The Power of Together

FIVE YEARS OF HEALTH TRANSFORMATION, 2012-2017

Five Years of Transformation

Over the past five years, there has been an impressive, transformative effort carried out within our health care system. We've seen our local communities come together to improve the health and health outcomes of Oregon Health Plan members, while simultaneously contributing cost savings to the system. Health Share has been at the center of it all, and our partners have done even more on their own to achieve Health Share's collective vision of a healthy community for all.

WE WORK WITH OUR COMMUNITY TO CONNECT OUR MEMBERS TO THE SERVICES THEY NEED TO BE HEALTHY.

203,399

MEMBERS SERVED IN CLACKAMAS, WASHINGTON, AND MULTNOMAH COUNTIES

AT HEALTH SHARE, WE BELIEVE

- member voice and experience are at the center of what we do
- health equity is achievable and requires deliberate action on our part
- in honoring our commitments
- using continuous improvement is vital to our efforts
- in operating transparently and using data to guide our work
- in working in partnership to maximize our resources

Advancing Our Vision — Strategically

To provide focus and direction for reshaping the delivery system and improving the health of our community, Health Share updates our core strategic goals regularly. Throughout Health Share's five-year history, our strategic goals evolved from building a foundation to seeing real results in better health, better care, and smarter spending.

Our next strategic plan will focus on three priorities, which you'll see highlighted in our work and our partners' work throughout the report: promote early life health, enhance behavioral health, and increase health equity.

FOUNDATIONAL BEGINNINGS | 2012-2014

Health Share 1.0 focused on building a foundation as well as outlining core transformation and strategic investment.

"What's transformative is to create something that doesn't exist."

— Health Share Board Member

ADMINISTRATIVE EFFICIENCIES

- IT/IS Infrastructure
- Provider Portal
- Centralized Benefits (i.e. NEMT)

COMMUNITY ENGAGEMENT

- Community Health Needs Assessment
- Community Health Improvement Plan
- Community Advisory Council

STRATEGIC INVESTMENT

- Data Analytics & Reporting
- Health Commons
- Quality Metrics
- Health Equity

TRANSFORMING CARE AT ITS CORE | 2014-2015

In 2014, Health Share committed resources to a body of work funded by a state transformation award.

"I want access to the services I need, from a perspective I can relate to, in a language I'm comfortable with, at a location I can get to."

— Health Share Member

BETTER HEALTH

- **Focus on prevention:** Early asthma interventions; primary care provider education on addictions
- **Improve delivery system improvement:** Project Nurture for pregnant women with addictions

BETTER CARE

- **Improve access & capacity:** Standardize transitions of care; PreManage for community providers
- **Promote system integrations:** Regional NEMT system; Project ECHO for telementoring in psychiatry and developmental pediatrics

SMARTER SPENDING

- **Address critical population needs:** System of care for high-utilizers and advanced primary care model
- **Redesign payment models:** Standardize outpatient mental health rates

HEALTHY COMMUNITIES, HEALTHY PEOPLE | 2015-2017

Health Share 2.0 prioritizes working within our community to connect our members to the services they need to be healthy. Together, they allow us to focus on upstream prevention, increase transparency, and improve health outcomes.

"Health doesn't just happen in the doctor's office — it starts in the community."

— Janet L. Meyer, CEO

ENHANCE CAPACITY & ACCESS

- Create sustainable infrastructure to support Community Health Workers and Peers, connecting underserved populations to health care and services
- Develop programs to leverage regional care systems to improve outcomes

PROMOTE EARLY LIFE HEALTH

- Reduce unintended pregnancies
- Improve screening and integrated services in maternity care
- Ensure children receive preventive services for kindergarten
- Coordinate support around children in foster care

Innovations in Care

To jump start our transformation work, the Centers for Medicare and Medicaid Innovation awarded Health Share a competitive $17.3 million Innovation Award grant in 2012. The Health Commons Grant included major components that we continue to prioritize past the conclusion of grant funds in 2015. Below are highlights from each initiative as they stand today.

STANDARD TRANSITIONS

- Created a regional standard set of discharge instructions for patients transitioning from a hospital to primary care
- All PCPs in Legacy, Multnomah, and Providence clinics receive the same discharge and follow-up information
- Currently undergoing revisions through a collaborative community process, maintaining a regional standard

HEALTH RESILIENCE PROGRAM

- Provides support to high-utilizers, helping address health literacy, psychosocial needs, and barriers to health
- Grew from 16 to 28 Health Resilience Specialists and expanded to Jackson, Columbia, and Clatsop counties
- New support dedicated to respiratory issues, substance use, and mental health support at Unity Center for Behavioral Health

NEW DIRECTIONS

- Provides short-term, intensive case coordination and outreach services to more than 400 high-utilizing ED patients annually at OHSU
- Grew from two to four full-time social work clinicians providing trauma-informed care with a "no wrong door" philosophy to address gaps in care

INTENSIVE TRANSITIONS TEAMS

- Provides transition support for patients who've had a psychiatric hospital admission
- Deploys crisis support specialists to meet patients at the hospital and follow their transition to outpatient care
- Expanded in Multnomah County, continues to operate in all three counties

CARE TRANSITION INNOVATION (C-TRAIN)

- Provides high-intensity support to high-utilizing patients discharged from OHSU and Legacy hospitals
- Transitions patients from inpatient to outpatient care, providing pharmacist support; links patients to resources to meet psychosocial needs
- Led to a new team at OHSU that supports people with substance use disorders, connecting patients to medication-assisted treatment and resources such as housing, primary care, and residential treatment upon discharge

TRI-COUNTY 911 SERVICE COORDINATION PROGRAM

- Provides intensive case management support to frequent 911 callers
- Expanded from four to seven full-time social work clinicians serving about 450 members annually
- Substantial return on investment: $887 saved per-member per-month with sustained savings after intervention

ED GUIDE PROGRAM

- Put traditional health workers (THWs) in EDs
- Helps patients without high acuity needs find the most appropriate place to get care
- Providence expanded this program from two to five hospitals

