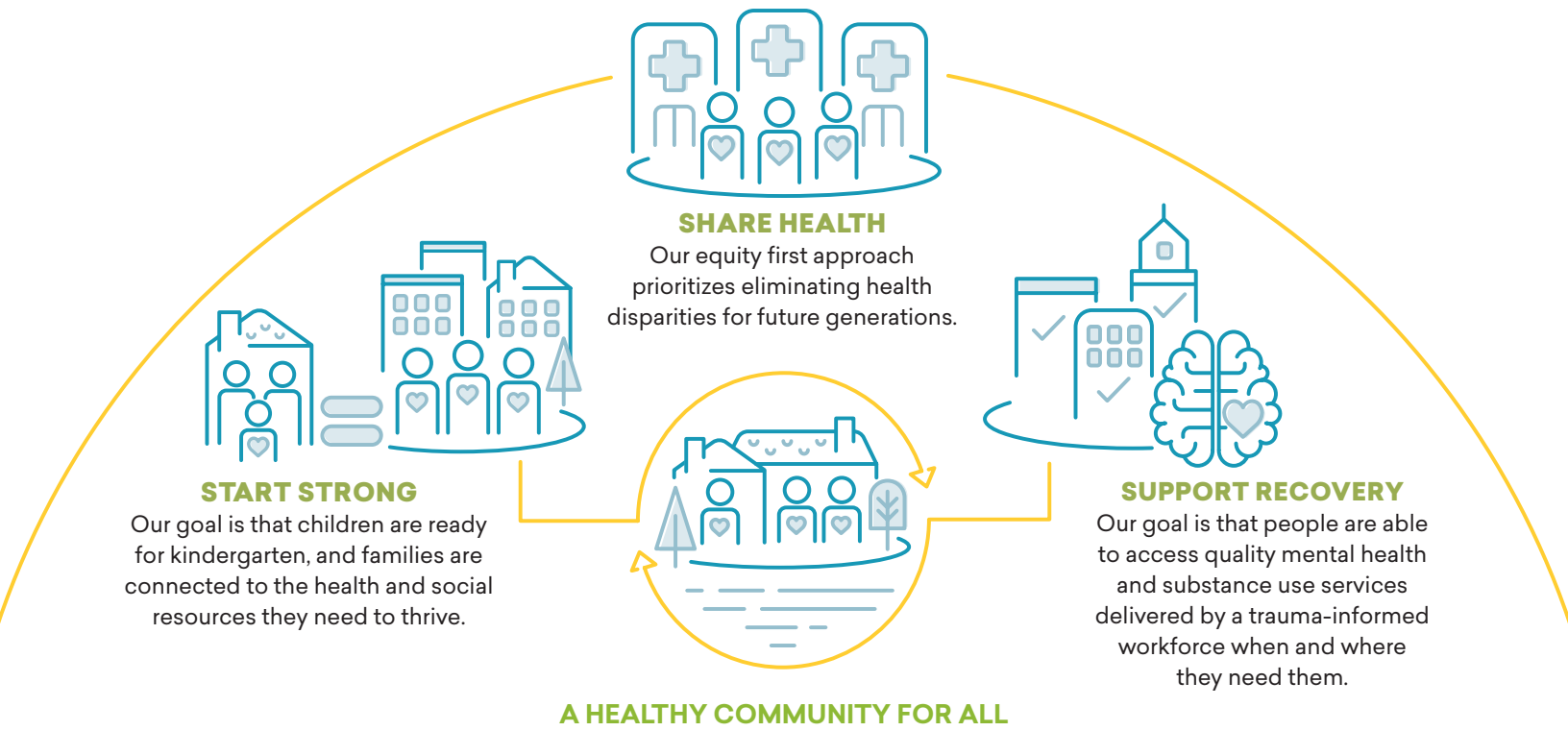
Ready+Resilient

Annual Report | October 2020

health share

Health Share of Oregon



SHARE HEALTH

Our equity first approach prioritizes eliminating health disparities for future generations.

START STRONG

Our goal is that children are ready for kindergarten, and families are connected to the health and social resources they need to thrive.

SUPPORT RECOVERY

Our goal is that people are able to access quality mental health and substance use services delivered by a trauma-informed workforce when and where they need them.

A HEALTHY COMMUNITY FOR ALL

CONTENTS

Ready + Resilient

In 2017, Health Share of Oregon's Board approved a three-year strategic investment strategy aimed at improving clinical and community outcomes in **early life health, behavioral health, and health equity**. These focus areas were prioritized based on analysis of our internal data, what we've learned from our members through the Life Study, and what we know from national literature. Prevention and early childhood are critical for us as almost 40% of our members are under age 18. In addition, we have focused on behavioral health, and in particular substance use disorders (SUD), given the tremendous negative impact on member health and morbidity and also because SUDs are the biggest driver of costs in our population.

This strategic investment plan, called Ready + Resilient, recognized that Health Share and its partners have a unique responsibility to drive system change to better support children and their families and those who engage with the behavioral health system, with a goal of eliminating health disparities. Ready + Resilient's focus on early life health and behavioral health are interconnected; when we build resilience and prevent trauma early in life, we build strong and healthy children while also helping prevent substance use and its many associated chronic conditions among adults. In turn, when we support recovery, we help create thriving families who provide healthy beginnings for children.

The goals and strategies within Ready + Resilient enhance and build on Health Share partners' priorities and initiatives, and many of the strategies align directly with the CCO's Quality Incentive Metrics measured by the state. We developed an aligned strategic framework building from the strong partnerships, clinical excellence, and community connections in Health Share's organizational model. This approach leverages the strengths of our partners, shares and promotes best practices, and builds from the collective efforts of all of Health Share's partners—thus creating a true community strategy that is the heart of Health Share's unique model. While this work has unquestionably strengthened alignment with and between clinical and community partners in the tri-county region, it has also helped establish Health Share of Oregon as a state and national leader in these important areas of population health and community impact.

What follows is a summary of the three years of work of Ready + Resilient, including establishing the All:Ready Regional Kindergarten Readiness Network; launching a regional resource for children and families (Help Me Grow) in collaboration with the region's Early Learning Hubs and Public Health entities; expanding health information access and connectivity through the Collective Platform, funding and providing regional equity trainings, investments in diversifying the behavioral health provider workforce, increasing access to medication supported recovery, improving systems to connect children in foster care to specialized services and social supports, and much more.

We have made significant progress towards the goals of Ready + Resilient and are proud of our collective accomplishments in this work over the past three years. There are still many opportunities to strengthen our work in prevention, behavioral health, and health equity. We look forward to working with Health Share's partners and cross-sector collaboratives as we strive to have even deeper impact for our community. If you would like to learn more about any of these initiatives or get involved with the work, please contact Christine Bernsten, bernstenc@healthshareoregon.org.

