health share

Health Share of Oregon

Community Health Improvement Plan

Progress Report

2022

Health Share Members 2022

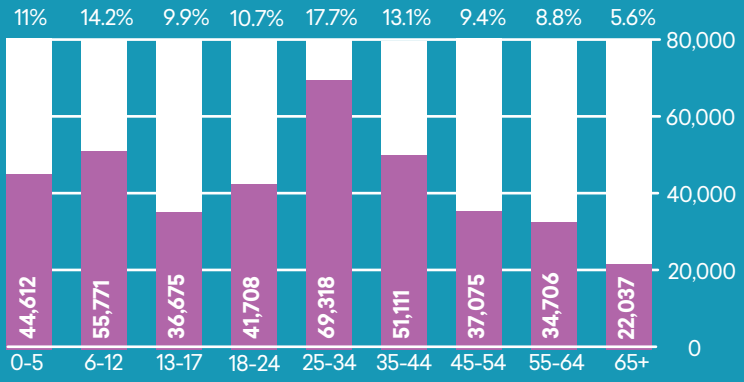
395,013 current members

139,058 (35.6%) age 17 or younger

Membership by aid category

Eligible because of ACA: adult 19-44	120,083	30.7%
Historic Medicaid eligibility: child 6-18	90,954	23.3%
Aged, blind, and disabled	50,505	12.9%
Historic Medicaid eligibility: child 1-5	36,462	9.9%
Eligible because of ACA: adult 45-54	27,578	7%
TANF	26,409	6.8%
Eligible because of ACA: adult 55-64	23,548	6%
All other categories	9,952	2.5%
Historic Medicaid eligibility: child 0-1	8,423	2.1%

Age



Primary Language

85% English

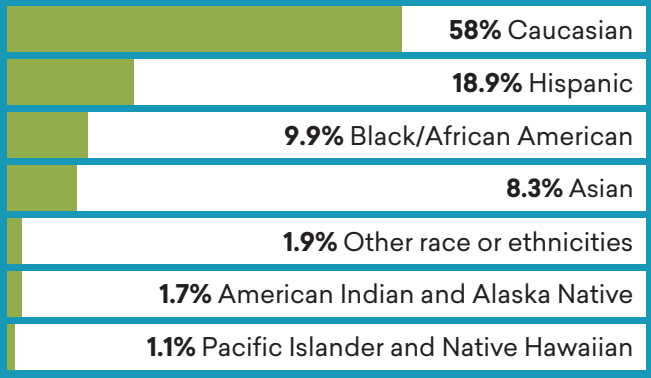
9% Spanish

5.7% other

Other languages include:

Russian: 1.3%
Vietnamese: 1.1%
Chinese: 1.0%
Arabic: 0.3%
Somali: 0.3%

Race/Ethnicity*



*Based on available data collected in OHP enrollment process. OHA did not provide ethno-racial identity data for 114,045 members.