Nurturing a Stronger Workforce

Traditional Health Workers are a vital component of the health care system, offering members a wide array of services to complement in-clinic care, such as cultural and linguistic support, health and social service system navigation, and more. Health Share is currently supporting the following Traditional Health Workers through investments and workforce infrastructure:

COMMUNITY HEALTH WORKERS

INTEGRATION
Commission culturally specific community-based organizations to develop and expand Community Health Worker (CHW) programs

WORKFORCE DEVELOPMENT Provide group supervision, ongoing trainings, learning collaboratives, and an annual CHW conference

TECHNICAL ASSISTANCE
Assist community-based organizations in developing CHW programs and work with health systems on contracting and maximizing return

PEERS

INVEST
Invest resources to enhance the capacity for culturally-specific Peer Delivered Services

WORKGROUP
Convene a workgroup to address funding challenges and improve the system of care for Peer Delivered Services

DOULAS

WORKFORCE DEVELOPMENT
Reach communities of color to promote doula support and build workforce

BUILD RELATIONSHIPS
Improve relationships with maternity care teams to increase trust, connect with pregnant women, and facilitate payment

TRACK EXPERIENCES
Track doulas' and patients' experiences to inform future strategic investments in this workforce

A Seamless Path to Wellbeing

HEALTH SHARE PATHWAYS

Supporting care for recovery and wellbeing

Our mental and physical health plan partners agreed we needed to improve how we deliver mental health and substance use disorder services. The result is a single, regional system for behavioral health care called Health Share Pathways. By combining mental health and substance use services and breaking down geographical limitations between Clackamas, Multnomah, and Washington counties, our members can access seamless care wherever they live. In addition, providers now have a single contract and claims administrator for all behavioral health services.

HEALTH SHARE BRIDGE

Connecting information for better health

Health Share's analytics program is a trusted source for cross-system health information. Our new platform, Health Share Bridge, enhances access to information and allows for partners to gain insight into how health care and community support systems work together in our region, allowing for decisions based on clear data and best practices. These tools provide valuable information about: member demographics, per member per month spending, incentive metrics performance, patient risk stratification, and a summary of Health Share's activity in the four areas.

WHEELHOUSE

A new model of care for opioid use disorder treatment

Opioid use disorder is a local and national epidemic. Oregon has the second largest prescription opioid misuse rate in the nation, but rank second to last for getting people the care they need. To address this treatment gap, Health Share is funding a new model of care for opioid use disorder treatment, Wheelhouse. The model will be led by Central City Concern and CODA to increase access to Medication Assisted Treatment in Clackamas, Multnomah, and Washington counties, and ensure patients can move seamlessly across levels of care without disrupting access to treatment.

Beyond the Doctor's Office

To provide the best possible care for our members at a lower cost to the health care system, Health Share utilizes flexible service funds to promote creative, economical, and effective care delivery. Health Share partnered with Project Access NOW to provide real-time online ordering of a variety of flexible services for members. The system enables Health Share to track and administer flexible services on a member level.

Flexible services can be used for individual members, or for the benefit of the community, including:

TRAINING & EDUCATION
Classes to improve or manage health, like preparing healthy meals or diabetes self-management

SUPPORT GROUPS
Self-help or support groups such as post-partum depression programs or Weight Watchers

CARE COORDINATION
Care coordination, navigation, or case management activities

HOME IMPROVEMENT
Home or living environment items or improvements such as items to improve mobility, access, hygiene, or improvements to address a health condition (i.e. air conditioner, athletic shoes, or clothing)

TRANSPORTATION
Transportation not covered under State Plan benefits

COMMUNITY HEALTH PROGRAMS
Programs to improve community health such as farmers' markets in "food deserts"

HOUSING SUPPORTS
Supports related to social determinants of health such as shelter, utilities, and critical repairs

RESOURCE ASSISTANCE
Supplemental food or social resources such as referral to job training or social services

OTHER
Cell phone or gift cards to purchase supplies, exercise classes, or athletic shoe

COMMUNITY INVESTMENTS

$5.8 MILLION
2.0 STRATEGIC GOALS

$3.25 MILLION
STATE TRANSFORMATION GRANT PROJECTS

$2 MILLION
UNITY CENTER FOR BEHAVIORAL HEALTH

$1.6 MILLION
WHEELHOUSE

$225,000
PROJECT ACCESS NOW

$50,000
COMMUNITY HEALTH WORKER PILOTS

$50,000
COMMUNITY EVENT SPONSORSHIPS

FOUNDING PARTNERS

ADVENTIST HEALTH
CAREOREGON
CENTRAL CITY CONCERN
CLACKAMAS COUNTY
KAISER PERMANENTE
LEGACY HEALTH
MULTNOMAH COUNTY
OHSU
PROVIDENCE HEALTH & SERVICES
TUALITY HEALTH ALLIANCE
WASHINGTON COUNTY

Founding Partner Transformation Highlights

ADVENTIST HEALTH | CAREOREGON | CENTRAL CITY CONERN | HEALTH SHARE PATHWAYS: CLACKAMAS, MULTNOMAH, AND WASHINGTON COUNTIES | KAISER PERMANENTE | LEGACY HEALTH | OHSU | PROVIDENCE HEALTH & SERVICES | TUALITY HEALTH ALLIANCE

Adventist Health

PROVIDER PARTNER | 2,627 HEALTH SHARE MEMBERS SERVED

OUR MISSION

ADVENTIST HEALTH'S MISSION IS TO LIVE GOD'S LOVE BY INSPIRING HEALTH, WHOLENESS AND HOPE.

SUMMARY OF SERVICES

Adventist Health takes pride in serving as a health and wellness resource for their community. Their faith-based, not-for-profit network encourages a healthy lifestyle through preventive and health care services offered at their 302-bed medical center, 34 medical clinics and home care and hospice services. They primarily serve southeast Portland where over 50 percent of their patient population receive charity care or are Oregon Health Plan members.

