October 2025

Supporting Health for All through Reinvestment (SHARE)

Contents

This guidance will help coordinated care organizations (CCOs):

- Meet the SHARE requirements; and
- Report accurately on their SHARE spending to the Oregon Health Authority (OHA).

2025 changes to SHARE

These changes apply to 2025 SHARE investments and reporting (based on 2024 CCO financials). Details about each of the changes are provided later in this document.

- **Attestation** – CCOs will attest to meeting SHARE requirements instead of submitting a full spending plan to OHA for approval.

- **Eligibility** – CCOs may use SHARE dollars for activities supporting health care access and quality.
- **Set-aside** – CCOs may set aside up to 25% of their annual designation to allocate to partners (and report to OHA) within three years.
- **Carry-forward** – When a CCO spends more on SHARE than required for a given year, the CCO may count the extra amount toward a future year's SHARE requirement (within three years).
- **CCO public posting** – CCOs will publicly post information about their SHARE investments on their website.

SHARE overview

SHARE implements state legislation, is in Oregon Administrative Rule and CCO contract, applies to CCOs that exceed financial requirements[1] and is from excess end-of-year profits. The primary goals of SHARE are to:

- Protect public dollars by requiring that a portion of CCOs' profits[1] are reinvested in their communities; and
- Improve CCO member and community health by requiring reinvestments go toward social determinants of health and equity (SDOH-E; see domains below).

SHARE includes the following program requirements:

Requirement 1: Investments must address SDOH-E and include spending toward a statewide housing priority.
Requirement 2: A portion of funds must go to SDOH-E partners.
Requirement 3: Spending must align with priorities from community health improvement plans (CHPs).
Requirement 4: CCOs must provide a role for their community advisory councils (CACs) in spending decisions.

SHARE is just one-way CCOs respond to SDOH-E, health inequities and the social needs of their members and communities. OHA encourages CCOs to create a community investment strategy that meets their local community needs and braids multiple investments including SHARE.

[1] House Bill 4018 (2018) refers to "annual net income or reserves of the CCO that exceed the financial requirements specified in this paragraph…." This document uses the term "profits" as a shorthand equivalent to encompass the statutory terms.

SHARE requirement 1: Investments in SDOH-E

Per Exhibit K, Section 8 of the CCO contract and OAR 410-141-3735:

- SHARE spending must meet OHA's definition of SDOH-E and fall into one or more of five domains: economic stability, neighborhood and built environment, education, social and community health, and health care access and quality; and
- A portion of a CCO's SHARE spending must be spent on housing-related services and supports.

Definition of SDOH-E

OHA's SDOH-E definition encompasses three interrelated terms, as defined in OAR 410-141-3735.

- ✓ **Social determinants of health (SDOH):** The social, economic and environmental conditions in which people are born, grow, work, live and age, which are shaped by the social determinants of equity. These conditions significantly impact length and quality of life and contribute to health inequities.
- ✓ **Social determinants of equity (SDOE):** Systemic or structural factors that shape the distribution of the social determinants of health in communities. Examples include the distribution of money, power and resources at local, national and global levels; institutional bias; discrimination; racism and other factors.
- ✓ **Health-related social needs (HRSN):** An individual's social and economic barriers to health, such as housing instability or food insecurity.

See Appendix A for more SHARE-related definitions.

Five SDOH-E domains for SHARE spending

In addition to meeting the general definitions above, SHARE investments must address at least one of five domains of SDOH-E:

- **Economic stability** − Connecting people to essential resources and support to have a healthy life. This includes addressing basic needs like stable housing and food security, as well as support in accessing childcare and steady employment.
- **Neighborhood and built environment** − Improving the quality and safety of places where people live, work and spend time. This includes safe and accessible housing and buildings, clean air and water, access to healthy foods, parks and venues for physical activities, and reliable or public transportation.