Gender*

52.8% Female

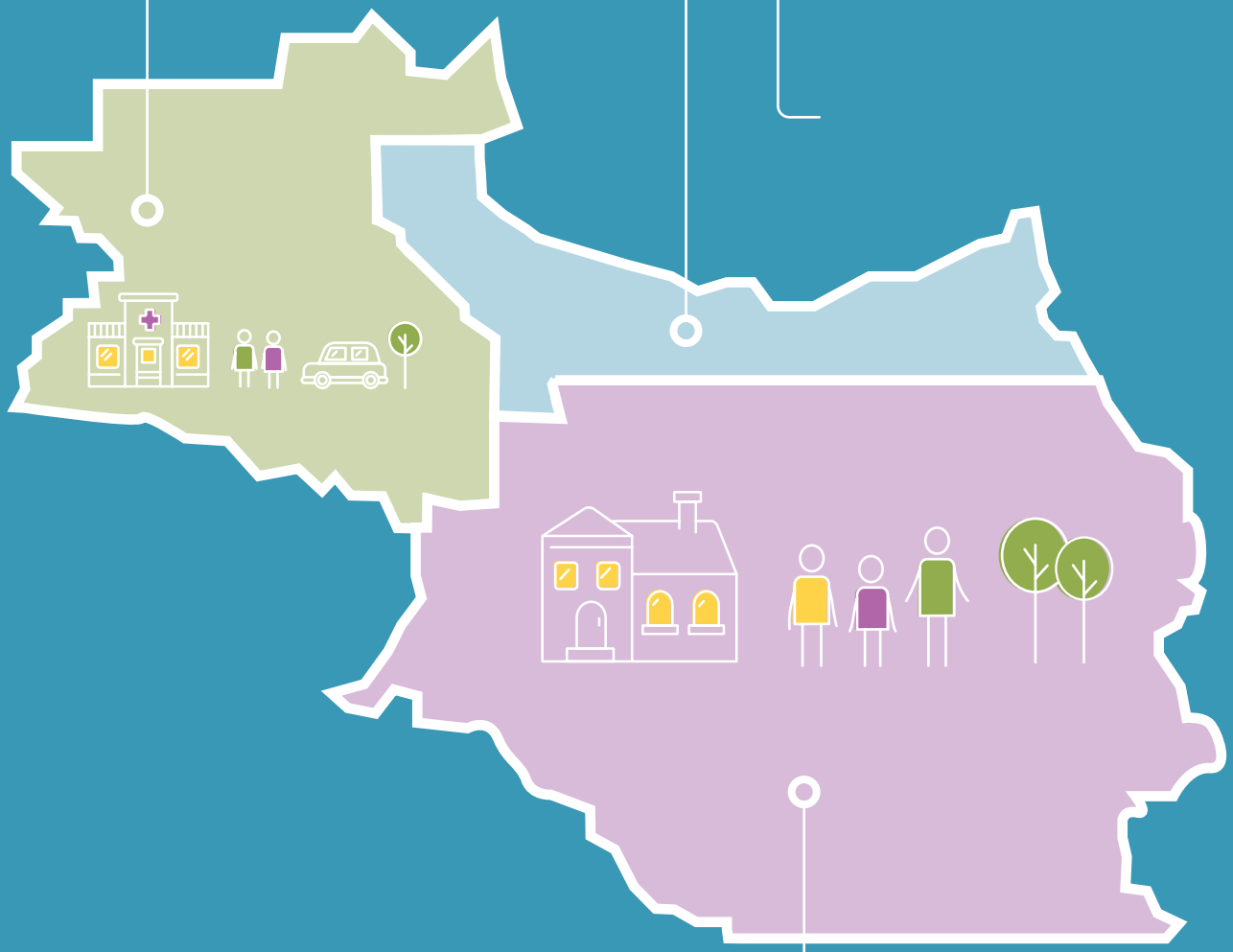
48.2% Male

*Data collected are limited to binary gender identity and therefore inaccurately reflect members who identify as transgender, two spirit, and otherwise outside of the gender binary.

Health Share Members by County

Washington County
107,625 members
~ 17.8% of county residents
~ 27.5% of Health Share members

Multnomah County
210,855 members
~ 25.9% of county residents
~ 54% of Health Share members



Clackamas County
76,866 members
~ 18.4% of county residents
~ 19.7% of Health Share members

Health Share's mission is to partner with communities to achieve ongoing transformation, health equity, and the best possible health for each individual. Our Community Health Improvement Plan is an important driver of our work.

Health Share's Board, with guidance from its Community Advisory Council, approved five areas for the multi-year Community Health Improvement Plan (CHIP) to span 2019-2024 (Access to Care, Housing, Chronic Conditions, Food Access, and Social Connection), and then prioritized Access to Care and Housing as initial areas to develop and resource strategies intending to add the others over time. A robust set of strategies and activities were developed and resourced. Then the COVID pandemic beginning in 2020 considerably added to the need for concentrating on Access to Care and confirmed the relevance of the other priorities. Health Share is pleased to bring you this progress report for the current CHIP.

Health Share has a strong commitment to health equity, and eliminating health disparities for our members of color, those most harmed by systemic and structural oppression, and the communities we serve. We know that racial inequities persist in every system across the country, and health care is no exception. In June of 2021, Health Share's Board made a commitment to Lead with Race and adopted the Racial Equity Statement below. We apply this commitment in all our work to advance our Community Health Improvement priorities.

