Health Share of Oregon

Transformation and Quality Strategy

March 2020

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Section 1: Transformation and Quality Program Information

A. CCO governance and program structure for quality and transformation:

i. Describe your CCO's quality program structure, including your process for developing and implementing your TQS:

Health Share Quality Program Structure

Health Share of Oregon is a collaborative partnership spanning Clackamas, Multnomah, and Washington counties and inclusive of nearly all health care organizations that serve the 320,000 Oregon Health Plan members in our community. Health Share acts as a single point of accountability for Oregon Health Plan (OHP) in the region. This collaborative structure—based on deep organizational partnership and governance—means that Health Share is uniquely positioned to drive and support quality improvement efforts for a significant number of the state's OHP recipients. Since Health Share's founding partners include integrated finance and health care delivery systems (IDSs) an Integrated Community Network (ICN) of clinics, FQHCs and all three local Public Health entities, there are multiple avenues to implement and spread of best practices. Health Share's Quality Program brings together staff, member organizations, and community stakeholders in a way that uniquely leverages regional expertise to promote the Quadruple Aim and health system transformation.

Health Share's Board of Directors has chartered multiple committees to guide different areas of the organization, including the Quality and Health Outcomes (QHOC) Committee, which is responsible for oversight of Health Share's Quality Program. The QHOC Committee receives regular reports from senior management on all aspects of the Quality Program, including incentive metrics, performance improvement projects (PIPs), transformation and quality strategy (TQS) projects, quality assurance, and grievances and appeals. The QHOC Committee makes recommendations and reports to the Board on strategies and programs within each of these areas.

New to Health Share's structure in 2020 is the formation of Member Organization Advisory Committees (MACs) for each Board Committee. The MACs are comprised of and staffed by leadership of Health Share's member organizations, which provides an opportunity for all member organizations to both offer guidance and share accountability for regional transformation efforts. The QHOC-MAC is being established in of the first half of 2020. The QHOC-MAC will provide input and recommendations to the QHOC Committee, and the QHOC Committee may make specific requests of the QHOC-MAC in support of the Committee's work. This group will hold critical accountability for implementation of improvement efforts spanning the delivery system and clinical realms, as well as supporting cross-sector quality improvement efforts through CCO partnerships across the region.

Day-to-day operation of the Quality Program are managed by Health Share management and staff. Health Share's Chief Quality Officer, Chief Medical Officer, Director of Operations, and Director of Quality Assurance and Compliance are accountable for the elements within the Program. The Quality Improvement (QI) team is responsible for the incentive metrics program, the TQS report, performance improvement projects, and tracking improvement efforts related to other key performance indicators. Staff on this team span multiple roles across the organization, including analytics, quality improvement technical assistance, strategic planning, and program evaluation. QI staff work to align transformation strategies across plan partners to share learnings from Health Share's diverse collaborative partners, and spread best practices to maximize impact for the region.

The Quality Assurance and Compliance teams are responsible for delegation oversight activities. The CCO's executive team 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 Director of Operations and its membership includes the Director of Compliance and Quality Assurance, Director of Behavioral Health, Director of Finance, Director of Information Systems and Analytics, Director of Health Systems Integration, Delegation Oversight Manager, Quality Assurance Specialists, and Information Systems Infrastructure and Operations Manager. The DOC reviews pre-delegation assessments, findings of annual reviews, on-going monitoring of delegated entities, and identifies areas of noncompliance requiring corrective action. The DOC provides regular delegation oversight activity reports to Health Share's Governance and Operational Excellence Committee.

Health Share Process for Developing and Implementing the TQS

A guiding principle of Health Share's TQS is that rather than considering it as a separate process and body of work, it is viewed as an integral component of a broader set of initiatives and projects directed toward achieving the Quadruple Aim. Health Share works in partnership with multiple stakeholders to develop its transformation and quality initiatives, many of which are aligned with the overall goals of Ready + Resilient (Health Share's multi-year tri-county strategic transformation plan) and its Community Health Improvement Plan. Strategies are discussed and developed among the collaborative using the committee structure described earlier, including input from the Clinical Advisory Panel, the CCO's Community Advisory Council, the QHOC Committee, and the Community Impact Committee.

Health Share leverages its collaborative partnerships to implement TQS initiatives that aim to align the priorities of its Integrated Delivery Systems (IDS) (including the region's hospital systems), Integrated Community Network (ICN) (including behavioral and dental health providers), and member organizations with existing and emerging initiatives across the community. Some of these initiatives highlight Health Share's leadership role among the collaborative aimed at greater standardization of a complex system. Other initiatives leverage Health Share's structure to pilot and refine innovative approaches with the goal of spreading that innovation across the CCO more broadly to create meaningful improvements to population health. The QHOC Committee receives regular updates on all TQS initiatives, and other Board Committees participate by providing input and guidance on other initiatives that fall within their scope (e.g. the Community Impact Committee and the Community Advisory Council receive updates on the Traditional Health Worker project, etc.).

i. 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 and CHP. The Council includes community and board engagement processes to ensure alignment and community input in strategic priorities and strategies. The strategic priorities and strategies outlined in the CHP then inform population health and health care system service plans. The Council appoints two liaisons who sit on the Board of Directors and have input into Health Share's strategic objectives identified by the Board, including those identified in the CHP.

The Health Share Community Advisory Council completed a CHNA in 2018 and a CHP in 2019. The 2019-2023 CHP identifies five strategic priorities: 1) Supportive housing, 2) Food access, 3) Social connection, 4) Access to care, and 5) Chronic conditions. The Council decided to work on the priorities in stages throughout the CHP cycle, with the first year focusing on Supportive Housing and Access to Care. These priorities are woven throughout Health Share's strategic transformation

efforts, as evidenced by the Regional Supportive Housing Impact Fund initiative, the Traditional Health Worker project, the project to improve access to transportation services, and the project to disaggregate Grievances and Appeals data.

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

Founded by organizations deeply rooted in cross-sector work, Health Share recognizes the importance of engaging with multiple community partners in carrying out transformational initiatives. Although Health Share's member organizations span most of the health care organizations in the Tri-County region, Health Share has also cultivated relationships with many cross-sector partners recognizing that our members' health is largely driven by factors and systems outside of the traditional medical delivery system. These partnerships include Early Learning Hubs, Local Public and Mental Health Authorities, Local Housing Authorities, Department of Human Services (DHS), school districts, patient centered primary care and other medical home practices, specialty care practices, mental health and substance use disorder providers, and multiple community-based organizations. Through these efforts and partnerships, Health Share works 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 with the goal of deploying collective resources more efficiently to address collective problems.

Examples of current cross-sector partnerships and strategic investments that advance the priorities of the TQS:

- Launched **Kindergarten Readiness Network** with 60 participating organizations and 5 co-funders: Social Venture Partners, United Way of Columbia Willamette, Providence Children's Health, Oregon Community Foundation and Early Learning Multnomah (representing the tri-county Hubs), this network continues to inform Health Share's early childhood strategies. The Network's Data and Metrics group is an important collaborator in the development of best practices for data interpretation, and Health Share has partnered with multiple school districts (e.g. Reynolds School District, Beaverton School District, and Tigard-Tualatin School District, among others) to provide aggregate data on their students. (TQS Project #6)
- Funded two **DHS Medicaid Liaison** positions, one for Multnomah County and one for Clackamas and Washington counties. (TQS Project #11)
- Convened **Medication Assisted Treatment (MAT) Data Workgroup** to identify regional MAT targets and the Substance Use Disorder (SUD) Taskforce to implement regional MAT service expansion. Both groups include provider, plan, and county experts and leaders. (TQS Project #4)
- Convened a **Traditional Health Worker Advisory (THW) Committee** to advance THW strategies. This group, which includes provider network partners as well as Multnomah, Clackamas, and Washington counties, will meet monthly to develop solutions to address barriers to integration of THWs and to increase utilization of THWs in Health Share's service area. (TQS Project #1)
- Serving as the backbone agency for the **Regional Supportive Housing Impact Fund (RSHIF),** a new collective impact-based fund designed to work in tandem with other regional efforts, such as affordable housing bonds, to address the homelessness crisis. RSHIF emphasizes connecting very low-income persons with complex health challenges to deeply affordable supportive housing options that include the services they need to remain stable and housed. To create maximum flexibility for aligning with other regional efforts, RSHIF will braid and blend funding from across

sectors and partners, then nimbly deploy those funds in ways that maximize their total community impact. (TQS Project #10)

- **Doula workforce** development and technical skills investment (TQS Project #1)

B. 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:

Health Share is a collaborative that serves approximately 320,000 Oregon Health Plan members in the tri-county region. Health Share's membership is large- it includes children in more than 25 school districts, 7,300 five-year-old children entering kindergarten each year (enough to fill about 290 kindergarten classrooms), 5,100 youth receiving foster care services and about 10,700 members with an opioid use disorder diagnosis. While our regional reach means that we can enact solutions that impact a large group of members, our deep relationships with community partners allow us to incubate tailored solutions for specific communities. This combination of regional scope and local voice is uniquely Health Share. A perfect example of this is the CCO's continued development of the Foster Care Medical Home model, which are expanding from three solutions tailored to individual clinics to a system of flexible services that will impact the majority of youth receiving foster care services in the region, recognizing the differences in community need, local resources and DHS Branch practice.

