REPORT TO OREGON HOUSE COMMITTEE ON HEALTH CARE

AS A REQUEST FROM REPRESENTATIVE MITCH GREENLICK, CHAIR

JUNE 17, 2015
WILLAMETTE VALLEY COMMUNITY HEALTH

WVCH CCO SUMMARY

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INTRODUCTION

This report is in response to a letter from Representative Mitch Greenlick, Chair of the 78th Legislative Assembly for the House Committee on Health Care. The letter has requested the following information to be presented ***solo*** on June 17th at 2pm:

The format for the presentation:
1. Describe your CCO structure, including the governance structure, the key partners, who bears the risk, the nature of the delivery system, the role of the community advisory council, and your profitability (5 minutes)
2. Describe what you are doing that will fundamentally change the way health care is delivered and financed in your community and specifically how this progress will be measured and when will results be broadly evident (5 minutes)
3. Describe specific efforts underway that integrate physical, mental and behavioral health (5 minutes)
4. Identify the three (3) quality measures on which your CCO recorded the worst performance and describe what actions have been implemented to improve performance in those areas (5 minutes)
5. Committee questions (5 – 10 minutes)

This report will contain the needed information as well as supporting documents that describe our projects and innovations along with some key results. A presentation will also be provided with graphical depictions for your visual review.

Willamette Valley Community Health (WVCH) is pleased to prepare this for your review. If you need further clarification regarding the information provided in this report, please contact me at your convenience.

Respectfully Submitted,

Bill Guest
Executive Director/CEO
June 17, 2015

WVCH CCO SUMMARY

STRUCTURE

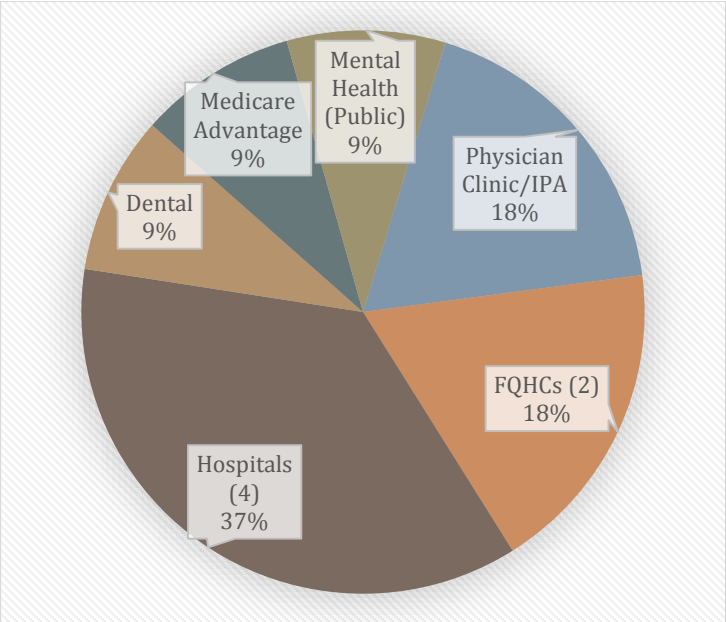
LEGAL STRUCTURE

Willamette Valley Community Health is organized as a Limited Liability Company with 11 equal owners. This legal structure allows non-profit tax exempt organizations, governmental organizations and taxable organizations to join and enjoy the current tax structure of their organization.

GOVERNANCE- BOARD OF DIRECTORS

WVCH Board is comprised of 19 members in our community and network. Board members serve for two years. There are representatives from the following areas: four Hospitals, two Counties, two independent providers, two Fully Qualified Health Clinics (FQHC), two public sector representative, two mental health entities, a dental care organization, the Community Advisory Council (CAC) Chair, a Medicare Advantage entity, and two physician entities.

WVCH Ownership



In addition we have the following committees that report to the Board of Directors:

- Finance Committee
- Community Advisory Council
- Clinical Advisory Panel
- Compliance Committee and Audit Committee

WVCH CCO SUMMARY

KEY PARTNERS

At WVCH we have many key partners in helping us to achieve success as the third largest CCO in the State of Oregon. We have Physician Groups, WVP Health Authority, Salem Clinic Medical Foundation, Northwest Human Services (FQHC), and Salud/Lancaster (YVFWC) (FQHC). Hospitals include Salem Health/Salem Hospital, West Valley Hospital (Polk County Critical Access Hospital), Silverton Health (Type B Hospital), and Santiam Memorial Hospital (Type B Hospital). Mental Health includes Mid Valley Behavioral Care Network, Marion, and Polk County Health Departments and one private health system (Silverton), a FQHC and ten additional community agencies. The Substance Abuse Disorder (SUD) partners includes WVP, (our local Independent Physician Association), and Mid Valley Behavioral Care Network as an Intergovernmental Agency. Our Dental partners are Capitol Dental, Advantage Dental, ODS Community Health and Willamette Dental Group. Other key partners include ATRIO Health Plan for Medicare Advantage and our dual eligible members, Marion and Polk County Health Departments, Salem-Keizer Transit District Triplink Transportation, PH Tech, WVP Administration, and MedImpact as our Pharmacy Benefits Manager.

RISK SHARING

Our risk sharing model includes alternative payment methodologies (APM) for providers, most of which share risk. The risk sharing groups include our local IPA, large clinics, groupings of smaller clinics and independent/solo practitioners, and Hospital systems.

One of the APM tools that WVCH uses is a pre-paid global risk budget model that mirrors the OHA's global budget methodology for physical, mental and dental health. There are withholds/holdbacks and risk pool sharing for specialists, hospitals and pharmacy. Also included is Patient Centered Primary Care Home funding (93.3% of our members are in Tier 3 PCPCHs and 4.2% are in Tier 2). There are incentives for access for clinics remaining open to new adults and/or children and payment adjustments for member acuity. WVCH also has a Quality Incentive Metric (QIM) payment model which weights measures and apportions compensation to those helping to achieve metric targets and goals.

Since the Affordable Care Act (ACA) expansion in 2014, our membership has grown by 68% and we are currently the third largest CCO in the State of Oregon. WVCH serves primarily Marion and Polk counties.

DELIVERY SYSTEM

MEDICAL/MENTAL/DENTAL

WVCH has a substantial and comprehensive delivery system and is continually working to add providers and improve access to care. We currently have 285 PCPs in 74 clinic settings that provide 3.3 primary care visits per member per year and 97.5 percent of our members in Primary Care Homes. We contract with 477 Specialists and Mid-Level providers that average 1.2 visits per member per year. Our local hospital network is comprised of four hospitals. Current Emergency Room utilizations average approximately 0.5 visits per member per year and .42 not including mental health. In regard to Mental Health we have embedded behaviorists in provider clinics. Our mental health network includes both County and private sector providers. Dental services are provided by via four Dental Care Organizations. Other important components of our delivery system include Substance Use Disorder Providers, and Ancillary Service Providers such as Home Health, Durable Medical Equipment, Non-Emergent Medical Transportation and Traditional Health Care Workers providing services to our members.

SCHOOL-BASED HEALTH CENTERS

West Valley Hospital is the medical partner in the Central High School, School-Based Health Center, in Independence opening later this month and ready for the school year start. There is an Open House for that facility June 25 4 - 6 pm. Our understanding is that perhaps it is one of the most integrated school-based clinics in the state.

- Central Health and Wellness Center at Central High School, Independence, OR
- A certified school-based health center that serves the entire community, with Central School District students as its priority
- Community Benefits: access to primary care and preventative health, care for children regardless of ability to pay, reduce costs of Emergency Department and In-Patient, save parents time, keep students in class
- Services: Medical, Mental Health, Dental
- Funded by grants from: Kaiser Permanente Foundation, Meyer Memorial Trust, Ford Family Foundation, Spirit Mountain Community Fund, Marion and Polk Early Learning Hub
- www.centralhealthandwellnesscenter.org

EARLY LEARNING HUB

CCO connections with the Marion and Polk Early Learning Hub, Inc.

