OB hospital admissions with 0-5 Emergency Room (ER) admissions or
(3) 1+ psychiatric admission with or without ER admissions or
(4) 6 + ER visits with or without hospital admissions
AND
(5) Receive primary care from a community care program participating primary care clinic*.

*Note: As of May 1, 2012 the participating clinics are the following:
1. Multnomah County Health Department (MCHD) – Northeast Clinic
2. Oregon Health Sciences University Family Practice at Richmond Clinic
3. Legacy Good Samaritan Internal Medicine Residency Practice
4. Legacy Emanuel Internal Medicine Residency Practice
5. Clackamas County Health Department-Beavercreek Clinic

CareSupport case managers may refer to the Community Care Program a member that they feel would benefit from the high-touch, face-to-face, community-based outreach that signifies this program. A standardized Community Care Program referral form is used to ensure this process is easy and effective.

Member Identification

Proactive Identification of Members at Risk:
The CS program conducts its proactive outreach and assessment activities using three methods:

1.) Level of Care Reports
The *Level of Care* report is a member-level file compiled from a number of internal data sources, including claims data, administrative records, and output from the Adjusted Clinical Groups (ACG) case-mix software system. The ACG case-mix system is proprietary software developed by John Hopkins University. We use the member-level risk scores generated by the Adjusted Clinical Groups-Predictive Model (ACG-PM), coupled with evidence-based disease and utilization stratification methods, to proactively identify high-risk member subpopulations. This stratification algorithm is used to triage members into one of four "level of care" outreach groups. Member lists categorized using these four groupings are generated monthly and are used by our Outreach Health Care Coordinators (HCCs) who attempt to contact each member on the list by telephone and complete a Clinical Assessment Questionnaire (CAQ). The CAQ is a secondary screening tool used to assess member's level of health risk in each of the five domains of care.

2.) New member or Annual Health Risk Assessments (HRAs)
Member health risk assessments (HRAs) are conducted by telephone or mail for all new Medicaid members who are eligible for exceptional needs care coordination; this is done within 90 days of enrollment into CareOregon. Dually-eligible CareOregon Advantage (COA) members are surveyed upon enrollment into COA. Dually-eligible members are surveyed again annually. HRA scores that meet or exceed a threshold score (a clinical algorithm scores the member responses and a threshold score was established using clinical and utilization research methods) indicate a need for further screening by Outreach HCC similar to the above workflow used for the Level-of-Care reports.

Weekly clinical review of the HRA follow-up findings may result in a member being enrolled in ongoing case management, particularly for those members with multiple clinical issues and modifiable risks.

3). Review of the *Emergency Department (ED) Daily Discharge* report (to identify members who have been seen in the ED for follow-up screening using the EDQ – [Emergency Department Questionnaire]).
Members who have been seen in the ED may indicate a need for further support and/or an opportunity to identify and change inappropriate future ED utilization trends. The *ED Daily Discharge* report, a list of all health plan members discharged from regional EDs in the prior 36 hours is reviewed on a daily basis by an HCC.

Outreach calls to these members are completed by an RN, HCC, or BHS as appropriate.

Contacted members are administered the EDQ, a standardized set of questions, if appropriate. Completed EDQs and supporting administrative and clinical data are reviewed weekly for modifiable risk. Members with multiple clinical issues and modifiable risks are enrolled into ongoing case management.

At this time, CareOregon does not receive data from practitioners which could be used for case finding.

Direct Referrals to CareSupport:
Member referrals to CareSupport are directly accepted from many sources, including self-referrals from members or from members' families or caregivers, and from a variety of health care providers, Aging & Disability Services (ADS) case managers, Department of Human Services (DHS) case workers, community partners, and other CareOregon departments. CS staff may also receive member referrals from affiliated programs, such as Health Integrated's Synergy or CareOregon's Primary Renewal (PCR) disease management programs, when member needs exceed the scope of those programs.

All referrals are reviewed for the presence of straightforward care coordination needs (such as *Brief Actions [care coordination]*) and/or modifiable risks warranting the Transition Protocol, on-going case management, or complex case management enrollment.

A very common internal CareSupport referral method results from the benefit management and discharge planning activity of CareOregon's concurrent review registered nurses (CR RNs). CR RNs recognize the modifiable risks that our members may face upon discharge from the hospital or SNF, and make direct referrals to the CareSupport Transition Protocol.

Member information and referrals are shared between our MMD's Pharmacy Unit staff and the CareSupport Department staff. Members who meet the eligibility criteria for the MMD Medication Therapy Management Program (MTMP) are also assessed for risk factors that should be addressed by CS staff, and are referred when indicated.

Finally, indications for CareSupport involvement may be identified by Quality Improvement (QI) staff during monitoring and resolution of member complaints, and while following up on adverse events. These referrals within the department occur on a regular basis and help to cast a broad net with which to identify members who would benefit from our CareSupport program.

CareSupport Processes

Assessment:
As described previously, CareSupport-enrolled members are identified through direct referral or via outreach screenings. Regardless of the method, telephonic member contact is initiated and an initial member assessment is completed within 30 days of member identification.

Specialized questionnaires, or "Qs" are used to elicit information regarding the member's current health status, current medications, co-morbidities, clinical history, relevant mental health status and cognitive function, chemical dependency history, cultural, linguistic, vision and hearing needs and preferences, functioning related to activities of daily living (ADLs) and independent activities of daily living (IADLs), status of life planning, social and caregiver supports, and available community resources.

Evidence-based tools are incorporated into the initial assessment, in preparation for the development of a plan of care. These tools may include one or more of the following: the PHQ2 and PHQ9 screens for depression, the GAD2 screen for anxiety, CAGE-AID (alcohol including drugs) and AUDIT-C (alcohol) screens, and the Edinborough Post-partum Depression Screen (EPDS). CareSupport clinicians review all positive screens and plan the clinically appropriate follow-up with the member and/or others involved with the member. If a member has been diagnosed with a chronic medical disease or multiple chronic medical diseases, disease-specific guidelines are utilized and referenced as the initial assessment is conducted.

Initial assessments for members with known chemical dependency issues are completed by telephone with the BHS gathering information from the member, chemical dependency provider, and primary care physician (PCP), as appropriate. This is done in compliance with CareOregon's Human Resources' Policy No. 402 ("Confidentiality of Member Information"), the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules and 45CFR.

When member consent is required for a release of information, it is obtained according to CareOregon's policies and procedures. Such consent is explicitly documented in the member health plan record in QNXT. CS staff request verbal consent from the member prior to eliciting or sharing any medical information with the family or caregivers. A written release of information (ROI) form is then sent to the member, according to CareOregon's policies and procedures and HIPPA Policy and Procedure manual. Staff leave their name and a direct phone line for the member to respond to if staff are unable to reach them by phone.

Member Plan of Care:
Each member enrolled in ongoing (long-term) or complex case management has an individualized member assessment and plan, which is reviewed and revised on an ongoing basis. At the minimum, there is a review and appropriate revision if/when the member's needs and plan of care change, and at the time of case closure. During each review, clinical staff evaluate the member's plan of care for goal completion and continued modifiable risk, to determine if the member meets the criteria for continued case management or case closure. This review is communicated to the provider as appropriate, and revisions are made to the plan of care in collaboration with the member or their representative (with appropriate ROI) whenever possible. The plan of care and revisions are completed and documented in the Case Management portal in QNXT. The review addresses at least one short-term and at least one long-term goal and real/potential barriers to meeting those goals.

