# Community Health Improvement Plan

## Progress Report

2023

health share

Health Share of Oregon

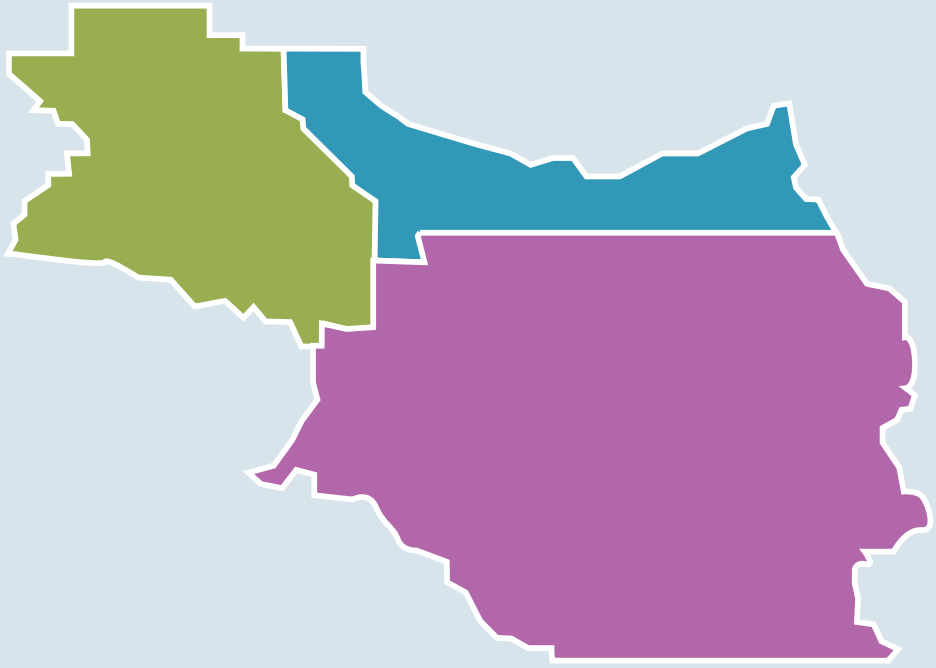
# 2023 HEALTH SHARE MEMBER DEMOGRAPHICS

## Health Share Members by County

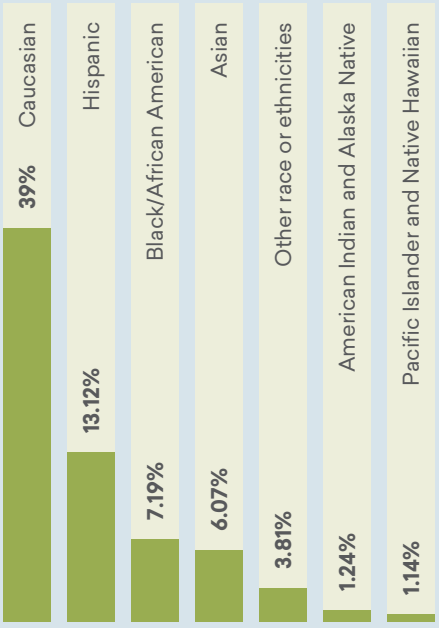
**Washington County**
**124,611 members**
~ 21% of county residents
~ 28% of Health Share members

**Multnomah County**
**236,593 members**
~ 31% of county residents
~ 52% of Health Share members

**Clackamas County**
**90,093 members**
~ 21% of county residents
~ 20% of Health Share members

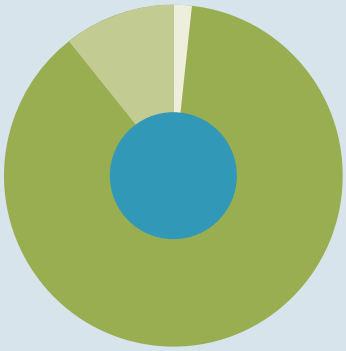


## Race/Ethnicity*




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

## Primary Language



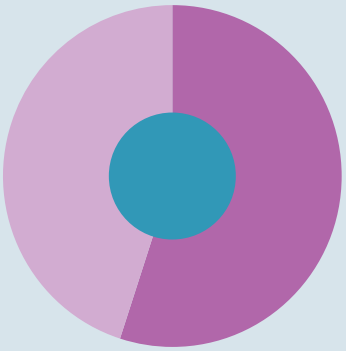
84.1% English

9.77% Spanish

2.59% other

Other languages include:
Russian: 1.3%
Vietnamese: 1.1%
Chinese: 1.0%
Arabic: 0.3%
Somali: 0.3%

## Gender*



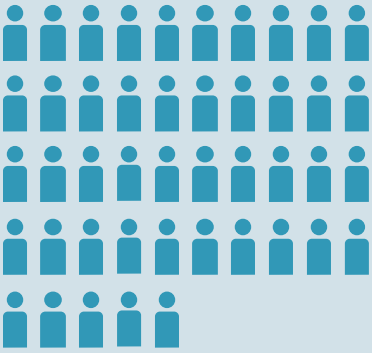
52.2% Female

48.8% Male

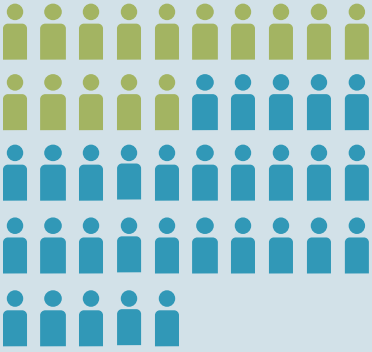
*Data collected are limited to binary gender identity and therefore inaccurately reflect members who identify as transgender, two spirit, and otherwise outside of the gender binary.