COMMUNITY BENEFIT

Adventist Health is proud of their efforts to improve the overall health of their community, which for the last several years has centered on improved access to care, chronic illness and behavioral health issues.

Adventist Health Medical Group, a subsidiary division of Adventist Health Portland, employs about 176 providers—one-third of whom are primary care providers. In addition, 16 of their 34 clinics are PCPCHs, providing extended hours for advanced access, fully integrated specialty care and on-site behavioral health and care coordinators.

TRANSFORMATIVE INITIATIVES

In addition to improved access to care, Adventist Health's extensive community wellness programs and ongoing education efforts teach community members how to live well and maximize their health. This includes the LivingWell program which provides health education, exercise, stress reduction and nutrition programs. Adventist Health also has a strong focus on heart disease and stroke backed by their accredited chest pain center and stroke program.

PRIORITIES

- Access to care
- LivingWell program
- Chronic illness care & management
- Behavioral health issues
- Diabetes management

Adventist Health

TRANSFORMING HEALTH TOGETHER

HEALTH SHARE GOAL: PROMOTE EARLY LIFE HEALTH

SUPPORT TO CCC

Partner with five other health care organizations in Portland to invest $21.5 million in a partnership with Central City Concern to support affordable housing in east Portland

HEALTH SHARE GOAL: ENHANCE BEHAVIORAL HEALTH

UNITY CENTER

Founding partner of the Unity Center for Behavioral Health, an innovative mental health services center in Portland

IOP/PHP

Opening of an intensive residential outpatient psychiatric program to manage complex psychiatric patient re-entry to independent living and avoid inpatient admissions

HEALTH SHARE GOAL: INCREASE HEALTH EQUITY

RESILIENCE CENTER

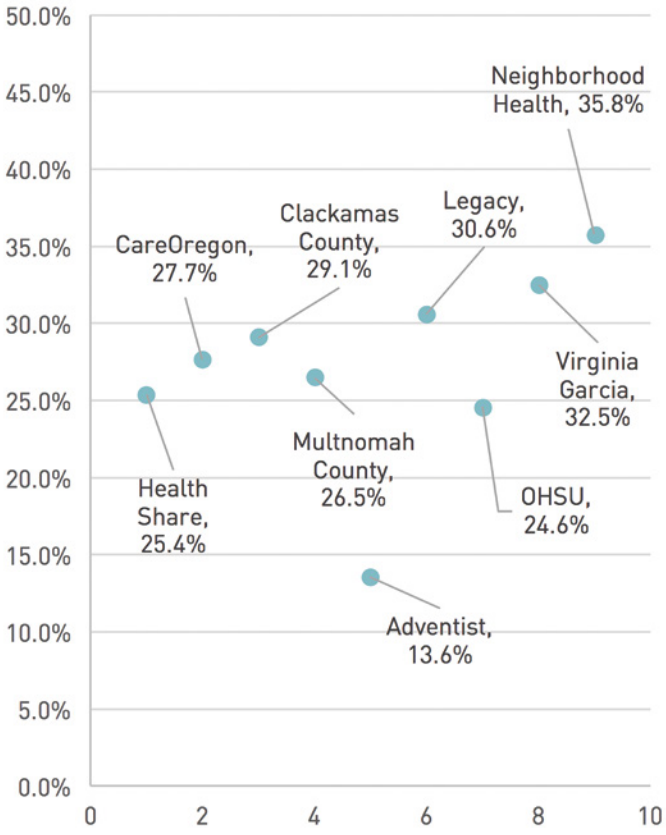
Intensive outpatient PCPCH designed to manage the high acuity population, reducing ED and inpatient admissions. Health care providers work together to augment traditional medical services with full spectrum social support including home visits

INITIATIVE HIGHLIGHT

Managing the health and education of their patients living with diabetes have been a key focus for Adventist Health. Their diabetes population health management efforts have revolved around three key areas:

- Educating patients about disease management and diabetes prevention
- Internal A1C reporting and targeted provider outreach
- Provider integration within the medical group

A1C CONTROL THROUGHOUT HEALTH SHARE OF OREGON



Dr. Leonard Bertheau, DO, serves as the Medical Director for Population Health Improvement and frequently assists other Health Share participants in developing focused initiatives to improve population health, especially related to diabetes management. As shown in the above graph, Adventist Health's A1C control performs well among Health Share partners.

CareOregon

HEALTH PLAN PARTNER | 117,883 HEALTH SHARE MEMBERS SERVED

OUR MISSION

CULTIVATING INDIVIDUAL WELL-BEING AND COMMUNITY HEALTH THROUGH SHARED LEARNING AND INNOVATION.

OUR VISION

HEALTHY COMMUNITIES FOR ALL INDIVIDUALS REGARDLESS OF INCOME OR SOCIAL CIRCUMSTANCES.

SUMMARY OF SERVICES

CareOregon has provided services to Oregon Health Plan members since 1994. CareOregon integrates physical, mental and dental health and addiction treatment, using both OHP-established benefits and flexible services.

COMMUNITY BENEFIT

To improve social determinants affecting members' lives, CareOregon makes substantial investments in local organizations that share its mission. In 2016, CareOregon's community benefit investments, and other grants and sponsorships exceeded $9.5 million. System investments for new services include Housing is Health, the Unity Center for Behavioral Health, the development of primary care infrastructure, and more.

TRANSFORMATIVE INITIATIVES

CareOregon has been supporting clinic efforts to improve care for many years, including transitioning from a fee-for-service funding model to whole-health funding. CareOregon's value-based payment program was collaboratively designed with clinics and has increased prevention, chronic illness management, and person-centered care.