Often, these barriers are related to the availability of their benefits, and staff incorporate this into the review as they educate the member regarding benefits and assist the member in finding alternate appropriate resources. Goals are prioritized with member and family/caregiver input.

In 2010 CMS began requiring all dually-eligible Special Needs Plans (SNP) to annually complete a HRA for all SNP members as well as develop an individualized plan of care. CareOregon has attempted to meet this requirement by developing a process by which each SNP member receives a HRA in the mail during the month of their birthday. Member responses to the HRA are entered into a data base and scored. Those members whose HRA scores are above a clinically-determined threshold score are forwarded to the CareSupport outreach staff for further assessment. In addition, each HRA that is completed by a SNP member also helps to inform an individualized plan of care which is sent to the member with a cover letter encouraging the member to share it with their PCP.

The plan of care is formulated using the member responses from the HRA, claims-based utilization information, and gaps in care identified from our administrative data. Each SNP member's plan of care will be unique based on their personal combination of HRA responses and the pattern of health care services they have received. Clinically-driven educational tips and prompts will populate the plan of care depending on the HRA responses and gaps in care identified. Within the plan of care, members are asked to call their PCP or given a direct CareOregon Customer Service or CareSupport phone line to contact with any questions or requests for information or assistance.

Case Management Interventions:
CareSupport interventions are geared toward empowering the member to improve their self-management in order to achieve their health goals and to overcome barriers to reaching those goals. CS interventions are categorized to address modifiable risk in each of the five care domains, which include barriers to achieving the member's goals. A member's case is considered eligible for closure when: the member's identified goals are met and/or there is not further modifiable risk, when the member is not willing to engage, or at the request of the member. Member consent for case closure is obtained whenever possible.

CareSupport staff use Microsoft Office *Outlook* tasks for tracking members' follow-up events. Outlook and QNXT are used in tandem for scheduling communication with member, follow-up, and documentation.

CareOregon has adopted *www.guidelines.gov* as our standard resource for clinical guidelines when condition-specific guidelines have not already been adopted by CareOregon's Quality Improvement Committee (QIC). Guidelines are incorporated into CareSupport's planning and case management processes as appropriate.

CareSupport clinicians adhere to the CMSA (Case Management Society of America) standards for the implementation of case management.

We tailor our interventions to each individual member using the assessment criteria; each intervention is member-specific and capitalizes on the member's and family/caregiver's involvement, preferences, and strengths. We assess each member globally and provide the interventions that are most likely to improve health status and assist in goal achievement for the individual member, rather than addressing only disease-specific interventions and outcomes. This often requires taking into consideration multiple chronic conditions simultaneously, as well as determining whether additional bio-psycho-social risks exist and need to be addressed. CareSupport staff apply motivational interviewing to highlight member strengths, utilize member ambivalence to prompt "change talk," and reinforce member progress. CareSupport staff also support members by providing community resource referrals, where available, and following up with members to determine whether those referrals were acted upon.

Our population, as well as enrollment into and out of our program is dynamic, not static. We offer continuous enrollment into the CS program as opposed to prescribing a finite enrollment and intervention period. Each member is enrolled when they are identified as having modifiable risk factors and are provided member-specific interventions for a non-specified time period that is determined by the member's progress toward individualized goals.

Infrastructure and Tools

The CareSupport Department operates in close cooperation with the Medical Management Department which includes these units: Quality Improvement (QI), Medical Benefits Assurance (MBA), Clinical Claims Review (CCR), and Pharmacy. Two medical directors, a pharmacy director, an Associate Medical Director of Psychiatry, and a chief medical officer (CMO) share the clinical oversight of these units. Please see *Appendix D* for role descriptions and responsibilities.

When there are health trajectory or service access concerns, a CareSupport case manager or a CareOregon medical director or clinical pharmacist will communicate directly with a primary care provider.

Information Systems

QNXT

QNXT is the CareOregon electronic claims, administrative and clinical documentation system. These capabilities operate within different modules within QNXT. QNXT automatically records the date, time, and individual making an entry into the system. CareSupport staff complete their clinical documentation in the Case Management module of QNXT and they use the Call Tracking module of QNXT to log outgoing and incoming calls to/from specific members or health care providers on behalf of members.

Document Management System (DMS) (SharePoint)

In 2009/2010 CareOregon implemented a document management system (DMS) based in Microsoft's SharePoint. CS developed and implemented its site and stores member and administrative documents which are not stored elsewhere in the overall CareOregon site.

Express Scripts

CareOregon has contracted with a pharmacy benefit manager (PBM) for pharmacy management of the members' medication benefit. CS staff have specific training in the electronic system used by the PBM called Express Scripts (a product of Trend Central). Staff are able to generate pharmacy reports, looking for such things as medication refill patterns and present these to the enrollment team or case management team, along with other CM assessment tools.

CareAnalyzer
CareAnalyzer is a proprietary analytic tool combining elements of care opportunities, risk, and provider effectiveness to provide a more complete member assessment. CareAnalyzer is the source of CareOregon's Adjusted Clinical Groups (ACG) case-mix software system. The ACG case-mix system is proprietary software developed by John Hopkins University. The member-level risk scores generated by the Adjusted Clinical Groups Predictive Model (ACG-PM) are an integral part of our stratification methods for outreach, as well as a source of organized data used in clinical management of members.

SAS Member Registry
The SAS registry is a web-based tool that provides a comprehensive 12-month historical snapshot of a member's claims-based utilization including hospital, ER, primary care and pharmaceutical utilization. To the extent possible, specific provider, pharmacy, and facility information is also presented. Any member that has a unique health plan identification number can be found within this registry. In addition, members that have been enrolled in specific programs, such as the *Community Care Program,* can be identified as active in these programs which promotes integration and information exchange and reduces the likelihood of duplication of services.

Measuring the Impact of CareSupport
There are a number of ways in which CareSupport measures the impact of its programs. The CareSupport Annual Evaluation, which is completed annually, describes and reports these measures in detail. What follows here is a brief description of the primary evaluation mechanisms used.

Quality Review Process:
The Quality Improvement Management Committee (QIMC) is responsible for reviewing and approving the CS program description, work plan, and annual evaluation as part of the overall Quality Improvement program description, work plan, and annual evaluation. The QIMC meets quarterly. Refer to the QI Program Description for further details.

Case Management Effectiveness Measures
CareSupport relies on a subset of case management effectiveness measures that are defined and required by NCQA for health plan accreditation. These measures, along with additional programmatic process and outcome metrics are identified in the table in *Appendix C.* Case management effectiveness measures are indicated with an asterisk (*).

In 2012, these include one member satisfaction measure and two transitional care program measures. The baseline measurement period for all three measures is January through June 2012. In early July, data will be analyzed and interventions will be developed and implemented. Effectiveness of interventions will be re-measured in January 2013 (data period: July through December 2012).

Programmatic Process and Outcome Metrics
Ongoing outcome and productivity metrics are listed in *Appendix C.*

Satisfaction
Member satisfaction surveys are administered telephonically to members who were enrolled in the case management or transitional care programs and who were defined as complex.

Member satisfaction is reviewed individually for any issues that require attention. Data is aggregated quarterly to look for trends within CS so that appropriate actions may be taken departmentally. In addition, results are shared annually with the QI Unit and QIMC as part of the CareSupport Annual Evaluation.

Member complaints are aggregated and analyzed quarterly in the QI Unit. CS-related complaints are forwarded to CS leadership quarterly and all complaints are reported to QIMC quarterly. Refer to the QI Program Description for information related to the member complaint process.