Start Strong

Build and enhance clinical and community interventions and referral systems

BACKGROUND

We have established strong partnerships with our Early Learning Hubs and Public Health authorities to co-create and advance initiatives that improve health and education outcomes for families and young children in our region. This includes work on promoting immunizations, tri-county behavior campaigns, and developing a regional coordinated referral system – Help Me Grow. We have a strong foundation to build shared clinical and community interventions. Our next step is the creation of a regional perinatal continuum of care and integration with Unite Us.

KEY INITIATIVES

Help Me Grow

While surveillance and screening are critically important, perhaps even more so are follow-up referrals and connections to services, and closing the loop on these referrals. Help Me Grow (HMG) strengthens those connections by making it easy for families to access community resources and giving clinicians and providers a central access point to a menu of family and early childhood services and supports such as home visiting and parenting supports.

In partnership with the tri-county Early Learning Hubs and the three counties, Health Share is funding HMG as the community intervention and referral system for child and family supports. Help Me Grow builds collaboration and coordination across sectors—health care, early childhood, preschool, and child care—focusing on connecting children and families to services through a central access point at Providence Swindells Resource Center. It is an ideal resource for kids in the "monitor zone" who might just miss eligibility requirements for Early Intervention, Developmental Disabilities, or home visiting, or be on the waitlist for Head Start or a clinical assessment. Help Me Grow also helps families navigate the systems for housing waiting lists, rent and utility assistance, food resources, and other essential services.

Providence Swindells Resource Center launched Help Me Grow in 2017, and began accepting referrals in April 2018.

Help Me Grow - By the Numbers

428 unique families supported through June 2020

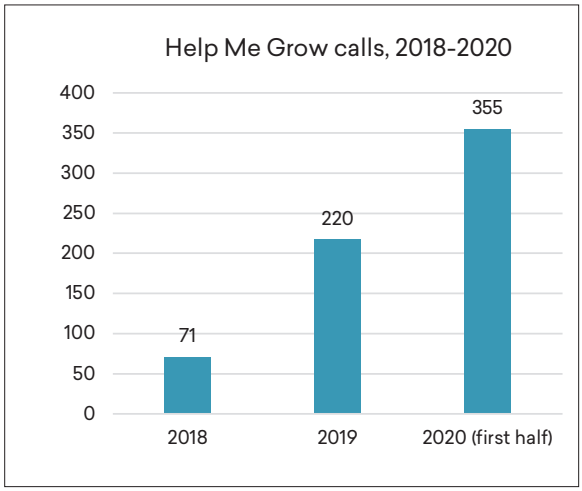
355 families referred in the first half of 2020

220 families referred in 2019

71 families are currently supported

7 weeks is the average amount of time families connected are engaged with Help me Grow

8 interactions are what each typical family had with Help Me Grow



Several pediatric offices are piloting referrals to HMG, focusing on families with parents who have higher ACE scores. At the suggestion of the pediatrician, parents can connect to Help Me Grow and staff will schedule regular check-ins for parenting coaching and more frequent developmental screenings than occur during well-child visits. The loop closure procedure with clinics alerts pediatricians to new concerns raised by families that could require intervention and ongoing support.

Help Me Grow is committed to reducing health disparities and is prioritizing outreach to culturally specific community-based organizations. In addition, Community Health Workers have been hired to serve as HMG Liaisons. Help Me Grow is also developing a new partnership with Home Forward, the housing authority in Multnomah County, to connect families with young children to resources through HMG.

HMG In Action

"I recently received a referral for a single mother having questions and concerns about the impact of trauma on her 4-year-old son. In the follow-up, she noted that HMG helped connect her to playgroups and behavioral health services. In addition, HMG connected her to a food box, free Comcast Internet, and a gas card. I cannot stress enough the importance of building relationships and connections with the families we serve."

Partner Spotlight
After hearing concerns from a Washington County Early Intervention therapist about potential learning loss for young children during COVID-19, Help Me Grow designed and built Learning Care Packages for families. Carefully selected materials (play scarves, play dough, stacking cups, crayons, and sidewalk chalk) are paired with printed activity guides and videos for parents. All activities support multiple domains of development. Health Share, CareOregon, and others are expanding this concept and partnering with culturally-specific organizations to provide the Learning Care Packages to families with additional culturally-specific resources. All:Ready partners contributed additional items, like dental kits, WIC enrollment information, and child safety information.

Partnerships with Public Health

Clackamas, Multnomah, and Washington County Public Health have been working together to address vaccine hesitancy across the region and create a culture of prevention. Since COVID-19 has arrived, the group has pivoted and shifted to focus on Vaccine Promotion more broadly, as well as working on removing access barriers. Over the next year, the tri-county Public Health agencies, Health Share and the Oregon Health Authority will collaborate on these primary strategies:

- **Strategy #1:** Design and implement multifaceted community mobilization initiatives, using evidence-based and promising practices, targeted towards multiple audiences with the purpose of influencing vaccine perception and behavior. Target Audience – Parents/Families
- **Strategy #2:** Advocate for policies that remove barriers to accessing immunizations for children and families with OHP insurance in the tri-county region.
- **Strategy #3:** Community education campaign encouraging parents with young children to seek vaccinations and promoting innovative locations where people can safely get vaccinated.

The campaign plan will include materials in seven languages to effectively reach our targeted audiences through a variety of channels.

Doula Investment

Health Share is partnering with Kimberly Porter Consulting and Birthingway College of Midwifery to offer a course for doulas of color with the goals to support workforce development, increase racial diversity of the regional doula workforce, and increase access to culturally-specific doula services. This six-month workshop series includes sessions to teach the fundamentals for creating a sustainable doula business. Health Share invested in the development of culturally-specific course curriculum. Upon completion of the series, doulas will register on the Traditional Health Worker (THW) Registry (a requirement for any THW to bill Medicaid). There are spots for 28 doulas to participate in this training program. The first cohort started late fall of 2019 and the second started February 2020. Health Share planned to partner with two maternity practices to identify workflows for clinics to access community-based doula services with the goal of streamlining connections between clinics and the community-based workforce. Due to the impact of COVID-19 on clinics, this component of the investment has been put on hold.

Start Strong

Decrease barriers to kindergarten readiness

BACKGROUND

In 2017, Health Share's Board made a commitment to support a Collective Impact initiative focused on kindergarten readiness. Poverty, racism, and ableism create disparities in early life experiences for children and their families that hinder kindergarten readiness. As a Network of sectors, systems, and organizations, it is our job to close those gaps and make it easy for families to thrive. The All:Ready kindergarten readiness Network was informed by a series of interviews with community partners and stakeholders. These conversations shaped the direction and strategies of the tri-county, cross-sector initiative.

