Health Share of Oregon

2018 Transformation and Quality Strategy

Introduction

Health Share of Oregon is committed to supporting a health care system in the Tri-County region that delivers improved care, spends health care dollars wisely and makes our members and the communities we serve healthier. Health Share works in partnership with health plans, health systems, and providers to achieve better outcomes in health and health care at a lower cost, in alignment with achieving the Triple Aim:

- **Better Care:** improve the overall quality of care by making health care more person-centered, reliable, accessible, and safe
- **Smarter Spending:** reduce the cost of quality health care for individuals, families and communities
- **Healthier People:** improve the health of the population we serve by supporting proven interventions to address behavioral, social and environmental determinants of health, and deliver higher-quality care

Health Share's Transformation and Quality Strategy provides a framework for aligning transformational efforts and strategic objectives to build a better health care system for our members. This transformed system puts our members at the center of care, and ensures access to high-quality health care and expanded access to preventive services. In implementing this Transformation and Quality Strategy we seek input from and collaborate with health plan, health system and delivery system partners; are responsive to member and provider needs; learn from others and foster learning collaboratives across our partners; and are a catalyst for health system improvement.

The Transformation and Quality Strategy incorporates the four foundational principles outlined in the 2016 Quality Strategy from the Centers for Medicare and Medicaid Services:

1. Eliminate health disparities

   Health Share's data shows that disparities exist among racial, ethnic and linguistic groups within our membership. Gaps in experience, quality and outcomes of health care, and the social determinants of health must be closed. Eliminating disparities is essential for improving the health of our members. Through the Disparities Analytics and Reporting Team, we are working to advance health equity by improving data collection to better measure and analyze disparities across programs and policies, as well as across communities and components of the delivery system.

2. Build strong data and health analytics systems

   A comprehensive, robust data and analytics system is essential to achieving the Triple Aim and underlies our quality strategy. From the founding of the organization, Health Share and our partners have prioritized data and analytics as an area of strategic focus. Health Share Bridge is an enhanced data and analytics system that includes a set of best-available platforms that combine to offer a flexible environment that can be used both internally and externally. The refined system enhances our ability to monitor trends in achievement of the incentive measures; monitor health status and health care among priority populations; and conduct in-depth studies of population health at the community level and for specific groups of individuals.

3. Support local innovation

   Health Share implements the quality strategy in partnership with health plans partners, and promotes innovation at all levels of the health care system. While our partners are aligned around achieving the incentive measures, each plan and each component of the delivery system implement their own methodologies and approaches in attaining them. Plans, providers and communities tailor the adoption of services and innovation to meet local needs.

4. Foster learning

   Health Share frequently takes on the role of convener and facilitator in support of a collective impact model with partners. We support learning across the health care system, through formal learning collaboratives and less formal learning opportunities linked to our strategic goals and objectives. We also provide continual learning opportunities for Health Share employees, such as our training series on equity and inclusion.

To assure we actively address these principles, we continuously evaluate how we embed the principles within our quality strategy as a whole, and within individual strategic objectives and initiatives.

Organizational Tenets

Health Share's Mission, Vision and Values are at the heart of our work, and inform and influence the Transformation and Quality Strategy:

Mission

We partner with communities to achieve ongoing transformation, health equity and the best possible health for each individual.

Vision

A healthy community for all.

Values

At Health Share we believe:

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

Section One: Transformation and Quality Program Information

A. CCO Governance and Program Structure

i. Quality Program Structure

The Quality Committee of the Health Share Board of Directors oversees the quality, credentialing and compliance programs, and the oversight of delegated entities. The Quality Committee receives quarterly reports from management on grievances and appeals, quality incentive metric performance, and performance improvement projects. The Committee also receives regular updates regarding delegation oversight and functions performed by delegated entities related to the quality program.

Day-to-day operation of the quality program is delegated to management by the Quality Committee. The Chief Operating Officer is accountable for the quality program which is managed by the Director Compliance and Quality Assurance.

The executive team charters the Transformation and Quality Committee (TQC) to develop, implement and monitor the quality program. The TQC is a cross-functional group of managers and staff, including the Chief Operating Officer, Chief Equity and Engagement Officer, Chief Information Officer, Associate Medical Director, Director Compliance and Quality Assurance, Director Strategic Initiatives, Director Health System Performance, Director Finance, Health Equity Strategist, and Health Systems Integration Manager, supported by the Oregon Health Authority Innovator Agent. The TQC is responsible for ensuring that Health Share has an effective quality program that addresses contractual obligations and meets the goals, objectives and components of the Transformation and Quality Strategy. The TQC provides regular reports to senior management and the Board Quality Committee.

The executive team also charters the Delegation Oversight Committee (DOC) which ensures that Health Share remains accountable for and compliant with contractual and regulatory requirements through oversight of delegation of core administrative and management functions. The DOC is chaired by the Chief Operating Officer and its membership includes the Chief Information Officer, Director Compliance and Quality Assurance, Director Contracting and Network Management, Director Finance, Quality Assurance Specialists, Senior Data Quality Analyst and Health Systems Integration Manager. The DOC reviews pre-delegation assessments,

and findings of annual reviews and on-going monitoring of delegated entities, and identifies areas of non-compliance requiring corrective action. The DOC provides regular reports to the Quality Committee.

Grievance and appeal system: Health Share members have access to a robust grievance system for response to grievances and appeals, as well as contested case hearings. Delegated entities are required to have a comprehensive grievance system that meets all federal and state contractual and regulatory requirements. Health Share is the final adjudicator of appeals and takes an active role in the appeal and contested case hearing process. Health Share collects and analyzes member grievances and appeals to ensure the quality and experience of care by members, as well as to identify opportunities for improvement. Quarterly grievance reports are submitted by delegated entities and aggregated for submission to the Oregon Health Authority. Quarterly analyses of grievances are reported to the Delegation Oversight Committee and the Quality Committee.

Utilization review: Utilization review is a function delegated to health plans and overseen by Health Share staff through annual reviews and on-going monitoring. Through delegation oversight Health Share assures appropriate structures and mechanisms are used by health plan partners to conduct utilization review, including monitoring over- and under-utilization of services. Annual reports submitted by the health plans are reviewed, and trend analysis is conducted to identify any disparities in utilization. In addition, through Health Share Bridge, we are able to determine utilization rates for various services broken out by specific demographic groups and sub-populations, providing an overarching view of how our members are accessing services.

ii. Organizational Structure for Developing and Managing Quality and Transformation Activities

The founding member organizations of Health Share include health systems, provider organizations, and county governments in the tri-county region, each with a long history of serving Oregon Health Plan Medicaid enrollees. The founding organizations are Adventist Health, CareOregon, Central City Concern, Clackamas County, Kaiser Permanente Northwest/Kaiser Foundation Health Plan, Legacy Health, Multnomah County, Oregon Health & Science University, Providence Health & Services/Providence Health Alliance, Tuality Healthcare/Tuality Health Alliance, and Washington County. Each of the founding members has a seat on Health Share's Board of Directors, along with elected directors from mental health, substance use disorders, primary care and oral health, as well as the community at large. The Community Advisory Council has an appointed liaison to the Board. The Board of Directors sets the strategic direction for Health Share.

Health Share subcontracts with a number of delegated entities, including sixteen health plans: behavioral health (Clackamas, Multnomah and Washington Counties); dental health (Access, Advantage, Capitol, CareOregon, Family, Kaiser, Managed, ODS and Willamette); and physical health (CareOregon, Kaiser, Providence and Tuality). The health plans are fully financially at risk for the populations enrolled with them, manage benefits, authorize services, conduct utilization review and utilization management, provide care coordination and care management, contract with provider networks, and pay claims. All delegated entities are required to have a

comprehensive grievance system; to participate in Health Share's quality program; and to ensure members have access to appropriate services and benefits.

Due to Health Share's delegated business model, we have instituted a comprehensive committee and workgroup structure to support engagement with health plan operations. The Integrated Steering Committee and Clinical Alignment Workgroup, each with representation from health plans, work with Health Share management and staff to develop and manage quality and transformation activities. Health Share operations provide a foundation for implementing the quality strategy and managing the quality program in concert with health plans.

iii. Community Health Improvement Plan

Both the Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHP) are integral components of Health Share's strategic planning process for transformation and quality. The Community Advisory Council (Council) oversees the development of the CHNA through engagement with the Healthy Columbia Willamette Collaborative. The Council partners with Health Share staff to develop a CHP based on identified priorities in the CHNA. The CHP serves as a strategic population health and health care system service plan. The activities defined in the CHP include outcomes and quality improvement, as well as integration of service delivery. The CHP is approved by the Health Share Board of Directors. Health Share staff act as liaisons between the Council and the TQC to ensure the activities of the CHP are aligned with and incorporated into the Quality Strategy. As noted above, the Council appoints a liaison who sits on the Board of Directors and has input into Health Share's strategic objectives identified by the Board.

iv. Engagement with Community Partners

Health Share engages with multiple community partners to advance the quality program and in carrying out transformational initiatives. These partners include Early Learning Hubs, Local Public and Mental Health Authorities, school based health centers, patient centered primary care and other medical home practices, specialty care practices, mental health and substance use disorder providers, and multiple community based organizations. Specific examples of engagement with community partners, both recently completed and those still in progress, include:

- Funded infrastructure development of the Oregon Community Health Worker Association to support the community health worker workforce
- Increased PCP consultation for psychiatric medication management through Project ECHO
- Implemented sustainable funding plan for Tri-County 911 Service Coordination Program
- Provided specialty mental health agencies access to hospital event notifications through PreManage
- Piloted integration of legal services in a health care team, the Medical Legal Partnership, to address and prevent health-harming social conditions
- Trained providers to administer Long-Acting Reversible Contraception

- Funding Project Nurture at three clinics for integrated maternity and addiction care of pregnant women with substance use disorders
- Increased PCP consultation for developmental pediatrics through Project ECHO
- Developed standard process and web-based platform to coordinate health assessments for children in foster care
- Led Advanced Primary Care Collaborative to develop seven medical home models for children in foster care
- Piloting culturally and linguistically adapted ASQ developmental screening tools
- Implementing centralized access point, Help Me Grow, to connect providers and families to resources for children developmentally at risk
- Developing peer family navigator training program and curriculum for peer support for families and children with special health care needs
- Created a learning collaborative for health plans focused on advancing health equity within their systems, integrating CLAS standards
- Participate in local community health improvement planning process in Clackamas, Multnomah and Washington Counties
- Participate in regional group identifying the ideal service model and sustainable funding for school based health centers

Through these efforts and partnerships, Health Share: works regionally to develop and implement an equitable health care delivery model that integrates behavioral, oral and physical health care; applies an equity lens to identify and address inequities in services, policies, practices, and procedures; and addresses the social determinants of health through supporting collaboration between the health care system and the community.

B. Review and Approval of Transformation and Quality Strategy

The Transformation and Quality Committee (TQC) described in the Quality Program Structure above is responsible for the development, implementation and oversight of the Transformation and Quality Strategy and operation of the quality program. The quality program is ongoing and comprehensive, and includes quality and performance improvement, quality assurance, program integrity, and performance monitoring through quality metrics and other tools. The TQC seeks input from and provides updates to the Community Advisory Council to ensure the quality program and Transformation and Quality Strategy are member-centered and member-focused.

The TQC meets at least quarterly, and frequently monthly. The TQC monitors the quality program and the Transformation and Quality Strategy throughout the year, and is responsible for compiling information to complete the required progress and annual reports. Members of the TQC provide regular updates to senior management and the Quality Committee of the Board of Directors on various components of the program and strategies. This includes providing quarterly reports on the achievement of the quality incentive metrics and the status of performance improvement projects, as well as strategic initiatives approved by the Board of Directors that are components of the Transformation and Quality Strategy.

C. CCO Strategic Approach and Connection to Quality

As of March 2018, Health Share serves more than 310,000 members in the tri-county region of Clackamas, Multnomah and Washington Counties. We operate through a collaboration of health plans, health systems, delivery systems, providers and community partners. Given our business model, the Transformation and Quality Strategy reflects work being done by our partners as well as strategic initiatives implemented and managed by Health Share staff. The strategic objectives adopted by the Health Share Board of Directors for 2018 – 2020 are known collectively as Ready + Resilient. With Ready + Resilient, Health Share is creating a long-term roadmap to support the wellbeing of children, families and communities through prevention, support for recovery, and focused investment in health equity.

The goal of one set of strategies, known as Start Strong, is that children are ready for kindergarten, and families are connected to the health and social resources they need to thrive. These strategies include improving the quality and quantity of screenings for women and children in health care and community settings; building and enhancing clinical and community interventions and referral systems; and improving systems of care for populations with complex needs, notably children in foster care. The goal of the second set of strategies, known as Support Recovery, is that people are able to access quality mental health and substance use services delivered by a trauma-informed workforce when and where they need them. These strategies include strengthening the behavioral health workforce; improving the substance use disorder system of care; and improving the availability of information across care settings. An overarching construct of Ready + Resilient is Share Health, our equity first approach that prioritizes eliminating health disparities for future generations.