A strong relationship with the early learning hub characterized by:

- CCO serves on the Marion & Polk Early Learning Hub, Inc. (ELH) Board of Directors
- The Executive Director of ELH serves on the CCO Board of Directors as community member
- Provision of in-kind support through office space, human resources, accounting and information technology functions
- Aligned metrics around developmental screening and children with regular well-child visits

Mutual and emerging work:

- Developmental Screening Transformation Grant - input the Ages and Stages Questionnaires (ASQ) results conducted by early learning providers into our Case Management information system
- Co-communication to plan members regarding 2015 kindergarten registration in Marion and Polk Counties
- Parent education and child care provider education focusing on health, nutrition and healthy lifestyles
- Referral coordinator position in Health Promotion Services to assist with clinical referrals to community based in-home services
- Mutual exploration of the effect of poor health outcomes in areas such as the effects of poverty in the community. Including the application of Trauma Informed Care and knowledge of Adverse Childhood Experiences (ACES)

Flexible Services

WVCH has implemented policies and procedures that will allow the plan to fund items not historically provided by the medical system that have a high probability of reducing the overall cost of care for an individual member. WVCH will make use of flexible goods or services to supplement traditional clinical services to prevent a more intensive level of care and to prevent or reduce hospital stays/claims expense in accordance with OAR 410-141-3120.

WVCH considers services such as:

- Training/education for health improvement or management (e.g., classes on healthy meal preparation, diabetes self-management curriculum)
- Self-help or support group activities (e.g. post-partum depression programs, Weight Watchers groups)

- Care coordination, navigation or case management activities (not covered under State Plan benefits, e.g., high utilize prevention programs)
- Home/living environment items or improvements (non-Durable Medical Equipment items to improve mobility, access, hygiene or other improvements to address a particular health condition, e.g., air conditioner, athletic shoes or special clothing)
- Transportation not covered under State Plan benefits (such as transportation to medical appointment)
- Housing supports related to social determinants of health (e.g., shelter, utilities, and critical repairs)
- Assistance with food or social resources (e.g., supplemental food, referral to job training or social services)

COMMUNITY ADVISORY COUNCIL

The Community Advisory Council meets no less than quarterly, however, has met monthly for the past two years. The meetings are public and held in a variety of locations as well as having translation to accommodate the needs of the public and consumer members.

The Community Advisory Council envisions a CCO where needs of members and families are central to the decisions of the Board of Directors and Clinical Advisory Panel and the goals of the Triple Aim are being met. The Council is made up of five Oregon Health Plan representatives, six community representatives and two county public health representatives.

The mission of the Willamette Valley Community Health Community Advisory Council is to ensure that the health care needs of the consumers and the community are being addressed by providing strategic direction to the WVCH Board of Directors. All CAC meetings are public and interpretation services are available.

The responsibilities of the Community Advisory Council's are to provide recommendations to the governing body and/or Clinical Advisory Panel on the following:

- Community Health Assessment
- Prevention programs and best practices for the Community Health Improvement Plan
    - Analysis and development of public and private resources
    - Health policy
    - System design
    - Outcome and quality improvement

- Integration of service delivery
- Workforce development
- Annual CHP progress report

- Policy guidelines on consumer related activities of WVCH

COMPENSATION

A stipend is provided to cover direct expenses to consumer members, including child-care, transportation, and meals, incurred by CAC consumer members attending CAC activities and is provided by WVCH to any consumer members of the CAC who face a financial hardship. No salary is paid for services as a member of the CAC.

MEMBERSHIP

Representation	Number of Seats
Consumer Members • Any individual who is a resident of Marion or Polk Counties and is a member of the Oregon Health Plan without extensive gaps in enrollment or family member of someone who is on the Oregon Health Plan. The group should reflect the age, ethnic, and geographic diversity of OHP and dual-eligible members. The following are suggestions for recruiting membership, recognizing that an individual may represent multiple perspectives • Families with OHP Children • Adults with chronic medical conditions and physical disabilities • Adults with mental health and/or substance use problems	No less than 4
Community representatives • Community representation includes individuals representing organizations with a vested interest in the health and wellbeing of the OHP population, serves the OHP population, and/or is an advocate on behalf of OHP members Representation may include those from the categories such as: • Community mental health and/or substance abuse Medicaid provider • Early learning representative	No less than 1

• Latino community organization representative • DHS hild Welfare representative • County mental health/chemical dependency representative • Social Service group representative (e.g., United Way, YMCA, Free Clinic, Housing, Transportation) • Community Support Group representative (e.g., Oregon Family Support Network)	
County Government Representatives	No less than 1 from each county

WVCH, like other CCO's, have vacancies on the CAC. To mitigate this challenge WVCH is using the Transformation Center's Technical Assistance Bank for consultation on this issue. The TA Bank consultant will be meeting with the CAC in the coming months to help devise a strategy for increasing consumer participation.

WVCH is actively recruiting consumers via our network providers and distributing recruitment materials throughout the community.

REPORTS

The CAC is scheduled to receive the following reports in 2015 for the CCO:

December 2014-

- Metrics report

January 2015-

- General demographics report, age, gender, zip code, language, race
- Report on last grievance report that was sent to the State
- Report on the secret shopper test process - how it works, questions they ask, frequency. Provide data from last test showing overall results, trends over time, geographic differences and contrast with the OHP provider map to show whether there are gaps in the system in terms of providers who are actively taking OHP members

February 2015-

- 6 month 2014 Metrics Performance report
- Insurance enrollment report
- Prenatal care report

- Number of members entering into care, by age, zip code, language, race, and week gestation compared with state OHP data and state and county data for the general population.

-Report on activity around meeting this CHIP measure

March 2015-

- Tobacco report
  - Data report - members who smoke by zip code, race, language, age, gender and referrals for smoking cessation,
  - Data report - tobacco related diseases by age, gender, race, language, zip code and whether they still smoke
  - Report on activity around meeting this CHIP measure
- The Future of Public Health: Task Force Report
- CHA Workgroup Executive Committee report: Initial Forum dates, invite Committee to attend CAC

April 2015-

- Obesity report
  - Data report - members with BMI 30-34 and 35+ by age, race, language, gender and zip code and those coded for obesity-related care
  - Data report - members with diabetes, by age, race, language, gender and zip code compared with state OHP and general population data at State and Local level
  - Report on activity around meeting this CHIP measure

May 2015-

- Depression/Mental Health Report
  - Data report -
  - Report on activity around meeting this CHIP measure

June 2015

- Status and Outcomes of 2014 Transformation Grants
  - Report on each of the four projects funded by OHA Transformation Funds

July – Dec 2015

- CAHPS (consumer satisfaction survey) Survey Results
- August: Report on Incentive dollars
- Others: to be determined, based on CAC experience with the other reports

WVCH CCO SUMMARY

PROFITABILITY

In 2014, WVCH recorded a net income of $14,105,925 (after audit adjustments). This represents 3.5% of the total revenues. It is the goal of WVCH to have a net income that is necessary to meet net worth requirements and establish reserves that allow WVCH to responsibly meet its current and future obligations. WVCH typically budgets to spend 90% to 92% of the available funds on services to members, 6% of the funds to administer the OHA contract and 1% to 3% for risk and reserves.

WVCH CCO SUMMARY

FUNDAMENTAL CHANGE

HEALTH CARE DELIVERY

Adding Flexible Services, Early Learning Hub, School-Based Health Centers and others have begun to open up a wide range of services that are critical in total population health.

In fall of 2013, WVCH considered several different projects for transformation. The four decided upon were:

1. Population Management Project: This project is related to the melding of clinical data from disparate electronic health record systems and health plan administrative data to be able to be available at primary care clinics. This would allow for a more complete view of member needs and use.
2. Medical Home Support and Learning Collaborative: This project made available resources for primary care to either develop or enhance their primary care medical home model of care.
3. Wraparound for Children with Complex Medical Conditions: This project developed centralized, single point of contact for families of children with complex medical conditions.
4. Early Learning Hub Developmental Screen Coordination: This project involved connecting the early learning system and WVCH primary care providers to enhance the communication and effectiveness around the coordinated care plans between education and health for kids with developmental delay.

Each of these projects are in various stages of completion. WVCH remains committed to these specific projects and also for ensuring the projects scope and effectiveness is continually evolving.

HEALTH CARE FINANCING

- Introduction of global capitation concepts
- Hospitals who employ primary care providers have adopted a financial model that changes emphasis on hospital utilization (a major change)
- Inclusion of hospitals in risk sharing is also a big difference from pre-CCO to post-CCO
- Case rates for some specialties (methadone, pain services)
- We are also hoping to leverage quality metric funds to pay for performance and clinical results rather than visits/volume

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Since the beginning of the WVCH in August 2012, the financial model has converted from a primarily fee-for-service driven model, to one that mirrors the current global budget methodology contract with Oregon Health Authority.

The financial model has expanded risk sharing groups to include communities, clinics and hospital systems, as well as support independent primary care providers. The global budget risk models encourage the use of flex funds and incentivize appropriate use of health care resources. It has also encouraged open access for OHP members with primary care providers in the community. This is evidence that an addition of approximately 40,000 members to the Oregon Health Plan now have an assigned primary care provider.