GOAL

By 2028, we as a network will redesign how we work together so that race, class, and disability no longer predict families' access to and use of quality early childhood supports and services that ensure readiness for kindergarten and beyond.

VISION AND STRUCTURE

All: Ready is a community-led effort with coordination, data, and communications support provided by Health Share. A Design Team makes strategic high-level decisions about governance, strategic partnerships, and the long-term roadmap for change. Four workgroups meet monthly and focus on making "critical shifts" to move from the status quo (that is not working for kids and families) to a place where systems are:

- Designed to be more family-focused and culturally excellent.
- Using data in conjunction with a racial equity framework and a focus on lived experiences and community voice.
- Actively working toward being anti-racist and trauma-informed, with principles, tools, and resources used in policy and practice.
- Working together to ensure that investments are flexible, braided, and distributed using an equity lens.

VISION AND STRUCTURE

Anti-Racist, Trauma-Informed Organizational Change Workgroup (ARTIO)

Supporting organizational transformation through tools, resources, and trainings

- Planning a three-hour training on cultural frameworks, asset-based approaches, and applying an equity lens in decision-making within network member organizations.
- Finalizing a Member Agreement that outlines a clear commitment to anti-racism work as a part of the All:Ready Network.
- Finalizing tools and resources including key terms and definitions, an organizational anti-racism reflection tool, an education and training needs assessment and a "basket of tools" to support organizational and individual learning.

Data + Metrics Workgroup

Supporting sectors to work collaboratively from a shared set of values, definitions, and metrics on kindergarten readiness

- Developed a definition of kindergarten readiness which was approved by Network members.
- Developed a comprehensive data snapshot of 15 cross-sector metrics reflecting kindergarten readiness, reviewed with a racial equity lens and will publish on Health Share's website in October 2020.

Funding + Political Will Workgroup

Supporting systems and programs to be well-resourced, aligned, and sustainable through research, stakeholder engagement, and policy briefs

- Developed an analysis of federal, state, and local funding sources that are targeted to families with children ages 0-5. Included with this is a summary brief are key findings and "calls to action."
- Developing a communications strategy to educate and advocate for the Network's key populations in budget discussions.
- Exploring economic development and childcare partnership opportunities.

Systems Alignment Workgroup

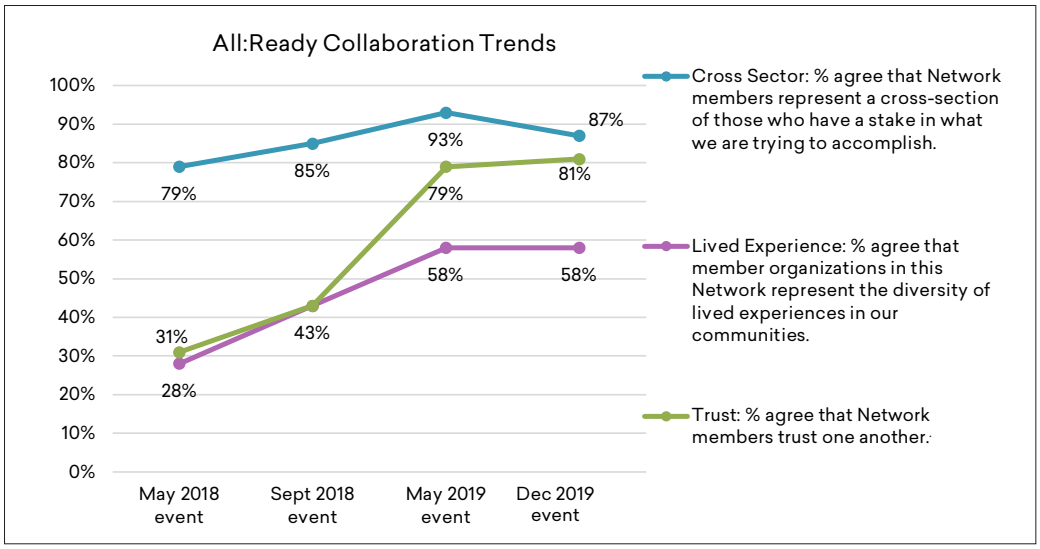
Supporting pilot projects and small initiatives that ensure care is family-centered, culturally excellent, and accessible when and where families need it

- Developed a comprehensive survey and report on the needs and barriers of families with children ages 0-5 during the initial quarantine of COVID-19.
- Secured funding and coordinated Network partners to purchase, assemble, and distribute 1,500 Help Me Grow Learning Care Boxes to support child development during the pandemic for families. Priority populations include families of color, immigrant and refugee families, children with developmental delays, and children receiving Wraparound services.

NETWORK ENGAGEMENT

All:Ready is focused on systems change, but equally thinking about the process of Collective Impact. Are we building trust? Are we strengthening cross-sector partnerships? Are we focused on centering families and individuals with lived experiences? All three of these metrics have increased since the Network launched in 2018, with levels of trust increasing the most dramatically (from 31% to 81% agreement). The following are collaboration trends from All:Ready Network convenings.

PARTICIPATING ORGANIZATIONS



School Districts:

Beaverton School District
N. Clackamas School District
Portland Public Schools
Reynolds School District
Tigard Tualatin School District
NW Regional ESD

Health Clinics and Systems:

CareOregon
Children's Clinic
Children's Health Alliance
Family Dental Care, Inc.
Health Share of Oregon
Kaiser Permanente
Legacy Health
Metropolitan Pediatrics
OHSU Health
Oregon Center for Children/Youth with Special Health Needs/OHSU
Providence Children's Developmental Health
Providence Swindells Resource Center

City, County, State, and Federal Partners:

Head Start
Portland Children's Levy
Home Forward (Mult. Co Housing Authority)
Clackamas County - Health, Housing and Human Services; Public Health Division; ESD; Workforce Partnership; DHS; Early Learning Hub
Multnomah County - Health Department; Public Health Division; Child Care Resource & Referral; Mental Health & Addictions; DHS; Early Learning Hub
Washington County - Children, Youth and Families; Behavioral Health; DHS; Beaverton Library; Early Learning Hub
OHA - Public Health Division; Women, Infant and Children
Federal Reserve

Community-Based Organizations:

Beaverton Library
Black Parent Initiative
Children's Institute
Dental3
Greater Than
Head Start
Help Me Grow
Home Forward
Immigrant and Refugee Community Organization
Kairos PDX
Latino Network
Metropolitan Family Services
Oregon Community Health Workers Association
Oregon Community Foundation
Oregon Health Equity Alliance
Oregon Infant Mental Health Association
Oregon Pediatric Improvement Partnership
Oregon Primary Care Association

Start Strong

Improve systems of care for populations with complex needs

BACKGROUND

This strategy aims to improve the health care system's ability to both understand and respond to the health care needs of complex populations of children and youth. Beginning with the unique challenges facing children in child welfare custody and placed out of home, the strategy has expanded to consider similar populations impacted by significant adversity in childhood, early traumatic stress, and child-serving system involvement. Building off established cross-system partnerships, Health Share is working to ensure that all system partners are aligned around the special health care needs of our most vulnerable members.