Highlights of the work being done through Ready + Resilient include:

- Integrated the Oregon Family Well Being Assessment, a risk stratification tool, into two large maternity providers (Providence and Women's Health Associates)
- Funded hiring of Help Me Grow program staff at Swindells Resource Center, two Help Me Grow liaisons in Early Learning Hubs and one in Public Health
- Partnering with Early Learning Hubs to promote "sign up for kindergarten early" campaign in 10 languages
- Partnering with Early Learning Hubs to develop culturally responsive messaging for cross-sector use on developmental screening and milestones
- Over 400 children enrolled at three Foster Care Medical Homes; in 2017, 90.8% of children in foster care had timely mental, physical and oral health assessments
- Established a regional Children's System of Care governance structure
- Secured joint funding from five organizations to support regional Kindergarten Readiness collaboration
- Developed Substance Use Disorder Best Practice Guidelines for regional implementation in Q3 2018, with participation from providers and behavioral health plans
- Continued expansion of Medication Assisted Treatment access through Wheelhouse (substance use disorder provider hub and spoke partnerships)
- Enrolled eight behavioral health organizations in Health Share Bridge, allowing access to comprehensive data not previously available

- Engaged with Reliance HIE; convening behavioral health providers to evaluate interest and needs for participation in HIE

Section Two: Transformation and Quality Program Details

1. Access

Health Share is committed to ensuring that members have an ongoing source of primary care, behavioral health care (mental health and substance use disorder treatment) and dental care appropriate to their needs including cultural, linguistic and geographic considerations, as well as access to 24/7 urgent and emergent care including post-stabilization services. Ensuring members have access to these services is accomplished through routine monitoring of member's access and availability of services by each delegated health plan.

The access domains identified in the "Proposed Medicaid Access Measurement and Monitoring Plan" published by the Urban Institute in August 2016 offer a framework for assessment and monitoring of access:

Provider availability and accessibility – measures of potential access to providers and services, whether or not the providers or services are used; the Delivery System Network report will be a primary source of information for assessing this domain of access

Member utilization – members' use of the providers and services available to them; various measures of utilization are available through Health Share Bridge as well as the quality incentive metrics program

Member perceptions and experiences – insights about care and provider interactions that cannot be identified in claims and encounter data; information obtained through analysis of grievances will be used to understand members' experience of care

With the influx of new members in February, increasing enrollment by 52%, Health Share has chosen to focus on access throughout 2018. Primary to that is understanding the demographic profile of our new members, learning where they prefer to receive services, and becoming familiar with their utilization of services. In 2018 we will be establishing baselines, identifying activities and targets to assess and improve access, based on initial analysis of data.

Other aspects of access are addressed as described below.

a. Availability of Services

Health Share ensures that members have an ongoing source of primary care, behavioral health and oral health care, and that all covered services are available and accessible to members in the time, amount, duration, scope and location consistent with their needs. Delegated health plans are responsible for ensuring they meet availability standards and that members have timely access to care and services. Health Share monitors health plan compliance with access standards through delegation oversight and the analysis of grievances and appeals.

b. Cultural Considerations

Efforts to respond to the culturally diverse needs of Health Share members include: building infrastructure to enable additional utilization of community-based traditional health workers; assuring communications are tailored to improve health literacy and meet cultural and linguistic needs; and conducting a Community Health Needs Assessment and Community Health Improvement Plan. Health Share also hosts a learning collaborative for staff of the health plans charged with leading diversity, equity and inclusion initiatives within their organizations. This learning collaborative provides a venue for health plan staff to brainstorm best practices, pilot new initiatives and garner support for their efforts to improve cultural responsiveness in clinical settings. Health Share has spent the last five years developing internal capacity to focus on health equity and community engagement, including attention to access and cultural considerations through the development of an Equity and Engagement team. The Equity and Engagement Team provide equity and access related technical assistance to Health Share health plans, delivery systems and community partners. They also provide internal technical assistance to advance knowledge, understanding, and integration of equitable practices to reduce health inequities. Internal advancing of equity includes optional hour long lunch and learn opportunities, mandatory equity training, and individual and cross organizational support.

c. Quality and Appropriateness of Care Furnished to All Members

Oversight of quality and appropriateness of care is conducted jointly by Health Share and health plan partners. Data is collected and monitored on a periodic basis to inform the development and implementation of interventions, and to measure results of the interventions for effective strategies to achieve appropriate utilization and quality of care. Much of this data comes from the metrics program. Plans are required to have a quality assurance and performance improvement program. Performance Improvement Projects, implemented jointly by Health Share and health plans, are designed to achieve improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have improve the health outcomes of the population and individual member.

d. Second Opinions

Provision of second opinions is a responsibility of health plans. Health Share monitors the provision of second opinions through delegation oversight and the analysis of grievances and appeals.

e. Timely

Ensuring that members have timely access to care and services consistent with access standards is a responsibility of health plans. Health Share monitors timely access through delegation oversight and the analysis of grievances and appeals.

2. CLAS Standards and Provider Network

Health Share facilitates the Cultural Competency and Health Equity Workgroup (CHEW), made up of health plan representatives. The group is focused on ensuring provision of culturally and linguistically appropriate health care services through implementation of the CLAS standards. The workgroup is facilitated in a learning collaborative format in recognition that many health plan partners are already employing best practices in this area. The learning collaborative supports sharing of knowledge and joint creation of solutions to ensure provision of culturally and linguistically appropriate health care services. Members of the group identify topics for further exploration and staff help facilitate the process.

3. Grievance and Appeals System

Health Share members have access to a robust grievance system. Each delegated entity is required to have a comprehensive grievance system, which is monitored by Health Share through delegation oversight and review of quarterly grievance reports submitted by delegates. In 2018, Health Share will focus on grievances that reflect issues with access to care, or member perception of access, in particular to address issues of health disparities and equity.

The assessment and analysis of the grievance and appeal system occurs quarterly with an annual review of data that may support initiating quality improvement activities. Health Share documents "any expression of dissatisfaction" as an opportunity for improvement. With that view of quality improvement, it is not Health Share's goal to reduce the number of grievances received in any category. Rather we look at this data as our members' attempt to provide Health Share with information with which to identify, when possible, improvements in the health care delivery system and the administrative infrastructure supporting it.

4. Fraud, Waste and Abuse

Program integrity activities at Health Share are designed to ensure federal and state funds are spent appropriately to deliver quality, necessary care and preventing fraud, waste and abuse. Delegated health plans are required to implement program integrity activities as well, and to report suspected instances of fraud, waste or abuse to Health Share. Health Share's Compliance Officer and quality assurance staff monitor delegated entities to ensure they have appropriate policies, procedures and processes in place to protect against fraud and abuse.

5. Health Equity and Data

a. Data

Health Share has developed a robust process for stratifying and making meaning of health and health care disparities faced by our members. The process includes stratifying key data indicators and metrics by race, ethnicity, language as well as other relevant social memberships. The data is then examined to uncover disparities faced by our members and compared to other local available data as a resonance check. When disparities are

identified, the process includes engagement with impacted communities to better understand the drivers of the disparities as well as to develop appropriate interventions. Finally, the process includes an equity lens applied to how we present the disparities in order to ensure cultural effectiveness in communication of the disparities. We are currently building upon this process by focusing on creating mechanisms to make this data actionable by our health plans through our Ready + Resilient strategic priorities. Our efforts will focus on how we can "make a case for responding to health disparities" through deliberately sharing data in ways that compel action and to provide technical assistance in translating data into actionable interventions. Finally, with the addition of over 100,000 members in February, we are conducting data analysis to better understand our new members and their unique health needs and disparities they face. Our process improvement goal will be "making a case for disparities" by using data to identify disparities and inform stakeholders to build a case for response.

b. Cultural Competence

Health Share ensures members receive care in a manner compatible with their cultural health beliefs, practices, preferred language and communication needs. Delegated health plans are required to ensure interpreter services are available to members and that written materials are offered in multiple languages. Health Share employs a Member Navigator and a Non-Emergent Medical Transportation Navigator, both of whom assist members in navigating the health care system and ensuring members have transportation to necessary services. In addition, Health Share has made investments in community organizations to further advance cultural competency within the health care system, such as supporting the infrastructure of ORCHWA, community health workers, peers and doulas. To ensure members receive care in a manner compatible with health beliefs, practices, preferred language and communication needs, over the next two years Health Share will focus on increasing the capacity of staff, partners and stakeholders to address health equity and cultural competency.

6. Health Information Technology

Health Share has implemented an enterprise data warehouse (EDW) and suite of five applications, referred to as Health Share Bridge. This solution allows Health Share to securely and conveniently pivot the wealth of information in the EDW and make it accessible to plan partners and providers. At the core of this effort is continuous data-driven quality improvement. This refers to the ability to track member experience, outcomes and costs over time to support care interventions, refine the current system of care, or understand the overlay of numerous systems serving our members. The information available in Health Share Bridge is reviewed as a regular part of strategic and operational meetings and informs a significant part of Health Share's decision making.

a. Health Information exchange

A key investment that Health Share plans to make is to engage with OHA and behavioral health providers in the region to promote the adoption of a Health Information Exchange. This will include a multi-year roll-out of HIE technology with the goal of enabling the physical health system to get more timely information related to their members who are being served in specialty behavioral health care, a gap in our region currently. Health Share will be

participating with OHA and the statewide opportunity to spread HIE and will aim to implement initially with the largest behavioral health providers in our region. We envision this work beginning in 2018 and continuing for multiple years with significant input from multiple sectors of the community as clinical information is shared and new opportunities for cross-system collaboration emerge.

b. Analytics

A key component of Health Share Bridge is the reporting software which allows users to interactively work with the EDW and create reports and dashboards of information tailored to their individual needs and uses. The analytics environment is available both internally and externally. A primary use of the analytics is the achievement of the quality incentive metrics. The analytics solution supports partner strategic objectives related to population management, integration of services and development of alternative payment methodologies. Health Share analytics support strategic investment strategy and will be developed to offer a deeper perspective on our membership in the areas of early life health, behavioral health and health equity (see below). These areas include a number of special populations (individuals struggling with substance use disorder, children in foster care, pregnant women, individuals with Severe and Persistent Mental Illness) and are intended to offer the richest data possible to enable our partners in program design and investment opportunities.

c. Patient engagement

Health Share's current website was last redesigned in 2014-2015. Health Share has engaged communications consultants to develop a mobile-friendly website that will enable members to more easily navigate the health plans, covered services, and benefits offered through Health Share. Our research shows that our member pages are accessed on mobile devices more than 50% of the time, so a mobile-friendly website is critical.

Given that nearly one in ten Health Share members note Spanish as their primary language, Health Share will also be transcreating the website in Spanish. Transcreation offers superior language access to members by avoiding the pitfalls of direct translation, such as idioms that do not translate.

In addition, Health Share is developing five digital engagement campaigns in 2018. The campaigns will drive Health Share members or potential members to: (1) enroll or renew in OHP; (2) seek behavioral health services when necessary; and (3) encourage members to seek effective contraception, adolescent well-child visits, and childhood immunizations. These campaigns will drive members to dedicated resource pages on Health Share's website and to seek services and supports from Health Share's partners. All digital campaigns will also be offered in Spanish.

7. Integration of Care

Health Share has formed an Integrated Steering Committee, with representation from each of the sixteen health plans, chartered to identify and address opportunities for operational and strategic alignment supportive of an integrated system of care. While integration of behavioral, oral and

physical health occurs at the delivery system level, integration of delivery of services is most successful when supported by operational alignment. The Integrated Steering Committee has identified the importance of whole-person health, with a focus on prevention and on achievement of quality metrics with an integration component, such as the DHS foster child assessments and ED utilization metrics. For 2018, the Integrated Steering Committee recommended investment of $1.3 million of 2016 quality metrics funds in integrated diabetes initiatives.

Health Share also facilitates a Care Integration Workgroup which has representation from physical, behavioral and dental health plans. The Workgroup is chartered to identify strategies to improve care management and coordination across plans, including communication channels, care planning for members and successful transitions from one care setting to another. The goals of the Workgroup are to optimize member utilization of services, and efficiently and effectively manage care through better integration of physical, behavioral and oral health, including consideration of social determinants of health.

8. Patient-Centered Primary Care Homes (PCPCH)

Health Share and its plan partners support the development and use of Patient-Centered Primary Care Homes, Certified Community Behavioral Health Centers, and other forms of medical home models that provide integrated, coordinated care. Health Share has funded Advanced Primary Care models with Centers for Medicare and Medicaid Innovation funds as well as quality incentive metric funds. Most recently, Health Share provided funding and technical assistance for the development of Advanced Primary Care homes to provide coordinated support for children in foster care.

9. Severe and Persistent Mental Illness (SPMI)

Individuals with serious and persistent mental illness (SPMI) are by definition individuals with special health care needs. Care management for these members is coordinated by the behavioral health plans, in collaboration with physical and dental plans. Care is managed through interdisciplinary care teams that provide direct member outreach and engagement, coordination of services and care conferences. Areas of focus for the behavioral health plans in serving members with SPMI include increasing urgent and walk-in services, and mobile crisis services, as well as access to Assertive Community Treatment teams and peer-delivered services. There are seven Certified Community Behavioral Health Centers (CCBHCs) operating in Health Share's service region, providing an opportunity to determine whether this model achieves improved health outcomes for members with SPMI, using the new quality incentive metric addressing emergency department utilization of members with mental illness (ED-MI) as a primary measurement.

