CCO 2.0 Application Executive Summary

Local, non-profit leadership meets nationally recognized innovation – Health Share of Oregon’s record of success is undeniable—setting the standard for creating community-based partnerships, executing on quality incentive metrics, working to eliminate health disparities, and investing in upstream strategic initiatives to improve the health of our community. These initiatives, many receiving statewide and national recognition, include programs like Project Nurture (a model of excellence serving pregnant women with substance use disorders), Wheelhouse (a hub-and-spoke model for increasing medication assisted treatment), TC911 (meeting unmet social needs that drive costly 911 calls), and much more.

A history of success, a foundation for the future – Health Share is a collaborative of Clackamas, Multnomah, and Washington counties and nearly all health care organizations that serve the 315,000 Oregon Health Plan members in our community—acting as a single point of accountability for OHP in the region. Our leadership is responding to the priorities outlined in CCO 2.0 by creating Health Share 2.0. As we evolve, Health Share 2.0, will leverage the strengths of this network in new ways, building on our past success and innovating to deliver the promise of true integrated care.

Advancing value-based payment models – Since CCO inception, we have had the largest and most comprehensive provider network in the state. In Health Share 2.0, the premier health care systems within our network—Kaiser Permanente, Legacy Health, OHSU health system, and Providence Health & Services—will realign to better serve members as integrated delivery systems (IDS) and we will build on the work CareOregon has done as a national leader in payment reform. On day one of the new contract, 68% of Health Share’s provider payments will qualify as HCP-LAN Category 2C or above. We will continue to build on this success through 2024.

Integrating behavioral health – Through the newly aligned IDSs and CareOregon, Health Share is fully integrating primary care behavioral health services into primary care settings. Specialty behavioral health will be centralized within CareOregon’s integrated community network (ICN)—where specialty behavioral health, oral health, NEMT, care coordination, and member services will be managed in a central, easy-to-navigate location. Health Share 2.0 will continue to support county-based safety net services with direct funding for the mental health crisis system and local public health, as well as coordinating with housing, corrections, education, early learning hubs, and other social service systems.

Containing costs – Health Share is proud to be a high-performing CCO with strong commitment to quality and cost containment. When adjusted for member churn and OHA’s addition of new benefits, Health Share’s average per-member trend for the most recent two years is 2.7%—well below the 3.4% growth cap. Through VBP innovations and the Health Share 2.0 restructure, we expect an even lower cost trend to achieve savings for investment back in the community.

Addressing social determinants of health and achieving health equity – At Health Share, we believe that health equity is achievable and requires deliberate action on our part. We bring this belief to our work addressing social determinants of health. Through our collaborative model and strategic investment fund, we take a collective impact approach to leverage resources within Health Share as well as from our partners to fulfill the promise of achieving ongoing transformation, health equity, and the best possible health for each individual.
CCO 2.0 References

Oregon Health & Science University

Contact: Liz Boileau
Senior Director
OHSU Payor Strategy
503-494-4390
boileaul@ohsu.edu

Statement of similar projects performed within the last five years:

OHSU has been a founding member organization, contracted hospital and primary care network provider, and health care system transformation partner of Health Share’s for more than five years. OHSU has insight into all that Health Share does from those perspectives.

Relationship to the Work under the Sample Contract:

As a network provider organization, OHSU has been witness to Health Share’s ability to ensure health plan operations within our networks run smoothly. As a member organization and health care system transformation partner, OHSU can attest to Health Share’s commitment to the transformation work and to fulfilling terms of our health-related services community benefit investments.
Clackamas County

Contact: Rich Swift
Director
Health, Housing and Human Services Department
503-650-5694
rswift@clackamas.us

Statement of similar projects performed within the last five years:

Clackamas County has been a founding member organization, delegated entity, local mental health authority contracting partner, local public health authority contracting partner, and health care system transformation partner of Health Share's for more than five years.

Relationship to the Work under the Sample Contract:

As a delegated entity, Clackamas County has been witness to Health Share’s ability to ensure health plan operations within our networks run smoothly and that we hold delegates accountable for subcontracted health plan functions. As an LMHA and LPHA contracting partner, Clackamas County can provide references to our ability to faithfully execute government contracts and commitment to leveraging community resources. As a member organization and health care system transformation partner, Clackamas County can attest to Health Share’s commitment to the transformation work and to fulfilling terms of our health-related services community benefit investments.
Cascadia Behavioral Health

Contact: Derald Walker, PhD
Chief Executive Officer
503-963-7729
Derald.Walker@cascadiabhc.org

Statement of similar projects performed within the last five years:

Cascadia Behavioral Health has been one of Health Share’s largest contracted mental health and substance use treatment providers for more than five years. Health Share has held the contract directly with Cascadia since 2016.

Relationship to the Work under the Sample Contract:

As a network provider, Cascadia Behavioral Health can attest to Health Share’s ability to ensure health plan operations, especially provider and member relations, are properly executed.
Willamette Dental

Contact: Matthew Sinnott
Senior Director of Government Affairs and Contract Management
503-952-2571
msinnott@willamette.com

Statement of similar projects performed within the last five years:

Willamette Dental has been one of Health Share’s largest contracted dental care organization (dental plan) subcontractors for more than five years.

Relationship to the Work under the Sample Contract:

As a delegated entity, Willamette Dental has been witness to Health Share’s ability to ensure health plan operations within our dental networks run smoothly and that we hold delegates accountable for subcontracted health plan functions.
Attachment 1 - Letter of Intent to Apply Form

1. Applicant's Legal Entity name: Health Share of Oregon

2. Applicant's Secretary of State Business Registration1: 849793-93

3. Oregon Headquarter Location: 2121 SW Broadway, Ste 200, Portland, OR 97201

4. Principle Place of Business (if different than Oregon Headquarter Location): 

5. Key Contact Person: Maggie Bennington-Davis, MD
   Key Contact Person Phone/Email: 503-416-3969 maggiebd@healthshareoregon.org
   Phone                            Email

6. To be eligible to apply, Applicant must be one (or more) of the following (Please check yes or no for each item):
   a. An organization that (1) has a certificate of authority in good standing as a health care service contractor or health insurance company from the Oregon Department of Consumer and Business Services (DCBS), and (2) issues health benefit plans, as defined in 743B.005, in Oregon.
      ☐ Yes  ☑ No
      If you selected Yes, please provide the DCBS Certificate of Authority number:

   b. An organization that is under, or during the last two years was under, a Medicaid contract with OHA to bear capitated health care financial risk in Oregon, including CCOs currently or formerly certified by OHA.
      ☑ Yes  ☐ No
      If you selected Yes, please provide the Medicaid contract type and number:
      Coordinated Care Organization Contract # 143115 - 11

   c. A Provider Organization which bears health care financial risk in Oregon (e.g. hospital systems with capitated contracts from self-insured health plans) but which DCBS has exempted from a certificate of authority by Bulletin 96-2, https://dir.oregon.gov/laws-rules/Documents/Bulletins/bulletin_96-02.pdf.
      ☐ Yes  ☑ No
      If you selected Yes, please explain the health care financial risk you bear in Oregon and how you meet the DCBS exemption:

   d. A Tribe or Tribal organization.
      ☐ Yes  ☑ No
      Note: A Tribe may sponsor an Indian Managed Care Entity or a CCO on a different timeline from that generally applicable to Applicants. Tribal members may be moved to that organization when it is approved by OHA.

---

1 If Applicant is formed under insurance law, furnish the registration number with the Oregon Department of Consumer and Business Services (DCBS).
e. An entity newly formed from one or more of the organizations described above.

☐ Yes ☑ No

If you selected Yes, please describe the newly formed organization and explain how the constituent or predecessor organizations meets one of the requirements in (a) through (d) above:

Please note: Applicant’s qualifications to apply will not be evaluated until after the Application due date.

7. Desired Service Area

<table>
<thead>
<tr>
<th>County (List each desired County separately)</th>
<th>In your Application, will you request to serve less than the entire County?</th>
<th>If yes, what zip codes will be in your requested Service Area in this County?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clackamas</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Multnomah</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Washington</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

Please note: If Applicant requests to cover less than a full County, it will be required to provide additional information and its reasoning for the request in its Application. OHA will consider requests during Application evaluation and will determine whether to approve or reject the request based on criteria that include, but are not limited to, how the request better serves the goals of CCO 2.0 than serving the entire County at issue. These Applicant requests and subsequent OHA responses do not limit OHA in any way from requiring additional changes to an Applicant’s proposed Service Area based on OHA’s needs and the needs of its Members. OHA may require an Applicant to accept OHA’s additional Service Area request(s) as a condition of receiving an award or a Notice to Proceed as OHA and its Members’ needs warrant. Applicant’s requests for Service Area will not be evaluated until after the Application due date.

8. In Exhibit A, please provide an organization chart complying with the requirements of Attachment 6.

9. In Exhibit B, describe your current lines of health plan business in Oregon. Provide total covered lives for each line of business. (Provide separate figures for the following markets: Medicaid, other OHA, non-OHA state health plans, other state or local public sector, Medicare, other federal, Marketplace, other commercial insured, and commercial self-funded. Within each market identify numbers for benefit coverage types such as oral and comprehensive medical and identify numbers that are administrative-services-only as opposed to at-risk).

10. Applicant’s Good Faith Intentions

Applicant has a good faith intention to submit an Application and believes it has the resources to do so. If at any time prior to or upon the Application due date Applicant determines it will not submit an Application, Applicant will submit to OHA a notarized letter, withdrawing this letter of intent and briefly stating the reason for the withdrawal. If at any time prior to seven days before the Application due date Applicant determines it must change the provisions of this LOI other than the requested Service Area, Applicant will submit to OHA a notarized letter, changing this letter of intent and briefly stating the reason for the change.
11. Acknowledgements

Applicant acknowledges that this Letter of Intent is binding upon Applicant if it proceeds to submit an Application and continues through the RFA process without withdrawing its Application. Applicant also acknowledges that OHA will publicly post the information in this LOI prior to the Application submission date. To be considered for a CCO Contract, Applicant must submit all required document in the RFA by the applicable dates in Section 1.2 of the RFA.

Representatives of Applicant have read the RFA in its entirety. By submitting this Letter of Intent, Applicant acknowledges and agrees to be bound by RFA Section 6.2 (Governing Laws) and 6.4 (Limitation on Claims). Applicant also agrees to be bound by all the other provisions of the RFA, subject to Applicant’s protest rights as set forth in the RFA.

12. Signature

The signature must be notarized, as follows

I. Marni Kuyl, being first duly sworn under oath, and representing Applicant, hereby depose and swear or affirms under penalty of perjury that:

a. I am an officer of the Applicant,
b. I have personal knowledge of this Letter of Intent and believe it to be accurate, and
c. I have full authority from the Applicant to submit this Letter of Intent.

Signature

Marni Kuyl, Chair of the Board of Directors

Printed Name and Title

Date

State of Oregon

County of Multnomah

Signed and sworn to before me on 1/29/19 (date) by Marni Kuyl (Affiant’s name).

Notary Public for the State of Oregon

My Commission Expires: 3/19/22
Exhibit A
Organization chart listing ownership, control or sponsorship, including the percentage Control each person has over the organization

Health Share of Oregon is a 501(c)3 non-profit membership corporation. Its member organizations are: Adventist Health, CareOregon, Inc, Central City Concern, Clackamas County, Kaiser Foundation Health Plan of the Northwest and Kaiser Foundation Hospitals, Legacy Health, Multnomah County, Oregon Health & Science University, Providence Health & Services and Providence Health Plan, Tuality Healthcare and Tuality Health Alliance, and Washington County. Health Share of Oregon’s 20-person Board of Directors is comprised of representatives of the member organizations and the community.
Exhibit B

Description of Current Lines of Health Plan Business in Oregon

Health Share of Oregon does not currently have lines of health plan business outside of its contracts with the Oregon Health Authority for Medicaid and Cover All Kids. However, Health Share’s affiliates (corporate member organizations) have substantial health plan business outside of Medicaid and Cover All Kids in Oregon.

Below, we provide the requested information for Exhibit B as outlined in the Letter of Intent to Apply Form with regard to Applicant, Health Share of Oregon. We intend to supply additional detail about our affiliates’ other lines of health plan business in Oregon pursuant to Attachment 6 of the Request for Application.

<table>
<thead>
<tr>
<th>Medicaid</th>
<th>Health Share of Oregon currently serves approximately 315,000 Oregon Health Plan (OHP) members.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CCOa (medical, mental health, &amp; dental): 303,000</td>
</tr>
<tr>
<td></td>
<td>CCOg (mental health &amp; dental only): 12,000</td>
</tr>
<tr>
<td></td>
<td>CCOb (medical only): 120</td>
</tr>
<tr>
<td></td>
<td>CCOe (mental health only): 90</td>
</tr>
<tr>
<td>Other OHA</td>
<td>Health Share currently serves approximately 1,900 members under the Cover All Kids program, which provides comprehensive medical, mental health, and dental coverage.</td>
</tr>
<tr>
<td>Non-OHA state health plans</td>
<td>None</td>
</tr>
<tr>
<td>Other state or local public sector</td>
<td>None</td>
</tr>
<tr>
<td>Medicare</td>
<td>None</td>
</tr>
<tr>
<td>Other federal</td>
<td>None</td>
</tr>
<tr>
<td>Marketplace</td>
<td>None</td>
</tr>
<tr>
<td>Other Commercial Insured</td>
<td>None</td>
</tr>
<tr>
<td>Commercial Self-Funded</td>
<td>None</td>
</tr>
</tbody>
</table>
Attachment 2 - Application Checklist

The checklist presented in this Attachment 2 is provided to assist Applicants in ensuring that Applicant submits a complete Application. Please complete and return with Application. This Application Checklist is for the Applicant’s convenience and does not alter the Minimum Submission requirements in Section 3.2.