# 2023 HEALTH SHARE MEMBER DEMOGRAPHICS

## 451,297 current members

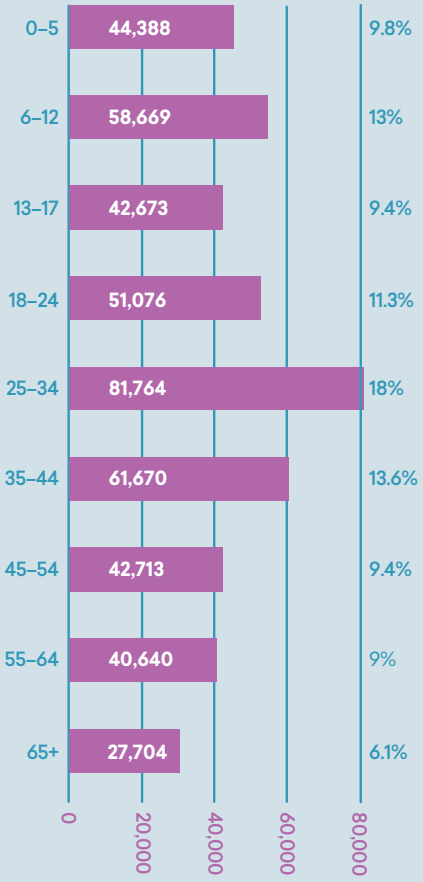


## 145,730 (32.2%) age 17 or younger

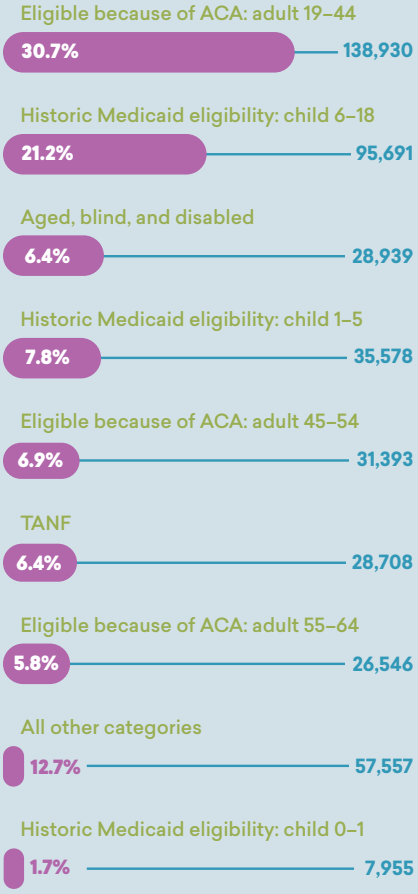


= 10,000 people

## Age




## Membership by Aid Category



# Introduction

Health Share of Oregon partners with community to transform health care and achieve the best possible health outcomes for each individual and family. Our Community Health Improvement Plan (CHIP) is a central driver of this work, demonstrating our strong commitment to health equity, and specifically, eliminating health disparities for our members of color and those most harmed by systemic and structural oppression. We know that racial inequities persist in every system across the country, and health care is no exception. In response to this reality, in June of 2021, Health Share's Board made a commitment to "Lead with Race" and adopted the following Racial Equity Statement below.

*"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."*

We strive to reflect this commitment in choosing our Community Health Improvement priorities and in the strategies and activities that support them. Informed by data from the Community Health Needs Assessment conducted by the Healthy Columbia Willamette Collaborative, as well as guidance from its Community Advisory Council, the Health Share Board of Directors approved this multi-year CHIP that spans 2019-2024 and identified five key areas of focus:

1. **Access to Care**
2. **Housing**
3. **Chronic Conditions**
4. **Food Access**
5. **Social Connection**

Health Share prioritized Access to Care and Housing as initial areas of focus to develop and resource strategies and activities—intending to build out the other focus areas over the course of the 5-year plan. The COVID-19 pandemic had the dual effect of highlighting the relevance of the areas identified in our CHIP and acute urgency of Access to Care and Housing, while delaying our capacity to expand beyond these initial focus areas. This

progress report contains highlights, data, and outcomes for strategies and activities laid out under the Access to Care and Housing priorities, as well as activities across the Health Share partnership that align to the other priority areas and will serve as a foundation for the next round of CHIP planning and design—informed by a new Community Health Needs Assessment and submitted with the new CHIP in 2024. This progress report is retrospective to the current CHIP priorities, strategies, and activities through June 2023.

# Community Health Improvement Plan Partnerships

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

**LOCAL PUBLIC HEALTH AUTHORITIES:**

Clackamas, Multnomah, and Washington counties

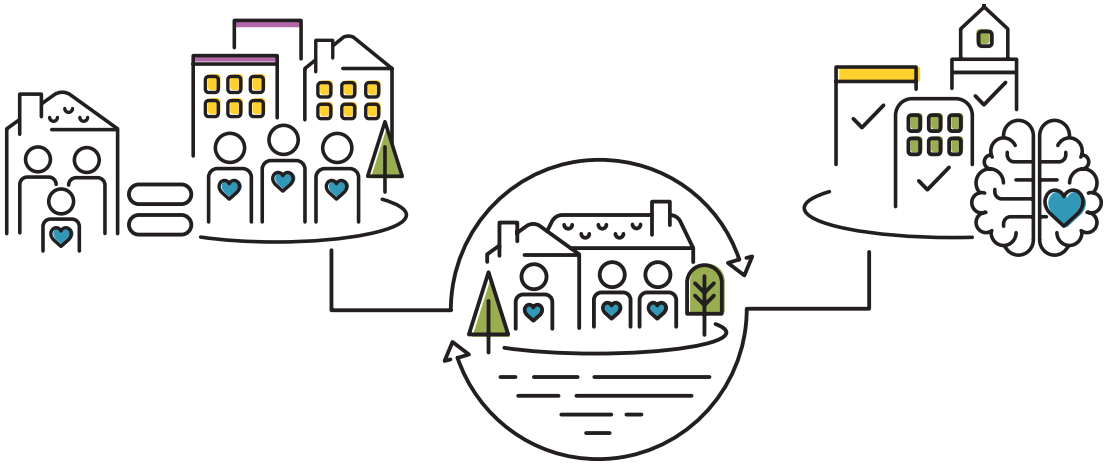
**HOSPITAL(S):**

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

**OTHER PARTNERS:**

CareOregon
Healthy Columbia Willamette Collaborative
Trillium Community Health Plan

In addition, Health Share partners with dozens of Community-Based Organizations (CBOs) across a wide variety of initiatives to support care access in community settings and address health-related social needs within our CHIP priorities, including housing navigation in partnership with Central City Concern and others, access to fresh food through partnership with local Community Supported Agriculture programs such as Zenger Farms, and connection to community-based THWs at organizations such as Familias en Acción, Immigrant and Refugee Community Organization, and other culturally specific CBOs. This also includes ongoing development of the Connect Oregon network, leveraging Community Information Exchange to connect members more effectively with these resources and strengthening relationships between clinical and community-based providers.



# Changes in Community Health Priorities, Goals, Strategies, Resources, or Assets

The COVID-19 pandemic confirmed the five areas chosen for Health Share's CHIP continue to be relevant and vital priorities in supporting Community Health. Consultation with the Community Advisory Committee, partner organizations, delivery systems, participating counties, our partner CCO in the region, tribal providers, and other community partners verified this and continue to inform our development of strategies and activities within these areas. Within the Access to Care priority, the prior years' focus on access to COVID tests, vaccinations, and treatments shifted as the pandemic evolved, allowing a refocus back to the broader, systemic goal articulated in the original CHIP—to "Improve connections for Health Share and community members seeking services through the delivery system, and the workforce that supports them." Behavioral Health, Child and Adolescent Health, Language Access, Culturally Specific Outreach, and integration of the Traditional Health Workforce remain the pillars of our Access to Care strategies, while Housing (especially as it relates to transitions of care), remains a primary driver of inequitable access and disparities in health outcomes.