10. Social Determinants of Health

Health Share collaborates with a number of partners to address social determinants of health including Early Learning Hubs, the Local Public Health Authorities and housing services. This includes developing strong partnerships with early learning hubs to improve health and education outcomes for children. We created regional strategic momentum with early learning hubs, home visiting programs, early intervention/early childhood special education to implement Help Me Grow, a centralized access point for providers and families to connect to resources for developmentally at

risk children and families. Health Share created a community collaboration involving multiple child serving systems to support a more coordinated system of care for children in foster care, including DHS Child Welfare, Juvenile Court, mental health provider agencies, primary care and oral health. In addition to these efforts, Health Share is currently working on developing a new Community Health Needs Assessment and Community Health Plan, which incorporates Social Determinants of Health. Finally, Health Share staff are actively involved in A Home For Everyone which is focused on ending homelessness, a key social determinant of Health.

11. Special Health Care Needs

Health Share utilizes criteria to identify members with special health care needs and, through Health Share Bridge, provides health plans access to pre-aggregated data to assist with targeting care management programs. Among the many populations that can be identified in Health Share Bridge are individuals flagged as having serious and persistent mental illness, those with significant chronic conditions, children in (or previously in) foster care, individuals who use Emergency or Inpatient services, and members belonging to particular rate categories such as Aged, Blind and Disabled. Plans are required to have a systematic process to assess, coordinate, and provide early intervention and ongoing care coordination for members with special health care needs. Care management staff are expected to coordinate across organizations, to ensure physical, behavioral and oral health needs of members are met. The Care Integration Workgroup is a forum to discuss improved processes for joint care plan development and information sharing to support coordinated services for members with special health care needs.

12. Utilization Review

Health Share requires that each health plan develop and implement a utilization management program that includes the collection, assessment and monitoring of data that pertains to utilization of covered services. Utilization management program activities are to include the evaluation of appropriateness of clinical services and treatment, and encourage the highest quality care. Utilization management includes a retrospective review of covered services already rendered or already incurred costs and the use of predictive modeling to identify individuals or populations for disease management or care management programs.

A component of a comprehensive utilization management program is utilization review, the process by which determinations are made as to whether a covered services is clinically appropriate and necessary. Utilization review is a function delegated to health plan partners and overseen by Health Share through delegation oversight.

13. Value-based Payment Models

Health Share requires each health plan to develop and implement alternate payment methodologies to move in the direction of value-based payment. Plans use the Exhibit L reports and Oregon Health Authority guidance regarding tracking and reporting of APMs. Health Share has aligned with the APM target set by the Centers for Medicare and Medicaid Services of 30% of total compensation. Plans have implemented a variety of APMs, including quality bonuses, case rates, and PMPM payments on top of fee-for-service reimbursement.

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i. Describe your CCO's quality program structure, including your grievance and appeal system and utilization review:

Quality Program Structure

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The executive team also charters the Delegation Oversight Committee (DOC) which ensures that Health Share remains accountable for and compliant with contractual and regulatory requirements through oversight of delegation of core administrative and management functions. The DOC is chaired by the Chief Operating Officer and its membership includes the Chief Information Officer, Director Compliance and Quality Assurance, Director Contracting and Network Management, Director Finance, Quality Assurance Specialists, Senior Data Quality Analyst and Health Systems Integration Manager. The DOC reviews pre-delegation assessments, and findings of annual reviews and on-going monitoring of delegated entities, and identifies areas of non-compliance requiring corrective action. The DOC provides regular reports to the Quality Committee.

Grievance and appeal system: Health Share members have access to a robust grievance system for response to grievances and appeals, as well as contested case hearings. Delegated entities are required to have a comprehensive grievance system that meets all federal and state contractual and regulatory requirements. Health Share is the final adjudicator of appeals and takes an active role in the appeal and contested case hearing process. Health Share collects and analyzes member grievances and appeals to ensure the quality and experience of care by members, as well as to identify opportunities for improvement. Quarterly grievance reports are submitted by delegated entities and aggregated for submission to the Oregon Health Authority. Quarterly analyses of grievances are reported to the Delegation Oversight Committee and the Quality Committee.

Utilization review: Utilization review is a function delegated to health plans and overseen by Health Share staff through annual reviews and on-going monitoring. Through delegation oversight Health Share assures appropriate structures and mechanisms are used by health plan partners to conduct utilization review,

including monitoring over- and under-utilization of services. Annual reports submitted by the health plans are reviewed, and trend analysis is conducted to identify any disparities in utilization. In addition, through Health Share Bridge, we are able to determine utilization rates for various services broken out by specific demographic groups and sub-populations, providing an overarching view of how our members are accessing services.

ii. Describe your CCO's organizational structure for developing and managing its quality and transformation activities (please include a description of the connection between the CCO board and CAC structure):

The founding member organizations of Health Share include health systems, provider organizations, and county governments in the tri-county region, each with a long history of serving Oregon Health Plan Medicaid enrollees. The founding organizations are Adventist Health, CareOregon, Central City Concern, Clackamas County, Kaiser Permanente Northwest/Kaiser Foundation Health Plan, Legacy Health, Multnomah County, Oregon Health & Science University, Providence Health & Services/Providence Health Alliance, Tuality Healthcare/Tuality Health Alliance, and Washington County. Each of the founding members has a seat on Health Share's Board of Directors, along with elected directors from mental health, substance use disorders, primary care and oral health, as well as the community at large. The Community Advisory Council has an appointed liaison to the Board. The Board of Directors sets the strategic direction for Health Share.

Health Share subcontracts with a number of delegated entities, including sixteen health plans: behavioral health (Clackamas, Multnomah and Washington Counties); dental health (Access, Advantage, Capitol, CareOregon, Family, Kaiser, Managed, ODS and Willamette); and physical health (CareOregon, Kaiser, Providence and Tuality). The health plans are fully financially at risk for the populations enrolled with them, manage benefits, authorize services, conduct utilization review and utilization management, provide care coordination and care management, contract with provider networks, and pay claims. All delegated entities are required to have a comprehensive grievance system; to participate in Health Share's quality program; and to ensure members have access to appropriate services and benefits.

Due to Health Share's delegated business model, we have instituted a comprehensive committee and workgroup structure to support engagement with health plan operations. The Integrated Steering Committee and Clinical Alignment Workgroup, each with representation from health plans, work with Health Share management and staff to develop and manage quality and transformation activities. Health Share operations provide a foundation for implementing the quality strategy and managing the quality program in concert with health plans.

iii. Describe how your CCO uses its community health improvement plan as part of its strategic planning process for transformation and quality:

Both the Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHP) are integral components of Health Share's strategic planning process for transformation and quality. The Community Advisory Council (Council) oversees the development of the CHNA through engagement with the Healthy Columbia Willamette Collaborative. The Council partners with Health Share staff to develop a CHP based on identified priorities in the CHNA. The CHP serves as a strategic population health and health care system service plan. The activities defined in the CHP include outcomes and quality improvement, as well as integration of service delivery. The CHP is approved by the Health Share Board of Directors. Health Share staff act as liaisons between the Council and the TQC to ensure the activities of the CHP are aligned with and incorporated into the Quality Strategy. As noted above, the Council appoints a liaison who sits on the Board of Directors and has input into Health Share's strategic objectives identified by the Board.

iv. Describe how your CCO is working with community partners (for example, health systems, clinics, community-based organizations, local public health, local mental health, local government, Tribes, early learning hubs) to advance the TQS:

Health Share engages with multiple community partners to advance the quality program and in carrying out transformational initiatives. These partners include Early Learning Hubs, Local Public and Mental Health Authorities, school based health centers, patient centered primary care and other medical home practices, specialty care practices, mental health and substance use disorder providers, and multiple community based organizations. Specific examples of engagement with community partners, both recently completed and those still in progress, include:

- Funded infrastructure development of the Oregon Community Health Worker Association to support the community health worker workforce
- Increased PCP consultation for psychiatric medication management through Project ECHO
- Implemented sustainable funding plan for Tri-County 911 Service Coordination Program
- Provided specialty mental health agencies access to hospital event notifications through PreManage
- Piloted integration of legal services in a health care team, the Medical Legal Partnership, to address and prevent health-harming social conditions
- Trained providers to administer Long-Acting Reversible Contraception
- Funding Project Nurture at three clinics for integrated maternity and addiction care of pregnant women with substance use disorders
- Increased PCP consultation for developmental pediatrics through Project ECHO
- Developed standard process and web-based platform to coordinate health assessments for children in foster care
- Led Advanced Primary Care Collaborative to develop seven medical home models for children in foster care
- Piloting culturally and linguistically adapted ASQ developmental screening tools
- Implementing centralized access point, Help Me Grow, to connect providers and families to resources for children developmentally at risk
- Developing peer family navigator training program and curriculum for peer support for families and children with special health care needs
- Created a learning collaborative for health plans focused on advancing health equity within their systems, integrating CLAS standards
- Participate in local community health improvement planning process in Clackamas, Multnomah and Washington Counties
- Participate in regional group identifying the ideal service model and sustainable funding for school based health centers

Through these efforts and partnerships, Health Share: works regionally to develop and implement an equitable health care delivery model that integrates behavioral, oral and physical health care; applies an equity lens to identify and address inequities in services, policies, practices, and procedures; and addresses the social determinants of health through supporting collaboration between the health care system and the community.

B. Review and approval of TQS

i. Describe your CCO's TQS process, including review, development and adaptation, and schedule:

The Transformation and Quality Committee (TQC) described in the Quality Program Structure above is responsible for the development, implementation and oversight of the Transformation and Quality Strategy

and operation of the quality program. The quality program is ongoing and comprehensive, and includes quality and performance improvement, quality assurance, program integrity, and performance monitoring through quality metrics and other tools. The TQC seeks input from and provides updates to the Community Advisory Council to ensure the quality program and Transformation and Quality Strategy are member-centered and member-focused.

The TQC meets at least quarterly, and frequently monthly. The TQC monitors the quality program and the Transformation and Quality Strategy throughout the year, and is responsible for compiling information to complete the required progress and annual reports. Members of the TQC provide regular updates to senior management and the Quality Committee of the Board of Directors on various components of the program and strategies. This includes providing quarterly reports on the achievement of the quality incentive metrics and the status of performance improvement projects, as well as strategic initiatives approved by the Board of Directors that are components of the Transformation and Quality Strategy.

C. OPTIONAL

i. Describe any additional CCO characteristics (for example, geographic area, membership numbers, overall CCO strategy) that are relevant to explaining the context of your TQS:

As of March 2018, Health Share serves more than 310,000 members in the tri-county region of Clackamas, Multnomah and Washington Counties. We operate through a collaboration of health plans, health systems, delivery systems, providers and community partners. Given our business model, the Transformation and Quality Strategy reflects work being done by our partners as well as strategic initiatives implemented and managed by Health Share staff. The strategic objectives adopted by the Health Share Board of Directors for 2018 – 2020 are known collectively as Ready + Resilient. With Ready + Resilient, Health Share is creating a long-term roadmap to support the wellbeing of children, families and communities through prevention, support for recovery, and focused investment in health equity.

The goal of one set of strategies, known as Start Strong, is that children are ready for kindergarten, and families are connected to the health and social resources they need to thrive. These strategies include improving the quality and quantity of screenings for women and children in health care and community settings; building and enhancing clinical and community interventions and referral systems; and improving systems of care for populations with complex needs, notably children in foster care. The goal of the second set of strategies, known as Support Recovery, is that people are able to access quality mental health and substance use services delivered by a trauma-informed workforce when and where they need them. These strategies include strengthening the behavioral health workforce; improving the substance use disorder system of care; and improving the availability of information across care settings. An overarching construct of Ready + Resilient is Share Health, our equity first approach that prioritizes eliminating health disparities for future generations.

Highlights of the work being done through Ready + Resilient include:

- Integrated the Oregon Family Well Being Assessment, a risk stratification tool, into two large maternity providers (Providence and Women's Health Associates)
- Funded hiring of Help Me Grow program staff at Swindells Resource Center, two Help Me Grow liaisons in Early Learning Hubs and one in Public Health
- Partnering with Early Learning Hubs to promote "sign up for kindergarten early" campaign in 10 languages
- Partnering with Early Learning Hubs to develop culturally responsive messaging for cross-sector use on developmental screening and milestones
- Over 400 children enrolled at three Foster Care Medical Homes; in 2017, 90.8% of children in foster care had timely mental, physical and oral health assessments

- Established a regional Children's System of Care governance structure
- Secured joint funding from five organizations to support regional Kindergarten Readiness collaboration
- Developed Substance Use Disorder Best Practice Guidelines for regional implementation in Q3 2018, with participation from providers and behavioral health plans
- Continued expansion of Medication Assisted Treatment access through Wheelhouse (substance use disorder provider hub and spoke partnerships)
- Enrolled eight behavioral health organizations in Health Share Bridge, allowing access to comprehensive data not previously available
- Engaged with Reliance HIE; convening behavioral health providers to evaluate interest and needs for participation in HIE

Section 2: Transformation and Quality Program Details

Table 1A

A. TQS COMPONENT(S)			
Primary Component:	Access	**Secondary Component:**	Grievances and appeals
Additional Components:			
Subcomponents:	Access: Availability of services	**Additional Subcomponent(s):**	Access: Timely

B. NARRATIVE OF THE PROJECT OR PROGRAM
Health Share ensures that members have an ongoing source of primary care, behavioral health and oral health care, and that all covered services are available and accessible to members in the time, amount, duration, scope and location consistent with their needs. Delegated health plans are responsible for ensuring they meet availability standards and that members have timely access to care and services. Health Share monitors health plan compliance with access standards through delegation oversight and the analysis of grievances and appeals.