<table>
<thead>
<tr>
<th>Application Submission Materials, Mandatory Except as Noted</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Attachment 1 – Letter of Intent</td>
</tr>
<tr>
<td>✓ Attachment 2 – Application Checklist</td>
</tr>
<tr>
<td>✓ Attachment 3 – Applicant Information and Certification Sheet</td>
</tr>
<tr>
<td>✓ Executive Summary</td>
</tr>
<tr>
<td>☐ Full County Coverage Exception Requests (Section 3.2) (Optional)</td>
</tr>
<tr>
<td>✓ Reference Checks (Section 3.4.e.)</td>
</tr>
<tr>
<td>✓ Attachment 4 – Disclosure Exemption Certificate</td>
</tr>
<tr>
<td>✓ Attachment 4 – Exhibit 3 - List of Exempted Information.</td>
</tr>
<tr>
<td>✓ Attachment 5 – Responsibility Check Form</td>
</tr>
<tr>
<td>✓ Attachment 6 – General Questionnaire</td>
</tr>
<tr>
<td>✓ Attachment 6 – Narratives</td>
</tr>
<tr>
<td>✓ Attachment 6 – Articles of Incorporation</td>
</tr>
<tr>
<td>✓ Attachment 6 – Chart or listing presenting the identities of and interrelationships between the parent, Affiliates and the Applicant.</td>
</tr>
<tr>
<td>✓ Attachment 6 – Subcontractor and Delegated Entities Report</td>
</tr>
<tr>
<td>✓ Attachment 7 – Provider Participation and Operations Questionnaire</td>
</tr>
<tr>
<td>✓ Attachment 7 – DSN Provider Report</td>
</tr>
<tr>
<td>✓ Attachment 8 – Value-Based Payments Questionnaire</td>
</tr>
<tr>
<td>✓ Attachment 8 – RFA VBP Data Template</td>
</tr>
<tr>
<td>✓ Attachment 9 – Health Information Technology Questionnaire</td>
</tr>
<tr>
<td>✓ Attachment 10 – Social Determinants of Health and Health Equity Questionnaire</td>
</tr>
<tr>
<td>✓ Attachment 11 – Behavioral Health Questionnaire</td>
</tr>
<tr>
<td>✓ Attachment 12 – Cost and Financial Questionnaire</td>
</tr>
<tr>
<td>✓ Attachment 12 – Pro Forma Workbook Templates (NAIC Form 13H)</td>
</tr>
<tr>
<td>✓ Attachment 12 – NAIC Biographical Certificate (NAIC Form 11)</td>
</tr>
<tr>
<td>✓ Attachment 12 – UCAA Supplemental Financial Analysis Workbook Template</td>
</tr>
<tr>
<td>✓ Attachment 12 – Three years of Audited Financial Reports</td>
</tr>
<tr>
<td>✓ Attachment 13 – Attestations</td>
</tr>
<tr>
<td>✓ Attachment 14 – Assurances</td>
</tr>
<tr>
<td>✓ Attachment 15 – Representations</td>
</tr>
<tr>
<td>✓ Attachment 16 – Member Transition Plan</td>
</tr>
<tr>
<td>✓ Redacted Copy of Application Documents for which confidentiality is asserted. All redacted items must be separately claimed in Attachment 4. (Optional)</td>
</tr>
</tbody>
</table>
Attachment 3 - Application Information and Certification Sheet

Legal Name of Proposer: Health Share of Oregon

Address: 2121 SW Broadway, Suite 200
         Portland, Oregon 97201

State of Incorporation: Oregon  Entity Type: 501(c)3 non-profit member corporation, CCO

Contact Name: Maggie Bennington-Davis, MD  Phone: 503-416-3969  Email: MaggieBD@healthshareoregon.org

Oregon Business Registry Number: 849793-93

Any individual signing below hereby certifies they are an authorized representative of Applicant and that:

1. Applicant understands and accepts the requirements of this RFA. By submitting an Application, Applicant acknowledges and agrees to be bound by (a) all the provisions of the RFA (as modified by any Addenda), specifically including RFA Section 6.2 (Governing Laws) and 6.4 (Limitation on Claims); and (b) the Contract terms and conditions in Appendix B, subject to negotiation and rate finalization as described in the RFA.

2. Applicant acknowledges receipt of any and all Addenda to this RFA.

3. Application is a firm offer for 180 days following the Closing.

4. If awarded a Contract, Applicant agrees to perform the scope of work and meet the performance standards set forth in the final negotiated scope of work of the Contract.

5. I have knowledge regarding Applicant’s payment of taxes. I hereby certify that, to the best of my knowledge, Applicant is not in violation of any tax laws of the state or a political subdivision of the state, including, without limitation, ORS 305.620 and ORS chapters 316, 317 and 318.

6. I have knowledge regarding Applicant’s payment of debts. I hereby certify that, to the best of my knowledge, Applicant has no debts unpaid to the State of Oregon or its political subdivisions for which the Oregon Department of Revenue collects debts.

7. Applicant does not discriminate in its employment practices with regard to race, creed, age, religious affiliation, gender, disability, sexual orientation, national origin. When awarding subcontracts, Applicant does not discriminate against any business certified under ORS 200.055 as a disadvantaged business enterprise, a minority-owned business, a woman-owned business, a business that a service-disabled veteran owns or an emerging small business. If applicable, Applicant has, or will have prior to Contract execution, a written policy and practice, that meets the requirements described in ORS 279A.112 (formerly HB 3060), of preventing sexual harassment, sexual assault and discrimination against employees who are members of a protected class. OHA may not enter into a Contract with an Applicant that does not certify it has such a policy and practice. See https://www.oregon.gov/DAS/Procurement/Pages/hb3060.aspx for additional information and sample policy template.

8. Applicant and Applicant’s employees, agents, and subcontractors are not included on:

   a. the “Specially Designated Nationals and Blocked Persons” list maintained by the Office of Foreign Assets Control of the United States Department of the Treasury found at: https://www.treasury.gov/ofac/downloads/branchlist.pdf, or

   b. the government wide exclusions lists in the System for Award Management found at: https://www.sam.gov/portal/
9. Applicant certifies that, to the best of its knowledge, there exists no actual or potential conflict between the business or economic interests of Applicant, its employees, or its agents, on the one hand, and the business or economic interests of the State, on the other hand, arising out of, or relating in any way to, the subject matter of the RFA, except as disclosed in writing in this Application. If any changes occur with respect to Applicant’s status regarding conflict of interest, Applicant shall promptly notify OHA in writing.

10. Applicant certifies that all contents of the Application (including any other forms or documentation, if required under this RFA) and this Application Certification Sheet are truthful and accurate and have been prepared independently from all other Applicants, and without collusion, Fraud, or other dishonesty.

11. Applicant understands that any statement or representation it makes, in response to this RFA, if determined to be false or fraudulent, a misrepresentation, or inaccurate because of the omission of material information could result in a "claim" {as defined by the Oregon False Claims Act, ORS 180.750(1)}, made under Contract being a "false claim" {ORS 180.750(2)} subject to the Oregon False Claims Act, ORS 180.750 to 180.785, and to any liabilities or penalties associated with the making of a False Claim under that Act.

12. Applicant acknowledges these certifications are in addition to any certifications required in the Contract and Statement of Work in Attachment 10 at the time of Contract execution.

Signature: [Signature]
Title: [Title] Date: [Date]

(State of [State])

(State of Oregon)

County of [County]

Notary Public for the State of Oregon

My Commission Expires: [Expiration Date]
Attachment 4 - Disclosure Exemption Certificate

Marni Kuyk (“Representative”), representing Health Share of Oregon (“Applicant”), hereby affirms under penalty of False Claims liability that:

1. I am an officer of the Applicant. I have knowledge of the Request for Application referenced herein. I have full authority from the Applicant to submit this Certificate and accept the responsibilities stated herein.

2. I am aware that the Applicant has submitted an Application, dated on or about April 22, 2019 (the “Application”), to the State of Oregon in response to Request for Application #OHA-4690-19 for CCO 2.0 (the RFA). I am familiar with the contents of the Application.

3. I have read and am familiar with the provisions of Oregon’s Public Records Law, Oregon Revised Statutes (“ORS”) 192.311 through 192.478, and the Uniform Trade Secrets Act as adopted by the State of Oregon, which is set forth in ORS 646.461 through ORS 646.475. I understand that the Application is a public record held by a public body and is subject to disclosure under the Oregon Public Records Law unless specifically exempt from disclosure under that law.

4. I have checked Box A or B as applicable:

A. ☑ The Applicant believes the information listed in Exhibit A to this Exhibit 4 is exempt from public disclosure (collectively, the “Exempt Information”), which is incorporated herein by this reference. In my opinion, after consulting with a person having expertise regarding Oregon’s Public Records Law, the Exempt Information is exempt from disclosure under Oregon’s Public Records Law under the specifically designated sections as set forth in Exhibit A or constitutes “Trade Secrets” under either the Oregon Public Records Law or the Uniform Trade Secrets Act as adopted in Oregon. Wherever Exhibit A makes a claim of Trade Secrets, then Exhibit A indicates whether the claim of trade secrecy is based on information being:

1. A formula, plan, pattern, process, tool, mechanism, compound, procedure, production data, or compilation of information that:
   i. is not patented,
   ii. is known only to certain individuals within the Applicant’s organization and that is used in a business the Applicant conducts,
   iii. has actual or potential commercial value, and
   iv. gives its user an opportunity to obtain a business advantage over competitors who do not know or use it.

   Or

2. Information, including a drawing, cost data, customer list, formula, pattern, compilation, program, device, method, technique or process that:
   i. Derives independent economic value, actual or potential, from not being generally known to the public or to other persons who can obtain economic value from its disclosure or use; and
   ii. Is the subject of efforts by the Applicant that are reasonable under the circumstances to maintain its secrecy.

B. ☐ Exhibit A has not been completed as Applicant attests that are no documents exempt from public disclosure.
5. The Applicant has submitted a copy of the Application that redacts any information the Applicant believes is Exempt Information and that does not redact any other information. The Applicant represents that all redactions on its copy of the Application are supported by Valid Claims of exemption on Exhibit A.

6. I understand that disclosure of the information referenced in Exhibit A may depend on official or judicial determinations made in accordance with the Public Records Law.

Representative’s Signature

Exhibit A to Attachment 4

Applicant identifies the following information as exempt from public disclosure under the following designated exemption(s):

<table>
<thead>
<tr>
<th>Section Redacted</th>
<th>ORS or other Authority</th>
<th>Reason for Redaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attachment 7, Question 12, Standard 6.f.6.</td>
<td>ORS 192.311 to 192.478&lt;br&gt;ORS 646.461 to 646.475</td>
<td>The information constitutes a trade secret because the information:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Is not patented.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Is known only to select members of the Health Share executive team and the business owner of the information. To the extent Health Share obtained the information from a delegated entity or affiliate, that information is known only to the executive team and/or business owner of the information of that delegated entity or affiliate.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Health Share makes reasonable efforts to keep the information from others by keeping the information in secure and protected electronic files or encrypted emails that are only accessible by select members of the Health Share executive team or the business owner of the information.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Is used in Health Share’s business.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Has actual or potential commercial value to Health Share.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Gives Health Share an opportunity to obtain a business advantage over competitors who do not know or use the information and derives independent economic value from not being generally known to the public or to other persons who can obtain economic value from the disclosure or use of the information because Health Share could lose an economic advantage in drug pricing costs if its Pharmacy Benefit Manager cost data is known by a competitor.</td>
</tr>
</tbody>
</table>
| Attachment 8, Question C.2.a. | ORS 192.311 to 192.478  
ORS 646.461 to 646.475 | The information constitutes a trade secret because the information:  
- Is not patented.  
- Is known only to the Health Share Executive Team and the business owner of the information. To the extent Health Share obtained the information from a delegated entity or affiliate, that information is known only to the executive team and business owner of the information of the delegated entity or affiliate.  
- Health Share makes reasonable efforts to keep the information from others by keeping the information in secure and protected electronic files or encrypted emails that are only accessible by select members of the Health Share executive team or the business owner of the information.  
- Is used in Health Share’s business.  
- Has actual or potential commercial value to Health Share.  
- Gives Health Share an opportunity to obtain a business advantage over competitors who do not know or use the information and derives independent economic value from not being generally known to the public or to other persons who can obtain economic value from the disclosure or use of the information because Health Share could lose an economic advantage in provider network contracting and costs if its PCPCH payment rates are known by a competitor. |
| --- | --- | --- |
| Attachment 8, Question C.2.b. | ORS 192.311 to 192.478  
ORS 646.461 to 646.475 | The information constitutes a trade secret because the information:  
- Is not patented.  
- Is known only to the Health Share Executive Team or the business owner of the information. To the extent Health Share obtained the information from a delegated entity or affiliate, that information is known only to the executive team and business owner of the information of the delegated entity or affiliate.  
- Health Share makes reasonable efforts to keep the information from others by keeping the information in secure and protected electronic files or encrypted emails that are only accessible by select members of the Health Share executive team or the business owner of the information.  
- Has actual or potential commercial value to Health Share.  
- Gives Health Share an opportunity to obtain a business advantage over competitors who do not know or use the information and derives independent economic value from not being generally known to the public or to other persons who can obtain economic value from the disclosure or use of the information because Health Share could lose an economic advantage in provider network contracting and costs if its PCPCH payment rates are known by a competitor. |
information in secure and protected electronic files or encrypted emails that are only accessible by select members of the Health Share executive team or the business owner of the information.

- Is used in Health Share’s business.

- Has actual or potential commercial value to Health Share.

- Gives Health Share an opportunity to obtain a business advantage over competitors who do not know or use the information and derives independent economic value from not being generally known to the public or to other persons who can obtain economic value from the disclosure or use of the information because Health Share could lose an economic advantage in provider network contracting and costs if its strategy and rationale for Value Based Payments is known by a competitor.

The information constitutes a trade secret because the information:

- Is not patented.

- Is known only to the Health Share Executive Team or the business owner of the information. To the extent Health Share obtained the information from a delegated entity or affiliate, that information is known only to the executive team and business owner of the information of the delegated entity or affiliate.

- Health Share makes reasonable efforts to keep the information from others by keeping the information in secure and protected electronic files or encrypted emails that are only accessible by select members of the Health Share executive team or the business owner of the information.

- Is used in Health Share’s business.

- Has actual or potential commercial value to Health Share.

- Gives Health Share an opportunity to obtain a business advantage over competitors who do not know or use the information and derives independent economic value from not being generally known to the public or to other persons.
who can obtain economic value from the disclosure or use of the information because Health Share could lose an economic advantage in provider network contracting and costs if its strategy and rationale for Value Based Payments is known by a competitor.

<table>
<thead>
<tr>
<th>Attachment 8, Question C.5.</th>
<th>ORS 192.311 to 192.478 ORS 646.461 to 646.475</th>
</tr>
</thead>
</table>

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- Health Share makes reasonable efforts to keep the information from others by keeping the information in secure and protected electronic files or encrypted emails that are only accessible by select members of the Health Share executive team or the business owner of the information.

- Is used in Health Share’s business.

- Has actual or potential commercial value to Health Share.

- Gives Health Share an opportunity to obtain a business advantage over competitors who do not know or use the information and derives independent economic value from not being generally known to the public or to other persons who can obtain economic value from the disclosure or use of the information because Health Share could lose an economic advantage in provider network contracting and costs if its strategy and rationale for Value Based Payments is known by a competitor.

<table>
<thead>
<tr>
<th>Value Based Payment Data Template</th>
<th>ORS 192.311 to 192.478 ORS 646.461 to 646.475</th>
</tr>
</thead>
</table>

The information constitutes a trade secret because the information:

- Is not patented.

- Is known only to the Health Share Executive Team or the business owner of the information. To the extent Health Share obtained the
| Attachment 12, Question D.2. | ORS 192.311 to 192.478  
ORS 646.461 to 646.475 |
---|---|

- Health Share makes reasonable efforts to keep the information from others by keeping the information in secure and protected electronic files or encrypted emails that are only accessible by select members of the Health Share executive team or the business owner of the information.

- Is used in Health Share’s business.

