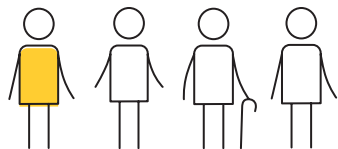




Measurable Outcomes

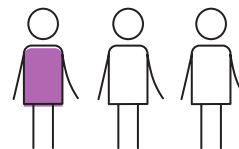
**A Five-Year Snapshot of
Health Share Performance Metrics**

1 of 4



Oregonians receives health insurance through the Oregon Health Plan

1 of 3



Oregonians with OHP coverage is a Health Share member

CCOs like Health Share of Oregon exist to transform how health care is delivered to communities.

Because one of every four Oregonians receives health insurance through the Oregon Health Plan (and one of every three Oregonians with OHP coverage is a Health Share member), these transformation efforts are crucial to a significant portion of the population—and to the overall success of OHP.

To ensure CCOs are working to transform care, the Oregon Health Authority uses a set of quality measures (tied to performance dollars) to determine how well CCOs are improving quality, access and outcomes, as well as curbing the rising cost of care. 2017 was the fifth year of Oregon's pay-for-performance program.

Over the past five years, Health Share has focused on and invested in many programs and initiatives to address these quality measures and improve outcomes:



Through the Health Commons Grant (2012-2015), a variety of programs were implemented and studied—some of which still operate today, including Tri-County 911, the Intensive Transition Teams provided by our county partners, and CareOregon's Health Resilience Program. Some of the programs informed and helped influence other programs such as Emergency Department Navigators at Providence.



Through the Life Studies project (2013), we learned what many had suspected: Our members are better served by changing the question from “what’s wrong with you?” to “what happened to you?”—a critical step in acknowledging and addressing the early life trauma, adverse childhood experiences, and social determinants of health that form a pathway to poorer health for many of our members.



This lesson led to Health Share 2.0 (2015-2017), with initiatives to build infrastructure to support community health workers, provide access to legal services within a clinic setting, and improve screening and access to care for foster children, among others.

Fast forward to 2018: The following pages provide a snapshot of each quality performance measure over the last five years. Health Share's investments, programs and partnerships have led to many achievements toward meeting the Oregon Health Authority's performance measures. But more than that, they've expanded our understanding of the communities we serve, increased our commitment to addressing social determinants of health and health equity and have helped build on our prevention-focused, upstream work that goes beyond the doctor's office—into schools, homes, and across social systems to reach our vision of a healthy community for all.

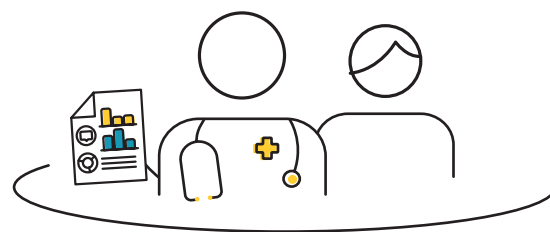
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Adolescent Well Care Visits

80%

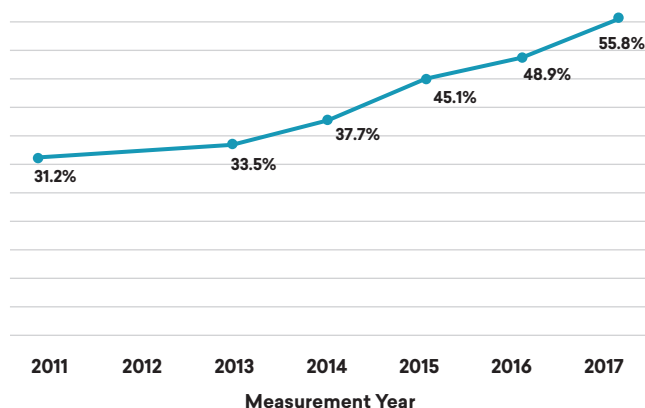
increase in adolescent well care visits rate



Across the state, including the tri-counties, adolescents are reporting poor physical and mental health, and higher rates of substance use and smoking, as captured in the 2018 Oregon Healthy Teens Survey. Connection to routine primary care, preventive screenings, and positive relationships is increasingly important.

To increase the number of adolescents who get a well care visit each year, Health Share collaborates across systems with health plans, providers, counties, schools and more—resulting in a nearly 80 percent increase over five years.

Adolescent Well Care Visits



Measures percentage of 12-21-year-olds who have at least one well care visit during the measurement year. Baseline data was captured in 2011. First-year results were captured in 2013.

Social Marketing Campaign

In 2018, Health Share worked with counties and school health centers to create a digital media and marketing campaign encouraging young adults to seek well care visits at their school health clinics—an existing, yet currently underutilized resource.

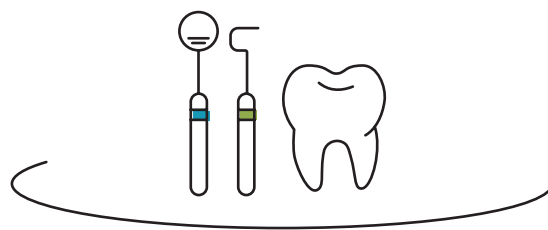
Key Initiatives

- Health Share plan partners provided incentives to members (e.g., iTunes gifts cards), encouraging adolescents to engage in preventive care and transition to adulthood by taking ownership of their health and care.
- Tuality, a leader on this measure—with particularly high rates from Hillsboro Pediatrics—distributes a monthly list to clinics identifying patients with gaps in care, helping to prioritize this population and send a consistent message to both providers and families about the importance of these annual check-ups.

