TQS Submission 2024

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Project title: Expanding Integrated Behavioral Health Services

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project

If continued, insert unique project ID from OHA: #103

Components addressed

Component 1: Behavioral health integration
Component 2 (if applicable): Choose an item.
Component 3 (if applicable): Choose an item.
Does this include aspects of health information technology? ☐ Yes ☒ No
If this is a CLAS standards project, which standard does it primarily address? Choose an item

Project context:

Continued projects

1. **Progress to date (include CCO- or region-specific data and REALD & GI data for the project population):**

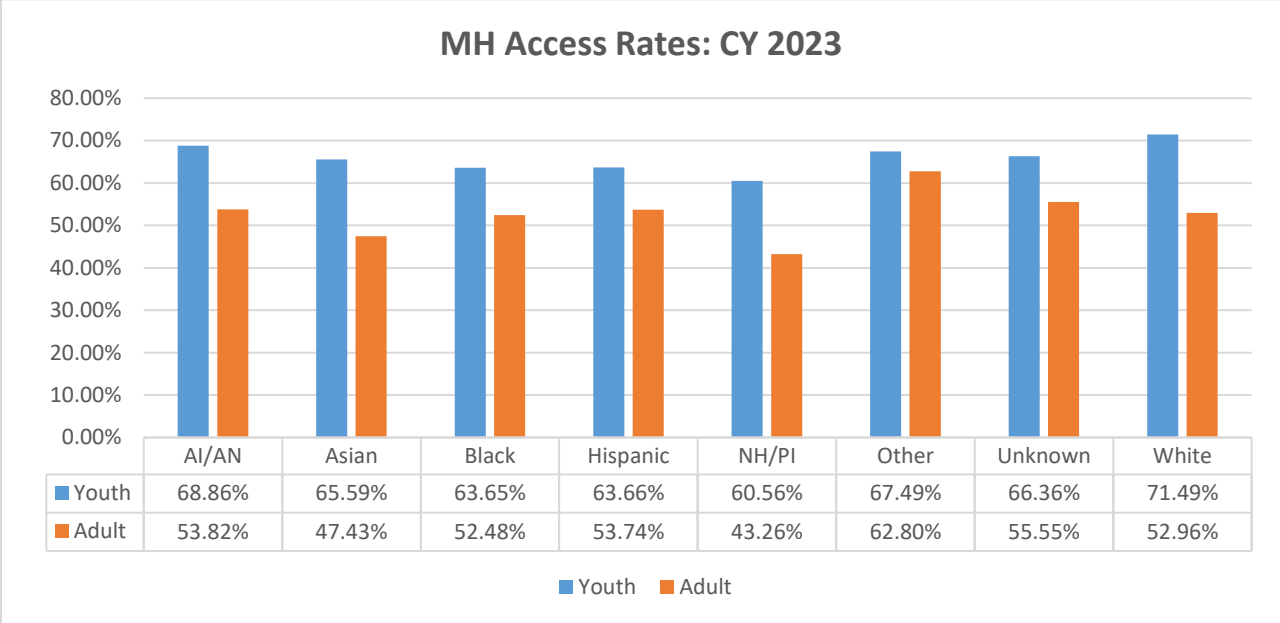
   In 2023, Health Share of Oregon engaged with its delegated physical health plans with the goal of improving the CCO's understanding of how and where behavioral health (BH) services are being provided in medical specialty settings. This exploratory process was initiated with the goal of developing strategies and recommendations to advance access and utilization of behavioral health services in medical specialty settings.

   Through the course of the project, Health Share identified that each individual medical specialty clinic uses unique processes and functions that structure their operations. Differences found across clinic settings has posed a challenge to creating uniform strategies and interventions, particularly when attempting to coordinate between the large and complex health systems in the metro-area.

   These challenges are further compounded by the lack of historical precedent for billing for behavioral health services that are delivered in medical specialty settings. Over the past year, Health Share conducted a review of behavioral health services in medical specialty settings and found that very few of these services are currently encountered.

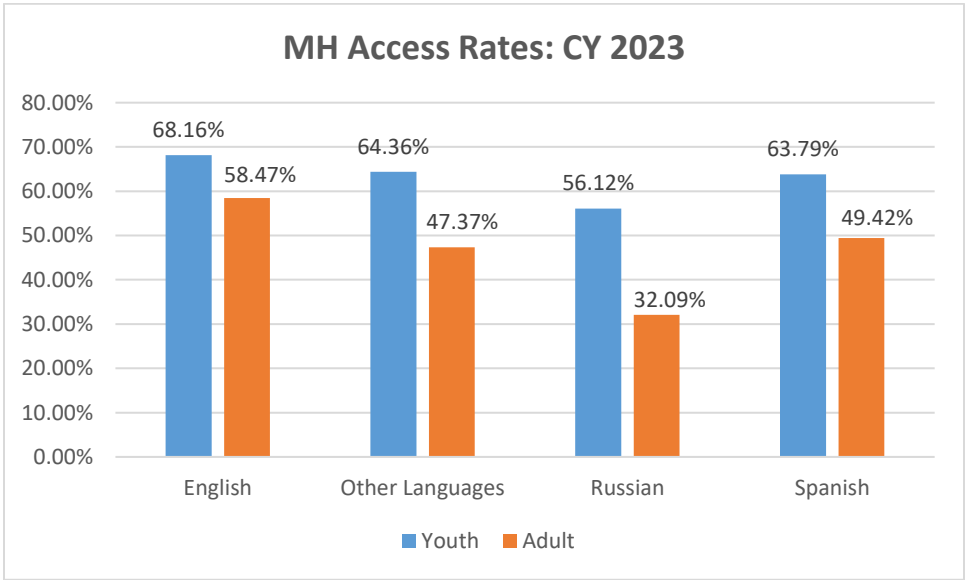
   The lack of documentation makes it difficult to determine the size and scope of financial support required to enhance behavioral health services in medical specialty settings. The Statewide Mental Health (MH) Access Performance Improvement Project (PIP) represents an excellent proxy for evaluating access to behavioral health service broadly. Data from the MH Access PIP data indicates that roughly four in ten Health Share members have an unmet behavioral health need. We believe this represents a clear need for improving access and availability of behavioral health services across settings. We also have strong evidence from our high-risk behavioral health analysis project that unmet behavioral health needs are a large driver of medical complications. This further underscores the need for behavioral health services to be increasingly available at multiple points of care.

   Health Share has used member-level data to analyze MH Access PIP rates by all REALD & gender identity (GI) aspects. While the most granular race/ethnicity and language categories have proven too small to yield statistically significant results, analysis comparing metric performance in CY 2023 shows that Native Hawaiian/Pacific Islanders have the lowest MH Access rate amongst both youth and adults:



	AI/AN	Asian	Black	Hispanic	NH/PI	Other	Unknown	White
Youth	68.86%	65.59%	63.65%	63.66%	60.56%	67.49%	66.36%	71.49%
Adult	53.82%	47.43%	52.48%	53.74%	43.26%	62.80%	55.55%	52.96%

Disparities have also been identified amongst Russian-speaking youth and adults:



No other disparities were identified. Currently, we do not include sexual orientation and gender identity (SOGI) data in our reporting. At this time, Health Share is exercising caution as it pertains to analysis and use of GI data. Our clinical partners have expressed concern around GI data collection and use, particularly for members under the age of 18. As such, Health Share has limited GI data exploration to targeted claims comparisons, missingness, analyses, and aggregation approaches. OHA has not yet made SO data available to CCOs, preventing any analysis on that dataset.

As anticipated encounters increase in medical specialty settings, Health Share will have greater ability to utilize SOGI data to identify potential inequities and engage plan partners in equity-driven interventions.

Health Share developed a $0.24 per member per month (PMPM) capitation to health plans for BH services in medical settings. This payment began on January 1, 2024, and equates to an approximate $1.2m yearly investment, which is significantly more than the total of existing encounters. The intention of this payment structure is to encourage growth in the provision and documentation of these services.

Social-Emotional Health Metric Activities

During the past year, Health Share continued to engage community partners in the development and implementation of strategies and interventions that connect young children with services and supports that address their social-emotional (SE) development. This includes working with physical and behavioral providers to increase access and availability of screening and early identification, assessment of social-emotional health and identification of potential delays, brief interventions, and referral to specialty treatment.

In 2023, Health Share hosted a series of learning collaboratives designed to enhance clinical capacity for providing social-emotional services and supports in primary care locations with integrated behavioral health. This work has been carried forward from previous years and is an ongoing response to community feedback emphasizing the importance of creating robust connections between physical and behavioral health. In total, 48 clinicians—representing a range of credentials—attend the learning collaborative. Participants included:

- 23 Licensed Clinical Social Workers
- 13 Qualified Mental Health Professionals
- 7 Doctors of Psychology
- 5 Licensed Professional Counselors
- 1 Licensed Marriage and Family Therapist
- 15 Clinicians with other credential types

2. **Describe whether last year's targets and benchmarks were met (if not, why):**

Monitoring Measure 1.1: Written reimbursement agreements for integrated behavioral health service in medical specialty setting exist between all our medical plan partners: This target was met.

Monitoring Measure 1.2: A minimum of two medical specialties begin payment project: This target was met.

Monitoring Measure 1.3: Establish utilization baselines of integrated behavioral health in specialty care: Health Share successfully developed a PMPM payment for BH services in specialty settings using available baseline information; however, more extensive data collection and analysis will be required to establish a comprehensive baseline.

Monitoring Measure 2.1: Assess capacity for integrated behavioral health services focused on addressing social emotional needs in primary care settings. This target was met and documented in the CCO's SE-Health asset map.

Monitoring Measure 2.2: Host learning collaborative to upskill integrated behavioral health in primary care to provide services to the birth-to-five population. This target was met.

3. **Lessons learned over the last year:**

   As noted in the project context portion of this document, there are very significant structural differences between medical specialty clinics (such as cardiology versus oncology versus dermatology, etc.). Further, some medical specialty clinics are independently operated and are not necessarily a part of a larger health system. This has led Health Share to attempt to focus its efforts in the area of Women's Health/OBGYN, while not necessarily limiting payment to just that setting.

Brief narrative description

Project population:
Any Health Share member being served through a medical specialty clinic with behavioral health needs.

Interventions:
Over the next year, Health Share will continue the Behavioral Health Expansion payment initiative and intends to complete the following activities:

i. A review and accounting of all BH services encountered in medical specialty settings since the beginning of the PMPM payment.
   a. While all medical specialty settings remain eligible, Health Share will be focusing on Women's Health/OBGYN clinics, as these settings have been consistently identified as a priority for improved access to behavioral health services.

ii. Revisit the PMPM payment for the 2025 budget year in order to ensure the current rate appropriately funds the desired services.

iii. Incorporate the BH in medical specialty encounter data into or alongside our existing BH in primary care dashboard and include data derived from the OHA's REALD and SOGI repository. This will allow Health Share to assess equity considerations and provide visibility into who is most likely to receive and benefit from these services.

iv. As part of Health Share's Action Plan for Social-Emotional Health, the CCO has allocated two years of funding to two culturally specific organizations: IRCO and Adelante Mujeres. This funding is intended to support the hire of Traditional Health Workers (THWs) that serve families with young children. The ultimate intent of this partnership is to explore avenues for THWs to deliver in-home social-emotional services to families and establish more robust pathways for reimbursement and monitoring.

Activities and monitoring for performance improvement

Activity 1 description: Development of integrated BH in medical specialty dashboard that can inform baseline utilization, as well as support for the ongoing payment rationale

☒ Short term or ☒ Long term

Monitoring measure 1.1	Develop baseline rate of services that is accessible via dashboard			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**

No dashboard exists	Dashboard provides reliable baseline on improved/increased encounter data	06/2025	To be developed based on baseline data	12/2025
Monitoring measure 1.2	Draft Dashboard is live on Health Share Bridge site and is accessible to all health plan partners			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No dashboard exists	Dashboard captures BH encounters from medical specialty settings	06/2025	Dashboard includes REALD and SOGI data summaries	12/2025

Activity 2 description: Development of enhanced payment model for integrated BH in medical specialty settings

☐ Short term or ☒ Long term

Monitoring measure 2.1	Analyze impact and sufficiency of current payment model			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Analysis of $0.24 PMPM has not been conducted	Conduct analysis to determine if current payment model needs enhancement(s)	01/2025	Update and enhance payment model as appropriate	01/2026

Project title: Increasing Meaningful Language Access

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project

If continued, insert unique project ID from OHA: #371

Components addressed

Component 1: CLAS standards
Component 2 (if applicable): Choose an item.
Component 3 (if applicable): Choose an item.
Does this include aspects of health information technology? ☐ Yes ☒ No
If this is a CLAS standards project, which standard does it primarily address? 5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services

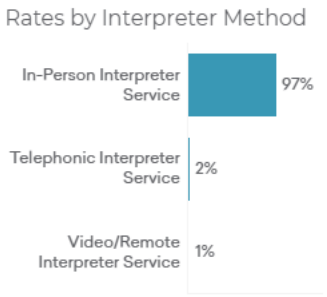
Project context:

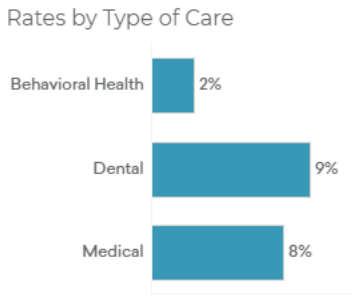
Continued projects

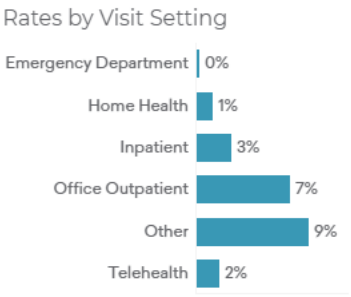
1. **Progress to date (include CCO- or region-specific data and REALD & GI data for the project population):**

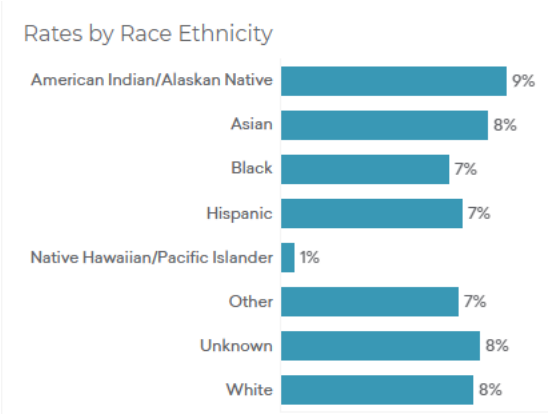
   In 2023, the Health Share of Oregon Bridge website was updated to include a Meaningful Language Access (MLA) Dashboard. This resource enables plan partners to monitor utilization of interpreter services and utilization of Oregon Certified interpreters across variables, such as time, location, enrollment, and REALD demographics. Over the course of the past year, this dashboard has become a critical component of the CCO's monitoring strategy (see screenshots below).

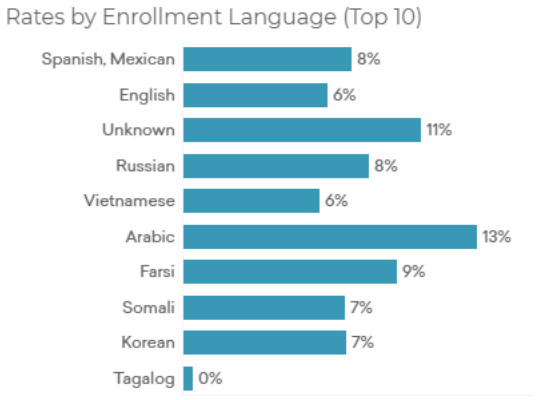
   Interpretation with Oregon Certified Qualified Interpreters

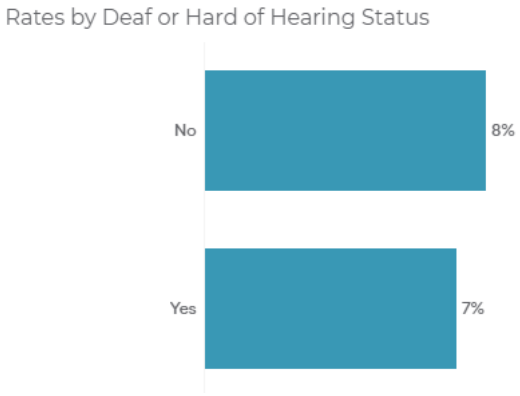


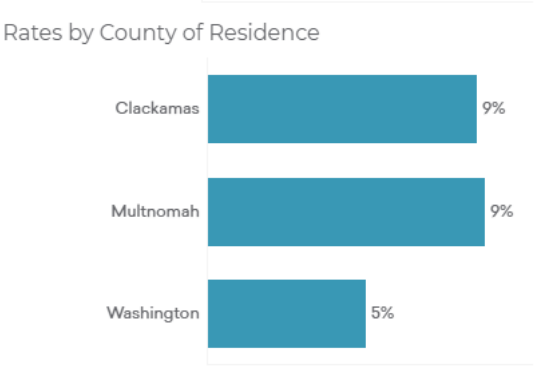












In 2023, Health Share members with an interpreter need made 148,065 visits to physical, behavioral, and oral health providers. In total, 7.7% of those visits had documentation of receiving services from Oregon Health Authority (OHA) Certified/Qualified interpreters. Health Share has analyzed interpreter rates by all REALD elements and identified notable disparities amongst the Native Hawaiian/Pacific Islander and Tagalog-speaking populations, with both populations receiving interpretation from certified/qualified interpreters at roughly 1%. Future work will be aimed at improving access and utilization of interpreter services for these populations.

At this time, Health Share is exercising caution as it pertains to analysis and use of sexual orientation and gender identity (SOGI) data. Our clinical partners have expressed concern around gender identity (GI) data collection and use, in particular for members under the age of 18 years. As such, Health Share has limited GI data exploration to targeted claims comparisons, missingness analyses, and aggregation approaches. While Health Share intends to incorporate analysis by sexual orientation (SO) in the future, the OHA has not yet made SO data available to CCOs, preventing any analysis on that dataset. Once available and standards for use of this data have been adopted, this data will be reviewed for disparities to aid with identifying specific populations that may need focused or modified support and integrated into the MLA dashboard.

During the past year, Health Share has leveraged the insights and expertise of the CCO's MLA Workgroup and Cultural Humility and Health Equity Workgroup (CHEW) to design and implement interventions that improve access to language assistance services. These workgroups are led by Health Share and comprised of plan partner and provider network representatives with extensive subject matter expertise. A summary of each group's respective scope is identified below.

MLA Workgroup Scope:

- Monitor collective performance on the results of the language access self-assessment.
- Inform Health Share's organizational strategy related to language access and access to services.
- Provide feedback regarding needed resources, investments, and data to support the delivery of equitable, accessible, and culturally specific language access services.
- Ensure the timely submission of interpretive services data to Health Share.
- Monitor and refine strategies to increase the percentage of interpretive services delivered by OHA-certified interpreters to Health Share members.
- Share and discuss best practices and promising practices pertaining to the delivery of language access services, as it related to the activities described in the self-assessment.

CHEW Scope:

- Collect and share baseline data or information through organizational assessment on current practices, policies, and procedures that impact cultural and linguistically appropriate services and health equity.
- Identify and align on priority areas for improvement and establishment of specific activities with measurable outcomes to achieve improvement over time.
- Promote shared agreement on mission, goals, and outcomes concerning cultural responsiveness and reduction of health inequities within Health Share affiliates and sub-contracted organizations.
- Promote and drive standardized improvement measurement, and participate in annual reporting requirements to ensure culturally and linguistically appropriate services are provided.
- Initiate and support implementation of tested initiatives or practices for continuous improvement.
- Assure Health Share's compliance with rules and regulations concerning culturally and linguistically appropriate care, and assure the promotion of health equity, including through its CCO contract with the Oregon Health Authority.

In 2023, the CHEW dedicated a portion of their meetings to aligning National CLAS Standards with our MLA incentive metric goals to provide recommendations that support the operationalization of National CLAS Standards across the CCO's network. This group worked to gather resources from their respective organizations and provided recommendations to support enhancements to governance policy guiding how Health Share and its partners ensure all members have access to culturally and linguistically appropriate services. As of July 1, the revised policy is undergoing final edits and is on track for approval by Health Share's governance prior to the end of the year.

The MLA Workgroup oversaw the process of administering a self-assessment to identify, established an MLA metric strategy, and ensured alignment with the specifications of the CCO Incentive Metric for MLA. These efforts included surveying partners to identify assets and barriers specific to each network which will continue to inform network specific and regional strategies.

Health Share has also been actively working with plan partners to identify activities, initiatives and investments that support improved access and capacity of culturally specific interpretation services. Notable activities from the past year include:

Workforce Expansion

- OHSU has expanded its centralized language services model across all partners. This initiative is supported by the addition of several full-time staff within OHSU Language Services, including interpreters, translators and dispatchers.
- Providence has hired additional bilingual staff and is compensating them to become certified for interpreter services.
- Legacy Health has sponsored a second cohort of Chuukese speakers to receive training and certification for healthcare interpretation.
- Kaiser Permanente Northwest (KPNW) has focused on hiring bilingual staff in key areas such as behavioral health and patient outreach.
- CareOregon added Adelante Mujeres to their network to bolster the availability of culturally specific providers serving children, youth, and families.

Development and Enhancement of Technology Supports

- OHSU implemented a new software tool, ServiceHub, that supports scheduling, reporting and optimization of interpreter services. This resource will help facilitate more efficient access to interpreter services by streamlining the process for requesting, assigning and documenting interpreter needs across the OHSU health system and network.
- Providence has convened a workgroup tasked with identifying opportunities for improvement in the documentation of interpreter service workflows in its Electronic Health Record (EHR) system. These efforts will support the efficient and effective provision of culturally and linguistically appropriate services.
- KPNW created an interpreter service documentation dashboard that is connected to their EHR. The dashboard enables KPNW to monitor interpreter rates across numerous variables. Ultimately, this tool will help support the identification of improvement opportunities and the monitoring of interventions.
- Legacy Health has ensured that video, in person and telephonic interpreter services are available to patients at all Legacy locations.
- CareOregon has developed workflows via Point Click Care to assist behavioral health providers identify members with interpreter needs.

2. **Describe whether last year's targets and benchmarks were met (if not, why):**

Monitoring measure 1.1: Update assessment of language access services available across Health Share's partners to establish baseline metrics and improvement plan. This target has been met.

Monitoring Measure 2.1: Complete development of MLA Dashboard. This target has been met. Plan partners can independently access this resource to monitor interpreter service performance.

Monitoring Measure 3.1: Create training and education activities specific to language access and implementation for better member experiences and outcomes across the network. This target has been partially met. The CHEW has hosted several trainings that have focused on health literacy and CLAS Standards. The group is in the process of updating and approving its charter to adopt a collaborative statement on CLAS.

Monitoring Measure 3.2: Leverage Health Equity Plan and MLA Self-Assessment to guide training. This measure has been partially met. Health Share accomplished revising its internal policy and will continue to engage community stakeholders to expand this resource.

Monitoring Measure 3.3: Develop internal training and learning collaborative model. This target has been met.