C. QUALITY ASSESSMENT	
Evaluation Analysis:	With a 52% increase in membership in February 2018, Health Share is particularly interested in ensuring that members have timely access to needed services, and will be monitoring access closely throughout 2018.

D. PERFORMANCE IMPROVEMENT					
Activity: Measure time to first appointment for primary care, mental health and dental services. Review Grievances and Appeals data for trends in grievances submitted related to access				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Quarterly review of data	TBD	No decrease in time to first appointments	12/2018	No decrease in time to first appointments over 2018	01/2019
Quarterly review of Grievance and Appeal data	39% of total grievances submitted in 2017 related to access	No change in proportion of grievances submitted related to access	Q2, Q3, Q4 2018	No change in proportion of grievances submitted related to access	01/2019

Table 1B

A. TQS COMPONENT(S)			
Primary Component:	Access	**Secondary Component:**	Health equity and data
Additional Components:			
Subcomponents:	Access: Cultural considerations	**Additional Subcomponent(s):**	Health Equity: Cultural Competence

B. NARRATIVE OF THE PROJECT OR PROGRAM
Efforts to respond to the culturally diverse needs of our members include: building infrastructure to enable additional utilization of community-based traditional health workers; assuring communications are tailored to improve health literacy and meet cultural and linguistic needs; and conducting a Community Health Needs Assessment and Community Health Improvement Plan. Health Share also hosts a learning collaborative for staff of the health plans charged with leading diversity, equity and inclusion initiatives within their organizations. This learning collaborative provides a venue for health plan staff to brainstorm best practices, pilot new initiatives and garner support for their efforts to improve cultural responsiveness in clinical settings. Health Share has spent the last five years developing internal capacity to focus on health equity and community engagement, including attention to access and cultural considerations through the development of an Equity and Engagement team. The Equity and Engagement Team provide equity and access related technical assistance to Health Share health plans, delivery systems and community partners. They also provide internal technical assistance to advance knowledge, understanding, and integration of equitable practices to reduce health inequities. Internal advancing of equity includes optional hour long lunch and learn opportunities, mandatory equity training, and individual and cross organizational support.

C. QUALITY ASSESSMENT	
Evaluation Analysis:	1. In support of Traditional Health Workers, Health Share funded a pilot program supporting culturally specific community health workers (CHWs) in community-based organizations. Following the successful completion of the pilot, in 2017 Health Share made a $3.3 million dollar investment in the Oregon Community Health Workers Association (ORCHWA) to build infrastructure supporting community-based CHW activities and their work with health care systems. This investment enables ORCHWA to identify and customize a health information tracking system to capture the efforts and outcomes of CHWs; identify sustainable payment mechanisms for CHWs; enable health systems to reliably contract for community-based CHW services; and enhance professional and workforce development efforts for CHWs. 2. In 2016 Health Share contracted with Aspire Inc. to analyze and assess addiction recovery peers within publicly funded behavioral health systems in our service region. The findings indicated a need for culturally-specific trainings for peers working with Latino communities and working with individuals with severe and persistent mental illness. Health Share has committed to advancing this work as part of Ready + Resilient. 3. Women who work with doulas can improve breastfeeding rates, bonding and attachment between mother and baby, decrease instances of preterm delivery, and decrease stress of mother before, during, and after delivery. Health Share is in the preliminary phase of investment in the doula workforce with the objective of increasing rates of fully trained doulas of color and increasing access for members to community-based doulas of color. We have engaged in information gathering to identify needs for doulas of color to practicing in the tri-county region, which have informed our efforts. Additional objectives of this investment include identifying promising practices for community-based doulas to engage with clinical maternity care teams, investment in workforce development and curriculum development of how to begin a sustainable doula practice.

D. PERFORMANCE IMPROVEMENT					
Activity 1: Increase community infrastructure to support effective utilization of CHWs in the community. **Activity 2:** Support culturally specific trainings for peers working with Latino communities and working with individuals with severe and persistent mental illness. **Activity 3**: Make an investment to support capacity of doulas of color to serve Health Share members.				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Quarterly reports from ORCHWA on number of contracts implemented (Activity 1)	Warriors of Wellness (WOW) CHW program works with 6 CBOs in Multnomah County. There is no consistent or coordinated HIT system to collect CHW activities. Health Share is the sole funder of the ORCHWA infrastructure investment.	Expand WOW program into one additional county, identify key requirements for HIT system, and secure at least one additional multi-year funding source.	12/2018	Expand WOW program into Washington and Clackamas Counties, develop a health information tracking system to track CHW activities and outcomes, and secure additional funding sources to sustain this work.	12/2019
Quarterly reports from staff on progress toward contracting with a trainer and scheduling trainings (Activity 2)	No contract for trainer exists, working with stakeholders to assess options for trainers.	Contract secured with identified best resource to provide trainings.	12/2018	At least two culturally specific peer trainings will be conducted by selected trainer.	12/2019
Quarterly reports on progress of contract negotiations and development of training curriculum (Activity 3)	Negotiating contract with BirthingWay	Have a contract in place with BirthingWay to develop doula of color workforce	12/2018	Curriculum on how to start a sustainable doula practice completed and trainings implemented	12/2019

Table 1C

A. TQS COMPONENT(S)			
Primary Component:	Access	**Secondary Component:**	Utilization review
Additional Components:			
Subcomponents:	Access: Quality and appropriateness of care furnished to all members	**Additional Subcomponent(s):**	

B. NARRATIVE OF THE PROJECT OR PROGRAM
Oversight of quality and appropriateness of care is conducted jointly by Health Share and health plan partners. Data is collected and monitored on a periodic basis to inform the development and implementation of interventions, and to measure results of the interventions for effective strategies to achieve appropriate utilization and quality of care. Much of this data comes from the metrics program. Plans are required to have a quality assurance and performance improvement program. Performance Improvement Projects (PIPs), implemented jointly by Health Share and health plans, are designed to achieve improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have improve the health outcomes of the population and individual member. (See Table 11 for more detail on improvement activities related to Health Share's PIPs.)

C. QUALITY ASSESSMENT	
Evaluation Analysis:	Immunization status is an important aspect of early child health for all children, as evidenced by the measure's inclusion in the Bonus Round of the CCO incentive metric program starting 2018. Compliance with Combo2 status by 24 months is closely aligned with the schedule of well child visits recommended by the American Academy of Pediatrics. Absence of needed vaccinations is often an indication of barriers to accessing routine preventive pediatric care, so a focus on childhood immunizations is really a focus on improving families' access to and engagement with primary care for the first 2 years of life. This builds a strong foundation to ensure children's health and development is being effectively monitored as they prepare for kindergarten at age 5. Compliance with the immunization requirement is a key piece of starting kindergarten or engaging in child care and improving early childhood immunization status for our population helps establish engagement with primary care as a routine and a priority early on.

D. PERFORMANCE IMPROVEMENT					
Activity: Health Share is in the process of launching a behavior change communications campaign targeting families with children under age two to encourage them to get or keep their children up-to-date on immunizations.				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Performance on the Childhood Immunizations quality metric in 2018	72.7%	74.7% (pending)	12/2018	79.1%	12/2020

Table 1D

A. TQS COMPONENT(S)			
Primary Component:	Access	**Secondary Component:**	Choose an item.
Additional Components:			
Subcomponents:	Access: Second opinions	**Additional Subcomponent(s):**	

B. NARRATIVE OF THE PROJECT OR PROGRAM

Provision of second opinions is a responsibility of delegated health plans. Health Share monitors the provision of second opinions through delegation oversight and the analysis of grievances and appeals.

C. QUALITY ASSESSMENT

Evaluation Analysis:

Health Share tracks the number of second opinions provided to members through the delegation oversight process. A review of 2016 data identified a reporting gap of second opinions from delegated entities. Training was provided to the Compliance Workgroup in August 2017 to ensure compliance with this requirement, with minimal improvement noted on review (see Tables 1 and 2). Delegated entities provide seamless access to care and do not require prior authorizations for second opinions. Currently few delegated entities track second opinions as their systems are not able to distinguish a service provided related to a second opinion from any other service. However, this has been identified as an improvement opportunity for 2018.

Table 1: Second Opinion Requests for Members-2016

Benefit Plan	*Total Reported*
Physical Health	36
Behavioral Health	1
Dental Health	267
Total	304

Table 2: Second Opinion Requests for Members-2017

Benefit Plan	*Total Reported*
Physical Health	42
Behavioral Health	None reported
Dental Health	34- ODS reported 45% increase in 2nd opinions
Total	76

D. PERFORMANCE IMPROVEMENT

Activity: Develop work plan and dates for reporting at April 2018 Compliance Workgroup meeting

☒ Short-Term Activity or
☐ Long-Term Activity

How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
TBD based on work plan	N/A	TBD	Q3 2018	TBD based on work plan	12/2018

Table 2

A. TQS COMPONENT(S)			
Primary Component:	CLAS standards and provider network	**Secondary Component:**	Health equity and data
Additional Components:			
Subcomponents:	Health Equity: Cultural competence	**Additional Subcomponent(s):**	

B. NARRATIVE OF THE PROJECT OR PROGRAM
Health Share facilitates the Cultural Competency and Health Equity workgroup (CHEW), made up of health plan representatives. The group is focused on ensuring provision of culturally and linguistically appropriate health care services through implementation of the CLAS standards. The workgroup is facilitated in a learning collaborative format in recognition that many health plan partners are already employing best practices in this area. The learning collaborative supports sharing of knowledge and joint creation of solutions to ensure provision of culturally and linguistically appropriate health care services. Members of the group identify topics for further exploration and staff help facilitate the process.

C. QUALITY ASSESSMENT	
Evaluation Analysis:	The CHEW group was originally convened in 2015 and focused on aligning CLAS standards across our health plan partners, delivery systems and community partners. In 2017 the group established a learning collaborative approach to address member communications, outreach, engagement and services to ensure they are culturally and linguistically appropriate. The new format allows the group to share expertise in advancing CLAS standards.

D. PERFORMANCE IMPROVEMENT					
Activity: Implement initiatives to advance CLAS within health plans				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Review progress at workgroup meetings	Identification of initiatives	Develop a work plan that identifies at least three focus areas to advance CLAS within the health plans and selects one initiative for implementation	12/2019	Implementation of initiative to advance CLAS within each health plan	12/2020

Table 3

A. TQS COMPONENT(S)			
Primary Component:	Grievances and appeals	**Secondary Component:**	Health equity and data
Additional Components:	Access		
Subcomponents:	Access: Cultural considerations	**Additional Subcomponent(s):**	Health Equity-Cultural Competency

B. NARRATIVE OF THE PROJECT OR PROGRAM

Health Share members have access to a robust grievance system. Each delegated entity is required to have a comprehensive grievance system, which is monitored by Health Share through delegation oversight and review of quarterly grievance reports submitted by delegates. In 2018, Health Share will focus on grievances that reflect issues with access to care, or member perception of access, in particular to address issues of health disparities and equity.

The assessment and analysis of the grievance and appeal system occurs quarterly with an annual review of data that may support initiating quality improvement activities. Health Share documents "any expression of dissatisfaction" as an opportunity for improvement. With that view of quality improvement, it is not Health Share's goal to reduce the number of grievances received in any category. Rather we look at this data as our members' attempt to provide Health Share with information with which to identify, when possible, improvements in the health care delivery system and the administrative infrastructure supporting it.

C. QUALITY ASSESSMENT

Evaluation Analysis:

<u>Grievance Evaluation Analysis</u>

Throughout 2017, the Data Analysis and Reporting Team (DART) developed a robust disparities analysis framework. The DART provided an analysis of grievance system data using the disparities framework for the Quality Assurance staff to evaluate the extent to which non-English speaking members and members in racial or ethnicity minority groups take advantage of their rights within the grievance system.

Table 1 illustrates Health Share's member mix by languages spoken and by race or ethnicity as of March 2018.

Table 1.

Population by language

Language group	Unique members	% of total
Arabic	1,095	0.4%
Burmese	511	0.2%
Chinese	2,807	1.0%
English	231,355	82.7%
Russian	4,577	1.6%
Somali	1,101	0.4%
Spanish	26,754	9.6%
Undetermined	4,139	1.5%
Vietnamese	3,785	1.4%
Other	3,789	1.4%
Grand Total	279,913	100.0%

Unique members and % of total broken down by Language group. The data is filtered on Most recent DH plan, Most recent BH plan and Most recent PH plan. The Most recent DH plan filter keeps 10 of 10 members. The Most recent BH plan filter keeps Clackamas, Multnomah and Washington. The Most recent PH plan filter keeps Null, CareOregon, Kaiser, Providence and Tuality.

Population by race/ethnicity

Race group	Unique members	% of total
American Indian or Alask..	2,839	1.0%
Asian or Pacific Islander	15,455	5.5%
Black or African American	15,416	5.5%
Caucasian	107,783	38.5%
Hispanic	25,631	9.2%
Native Hawaiian or Pacifi..	1,483	0.5%
Other Race or Ethnicity	3,939	1.4%
Undetermined	107,367	38.4%
Grand Total	279,913	100.0%

Unique members and % of total broken down by Race group. The data is filtered on Most recent BH plan, Most recent DH plan and Most recent PH plan. The Most recent BH plan filter keeps Clackamas, Multnomah and Washington. The Most recent DH plan filter keeps 10 of 10 members. The Most recent PH plan filter keeps Null, CareOregon, Kaiser, Providence and Tuality.