Dental Sealants

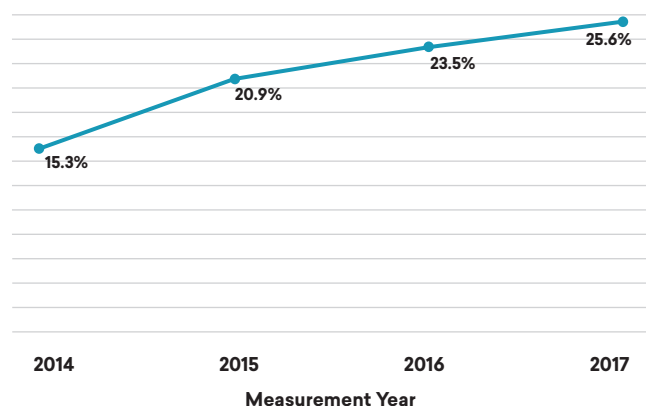
67%

increase in dental sealant rate



A healthy mouth is just as important as a healthy body and a healthy mind. Because cavities are the most common childhood disease—and one of the top reasons kids miss school—Health Share has worked with our dental plan partners to increase access to oral health care for kids, specifically services like dental sealants that help prevent tooth decay.

Dental Sealants



Measures percentage of 6-14-year-olds who received a dental sealant during the measurement year. The dental sealant measure was introduced in 2014.

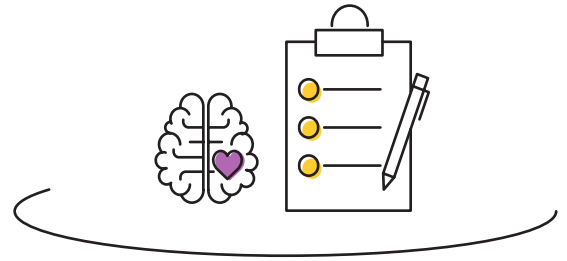
Key Initiatives

- The Dental 3 (D3) group provides community-based dental services throughout the tri-county region, including sealant services in schools.
- Through a unique collaboration among dental and clinical leadership at Federally Qualified Health Clinics—fostering buy-in, establishing goals and tying performance to incentive funds—CareOregon Dental achieved a sealant rate of nearly 40 percent in 2017.

Depression Screenings & Follow-Ups

61%

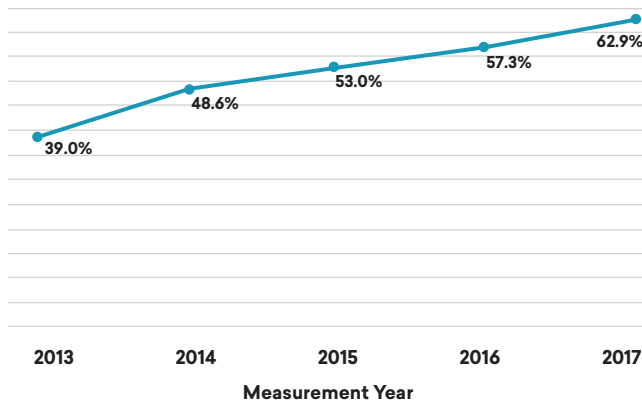
increase in rate of depression screenings
and follow-up appointments



Millions of people live with major depression. Fortunately, when detected early, it can be treated effectively. By screening for depression in a primary care setting, doctors and providers can work with patients to create a follow-up plan that works for them. Making depression screening a routine part of primary care visits also helps eliminate the stigma of depression and other mental health conditions.

To improve performance on this measure, Health Share focused on integration of behavioral health supports in the primary care setting—resulting in an over 60 percent increase in five years.

Depression Screenings & Follow-Ups



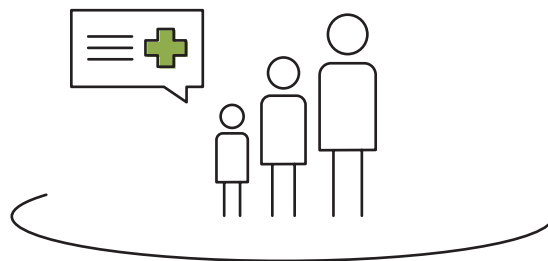
Measures percentage of members 12 years and older who had appropriate screening and follow-up planning for major depression. This measure was introduced in 2013.

Key Initiatives

- Central City Concern embedded depression screening workflows into its routine practice and achieved a screening and follow-up rate of nearly 83 percent in 2017.
- Kaiser Permanente increased its screening rate nearly five-fold between 2014 and 2017, from 11.5 percent to 55.3 percent.

247%

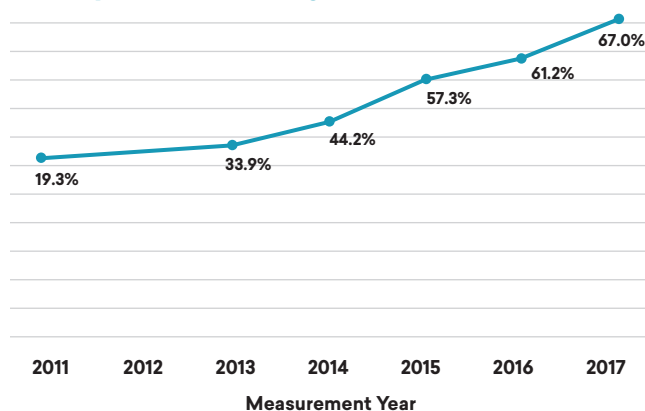
increase in developmental screening rate



We want to make sure kids and families are equipped with the resources they need to thrive. Developmental screenings are just one of many tools helping families pinpoint developmental progress and catch delays in young children.