3. **Lessons learned over the last year:**

While there were many accomplishments in the past year, Health Share recognizes that successful implementation of the National CLAS Standards is dependent upon meaningful and sustained collaboration from providers and the community. The MLA incentive metric has proven particularly challenging, as providers continue to voice concerns relating to the resources required to monitor services in adherence to the metric requirements. These concerns are further compounded by questions regarding the accuracy and value of reporting structure, which strains partner engagement and lowers morale. Key areas to still sort out are how to continue to improve tracking of provided interpreter services, navigating the tension between the use of national interpreter services who are readily accessible but are not Oregon certified/qualified, and continuing to identify actual gaps in language services rather than data tracking gaps. Health Share will strive to promote member, interpreter, and provider voices on this subject moving forward.

Brief narrative description

Project population:
Health Share members with interpreter needs

Intervention (address each component attached):
Health Share of Oregon will continue to assess its organizational infrastructure, operations, policies, procedures, and practices to meet CLAS standards in health care. The primary activities for the upcoming year include:

- Revising Health Share's CLAS Policy "Serving A Culturally and Linguistically Diverse Membership" to incorporate National CLAS Standards. The CLAS Standards Blueprint will be used to guide this initiative.
- Developing a community engagement framework that informs the ongoing development of equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
- Developing a CLAS-specific standard culturally responsive training criteria and education opportunities in alignment with the Health Share Health Equity Plan training and education plan.
- Expanding engagement of community-based organizations to participate in future CHEW and MLA meetings. This will include, but is not limited to, organizations such as the Oregon Health Care Interpreter Association (OHCIA) to partner in evaluating and co-developing policies, practices, and strategic communication recommendations that support the operationalization of National CLAS Standards.

- Fostering collaboration between Health Share's Health Equity and Engagement Team (HEET) and Compliance and Delegation Team to provide recommendations for enhancing grievances and appeals processes/policies concerning language access and identifying any recurring problematic patterns.
- Continue to improve performance on the MLA metric.

Activities and monitoring for performance improvement

Activity 1 description: Develop a formal workplan based upon most recent self-assessment results.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Expand self-assessment review to include broader assessment of network compliance with National CLAS standards			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Review of 2023 assessment results and subsequent development of CLAS specific recommendations has not occurred	Written recommendations are developed and presented to relevant Health Share governance bodies	12/31/2024	Identify key areas of improvement with interpreter services to share with the workgroup (i.e. identify languages needed)	7/31/2025
Monitoring measure 1.2	Work with plan partners to document and review investments for MLA improvement			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Health Share has instituted a requirement that plan partners report on MLA efforts and investments as a condition to receiving incentive metric funds.	Partner efforts and investments are reported and assessed for impact and sustainability.	05/31/2025	Findings are incorporated into formal MLA improvement plan that is adopted across the network.	8/31/2025
Monitoring measure 1.3	Establish baseline understanding of plan partner interpreter workforce composition and availability			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Health Share has instituted a requirement that plan partners report on the number and type of OHA	Plan partner interpreter composition and availability is collected. Findings are assessed for	05/30/2025	Findings are incorporated into formal MLA improvement plan that is adopted across the network.	8/31/2025

certified/qualified interpreters in their respective networks. Completion of this report is a condition to receiving incentive metric funds.	adequacy and potential improvements.			

Activity 2 description: Alignment of priorities between MLA workgroup & CHEW

☒ Short term or ☒ Long term

Monitoring measure 2.1	Enhance alignment between MLA workgroup & CHEW priorities with OHCIA			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
MLA, CHEW and OHCIA are not deliberately aligned with regards to priorities and quality metrics	Established relationship with MLA, CHEW, and OHCIA to align priorities This will be measured by documentation of meaningful information sharing between groups	12/31/2024	Create a crosswalk between quality metric priorities and relevant policies and interventions	7/31/2025
Monitoring measure 2.2	Develop MLA communication strategy. Develop outreach/engagement opportunities to inform members of interpreter/translation services and how to access culturally and linguistically appropriate services providers - the plan is in ideation still with the CHEW			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
MLA communication strategy has not been developed. Members do not receive individualized information on interpreter services.	MLA communication plan developed and socialized through Health Share Governance Structure. Community-based organizations are given an opportunity to provide input/recommendations	12/31/2024	MLA communication plan formally approved and adopted. Information and materials are made available on the Health Share website and shared with community-based organizations	07/31/2025

Activity 3 description: Improve MLA reporting methods and data collection

☒ Short term or ☒ Long term

Monitoring measure 3.1	Percentage of members with interpreter needs receiving interpretation services from Oregon certified / qualified interpreter			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**

In 2023, 7% of visits by members with interpreter needs had documentation of interpreter services being provided by OHA certified or qualified interpreters	12% of members with interpreter needs have documentation of interpreter services being provided by OHA certified or qualified interpreters	12/31/2024	Oregon Metrics and Scoring Committee benchmark is 75%	12/31/2027
Monitoring measure 3.2	Percentage of members with interpreter needs receiving interpretation services			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
In 2023, 17.8% of visits by members with interpreter needs had documentation of interpreter services being provided	24% of members with interpreter needs have documentation of interpreter services being provided	12/31/2024	75% of members with interpreter needs have documentation of interpreter services being provided	12/31/2026

Project title: Expanding Access to Traditional Health Workers

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project

If continued, insert unique project ID from OHA: #100

Components addressed

Component 1: Health equity: Cultural responsiveness
Component 2 (if applicable): Choose an item.
Component 3 (if applicable): Choose an item.
Does this include aspects of health information technology? ☐ Yes ☒ No
If this is a CLAS standards project, which standard does it primarily address? Choose an item

Project context:

Continued projects

1. **Progress to date (include CCO- or region-specific data and REALD & GI data for the project population):**

   Health Share of Oregon has a long-standing commitment to creating a diverse workforce of Traditional Health Workers (THW) and collaborating with and empowering them to enhance the well-being and experiences of our members. Within the project scope of expanding access to THW, Health Share fosters growth, nurtures talent, and bolsters essential resources to this workforce. Past investments within this project have resulted in the following:

   - Development of infrastructure with the Oregon Community Health Worker's Association;
   - Creation and deployment of culturally and linguistically responsive training provided to Doulas;
   - Establishment of a THW Advisory Committee, which meets monthly, provides a venue for THW to identify barriers to THW integration and utilization, and works to develop solutions to address those barriers;
   - Support for the Swindells Resource Center and Local Public Health Authorities Help Me Grow programs, which provides THW services to Early Childhood / 0–5-year-olds;
   - The convening of community partners, THW, and Substance Use Disorder (SUD) specialists into an SUD taskforce and High-Risk Behavioral Health Clinical Model Workgroup to ensure equitable access to evidence-based substance use treatment for all Health Share of Oregon members. Key strategies include expanding access to SUD peers; and
   - A pilot that connects members with SUD who receive care in Emergency Department (ED) settings with Peer Support Specialists (PSS). These PSS' subsequently help facilitate ongoing medication/SUD treatment in the member's preferred setting.

   Health Share conducted an analysis between 2022 and 2024 to understand trends in doula utilization.

   - July 2022 – June 2023: there were 4,539 deliveries and 292 birth doula services (6.4%)
   - May 2023 – April 2024: there were 4,860 deliveries and 448 birth doula services (9.2%)

   We analyzed Doula services by Health Share partners and billing entities to understand variation in accessing doula services in our network. Rates of doula services varied between 2-12% by different IDS/ICN partners.

Health Share has reviewed Doula utilization by all REALD/GI elements. At this time, the CCO is exercising caution as it pertains to analysis and use of sexual orientation and gender identity (SOGI) data. Our clinical partners have expressed concern around GI data collection and use, in particular for members under the age of 18. As such, Health Share has limited GI data exploration to targeted claims comparisons, missingness analyses, and aggregation approaches. While Health Share intends to incorporate analysis by Sexual Orientation (SO) in the future, the OHA has not yet made SO data available to CCOs, preventing any analysis on that dataset. Once available and standards for use of this data have been adopted, this data will be reviewed for disparities to aid with identifying specific populations that may need focused or modified support.

Examination of REAL identified that there is high uptake of Doula services among American Indian/Alaska Native, and Black/African American members, and lower uptake of Doula services among White, Hispanic, Asian, and Native Hawaiian/Pacific Islander members.

Member Race/Ethnicity (Number of Members)	% of Pregnant Members with Doula Services
American Indian/Alaskan Native (70)	13%
Black/African American (456)	11%
Other Race (237)	9%
White (1682)	7%
Hispanic (1053)	5%
Unknown Race (699)	5%
Asian (238)	5%
Native Hawaiian/Pacific Islander (104)	0%

Member Language (Number of Members)	% of Pregnant Members with Doula Services
English (3947)	6%
Spanish (382)	6%
Russian (74)	4%
Vietnamese (23)	0%
Somali (6)	0%
Arabic (4)	0%
Amharic (3)	33%

2. **Describe whether last year's targets and benchmarks were met (if not, why):**

Monitoring Measure 1.1: Establish consistent and regular technical assistance, professional development, and collaborative learning spaces for CCO, THWs, and other Community-Based Organization staff (application assisters, navigators, case managers, etc.). This target was not met. Limitations in staffing capacity hindered our ability to establish consistent and regular TA opportunities.

Monitoring Measure 1.2: Update Health Share communications infrastructure to facilitate outreach and support for Community-based THWs and employers to support desired partnership and business development activities. This target was partially met. Health Share successfully updated the CCO's

website to include basic information on accessing THW resources. The organization has also utilized communication channels to support the THW Advisory Committee and The Doula Workgroup. Further progress will need to be made regarding Community-Based Organization engagement to meet the full extent of this measure.

Monitoring Measure 2.1: Develop workforce tracking systems and set system-wide THW targets. This measure was partially met. In 2023 Health Share of Oregon worked with CCO partners to identify and address barriers to tracking and reporting of REALD/SOGI data relating to the THW workforce. While data continues to be collected, processes and definitions are inconsistent across the network. Health Share will continue working with plan partners to refine these processes in 2024 and acknowledges the current structure limits broad learnings and applications.

Monitoring Measure 3.1: The number of Doulas serving Health Share members, as reported by the THW Advisory Committee and health care claims. This target was met. Health Share has transitioned future performance monitoring to be based upon the percent of pregnant members who utilize Doula services, as this measurement is believed to represent a better assessment of access and utilization.

Monitoring Measure 3.2: The number of culturally specific doulas serving Health Share members, as reported by the THW Advisory Committee and health care claims. This target was partially met, as data continues to be collected but inconsistencies in collecting workforce data have limited the confidence in the findings. This is an area of focus for improvement in 2024.

Monitoring Measure 3.3: Achieve a 20% increase in claims for doula care among Health Share members. This target was met. Health Share almost doubled the number of Doula claims—from 292 to 448—it received from plan partners compared to the previous year.

3. **Lessons learned over the last year:**

In 2023, Health Share refined its focus on expanding Doula services and ensuring culturally and linguistically appropriate Birth Doula services to Black, Indigenous, and People of Color. Health Share developed and implemented a Birth Doula policy that describes how Health Share ensures access to Birth Doulas for Health Share members across Health Share's Plan Partners service areas. Health Share also developed standard contract and reimbursement agreements to support the increase and utilization of Birth Doulas in Health Share's service area. Health Share invested in the Oregon Doula Association to strengthen internal infrastructure that supports community-based Doula providers, such as building Doula hubs in our service area, providing technical assistance to community-based Doulas, and supporting the Doula workforce, particularly for culturally and linguistically diverse communities. Activities included supporting culturally and linguistically community-based Doula providers that are interested in obtaining and maintaining Doula certification and helping to arrange mentoring for individuals from those communities who want to become Doulas.

Health Share also worked with Project Nurture sites within Legacy, OHSU, and Providence to review the barriers encountered in providing Doula services to members who struggle with substance use addiction. Project Nurture is a Center of Excellence model, integrating maternity care and addiction treatment for pregnant women with substance use disorders. Members enrolled in Project Nurture receive outpatient addiction treatment by certified alcohol and drug counselors (CADCs) and receive

Medications for Opioid Use Disorder (MOUD), including methadone or buprenorphine, alongside their pregnancy care. This program provides comprehensive evidence-based care for both the pregnancy and addiction, improving maternal and infant outcomes.

The need for billing support and alignment of services and coverage has been identified from Soula providers and Health Share Plan Partners as a key source of needed improvement.

Brief narrative description

Project population:
The population of focus of our current project are pregnant individuals who are Black, Indigenous, and People of Color, along with those who speak languages other than English.

Intervention (address each component attached):
In the year ahead, Health Share will continue to monitor Doula service utilization, including culturally specific Doula services provided to members that identify as Black, Indigenous, and People of Color, along with those who speak languages other than English. We will engage the THW Advisory Committee and focus on developing a method for collecting information on all REALD & SOGI elements—this time, better informed by the challenges we have faced in gathering this data in the past. Health Share has also engaged process improvement and value-based payment consultants, The Eleva Group, to work with the THW Advisory Committee to address the unique challenges associated with integrating and utilizing culturally and linguistically specific Doulas in our network. Interventions will fall within three activities, which are 1) communication and technical assistance, including development of a billing guide, 2) further support of integration and utilization of Doulas providing services to Black, Indigenous, and People of Color and those who speak languages other than English, and 3) application of funding models to support Doula services.

Activities and monitoring for performance improvement

Activity 1 description: Communication and Technical Assistance. Health Share, in consultation with the THW Advisory Committee and The Eleva Group, will provide outreach and technical assistance to Birth Doulas. This assistance will support developing billing guides, communication materials, and strategic community outreach strategies. These efforts will support Doulas in the community by helping them navigate Health Share's network, increasing the number of Doulas in our network, reducing barriers to reimbursement, and assisting members in accessing culturally and linguistically tailored Doula services.

☒ Short term or ☐ Long term

Monitoring measure 1.1	Implementation of a supports to aid Doulas in receiving reimbursement for their services			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Community feedback that Doulas have difficulty navigating Medicaid reimbursement process	A billing guide to support Doula services is distributed and commonly available	12/31/2024	Use of and feedback on Doula Billing Guide is collected and reviewed	06/30/2025

Monitoring measure 1.2	Health Share communications infrastructure facilitates outreach and technical assistance for community-based THW and employers to support desired partnership and business development activities			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Community-Based Organizations do not have a central communication channel to engage Health Share	Strategic technical assistance and community engagement plan is developed	12/31/2024	Health Share has a system in place to accept inquiries from Community-Based Organizations/certified THW interested in providing services to the network. Health Plan and CBO partners are receiving regular communication about THW workforce development activities and opportunities.	07/31/2025

Activity 2 description: Support of Integration and Utilization of Doulas providing services to Black, Indigenous, and People of Color, along with those who speak languages other than English.

Health Share will continue efforts to increase THW utilization supporting culturally specific and community-based organizations--specifically, the Immigrant and Refugee Community Organization (IRCO) and Adelante Mujeres.

Health Share supports organizations in employing Community Health Workers (CHW) who have expertise in serving people of color and those who speak languages other than English, implementing Second Step (a cultural adaptation of Social-Emotional Health curriculum) and developing services specific to Spanish-speaking, Ukrainian, and Karan members.

Health Share will support Black, Indigenous, and People of Color and those who speak languages other than English entering Doula employment by adoption of culturally and linguistically specific (CLSS) payment models across all THW types and by expanding linguistic-directed payments for qualified, participating/contracted, behavioral health providers who deliver culturally and/or linguistically specific services. We will evaluate processes to identify and track service providers who qualify for CLSS reimbursement in an effort to apply the learnings across all THW types.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Develop tracking systems and set system-wide THW REALD/SOGI targets			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**

No uniform THW tracking system for Doula workforce	Doula data collection reflects REALD/SOGI and is consistent across the partnership	12/31/2024	Health Share has a consistent THW data collection method that allows for the ability to identify culturally and linguistically specific THWs in our network	06/30/2025
Monitoring measure 2.2	Evaluate the current processes for identifying and tracking peer-delivered services who qualify for CLSS reimbursement in an effort to apply the learnings across all THW types			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No established process of identifying and tracking CLSS PSS providers	THW advisory committee will identify tracking process for PSS who are currently CLSS providers	06/30/2025	Health Share uses THW demographic data to inform workforce development activities and engage community partners	12/312025

Activity 3 description: Develop funding models which support provision of doula services across Health Share Plan Partners. Review possibilities to fund doula hubs, leverage technical assistance, and remove barriers to payment, to allow more doulas to offer services across the Health Share network. With special attention toward culturally and linguistically specialized doulas and doulas engaged in Project Nurture programs. Outcomes would be higher doula utilization rates 1) across whole population 2) with language other than and 3) Project Nurture Doula services

☒ Short term or ☐ Long term

Monitoring measure 3.1	The percent of members with live births who have a claim for Doula services			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
9.21% (05/23 to 04/24)	12% (CY 2024)	12/31/2024	15% (CY 2025)	12/31/2025
Monitoring measure 3.2	The percent of members who speak a language other than English with live births who have a claim for Doula services			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
2% (05/23 to 04/24)	5% (CY 2024)	12/31/2024	10% (CY 2025)	12/31/2025
Monitoring measure 3.3	The variation of utilization of doula services across Health Share Plan Partners			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
10% difference	<6% difference	6/30/2025	<4% difference	12/31/2025

Project title: Oral Health Services in Primary Care

Continued or slightly modified from prior TQS? ☒ Yes ☐ No, this is a new project

If continued, insert unique project ID from OHA: 431

Components addressed

1. Component 1: Oral health integration
2. Component 2 (if applicable): Choose an item.
3. Component 3 (if applicable): Choose an item.
4. Does this include aspects of health information technology? ☒ Yes ☐ No
5. If this is a CLAS standards project, which standard does it primarily address? Choose an item

Project context:

Continued project

1. **Progress to date (include CCO- or region-specific data and REALD & GI data for the project population):**

   Health Share of Oregon and CareOregon understand that the most impactful pediatric oral health integration efforts include screening, fluoride varnish application, and referral during well child visits. With our focus on the delivery of oral health services outside of traditional dental settings, there is a concurrent need for effective member-level data sharing between referring primary care providers and dental providers to create a closed loop referral system. The new efficient and transparent data sharing pathways we are creating between health care providers to support members' total health are proving to be innovative and pioneering. We met major project milestones of our oral health integration project, such as the addition of dental data and actionable member lists to PCP metrics dashboards.

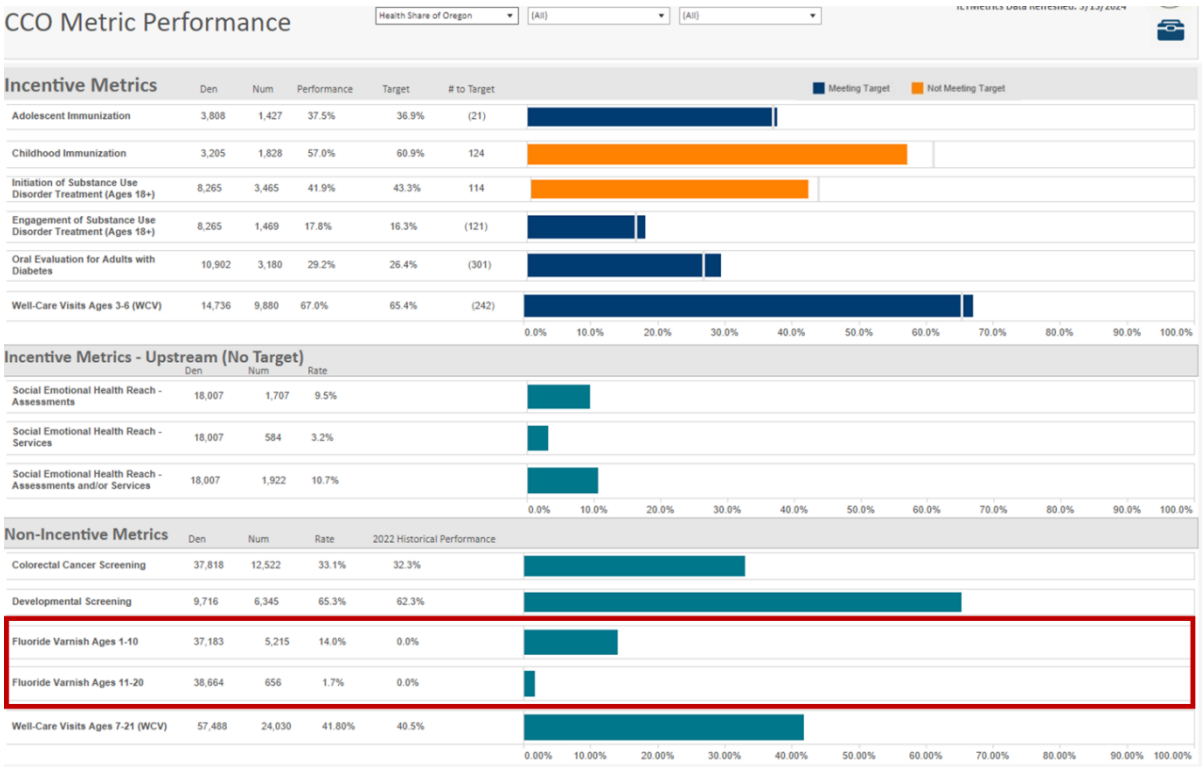
   One of the biggest learnings from the review of our 2023 TQS was the underestimation of resources needed to develop Health Information Technology (HIT) with row-level security between six dental care organizations, our plan partner CareOregon, and our primary care network of referring providers. Our previous years' work developed the infrastructure for dental navigation tools and referral submissions from primary care providers (PCP), community benefit organizations, (CBO) and maternity providers. As the number of engaged PCPs sending referrals to dental continues to increase, we became solutions-focused to work through emerging barriers with HIT. Data quality issues emerged with our large, enterprise-wide, bidirectional referral project, requiring executive action across departments to reassess and realign product functionality. In the 2024 brief narrative section, we enhanced project activities from our lessons learned to ensure that we will have a quality final product.

   Progress to date on last year's goals include:

   Activity 1) Enhancing HIT: Add dental engagement data to PCP dashboards, including dental visit information, preventive dental services metric data by PCP, and dental plan/clinic assignment

   Monitoring Measure 1.1 The addition of actionable dental data on PCP dashboards was met by the target timeline.

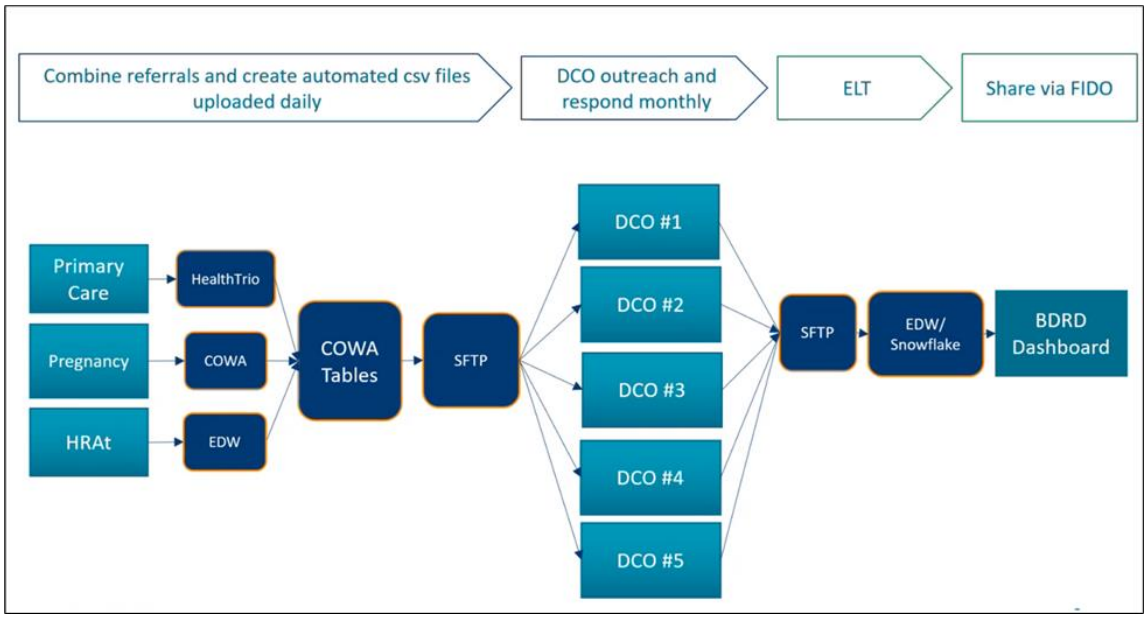
Monitoring Measure 1.2 Ten (10) provider sites trained on the use of the actionable dashboard were met by target timeline.