PRIORITIES

- Improve the system of care to support high-risk/complex members
- Increase primary care capacity to deliver reliable, high-quality outcomes and access for members
- Integrate behavioral health services into primary care
- Integrate clinical oral and physcial health strategies

CareOregon®

TRANSFORMING HEALTH TOGETHER

HEALTH SHARE GOAL: PROMOTE EARLY LIFE HEALTH

PANEL COORDINATOR PROGRAM	Embed panel coordinators for proactive outreach to members to close gaps in care for adolescents and children
PRIMARY CARE PAYMENT MODEL	Develop and implement quality improvement-based incentive payment program improving health outcomes for 85% of CareOregon members

HEALTH SHARE GOAL: ENHANCE BEHAVIORAL HEALTH

OPIOID REDUCTION	Provider education, technical assistance, data and community collaboratives to increase capacity to address persistent pain
AMBULATORY ICU	Support Central City Concern in building a robust ambulatory ICU care model that provides behavioral and mental health support to complex members

HEALTH SHARE GOAL: INCREASE HEALTH EQUITY

ACE'S COMMUNITY LEARNING COHORT	Fund and facilitate community organizations focused on reducing the impact of ACEs and sharing best practices, such as trauma-informed care training
HEALTH RESILIENCE PROGRAM	Expand the reach of the program to provide trauma-informed support to highest-risk members

INITIATIVE HIGHLIGHT

Starting in 2008, CareOregon supported early development of integrated behavioral health in primary care among major delivery system partners. Since then, the evidence that integrated behavioral health improves outcomes, improves patient satisfaction, and reduces cost has only increased. In 2014, CareOregon launched a major expansion of integrated behavioral health services by recruiting health care practices who were already using the model, as well as practices who were ready, but hadn't yet implemented. Together, CareOregon and its partners provided grants, a learning collaborative, and one-on-one technical assistance to support 15 practices. In 2015, this was expanded to 40 practices that now serve 65 percent of CareOregon's member network. Today, the program is expanding to include specialty providers.

Photo credit: Curtis Peterson, Portland Business Journal.

CareOregon's behavioral health integration program supports behavioral health providers in more than 40 primary care clinics touching 65 percent of members.

Central City Concern

PROVIDER PARTNER | 2,199 HEALTH SHARE MEMBERS SERVED

OUR MISSION

PROVIDING COMPREHENSIVE SOLUTIONS TO ENDING HOMELESSNESS AND ACHIEVING SELF-SUFFICIENCY.

SUMMARY OF SERVICES

Central City Concern provides integrated services to help people who are experiencing or vulnerable to homelessness in the Portland area. These services include primary health care, mental health care, addictions treatment, sobering, sub-acute and recovery services, peer mentoring, supportive housing, recuperative care, employment services, expedited acquisition of benefits and entitlements, and a variety of specialized programs.

COMMUNITY BENEFIT

Over the past several years, Central City Concern has focused on expanding capacity, improving integration, responding to outcome and access disparities among several key, underserved communities, and refining its complex care model.

TRANSFORMATIVE INITIATIVES

Transformation initiatives benefiting members include expanding already successful programs such as the Old Town Clinic and Eastside Concern, establishing new sites and programs to meet the needs of underserved communities such as those offered through the Imani Center, developing complex care programs such as IHART, and much more

PRIORITIES

- Increase access
- Improve equity
- Enhance person- and community-focused services
- Become a higher performing organization
- Ensure sustainability and growth

CENTRAL CITY CONCERN

HOMES HEALTH JOBS

TRANSFORMING HEALTH TOGETHER

HEALTH SHARE GOAL: PROMOTE EARLY LIFE HEALTH

IHART TEAM
CCC's integrated mental health team, serving patients with serious mental illness and complex physical health conditions, combines patient-centered medical home concepts with trauma-informed care principles

EASTSIDE MAT1
Expansion of CCC's medication assisted treatment program (MAT) at Eastside Concern location, offers patients with opioid use disorders a blend of individual and group therapy and access to medication

WHEELHOUSE
In partnership with Health Share and CODA, Wheelhouse plans to bring MAT to clinics throughout the Tri-County area

HEALTH SHARE GOAL: INCREASE HEALTH EQUITY

SUMMIT
CCC's ambulatory intensive care unit, designed to improve health outcomes and access, as well as control cost of care for homeless patients and those at risk of homelessness

IMANI CENTER
CCC's African American behavioral health center, offering mental health and substance use disorder treatment in a trauma-informed, culturally specific environment

BUD CLARK CLINIC
CCC's shelter-based clinic, improving access and providing low-barrier acute services to homeless patients

INITIATIVE HIGHLIGHT

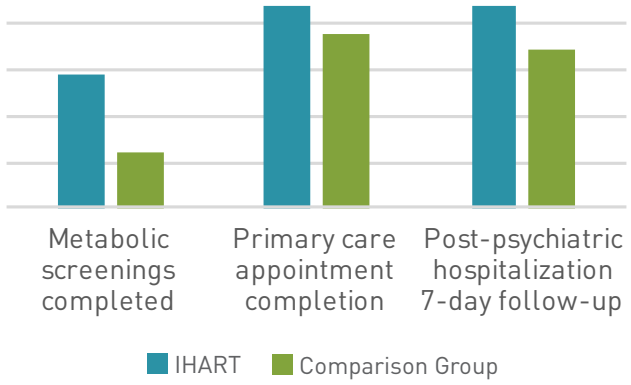
INTEGRATED HEALTH & RECOVERY TREATMENT

The Integrated Health and Recovery Treatment (IHART) team is Central City Concern's integrated program serving patients with serious mental illness and complex physical health conditions.

IHART employs best practices of team-based care, barrier-free access, population-based management, person-centered care, and data-driven care.

The program is embedded within Old Town Recovery Center /Old Town Clinic, and has been designed to improve patient experience, improve outcomes, and increase access to both primary and behavioral health. Merging the best practices from primary care and mental health, CCC has established a care team that provides psychiatric care, primary care coordination, mental health and substance use counseling, case management, health education, peer services, and housing and employment support.

IHART KEY PERFORMANCE METRICS



"This has been the most comprehensive and best coordinated interdisciplinary care I've received in the last 20 years, if not my life."

– IHART patient

Tyrone Rucker of CCC's IHART team confers with Nerissa Heller, CCC's Director of Intensive Substance Abuse Disorders Services, about a patient in need of housing.