Over the past five years, Health Share has worked with plan partners and community-based organizations to target communities with historically low screening rates in order to understand their needs and ensure these families have access to culturally relevant and linguistically appropriate screening tools. Overall, the percentage of children who were screened for risks of developmental, behavioral, and social delays using standardized screening tools **more than tripled** in five years.

Developmental Screenings

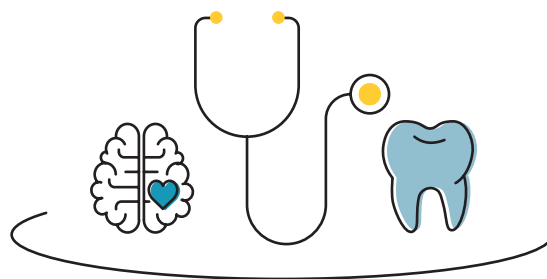


Measures percentage of children who were screened for risks of developmental, behavioral, and social delays using standardized screening tools in the 12 months preceding their first, second or third birthday. Baseline data was captured in 2011. First-year results were captured in 2013.

Key Initiatives

- Breaking down screening data by language helped identify disparities that were addressed in one of Health Share's first Performance Improvement Projects (PIP).
- Health Share convened community partners, including Early Learning Hubs, Early Intervention, the Immigration and Refugee Community Organization (IRCO), and the University of Oregon, to promote not only the translation of the Ages and Stages Questionnaire (ASQ) screening tool into other languages, but also its adaptation to different cultural norms.

200%

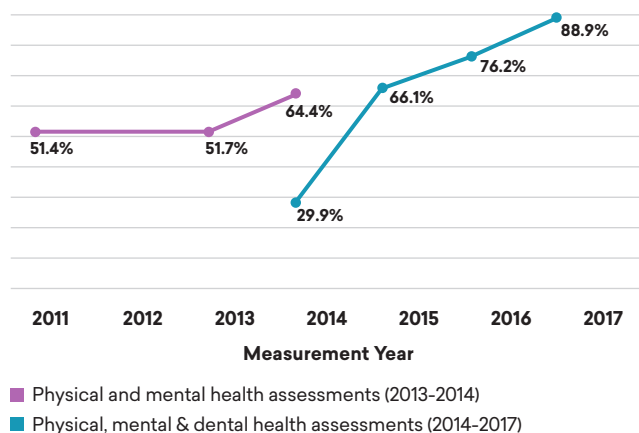


increase in rate of physical, mental and dental health assessments for kids entering DHS custody

Children in foster care experience a higher burden of disease, incredible social complexity, and have multiple changes in caregivers, presenting unique challenges for health plans and care providers, and contributing to significant health and health care disparities.

To address these issues, Health Share created a community collaboration involving multiple child-serving systems to build a more coordinated system of care including Department of Human Services, juvenile court, mental health organizations, schools, primary care, oral health, and more. These efforts played a big role in ensuring foster children receive timely care and that Health Share meets the health assessment metric as evidenced by improvement in performance, **which nearly tripled in the past three years.**

Assessments for Children Entering DHS Custody



Measures percentage increase of children ages 4 and above who received a mental, physical, and dental health assessment within 60 days of the state notifying CCOs that the children were placed into DHS custody. Methodology changed in 2014 to include dental assessments.

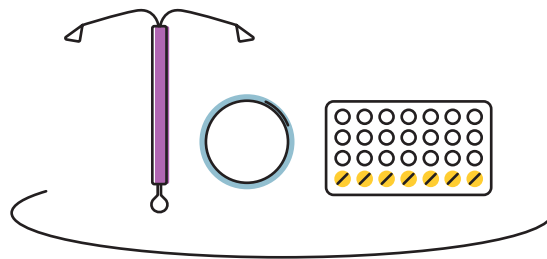
Key Initiatives

- Health Share developed the Referral Manager platform with PH Tech—an online tool that helps behavioral health plan partners coordinate assessments for every foster child who enters custody, not just those who meet metric criteria.
- Health Share funded a medical liaison position at Multnomah County Department of Human Services to help prioritize the health needs of foster children and to share information with the plan partners coordinating their initial assessments and ongoing care.
- Health Share led an Advanced Primary Care learning collaborative to share best practices in providing trauma-informed primary care services to foster children. Hillsboro Pediatrics, OHSU General Pediatrics, and Randall Children's Clinic are continuing to develop and implement a model of care for foster children, helping to transform the way primary care systems respond to the unique needs of foster children.