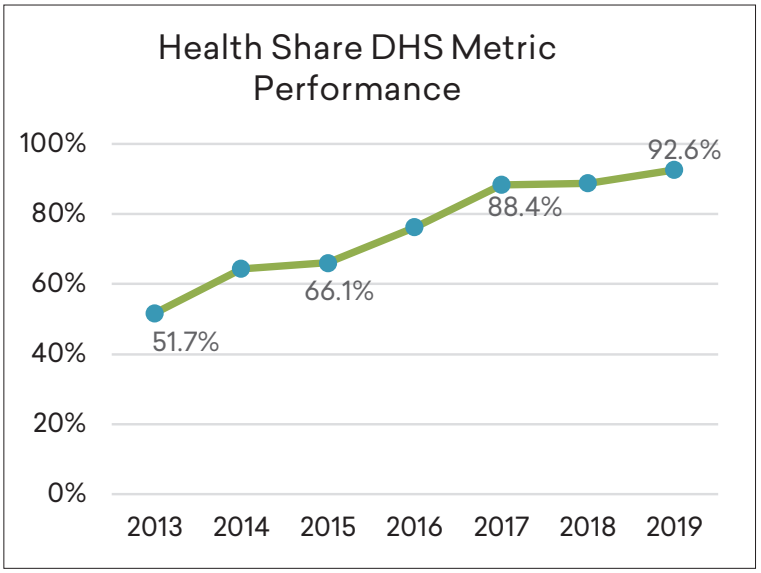
Approximately 5,100 Health Share youth currently quality for the Oregon Health Plan through DHS involvement, and about 8,200 have current or past foster care involvement. Youth in foster care face unique physical, emotional, and social challenges and often trauma from experiencing multiple changes in caregivers. Communities of color are disproportionately represented among youth in foster care, especially among the African American and Native American communities. The Oregon Child Integrated Dataset's findings indicate that tri-county youth in foster care have dramatically different health and educational outcomes than the overall youth population.

- Youth in foster care are more than twice as likely to be born with a low birthweight (174 per 1,000 for youth in foster care compared to 70 per 1,000 for the general population).
- Youth in foster care are almost twice as likely to have chronic school absenteeism (24% of youth in foster care compared to 15% of youth overall).
- Only one in four youth in foster care meets third-grade reading standards.

KEY INITIATIVES

Metrics Performance

Health Share's focus on children in foster care started with efforts on the CCO quality metric for children entering foster care. The DHS Assessment metric represents a true care coordination challenge, demanding high levels of performance across physical, mental, and dental health care. In 2020, the support structures and health plan leads assigned to meet metric benchmarks have refocused efforts to ensure all foster children and families have access to basic resources and assistance in navigating health care during the current health crisis.



Every Step Community of Care

Every Step clinics offer an advanced primary care model designed to meet the needs of children in foster care. There are currently 11 Every Step clinics in the tri-county region. Health Share began funding Every Step clinics at Legacy Randall Children's Clinic, OHSU Doernbecher, and Hillsboro Pediatrics in 2017. Six Metropolitan Pediatrics clinics and Gladstone Health Center began providing Every Step services in 2019 and Hillsboro Pediatrics spread the model to a second clinic site. Approximately 1,700 children have received services from an Every Step clinic since 2017.

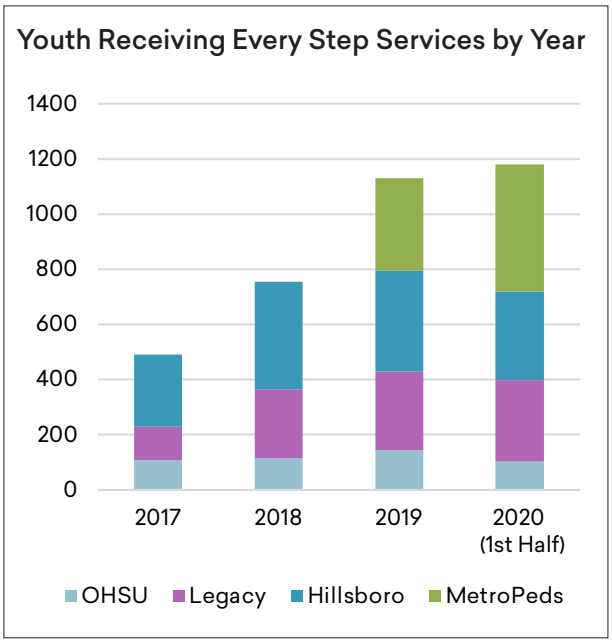
Every Step Core Elements

- Identifying and monitoring children in foster care
- Education on trauma informed care/parenting
- Standardized care aligned with AAP guidelines
- Connections with community resources and referrals
- Integration with mental health providers
- Integration with oral health providers
- Transition support
- Dedicated care coordination

Every Step services have increased significantly since their inception in 2017, and these clinics have served over 1,000 youth in the first half of 2020. An analysis of health care metrics, stability, and utilization shows the following conclusions:

1 Every Step clinics outperform the overall DHS population and the overall Health Share population on quality incentive metrics.

2 Youth in Every Step clinics received increased primary, dental, and behavioral health care in the year after they start receiving these services. They receive this care at a higher rate than a reference group of DHS-involved youth. The majority of youth remained assigned to their Every Step clinic for at least a year, even those youth with a history of multiple care assignments.



3 Among a subgroup of recent DHS entrants, youth at Every Step clinics saw increases in primary, dental, and behavioral health care, and decreases in emergency department visits. They had increased PCP, dental, and behavioral health visits and decreased ED visits when compared to a group of recent DHS entrants with similar demographics.

Health Share is partnering with Portland State University to complete a qualitative evaluation, to assess feedback from foster youth and families who have received Every Step services, with results expected in early 2021.