API/LEAN
In 2011 an Accelerated Process Improvement (API)/LEAN team was developed to focus on designing the most effective benefit management and case management processes for the dually-eligible SNP members who experience psychiatric hospital admissions. This work has continued into 2012.

Appendices
Appendix A – Five Care Domains and Examples of CareSupport Interventions
Appendix B – Example of SNP Annual Plan of Care
Appendix C – CareSupport Metrics
Appendix D – CareSupport Roles and Responsibilities
Appendix E – CareSupport Organizational Chart
Appendix F – Program Structure 2012 (chart)
Appendix G – Work Plan 2012
Appendix H – Table of CareSupport P&Ps

Examples of CareSupport interventions that address risk factors in each of the five care domains and assist members in attaining their goals are as follows:

1) Health Trajectory: We look for opportunities to provide more comprehensive information to the member's primary care provider (PCP) in circumstances where we feel it may lead to better medical management of the member, and consequently improve the member's health status. Often this takes the form of:
   A. Medication profile reviews and resulting pharmacotherapy recommendations to the prescribing physician(s)
   B. Clinical reviews resulting in recommendations for referral to specialty services
   C. General oversight of the clinical care our members are receiving and medical management recommendations as appropriate to the members' physician(s). All medical status recommendations are made by a CareOregon medical director or registered pharmacist.

2) Medical Home Relationship: We look for opportunities to optimize the interaction between the member and the member's PCP. Our case management model is founded on the belief that productive communication between member and provider is crucial to optimal health outcomes. We also recognize that some members have barriers to developing and maintaining an optimal relationship. One of the areas that we focus on is helping members get the most from their relationship with their PCP through appropriate assignment to a PCP, taking into consideration interpersonal preferences, clinical expertise, geographic location, and cultural considerations. We also coach members toward optimal communication and sharing their self-management plan with their PCP. In some cases, this involves coaching members who are displaying disruptive behaviors that risk their medical home stability to learn other ways to appropriately have their needs met.

3) Medical Services Access: We evaluate each member to ensure that the member is receiving all necessary and medically appropriate services. We work to remove barriers to receiving these services, including but not limited to providing transportation assistance, scheduling assistance, coordination of services between providers and vendors, and making benefit limitation exceptions when appropriate.

4) Self-management Capability/Willingness: All members with chronic illness are assessed to determine their willingness and ability to self manage their condition(s). After determining the PCP's treatment plan, we work with our members to educate, motivate, engage, and further develop the behavioral self-management skills necessary to stabilize or improve their health status. We use motivational interviewing to help members engage in their own self management, even when they are ambivalent about making necessary lifestyle changes. Improvement in the member's activation level is assessed using the Patient Activation Measurement (PAM) tool. We provide educational materials with visual cues that can help members with decision making and symptom management. We provide information regarding diet, exercise, and medication management.

Most importantly, we encourage and support members as they work toward their own self-management goals.

5) Social Support System: We evaluate each member to determine the status of their social support system, paying close attention to psychosocial risk factors that contribute to declines in health status including social isolation, cultural isolation or unmet cultural needs, home safety risks, chemical dependency, barriers to the ability to engage in pleasurable activities, depression or major mental illness, unstable housing, suboptimal nutrition, and inability to perform independent activities of daily living. If risk factors are present, we attempt to reduce these risks. Specific interventions might include initiation of Meals on Wheels, connection to vocational or recreational activities, referral to a community-based support group, facilitation of family or friend accompaniment to PCP visits, encouragement to see a mental health counselor or sustain chemical dependency (CD) treatment, or advocacy for additional caregiver resources.

Appendix B
Example SNP Annual Plan of Care

CareOregon
Advantage

[redacted]

March 08, 2011

[redacted]

You are the most important member of your health care team. At CareOregon, our goal is to support the efforts you and your primary care provider are making to improve your health.

We sent you a "How is Your Health?" survey a few months ago. Thank you for taking the time to fill out and return it. We've summed up what we learned together about your health.

To get the most out of the health summary attached to this letter:

- Read the information in your health summary.
- You may want to call or visit your provider to discuss any areas of health concern outlined in the summary.
- Take the summary with you to your next appointment.
- Keep in mind that your health changes. If something new happens with your health, it is even more important to call your provider.

The CareOregon member website has good information and many helpful tips about common health issues, different medications and staying healthy. Go to: www.careoregon.org and select the "Health & Wellness" tab.

If you or your primary care provider have any questions about how to use this health summary, please call us. We are here for you.

Sincerely,

Your Customer Service and CareSupport Teams
CareOregon

HEALTH SUMMARY

Name: Page 1 of 4

Age: 63 Sex: F ID: Survey Date: 11/02/2010

In the survey, you reported the following:

Health Status		Information to Consider
0-100 rating	40	This is how you rated your health on the day you answered the survey using a scale where: 0 = *WORST health imaginable* and 100 = *BEST health imaginable*
Number of prescription medications you take	8 or more	Always tell your primary care provider (PCP) about any vitamins, herbal products or over-the-counter (OTC) medicines you use regularly. Common OTC medicines such as acetaminophen (Tylenol®), aspirin, ibuprofen (Motrin®) and naproxen (Aleve®) can possibly interact with prescription drugs and cause side effects. Even products considered "natural" such herbal supplements or vitamins can cause drug interactions. Be sure to let your PCP know when you start or stop taking any new herbal products or vitamins.
Number of hospital stays in the past 6 months	1 - 2	No one wants to be in the hospital. But if that happens, our CareSupport staff can help in ways that make the transition from hospital to home easier. To learn more, call the CareSupport team at: 503-416-8055 or toll free at: 1-800-224-4840 and ask for the CareSupport department.
Number of emergency room visits in the past 6 months	1	When you need medical care or advice URGENTLY, you can call your primary care provider (PCP)'s clinic phone number any time – day or night, 24 hours a day, seven days a week. You will speak with someone who will contact your PCP or give you advice about what to do. If you do not have a PCP, we can help. Call CareOregon customer service at 503-416-4100 or toll free: 1-800-224-4840. TTY/TDD users call: 1-800-735-2900

HEALTH SUMMARY

Name:

Based on your survey answers:

Your Health Risks		Information to Consider
Risk of falling	Moderate	Falls at home are a leading cause of injury and hospitalization. You can prevent falls by: • Exercising regularly to help your muscles stay strong • Taking a brisk walk every day – start with 10 minutes at a time • Keeping floors clear of throw rugs, electric cords and clutter • Having your vision checked • Reviewing your medications with your primary care provider (PCP)
Life stress or depression	Low	
Managing your own health	Somewhat confident	When you are faced with different treatment options or have questions about managing your health, the Healthwise Knowledgebase® on the CareOregon website is an excellent resource. Go to: www.careoregon.org and select the "Health & Wellness" tab.
Tobacco or other drugs		If you are a smoker and ready for a change – call a Quit For Life® coach toll-free at 1-866 784-8454. Telephone counseling services and quitting medications, such as nicotine gum or patch, are covered under your CareOregon benefits. If you want assistance with alcohol/other drug use or abuse, you do not need a referral from your PCP. You can go to any treatment agency that accepts your CareOregon ID card. If you want help with this process or have problems finding services, our CareSupport staff can answer questions. For more information, call the CareSupport team at: 503-416-8055 or toll free at: 1-800-224-4840 and ask for the CareSupport department.