We will respond to the priorities outlined in CCO 2.0 by leveraging the strengths of this network in new ways, building on our past success and innovating to deliver the promise of true integrated care. Several of the projects outlined in this year's TQS report continue efforts on the strategic objectives adopted by the Health Share Board of Directors for 2018 – 2020, which 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. In addition, several projects begin and/or continue foundational work in the areas of access and housing, which our Community Advisory Council prioritized as the first two areas to address from Health Share's 2019 Community Health Improvement Plan.

OHA Transformation and Quality Strategy (TQS) **CCO:** Health Share of Oregon

The following table shows which initiatives meet each TQS component.

TQS Component	Project(s)
Access: Cultural Considerations	#1: Expanding Access to Traditional Health Workers
Access: Quality and Adequacy of Services	#2: Improving Provider Network Reporting
Access: Timely	#3: Improving Non-Emergency Medical Transportation (NEMT) Services
Behavioral Health Integration	#4: Expanding Medication Supported Recovery (MSR) Services
CLAS Standards	#1: Expanding Access to Traditional Health Workers
Grievance and Appeal System	#5: Expanding Grievances and Appeals (G&A) Analysis
Health Equity: Cultural Responsiveness	#1: Expanding Access to Traditional Health Workers
Health Equity: Data	#5: Expanding Grievances and Appeals (G&A) Analysis #6: Equity Driven Data Best Practices
Oral Health Integration	#7: Connecting Members with Diabetes to Oral Health Care
Patient-Centered Primary Care Home	#8: Strategic Patient-Centered Primary Care Home (PCPCH) Improvement Efforts
Serious and Persistent Mental Illness	#9: Diabetes Integration Project (DIP)
Social Determinants of Health and Equity	#10: Establishing Infrastructure to Launch the Regional Supportive Housing Impact Fund
Special Health Care Needs	#11: Improving Services for Youth in Foster Care
Utilization Review	#12: Utilization Review Workgroup

Section 2: Transformation and Quality Program Details

A. Project or program short title: Project #1: Expanding Access to Traditional Health Workers

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

B. Components addressed

i. Component 1: Access: Cultural considerations
ii. Component 2 (if applicable): Health equity: Cultural responsiveness
iii. Component 3 (if applicable): CLAS standards
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health

C. Background and rationale/justification:

This is a continuation of the 2019 project, "Expanding access to culturally specific Traditional Health Workers." The 2019 project was working towards three outcomes. The first outcome was identifying the next steps for the CCO's investment in developing infrastructure with the Oregon Community Health Worker's Association (ORCHWA). The Health Share Board of Directors is currently considering next steps on this investment and has requested the Health Share Community Impact Committee provide input on this decision. The second outcome was to invest in local peer run organizations to support workforce development. Health Share funded 25 full scholarships for underrepresented students to enroll in the Portland Community College Alcohol and Drug Counseling degree and certificate programs. These scholarships were awarded to people of color and/or LGBTQAI students with the goal of diversifying the workforce and creating opportunities for workforce professional development. Health Share also funded the Mental Health and Addiction Association of Oregon (MHAAO) with scholarships for twelve peers to attend the 2019 "Peerpocalypse", a four-day conference created by and for peers. The third outcome was to develop a doula curriculum, and this was completed in the fall of 2019. The project highlighted in this report is the continued work to increase the utilization of doulas among members of color.

Oregon Public Health Division maternal and child data as well as Medicaid data illustrate health disparities experienced across communities of color, including in the areas of preterm birth rates, prenatal and postpartum depression, and infant mortality. Health Share is aiming to impact these pronounced disparities through investing in a multi-pronged intervention in the care and outcomes of communities of color in Clackamas, Washington and Multnomah Counties. Doulas play an important role in improving pre- and post-natal health outcomes, access to health-related services, reducing unnecessary utilization of services and cesarean rates, and encouraging attachment between the mother and newborn through breastfeeding, perinatal education, and advocacy. A 2019 March of Dimes position paper cited multiple studies that show that increasing access to doula care, especially in underresourced communities, may improve birth outcomes, improve the experience of care, and lower costs by reducing non-beneficial and unwanted medical interventions.

This investment is intended to provide promising practices and replicability in streamlining connections between clinics and the community-based doula workforce. The goals of this project are to:

1. Increase access to doulas of color/regional capacity to deliver culturally specific doula services,
2. Workforce development and sustainability; and
3. Integration of community-based doulas of color in clinical maternity care teams.

This investment aligns with Health Share's Community Health Improvement Plan strategy of Access to Care through *increasing sustainability and integration of THW workforce in clinical and community-based settings*. This initiative

also directly relates to CLAS Standard #3: *"Recruit, promote, and support a **culturally and linguistically diverse** governance, leadership, **and workforce** that are responsive to the population in the service area."*

The ongoing work to increase utilization of doulas among members of color is part of Health Share's broader strategy to increase access to THWs. To further this broader strategy, Health Share launched a Traditional Health Worker Advisory Committee in February 2020. This group, which includes provider network partners as well as Multnomah, Clackamas, and Washington counties, will meet monthly to develop solutions to address barriers to integration of THWs and to increase utilization of THWs in Health Share's service area.

D. **Project or program brief narrative description**:

Increase Access & Workforce Development:
Health Share partnered with Birthingway College of Midwifery to create curriculum that supports the professional and skills development for community-based doulas to sustainably own and operate private or community-based doula businesses. Teaching of the developed curriculum is intended to aid in increasing community capacity of comprehensively trained and registered, under the Oregon Traditional Health Worker Registry, community-based doulas of color and accordingly enhance access for Medicaid members to culturally responsive and linguistically appropriate doula services.

The curriculum will be taught to two cohorts in six-month series. Upon completion of the series, doulas will be registered on the THW Registry, have deepened knowledge of necessary steps to bill Medicaid as a provider, have registered a private doula business and/or participate as part of a doula collaborative, hold deeper understanding of how to develop and maintain sustainable doula businesses, and built mentorship/relationship connections with other doulas of color in the region. There are spots for 28 doulas to participate in this initiative; the first cohort began October 2019 and the second in February 2020.

Integration of Community-Based Doulas of Color:
Health Share is working with a consultant who will partner with two maternity practices to: assess barriers for clinical staff to connect prenatal patients to community-based doulas, identify effective workflows for clinics to access community-based doula services that connect prenatal women of color to doulas throughout the episode of pregnancy, support clinic knowledge/education of scope of doula services, and assess clinics current utilization of community and clinic-based doulas.

E. **Activities and monitoring for performance improvement**:

Activity 1 description: Workforce Development: Implementation of doula curriculum cohorts

☒ Short term or ☐ Long term

Monitoring activity 1.a for improvement: Frequency of cohort meetings

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
1st cohort is meeting monthly	Cohorts 1 and 2 meet monthly.	09/2020	Ongoing cohorts meet monthly.	12/2020

Monitoring activity 1.b for improvement: Percentage of curriculum participants on Oregon THW registry

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
NA- 1st and 2nd cohort still underway	90% of doula participants are on	09/2020	90% of doula participants are on	09/2020

	Oregon THW registry.		Oregon THW registry.	

Monitoring activity 1.c for improvement: Number of doulas completing curriculum

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
0- 1st and 2nd cohort still underway	At least 20 doulas complete the course series.	09/2020	At least 20 doulas complete the course series.	09/2020

Activity 2 description: Integration of community-based doulas of color: Connect maternity care team members to community-based doulas at two focus clinics.

☐ Short term or ☒ Long term

Monitoring activity 2.a for improvement: Agreement of two focus clinics to partner on this initiative.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Two potential clinics have been identified.	Two clinics have agreed to partner on this initiative.	03/2020	Two clinics have agreed to partner on this initiative.	03/2020

Monitoring activity 2.b for improvement: Frequency of meetings between consultant and partner clinics.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Not meeting	Monthly meetings between consultant and partner clinics.	05/2020	Monthly meetings between consultant and partner clinics.	05/2020

Monitoring activity 2.c for improvement: Development and approval of clinic practices.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Not developed	Review and approval of developed practices by clinic.	12/2020	Review and approval of developed practices by clinic.	12/2020

Monitoring activity 2.d for improvement: Number of members at two clinics served by a doula

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
TBD once clinics are participating	Set target in 03/2020.	03/2020	TBD- based on target set in March 2020.	12/2020

A. **Project or program short title**: Project #2: Improving Provider Network Reporting

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

B. **Components addressed**

i. Component 1: Access: Quality and adequacy of services
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☒ Yes ☐ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health

C. **Background and rationale/justification**:

Provider network adequacy is foundational to ensuring that Health Share members have access to high quality services. Health Share's provider network must have sufficient capacity and expertise to provide adequate, timely, and medically appropriate access to covered services to all members. One mechanism for measuring Health Share's network adequacy is its Delivery System Network (DSN) Report. This quarterly report, which includes both narrative and capacity components, describes the size and adequacy of Health Share's provider network.