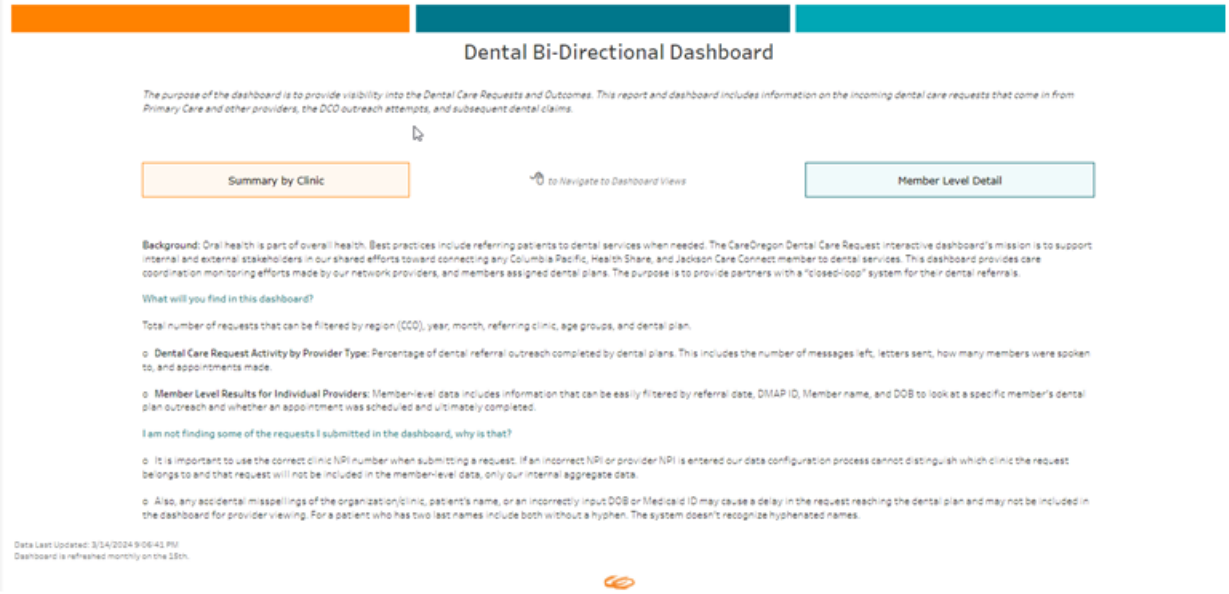


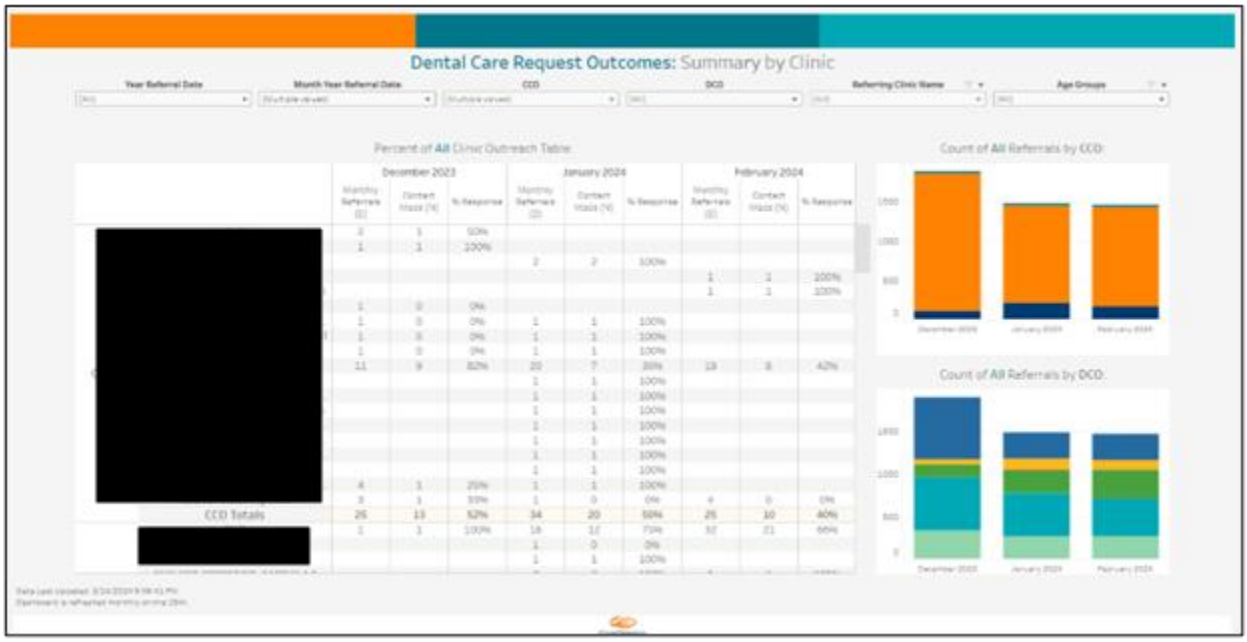
Activity 2) Enhancing HIT: Work with the analytics team to determine the number and percentage of children who had a dental care request form submitted by the physical health provider and who completed a dental visit and to develop a data dashboard visualization

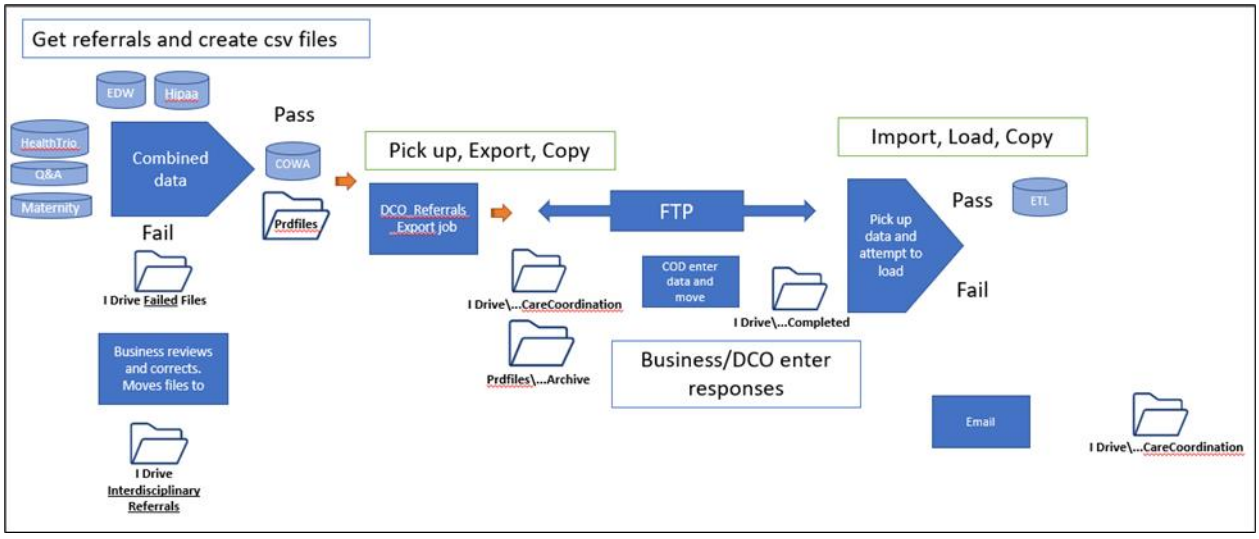
Monitoring Measure 2.1 Completion of a dashboard to visualize dental care requests is in progress but was not completed by the target date. A draft dashboard is complete and undergoing improvements. Included below are process flow visuals for dashboard build out and examples of the draft dashboard landing page, Summary by Clinic page, and Member Level Detail page that are being enhanced prior to launch.

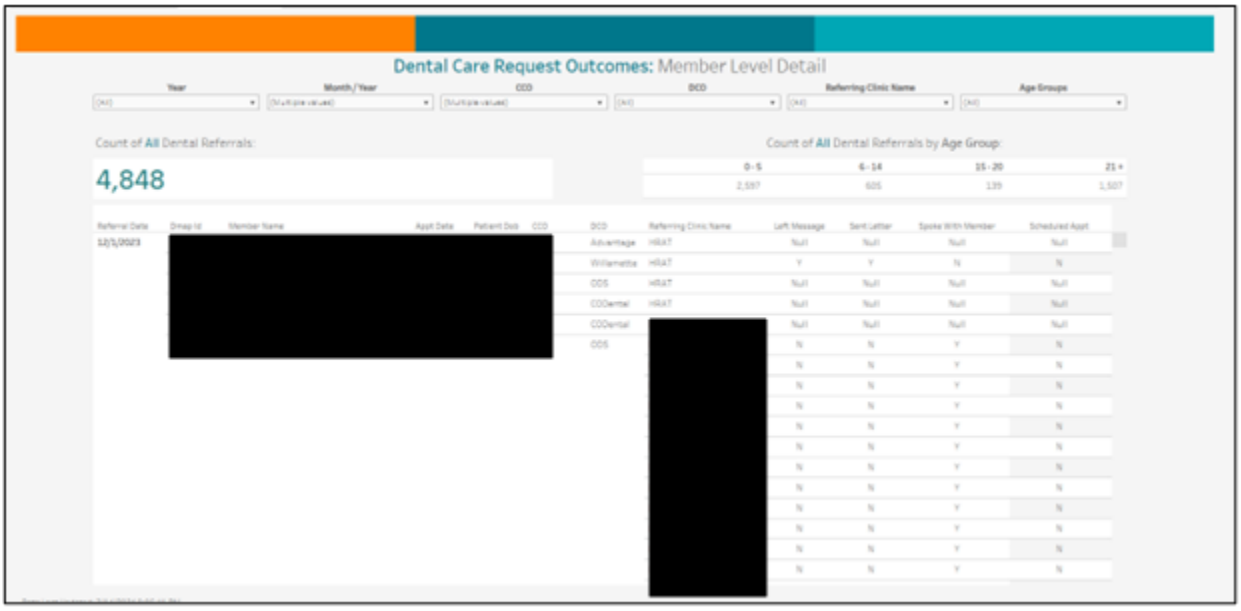
Monitoring Measure 2.2 Analyze and monitor the number and percentage of dental care requests for children that result in a completed dental visit within 30, 60, and 90 days of the request is not met, as the dashboard is not complete at this time.


Combine referrals and create automated csv files uploaded daily
DCO outreach and respond monthly
ELT
Share via FIDO
Primary Care
Pregnancy
HRAt
HealthTrio
COWA
EDW
COWA Tables
SFTP
DCO #1
DCO #2
DCO #3
DCO #4
DCO #5
SFTP
EDW/ Snowflake
BDRD Dashboard


Dental Bi-Directional Dashboard
The purpose of the dashboard is to provide visibility into the Dental Care Requests and Outcomes. This report and dashboard includes information on the incoming dental care requests that come in from Primary Care and other providers, the DCO outreach attempts, and subsequent dental claims.
Summary by Clinic
to Navigate to Dashboard Views
Member Level Detail
Background: Oral health is part of overall health. Best practices include referring patients to dental services when needed. The CareOregon Dental Care Request interactive dashboard's mission is to support internal and external stakeholders in our shared efforts toward connecting any Columbia Pacific, Health Share, and Jackson Care Connect member to dental services. This dashboard provides care coordination monitoring efforts made by our network providers, and members assigned dental plans. The purpose is to provide partners with a "closed-loop" system for their dental referrals.
What will you find in this dashboard?
Total number of requests that can be filtered by region (CCO), year, month, referring clinic, age groups, and dental plan.
o Dental Care Request Activity by Provider Type: Percentage of dental referral outreach completed by dental plans. This includes the number of messages left, letters sent, how many members were spoken to, and appointments made.
o Member Level Results for Individual Providers: Member-level data includes information that can be easily filtered by referral date, DMAP ID, Member name, and DOB to look at a specific member's dental plan outreach and whether an appointment was scheduled and ultimately completed.
I am not finding some of the requests I submitted in the dashboard, why is that?
o It is important to use the correct clinic NPI number when submitting a request. If an incorrect NPI or provider NPI is entered our data configuration process cannot distinguish which clinic the request belongs to and that request will not be included in the member-level data, only our internal aggregate data.
o Also, any accidental misspellings of the organization/clinic, patient's name, or an incorrectly input DOB or Medicaid ID may cause a delay in the request reaching the dental plan and may not be included in the dashboard for provider viewing. For a patient who has two last names include both without a hyphen. The system doesn't recognize hyphenated names.
Data Last Updated: 3/14/2024 9:06:41 PM
Dashboard is refreshed monthly on the 15th.


Dental Care Request Outcomes: Summary by Clinic
Year Referral Date
Month Year Referral Date
CCO
DCO
Referring Clinic Name
Age Groups
Percent of All Clinic Outreach Table
December 2023
January 2024
February 2024
CCO Totals
Count of All Referrals by CCO
Count of All Referrals by DCO


Get referrals and create csv files
EDW
Hipaa
HealthTrio
Q&A
Maternity
Combined data
Pass
COWA
Prdfiles
Fail
I Drive Failed Files
Business reviews and corrects. Moves files to
I Drive Interdisciplinary Referrals
Pick up, Export, Copy
DCO_Referrals_Export job
FTP
I Drive\...CareCoordination
Prdfiles\...Archive
COD enter data and move
I Drive\...Completed
Business/DCO enter responses
Import, Load, Copy
Pick up data and attempt to load
Pass
ETL
Fail
Email
I Drive\...CareCoordination



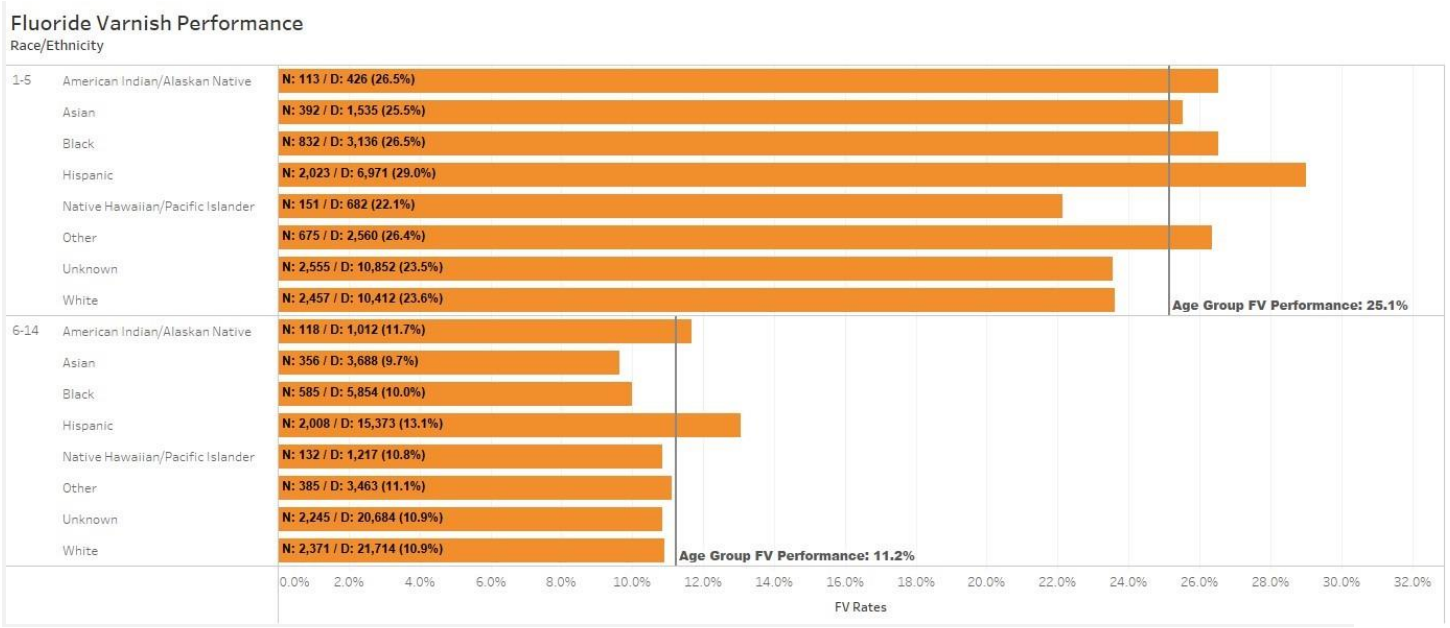
Activity 3) Oral health outside of dental settings: Analysis of dental services in physical health claims for quality improvement

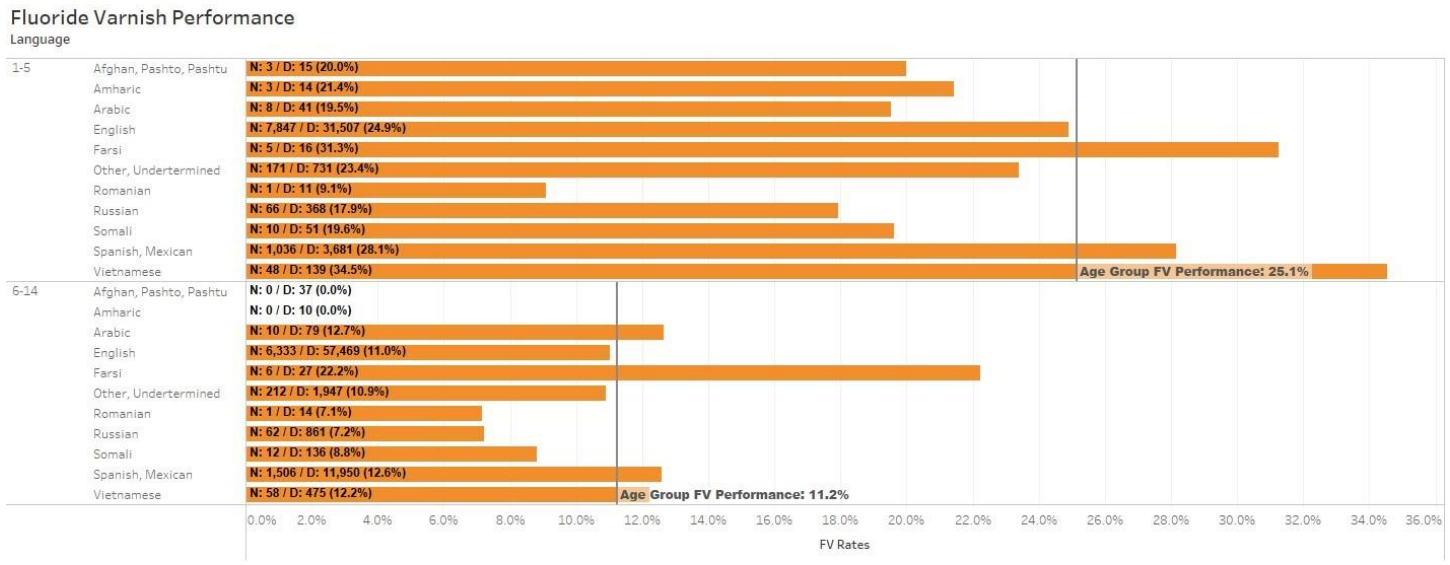
Monitoring measure 3.1 Determine baseline performance at the PCP-level of sites applying fluoride varnish in primary care and determine an improvement target for fluoride varnish applications in 2024 has been met by the target timeline.

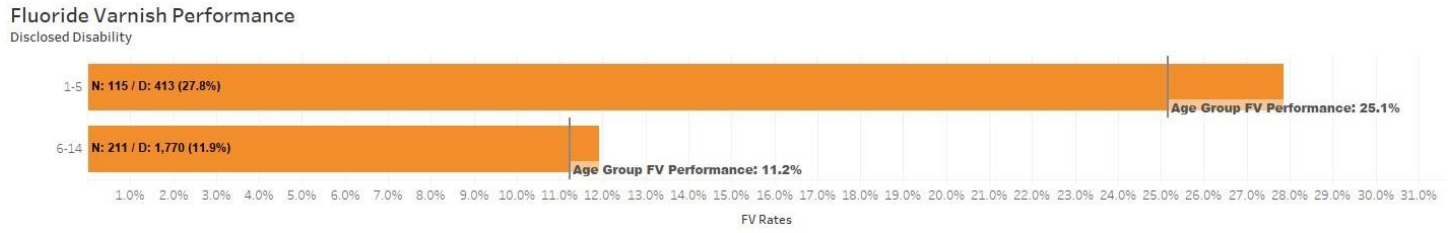
> Fluoride varnish application in primary care data has been disaggregated by REALD for analysis. At this time, Health Share is exercising caution as it pertains to analysis and use of sexual orientation and gender identity data. Our clinical partners have expressed concern around Gender Identity (GI) data collection and use, in particular for members under the age of 18. As such, Health Share has limited GI data exploration to targeted claims comparisons, missingness analyses, and aggregation approaches. While Health Share intends to incorporate analysis by Sexual Orientation (SO) in the future, the OHA has not yet made SO data available to CCOs, preventing any analysis on that dataset. This data represents only members receiving varnish in primary care and does not include dental provider contributions.

Monitoring measure 3.2 Dental claims in physical health data analysis developed and reported is on track to be met by target timeline of June 2024

Monitoring measure 3.3 Deliver provider findings and resources for quality improvement to ten (10) provider sites is on track to be met by target timeline of December 2024







Activity 4) Addressing health disparities: Analysis of dental care requests resulting in a completed dental visits stratified by member race and language

- The target date for this activity was originally June 2025

- This work is contingent on the progress with the dashboard buildout and is slated for completion by August 2025

At this time, Health Share is exercising caution as it pertains to analysis and use of GI data. Our clinical partners have expressed concern around GI data collection and use, particularly for members under the age of 18. As such, Health Share has limited GI data exploration to targeted claims comparisons, missingness, analyses and aggregation approaches. OHA has not yet made SO data available to CCOs, preventing any analysis on that dataset.

2. Describe whether last year's targets and benchmarks were met (if not, why):

In 2023, we successfully added dental data, in the form of a fluoride varnish measure, to our metrics dashboard that is available externally to our primary care partners. In addition to metrics performance data, the dashboard allows providers to export an actionable member list for engagement. All providers with dashboard access received information on the data update, and additional technical assistance was provided when requested by partners. We also determined the baseline of fluoride varnish applications in physical health claims for quality improvement which keeps us on track for the data analysis and opportunities for quality improvement.