"Health Share of Oregon acknowledges the inequitable health outcomes, and the deep and lasting impacts of structural and pervasive racism on marginalized populations, in particular for communities of color. As part of our continual learning and actions we seek to recognize, reconcile and rectify historical and contemporary injustices. Recognizing that change starts with us individually, we commit to continue this equity journey. We will disrupt and dismantle systems; identify equitable distribution or redistribution of resources and power; change policies, processes, investment strategies and data sharing within our organization; and continuously center our members, collaborate with our community partners and support tribal sovereignty and culture."

Community Health Improvement Plan Partnerships

Health Share works in partnership with several agencies and organizations in order to implement the strategies to address Community Health Improvement Plan priorities. These partners include:

Hospital(s)

- Adventist Medical Center
- Hillsboro Medical Center
- Kaiser Permanente
  - Sunnyside Medical Center
  - Westside Medical Center
- Legacy Health
  - Emanuel Medical Center
  - Good Samaritan Medical Center
  - Meridian Park Medical Center
  - Mount Hood Medical Center
  - Salmon Creek Medical Center
- OHSU
- Providence Health & Services
  - Milwaukie Hospital
  - Providence Portland Medical Center
  - St. Vincent Medical Center
  - Willamette Falls Medical Center

Local Public Health Associations

- Clackamas County
- Multnomah County
- Washington County

Other Partners

- CareOregon
- Healthy Columbia Willamette Collaborative
- Trillium Community Health Plan

In addition, Health Share partners with dozens of Community-Based Organizations (CBOs) on a wide variety of initiatives. During the last reporting period, Health Share funded and invested in areas specific to CHIP priorities exacerbated by the pandemic. We know that COVID-19 has had a tragically unequal effect on communities of color. CBOs play a critical role in supporting the health of these communities. We provided $4.8 million in COVID Impact Support Funds to 60 CBOs serving communities of color; these resources have continued to support community need through this reporting period. In addition, we provided $600,000 to local public health authorities to support implementation of tri-county CHIP priorities.

Changes in community health priorities, goals, strategies, resources or assets

If anything, the experience of the pandemic emphasized that the five areas chosen for Health Share's CHIP are indeed the right priorities, and review/consultation with the Community Advisory Committee, partner organizations/delivery systems, participating counties, the other CCO in our region, tribal providers, and other community partners have verified this. Access to Care expanded to include access to COVID tests, vaccinations, and treatments as well as access to shrinking behavioral health services – both of those categories fueled strategies and caused us to direct resources accordingly. Housing, especially as it relates to transitions of care, became even more pertinent and emphasized that our housing investments were the right places for us to be concentrating. Chronic conditions and pent-up need for care as a result of the pandemic has heightened our vigilance and understanding of the importance of this priority; similarly, the need for food access during the pandemic helped to direct funding and engagement with food-providing CBOs. Finally, the need for social connection and the hazards of social isolation have never been so starkly on display as now, in the context of and wake of the pandemic. All of this to say our Community Health Improvment Plan priorities and goals have not changed. Our strategies have evolved and developed as you will see in the progress report and those guide where we assign resources.

Progress made toward strategies to address CHIP priorities

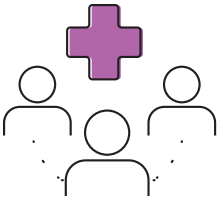
ACCESS TO CARE

Goal: Improve connections for Health Share and community members seeking services through the delivery system, and the workforce that supports them.

Outcomes: Decrease the racial, disability, cultural and linguistic disparities in the utilization of health care services by Health Share members; and increase sustainability and integration of the Traditional Health Worker (THW) workforce in clinical and community-based settings.

1. COVID Vaccinations

Health Share's primary focus on addressing health disparities over the last year has been on ensuring our most vulnerable populations have access to COVID vaccinations. Community-Based Organizations, supported by our Public Health infrastructure, held hundreds of culturally and geographically specific vaccine clinics and reached people who would have been left out by a more conventional approach. Health Share convened a tri-county equity-focused vaccine collaborative group every week for 18 months that relied on data showing vaccination rates by age, ethnicity, race, language, mental health and Substance Use Disorder diagnoses, county of residence, and at-home status; these data were scrutinized for disparities by workgroup members comprised of leaders from Health Share, the three county public health departments, and major delivery systems. Gaps were identified, action plans developed (including how and when to engage with CBOs), and progress monitored. A year after vaccinations were available, Health Share had the highest CCO vaccination rates in the state and had successfully improved equity considerably. Our vaccine dashboard added pediatric vaccinations and booster information once those were started and used the same process for improving equitable access.