Clackamas, Multnomah, and Washington Counties

CLACKAMAS 36,121 | MULTNOMAH 110,730 | WASHINGTON 56,547
TOTAL MEMBERS SERVED 203,398

OUR MISSION

CLACKAMAS, MULTNOMAH, AND WASHINGTON COUNTIES ARE WORKING TOGETHER TO ENHANCE AND MAINTAIN HIGH-QUALITY, ACCESSIBLE, AND CULTURALLY-APPROPRIATE SYSTEMS OF CARE FOR CHILDREN, YOUTH AND ADULTS WITH MENTAL ILLNESSES AND EMOTIONAL AND ADDICTIVE DISORDERS.

Clackamas County

Multnomah County

Washington County, Oregon

health share PATHWAYS

SUMMARY OF SERVICES

Together, Clackamas, Multnomah, and Washington counties form a regional behavioral health system of care. These three counties administer the behavioral health benefit for Health Share members, referred to as Health Share Pathways. This collaboration with Health Share leverages the collective resources of a regional CCO and three Local Mental Health Authorities.

COMMUNITY BENEFIT

The Tri-County partners serve people through prevention, early intervention, and safety net and crisis services. This benefits the community by providing different treatment options to meet individual needs.

TRANSFORMATIVE INITIATIVES

PREVENTION AND EARLY INTERVENTION

- Early childhood intervention
- Alcohol & drug prevention for children/young adults
- Mental health first aid for youth & adults
- Peer-delivered services

COMMUNITY-BASED TREATMENT

- Mental health and substance abuse outpatient services for children, adults, and families
- Early childhood mental health treatment
- School-based mental health services

INTENSIVE TREATMENT

- Youth and adult residential addiction treatment
- Housing for people who need detox services

SAFETY NET/CRISIS SERVICES

- Mobile crisis services
- Urgent walk-in care
- Locally-operated crisis lines available 24 hours a day, seven days a week

TRANSFORMING HEALTH TOGETHER

HEALTH SHARE GOAL: PROMOTE EARLY LIFE HEALTH

EARLY INTERVENTIONS

Intervene early with high-risk children and families by partnering with community organizations like LifeWork's Children's Relief Nursery, and implement the Nurse Family Partnership program.

HEALTH SHARE GOAL: ENHANCE BEHAVIORAL HEALTH

OUTCOME BASED CARE

Adopt outcome-based care that is person-centered, includes the voice of consumer and uses a treat-to-target approach.

COORDINATE W/ PUBLIC SAFETY & JUSTICE SYSTEM

Work with partners to help individuals experiencing mental illness avoid the criminal justice system and access appropriate care.

HEALTH SHARE GOAL: INCREASE HEALTH EQUITY

SCHOOL BASED CARE

Improve school-based mental health service delivery in communities of color.

PEER SERVICES

Increase access to peer-delivered services in which community members with lived experience support people recovering from addiction and mental illness.

PRIORITIES

- Integrate care by treating mental health, substance use, and other health services equitably in local communities
- Increase consumer & family voice
- Increase peer-delivered services
- Enhance the substance use disorder system of care
- Build wellness, prevention, and early intervention in the system
- Adopt a payment model that pays for outcomes rather than volume
- Increase equitable access to care
- Invest in culturally-specific services
- Increase access to health, supportive, and affordable housing
- Prevent suicide through the Zero Suicide initiative
- Work with providers to ensure a stable, competent workforce

INITIATIVE HIGHLIGHT

The Tri-County partners have been actively involved in several statewide efforts to improve behavioral health. This includes:

- Partnering in a demonstration project to better integrate care for people experiencing severe and persistent mental illness through Certified Community Behavioral Health Clinics
- Collaborating with the Oregon Health Authority, coordinated care organizations, and community providers to support people with severe and persistent mental illness to live in their communities and avoid unnecessary hospitalization and incarceration.
- Participating in the Oregon Health Authority's Behavioral Health Collaborative to promote better access, better care and better collaboration across systems.

Working together, across communities, the Tri-County partners help improve behavioral health care for the OHP population.

Kaiser Permanente

HEALTH PLAN PARTNER | 30,488 HEALTH SHARE MEMBERS SERVED

OUR MISSION

KAISER PERMANENTE EXISTS TO PROVIDE AFFORDABLE, HIGH QUALITY HEALTH CARE SERVICES TO IMPROVE THE HEALTH OF OUR MEMBERS AND COMMUNITIES WE SERVE.

SUMMARY OF SERVICES

For more than 60 years, Kaiser Permanente has provided high-quality health care, and is dedicated to improving the health of their members and the communities they serve.

COMMUNITY BENEFIT

Kaiser Permanente believes that good health starts where we live, work and play. In 2014, Kaiser Permanente's contributions to their Northwest region totaled $120 million, and included investments in care for low-income people, safety-net partnerships, community health initiatives, research and education, and community engagement.

TRANSFORMATIVE INITIATIVES

Access to Care: Increase the number of low-income and underserved individuals in communities served who receive the right care, at the right times, in the right setting, from a diverse workforce that meets their needs.

Behavioral Health: Improve the behavioral health and resiliency in communities through trauma sensitive systems of care and prevention efforts, and integrate physical and behavioral health care in clinical and community settings.

Chronic Disease Management: Improve health and prevent chronic disease in populations with disparate health outcomes by focusing on community-based prevention and empowering individuals and families to prevent, manage and treat their chronic diseases.

Economic Opportunity: Increase economic opportunity for vulnerable populations in served areas with a focus on educational attainment, skilled employment, and stable housing.

Oral Health: Improve the quality and access to affordable, integrated oral health care in community and clinical settings.

PRIORITIES

- Access to Care
- Behavioral Health
- Chronic Disease Management
- Economic Opportunity
- Oral Health

KAISER PERMANENTE®

TRANSFORMING HEALTH TOGETHER

HEALTH SHARE GOAL: PROMOTE EARLY LIFE HEALTH

EARLY LIFE HEALTH WORK	School-based health centers; team-based care for complex pediatric patients
EXERCISE AS A VITAL SIGN	Address exercise habits at each visit, connect high-risk kids with exercise forms of interest via flex funds.