The analysis of grievance data shows that Caucasian members are overrepresented in grievance data, accounting for 59% of all grievances files in 2017 but comprising only 39% of Health Share's population (see Table 2). There is also a higher percent of grievances submitted by African American members compared to their percent of the population (10.1% vs. 5.5%). Greatest representation of African-American members is seen in the "Access", "Interaction with Staff" and "Quality of Care" grievance categories. Otherwise, non-white members are vastly underrepresented in grievance data to varying degrees, most notably Hispanic and Asian groups.

Table 2.

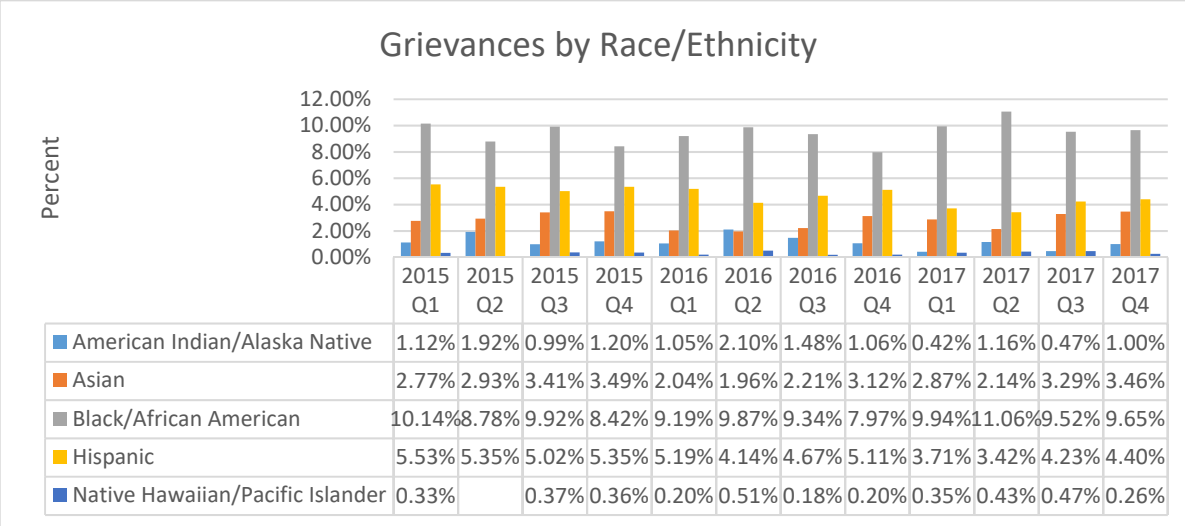
Grievances by race/ethnicity

	% of grievances				Count of grievances				% of grievances	Count of grievances
Race/ethnicity	2017 Q1	2017 Q2	2017 Q3	2017 Q4	2017 Q1	2017 Q2	2017 Q3	2017 Q4	Total	Total
American Indian or Alaska..	0.4%	1.2%	0.5%	1.0%	6	19	7	19	0.8%	51
Asian or Pacific Islander	2.9%	2.1%	3.3%	3.5%	41	35	49	66	3.0%	191
Black or African American	9.9%	11.1%	9.5%	9.6%	142	181	142	184	10.0%	649
Caucasian	58.8%	56.1%	59.6%	60.3%	840	919	889	1,149	58.7%	3,797
Hispanic	3.7%	3.4%	4.2%	4.4%	53	56	63	84	4.0%	256
Native Hawaiian & Pacific ..	0.4%	0.4%	0.5%	0.3%	5	7	7	5	0.4%	24
Other Race or Ethnicity	1.3%	0.9%	1.0%	0.5%	19	14	15	10	0.9%	58
Undetermined	22.5%	24.8%	21.4%	20.5%	322	406	319	390	22.2%	1,437
Grand Total	100.0%	100.0%	100.0%	100.0%	1,428	1,637	1,491	1,907	100.0%	6,463

% of grievances and Count of grievances broken down by Receipt Date Quarter vs. Race/ethnicity. The data is filtered on Receipt Date (MY), RAE, Grievance subtype and Grievance Category . The Receipt Date (MY) filter keeps 12 members. The RAE filter keeps 18 of 18 members. The Grievance subtype filter keeps multiple members. The Grievance Category filter keeps 7 of 7 members.

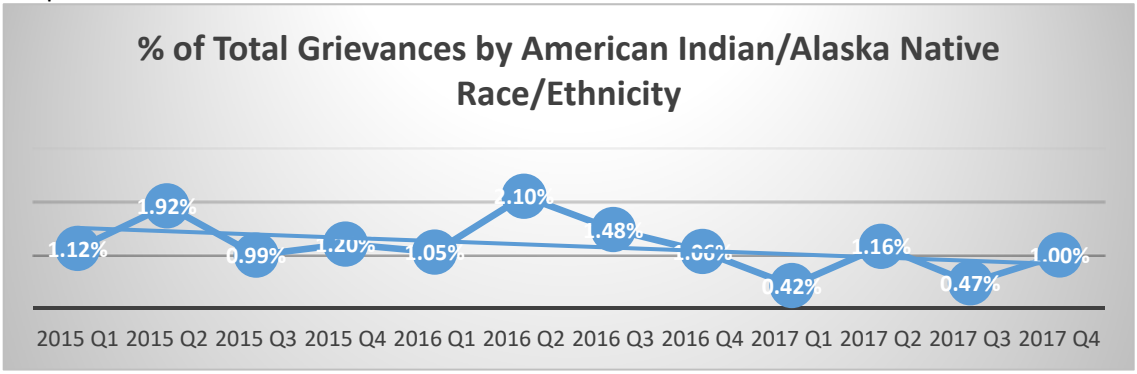
Graph 1 shows the percent of the population by racial and ethnic groups who submitted grievances over time with the removal of Caucasian and Undetermined populations. When viewed separately, the numbers have remained constant over time for this subset of the population (Graphs 2 and 3), with a small reduction in grievances submitted in the American Indian/Alaska Native population (- .12%) and the Hispanic population (from 5.53% down to 4.4%). No upward trends have been identified.

Graph 1.

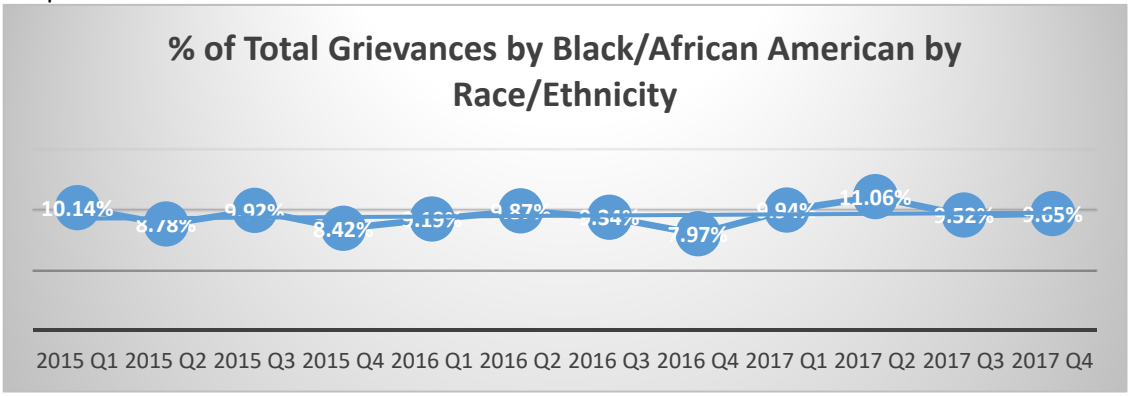


	2015 Q1	2015 Q2	2015 Q3	2015 Q4	2016 Q1	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3	2017 Q4
American Indian/Alaska Native	1.12%	1.92%	0.99%	1.20%	1.05%	2.10%	1.48%	1.06%	0.42%	1.16%	0.47%	1.00%
Asian	2.77%	2.93%	3.41%	3.49%	2.04%	1.96%	2.21%	3.12%	2.87%	2.14%	3.29%	3.46%
Black/African American	10.14%	8.78%	9.92%	8.42%	9.19%	9.87%	9.34%	7.97%	9.94%	11.06%	9.52%	9.65%
Hispanic	5.53%	5.35%	5.02%	5.35%	5.19%	4.14%	4.67%	5.11%	3.71%	3.42%	4.23%	4.40%
Native Hawaiian/Pacific Islander	0.33%		0.37%	0.36%	0.20%	0.51%	0.18%	0.20%	0.35%	0.43%	0.47%	0.26%

Graph 2.



Graph 3.

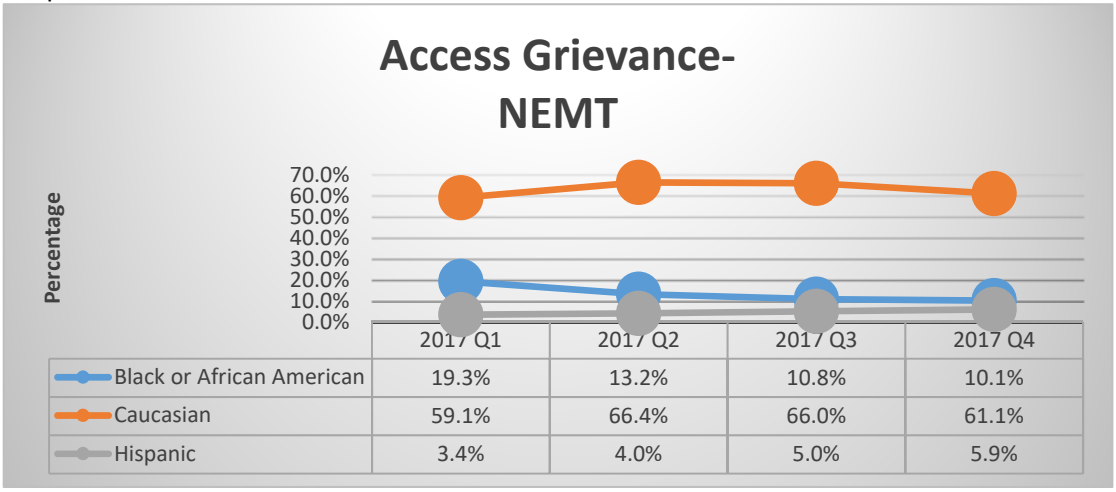


English speaking members are overrepresented in grievance data, accounting for 93% of all grievances filed in 2017 but comprising 83% of Health Share's population. We also see a higher percent of grievances from Arabic speakers, compared to their percent of the population (.09% vs. 0.4%). This accounted for 14 grievances for 2017. Arabic speakers are not identified in race/ethnicity data received from OHA.

English speakers are most notably represented in Quality of Care (98%), Consumer Rights (96%), and Interaction with Staff (94%). Overrepresentation of Arabic speakers is driven by grievances in Quality of Service (1.8%) and Consumer Rights (1.4%). Otherwise, non-English speakers are vastly underrepresented in grievance data to varying degrees: Spanish 1:4; Vietnamese 1:4; Somali 1:2; Russian 1:2; Chinese 1:3; Burmese 1:2.

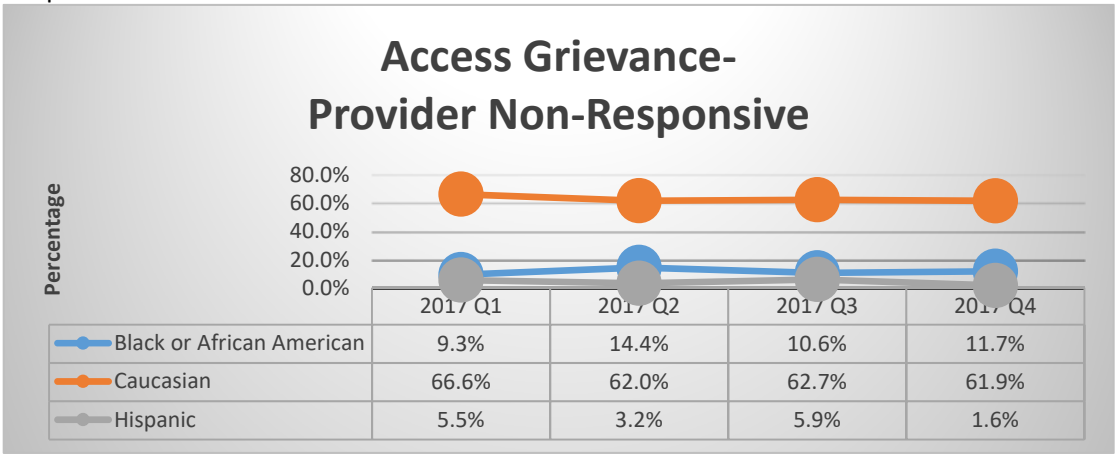
In the Access category, the "Provider Unresponsive" and "NEMT" sub-categories have remained highest over time. In reporting grievances in these sub-categories, the Black or African American group represented the next highest population following Caucasian and Undetermined, at 11.5% of grievances submitted and 4% for Asian or Pacific Islanders. This data was further broken into four quarters for 2017 to develop a baseline for further review during 2018 (Graphs 4 and 5). While there is no real correlation between race and ethnicity grievances, this data provides a baseline from which to monitor changes and determine actions accordingly.