2. Traditional Health Workers

Health Share and our partners have continued our efforts to increase access to high-quality, integrated Traditional Health Worker (THW) services, and we have increased the number of THWs serving Health Share members by 41% from 425 to 601. THWs are rooted in and connected to their community which enables a person-centered approach to the services they provide. Their lived experience, passion, and foundation of relationship-building contribute to their ability to help marginalized communities reach their highest health outcomes. They are a valued and trusted part of a member's care team, and as such, they impact the accessibility and acceptability of realized access.

Effective integration and increased utilization of THWs requires capacity from each of Health Share's subcontractors as well as from Community-Based Organizations. To this end, Health Share convenes a THW Advisory Committee, which includes representatives from each of Health Share's subcontractors as well as Multnomah, Clackamas, and Washington counties. The THW Advisory Committee meets monthly to identify barriers to THW integration and utilization, develop solutions to address those barriers, and to operationalize increasing member access to clinic- and community-based THW services in Health Share's service area.

Health Share has continued to make significant strides toward integrating and access to THWs, including:

- Completing a comprehensive four 3-hour strategic visioning sessions, resulting in the establishment of collective THW goals and strategies across the CCO
- Continuing to increase education and knowledge of THW services through community engagement and learning collaboratives
- Drafting a Universal Traditional Health Worker Integration Policy and Procedure to guide implementation of our THW Strategy.

Traditional Health Workers have played a pivotal role in helping to bridge the gap between traditional service delivery and meaningful community engagement but there continue to be gaps in THW infrastructure, including barriers to billing and reporting.

Additionally, through our agreements with the three counties in our service area, Health Share has provided funding to support multiple peer providers that serve members as well as the community at large. We provide this support in a direct fashion to support peer work without the additional requirements of billing for services, meaning these agencies can work with anyone in the community with fewer administrative burdens. We also hold contracts to support the ongoing need for peers in our behavioral health network and directly support NAMI and the Mental Health and Addictions Association of Oregon, for the provision of peer-to-peer education classes and peer support specialist trainings. Supporting training and certification increases the peer workforce available to both our behavioral health provider network and community-based organizations across the region.

Community Health Workers (CHW) supplement the behavioral health network in our region and provide additional support in addressing the social determinant needs of our members. This occurs not just in the specialty behavioral health network but is integrated into our medical delivery systems.

3. Health Equity and Culturally Specific Outreach

Over the last year Health Share has engaged in the following activities to work towards health equity and strengthen our relationships with organizations serving culturally specific communities.

- Convened a Transgender Health workgroup of our provider and health plan partners to resolve barriers to accessing gender affirming care including medication, surgery, behavioral health supports, and care coordination. The workgroup also developed a Community of Practice for health plan staff who work directly with members seeking gender-affirming care.
- Provided ten "Unpacking Equity Through a Language Access Lens" workshops for

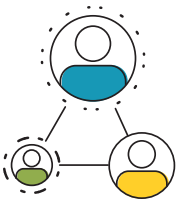
culturally and linguistically specific CBOs and our provider networks. The goals of the workshops were to 1) increase understanding about the essential role of an interpreter, service provider, and how together they honor the voices that are often unheard, 2) explore how effective interpretation impacts the power, privilege and access to communication and information, and 3) share and exchange interpreting tools and techniques to reduce interpreter error and improve access.

- Hosted eleven "Basic Health Plan Navigation Community Conversations" with culturally and linguistically specific CBOs to 1) increase understanding about the Medicaid Program and services available to members, and 2) define and review basic health literacy concepts.
- Participated in OHA Collaboratives with over 60 community partners from culturally and linguistically specific CBOs in the tri-county region to develop relationships, be aware of member/community barriers identified by application assistors and OHA and provide resolution, and to share knowledge around benefits such as Health Related Services and Care Coordination.