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

Unmet demand for care linked to the pandemic has sharpened our understanding of the importance of addressing Chronic Conditions as a continued CHIP priority. Similarly, the need for Food Access during the pandemic elevated this area of focus and direct investment in culturally specific CBOs who focus on food and nutrition. Finally, the need for Social Connection and the danger of social isolation remains clear in the wake of the pandemic. The impact of this isolation is reflected in increased behavioral health utilization, as well as continued decline in workforce.

All of this to say our Community Health Improvement Plan priorities and goals have not substantively changed. While strategies have not been fully developed in every priority area, due to the needed focus on vaccination and behavioral health during the pandemic, these priorities inform allocation of resources and development of new partnerships and assets. This is reflected in this progress report, including our SHARE Spending Plan for 2022, which includes sustaining or expanding investments in housing, culturally specific food access, early life support and social-emotional health, language access, behavioral health/addiction services, CBO waiver readiness and capacity-building, and Community Information Exchange.

# Progress Made Towards 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.

*Health Share's vaccine workgroup surfaced disparities, identified gaps, and developed action plans that led Health Share to the highest CCO vaccination rates in the state, including disproportionately robust rates for the prioritized populations.*

### 1. COVID VACCINATIONS

For the last two years, Health Share's primary focus in addressing health disparities had been on ensuring our most vulnerable populations had access to COVID vaccinations. As noted in previous reports, we partnered with Community-Based Organizations and Public Health infrastructure to ensure vaccine access for members who may have been left out without intentional focus and an equity-informed approach. Using data on vaccination rates by age, ethnicity, race, language, mental health, Substance Use Disorder diagnoses, county of residence, and at-home status, Health Share's vaccine workgroup surfaced disparities, identified gaps, and developed action plans that led Health Share to have the highest CCO vaccination rates in the state, including disproportionately robust rates for the prioritized populations. While the focus on vaccine rates ebbed a bit in 2022 with the reduced urgency of a steadily improving public health landscape, Health Share's vaccination rates have remained relatively stable (see in Metrics and Indicators section), indicating that our efforts have had a sustained impact in improving access.

### 2. TRADITIONAL HEALTH WORKERS

Health Share and our partners have continued our efforts to increase access to high-quality, integrated Traditional Health Worker services. 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, with representatives from each of Health Share's plan partners as well as Multnomah, Clackamas, and Washington counties. The 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.

In 2022 the THW Advisory Committee reported that while overall the THW workforce increased by 17% (from 601 to 705), only 26% of the 705 reported THW Full Time Equivalent (FTE) employees were funded by a sustainable payment method (currently defined as an Alternative Payment Methodology (APM) or direct employment). Health Share's plan partners will continue to increase awareness of billing options and billing codes among THW partners. Many plan partners have developed various guidance documents to increase billing awareness for CBO partners. Health Share's Equity and Engagement staff and plan partners continue to address several key system-level barriers to integrating THWs into the delivery of health care services. These barriers include billing and payment sustainability, community-based supervision limitations, supply, and demand of THWs, Certificate of Approval limitations, and training and certification challenges.

Traditional Health Workers represent the communities in which they work. In 2022, the THW Integration and Data report on THW's Race, Ethnicity, Language, and Disability Status showed that:

- 21% of THWs prefer to speak a language other than English
- 31% of THWs identify as a Racial and/or Ethnic minority (defined as a Race/Ethnicity other than White and Unknown)
- 15% of THWs identify as someone living with a disability

In late 2021 and early 2022, the THW Performance Improvement Project was narrowed to focus on increasing doula services among Health Share members. Our focus for Birth Doulas will be on integration, workforce sustainability and growing a culturally and linguistically diverse workforce. This approach is designed to increase the number of members who have access to culturally responsive, member-centered Birth Doula services.

The areas of implementation will be on building infrastructure for culturally and linguistically focused community-based Doula providers with the following actions: establishing a targeted member ratio to Doula (Population focus Black/African American), sustainable funding, increasing access, and integration and training.

In 2023, Health Share will continue to focus its efforts on the measures we have been working on in 2022. We have seen substantial improvement in the growth of the Doula workforce and will continue to build on that. In the first quarter of 2023, Health Share and CareOregon signed a contract with the Oregon Doula Association to have an additional community partnership to develop the doula services available to our members.

As Health Share launches a pilot project to develop a housing benefit package, we recognize the direct link between housing navigation services (a critical part of the benefit) and the role of THWs in community housing settings. Within the THW scope of practice, housing navigation is regularly provided by Peer Support Specialists, Peer Wellness Specialists, and Community Health Workers. As we establish CBO partnerships in this work, we will consider the OHA Office of Equity and Inclusion THW best practices for contracting with CBOs for THW services. The main goal is to align the work of THWs as part of the housing benefit delivery model. This will help establish partnerships between CBOs and health system partners to access the Traditional Health Workers workforce. It will also ensure that THWs are trained in housing first principles, homeless and housing services, and that they offer culturally inclusive services to meet the needs of members.

For 2023, Health Share's plan partners will continue to work on expanding contracts with CBOs for community-based THW services based on CBO readiness and interest in contracting models. The THW Advisory Committee has expanded to create a Doula Subgroup that will include community-based Doula members. Health Share recognizes that supporting the infrastructure needs of community-based THWs aligns with the upcoming 1115 Medicaid Waiver's Health Related Social Needs benefits.

### 3. HEALTH EQUITY AND CULTURALLY SPECIFIC OUTREACH

The COVID-19 pandemic highlighted the stark disparities in health outcomes experienced by many populations that Health Share serves, namely communities of color, immigrants and refugees, people with disabilities, and LGBTQIA+ communities. Systemic mistreatment by health care institutions and subsequent mistrust of these systems by those who are often in most need of their services, points to the vital need for healing, relationship-building, partnership, and ultimately co-creation of a new relationship between health care and community that is fundamental to meaningfully improving access to care. Over the last year, Health Share has continued to prioritize health equity and strengthen relationships with organizations that serve these culturally-specific communities:

- Health Share's Transgender Health Workgroup has continued meeting every other month and formed a Community of Practice for health plan staff who work directly with members seeking gender-affirming care.