- Has actual or potential commercial value to Health Share.

- Gives Health Share an opportunity to obtain a business advantage over competitors who do not know or use the information and derives independent economic value from not being generally known to the public or to other persons who can obtain economic value from the disclosure or use of the information because Health Share could lose an economic advantage in provider network contracting and costs if its strategy and specific costs/financial forecasting for Value Based Payments is known by a competitor.

The information constitutes a trade secret because the information:

- Is not patented.

- Is known only to the Health Share Executive Team or the business owner of the information. To the extent Health Share obtained the information from a delegated entity or affiliate, that information is known only to the executive team and business owner of the information of the delegated entity or affiliate.

- Health Share makes reasonable efforts to keep the information from others by keeping the information in secure and protected electronic files or encrypted emails that are only accessible by select members of the Health Share executive team or the business owner of the information.

- Is used in Health Share’s business.
| Attachment 12, Question D.3. | ORS 192.311 to 192.478  
ORS 646.461 to 646.475 |
|-------------------------------|--------------------------|

- Has actual or potential commercial value to Health Share.
- Gives Health Share an opportunity to obtain a business advantage over competitors who do not know or use the information and derives independent economic value from not being generally known to the public or to other persons who can obtain economic value from the disclosure or use of the information because Health Share could lose an economic advantage in drug pricing costs if specifics of its contractual arrangements with its Pharmacy Benefit Manager is known by a competitor.

The information constitutes a trade secret because the information:

- Is not patented.
- Is known only to the Health Share Executive Team or the business owner of the information. To the extent Health Share obtained the information from a delegated entity or affiliate, that information is known only to the executive team and business owner of the information of the delegated entity or affiliate.
- Health Share makes reasonable efforts to keep the information from others by keeping the information in secure and protected electronic files or encrypted emails that are only accessible by select members of the Health Share executive team or the business owner of the information.
- Is used in Health Share’s business.
- Has actual or potential commercial value to Health Share.
- Gives Health Share an opportunity to obtain a business advantage over competitors who do not know or use the information and derives independent economic value from not being generally known to the public or to other persons who can obtain economic value from the disclosure or use of the information because Health Share could lose an economic advantage in drug pricing costs if specifics of its contractual arrangements with its Pharmacy Benefit Manager is known by a competitor.
| Attachment 12, Question F, Pro Forma Workbook Templates (NAIC Form 13H) | ORS 192.311 to 192.478 ORS 646.461 to 646.475 | The information constitutes a trade secret because the information:

- Is not patented.
- Is known only to the Health Share Executive Team or the business owner of the information. To the extent Health Share obtained the information from a delegated entity or affiliate, that information is known only to the executive team and business owner of the information of the delegated entity or affiliate.
- Health Share makes reasonable efforts to keep the information from others by keeping the information in secure and protected electronic files or encrypted emails that are only accessible by select members of the Health Share executive team or the business owner of the information.
- Is used in Health Share’s business.
- Has actual or potential commercial value to Health Share.
- Gives Health Share an opportunity to obtain a business advantage over competitors who do not know or use the information and derives independent economic value from not being generally known to the public or to other persons who can obtain economic value from the disclosure or use of the information because Health Share could lose an economic advantage in its service area if specifics of its corporate structure and financial strategy and forecasting is known by a competitor. |

| Attachment 12, Question F, NAIC Biographical Affidavits (NAIC Form 11) | ORS 192.335(2)(a) ORS 192.335(3) | The information contained in the NAIC Biographical Affidavits is of a personal nature such as that kept in a personal, medical or similar file, the public disclosure of which would constitute an unreasonable invasion of privacy. To the extent the information is not treated as of a personal nature, the information should be treated as personal information exempt from disclosure under ORS 192.335(3). |
| Attachment 12, Question F, UCAA Supplemental Financial Analysis Workbook Template | ORS 192.311 to 192.478 ORS 646.461 to 646.475 | The information constitutes a trade secret because the information:

- Is not patented.

- Is known only to the Health Share Executive Team or the business owner of the information. To the extent Health Share obtained the information from a delegated entity or affiliate, that information is known only to the executive team and business owner of the information of the delegated entity or affiliate.

- Health Share makes reasonable efforts to keep the information from others by keeping the information in secure and protected electronic files or encrypted emails that are only accessible by select members of the Health Share executive team or the business owner of the information.

- Is used in Health Share’s business.

- Has actual or potential commercial value to Health Share.

- Gives Health Share an opportunity to obtain a business advantage over competitors who do not know or use the information and derives independent economic value from not being generally known to the public or to other persons who can obtain economic value from the disclosure or use of the information because Health Share could lose an economic advantage in its service area if specifics of its corporate structure, actuarial analysis, payment arrangements, and financial strategy and forecasting is known by a competitor.

| Attachment 13, Question B.1.h. | ORS 192.311 to 192.478 ORS 646.461 to 646.475 | The information constitutes a trade secret because the information:

- Is not patented.

- Is known only to the Health Share Executive Team or the business owner of the information. To the extent Health Share obtained the information from a delegated entity or affiliate, that information is known only to the executive team and business owner of the information of the delegated entity or affiliate.
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• Is used in Health Share’s business.

• Has actual or potential commercial value to Health Share.

• Gives Health Share an opportunity to obtain a business advantage over competitors who do not know or use the information and derives independent economic value from not being generally known to the public or to other persons who can obtain economic value from the disclosure or use of the information because Health Share could lose an economic advantage in provider network contracting and costs if provider payment arrangements are known by a competitor.
Attachment 5 - Responsibility Check Form

OHA will determine responsibility of an Applicant prior to award and execution of a Contract. In addition to this form, OHA may notify Applicant of other documentation required, which may include but is not limited to recent profit-and-loss history, current balance statements and cash flow information, assets-to-liabilities ratio, including number and amount of secured versus unsecured creditor claims, availability of short and long-term financing, bonding capacity, insurability, credit information, materials and equipment, facility capabilities, personnel information, record of performance under previous contracts, etc. Failure to promptly provide requested information or clearly demonstrate responsibility may result in an OHA finding of non-responsibility and rejection.

1. Does Applicant have available the appropriate financial, material, equipment, facility and personnel resources and expertise, or ability to obtain the resources and expertise, necessary to demonstrate the capability of Applicant to meet all contractual responsibilities?

YES ☑ NO ☐

2. Within the last five years, how many contracts of a similar nature has Applicant completed that, to the extent that the costs associated with and time available to perform the contract remained within Applicant’s Control, Applicant stayed within the time and budget allotted, and there were no contract claims by any party? Number: _2_

How many contracts did not meet those standards? Number: _0_ If any, please explain.

Response:

3. Within the last three years has Applicant (incl. a partner or shareholder owning 10% or more of Applicant’s firm) or a major Subcontractor (receiving 10% or more of a total contract amount) been criminally or civilly charged, indicted or convicted in connection with:
   - obtaining, attempting to obtain, or performing a public (Federal, state, or local) contract or subcontract,
   - violation of federal or state antitrust statutes relating to the submission of bids or proposals, or
   - embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, or receiving stolen property?

YES ☐ NO ☑

If "YES," indicate the jurisdiction, date of indictment, charge or judgment, and names and summary of charges in the response field below.

Response:

4. Within the last three years, has Applicant had:
   - any contracts terminated for default by any government agency, or
   - any lawsuits filed against it by creditors or involving contract disputes?

YES ☐ NO ☑

If "YES," please explain. (With regard to judgments, include jurisdiction and date of final judgment or dismissal.)

Response:
5. Does Applicant have any outstanding or pending judgments against it?

   YES ☐  NO ☑.

   Is Applicant experiencing financial distress or having difficulty securing financing? YES ☐  NO ☑.

   Does Applicant have sufficient cash flow to fund day-to-day operations throughout the proposed Contract period?

   YES ☑  NO ☐

   If "YES" on the first question or second question, or "NO" on the third question, please provide additional details.

   Response:

6. Within the last three years, has Applicant filed a bankruptcy action, filed for reorganization, made a general assignment of assets for the benefit of creditors, or had an action for insolvency instituted against it?

   YES ☐  NO ☑.

   If "YES," indicate the filing dates, jurisdictions, type of action, ultimate resolution, and dates of judgment or dismissal, if applicable.

   Response:

7. Does Applicant have all required licenses, insurance and/or registrations, if any, and is Applicant legally authorized to do business in the State of Oregon?

   YES ☑  NO ☐.

   If "NO," please explain.

   Response:

8. Pay Equity Certificate. This certificate is required if Applicant employs 50 or more full-time workers and the prospective Contract price is estimated to exceed $500,000. [This requirement does not apply to architectural, engineering, photogrammetric mapping, transportation planning or land surveying and related services contracts.] Does a current authorized representative of Applicant possess an unexpired Pay Equity Certificate issued by the Department of Administrative Services?

   YES ☑  NO ☐  N/A ☐

   Submit a copy of the certificate with this form.

   Response:

**AUTHORIZED SIGNATURE**

By signature below, the undersigned Authorized Representative on behalf of Applicant certifies to the best of his or her knowledge and belief that the responses provided on this form are complete, accurate, and not misleading.

Applicant Name: Health Share of Oregon  
RFA: OHA 4690-19  
Project Name: CCO 2.0

Signature: M. Bennington-Davis  
Title: Interim CEO  
Date: 4-19-2019  

(Authorized to Bind Applicant)
Certificate of Completion

The State of Oregon, Other, Non State Employees, hereby certifies that

Health Share of Oregon

Has successfully completed the following:

DAS - CHRO - Overview of Pay Equity

On 4/19/2019
SUMMARY OF QUALIFICATIONS
Experienced physician leader in developing systems, improving quality, leading change, working with physicians, and inspiring employees. Strong clinical and management education, teaching experience, leadership experience, and credentials. Thorough understanding of health systems and finances. Co-creator of The Engagement Model, based on Dr. Sandra Bloom’s Sanctuary Model. Helped a large organization (Cascadia) stabilize its finances and operations while improving quality. Closely engaged in Oregon’s health transformation process, currently serving as interim CEO and CMO at Oregon’s largest coordinated care organization.

LICENSING INFORMATION
OR License: MD16578
HA License: MD9565
American Board of Psychiatry and Neurology Board Certification/recertification: #39895 11/94 and 08/04

PROFESSIONAL EXPERIENCE
Health Share of Oregon 05/15 – present
Interim CEO 09/18 - present

Cascadia Behavioral Healthcare 03/06 – 05/15
Chief Medical Officer and Chief Operating Officer

Samaritan Health Systems 07/08 – 07/09
Psychiatry Residency Training Director

National Association of Mental Health Program Directors Faculty 2005 – 2007

Salem Hospital, Salem, Oregon 2000 - 2005
Medical Director, Psychiatry

Salem Hospital, Salem, Oregon 2003 - 2005
Chief of Staff, Medical Staff

Salem Hospital, Salem, Oregon 1994 - 2000
Psychiatrist

Oregon Health Sciences University 1994 – present
Associate Clinical Professor

EDUCATION

Tulane School of Public Health, New Orleans, LA
- Masters in Medical Management 05/05

American College of Physician Executives Certification 12/03

Oregon Health Sciences University, Portland, Oregon
- Residency, Psychiatry (Chief Resident) 06/93
- M.D. 06/89 cum laude

Portland State University, Portland, Oregon
- M.S. Biology 06/84 cum laude
- M.S. Psychology 03/83

University of Montana, Missoula, Montana
- B.A. Psychology 06/78 cum laude
- B.A. English 06/78

ADDITIONAL RESPONSIBILITIES

- Statewide Health Plan Quality Metrics Committee 2017-present
- CTIPP Board member 2016-present
- OHLC Evidence Based Practice Committee (and opioids subcmte) 2016-present
- International Transformational Resilience steering committee 2014-present
DEBORAH P. FRIEDMAN, MA, MBA

EXPERIENCE

Chief Operating Officer
Health Share of Oregon, February 2015 – present

Member of executive staff of Medicaid Coordinated Care Organization serving 315,000 members with annual budget of $2 billion. Develops, implements and maintains the operating plan to support the business strategy for the company. Directs, administers and coordinates internal operational activities in accordance with the goals and objective established by the executive team and Board of Directors. Directs the development of operational procedures and controls to promote communication and adequate information across departments to support the direction of the company. Participates in the development and preparation of short-term and long-range plans and budgets based on broad organizational objectives. Accountable for the creation, implementation and ongoing monitoring of the quality management and compliance plans and customer service function. Staff to Board committees.

Behavioral Health Director
Health Share of Oregon, April 2013 – February 2015

Led Health Share’s efforts to integrate mental health, addictions and physical health services to ensure behavioral health needs of enrolled members. In collaboration with partner organizations, developed, implemented and oversaw a Behavioral Health Transformation Plan to more effectively meet member mental health and substance use needs. Provided leadership for the development and operation of specific integrated mental health utilization, quality improvement and evaluation programs for members with mental health diagnoses, including the development of new payment and delivery system models.

Mental Health Organization Director
Clackamas County Behavioral Health Division, 2005 - 2013

Planned, organized and directed the Oregon Health Plan Medicaid mental health program for 28,000 members and a program of mental health and addiction treatment services to uninsured, indigent residents of Clackamas County. Responsible for the continuum of behavioral health services and the service delivery system, including quality management, performance management, contracts administration, and fiscal management. Responsible for $20 million annual budget. Planned, developed and implemented programs and strategies to meet needs of clients served and support the provider delivery system.
Director, Provider Services and Development
CareOregon, Inc., 1998 - 2003

Member of senior management team responsible for planning, directing, organizing and assessing health plan operations of Medicaid managed care health plan serving 16 counties with $250 million annual revenue. Statewide responsibility for provider network and business development with reporting responsibilities to Board of Directors and staff to Board committees. Represented organization and its mission to diverse range of stakeholders and partners. Identified and developed opportunities to expand health plan enrollment and enhance revenue. Collaborated with key community partners to meet organizational goals and objectives.

EDUCATION

Master of Business Administration – Portland State University, Portland, Oregon

Master of Arts, Counseling Psychology – Lewis and Clark College, Portland, Oregon

Bachelor of Science, Sociology – Oregon State University, Corvallis, Oregon
LARRY SODERBERG
824 JACKSON COURT ~ LAFAYETTE, OR 97127
MOBILE: 971-241-7787 ~ EMAIL: LSODERBERG101@HOTMAIL.COM
WWW.LINKEDIN.COM/IN/LARRY-SODERBERG-59188352

CORPORATE FINANCIAL MANAGEMENT EXECUTIVE
High quality executive with extensive finance, administration, and accounting experience in diverse public and private industries, including non-profit, retail, financial services, medical administration, and manufacturing. Proven ability to impact overall operations, reduce costs, improve internal controls, and quickly adapt to fluctuating markets. Over fifteen years of experience in effective general and financial management, strategic planning, process design and implementation, staff leadership and development, and a track record of independent audits resulting in unmodified opinions.