Effective Contraception Use

24%

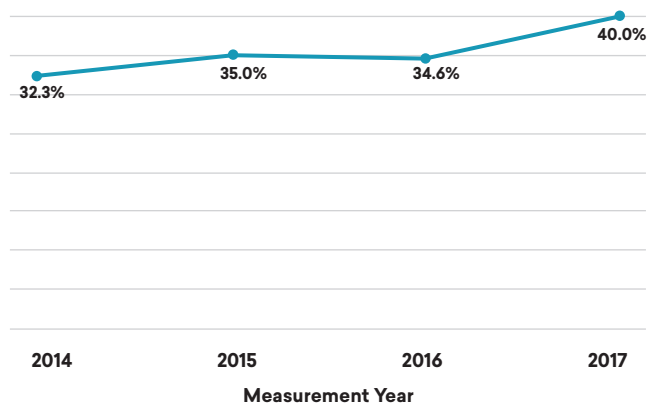
increase in rate of effective contraception use



Nationally, half of all pregnancies are unintended, despite the availability of highly effective, long-acting forms of birth control. At the same time, contraception failure due to inconsistent or incorrect use accounts for half of all unintended pregnancies.

To increase effective contraception use among women, Health Share's plan and clinic partners began promoting the use of One Key Question®, asking women about their intentions to become pregnant and discussing and prescribing effective birth control options.

Effective Contraception Use



Percentage of women ages 18-50 with evidence of one of the most effective or moderately effective contraceptive methods during the measurement year: IUD, implant, contraception injection, contraceptive pills, sterilization, patch, ring, or diaphragm. Measure was adopted in 2014.

Social Marketing Campaign

In 2017, Health Share identified the need for enhanced awareness around the availability of effective birth control options. Health Share launched a digital media campaign informing women that the Oregon Health Plan covers contraception, and encouraging them to make an appointment with their primary care doctor to seek the method that is best for them. The success of the campaign led to its continuation in 2018.

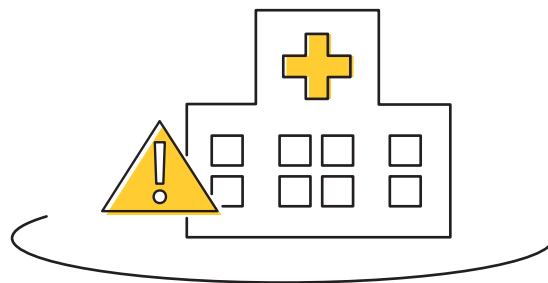
Key Initiatives

- CareOregon helped capture the use of long-acting contraception through coding prompts to providers.
- Kaiser Permanente made contraception use a regional priority and added it into its electronic health record (EHR) system.

Use of the Emergency Department

27%

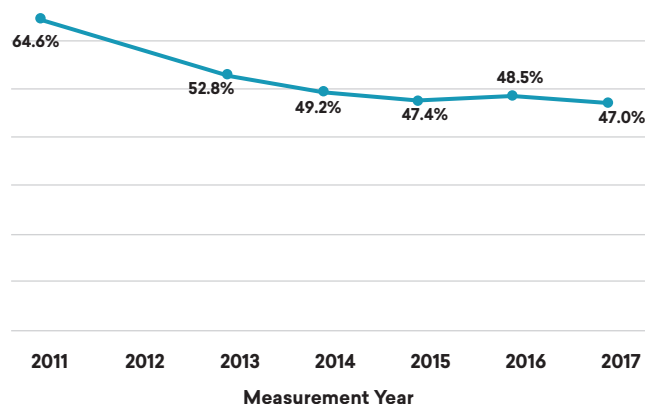
decrease in rate of emergency department use



The emergency department is often visited for treatments that are better managed in a primary care office or urgent care clinic. At the same time, many people are forced to go to the ED for ailments that could have been prevented by looking upstream, before certain conditions become acute. This unnecessary use of the ED leads to high costs for the health care system overall.

To address this, most Health Share members are assigned a primary care provider when they're first enrolled in coverage. In addition, Health Share partners placed care coordinators in emergency departments and in the community to intervene if an individual's treatment is better managed through regular or one-time services in primary or specialty care.

ED Utilization



Measures rate of patient visits to an emergency department. Lower number suggests more appropriate use of care. Baseline data was captured in 2011. First-year results were captured in 2013.

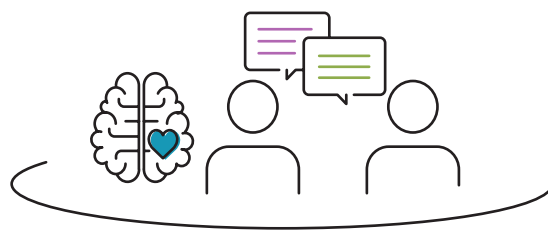
Key Initiatives

- Emergency Department Navigator programs helped reduce ED use and maintain low usage rates at Kaiser Permanente and Providence.
- At Tuality, the daily review of ED reports has helped identify members with three or more emergency department visits, who have then received outreach and case management support, including education on urgent care and primary care resources.

Follow-Ups After Hospitalization for Mental Illness

32%

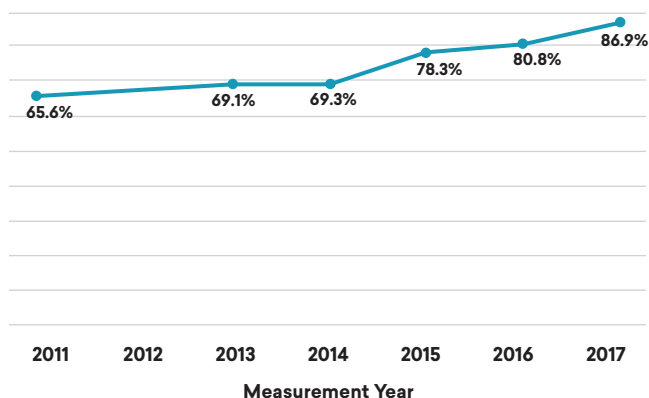
increase in rate of follow-ups after hospitalization for mental illness



When someone is hospitalized for mental illness, it's vital that a follow-up appointment is scheduled once that person is discharged. This can lower rates of re-admission and increase the likelihood that any progress made while hospitalized is maintained after discharge.