This oral health integration project encountered some barriers with the finalization of the HIT dashboard to visualize dental care requests, which we planned to complete by December 2023. The complexities of this enterprise-wide, large-scale project, which includes health information data exchange with row-level security between six dental care organizations, CareOregon, and our primary care network of referring providers, has proven to be challenging. The win is that multiple milestones have been met, including the product platform and methodology. Milestones include the implementation of referral outreach data exchange from dental plans and the draft dashboard build out in FIDO, our data and analytics platform. During the validation process, data quality issues and inconsistencies were uncovered. To ensure accuracy and quality of information sharing, teams stepped back to re-evaluate the product. We are neither able to meet our goals to analyze and monitor the dental care requests nor able to build additional data visualizations until the dashboard is final.

3. Lessons learned over the last year:

While this large-scale, HIT dashboard project operates under an approved, enterprise-wide charter and weekly project management huddles, the greatest learning was the need for a steering committee comprised of multi-department leadership. The complexities of numerous dependencies spread amongst various departments and teams proved to be a challenge and required additional oversight to ensure alignment and communication for the final product. With the establishment of steering, we have already seen great strides in movement towards the desired end goal and product.

Brief narrative description

Project population:

Children ages 1-5 years in Primary Care settings

Intervention (address each component attached):

Understanding that primary care teams have multiple demanding priorities for provision of care during a short visit time, we believe that provider buy-in is essential for the successful implementation of oral health integration practices. To best align with the Bright Futures and United States Preventive Services Task Force (USPSTF) primary care recommendations for fluoride varnish application at the time of primary tooth eruption, the project population age has been updated to ages 1-5. An important lever to note is the incentive offered through our Primary Care Payment Model (PCPM) for fluoride varnish application and dental referrals for this age group. Additionally, we strive to make oral health integration an easy lift and as seamless as possible for network partners. Our integration and dental navigation tools, with targeted training, help advance the knowledge and awareness of primary care teams on the importance of oral health for children ages 1-5 years. We also aim to improve dental navigation and dental visit adherence with the ultimate goal of increasing dental utilization and lowering the incidence of dental caries.

Now that we have current and historical claims and dental care request data from multiple partners, we are positioned to implement thorough and meaningful data analysis practices for quality improvement with an equity lens. The PCP children's preventive dental services dashboard is our own health information technology tool designed to further strengthen integration efforts. This dashboard transmits basic dental health data points to PCPs and includes information on their members' dental needs that they did not previously have easy access to.

Provider training on the use of the dashboard, with oral health education and dental navigation tools, is available and provided to take actionable steps on the data and support member outcomes. Continued PCP training, utilization, and spread of the dental care request process build communication pathways for care coordination with dental plans. This health plan support addresses a gap identified in navigation to dental services where the burden often falls on the PCP and patient to understand and navigate the complexities of the benefit structure.

Continuation of HIT enhancement to improve our dental care referral platform and bidirectional communication is key to support member care. Data analytics and dashboard buildout on the percentage of children who had a dental care request submitted by the physical health provider and who completed a dental visit may provide insight on gaps within the navigation system, health disparities, and/or access concerns. This will allow for data-driven conversations and improvement activities with PCP and dental plan partners on timely access to care. Analysis of covered oral health services in primary care, such as screening or assessment and fluoride varnish claims data to understand variability in data and determine strong and underperforming clinics will allow for shared learning and additional technical assistance.

This is the first year we have disaggregated oral health in primary care data available for analysis. Elements of REALD data were analyzed to identify gaps. This data allows for a discussion on populations accessing oral health services by PCPs. Denominators are small, as this data does not reflect the entire assigned population--only members who received fluoride varnish in primary care settings. 2023 fluoride varnish claims data in primary care by race/ethnicity for children ages 1-5 show that the percentage of American Indian/Alaska Native, Asian/Native Hawaiian/Pacific Islander, and white children is below the performance of the total age group. In this evaluation, we are aware that the white population has the most numerators and largest denominator of any population.

Further strengthening this work, we plan to add REALD data to both our oral health services in primary care and dental care request dashboards to allow continuous evaluation for interventions and discussion with network partners. If any disparities or meaningful differences are identified, we will explore the causes and develop a strategic plan to address those differences.

To ensure that oral health services in primary care and dental navigation initiatives are kept at the forefront with our PCP network providers, we will continue to facilitate workshops and workgroup presentations throughout the year. Additionally, our MedsEd continuing education series for health care professionals is hosting a webinar in June 2024 on the importance of integrating oral health care referrals into practice workflows. The webinar's focus includes champion providers presenting their work integrating oral assessments and fluoride varnish application with dental referrals into standard practice and addresses the importance of oral health in social determinants and overall health impacts.

Activities and monitoring for performance improvement

Activity 1 description: Enhancing HIT: Work with the analytics team to determine the number and percentage of children who had a dental care request form submitted by the physical health provider and who completed a dental visit and to develop a data dashboard visualization

☐ Short term or ☒ Long term

Monitoring measure 1.1	Completion of a dashboard to visualize dental care requests			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Dashboard not available	Dashboard created	05/2025	Dashboard created	05/2025
Monitoring measure 1.2	Analyze and monitor the number and percentage of dental care requests for children that result in a completed dental visit within 30, 60, and 90 days of the request			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Baseline not available	Determine 2024 baseline and future improvement target set.	08/2025	Baseline determined and future improvement target set.	08/2025
Monitoring measure 1.3	Number of findings delivered to primary care partners for quality improvement			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No findings available	1-5 Findings delivered to primary care partners	12/2025	1-5 Findings delivered to primary care partners	12/2025

Activity 2 description: Oral health outside of dental settings: Analysis of dental services in physical health claims for quality improvement

☐ Short term or ☒ Long term

Monitoring measure 2.1	Number of fluoride varnish claims in physical health for ages 1-5 analyzed for quality improvement			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Data not analyzed yet	Data fully analyzed with accompanying findings and progress report	06/2024	Data fully analyzed with accompanying findings and progress report	06/2024
Monitoring measure 2.2	Number of findings delivered to primary care partners for quality improvement			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No findings available	1-5 Findings and resources delivered to ten (10) provider sites	12/2024	1-5 Findings and resources delivered to ten (10) provider sites	12/2024
Monitoring measure 2.3	Number of fluoride varnish claims data from all Health Share IDS partners included in current oral health services dashboard for quality improvement			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
CareOregon /Health Share fluoride varnish claims are currently included in the dashboard	All Health Share IDS/ICN primary care fluoride varnish claims data will be available on the dashboard	12/2024	All Health Share IDS/ICN primary care fluoride varnish claims data will be available on the dashboard	12/2024
Monitoring measure 2.4	Enhance current oral health services in primary care dashboard to include REALD and SOGI data			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Stratification data (REALD and GI) is available, not currently on the oral health services dashboard	Enhanced dashboard includes REALD and SOGI data	12/2025	Enhanced dashboard includes REALD and SOGI data	12/2025

Activity 3 description: Addressing health disparities: Analysis of dental care requests resulting in a completed dental visit, stratified by member race and language

☐ Short term or ☒ Long term

Monitoring measure 3.1	Dental care request data stratified by race, ethnicity, language, disability, sexual orientation and gender identity is added to data visualizations			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Stratification data (REALD and GI) is available, not currently combined with dental care request data	Stratification data (REALD and SOGI) combined with dental care request data	08/2025	Stratification data (REALD and SOGI) combined with dental care request data	08/2025
Monitoring measure 3.2	Number of dental care requests by race, ethnicity, language, disability, sexual orientation, and gender identity analyzed to identify health disparities			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No current analysis of dental care request data by REALD and SOGI	Data fully analyzed by REALD and SOGI	12/2025	Data fully analyzed by REALD and SOGI	12/2025

Project title: Strategic Patient-Centered Primary Care Home (PCPCH) Efforts

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project

If continued, insert unique project ID from OHA: 107

Components addressed

Component 1: PCPCH: Member enrollment
Component 2 (if applicable): PCPCH: Tier advancement
Component 3 (if applicable): Choose an item.
Does this include aspects of health information technology? ☒ Yes ☐ No
If this is a CLAS standards project, which standard does it primarily address? Choose an item

Project context:

Continued projects

1. **Progress to date (include CCO- or region-specific data and REALD & GI data for the project population):**

   Over the course of the past year, Health Share of Oregon worked to increase the number of Tier 4 and 5 PCPCHs in the CCO's network, as well as the percentage of Health Share members assigned to higher tier clinics. Prominent activities have included the following:

   PCPCH Tier Advancement

   In early 2023, Health Share partners conducted outreach to primary care clinics with the goal of supporting participation in the Primary Care Practice Transformation Training (PCPCT) program. This initiative was a collaboration between CareOregon and the University of California San Francisco's Center for Excellence that focused on the fundamentals of patient centered primary care homes. Incentives designed to minimize the burden of attendance, such as financial assistance for registration fees, were made available to primary care practices interested in participating.

   Health Share member CareOregon also successfully launched a learning collaborative series, Applying Value to Community Health Worker Integration. This initiative, developed in partnership with the Oregon Primary Care Association (OPCA), focused on building stronger strategic partnerships with Federally Qualified Health Centers (FQHC) to promote alignment with Community Health Worker (CHW) scope and practices. Two major primary care clinics are participating in the collaborative, with work continuing into 2024 and culminating in a final project over the summer.

   Health Share partners also worked diligently to provide hands-on support to clinics preparing for PCPCH site visits. Kaiser Permanente Northwest (KPNW), for example, engaged its primary care network with clinic-specific documentation and reports that focused on each site's unique needs and concerns that could impact PCPCH certification. These resources helped clinics proactively address any issues or deficiencies in advance of their site visit.

   As part of these "site visit readiness" activities, KPNW hosts a series of meetings and presentations with clinic managers, primary care (family medicine/internal medicine) physician leads, and other operational leaders to re-introduce the PCPCH program, provide concise information about both the certification

and site visit processes, and emphasize the importance of adherence to PCPCH standards across the region. The organization works continuously to refine and enhance site visit planning processes to make it more efficient for both the centralized quality staff and the clinic managers.

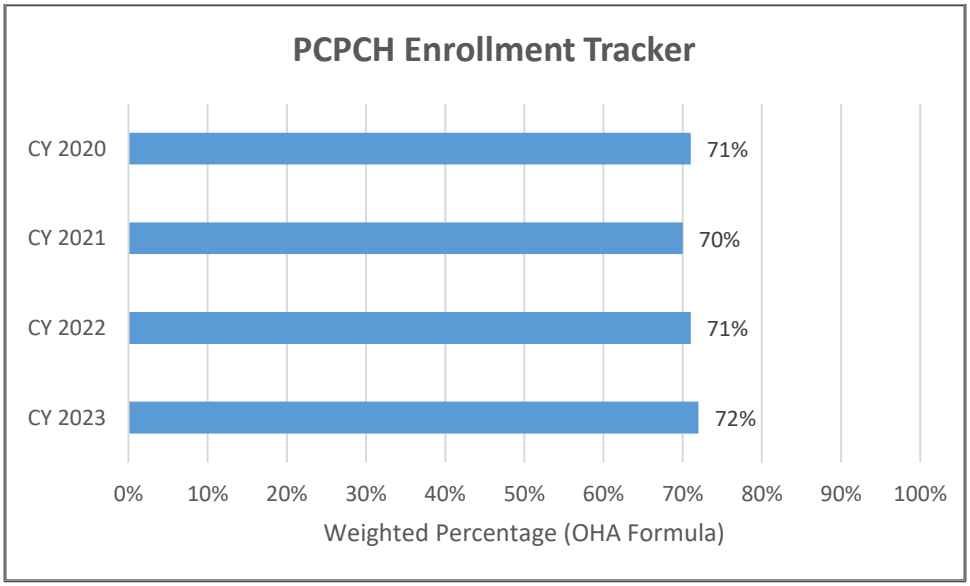
This approach proved successful, as KPNW completed the recertification process in 2023 and all paneling primary care clinics-maintained Tier 4 status. It is also notable that each clinic also increased their point totals since the previous certification cycle, which indicates that progress is being made to ultimately achieve Tier 5 status.

PCPCH Enrollment

Many Health Share partners have deployed a preferential assignment process to connect members to high-performing PCPCH clinics. CareOregon, for instance, has established a Provider Network Operations (PNO) team designed to standardize and streamline network adequacy efforts such as preferential assignment.

Value-Based Payments (VBPs) are another tool utilized by Health Share partners to reward clinics for PCPCH certification status. In 2023, CareOregon enhanced per-member per-month (PMPM) payments to PCPCH recognized clinics and Health Share continues to view VBPs as an integral component of the CCO's PCPCH strategy.

Ultimately, Health Share monitors PCPCH enrollment over time using the OHA's weighted formula. Health Share's overall rate has remained consistent since 2020; however, the CCO has continued longstanding efforts to increase both the number of Tier 4 and 5 PCPCHs in the CCO's network and the percentage of members assigned to higher tier clinics.



While Health Share's overall rate has stabilized over the past few years, this should not overshadow significant accomplishments achieved by plan partners, including the following:

- Legacy Health/PacificSource: All clinics in the LHPS network are Tier 4
- Kaiser Permanente Northwest: All clinics in the KPNW are Tier 4

- Oregon Health and Sciences University: 98% of OHSU's membership is assigned to a clinic certified as Tier 4 or higher
- CareOregon: 85% of CareOregon's membership is assigned to a clinic certified as Tier 4 or higher
- Providence Health Alliance: All PHA members are assigned to at least a tier 3 PCPCH clinic, with 77.7% of members being assigned to a tier 4 or 5 clinic

2. **Describe whether last year's targets and benchmarks were met (if not, why):**

   In 2023, Health Share had two primary goals for PCPCH Tier Advancement and Member Enrollment:

   Monitoring Measure 1.1: Increase PCPCH percentage, as calculated by OHA weighted methodology, to 75%.

   Health Share did not meet this target; however, the CCO's overall PCPCH rate increased by one percentage point over the previous year. The major barrier to achieving substantial increases in PCPCH weighted average remains the substantial administrative and financial burden associated with improving PCPCH certification status, particularly amongst primary care providers with relatively small numbers of Oregon Health Plan (OHP) recipients assigned to their clinics. These challenges, coupled with the rollout of new PCPCH standards, have made improvement to network-wide PCPCH rates especially daunting.

   Monitoring Measure 1.2: Collaborate with University of California San Fransisco's Center for Excellence to host a two-part learning series on the 10 Building Blocks for High Performing Primary Care.

   This goal was partially met. Health Share partners successfully collaborated with the University of California San Francisco's Center for Excellence to host a learning series, but attendance fell short of expectations and resulted in the cancellation of the second portion of the series.

3. **Lessons learned over the last year:**

   The new standards taking effect in 2025 have had a significant impact on clinics. Many primary care providers have expressed hesitancy to attest in 2024, given that they will need to attest again in 2025. In some instances, this has resulted in decreased engagement in processes and activities that focus on PCPCH certification. These challenges are compounded by longstanding limitations to staffing and resources within primary care.

   Many Health Share partners have found it difficult to sustain continuous and robust engagement amongst clinics serving small numbers of OHP recipients. A wide range of strategies and supports have been implemented to mitigate challenges associated with supporting these clinics. That said, achieving and maintaining PCPCH certification is resource intensive, and some clinics simply do not believe participation makes sense from a financial or staffing perspective.

   From a program management perspective, one salient lesson from the past year was identified by the PCPCT team. They discovered that spreading trainings out over the course of the year—with breaks—did not result in a high level of participant retention. For 2024, the PCPCT team has decided to host trainings in one continuous block so that clinics can engage in the full learning series and [hopefully] retain more participants. They are also offering a discounted rate to those who attended last year's first block of trainings but were unable to attend the second half.

Brief narrative description

Project population:
All Health Share members with physical health coverage.

Intervention (address each component attached):
During the upcoming year, Health Share will continue to work with plan partners to increase both the number of Tier 4 and 5 clinics and the percent of members assigned to them. Prominent strategies include the following:

PCPCH Tier Advancement

Learning Collaboratives & Practice Coaching

The CareOregon Innovation Team will continue to support clinics advance PCPCH certification status through ongoing outreach and support. These efforts focus on providing individual practice coaching and technical assistance that enhance clinical understanding and strategies relating to PCPCH standards. One-on-one meetings are designed to provide tailored support specific to the clinics' needs and provide clinics with an opportunity to work with innovation specialists to review current tier status, evaluate areas of opportunity, and discuss project implementation for tier advancement. In some cases, this support includes assisting clinics with identifying work occurring within their system that they may contribute to practice standards, if properly documented.

Learning Collaboratives will continue to be a major focus for Health Share over the course of the next year. These spaces represent an opportunity for clinics to learn about innovative practices happening within their region, seek support, and develop strategies for implementing practices that contribute to PCPCH tier advancement. As an example, CareOregon will continue to sponsor a CHW Collaborative that provides clinics with one-on-one support for improving performance on specific practice areas. This work is particularly impactful for clinics looking to improve on PCPCH standards, such as:

- 5.C: Complex Care Coordination and Core Attribute and
- 6: Person and Family Centered Care (specifically around 6.B Education and Self-Management Support).

Health Share partners are also actively engaging with the Children's Health Alliance (CHA), which represents pediatric clinics that collectively provide services of over 28,000 children covered by Health Share. CHA provides clinics in it's network with a robust set of resources aimed at improving PCPCH reporting and performance. CHA aims to support clinics in advancing the number of standards to which they can attest, without causing undue administrative burden, by facilitating the sharing of resources, learnings, and activities that support the PCPCH attestation. In addition to ongoing support in population health, quality improvement, value-based payments, experience of care, and complex care management, CHA is leading activities to help practices:

- Create a self-assessment tool to outline the 2025 Standards, points allocation, and qualification for the Equity designation;
- Identify standards by which CHA can assist the clinics in their attestation;

- Access a New PCPCH Standard overview by Creach Consulting;
- Engage in a monthly PCPCH roundtable to share best practices and answer questions related to specific PCPCH Standards;
- Maximize attendance and learnings from OHA-sponsored webinars on the 2025 Standards; and
- Review new PCPCH standards and identify ways that CHA can support practices in their attestation.

CHA also provides pediatric practices within its system with supports that specifically address individual PCPCH standards. A sample of standard-specific supports provided by CHA include:

- Standard 2.A. – Performance and Clinical Quality – CHA maintains a population health tool that connects directly with clinic data to calculate quality measures, including proactive gap lists for outreach. Clinics are supported with real-time data on quality measures. Work in 2024 includes disaggregating the measures by race, ethnicity, and language to identify if opportunities exist to address disparities based upon one of the important categories.
- Standard 2.B. – Value-based payment – CHA contracts on behalf of its clinics and holds the majority of the value-based contracts. CHA has summarized the arrangements and provided the information to allow clinics to attest to these measures.
- Standard 2.D. – Quality improvement – CHA supports clinics in providing data to allow for quality improvement activities at the clinic level for a variety of measures. In addition, CHA provides best practices to support clinics in their QI strategy and projects.
- Standard 2.E. – Ambulatory Sensitive Conditions – CHA provides data through its population health tool to support clinics in ED and Inpatient discharges and provides real time data of discharge to support clinics in outreach for transitions in care.
- Standard 3.A – Preventive Services – CHA provides clinics with proactive care gaps for preventive care to allow for outreach and closing of care gaps for patients who have not been in the office for well visits and other important screenings and immunizations.
- Standard 3.D. – Comprehensive Health Assessment & Intervention – CHA supports practices as they implement health-related social needs screening, from selection of assessment tools to operational considerations. In 2024, CHA will continue to work with practices to identify the best way to record the screening and results in their EMR to allow for extraction and reporting. In addition, CHA is supporting practices in connecting with platforms, such as UniteUs, to refer patients to community-based organizations.
- Standard 4.E. – Hospital Setting Transitions – CHA supports the practices in the development of processes for transitions of care, utilizing the population health tool as the source of discharges from the ED and inpatient settings.
- Standard 5.A. – Population Data Management – CHA supports the practices in stratifying the population according to health risk and identifying the appropriate proactive strategies for outreach for complex patients. 2024 and future work will identify ways that the population might be stratified by HRSN.
- Standard 5.C. – Complex Care Coordination – CHA supports practices in methods to identify Service Level Assessment of complex payments through a CHA-developed assessment tool and/or practice-identified assessment. CHA supports care managers through a quarterly collaborative meeting in which we highlight community partners and services, share best practices, and follow up on needs identified by individual care managers.
- Standard 6.C. – Experience of Care – On behalf of the CHA practices, CHA administers a CAHPS survey annually, including promotion of participation in the CAHPS survey, collection of data, analysis of data,

reporting data back to practices, and working with practices to identify areas of improvement for incorporation into their QI strategy.

- Standard 6.E. – Cultural Responsiveness of Workforce – CHA has developed a Trauma-Informed Care training series applicable to providers and staff at pediatric practices. This is available on a shared learning platform and can be accessed at any time by the practices to support a trained workforce. In addition, CHA identifies and hosts other applicable trainings to support continuous learning in culturally appropriate and trauma informed care. CHA is further supporting the growing interest in CHWs and is providing a forum for CHWs to come together to discuss best practices, this new position in pediatric care, and how to best serve the population.

PCPCH Enrollment

Preferential Assignment

CareOregon's preferential assignment process is an automated mechanism that preferentially assigns new members to Primary Care Clinics (PCC) that have demonstrated that they provide high quality care. PCPCH recognition is one of the foundational requirements for a clinic to become eligible for preferential assignment. When the process is in effect, it results in a higher proportion of new members being assigned to high tier PCPCH clinics.

CareOregon will continue to refine its preferential assignment process to ensure more Health Share members are connected to clinics that are certified as Tier 4 or 5. This process will be overseen by the newly established PNO team. The PNO team is comprised of a Network Adequacy Analyst, a Senior Planning and Operations Specialist, a Provider Network Communications Specialist, and a Training Specialist. This team operates under the leadership of the Provider Network Operations Manager, who reports through the newly appointed Senior Vice President of Operations, with support from a Vice President (VP) of Provider Network and a Director of Network Operations. Both the VP of Provider Network and Director of Network Operations positions are expected to be filled in 2024.

The PNO team will develop and implement a centralized intake request form for issues, concerns, or enhancement requests related to our primary care auto-assignment and auto-reassignment algorithms, including preferential assignment issues. This tracker will be created this year and will serve as a centralized tool—owned, maintained, and operated by PNO—that will provide better insights into patterns, trends, and improvements. The aim is to increase assignments to PCPCH clinics and optimize responses to member behavior, thereby improving access to higher-quality care.

This will be coupled with the utilization of a Training Specialist focused on internal team training, with additional support for external provider training, as needed. A critical charge of this team is to integrate REALD and SOGI data into network adequacy and assignment management practices. This integration will enable us to identify and address health disparities more effectively, ensuring our services are tailored to meet the diverse needs of our community.

Other Health Share partners will be working towards developing preferential assignment methodology that makes sense for their networks. Providence Health Alliance (PHA) , for example, is in the process of investigating ways to incorporate PCPCH tier status into the organization's primary care assignment algorithm. The current process takes multiple factors into consideration, such as prior assignment, location, clinic capacity, age, etc. While 77.7% of PHA members are already assigned to a tier 4 or 5 clinic, enhancing the assignment algorithm to account for tier status could be an avenue for further improvement.

Value-Based Payments
Health Share partners will also continue to use Value-Based Payments (VBP) to increase the proportion of membership assigned to Tier 4 and 5 PCPCHs.