In addition to this evolving risk model, WVCH has engaged specialties to adopt case rate payment mechanisms that give specialists some flexibility in caring for members referred to them. Examples of case rate models that have increased access for members are with those members with chronic pain.

	Before	Now under CCOs
Primary Care	Fee For Service, Capitation, Access Fees	Primary Care groups have formed to accept a global capitation and risk for the entire cost of care with some carve outs (Substance Use Disorder, Non Emergent Medical Transportation, Mental Health, and Dental). Within global cap, access, PCPCH and chronic condition fees are paid as well as risk sharing balances in Pharmacy and specialty and hospital services
Specialty Care	Fee For service with risk	Fee for service with risk sharing but also have case rate payments for chronic pain procedures and chronic pain counseling if a procedure is not indicated

WVCH CCO SUMMARY

Hospital	Fee for service – no risk sharing	Two hospital systems who employ primary care have accepted a global capitation for facility services and professional services. Also risk share with primary care groups that are not part of hospital system
	Before	Now under CCOs
Mental Health	Capitation handled by Counties/BCN	Capitation handled by BCN. Mental Health has assisted in funding behaviorists. Psychiatry and medication management also located within Primary Care Physician setting. Behavioral health home also added primary care to services, so both mental health services and physical health services provided by clinics
Substance Use Disorder	Evidence Based Guidelines used and services paid FFS	Still use evidence based guidelines for Out Patient services and work with facilities across the state for residential services. Services paid Fee For Services
Pharmacy	Risk Sharing	Risk Sharing between CCO and Primary Care risk groups based on funding vs. expenses.
Primary Care Homes	None	Over 90% of our members are in Tier 3
Quality Incentive Metrics	Quality was not reimbursed	CCO has developed methodologies to reward providers for quality incentives that can be attributed to

		the providers who were largely responsible for the metric. These funds are distributed to providers and have provided significant impact to providers and is being mimicked with some commercial payers
Dental	Fee For Service and Staff Model	Same as before, though we did contract with Dental Care Organization (DCO) to provide dental caries procedure for kids in the dental office rather than a surgery center. Reduced cost by 40%, improved member experience and convenience
Behaviorists	None	Embedded behaviorists in primary care offices. We have a total of 14 Full Time Equivalent (FTE) behaviorists assisting primary care with mental health and substance abuse issues

MEASUREMENT OF PROGRESS

WVCH has increased primary care engagement, and have added approximately 40,000 new members with a primary care home from the ACA expansion and other population seen since 2013. Most of the quality metrics have been met and we are striving hard to meet the two that have not been met. The formation and implementation of PCPCH has taken hold and is the community standard for primary care. Dental integration is not yet evident due primarily to the delayed start of contracting in summer of 2014 in addition to the complexities inherent with contracting via four separate Dental Care Organizations (DCOs). And finally, the Quality Metrics are beginning to provide the impetus to value based care as a portion of provider compensation.

WVCH CCO SUMMARY

BROADLY EVIDENT

Quality improvement results are already evident in the reports released by OHA.

Key Results

1. Excellent results in 2013 quality metrics. (14.6 out of 17 measures met)
2. Enrollment with members in a patient-centered primary care home is currently 93.3% in Tier 3 PCPCHs and 4.2% are in Tier 2
3. Emergency Room utilization is below the State Benchmark, (2013 metrics)
4. Percentage of Medicaid members (adults and children) who self-report their overall health as excellent or very good increased. For adults, rate increased from 57% to 64%, children increased from 92% to 96%.
5. Transformation projects are on schedule.
6. Strong cross-governance with Early Learning Hub in Marion and Polk Counties.
7. Financial Model Supports OHA global budget methodology
8. 2015 cost to state and taxpayers declined 0.4% per member per month compared to 2014 (Blended Per Member Per Month in 2015 is $332.50 compared to same services in 2014 of $333.76) – This difference when compared to the 3.4% increase benchmark saved the State of Oregon and its taxpayers an estimated $15.6 million dollars over one year (based on 102,857 members each month)

Key Results and the Triple Aim

1. Reduce the per capita cost of healthcare: Yes – Key Results 5, 7, 8
2. Improve the Patient Experience (quality and satisfaction): Yes – Key Results 2, 3, 4, 5
3. Improve the Health of the Population: Yes – Key Results 1, 2, 5, 6, 9

WVCH CCO SUMMARY

WVCH 2014 QIM Preliminary Results

Measure	Target	Rate	Met?
Adolescent Well Care	28.1%	28.7%	YES
Assessment For Kids in DHS Custody	68.7%	74.8%	YES
Controlling Hypertension	N/A	N/A	YES
Developmental Screening	26.5%	34.4%	YES
Depression Screening and Follow-Up	N/A	N/A	YES
Diabetes: HbA1c Poor Control	N/A	N/A	YES
Early Elective Delivery	5%	0.5%	YES
Emergency Department Utilization	44.6/1,000	42.2/1,000	YES
EHR Adoption	71%	81.9%	YES
PCPCH Enrollment	60%	91.2%	YES
Follow-Up for Children Prescribed ADHD Rx	46.4%	51.4%	YES
MH Hospitalization Follow-Up	68.8%	65.7%	NO
SBIRT	11.7%	15.2%	YES

Transformation

Willamette Valley Community Health, LLC (WVCH), took on the challenge of healthcare transformation, and the goal of the triple aim from the inception of the company in June 2012.

In order to take on the significant challenges proposed by the State of Oregon and the policy leaders of Oregon, WVCH and the providers in the community organized WVCH with a broad governance structure that includes County Commissioners, Primary Care Providers, Hospitals, Dental Providers, Mental Health Providers and community representatives. This new governance structure has driven new dialogue, new financial models and new cooperation and collaboration. While not without controversy and difficult discussions, WVCH leaders remain committed to transforming our healthcare system to meet the challenge of the Triple Aim. The mission statement of WVCH is:

"The purpose of WVCH is to improve the health status and outcomes for Marion and Polk residents through promoting prevention and wellness in a system that is cost-effective, integrated and equitable."

The following is an outline of WVCH programs that have been implemented or are being implemented along with some of the documented successes that have been achieved in the last 2½ years since the start of the plan.

Programs to Improve Patient Experience or Enhance Patient Engagement:
Living Healthy Program

With the implementation of Affordable Care Act (ACA), WVP medical management is managing more than 100,000 members. There is increased pressure on both clinical and public health sectors represented in WVCH to lower delivery costs and improve clinical health outcomes in this increased caseload. Integration of evidence based lifestyle management will be critical to achieve this.

Research has clearly shown what we eat, how active we are, how we respond to stress, and the depth of our support system has the opportunity to reverse the costly burden of chronic disease and allow us to live better, yet WVCH members face tremendous barriers in adopting a healthy lifestyle. From low health literacy, to increased incidence of trauma, poverty, and toxic stress improving access and empowering members engage in self-management and health promotion services requires a seamless, coordinated approach bridging public health, public housing, non-profits and government programs providing social support services, with medical and mental health providers and hospitals. Over the past year, WVP Living Healthy has worked to support this vision.

2014 PROGRAM HIGHLIGHTS

HIGHLIGHT	DESCRIPTION
Walk with Ease	Living Healthy staff was trained to deliver "*Walk with Ease"*, a evidence based walking program developed by the Arthritis Foundation. This program assists participants to improve both physical and mental health as it moves participants toward a level of walking endurance consistent with recommendations required to maintain a healthy weight and manage chronic disease (30 minutes/day).
Stanford Self-Management	Living Healthy staff (2) received Master Trainer training at Stanford University, which allowed them not only to lead self-management workshops offered by WVP, but also to adapt the self-management tools to members earlier in their lives by reaching 38 WVCH teen mothers participating in Salem-Keizer School District's Teen Parent Program.

Nutrition Phone Consult	The addition of a Registered Dietitian to Living Healthy allowed for phone consultation services and clinical case review with a WVP embedded behaviorist. During weekly 1 hour consults, the RD reviewed food logs and the medical history to provide specific nutrition recommendations and coaching to the Behaviorist. 33 cases were reviewed within a 10 (1hr/week) week time frame.
Integration of Nutrition in the Primary Care Home	The RD participated in a modified Group Medical Appointment with an intensive team to manage members with A1C>9.0. Piloted by a physician at the "Doctors Clinic", the dietitian provided 1.5 hours of member education during 2 weeks of a 6 week program to 14 members. The show rate in this model was dramatically improved over traditional outmember nutrition services with 70% of those appointed (10/14) attending sessions. It is being provided again in 2015.