PROFESSIONAL EXPERIENCE

Health Share of Oregon – Portland, OR
2013 - Present

Chief Financial Officer (March 2018 – Present)
Director of Finance (January 2017 - March 2018)
Controller (January 2014 - January 2017)

Corporate officer promoted from within for an industry leading $2 billion per year non-profit Coordinated Care Organization (CCO), providing managed health care to over 320,000 Oregon Health Plan members. Managed the financial impacts of a 40% increase in membership, revenues, and expenses, with a one-month condensed timeline. Built and supervised a team of three staff. Managed financial oversight of multiple contractors, including third party administrators and 17 sub-contracted healthcare plans; includes management of multiple related party transactions. Key member of management teams such as Executive and Leadership teams, Data Governance Committee, and Compliance & Delegation Oversight Committee. Designed and implemented a shared regional risk payment model for behavioral health, spanning three counties. Oversight of actuarial processes and consultants, inclusive of rate setting and risk adjustment. Consulted in design and implementation of a new data and analytics platform.

Oregon State Hospital – Salem, OR
2010 - 2013

Accounting & Banking Services Manager (March 2011 – March 2013)
Contracts Accountant (March 2010 - March 2011)

Financial manager of one of the largest branches of the Oregon Health Authority at $500 million in expenses annually, supervising a team of seven staff. Managed financial oversight of all accounting functions for the facility, and client banking and payroll services for over 600 patients. Centralized and updated processes for annual Medicare and Medicaid cost reporting and cost of
care rate development. Implemented internal Lean processes and metrics, inclusive of a system overhaul of the contracting and tracking of interpreter services aimed at reducing waste. Developed financial dashboard package for hospital executives, to improve communications, transparency, and management of operations. Managed the design, preparation, and initial transitions of financial services to new facilities in two locations.

Valley RV Center, Inc. – McMinnville, OR  
**Accounting Supervisor (July 2003 – February 2009)**

Financial manager on the fast track to promotion, while being mentored as the successor to the Controller. Managed corporate operations for a $50 million in annual revenues recreational vehicle dealership, with a ten-acre sales, full service, and parts facility. Served as Title Clerk, overseeing all licensing and registration requirements, and implementation of on-site electronic licensing systems to improve administrative efficiencies and customer satisfaction. Licensed Finance and Insurance representative, securing and completing necessary documentation for customer loans and service warranties. Supervised a diverse staff of six, inclusive of procurement, parts inventory, shipping/receiving, and waitstaff for a 1950’s style diner. Efficiently maintained high quality levels of full-time production, while also attending college part time.

### KEY SKILLS & ABILITIES

- Corporate/Operational Finances
- Budgeting & Forecasting
- Capitation Rate Setting & Negotiations
- Treasury/Investment Management
- Accounting & Auditing
- Risk Management
- Policy Development
- Value Based Payment Development
- Board of Director Relations
- Contracts Management
- Delegation Oversight
- Regulatory Compliance
- Regulatory Reporting
- Financial Analysis
- Strategic Planning
- GAAP and GASB Compliance
- Leadership/Supervision/Mentoring
- Committee/Workgroup Facilitation
- Internal Controls Development
- Diverse Software Experience

### EDUCATION

- **Associates in Arts & Sciences Degree**
  *Whatcom Community College - Bellingham, WA (1994 - 1996)*

- **Bachelors of Science in Accounting**
  *Linfield College - McMinnville, OR (2006 - 2009)*
JOHN A. SANDERS PhD
11631 NW Old Cornelius Pass Rd. Portland, Oregon 97231
john.sanders@jnj-assoc.com, 503-715-6090, https://www.linkedin.com/in/johnsandersphd/

STRATEGIC VISION, MANAGEMENT TALENT, AND TECHNOLOGY EXPERTISE

Innovative and effective leader with more than 15 years experience driving change and positively impacting business and clinical performance. Broad expertise in the development and management of advanced technology solutions. Uniquely able to use technology as a basis for achieving company operational efficiencies, creating and realizing market opportunities, and ensuring progress towards strategic goals. Skillfully align technology resources with enterprise objectives by applying a unique combination of management vision and talent, experience that spans both inpatient and outpatient environments, deep technology and industry insight, program and operations management expertise, high-level medical and engineering training, and the ability to engage and motivate all types of stakeholders. Established track record of building and strengthening organizations, successfully applying technologies for maximal benefit, creating and leading high performance teams, and cultivating profitable relationships with a variety of partners.

Strategic Planning • Project Management • Operational Management • Business Development
EHR & Clinical Information Systems • Infrastructure Design & Improvement • Multi-Site Operations • Technology Partnerships • Analytics • Interoperability • ROI Analysis • Benchmarking • Workflow Optimization
• Biomedical Engineering • Product Development • Quality Metrics • Process Improvement • Healthcare IT

PROFESSIONAL EXPERIENCE

Health Share of Oregon, Portland, Oregon • 2015-present
Chief Information Officer
My role is to develop, apply, and promote technology solutions for improving services and outcomes for our members. This includes coordination and interoperability between payment, clinical records, and analytics systems. It also includes providing technology support for Health Share’s innovative programs targeting opportunities to improve healthcare in the community. More fundamentally I led a major company technology transition from rushed start-up to business-grade systems and processes. This included constructing an extensive enterprise data management and information delivery program.

THE PORTLAND CLINIC, Portland, Oregon • 2013-2014
Chief Information Officer
Responsible for technology implementation and management. Extensive operations and workflow planning due to the close relationship with the Epic EHR and other electronic systems. Provided the technology and analytics that allowed effective partnerships - as the leading partner in a collaborative of independent practices and with several large hospital-based systems. The effective delivery of multiple simultaneous technology projects allowed the company to pursue an aggressive HIT-fueled strategy to position itself favorably in the marketplace. I was able to develop a relatively small high performing team that surprised larger organizations with what we were able to accomplish.

COLORADO SPRINGS HEALTH PARTNERS, Colorado Springs, Colorado • 2009-2013
Vice President of Information Technology & Chief Information Officer
Responsible for all technology strategy, implementation, and management. Extensive operations responsibilities included provider and staff scheduling, communications, and patient access. As part of the executive leadership team, I identified and evaluated industry trends in order to define and execute company strategy. I had a transformational role in establishing best-practice systems and processes in order to drive company change towards efficient business and clinical operations based completely on electronic workflows.

JNJ ASSOCIATES LLC, Centennial, Colorado • 2006-2009
Partner & Consultant
Responsible for business development and project management for healthcare IT and technology development segments. Identified potential clients, developed compelling business cases and project plans, and assured effective project execution. Examples of projects include:

RADIOLOGY IMAGING ASSOCIATES, Englewood, Colorado • 2000-2006
Chief Technology Officer
Biomedical Engineer & Medical Physicist
Spearheaded development of new clinical and information technologies that enabled rapid company growth. Led the development of a new enterprise-wide IT strategy that allowed the implementation of enterprise-grade infrastructures and the establishment of IT best practices operations. Orchestrated all business and clinical IT activities, including multi-site WAN/LAN network; datacenter and servers; applications, workstations; voice and data services; help desk operations; imaging modalities; PACS, RIS, CAD, image processing/display, and transcription systems. Evaluated a wide range of new technologies for cost, feasibility, and revenue potential. Delivered training programs for staff and colleagues. Liaised with healthcare partners and technology vendors.

EDUCATION
UNIVERSITY OF CALIFORNIA, Davis, California
Ph.D. in Biomedical Engineering
Specializing in image processing and computer science.

UNIVERSITY OF OREGON, Eugene, Oregon
B.S. in both Chemistry & Biology
Specializing in biochemistry, physiology, and molecular biology.

CERTIFICATIONS
Project Management Professional (PMP)
Certified Professional in Healthcare Information and Management Systems (CPHIMS)

PROFESSIONAL AFFILIATIONS
Healthcare Information and Management Systems Society (HIMSS)
College of Healthcare Information Management Executives (CHIME)
Project Management Institute (PMI)
Biomedical Engineering Society (BMES)
Society for Imaging Informatics in Medicine (SIIM)
Institute of Electrical and Electronics Engineers (IEEE)
Michael Anderson-Nathe  
6707 NE Cleveland Avenue ~ Portland, Oregon 97211  
971-645-8244  
mandersonnathe@gmail.com

QUALIFICATIONS

- Passion for health equity
- Healthcare transformation
- Deep community engagement
- Strategic planning
- Management expertise
- Political savvy
- Strong convening skills
- Community health assessment
- Mission driven team leadership

PROFESSIONAL EXPERIENCE

Health Share of Oregon  
Portland, OR  
Chief Equity & Engagement Officer  
2014 – present

- Provide strategic leadership and oversight of Coordinated Care Organization community engagement, community health, and health equity efforts
- Develop, manage, and oversee equity and inclusion initiatives to eliminate health disparities
- Oversee population and community health transformation, upstream prevention, and social determinants of health efforts
- Provide senior executive leadership to agency including consultation to the board and board committees, oversight and supervision of board-approved initiatives, and strategic planning
- Represent Health Share on local and statewide committees, coalitions, and collaborations: Healthy Columbia Willamette Collaborative, Oregon Health Authority, Early Learning Hubs, Community Health Improvement committees, Regional Community Health Network, and public health advisory councils
- Build and sustain partnerships with local public health authorities, community-based organizations, and community stakeholders
- Provide supervision, human resource management, and program support

Cascade AIDS Project  
Portland, OR  
Interim Deputy Executive Director  
2013 – 2014

- Designed, implemented, and evaluated HIV prevention and education programs
- Developed and managed annual department budget ($1.8 million) and assisted with development of $5 million agency budget
- Provided supervision, human resource management, and program support
- Wrote grants, negotiated, and executed contracts with county, state, and federal grantors
- Identified community needs and created successful programs via coalitions, advisory boards, and funded collaborations
- Cultivated and maintained local and national community networks
- Developed programmatic and agency-wide policy and procedures
- Engaged in political advocacy, community organizing, public presentations, and community education
- Created a nationally recognized HIV prevention program including a strong partnership with the CDC with a focus on implementing evidence-based programs

Clackamas County Public Health  
Oregon City, OR  
HIV Prevention Program Coordinator  
2004 – 2005
Hennepin County Community Health  
Red Door Clinic Community Health Specialist  
Minneapolis, MN  
2002 – 2004

Face to Face Health & Counseling Service  
Assistant to the Executive Director  
St. Paul, MN  
2001 – 2002

Minnesota AIDS Project  
Community Health Specialist  
Minneapolis, MN  
2000

StreetWorks / District 202  
Case Manager / Outreach Worker  
Minneapolis, MN  
1998 – 2002

EDUCATION

Cornell University  
Diversity & Inclusion Certificate  
Ithaca, NY  
2019

Portland State University  
Master of Public Administration  
Portland, OR  
2012
  Organizational Development; Nonprofit Management; Intercultural Communication & Leadership

University of Minnesota  
Bachelor of Science  
Minneapolis, MN  
2000
  Family Social Science

COMMUNITY ENGAGEMENT

Oregon Health Policy Board: Health Equity Committee (Co-chair)  
2017 - present
A Home for Everyone Coordinating Board (Member)  
2014 - present
Developing Equity and Leadership through Training and Action (DELTA)  
2014
Allies for a Healthier Oregon (Member)  
2013 - 2014
Clackamas County Public Health Advisory Committee (Member)  
2013 - present
Healthy Oregon Partnerships for Equity (Coalition member)  
2012 – 2014
AIDS Project Los Angeles Advisory Board (Member)  
2006 – 2010
Havurah Shalom Reconstructionist Congregation Steering Committee (Member)  
2008 – 2009
National Gay Men’s Health Summit Steering Committee (Member)  
2005
Statewide HIV Prevention Planning Group (Member)  
2004 - 2014
HIV Stops with Me Campaign (Advisory member)  
2004 - 2009
Sexual Health 4 Men Coalition (Member)  
2004 - 2009
MN Sexuality Education Resource Review Panel (Member)  
2002 - 2004
GLBT Host Home Project Advisory Board (Member)  
2002 - 2004
StreetWorks (Consultant and public relations specialist)  
1998 - 2000
Minnesota Men of Color (Founder and board chair)  
1997 - 1999
Youth & AIDS Projects (Peer educator)  
1996 – 1997
Attachment 6. A.1.m. Provide a chart (as a separate document, which will not be counted against page limits) identifying Applicant’s contact name, telephone number, and email address for each of the following:

<table>
<thead>
<tr>
<th>Name</th>
<th>Telephone</th>
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State of Oregon
OFFICE OF THE SECRETARY OF STATE
Corporation Division

Certified Copy   230L506W9

I, LESLIE CUMMINGS, Deputy Secretary of State of Oregon, and Custodian of the
Seal of said State, do hereby certify:

That the attached

Document File

for

HEALTH SHARE OF OREGON

is a true copy of the original document(s).

In Testimony Whereof, I have hereunto set
my hand and affixed hereto the Seal of the
State of Oregon.

[Signature]

LESLIE CUMMINGS, DEPUTY SECRETARY OF STATE

3/14/2019
ARTICLES OF INCORPORATION
OF
TRI-COUNTY MEDICAID COLLABORATIVE

The undersigned, in order to form a nonprofit, public benefit corporation under ORS Chapter 65, the Oregon Nonprofit Corporation Act (the “Act”), hereby signs and verifies the following Articles of Incorporation:

ARTICLE I
NAME

The name of the corporation is Tri-County Medicaid Collaborative (the “Corporation”).

ARTICLE II
MEMBERSHIP

The Corporation shall have members within the meaning of the Act. Qualifications for membership in the Corporation, and the powers of the membership, shall be set out in the Corporation’s Bylaws.

ARTICLE III
TYPE AND DURATION

The Corporation is a public benefit corporation and its duration shall be perpetual.

ARTICLE IV
REGISTERED OFFICE AND AGENT

The initial registered office of the Corporation is 1300 SW Fifth Avenue, Suite 2400 Portland, Oregon 97201, and the initial registered agent at such address is DWT Oregon Corp.

ARTICLE V
PRINCIPAL OFFICE

The mailing address of the initial principal office of the Corporation, to which notices, as required under ORS Chapter 65, may be mailed, is 315 S.W. Fifth Ave., Suite 300, Portland, Oregon 97204.

ARTICLE VI
PURPOSES, LIMITATIONS AND POWERS

Section 6.1 Purposes. The Corporation shall be organized and operated exclusively for religious, charitable, scientific, literary, or educational purposes, within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the “Code”), or any successor provision.
Section 6.2 Limitations.

6.2.1 The Corporation shall have no capital stock, and no part of its net earnings shall inure to the benefit of any director or officer of the Corporation, or of any private individual.

6.2.2 No director, officer, or any private individual shall be entitled to share in the distribution of any of the corporate assets upon dissolution of the Corporation, or upon the winding up of its affairs.

6.2.3 No substantial part of the activities of the Corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, except as may be permitted to Section 501(c)(3) organizations by the Code, and the Corporation shall not participate in, or intervene in (including the publication or distribution of statements) any political campaign on behalf of (or in opposition to) any candidate for public office.