HEALTH SHARE GOAL: ENHANCE BEHAVIORAL HEALTH

BEHAVIORAL HEALTH WORK	Integrate behavioral health in primary care; depression case management; physician support tools for screening, brief intervention and referral to treatment

HEALTH SHARE GOAL: INCREASE HEALTH EQUITY

HEALTH EQUITY WORK	Culturally-specific community health workers; Spanish-speaking navigators; decrease disparity gap for blood pressure

INITIATIVE HIGHLIGHT

WARRIORS OF WELLNESS

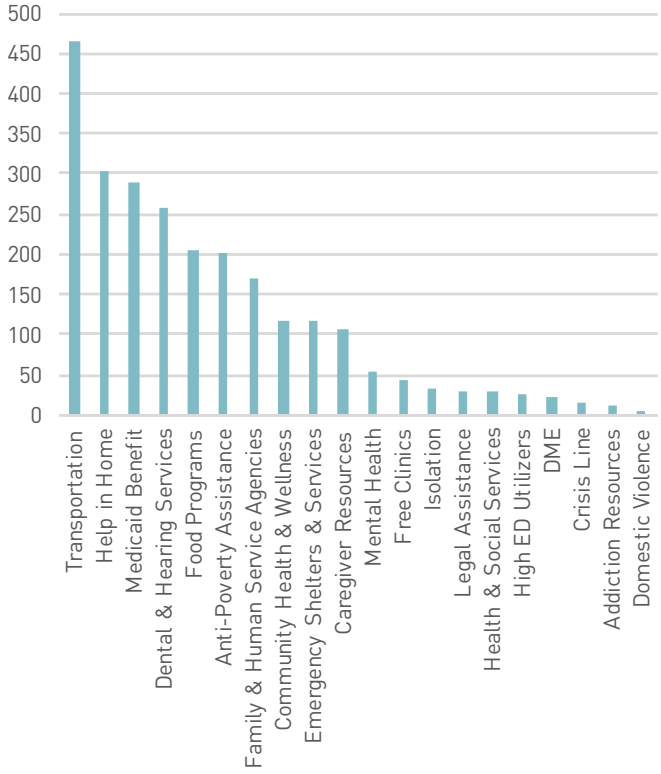
Community health workers help people understand and use health services. They bring people together to identify and address community health needs. Kaiser Permanente supports the Warriors of Wellness (WOW) project, which connects culturally specific community health workers from Portland's communities of color with health care organizations and clinics.

WOW community health workers serve people through groups, home visits, community events, and one-on-one support. People who receive intensive support reported significant improvements in their physical and emotional health and their sense of empowerment.

HEALTH CONNECT

Kaiser's Community Health Navigators support members' non-medical needs by connecting them to community resources. They use their EHR system, Health Connect, to code and capture these needs and track how they can help address them. Ultimately, they will use this data to track utilization, such as Emergency Department visits. See the chart below for more insight into this data.

TOP RESOURCES IDENTIFIED TO ADDRESS SOCIAL NEEDS



Based on referrals from August 2016 through December 2016. (Transport and Help in Home disproportionately high due to initial focus on 65+ population.)

Legacy Health

PROVIDER PARTNER | 8,182 HEALTH SHARE MEMBERS SERVED

OUR MISSION

OUR LEGACY IS GOOD HEALTH FOR:

OUR PEOPLE
OUR PATIENTS
OUR COMMUNITIES
OUR WORLD

ABOVE ALL, WE WILL DO THE RIGHT THING.

SUMMARY OF SERVICES

Legacy Health is a locally owned non-profit organization well known for its integrated system of hospitals, clinics, and complete medical care, including a specialized children's hospital.

COMMUNITY BENEFIT

In 2016, Legacy Health delivered $320 million in community benefit, including uncompensated care to under- and uninsured patients; charitable donations and grants to nonprofit community partners and safety net clinics; and in-kind and other donations and services to support marginalized communities and those who lack access to health care.

TRANSFORMATIVE INITIATIVES

In addition to community benefits, Legacy Health joined other health care systems in 2016 to support the Housing is Health Initiative, giving a combined $21.5 million in support to Central City Concern to add 380 new beds for Portland's homeless community. This follows on Legacy's ongoing collaborative work to address the needs of marginalized and uninsured communities through such activities as Project Access NOW and the Healthy Columbia Willamette Collaborative.

PRIORITIES

- Access to health care among marginalized populations with disparate health outcomes
- Chronic disease management
- Behavioral health, health literacy, and care and support for children

LEGACY HEALTH

TRANSFORMING HEALTH TOGETHER

HEALTH SHARE GOAL: PROMOTE EARLY LIFE HEALTH

LEGACY TRAUMA NURSES TALK TOUGH	Reach 56,000 people each year with injury prevention efforts, part of Legacy's larger safety initiatives

HEALTH SHARE GOAL: ENHANCE BEHAVIORAL HEALTH

UNITY CENTER	Psychiatric emergency room and inpatient services collaboration among four health systems

HEALTH SHARE GOAL: INCREASE HEALTH EQUITY

SPANISH-SPEAKING OUTREACH	Since 1998, have awarded 47 grants totaling more than $8 million to promote access to health care in our communities
PROJECT ACCESS NOW	Provide access to specialty care for the uninsured; help sign up people for health insurance; help low-income families pay health insurance premiums
HEALTHY COLUMBIA WILLAMETTE COLLABORATIVE	Data-gathering collaborative to inform Community Health Needs Assessments and Community Health Improvement Plans among health care, public health and CCOs

INITIATIVE HIGHLIGHT

Collaboration is the watchword for Portland health care organizations, showing a level of cooperation that is uncommon or completely absent in other large American cities.