Through various follow-up programs and by working with hospitals in our network, Health Share increased the percentage of members receiving a follow-up visit within seven days of being discharged from a mental health-related hospitalization by nearly 32 percent in five years.

Follow-Ups After Hospitalization for Mental Illness

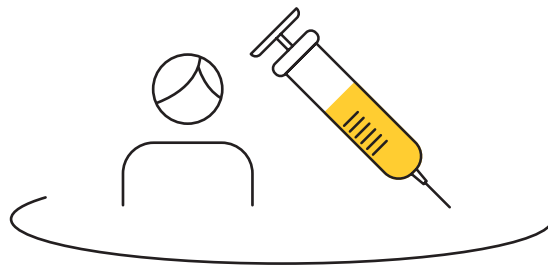


Measures percentage of members 6 years and older who received a follow-up visit with a health care provider within seven days of being discharged from a mental illness-related hospitalization. Baseline data was captured in 2011. First-year results were captured in 2013. (Results prior to 2014 are not directly comparable to later years due to a change in methodology.)

Key Initiatives

- The expansion of Intensive Transition Teams into all three counties increased the rate of follow-up with behavioral health services significantly, with considerable impact in Multnomah County.
- Measure specifications changed in 2015 to capture follow-up visits on the same day as discharge, which all partners were providing at a high rate in accordance with best practices.

5%

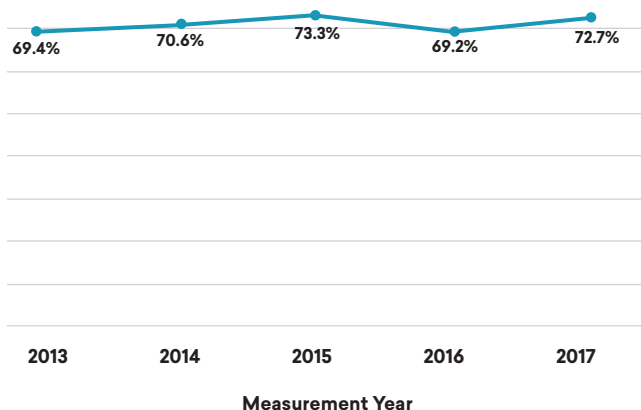


increase in rate of childhood immunizations

Childhood immunizations can help prevent serious illness, including diseases like whooping cough, chickenpox, measles, meningitis, and hepatitis. Preventing such illnesses saves lives and curbs the number of missed days at school and work.

Ensuring children receive recommended vaccines before their second birthday has been a challenge. However, Health Share and our partners continue to work with clinic systems and public health agencies to ensure children are getting these important vaccines, and that parents understand the community value of a well-immunized population.

Childhood Immunizations



Measures percentage of children who received recommended vaccines before their second birthday, including DTaP, IPV, MMR, HiB, Hepatitis B, and VZV.

Social Marketing Campaign

In 2018, Health Share began to focus on childhood immunization rates through strategic communication efforts. To encourage improvement on this measure and ensure children are getting proper immunizations at the right time, Health Share is working with community and clinic partners to launch a marketing campaign in early 2019.

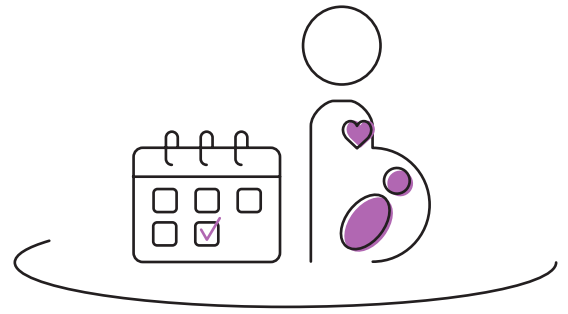
Key Initiatives

- Many clinic partners, including Providence Medical Group, Virginia Garcia Memorial Health, Randall Children's Clinic, and Oregon Pediatrics, participated in an immunization workshop sponsored through Oregon Health Authority's Transformation Center in April 2017.
- Use of ALERT data received quarterly from OHA has helped plans and clinics reach out to children who could be caught up on their immunizations with just one visit, identify where birth doses of HepB had not been recorded by the delivering hospital, and highlight disparities in immunization rates for certain populations.

Timeliness of Prenatal Care

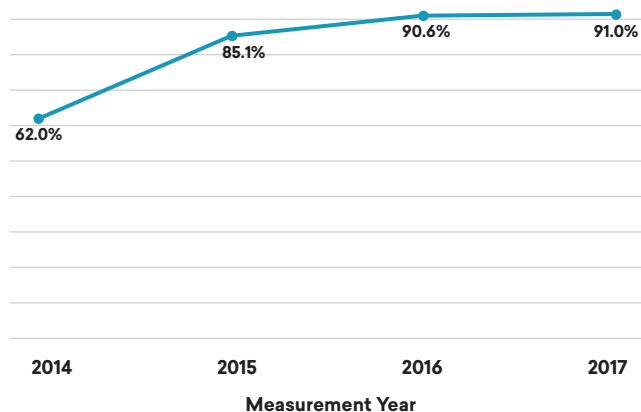
47%

increase in rate of timely prenatal care



Ensuring pregnant women receive a prenatal visit within the first trimester can help identify risks for complications and provides an important opportunity to establish support for mothers throughout pregnancy and into motherhood.