An accurate and complete understanding of the characteristics of the provider network in its entirety is critical to Health Share's Community Advisory Council's CHP priority of ensuring that members can easily access services and supports to get their health care needs met. In addition, it is the first step to understanding how well the network is capable of meeting the needs of specific groups of members. OHA's daily enrollment data populates *Health Share Bridge* (Health Share's data platform) which allows Health Share staff to sort and analyze demographic data such as race/ethnicity, language, age, gender, location, foster care status, presence of serious and persistent mental illness (SPMI), plan assignment, etc. Health Share staff use these data to identify communities with specific outreach and member education needs and develop focused outreach efforts to address those needs. For example, Health Share's analysis of the language and cultural needs of enrollees created the frame for its *2018-2020 Community Health Needs Assessment*, in which data for six unique member populations was disaggregated in order to describe the overall health of each, including community strengths, resources, top illnesses and chronic conditions. Since no single community is universally served by only one of Health Share's plan partners, a full network picture is vital for building alignment and ensuring that care needs are met across the population.

The DSN report aims to collect valuable information about Health Share's provider network and as such relies on multiple sources of data. This project will aim to ensure consistency and cleanliness of reporting to both reduce administrative burden and, more importantly, make the DSN product maximally beneficial for CCO and OHA use. This includes for capacity monitoring, workforce adequacy and analytic reporting functions

D. **Project or program brief narrative description**:

In order to better align its Delivery System Network Report, Health Share will convene a DSN Workgroup to refine and collaboratively define common data elements that each smaller network must track and report. The DSN Workgroup will be comprised of provider relations experts from Health Share's system partners, as well as key Health Share IT, Analytics, and Equity and Engagement staff, and it will collaborate closely with Health Share's Community Advisory Council. The workgroup will further standardize format, definitions, and user case rules to ensure that provider network data is consistent and comparable. These definitions will be used to populate the DSN report as well as the Primary Care Provider (PCP) roll-up files. The PCP roll-up files are central to Health Share's analytics and reporting program. Once these definitions are approved by the group, partners will be held accountable to using them each quarter. Health Share staff will review and track both the accuracy and completion of DSN reporting for each plan partner and work to ensure that any inconsistencies are identified and resolved prior to submission to OHA.

The outcome of these efforts will be Health Share's timely production of information that accurately and consistently describes whether and how the provider network, in its entirety, is adequate and sufficient to deliver culturally appropriate, timely, and medically appropriate access to covered services to members across the age span, including dual eligible members. Though Health Share has worked hard to consolidate this information in the past, enhancing the standardization of data elements, expectations about delivery and format will reduce administrative burden and allow more time for analyzing the network itself. Health Share staff will use the DSN report to inform its transformation team, its equity and engagement team, and the Community Advisory Council's CHP efforts and strategies.

E. **Activities and monitoring for performance improvement**:

Activity 1 description: The DSN workgroup establishes standardized format, definitions, and use case rules for populating the plan partners' DSN capacity reports, which are used to populate Health Share's composite DSN capacity report.

☒ Short term or ☐ Long term

Monitoring activity 1.a for improvement: Development of DSN standardized definitions

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Partners may interpret OHA definitions differently.	Establish standard DSN field definitions for each type of provider and ensure alignment across the network.	06/2020	Established DSN field definitions and alignment across the network.	06/2020

Monitoring activity 1.b for improvement: DSN completeness the first time it gets sent to Health Share by plan partners (in established format and definitions).

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
0% (in established definitions since they are not yet established).	70% completeness the first time sent in.	08/2020	90% completeness the first time sent in.	12/2020

Activity 2 description: Health Share staff present a summary of the aligned DSN report to Health Share stakeholders to inform strategic planning.

☒ Short term or ☐ Long term

Monitoring activity 2.a for improvement: Dissemination of DSN findings to Health Share QHOC Committee and Operational Excellence Committee to ensure alignment with strategic initiatives.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
The Health Share governance Committees do not receive a summary of the DSN report.	A summary of the DSN goes to the Health Share governance committees each quarter.	08/2020	A summary of the DSN goes to the Health Share governance committees each quarter.	12/2020

Monitoring activity 2.b for improvement: Dissemination of DSN findings to Health Share Community Advisory Council

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
The Health Share Community Advisory Council does not receive a summary of the DSN report.	A summary of the DSN goes to the Health Share Community Advisory Council each quarter.	08/2020	A summary of the DSN goes to the Health Share Community Advisory Council each quarter.	12/2020

A. Project or program short title: Project #3: Improving Non-Emergency Medical Transportation (NEMT) Services

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

B. Components addressed

i. Component 1: Access: Timely
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health

C. Background and rationale/justification:

This project applies to improving the way that Health Share meets OAR 410-141-3920: Transportation: NEMT General Requirements- specifically that "A CCO shall provide non-emergency medical transportation (NEMT) services for its members" and "A CCO shall provide a toll-free call center for members to request rides." Health Share's Ride to Care program provides 8000 rides per day and more than 2 million rides annually. Ensuring safe, reliable, on-time transportation to OHP-covered services plays a vital part in timely access to health care. Health Share's Community Health Improvement Plan specifically notes transportation in its clinical service strategy*: Make clinical spaces more accessible (location + **transportation**) and inclusive for people living with disabilities and in rural communities*.

NEMT has a new vendor in 2020 and Health Share is strongly focused on the successful transition and implementation of services. Health Share worked closely with the previous Ride to Care vendor on quality improvement through multiple mechanisms- the contract, audits, corrective action plans –as well as providing oversight and technical assistance. In the fall of 2019 Health Share announced a Request for Proposal (RFP) process to select a transportation vendor, and the new vendors began providing services in early 2020. Health Share is committed to continuously improving this service and is closely tracking several metrics related to ride reliability, including on time performance, call center wait times, provider no-show rates, and member grievances.

D. Project or program brief narrative description:

Health Share's 2020 NEMT improvement strategies encompass four primary areas:

1. **Addressing provider no-shows** by reviewing grievances and meeting with provider to assess and mitigate issues leading to no-shows.
2. **Addressing on-time ride performance** by auditing the past on-time performance of each transportation provider; meeting with providers who are not meeting standards to assess and mitigate specific issues; and pre-scheduling "predictable" rides (for dialysis, chemotherapy, etc.) 30 days in advance.
3. **Reducing call center wait times** by assessing staffing levels and training plans; hiring and training additional staff as necessary; implementing improvements in the Interactive Voice Response (IVR) system; and providing on-site oversight of the call center function.
4. **Addressing member grievances** by auditing all past grievances; addressing acute unresolved issues that have been identified in grievances; and engaging the regional Disability and Aging Services Advisory Committees to make recommendations for better serving vulnerable populations.

E. **Activities and monitoring for performance improvement**:

Activity 1 description: reviewing grievances and meeting with provider to assess and mitigate issues leading to no-shows.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Provider no-show rate

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
14% no-show rate	<10% no show rate	04/2020	<5% no show rate	12/2020

Activity 2 description: Auditing the past on-time performance of each transportation provider and pre-scheduling 'predictable' rides (for dialysis, chemotherapy, etc.) 30 days in advance

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Provider on-time rate

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
63% on-time rate	75% on-time rate	04/2020	90% on-time rate	12/2020

Activity 3 description: Assessing staffing levels and training plans, hiring and training additional staff as necessary, implementing improvements in the Interactive Voice Response (IVR) system, and providing on-site oversight of the call center function.

☒ Short term or ☐ Long term

Monitoring activity 3 for improvement: Call center wait time

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
76% of calls answered in <5 minutes	90% of calls answered in <5 minutes	04/2020	90% calls answered in <5 minutes	12/2020

Activity 4 description: Auditing all past grievances, addressing acute unresolved issues that have been identified in grievances, and engaging the regional Disability and Aging Services Advisory Committees to make recommendations for better serving vulnerable populations.