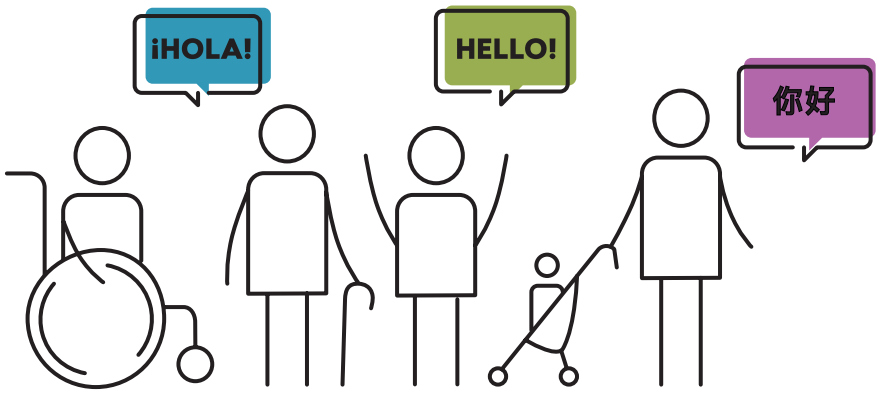
- Community Engagement staff have increased collaboration with the OHA Community Partner Outreach Program (CPOP), creating strong linkages with culturally specific CBOs who contract with OHA to provide community-based enrollment assistance and health navigation. This includes:
  - Supporting Monthly Collaborative meetings in each metro county, led by the Regional Outreach Coordinator's at OHA, to provide CCO updates and answer questions from over 100 culturally and linguistically specific CBO partners from all three counties.
  - Arranging for CareOregon staff to present and answer questions on Behavioral Health access, care coordination and system navigation.
  - Hosting "Connect to Care" presentation for the entire network in collaboration with CareOregon, highlighting Health Share's unique structure and providing information on system navigation, available benefits, and additional member supports. This will become a regular training delivered to the CPOP network moving forward.
  - Supporting a Community Partner recognition event, to celebrate reconnection in physical space and deepen working relationship between CBO and CCO staff.
  - Facilitating connections to customer service, member navigation, and OHA Ombuds as appropriate for OHA staff and community partners.
  - Co-developing a "Healthier Oregon Connects" community event for Healthier Oregon Population grantees, CBOs serving culturally specific members in the Healthier Oregon program.

- Hosting Community Conversations on "Basic Health Plan Navigation" with largely culturally and linguistically-specific/responsive Community-Based Organizations to increase understanding about Medicaid benefits and services available to members, explore navigation of complex health needs and illuminate available supports, as well as address partner questions and specific situational challenges. Participants included: Metropolitan Family Service, Lutheran Community Services, African Immigrant Refugee Organization (also planning a community event with this CBO later in the year), P-3 system collaborative (multiple CBOs supporting early childhood development and health), Washington County housing navigation teams, Greater Good NW, Familias en Acción, and the Oregon Community Health Worker Association, among others.

Finally, Health Share is preparing to launch an internal Health Equity Assessment in partnership with our health plan partners and the tri-counties. This work was disrupted by turnover in key staff, but a new team is in place to support the work, which will include updating the assessment and start with an internal test of survey. This will inform development/updating of our Health Equity Plan; we also have an internal Cultural Humility & Health Equity (CHEW) Workgroup that provides updates on work happening across the Health Share collaborative, surfaces opportunities for collaboration, and builds a shared framework of accountability to the commitments in our statement on racial equity.

### 4. LANGUAGE ACCESS

Language assistance services continue to be an area of importance for Health Share. We are committed to ensuring access for all our members. Fifteen percent of Health Share members speak languages other than English as their primary language, including approximately 13,000 members identified as having Limited English Proficiency (LEP) based on their Oregon Health Plan enrollment file. In 2022, members with LEP had nearly 40,000 visits with providers.




Since 2021, Health Share has gathered data to assess how often language assistance was provided to members with LEP. 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, the modality of service (e.g., in-person interpretation, telephonic, or video), and whether the interpreter who provided the service was accredited by OHA. The table in the Metrics and Indicators section includes data for 2022 versus 2021 baseline and demonstrates a slight decline in this area. This data more than likely undercounts the number of interpretive services that are provided to Health Share members, due to claims lag and challenges with acquiring data from vendors. In 2023, Health Share will continue to refine our data collection practices, with OHA's 2023 benchmark of *75% of interpreter services provided by an OHA certified/qualified interpreter* firmly in mind.

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 plan partners. 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. In 2022, Health Share worked with the Cultural Humility & Health Equity workgroup (CHEW), which is comprised of representatives from our plan partners who are responsible for operationalizing strategic equity measures, programs, and policies across their organization. In 2022, the CHEW discussed language access needs and strategies, strengthening relationships and intentional collaboration with Indigenous/Tribal communities, and the impact of health literacy in a post-COVID health care landscape. These topics have been noted as future training and education opportunities across the Heath Share collaborative.

## 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

- Health Share, the three Early Learning Hubs, and the three Public Health Agencies work closely together to design and refine a Regional Perinatal Continuum of Care for families in our region. The goal is to ensure families have easy access to perinatal services and supports from the time they are pregnant until the child enters Kindergarten. This includes easy access to Family Connects, WIC, Help Me Grow, Preschool and child care supports and culturally specific early childhood programs to support early childhood development.
- Health Share and county partners are working on expansion of Healthy Birth Initiative to Clackamas and Washington counties to increase access for the African and African American community.
- Health Share and plan partners implemented and evaluated a pilot called "Safe Beginnings" at all Project Nurture clinics—providing pregnant members in SUD treatment with access to a pre-approved menu of items to support them and their child on a healthy start. Between August 2022–March 2023, 89 Project Nurture members were served.
- Starting in May 2023, Safe Beginnings hass expanded to Healthy Birth Initiative, Nurse Family Partnership (Washington Co.) and Babies First (Clackamas Co.)—county run home visiting programs.

## Developmental and Behavioral Health

- Health Share continues to support the Help Me Grow (HMG) network to achieve the following strategic outcome for families navigating complex developmental and behavioral health needs:
  - Increase familial resilience
  - Increase system navigation skills
  - Increase advocacy skills
  - Decrease familial isolation
- Last year, HMG served 1,378 children, 65% of whom were children of color.
- HMG averaged 3.5 calls per family to provide developmental supports and ensure families had access to community resources, including partnership with Connect Oregon to receive referrals through the Unite Us platform.
- HMG liaisons (Peer Support Specialists) in the three counties serve Native American families, as well as immigrant and refugee families.
- HMG increased trainings on anti-bias, motivational interviewing, and Autism 101 to be better equipped to serve Oregonian families.

## Youth in Temporary Care

- Continued to convene the EveryStep Leadership Council and Community of Practice to discuss ways to improve and advance best practices around care for youth in foster care. In early 2023, we met with a local health system that is newly interested in adopting the EveryStep model beginning in 2024. 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 youth in temporary care.
- Established an Autism Assessment and Capacity Steering Committee to oversee a new investment in a three pronged strategy to address the crisis in wait times for an autism assessment: 1) expansion of Autism Alerts at Help Me Grow to help families navigate systems and connect to supports (we anticipate up to 50 referrals per month across the region), 2) clinical training and support for a small cadre of primary care clinicians to diagnose certain cases of autism, and 3) development of new payment models and exploration of a cross-system regional Autism Assessment center.
- Fully implemented use of the RAPID assessment in two of the three metro area counties with the third county considering implementation later this year. In 2022, 278 youth received a RAPID assessment.