Provider Outreach: 21 presentations were made to 18 providers and/or hospitals between April 1 and December 31, 2014 to encourage referrals to self-management programs and collaborate on medical management efforts of WVCH members, including extensive collaboration with MVBCN to better serve members requiring behavioral health services.

ORGANIZATION	***SERVICES***
WVP Clinics	Hosted 7 self-management workshops at Liberty and Mission Street Clinics.
Salem Clinic	Hosted 13 self-management workshops, including 2 Tomando, collaborated to provide Self-Management for Heart Failure members in 2015, and hosted 2 presentations to providers to increase referrals.

NWHS West Salem Clinic	Hosted and provided 50% of staffing for 17 self-management workshops, including 1 Tomando workshop.
Flaming Medical Center	Agreed to host Polk County classes and held their first workshop in September, 2014.
Childhood Health Associates of Salem	Agreed to pilot self-management class for families & teens in 2015
Doctor's Clinic	Hosted 3 self-management workshops and developed a diabetes team intervention for members with A1C>9.
Salem Free Clinic	Hosted 2 self-management workshops.
Chemawa Indian Health Services	Staffed and hosted 2 self-management workshops.
Woodburn Pediatric Clinic	Hosted 1 self-management workshop adapted for parents of children with asthma.
Salud Medical Center & Lancaster Family Medicine	Agreed to open all classes they offer to all WVCH members to improve access to services in north Marion County.
New Perspectives	Hosted 4 self-management workshops and agreed to host our new program "Jump Start" which targets members with metabolic syndrome in need of weight management.
Santiam Memorial Hospital	Agreed to host self-management workshops in 2015.
Marion County Behavioral Health	Hosted 1 self-management workshop and 2 presentations to providers to increase referrals.
Salem Health	Collaborate to offer consistent Self-Management for Heart Failure with Salem Clinic and WVP which will be offered at both CHEC and Salem Clinic for members with Heart Failure in 2015. Living Healthy staff participates in the hospital led county wide diabetes collaborative.

COMMUNITY PARTNERSHIPS & OUTREACH

ORGANIZATION	***IMPACT***
SK School District	Entered into contractual agreement with WVP to provide nutrition screening and education services for the 292 children enrolled in Head Start. Hosted the pilot of the adaptation of Stanford's curriculum to reach 38 teen moms.
Community Action Agency Head Start & Arches	Provided staff training on 5210 & Self-Management to Head Start Family Advocates and Teachers to reach 1000 children with 5210 and boost referrals to WVP self-management programs. Provided staff training to 25 ARCHES staff so referrals can be made to WVP Self-Management Programs by staff working directly with individuals and families experiencing homelessness or at risk of becoming homeless.
Family Building Blocks	Provided staff training on healthy living, self-management, and 5210 to 80 staff that work directly with families at high risk for abuse and neglect.
Marion County WIC	Entered into an MOU with Marion County WIC where WIC members will receive nutrition education class credit for attending WVP Self-Management workshops, and referral of their high risk prenatal members to WVP self-management workshops or classes.
OCDC	Provided staff training on self-management workshops & 5210 to 150 bilingual staff working directly with migrant families providing childcare and Head Start services in an effort to increase referrals.
Salem Leadership Foundation	Provided brochures and contact information for distribution at SLF's 21 CAN centers (Churches as Neighbors) which are neighborhood centric to increase referrals. Provided training on "Read. Walk. Garden." collaborative with YMCA, OSU Extension, and Marion Polk Food Share to boost neighborhood health.
OSU Extension Services-Marion County	Living Healthy staff received training from OSU Extension at no cost for "Walk with Ease". WVP Living Healthy assisted in collaboration and provided a letter of support to OSU Extension Services on a grant application that would expand "Just Walk!" a neighborhood centric walking program supported by the City of Salem Neighborhood Service Division, Neighborhood Associations.
Marion County Housing Authority	Provided brochures on Self-Management programs and 5210 trackers they will deliver to members in their 150 units in an

	effort to increase referrals. In addition they agreed to host workshops in their housing complexes in 2015.
Salem Housing Authority	Provided brochures on Self-Management to increase referrals. In addition they agreed to host workshops in their housing complexes in 2015.
West Salem Housing Authority	Offered Tai Chi & Walk with Ease at Pioneer Village, one of their complexes in 2014 with a request made to offer onsite workshops in 2015.
SK Transit Authority	Offered training on 5210 to 80 staff in 2014. Working to integrate self-management program promotional materials on their buses in 2015.
Marion County Health Department	Staff participated regularly in Marion County CHIP development. Marion County Worksite Wellness has provided outreach and promotion of 5210 and WVP Self-Management programs.
Polk County Health Department	Polk County staff receives update on WVP Healthy Living Classes for posting in clinics and agree to offer promotional materials for members and referrals for behavior health members to Self-Management classes.
Northwest Seniors & Disability Services	Entered into contractual agreement to provide 4 Tai Chi and 4 CDSMP workshops in community and senior centers in Marion and Polk County for 2014, as well as a contractual agreement for 2015 for WVP to provide 2 Tomando and 3 Tai Chi workshops in community settings.
YMCA of Marion & Polk Counties	Hosted one Self- Management workshop with the option of additional workshops if space is needed for 2015. WVP Living Healthy helps promote the YMCA DPP to the medical and mental health providers as evidence based option for members with pre-diabetes.
Diabetes Support Services	DSS support classes are promoted on the resource table at the Diabetes Self-Management workshops. WVP Living Healthy participated at DSS annual Diabetes Forum in 2014 in an effort to increase referrals to our DSMP classes.
NWHS Team in Action	WVP Living Healthy hosted the November TIA meeting and promoted our programs to the 6 partners present.
Boys and Girls Club Marion & Polk Counties	Living Healthy Program Director met with the Executive Director to begin discussion on how to better integrate the medical providers in their community health screenings which reach more than 1700 children annually.
Catholic Community Services Safe Families	WVP Living Healthy provided materials on 5210 and Self-Management programs to participants attending their health fair in Woodburn in an effort to increase referrals.

Presentations: WVP Living Healthy Program Manager provided 13 presentations reaching an estimated 895 individuals from 10 organizations between April 1 and December 31, 2014.

- WVCH CCO Community Forum April 10, 2014 Silverton Health
- Mid Valley Behavior Care Network, "Metabolic Syndrome Prevention & Management" June 12, 2014
- Center 50+ Key Note Presenter, "Cultivating Whole Hearted Healthy Living, " April 12, 2014
- Family Building Blocks Home Visitor Wellness, "Cultivating Whole Hearted Healthy Living" September 2014.
- SK Head Start and CAA Head Start, "5210 Kids Learn Better" September, 2014.
- Four Corners and Schirle Elementary School Head Start sites parent meetings, "5201 for Families", November, 2014.
- SAIF, "5210 and Self- Management for the Worksite" October, 2014.
- ODE Retired, "Whole Hearted Healthy Living," October 2014.
- Mid Valley Behavioral Care Network, "Fostering a Nourishing Environment Despite the Odds" 2.5 hour training December, 2014.
- OCDC, "Fostering a Nourishing Environment with 5210" December, 2014.
- SK Transit Authority, "5210 Challenge Kick Off" December, 2014.

Program Participation

In 2014, Living Healthy offered 52 workshops and reached 681 participants. We processed 557 referrals as of 12/16/14.

Emergency Department Intervention Team (EDIT)

The EDIT program is currently comprised of 5 full-time navigators, 1 coordinator, and 1 outreach coordinator who works with both of the Special Programs and carries a caseload of 5 in EDIT. Currently EDIT has 70 members enrolled in the program and actively working with navigators. Typical caseload is 13-15 members per full-time navigator. The program is overseen by a Case Manager Nurse, who will participate in Care Conferences and meets regularly with community partners to coordinate care for members.

The goal of the EDIT program is to decrease Emergency Room utilization and to assist the member in learning how to use community resources and Primary care appropriately. We often find that lack of education regarding medical care is a driving force in high ED utilizers. Another factor that greatly impacts this population are those who are actively abusing drugs – either prescription or illicit. Walking alongside these members and guiding them into appropriate treatment programs directly affects their stability and medical care. Other factors like homelessness, untreated psychiatric illness, and lack of transportation, adversely affect our members who are high utilizers. The

EDIT program has begun to interact more in depth with Marion County Mental Health Mentoring program, and we are working to pair Navigators with Mental Health Mentors in an effort to provide more support and services for the members we work with.