☒ Short term or ☐ Long term

Monitoring activity 4 for improvement: Call center call abandonment rate

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
19% call abandonment rate	10% call abandonment rate	12/2020	10% call abandonment rate	12/2020

A. **Project or program short title**: Project #4: Expanding Medication Supported Recovery (MSR) Services

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

B. **Components addressed**

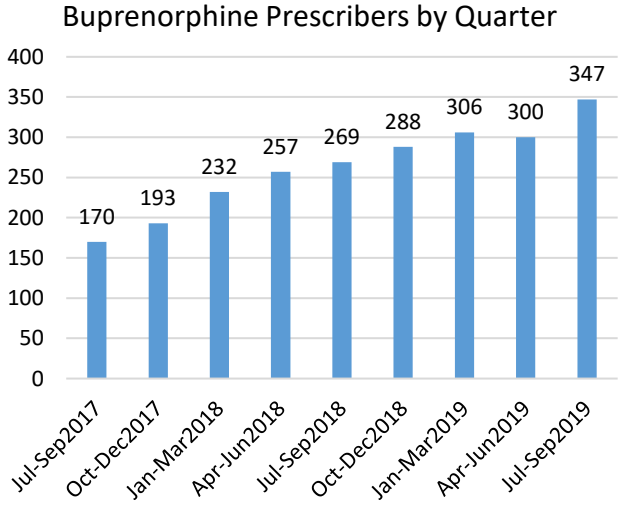
i. Component 1: Behavioral health integration
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

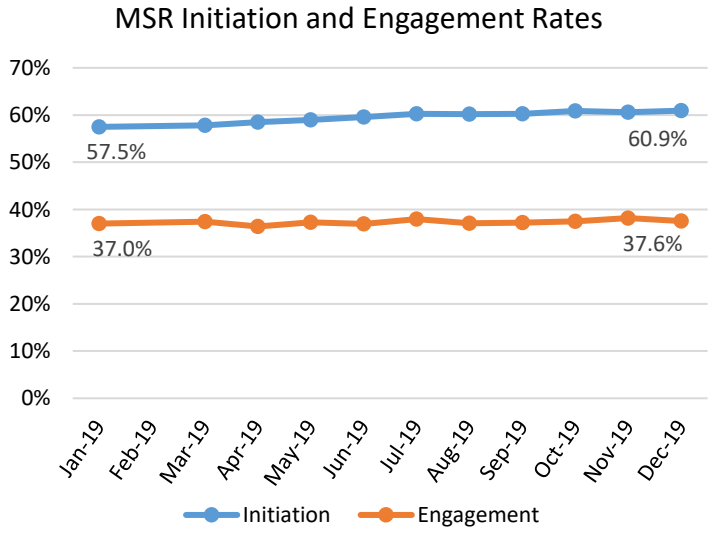
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health

C. **Background and rationale/justification**:

Medication Supported Recovery (MSR, also known as Medication Assisted Treatment (MAT)) has demonstrated success as part of treatment in reducing heroin use and prescription opioid misuse. MSR services can help decrease fatal and non-fatal overdoses, reduce transmission of infectious disease, increase treatment retention, and improve social functioning. MSR was traditionally often unavailable to those in need because of inadequate funding for treatment programs and a lack of qualified providers who can deliver these therapies. In 2017 Health Share began the Wheelhouse initiative to expand MSR services among behavioral health providers, and in 2019 Wheelhouse '2.0' was launched with a focus on expanding MSR among primary care providers. In 2019 Wheelhouse conducted a series of four MSR Learning Collaboratives for primary care clinics. These events were very well-received and had participants from 30 primary care clinics across the Portland area. In 2020 Wheelhouse continues to focus on expanding MSR services within primary care for members with Opioid Use Disorder (OUD) through the work of a newly convened Substance Use Disorder (SUD) Taskforce. The Taskforce has decided to expand its focus to also include planning strategies to increase behavioral health services within primary care for members with other substance use disorders.

This work is a continuation of one part of last year's project, "Supporting Access to Care for Vulnerable Populations." The MSR related outcome of that project is the percent of members with an OUD diagnosis who receive MSR services. This metric was updated in 2019 to include members with an OUD in any diagnosis field (not just primary). Health Share continues to track this updated metric, along with the number of buprenorphine providers each quarter and the percent of members with an OUD diagnosis who are 'highly engaged' with MSR services, using the metric developed by an MAT data workgroup that was convened in late 2018. The following graph details the trends for each metric. This initiative continues to strive to meet its 70% MSR engagement rate.





D. **Project or program brief narrative description**:

Wheelhouse, a regional collaboration to increase MSR and to broadly support SUD initiation and engagement, is led by the newly formed Regional SUD Taskforce. Health Share and CareOregon jointly convene this group, which includes representatives from Health Share's Integrated Delivery System partners, specialty behavioral health providers, and the three counties. The group had its first meeting in December 2019 and will meet monthly to address both the expansion of MSR services and the expansion of optimal SUD treatment for other types of substances (with an initial focus on alcohol use disorder). At the group's first two meetings it reviewed the current state of regional MSR services and current MSR initiation and engagement rates, as well as preliminary data on the Initiation and Engagement into Treatment (IET) CCO incentive metric. Based on these data, the group agreed to focus its 2020 efforts on 1) increasing MSR services for members with OUD and 2) forming an alcohol use disorder subgroup to explore best practices and strategies for increasing behavioral health services and referrals for members with Alcohol Use Disorder. The group agreed that each system partner will present their 2020 strategies in both areas to the group at its April meeting. The rest of the year will be spent supporting each partner in implementing their strategies. The SUD Taskforce may decide to utilize Ready + Resilient strategic investment funding to address overlapping strategies at a regional level.

E. **Activities and monitoring for performance improvement**:

Activity 1 description: Continue to convene the Regional SUD Taskforce to design, implement, and support each partner's 2020 MSR and SUD strategies.

☐ Short term or ☒ Long term

Monitoring activity 1.a for improvement: Representation from all physical and behavioral health plan partners

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Representation is present from all plan partners but in the process of finalizing which role(s) should be represented	Adequate representation across QI, operational, and clinical leadership for each plan partner.	12/2020	Adequate representation across QI, operational, and clinical leadership for each plan partner.	12/2020

Monitoring activity 1.b for improvement: Number of buprenorphine prescribers per quarter

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Approximately 350 buprenorphine prescribers in Q3 2019	425 buprenorphine prescribers	12/2020	500 buprenorphine prescribers	12/2021

Monitoring activity 1.c for improvement: MSR Initiation rate among members with OUD

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
61% of members with OUD have initiated MSR within the past 12 months	65% of members with OUD have initiated MSR within the past 12 months	12/2020	70% of members with OUD have initiated MSR within the past 12 months	12/2021

Monitoring activity 1.d for improvement: MSR Engagement rate among members with OUD

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
38% of members with OUD have a current 'highly engaged' MSR status	44% of members with OUD have a current 'highly engaged' MSR status	12/2020	50% of members with OUD have a current 'highly engaged' MSR status	12/2021

Monitoring activity 1.e for improvement: Treatment initiation rate for members with SUD

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
44% of members with SUD initiate treatment	47% of members with SUD initiate treatment	12/2020	50% of members with SUD initiate treatment	12/2021

A. **Project or program short title**: Project #5: Expanding Grievances and Appeals (G&A) Analysis

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

B. **Components addressed**

i. Component 1: Grievance and appeal system
ii. Component 2 (if applicable): Health equity: Data
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health

C. **Background and rationale/justification**:

Last year's project evaluation on the grievance and appeals element was on the oversight monitoring of second opinions. It was a quality assurance project and it met targets. Therefore this element of the TQS will be closed, and with the emergence of CCO 2.0 Health Share has identified new opportunities for measuring improvement in this area. The work of this 2020 project will be to take a deeper dive into grievance patterns and trends. Health Share will analyze grievances data at a more granular demographic level (including by race/ethnicity, language, age, gender, and geography), and compliance staff will present results to the Community Advisory Council to collaborate with them on strategies to address disparities in grievances.

Health Share's three most common categories of grievances have consistently remained the same over the past several years. Initial demographic analyses revealed that Caucasian and African American members are over-represented in 2019 grievance data, while Hispanic, Asian, and Pacific Islander members are underrepresented. English speaking members were also over-represented in 2019 grievance data. Health Share decided that further analysis of this type of data may provide insights into multiple questions, including:

Are there geographic areas where providers may need education?
Are there language differences that impact the ability to file grievances?
Is there a reason why certain populations do or do not report grievances?

D. **Project or program brief narrative description**:

Health Share will develop a grievances and appeals workgroup to implement the process of adding demographic data to include race, ethnicity, language, age, gender, address to the Grievance System data. The workgroup will include representatives from compliance, quality improvement, analytics, and equity and engagement, and will align efforts with Health Share's emerging Health Equity Plan. All Grievance System data inclusive of grievances, notices of adverse benefit determinations and appeals will be mapped. Health Share will disaggregate this data into categories and sub-categories and geo-map data in an effort to identify trends not visualized previously. Compliance staff will present the quarterly results to the Quality and Health Outcomes (QHOC) board committee, and it will collaborate with the equity and engagement team to present results to the Community Advisory Council. Both the QHOC Committee and CAC can advise on further information needed and potential strategies, such as provider education, language accessibility, etc.