- **Education** − Investing in long-term health and opportunity of communities and people by increasing access to quality learning and skill development, such as early intervention, preschool, reading support, high school graduation, health literacy and job training, including health care workforce education and training.
- **Social and community health** − Addressing how connected, supported and included people feel in their communities. This includes helping communities to create meaningful relationships, feel safe and participate fully in community life. Social and community health projects also focus on addressing discrimination, trauma, lack of support or social isolation that negatively impact health and well-being.
- **Health care access and quality** − Improving the connection between people's access to and understanding of health services and their health. This includes providing timely, effective, safe and people-centered care that is equitable, efficient and responsive to individual needs and preferences. This focus makes sure that services are based on the latest evidence; reduce barriers such as financial constraints, geographic limitations, workforce shortages including health care workforce education and training, and system-level barriers; and ensure care is accessible to all populations.

See Appendix B for a list of project ideas and prior CCO examples within each of the domains, including examples of using braided funding.

Statewide priority: Housing-related services and supports

The Oregon Health Policy Board identified housing-related services and supports as a statewide priority of SHARE spending. These are **services and supports that help people find and maintain stable and safe housing**.

SHARE projects may fund room and board as long as it's not a covered benefit for the population being served. SHARE dollars may **not** be spent on the health-related social needs housing supports that are covered benefits for OHP members who qualify under Oregon's 1115 Medicaid waiver or Substance Use Disorder 1115 waiver. See SHARE and health-related social needs (HRSN) benefits of this guidance document for more details.

Examples of projects addressing the housing requirement are in Appendix B, which includes a range of investment types from permanent supportive housing to temporary and emergency housing.

SHARE requirement 2: SDOH-E partners

CCOs' SHARE investments should support cross-sector partnerships with organizations already trusted in their communities to provide SDOH-E services and work for policy and systems change. OHA refers to these types of organizations as SDOH-E partners. Per Exhibit K, Section 8 (b) of the CCO contract and OAR 410-141-3735:

- A portion of SHARE dollars must go directly to SDOH-E partners.

As described in OAR 410-141-3735 (2) (g), an SDOH-E partner is:

A) A single organization, local government, one or more of the Nine Federally Recognized Tribes of Oregon, the Urban Indian Health Program, or a collaborative that

B) Delivers SDOH-E related services or programs, or supports policy and systems change, or both, within a CCO's service area.

SDOH-E partners include many types of organizations — partners that primarily address individual social needs, organizations that work for policy and systems change to address SDOH-E, and those that do both. Clinical partners who are addressing health disparities by improving health care access and quality are also considered SDOH-E partners for SHARE. Here are some examples of potential SDOH-E partners (this list does not include all possible partners who can receive SHARE funding):

- Nonprofit social and human service organizations
- Culturally specific organizations
- Local public health authorities
- Regional health equity coalitions
- Local government entities
- Local housing authorities
- Nine Federally Recognized Tribes of Oregon and the Urban Indian Health Program
- Educational services districts and school districts
- Early learning hubs
- Federally Qualified Health Centers
- Community mental health providers

The CCO must have a written agreement (for example, contract, memorandum of understanding or grant agreement) with each SDOH-E partner that defines the services to be provided and data collection methods.

If the written agreement is a subcontract as defined in the CCO contract, then it must also satisfy all requirements in Exhibit B, Part 4, Section 11 of the CCO contract. The CCO must include any subcontracts with SDOH-E partners in its next Subcontractor and Delegated Work Report submission to OHA.

SHARE requirement 3: Community health improvement plan alignment

SHARE spending must align with community priorities in the community health improvement plan. Per Exhibit K, Section 8 of the CCO contract and OAR 410-141-3735:

- ➢ SHARE spending priorities must be based on shared priorities from the community health improvement plans (CHPs) in a CCO's service area.

The CCO contract and OAR 410-141-3730 require CCOs to develop shared CHPs with local public health authorities, hospitals, other CCOs and any of the Nine Federally Recognized Tribes of Oregon in the CCO's service area. For more details, see the CHP webpage.

If a CCO's community doesn't have a fully shared CHP, the CCO must identify SHARE spending priorities by looking at how their CCO's CHP priorities align with the CHPs of community partners (including local public health, hospitals, Tribes and CCOs in the area). CCO priorities might be fully aligned with other CHPs in its service area, or alignment could be based on:

- **A common health outcome:** For example, a community priority is obesity, and the CCO's SHARE spending priority is food security to address obesity; or
- **A common priority population:** For example, the community priority is children, and the CCO's SHARE spending priority is stable housing for children and families.