HEALTH SUMMARY

Name:

In the survey, you reported the following health conditions:

Health Conditions	Information to Consider
Asthma	You can breathe easier and keep your asthma under control by: • Taking your control medicine very day, even when you feel well. • Know your triggers and symptoms so you can act quickly when symptoms start. • Talk to your primary care provider (PCP) to be sure you are on the right medicines, especially if your symptoms change. • Work with your PCP to make an Asthma Action Plan that works for you.
Diabetes	Staying healthy with DIABETES depends on you and your primary care provider (PCP) working together. Your day-to-day care of diabetes includes: tracking your blood sugar level, checking your feet, eating a healthy diet, exercising regularly and keeping regular doctor visits. See the next page for information about your current status on recommended diabetes tests. Your CareOregon benefits cover the cost of diabetes self-monitoring equipment, including test strips, lancets, and blood glucose monitors. For more information, call the CareOregon customer service at 503-416-4100 or toll free: 1-800-224-4840. TTY/TDD users call: 1-800-735-2900.
High blood pressure	High blood pressure can increase your risk for heart attack, stroke, kidney, and eye damage. Changes in your lifestyle like losing weight, reducing the salt in your diet, and becoming more physically active can help to lower your blood pressure. You may also need to take some medicine to control your blood pressure. Ask your primary care provider about what is best for you. High blood pressure usually has no symptoms -- so it is important to take your medicine even when you feel good!
Heart failure or other heart problems	We invite you to join CareOregon's LIVING WELL with CONGESTIVE HEART FAILURE program. This free program can help you learn to see warning signs, know how to control CHF symptoms, make healthy choices, and work well with your doctors and other providers. Please give the CareSupport team a call at: 503-416-8055 or call toll free: 1-800-224-4840 and ask for the CareSupport department.
COPD or other breathing problems	Your survey responses indicate that you qualify for services from our CareSupport team. Our staff can help you manage breathing problems so you can breathe easier. If you are interested in learning more about these free services, call the CareSupport team at: 503-416-8055 or toll free at: 1-800-224-4840 and ask for the CareSupport department.

HEALTH SUMMARY

Name:

Our records show that you may be due for the following tests. If you recently visited your doctor, our records may not show the visit yet.

Managing Your Health		Information to Consider
Seasonal flu shot	Recommended	Each year thousands of adults are hospitalized, and some die, from the flu. Getting a flu shot is the most important step you can take to protect yourself. Get a flu shot every year if you are: 50 year or older, pregnant, have chronic health problems (such as heart disease, diabetes, lung problems, or weak immune system), live or work with people at high risk, or take care of young children.
Pneumonia vaccine	Ask your doctor	Pneumococcal bacteria can cause serious, sometimes fatal, lung or blood infections. Some groups are at higher risk. Ask your doctor if you need the pneumococcal vaccine, especially if you are: 65 years or older, have chronic health problems (such as heart or lung disease), have a damaged or missing spleen, or are a smoker.
Hemoglobin A1c blood test	Up to date	This test helps your doctor decide if your medicines and diet are keeping your blood sugars at best level. You need at least one test every 6 months.
Cholesterol blood test	Due for testing	This test helps your doctor decide if your diet or medicine needs changes to lower your cholesterol level. Lowering cholesterol prevents damage to your blood vessels and heart. You need at least one test every year.
Urine and blood tests for kidney function	Up to date	Diabetes can cause kidney damage and failure, especially if untreated or poorly controlled. You need urine and blood tests every year to test your kidney function.
Diabetes eye exam	Due for testing	Diabetes can lead to vision problems and blindness. Have your eyes examined once a year to detect vision changes and prevent loss of sight.
Cervical cancer screening	Due for testing	The Pap test is a quick, simple test used to help find cancer of the cervix as early as possible. Found early, this cancer is easier to cure. Pap tests are recommended every 1 - 3 years until age 65. Women with higher risk should be tested every year. Ask your doctor what is best for you.
Breast cancer screening	Up to date	Breast cancer can often be cured if found early. A mammogram is a breast x-ray that can find tumors while they are still too small to be felt in a breast exam. If you are age 40 or over, have a mammogram every 1 to 2 years. Women with higher risk need to have a mammogram every year.

Appendix C
CareSupport Metrics

Metric	Description	Data Source	Goal	Frequency of Reporting
Member satisfaction with CareSupport*	Aggregated findings from 6-question, evidence-based tool with open comment fields, administered at case closure by mail and telephonically	Member self report on survey	20% return rate; 80% aggregate at/above satisfactory ratings	Reviewed as received; aggregated monthly; reported to CS leadership quarterly and QI annually
Total number of Candidate Referrals for calendar year (CY) Top 5 Referral Reasons and corresponding number of referrals for CY Candidate Disposition Status	Total number of referrals Percent of all referrals received by category and ranked by referral reason (top 5) Count and percent of the total for each type of candidate disposition status	QNXT	N/A	Monthly to CS Leadership
Total number of Brief Actions (care coordination) for CY Top 5 Brief Action (care coordination) categories for CY	Total number of brief actions (care coordination) Percent of all brief actions (care coordination) completed by category and ranked by incidence (top 5)	QNXT Call Tracking system	Self management will remain in top 5 brief actions (care coordination)	Weekly to CS leadership
CS screening questionnaires completed	Number of questionnaires completed out of all members identified to receive a questionnaire, expressed as a percent	QNXT Reporting Services	50% of all screening questionnaires will be completed	Weekly to CS leadership

Rebecca Ramsay, Sr. Manager, CareSupport

Metric	Description	Data Source	Goal	Frequency of Reporting
Members enrolled in CS	Number of unique members enrolled in any of the CareSupport case management programs (does not include brief interventions) at any given time – this is a snapshot in time measure	QNXT Reporting Services	710	Monthly to CS and CO leadership
Transitional Care Program Outcomes	Hospital Readmissions for members enrolled ED visits by % members enrolled Provider follow up within 7 days of discharge	Administrative Data	Less than 20% Less than 10% 25% within 7 days	Quarterly to CS leadership and annually to QIC
*CCM effectiveness: Transitional Care Program process measure	Coaching to get members into PCP or specialist within X number of days following discharge	Administrative Data/Chart Review	To be determined following review of data – July 2012	Annually to CS leadership and to QIC
*CCM effectiveness: Transitional Care Program outcome measure	Reduce readmission rates for "enrolled" transitional care members	Administrative Data	To be determined following review of data – July 2012	Annually to CS leadership and to QIC
*CCM effectiveness: Member Satisfaction	To be determined following review of data – July 2012	Survey Data	To be determined following review of data – July 2012	Quarterly to CS leadership and annually to QIC

Appendix D
CareSupport Roles and Responsibilities

Title of Position	Qualifications	FTEs
Medical Director, Director of Clinical Learning & Support	Position requires a board-certified medical doctor or doctor of osteopathy. An administrative graduate degree, certificate of educational achievement in medical administration, or equivalent experience is desirable. Three years of progressively responsible managerial experience is highly desirable, preferably to include managed care, quality assurance, utilization review, and case management experience. At a minimum, several years of progressive leadership experience in a managed care organization or practice setting (Medicaid experience preferred), including or following strong clinical practice activity. A current unrestricted license to practice is required.	1*
Senior Manager of CareSupport & Clinical Programs	Position requires a physical or behavioral health degree and experience. Bachelor's degree in related field also required. Preference maybe given to those candidates who possess an unrestricted license for Nurse Practitioners or have a Masters degree in Public Health or Nursing or have an unrestricted License for Clinical Social Worker. Experience in developing and implementing programs, supervising staff, and knowledge of the principles of quality improvement and evaluation are required.	1*
CareSupport Manager	Position requires physical or behavioral health degree and clinical experience is required. Candidates with advanced degrees such as MPH, MSW, or NP may be given preference. A current unrestricted Oregon RN license with a bachelor's degree or higher in related field is preferred. Management experience with strong leadership and supervisory skills required. Health plan experience is preferred.	1
CareSupport Team Supervisor	Position requires 2-3 years of supervisory experience. Preference may be given to candidates with clinical and/or case management experience, including degrees in public health, nursing, social work, health education, social services, and behavioral health.	2
CareSupport Program Evaluation Coordinator	Position requires Master's Degree in Public Health (Doctoral Degree preferred) with disciplinary training in epidemiology, biostatistics, health education, and health administration with experience and training in program evaluation with at least 3-5 years of relevant experience designing applied evaluation studies, or evaluating the implementation and dissemination of health care innovations. Understanding of empirical research, formative evaluation, behavioral sciences, experimental research design, translational research, and epidemiologic and public health principles required. Understanding of and experience with process improvement methodologies such as rapid cycle testing and case by case learning is highly preferred. Exposure to and experience with statistical and analytical processes highly preferred.	1*