For example, in Portland, we've collaborated in various way to impact our communities for the better:

- With Adventist Health, Kaiser Permanente and OHSU, Legacy Health launched the Unity Center for Behavioral Health, an innovative patient-centered care environment for adults and adolescents experiencing a mental or behavioral health crisis.
- Legacy continues to offer major support to Project Access NOW. In its tenth year, PANOW coordinates specialty medical care for the uninsured. And since the ACA launched, PANOW has helped sign up more than 25,000 individuals for health insurance.

On its own, Legacy also has coordinated an annual Health Literacy Conference. Now in its sixth year, the conference has drawn more than 2,200 participants, encouraging the use of plain language in health care so people have a better understanding of how to improve and maintain their health.

Unity Center for Behavioral Health, which opened in January 2017.

Legacy Health's annual Health Literacy Conference, now in its sixth year.

Oregon Health & Science University

PROVIDER PARTNER | 11,224 HEALTH SHARE MEMBERS SERVED

OUR MISSION

AS PART OF ITS MULTIFACETED PUBLIC MISSION, OHSU STRIVES FOR EXCELLENCE IN EDUCATION, RESEARCH AND SCHOLARSHIP, CLINICAL PRACTICE AND COMMUNITY SERVICE. THROUGH ITS DYNAMIC INTERDISCIPLINARY ENVIRONMENT, OHSU STIMULATES THE SPIRIT OF INQUIRY, INITIATIVE, AND COOPERATION AMONG STUDENTS, FACULTY AND STAFF.

SUMMARY OF SERVICES

OHSU is Oregon's only public academic health center, training doctors, dentists, nurses, pharmacists and advanced care professionals crucial to the health care of Oregonians. Today, their public commitment extends beyond formal education. OHSU and its 15,500 employees engage communities, providing personal health education, care access for underserved populations, community-focused health research and support other health advocacy groups.

COMMUNITY BENEFIT

OHSU provided $368 million in community benefit for the 2015-2016 fiscal year. An important part of this benefit is directly funded by revenues from our hospitals and clinics, which this year equaled $90 million directly to research and education programs. This significantly reduces the level of state taxpayer support otherwise required to provide these services.

TRANSFORMATIVE INITIATIVES

Through multiple efforts, OHSU is focused on preventable injuries in children, comprehensive care for people facing mental health crisis, and public health, including addressing social determinants of health, in order to improve the health of the population they serve.

PRIORITIES

- Doernbecher Hospital's Tom Sargent Safety Center
- Unity Center for Behavioral Health
- OHSU-PSU School of Public Health

OREGON HEALTH & SCIENCE UNIVERSITY

TRANSFORMING HEALTH TOGETHER

HEALTH SHARE GOAL: PROMOTE EARLY LIFE HEALTH

TOM SARGENT SAFETY CENTER

Dedicated to reducing preventable injuries in children throughout the Pacific Northwest through public and professional education and training; access to low-cost safety supplies and resources; encouraging providers, families and community leaders to get involved in finding ways to reduce injury; supporting safety-related advocacy in the Pacific Northwest

HEALTH SHARE GOAL: ENHANCE BEHAVIORAL HEALTH

UNITY CENTER

OHSU is a partner in the area's first comprehensive care center for people facing mental health crisis, the Unity Center for Behavioral Health. The Unity Center is expected to be a national model for providing compassionate mental health care in times of need

HEALTH SHARE GOAL: INCREASE HEALTH EQUITY

OHSU-PSU SCHOOL OF PUBLIC HEALTH

The mission of the School of Public Health is to prepare a public health workforce, create new knowledge, address social determinants, and lead in the implementation of new approaches and policies to improve the health of populations.

INITIATIVE HIGHLIGHT

OHSU ECHO enhances the ability of primary care physicians to treat chronic and complex illnesses in their hometown clinic and increases patient access to care.

OSHU ECHO connects primary care providers with OHSU specialists for live, weekly video teleconferences. These one-hour virtual clinics give primary care physicians real-time reviews of complex cases. OHSU specialists provide written treatment recommendations.

OHSU's first ECHO initiative, a Psychiatric Medication Management pilot program, was launched in September 2014 in conjunction with and support from Health Share. OHSU ECHO has since expanded to include Addiction Medicine and Team-Based Care.

OHSU specialists providing real-time support through Project Echo.

Project ECHO participants joining by video teleconference.

Providence Health & Services

HEALTH PLAN PARTNER | 35,254 HEALTH SHARE MEMBERS COVERED
PROVIDER PARTNER | 28,600 MEMBERS SERVED IN PRIMARY CARE

OUR MISSION

AS PEOPLE OF PROVIDENCE WE REVEAL GOD'S LOVE FOR ALL, ESPECIALLY THE POOR AND VULNERABLE, THROUGH OUR COMPASSIONATE SERVICE.

SUMMARY OF SERVICES

Providence is focused on population health—improving the overall health and wellbeing of the communities they serve. Across their continuum of services, they continue to adopt integrated care models and co-located services to provide a connected experience of care built on a foundation of clinical excellence.

- Eight hospitals, located in communities from the Columbia Gorge to Southern Oregon
- Providence Medical Group, with more than 90 clinics offering patient-centered primary care and specialty care.
- Providence Health Plan, offering insurance options for individuals and families.
- Specialty programs and services offering internationally recognized clinical care.

COMMUNITY BENEFIT

Continuing a history of compassionate service, Providence reaches beyond the walls of their clinical settings to touch the lives of vulnerable individuals. They collaborate with local partners to assess community health needs and create solutions together. In the Portland area, Providence participates with the Healthy Columbia Willamette Collaborative to produce a shared community health assessment. In 2015, Providence invested more than $417.5 million in community benefit in Oregon.

PRIORITIES

- Providence's top priority health needs for 2017-2019, identified from their most recent community health needs assessment.
- Access to care: primary care, dental care, and culturally-responsive services.
- Behavioral health: mental health, substance use treatment, and adverse experience/trauma prevention.
- Chronic conditions: diabetes, hypertension, and obesity (particularly amongst youth).
- Social determinants of health: affordable housing, food access, living wage jobs, and transportation.