- CareOregon has established a PMPM that is based upon PCPCH status. The organization has made participation in other VBP programs, such as the Primary Care Payment Model, contingent on clinics being recognized as Tier 4 or Tier 5. This approach effectively leverages the impact of the PCPCH program across a wide range of payment initiatives.

Finally, Health Share will continue to assist plan partners by developing and deploying analytic resources that support monitoring primary care performance. This will include further enhancing the CCO's suite of dashboards to incorporate REALD and SOGI analysis, with the ultimate goal of identifying and eliminating any inequities in PCPCH assignment, access, and utilization.

Activities and monitoring for performance improvement

Activity 1 description: Health Share partners employ trainings and learning collaboratives to increase Tier 4 and 5 assignment

☒ Short term or ☒ Long term

Monitoring measure 1.1	PCPCH percentage as calculated by OHA weighted methodology			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
72% PCPCH Rate	75% PCPCH Rate	12/31/2024	80% PCPCH	12/31/2026
Monitoring measure 1.2	Completion rate for clinics participating in the OPCA CHW Collaborative.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Learning collaborative has not concluded	100% of clinics currently engaged in the collaborative complete the series.	12/31/2024	100% of clinics currently engaged in the collaborative complete the series.	12/31/2024

Project title: Vulnerability Framework and Rapid Access Care Planning

Continued or slightly modified from prior TQS? ☒ Yes ☐ No, this is a new project

If continued, insert unique project ID from OHA: 508

Components addressed

1. Component 1: SHCN: Full benefit dual eligible
2. Component 2 (if applicable): Choose an item.
3. Component 3 (if applicable): Choose an item.
4. Does this include aspects of health information technology? ☒ Yes ☐ No
5. If this is a CLAS standards project, which standard does it primarily address? Choose an item

Project context:

Continued projects

1. **Progress to date (include CCO- or region-specific data and REALD & GI data for the project population):**

   In 2023, Health Share of Oregon's plan partner, CareOregon, launched a Regional Care Team (RCT) focused on the Dual Eligible population. After intense recruitment, training, and onboarding, member empanelment gained momentum in July through August 2023. Care coordinators leveraged Rapid Access Care Plan (RACP) data, in addition to Health Risk Assessment Tool (HRAT) results, claims data, and event notifications in their risk stratification work. In November, CareOregon transitioned care coordination software platforms from GSI to Epic Compass Rose (Epic). Adopting Epic required us to rebuild workflows and reports, which also gave us a chance to refine how the Dual Eligible RCT works with members, set new documentation expectations, and begin to identify new quality and process improvement opportunities.

   In 2023, 3,375 members met the criteria for most vulnerable Dual Eligible members. The most vulnerable cohort was disaggregated by REALD and Gender Identity. The most vulnerable cohort is a racially diverse group, as demonstrated in the table below. Individuals in this cohort identify with more than 30 unique racial and ethnic groups. This diversity underscores the importance of the robust training care coordinators receive around cultural responsiveness, as well as their emphasis on respecting member desires for culturally specific care.

Race/Ethnicity	Percentage of Cohort
American Indian/Alaska Native	3.3%
Asian	7.8%
Black/African American	5.5%
Latino/a/x/e	13.4%
Middle Eastern/North African	1.0%

Multi/Other	2.1%
Native Hawaiian/Pacific Islander	0.8%
White/Caucasian	59.7%
Missing or Unknown	6.4%

Approximately one quarter of the members in this cohort identify as having at least one disability. Close to one third of the disability data was missing or unknown, which affects the reliability of this data. Because of the nature of this cohort, we expect that a larger percentage of members in the cohort have a disability than is reflected below.

Disability Status	Percentage of Cohort
2+ Disabilities	1.4%
Cognitive Disability	1.0%
Communication Disability	0.1%
Hearing Disability	0.4%
Independent Living/Self Care Disability	6.2%
Learning Disability	0.1%
Mental Health Disability	0.2%
Non-Disabled	57.0%
Physical Disability	1.0%
Vision Disability	0.4%
Missing or Unknown	32.1%

Members in the most vulnerable cohort speak a variety of languages as their preferred spoken and/or home languages. English, Russian, Spanish and Vietnamese are the most commonly spoken languages in the cohort. This highlights the need for the RCTs to utilize bilingual staff and to be well-trained in the use of interpreters when working with this population.

Primary Spoken Language	Percent of Cohort
Additional Languages*	1.5%
Arabic	0.5%

Bosnian	0.2%
Cantonese (Yue Chinese)	1.9%
English	54.8%
Farsi/Persian	0.4%
Iu Mien	0.4%
Khmer/Cambodian	0.3%
Korean	1.1%
Mandarin (Chinese)	1.2%
Romanian/Moldovan	0.5%
Russian	4.9%
Sign Languages	0.4%
Spanish	4.5%
Tagalog	0.2%
Ukrainian	0.2%
Vietnamese	5.9%
Missing or Unknown	2.1%

*Additional languages category includes all languages in which the n was six or fewer. This group includes the following languages: Algerian Arabic, Amharic, Bengali, Burmese, Chinese, Dari, Filipino, Finnish, French-based Creoles and Pidgins, Gujarati, Hindi, Hmong, Hmong Njua, Japanese, Karen Languages, Lao, Nepali Norwegian Nynorsk, Panjabi, Portuguese, Somali, Standard Arabic, Thai, Tibetan, Tigrinya, Tonga (Nyasa), and Urdu.

Health Share is exercising caution as it pertains to analysis and use of Gender Identity data. Our clinical partners have expressed concern around data collection and use, in particular for members under the age of 18. As such, Health Share has limited Gender Identity data exploration to targeted claims comparisons, missingness analyses and aggregation approaches. OHA has not yet made SO data available to CCOs, however Health Share expects to incorporate that information into future analysis once it is made available.

2. **Describe whether last year's targets and benchmarks were met (if not, why):**

Monitoring measure 1.1 Percent of identified members who have a Rapid Access Care Plan (RACP) developed in 2023: Both targets were met in 2023, and completed RACPs are used to inform the development of 100% of members' care plans.

Monitoring measure 1.2 Percent of members' RACP have been actively updated: The July 2023 target of 25% of members having an RACP updated by their assigned care coordinator was not met. Due to the

need to staff-up the new RCT, we did not have enough care coordinator full time equivalents (FTE) to update the necessary number of members' RACPs.

However, the December 2023 benchmark of 50% was met and exceeded, despite the transition of care coordination software platforms to Epic Compass Rose starting in November. Health Share attempted to identify any differences between members who had an updated RACP by the end of 2023 and those members who did not have an updated RACP by the end of 2023 through the lens of REALD data. Ultimately, the sample sizes were too low for any findings to be generalizable to either group.

Monitoring measure 2.1 Percent of members with social risk who receive an accompanied service (Unite Us referral, connection to Papa Pals, or food services through Mom's Meals or member OTC card): Due to the complexity of the various sources for 2.1, this breakdown was not feasible at this time. Our Information Systems Business Intelligence (ISBI) team is actively working on creating a source table for these various programs, with the hope of accurately reporting this in the future.

Monitoring measure 2.2 Member engagement with PCP or other specialty services: The target of 50% of members identified will have a primary care physician (PCP) or specialty care visit by July 2023 was met. Additionally, the benchmark of 80% of members with access or social risk receive a targeted service/intervention from their RACP was also met. The final total reach in 2023 was 89.8% of members. Health Share attempted to identify any differences between those members who were seen by a PCP and those who were not seen by a PCP in 2023 through the lens of REALD data. However, the sample sizes were too low for any findings to be generalizable to either group.

Monitoring measure 3.1 Medication adherence for improved disease management: Health Share's target for this measure was to achieve a 2% improvement over the previous year's adherence measure for prescribed Renin Angiotensin System Antagonists (RASA), statins, and diabetes medications. Overall, Health Share achieved a 1% average improvement across all three measures. The final target performance was as follows:

- 2023 RASA adherence rate target = 88%. End of year performance = 87%.
- 2023 Statin adherence rate target = 89%. End of year performance = 87%.
- 2023 Diabetes adherence rate target = 89%. End of year performance = 88%.

Health Share attempted to identify any differences between these three measures through the lens of REALD data, but the sample sizes were too low for any findings to be generalizable.

Monitoring measure 3.2 Avoidable ED Visits:
Due to issues with data availability resulting from systems transitions, we are not able to determine a 2022 baseline to which 2023 performance can be compared. We established a 2023 baseline for comparing 2024 performance and intend to continue this improvement project into 2025. Health Share attempted to identify any differences between those members who had an avoidable emergency department (ED) visit and those who did not have an avoidable ED visit in 2023 through the lens of REALD data. However, the sample sizes were too low for any findings to be generalizable to either group.

3. **Lessons learned over the last year**:

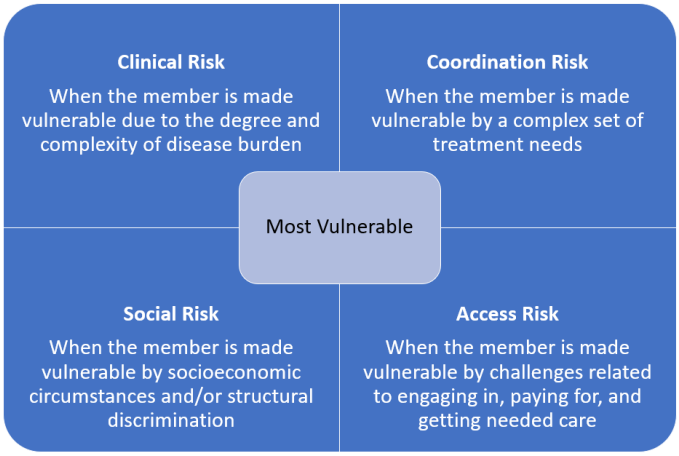
While we have multiple teams prioritizing and engaging in this work, the greatest learning was the overall need for more dedicated Information Service (IS) resources and the need for a dashboard. The complexities of the numerous data sources proved to be a challenge and required additional oversight to ensure alignment and communication for the final product.

Brief narrative description

Project population:

CareOregon Advantage (COA) defines vulnerability as a state of increased need, often imposed on members by circumstances outside their direct control. It places them at increased risk of ineffective medical treatment and/or poor health outcomes. This state of member vulnerability requires additional health plan resources and focused support as we work to achieve COA's mission of making health care work for everyone. COA and Health Share directly collaborate on project design, data sharing, and measurement implementation through our comprehensive governance structure, known as CareOregon Quality Health Outcomes Committee (COQHO), to support this mission. This governance structure includes representation from both teams, ensuring integrated and cohesive project management.

Last year's TQS report highlighted our member risk stratification methodology. Briefly, we define the sickest and most vulnerable members as those with clinical risk accompanied by at least one additional risk (social risk, coordination risk, or access risk).



Applying this risk stratification method to the full CareOregon Advantage (COA) population, RACPs were developed. Members were divided into four overall risk categories: High Risk, Rising Risk, At-Risk, and Healthy.

Risk Category	Description of an Example Population
High Risk (5%)	• Complex patients • Multiple comorbidities • Palliative care; Frail elderly

Rising Risk (20%)	• Chronic disease • Heart failure, COPD, ERSD, diabetes with end-organ disease • Active oncology treatment • Frequent ED utilization for non-emergent needs
At-Risk (40%)	• Moderate care needs • Acute episodic care • Tobacco use; obesity; sedentary lifestyle
Healthy (35%)	• Healthy, no risk • Maintenance activities • Routine testing

To begin the program, CareOregon targeted a cohort of 3,500 COA members (21%), which were referred to as the Model of Care (MOC) Most Vulnerable population. Being the first year of program approval, 2023 was spent building the infrastructure needed to implement the core elements of the care coordination model that would support these members. According to the appropriate intervention, each member is assigned to an Intensive Care Coordinator (ICC) who maintains a caseload tailored to their needs. Depending on the need, the member may be assigned to ICCs specializing in physical health, behavioral health, or social health. This ICC is the single point of contact for the member.

As discussed in Monitoring measure 1.2, above, hiring and onboarding the COA-specific RCT was a barrier to outreaching the target number of members to update their RACPs as planned. In part due to this limitation, the priority MOC Most Vulnerable population was further subdivided to a roster of 550 members. By the end of 2023, 100% of this priority group had received care coordination outreach and had their care plans updated.

CareOregon transitioned care management platforms from GSI to Epic Compass Rose under an uncommonly tight timeline. While we believe this change will greatly enhance integration of care management information in many areas, it impacted timelines and efforts in this work. Newly hired care coordination staff were onboarded to one set of workflows and documentation guidelines and then had to re-learn all of that for the Epic “go-live” in November 2023. Reporting was also similarly affected. All care coordination dashboards and reports had to be rethought and rebuilt. As of this writing in Q2 2024, that work continues. Long term, CareOregon’s adoption of Epic as an opportunity to better integrate payer operations, our clinical network, and the state Clinical Information Exchange (CIE).

As essential operations were established, our focus expanded in the second half of 2023 to include clinical performance improvements. We began developing a performance improvement dashboard to be used by our clinical quality governance bodies to guide project work. We launched our ED utilization project, and we also partnered with our Pharmacy Team to intervene on medication adherence. We look forward to continuing this momentum in 2024.

Intervention (address each component attached):

The illustration below combines the risk types in a visual demonstrating the relationship between the most vulnerable members, their demographics, and anticipated unique clinical interventions. To meet the needs

of our most vulnerable population we have designed special services, staff training, and care planning activities.

Risk Category	Description of an Example Population	Anticipated Interventions
High Risk (5%)	• Multiple complex comorbidities • Frail elderly • Trauma care	• Intensive Care Coordination • AIC/palliative care
Rising Risk (20%)	• Chronic disease • Heart failure, COPD, ERSD, advanced DM • Active oncology treatment • Frequent ED utilization for non-emergent needs	• Intensive Care Coordination • Avoidable ED utilization outreach • In-home primary care options • COPD program • Health-Related Service Flex Funds (Medicaid benefit)
At-Risk (40%)	• Moderate care needs • Acute episodic care • Tobacco use, DM, HTN, CAD, asthma • Managing surgical admissions and follow-up	• Navigation • Medication adherence • Papa Pals social support
Healthy (35%)	• Healthy, little-to-no risk • Routine testing • Maintenance activities	

For 2024, we have selected Activities that build on and expand our 2023 achievements, with a preference for Monitoring Measures that reflect and incorporate the full breadth of work and staff types. The new activities and Monitoring Measures reflect our desire to continuously improve outcomes for members, with an emphasis on work that deepens integration across the care continuum.

Activity 1: Engagement of prioritized members with care coordination services
In 2024, Activity 1 focuses on growth. We believe that reaching more members is an important target for the health of our population. The process starts by engaging members, offering care coordination services, and ultimately increasing the number of members actively empaneled.

Activity 2: Engagement in appropriate services as identified in RACPs, HRAs, or other means.
On the outcomes side, we have decided to focus on members who may benefit from palliative care support. According to our analysis of RACP issue data and the utilization patterns of existing palliative care programs, we feel there is an opportunity to increase member participation.

On the process side, we will be looking at the percentage of members who completed a face-to-face encounter with a qualifying provider because this measure better encompasses the interdisciplinary continuum of care available to our members. A qualifying provider is defined by our MOC as a physician, nurse, social worker, care coordinator, dentist, PT/OT, community or traditional health worker, and other roles.

Activity 3: Improve health outcomes of the most vulnerable population
Health Share was pleased with the progress made in 2023 on these two quality improvement projects. The work in 2024 will be to build on that success. Avoiding unnecessary ED utilization will remain a cornerstone intervention for its value in indicating multiple different dynamics, from member health literacy to PCP access. Health Share also will focus on helping members remain stable on prescribed medications, given the role that prescribers play in transitions of care and chronic disease management.

Activities and monitoring for performance improvement

Activity 1 description: Engagement of prioritized members with care coordination services

☒ Short term or ☐ Long term

Monitoring measure 1.1	Percentage of MOC Most Vulnerable cohorts that received coordination			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
By the end of 2023, 100% of the MOC Most Vulnerable First Focus Group cohort had received care coordination outreach.	100% of Q1 and Q2 MOC Most Vulnerable cohorts will receive care coordination outreach to (a) update their care plan and (b) offer care coordination services	08/2024	100% of Q3 and Q4 MOC Most Vulnerable cohorts will receive care coordination outreach to (a) update their care plan and (b) offer care coordination services	12/2024
Monitoring measure 1.2	Panel sizes of RCT care coordinators who are working with MOC Most Vulnerable-identified members			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Baseline is 50 active members per individual panel	Establish a target for the number of members empaneled needed to achieve SNP plan goals	08/2024	By the end of 2024, we will have begun implementation of the panel size expansion project	12/2024

Activity 2 description: Engagement in appropriate services as identified in Rapid Access Care Plans (RACPs), HRAs, or other means

☒ Short term or ☐ Long term

Monitoring measure 2.1	Number of accepted Advanced Illness Care (AIC) referrals			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Currently, three to five members are evaluated for referral by the AIC referral workgroup every month	Establish a baseline for number of accepted AIC referrals and formalize and refine referral criteria	08/2024	Increase the number of accepted AIC referrals by 25%	12/2024
Monitoring measure 2.2	The percentage of members with a completed, qualifying face-to-face (f2f) encounter in the past 12 months, or else have declined engagement or are unable to be reached.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
As of December 2023, approximately 50% of all COA members met the goal	75% of COA members will have had a f2f encounter in the past 12 months	08/2024	100% of COA members will have had a f2f encounter in the past 12 months	12/2024

Activity 3 description: Improve health outcomes of the most vulnerable population

☐ Short term or ☒ Long term

Monitoring measure 3.1	Percentage of avoidable ED Visits			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
2023 baseline = 22.2% are avoidable ED visits	5% lower than expected avoidable ED visits	12/2024	7% lower than expected avoidable ED visits	12/2025
Monitoring measure 3.2	Percentage improvement with medication adherence for disease management			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
By the end of 2023, achieved 1% improvement over 2022 performance	2% improvement over 2023 performance for: • RASA • Statins • Diabetes	12/2024	2% improvement over 2024 performance for: • RASA • Statins • Diabetes	12/2025

Project title: Dual Eligible SHCN Outreach Initiative

Continued or slightly modified from prior TQS? ☒Yes ☒No, this is a new project

If continued, insert unique project ID from OHA: 428

Components addressed

Component 1: SHCN: Full benefit dual eligible
Component 2 (if applicable): Choose an item.
Component 3 (if applicable): Choose an item.
Does this include aspects of health information technology? ☒ Yes ☐ No
If this is a CLAS standards project, which standard does it primarily address? Choose an item

Project context:

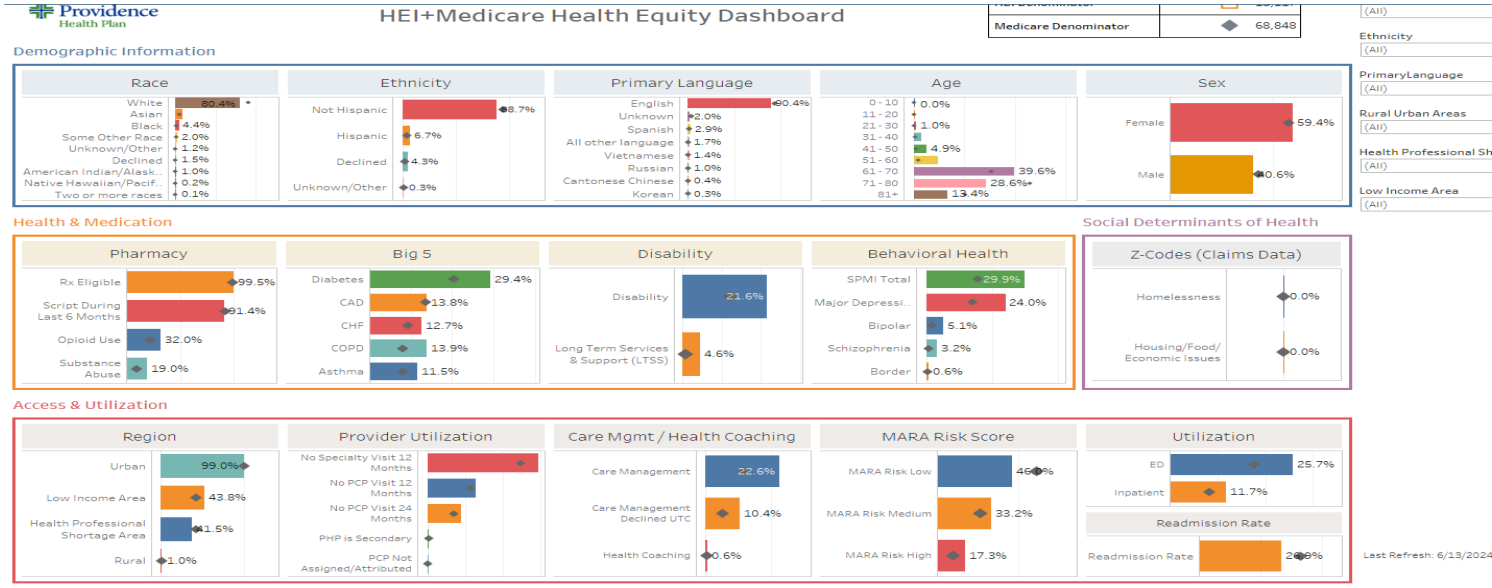
Continued projects

1. **Progress to date (include CCO- or region-specific data and REALD & GI data for the project population):**

   Dual Eligible members with Special Health Care Needs (SCHN) are among the most vulnerable populations covered by CCOs. Many Dual Eligible members assigned to Health Share have clinical and/or social factors that align with the Center for Disease Control's identification of people who need extra precautions, such as those with disabilities, belonging to racial and ethnic minority groups, and those residing in nursing homes or long-term care facilities. In recognition of the unique needs of this population, Health Share works with plan partners to ensure that Dual Eligible members with SHCNs are connected to primary care providers and receive critical preventative services. By increasing utilization of primary care services, like Annual Wellness Visits (AWV), the CCO is striving to enhance care coordination and improve health outcomes for its most vulnerable members.

   Providence Health Assurance (PHA), a Health Share partner, utilizes a Health Equity Index (HEI) Dashboard to evaluate and monitor health equity amongst Dual Eligible, Low-Income Subsidy, and Disability Medicare members. The HEI dashboard enables PHA to examine these populations by race, ethnicity, age, language, and disability. SOGI data is not currently incorporated into the tool due to the lack of available data, however that information is intended to be built into the tool over the course of the coming year.