Rebecca Ramsay, Sr. Manager, CareSupport

Title of Position	Qualifications	FTEs
CareSupport Program Coordinator/Administrative Assistant	Three years of administrative and program assistant experience, or any work experience and/or education that likely provides the ability to perform the essential functions of the position. Previous project management support experience preferred.	1
CareSupport Registered Nurse (RN)	Current unrestricted Oregon RN license required. Current driver's license required. One (1) year experience with a health plan in a care coordinator/case management role preferred. Preference may be given to individuals who have experience with the Oregon Health Plan benefit administration.	8
CareSupport Behavioral Health Specialist (BHS) CareSupport Behavioral Health Coordinator (BCC)	Master's degree in social work or psychology with at least three (3) years experience in mental health and/or drug and alcohol treatment is required. Experience in the use of Motivational Interviewing is highly desired. Strong emphasis will be placed on those candidates who have CADC II certification, experience with case management and care coordination and an understanding of DMAP OARs (Oregon Administrative Rules). Preference may be given to those candidates with previous experience working in a managed care setting.	4
CareSupport Healthcare Coordinator (HCC)	High school diploma required. Two years experience working in a clinic, hospital, or health insurance plan interviewing patients and/or members for health information required; or any work experience and/or training that would likely provide the ability to perform the essential functions of the position. Preference may be given to those candidates who are a licensed practical nurse or who have a medical assistant or certified nurse's assistant certificate.	10

*The Director of Clinical Learning and Support, the Senior Manager of CareSupport and Clinical Programs, and the Program Evaluation Coordinator have responsibilities in other CareOregon units/departments, so a percentage of their FTE is involved in activities other than CareSupport.

Refer also to the attached organizational chart for CareSupport.

Rebecca Ramsay, Sr. Manager, CareSupport

Appendix E

QI Program

CareOregon

Organizational Chart

April 2012

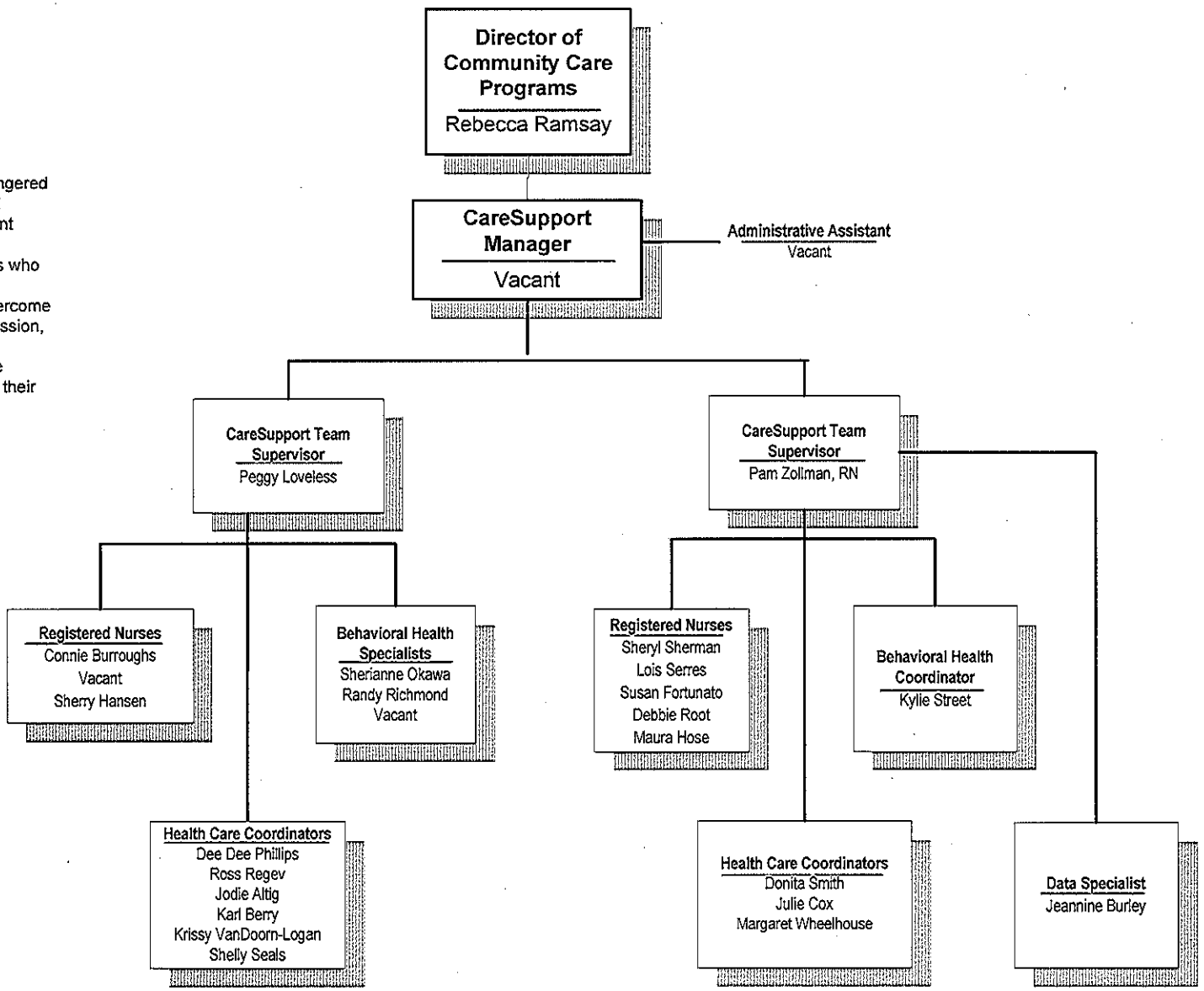
CareSupport Department

(7h floor)

Yamhill County Care Organization

Key Functions

- Help patients whose treatment is endangered by complex medical, behavioral or social conditions by providing case management services
- Use motivational coaching with patients who are resistant to health behavior change
- Look for community support to help overcome the obstacles of poverty, isolation, depression, mental illness and substance abuse
- Help members navigate the health care system and become actively engaged in their care