E. **Activities and monitoring for performance improvement**:

Activity 1 description: Integrate demographic data into the Grievance System data for further study

☒ Short term or ☐ Long term

Monitoring activity 1.a for improvement: Development of G&A workgroup

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No workgroup focused specifically on the demographic analysis of G&A data	Workgroup developed	04/2020	Workgroup developed and held initial meeting	04/2020

Monitoring activity 1.b for improvement: G&A demographic data fully integrated into Tableau workbook and dashboard

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Grievances and Appeals demographic data is not fully integrated into a Tableau workbook.	Completion of a Tableau workbook and dashboard that displays G&A data by demographic and geographic characteristics.	04/2020	Completion of a Tableau workbook and dashboard that displays G&A data by demographic and geographic characteristics.	06/2020

Monitoring activity 1.c for improvement: Completion of Grievances and Appeals disparities analysis (to be repeated quarterly)

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
G&A disparities data analysis not completed	G&A disparities data analysis completed	06/2020	G&A disparities data analysis completed each quarter	12/2020

Activity 2 description: Develop an action plan to address Grievances and Appeals disparities.

☒ Short term or ☐ Long term

Monitoring activity 2.a for improvement: Present results of G&A disparities analysis to multiple stakeholders.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
G&A data presented to Health Share's QHOC Committee (but not with full disparities analysis), not presented to Community Advisory Council	Results of the G&A disparities analysis presented to QHOC and CAC	08/2020	Results of the G&A disparities analysis presented to QHOC and CAC	08/2020

Monitoring activity 2.b for improvement: Action plan developed (in collaboration with CAC)

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No action plan to address disparities	Action plan developed to address disparities	12/2020	Action plan developed to address disparities	12/2020

A. **Project or program short title**: Project #6: Equity-Driven Data Best Practices

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

B. **Components addressed**

i. Component 1: Health equity: Data
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☒ Yes ☐ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health

C. **Background and rationale/justification**:

This project continues to advance Health Share's long-standing commitment to improving capacity to address health disparities by increasing community access to equity-informed data. Last year's project, "Making Disparities Data Actionable" worked towards two outcomes:

1) **Publish Early Life Dashboard in Bridge** (Health Share's data platform). The Early Life Dashboard was published in Bridge in 2019 and continues to inform Bridge users. This dashboard can be dis-aggregated by race/ethnicity, language, age, gender, and county, and it supports cross-sector collaboration through school catchment-specific views.

2) **Publish Early Life Dashboard for at least two marginalized populations**. While the current Early Life Dashboard can be disaggregated based on demographics, Health Share is still in the process of adopting and implementing best practices to apply to data collection and sharing, analysis, visualization, and interpretation data with an equity first lens.

Health Share's 2020 efforts will build on these initial efforts by 1) adopting and implementing a set of equity-driven data best practices, and 2) developing a community-focused data website that frames Community Health Needs Assessment (CHNA) and early childhood data with an equity lens to better understand the disparities faced by specific communities. In this way, data are not comparing marginalized communities against each other, but rather looking within a community to better understand their experiences. The development of an equity-driven data website will allow regional community partners to learn more about specific underserved populations.

D. **Project or program brief narrative description**:

This work has two components: 1) adopting and implementing a set of best practices for data collection and sharing, analysis, interpretation, and visualization; and 2) implementing a community-focused data website that frames CHNA and early childhood data with an equity lens.

The adoption and implementation of data best practices is being informed through multiple forums, including a collaborative capacity building effort with CareOregon. The two organizations are co-sponsoring a workshop entitled "Embedding Equity in Your Data: Analysis and Application" for their health equity, community engagement, quality improvement, and analytic staff. The two-part workshop is being delivered by Tusk Consultants, a local social change consulting firm that helps organizations bring forward social, economic, and environmental justice in their work. The workshops focus on deepening the organizations' capacity to apply an equity lens to data analysis, evaluation, and quality improvement. Twenty-four (24) staff across the two organizations are participating in these workshops. The first session was conducted in January 2020 and the second session will be in the spring of 2020. Lessons learned in these workshops will be one resource informing Health Share's adoption and implementation of equity-informed data best practices, which will guide and continually be refined through all future Health Share analytics efforts.

Parallel to and in conjunction with these efforts is the development of a community-facing data website with information related to Health Share's Community Health Needs Assessment and community early childhood data. The purpose of this data website (which will be accessible through Health Share's main website) is to provide diverse audiences in the tri-county region with a place to access aggregate data about its community. Local organizations can use the information for grant writing and project planning purposes, and to get a general 'state of the state' of regional community health needs assessment or early childhood indicators. Other website users may include plan and community partners, other sectors such as education or justice, the general population, and academia. The first phase of the website build, centered on content from the 2018 Community Health Needs Assessment, is currently underway. The second phase of the website build will be the Early Childhood indicators portion. Both phases of the project will be informed by the emergent set of data best practices.

E. **Activities and monitoring for performance improvement**:

Activity 1 description: Development of best practices for data analysis, interpretation, and visualization using an equity lens

☒ Short term or ☐ Long term

Monitoring activity 1.a for improvement: Completion of equity lens workshop

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No staff training specific to using an equity lens within data analytics.	Completion of workshop- Increased staff knowledge and self-efficacy related to using an equity lens in data analysis and interpretation.	06/2020	Completion of workshop- Increased staff knowledge and self-efficacy related to using an equity lens in data analysis and interpretation.	06/2020

Monitoring activity 1.b for improvement: Adoption and implementation of equity-informed best practices

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Lack of consistent best practices for data analysis, interpretation, and visualization using an equity lens.	Draft set of best practices.	07/2020	Finalized set of best practices and implementation plan including process for ongoing feedback and refinement.	10/2020

Activity 2 description: Develop of community-facing data website to increase equitable access to regional population data, including data about disparities.

☒ Short term or ☐ Long term

Monitoring activity 2.a for improvement: Completion of data website phase one: Community Health Needs Assessment data

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Health Share does not have a place for a broad population to view aggregate data about members.	Complete community facing data website that includes CHNA data and cross-sector early childhood indicators.	06/2020	Complete community facing data website that includes CHNA data and cross-sector early childhood indicators.	06/2020

Monitoring activity 2.b for improvement: Completion of data website phase two: Early Childhood indicators

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Health Share does not have a place for a broad population to view a compiled set of early childhood indicators that highlight disparities using an equity lens.	Complete community facing data website that includes cross-sector early childhood indicators.	12/2020	Complete community facing data website that includes cross-sector early childhood indicators.	12/2020

A. **Project or program short title**: Project #7: Connecting Members with Diabetes to Oral Health Care

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

B. **Components addressed**

i. Component 1: Oral health integration
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☒ Yes ☐ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health

C. **Background and rationale/justification**:

There is a bidirectional relationship between diabetes control and oral health. Diabetes, especially poorly controlled, leads to increased prevalence and severity of periodontal disease. Periodontal treatment is associated with glycemic control improvements and improved health outcomes. Data from a meta-analysis of diabetes intervention studies show that periodontal therapy can lead to a 0.4% improvement in HbA1c. This improvement supports overall efforts for glycemic control. A diabetes study in the Cochrane Database of Systematic Reviews showed that a 1% HbA1c reduction leads to better health outcomes such as 14% reduction in myocardial infarction, 37% reduction in microvascular complications, and 21% drop in deaths. Understanding the importance of oral health care by Family Practice and Internal Medicine providers for their patients with diabetes is critical. Primary care currently has patient messaging for routine diabetes procedures such as annual blood work, foot and eye exams. Key messaging should include oral health and the importance of an annual dental exam as well. Patients will often follow through with procedures when recommended by a trusted care team.

In addition, dental navigation has been challenging for both primary and behavioral health providers and patients. Chief among the struggle is knowing which dental clinics accept which dental plans. To mitigate this struggle, a dental care request form was created in the provider portal that allows primary care providers to submit a request for dental navigation and coordination by dental plan coordinators. This alleviates the burden of care coordination from both primary care provider and patient and allows the dental plan to provide outreach and support to patients identified by their Primary Care Provider.

D. **Project or program brief narrative description**:

CCO staff and provider networks will receive educational materials on the importance of oral health care for their patients with diabetes and other chronic conditions as well as tools on how to discuss the importance of oral health care with their patients. The materials will be appropriate to the audience, comprehensive and evidence-based. Technical assistance for care coordination and workflow development, such as incorporating oral health messaging as part of standard diabetes care, will also be available for providers.

In addition, providers will receive information on how to use the dental care request form for their adult members with diabetes or other chronic conditions. Through the provider portal, physical health providers will access an online form and input basic patient information. From there, the dental care team sends the information to each respective dental plan for outreach and care coordination. The dental care coordinators reach out to the identified members, schedule dental visits and assist with non-emergent medical transportation and language services. Initial implementation of the dental request function has been with pediatric providers. The goal for 2020 is to spread and implement this process outside of pediatrics to include adult members with diabetes or other chronic conditions. Concurrently, data analytics will be developed for summary reports on members engaged in care.

E. **Activities and monitoring for performance improvement**:

Activity 1 description: Develop and share a set of educational and navigational tools for CCO staff and network providers on the dental care request form and the importance of oral health care for members with diabetes.