SHARE spending should align with the CCO's most recent CHP at the time of SHARE attestation.

SHARE requirement 4: Community advisory council role

Each CCO has at least one community advisory council (CAC), which includes CCO consumer members and other community members who advise the CCO on how to improve health quality and services in their community. Per Exhibit K, Section 8 of the CCO contract and OAR 410-141-3735:

- ➢ The CCO must provide a role for its CAC in SHARE spending decisions.

The CAC role, along with CHP alignment, helps to ensure SHARE investments are meeting local community need. Below are some examples of what the CAC role could include, but this list is not comprehensive:

- The CAC identifies and/or approves SDOH-E priorities for SHARE that align with CHP priorities.

- The CAC develops a rubric to score SHARE proposals.
- The CAC (or a subset of its members) reviews SHARE proposals and makes recommendations to the CCO leadership or board.
- The CCO designates a portion of SHARE funding for the CAC to decide how to reinvest.
- The CAC designs the SHARE spending process, including plans for ongoing monitoring and evaluation.

For CAC resources, visit the CAC supports webpage.

SHARE minimum financial formula and obligation

A formula determines CCOs' required minimum SHARE obligation based on their prior calendar year financial reporting. CCOs will follow the instructions in the Exhibit L, Report L6.7 financial reporting template to apply this formula to their prior year financials and report their current year SHARE minimum obligation (cell G38) and designation (cell G40). The formula is in OAR 410-141-3735.

If a CCO does not exceed minimum financial reserve requirements,[2] they are not required to participate in SHARE.

The SHARE obligation shall equal or exceed the greater of:

- **A percentage of average adjusted net income** for the prior three calendar years on a sliding scale based on the CCO's risk-based capital (RBC) percentage at the end of the prior calendar year (but prior to the SHARE portion calculation):
    - 0% of adjusted net income at or below 300% RBC, grading up to 20% of adjusted net income at or above 500% RBC; or
- 10% of dividends recorded and/or similar payments to shareholders, including adjusted net income earned by capitated affiliates
    - Capitated affiliates' adjusted net income is calculated with respect to the capitated affiliates' lines of business under the CCO as reported to OHA through the CCO's financial statements under OAR 410-141-5015.
    - Dividends or similar payments solely designated to satisfy tax obligations of affiliates that arise on account of serving the CCO's Oregon Health Plan members

[2] 2019 legislation modified minimum financial standards for CCOs, over which a portion must be dedicated to SHARE, available in Senate Bill 1041, Section 57, 1(b).

shall be excluded, provided that the CCO provides documentation approved by OHA.

The formula and specifications are reflected in the Exhibit L template published to OHA's CCO Contract Forms page. See OAR 410-141-3735 for more details on the formula and its defined terms.

SHARE spending flexibilities

Three-year spend down

CCOs have three years to spend down each year's SHARE designation. That means CCOs report how they will spend the full funds on that year's attestation form, but they have three years to disburse the funds to the partners listed. CCOs may request a one-year extension (four years total).

Set-aside

A CCO may set aside up to 25% of their annual SHARE designation to allocate to partners (and report spending to OHA) within three years. CCOs will list the set-aside amount and percentage of total designation on the attestation form. In Exhibit L, Report 6.71, CCOs will list "set aside" in the partner spend-down table until the total amount has been allocated to a partner. Once allocated, CCOs will include the partner name(s) with allocated amounts.

Carry-forward

This flexibility will go into effect starting with CCOs' 2025 SHARE attestations (reflective of 2024 financials). When a CCO spends more on SHARE than required for a given year, the CCO may choose to count the extra investment toward a future year's SHARE requirement within three years. CCOs will list the carry-forward amount on the attestation form in the year it is being applied. The Exhibit L, Report 6.7, will be updated so CCOs can indicate that the excess amount will be carried forward, starting the three-year carry forward period.