4. Language Access

Health Share continues to demonstrate progress in implementing and establishing language access efforts and practices related to member language accessibility. We are committed to ensuring access for all our members. Approximately 15% of Health Share members speak languages other than English as their primary language, including about 13,000 members who identify as having Limited English Proficiency (LEP) based on their Oregon Health Plan enrollment file. In 2020, members with LEP had nearly 40,000 visits with providers. In 2021, Health Share gathered data that assessed how often language assistance was provided to members. For all members identified as needing language assistance services that received a service during the quarter, Health Share analyzed which of these members received an interpretive service for that visit, how the visit happened (e.g., in-person, interpretation, telephonic, or video), and whether the interpreter who provided the service was accredited by OHA.

In 2021, Health Share leveraged the insights and expertise of our Meaningful Language Access (MLA) Workgroup to ensure Cultural and Linguistically Appropriate Services (CLAS) are available to all members. The MLA Workgroup is comprised of representatives from Health Share's subcontractors. The collective knowledge and experience of the workgroup is a critical resource for Health Share to advance alignment across the CCO network by sharing, discussing, and implementing practices that promote high quality language service for all members. Health Share hosted and partnered to deliver over 10 "Unpacking Equity Through a Language Access Lens" workshops with the goal of helping inform policies and procedures, training, and other support mechanisms to establish better engagement and healthcare experiences for members.

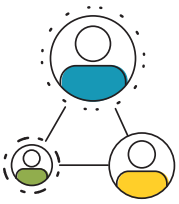


5. Child and Adolescent Health

Oregon's Community Health Improvement Plan legislation requires a focus on addressing the health of children and youth. Health Share has implemented several strategies to improve access to care and reduce disparities for this population. Below are highlights of progress for our priority populations.

Maternal Child Health:

- Partnered with the three regional Early Learning Hubs, Public Health agencies, and Trillium Community Health Plan to co-create a Regional Perinatal Continuum of Care to provide seamless services for families prenatal to school age. One component of this work is expanding access to the Healthy Birth Initiative (HBI) into Washington and Clackamas counties. HBI is focused on serving Black and African American pregnant members to decrease health disparities.
- Expanded access to Project Nurture, an integrated maternity and Substance Use Disorder care model, through the addition of more clinics providing this model of care.
- Developed a Health-Related Services postpartum package to support high-risk women by providing essential health related material and social needs (e.g., cribs, diapers, safety kits).



Developmental and Behavioral Health:

- Continued to expand the Help Me Grow system across the region, providing a centralized access point for a triaged menu of services and supports for families. In 2021, Help Me Grow had 12,429 contacts with families to support developmental and behavioral health for prenatal to five-year-olds, over three times the number of contacts recorded in 2020.
- Initiated a pilot to increase access to infant and early childhood mental health consultation, helping to fill a longstanding gap in our region.
- Worked with our provider and health plan partners to develop a regional approach to decrease the long wait times for an autism evaluation in our region.

Youth in Temporary Care:

- Continued to partner with clinics focused on providing primary care to children and youth involved with Child Welfare through the EveryStep clinics. EveryStep clinics provide trauma informed care, dedicated care coordination, coordination of oral health and behavioral health services, and connection to community-based programs that support foster youth.
- Invested in two DHS medical liaisons based in county district offices who provide vital navigation to support the health care needs of youth in foster care and coordinate supports between health care and Oregon Department of Human Services.
- Conducted comprehensive mental health assessments for youth entering foster care (RAPID assessment). The RAPID assessment can quickly identify needs and connect children and youth to the services they need (e.g., mental, developmental health, Early Intervention, Intellectual and Developmental Disabilities, and support for complex medical needs).

6. Behavioral Health

The highly intersectional issues of the instability of the behavioral health workforce and access to high quality services reached new heights of concern in 2021. Behavioral health agencies were reporting vacancy rates as high as 50% and difficulty recruiting new staff. Several programs in the Metro region closed or discontinued services, and, for those that remain open, waitlists are many months long or are closed to new admissions. Waitlists exist at every level of care and lack of capacity at a given level of care means that members cannot transition either up or down into that level, which creates lack of capacity in the level that the member is ready to transition out of. While not wholly responsible for these access and workforce crises, steep curtailing of civil admissions to the Oregon State Hospital (OSH) in the past few years has contributed to both areas of concern – members who would otherwise be served at OSH remain in acute inpatient care for far too long or are discharged to the community, reducing capacity for those in need of shorter-duration services and raising the acuity level of outpatient caseloads in ways that increase the stress and burnout of the outpatient clinical workforce.