☒ Short term or ☐ Long term

Monitoring activity 1.a for improvement: Development of informational tools

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Tools not available	Tools developed	08/2020	Tools developed	08/2020

Monitoring activity 1.b for improvement: Distribution of informational tools

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No tools distributed	Tools distributed to 15 provider sites	10/2020	Tools distributed to 15 provider sites	10/2020

Monitoring activity 1.c for improvement: Number of adult practices actively using the Dental Care Request form for their patients with diabetes.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
1 site using request form	13 sites using request form	12/2020	13 sites using request form	12/2020

Monitoring activity 1.d for improvement: Number of Dental Care Request forms submitted for adults.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
58 forms submitted in 2019	116	12/2020	116	12/2020

Activity 2 description: Work with the analytics team to determine the number and percentage of members with diabetes who had a dental care request form submitted by the physical health provider and who completed a dental visit, and to develop a data dashboard visualization.

☐ Short term or ☒ Long term

Monitoring activity 2.a for improvement: Completion of a dashboard to visualize dental care requests

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Dashboard not available	Dashboard created	06/2020	Dashboard created	06/2020

Monitoring activity 2.b for improvement: The number and percentage of Dental Care requests for members with diabetes that result in a completed dental visit within 30, 60, and 90 days of the request.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Baseline not available	Determine baseline	06/2021 (due to All Payer All Claims (APAC) claims lag and claims runout)	Determine baseline	06/2021 (due to APAC claims lag and claims runout)

A. **Project or program short title**: Project #8: Strategic Patient-Centered Primary Care Home (PCPCH) Improvement Efforts

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

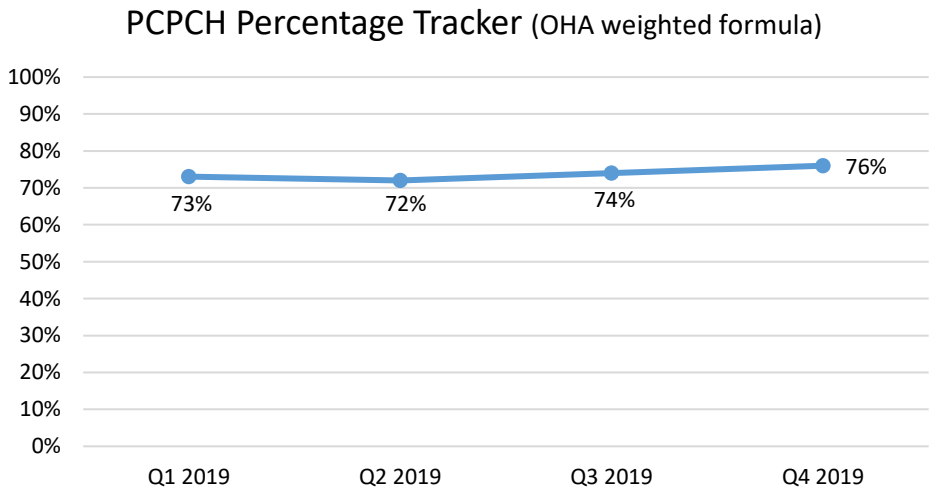
B. **Components addressed**

i. Component 1: Patient-centered primary care home
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☒ Yes ☐ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health

C. **Background and rationale/justification**:

This is a continuation of last year's efforts to increase the number of tier four and five PCPCHs in the Health Share network. Nearly all Health Share members are assigned to a PCPCH and the majority are assigned to a Tier 4 or 5 clinic. Health Share is using the OHA tiered PCPCH formula to track progress in this area. The following graph shows Health Share's 2019 progress with the OHA PCPCH formula. Health Share ended the year at 76% and aims to increase that to 80% in 2020.



D. **Project or program brief narrative description**:

Health Share will be working with health system partners to support their efforts to increase the number of Tier 5 clinics in their networks and to increase the percentage of individuals assigned to those clinics. Each partner will complete an inventory of their system's current state and efforts to strategically move their network toward higher tiers. Health Share will continue to track partner activities and the PCPCH percentage tracker. Health Share will also prepare for the member level PCPCH reporting that will be implemented by the end of 2020.

Health Share's physical health system partners have varying models and strategies for increasing their number of PCPCHs. Current strategies include technical assistance to clinics, Learning Collaborative opportunities, and value-based payment (VBP) arrangements.

E. **Activities and monitoring for performance improvement**:

Activity 1 description: Each Health Share physical health system partner will complete an assessment of their current state and a plan to increase Tier 4 and 5 clinics.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Completion of physical health system partner assessment and implementation plans.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Physical health system partners have completed draft assessment and implementation plans	Implementation plans are complete.	04/2020	Implementation plans are complete.	04/2020

Activity 2 description: Health Share's system of partners implement their plans to drive increased number of Tier 4 and 5 PCPCHs.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: PCPCH percentage tracker using the OHA weighted tier methodology

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
76% PCPCH weighted tracker percentage	80% weighted tracker percentage	12/2020	80% weighted tracker percentage	12/2020

A. **Project or program short title**: Project #9: Diabetes Integration Project (DIP)

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

B. **Components addressed**

i. Component 1: Serious and persistent mental illness
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☒ Yes ☐ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health

C. **Background and rationale/justification**:

This project builds on the 2019 project "Comprehensive Diabetes Strategy." That project met its 2019 goal of successfully funding the Diabetes Integration Project, and the 2020 project reports on its implementation. The Diabetes Integration Project (DIP) is a pilot effort being implemented by CareOregon, with the hopes that its learnings will provide valuable insights to the rest of the Health Share network. The DIP pilot is an example of Health Share's efforts to implement ideas and then extend successful practices to other parts of its network.

CareOregon prioritized integration of primary, behavioral, and dental health as a 2018 strategic goal. One challenging population to engage in treatment across these domains is patients diagnosed with both Type II Diabetes and severe and persistent mental illness (SPMI). 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. As individuals with behavioral health diagnoses are at an increased risk for developing diabetes, and individuals' mental health plays an important role in their ability to manage their co-occurring diabetes, the Diabetes Integration Project (DIP) aims to improve treatment and engagement of this cohort through the collaboration of diabetes care, oral health services, and behavioral health programs.

CareOregon met the CCO diabetes quality metric in 2018 through technical assistance to clinics, providing patient-level Diabetes Dashboards and a Treatment Pathway through clinical pharmacists and embedded panel coordinators. The clinics participating in the diabetes initiative described above on average achieved lower uncontrolled DM percentages than comparator clinics. This initiative builds on this success of the embedded Panel Coordinator and Health Resilience Specialists, to focus on patients with SPMI and diabetes.

Partner sites include Cascadia Behavioral Healthcare, LifeWorks NW, Clackamas County Health Department (PCP and specialty behavioral health), Wallace Medical Concern, along with Dental Care Organizations: CareOregon Dental, ODS Dental, and Willamette Dental. During the first year of work CareOregon brought together oral health, physical health, and behavioral health professionals at 3 Learning Collaboratives to refine technical workflows and communication strategies, building out innovative pilot integration efforts among the partner sites. The second year of funding will be dedicated to improved implementation with technical enhancements and evaluation of the new integration model.

D. **Project or program brief narrative description**:

The overarching goals for DIP include:

- Explore, develop and test initial operational and health plan infrastructure elements needed to systematize coordination of care across primary, specialty behavioral health and dental care, customized to the individual for the DIP target population and focused on member experience.
- Increase engagement among the DIP target population (diabetic patients with SPMI) in primary care, in oral health care, and in active behavioral health treatment as appropriate.

- Improve performance in Diabetes Management (DM) metric among the DIP target population.
- Develop an operational vision of key elements and success factors for any population-specific care coordination in the Metro Integrated Care Network (ICN), and a Community of Practice to support ongoing implementation and learning.

The focus population is members diagnosed with both Type II Diabetes and a Serious and Persistent Mental Illness (SPMI). The total focus population as of December 2019 includes 5,384 Health Share members.

CareOregon and their partners have a 2020 charter to establish site workplans and explore structural changes to support the integration work. The Workgroup and team of Primary Care and Behavioral Health Innovation Specialists have started visiting sites to administer an Integration Assessment Tool. The tool is a review of 13 measures of Organizational, Treatment, and Care Coordination characteristics, each measuring a relevant aspect of integration work at the site, used to identify which should be discussed as an area of strength and to review where additional work could be undertaken to improve integration work at the site.

CareOregon continues to provide monthly member rosters to partners as a tool to know the DCO (Dental Care Organization), PCP, and Behavioral Health (BH) assignment, and track the utilization and care coordination support for their patients. The long-term goal is to ensure members are active in diabetes management (A1c poor control), receive dental care, and engage with BH services as needed. Care Coordinators are in place at Cascadia, Lifeworks, and CHC to support in reach/outreach to their patient population. To assist Dental in referring patients to Primary Care and Behavioral Health they will utilize CareOregon's Regional Care Teams (RCT) and are working to establish the best workflow. Additionally, they are exploring health plan operations that would help sustain the work of the sites such as alternative payments for coordination of care of high-risk populations.