Timeliness of Prenatal Care

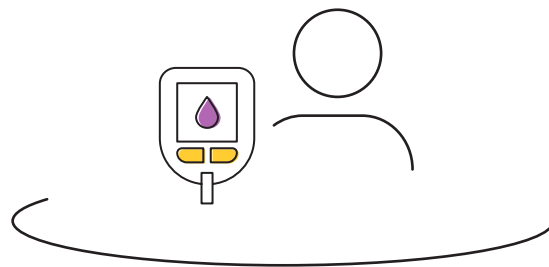


Measures percentage of pregnant women who received a prenatal care visit within the first trimester or within 42 days of enrollment in OHP. In 2014, measure specifications were changed to include medical record review.

Key Initiatives

- Women's Healthcare Associates has provided a large portion of the prenatal care to our member population.
- Kaiser Permanente has consistently demonstrated a high rate of timely prenatal care for its members.

15%

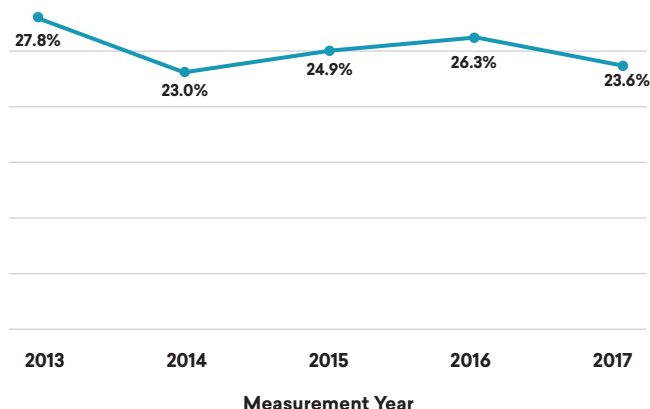


increase in rate of controlling blood sugar levels

Ensuring members with diabetes have the resources they need to manage their disease is vital for overall health and wellness. Over the past five years, Health Share and our partners have decreased the overall percentage of members who had hemoglobin A1c of more than 9 percent in a measurement year. That said, the ups and downs in performance highlight the difficulty in managing this complex condition for a population experiencing multiple health conditions and other social determinants of health.

In addition, we know that diabetes mutually impacts both oral and behavioral health, with poorly controlled blood sugar levels leading to gum disease and difficulty managing depression, and vice versa. All of Health Share's partners understand that whole-person, integrated approaches are necessary to support truly sustainable systems for diabetes management and prevention in our community. The 2019 measure that captures oral evaluation for members with diabetes will be a great step in fostering communication and integration across systems to support better, more measurable outcomes for our members.

Diabetes Poor Control



Measures percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c greater than 9 percent during the measurement period. A lower score is better.

Key Initiatives

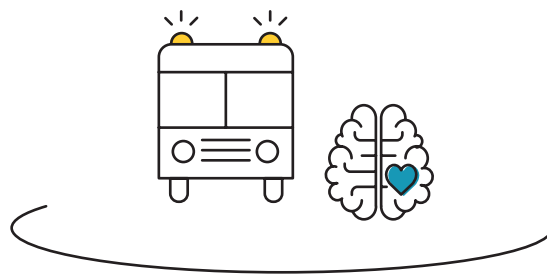
In April 2018, Health Share hosted a Diabetes Summit featuring representation from physical, dental, and behavioral health plans and providers. Participants collectively identified some of the barriers to successful diabetes management that Health Share members experience, and learned some of the successful and innovative programs addressing these barriers, including:

- Health equity | *Diabetes Prevention Program*
- Unique care integration for members experiencing mental illness and diabetes | *Cascadia Behavioral Health*
- Relationships between oral health and diabetes management | *Medical-dental pilot projects*
- Changes in clinical workflows that foster more effective population health strategies in primary care | *CareOregon and Kaiser Permanente models*

ED Utilization Among Members Experiencing Mental Illness

5%

reduction in rate of emergency department use

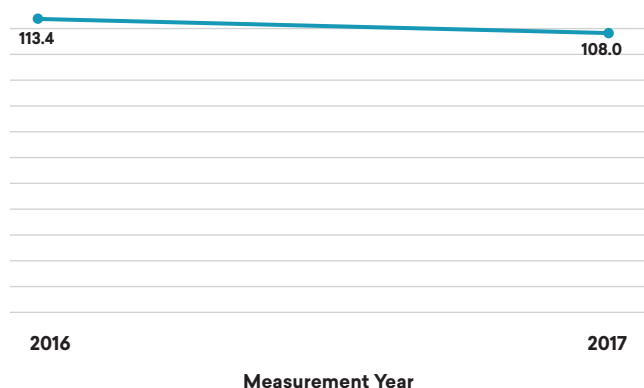


Starting in 2018, a new measure is focusing on reducing emergency department use for physical health conditions among adult members experiencing mental illness. The metric is meant to address a clear disparity in health outcomes, as adults living with serious mental illness have a lower life expectancy (by 25 years) than others in the community.