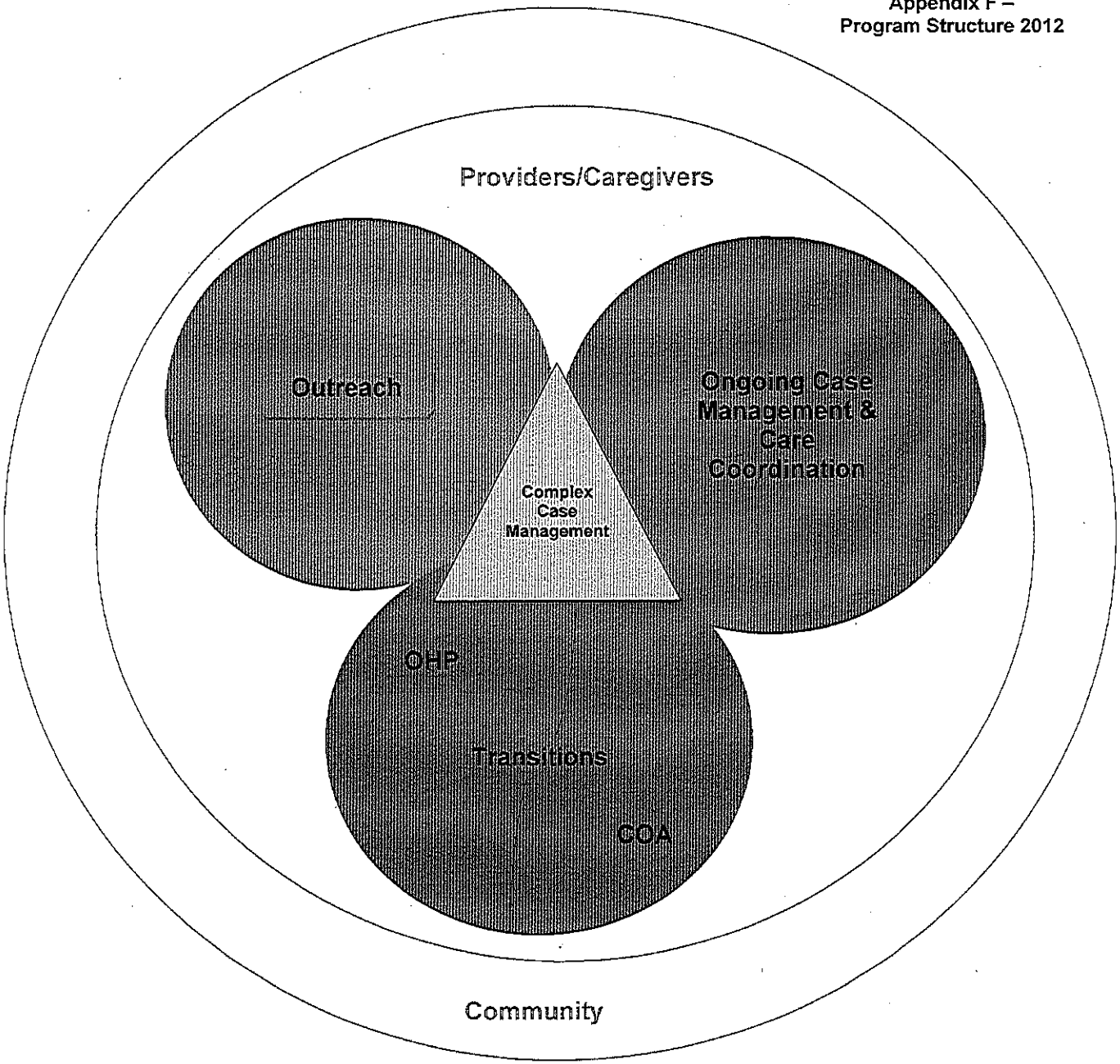
Outreach:
- Levels of Care
- HRA Follow-up
- ED Follow-up

Ongoing Case Management and Care Coordination
- Internal Referrals
- External Referrals

Transitions:
- COA
- OHP
- ED Follow-up

Complex Case Management:
- OHP members with equal to or greater than 0.5 ACG
- COA members, regardless of ACG
- Member and/or direct caregiver contact

Case open at least 60 days for inclusion in NCQA file review



CareOregon

CareSupport Department
Work Plan 2012

Part I– Annual Reporting

CareSupport Annual Reporting	Review Frequency	Responsible Person	Start Date	Committee and Report Date	Completion Date
Prepare **CS Program Annual Evaluation (AE)** ➢ Evaluation year 2011 o Incorporate QI 7 (complex case management; member satisfaction; etc...) o Incorporate and/or reference 3 CCM Effectiveness reports (effective 2012, an annual requirement for NCQA) o Incorporate and/or reference DMAP AE and Chronic Care Improvement Program (CCIP) Report (no CCIP for data year 2010; report for 2011 due May 2012) o Metrics/Analysis: CM, Brief Actions (Productivity) o Transitional Care Program (COA and OHP) o RCP Program o Referrals to HI, Palliative Care, etc... o COA MH Integration o COA HRA/Annual Care Plans	Annual Report	CS Sr. Manager (RR) CS Program Evaluator (DR)	Qtr 1 2012 Confirmed: Due to Ann Blume, QI Manager, 04-30-2012	QIMC in early May	
Prepare **CS Program Description (PD)** ➢ Program year 2012	Annual Report	CS Sr. Manager (RR) CS Supervisors (PL & PZ) CS Contractor (NJHJ)	Qtr 1 2012 Confirmed: Due to Ann Blume, QI Manager, 04-30-2012	QIMC in early May	05-01-2012
Review and update **CS 2012Work Plan (WP)** ➢ Attachment to 2012 CS PD	Ongoing	CS Contractor (NJHJ)	Ongoing	As part of CS PD 2012	
Prepare **DMAP Annual Evaluation (AE)** ➢ Subset of organizational DMAP AE – QI "owns" ➢ Incorporated and/or referenced in CS AE	Annual	CS Sr. Manager (RR)	TBA – Ann Blume, QI Manager	TBA – Ann Blume, QI Manager	

CareOregon

CareSupport Department
Work Plan 2012

CareSupport Annual Reporting	Review Frequency	Responsible Person	Start Date	Committee and Report Date	Completion Date
Prepare **External Quality Review** documents ➢ Subset of organizational submission	Annual or every two years	CS Supervisors (PL & PZ) CS Contractor (NJHJ)	Qtr 4 2012 (assumption based on cycle for CY 2011)	TBA – Ann Blume, QI Manager	
Prepare **SNP Submission** ➢ 2010/11 data – submission delayed by CMS to October 2012 ➢ Subset of organizational SNP submission – QI "owns" ➢ Incorporate and/or referenced in CS AE o SNP 1 Complex Case Management (CMS/NCQA consider all COA complex) o SNP 4 Transitions	Annual	CS SNP Project Team lead by: CS Contractor (NJHJ)	Qtr 2 2012 (due 10-15-2012)	TBA – Ann Blume, QI Manager	

CareOregon

CareSupport Department
Work Plan 2012

Part II – Programs and Activities

CareSupport Programs and Activities	Review Frequency	Responsible Person	Start Date	Report and Date	Completion Date
Transitional Care Protocol (candidates/cases) ➢ CareOregon Advantage members ➢ Oregon Health Plan members ➢ Subset of QIP 2012 ➢ Develop/revise audit ➢ Develop/revise data and collection o Reporting includes staff/productivity, and how many members are impacted	Annual/ monthly	CS Supervisor (PZ)	Ongoing	CS AE (Q1 each year) SNP Submission (Q3 2012)	
Transition Protocol – BH/MH ➢ Chemical Dependency ➢ COA Mental Health Integration	Annual/ monthly	CS Supervisor (PL)	Ongoing	CS AE (QI each year)CS SNP Submission (Q3 2012)	
Ongoing Case Management (candidates/cases) ➢ Oregon Health Plan members (ACG less than .5) ➢ Develop/revise audit ➢ Develop/revise data and collection	Annual/ monthly	CS Supervisors (PL & PZ)	Ongoing	CS AE (Q1 each year)	
Ongoing **Complex** Case Management (cases) ➢ CareOregon Advantage members (regardless of ACG) ➢ Oregon Health Plan members (ACG equal to or greater than .5) ➢ Revise audit ➢ Revise data and collection	Annual/ monthly	CS Supervisors (PL & PZ)	Ongoing	CS AE (Q1 each year) SNP Submission (Q3 2012) NCQA (survey)	
Brief Actions/Care Coordination (Call Tracking and candidates) ➢ CareOregon Advantage members ➢ Oregon Health Plan members ➢ Includes referrals to palliative care, hospice, etc... ➢ Develop/revise audit ➢ Develop/revise data and collection	Annual/ monthly	CS Supervisors (PL & PZ)	Ongoing	CS AE (Q1 each year)	