E. **Activities and monitoring for performance improvement**:

Activity 1 description: Identify a prioritized core infrastructure for care coordination of SPMI DM across partners.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Development of Information Services (IS) plan workplans

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
In process with partners to develop IS workplans	Completed IS workplans	06/2020	Completed IS workplans	06/2020

Activity 2 description: Develop workflows between DCO care coordinator and RCT.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Development of IS plan workplans

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
In process with partners to develop workflows	Completed workflows	06/2020	Completed workflows	06/2020

Activity 3 description Move into test/improve phase with members of the DIP target population.

☒ Short term or ☐ Long term

Monitoring activity 3.a for improvement: % of A1C levels in the DIP target population that are tracked

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
A1C levels are tracked for 78% of members in the DIP target population	A1C levels are tracked for 81% of members in the DIP target population.	12/2020	A1C levels are tracked for 81% of members in the DIP target population.	12/2020

Monitoring activity 3.b for improvement: % of DIP target population meeting the Oral Health exam for Diabetes metric

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
20% of members in the DIP population are meeting the metric	27% of members in the DIP population are meeting the CCO metric.	12/2020	27% of members in the DIP population are meeting the CCO metric.	12/2020

Activity 4 description: Conduct quarterly in-person convenings of DIP/DCO care coordinators, RCT representatives, and CareOregon DIP workgroup to share learnings, support the work, and focus on patient experience.

☒ Short term or ☐ Long term

Monitoring activity 4 for improvement: Representation from each partner at quarterly convenings

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Representation from 1 of 4 partners	Representation from 4 of 4 partners.	12/2020	Representation from 4 of 4 partners.	12/2020

Activity 5 description: Explore and scope a sustainability pathway for funding SPMI diabetes management care coordination.

☒ Short term or ☐ Long term

Monitoring activity 5 for improvement: Development of billing/funding options

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Grant funded	Plan in place for billing/funding options for each of the partner types.	12/2020	Plan in place for billing/funding options for each of the partner types.	12/2020

Activity 6 description: Develop and implement an evaluation plan to measure population engagement rates, metrics, and successful care coordination features/functions.

☐ Short term or ☒ Long term

Monitoring activity 6 for improvement: Development/implementation of an evaluation plan

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Working with quality improvement department to build an evaluation	Development of an evaluation plan to measure baseline data to intervals throughout the project, along with analysis of segmented groups within focus population.	12/2020	A report that is available for DIP steering partners and Health Share with full analysis throughout the project. This report will be used to promote successful practices throughout the Health Share network.	04/2021

A. Project or program short title: Project #10: Establishing Infrastructure to Launch the Regional Supportive Housing Impact Fund

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

B. Components addressed

i. Component 1: Social determinants of health & equity
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

☒ Economic stability ☐ Education
☒ Neighborhood and build environment ☐ Social and community health

C. Background and rationale/justification:

Last year's project was "Aligning Resources to Invest in Social Determinants of Health," and it was working towards the following two outcomes:

1) **Community Health Improvement Plan (CHP) completed and approved by Health Share Board.** This was completed and approved by the Board in August 2019. The CHP outlined six priority areas and further focused on supportive housing as one of the first two priority areas of focus for Health Share.

2) **Identify a convener and process for reaching regional alignment on investments in SDOH.** Health Share, in partnership with community stakeholders, developed a process for reaching alignment on investments in supportive housing, and the 2020 project builds the infrastructure for this process. Health Share continues to develop a process for aligning other strategic investments and the RSHIF model could potentially be applied to other areas.

In 2020, Health Share is supporting the creation of an entity, the Regional Supportive Housing Impact Fund (RSHIF) that can receive funds from a variety of sources, including the health care sector, but also philanthropy, the business community, or others. Those funds will be pooled and invested in efforts to help solve the region's homelessness crisis for individuals with co-occurring medical conditions. This initiative relates to two SDOH-E domains, *Economic Stability* and *Neighborhood and Built Environment*, as it relates to both housing affordability and increasing housing stability among community members.

Supportive housing combines affordable housing with services, provided either directly or through referrals. Those services may include case management services; medical services, behavioral health services, or peer support; parenting skills, education, vocational and employment services money management services, life skills training and advocacy. The catalyst project for this fund is Kaiser Permanente's "Metro 300" project, which will fund supportive housing for 300 low income seniors. The 2020 activities focus on building operational and governance structures for the fund, and establishing a comprehensive evaluation strategy.

D. Project or program brief narrative description:

RSHIF – the Regional Supportive Housing Impact Fund -- is a new flexible fund designed to work in tandem with other regional efforts, such as affordable housing bonds, to address the homelessness crisis. RSHIF emphasizes connecting very low-income persons with complex health challenges to deeply affordable supportive housing options that include the services they need to remain stable and housed. To create maximum flexibility for aligning with other regional efforts, RSHIF will braid and blend funding from across sectors and partners, then nimbly deploy those funds in ways that maximize their total community impact. A data strategy and evaluation plan is built into

the fund's design, ensuring that investments are smartly targeted and that the positive impacts of those investments are rigorously captured to create sustainability pathways for the fund's work.

The 2020 RSHIF activities focus on building the fund's infrastructure, and include:

1) Establish the initial operational structure
2) Establish an ongoing governance structure
3) Create comprehensive data and evaluation strategy
4) Develop evaluation plan for Metro 300

E. **Activities and monitoring for performance improvement**:

Activity 1 description: Establish RSHIF initial operational structure (Includes ensuring appropriate legal agreements are in place for Health Share to receive funding as fiscal agent, developing tracking and reporting mechanism for RSHIF funds, and identifying initial oversight structures needed to administer RSHIF grants).

☒ Short term or ☐ Long term

Monitoring activity 1.a for improvement: Legal agreements in place to receive and allocate funding.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
RSHIF legal agreements are not in place.	Legal agreement in place to receive funds.	03/2020	Legal agreement in place to receive funds.	03/2020

Monitoring activity 1.b for improvement: Contracts are in place to receive and allocate funding.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
RSHIF contracts are not in place.	Contracts between Health Share and counties are fully executed.	02/2020	Health Share and counties meeting monthly to share updates and learnings.	03/2020

Monitoring activity 1.c for improvement: Funding tracking mechanisms are in place.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
RSHIF fund tracking mechanisms not in place.	RSHIF fund tracking mechanisms fully developed.	01/2020	Regular financial reports provided to key stakeholders.	06/2020

Activity 2 description: Establish ongoing governance structure: (Includes engaging with Oregon Health Equity Alliance (OHEA) and others to ensure application of equity first approach to governance model; identifying options for legal structure and ongoing advisory structures needed to govern RSHIF; creating new RSHIF entity with operating agreement, oversight/board, and advisory bodies; identifying and completing process for seeing financial commitment from RSHIF partner entities; develop an approach for future portfolio.)

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Creation of RSHIF entity.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
RSHIF entity not yet created.	RSHIF entity has operating agreement, oversight/board, and advisory bodies.	06/2020	Oversight/board and advisory bodies meeting regularly.	09/2020

Activity 3 description: Create comprehensive data and evaluation strategy: (Includes identifying key evaluation partners, engaging with equity consultants around evaluation strategy; establishing data sharing agreements with key partners; outlining RSHIF data infrastructure needs and explore solutions; identifying key metrics to support monitoring and evaluation; and exploring data use cases.)

☒ Short term or ☐ Long term

Monitoring activity 3 for improvement: RSHIF Evaluation Oversight group established.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Evaluation Oversight group not established.	Key evaluation stakeholders identified, including community-based researchers, and Evaluation Oversight group launched.	06/2020	Data strategy and evaluation plan developed by Evaluation Oversight group.	09/2020

Activity 4 description: Develop evaluation plan for Metro 300: (Includes engaging with key partners from health care, housing, and public safety sectors; developing evaluation plan for Metro 300 project; ensuring connection of Metro 300 evaluation plan to comprehensive evaluation strategy.)

☒ Short term or ☐ Long term

Monitoring activity 4 for improvement: Development of Metro 300 evaluation plan.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Metro 300 evaluation plan not yet developed.	Orientation to the Metro 300 project shared with RSHIF Evaluation Oversight group.	09/2020	Metro 300 evaluation plan developed in partnership with RSHIF Evaluation Oversight group, complete with indicators and methods.	12/2020

A. **Project or program short title**: Project #11: Improving Services for Youth in Foster Care

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

B. **Components addressed**

i. Component 1: Special health care needs
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health

C. **Background and rationale/justification**:

This is a continuation of part of a project from last year, "Supporting Access to Care for Vulnerable Populations." The foster-care related outcome of the 2019 project was "75% of youth who receive a Relational health, Academic, Psychological, Intellectual, Developmental (RAPID) assessment and have a behavioral health recommendation will receive an authorization within 30 days." This outcome was modified slightly in 2019 to "75% of youth ages three and over who receive a RAPID assessment will receive a behavioral health authorization within 70 days." The changes were made because data from MindSights showed that the vast majority of youth over three had a behavioral health recommendation made at the time of the RAPID assessment, and because the RAPID workgroup determined that 30 days was not a long enough timeframe for many cases.