PROVIDENCE
Health & Services

TRANSFORMING HEALTH TOGETHER

HEALTH SHARE GOAL: PROMOTE EARLY LIFE HEALTH

HEALTHIER KIDS, TOGETHER

Partnering to initiate a range of programs promoting increased activity and improved nutrition, our Portland-area community partners in this work include:

American Diabetes Association, Zenger Farm, The FIT Project, Children First for Oregon, Self Enhancement Inc., Partners for a Hunger-Free Oregon, and Mental Health Association of Oregon.

HEALTH SHARE GOAL: ENHANCE BEHAVIORAL HEALTH

NAVIGATION AND SOCIAL SERVICES

Develop innovate models of care that respond to the diverse needs of communities, our Portland-area community partners in this work include:

Oregon Public Health Institute's BUILDing Health Equity in East Portland, Community Services Consortium, Oregon Community Health Worker Association. Providence also runs the Promotores program, led by lay Community Health Workers.

HEALTH SHARE GOAL: INCREASE HEALTH EQUITY

ACCESS TO COMMUNITY BASED SERVICES

Ensure there is timely access to community-based mental health and substance use service, our Portland-area community partners in this work include:

Central City Concern, Lifeworks NW, Mental Health Association of Oregon, Multnomah County/ Tri-County 911, NAMI Oregon, Clackamas County, Cascadia.

INITIATIVE HIGHLIGHT

PROVIDENCE MILWAUKIE HOSPITAL

Providence has supported Project Nurture, including providing funding and supervision for an integrated peer support specialist and trained doula through Mental Health Association of Oregon. This peer is embedded with the care team and provides support for mothers in recovery throughout their pregnancy and after delivery.

PROVIDENCE PORTLAND MEDICAL CENTER

Providence has partnered with Impact NW to co-locate their staff in the lobbies of some of the highest needs clinics in the state. This program has provided social service and resource connections for more than 2,000 patients and community members in Multnomah County.

PROVIDENCE ST. VINCENT MEDICAL CENTER

Providence supported Neighborhood Health Center's Tanasbourne location, which will provide integrated care for more than 6,000 individuals and is equipped with nine dental chairs.

PROVIDENCE WILLAMETTE FALLS MEDICAL CENTER

Providence continues to partner with The Canby Center to support Medical Teams International's mobile dental program, as well as Oregon City High School's Pioneer Pantry program, providing more than 3,500 nutritious weekend meals to homeless and food insecure youth at four high school locations in Oregon City. This program contributed to the successful graduation of 32 homeless youth in 2016.

Between their arrival at Fort Vancouver in 1856, and Mother Joseph's death in 1902, the Sisters of Providence established ministries in the Northwest at an amazing rate. Their tradition of compassionate service, especially for the poor and vulnerable, and dedication to community is carried on today by Providence caregivers.

Tuality Health Alliance

HEALTH PLAN PARTNER | 11,461 HEALTH SHARE MEMBERS SERVED

OUR MISSION

TUALITY HEALTH ALLIANCE IS COMMITTED TO IMPROVING OUTCOMES BY SERVING MEMBERS AND PROVIDERS WITHIN OUR COMMUNITY.

SUMMARY OF SERVICES

Tuality Health Alliance has been serving physicians, patients and community members in Washington County since 1994. They work closely with their providers and members, and strive to build strong community partnerships with non-profit and government bodies, to improve quality of care, access to care, and the overall health of the people they serve.

COMMUNITY BENEFIT

At Tuality, they believe that a community is about the people who live within it. They are proud to have a home in Washington County, and a team comprised of local people who care about the community we share. Tuality advocates for physicians who believe that working collaboratively improves access to care and lowers costs for the community overall, and that improving health outcomes goes well beyond excellence in care—it requires us to be active in community health outreach and involvement.

TRANSFORMATIVE INITIATIVES

Tuality Health Alliance has identified three health priorities to address, based on the most recent Community Health Needs Assessment cunducted by the Healthy Columbia Willamette Collaborative, including opioid prescribing and misuse, prenatal care, and mental health issues.

PRIORITIES

- Opioid prescribing and misuse
- Prenatal care
- Mental health

TualityHealthAlliance
The right care. Right here.

TRANSFORMING HEALTH TOGETHER

HEALTH SHARE GOAL: PROMOTE EARLY LIFE HEALTH

REACH OUT AND READ	Clinic encourages families to read aloud together by prescribing and giving them a book at each routine health check-up from infancy through 5-years
FIRST TOOTH TOOLKIT	Participated in Washington County Access to Integrated Care committee that developed toolkit for PCP clinics

HEALTH SHARE GOAL: ENHANCE BEHAVIORAL HEALTH

WASH. CO. MENTAL HEALTH & ADDICTIONS COLLABORATION	Meet monthly to collaborate services for high-risk and complex members who have physical and mental health needs
FOSTER CARE ADV. PRIMARY CARE COLLABORATIVE	Hillsboro Pediatric Clinic is currently participating in this collaborative

HEALTH SHARE GOAL: INCREASE HEALTH EQUITY

SPANISH-SPEAKING OUTREACH	Spanish-speaking community outreach specialists work directly with members. All of our member materials are in both English and Spanish

INITIATIVE HIGHLIGHT

POPULATION HEALTH – PREMANAGE

In 2016, Tuality Health Alliance contracted with Collective Medical Technologies to incorporate PreManage into the Medical Management Department. This tool is used to identify, in real-time, members with high-risk health conditions or behaviors, such as excessive ED use, members without a PCP, members using the ED for mental health needs, etc.

We work closely with Tuality clinics and providers to promote and incorporate PreManage into their own workflows, allowing them to provide better coordinated care while reducing unnecessary admissions, costs, and duplication of services.

Reach Out & Read®

where great stories begin™

Through the Reach Out & Read program, clinics "prescribe" reading to families and encourage them to read aloud to each other by giving them a book at each routine check-up.

"Progress is a nice word. But change is its motivator."

—ROBERT KENNEDY

health share

Health Share of Oregon

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