Quality Incentive Metrics (Jan-Dec 2019)	Every Step cohort (# required)	All DHS rate code (# required)	All Health Share (# required)
Developmental screening	83.3% (108)	74.5% (318)	73.5% (16,370)
Adolescent well child visit	85.5% (255)	61.8% (1634)	56.3% (46,831)
DHS assessments	95.0% (121)	92.6% (551)	92.6% (551)
Childhood immunizations	80.1% (36)	78.1% (114)	74.6% (4650)

DHS Medical Liaison

The DHS Medical Liaison position allows Child Welfare partners to maintain an active focus on supporting the health needs of vulnerable children in their custody. Launched in 2016, the position aims to improve performance on the DHS Assessment metric, provide plans and providers a primary point of contact to navigate a complex child-serving system, and support the transformative work of the Every Step clinics and RAPID providers. Based on the success of this model to integrate a position into DHS focused on the health needs of children in foster care, a second Medical Liaison was added in 2019 to serve Clackamas and Washington counties.

Rapid Assessment

MindSights, a local psychological assessment organization specializing in children in foster care, developed the RAPID (Relational, Academic, Psychological, Intellectual, and Developmental Health) evaluation as a comprehensive assessment of a child's most prominent needs upon entering foster care. The RAPID provides screening for emotional, behavioral, developmental, and educational issues for which children involved with the child welfare agency are at elevated risk. The results are used to identify initial service needs, develop intervention and support strategies, and to inform initial Child Welfare case-planning efforts.

The RAPID was piloted in Multnomah County and now all children one year and older who have a new Multnomah County DHS case receive a RAPID assessment. Over the past three years, MindSights has completed almost 1,000 RAPID assessments. MindSights conducts a trauma-informed debrief after each assessment to review strengths, needs, and recommendations with key team members, including foster parents and caseworkers. Recommendations are also shared with other critical supports through education, early intervention, primary care, etc., ensuring that recommendations result in a connection to necessary services, supports, and providers working with the child and family.

Partner Spotlight

In September 2020, the RAPID pilot expanded to youth entering foster care in Washington County DHS through an exciting partnership between DHS, MindSights, and Hillsboro Pediatrics.

Tri-County System of Care

Health Share convenes the Tri-County System of Care (SOC), a multi-system, collaborative governance structure charged to ensure services and supports for children, youth, and families are accessible, culturally responsible, trauma-informed, and youth and family guided. When communities, families, caregivers, and system partners identify barriers to care, the barriers are submitted to the SOC for review and resolution. The SOC has three distinct committees that use diverse strategies to solve these barriers. New efforts are underway to develop an even more robust collaborative structure including the development of an equity lens, defining new strategic directions, and creation of a data dashboard.

In 2020, the SOC is working on three primary areas of focus: increasing access to children's Wraparound services; trauma-informed care in crisis services; and expanding culturally matching services in the region. Additionally, the SOC will launch a series of System of Care 101 trainings, designed and delivered through cross-system partnerships. These trainings were requested by front line staff from multiple agencies and organizations in order to increase inter-agency knowledge and relationships. Finally, the SOC has played a key role in standing up a statewide SOC learning collaborative for council chairs as well as a monthly consultation call between statewide SOC coordinators.

Support Recovery

Strengthen the behavioral health workforce

BACKGROUND

In order to build a recovery-oriented system of care, Ready + Resilient is increasing the number of providers who reflect the culture and language of our members and implementing new culturally-specific models of care.

Approximately 57,000 Health Share members have had a mental health related diagnosis in the past year. This equates to 11% of all youth members (n=14,824) and 19% of all adult members (n=42,042).

KEY INITIATIVES

Substance Use Disorder Provider Investment

Health Share invested $1.8M in the fourteen largest Substance Use Disorder (SUD) providers in key areas including: workforce retention, staff development, care coordination, and improved member care/experience in care. Workforce retention investments included funds for market wage adjustments, signing and retention bonuses, and enhanced supervision. Staff development efforts included training, credentialing, and professional certifications and tuition reimbursements. Additional workforce has been hired within the SUD provider network to expand care coordination services and improve member care. Member care/experience in care was also enhanced through infrastructure investments and member-facing clinic improvements for community-based treatment centers.

Intensive Community Based SUD Services

Health Share has invested in creating a regional, intensive, and community-based mobile team to serve adult members with SUDs who are not well-served by existing services. The team is designed to meet members wherever is convenient for them in the community, and to provide assertive and innovative engagement and treatment. The team serves a variety of functions, including:

- Providing outreach and in-reach to members with SUD diagnoses who have avoidable acute care costs.
- Working with members to develop individual plans with functional outcomes as defined by the member.
- Implement focused, mobile outreach to ensure low-barrier, community-based, equitable access, with certified recovery mentors as the first contact whenever possible.

Health Share has contracted with Bridges to Change to develop and implement this new mobile SUD team. Bridges to Change has partnered with the Collective Platform (PreManage) to access real-time medical and health information for community members who experience high-need and frequent use of emergency department services. The team includes one Outreach Program Manager and eight Peer Support Specialists; one more Peer Support Specialist and a Co-occurring Therapist will join the team soon.

Regional County Based Addiction Benefit Coordinators

The Addiction Benefit Coordinators facilitate addiction treatment and recovery services for Health Share members diagnosed with a Substance Use Disorder. Based out of the counties, these staff are unique for their efforts to "Reach clients where they are", through community outreach, networking, and collaboration with the treatment and recovery communities. Care coordinators provide a variety of services to clients, including outreach, face-to-face meetings, developing treatment plans, and networking with providers and the treatment and recovery community. Washington County served 121 clients in Q3 of 2019, 26 clients in Q1 of 2020, and 39 clients in Q2 of 2020. The decrease in services were due to staff turnover and COVID-19. The vast majority of clients (between 73-84% each quarter) make progress on at least 75% of their goals. The Coordinators in Multnomah County have a particular focus on outreach to members from communities of color.

Culturally Specific Addiction Counseling Program

In an effort to increase services and workforce diversity, specifically racial and LGBTQIA+ representation in the Addictions Counseling profession, Health Share is funding 40 full scholarships in Portland Community College's (PCC) Alcohol and Drug Counseling degree and certificate program. This includes scholarships to support professional development of applicants currently employed as peers, providing SUD services with community-based organizations, and also funds a coordinator at PCC to provide support services to scholarship awardees. This strategy aids in addressing long-standing workforce shortages in the behavioral health provider network and will increase capacity of culturally-specific services for members in the tri-county region.

Regional Behavioral Health Collaborative

The Regional Behavioral Health Collaborative (RBHC) is a cross-sector collaborative with a shared goal of identifying and delivering strategies to improve the Substance Use Disorder peer system in the tri-county region. The RBHC developed four workgroups that met over 12-months; the Communities of Color workgroup proposal was funded; it incorporated inclusive practices, shared decision-making, and consensus building, to develop strategies to address disparities in access to SUD peer services for communities of color. The strategies they identified include:

- Expanding access to culturally and linguistically appropriate trainings for SUD peers of color, including peers with immigrant and refugee experiences.
- Creating culturally-specific, peer-run, emergency short-term housing resources to support people with SUD transitioning out, of or awaiting treatment.
- Focused community engagement and outreach to communities with immigrant and refugee experiences.
- Increasing capacity of culturally-specific organizations to provide SUD peer-run transitional housing services.