## Youth Experiencing Substance Use Disorder

A new subgroup of Health Share's SUD Taskforce was created with a focus on building out the continuum of care for youth with SUDs. One of the two tracks of work is regional targeted outreach to School-Based Health Centers (SBHC). The overarching goals of the Youth SUD Taskforce are to:

- Address increasing rate of youth fatal and non-fatal overdose
- Support clinicians, SBHC's, community providers
- Increase availability of services in physical and specialty behavioral health
- Share up-to-date evidence-based practices

Health Share has two SBHC clinicians on our Children's Health Advisory Council to provide connections and alignment to that work and will be partnering with our fellow CCO in the region, Trillium, to increase outreach to School-Based Health Centers in the next round of CHIP design work.

## 6. BEHAVIORAL HEALTH ACCESS

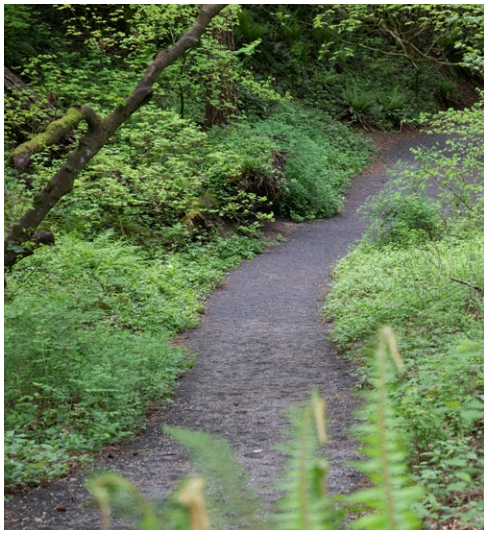
In response to instability of the behavioral health workforce and lack of access to high quality services, Health Share convened a Behavioral Health Workforce & Access Taskforce in 2021 that was charged to 1) develop and assure implementation of a service prioritization framework for a Health Share-wide 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 generated a set of recommendations to improve access to behavioral health services in our region, from re-balancing our global budget by moving funding out of the medical benefit and into the Behavioral Health (BH) benefit, to longer term workgroups focused on strengthening and improving the complex workflows between multiple system partners. Some key recommendations that Health Share has worked on in the past year include:

- 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 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

These recommendations informed nearly $60 million of investment in Behavioral Health care access, including:

### Intensive and Inpatient Capacity Expansion

This is an effort to support expanded behavioral health service capacity for OHP members by providing funds to assess the feasibility of expanding intensive and inpatient psychiatric services in the tri-county area at Unity, Legacy Health and Providence Health and Services. Funds will be used for expenses associated with an architectural feasibility study and business and implementation plan development. The remaining funds to be scoped upon completion of study.

## Strategic Health care Investment for Transformation (SHIFT)

CareOregon's SHIFT program is a new investment in transforming specialty behavioral health organizations across Oregon. SHIFT aims to ensure that people with behavioral health needs are truly at the center of care delivery, and the care teams that serve them thrive. Through a collaborative process, SHIFT will build member-driven, outcome-focused, team-based care models that reduce health disparities, assure timely access to care and prepare providers for advanced value-based payment models.

## Informing our Future of Homelessness Analysis

This initiative develops and expands Health Share's analyses of members with Opioid Use Disorder, Stimulant Use Disorder, Alcohol Use Disorder and Severe and Persistent Mental Illness to increase understanding of drivers of houselessness and to develop new interventions with key stakeholders. Analytic tools from this project will be available across the Health Share network and with key community stakeholders, enabling clinic and population focused strategies, in addition to broader regional efforts.

Health Share's strategy to improve access to behavioral health services also includes a focus on reducing unintended health system traumas by advancing trauma-informed care and strengthening the health system's capacity to identify and address structural racism. Health Share has worked with our Behavioral Health Benefit Administrator, CareOregon, to address this goal in two ways:

1. **Requiring cultural responsiveness /competence training in behavioral health contracts:**
   The Mental Health Statements of Work template for all contracted providers includes the following language: "Provider must deliver services in a trauma-informed and culturally appropriate manner." CareOregon's Quality Management team reviews requirements pertaining to cultural responsiveness included in OAR (including new training requirements), licensing boards, CCO contract, State Plan and DSM-5-TR (for the cultural elements of substantiating diagnosis.)

2. **Providing trauma informed care training to SUD providers:**
   Trauma informed care didactics were as integrated into Alcohol Use Disorder learning series offered to all providers, community-based organization and clinics contracted with Health Share of Oregon. The learning series consisted of five partial days and 55 clinics/organization from across the Health Share network attended the series.

Finally, key investments from Health Share's 2022 SHARE Spending Plan are focused on improvements to behavioral health access. These include support for a comprehensive, low-barrier Behavioral Health Resource Center (BHRC) in Multnomah County, to offer immediate basic needs services, including a day center with peer-delivered, trauma-informed programming; resource connections; showers/restrooms/laundry; and basic nurse care. BHRC also supports long-term stabilization through linkage to services and treatment, a short-term shelter (33 beds) and a bridge to housing program (19 beds). Additionally, SHARE funds will be used to support a Center for Addiction Triage and Treatment (CATT) in Washington County, a two-campus continuum of SUD services for adults, beginning in 2025. CATT will include certified recovery mentors to offer navigation and support to individuals, as well as have two vehicles to assist in helping members get to services the moment they are ready to engage.

## Supportive Housing

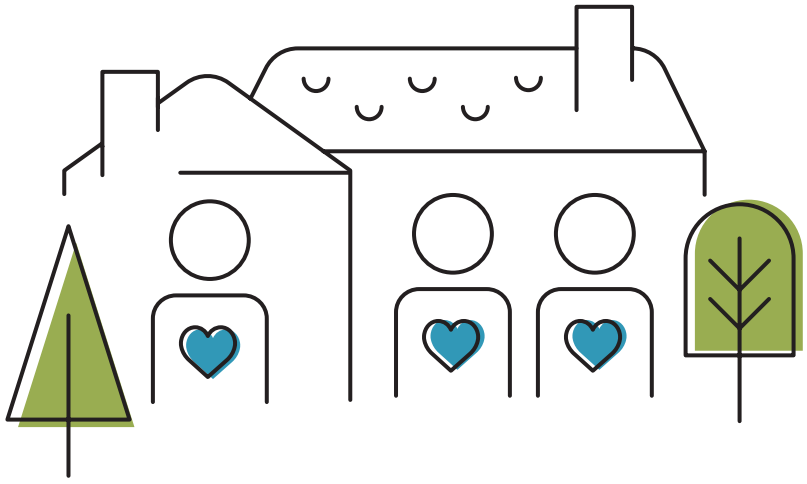
**Goal:** Increase access to safe, affordable, and supportive housing for Health Share members and the community.