Members with mental health conditions, as well as physical health conditions, can experience barriers to treatment for their physical health in standard primary care settings, leading many to seek services in the emergency department. This measure highlights the need for integration between physical and behavioral health entities to ensure a more positive experience of care and improve overall health outcomes for members with mental illness.

Early data from 2016 and 2017 shows an improvement in Health Share's performance, as well as a trend in reducing emergency department use among this population for 2018, the first year the measure has been incentivized.

ED Utilization Among Members Experiencing Mental Illness



Measures reduction of emergency department use per 1,000 member months for physical health conditions among adult members experiencing mental illness. The above chart shows early results, though the measure is new for 2018.

Key Collaborative Work

In 2018, CareOregon has involved primary care clinics, emergency department staff, and behavioral health providers in a learning collaborative around the reduction of emergency department use. The collaborative has worked to understand the perspective of each part of the system and find places to integrate care and communicate more effectively. Key partners, such as Multnomah and Clackamas County clinics, Central City Concern, Cascadia Behavioral Health, Lifeworks NW, and Western Psychological, have been mobilized by this collaborative knowledge sharing and are working to develop workflows to better meet the needs of this high-priority population.

Patient-Centered Primary Care Homes

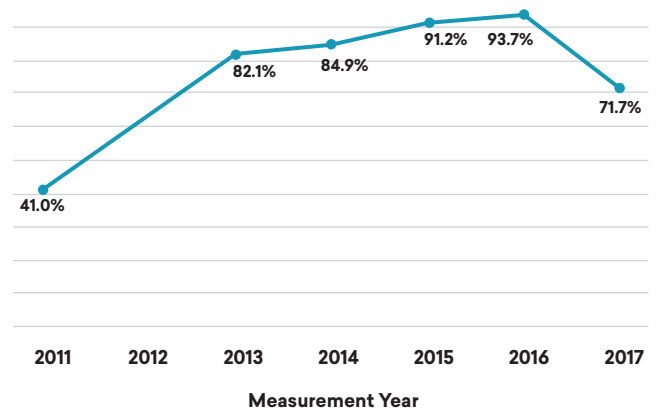
Consistently meets benchmark



Patient-centered primary care homes (PCPCHs) are recognized clinics providing certain standards of care to members. From 2011 through 2016, the program had a three-star rating system. In 2017, the program shifted to a five-star system, with five stars being the most robust rating for meeting best practices in integrated and coordinated whole-person care—and more difficult to achieve.

The calculation of PCPCH enrollment for the incentive measure changed accordingly, causing a drop in all CCOs' performance. For Health Share, 24 percent of members were assigned to a three-star PCPCH in 2017, and 64 percent to a four-star PCPCH, while just 3 percent were assigned to a five-star PCPCH—an issue we aim to improve in the coming years.

Patient-Centered Primary Care Home Enrollment



Measures member enrollment in a patient-centered primary care home (PCPCH). Baseline data was captured in 2011. First-year results were captured in 2013. In 2017, the PCPCH program changed to include a five-star rating level. This changed the measure to use a weighted methodology to ensure members are not just enrolled in a PCPCH, but are enrolled in PCPCHs with higher star ratings, hence the rapid decline in 2017.

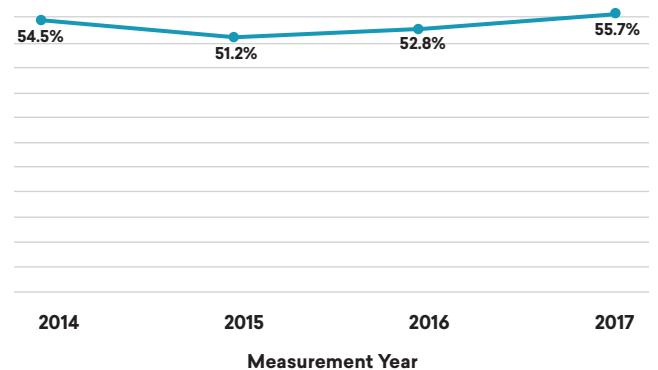
Colorectal Cancer Screenings

Consistently meets benchmark



People who develop colorectal cancer have relatively high survival rates due, in part, to concerted efforts to increase routine screening, which is key to early diagnosis and initiation of treatment. Health Share has remained consistent on performance for this measure.

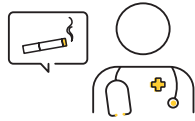
Colorectal Cancer Screenings



Measures percent of adult members 50-75 years old who had appropriate screening for colorectal cancer. This measure was adopted in 2014.

Cigarette Smoking Prevalence

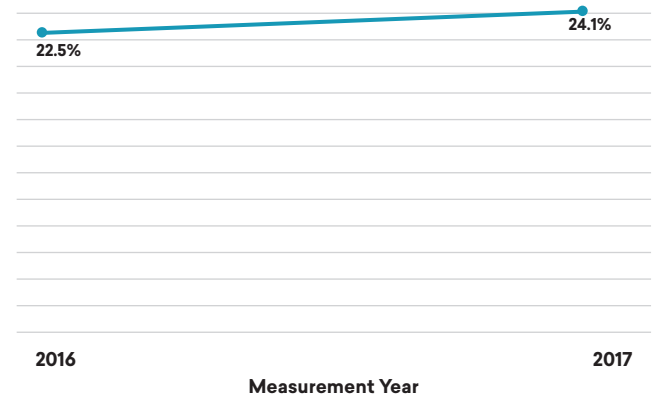
Consistently meets benchmark



New in 2016, cigarette smoking prevalence was the first population health-focused measure, capturing not just the offering of cessation benefits in primary care, but also tracking the outcome of actual tobacco use for a whole population.