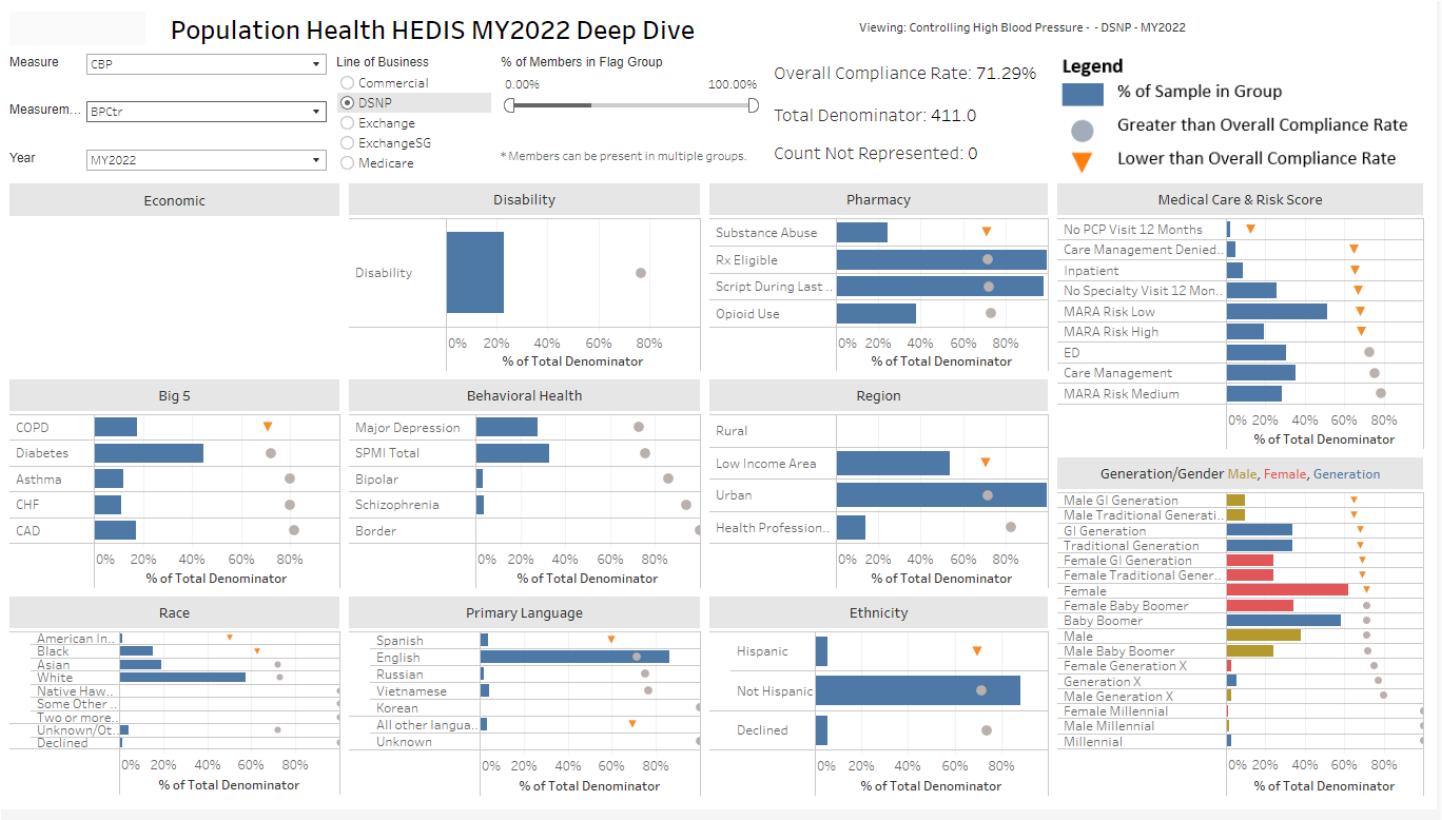
   Examination of the HEI dashboard (see example below) indicates that, overall, the HEI population has higher rates of health disparities than the overall Medicare population.



Pertinent observations from the evaluation of the HEI population compared to the overall Medicare population include the following:

- 21.6% have a disability compared to 12.1% of Medicare
- 59.4% identify as female
- Higher rates of members between the ages of 31 and 70
- Higher rates of Diabetes, COPD, CHF, and Asthma
- Higher proportions of Black and Asian identifying members
- Higher proportion of members identifying as Hispanic
- Higher rates of SPMI, Major Depression, Bipolar, and Schizophrenia
- Higher rates of members living in a low-income area
- Higher rates of members that speak a language other than English
- Higher rates of members who have not seen a specialist or PCP in the last 12 months or a PCP in the last 24 months
- Higher rates of ED utilization, inpatient admissions, and readmissions

In looking more granularly at the Dual Eligible Special Needs Plans (D-SNP) population, PHA identified that 30% of the D-SNP population has a physical or developmental disability. PHA also evaluates D-SNP measure performance by REALD data and noted that D-SNP members with disabilities had lower performance rates on most measures compared to the overall D-SNP population. D-SNP members with disabilities were also more likely to not have had a PCP or specialist visit within the last 12 months.



Due to the large portion of D-SNP members with disabilities, their lower engagement with PCPs and specialists, and their lower health outcomes, PHA identified an opportunity to engage D-SNP members with disabilities with care through AWV. AWV services cover a large range of care and can get members connected with other treatments or providers, as necessary.

2. **Describe whether last year's targets and benchmarks were met (if not, why):**

In 2023, PHA had an increase in annual wellness visits for the D-SNP population with physical and developmental disabilities. The AWV rate increased by approximately five percent from 2022 to 2023. D-SNP members with disabilities now have a slightly higher rate of AWV than the overall D-SNP population. PHA met last year's target and benchmark that was set for overall AWV rate. Of the D-SNP members with disabilities who were eligible for an incentive, 42.3% received an AWV, which was a 12% increase from prior year. PHA also saw a one percent increase in the completion of the Health Risk Assessment Tool (HRAT) for D-SNP members with disabilities who were eligible for an incentive.

When reviewing health outcomes for the D-SNP members with disabilities, PHA identified that there was not a lot of improvement or change in ED utilization and readmissions. With this being a small population, there can be significant fluctuation in performance. This is also a high-needs population, so PHA anticipates that progress will be slow when it comes to these areas, as members develop relationships with providers and further engage in care. PHA Care Managers have reviewed readmissions data in the past and determined that most readmissions were appropriate given the nature of the population. A promising finding from the health outcomes data is that D-SNP members with disabilities had an improvement in controlling blood pressure by 7.3% from prior year performance.

This population also performed approximately the same as the overall D-SNP population, which is an improvement from prior year performance.

3. **Lessons learned over the last year:**

   Based on findings from this project, PHA learned that incentivizing D-SNP members with disabilities to engage in care has led to improvements in health outcomes and completion of services, with four percent more members completing the HRAT in 2023. PHA will continue to offer this incentive through 2024 to further increase engagement of this high-risk population.

Brief narrative description

Project population:
Full Benefit Dual Eligible Health Share members assigned to Providence Medical

Intervention (address each component attached):
In order to address the disparities in health outcomes of D-SNP members with disabilities and to support D-SNP members with disabilities with barriers to accessing care, PHA will be working to increase PCP engagement of these members through AWV. The project will incentivize D-SNP members with disabilities to receive $50 upon completion of an AWV. The funds provided to these members can be used to purchase a variety of items, including but not limited to over-the-counter items, bedding, clothing, shoes, exercise equipment, and more. The funds cannot be used to purchase alcohol, tobacco, firearms, lottery, or prescription drug copays.

PHA is also implementing interventions to ensure these members receive a HRAT during the measurement year to capture social determinants of health and address unmet social needs. PHA Care Management works directly with members and in conjunction with providers to complete HRATs. Upon identification of an unmet social need, the PHA Care Management team refers and works collaboratively with multiple community partners, including Area Agency on Aging/Aging and People with Disabilities county offices, County Case Managers, Behavioral Health Specialists and Community Health Workers, to assist in reducing barriers and addressing identified needs. PHA provides an incentive for this population to complete the HRAT, along with incentives for AWVs.

Activities and monitoring for performance improvement

Activity 1 description Implement AWV Member Incentive Initiative

☒ Short term or ☐ Long term

Monitoring measure 1.1	Percentage of D-SNP members with physical or developmental disabilities that received an AWV			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
40% in 2023	42.0%	06/2024	45%	12/2024
Monitoring measure 1.2	Compliance rate of D-SNP members with a developmental or physical disability who were eligible for an incentive and completed an AWV			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**

42.3% in 2023	40.0%	06/2024	45.0%	12/2024
Monitoring measure 1.3	ED Utilization rate of D-SNP members with physical and developmental disabilities per member per month (PMPM)			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0.19 ED visits PMPM	0.17 ED visits PMPM	06/2024	0.15 ED visits PMPM	12/2024
Monitoring measure 1.4	Readmission rate of D-SNP members			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
10.4% in 2023	10.2%	06/2024	10.0%	12/2024
Monitoring measure 1.5	Percentage of D-SNP members with physical or developmental disabilities that had controlled blood pressure			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
73.1% in 2023	75.0%	6/2024	80.0%	12/2024

Activity 2 description: Completion of HRAT for D-SNP members with physical or developmental disabilities, in order to encourage them to complete their AWV and address any unmet social needs

☐ Short term or ☒ Long term

Monitoring measure 2.1	Percentage of D-SNP members with physical or developmental disabilities that receive an HRAT			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
87.0% in 2023	90.0%	06/2024	100%	12/2024
Monitoring measure 2.2	Compliance rate of D-SNP members with a developmental or physical disability who were eligible for an incentive and completed an HRAT			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
81.9% in 2023	90.0%	6/2024	100%	12/2024

Project title: Emergency Department Pilot for Members with SUD

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project

If continued, insert unique project ID from OHA: 429

Components addressed

1. Component 1: SHCN: Non-duals Medicaid
2. Component 2 (if applicable): Choose an item.
3. Component 3 (if applicable): Choose an item.
4. Does this include aspects of health information technology? ☒ Yes ☐ No
5. If this is a CLAS standards project, which standard does it primarily address? Choose an item

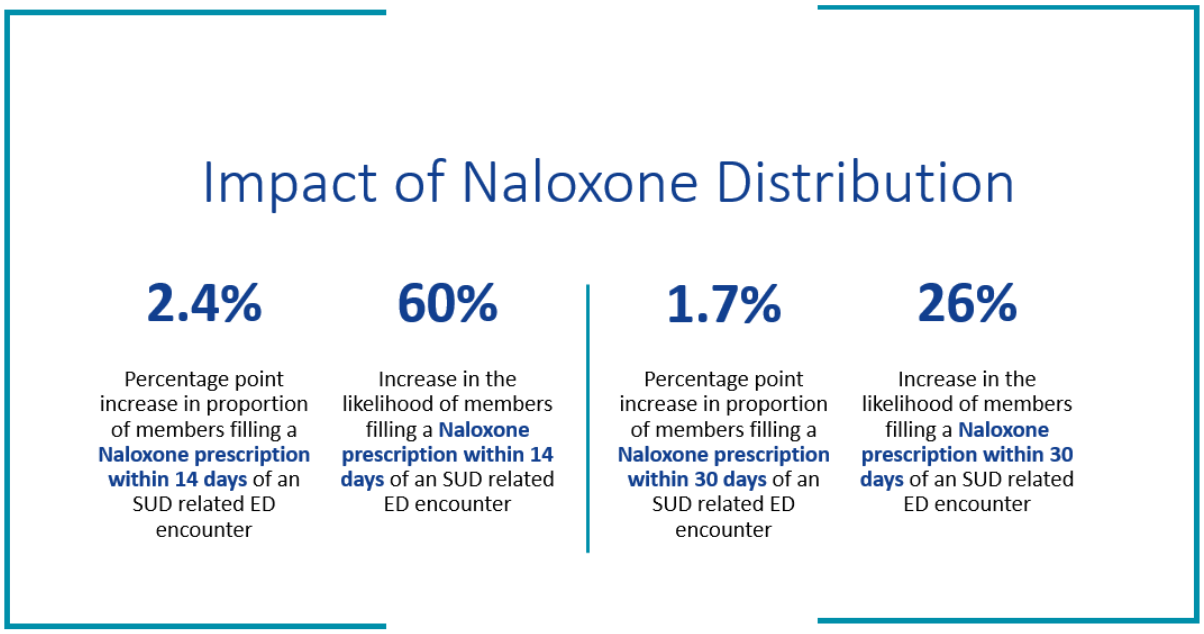
Project context:

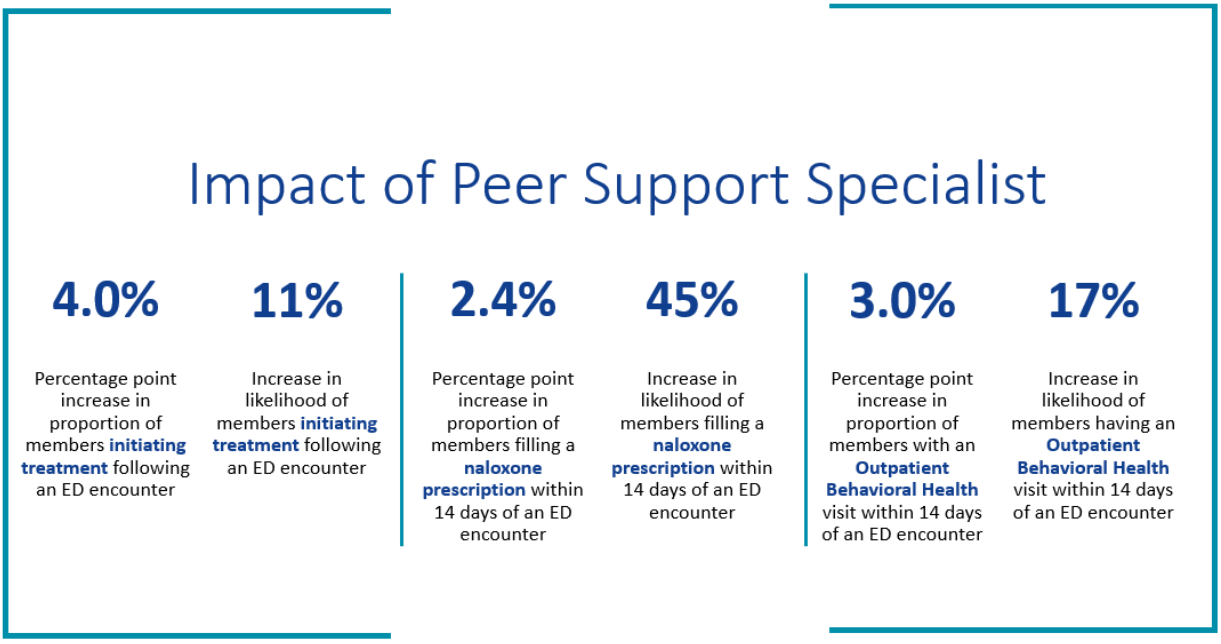
Continued projects

1. **Progress to date (include CCO- or region-specific data and REALD & GI data for the project population):**
   The Emergency Department (ED) Substance Use Disorder (SUD) Pilot went live on July 1, 2022 at Adventist Emergency Department. To support the launching of the pilot, CareOregon hired a peer, developed and implemented peer workflows, developed and deployed clinical trainings. Through these workflows, the ED began distribution of naloxone. The workflows were updated using a process improvement methodology. In 2023, the ED SUD Pilot workgroup met bi-weekly to track deliverables and progress and to make adjustments, as needed. The Mental Health and Addiction Association of Oregon (MHAAO) continued to provide peer-related services for the pilot, and this contract is expected to be renewed annually. Additionally, in 2023, the focus was on outcomes data and the development of a "play book" for expanding the pilot to a second ED site. The analysis of the ED pilot outcomes data was completed.

   Key findings include:

   Health Share partnered with Providence CORE to evaluate the impact of the ED pilot across a broad range of indicators. The findings from the analysis have been encouraging, with results indicating the intervention has increased the likelihood of members filling Naloxone prescriptions, engaging in outpatient behavioral health services and initiating and engaging in SUD treatment (see visuals below).


Impact of Naloxone Distribution
2.4%
Percentage point increase in proportion of members filling a Naloxone prescription within 14 days of an SUD related ED encounter
60%
Increase in the likelihood of members filling a Naloxone prescription within 14 days of an SUD related ED encounter
1.7%
Percentage point increase in proportion of members filling a Naloxone prescription within 30 days of an SUD related ED encounter
26%
Increase in the likelihood of members filling a Naloxone prescription within 30 days of an SUD related ED encounter


Impact of Peer Support Specialist
4.0%
Percentage point increase in proportion of members initiating treatment following an ED encounter
11%
Increase in likelihood of members initiating treatment following an ED encounter
2.4%
Percentage point increase in proportion of members filling a naloxone prescription within 14 days of an ED encounter
45%
Increase in likelihood of members filling a naloxone prescription within 14 days of an ED encounter
3.0%
Percentage point increase in proportion of members with an Outpatient Behavioral Health visit within 14 days of an ED encounter
17%
Increase in likelihood of members having an Outpatient Behavioral Health visit within 14 days of an ED encounter

Impact on Initiation and Engagement of Treatment

	Naloxone Distribution		Peer Support Specialist	
	Absolute Rate	**Relative Likelihood**	**Absolute Rate**	**Relative Likelihood**
Initiation	2.8%	7.6%	↑4.0%*	↑10.8%*
Engagement	2.0%	9.9%	2.0%	10.5%

* p <0.05 ** p < 0.01 *** p < 0.001

Primary program outcomes were disaggregated by race, ethnicity, and language, to identify potential inequities:

- Percent of pilot participants receiving naloxone
- Percent of with one or more pharmacy claims for opioid use disorder (OUD) medications
- Percent of with one or more pharmacy claims for alcohol use disorder (AUD) medications
- Percent of members with a claim documenting a substance-related overdose within 90 days of an ED encounter
- Percent of members with IET initiation
- Percent of members with IET engagement

The following tables show the REAL results for each outcome. At this time, Health Share is exercising caution as it pertains to analysis and use of sexual orientation and gender identity (SOGI) data. Our clinical partners have expressed concern around gender identity (GI) data collection and use, in particular for members under the age of 18 years. As such, Health Share has limited GI data exploration to targeted claims comparisons, missingness analyses, and aggregation approaches. While Health Share intends to incorporate analysis by sexual orientation (SO) in the future, the OHA has not yet made SO data available to CCOs, preventing any analysis on that dataset. Once available and standards for use of this data have been adopted, this data will be reviewed for disparities to aid with identifying specific populations that may need focused or modified support from the care coordination team.

For each of the tables below, green indicates better rates compared to the overall average, and orange indicates worse rates than the overall average. Disaggregating data in this way offers perspectives on how well this program may be working with different populations and offers important avenues to

explore in terms of variable outcomes across groups, program workflow, and overall data/tracking methodology.

Naloxone fills within 30 days by race/ethnicity.
Members identifying as American Indian/Alaskan Native, Asian, Latino/a/x/e, and White had higher rates of receiving naloxone after the pilot than before. Members identifying as Black/African American/African, Middle Eastern/North African, and Native Hawaiian/Pacific Islander had lower rates of receiving naloxone than the overall average after participation in the pilot. As noted below, the Middle Eastern/North African and Native Hawaiian/Pacific Islander groups both had small numbers of members (<40 participants each).

Race/ethnicity (# pilot participants)	% receiving naloxone (PRE)	% receiving naloxone (POST)	% difference between Pre-Post
American Indian/ Alaskan Native (120)	11.0%	14.7%	34%
Asian (145)	5.7%	8.4%	47%
Black/African American/ African (159)	11.2%	6.9%	-38%
Latino/a/x/e (470)	4.1%	9.4%	128%
Middle Eastern/ North African (17)	9.5%	0.0%	-100%
Native Hawaiian/ Pacific Islander (35)	13.3%	0.0%	-100%
White (1460)	6.1%	7.8%	28%
Multiple/Not Listed (77)	9.5%	8.6%	-10%
Unknown (575)	4.7%	7.6%	62%
Overall (3058)	6.1%	8.1%	33%

Naloxone fills within 30 days by spoken language.
Spoken language groups of 10 or fewer members are not shown. Spanish speaking members had higher rates of receiving naloxone compared to the overall average after the pilot, along with members who speak another language and those with an unknown spoken language.

Language (# pilot participants)	% receiving naloxone (PRE)	% receiving naloxone (POST)	% difference between Pre-Post
English (234)	7.0%	7.3%	4%
Spanish (64)	0.0%	12.9%	NA (Pre is 0) / >100%
Russian (17)	0.0%	0.0%	0%
Other (36)	5.6%	12.5%	125%
Unknown (2691)	6.2%	8.2%	32%
Overall (3058)	6.1%	8.1%	33%

OUD medication within 30 days by race/ethnicity.
Almost all groups decreased in their receipt of OUD medication within 30 days between the pre-and post- participation time period. Members who identify as Latino/a/x/e had the smallest decrease in receipt of OUD medication, while Asian, Black/African/African American, Middle Eastern/North African,

and Native Hawaiian/Pacific Islander members had larger decreases. The reason for this decrease is unclear and will be investigated further. With a consistent counterintuitive reduction like this, it will be important to review the design of the analysis and the program's member flow to understand what is driving this pattern, as it has significant impacts on the potential impact of the program.

Race/ethnicity (# pilot participants)	% receiving OUD med (PRE)	% receiving OUD med (POST)	% difference between Pre-Post
American Indian/ Alaskan Native (120)	11.0%	8.8%	-20%
Asian (145)	17.1%	8.4%	-51%
Black/African American/ African (159)	12.4%	5.9%	-52%
Latino/a/x/e (470)	9.6%	9.4%	-1%
Middle Eastern/ North African (17)	23.8%	0.0%	-100%
Native Hawaiian/ Pacific Islander (35)	13.3%	5.9%	-56%
White (1460)	10.6%	8.7%	-19%
Multiple/Not Listed (77)	7.1%	14.3%	100%
Unknown (575)	11.2%	10.0%	-11%
Overall (3058)	11.1%	8.9%	-20%

OUD medications within 30 days by spoken language.

Spoken language groups of 10 or fewer members are not shown. Almost all groups decreased in their receipt of OUD medication within 30 days between the pre-and post- participation time period. Members with Spanish spoken language increased to 3.2%, which is still lower than the overall average.

Language (# pilot participants)	% receiving OUD med (PRE)	% receiving OUD med (POST)	% difference between Pre-Post
English (234)	9.1%	4.0%	-56%
Spanish (64)	0.0%	3.2%	>100%
Russian (17)	0.0%	0.0%	0%
Other (36)	22.2%	0.0%	-100%
Unknown (2691)	11.4%	9.5%	-16%
Overall (3058)	11.1%	8.9%	-20%

AUD medication within 30 days by race/ethnicity.

American Indian/Alaskan Native and White members had the largest rates of increase between pre- and post-, and Middle Eastern/North African members had the highest rate of AUD medication at post-pilot. No Black/African American/African or Native Hawaiian/Pacific Islander members received AUD medications in the post- time period.

Race/ethnicity (# pilot participants)	% receiving AUD med (Pre)	% receiving AUD med (Post)	% difference between Pre-Post
American Indian/ Alaskan Native (120)	1.2%	7.4%	503%

Asian (145)	3.8%	1.1%	-72%
Black/African American/ African (159)	0.0%	0.0%	0%
Latino/a/x/e (470)	6.4%	7.4%	16%
Middle Eastern/ North African (17)	14.3%	18.2%	27%
Native Hawaiian/ Pacific Islander (35)	6.7%	0.0%	-100%
White (1460)	3.9%	6.2%	58%
Multiple/Not Listed (77)	0.0%	0.0%	0%
Unknown (575)	1.6%	1.6%	0%
Overall (3058)	3.6%	4.8%	34%

AUD medications within 30 days by spoken language.

Spoken language groups of 10 or fewer members are not shown. Members with spoken language English and Spanish had the largest increases between the pre- and post- time periods. No Russian speaking members received AUD medications at either pre- or post-.

Language (# pilot participants)	% receiving AUD med (PRE)	% receiving AUD med (POST)	% difference between Pre-Post
English (234)	1.4%	3.2%	131%
Spanish (64)	5.6%	9.7%	74%
Russian (17)	0.0%	0.0%	0%
Other (36)	11.1%	6.2%	-44%
Unknown (2691)	3.7%	4.9%	31%
Overall (3058)	3.6%	4.8%	34%

Substance-related overdose within 90 days by race/ethnicity.