Children in foster care are enrolled in OHP coverage through the CAF rate category, which is used as a proxy to identify foster children in Health Share's data. There are currently approximately 5,100 members in this rate category, representing 3-4% of the total Health Share youth population. According to the National Survey of Children's Health, almost half of all children in foster care have had four or more Adverse Childhood Experiences (ACEs). While removal from traumatic situations is critical in ensuring a child's immediate safety, this alone does not heal the impacts of the experienced trauma. Intentional, responsive and trauma-informed intervention is necessary to foster resilience and strengthen protective factors in foster children. Health Share's work with children in foster care started with efforts on the CCO incentive metric and has evolved over time to include several initiatives within Health Share, which are part of Health Share's Ready + Resilient early life strategies:

- The design and implementation of Foster Care Medical Homes, which address the unique needs of children in foster care and incorporate best practice recommendations.
- The funding of two Medical Liaison positions within DHS Child Welfare.
- The development of a partnership between DHS and Mindsights, a local psychological assessment firm who developed a RAPID assessment process for children entering foster care.

Efforts in 2020 to improve services for youth in foster care include the expansion of the use of the RAPID assessment as well as expansion of the Foster Care Medical Home model.

D. **Project or program brief narrative description**:

There are several concurrent efforts to support youth in foster care in 2020.

The focus of the RAPID assessment pilot project will be to fully operationalize care coordination pathways between MindSights, care coordinators, providers of primary care, behavioral health and dental services, and the education system. The DHS Medical Liaison will continue to attend all RAPID debriefs to help connect youth to care recommendations. Health Share staff will continue to send the Liaison a monthly list of youth who have not connected to behavioral health services within 60 days of their RAPID assessment. The Liaison reviews the list and follows up with case workers.

Recognizing the complexity of needs for children in foster care, and the strong ties between early life trauma and behavioral health needs, CareOregon's Regional Care Team will now aim to attend all RAPID debrief meetings and the monthly RAPID meetings, and all youth are referred to them after their RAPID assessment. This will ensure a quick connection to behavioral health services as well as heightened care coordination between behavioral health and primary care services across Health Share's network of partners.

The RAPID is also being sent to the foster child point of contact at the youth's school district. DHS and Mindsights are working to identify a clear process for school distribution, including increasing the number of Release of Information (ROI) forms sent to MindSights and identifying the school placement at the start of the case. MindSights and DHS have also partnered closely with local Intellectual and Developmental Disabilities (IDD) services to ensure that potential IDD needs are referred to follow up testing and expedited qualification for services. This new pathway has resulted in IDD qualification in a fraction of the time standardly required (as quickly as three weeks versus the standard six to twelve months), ensuring needs are identified and supported at the earliest point possible.

Health Share will complete a qualitative and quantitative evaluation of Foster Care Medical Home (FCMH) services to assess the impact of services on care continuity and health outcomes, as well as to gather input from foster youth and their families. Health Share is completing the claims analysis internally, comparing health and care continuity outcomes among youth who have received Foster Care Medical Home services to a cohort of foster youth with similar demographics who have not received Foster Care Medical Home services. In addition, Health Share is partnering with Portland State University to conduct interviews and focus groups of foster youth, foster parents, bio parents, and adoptive parents who have received FCMH services. Interviewer and focus group participants will be asked about their experiences receiving services from a Foster Care Medical home with the intent of helping the network of FCMH providers with insight about how to improve their services.

In addition, the FCMH network will be expanded and re-branded in 2020. The eleven clinics that currently provide advanced primary care for children in foster care have come together under the network identity, "The EveryStep Community of Care". This regional network of excellence will officially launch in early 2020, with promotional materials, a new logo, and a communication strategy to ensure visibility and integration within the children's System of Care. This group of dedicated clinics will serve as a regional and statewide voice for the needs of this population and will guide the CCO's broader efforts at improving the pediatric system of care for children on the Oregon Health Plan.

E. **Activities and monitoring for performance improvement**:

Activity 1 description: The RAPID workgroup continues to develop processes to increase care coordination and referral completion among youth receiving the RAPID assessment.

☒ Short term or ☐ Long term

Monitoring activity 1.a for improvement: Behavioral health authorizations within 70 days of the RAPID assessment

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Most recent data is that 26% of youth had an open behavioral health authorization within	75% of youth have an open behavioral health authorization within 70 days after the RAPID assessment.	12/2020	75% of youth have an open behavioral health authorization within 70 days after the RAPID assessment.	12/2020

70 days after the RAPID assessment.				

Monitoring activity 1.b for improvement: Referrals to the CareOregon Regional Care Team

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Some, but not all, youth are referred to the CareOregon Regional Care Team upon completion of the RAPID assessment.	All youth are referred to the CareOregon Regional Care Team upon completion of the RAPID assessment.	04/2020	All youth are referred to the CareOregon Regional Care Team upon completion of the RAPID assessment.	04/2020

Activity 2 description: Complete a qualitative and quantitative evaluation of Foster Care Medical Home services.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Completion of evaluation

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Evaluation is in process.	Completion of focus groups and interviews with foster youth, foster parents, bio and adoptive parents. Completion of quantitative evaluation using health claims data. Final report is presented to the EveryStep steering committee and other Health Share committees (QHOC, Children's Health Council).	09/2020	Completion of focus groups and interviews with foster youth, foster parents, bio and adoptive parents. Completion of quantitative evaluation using health claims data. Final report is presented to the EveryStep steering committee and other Health Share committees (QHOC, Children's Health Council).	09/2020

Activity 3 description: Expand Foster Care Medical Home services and complete a branding and outreach campaign to convert them to EveryStep centers.

☐ Short term or ☒ Long term

Monitoring activity 3 for improvement: Level of stakeholder awareness of EveryStep clinics

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
EveryStep clinics are not known to most stakeholders supporting children in foster care.	EveryStep clinics are broadly known by all key stakeholders within child welfare and the broader System of Care.	01/2021	Increase number of children served by FCMH models within the EveryStep network to represent the majority of children in foster care regionally.	01/2022

A. Project or program short title: Project #12: Utilization Review Workgroup

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

B. Components addressed

i. Component 1: Utilization review
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health

C. Background and rationale/justification:

Last year's Utilization Review project was related to promoting the use of the Collective Platform by specialty behavioral health providers. While work in this area continues, it was determined that the development of a utilization review workgroup is foundational to multiple areas and is a high priority for 2020. Although Health Share has multiple mechanisms and forums to review utilization, there is a recognized need to convene an aligned internal utilization review committee. This committee will monitor utilization against practice guidelines and provide a venue to monitor both over-and under-utilization of services. A utilization workgroup can provide technical assistance to plan partners across multiple realms: Potentially Avoidable Complications (PAC), incentive metrics, practice guidelines, and utilization disparities.

With the advent of the Prometheus data tool, Health Share has an increased focus on monitoring PAC costs related to the three topics included in the Prometheus action plan (Diabetes, SUD, and pregnancy). This is a project in development which also requires a feedback loop following the plan, do, study, act (PDSA) cycle. The Utilization Review Committee will provide the PDSA guidance and feedback with this project.

D. Project or program brief narrative description:

Health Share will launch a Utilization Review Committee (URC) that will guide multiple areas of utilization review, including practice guidelines, mental health parity reviews, and Prometheus action plan implementation. A multi-disciplinary Health Share internal committee will be launched that includes Clinical leadership, Quality Improvement, Quality Assurance, and Analytics staff. The group will develop a charter and set a meeting schedule, with an initial focus on providing analytics support and guidance to the Prometheus action plan. The group will analyze PAC cost drivers for each of the three chosen episodes and provide PDSA recommendations and guidance to Health Share's Clinical Advisory Panel and its Quality Health Outcomes Committee (QHOC). Both over- and under-utilization of services will be examined as part of the Prometheus action plan episodes.

E. Activities and monitoring for performance improvement:

Activity 1 description: Successful launch of a Utilization Review Committee

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: First meeting and development of URC charter

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Group not yet launched	Group is launched and approves a charter.	07/2020	Group is launched and approves a charter.	07/2020

Activity 2 description: URC completes Prometheus PAC data analysis

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Completion of Prometheus PAC data analysis

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Not yet completed	URC group works together to scope and complete an analysis of each Prometheus action plan episode.	09/2020	URC group works together to scope and complete an analysis of each Prometheus action plan episode.	09/2020

Activity 3 description: URC provides Prometheus recommendations to Health Share's Clinical Advisory Panel and QHOC committee.

☒ Short term or ☐ Long term

Monitoring activity 3 for improvement: Development and presentation of recommendations

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Not yet completed	URC group develops and presents recommendations to Health Share's Clinical Advisory Panel and QHOC Committee.	12/2020	URC group develops and presents recommendations to Health Share's Clinical Advisory Panel and QHOC Committee.	12/2020