Statewide data has shown higher rates of cigarette smoking among the Medicaid population compared to other insurance types. And even though tobacco prevalence increased between 2016 and 2017, Health Share remained below the 25 percent threshold for this measure in the first two years—allowing us to achieve the benchmark. **We still see a lot of opportunity to decrease prevalence of cigarette smoking, especially among adolescents, through targeted messaging, policy changes and engagement with our county public health partners.**

Cigarette Smoking Prevalence



Measures includes three weighted components, including meeting a cessation benefit requirement, reporting EHR-based prevalence data and reducing tobacco prevalence.

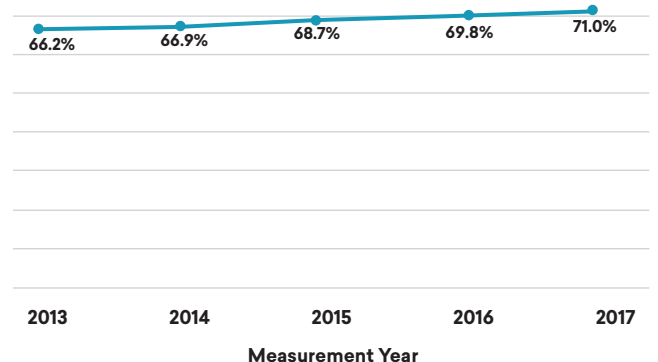
Hypertension Control

Consistently meets benchmark



Controlling hypertension decreases the risk of serious health problems like heart disease and stroke. It is also connected to many other metric-related conditions such as diabetes, colorectal cancer and cigarette smoking. Health Share has steadily increased performance among its members in controlling hypertension, consistently meeting the target for this measure over the years.

Hypertension Control

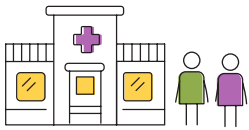


Measures percentage of adults 18-85 years old with a diagnosis of hypertension, whose condition was adequately controlled.

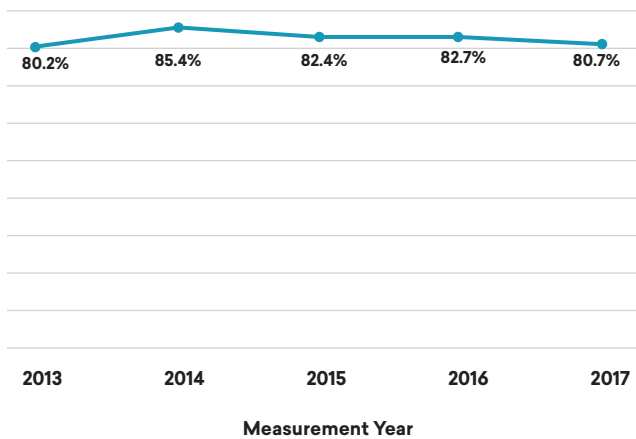
Consumer Assessment of Healthcare Providers & Systems

Each year, the Consumer Assessment of Healthcare Providers & Systems (CAHPS) survey asks consumers and patients to report on and evaluate their experience with health care, including access to and satisfaction with care.

Although Health Share and our partners strive for continuous improvement, there have been only mild upticks in performance in each measure over the past five years. That said, Health Share's decision to focus on access to care and eliminating health care disparities within our Ready + Resilient strategic initiatives is a critical step in the right direction. In addition, improving access to care leads to improved performance on other measures, as we ensure members get the right care, at the right place and at the right time for them.



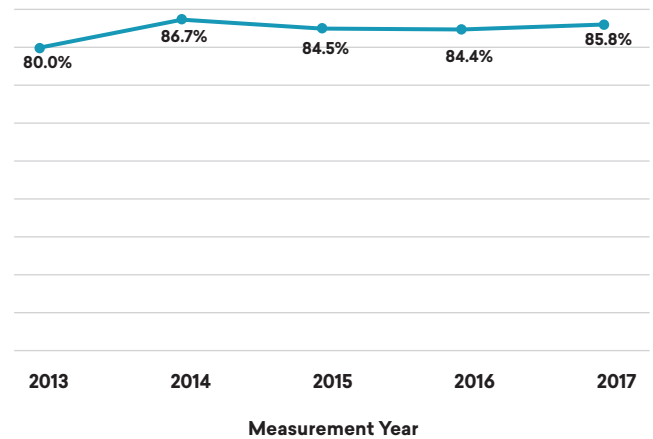
CAHPS—Access to Care



Measures percentage of members who thought they received appointments and care when they needed them.



CAHPS—Satisfaction with Care



Measures percentage of members who received needed information or help and thought they were treated with courtesy and respect by customer service staff.

Highlighted throughout these pages is a clear dedication to community partnerships, cross sector collaboration, and Health Share's overall vision of a healthy community for all. Without these coordinated efforts to transform the health and health care of the communities we serve, our performance on such measures would not be where it is today.

Looking forward to 2019 and beyond, we are confident in our abilities to continue these efforts, even as our landscape shifts with the introduction of new measures, a larger population, and the natural evolution of the coordinated care model.

We are grateful for each of our founding partner organizations and our many community partnerships for the dedication they bring to those they serve, as well as the overall community.

Founding Partners

ADVENTIST HEALTH
PORTLAND





Health Share of Oregon

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