Graph 4.



	2017 Q1	2017 Q2	2017 Q3	2017 Q4
Black or African American	19.3%	13.2%	10.8%	10.1%
Caucasian	59.1%	66.4%	66.0%	61.1%
Hispanic	3.4%	4.0%	5.0%	5.9%

Graph 5.



	2017 Q1	2017 Q2	2017 Q3	2017 Q4
Black or African American	9.3%	14.4%	10.6%	11.7%
Caucasian	66.6%	62.0%	62.7%	61.9%
Hispanic	5.5%	3.2%	5.9%	1.6%

<u>Appeals Evaluation Analysis</u>

Health Share members filed 981 appeals for Notices of Actions adverse to them. We continue to see an overrepresentation of English and Arabic speakers in our appeals data, along with an underrepresentation of Spanish, Vietnamese and Somali speakers (Table 3). Caucasian members are overrepresented in appeals data and Hispanic members are most notably underrepresented. We also see underrepresentation of American Indian/Alaska Native and African American members in filing appeals (Table 4).

Table 3.

Appeals by language

Language group	% of appeals 2017 Q1	% of appeals 2017 Q2	% of appeals 2017 Q3	% of appeals 2017 Q4	Count of appeals 2017 Q1	Count of appeals 2017 Q2	Count of appeals 2017 Q3	Count of appeals 2017 Q4	% of appeals Total	Count of appeals Total
Arabic	0.7%	1.1%	0.4%	1.7%	2	3	1	3	0.9%	9
Burmese	0.0%	0.4%	0.0%	0.0%	0	1	0	0	0.1%	1
Chinese	0.7%	1.4%	1.3%	0.0%	2	4	3	0	0.9%	9
English	91.2%	89.1%	91.6%	91.9%	268	246	218	159	90.8%	891
Russian	2.4%	2.2%	1.7%	0.6%	7	6	4	1	1.8%	18
Somali	0.3%	0.0%	0.0%	0.6%	1	0	0	1	0.2%	2
Spanish	2.0%	2.5%	1.7%	1.2%	6	7	4	2	1.9%	19
Undetermined	2.0%	1.1%	1.7%	0.6%	6	3	4	1	1.4%	14
Vietnamese	0.0%	0.7%	1.3%	0.6%	0	2	3	1	0.6%	6
Other	0.7%	1.4%	0.4%	2.9%	2	4	1	5	1.2%	12
Grand Total	100.0%	100.0%	100.0%	100.0%	294	276	238	173	100.0%	981

% of appeals and Count of appeals broken down by Date Of NOA Quarter vs. Language group . The data is filtered on Date Of NOA (MY), RAE, Action Category and Service Type (group). The Date Of NOA (MY) filter keeps 12 members. The RAE filter keeps 18 of 18 members. The Action Category filter keeps 7 of 7 members. The Service Type (group) filter keeps 20 of 20 members.

Table 4.

Appeals by race/ethnicity

Race/ethnicity	% of appeals 2017 Q1	% of appeals 2017 Q2	% of appeals 2017 Q3	% of appeals 2017 Q4	Count of appeals 2017 Q1	Count of appeals 2017 Q2	Count of appeals 2017 Q3	Count of appeals 2017 Q4	% of appeals Total	Count of appeals Total
American Indian or Alaskan Native	0.3%	1.8%	0.4%	0.0%	1	5	1	0	0.7%	7
Asian or Pacific Islander	2.4%	5.4%	5.0%	2.9%	7	15	12	5	4.0%	39
Black or African American	6.5%	5.1%	5.9%	5.2%	19	14	14	9	5.7%	56
Caucasian	53.7%	52.2%	53.4%	54.9%	158	144	127	95	53.4%	524
Hispanic	4.4%	4.0%	3.4%	1.7%	13	11	8	3	3.6%	35
Native Hawaiian & Pacific Islander	0.0%	0.7%	0.0%	0.0%	0	2	0	0	0.2%	2
Other Race or Ethnicity	1.7%	1.8%	2.9%	0.6%	5	5	7	1	1.8%	18
Undetermined	31.0%	29.0%	29.0%	34.7%	91	80	69	60	30.6%	300
Grand Total	100.0%	100.0%	100.0%	100.0%	294	276	238	173	100.0%	981

% of appeals and Count of appeals broken down by Date Of NOA Quarter vs. Race/ethnicity. The data is filtered on Date Of NOA (MY), RAE, Action Category and Service Type (group). The Date Of NOA (MY) filter keeps 12 members. The RAE filter keeps 18 of 18 members. The Action Category filter keeps 7 of 7 members. The Service Type (group) filter keeps 20 of 20 members.

Hearings Evaluation Analysis

In 2017 Health Share adjudicated 180 hearings from members. As with grievances and appeals, hearings disproportionately involve English speaking members, increasingly so over the year as fewer hearings were reported for Q4 (Table 5). Key differences in hearings requested by ethnicity of members continue to be overrepresentation of Caucasian and African American members and underrepresentation of Hispanic, American Indian, and Asian/Pacific Islander members (Table 6).

Table 5.

Hearings by language

Language group	% of hearings occurred 2017 Q1	2017 Q2	2017 Q3	2017 Q4	Count of Hearings Occurred 2017 Q1	2017 Q2	2017 Q3	2017 Q4	% of hearings occurred Total	Count of Hearings Occurred Total
Arabic	2.1%	2.1%	2.1%	2.6%	1	1	1	1	2.2%	4
Burmese	0.0%	0.0%	0.0%	0.0%	0	0	0	0	0.0%	0
Chinese	0.0%	0.0%	0.0%	0.0%	0	0	0	0	0.0%	0
English	85.1%	87.2%	87.2%	94.9%	40	41	41	37	88.3%	159
Russian	2.1%	6.4%	4.3%	0.0%	1	3	2	0	3.3%	6
Somali	0.0%	0.0%	0.0%	0.0%	0	0	0	0	0.0%	0
Spanish	8.5%	0.0%	2.1%	0.0%	4	0	1	0	2.8%	5
Undetermined	0.0%	2.1%	4.3%	0.0%	0	1	2	0	1.7%	3
Vietnamese	0.0%	0.0%	0.0%	0.0%	0	0	0	0	0.0%	0
Other	2.1%	2.1%	0.0%	2.6%	1	1	0	1	1.7%	3
Grand Total	100.0%	100.0%	100.0%	100.0%	47	47	47	39	100.0%	180

% of hearings occurred and count of Hearings Occurred broken down by Date Of NOA Quarter vs. Language group . The data is filtered on Date Of NOA (MY), RAE, Action Category and Service Type (group). The Date Of NOA (MY) filter keeps 12 members. The RAE filter keeps 18 of 18 members. The Action Category filter keeps 7 of 7 members. The Service Type (group) filter keeps 20 of 20 members.

Table 6.

Hearings by race/ethnicity

Race/ethnicity	% of hearings occurred 2017 Q1	2017 Q2	2017 Q3	2017 Q4	Count of Hearings Occurred 2017 Q1	2017 Q2	2017 Q3	2017 Q4	% of hearings occurred Total	Count of Hearings Occurred Total
American Indian or Alaska..	0.0%	2.1%	0.0%	0.0%	0	1	0	0	0.6%	1
Asian or Pacific Islander	2.1%	4.3%	2.1%	2.6%	1	2	1	1	2.8%	5
Black or African American	6.4%	8.5%	10.6%	5.1%	3	4	5	2	7.8%	14
Caucasian	53.2%	55.3%	57.4%	48.7%	25	26	27	19	53.9%	97
Hispanic	8.5%	0.0%	2.1%	2.6%	4	0	1	1	3.3%	6
Native Hawaiian & Pacific ..	0.0%	0.0%	0.0%	0.0%	0	0	0	0	0.0%	0
Other Race or Ethnicity	2.1%	0.0%	4.3%	0.0%	1	0	2	0	1.7%	3
Undetermined	27.7%	29.8%	23.4%	41.0%	13	14	11	16	30.0%	54
Grand Total	100.0%	100.0%	100.0%	100.0%	47	47	47	39	100.0%	180

% of hearings occurred and count of Hearings Occurred broken down by Date Of NOA Quarter vs. Race/ethnicity. The data is filtered on Date Of NOA (MY), RAE, Action Category and Service Type (group). The Date Of NOA (MY) filter keeps 12 members. The RAE filter keeps 18 of 18 members. The Action Category filter keeps 7 of 7 members. The Service Type (group) filter keeps 20 of 20 members.

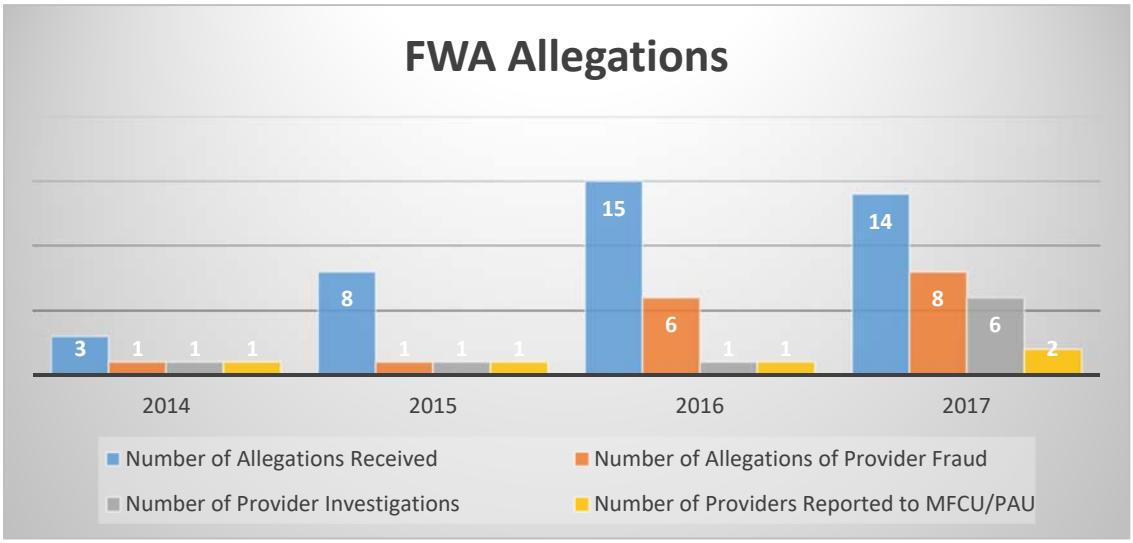
D. PERFORMANCE IMPROVEMENT

Activity: Increase engagement of non-English speaking and racial and ethnic minority members in pursuing their grievance, appeal and hearings rights.				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Quarterly review of grievance data, stratified by language, race and ethnicity	TBD based on analysis	TBD based on analysis	Q2, 2018	TBD	12/2019

Table 4

A. TQS COMPONENT(S)			
Primary Component:	Fraud, waste and abuse	**Secondary Component:**	Choose an item.
Additional Components:			
Subcomponents:	Choose an item.	**Additional Subcomponent(s):**	

B. NARRATIVE OF THE PROJECT OR PROGRAM
Program integrity activities at Health Share are designed to ensure federal and state funds are spent appropriately to deliver quality, necessary care and preventing fraud, waste and abuse. Delegated health plans are required to implement program integrity activities as well, and to report suspected instances of fraud, waste or abuse to Health Share. Health Share's Compliance Officer and quality assurance staff monitor delegated entities to ensure they have appropriate policies, procedures and processes in place to protect against fraud and abuse.

C. QUALITY ASSESSMENT	
Evaluation Analysis:	In 2017, delegated entities reported fourteen (14) allegations of fraud, waste or abuse (see Table 1). One overpayment issue was identified and resolved. Not all allegations are investigated because the allegations may be reported anonymously and with insufficient detail to investigate, or are not related to fraud or abuse in any way. Table 1.  Seven allegations of FWA were reported through the Compliance Hotline. Four calls were from non-Health Share members. Two reported people believe to be committing welfare fraud. They were provided information on contacting the Oregon Health Authority. One had a complaint regarding finger surgery. One was concerned because an agency told them there was a compliance issue with the information provided to be eligible for food stamps. Two Health Share members contacted the hotline to file an appeal for a denial of services and were assisted in filing an appeal. One Health Share member filed a fraud allegation against an ex-spouse regarding TANF/SNAP benefits for four years and being over income. This complaint was forwarded to the DHS Fraud Investigation unit the same day the hotline call was received.

	Health Share received eight notices and/or allegations of provider fraud, one overpayment notification and one notification of an excluded provider via email in 2017. Upon investigating, one allegation regarding non-emergent medical transportation was deemed not to be fraud and closed. Three notifications came from the Oregon Department of Justice seeking information from Health Share and delegated entities. Two allegations of provider fraud came from delegated entities. Upon investigation, one was forwarded to both the Medicaid Fraud Control Unit and the Provider Audit Unit. The other was found to be a newly licensed provider with a lack of knowledge of coding and required Medicaid procedures. The provider was put on an improvement plan and is being closely monitored. Health Share received three notices from delegated entities of alleged member fraud that were forwarded to the Medicaid Fraud Control Unit. Health Share conducted quarterly compliance training for new employees and an annual training for all employees. 100% of Health Share staff completed this mandatory training on time. To assure ongoing education and professional development, Quality Assurance staff completed five (5) compliance training sessions in addition to accessing resources such as HCCA Compliance Today and the National Council Compliance Watch.