SHARE and health-related social needs (HRSN) benefits

SHARE investments may not be used to pay for any Medicaid covered services or benefits. As part of Oregon's 1115 Medicaid waiver, the HRSN benefit includes housing, nutrition, and outreach and engagement services and related administrative costs as outlined in the CCO contract. The covered services will be implemented over 2022–2027 for eligible populations. Please refer to

the CCO contract documents and HRSN webpage for updates on HRSN benefit guidance, details on implementation timelines, eligible populations and covered services.

Since SHARE investments cannot support HRSN covered services, OHA advises CCOs to consider the following:

- Use SHARE investments to support populations who are not eligible for HRSN covered services.
- Invest in SDOH-E efforts that do not overlap with specific HRSN covered services.
- Braid SHARE funding and HRSN covered services to support the specific activities eligible through each funding stream to meet community needs. See examples of braided funding in Appendix B.

Spending exclusions for SHARE

In general, SHARE dollars may be spent in a variety of ways if they comply with the overall requirements in this guidance document, in rule and in CCO contract. Because these dollars are part of a CCO's annual net profits, they are not held to the same restrictions as the CCO's Medicaid global budget.

However, SHARE dollars **may not** be spent on:

- **Medicaid-covered benefits**[3] (a CCO may not count expenses that are factored into its global budget) including:
    - Any covered services or benefits in Oregon's 1115 Substance Use Disorder waiver (housing or employment supports for eligible members);
    - Any covered services or benefits in Oregon's 1115 Oregon Health Plan waiver, including HRSN covered services for eligible members;
- **General CCO operations**, administrative costs and activities that:
    - The CCO is required to perform under their contract with OHA for OHP Medicaid services, OHP State-funded service or OHP Basic Health Plan services. However, SHARE could be spent on provider education and training that supports improved health care access and quality.

[3] Medicaid-covered benefits do not qualify as SHARE spending, as they are already reported through existing financial reporting mechanisms. While certain Medicaid-covered benefits address an individual's social needs (for example, some behavioral health populations may be eligible for certain housing supportive services through Medicaid), these services are not eligible for SHARE spending.

    - Are necessary for regular business operations of the CCO and compliance with federal and state requirements.
- **Expenses that have been reported separately**, such as health-related services (HRS) or in lieu of services (ILOS) — CCOs may not double-count spending;
- **CCO marketing expenses**;
- **Political campaign contributions**; or
- **Advocacy specific to CCO operations and financing** (as opposed to advocacy for policy that advances SDOH-E objectives).

This list of exclusions is updated for 2025 to align with the new health care access and quality domain and federal and state requirements. CCOs are encouraged to contact OHA at Transformation.Center@odhsoha.oregon.gov with questions about allowed and disallowed uses of SHARE dollars prior to developing their spending plans. See the "Optional OHA feedback on SHARE project eligibility" section below.

See Appendix C for a checklist to help determine whether a project is eligible for SHARE spending.

SHARE reporting

CCOs are required to submit annual financial and attestation reports related to SHARE. Details and deadlines are listed in the table below and Appendix D: SHARE Timeline. The templates and form listed below are available on the CCO Contract Forms webpage and the SHARE webpage.

CCO deliverable	Description	Next due
SHARE Spend-Down Report Exhibit L, Report 6.71	Annual report of year-over-year spend-down of total SHARE funds and detailed spending per partner.	**June 30**; reporting on prior year (Jan–Dec) spending
CCO public posting: SHARE spending plan (Optional template**)**	Annual, retrospective report of CCO SHARE investments posted to the CCO's website. CCOs may choose format for report with minimum content requirements (see instructions below).	**June 30**; reporting on prior year investments (first posting in 2026)
SHARE Designation Exhibit L, Report 6.7	Annual report for CCO to identify its SHARE designation based on the prior year's financials (the portion of net income/reserves the CCO will contribute to SHARE). This report also includes	**June 30**; based on prior year financials

	other related values, including: 1) annual risk-based capital prior to SHARE contribution; 2) annual pre-tax net income prior to SHARE contribution; and 3) dividends recorded.	
SHARE Spending Plan Attestation (Attestation template)	Annual attestation of meeting SHARE requirements in rule and CCO contract using attestation form provided. CCOs list partners, dollar amounts, project names, and activities/items being funded (see examples on the form). OHA will publicly post this information.	**December 31** for CCOs with a SHARE obligation (based on prior year financials)

Optional OHA feedback on SHARE project eligibility

CCOs may share project ideas with OHA for feedback on eligibility any time prior to submitting their attestations. This step is optional. To receive feedback on SHARE project ideas, please email project descriptions to Transformation.Center@odhsoha.oregon.gov and allow two weeks for response.