6.2.4 Notwithstanding any other provisions of these Articles, the Corporation shall not conduct or carry on activities not permitted to be conducted or carried on by an organization qualified under Section 501(c)(3) of the Code, or any successor provision, or by an organization, contributions to which are deductible under Section 170(c)(2) of the Code, or any successor provision.

Section 6.3 Powers. In general, and subject to such limitations and conditions as are or may be prescribed by law, or in the Corporation’s Articles of Incorporation or Bylaws, the Corporation shall have all powers which now or hereafter are conferred by law upon a corporation organized for the purpose set forth above, or are necessary or incidental to the powers so conferred, or are conducive to the attainment of the Corporation’s purpose.

ARTICLE VII
LIMITATION OF DIRECTORS’ LIABILITY

Directors and uncompensated officers of the Corporation shall have no civil liability to the Corporation or its members for conduct as a director or officer, except for breaches of the duty of loyalty to the Corporation, acts or omissions which are not in good faith or which involve intentional misconduct or knowing violations of law, unlawful distributions, transactions from which such director or officer derives an improper personal benefit, and any act or omission in violation of ORS 65.361 through 65.367, as in effect, or hereinafter amended. If the Act is hereafter amended to authorize corporate action further eliminating or limiting the personal liability of directors or officers, then the liability of a director or officer shall be eliminated or limited to the full extent permitted by the Act, as so amended. Any repeal or modification of this Article shall not adversely affect any right or protection of a director or officer of the Corporation existing at the time of such repeal or modification for or with respect to an act or omission of such director occurring prior to such repeal or modification.
ARTICLE VIII
INDEMNIFICATION

Section 8.1 Indemnification. Pursuant to ORS 65.387 to 65.414, the Corporation shall indemnify, to the fullest extent provided in the Act, any Director or Officer who was or is a Party or is threatened to be made a Party to any Proceeding (other than an action by or in the right of the Corporation) by reason of or arising from the fact that such person is or was a Director or Officer of the Corporation. The determination and authorization of indemnification shall be made as provided in the Act.

Section 8.2 Advancement of Expenses. The Corporation may pay for or reimburse the reasonable Expenses incurred by a Director or Officer who is a Party to a Proceeding in advance of final disposition of the Proceeding as provided in the Act.

Section 8.3 Insurance. At the discretion of the Board of Directors, the Corporation may purchase and maintain insurance on behalf of any person who is or was a Director or Officer of the Corporation against any Liability asserted against such person and incurred by such person in any such capacity, or arising out of such person's status as such, whether or not the Corporation would have the power to indemnify such person against such Liability under the provisions of this Article.

Section 8.4 Nonexclusivity of Rights. The indemnification referred to in the various sections of this Article shall be deemed to be in addition to and not in lieu of any other rights to which those indemnified may be entitled under any statute, rule of law or equity, provision of the Articles of Incorporation, agreement, vote of the Board of Directors or otherwise.

Section 8.5 Definitions. Capitalized terms used in this Article and not otherwise defined herein shall have the same meanings given them in ORS 65.387 to 65.414.

ARTICLE IX
DIRECTORS

The management of the Corporation will be vested in a board of directors. The number, qualifications, terms of office, manner of election, time and place of meeting, and powers and duties of directors shall be prescribed by the Bylaws of the Corporation.

ARTICLE X
AMENDMENT OF BYLAWS

The authority to make, alter, amend or repeal Bylaws is vested in the members of the Corporation. The board of directors may recommend alterations, amendments, or repeal of the Bylaws, but any such recommendation shall be effective only upon approval by the members.

ARTICLE XI
DISSOLUTION

Upon dissolution or winding up, all the Corporation's remaining assets shall be distributed by the board of directors, subject to approval by the members, for similar or identical
uses and purposes, to any organization that would then qualify for exemption under the
provisions of Sections 501(c)(3) of the Code, or any successor provision, or to a state or local
government for a public purpose.

ARTICLE XII
INCORPORATOR

The incorporator’s name and address are:

Name Address
Ingrid Brydolf c/o Davis Wright Tremaine LLP
1300 SW Fifth Avenue, Suite 2400
Portland, Oregon 97201

IN WITNESS WHEREOF, I hereby declare that this filing is, to the best of my
knowledge and belief, true, correct, and complete.

DATED this 16th day of April 2012

[Signature]
Ingrid Brydolf
Incorporator
RESTATED ARTICLES OF INCORPORATION - NONPROFIT

SECRETARY OF STATE - CORPORATION DIVISION - 266 CAPITOL ST. NE, SUITE 151 - SALEM, OR 97310-1327 - http://www.oregon.gov/SOS/Corporations/ - Phone: (503) 986-2200

FILED

SEP 21 2012

OREGON
SECRETARY OF STATE
For office use only

REGISTRY NUMBER: 849793-93

In accordance with Oregon Revised Statute 652.410-652.480, the information on this application is public record. We must release this information to all parties upon request and it will be posted on our website.

Please Type or Print Legibly In Black Ink. Attach Additional Sheet If Necessary.

1) NAME OF CORPORATION: Tri-County Medicaid Collaborative

2) NEW NAME OF THE CORPORATION: (If changed) Health Share of Oregon

3) A COPY OF THE RESTATED ARTICLES MUST BE ATTACHED.

4) CHECK THE APPROPRIATE STATEMENT:

☐ The restated articles contain amendments which do not require membership approval. The date of the adoption of the amendments and restated articles was __________________. These amendments were duly adopted by the board of directors.

☐ The restated articles contain amendments which require membership approval. The date of the adoption of the amendments and restated articles was __________________.

The vote of the members was as follows:

<table>
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<tr>
<th>Class(es) entitled to vote</th>
<th>Number of members entitled to vote</th>
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5) EXECUTION: (Must be signed by at least one officer or director.)

By my signature, I declare as an authorized authority, that this filing has been examined by me and is, to the best of my knowledge and belief, true, correct, and complete. Making false statements in this document is against the law and may be penalized by fines, imprisonment or both.

Signature: __________________________

Printed Name: George J. Brown, M.D.

Title: Chair, Board of Director

CONTACT NAME: (To resolve questions with this filing.)

Felyn George

HEALTH SHARE OF OREGON

FEES

Required Processing Fee $50

Processing Fees are nonrefundable. Please make check payable to "Corporation Division."

Free copies are available at FilingInOregon.com, using the Business Name Search program.
AMENDED AND RESTATED
ARTICLES OF INCORPORATION
OF
HEALTH SHARE OF OREGON

These Amended and Restated Articles of Incorporation amend and restate those certain Articles of Incorporation filed with the Oregon Secretary of State on April 16, 2012.

ARTICLE I
NAME

The name of the corporation is Health Share of Oregon (the "Corporation").

ARTICLE II
MEMBERSHIP

The Corporation shall have members within the meaning of the Act. Qualifications for membership in the Corporation, and the powers of the membership, shall be set out in the Corporation's Bylaws.

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6.2.4 Notwithstanding any other provisions of these Articles, the Corporation shall not conduct or carry on activities not permitted to be conducted or carried on by an organization qualified under Section 501(c)(3) of the Code, or any successor provision, or by an organization, contributions to which are deductible under Section 170(c)(2) of the Code, or any successor provision.

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uses and purposes, to any organization that would then qualify for exemption under the provisions of Sections 501(c)(3) of the Code, or any successor provision, or to a state or local government for a public purpose.

CERTIFICATE OF OFFICER

The undersigned, being the Chair of the Board of Directors of the Corporation, does hereby affirm that these Articles were duly adopted on September 19, 2012 by the Members in accordance with the provisions of the Oregon Nonprofit Corporation Act.

[Signature]

George J. Brown, M.D., Chair
Health Share of Oregon is a 501(c)3 non-profit membership corporation with eleven founding member organizations. All members have the same rights and responsibilities with respect to voting, dissolution, redemption, and transfer.

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HEALTH SHARE OF OREGON

SIXTH AMENDED AND RESTATED PHYSICAL HEALTH RISK ACCEPTING ENTITY PARTICIPATION AGREEMENT

THIS SIXTH AMENDED AND RESTATED PHYSICAL HEALTH RISK ACCEPTING ENTITY PARTICIPATION AGREEMENT (“Agreement”) is effective as of the date set forth below (“Effective Date”) by and between Health Share of Oregon, an Oregon nonprofit corporation (“Health Share”), and ____________________________, referred to herein as a Risk-Accepting Entity (“RAE”).

RECITALS

A. Health Share was created as a Coordinated Care Organization (“CCO”), to enter into a risk contract that covers coordinated care services with the Oregon Health Plan (“OHP”), and facilitate the management and coordination of patient care for OHP members (“Members”) and individuals who are dually eligible for coverage under OHP and the Medicare program (“Dual Eligibles”).

B. Health Share has entered into a contract with the Oregon Health Authority (“OHA”) to become a CCO, effective September 1, 2012.

C. RAE and its participating healthcare facilities, practitioners and other providers desire to participate in Health Share’s CCO by providing or arranging for services to Members on a fully-capitated basis in coordination with Health Share under the terms and conditions specified in this Agreement.

D. As Health Share and RAE may presently be parties to the Risk Accepting Entity Participation Agreement, as the same may have been amended and restated from time to time, or as Health Share and RAE may desire to enter into an initial contract related to the subject matter of this Agreement, the parties now desire to enter into this Agreement to replace and supersede any and all prior contracts or agreements between them related to the same subject matter.

E. NOW THEREFORE, this Agreement states the terms and conditions upon which RAE will participate in the CCO of Health Share.

AGREEMENT

I. Effective Date and Duration

A. **Term.** The term of this Agreement shall commence on January 1, 2019 (“Effective Date”).

B. **Termination.** Unless extended or terminated earlier in accordance with Exhibit D, Section 10 herein, this Agreement shall expire on December 31, 2019.

II. Contract in its Entirety

A. This Agreement consists of this document together with the following exhibits
and schedules (some of which in turn have attachments), which are attached hereto and incorporated into this Agreement by reference:

**Exhibit A:** Definitions  
**Exhibit B:** Statement of Work  
**Exhibit C:** Consideration  
**Exhibit D:** Standard Terms and Conditions  
**Exhibit E:** Required Federal Terms and Conditions  
**Exhibit F:** Insurance Requirements  
**Exhibit G:** Delivery System Network Provider and Hospital Adequacy Report Reporting Requirements  
**Exhibit H:** Practitioner Incentive Plan Regulation Guidance  
**Exhibit I:** Grievance System  
**Exhibit J:** [Reserved]  
**Exhibit K:** [Reserved]  
**Exhibit L:** Solvency Plan and Financial Reporting  
**Exhibit M:** [Reserved]

B. Intentionally omitted.

C. There are no other Agreement documents unless specifically referenced and incorporated in this Agreement.

D. Intentionally omitted.

E. Intentionally omitted.

III. Intentionally omitted.

IV. Intentionally omitted.

V. **Enrollment Limits and Service Area**

A. **Service Area.** RAE’s Service Area by zip code is: ____________________.
B. **Enrollment Limit.** RAE’s current Enrollment Limit is: ______________.

VI. **Interpretation and Administration of Agreement.** The parties acknowledge and agree that this Agreement is subject to the terms and conditions of the Health Plan Services Contract (“Core Contract”) between Health Share and the Oregon Health Authority (OHA) and as further defined in Exhibit A. The parties shall interpret and administer this Agreement in accordance with the Core Contract, Section VI titled “Interpretation and Administration of Agreement” which shall be incorporated herein by reference.

The parties further acknowledge and agree that in the event that any provision, clause or application of this Agreement is ambiguous with respect to the delegation of Core Contract provisions by Health Share to the RAE due to drafting, technical or similar issues, the parties shall interpret this Agreement in a manner consistent with the original intention of the parties, to allow Health Share to delegate as many duties and obligations related to providing Covered Services to Members under the Core Contract to RAE as Health Share deems reasonably possible and appropriate in light of Health Share’s mission and objectives.

VII. Intentionally omitted.

VIII. **Performance of Agreement.** RAE agrees to perform its duties and obligations under this Agreement in accordance with applicable federal, state and local laws, the terms and condition of this Agreement, and all applicable policies and procedures adopted by Health Share. Health Share shall make best efforts to provide RAE with copies of all such policies and procedures prior to RAE being held accountable for complying with such policies and procedures. RAE shall ensure that its Participating Providers also comply with the same. RAE shall be responsible for distributing copies of Health Share policies and procedures to its Participating Providers. In addition to the policies and procedures specifically referenced in this Agreement, Health Share may adopt policies and procedures related to additional subjects including but not limited to: (i) allocating Members to RAEs; (ii) establishing restricted reserve requirements; (iii) defining exclusions and establishing reinsurance policies; (iv) developing performance standards including medical loss ratios; (v) data reporting and analytic support; (vi) maintaining risk adjustment factors; (vii) defining shared savings programs and policies; and (viii) establishing and implementing policies, procedures, and guidelines regarding Covered Services that overlap with, influence, or otherwise impact Behavioral Health Services provided by Behavioral Health RAEs. If RAE fails to comply with any provisions of this Agreement or with Health Share policies and procedures, Health Share may terminate this Agreement in accordance with Exhibit D, Section 10 hereunder.

IX. **Restricted Reserves.** For purposes of this Agreement, "Restricted Reserves" are defined as contractually determined levels of primary and secondary reserve funds held for the sole purpose of making payments to providers in the event of Health Share's insolvency. According to contractual requirements, RAE is required to maintain minimum primary and secondary Restricted Reserve levels. In the event of Health Share's insolvency, OHA may distribute Restricted Reserve funds for reasons including but not limited to: (i) the withholding of all
monies due for Work and Work Products Health Share has failed to deliver under the Core Contract; (ii) recovery of overpayments; and (iii) payment of Health Share's or any Subcontractor's debts or liabilities for health care services. To the extent that Restricted Reserves remain following OHA's distributions, Health Share shall distribute, release, pay or otherwise make available the remaining Restricted Reserve funds to RAE and other Risk Accepting Entities in amounts not to exceed the primary and secondary Restricted Reserve levels maintained by each such entity.

X. Signatures

[Signatures contained on the following page]
IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the Execution Date set forth below.

Execution Date: __________________, 2018

"Health Share"
HEALTH SHARE OF OREGON, an Oregon nonprofit corporation

By: ____________________________________________________________

Name: __________________________________________________________________________

Title: __________________________________________________________________________

"RAE"

By: __________________________________________________________________________

Name: __________________________________________________________________________

Title: __________________________________________________________________________

TIN: __________________________________________________________________________
Exhibit A – Definitions

In addition to any terms that may be defined in this Exhibit A or elsewhere in this Agreement, the terms in this Agreement have the same meaning as those terms appearing in the Core Contract, Exhibit A, titled “Definitions” which shall be incorporated herein by reference.

“Behavioral Health Services” means the specific categories of Mental Health Services and Substance Use Disorder Services that Health Share defines by policy, subject to adjustment by Health Share from time to time in Health Share’s sole discretion.