Historically, members are involved in the EDIT program for anywhere from 6 months to 2 years. Graduation occurs when members can identify community resources and know how to use them appropriately; when they understand how to communicate their needs to their physicians; and when they have greatly reduced (or ceased) unnecessary emergency room visits.

The EDIT program has had some significant successes in changing the lives of our members. It is a difficult population to work with because mental health and physical health are affected by so many factors – some members will always have difficulties that we are not able to "fix".

MOMS Program

The MOMS program is currently comprised of 3 full-time mentors, and 1 outreach coordinator who works with both of the special programs and carries a caseload of 5 in EDIT. Currently MOMS has 30 members enrolled in the program and actively working with mentors. Typical caseload is 11-13 members per full-time mentor. The caseload in this program is much more demanding, even though they carry fewer members. One of the mentors was hired in early January to fill a vacancy and is still building her caseload. The program is overseen by a Case Manager Nurse, who is available for clinical information and attends to several meetings related to the MOMS program – TOT court and the NAS program, for example.

Certificate is given. Once they graduate we refer them to MOMS+ and encourage their continued path to recovery.

The MOMS program has had some significant successes in changing the lives of our members. It is a difficult population to work with. The women on the caseloads are coming with drug abuse, prior cases with parole/probation, and DHS. They may be in bad relationships with domestic violence, or they may be homeless. All of them have been traumatized in one way or another. Every success, like the following case, is celebrated.

Mid-Valley Pain Clinic:

With the assistance of WVCH and the prior FCHP, Mid-Valley Pain Clinic was started to offer a holistic approach to pain management to help provide members with the tools needed to move forward with life in a meaningful way. Primary care providers have long been frustrated with the lack of resources and options for members who indicate chronic pain is of primary concern.

WVCH CCO SUMMARY

WVCH supported local clinicians to create a program to help members understand and cope with chronic pain. Services include, review of medications to ensure the current medications are optimal for the pain experienced by the member, a program focused on improving quality of life, goal-setting, activity program, coping tools, member education and group support.

This program has been successful for hundreds of members who have graduated from the program. Overall narcotic prescribing is significantly less after completion of the program, as are overall costs.

INTEGRATION OF CARE

Integration of "Behaviorist" Providers in Primary Care Clinics (mental health and primary care integration):

Since August 2013, seven behaviorists have been hired and embedded into high volume primary care clinics. These primary care clinics represent 56% of all assigned members. The objective of the program is to train a workforce of currently licensed psychologists, social-workers, professional counselors to meet the emerging demand for integrated behavioral health care services in primary care environments.

The benefits to the members and to primary care providers have been significant. Behaviorists have impacted the ability for members to access not only primary care services and mental health services, but also situations where surgical services and prescription drug therapies were advocated for and obtained. Behaviorists spend their days coordinating and communicating with specialty mental health services and chemical dependency services to be clear on what each provider is prescribing and treating. This adds to member safety and provides clear communication on treatment for members needing to access multiple providers in the delivery system. In addition, the behaviorists work with members behaviorally who are struggling to manage diabetes, hypertension, chronic pain and chronic medical conditions. The behaviorists work with members who are utilizing the ED frequently by coordinating with mental health services.

This program has been very successful for primary care clinics which has prompted us to expand the program to 15 behaviorists across our network in primary care clinics that comprise 77% of our membership. Some clinics that had one of the initial seven behaviorists found such need and impact, that they are adding another behaviorist to address the needs of the members.

However, we have much work remaining to do with this integration strategy. Streamlining communication between primary care and mental health is at the crux of the areas in need of improvement. This model will continue to evolve and WVCH is committed to this as the primary mental health integration strategy.

Dental Health Integration:
Due to the financial integration of dental services occurring more than a year later than mental health financial integration, and the less than 100% integration of DCO's, dental integration projects are not fully developed. Areas in which there has been dialogue and demonstrated efforts are:

1. Dental services represented at all levels of governance and committee structures including Board, Finance, Clinical, Compliance and Quality Improvement.

2. Financial integration pilot with federally qualified health clinic that has primary and dental care, for dental services.
3. Notification to dental care organizations on individual members seeking care in emergency department that is related to dental issues.

Further integration strategies are planned related to dental care services available in primary care settings, tele-dental capabilities and inclusion of dental services in quality incentive funding.

QUALITY MEASURES

WVCH failed to meet two incentive measures in 2013. (WVCH was within 3% of meeting both targets).

- Adolescent Well Care Visits
- Follow-up care for children prescribed ADHD medication

ADOLESCENT WELL CARE VISITS

There are inherent barriers to adolescent access as many CCO's experience. Adolescents tend to enter the health care system from many points of entry; e.g., sports physicals. Unfortunately we suffer from competing adolescent attitudes, beliefs and behaviors and sometimes a lack of motivation. Also noted are issues with developmental appropriateness and confidentiality.

In research to this issue of not meeting the metric, we found that providers question the practicality and efficacy of the incentive measure. This creates a barrier. Policies and reimbursement vary across payers, necessitating unique workflows for Medicaid members. We also note that there is a lack of understanding amongst providers regarding impact of adolescent well care visits; wide-spread sentiment that this is simply "counting widgets".

All of the CCO's have suffered the consequence of the expansion of Medicaid population in that it has stretched capacity for clinics to conduct outreach.

The following actions have been put into place to help the plan achieve this metric:

- Provided assistance with targeted member outreach and appointment scheduling
- Distributed member-level reports identifying adolescents in need (gap analysis) of care
- Developed quality pool payment methodology that incentivized providers to make incremental improvements
- Modified WVCH benefit package to align with incentive measure

FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION

The other metric the plan failed to meet is the "Follow-up after ADHD prescription". The prevalence of ADHD amongst WVCH members has historically exceeded the

statewide OHP population. This tends to be driven by community prescribing practices that favor medication. It is also exacerbated by CCO and Pharmacy Benefit Manager (PBM) oversight of ADHD medication.

Many physicians view the required office visit as an inappropriate use of resources and believe a phone call would be sufficient for follow-up. Because of a claims lag it makes it difficult for the CCO to provide case management support within the 30 day window.

The following actions have been put into place to help the plan achieve the metric:

- Implemented strict prior authorization process for new prescriptions
- Engaged provider community in discussion surrounding ADHD prescribing practices
- Collaboration between Mid-Valley Behavioral Health Care Network (MVBCN) and primary care practices to educate providers regarding impact of ADHD medication on children

WVCH has already seen marked improvement and the 2014 preliminary results indicate WVCH surpassed improvement target for both Follow-Up After ADHD Prescriptions and Adolescent Well Care Visits.

EXHIBIT A TRANSFORMATION PROJECTS

Transformation Project Update

November 2014

WVCH Transformation Fund projects remain on track to meet established goals. WVCH will continue to utilize existing workgroups and member affiliates to bolster these initiatives. In an effort to keep stakeholders abreast of major milestones and benchmarks, a brief summary of each group's progress to date is provided below:

Project 1: Health Information Exchange

WVCH and Silverton Health have partnered with Arcadia HealthCare Solutions on a data integration pilot project that meets the aims of the Community Health Information Sharing Initiative. This arrangement enables WVCH to bypass significant time constraints associated with the vendor selection and legal review processes and ultimately presents an opportunity for the CCO to evaluate the feasibility of implementing the system on a plan-wide scale.

The terms of the agreement stipulate the following:

- There will be no financial considerations made by WVCH to Arcadia for any pilot activities and, consequently, no financial risk to WVCH for Arcadia costs directly related to the pilot. If the CCO ultimately determines to expand the scope of the project financial considerations will be reevaluated.
- Arcadia and Silverton will model the pilot in a manner that supports scalability to all CCO providers and risk entities.
- WVCH will commit to staffing technical resources to transmit health plan data to Arcadia.
- Arcadia and Silverton agree to include the independent physicians in their PHO in the pilot with the cost of the additional systems born by WVCH, thus expanding the electronic health record systems integration to three or more.