D. PERFORMANCE IMPROVEMENT

Activity 1: Investigation of alleged fraud or abuse reported through the Compliance Hotline or by delegated entities
Activity 2: Staff compliance training

☐ Short-Term Activity or
☒ Long-Term Activity

How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Quarterly review of allegations of fraud or abuse (Activity 1)	100% of alleged instances of fraud or abuse investigated in 2017	100% of alleged instances of fraud or abuse will be investigated within 30 days of receipt in 2018	Q1, Q2, Q3, Q4 2018	100% of alleged instances of fraud or abuse will be investigated within 30 days of receipt in 2018	01/2019
Quarterly review of training logs (Activity 2)	100% of staff completed mandatory trainings on time in 2017	100% of staff will complete mandatory trainings in 2018	Q1, Q2, Q3, Q4 2018 trainings for new staff	100% of staff will complete mandatory trainings in 2018	12/2018

Table 5A

A. TQS COMPONENT(S)			
Primary Component:	Health equity and data	**Secondary Component:**	Choose an item.
Additional Components:			
Subcomponents:	Health Equity: Data	**Additional Subcomponent(s):**	Health Equity: Cultural Competence

B. NARRATIVE OF THE PROJECT OR PROGRAM
Health Share has developed a robust process for stratifying and making meaning of health and health care disparities faced by our members. The process includes stratifying key data indicators and metrics by race, ethnicity, language as well as other relevant social memberships. The data is then examined to uncover disparities faced by our members and compared to other local available data as a resonance check. When disparities are identified, the process includes engagement with impacted communities to better understand the drivers of the disparities as well as to develop appropriate interventions. Finally, the process includes an equity lens applied to how we present the disparities in order to ensure cultural effectiveness in communication of the disparities. We are currently building upon this process by focusing on creating mechanisms to make this data actionable by our health plans through our Ready + Resilient strategic priorities. Our efforts will focus on how we can "make a case for responding to health disparities" through deliberately sharing data in ways that compel action and to provide technical assistance in translating data into actionable interventions. Finally, with the addition of over 100,000 members in February, we are conducting data analysis to better understand our new members and their unique health needs and disparities they face. Our process improvement goal will be "making a case for disparities" by using data to identify disparities and inform stakeholders to build a case for response.

C. QUALITY ASSESSMENT	
Evaluation Analysis:	Health Share has built significant infrastructure to support an equity approach to data analytics. Early work on developing a standard and robust process to stratify data by race, ethnicity and language was conducted by the Disparities Analytics and Reporting Team (DART). This early work is the basis for the next iteration of ensuring data is driving our work towards health equity. We will be working over the next year to build a work plan with targets and benchmarks to carry the work forward. Initial areas of focus include: • Conduct disparities analyses that leverage alignment in Performance Improvement Projects and Public Health initiatives • Engage with Integrated Steering Committee and Clinical Alignment Group to inform how best to encourage plans to use data and analytics to identify and reduce specific health disparities • Build in-house capacity with additional tools for disparities analytics • Communicate business case and lessons learned to broad stakeholder groups

D. PERFORMANCE IMPROVEMENT					
Activity: Leverage internal data analytics and health equity expertise to create an action plan to make data on health and health care disparities actionable for health plan partners				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Quarterly reports on progress of completing action plan	N/A	Completion of an action plan	12/2018	Data regularly provided to plans to support them in addressing health	12/2019

				disparities in assigned member populations	

Table 5B

A. TQS COMPONENT(S)			
Primary Component:	Health equity and data	**Secondary Component:**	CLAS standards and provider network
Additional Components:			
Subcomponents:	Health Equity: Cultural competence	**Additional Subcomponent(s):**	

B. NARRATIVE OF THE PROJECT OR PROGRAM
Health Share ensures members receive care in a manner compatible with their cultural health beliefs, practices, preferred language and communication needs. Delegated health plans are required to ensure interpreter services are available to members and that written materials are offered in multiple languages. Health Share employs a Member Navigator and a Non-Emergent Medical Transportation Navigator, both of whom assist members in navigating the health care system and ensuring members have transportation to necessary services. In addition, Health Share has made investments in community organizations to further advance cultural competency within the health care system, such as supporting the infrastructure of ORCHWA, community health workers, peers and doulas, as well as facilitating the Cultural Competency and Health Equity Workgroup. To ensure members receive care in a manner compatible with health beliefs, practices, preferred language and communication needs, over the next two years Health Share will focus on increasing the capacity of staff, partners and stakeholders to address health equity and cultural competency.

C. QUALITY ASSESSMENT	
Evaluation Analysis:	<u>Internal staff trainings</u>: Health Share started an internal equity and inclusion training series for Health Share staff in 2015 with the goal of embedding equity practices across the organization and at all levels. The trainings have included mandatory quarterly 2-hour trainings and optional monthly 1-hour lunch and learns. Topics covered have included: power and privilege; racism; health equity and social determinants of health; implicit bias; transgender competency; understanding poverty and more. We aimed to include theoretical content paired with active skills for implementing equity best practices into our work. Staff have reported increased knowledge and understanding as well as intent to implement equity approaches to their efforts. The staff trainings will continue and be expanded to include enhanced equity trainings targeted to people in leadership roles where decision-making resides. This is in recognition of the unique role leaders hold in deciding on organizational priorities, resource allocation and in setting organizational culture. These trainings would focus on helping leaders understand the vital roles they play in infusing equity within the organization and provide the skills to implement change. <u>Technical assistance</u>: The Health Share Equity and Engagement team has begun to receive requests for equity related technical assistance from a wide variety of stakeholders, including health plans, delivery systems and community partners. Technical assistance has been provided on a wide variety of topics including reviewing patient forms for cultural appropriateness, self-care strategies for people of color doing equity work, and general equity trainings. We are actively working on building out a more systematic way to promote, coordinate, and offer technical assistance and training on equity to our partners. <u>Organizational culture</u> In recognition that achieving health equity means infusing equity at all levels and areas within the organization, we want to collaborate with key stakeholders within Health Share to shift organizational culture to better infuse equity and inclusion. In many ways, Health

	Share sees this as the bedrock to support the rest of our initiatives aimed at addressing health equity for our members. We will conduct an internal organizational culture assessment and then an action plan for how we will work with key stakeholders to support an organizational culture that further advances equity and inclusion.				
D. PERFORMANCE IMPROVEMENT					
Activity 1: Create and implement a yearly equity and inclusion training plan for all staff and an enhanced training series for leadership. **Activity 2:** Provide technical assistance on health equity related topics to stakeholders to support advancement of cultural competency **Activity 3:** Develop an action plan to advance equity and inclusion practices within Health Share				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Quarterly review of progress on training plan (Activity 1)	Schedule of mandatory quarterly all staff equity and inclusion trainings and optional monthly trainings	Complete training calendar and enhanced training series	12/2018	Implement equity and inclusion trainings for all staff and measure impact on staff knowledge and intent to implement changes to work approaches. Implement enhanced equity training for leadership and measure sense of self-efficacy in advancing equity.	06/2020
Quarterly review of technical assistance provided (Activity 2)	Technical assistance provided on a requested basis	Develop an engagement process to better assess equity related training needs of stakeholders requesting technical assistance and develop two trainings	12/2018	Create and implement a technical assistance marketing plan promoting services to stakeholders. Fulfill at least four technical assistance requests on equity-related topics.	06/2020

Quarterly review of progress on action plan (Activity 3)	Health Share addresses equity and inclusion in several areas across the organization, but has yet to systematically address infusing equity into organizational culture, policies and practices	Conduct an organizational culture assessment and identify key opportunities to infuse equity and inclusion practices in policies and procedures and human resources	06/2019	Create and implement an action plan for advancing equity and inclusion within organizational culture, policies and practices. The action plan should include clear goals and objectives, identify resources needed, and include concrete metrics for accountability.	06/2020

Table 6A

A. TQS COMPONENT(S)			
Primary Component:	Health information technology	**Secondary Component:**	Choose an item.
Additional Components:			
Subcomponents:	HIT: Health information exchange	**Additional Subcomponent(s):**	

B. NARRATIVE OF THE PROJECT OR PROGRAM
A key investment that Health Share plans to make is to engage with OHA and behavioral health providers in the region to promote the adoption of a Health Information Exchange. This will include a multi-year roll-out of HIE technology with the goal of enabling the physical health system to get more timely information related to their members who are being served in specialty behavioral health care, a gap in our region currently. Health Share will be participating with OHA and the statewide opportunity to spread HIE and will aim to implement initially with the largest behavioral health providers in our region. We envision this work beginning in 2018 and continuing for multiple years with significant input from multiple sectors of the community as clinical information is shared and new opportunities for cross-system collaboration emerge.

C. QUALITY ASSESSMENT	
Evaluation Analysis:	Broadly, our goal is to increase the number of behavioral health providers connected to an HIE. We can determine the number of providers who are engaged with an HIE and the number of members they serve as a percentage of all members receiving Behavioral Health services and would hope to see this percentage increase.

D. PERFORMANCE IMPROVEMENT

Activity: Work with Reliance and OHA to explore opportunities for HIE implementation and support; identify interested behavioral health providers to pilot connection and use of HIE.	☐ Short-Term Activity or ☒ Long-Term Activity

How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Quarterly review of progress toward identifying project sites	No functional HIE in region	Multiple pilot sites identified and engaged in HIE	12/2019	All large BH providers have active HIE supporting integration and care planning	12/2022

Table 6B

A. TQS COMPONENT(S)			
Primary Component:	Health information technology	**Secondary Component:**	Special health care needs
Additional Components:			
Subcomponents:	HIT: Analytics	**Additional Subcomponent(s):**	Integration of Care

B. NARRATIVE OF THE PROJECT OR PROGRAM
A key component of Health Share Bridge is the reporting software which allows users to interactively work with the EDW and create reports and dashboards of information tailored to their individual needs and uses. The analytics environment is available both internally and externally. A primary use of the analytics is the achievement of the quality incentive metrics. The analytics solution supports partner strategic objectives related to population management, integration of services and development of alternative payment methodologies. Health Share analytics support strategic investment strategy and will be developed to offer a deeper perspective on our membership in the areas of early life health, behavioral health and health equity. These areas include a number of special populations (individuals struggling with substance use disorder, children in foster care, pregnant women, individuals with Severe and Persistent Mental Illness) and are intended to offer the richest data possible to enable our partners in program design and investment opportunities.

C. QUALITY ASSESSMENT	
Evaluation Analysis:	The analytics platform is currently functioning. A Data Governance Committee, made up of executive and senior leadership, meets monthly to prioritize data and analytic needs for the organization, including prioritization of measures and new dashboards. An area of focus in 2018 is the potential development of a broader set of access and engagement measures spanning behavioral, oral and physical health. The focus of these measures would be to evaluate access to services for new enrollees, with a particular focus on disparities across race, ethnicity or language.

D. PERFORMANCE IMPROVEMENT

Activity: Streamline the governance and decision making process to align the number of requests for data and new development with the resources available and with strategic and operational priorities.				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Review and prioritization of analytics requests at monthly Data Governance Committee meetings	Active analytics platform	Active analytics platform with more information geared toward measuring access and engagement, and health disparities	12/2019	Incorporation of more measures in the data warehouse to understand engagement of members in health services, and health disparities within our population	12/2020

Table 6C

A. TQS COMPONENT(S)			
Primary Component:	Health information technology	**Secondary Component:**	Choose an item.
Additional Components:			
Subcomponents:	HIT: Patient engagement	**Additional Subcomponent(s):**	

B. NARRATIVE OF THE PROJECT OR PROGRAM

Health Share's current website was last redesigned in 2014-2015. Health Share has engaged communications consultants to develop a mobile-friendly website that will enable members to more easily navigate the health plans, covered services, and benefits offered through Health Share. Our research shows that our member pages are accessed on mobile devices more than 50% of the time, so a mobile-friendly website is critical.

Given that nearly one in ten Health Share members note Spanish as their primary language, Health Share will also be transcreating the website in Spanish. Transcreation offers superior language access to members by avoiding the pitfalls of direct translation, such as idioms that do not translate.

In addition, Health Share is developing five digital engagement campaigns in 2018. The campaigns will drive Health Share members or potential members to: (1) enroll or renew in OHP; (2) seek behavioral health services when necessary; and (3) encourage members to seek effective contraception, adolescent well-child visits, and childhood immunizations. These campaigns will drive members to dedicated resource pages on Health Share's website and to seek services and supports from Health Share's partners. All digital campaigns will also be offered in Spanish.

C. QUALITY ASSESSMENT	
Evaluation Analysis:	Health Share will use website and search analytics to evaluate utilization of member pages on Health Share's updated website compared to existing website. Health Share will use click-through and conversion rates to evaluate digital engagement campaigns, as well as monitoring utilization rates of targeted health services.