“Core Contract” means that certain Health Plan Services Contract, Coordinated Care Organization Contract in effect during the term of this Agreement by and between the State of Oregon, acting through its Oregon Health Authority, and Health Share of Oregon, f/k/a Tri-County Medicaid Collaborative, as the same may be updated, amended, modified, or supplemented from time to time, including without limitation, those provisions providing mechanisms for identifying and addressing compensation pursuant to Exhibit C hereunder.

“Delegated to RAE” means that, subject to RAE’s Enrollment Limit and Service Area, Health Share shall delegate to RAE, and RAE shall assume, the performance of the duties and obligations as expressed in, and in accordance with, the designated Exhibits, Parts and Sections of the Core Contract, which Exhibits, Parts and Sections shall be incorporated into this Agreement by reference. In so doing, subject to RAE’s Enrollment Limit and Service Area, RAE expressly assumes the duties, obligations, rights and privileges applicable to “Contractor” as described in the designated Exhibits, Parts and Sections of the Core Contract. Any amendments, additions, deletions or revisions made to sections of the Core Contract that the RAE Agreement indicates are “Delegated to RAE” shall be deemed delegated to RAE as of the effective date of such amendments, additions or revisions to the Core Contract. Notwithstanding the foregoing, the term “Delegated to RAE” as used herein shall not include the delegation of duties and obligations related to the provision of Behavioral Health Services, except as reasonably related to RAE’s integration and care coordination responsibilities hereunder or as otherwise expressly stated in this Agreement.

“Dental Services” are those services provided within the scope of practice as defined under State law by or under the supervision of a dentist, denture services provided within the scope of practice as defined under State law by a denturist or Expanded Practice Dental Hygienist.

“Enrollment Limit” means the number of Members that Health Share may Enroll with RAE subject to the conditions and limitations expressed in this Agreement.

“Medically Appropriate” has the definition described in OAR 410-120-0000(145) when related to provision of covered services.
Exhibit B – Statement of Work

Part 1 – Governance and Organizational Relationships

1. Intentionally omitted.

2. **Community Advisory Council (CAC).** RAE shall support Health Share’s establishment of a Community Advisory Council (“CAC”) as reasonably requested by Health Share, and shall provide Health Share with data, reports and information related to CAC activities as reasonably requested by Health Share.

3. **Clinical Advisory Panel.** RAE shall support Health Share’s establishment of a Clinical Advisory Panel (“CAP”), if any, and shall provide representatives to serve on the CAP as reasonably requested by Health Share, if any.

4. Intentionally omitted.

5. Intentionally omitted.

6. **Children’s System of Care Governance Structure.** RAE shall cooperate with and assist Health Share to fulfill its obligations under Exhibit B, Part 1, Section 6 of the Core Contract titled “Children’s System of Care Governance Structure.” Specifically, RAE shall assist Health Share to develop a System of Care Governance Structure that is accountable for the implementation and coordination of the provisions of all services within the System of Care.

Part 2 – **Benefits and Covered Services.** RAE expressly assumes the duties, obligations, rights and privileges applicable to “Contractor” as described in the designated exhibits, parts and sections of the Core Contract, as they relate to the provision of Covered Services. Except as otherwise stated in this Agreement, RAE shall provide or arrange for the provision of Covered Services as defined in this Agreement in exchange for the RAE Payment defined in Exhibit C. The duties and obligations of this Exhibit B, Part 2 shall apply to Health Share and RAE only to the extent that RAE is licensed to perform, and does actually provide the applicable category or type of Covered Services to Members under this Agreement. If RAE does not provide the applicable category or type of Covered Services to Members under this Agreement, such duties and obligations shall not apply to Health Share or RAE.

1. **Covered Services.** Exhibit B, Part 2, Section 1 of the Core Contract shall be Delegated to RAE.

2. **Provision of Covered Services.** Exhibit B, Part 2, Section 2 of the Core Contract shall be Delegated to RAE.

3. **Authorization of Denial of Covered Services.** Exhibit B, Part 2, Section 3 of the Core Contract shall be Delegated to RAE, subsection 3.k excepted. If RAE adopts a policy
regarding an objection on moral or religious grounds to provide a Covered Service, RAE shall submit such policy to Health Share as requested by Health Share.

4. **Covered Service Components.** Exhibit B, Part 2, Section 4 of the Core Contract shall be Delegated to RAE, with the exception of Behavioral Health Services. The Sections of the Core Contract identified below shall be excepted to the extent that each Section applies to Behavioral Health Services.

a. “Crisis, Urgent and Emergency Services for Mental Health” (Exhibit B, Part 2, Section 4.b);

b. “Emergency Ambulance Transportation” (Exhibit B, Part 2, Section 4.b.3);

c. “Preventive Care” (Exhibit B, Part 2, Section 4.d);

d. “Post Hospital Extended Care (PEHC) Coordination” (Exhibit B, Part 2, Section 4.g);

e. “Mental Health Conditions that may Result in Involuntary Psychiatric Care” (Exhibit B, Part 2, Section 4.h);

f. “Covered Services for Members Receiving Long Term Psychiatric Care (LTPC)” (Exhibit B, Part 2, Section 4.i);

g. “Acute Inpatient Hospital Psychiatric Care” (Exhibit B, Part 2, Section 4.j);

h. “Adult Mental Health” (Exhibit B, Part 2, Section 4.k);

i. “Children and Youth Mental Health” (Exhibit B, Part 2, Section 4.l);

j. “Wraparound Services” (Exhibit B, Part 2, Section 4.m);

k. “Health-Related Services” (Exhibit B, Part 2, Section 4.n);

l. “Substance Use Disorders” (Exhibit B, Part 2, Section 4.o);

m. “MOTS Reporting” (Exhibit B, Part 2, Section 4.p);

n. “Medication Management” (Exhibit B, Part 2, Section 4.q);

o. “Intensive Case Management” (Exhibit B, Part 2, Section 4.r);

p. “Tobacco Cessation” (Exhibit B, Part 2, Section 4.s);

5. **Optional Covered Services with Care Coordination.** For all services designated in
Part II, Section D of this Agreement, RAE shall provide care coordination. Notwithstanding the foregoing, RAE shall provide care coordination only to the extent that RAE is licensed to perform, and does actually provide the applicable categories or types of Covered Services to Members.

6. **Non-Covered Health Services with Care Coordination.** Exhibit B, Part 2, Section 6 shall be Delegated to RAE, excepting Exhibit B, Part 2, Section 6(b).

7. **Non-Covered Health Services without Care Coordination.** Exhibit B, Part 2, Section 7 shall be Delegated to RAE.

8. **Health-Related Services.**
   
a. **Health-Related Services.** In addition to Covered Services, RAE shall also provide Health-Related Services, in accordance with OAR 410-141-3150, 45 CFR §158.150 and 45 CFR §158.151 that are consistent with achieving Member wellness and the objectives of an individualized care plan or improving population health and health care quality. Health-related services must be coordinated by RAE, and may be in collaboration with the PCPCH or other PCP in the DSN.

b. **Health-Related Services Policies.** RAE shall establish written policies and procedures for authorizing Health-Related Services. The policies and procedures shall enable the RAE’s Provider Network to order and supervise the delivery of Health-Related Services. RAE shall, upon Health Share’s request, attest that its policies and procedures are current and conform to applicable state and federal laws and provide policies upon specific request by Health Share.

c. **Expanded Covered Services.** Covered Services may be substituted with or expanded to include Health-Related Services, in compliance with RAE’s policy as approved by Health Share and agreed to by RAE, the Member and, as appropriate, the family of the Member, as being an effective alternative.

Part 3 – **Patient Rights and Responsibilities, Engagement and Choice**

1. **Member and Member Representative Engagement and Activation.** Exhibit B, Part 3, Section 1 of the Core Contract shall be Delegated to RAE.

2. **Member Rights under Medicaid.** Exhibit B, Part 3, Section 2 of the Core Contract shall be Delegated to RAE.

3. **Provider’s Opinion.** Exhibit B, Part 3, Section 3 of the Core Contract shall be Delegated to RAE.

4. **Informational Material and Education of Members and Potential Members.** Health Share shall develop and provide written informational materials and educational programs, in accordance with the requirements of Exhibit B, Part 3, Section 4 of the Core Contract, to help Members and Potential Members understand the requirements and
benefits of coordinated and integrated care. RAE shall assist Health Share in the development and distribution of such written information materials and educational programs as reasonably requested by Health Share and in accordance with applicable policies and procedures adopted by Health Share.

5. **Grievance System.** Exhibit B, Part 3, Section 5 of the Core Contract shall be Delegated to RAE. RAE shall follow all Health Share Grievance and Appeals policies and procedures related to communication or access to Covered Services or facilities. Health Share expressly reserves to itself adjudication of final Grievances and Appeals as described in the Health Share policies and procedures. RAE shall submit its Grievance and Appeals policies and procedures to Health Share as requested by Health Share.

6. **Enrollment and Disenrollment.**

   a. **Enrollment.** Enrollment is the process by which Health Share assigns Members to RAE. RAE shall provide Covered Services to Members as required by the terms and conditions of this Agreement as of the effective date of the Member’s enrollment with RAE. An individual becomes an enrolled Member of RAE for purposes of this Agreement as of the effective date Health Share assigns the individual to RAE. As reflected in Exhibit B, Part 2, Section 2.c. of the Core Contract, the term “Member” includes individuals enrolled with Health Share in accordance with OAR 410-141-3160 who were receiving OHP benefits on a fee-for-service basis on October 31, 2012.

   (1) **Initial Enrollment.** Upon the Effective Date of this Agreement, RAE shall accept, without restriction, the initial population of Members assigned by Health Share from RAE’s Service Area to provide Covered Services as required by the terms and conditions of this Agreement, unless RAE’s enrollment becomes closed as described under paragraph 6.a.(3) below.

   (2) **Open Enrollment.** RAE shall have an open enrollment policy at all times, during which RAE shall accept, without restriction, all eligible Members assigned by Health Share from RAE’s Service Area to provide Covered Services as required by the terms and conditions of this Agreement in the order in which they are assigned to RAE by Health Share, unless RAE’s enrollment becomes closed as described under paragraph 6.a.(3) below.

   (3) **Closed Enrollment.** Unless RAE does not have an Enrollment Limit, new Member enrollment may be denied by RAE: (i) if the total number of Members enrolled with RAE reaches 120% of RAE’s Enrollment Limit; (ii) for any other reason mutually agreed to by Health Share and RAE; (iii) as otherwise authorized under this Agreement; or (iv) as otherwise authorized under OAR 410-141-3060. If RAE closes enrollment, RAE shall immediately notify Health Share.
(4) **Enrollment Discrimination.** RAE shall not discriminate against individuals eligible to enroll on the basis of health status, the need for health services, race, color, national origin, marital status, age, gender identity, or disability and shall not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, marital status, age, gender identity, or disability.

(5) **Enrollment Errors.** If Health Share enrolls a Member with RAE in error, and the erroneously enrolled Member has not received services from RAE, Health Share may retroactively disenroll the Member from RAE and enroll the Member with the appropriate entity up to 60 days from the date of the erroneous enrollment.

(6) **Enrollment Validation.** RAE shall provide enrollment validation as described in Exhibit B, Part 8, Section 6 of this Agreement.

(7) **Transition of Dual Eligibles.** RAE shall support and assist Health Share in the transition of dual eligible beneficiaries from partial CCO/FFS enrollment to CCOA during dual passive enrollment initiative, as described in Exhibit B, Part 3, Section 6.a.(7) of the Core Contract.

**b. Disenrollment.**

(1) A Member shall no longer be assigned to RAE for purposes of this Agreement as of the effective date of the Member’s disenrollment from RAE, as described in Section 6.b.(4) below. As of that date, RAE is no longer required to provide Covered Services to such Members under the terms and conditions of this Agreement, unless the Member is hospitalized at the time of disenrollment of a Member from RAE. In such an event, RAE is responsible for inpatient hospital services until discharge or until the Member’s PCP determines that care in the hospital is no longer Medically Appropriate. OHA will assume responsibility for other services not included in the Diagnosis Related Group (DRG) applicable to the hospitalization.

(2) Health Share may disenroll a Member from RAE for any reason described in the Core Contract, Exhibit B, Part 3, Section 6.b.(6) excepted.

(3) RAE shall not request disenrollment of any Member for reasons described in the Core Contract, Exhibit B, Part 3, Section 6.b.(6)

(4) Except for disenrollment due to erroneous enrollment, the effective date of disenrollment of a Member from RAE shall be the first day of the month following the date of delivery of notice from Health Share to RAE of the Member’s disenrollment.
If Health Share disenrolls a Member from RAE retroactively, Health Share will recoup any RAE Payments made to RAE after the effective date of disenrollment. If the disenrolled Member was otherwise eligible for benefits under OHP, services the Member received during the period of the retroactive disenrollment may be eligible for fee-for-service payment under OHA rules.

c. **Member Benefit Package Changes.** Health Share shall provide to RAE the Weekly and Monthly Enrollment file (as described in the Core Contract, Exhibit B, Part 3, Section 6.c.) to identify the current eligibility status of RAE’s enrolled membership.

d. **Enrollment Reconciliation.** Health Share and RAE shall reconcile on a monthly basis the Weekly and Monthly Enrollment file described above with the membership enrolled with RAE. If there are any discrepancies, RAE shall cooperate and assist Health Share to prepare and submit any forms required under the Core Contract, Exhibit B, Part 3, Section 6.d. to correct the errors.

7. **Identification Cards.** Health Share shall provide to its enrolled Members ID cards related to eligibility for Covered Services.

8. **Marketing to Potential Members.** Exhibit B, Part 3, Section 8 of the Core Contract shall be Delegated to RAE. RAE shall provide copies of all written Marketing Materials to Health Share for approval, as requested by Health Share.