The work of this collaborative includes an environmental scan of existing services and barriers to services, culturally-specific SUD recovery transitional housing, culturally-specific peer services, immigrant/refugee community recovery education, and outreach and development of culturally-specific peer curriculum. The project launched in March 2020; two houses have been procured, two Peer Support Specialists have been hired, multiple outreach events have been conducted, and the environmental scan and curriculum development are underway.

Tri-County Behavioral Health Provider Association-Equity Investment

Health Share is funding the Tri-County Behavioral Health Providers Association (TCBHPA) to provide equity training support to five of the Association's member organizations. These organizations are working with an outside consultant to complete an organizational equity assessment that will inform the development of an equity work plan. Each organization will be linked with a TCBHPA Equity and Inclusion Committee member or Health Share equity staff to track progress and provide support and check-ins for one year after consultant work is complete. Organizations are encouraged to use the Coalition of Communities of Color's Protocol for Culturally Specific Responsive Organizations to guide their work. As part of the investment, the TCBHPA Equity Workgroup will curate 12 lunchtime panels and quarterly trainings; this series is open to all Association member organizations. The panels will start with an overview, sessions on forming a Racial Equity Team, conducting an assessment, and the nine Protocol domains. Quarterly training topics will include implicit bias, structural racism, intervening in oppressive language, and white fragility. The equity series panel kicked off in September 2019.

Partner Spotlight

The regional behavioral health collaborative resulted in a partnership between the Miracles Club of Portland, Instituto Latino De Adicciones, Native American Rehabilitation Association, 4th Dimension Recovery Center, Lutheran Community Services Northwest, MetroPlus Association of Addiction Peer Professionals, and Bridges to Change to carry out the strategies above.

Regional Peer Facilitation Center

Health Share has a history of investing in the peer workforce and has engaged a task force to identify high-priority objectives and recommendations to develop addiction peer-delivered services across the tri-county region, and develop strategic initiatives to promote use of the workforce. Health Share invested in the Regional Peer Facilitation Center (RPFC) to support activities that align with recommendations developed by the task force, specifically striving toward members receiving high-quality, trauma-informed, and culturally responsive mental health and substance use disorder services. The RPFC is offering learning opportunities for the professional peer community including: motivational interviewing and outreach for co-occurring disorders, ethics for peer mentors, MAT for co-occurring disorders, and Child Welfare best practices for co-occurring disorders. Course offerings also include Spanish language-specific training that covers core peer training, ethics for peer mentors, and support of the 2020 Instituto Latino de Adicciones Annual Conference.

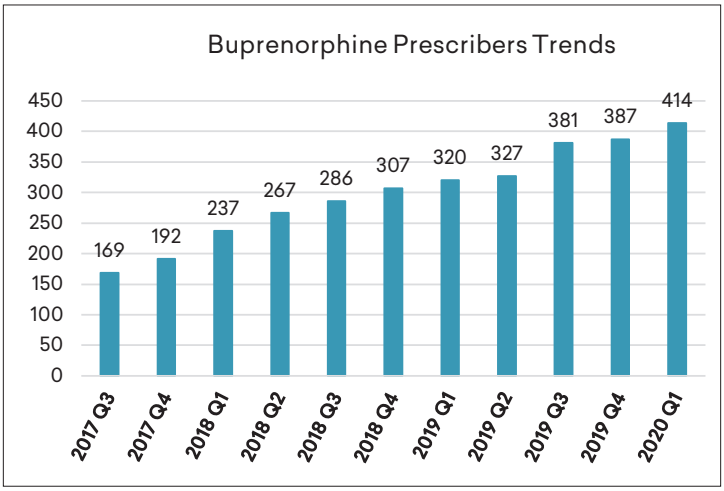
Support Recovery

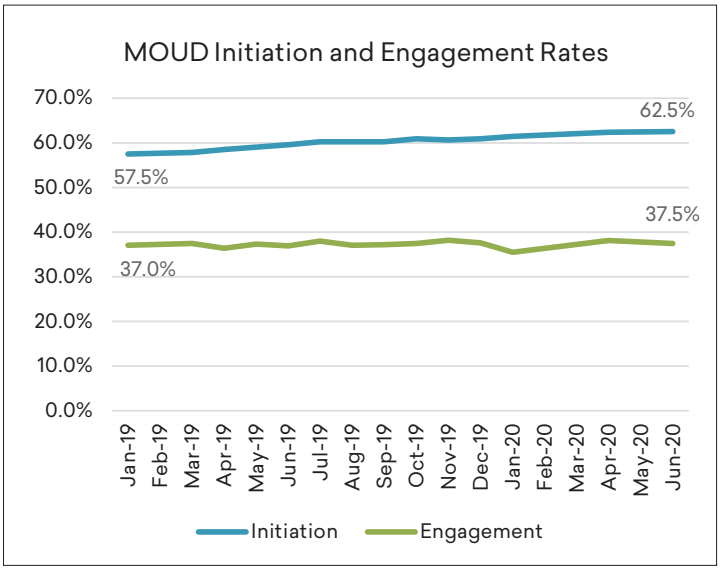
Improve the substance use disorder (SUD) system of care

BACKGROUND

Approximately 50,000 Health Share members have had a substance use disorder (SUD) diagnosis in the past three years. This equates to 1% of all youth members and 22% of all adult members. Alcohol, cannabis, and opioids are the most common substances in SUD diagnoses among Health Share members.

The Health Share vision is a Substance Use Disorder system of care that is recovery-oriented, trauma-informed, culturally responsive, user-friendly, and demonstrably effective. This strategy aims to improve the SUD system of care by increasing the number of providers who endorse and adopt best practice guidelines, increasing access to Medication for Opioid Use Disorder (MOUD) services, and increasing access to high-quality maternity care for pregnant members with SUDs. A comparative analysis of members with Opioid Use Disorder (OUD) showed that members receiving medication for more than six months have lower emergency and inpatient costs than members not receiving treatment.





The number of buprenorphine prescribers increased by 129% between 2017 and 2019. In 2019 Health Share began tracking the % of members with an Opioid Use Disorder (OUD) diagnosis who have initiated any MOUD services and those who are highly engaged (receiving MOUD services for 30 or more days and possessing medication 75% or more of treatment days).

Utilization trends among members with OUD shows that ED visits per 1,000 member months decreased by 14% from 2016-2019, while remaining steady among all Health Share adult members. Concurrently, the percentage of members with an OUD diagnosis receiving Outpatient SUD services increased from 20% in 2016 to 33% in 2019, which represents a 69% increase.