D. PERFORMANCE IMPROVEMENT

Activity: Develop and launch new website and five digital engagement campaigns				☒ Short-Term Activity or ☐ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Reduced abandonment rates on member web pages. Spanish language website will be monitored separately.	TBD	TBD	12/2018	TBD	12/2018
Click-through and conversion rates on digital engagement campaigns will be monitored and evaluated throughout.	TBD	TBD	06/2018 – 12/2018	TBD	6/2018-12/2018

Table 7

A. TQS COMPONENT(S)			
Primary Component:	Integration of care (physical, behavioral and oral health)	**Secondary Component:**	Choose an item.
Additional Components:			
Subcomponents:	Choose an item.	**Additional Subcomponent(s):**	

B. NARRATIVE OF THE PROJECT OR PROGRAM
Health Share has formed an Integrated Steering Committee, with representation from each of the sixteen health plans, chartered to identify and address opportunities for operational and strategic alignment supportive of an integrated system of care. While integration of behavioral, oral and physical health occurs at the delivery system level, integration of delivery of services is most successful when supported by operational alignment. The Integrated Steering Committee has identified the importance of whole-person health, with a focus on prevention and on achievement of quality metrics with an integration component, such as the DHS foster child assessments and ED utilization metrics. Health Share also facilitates a Care Integration Workgroup which has representation from physical, behavioral and dental health plans. The Workgroup is chartered to identify strategies to improve care management and coordination across plans, including communication channels, care planning for members and successful transitions from one care setting to another. The goals of the Workgroup are to optimize member utilization of services, and efficiently and effectively manage care through better integration of physical, behavioral and oral health, including consideration of social determinants of health.

C. QUALITY ASSESSMENT	
Evaluation Analysis:	In 2016, 17,000 Health Share adult members had a diabetes diagnosis, a disproportionate number of whom were racial and ethnic minorities. These diabetes diagnoses directly led to over 900 inpatient stays and more than 900 ED visits that year. The total cost of care provided for primary diabetes diagnoses was over $11 million for these members in 2016.Eevidence shows that diabetes puts individuals at an increased risk for an array of oral health and physical health complications, including serious gum disease, heart disease, and stroke. It is also known that individuals with behavioral health diagnoses are at an increased risk for developing diabetes, and that an individuals' mental health plays an important role in their ability to manage their co-occurring diabetes. The diabetes control quality metric has been challenging for Health Share to meet, and there has been widespread interest across health plan clinical and operational leadership to invest in innovative approaches to improve performance on this metric. The Integrated Steering Committee recommended investment of $1.3 million of 2016 quality metrics funds in diabetes initiatives that will support integration of care for members with diabetes, address inequities in care, and improve performance on the diabetes quality incentive metric. Funded projects will include explicit efforts to eliminate the disparities in health and health care faced by Health Share members. Tactics should be driven by data, show demonstrable impact on reducing disparities, have clear metrics and include adequate resources to be successful.

D. PERFORMANCE IMPROVEMENT					
Activity: Fund integrated diabetes initiatives with established metrics for outcomes and performance				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**

Review of data submitted by funded projects	TBD based on project	TBD based on project	TBD based on project	TBD based on project	TBD based on project

Table 8

A. TQS COMPONENT(S)			
Primary Component:	Patient-centered primary care home	**Secondary Component:**	Choose an item.
Additional Components:			
Subcomponents:	Choose an item.	**Additional Subcomponent(s):**	

B. NARRATIVE OF THE PROJECT OR PROGRAM
Health Share and its plan partners support the development and use of Patient-Centered Primary Care Homes, Certified Community Behavioral Health Centers, and other forms of medical home models that provide integrated, coordinated care. Health Share has funded Advanced Primary Care models with Centers for Medicare and Medicaid Innovation funds as well as quality incentive metric funds. Most recently, Health Share provided funding and technical assistance for the development of Advanced Primary Care homes to provide coordinated support for children in foster care.

C. QUALITY ASSESSMENT	
Evaluation Analysis:	Health Share's physical health plan partners contract with PCPCHs, including federally qualified health centers, school-based health centers, and other safety net providers. Health Share has consistently had a high percentage of members who receive care at a PCPCH (over 90% in 2016). With the introduction of the new recognition criteria in 2017, the rate has dropped to 70%. There are opportunities to increase integration of behaviorists in PCPCHs as well as co-location of specialty mental health or substance abuse providers, in addition to use of payment incentives to support the PCPCH model.

D. PERFORMANCE IMPROVEMENT

Activity: Track the number of Health Share members assigned to a PCPCH				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Quarterly reports of member assignment to PCPCHs	70%	75%	12/2018	80%	12/2019

Table 9

E. TQS COMPONENT(S)			
Primary Component:	Severe and persistent mental illness	**Secondary Component:**	Health information technology
Additional Components:	Utilization Review		
Subcomponents:	HIT: Health information exchange	**Additional Subcomponent(s):**	

F. NARRATIVE OF THE PROJECT OR PROGRAM
Individuals with serious and persistent mental illness (SPMI) are by definition individuals with special health care needs. Care management for these members is coordinated by the behavioral health plans, in collaboration with physical and dental plans. Care is managed through interdisciplinary care teams that provide direct member outreach and engagement, coordination of services and care conferences. Areas of focus for the behavioral health plans in serving members with SPMI include increasing urgent and walk-in services, and mobile crisis services, as well as access to Assertive Community Treatment teams and peer-delivered services. There are seven Certified Community Behavioral Health Centers (CCBHCs) operating in Health Share's service region, providing an opportunity to determine whether this model achieves improved health outcomes for members with SPMI, using the new quality incentive metric addressing emergency department utilization of members with mental illness (ED-MI) as a primary measurement.

G. QUALITY ASSESSMENT	
Evaluation Analysis:	Health Share has formed an ED-MI workgroup with key stakeholders from the behavioral health plans. The group completed an extensive data analysis to better understand the population. One strategy identified by the workgroup is to target highest utilizers of emergency departments who have authorizations for mental health services with Cascadia Behavioral Healthcare and LifeWorks. Both Cascadia and LifeWorks operate CCBHCs, use PreManage and have existing strategies to reduce emergency department utilization in the populations they serve. Initial activities identified include developing PreManage workflows to identify members recently seen in an ED; develop standards for care plans in PreManage; identify workflows for linking behavioral health clinics with primary care clinics with high member overlap to encourage coordination of care; and build relationships between behavioral and physical health when care coordination and system navigation needs are present.

H. PERFORMANCE IMPROVEMENT					
Activity: Expand use of Pre-Manage and optimize workflows for providers and plans.				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
ED-MI workgroup monitor increased usage of Pre-Manage at monthly meetings	TBD, # of current users of Pre-Manage	25% increase in users of Pre-Manage	12/2018	TBD, increased usage of Pre-Manage	12/2020

Table 10

A. TQS COMPONENT(S)			
Primary Component:	Social determinants of health	**Secondary Component:**	Choose an item.
Additional Components:			
Subcomponents:	Choose an item.	**Additional Subcomponent(s):**	

B. NARRATIVE OF THE PROJECT OR PROGRAM
Health Share collaborates with a number of partners to address social determinants of health including Early Learning Hubs, the Local Public Health Authorities and housing services. This includes developing strong partnerships with early learning hubs to improve health and education outcomes for children. We created regional strategic momentum with early learning hubs, home visiting programs, early intervention/early childhood special education to implement Help Me Grow, a centralized access point for providers and families to connect to resources for developmentally at risk children and families. Health Share created a community collaboration involving multiple child serving systems to support a more coordinated system of care for children in foster care, including DHS child welfare, Juvenile Court, mental health provider agencies, primary care and oral health. Finally, Health Share staff are actively involved in A Home for Everyone which is focused on ending homelessness; a key social determinant of health.

C. QUALITY ASSESSMENT	
Evaluation Analysis:	<u>Community Health Needs Assessment/Community Health Improvement Plan</u> Health Share works in partnership with our Community Advisory Council on the development and oversight of the CHNA and CHP. Health Share is a participant in the Healthy Columbia Willamette Collaborate (HCWC), a coalition comprised of 15 hospital systems, four county health departments and the CCO. The HCWC works collaboratively to produce a regional CHNA that each participant uses as a foundation for their organizational CHNA. Health Share works with our Council to add data and information to tailor the CHNA to Health Share and to develop a CHP to address the health priorities and needs identified in our CHNA. The CHNA and CHP for 2018 will include social determinants of health. <u>Health Related Services</u> Health Share has partnered with Project Access Now to develop infrastructure to support the use of Health Related Services provided to members. Over the next two years, Health Share will evaluate the role and impact of Health Related Services on addressing social determinants of health.

D. PERFORMANCE IMPROVEMENT					
Activity 1: Partner with Community Advisory Council to produce a new CHNA and CHP that addresses social determinants of health **Activity 2**: Increase the use of Health Related Services funding to address social determinants of health.				☐ Short-Term Activity <u>or</u> ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Review of Council meeting notes and production of key documents (Activity 1)	Use of the most recent HCWC produced regional CHNAs to create a Health Share specific CHNA	New CHNA approved by Council and Board of Directors	12/2018	Create a new CHP based on the CHNA; develop a process to allocate resources to the community in	06/2019

				support of our CHP priorities overseen by the Council.	
Quarterly review of Exhibit L reports submitted by plan partners (Activity 2)	TBD	10% increase over baseline	12/2018	10% increase	12/2019

Table 11

A. TQS COMPONENT(S)			
Primary Component:	Special health care needs	**Secondary Component:**	Utilization review
Additional Components:	Integration of care		
Subcomponents:	Choose an item.	**Additional Subcomponent(s):**	

B. NARRATIVE OF THE PROJECT OR PROGRAM

Health Share utilizes criteria to identify members with special health care needs and, through Health Share Bridge, provides health plans access to pre-aggregated data to assist with targeting care management programs. Among the many populations that can be identified in Health Share Bridge are individuals flagged as having serious and persistent mental illness, those with significant chronic conditions, children in (or previously in) foster care, individuals who use Emergency or Inpatient services, and members belonging to particular rate categories such as Aged, Blind and Disabled. Plans are required to have a systematic process to assess, coordinate, and provide early intervention and ongoing care coordination for members with special health care needs. Care management staff are expected to coordinate across organizations, to ensure physical, behavioral and oral health needs of members are met. The Care Integration Workgroup is a forum to discuss improved processes for joint care plan development and information sharing to support coordinated services for members with special health care needs.

C. QUALITY ASSESSMENT

Evaluation Analysis:

As shown in Table 1, delegated health plans provided care management services for over 8,300 members with special health care needs in 2017. There were almost 30,000 referral or authorization requests received and 92.4% of those were approved.

Table 1.

	Members receiving care management services	Authorization/ Referral Requests	Approved Requests	Denied Requests	Expedited Requests
CareOregon	1,875	6,846	6,070	545	819
Clackamas MH	247	906	579	327	18
Kaiser Permanente	4,589	12,474	12,180	294	0
Multnomah MH	911	647	530	17	0
Providence	533	8458	7,804	643	113
Tuality	114	370	291	67	0
Washington County	123	53	50	3	0
Total	8,392	29,754	27,504	1896	950
Percentage			**92.4%**	**7.6%**	

Members will special health care needs can directly access specialty care through a standing referral from a primary care provider. Standing referrals, which are reviewed annually and updated as appropriate, provide seamless access to specialty care for any covered service.

In 2018, Health Share is implementing two new Performance Improvement Projects that address the needs of specific sub-populations. The first is an expansion of medication assisted treatment (MAT) as an effective response to Opioid Use Disorder. The second is

	implementation of the RAPID (relational health, academic, psychological, intellectual, developmental) assessment for children in foster care.				
D. PERFORMANCE IMPROVEMENT					
Activity 1: Access to specialty services for members with special health care needs **Activity 2**: MAT Expansion PIP **Activity 3:** Foster Care RAPID PIP				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Review of quarterly utilization reports to ensure members with special health care needs continue to receive clinically appropriate services (Activity 1)	92.4%	90%	Q1, Q2, Q3, Q4 2018	90%	12/2018
Quarterly PIP reports of members with a primary OUD diagnosis receiving MAT services (Activity 2)	66%	TBD	TBD	85%	12/2021
Quarterly PIP reports of the effectiveness of specialized assessments for youth entering foster care (Activity 3)	RAPID assessment piloted in 2017, no baseline data available	TBD	TBD	75% of youth with a behavioral health recommendation receive an authorization within 30 days of the RAPID assessment; foster care medical homes receive the RAPID assessment within 30 days for 75% of youth assesses; and 90% of youth identified as having a particular physical or behavioral health need receive that service within six months of the assessment	12/2021

Table 13

A. TQS COMPONENT(S)			
Primary Component:	Value-based payment models	**Secondary Component:**	Choose an item.
Additional Components:			
Subcomponents:	Choose an item.	**Additional Subcomponent(s):**	

B. NARRATIVE OF THE PROJECT OR PROGRAM
Health Share requires each health plan to develop and implement alternate payment methodologies to move in the direction of value-based payment. Plans use the Exhibit L reports and Oregon Health Authority guidance regarding tracking and reporting of APMs. Health Share has aligned with the APM target set by the Centers for Medicare and Medicaid Services of 30% of total compensation. Plans have implemented a variety of APMs, including quality bonuses, case rates, and PMPM payments on top of fee-for-service reimbursement.

C. QUALITY ASSESSMENT	
Evaluation Analysis:	Payment models employed by delegated health plans vary widely. Health Share will continue to work with plans to gain a better understanding of strategies used to move away from traditional fee-for-service payment toward paying for outcomes across a variety of payment and risk-sharing mechanisms.

D. PERFORMANCE IMPROVEMENT					
Activity: Increase the percentage of total compensation paid to providers by delegated health plans attributed to alternate payment methodologies				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Quarterly Exhibit L reports	35% of total compensation	30% of total compensation	Ongoing	35% of total compensation	Ongoing