Project 2: Patient Centered Primary Care Home (PCPCH) Proliferation

WVCH has partnered with the Patient Centered Primary Care Institute (PCPCI) to facilitate a series of learning collaborative for providers interested in enhancing PCPCH capabilities. Together, WVCH and PCPCI have begun working directly with clinics to solicit input and develop content. Based upon input provided by interested clinics, a learning collaborative structure has been devised with the intention of encouraging broad-based participation from organizations with a diverse range of PCPCH experience. This preliminary structure provides clinics with an opportunity to participate in one of the following collaborative:

PCPCH Basics: This option includes information relevant to practices interested in becoming recognized as a Patient-Centered Primary Care Home (PCPCH) by the Oregon Healthy Authority. The PCPCH Basics Collaborative focuses on helping each practice establish a unique vision for building essential elements of a primary care home such as developing a quality improvement strategy, team-based care and empanelment.

WVCH has selected the Oregon Rural Practice-based Research Network (ORPRN) to lead a *PCPCH Basics Learning Collaborative*. ORPRN is ideally positioned to lead this Collaborative; they have partnered with the Institute to lead two other Collaborative, including one which helped five primary care practices in eastern Oregon become PCPCH recognized at Tier 2 or 3 in a nine-month Learning Collaborative similar to this one. ORPRN's reach extends well beyond its work with the Institute – they provide technical assistance through the CMS Comprehensive Primary Care Initiative, and are designated as one of eight National Centers of Excellence in Primary Care Research and Learning in 2012. ORPRN is nationally regarded for their ability to partner with multiple researchers and agencies, mobilize primary care practices to redesign care, and to study the impact of transformation on care processes and outcomes.

Practices participated in the first in-person Collaborative session on Friday November 7, 2014. Pre-work included an Assessment and a link to complete a series of online learning modules about the PCPCH program standards. In addition, staff from ORPRN visited each site for an initial meeting during the last two weeks of September.

PCPCH Advanced: This collaborative is for clinics that are already recognized but would like to make progress in more advanced aspects of the Patient Centered Primary Care Home model. The Collaborative will focus on helping a practice establish their unique vision for primary care home while building skills related to necessary to achieve their goals.

A series of half-day meetings and learning events will be held to connect practices with primary care home transformation information and ideas. Each session will include:

1. A presentation from a content expert and/or facilitated group discussion
2. Presentation from a local practice
3. Opportunities for networking and implementation planning

- **February 2015- Care Coordination:** Managing Care Transitions and Linkages to Community Resources
- **March 2015 – Data-Driven Quality Improvement**: Workshop for practices to discuss how to further improve their quality improvement work, including forming a stable, multi-disciplinary QI Committee and QI strategies, tools and approaches.
- **April 2015 – Care Coordination: Community Mental Health & Primary Care**: Discuss and brainstorm ways to address challenges coordinating between community mental health and primary care, including but not limited to: systems for communication, removing barriers to access, identify possible workflows for referral and follow-up.

- **April 2015 – Behavioral Health Integration**: Facilitated networking meeting for behaviorists, Behavioral Health Consultants or other mental/behavioral health professionals who are embedded in primary care settings. Discuss the variety of roles behaviorists take in care teams across clinics, behavioral health integration challenges, best practices, etc. Attendees should include BH professionals and those who work to embed them in the primary care team (clinician champion, administrator, program manager, etc.)
- **May 2015 – Care Management**: Risk stratification and care plan deployment, including review of each practice's care management functions and roles and coordination with external care managers

Improving Patient Experience of Care:

This Learning Community is an opportunity for clinics to improve engagement activities at the visit and practice levels. Participants in this track will receive the following:

- Ongoing technical assistance (virtual and in-person) to meet goals related to improving member engagement; this includes information delivered via learning sessions and webinars, as well as connection to written resources, tools and information.

- Consultation and support for developing goals, measuring progress, and planning and implementing projects.

Overall, the development of the three learning collaborative has had several important successes to date. There have also been challenges, which Q Corp is working with WVCH to address. The table below summarizes both. At this juncture the main challenge facing the *PCPCH Basics Learning Collaborative* and *Patient Engagement Learning Community* are practice motivation to participate and competing demands. Q Corp and WVCH hope to work with the Transformation Center Technical Assistance (TA) Partners leading each Collaborative to address these barriers as much and as quickly as possible.

Outcomes & Successes	**Challenges/Barriers**
Positive reception of project at PCPCH Workgroup meeting hosted by WVCH and facilitated by Q Corp (June 2014) Six practices have agreed to participate in the ***PCPCH Basics Learning Collaborative*** Three pediatric practices have agreed to participate in the ***Patient Engagement Learning Community*** Five practices have signed up to in an ***Advanced Learning Collaborative*** Accessibility of existing Institute materials to prepare for Collaborative, including but not limited to a series of online learning modules on PCPCH Program Standards	Varying levels of intrinsic motivation to change – some practices seem less interested than others in participating in this project, as indicated by the effort required to schedule meetings and learning sessions, email and phone call response, etc. In addition there is significant difficulty getting clinician leaders to participate because of reluctance to close clinical schedules, even for a few hours. Competing demands threaten practice availability to participate; competing demands include other projects and initiatives, influx of new members, staffing challenges and transitions, etc. Lack of interest and/or availability from TA Partners to lead Advanced Learning Collaborative as originally conceived – organizations with curriculum on advanced topics (e.g. Care Management and Care

	Coordination) are already committed to other projects and are unavailable. Concerns about duplicating efforts with other projects sponsored or supported by WVCH or other regional entities, including a project on Regional Care Management Development which is likely to involve several of the practices and clinical leaders to be engaged in the Advanced Track Collaborative

PCPCH Collaborative Timeline:

	PCPCH Basics	**Patient Engagement**	**Advanced/TBD**
September	Site visits with each practice; practices complete pre-work	Practice facilitation begins; practices completed Agreement	Schedule visits with each practice
October	Practices continue pre-work	Practice facilitation continues	Practice visits
November	First in-person session; practice facilitation begins		Determination of next steps
December	Practice facilitation continues		Practices complete pre-work
January		First Learning Session	Initial Collaborative activities begin

Project 3: Comprehensive Care Coordination for Complex Kids

The Comprehensive Care Coordination for Children with Complex Medical Conditions project, initiated by Willamette Valley Community Health (WVCH), aims to develop a centralized care coordination system that brings together the medical, mental health, school, and support services that provide care to children with complex medical needs and their families. While each individual service provides excellent care and support, no one entity coordinates the many services involved with these children and families. WVCH is using a range of care coordination approaches, including, but not limited to, a wraparound process to coordinate the various "Systems of Care". The goal of these coordinated care approaches is to "formulate a comprehensive, non-redundant, well-communicated, family-centered plan of care" that will improve the lives and well-being of children with complex medical needs and their families. The project further wants to demonstrate value related to member satisfaction, member/family functioning, health system navigation, and utilization efficiencies.

This report details some of the steps taken by the TRI evaluation team as well as the progress of the care coordination system through October 2014. The evaluation team has been in constant contact with staff from WVCH, The Children's Health Alliance (CHA), Northwest Human Services, and the Marion Polk Coalition for Special Needs Children and their families during the past few months to ensure full communication about the evaluation efforts.

- The TRI evaluation team has met with the team at CHA, to design the pre and post surveys that will be completed by the families (approximately 50 families) involved in the coordinated care system.
- The TRI evaluation team attended the first kickoff meeting at WVCH on June 9, 2014.
- The team has met on an ongoing basis. Through these meetings and ongoing emails and phone meetings we have also discussed member confidentiality and secure storage of medical records.
- A meeting on September 23, 2014 discussed the ongoing evaluation efforts and updated the TRI team on the coordinated care system efforts to date. We agreed on the approach and topics of any further evaluation efforts.

- The actual care coordination system has started during June/July 2014 by hiring two Family Services Coordinators (FSCs) and working out the particulars of member selection procedures.
    - Mandy Stanley, TRI Project Coordinator, provided in-person training on July 25, 2014 on data privacy and the actual family surveys to the new Family Service Coordinators.
- A meeting on October 17, 2014 with Stuart Bradley and the two Family Support Coordinators allowed the evaluation team to gain more in-depth knowledge about the services being developed, clinic connections made, and participant engagement and impact.

Efforts by Family Support Coordinators to Create the Coordinated System of Care

The Family Support Coordinators (FSCs) work with the individual clinics and medical providers to identify families that would benefit from this coordinated care system. To streamline the process and ensure guidelines are followed, FSCs have developed a protocol for clinic staff, including an "engagement script" to be used when calling designated families. After a family expresses interest in the program, clinics inform the FSCs who then in turn call the families within 48 hours. After three attempts to reach a designated family by phone, a subsequent letter informs the family of the available services. This mailing includes a brochure further explaining the system of care and inviting families to join.