Most groups had an increase in substance-related overdose between the pre- and post- time period, but Native Hawaiian/Pacific Islander members and members with multiple/not listed race/ethnicity had decreases. American Indian/Alaskan Native, Asian, Latino/a/x/e, and Middle Eastern/North African members had larger than average increases in substance-related overdose.

Race/ethnicity (# pilot participants)	% w/overdose (PRE)	% w/overdose (POST)	% difference between Pre-Post
American Indian/ Alaskan Native (120)	12.2%	17.6%	45%
Asian (145)	17.1%	26.3%	54%
Black/African American/ African (159)	15.7%	25.7%	64%
Latino/a/x/e (470)	14.6%	19.9%	36%
Middle Eastern/ North African (17)	4.8%	36.4%	664%
Native Hawaiian/ Pacific Islander (35)	20.0%	17.6%	-12%
White (1460)	13.9%	16.5%	19%
Multiple/Not Listed (77)	19.0%	14.3%	-25%

Unknown (575)	14.4%	21.1%	47%
Overall (3058)	14.3%	19.0%	33%

Substance-related overdose within 90 days by spoken language.

Spoken language groups of 10 or fewer members are not shown. English speaking members had lower than average increases in substance-related overdoses, while Spanish speaking members had slightly higher than average increases between pre- and post-.

Language (# pilot participants)	% w/overdose (PRE)	% w/overdose (POST)	% difference between Pre-Post
English (234)	16.8%	21.0%	25%
Spanish (64)	16.7%	22.6%	36%
Russian (17)	0.0%	0.0%	0%
Other (36)	16.7%	12.5%	-25%
Unknown (2691)	14.1%	18.9%	34%
Overall (3058)	14.3%	19.0%	33%

IET Initiation by race/ethnicity.

The largest increases in IET initiation were seen in American Indian/Alaskan Native, Latino/a/x/e, White, and Multiple race members. All groups showed increases except Asian and Middle Eastern/North African members. Of note, the MENA group has a very small n.

Race/ethnicity (# pilot participants)	% with IET initiation (PRE)	% with IET initiation (POST)	% difference between Pre-Post
American Indian/ Alaskan Native (120)	40.2%	50.0%	24%
Asian (145)	40.0%	29.5%	-26%
Black/African American/ African (159)	28.1%	37.6%	34%
Latino/a/x/e (470)	38.5%	40.7%	6%
Middle Eastern/ North African (17)	61.9%	36.4%	-41%
Native Hawaiian/ Pacific Islander (35)	33.3%	35.3%	6%
White (1460)	37.7%	40.4%	7%
Multiple/Not Listed (77)	28.6%	54.3%	90%
Unknown (575)	34.2%	36.1%	5%
Overall (3058)	37.0%	39.5%	7%

IET Initiation by spoken language.

The largest increases in IET initiation were seen among English and Spanish speaking members. Members with Russian and other spoken languages saw decreases (of note, both of these groups have small ns).

Language (# pilot participants)	% with IET initiation (PRE)	% with IET initiation (POST)	% difference between Pre-Post
English (234)	25.9%	37.1%	43%
Spanish (64)	16.7%	41.9%	152%
Russian (17)	44.4%	12.5%	-72%
Other (36)	38.9%	18.8%	-52%
Unknown (2691)	38.1%	39.9%	5%
Overall (3058)	37.0%	39.5%	7%

IET Engagement by race/ethnicity.

The largest increases in IET engagement were seen in American Indian/Alaskan Native, Black/African American/African, Latino/a/x/e, and Multiple race members. Asian, Middle Eastern/North African, and Native Hawaiian/Pacific Islander members saw decreases while White members' rate stayed virtually the same. Of note, the MENA and NH/PI groups have small ns.

Race/ethnicity (# pilot participants)	% with IET engagement(PRE)	% with IET engagement(POST)	% difference between Pre-Post
American Indian/ Alaskan Native (120)	22.0%	26.5%	21%
Asian (145)	22.9%	17.9%	-22%
Black/African American/ African (159)	16.9%	20.8%	23%
Latino/a/x/e (470)	22.3%	25.6%	15%
Middle Eastern/ North African (17)	38.1%	18.2%	-52%
Native Hawaiian/ Pacific Islander (35)	26.7%	17.6%	-34%
White (1460)	22.5%	22.5%	0%
Multiple/Not Listed (77)	11.9%	40.0%	236%
Unknown (575)	19.1%	19.5%	21%
Overall (3058)	21.5%	22.4%	4%

IET Engagement by spoken language.

The biggest increases in IET engagement were seen among Russian, Spanish, and English-speaking members. Members who speak other languages saw a decrease in IET engagement (of note, this group has a small n).

Language (# pilot participants)	% with IET engagement(PRE)	% with IET engagement(POST)	% difference between Pre-Post
English (234)	17.5%	18.5%	6%
Spanish (64)	11.1%	22.6%	103%
Russian (17)	0%	12.5%	>100%
Other (36)	27.8%	12.5%	-55%
Unknown (2691)	22.1%	22.9%	4%
Overall (3058)	21.5%	22.4%	4%

The play book development began in 2023. Components completed include an overview of program, implementation lessons learned from ED staff, core trainings developed and accessible on MOUD, harm reduction, stigma and bias. Development of the core components of the play book continues into 2024.

In 2023, a second pilot site within the Legacy Health Metro (Legacy Health) hospital system was identified. Legacy Health and Health Share have agreed upon the terms of the letter of agreement (LOA), and the final document is ready to be signed. CareOregon has signed a contract for a clinical champion who is board certified in addiction medicine--a key role within the pilot. Legacy Health system includes peer support, and an assessment of how current roles will be maximized is in discussion.

2. **Describe whether last year's targets and benchmarks were met (if not, why):**

In 2022, this project's goal was to develop a mechanism to track pilot project outcomes. This was not met in 2022 but was completed during 2023. Data is provided in the monitoring measures below and in the progress-to-date section.

2023 Activities and Monitoring Measures:
Activity 1: Implementation of ED Pilot Workflows had two monitoring measures.

Monitoring Measure 1.1: Implementation of Peer Workflows had a target of identifying key peer workflows needed by July 2023 and developing peer workflows for referral to physical health, behavioral health, and community-based organizations by July 1, 2023. Both the target and benchmark were met.

Monitoring Measure 1.2: Implementation of Naloxone Distribution Workflows had a target of tracking the number of naloxone kits to SUD pilot participants by July 23 and a benchmark of providing the kits or a prescription to prevent overdose by July 2023. Both goals were met by the target date.

Activity 2: Implementation of the ED Pilot and Tracking of Outcomes had the following five monitoring measures:

Monitoring Measure 2.1 Number of people served by the pilot had a target/benchmark of engaging 20% of individuals presenting to the ED pilot site engaging in the pilot. Health Share was unable to calculate the measure denominator for the time period associated with the intervention; however, the pilot successfully engaged 216 Health Share members who presented to the pilot site.

Monitoring Measure 2.2 Number of peer services received by pilot participant had a target/benchmark that 40% of pilot participants receive at least one contact from the peer by July 2023. This target was met, as 100% of the 216 pilot participants received peer services.

Monitoring Measure 2.3 Percent of pilot participants receiving naloxone had a target/benchmark that 50% by July 2023. This goal was met, with 128 of the 216 (59.3%) participants receiving naloxone.

Monitoring Measure 2.4 Percent of members eligible to participate in the pilot receiving medication for OUD or AUD had a target/benchmark to increase the number of pilot participants with one or more pharmacy claims for OUD or AUD (within 30 days of the ED visit) medications by 20% by July 2023. This target was partially met, as AUD medication increased by 34% whereas an overall decrease in OUD medications was observed during the same period.

Monitoring Measure 2.5 Implementation of technical assistance package had a goal to provide a technical assistance package focused on SUD and MOUD best practices to Adventist ED by 7/2023. The benchmark was to engage in ongoing monitoring, hold a feedback session with clinical staff, and present at one Adventist RN staff meeting by December 2023. The target and benchmark were both met.

Activity 3 Initiate Process of Launching Another ED Pilot at a second site had two monitoring measures in 2023.

Monitoring Measure 3.1 Identify site for expansion of ED SUD pilot had a target of identifying an ED willing to participate in the SUD pilot and engaging with administrator and clinician to determine interest and readiness by September2023. The benchmark was to have a signed LOA with the ED by December 2023. The target for this measure was met, and an ED was identified. The contracting process progressed more slowly than planned for, so the LOA was not signed by 12/2023. However, the LOA is currently ready for signature.

Monitoring Measure 3.2 Identify clinical and administrative champions had a target to identify clinical and administrative champions by September 2023 and a benchmark to convene a core workgroup to oversee implementation and progress by December 2023. Both the target and benchmark were met.

3. **Lessons learned over the last year:**

Hiring of the peer was especially difficult due to staff shortages. Other lessons learned were to include an RN role in the initial roll out, as well as a clinical champion with decision-making power. We have also decided to add an administrative clinical champion. Our initial project timeline was only one year, which we found to be too ambitious, especially given the hiring challenges. A two-year timeline for future pilot sites would be preferable. Finally, it was critical to have pharmacy cooperation and to ensure that all SUD medication were available in ED throughout the pilot. The decrease in OUD medications and increases in overdoses needs further exploration. We are conducting further statistical analyses (a differences in differences analysis) in order to assess positive and negative outcomes of the pilot compared to a standardized control group.

Brief narrative description

Project population:

Health Share members seen at the ED with SUD. In 2023, the project population was restricted to members visiting the Adventist Emergency Department. In 2024, this will expand to include the members visiting the Legacy Emergency ED. We conducted a preliminary analysis on baseline data to understand the scope of potential impact of the ED pilot. The following describes members seen at Adventist ED with SUD between

July 2021 and June 2022:

- 398 total members
- 547 claims
- 97% English speaking
- 52% White
- 8% Black
- 5% Hispanic
- 2% American Indian, Alaskan Native
- 2% Asian
- 63% male
- 37% female

Intervention (address each component attached):
This project aims to connect Health Share members who present at the ED with SUD to treatment services. This includes connecting the member with peer services, ensuring they have access to naloxone as a harm reduction strategy, and offering medication for treatment for OUD and AUD. EDs offer an excellent opportunity to provide best practice SUD treatment and overdose prevention. Data consistently shows that members who are seen in the ED for SUD-related reasons are the least likely to be connected to follow-up treatment in any setting. By offering evidence-based SUD treatment in the ED, we aim to see reduction in fatal overdoses, increase in medication use for OUD, and increase in initiation and treatment for substance use. Completing an ED analysis annually will give us data on success of interventions.

The ED pilot will be at Adventist ED and launch at our second pilot site, Legacy Health ED. Work needed to launch this second site includes review of data—specifically, number of members seen in the ED for SUD, identification and hiring of team, workflow for clinical care and peer involvement, and identifying and providing needed training. The MHAAO will continue to provide the peer-related services for the pilot. Additionally, the ED pilot workgroup will continue to meet bi-weekly to track progress and deliverable and outcomes measures. Work will also continue to develop the ED pilot play book, which will be used as a tool to support adoption at the second pilot site. Further analysis will review intervention differences which lessen disparities identified.

Activities and monitoring for performance improvement

Activity 1 description: Implementation of ED pilot workflows

☐ Short term or ☒ Long term

Monitoring measure 1.1	Implementation of peer workflows			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Workflows were implemented in the first pilot site	Key peer workflows needed for success are identified for second pilot site	12/31/2024	Peer workflows for referral to physical health, behavioral	12/31/2024

	Progress tracked at bi-monthly ED Pilot steering committee		health and community-based organizations are developed for the second pilot site	
Monitoring measure 1.2	Implementation of naloxone distribution workflows			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Workflows are implemented in the first pilot site	Number of naloxone kits distributed to SUD pilot participants is tracked	12/31/2024	SUD pilot participants at risk of overdose who receive naloxone kit or RX. Number provided is tracked and reviewed during bi-weekly Pilot workgroup	12/31/2024

Activity 2 description: Implement project and track outcomes.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Percent of program participants at the second pilot site who receive at least one contact from the peer			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No baseline for second pilot site.	40% of second pilot site participants	3/31/2025	40% of second pilot site participants	3/31/2025
Monitoring measure 2.2	Percent of program participants at the second pilot site receiving naloxone (claims or kit) within 30 days of the ED encounter			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
128/216 (59.3%) at first pilot site	50% of second pilot site participants	3/31/2025	50% of second pilot site participants	3/31/2025
Monitoring measure 2.3	Percent of members eligible to participants at the original pilot site with a pharmacy claim for OUD or AUD medication within 30 days of the ED encounter			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
8.9% of eligible members had an OUD medication within 30 days	20% improvement over baseline for CY 2024	12/31/2024	25% improvement over baseline for CY 2025	3/31/2024

4.8% of eligible members had an AUD medication within 30 days				
Monitoring measure 2.4	Implementation of technical assistance package			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Technical assistance package was delivered to first pilot site	Provision of technical assistance package to Legacy ED staff focused on SUD and MOUD best practices with ongoing monitoring for educational needs	3/31/2025	Ongoing monitoring and feedback session with clinical staff to gauge educational needs. Attend and present at 1 Legacy RN and ED staff meeting.	3/31/2025
Monitoring measure 2.5	Percent of members with a claim documenting a substance-related overdose within 90 days of an ED encounter			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
15.4% (pre-implementation of the first pilot site)	12.4%	12/31/2024	10%	12/31/2025

Monitoring measure 2.6	Percent of members seen at Adventist pilot site who initiate treatment for SUD within 14 days of index episode			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
40.13%	44.14%	12/31/2024	49.1%	12/31/2024
Monitoring measure 2.7	Percent of members seen at Adventist pilot site who engage in SUD treatment within 14 days of index episode			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
22.58%	24.84%	12/31/2024	27.1%	12/31/2025
Monitoring measure 2.8	Percent of members with a claim documenting a Behavioral Health Services within 14 days of ED encounter			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**

17.9%	26.6%	12/31/2024	41.5%	12/31/2025

Project title: Seven Day Follow-Up Improvement Project

Continued or slightly modified from prior TQS? ☒ Yes ☐ No, this is a new project

If continued, insert unique project ID from OHA: 430

Components addressed

1. Component 1: Serious and persistent mental illness
2. Component 2 (if applicable): Choose an item.
3. Component 3 (if applicable): Choose an item.
4. Does this include aspects of health information technology? ☐ Yes ☒ No
5. If this is a CLAS standards project, which standard does it primarily address? Choose an item

Project context:

Continued projects

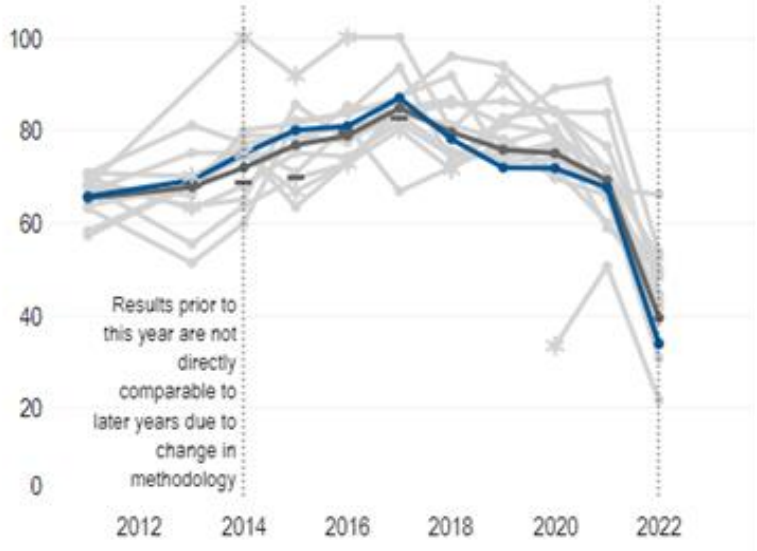
1. **Progress to date (include CCO- or region-specific data and REALD & GI data for the project population):**

   Seven-day follow up after hospitalization for mental illness

   Bolstering care coordination and clinical program offerings for members with Serious and Persistent Mental Illness (SPMI) remains a top priority for Health Share of Oregon. The CCO and its partners have worked diligently to mitigate the ongoing impacts of the behavioral health workforce shortage and ensure members with SPMI receive person-centered care that allows them to live as integrated as possible within the community. This has spanned a thorough review and analysis of the clinical programs and care coordination services needed, as well as the payment and reimbursement models that will support a new model of care.

   In 2023, Health Share's Behavioral Health Plan, CareOregon encountered challenges associated with producing data on seven-day follow-up after hospitalization for mental illness in-house. The decision was made to use data that the OHA produces and makes available to the CCOs. The limitation of this data is that it is only produced once a year and the data lag is longer than it would be if we were able to produce the data in house. However, given the chronic challenges, it was determined that this approach would allow the project to progress forward while the internal data issues are being resolved.

Figure 1. Seven-day follow-up after hospitalization from mental illness from 2012-2022

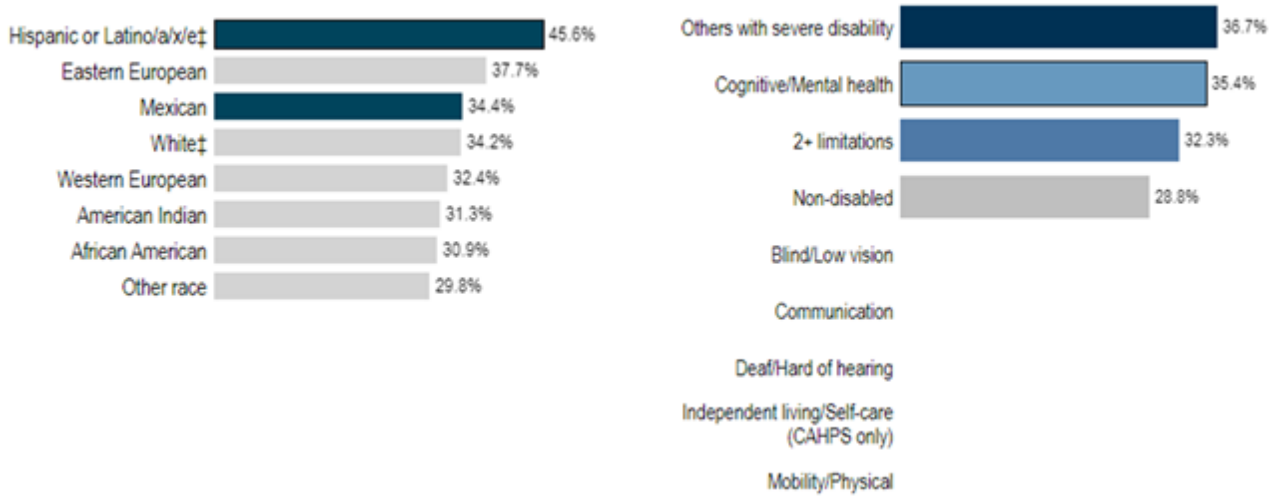


Blue line represents Health Share of Oregon while the brown line represents the state average.

The specifications for this measure were changed, which makes it difficult to compare 2022 data to previous years; however, there was a downward trend in this measure starting prior to and continuing through the COVID-19 pandemic and Health Share's performance in 2022 was 33.7% which is >5 percentage points lower than the state average of 39.3%.This trend continued in 2023, as Health Share's performance on the metric 31.2% was lower than the statewide average of 34.5%.

This data reinforces existing analysis that showed the follow-up rates after hospitalization worsened across the state during and immediately after the pandemic, as members delayed or chose to forgo needed care. The pandemic also increased strain on the capacity of the mental health system. While we are beginning to see stabilization, there are still substantial workforce shortages in behavioral health across the state, and in the Portland Metro area that we believe are impacting the ability of members to receive follow up care in a community-based setting within seven days of discharge.

Figure 2. 2022 7-day follow-up after hospitalization from mental illness disaggregated by REALD



Data was disaggregated by race/ethnicity, language, and disability status. Small numbers prevented us from drawing meaningful conclusions about linguistic disparities in this measure. This data highlighted opportunities to improve outcomes most notably for American Indian and Black/African American members. Both of these groups have rates lower than the CCO average. Members with severe disability and cognitive/mental health disability had higher than average follow up rates, though an area of opportunity is members reporting two or more limitations. Spotlighting inequities and identifying members experiencing barriers to care is a critical step towards improving health outcomes within this project. Addressing these disparities will be a key focus of this project moving forward.

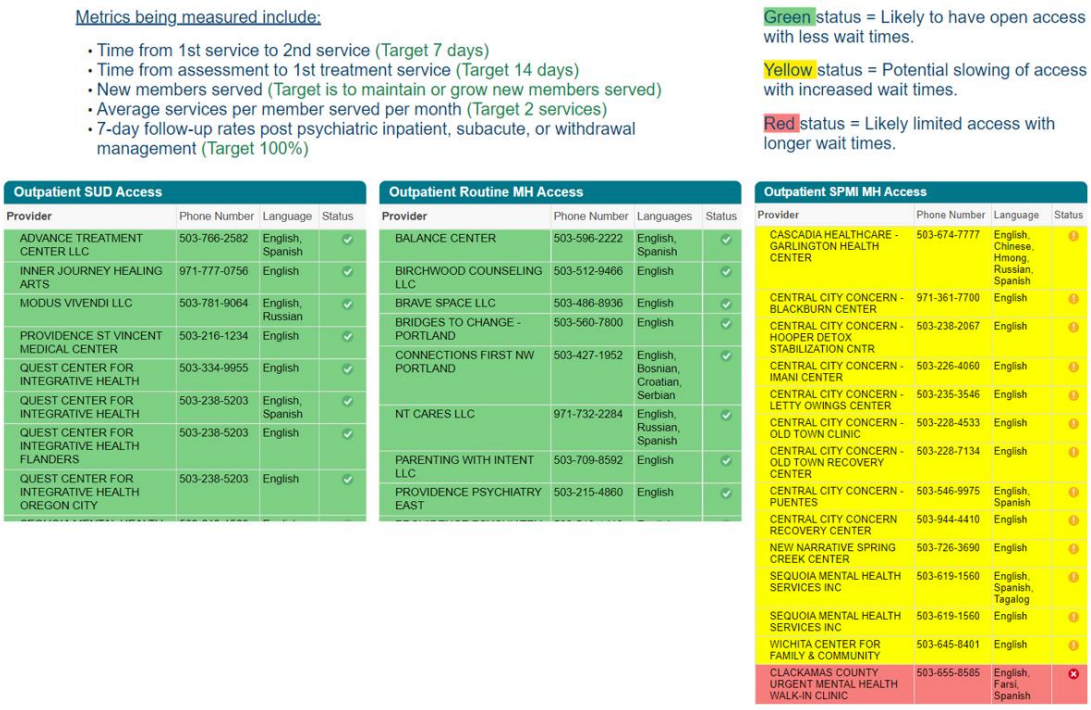
At this time, Health Share is exercising caution as it pertains to analysis and use of sexual orientation and gender identity (SOGI) data. Our clinical partners have expressed concern around gender identity (GI) data collection and use, in particular for members under the age of 18. As such, Health Share has limited GI data exploration to targeted claims comparisons, missingness analyses, and aggregation approaches. While Health Share intends to incorporate analysis by Sexual Orientation (SO) in the future, the OHA has not yet made SO data available to CCOs, preventing any analysis on that dataset. Once available and standards for use of this data have been adopted, this data will be reviewed for disparities to aid with identifying specific populations that may need focused or modified support from the care coordination team.