**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 Health Share is working to reduce health disparities for members who do not have stable housing.

### 1. REGIONAL SUPPORTIVE HOUSING IMPACT FUND (RSHIF)

The RSHIF committee oversees the work of Health Share and its housing initiative, ensuring all components are grounded in the core values of racial equity, community voice, and strength-based, flexible, adaptive, and emergent practice. The Steering Committee, in partnership with Health Share's leadership, provides regular updates to Health Share's Board of Directors and consults with Health Share's Community Advisory Council (CAC) and the Community Impact Committee (CIC). The Committee also ensures the Board is provided with recommendations on key decisions, such as funding requests, opportunities, and priorities and investments in new housing initiatives. They are also informed of the potential strategic, operational and equity impacts of these decisions. The committee has continued meeting every month throughout this reporting period and has taken on an increasingly strategic role in Health Share's community health and health equity work.



## 2. MEDICAID HOUSING BENEFIT

As an evolution of the RSHIF work from the last several years, in 2022 Health Share implemented a demonstration pilot of a supportive housing benefit package for members, with the long-term goal for these housing services 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 current efforts have focused on creating a flexible housing benefit to support eligible Medicaid members at risk of homelessness in eight transition settings:

1. **Substance Use Disorder Residential**
2. **Exiting 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 has been administered by Oregon Health Science University in collaboration with Central City Concern. The benefit has gone live for five of the identified transition settings. As of May 2023, 429 members have been enrolled in the benefit, 258 of which have been successfully housed (see Metrics and Indicators section). The first three populations that Health Share rolled out the benefit with include members transitioning out of SUD Residential Treatment, Corrections, and those exiting Foster Care. These populations were prioritized because Health Share recognized disproportionate representation of BIPOC members compared to the general population in these settings. The full set of guiding principles used to inform this decision were:

- Alignment with Health's Share Strategic Plan: Emphasis on racial equity, behavioral health, supporting youth
- Level of current engagement from community resources: ability to support members and ensure benefit effectiveness
- Operational lift and population size: ability to make the work happen in an expedited manner
- Covering multiple approaches: Including prevention-focused populations and complex populations

In collaboration with housing service providers, the benefit is covering the cost of transitional housing, (moving fees, rent support, utility assistance, etc.) and connection to health and housing services as needed. We are identifying ways to lead with equity and inclusion and apply an equity lens in every step. We also recognize that OHA and the counties are key collaborators, so the systems we are developing are aligned with their work and the newly approved 1115 Medicaid Waiver.

In its role as Central Benefit Administrator, OHSU Health Services is working collaboratively with Health Share, housing service providers, and clients to complete eligibility review and screening processes for all members, build and maintain a network of supportive housing service providers, ensure tracking and fulfillment of member needs, develop processes to submit encounter data, and process payment to service providers. They are also developing and documenting workflows from member identification and referral to discharge from housing program for each of the eight populations. The program data is incorporated into a monthly dashboard that includes a breakdown of program enrollment by race/ethnicity (see Metrics and Indicators section).

Health Share is engaging strategically with our county partners and Metro to position the benefit in support of the broader regional, cross-sector response to the houselessness crisis. Health Share participates in Multi-Agency Coordinating Committees to improve access to care coordination and needed flex services for members engaged in these processes. We also participate in the Metro Tri-County Planning Body to support integration of health and housing services strategies and Multnomah County's Coordinated Access Assessment Oversight Committee.

This housing benefit pilot will run through the end of 2023, when Health Share will transition these efforts to align with implementation of the new Health-Related Social Need (HRSN) housing benefit that goes live in 2024.

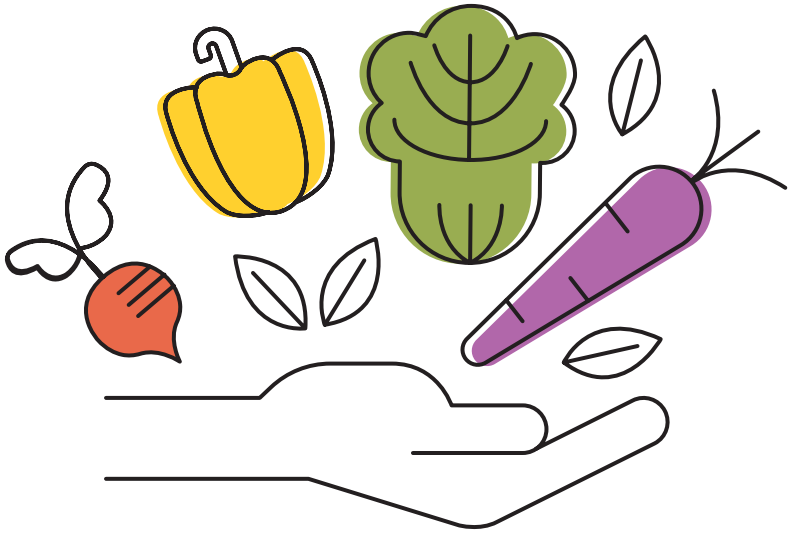
## Food Access, Chronic Conditions, and Social Connection

### While a full set of strategies and metrics has yet to be developed for these focus areas, Health Share had the opportunity to leverage our SHARE spending plan to support key community health priorities, including Food Access.

The 2022 Healthy Columbia Willamette Collaborative Community Health Needs Assessment highlighted a regional shortfall of **$140,638,164** in resources needed address the food insecurity gap in our region:

| **Annul Food Budget Shortfall** (Access to culturally specific and healthy foods) | |
|---|---|
| **REGION** | **$140,638,164.29** |
| Clackamas | $22,305,789.04 |
| Multnomah | $59,185,810.87 |
| Washington | $30,296,159.90 |
| Clark | $28,850,404.49 |

Note: Calculated using the weekly food budget shortfall of people reporting food insecurity, weighted by the time spent food-insecure. This number can be interpreted as the amount of food benefits that would be needed to ensure nobody goes to bed hungry. Source: Feeding America (Map the Meal Gap 2020)



In response to this data, and in light of our established CHIP priority in this area, Health Share's Community Advisory Council advanced a proposal for culturally specific food access that was approved by our Board, resulting in a $1.5 million investment to provide operational support for culturally specific organizations and those serving diverse community members who are being under-served by our current system, as well as capacity building support for those same organizations to help develop longer term strategies and solutions to address food access. Health Share will be partnering with the Oregon Public Health Institute to distribute these funds and provide training, technical assistance, and compliance support to grantees, as well as facilitate network building for mutual support, shared learning, and movement building.