Changes to SHARE designations and plans

A CCO may not reduce their SHARE designation below their required minimum obligation (based on the formula described above). CCOs should honor their financial commitments to community partners through SHARE and consider the impact of a funding change before doing so.

If a CCO needs to change their total SHARE designation amount (and it is still above the required minimum amount); the partners they're funding; funding amounts per partner; or their funded projects, they must notify OHA of the change and resubmit their attestation form (or spending plan, if related to SHARE funding prior to 2025). CCOs don't need to notify OHA about changes to project activities. For changes to 2025 plans (and beyond), CCOs must also update their publicly posted SHARE spending plan to reflect the changes. OHA will work with the CCO to establish a timeline for implementing and documenting needed changes.

CCO public posting instructions

By June 30 of each year (beginning in 2026), CCOs will publicly post information about the investments from their prior year's SHARE attestation on the CCO's website. OHA will provide an optional template, but CCOs may choose a different format or include more information. At a minimum, public posting must include:

- CHP priority alignment with SHARE investments
- SDOH-E partner selection process

- SHARE investment descriptions (partner names, project activities and funding amounts)

If a CCO doesn't have a SHARE designation for a given year, they will be exempt from public posting requirements in the following June.

Program background

OHA developed SHARE to implement the requirements in Enrolled Oregon House Bill 4018 (2018) to address health disparities and the social determinants of health. CCOs first reported SHARE spending in 2021 based on 2020 profits.

These program requirements are informed by the Oregon Medicaid Advisory Committee's definition of social determinants of health and the Oregon Health Policy Board's CCO 2.0 policy recommendations. More guidance and definitions are in the 2025 CCO contract, OAR 410-141-3735 and on OHA's SHARE webpage.

Appendix A: Definitions

Community health improvement plan (CHP): Long-term, systematic efforts to address community health issues, needs and priorities based on the results of community health assessment (CHA) activities and the community health improvement plan process. Both CHAs and CHPs require significant partner and community engagement. Coordinated care organizations (CCOs) are required, per Oregon Revised Statue and CCO contract, to complete a CHP, based on a CHA, at least every five years. CCOs are also required to submit annual CHP progress reports to OHA.
Source: ORS 414.578

Health equity: When all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances. Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments, to address:

- The equitable distribution or redistributing of resources and power; and
- Recognizing, reconciling and rectifying historical and contemporary injustices.

Source: CCO contract, Exhibit A

Health-related services (HRS): HRS are non-covered services that complement covered benefits under Oregon's Medicaid State Plan to improve member and community health and well-being. HRS is optional for CCOs and may be available at the member and community levels. In January 2026, the HRS name will change to flexible services, but what CCOs are allowed to offer will not change.

Health-related social needs (HRSN): An individual's social and economic barriers to health, such as housing instability or food insecurity.
Source: OAR 410-141-3735

In lieu of services (ILOS): ILOS are services determined by the state to be medically appropriate and cost-effective substitutes for covered services or settings under the State Medicaid Plan. ILOS must meet requirements outlined in 42 CFR 438.3(e)(2). Coordinated care organizations (CCOs) are not required to offer ILOS to members. A member cannot be required to use the alternative service or setting.

Permanent supportive housing: Permanent supportive housing combines lease-based, affordable housing with tenancy supports and other voluntary services to more effectively serve the most vulnerable populations. This includes people who are houseless or at risk of becoming houseless and people who are institutionalized or at risk of institutionalization.