**Part 4 – Providers and Delivery System**

1. **Integration and Coordination.**

a. RAE shall implement and participate in activities to develop, support and promote Health Share’s efforts to integrate and coordinate care among providers to create a continuum of care that integrates mental health, addiction treatment, dental health, physical health and community based interventions seamlessly and holistically, including new member screenings. RAE shall also participate in activities to foster communication, share information, and integrate and coordinate care between RAE, Dental Health RAES, and/or Behavioral Health RAES, as applicable.

b. RAE shall support and assist Health Share in the development and implementation of integration and coordination activities including but not limited to the following in support of this arrangement: (i) enhanced communication and coordination between Physician, Health Plan, Hospitals, Dental Care Providers, Mental Health, Substance Use Disorder and other participating providers and community service organizations; (ii) development of infrastructure support for sharing information, coordinating care and monitoring results; (iii) use of treatment standards and guidelines that support integration; (iv) development of alternative workforce...
solutions to support better patient outcomes; and (v) support of a shared culture of integration among all RAE’s providers and among Physical Health RAEs, Dental Health RAEs, and Behavioral Health RAEs.

c. RAE shall support and assist Health Share in the development and subsequent implementation of all Health Share policies and programs adopted to help ensure that Members have access to high quality, appropriately integrated and coordinated care and services, through a Provider Network capable of meeting Health System Transformation objectives in accordance with the Core Contract, Exhibit B, Part 4, Section 4. Specifically, RAE shall fully implement Health Share’s policies and programs related to: (i) patient-centered care in both primary, behavioral and dental health settings; (ii) care coordination; and (iii) care integration, as such elements are discussed in the Core Contract, Exhibit B, Part 4, Section 4.

d. RAE shall support Health Share in creating and fully implementing all Health Share’s evidence-based clinical practice guidelines.

e. RAE shall make best efforts to conduct an initial screen of each new Member’s needs within 90 days of enrollment, and make additional attempts if initial outreach is unsuccessful.

f. RAE shall ensure that in coordinating care, each Member’s privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable, and consistent with other State law or Federal regulations governing privacy and confidentiality of health records. In furtherance of the above, RAE agrees to enter into a HIPAA business associate addendum or agreement, in the form directed by Health Share.

g. RAE shall coordinate the services that RAE furnishes its Members with the services the Member receives from any other prepaid managed care health services organization to avoid duplication of services as required by 42 C.F.R. § 438.208(b)(2) and (5).

h. RAE shall contract with Oregon State Public Health Laboratory to accept claims for the following tests:

1. Hepatitis
2. Syphilis
3. Chlamydia/Gonorrhea
4. HIV
5. Miscellaneous Serology tests
6. Brucella
7. Hanta virus
8. Rickettsial Battery
9. Rubella
10. Varicella
11. Norovirus
(12) Virus Isolation
(13) Influenza
(14) Mumps and Rubeola
(15) Malaria (Blood smear for parasites)
(16) Mycobacterium tuberculosis
(17) qPCR
(18) Quantiferon
(19) Bordatella pertussis/parapertussis


   a. Exhibit B, Part 4, Section 2 shall be Delegated to RAE. However, the duties and obligations of Exhibit B, Part 4, Section 2 shall apply to Health Share and RAE only to the extent that RAE is licensed to perform, and does actually provide the applicable category or type of Covered Services to Members under this Agreement. If RAE does not provide the applicable category or type of Covered Services to Members under this Agreement, such duties and obligations shall not apply to Health Share or RAE.

   b. Consistent with OAR 410-141-3220, RAE shall have an access plan that establishes standards for access, outlines how capacity is determined and establishes procedures for monthly monitoring of capacity and access, and for improving access and managing risk in times of reduced participating provider capacity. The access plan shall also identify populations in need of interpreter services and populations in need of accommodation under the Americans with Disabilities Act.

3. Delivery System and Provider Capacity.

   a. Exhibit B, Part 4, Section 3 of the Core Contract shall be Delegated to RAE; Section 3.b.(1) excepted.

   b. RAE shall complete and submit to Health Share the initial Delivery System Network reports described in Exhibit G of the Core Contract (“DSN Reports”). Thereafter, RAE shall submit DSN Reports on an annual basis as directed by Health Share. RAE shall submit updates to its DSN Reports as soon as reasonably possible following any Material Change in RAE’s operations that could affect adequacy of capacity and services.

   c. RAE’s Use of Direct Providers.

      (1) Health Share has entered into direct contractual relationships (“Direct Agreements”) with various service providers (“Direct Providers”) to furnish a specific set of Covered Services to Members (“Contracted Services”). According to each Direct Provider’s Direct Agreement with
Health Share, each Direct Provider has agreed to furnish a specific set of Contracted Services to Members in exchange for the compensation described in such Direct Agreement. Direct Providers shall not be entitled to compensation for furnishing any items or services not described in their Direct Agreement with Health Share.

(2) Health Share shall involve RAE in the development of Direct Agreements and provide RAE an opportunity to review and approve such Direct Agreements prior to their use with Direct Providers to the extent that the Contracted Services contemplated in the Direct Agreement are those that would have otherwise been provided by RAE’s provider network. Additionally, Health Share shall provide reasonable notice to RAE when Health Share has entered into any Direct Agreement or when it proposed to change the material terms of any such Direct Agreement. Such notice shall include a description of the Contracted Services to be provided and the terms and conditions that relate to compensation. Health Share shall not implement any material changes to Direct Agreements without providing RAE an opportunity to review and approve the proposed material changes.

(3) When obtaining any Contracted Services for Members assigned to RAE, RAE shall be required to obtain such services from Direct Providers. However, if RAE has an existing network of providers who are providing the same Covered Services, as described in a Direct Agreement with Health Share, RAE may utilize that provider network as long as the providers in that network meet or exceed the performance and outcomes of Health Share’s Direct Providers, including price and access.

(4) RAE and Health Share shall agree to comply with the following terms and conditions when obtaining Contracted Services from Direct Providers for its Members:

a. Health Share shall require Direct Providers to comply with the same policies and procedures that RAE applies generally to the other Participating Providers in the RAE’s Provider Network. Specifically, RAE shall apply to Direct Provider(s) those policies and procedures referenced in this Agreement including but not limited to those regarding: service authorization requests; Member rights under Medicaid; Third Party Recovery; Evidence-Based Clinical Practice Guidelines; Maintenance and Security; care integration and coordination activities; evidence-based clinical practice guidelines; and all others that RAE applies to its other Participating Providers.

b. RAE shall request and receive any reports, information, or documents from Direct Provider(s) that are required of its Network
Providers under the Agreement. Such reports may include without limitation reports regarding utilization, performance measures, quality metrics, patient satisfaction, coordination, expenses and savings, etc.

c. RAE shall be solely responsible to compensate Direct Providers for Contracted Services furnished by Direct Providers to RAE’s Members. RAE shall compensate Direct Providers in accordance with the compensation terms described in each Direct Provider’s Direct Agreement with Health Share, and in accordance with RAE’s applicable written policies and procedures related to billing, coding, claim submission, clean claims, overpayment recovery, audits, documentation, etc.

d. RAE acknowledges and agrees that Health Share is not responsible for compensating Direct Providers for providing any items or services to Members. RAE hereby waives, releases, relinquishes, and discharges Health Share and its officers, directors, employees, agents, and their successors and assigns, and each of them (hereinafter “Released Parties”) from any and all claims, suits, damages, actions, or manner of actions that RAE now has or may in the future have against Released Parties, or any of them, in any way relating to or arising out of any failure to pay compensation or reimbursement to Direct Provider(s) for the provision of any items or services. RAE acknowledges and agrees that the foregoing release shall survive termination of this Agreement for any reason.

e. If RAE believes that a Direct Provider has not adhered to the terms and conditions of its Direct Agreement or the RAE’s written policies and procedures, RAE’s remedy shall be to notify Health Share of the suspected breach. Health Share shall take all reasonable steps to bring the Direct Provider into compliance with the Direct Agreement or RAE’s written policies and procedures. To the extent that Health Share is unable to bring a Direct Provider into compliance with the Direct Agreement or RAE’s written policies and procedures, Health Share shall exercise its rights against Direct Provider under the Direct Agreement, including termination of the Direct Agreement.

4. **Delivery System Features.** Exhibit B, Part 4, Section 4 of the Core Contract shall be Delegated to RAE; Sections b(1)(d)-(f) excepted.

5. **Delivery System Dependencies.** Exhibit B, Part 4, Section 5 of the Core Contract shall be Delegated to RAE; Section 5.a. excepted.

6. **Evidence-Based Clinical Practice Guidelines.** In addition to supporting and adopting
the evidence-based clinical practice guidelines implemented by Health Share, RAE shall develop and adopt supplemental evidence-based clinical practice guidelines consistent with Exhibit B, Part 4, Section 6 of the Core Contract.

7. **Health Promotion and Prevention.** Exhibit B, Part 4, Section 7 of the Core Contract shall be Delegated to RAE.

8. Intentionally omitted.

9. **Patient Centered Primary Care Homes (PCPCH).** The duties and obligations of Exhibit B, Part 4. Section 9 shall be Delegated to RAE only to the extent that RAE is licensed to perform, and does actually provide the applicable category or type of Covered Services to Members under this Agreement. If RAE does not provide the applicable category or type of Covered Services to Members under this Agreement, such duties and obligations shall not apply to Health Share or RAE.

   a. RAE shall fully participate in Health Share collaborative efforts to further develop the “health home” model in both physician health and behavioral health settings.

   b. RAE shall provide a report to Health Share no later than 15 days following the end of each quarter that includes the following: (i) number of health care teams or clinics meeting PCPCH standards, by tier; (ii) number of primary care Practitioners accepting Members in a PCPCH listed out by tier 1, 2, 3, 4 or 5; and (iii) number of Members assigned to Providers in PCPCH practices listed out by tier 1, 2, 3, 4 or 5.

   c. RAE is participating in Comprehensive Primary Care Initiative (CPC Initiative) consistent with their MOU with CMS. There is no additional funding for this Initiative beyond the capitated payment outlined in Exhibit C of this Agreement.

10. **Subcontract Requirements.** RAE may subcontract any or all of the Work to be performed under this Agreement. If RAE subcontracts any or all of the Work to be performed under this Agreement, RAE shall subcontract in accordance with Exhibit D Section 18 of this Agreement, and Exhibit B, Part 4, Sections 10.a.(1) through 10.a.(2), 10.a.(5) through 10.a.(11), and 10.a.(13) of the Core Contract. RAE shall notify Health Share in writing within 15 days of terminating any RAE Provider when such termination is the result of the failure to meet requirements under this Agreement, deficiencies identified through compliance monitoring of the RAE Provider, or any other for-cause termination. RAE shall require subcontractor to submit Valid Claims for Covered Services including all the fields and information needed to allow the claim to be processed without further information from the subcontractor, and within time frames that assure all corrections have been made within four months of the date of service.

11. **Adjustments in Service Area or Enrollment**

   a. **Enrollment Decrease.** If RAE reasonably anticipates losing a substantial number of Members from its enrollment, or experiencing a reduction in its network or
capacity due to: (i) the occurrence of a Material Change or other significant change; (ii) the termination or loss of Participating Providers; or (iii) other factors significantly impacting access in RAE’s Service Area, RAE shall notify Health Share at least 120 days, or as soon as reasonably practicable, prior to the date of such anticipated loss or reduction.

(1) In such an event, RAE shall cooperate with and assist Health Share to develop a written plan for removing or reassigning the Members, and to cooperate and assist in the preparation of any written reports required by the Core Contract or the OHA related to the removal or reassignment.

(2) RAE shall remain responsible for maintaining sufficient capacity and solvency, and providing Covered Care Services through such 120-day period, without limitation, for all Members for which RAE has received RAE Payments.

(3) If RAE cannot demonstrative sufficient capacity to provide Covered Services to Members during such 120-day period, Health Share may seek other avenues to provide Covered Services to Members.

(4) RAE shall complete submission and corrections to encounter data for services received by Members; shall assure payment of Valid Claims by employees and subcontractors, and for Non-Participating Providers providing Covered Services to Members, consistent with the provisions of ORS 414.743, OAR 410-120-1340 and OAR 410-141-3420; and shall comply with the other terms of this Agreement applicable to the dates of service before removing or reassigning Members pursuant to this section.

Part 5 – Health Equity and Elimination Health Disparities

RAE and Health Share shall work together to meet obligations under the Core Contract, Exhibit B, Part 5 titled “Health Equity and Elimination Health Disparities.” Specifically, RAE shall work with Health Share to gather and maintain race, ethnicity, and primary language data, including mental health and substance abuse disorder data, for all Members on an ongoing basis. RAE shall also work with Health Share to track and report on any quality performance improvements and outcome measures by these demographic factors and develop, implement, and evaluate strategies to improve health equity and address health disparities.

Part 6 – Value-Based Payment

Exhibit B, Part 6 of the Core Contract shall be Delegated to RAE. At Health Share’s request, RAE shall collaborate with Health Share to develop value-based payment methodologies.

Part 7 – Health Information Systems.

1. Exhibit B, Part 7 of the Core Contract shall be Delegated to RAE. In addition, RAE shall
participate in Health Share programs, workshops and training sessions pertaining to Health Share’s health information technology (“HIT”) systems. RAE shall implement all policies and procedures adopted by Health Share related to HIT, and accordingly, shall comply with the following:

a. RAE shall support and assist Health Share to develop appropriate measurement, analysis, and reporting systems.

b. RAE shall receive, process and submit enrollment, disenrollment, claims-related, and other types of electronic files to or from OHA or Health Share after the Effective Date of this Agreement, as directed by Health Share. Accordingly, RAE shall continue to submit encounter data to OHA in the form, and according to the timing requirements, mandated by OHA, OAR 410-141-3430 and OAR 943-120-0100 through 943-120-0200, and other applicable law, until such time that Health Share directs RAE to cease.

c. RAE shall cease submitting to OHA the Enrollment Reconciliation Certifications Forms, as required pursuant to Exhibit O of RAE’s OHA Health Plan Contract for all Health Share members.

d. RAE shall commence submitting encounter data (837, NCPDP, APAC) and Enrollment Reconciliation Certification Forms to Health Share in the form, and according to the timing requirements, adopted into Health Share policies and procedures.

e. RAE shall receive and process the following electronic data files when transmitted by Health Share: (i) member enrollment/eligibility files (834); (ii) payment remittance (820); (iii) electronic payment remittance advice (835); and (iii) 7/11 Rx files, if applicable. RAE shall process member terminations received from OHA before processing new member enrollments received from Health Share.

f. RAE shall designate and make available to Health Share and OHA an individual with whom to communicate regarding HIT and health information systems issues, notifications and resolutions.

g. **Electronic Health Information.** To the extent possible, RAE shall cooperate in communicating with Health Share and other Providers, including a Member’s PCPCH, to coordinate care in a timely manner, using health information technology (HIT) to the maximum extent feasible.

**Part 8 – Operations**

1. **Accountability and Transparency of Operations.**

a. Exhibit B, Part 8, Section 1 of the Core Contract shall be Delegated to RAE, Sections 1.c, 1.f, 1.g and 1.i excepted.
b. RAE shall assist Health Share with the development and distribution of survey instruments and participate in other evaluation procedures described in the Core Contract, Exhibit B, Part 8, Section 1.c.

c. RAE shall review its policies and procedures on a regular basis, and update them as needed.

d. RAE shall submit timely, accurate and complete reports to Health Share as Health Share may reasonably request from RAE in writing.

2. **Privacy, Security and Retention of Records.** Exhibit B, Part 8, Section 2 of the Core Contract shall be Delegated to RAE.

3. **Payment Procedures.** Exhibit B, Part 8, Section 3 of the Core Contract shall be Delegated to RAE. RAE shall notify Health Share immediately upon identification of any known or suspected overpayment.