CareOregon

CareSupport Department
Work Plan 2012

CareSupport Programs and Activities	Review Frequency	Responsible Person	Start Date	Report and Date	Completion Date
Proactive Outreach Program (Call Tracking, candidates and cases) ➢ CareOregon Advantage members ➢ Oregon Health Plan members o ACG score o HRA score o ED (COA)	Annual/ monthly	CS Supervisor (PL)	Ongoing	CS AE (Q1 each year) SNP Submission (Q3 2012) NCQA (survey)	
RCP Program (candidates) ➢ CareOregon Advantage members ➢ Oregon Health Plan members ➢ Member must "reside" in Multnomah County ➢ Develop/revise audit ➢ Develop/revise data and collection	Annual/ monthly	CS Supervisor (PL)	Ongoing	CS AE (Q1 each year)	
Motivational Interviewing ➢ Maintain and improve staff competency ➢ Orient and train new staff	Leadership Meetings Quarterly	CS Supervisor (PL) RN (SH)	Ongoing	CS PD and AE (each year)	Ongoing
Member Satisfaction (Complex Case Management) (QI 7 H) ➢ CareOregon Advantage members ➢ Oregon Health Plan members (ACG score equal to and greater than .5) ➢ Phone calls made weekly to CCM members whose cases closed the prior week ➢ Quarterly summaries, reported annually to QIC ➢ Revise data and collection	Refer to Audit & Oversight Table	CS Supervisors (PL & PZ) CS Contractor (NJHJ)	Ongoing	Refer to Audit & Oversight Table	Ongoing
#1 Complex Case Management (CCM) Effectiveness Measurement (QI 7 I & J) (Transitional Care Program) ➢ Process measure: Coaching to get members into PCP or specialist within X number of days following discharge	Refer to Audit & Oversight Table	CS Supervisors (PL & PZ)	Ongoing	Refer to Audit & Oversight Table	Ongoing

CareOregon

CareSupport Department
Work Plan 2012

CareSupport Programs and Activities	Review Frequency	Responsible Person	Start Date	Report and Date	Completion Date
#2 **CCM Effectiveness Measurement** (QI 7 I & J) (Transitional Care Program) ➢ Outcome measure: Reduce readmission rates for "enrolled" in transitional care program members	Refer to Audit & Oversight Table	CS Supervisors (PL & PZ)	Ongoing	Refer to Audit & Oversight Table	Ongoing
#3 **CCM Effectiveness Measurement** (QI 7 I & J) (Member Satisfaction) ➢ To be determined	Refer to Audit & Oversight Table	CS Supervisors (PL & PZ)	Ongoing	Refer to Audit & Oversight Table	Ongoing
Review/update **CS policies and procedures** (P&P or PP) ➢ Refer to PP Tracking Worksheet in DMS ➢ Refer to 2012 Distribution to Staff Schedule in DMS ➢ Develop oversight P&P for various CS processes ➢ Develop oversight tool – completed 10/18/2010 ➢ Update orientation documents/processes	Annual	CS Supervisors (PL & PZ) CS Contractor (NJHJ) CS Sr. Manager (RR) (final approver)	Continuous cycle	CS AE (Q1 each year) SNP Submission (Q3 2012) NCQA (survey) (P&Ps provided as evidence to multiple entities)	Continuous cycle
Formalize/finalize **SOP** and distribution, updates processes	As indicated	CS Supervisors (PL & PZ) CS Contractor (NJHJ) Staff	Ongoing	As indicated for evidence	Ongoing

CareOregon

CareSupport Department
Work Plan 2012

Part III – Audits and Oversight

CareSupport Audits and Oversight	Review Frequency	Responsible Person	Start Date	Report and Date	Completion Date
Audit of case management files ➢ Includes complex case members related to NCQA (9 initial and 6 follow-up) (QI 7, F & G) ➢ Define Outlook Tasks audits ➢ Define audits of other case types, such as Transition related to SNP, etc... ➢ Formalize IRR process	Monthly	CS Supervisors (PL & PEZ) CS Contractor (NJHJ)	Ongoing	CS AE (each year) SNP Submission (CCM & Transitions) NCQA (survey) (CCM)	Ongoing
Analyze member satisfaction with CS process (QI 7 H) ➢ Identify sources of dissatisfaction with CS process through member satisfaction surveys (supervisors to meet quarterly to review results) ➢ Complex members are surveyed telephonically ➢ CS leadership to meet quarterly to review results and provide report (documents in DMS and CS Contractor is lead) **Analyze provider complaints** received via Provider Services ➢ CS leadership to meet quarterly to review results	Annual/ quarterly	CS Supervisors (PL & PZ) CS Contractor Provider Services CS Leadership	Ongoing	QIC – annually (via CS Annual Evaluation) CS Department Leadership - quarterly	
Analyze member satisfaction with CS process (QI 7 H) ➢ Identify sources of dissatisfaction with CS process through QI's member complaint process (CS related complaint reported to CS manager quarterly – 2/15, 4/15, 8/15, and 12/15)	Annual	QI Manager	Ongoing	QIC – annually (via CS Annual Evaluation) CS Department Leadership - quarterly	
Address identified sources of dissatisfaction with the CS process (QI 7 H) ➢ Implement actions targeting sources of dissatisfaction	As identified	CS Supervisors (PL & PZ)	As identified	As identified	As identified

Policy and/or Procedure Name	Policy and/or Procedure Number	Originating Department	Effective Date	Last Revision Date	Revision Cycle (Month/Year)	Responsible for Review/Revision (Title)	Approver (Title/Committee)
CareSupport Acronyms and Definitions.docx	N/A	CareSupport	3/12/2012	3/12/2012	as indicated	CS Supervisors (Pam Zollman) (Peggy Loveless)	CS Sr. Manager (Rebecca Ramsay)
QNXT Acronyms and Definitions 1-19-2012.docx	N/A	CareSupport		2/14/2012	as indicated	CS Supervisors (Pam Zollman) (Peggy Loveless)	CS Supervisors (Pam Zollman) (Peggy Loveless)
141 PP Call Tracking for CS Approved 11-28-2011.doc	N/A	CareSupport	2007	9/1/2011	11/28/2012	CareSupport Supervisor (Pam Zollman)	CS Sr. Manager (Rebecca Ramsay)
141 PP CHF Protocol Approved 09-24-2011.docx	N/A	CareSupport	2/1/2008	9/23/2011	9/23/2012	CS Supervisor (Pam Zollman)	CS Sr. Manager (Rebecca Ramsay)
141 PP Clinical Assessment Survey Process Approved 11-28-2011.doc	N/A	CareSupport	5/8/2008	3/17/2011	3/17/2012	CareSupport Supervisor (Pam Zollman)	CS Sr. Manager (Rebecca Ramsay)
141 PP COA HRA Follow-up Approved 09-26-2011.doc	N/A	CareSupport	5/3/2005	9/23/2011	9/23/2012	CS Supervisor (Pam Zollman) & CS Sr. Manager (Rebecca Ramsay)	CS Sr. Manager (Rebecca Ramsay)