KEY INITIATIVES

Medication for Opioid Use Disorder Services Expansion: Wheelhouse 1.0

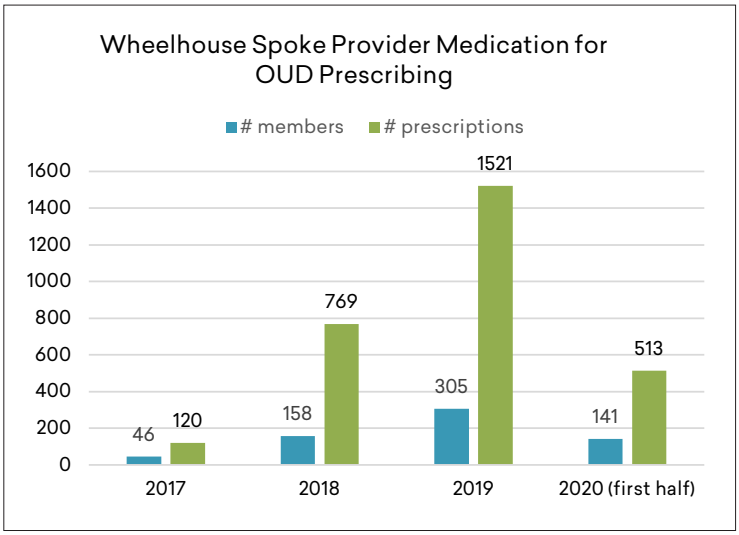
Wheelhouse began as a program to support specialty addictions and behavioral health providers as they built high-quality Medication for Opioid Use Disorder (MOUD) programs. The goal of the first-round of Wheelhouse funding was to expand access to buprenorphine in the regional behavioral health treatment network. An adapted model of a "Hub and Spoke" network, it connected new outpatient MOUD providers "Spokes" to a specialized "Hub" (composed of Central City Concern and CODA) with advanced experience with MOUD.

Wheelhouse staff held seven learning collaborative events that were attended by over 500 regional SUD staff. Throughout the events, 90% of respondents agreed that the events were valuable, and 95% learned new information that they can apply to their work. Wheelhouse resulted in practice and culture change, increased access points among new spoke providers, and increased integration among the two Hub organizations.

The number of Medication for Opioid Use Disorder prescriptions written by providers increased dramatically, from 120 in 2017 to 1,521 in 2019.

Medication for Opioid Use Disorder Services Expansion: Opioid Use Disorder Population Analysis and Primary Care Expansion

The second phase of initiatives focuses on expanding MOUD services directly within primary care and building connections between primary care and specialty addiction services. Health Share plans and providers formed a data workgroup to develop an analytic framework to guide expansion. Health Share used this analytic framework to develop a MOUD dashboard within its Bridge data application website to help clinics track progress towards their initiation and engagement targets.



Physical health plan partners and the Wheelhouse initiative submitted proposals to invest in the expansion of MOUD services, and the joint Clinical Alignment Group/Integrated Steering Committee reached consensus on a funding structure that includes both regional and plan-specific investments. Allocations were based on the following principles:

- MOUD expansion is a long-term investment. This is the first phase in a multi-year, multi-phase initiative.
- Initiatives must be data-driven to achieve the proposed metrics.
- Support a sustainable model for a community coordination/TA utility.
- All partners receive some funding to support internal efforts.
- Phase 1 funds focused on increasing MOUD access in primary care and/or transitions to primary care.

The regional investment included a seven-session learning collaborative (convened by Wheelhouse in partnership with CareOregon) which brought together implementation teams from 30 clinics on a bi-monthly basis. The events averaged 70-80 participants and were rated highly by participants. CareOregon also convened a community event related to Workforce and SUD and an additional data waiver training. Additional trainings have been postponed due to COVID-19.

The regional investment continues with the formation of the Regional SUD Taskforce in December 2019. This group, which includes representatives from Health Share's physical plan partners, specialty behavioral health providers, and the three counties, meets monthly to address expanding optimal SUD treatment for Health Share members. A subset of group members formed an Alcohol Use Disorder (AUD) workgroup to begin developing regional strategies and interventions for AUD.

Partner Spotlights

Highlights from the first year of plan partner interventions include:

- The number of Kaiser Permanente PCP buprenorphine prescribers doubled in 2019.
- Providence expanded MOUD services and expanded inter-clinic coordination with stand-alone community MOUD providers as well as other Providence Medical Group MOUD providers.
- 12 CareOregon clinics completed the Learning Collaborative and data waivered providers are now present in Federally Qualified Health Centers in all three counties.
- Kaiser Permanente implemented its Project Nurture program, which includes integrated maternity and SUD care and peer support services. With this program up and running, all Health Share members now have access to this best model practice.

Support Recovery

Improve availability of information across care settings

BACKGROUND

This strategy aims to ensure that providers and plans have access to health information and analytics in order to decrease disparities and improve integrated care for members. Key initiatives include expanding the use of Health Share's web-based data platform (Bridge), the Collective Platform (PreManage), and increasing Health Share's capacity to analyze health disparities.

KEY INITIATIVES

Disparities Analysis Capacity Building

Health Share and CareOregon co-sponsored a workshop entitled "Embedding Equity in Your Data: Analysis and Application" for their health equity, community engagement, quality improvement, and analytic staff. The two-part workshop series focused on deepening organizational capacity to apply an equity lens to data analysis, evaluation, and quality improvement. Twenty-four staff across the two organizations participated in these workshops, which were conducted in the spring and summer of 2020. Lessons learned in these workshops will be one resource informing Health Share's adoption and implementation of equity-informed data best practices, which will guide Health Share's future analytics efforts.

Unite Us Community Information Exchange

A key to Health Share's vision is transforming how health systems connect with community-based resources to meet the non-clinical needs of our members. In the current public health emergency, demand for efficient access and referral pathways between healthcare providers, community-based organizations, and other sectors has never been stronger. Health Share and Unite Us have entered into a contract which allows Health Share to hold a single regional contract for the Unite Us social service resource locator (SSRL) platform, a type of Community Information Exchange (CIE). The CIE will enable enhanced communications and closed-loop referrals between the health sector and community-based organizations. Health Share's role in the centralized contract with Unite Us will include significant community and clinical engagement efforts.

Partner Spotlight

Kaiser Permanente NW's Thrive Local program is built on the Unite Us Platform. As of August 19th, there are 133 active licensed partners on the platform, including community-based and clinical organizations. To date Unite Us has processed 592 referrals. These values account for Oregon and SW WA including Clark and Cowlitz counties.