Permanent supportive housing generally refers to a specific building or site dedicated to providing deeply affordable housing paired with housing supports.
Source: Oregon's Statewide Housing Plan (2019-2023)

SDOH-E partner: A single organization, local government, one or more Nine Federally Recognized Tribes of Oregon, the Urban Indian Health Program, or a collaborative, that delivers social determinants of health and health equity (SDOH-E) related services or programs, or supports policy and systems change, or both, within a CCO's service area. Clinical partners who are addressing health disparities by improving health care access and quality are also considered SDOH-E partners for SHARE.
Source: OAR 410-141-3735

SHARE designation: The amount of funding a CCO chooses and reports as a contribution for SHARE initiative spending; designation amount must be at least the minimum SHARE obligation.

SHARE designation year: The year in which the CCO reports the SHARE designation amount to OHA (based on previous year's financials).

SHARE obligation: The amount of funding a CCO is required to contribute to the SHARE Initiative based on audited financials and the statutory required formula. The formula and specifications are reflected in the Exhibit L, Report L6.7 template published to OHA's CCO Contract Forms page. See OAR 410-141-3735 for more details on application of the formula and its defined terms.

Social determinants of health (SDOH): The social, economic and environmental conditions in which people are born, grow, work, live and age, which are shaped by the social determinants of equity. These conditions significantly impact length and quality of life and contribute to health inequities.
Source: OAR 410-141-3735

Social determinants of equity (SDOE): Systemic or structural factors that shape the distribution of the social determinants of health in communities. Examples include the distribution of money, power and resources at local, national and global levels; institutional bias; discrimination; racism and other factors.
Source: OAR 410-141-3735

Supported housing: Supported housing is permanent housing with tenancy rights and support services that enables people to attain and maintain integrated affordable housing. Support services offered to people living in supported housing are flexible and are available as needed and desired but are not mandated as a condition of obtaining tenancy. Tenants have a private and secure place to make their home, just like other members of the community, with the same

rights and responsibilities. Supported housing is scattered site housing. To be considered supported housing, for buildings with two or three units, no more than one unit may be used to provide supported housing for people with serious and persistent mental illness (SPMI) who are referred by OHA or its contractors, and for buildings or complexes with four or more units, no more than 25% of the units in a building or complex may be used to provide supported housing for people with SPMI who are referred by OHA or its contractors. Supported housing has no more than two people in a given apartment or house, with a private bedroom for each person. If two people are living together in an apartment or house, the individuals must be able to select their own roommates. Supported housing providers cannot reject individuals for placement due to history of medical or substance use disorder needs.
Source: CCO contract, Exhibit A

Supporting Health for All through Reinvestment (SHARE): The requirement, created through HB 4018, that CCOs invest a portion of profits back into communities to address health disparities and the social determinants of health.
Source: Oregon House Bill 4018 (2018)

Appendix B: SHARE project examples

Project ideas and prior CCO examples by social determinants of health and equity (SDOH-E) domain

The following project examples and partner types include some (but not all) of the ways CCOs may use SHARE funds for community investment. Other projects and partners that meet SHARE requirements are also eligible.

Economic stability

Connecting people to essential resources and support to have a healthy life. This includes addressing basic needs like stable housing and food security, as well as support in accessing childcare and steady employment.

- Train childcare teachers of children of domestic violence survivors
- Purchase mobile shower and laundry facility
- Develop an independent living curriculum for residents at a youth transitional housing facility
- Fund local food system resiliency efforts, including strategic planning, Farm to School implementation, nutrition education and supports for culturally specific food organizations
- Renovate a multi-service center for providing housing supports and services
- Pay for assistance and fees for obtaining personal identification documents to help people access housing, employment, education and other services
- Provide families with rental assistance, work clothing and financial literacy classes to remain housed and employed
- Provide childcare for families during community events
- Expand drop-in center's outreach and education on housing and stabilization supports

Neighborhood and build environment

Improving the quality and safety of places where people live, work and spend time. This includes safe and accessible housing and buildings, clean air and water, access to healthy foods, parks and venues for physical activities, and reliable or public transportation.