Addressing Chronic Conditions and building Social Connection for members will likely remain priorities for Health Share in its new CHIP in 2024. Work is underway with health plan and community partners, to surface key intended impacts in these areas and begin to build out strategies in these areas.

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

### Health Share of Oregon and Trillium Community Health Plan continue to develop a strong partnership, aligned across several CHIP priorities.

Within the Access to Care focus area, both CCOs 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) support for 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) expansion of Healthy Birth Initiative (HBI), a culturally specific program addressing the needs of Black and African American women, and 3) investment 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 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 collaborative focus.

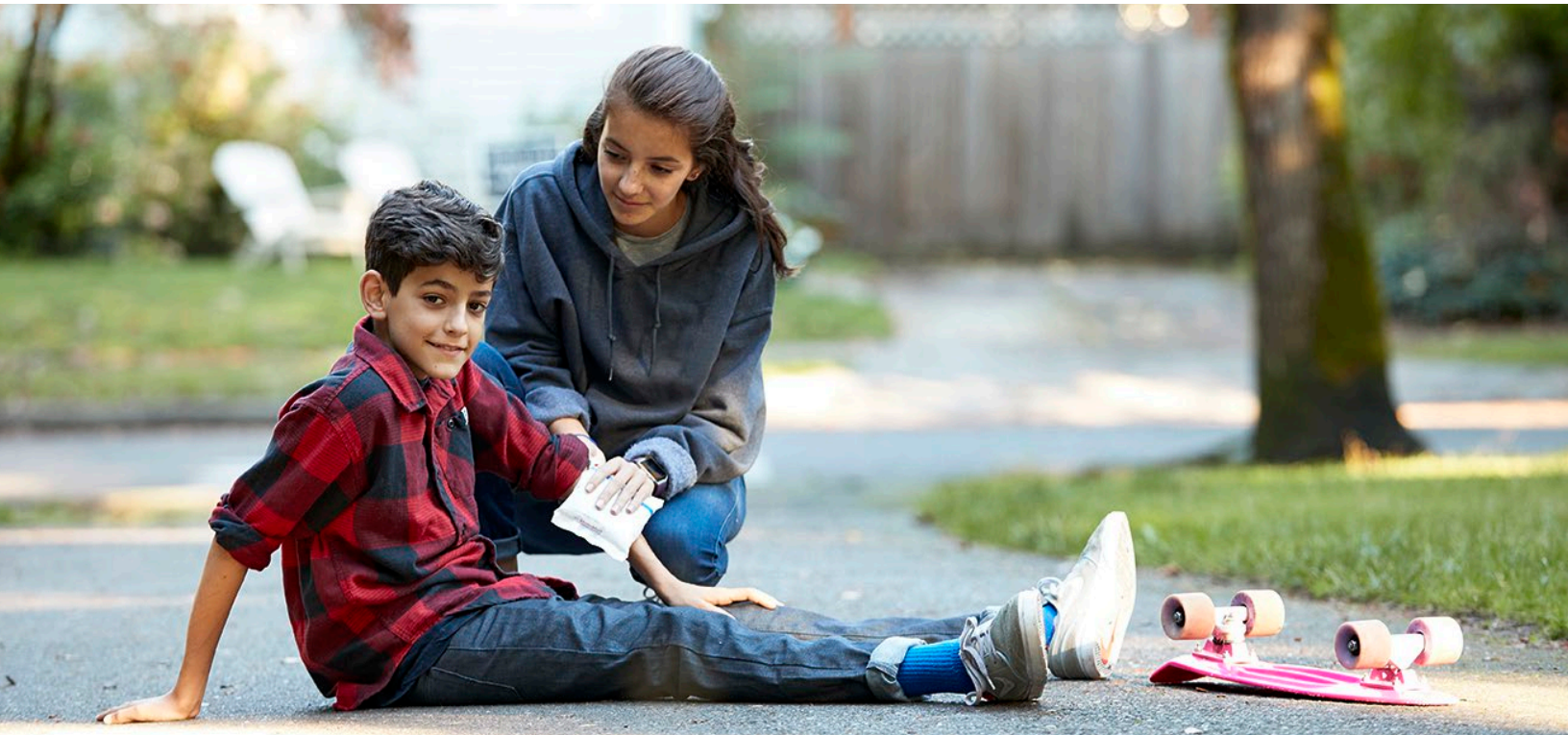
In the domain of healthier Food Access, Health Share and Trillium continue to partner with the Women, Infant, and Children (WIC) program on a regional campaign to increase enrollment and participation in WIC. We meet regularly to design strategies to better connect our members to nutrition supports.

Health Share is piloting its housing benefit for priority populations and will leverage learning from this pilot to inform implementation of the HRSN housing benefit for the region in partnership with Trillium.

Both CCOs support the development of the Connect Oregon (Unite Us) social needs referral network across the region, including engagement of potential CBO providers in the network and analysis of network data to inform community health priorities. 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 meet regularly, along with Unite Us, to ensure we are coordinating our outreach to community partners and collaborating on building the network.

In 2022, both CCOs focused on addressing the complex system-level factors, including payment or policy barriers that impact services for kids and families. The Social-Emotional Health (SEH) vision is that children from birth to age 5, and their families, have equitable access to services that support their social-emotional health and are the best match for their needs. These identified target areas in 2022 will inform community conversations in 2023. In partnership with Health Share, both CCOs will be hosting a SEH event in July 2023 and collaborate on implementation and integration of OHA's SEH metric for CCOs.

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 and we look forward to applying this assessment's findings in our development of joint community health improvement priorities in the coming years. Additionally, HCWC member organizations identified the need for additional engagement with Tribal Nations and School-Based Health Centers. The CCOs have committed to this engagement as part of our planning for our 2024 CHIP submission.



# Metrics and Indicators (by Focus Area)

## Access to Care

### 1. COVID VACCINATION

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

| Race/Ethnicity | Percent of Members 12+ Having Any COVID Vaccine *(as of 6/13/21)* | Percent of Members 12+ Having Any COVID Vaccine *(as of 4/24/22)* | Percent of Members 12+ Having Any COVID Vaccine *(as of 5/17/23)* |
|---|---|---|---|
| American Indian/ Alaskan Native | 42% | 66% | 66% |
| Asian | 71% | 85% | 84% |
| Black | 36% | 63% | 62% |
| Hispanic | 44% | 71% | 70% |
| Native Hawaiian/ Pacific Islander | 35% | 63% | 60% |
| Other | 48% | 65% | 66% |
| Unknown | 44% | 65% | 65% |
| White | 48% | 65% | 65% |
| **Grand Total** | **46%** | **66%** | **67%** |