Focus on these paired priority issues – workforce and access – is paramount to accomplishing any other goals that OHA or Health Share has envisioned for Medicaid services in our region. To address these issues, Health Share convened a Behavioral Health Workforce & Access Taskforce in July 2021 that was charged to 1) develop and assure implementation of a service prioritization framework for a Health Share-wide response to the immediate behavioral health workforce and access crisis, and 2) establish long-term strategic recommendations from the provider level, CCO level and State level.

The Taskforce has generated a suite of recommendations to improve access to behavioral health services in our region. Some of those recommendations were promptly implemented, such as re-balancing our global budget and moving funding out of the medical benefit and into the BH benefit, as well as providing regulatory reform recommendations to the OHA for consideration. Several ongoing workgroups have been created to move forward the recommendations that have medium to long term implementation time frames and which involve complex workflows between multiple system partners. An example of this is work around improving the transition process for members leaving acute psychiatric settings and which involve collaboration with primary care, specialty behavioral health, health plan care coordination teams, and health information technology systems. Other recommendations that are moving forward involve:

- Better measurement of access to BH services in the Health Share network
- Service Prioritization of critical services at our contracted providers

- Expansion of pre-treatment services to expand the spectrum of BH services that can be delivered in the community
- Rate setting and cost studies that will help guide targeted investments in BH rates
- Improving communication and workflow between primary care and behavioral health providers that have significant overlapping populations
- Creation of a BH navigation team to improve the assignment of complex members to intensive BH services
- Expansion of telehealth services across our BH network
- Additional investments in BH staff recruitment

SUPPORTIVE HOUSING

Goal: Increase access to safe, affordable, and supportive housing for Health Share members and the community.

Outcomes: Increase the provision of integrated housing supportive services paired with deeply affordable housing in the tri-county area; and supportive housing investments are aligned, coordinated and engaged in cross-sector partnerships, and directed to address disparities in homelessness.

Housing is a social determinant of health influencing behavioral, physical, and mental health outcomes. Addressing housing needs of members is critical to reducing health inequities experienced by members in various stages of being housed. Below are two examples of how the CCO is working to reduce health disparities for members who do not have stable housing.

1. Regional Supportive Housing Impact Fund

In 2020, Health Share established a Regional Supportive Housing Impact Fund (RSHIF) to serve as a flexible funding source to promote housing stability and health equity by connecting people experiencing homelessness and complex health challenges to affordable supportive housing options and services necessary to remain stable and housed. RSHIF's start-up was funded with support from Health Share's partners and community foundations for a collective investment of $5.7M which supported service delivery and infrastructure development. Through Metro 300, a partnership between health systems, community-based service providers, and counties, $5M in flexible funding was distributed to local governments and community-based organizations in the tri-county region to support over 390 homeless seniors with disabling conditions return to stable, affordable housing. The RSHIF Steering Committee meets regularly to ensure that Health Share's housing efforts are grounded in racial equity, community voice, and strength-based, flexible, adaptive, and emergent practice.

2. Medicaid Housing Benefit

Health Share has made significant progress towards ensuring access to supportive housing by integrating with health systems, counties, the state, and housing providers. In 2021, our Board supported launching an 18-month demonstration pilot to design and test a housing benefit package for members with the long-term goal for housing benefits to be covered as regular benefits for eligible Oregon Health Plan members. The housing benefit is a collaborative effort with health and housing systems in Clackamas, Multnomah, and Washington counties and community-based service housing and homeless service providers.

The benefit emphasizes connecting low-income persons with health challenges living in homelessness, or at risk of homelessness, to affordable housing options that include the services they need to remain stable and housed. During the demonstration period, we are focusing on supporting members transition from the eight high-risk settings identified below with an initial focus on members in transition back to community from Substance Use Disorder residential settings, corrections, and youth aging out of foster care.