- Provide nutritious meals for homebound seniors and in congregate settings
- Implement Veggie Rx programs
- Purchase age-inclusive accessible playground equipment
- Build a commercial kitchen to provide shelf-stable, nutritious meals for community members

- Fund site and architecture planning for a community of small, affordable cottages
- Build an ADA-accessible wheelchair ramp to a community storefront that provides free clothes, furniture and household items
- Renovate and provide critical repairs to restore operations of a local fire department and public library
- Install signage in community parks that provide exercise prompts, tips on navigating unfamiliar areas and a map of accessibility features to encourage physical activity through the winter
- Buy transit passes for community members to access non-medical services and supports
- Install heating and air conditioning at daytime support shelter to ensure safe conditions

Education

Investing in long-term health and opportunity of communities and people by increasing access to quality learning and skill development, such as early intervention, preschool, reading support, high school graduation, health literacy and job training, including health care workforce education and training.

- Provide intergenerational youth enrichment activities
- Plan and construct a new schoolyard
- Support school districts to fund skills trainers and behavioral interventionists
- Launch a kindergarten readiness program for Black, African American, African immigrants and refugee children and families
- Expand parenting education and child development program to support American Indian and Alaska Native families
- Renovate classrooms, including ADA-accessible restrooms, at an early education center
- Buy equipment and educational and vocational materials for a technology room within a women and children's transitional housing facility
- Start a fast-track educational training program to address staffing shortages in early learning programs
- Fund a mentoring and tutoring program for individuals to achieve high school equivalency (GED)
- Fund a community book-gifting program that sends one age-appropriate book to children each month

Social and community health

Addressing how connected, supported and included people feel in their communities. This includes helping communities to create meaningful relationships, feel safe and participate fully in community life. Social and community health projects also focus on

addressing discrimination, trauma, lack of support or social isolation that negatively impact health and well-being.

- Fund staff time and training for traditional health worker and peer wellness support specialists for social service navigation
- Build capacity and develop workforce to provide social-emotional health resources for families and children
- Fund capital expenses for a community health worker community center
- Support capacity of a community center to increase frequency of social functions and reduce social isolation
- Provide socializing and peer-support group opportunities for older adults, individuals experiencing chronic pain, gender-specific support and individuals experiencing grief and loss
- Hire a cultural specialist to incorporate Chinuk WaWa language into public health programs
- Increase the capacity of respite care program for parents and caregivers through community engagement, marketing materials, volunteer procurement and training and other process materials

Health care quality and access

Improving the connection between people's access to and understanding of health services and their health. This includes providing timely, effective, safe and people-centered care that is equitable, efficient and responsive to individual needs and preferences. This focus makes sure that services are based on the latest evidence; reduce barriers such as financial constraints, geographic limitations, workforce shortages including health care workforce education and training, and system-level barriers; and ensure care is accessible to all populations.

- Fund recruitment, training and credentialing for health care interpreters
- Establish a centralized hub to support community-based organizations that employ community health workers in activity tracking, reporting and billing
- Construct a clinical simulation lab at a community college to improve capacity to deliver allied health education and training
- Purchase a mobile unit and supplies for a mobile dental clinic that provides preventive care and oral health education
- Provide cancer prevention classes in Spanish
- Fund construction for residential treatment center
- Fund trauma-informed renovations of an office providing behavioral health programs

- Provide childcare and housing supports for health care providers to address workforce shortages

Multiple domains

- Fund a medical legal partnership to support members with legal concerns related to housing, discrimination, immigration and other areas
- Fund community-based organization licenses and/or infrastructure to use community information exchange platform
- Aggregate and evaluate local health and community services data to inform local decision-makers and improve population health and equity
- Facilitate a series of workshops with HRSN housing providers to inform workflows and support smooth implementation of housing benefits
- Fund operational costs of an organization providing housing and wraparound support, including support securing employment, vocational trainings, behavioral health treatment and other supports to engage with the community
- Support management and administration of a new Recovery High School that brings evidence-based behavioral health services directly to students in recovery
- Hire specialized staff to support the efforts of multiple organizations providing shelter, housing and supportive services in data management and reporting across system
- Pay remaining mortgage to secure long-term availability of supportive transitional housing for individuals transitioning back into the community after incarceration or substance use treatment
- Fund community reintegration programs including support in job seeking, learning life skills, recovery support and securing permanent housing