FSCs have also developed their own guidelines to document all steps taken, with clearly established and measurable goals for each family. Materials for families have been translated into Spanish, and translators are available when needed.

Steps in the Coordinated System of Care

Once a family enters the coordinated care system, the initial face-to-face meeting with the family and the FSC can last well over two hours, depending on the family's needs and interests. The FSCs help the families understand what services and materials to which they have access. The FSCs keep detailed logs to map out the family's primary needs. FSCs ability to navigate quickly through the complex medical and educational systems allows them to pinpoint how families can receive the services or materials they need as quickly as possible.

After this initial meeting, the FSCs work with the families to contact numerous agencies in the community to aid in obtaining needed services. FSCs also work directly with a variety of partners/agencies to locate and provide services to families. Some of the partnerships that have aided families so far include:

- New Beginnings - a faith based baby boutique for pregnant women and their children
- Willamette Valley Food Assistance Program
- Mid-Willamette Valley Community Action Agency
    - Energy Services Program
- Salem-Keizer School District
    - Special Programs

Survey among Parents/Caregivers

As part of the initial meeting between the FSC and a family, parents are asked to complete a short survey. Assistance is offered to explain the survey to parents; Spanish translators are available.

While results only reflect the opinions of 11 parents at this time who have been seen by FSCs and had an opportunity to complete the survey, they do show the difficulties faced by the families in caring for a child with complex medical conditions. Over the past three months, before joining the coordinated care system, the children missed an average of 3.5 days of school or day care due to injury or illness. They also missed an average of 7.0 days of other activities during that time frame. In addition, the parents themselves missed an average of nearly three days (2.8) of work due to their child's illness or injury (see Table 1).

Table 1. Activity missed in past 3 months	Average (days)
School/ day care	3.5
Other activity	7.0
Parent - work	2.8

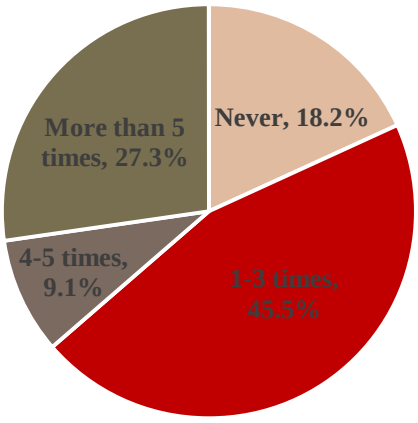
Nearly all (91%) parents indicate that it is difficult to find care that supports their child's need in their absence or while they are at work. While over half (60%) of the parents indicate they have the needed support to cope with the day-to-day demands of managing their child's health, another two in five (40%) feel they lack enough support.

The majority of parents (73%) indicate they have received help to connect with additional resources, such as specialized doctors, occupational therapy, or the Department of Human Services, in the past six months. Respondents' children were referred to an average of over two (2.3) different resources. Likewise, over four in five (82%) of the children have been referred to special educational services for school.

While two-thirds (64%) of parents feel they can access the services they need for their child's health, nearly half (46%) also feel that it is difficult to coordinate or handle such services. The majority (80%) also describes the coordination of these services as not very (40%) or only somewhat (40%) coordinated. Nearly half (45%) believe their child could benefit from additional services.

Parents have stayed in constant contact with their child's primary physician. In the past 3 months, three in four (73%) have called or emailed the doctor's office for advice or help, with one in four (27%) doing so more than five times (See Figure 1).

Figure 1. # of Times Contacted Primary Physician's Office in Past Three Months



Overall, parents feel the information received from the primary office was either somewhat (40%) or very helpful (50%). They also see the primary care provider as usually (55%) or always (27%) informed and up-to-date about their child's care.

Clearly, families rely on their child's primary physician for information and help. While the majority has been referred to various services, including additional educational services, the coordination of the many possible connections and services is seen as difficult and hard to navigate.

Impact of the Coordinated Care System

The impact of FSCs and the coordinated care system on families is extensive:

- They act as a liaison between families and physicians and already report an increase in their own interactions with these physicians.
- They have the ability to expedite the process of a family's need, providing rapid response to critical situations.
- They have bridged gaps with insurance companies by opening doors and breaking down the barriers through their knowledge of "how" to ask for needed medical equipment or services.
- They formed connections with other agencies to make resources accessible to families.
- As a result, parents are reporting feeling better equipped and able to advocate for their needs.

It is important to emphasize the strong support and connections that are being built to help families navigate through a complex system. The following three case examples demonstrate the role of the Family Support Coordinators in the services they provide to the families and the direct impact on families' lives.

A. Project: ADA Compliant Wheelchair Ramp

The member has muscular dystrophy with weak muscles and very limited movement. She also has difficulty gaining and maintaining weight to such a degree that it puts her health at risk. Due to the member's complex medical needs, she uses a very special motorized wheelchair for mobility and independence. This wheelchair cost more than $14,000 and was paid for by WVCH. Unfortunately, the family lacked a wheelchair

ramp, so the wheelchair was only used at school but not in the home. The wheel chair was locked up in a shed next to the house. In the family's previous home, the member was independent and mobile. Without a ramp, she now needed to be carried by a parent from room to room. She began to develop challenging behaviors when it was time to leave her wheelchair outside. She also started to resist eating and taking her medications. The FSC obtained a prescription from the primary care doctor for a ramp; flex spending for this was approved by the medical director for this purpose. After research by the FSC, it was decided to hire a private contractor to build the ramp. The ramp has now been installed.

B. Project: Fully Supported Bath Seat

In August, a member's mother expressed the need for a fully supported bath seat for her child as it took both her and her husband to support the child with his bath. The FSC contacted Salem Pediatrics to ask for a prescription for the bath seat and subsequently also met with the medical director and the Nurse Case Manager to discuss. After numerous phone calls with the mother and Salem Pediatrics, the FSC researched bath seats and arranged through the Nurse Case Manager to get the order placed. Furthermore, the FSC arranged the approval and order of the correct bath seat with Salem Pediatrics, Salem Rehab, and Nu Motions. While the process of approval and order placement took until October, the family has now received the bath seat.

C. Project: Surgery Approval

While checking that member's PediaSure prescription was switched to the correct provider to ensure delivery, it was noticed that the member's surgery for tibial torsion was denied. The FSC called the WVCH Government Relations representative to check on the reasons behind the denial. She in turn discussed the case with the medical director who clarified that this is an essential surgery that should always be approved. The surgery for this specific member was subsequently approved. In the future, any other critical denials can be brought directly to the Government Relations representative's attention by an FSC.

<u>Project 4: Early Learning HUB (ELH) Developmental Screening Initiative</u>

The Early Learning Hub continues to engage pertinent community stakeholders for their developmental screening initiative. Milestones thus far include:

Distribution of community survey: This tool was used to identify the frequency of developmental screens being administered in the community. It also enabled the ELH to better assess the barriers associated with developmental screening and identify ways to capture screens that are taking place in the community.

Site visits and interviews with key early learning partners: ELH representatives have visited early learning providers to document each practices and system for conducting, recording, and transmitting ASQ screens. The findings of these activities have prompted the Care Coordination and Screening Action Team to devise a strategy for electronic transition of developmental screens

Registration process for developmental screens: The ELH and WVCH are in the process of upgrading the CIM system to enable documentation of developmental screens that are taking place outside of the medical system. With this enhancement, participating early learning providers will have restricted access to CIM and begin documenting developmental screens in the system. These early adopters will receive developmental screening materials from the Early Hub and have the opportunity to collect reimbursement for each developmental screen administered to a WVCH member.

Hiring of a Screening and Care Systems Coordinator: The ELH has hired a Screening and Care Systems Coordinator to work with early learning providers in the community. This individual will serve as an educational resource for providers interested in utilizing the Ages and Stages Questionnaire (ASQ) at their location. The Coordinator will teach participating early learning providers how to use the CIM system and coordinate follow-up services for members who have been identified as having a developmental delay.