*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.**

| CY 2021 (baseline) | Visits with Interpretive Services | Visits with OHA Qualified/Certified Interpreters | CY 2022 | Visits with Interpretive Services | Visits with OHA Qualified/Certified Interpreters |
|---|---|---|---|---|---|
| Dental | 15% | 6% | Dental | 18% | 4% |
| Medical | 18% | 4% | Medical | 13% | 5% |
| Mental/ Behavioral | 11% | 2% | Mental/ Behavioral | 7% | 2% |
| **Grand Total** | **17%** | **4%** | | **13%** | **5%** |

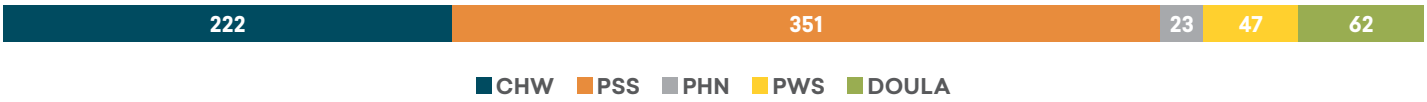
*Data Source—Health Share Claims

## 3. TRADITIONAL HEALTH WORKERS

### Traditional Health Worker Payment Grid Summary 2022

**FTE reported by Health Share plan parters in the 2022 THW Payment Grid.**

- **705 FTE** were reported by Health Share plan partners (17% increase from 2021)
- **81%** of reported FTE was attributed to either Community Health Workers (31%) or Peer Support Specialists (50%)




### How are they funded?

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


**CHW:** Other/Unknown (65%), Alternative payment model (2%), Directly employed by health plan (16%), Grants (17%), Fee for Service (0%)

**PSS:** Other/Unknown (75%), Fee for service (16%), Alternative payment model (3%), Directly employed by health plan (3%), Grants (3%)

**PHN:** Directly employed by health plan (57%), Other/Unknown (40%), Grants (3%), Alternative payment model (0%), Fee for Service (0%)

**PWS:** Other/Unknown (59%), Directly employed by health plan (9%), Alternative Payment Model (19%), Grants (13%), Fee for Service (0%)

**Birth Doula:** Grants (20%), Other/Unknown (23%), Fee for service (57%), Alternative payment model (0%), Directly employed by health plan (0%)

**ALL:** Other/Unknown (65%), Directly employed by health plan (10%), Fee for service (12%), Alternative payment model (3%), Grants (10%)

**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 plan partners

## 4. PRIMARY CARE PROVIDER UTILIZATION

Utilization of primary care services is often expressed with rates per 1,000 member months ("1000 mm"). This approach helps readers compare utilization across groups of different sizes by looking at the ratio of services per 1,000 months of enrollment. In the graphs below, PCP Utilization per 1,000 MM is calculated by dividing the overall number each group's PCP visits by the group's total number of member months during the same period and multiplying the result by 1,000. Access to care integrates many factors difficult to measure at the system level including service location, transportation, and comfort with providers. These utilization rates reflect only one measure, utilization of primary care, and are not intended to represent the full spectrum of ways members can access preventive care or other important services.

Interestingly, PCP utilization for adults generally decreased across most demographic categories between 2021 and 2022, whereas utilization for children generally increased across most categories. While it is difficult to determine the precise reasons for this trend, we posit that some pandemic-driven factors may be at play, such as children returning to fully in-person learning and expanded availability of childhood covid vaccinations. Additionally, the increase in adult utilization we saw in the previous year could be attributed to a one-time surge in members returning to primary care after a pause during the pandemic, whereas child visits would see a similar spike but also be sustained by more frequent well-child visits and typical childhood illness visits that were deferred during COVID.

## PCP Utilzation per 1000 member months

### Child

| Race/Ethnicity | PCP Utilization (2021) per 1000 member months | PCP Utilization (2022) per 1000 member months |
|---|---|---|
| American Indian/Alaskan Native | 131.7 | 143.3 |
| Asian | 127 | 134.3 |
| Black | 132.5 | 139.9 |
| Hispanic | 139.5 | 151.1 |
| Native Hawaiian/Pacific Islander | 108.1 | 105.5 |
| Other | 130.6 | 130.8 |
| Unknown | 145.5 | 158.2 |
| White | 156.2 | 160.2 |

### Adult

| Race/Ethnicity | PCP Utilization (2021) per 1000 member months | PCP Utilization (2022) per 1000 member months |
|---|---|---|
| American Indian/Alaskan Native | 174.3 | 173.6 |
| Asian | 120.2 | 123 |
| Black | 164.8 | 150.3 |
| Hispanic | 132.3 | 122.6 |
| Native Hawaiian/Pacific Islander | 107.4 | 96.4 |
| Other | 161.3 | 143.6 |
| Unknown | 158.6 | 148.8 |
| White | 185.3 | 173.6 |

### Child

| Language | PCP Utilization (2021) per 1000 member months | PCP Utilization (2022) per 1000 member months |
|---|---|---|
| Arabic | 118.8 | 93.1 |
| Cantonese, Mandarin, Other Chinese / Asian, Teochew | 100.4 | 121 |
| English | 153.7 | 161.2 |
| Other / Undermined | 153.9 | 207.6 |
| Russian | 63.8 | 84.8 |
| Somali | 93.4 | 108.8 |
| Spanish | 113.7 | 128.8 |
| Vietnamese | 115 | 119 |

### Adult

| Language | PCP Utilzation (2021) per 1000 member months | PCP Utilzation (2022) per 1000 member months |
|---|---|---|
| Arabic | 199.3 | 169.7 |
| Cantonese, Mandarin, Other Chinese / Asian, Teochew | 86.9 | 87.2 |
| English | 171.9 | 160.6 |
| Other / Undermined | 129.7 | 113.6 |
| Russian | 120.7 | 126.3 |
| Somali | 111.2 | 117.9 |
| Spanish | 114.3 | 106.1 |
| Vietnamese | 149.7 | 164.9 |

*Data Source—Health Share Claims

## Housing

### ELIGIBLE ENROLLED MEMBERS BY TRANSITION COHORT

**429** Members Enrolled **20** # of Housing Service Providers

**258** Members Housed **$1,165,648** Total Spend**

### Eligible Enrolled Members by Transition Cohort

| Population | Total |
|---|---|
| Substance Use Disorder Residential Program | 159 |
| Corrections | 97 |
| Recuperative Care Program | 31 |
| Existing Foster Care | 48 |
| Project Nurture | 34 |
| IMPACT | 7 |
| Other | 0 |
| **Total** | **376** |

*active enrollment as of 5/31/23
**YTD Spend reflects direct payments made by OHSU Health IDS during the specified time period.

**Definitions**

**Members Enrolled—**These are the individuals who meet eligibility requirements and are actively enrolled in the Program

**# of Housing Service Providers—**These are housing navigators who have a signed MOU for the program or are working in good faith providing navigation services while MOU discussions are underway