1. Substance Use Disorder residential
2. Aging out of foster care
3. Transitioning out of Corrections
4. Inpatient medical settings
5. Recuperative care program
6. Acute care rehab (discharge from LTC)
7. Assertive Community Treatment (ACT) Programs
8. Inpatient psychiatric settings

The Housing Benefit offers a wide variety of supports including:

Housing navigation, support, and sustaining services	Move-in fees	Home accessibility and safety modifications
Hotel/motel stays	Utility deposit	Home remediation services
Move-in support	Utility back payment	Healthy home goods
Monthly rent support	Monthly utility assistance	Renter's insurance

FOOD ACCESS, CHRONIC CONDITIONS, AND SOCIAL CONNECTION

Our Community Advisory Council and Board of Directors will identify strategies and metrics/indicators for these three remaining CHIP priorities in the Fall of 2022. We anticipate that Connect Oregon, a technology platform which enables providers and Community-Based Organizations to send and receive electronic referrals, to address people's social needs and improve health across communities, will be a central part of these strategies. In addition, Health Share provided Covid Impact Support Funds to several CBOs who distributed food to community members during the pandemic, and some of these organizations had a focus on ensuring access to culturally specific foods. We expect to build on these efforts as well as develop a food benefit in response to the anticipated changes from the 1115 Waiver.

CCO Collaboration on Community Health Priorities in the Tri-County Region

Health Share of Oregon and Trillium Community Health Plan are developing a strong partnership and working on alignment across several CHIP priorities. Within the Access to Care focus area, we both work closely with the tri-county Early Learning Hubs, as well as the tri-county Maternal Child Health teams on regional rollout and investment in improving the perinatal continuum of care, including:

1. Supporting Help Me Grow, a regional (and growing statewide) centralized access point to a triaged menu of services and supports for pregnant members and families with young children.
2. Funding expansion of Healthy Birth Initiative (HBI), and Afrocentric program addressing the needs of Black and African American women. HBI opens up access to health care and provides ongoing support to pregnant women and their families before and after birth, and
3. Investing in All:Ready, a regional collective impact network whose north star is ensuring that race, class and disability are no longer predictors of Kindergarten Readiness. The All:Ready network designs clinical and community interventions to make this happen.

To increase access to healthier Food, Health Share and Trillium are partnering with the tri-county Women, Infant, and Children (WIC) programs on a regional campaign to increase enrollment and participation in WIC. We meet regularly together to design strategies to better connect our members to nutrition supports.

Health Share is engaged a pilot to provide a Temporary Supportive Housing Benefit Package for priority populations. Trillium is also interested in developing a similar supportive housing benefit. The two CCOs are planning to explore a collaboration between these efforts to offer and aligned opportunity across our shared service area.

Both CCOs are active in the implementation and spread of Connect Oregon across the region. This referral platform enables health care providers and Community-Based Organizations to securely send and receive electronic referrals to organizations on the network. The collective vision of this effort is threefold:

1. Foster greater partnerships across community-based organizations, health systems, and public service providers.
2. Leverage knowledge and data from the Connect Oregon network to understand and address the needs of our community, and

3. Advocate for policy change and new funding models to increase availability of and access to resources in the community.

We believe that establishing an infrastructure to connect members to needed social supports will increase our ability to address members social determinants of health. Health Share and Trillium will meet regularly, along with Unite Us, to ensure we are coordinating our outreach to community partners and collaborating on building the network.

The two CCOs share the goal of expanding the interpreter workforce by investing in Health Care Interpreter training to increase knowledge and improve the process of working with interpreters. Additionally, increasing Traditional Health Workers to provide support the historically underserved in our community who experience barriers when navigating the health care system and connecting them to needed services has been an area of focus.

Finally, Health Share and Trillium have just wrapped up collaboration on our region's Community Health Needs Assessment guided by the Healthy Columbia Willamette Collaborative. Both CCOs are engaged members of the Collaborative. We look forward to continuing to collaborate on the health priorities identified by our community in the coming years.