Health Share funds an Intensive Transition Team dedicated to connecting SPMI individuals to follow up behavioral health care. We believe the overall re-building of the follow-up metric, as well as incorporating REALD into our outcomes, will help inform the work of this team and provide actionable information on disparities and barriers to care.

Behavioral Health Access and Capacity Dashboard

Progress was also made on the development of a Behavioral Health Access and Capacity Dashboard. A monthly, standardized data collection process was launched. This tool helps address some of the data quality issues that were present when different agencies reported data in a non-standardized way. This information is self-reported and allows CareOregon to capture data that would not otherwise be available to the CCO through claims. However, the dashboard did not prove to have the utility that was anticipated. There continues to be lack of agreement about a standard definition of third next available appointment due to the variety of access models, lack of data resources among providers, and general lack of provider workforce resources to track and submit this data consistently. Additionally, claims lag has affected the dashboard and limited the timeliness and actionability of the data in the dashboard. To this end the dashboard has not been moved beyond internal testing as it does not appear an effective tool for our community. CareOregon plans to continue attempts to improve this dashboard over the next year and will evaluate in that time if continued work on this tool is viable. The committee structure will continue to be utilized in 2024 to identify and address these problems.

Figure 3. Behavioral Health Access and Capacity Dashboard Screenshots



Metrics being measured include:

- Time from 1st service to 2nd service (Target 7 days)
- Time from assessment to 1st treatment service (Target 14 days)
- New members served (Target is to maintain or grow new members served)
- Average services per member served per month (Target 2 services)
- 7-day follow-up rates post psychiatric inpatient, subacute, or withdrawal management (Target 100%)

Green status = Likely to have open access with less wait times.

Yellow status = Potential slowing of access with increased wait times.

Red status = Likely limited access with longer wait times.

Outpatient SUD Access

Provider	Phone Number	Language	Status
ADVANCE TREATMENT CENTER LLC	503-766-2582	English, Spanish	
INNER JOURNEY HEALING ARTS	971-777-0756	English	
MODUS VIVENDI LLC	503-781-9064	English, Russian	
PROVIDENCE ST VINCENT MEDICAL CENTER	503-216-1234	English	
QUEST CENTER FOR INTEGRATIVE HEALTH	503-334-9955	English	
QUEST CENTER FOR INTEGRATIVE HEALTH	503-238-5203	English, Spanish	
QUEST CENTER FOR INTEGRATIVE HEALTH FLANDERS	503-238-5203	English	
QUEST CENTER FOR INTEGRATIVE HEALTH OREGON CITY	503-238-5203	English	

Outpatient Routine MH Access

Provider	Phone Number	Languages	Status
BALANCE CENTER	503-596-2222	English, Spanish	
BIRCHWOOD COUNSELING LLC	503-512-9466	English	
BRAVE SPACE LLC	503-486-8936	English	
BRIDGES TO CHANGE - PORTLAND	503-560-7800	English	
CONNECTIONS FIRST NW PORTLAND	503-427-1952	English, Bosnian, Croatian, Serbian	
NT CARES LLC	971-732-2284	English, Russian, Spanish	
PARENTING WITH INTENT LLC	503-709-8592	English	
PROVIDENCE PSYCHIATRY EAST	503-215-4860	English	

Outpatient SPMI MH Access

Provider	Phone Number	Language	Status
CASCADIA HEALTHCARE - GARLINGTON HEALTH CENTER	503-674-7777	English, Chinese, Hmong, Russian, Spanish	
CENTRAL CITY CONCERN - BLACKBURN CENTER	971-361-7700	English	
CENTRAL CITY CONCERN - HOOPER DETOX STABILIZATION CNTR	503-238-2067	English	
CENTRAL CITY CONCERN - IMANI CENTER	503-226-4060	English	
CENTRAL CITY CONCERN - LETTY OWINGS CENTER	503-235-3546	English	
CENTRAL CITY CONCERN - OLD TOWN CLINIC	503-228-4533	English	
CENTRAL CITY CONCERN - OLD TOWN RECOVERY CENTER	503-228-7134	English	
CENTRAL CITY CONCERN - PUENTES	503-546-9975	English, Spanish	
CENTRAL CITY CONCERN RECOVERY CENTER	503-944-4410	English	
NEW NARRATIVE SPRING CREEK CENTER	503-726-3690	English	
SEQUOIA MENTAL HEALTH SERVICES INC	503-619-1560	English, Spanish, Tagalog	
SEQUOIA MENTAL HEALTH SERVICES INC	503-619-1560	English	
WICHITA CENTER FOR FAMILY & COMMUNITY	503-645-8401	English	
CLACKAMAS COUNTY URGENT MENTAL HEALTH WALK-IN CLINIC	503-655-8585	English, Farsi, Spanish	

2. **Describe whether last year's targets and benchmarks were met (if not, why):**

In 2023, Health Share and CareOregon worked to achieve the following TQS targets and benchmarks for this component:

Monitoring Measure 1.1: The CareOregon data analytics team reconciles data to produce a seven day follow up report in-house: This goal was not met because there remain ongoing difficulties associated with using multiple complex data sources to create this report. Additionally, this data build was deprioritized because of competing regulatory data demands.

Monitoring Measure 2.1: R**EALD data stratification by CareOregon analytics team.** This target was partially met. Due to the limitations described above, the depth of data CareOregon had hoped to develop through the Behavioral Health Access and Capacity Dashboard was not possible. However, seven-day hospital follow-up, stratified by Race and Ethnicity, was analyzed.

Monitoring Measure 3.1: This measure was based upon achieving the following goals:

- Implementing ongoing surveys that track access timelines across agencies by 12/31/2022;
- Standardizing access survey and data collection process across agencies by 7/31/2023;
- Selecting and confirming key access indicators with Health Share's governance committees (e.g. CAP, QHOC) by 7/2023; and
- Launching a functional access dashboard by 12/31/2023.

These targets were all met. Access data was standardized and collection occurs on a monthly cadence. The access indicators were approved by Health Share's governance committees, and the access dashboard is now live; however, the dashboard has not yet been made available to all Health Share partners as anticipated. This is due to the data reliability issues that are still being resolved.

Monitoring Measure 4.1: Compare the results of workflow improvements on seven-day follow-up rates. The target has not been met.

3. **Lessons learned over the last year:**
   This project produced some achievements in the last year, after significant work spanning the two previous years. One major lesson learned was that the project was being significantly delayed by data issues, leading the project team to determine that it was necessary to use "second-best" data. This is true of the 7-day follow-up data and the access dashboard project. For example, one of the goals of developing the access dashboard was to assist the Regional Care Teams (RCTs) in determining where the member could receive follow up care within 7 days of discharge. Because the information was less timely and accurate than anticipated, a workaround was developed to help assist the team in the meantime. Several providers send access information to CareOregon outside of the formal data collection process, this information is routed to the RCTs so they can factor it into their approach. Another lesson learned is related to the need for additional data literacy support for behavioral health providers to assist in collecting more accurate data.

Brief narrative description

Project population:
Members with an inpatient admission with a mental health diagnosis

Intervention (address each component attached):
Transitional care is a core function within our care coordination services. Hospital discharge is a complex process representing a time of significant vulnerability for members. Transitional support is provided to all Health Share of Oregon members experiencing psychiatric hospitalization.

This work reflects best practice in member care, improves health outcomes, and has been demonstrated to support meaningful reductions in readmission rates.

Members who are admitted to inpatient acute care are screened by an intensive care coordination (ICC) team. ICCs help connect members to the most appropriate care coordination team and ensure that members receive a follow-up appointment with a new or established behavioral healthcare provider. Care Coordinators on the ICC and Regional Care Teams (RCTs) are uniquely positioned and trained to access health plan supports for both clinical and social needs concerns. They assist members in accessing care through coordination of services with the provider, as well as assisting members to access resources such as the health-related social needs benefit, non-emergent medical transportation, and housing supports. Access to these resources aids to address barriers to seeking and receiving follow-up care. Care Coordinators work with the members to access care in a way that is member-centered and respects client autonomy. Members choose locations and providers that meet their self-identified needs. Connecting members to community-based services helps them receive care in more integrated and whole-person care focused settings. This reduces the likelihood of additional mental health related hospitalization being needed.

Two populations of focus receive specialized workflows.

For youth members, the RCT utilizes Point Click Care notifications to review multiple data sources to identify current care coordinator involvement and provider involvement to determine if the member is already being supported in the community. If the member is not already engaged with a behavioral health provider or if the level of support is unclear, the member will be assigned an Intensive Care Coordinator. Additionally, interdisciplinary care team (ICT) meetings are utilized for cross-system consultation, support and referral considerations. The assigned care coordinator will continue to engage with the member and conduct outreach for as long as needed/appropriate to ensure the follow up appointment(s) are made.

For adult members with 3–5-day BH inpatient stays, engagement is dependent on capacity of the RCT. The RCT utilizes Point Click Care notifications to review members with psychiatric hospital stays longer than three days. The RCT team review multiple data sources to identify whether the member has a current care coordinator and is being supported in the community. If the member is not engaged with a behavioral health provider, or if the level of support is unclear an Intensive Care Coordinator is assigned. Additionally, ICT meetings are utilized for cross-system consultation, support and referral considerations. The assigned care coordinator will continue to engage with the member and conduct outreach for as long as needed/appropriate to ensure the follow up appointment(s) are made.

Activities and monitoring for performance improvement

Activity 1 description: Improve the timeliness, accuracy and quality of access information available in the Behavioral Health Access and Capacity Dashboard.

☒ Short term or ☐ Long term

Monitoring measure 1.1	3rd Next Available Appointment Data Quality			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
All agencies report in a standard template.	Design data definition of 3rd next available	3/31/2025	Education and Technical Assistance	6/31/2025

Data definition issues exist	with Provider cohort		provided around adoption of new definition	

Activity 2 description: Utilize Regional Care Team and Intensive Care Coordination Processes to improve health outcomes for members experiencing hospitalization for mental health conditions

☐ Short term or ☒ Long term

Monitoring measure 2.1	Seven day follow up after hospitalization for mental illness			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
2022 Rate: 33.7%	3 percentage point improvement	12/31/2024 (data available 6/25)	2023 Medicaid National Average	12/31/2025 (data available 6/26)

Activity 3 description: High Risk Behavioral Health Care Model Development to Reduce Medical Inpatient Bed Days for SPMI Individuals

☒ Short term or ☒ Long term

Monitoring measure 3.1	Decreasing Inpatient medical inpatient admissions for psychosis			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
17.9 medical inpatient admissions per 1,000 member months for members with psychosis diagnosis (CY 2023).	15 medical inpatient admissions per 1,000 member months for psychosis	12/31/2024	12 medical inpatient admissions per 1,000 member months for members with psychosis diagnosis	12/31/2025

Section 2: Optional Supporting Information

TITLE: Birth Doula Access

DEFINITIONS:
Birth Doula: A birth companion who provides personal, nonmedical support to birthing persons and their families throughout a birthing person's pregnancy, childbirth, and post-partum experience.

Covered Service(s): Medically necessary and appropriate health services and items described in ORS Chapter 414 and applicable Oregon Administrative Rules and the Prioritized List of Health Services above the funding line set by the Oregon Legislature. Covered Services include services that are (a) ancillary services; (b) diagnostic services necessary to determine the existence, nature, or extent of the Member's disease, disorder, disability or condition; (c) necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in 42 CFR part 438, subpart K; and (d) necessary for compliance with the requirements for Early and Periodic Screening, Diagnosis and Treatment as specified in the Oregon Health Plan 1115 Demonstration Project.

Doula Hub: A business, agency or community organization that has been established to support Birth Doulas by billing on their behalf. Additional services may include support for referrals, supervision and serving as a liaison between Birth Doulas and Providers.

Member: An Oregon Health Plan client enrolled with Health Share of Oregon.

Non-Participating Provider: A provider of health care services that does not have a contractual relationship with a Health Share Subcontractor, but can, in certain circumstances, provide Covered Services to Members.

Oregon Health Authority: The State of Oregon acting by and through its Oregon Health Authority, Health Services Division.

Plan Partner: An entity that: 1) holds a fully capitated contract with Health Share of Oregon to provide services as defined in the Health Plan Services Contract for Coordinated Care Organizations between the Oregon Health Authority and Health Share; 2) assumes the financial risk of providing health services to Members; and 3) is compensated on a prepaid capitated basis.

Provider: An individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a rendering Provider, or that bills, obligates and receives reimbursement on behalf of a rendering Provider, also termed a billing Provider.

PURPOSE: To describe how Health Share of Oregon (Health Share) ensures access to Birth Doulas for Health Share Members across Health Share's Plan Partners.

POLICY:

I. Health Share ensures that Members have access to Covered Services from a Birth Doula as detailed in OAR 410-130-0015.

II. Plan Partners may contract with certified independent Birth Doulas and/or interested community Doula Hubs. Independent Birth Doulas can receive payment for services rendered as Non-Participating Providers.

III. Plan Partners are responsible for the payment of Covered Services provided by Birth Doulas.

A. To be reimbursed for services rendered, independent Birth Doulas and community Doula Hubs must follow the billing process of the Plan Partner.

B. To be eligible for reimbursement a Birth Doula must:

1. Be certified with Oregon Health Authority per OAR 950-060-0040 and actively listed on Oregon Health Authority THW registry at the time of service.

2. Follow Plan Partner claims submission guidelines.

a. These claims will fall under the Oregon Health Plan pregnancy benefit where a pregnancy diagnosis is used.

b. Timely filing requires a claim to be received within 365 days from the date of service per OAR 410-141-3565.

c. Services may be billed once per pregnancy and additional payment is not available for multiple births (i.e., twins or triplets).

d. Certified Birth Doulas should be listed as the rendering provider for doula services.

e. Claims coding will need to be within the specifications of OAR 410-130-0015.

IV. Plan Partners will agree to standard terms and conditions based on OHA's billing guide for Birth Doulas.

V. There is no need for financial reconciliation.

VI. Health Share and its Subcontractors are required to comply with all applicable Federal and State laws, and requirements in the CCO Contract and Oregon Administrative Rules pertaining oversight of Medicaid services and the prevention and detection of Fraud, Waste, and Abuse.

VII. Plan Partners will report the same information for Non-Participating Providers as is required for the Oregon Health Authority Traditional Health Worker Integration and Utilization Annual report.

ATTACHMENTS:

Attachment A: HSO CareOregon Doula Coverage FAQ

REFERENCES:
OAR 410-130-0015, Doula Services
OAR 410-141-3565, Managed Care Entity Billing
OAR 950-060-0040, Birth Doula Certification Requirements
Oregon Health Authority THW Registry
Health Plan Services Contract
Exhibit L Financial Reporting Form
Health Share Policy: CORP-2 Delegated Functions and Oversight

DocuSigned by:
Mindy Stadtlander
CD07E4FA3661448...
Mindy Stadtlander, COO

8/7/2023
Date

Department: Integration	**Author:** Alyssa Craigie, Director, Health Systems Integration
Effective Date: August 2023	**Review Frequency:** Every 2 years
Revision Date(s):	

☐ *Required by Health Plan Services Contract*

CareOregon doula coverage FAQ: External guidance document

Last Updated: 09/24/21

CareOregon is committed to supporting our membership during the perinatal and birth experience. Doula care is a covered benefit for Oregon Health Plan (OHP) members whose benefit package covers labor and delivery. We are working closely to build our relationship with birth workers across the state to improve access to doula services, as well as increasing awareness of this service/benefit to our members. Below is information outlining the process and covered benefit for doulas interested in serving CareOregon members.

Covered doula services

- Under the current OHP benefit, CareOregon will provide reimbursement for doula services when a certified doula submits a claim with required billing information. This includes being listed as active on Oregon's State THW Registry (see CareOregon's "Traditional health worker claims submission guide" for more information):
- OHP covers doula support once per pregnancy for any birthing parent whose benefit package covers labor and delivery.
- The standard doula benefit includes, at a minimum, four support visits (two visits before delivery and two visits after delivery), and doula support during the labor and delivery event. These services can be billed as a bundle or itemized.
- Support visits can take place at the birthing parent's home, as part of an office visit, or virtually.

Reimbursement for doula services

Based on the current OHP benefit, doula care can only be reimbursed when a certified Doula submits a claim with the required billing information following coding guidelines per OAR 410-130-0015 Doula Services. Doulas can be compensated at a bundled rate when they provide all covered services, or at the itemized rate when not all covered services can be provided.

We are enhancing our fee schedule at rates that are higher than Fee for Service (FFS). As of 8/1/2020, CareOregon has enhanced our reimbursement rates for the bundled services and itemized labor/birth service, beyond the OHP Fee-for-Service (FFS) rates. A contract is not needed for enhanced rates to be paid.

The OHP Fee-for-Service (FFS) rates for doula services are below. Please reach out to the CareOregon support contact at *metrothw@careoregon.org* for more information about CareOregon's enhanced rates. Please note due to laws and regulations we cannot tell how to bill and suggest working with a medical billing company if additional support is needed.

Please note it is important that you bill your standard billing costs regardless of insurance even if they are higher than noted below or the enhanced rates. Billing your standard rates will allow us to capture this data for encounter purposes and take that into consideration for future rate setting.

Service		Codes	Description	Modifier	OHP FFS Rate
Bundled	• 2 prenatal visits minimum • Labor and delivery support • 2 postpartum visits	59400	Vaginal delivery	U9	$350
		59510	Cesarean delivery		
		59610	VBAC		
		59618	Attempted VBAC/ cesarean		
Itemized	Prenatal/postpartum visits	59899	Support visits	U9	$50
	Labor and delivery	59409	Vaginal delivery	U9	$150
		59514	Cesarean delivery		
		59612	VBAC		
		59620	Attempted VBAC/ cesarean		

Submitting doula claims

- Doula claims fall under the OHP pregnancy benefit, where a pregnancy diagnosis is used; therefore, timely filing requires a claim to be received within 365 days from the date of service (OAR 410-141-3565).
- Doula services may only be billed once per pregnancy. Additional payment is not available for multiple births (i.e., twins, triplets).
- Certified doulas should be listed as the rendering provider for doula services.
- When billing for itemized services, include the most appropriate place of service on the claim form. When billing for bundled services, use the place of service that best describes where labor and delivery took place. Place of service codes are available *here*.

Confirming client/patient insurance status

Prior to submitting a claim, the client/patient's insurance status should be verified so that the correct insurer is billed:

- After enrolling as a DMAP provider, you will be entered into the *Medicaid Management Information System*. Use the PIN you were provided during enrollment to access this system to check insurance status.
- We recommend confirming eligibility for the date that the service was provided.

Coding per OAR 410-130-0015 Doula Services

Doula services should be billed using the appropriate codes, followed by the unique Medicaid modifier of U9. Billable codes for doula services as it relates to the diagnosed condition of pregnancy are as follows:

- Global (bundled) doula package:
  - » CPT 59400+U9, 59510+U9, 59610+U9, or 59618+U9
  - » One-time claim per pregnancy
  - » When billing for the global package, all services must be provided by the same doula
- Itemized (support visits) billing:
  - » CPT 59899+U9 for each visit, up to four (not to exceed the bundle total)
- Acceptable day-of-delivery-only codes:
  - » 59409+U9, 59514+U9, 59612+U9, or 59620+U9

Billing Examples

Below are two examples of the CMS-1500 form, from OHA's *Billing for Doula Services guide*. These examples show billing for the standard doula benefit, including:

- The licensed practitioner services are billed using the appropriate delivery code.
- The doula services are billed using the appropriate code(s), followed by modifier U9, with the enrolled doula listed as the rendering provider.
- Please note that Place of Service is a required field, although it is not shown in these examples.

CMS-1500 Example 1 – Single birth

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	05	01	15	05	01	15			59409				1		NPI	
2	05	01	15	05	01	15			59400	U9			1		NPI	

CMS-1500 Example 2 - Multiple births (twins)

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	05	01	15	05	01	15			59409				1		NPI	
2	05	01	15	05	01	15			59400	59			1		NPI	
3	05	01	15	05	01	15			59400	U9			1		NPI	

Documentation per OAR 410-130-0015

Doula services should be documented in the client's medical record by the licensed obstetrical practitioner. The goal of documentation is to verify services were provided and facilitate communication between the member and the obstetrical practitioner. The doula should provide a record of visits to the practitioner, including:

- Dates of service.
- A brief description of education or services provided.
- Assessment of any member needs beyond routine care.
- Any referrals made.
- Birthing plans developed with the member, with member approval.

Note: *This information was updated in June 2021. OHA is in the process of reviewing this OAR and documentation requirements may change as a result.*

Contracting with CareOregon for doula services

- Contracts are not required for doula reimbursement.
- CareOregon may consider contracting with organizations/clinics for enhanced or culturally specific doula services. If you are interested in learning more, please reach out to the CareOregon support contact at *metrothw@careoregon.org*

Doula Hubs

A doula hub is a business, agency, or community organization that has been established to support doulas by billing on their behalf. Doula hubs often serve additional purposes beyond billing, including support for referrals, supervision, and serving as a liaison between doulas and providers. Get in touch with the CareOregon support contact at *metrothw@careoregon.org* to learn more about doula hubs in your county.

Oregon Administrative Rules for doulas

Please refer to the following Oregon Administrative Rules (OARs) for more information about doula services and requirements:

- *OAR 410-130-0015, Doula Services*
- *OAR 410-180-0315, Birth Doula Certification Requirements*
- *OAR 410-180-0375, Birth Doula Certification Curriculum Standards*

OHA Office of Equity and Inclusion contact information

For additional Information about the THW program, please contact OHA/OEI at:

- Telephone: 971-673-3353
- Fax: 971-673-1128
- Email: *thw.program@dhsoha.state.or.us*

CareOregon support

Additional questions can be directed to the CareOregon support contact at *metrothw@careoregon.org*

Additional resources

- *OHA's Office of Equity and Inclusion doula webpage*
- *OHA's THW Registry*
- *Oregon Doula Association website*

DocuSign

Certificate Of Completion

Envelope Id: A5C7F53FBF9148B9BB15A09C7284ED02
Subject: NEW Policy: OPS-15 Birth Doula Access
Source Envelope:
Document Pages: 8
Certificate Pages: 1
AutoNav: Enabled
EnvelopeId Stamping: Enabled
Time Zone: (UTC-08:00) Pacific Time (US & Canada)

Signatures: 1
Initials: 0

Status: Completed

Envelope Originator:
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Electronic Record and Signature Disclosure:
Not Offered via DocuSign

In Person Signer Events	Signature	Timestamp

Editor Delivery Events	Status	Timestamp

Agent Delivery Events	Status	Timestamp

Intermediary Delivery Events	Status	Timestamp

Certified Delivery Events	Status	Timestamp

Carbon Copy Events	Status	Timestamp

Witness Events	Signature	Timestamp

Notary Events	Signature	Timestamp

Envelope Summary Events	Status	Timestamps
Envelope Sent	Hashed/Encrypted	7/6/2023 | 08:49 AM
Certified Delivered	Security Checked	8/7/2023 | 02:01 PM
Signing Complete	Security Checked	8/7/2023 | 02:01 PM
Completed	Security Checked	8/7/2023 | 02:01 PM

Payment Events	Status	Timestamps