Health Share Bridge and Data Website

Over the past year, Health Share has continued to connect plan partner and community stakeholders with data through our Bridge platform. New tools added to Bridge this past year include an Early Life Dashboard (demographics on our youth members), Enrollment Dashboard (information about enrollment trends), and multiple revamped quality incentive metric dashboards. Health Share also increased access to Medicaid data to other stakeholders over the past year, including community-based organizations such as 211, and has been developing a more efficient mechanism to on-board new users while ensuring the safety and integrity of the data on Bridge.

Parallel to and in conjunction with the Bridge platform, is the development of a community-facing data website with information related to Health Share's Community Health Needs Assessment and community Early Childhood data. The purpose of this data website is to provide diverse audiences in the tri-county region with a place to access aggregate data about its community. The information is easy to access through Health Share's main website. Local organizations can use the information for grant writing and project planning purposes, and to get a general 'state of the state' of regional Community Health Needs Assessment or Early Childhood indicators.

Other website users may include plan and community partners, other sectors such as education or justice, the general population, and academia. The first phase of the website build, centered on content from the 2018 Community Health Needs Assessment, is currently underway. The second phase of the website build will be the Early Childhood indicators portion.

Collective Medical/Transitions of Care

We identified that medically fragile, Transition of Care (TOC) eligible members transitioning between Coordinated Care Organizations (CCOs) or from Fee for Service were at risk of experiencing a gap in care. As a solution, Health Share's IT team created a mini Health Information Exchange that exchanges claims, prior authorizations, and care plans among CCOs and from Fee for Service so that members can continue receiving care.

The exchange of both detailed claims and prior authorizations is particularly useful for health plans. Providers, care teams, and health plans also benefit from easy access to care plans, so we partnered with Collective Medical Technologies to leverage their platform and securely load care plans onto it — giving providers, care teams, and health plans the information needed to provide quality care. Recognizing that transparency and communication are key to this process, we provide our health plans with a list of members who are joining or leaving the plan, and that identifies if they are TOC eligible. For those accessing the Collective Platform, we also issue a TOC flag and an indicator to identify TOC eligible members. The flag also identifies a low, moderate, or high level of how medically fragile the member is, so that providers, care teams, and health plans can prioritize the timing of outreach. In addition to eliminating possible gaps in care, this new Health Information Exchange also fulfills the new OHA requirements for member Transitions of Care.

Health Information Exchange (HIE)

Health Share's partners in the Health Information Technology Governance group have agreed to move forward with expanding HIE functionality largely by focusing on interoperability between electronic health records. Health Share continues to work with Collective Medical to ensure the timely transition of care notifications and is working on a corporate data sharing policy to more effectively support the flow of claims and enrollment information across the network. Ensuring access to timely and complete health information will continue to be a key priority of CCO 2.0 and the CCO's Health Information Technology Roadmap.

Investment Summary

Strategic Initiatives Fund Distribution

FUNDED PARTNERSHIPS + COLLABORATIVES - EARLY LIFE HEALTH

Every Step Clinics
Gladstone Health Center, Hillsboro Pediatrics, Legacy Randall, Metropolitan Pediatrics, OHSU, Oregon Foster Youth Council

Foster Care Medical Liaisons
Clackamas County DHS, Multnomah County DHS

Help Me Grow
Providence Swindells, Tri-County Early Learning Hubs, Tri-County Public Health Departments

All:Ready - Kindergarten Readiness Network
Regional Collaborative of 60+ organizations

Oregon Childhood Integrated Dataset
OHSU

Public Health Vaccine Promotion
Clackamas County Public Health Department, Brink

SDOH Resource Capacity + Access
Project Access NOW

System of Care
Regional Collaborative of 40 organizations and systems

FUNDED PARTNERSHIPS + COLLABORATIVES - BEHAVIORAL HEALTH

Behavioral Health Anti-Stigma Campaign
Brink

Behavioral Health Workforce
Tri-County BH Providers Assoc., Mental Health & Addiction Association of Oregon, Oregon Recovers

Culturally Specific Addiction Counselor Program
Portland Community College

Health Information Exchange
Collective Medical Technologies

Medication for Opioid Use Disorder Expansion in Maternity Care
Women's Healthcare Associates

Medication for Opioid Use Disorder Expansion in Primary Care
CareOregon, Kaiser, Providence, Tuality, Wheelhouse [CareOregon, CODA, Central City Concern]

Project Nurture
CODA, Legacy, Lifeworks, OHSU, Providence, Kaiser, Regional Collaborative

Regional Addiction Benefit Coordinators
Clackamas County, Multnomah County, Washington County

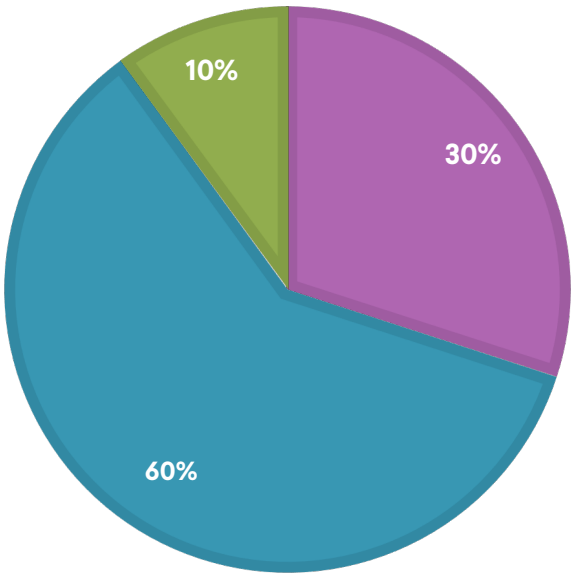
Intensive Community Based SUD Services
Bridges to Change

Regional Peer Facilitation
Mental Health & Addiction Certification Board of Oregon

Regional Behavioral Health Collaborative
Miracles Club of Portland, Instituto Latino De Adicionnes, NARA, 4th Dimension Recovery Center, Lutheran Community Services Northwest, MetroPlus Association of Addiction Peer Professionals, Bridges to Change

Substance Use Disorder Provider Investment
Acadia NW, Cascadia, Central City Concern, Clackamas Co. Health Centers, CODA, CRC Health, DePaul, Integrated Health Clinics, Lifeworks Northwest, NARA, Quest, Treatment Services NW, VOA, Western Psychological

STRATEGIC INITIATIVES FUND DISTRIBUTION ($13,857,405)



- Early Life Health investments - $4,195,394
- Behavioral Health investments - $8,291,399*
- Project supports, CMEs + trainings, communications, community sponsorships - $1,370,612

*includes investments funded through the Behavioral Health Strategic Investment