Metrics and Indicators

ACCESS TO CARE

1. COVID Vaccinations

Race/Ethnicity	Percent of Members 12+ Having Any COVID Vaccine (as of 6/13/21)	Percent of Members 12+ Having Any COVID Vaccination (as of 4/24/21)
American Indian/Alaskan Native	42.0%	65.7%
Asian	70.8%	85.1%
Black	35.7%	62.9%
Hispanic	44.4%	71.1%
Native Hawaiian/Pacific Islander	35.0%	62.7%
Other	48.1%	65.0%
Unknown	43.5%	64.8%
White	48.3%	64.5%
Grand Total	46.3%	66.2%

Health Share members ages 12+ who have record of any COVID vaccination by race/ethnicity

*Data Source – Health Share claims

2. Language Access

Health Share interpreter Service Reporting: Percent of visits with interpretive for members with an "needs interpreter" flag in 834 files. Baseline data.

CY 2021	Visits with Interpretive Services	Visits with OHA Qualified/Certified Interpreters
Dental	15.19%	5.69%
Medical	17.89%	4.17%
Mental/Behavioral	11.26%	1.92%
Grand Total	17.20%	4.27%

*Data Source – Health Share claims

3. Traditional Health Workers

PAYMENT SUMMARY GRID

601 FTE were reported by Health Share plan partners (41% increase from 2020).
83% of reported FTE was attributed to either Community Health Workers (42%) or Peer Support Specialists (41%).

How are they funded?

Payment types vary greatly by worker type. Overall, the most commonly used payment models are contracts with an organization and grants (primarily received by clinics). The following graphs show funding models by worker types.

CHW: Other/Unknown (55%), Alternative payment model (19%), Directly employed by health plan (13%)

Birth Doula: Grants (71%), Directly employed by health plan (14%), Fee for service (14%)

PSS: Other/Unknown (52%), Fee for service (29%), Alternative payment model (12%)

PWS: Other/Unknown (64%), Fee for service (21%), Directly employed by health plan (15%)

PHN: Directly employed by health plan (85%), Other/Unknown (11%)

ALL: Other/Unknown (50%), Directly employed by health plan (16%), Fee for services (15%), Alternative payment model (13%)

Worker Types:

- **Community Health Worker (CHW):** frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served.
- **Birth Doula:** birth companion who provides personal, nonmedical support to women and families throughout a woman's pregnancy, childbirth, and postpartum experience.
- **Peer Support Specialist (PSS):** individual with lived experience of substance use and/or a mental health condition who provides supportive services to a current or former consumer of mental health or addiction treatment.
- **Peer Wellness Specialist (PWS):** individual who has lived experience with a psychiatric condition(s) plus intensive training, who works as part of a person-driven, health home team, integrating behavioral health and primary care to assist and advocate for individuals in achieving well-being.
- **Personal Health Navigator (PHN):** individual who provides information, assistance, tools and support to enable a patient to make the best health care decisions.

*Data Source – Health Share claims and reports from subcontractors

4. Primary Care Provider Visits and Utilization

Measuring access to care can be difficult. A person's ability to access healthcare is dependent upon a number of different factors, including things like transportation and the availability of providers who speak your language. This measure reflects only one component of access, utilization of primary care, and is not intended to represent the full spectrum of ways members can access preventive care or other important services.

Utilization of primary care services is often expressed with rates per 1,000 member months ("1000 mm"). While the overall number of primary care visits increased from 2020 to 2021, primary care utilization per 1,000 member months decreased slightly over the same period. The decrease in Primary Care Provider (PCP) utilization per 1,000mm is consistent across most demographic groups; however, the adult population has had the most pronounced decline. The reduction in PCP utilization is due to a multitude of factors, but changes in rates per 1000mm are likely a reflection of increases in Health Share's overall population from 2020 to 2021. However, we did see an increase in PCP utilization among children who speak Spanish, Vietnamese, Cantonese, Mandarin, other Chinese, and Somali, and among adults who speak Spanish, Vietnamese, Cantonese, Mandarin, other Chinese, Arabic, and Somali.

*Data Source – Health Share claims

5. Supportive Housing

1. Regional Supportive Housing Investment Fund

The investment in Metro 300 was intended to support 300 homeless seniors with disabling conditions return to stable, affordable housing. Metro 300 ended up serving over 390 seniors.

*Data Source – Reporting from tri-county Housing Departments

2. Medicaid Housing Benefit

We are currently designing the housing benefit and will have utilization data to report next period.