EXHIBIT B CCO COST UTILIZATION COMPARISON

*Source
Jeff Fritsche
Finance Director
Oregon Health Authority
Added weighted averages by dividing by months

FINANCIAL DATA	CY 2013 Final			Q1_2014 Preliminary			Q2 2014 Preliminary			Average (Wgtd)		
Category	STATEWIDE	Willamette Valley Community Health	WVCH as a % of Statewide Average	STATEWIDE	Willamette Valley Community Health	WVCH as a % of Statewide Average	STATEWIDE	Willamette Valley Community Health	WVCH as a % of Statewide Average	STATEWIDE	Willamette Valley Community Health	WVCH as a % of Statewide Average
UTILIZATION DATA (ANNUALIZED / 1000 MEMBERS)												
Inpatient -- Medical / General -- Patient Days	166.0	156.3	94%	168.9	170.1	101%	134.7	150.0	111%	161.3	157.6	98%
Inpatient -- Surgical -- Patient Days	81.6	74.4	91%	84.4	62.8	74%	76.0	70.4	93%	81.1	71.8	88%
Inpatient -- Maternity / Normal Delivery -- Patient Days	41.4	42.9	104%	30.3	34.2	113%	28.6	38.4	134%	37.4	40.7	109%
Inpatient -- Maternity / C-Section Delivery -- Patient Days	23.6	20.7	88%	18.3	16.9	92%	14.7	13.5	92%	21.2	18.9	89%
Inpatient -- Maternity / Non-Delivery -- Patient Days	8.1	7.6	94%	5.2	4.1	79%	5.0	6.6	132%	7.1	6.9	96%
Inpatient -- Newborn / Well -- Patient Days	34.2	35.1	103%	23.4	29.3	125%	19.3	29.0	150%	29.9	33.1	111%
Inpatient -- Newborn / With Complications -- Patient	47.5	51.0	107%	30.0	34.3	114%	30.3	35.2	116%	41.7	45.6	109%
Inpatient -- Mental Health / Psychiatric -- Patient Days	46.3	25.9	56%	42.4	25.7	61%	37.5	23.5	63%	44.2	25.5	58%
Inpatient -- Mental Health / Alcohol and Drug Abuse --	5.6	8.1	145%	9.0	15.0	167%	8.2	16.5	201%	6.6	10.7	161%
Inpatient -- Physician Procedures	317.9	296.8	93%	301.1	314.5	104%	284.8	298.5	105%	309.6	300.0	97%
Outpatient -- Primary Care Medical Visits	2,946.9	3,275.9	111%	2,855.0	3,391.1	119%	2,629.8	3,089.1	117%	2,878.7	3,264.0	113%
Outpatient -- Specialty Care Visits	1,227.5	1,150.4	94%	1,197.6	1,126.6	94%	1,251.6	1,149.9	92%	1,226.5	1,146.4	93%
Outpatient -- Mental Health Visits	2,067.3	1,662.8	80%	1,674.7	1,522.0	91%	1,707.5	1,758.6	103%	1,941.9	1,655.3	85%
Outpatient -- Dental Procedures	3,203.1	3,564.1	111%	3,071.1	3,510.9	114%	2,718.6	3,170.8	117%	3,100.4	3,489.7	113%
Outpatient -- Emergency Dept Visits	608.7	412.8	68%	599.2	501.5	84%	581.9	516.2	89%	602.7	444.8	74%
Outpatient -- Pharmacy Prescriptions Filled	9,121.4	5,973.6	65%	8,988.4	5,458.2	61%	8,774.1	5,634.2	64%	9,041.4	5,831.1	64%
Outpatient -- Imaging Visits	233.8	182.7	78%	248.6	192.2	77%	255.7	201.7	79%	239.9	187.5	78%
Outpatient -- Lab Bills	515.9	391.3	76%	485.3	402.9	83%	468.5	408.5	87%	502.9	396.1	79%
Outpatient -- Surgery (Hospital and ASC) Cases	80.3	76.4	95%	76.4	75.7	99%	84.8	87.1	103%	80.4	78.1	97%
COST PER MEMBER PER MONTH (PMPM)												
Inpatient -- Medical / General	$ 25.69	$ 21.83	85%	$ 26.21	$ 24.90	95%	$ 21.90	$ 21.59	99%	$ 25.15	$ 22.30	89%
Inpatient -- Surgical	$ 20.70	$ 18.92	91%	$ 20.18	$ 15.64	78%	$ 19.34	$ 19.02	98%	$ 20.39	$ 18.39	90%
Inpatient -- Maternity / Normal Delivery	$ 6.12	$ 6.23	102%	$ 4.88	$ 5.70	117%	$ 4.67	$ 6.12	131%	$ 5.67	$ 6.12	108%
Inpatient -- Maternity / C-Section Delivery	$ 3.68	$ 2.97	81%	$ 2.87	$ 2.82	98%	$ 2.47	$ 2.37	96%	$ 3.34	$ 2.85	85%
Inpatient -- Maternity / Non-Delivery	$ 0.96	$ 0.70	73%	$ 0.72	$ 0.60	83%	$ 0.69	$ 0.71	103%	$ 0.88	$ 0.69	78%
Inpatient -- Newborn / Well	$ 2.10	$ 1.72	82%	$ 1.86	$ 2.02	109%	$ 1.56	$ 2.00	128%	$ 1.97	$ 1.82	92%
Inpatient -- Newborn / With Complications	$ 6.69	$ 6.51	97%	$ 5.09	$ 5.14	101%	$ 4.74	$ 4.68	99%	$ 6.10	$ 5.98	98%
Inpatient -- Mental Health / Psychiatric	$ 3.30	$ 2.04	62%	$ 2.87	$ 1.83	64%	$ 2.74	$ 1.97	72%	$ 3.14	$ 1.99	64%
Inpatient -- Mental Health / Alcohol and Drug Abuse	$ 0.48	$ 0.40	83%	$ 0.86	$ 1.10	128%	$ 0.81	$ 1.14	141%	$ 0.60	$ 0.64	107%
Inpatient -- Physician Services	$ 12.75	$ 13.06	102%	$ 11.46	$ 12.00	105%	$ 10.56	$ 11.35	107%	$ 12.17	$ 12.60	104%
Outpatient -- Primary Care and Preventive Services	$ 23.08	$ 26.67	116%	$ 23.80	$ 28.39	119%	$ 22.20	$ 25.89	117%	$ 23.05	$ 26.83	116%
Outpatient -- Specialty Care	$ 12.50	$ 12.80	102%	$ 12.09	$ 11.61	96%	$ 12.87	$ 12.42	97%	$ 12.49	$ 12.54	100%
Outpatient -- Mental Health	$ 21.09	$ 19.25	91%	$ 17.73	$ 18.03	102%	$ 17.33	$ 19.23	111%	$ 19.90	$ 19.04	96%
Outpatient -- Dental	$ 8.85	$ 8.98	101%	$ 8.72	$ 9.67	111%	$ 8.50	$ 9.83	116%	$ 8.77	$ 9.24	105%
Outpatient -- Emergency Department	$ 20.65	$ 14.71	71%	$ 21.75	$ 16.38	75%	$ 22.03	$ 16.72	76%	$ 21.06	$ 15.32	73%
Outpatient -- Pharmacy Prescriptions	$ 34.23	$ 22.85	67%	$ 36.16	$ 22.25	62%	$ 36.64	$ 23.58	64%	$ 34.95	$ 22.87	65%
Outpatient -- Imaging (Professional and Technical)	$ 8.41	$ 6.83	81%	$ 9.02	$ 7.48	83%	$ 9.21	$ 7.52	82%	$ 8.65	$ 7.05	82%
Outpatient -- Labs (Professional and Technical)	$ 6.11	$ 5.72	94%	$ 6.44	$ 6.22	97%	$ 6.50	$ 6.24	96%	$ 6.23	$ 5.89	95%
Outpatient -- Surgery (Hospital and ASC/ Professional and	$ 15.87	$ 13.65	86%	$ 15.64	$ 15.67	100%	$ 17.53	$ 17.37	99%	$ 16.11	$ 14.61	91%
Outpatient -- Other Hospital Services	$ 7.89	$ 7.73	98%	$ 7.14	$ 7.08	99%	$ 7.20	$ 7.30	101%	$ 7.65	$ 7.55	99%
Outpatient -- All Other	$ 25.25	$ 23.28	92%	$ 23.40	$ 23.04	98%	$ 21.76	$ 23.52	108%	$ 24.36	$ 23.28	96%
Total	$ 266.40	$236.85	89%	$ 258.89	$ 237.57	92%	$ 251.25	$ 240.57	96%	$ 262.62	$ 237.59	90%
Total Inpatient days	454.3	422.0	93%	411.9	392.4		354.3	383.1	108%	430.6	410.6	95%
Total Inpatient cost	$ 82.47	$ 74.38	90%	$ 77.00	$ 71.75		$ 69.48	$ 70.95	102%	$ 79.39	$ 73.37	92%
		218774			218774			218774				
Claims/encounter received through	10/31/2014			10/31/2014			10/31/2014					
Report run date	11/12/2014			11/12/2014			11/12/2014					