141 PP Collaboration and Coordination between MH and Medical and Other Providers Approved.docx	N/A	CareSupport	9/29/2009	10/12/2011	10/12/2012	CS Supervisor (Peggy Loveless)	CS Sr. Manager (Rebecca Ramsay)
141 PP Complex Case Management Approved 09-26-2011.doc	N/A	CareSupport	10/15/2009	9/24/2011	9/24/2012	CS Sr. Manager (Rebecca Ramsay)	CS Sr. Manager (Rebecca Ramsay)
141 PP CS Attendance Punctuality and Time-Off Policy Approved 11-28-2011.doc	N/A	CARE	7/18/2003	3/17/2011	3/17/2012	CS Supervisor (Pam Zollman)	CS Sr. Manager (Rebecca Ramsay)
141 PP CS Central Phone Line Approved 09-26-2011.doc	N/A	CareSupport	2/1/2011	9/20/2011	9/20/2012	CS Supervisor (Pam Zollman)	CS Sr. Manager (Rebecca Ramsay)
141 PP Development Implementation and Maintenance of PPs and SOPs Approved 11-28-2011.doc	N/A	CareSupport	9/27/2011		9/27/2012	CS Contractor (Nola Horton-Jones) CS Supervisor (Pam Zollman) CS Supervisor (Peggy Loveless)	CS Sr. Manager (Rebecca Ramsay)
141 PP Disease Management Referrals to and from CS Approved 09-28-2011.doc	N/A	CareSupport	9/1/2009	1/21/2011	1/21/2012	CareSupport Sr. Manager & CareSupport Supervisor (Pam Zollman)	CareSupport Sr. Manager
141 PP ED Follow-up Approved 09-26-2011.docx	N/A	CareSupport	5/27/2007	9/23/2011	9/23/2012	CS Supervisor (Pam Zollman)	CS Sr. Manager (Rebecca Ramsay)

141 PP ENCC Approved.docx	N/A	CareSupport	10/24/2007	9/14/2011	9/14/2012	CS Supervisor (Peggy Loveless)	CS Sr. Manager (Rebecca Ramsay)
141 PP Evidence-based Clinical Guidelines Used in CCM Approved.doc	N/A	CareSupport	1/1/2010	9/19/2011	9/19/2012	CS Supervisor (Pam Zollman)	Medical Director, Director of Clinical Support and Innovations/ David Labby, MD
141 PP Fraud Waste and Abuse for CS Approved 11-28-2011.doc	N/A	CareSupport	2/1/2008	7/18/2011	7/18/2012	CareSupport Supervisor (Pam Zollman)	CS Sr. Manager (Rebecca Ramsay)
141 PP Health Literacy Approved 06-16-2011.doc	N/A	CareSupport	1/1/2009	4/4/2011	4/4/2012	CS Supervisor (Peggy Loveless)	CS Manager (Lisa Mariea Fithian)
141 PP Member Satisfaction wCS Services.doc	N/A	CareSupport	3/1/2012	3/1/2012	3/1/2013	CS Contractor (Nola Horton-Jones)	CS Sr. Manager (Rebecca Ramsay)
141 PP Motivational Interviewing.doc	N/A	CareSupport	3/31/2009	6/14/2011	6/14/2012	CS Supervisor (Peggy Loveless)	CS Manager (Lisa Mariea Fithian)
141 PP Multidisciplinary Team Meetings Approved.docx	N/A	CareSupport	4/7/2009	10/18/2011	10/18/2012	CS Supervisor (Peggy Loveless)	CS Manager (Lisa Mariea Fithian)
141 PP Outlook Tasks Approved 01-11-2012.docx	N/A	CareSupport	4/30/2010	9/14/2011	9/14/2012	CS Supervisor (Peggy Loveless)	CS Sr. Manager (Rebecca Ramsay)
141 PP Population Assessments and CS Operational Planning.doc	N/A	CareSupport	1/1/2011	7/1/2011	7/1/2012	CS Manager (Lisa Mariea Fithian) & CS Evaluation Coordinator (Deb Read)	CS Manager (Lisa Mariea Fithian)
141 PP Proactive Outreach Approved 09-24-2011.doc	N/A	CareSupport	10/1/2007	9/14/2011	9/14/2012	CS Supervisor (Pam Zollman)	CS Sr. Manager (Rebecca Ramsay)

141 PP Recuperative Care Program RCP Approved 09-26-2011.doc	N/A	CareSupport	7/1/2006	9/23/2011	9/23/2012	CS Supervisor (Pam Zollman) CS RCP Team	CS Sr. Manager (Rebecca Ramsay)
141 PP Referrals to CS Combined Approved 09-24-2011.doc	N/A	CareSupport	9/24/2011	9/24/2011	9/24/2012	CS Supervisor (Pam Zollman)	CS Sr. Manager (Rebecca Ramsay)
141 PP Transition Protocol Approved 09-24-2011.doc	N/A	CareSupport	1/1/2008	9/23/2011	9/23/2012	CS Supervisors (Pam Zollman) (Peggy Loveless	CS Sr. Manager (Rebecca Ramsay)

Yamhill County Care Organization
Appendix D – Medicare/Medicaid Alignment Questionnaire

Section 2 Demonstration Participation

D.2.1 Letter of Intent submitted April 2, 2012

D.2.2 YCCO's Affiliate, CareOregon, has operated a Medicare Advantage program since 2006. Our dual-eligible Special Needs Plan (SNP), CareOregon Advantage Plus, has more than 7,000 members, and includes Yamhill County in its service area.
More than 90% of CareOregon Advantage members receive both Medicare and Medicaid services through CareOregon. Members have a single local phone number, with specialized staff, to answer any questions they have regarding the complex set of Medicare parts A and B, Medicare Part D, and Medicaid benefits. Our care management staff has extensive experience working with individuals who have both Medicare and Medicaid coverage. More than 50% of our SNP members are younger than age 65, and many have multiple chronic conditions, that include both physical and mental health.

D.2.3 YCCO's affiliate, CareOregon already has a contract in place with CMS for individuals who have Medicare and Medicaid.

D.2.4 YCCO's affiliate, CareOregon has participated in the statewide CCO dialogue regarding integration of Medicare and Medicaid services through the CCO Medicare/Medicaid Work group and the ongoing DMAP Medicare/Medicaid Work Group. CareOregon is committed to working with the state to participate in the CMS Medicare/Medicaid alignment Demonstration. We are enthusiastic about the opportunities the Demonstration brings in terms of better alignment of both programs to benefit the member. If the state does not pursue that option, CareOregon Advantage would continue its current contract with CMS as a Medicare Advantage plan.

D.2.5.a YCCO's affiliate, CareOregon, has offered the Part D benefit since its plan's inception in 2006, and would meet the requirement as it meets the current Part D requirements, through a pharmacy benefit manager, Express Scripts, that has significant Medicare Part D experience.

D.2.5.b YCCO's affiliate, CareOregon, has offered the Part D benefit through its existing Medicare Advantage entity, Health Plan of CareOregon (CMS Contract ID: H5859) since 2006.

D.2.5.c Not applicable.