Braided funding project examples

- With SHARE funds, build capacity of the local Healthy Homes program to implement social needs screening and increase bi-directional referrals through community information exchange. When social needs for participants are identified, HRSN or HRS at the member level are used to address qualifying member needs. SHARE funds will be used to provide Healthy Homes services to individuals not served by HRSN or HRS at the member level.
- With SHARE funds, support the local community action agency's rapid rehousing program by purchasing housing units that will be reserved for CCO members. Through HRS and HRSN, provide short-term rental assistance for CCO members housed in the units.
- With SHARE funds, buy kitchen equipment to expand existing meal service into medically tailored meals and provide training to support the HRSN nutrition workforce. HRS and HRSN will be used to provide medically tailored meals and other nutrition supports.

Housing project examples

Individual level

- Provide healthy homes assessments, repairs and enhancements for members with respiratory illness or mobility challenges to improve health and prevent falls, injuries or worsening of health conditions
- Provide navigation services, move-in and rental assistance for community members living with HIV and experiencing houselessness
- Fund daytime drop-in service center that provides first- and next-step housing conversations, emergency housing vouchers and help with rental and housing applications
- Provide homeownership trainings and support services for families with children
- Cover downpayment of a home to be used as transitional housing for recently arrived refugee families
- Certify instructors to provide trauma-informed tenant education courses in multiple languages to individuals and families facing housing instability

Community level

- Partner with local housing organizations and/or community-based organizations to combat discrimination in housing communities
- Create, convene and fund a regional housing coalition
- Construct ADA-accessible temporary housing units, including on-site showers, kitchen and laundry units
- Renovate a substance use treatment facility with on-site peer support social needs services
- Contribute to capital costs for permanent affording housing through land trusts and limited equity cooperatives
- Research and plan development of a transitional living program for youth
- Establish interoperability between a housing organization's case management software and community information exchange
- Fund a property manager to oversee a multiple room, single-occupancy permanent supportive housing facility for women
- Purchase and renovate an emergency, low-barrier substance housing facility for individuals on the waiting list for residential treatment or withdrawal management due to substance use
- Upgrade fire hall to provide temporary shelter to people affected by disasters and respite from extreme weather events

Appendix C: SHARE project eligibility checklist

To be eligible for SHARE spending, projects or activities must meet the following criteria. More details are available in the "Spending exclusions for SHARE" section of this guidance document. If you have questions, please email Transformation.Center@odhsoha.oregon.gov.

The project **WILL**:

- ☐ Address at least one domain of **social determinants of health and equity (SDOH-E)**: economic stability, neighborhood and built environment, education, social and community health, or health care access and quality. See Appendix B for examples of each of the domains.
- ☐ **Align with the CCO's community health improvement plan priorities**.
- ☐ **Address the statewide priority of housing-related services and supports**. If it does not address housing in some way, the CCO's SHARE spending plan must include at least one other project that does.
- ☐ Include a **role for the CCO's community advisory council** in selecting or approving the project.
- ☐ **Fund an SDOH-E partner**. If the dollars aren't going to an SDOH-E partner, the CCO's SHARE spending plan includes other projects with funds going to one or more SDOH-E partners.

The project will **NOT fund**:

- ☐ **Medicaid/Oregon Health Plan (OHP)-covered benefits** or the delivery of Medicaid/OHP-covered benefits. This includes the expanded covered benefits in Oregon's Substance Use Disorder (SUD) waiver (housing or employment supports for eligible members) or 1115 Medicaid waiver (health-related social needs services for eligible members).
- ☐ **Activities also submitted as health-related services (HRS)** or otherwise double-counted as other expenses.
- ☐ **General administrative costs** that are necessary for the regular business operations of the CCO, required under CCO contract, or are required for compliance with state or federal requirements.
- ☐ **Political campaign contributions**
- ☐ **Advocacy specific to CCO operations and financing**
- ☐ **CCO marketing expenses**

Appendix D: Timeline of SHARE planning, reporting and spending