4. **Claims Payment.** Exhibit B, Part 8, Section 4 of the Core Contract shall be Delegated to RAE; Section 4.f excepted. RAE shall pay claim Indian Health Care Providers for Covered Services provided to any AI/AN enrolled with RAE who are eligible to receive services from such providers, in accordance with the following:

   a. If RAE has executed a subcontractor arrangement with an Indian Health Care Provider in accordance with Exhibit B, Part 4, Section 10 of this Agreement, RAE shall pay claims of such Indian Health Care Provider in accordance with the terms and conditions of that specific subcontract.

   b. If RAE has not executed a subcontractor arrangement with the Indian Health Care Provider that furnished Covered Services to the AI/AN Member enrolled with RAE, RAE shall pay claims of such Indian Health Care Provider in accordance with the terms and conditions of the coverage agreement negotiated and executed by and between Health Share and the Indian Health Care Provider, if any.

   c. If neither Health Share nor RAE has not executed an arrangement with the Indian Health Care Provider that furnished Covered Services to the AI/AN Member enrolled with RAE, RAE shall pay claims of such Indian Health Care Provider at a rate equal to the amount of payment that the Contractor would make for the services if the services were furnished by a Participating Provider which is not an Indian Health Care Provider.

5. **Medicare Payers and Providers.** Exhibit B, Part 8, Section 5 of the Core Contract shall be Delegated to RAE; Section 5.a excepted. RAE shall demonstrate to Health Share on a yearly basis that its Provider Network is adequate to provide both the Medicare and the Medicaid Covered Services to its Fully Dual Eligible population.
6. **Eligibility Verification for Fully Dual Eligible Clients.** If RAE is affiliated with or contracts with an entity that provides services as a Medicare Advantage plan serving Fully Dual Eligibles, Exhibit B, Part 8, Section 6 of the Core Contract shall be delegated to RAE.

7. **Encounter and Claims Data.** RAE shall cooperate with and assist Health Share to fulfill its obligations under the Core Contract, Exhibit B, Part 8, Section 7 entitled “Encounter and Claims Data.” Specifically, RAE shall provide to Health Share valid Encounter Claims Data, Pharmacy Data and other necessary reports and information referenced in Exhibit B, Part 8, Section 7 of the Core Contract in the manner and form directed by Health Share.

8. **Encounter Claims Data (Non-Pharmacy).** RAE shall cooperate with and assist Health Share to fulfill its obligation under the Core Contract, Exhibit B, Part 8, Section 8 entitled “Encounter Claims Data (Non-Pharmacy).”

9. **Encounter Pharmacy Data.** RAE shall cooperate with and assist Health Share to fulfill its obligations under the Core Contract, Exhibit B, Part 8, Section 9 entitled “Encounter Pharmacy Data.”

10. **Administrative Performance Program.** RAE shall cooperate with and assist Health Share to fulfill its obligations under the Core Contract, Exhibit B, Part 8, Section 10 entitled “Administrative Performance Program.”

11. **Third Party Liability and Personal Injury Liens.** Exhibit B, Part 8, Section 11 of the Core Contract shall be Delegated to RAE. Section 11.d excepted. RAE shall submit its written policies regarding Third Party Recovery to Health Share as requested by Health Share. RAE shall also, at Health Share’s request, attest to Health Share that those policies and procedures are current and conform to applicable state and federal laws. Health Share and RAE shall work together to develop a mutually agreeable system to ensure that services rendered that are eligible for payment by a third party are appropriately identified and processed, pursuant to existing regulations and the Core Contract.

12. **Drug Rebate Program.** RAE shall make best effort to furnish to Health Share the information requested by Health Share regarding rebates for any covered outpatient drug provided by RAE and its Participating Providers. RAE shall report prescription drug data within 45 days of the date of service and as specified in Exhibit B, Part 8, Sections 8 and 9 of this Agreement, including the National Drug Code of each covered outpatient drug dispensed to Members.

13. **All Payers All Claims (APAC) Reporting Program.** RAE shall cooperate with and assist Health Share in its participation in the All Payers All Claims (APAC) reporting system established under ORS 442.464 and 442.466.

14. **Prevention/Detection of Fraud, Waste and Abuse.** RAE shall report to Health Share any Participating Providers identified during the credentialing process who are on the List...
of Excluded Individuals (LEIE) and/or the Excluded Parties List System (EPLS), also known as SAM (System for Award Management). In addition, Exhibit B, Part 8, Section 14 of the Core Contract shall be Delegated to RAE, excepting the following:

a. Sections 14.a.(10) and 14.c, provided, however, that RAE shall review and update, as needed, its Compliance Plan and Fraud, Waste and Abuse policies annually and attest to Health Share, by January 1st of every year this Agreement is in effect, that its Compliance Plan and Fraud, Waste and Abuse policies are current and conform to applicable state and federal laws;

b. Section 14.b.(6), provided, however, that RAE’s Compliance Plan shall include a provision for reporting to Health Share within 45 calendar days when RAE has identified capitation payments or other payments in excess of amounts specified in this Agreement;

c. Section 14.b(7), provided, however, that RAE’s Compliance Plan shall require RAE to promptly report to Health Share all overpayments identified or recovered, specifying overpayments due to fraud, waste and abuse on RAE’s Exhibit L report;

d. Section 14.b.(9), provided, however, that RAE’s Compliance Plan shall include a provision for RAE to promptly report to Health Share information about changes in an enrollee’s circumstances, including changes in an enrollee’s residence and death of an enrollee;

e. Section 14.d, provided, however, that RAE shall provide to Health Share by January 1st of every year this Agreement is in effect a report on the quality of the fraud, waste and abuse program, including the number of preliminary investigations and the number of referrals. The report must also address activities that were performed during the reporting year, describe the outcomes of these activities, and identify proposed or future process improvements to address deficiencies;

f. Section 14.f, provided however that RAE shall promptly refer all suspected cases of Fraud, Waste and Abuse to Health Share and the characteristics of suspicious cases that should be referred are described in the Core Contract, Exhibit B, Part 8, Section 14.f. Further, if RAE is made aware of a credible allegation of fraud for which an investigation by MFCU is pending against a Direct Provider or Participating Provider, RAE shall, upon notification of an investigation by MFCU, suspend payments to the Direct Provider or Participating Provider unless MFCU determines there is good cause not to suspend payments or to suspend payments in part.

15. **Abuse Reporting and Protective Services.** Exhibit B, Part 8, Section 15 of the Core Contract shall be Delegated to RAE.

16. Intentionally omitted.
17. Intentionally omitted.

18. **Credentialing.** Except with respect to Direct Providers, Exhibit B, Part 8, Section 18 of the Core Contract shall be Delegated to RAE. If Participating Providers are not required to be licensed or certified by a State of Oregon board or licensing agency, RAE shall document, certify and report to Health Share on Exhibit G the date that the person’s education, experience, competence, and supervision are adequate to permit the person to perform his or her specific assigned duties.

19. **Subrogation.** RAE shall subrogate to Health Share and OHA any and all claims RAE has or may have against manufacturers, wholesale or retail suppliers, sales representatives, testing laboratories, or other providers in the design, manufacture, marketing, pricing, or quality of drugs, pharmaceuticals, medical supplies, medical devices, durable medical equipment, or other products.

20. Intentionally omitted.

**Part 9 Quality, Transformation, Performance Outcomes and Accountability**

1. Intentionally omitted.

2. **Transformation and Quality Strategy Requirements.** RAE shall assist and cooperate with Health Share in the development and implementation of a Transformation and Quality Strategy and work plan. RAE shall implement the quality assurance and performance improvement measures that are developed by Health Share as part of Health Share’s Transformation and Quality Strategy and work plan. In addition, RAE shall have its own Transformation and Quality Strategy and work plan, which is reviewed by RAE annually and, which contains measures for demonstrating the methods and means by which RAE carries out the performance improvement measures that are developed by Health Share’s Transformation and Quality Strategy and work plan.

3. **Revised Transformation and Quality Strategy.** RAE shall assist and cooperate with Health Share in making changes to Health Share’s and/or RAE’s Transformation and Quality Strategy, at OHA’s request or as required by an amendment to the Core Contract. RAE shall implement the quality assurance and performance improvement measures that are developed by Health Share in the process of revising its Transformation and Quality Strategy.

4. **Transformation and Quality Strategy Monitoring and Compliance Review.** RAE shall assist and cooperate with Health Share in its efforts to cooperate with OHA in providing evidence of progress consistent with Health Share’s Transformation and Quality Strategy and Areas of Transformation.

5. **Transformation and Quality Strategy Deliverables.** RAE shall assist and cooperate with Health Share in the development and submission of Transformation and Quality Strategy Deliverables.
6. **Goals for Transformation and Quality Strategy Amendments.** RAE shall assist and cooperate with Health Share in the establishment of one or more goals for transformation and quality strategy.

7. **Quality and Performance Outcomes.** RAE shall implement the data reporting systems necessary for Health Share to measure its performance on outcomes, quality, and efficiency measures as outlined in the Core Contract and to report such to OHA.

8. **Performance Measurement and Reporting Requirements.** RAE shall plan for and implement the necessary organizational infrastructure to address performance standards established by OHA for the Core Contract, as provided in the Exhibit B, Part 9, Section 8 of the Core Contract.

9. **Quality Performance Improvement Projects.** RAE shall assist, cooperate and participate with Health Share in the development and implementation of ongoing performance improvement projects (PIP) that Health Share designs to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and non-clinical areas that are expected to have favorable effect on health outcomes and Member satisfaction.

10. **Program Requirements.** RAE shall report to Health Share Health Promotion and Disease Prevention Activities, national accreditation organization results and HEDIS measures in the form and frequency directed by Health Share.

11. **External Quality Review.** RAE shall, and shall require its subcontractors and Participating Providers, to cooperate with Health Share and OHA by providing access to records and facilities and sufficient information for the purpose of an annual external, independent professional review of RAE compliance with all applicable state and federal rules, this Agreement and of the quality outcomes and timeliness of, and access to Covered Services furnished under this Agreement.

12. **Monitoring and Compliance Review.** RAE and Health Share intend to work together to monitor RAES progress. Monitoring and oversight will be aligned with review of progress on the Quality Assurance and Performance Improvement Program and Annual Quality Work Plan, as well as overall performance of Agreement deliverables. On identification of performance issues, indications that quality, access or expenditure management goals are being compromised, deficiencies, or issues that affect Member rights or health, Health Share shall address those issues based on its policies and procedures governing performance improvement.

13. **Quality Pool.** OHA has implemented a Quality Pool to be a payment mechanism that rewards CCOs that demonstrate quality of care provided to their Members as measured by their performance or improvement on the outcome and quality measures established by OHA. RAE shall collaborate with Health Share to address outcome and quality measures, as applicable to RAE, and work towards sustained improvement in order to
assist Health Share in meeting or exceeding its performance targets as set by OHA. If earned, Health Share shall distribute monetary incentive payments from the Quality Pool to the RAE based on Health Share’s policies and procedures governing quality pool funds.
Exhibit C – Consideration

1. Payment Types and Rates

a. In consideration of all the Work to be performed under this Agreement, Health Share shall pay RAE a RAE payment for each Member enrolled with RAE under this Agreement according to Health Share’s records (“RAE Payment”). OHA will prorate the RAE Payment for Members who are enrolled mid-month with RAE. The amount of the RAE Payment for each Member shall be:

(1) The amounts described in Exhibit C of the Core Contract, less the amounts described in Exhibit C of the Core Contract attributable to Behavioral Health Services, as identified by Health Share in its sole discretion, which shall be adjusted pursuant to Health Share’s risk adjustment policy adopted and amended if applicable by the Health Share Board of Directors and Health Share members;

(2) Less an amount determined by the Health Share Board of Directors and Health Share members to account for the costs of Health Share administration, reserve funding, transformation funding, and any other costs reasonable and necessary for the effective implementation of this Agreement; and

(3) Beginning on or after July 1, 2013, RAE Payments may be subject to an AP Withhold (APW), pursuant to Health Share policies and the Administrative Performance (AP) Standard implemented by OHA, as described in the Core Contract, Exhibit B, Part 8, Section 10.

b. If RAE has a contractual relationship with a designated Type A, Type B, or Rural critical access hospital, RAE and each said hospital shall provide the following representations and warranties directly to Health Share:

(1) That said contract establishes the total reimbursement for the services provided to persons whose medical assistance benefits are administered by RAE; and

(2) That hospital reimbursed under the terms of said contract is not entitled to any additional reimbursement from OHA for services provided to persons whose medical assistance benefits are administered by RAE.

c. Health Share shall pay RAE all funds received by Health Share directly related to RAE’s activities to establish, train or provide qualifying patient centered medical home services under the Patient Protection and Affordable Care Act of 2010.

d. Intentionally omitted.
e. Intentionally omitted.

f. RAE may also be entitled to additional compensation pursuant to Exhibit B, Part 4, Section 9 of this Agreement for participating in Health Share’s Patient Centered Primary Care Home clinics. The amount of such additional compensation, and the terms and conditions related to such additional compensation, shall be agreed upon by the Health Share Board and its members, and established in subsequent Health Share policies and procedures.

2. **Payment in Full.** The consideration described in this Exhibit C and Exhibit C, Attachment 1 is the total consideration payable to RAE for all work performed under this Agreement.

3. **Changes in Payment Rates.** The RAE Payment rate established in Exhibit C and Exhibit C, Attachment 1 may be changed by amendment to this Agreement by the parties pursuant to Exhibit D, Section 20 of this Agreement.

4. **Timing of RAE Payments**

   a. The date on which Health Share will process RAE Payments for RAE’s Members depends on whether the Enrollment occurred during a weekly or monthly Enrollment cycle.

   (1) For Members enrolled with RAE during a weekly Enrollment cycle, Health Share shall make or cause the RAE Payment to be made to RAE no later than twenty-one (21) calendar days following the date of Member’s Enrollment with RAE, except for those occurrences each year when the weekly and monthly Enrollment start date are the same day.

   (2) For Members enrolled with RAE during a monthly Enrollment cycle, Health Share shall make or cause the RAE Payment to be made to RAE no later the fifteenth (15th) calendar day of the month to which such payments are applicable, except for those occurrences each year when the weekly and monthly RAE Payments coincide with each other.

   b. Both sets of payments described in Subsection a, of this section shall appear on the monthly RAE Payment/Remittance Advice. If RAE believes that there are any errors in the Enrollment information, RAE shall notify Health Share. RAE may request an adjustment to the Remittance Advice no later than 18 months from the affected Enrollment period.

   c. Health Share will make retroactive RAE Payments to RAE for any Member(s) erroneously omitted from the Enrollment transaction files. Such payments will be made to RAE once Health Share manually processes the correction(s).

   d. Health Share will make retroactive RAE Payments to RAE for newborn Members. Such payments will be made to RAE by the fifteenth (15th) calendar
day of the month after Health Share enrolls the newborn Member with RAE.

e. Services that are not Covered Services provided to a Member or for any health care services provided to Clients are not entitled to be paid as Capitated Premium/Payments. Fee-for-service Claims for payment must be billed directly to OHA by RAE, its Subcontractors, or its Participating Providers, all of which must be enrolled with OHA in order to receive payment. Billing and payment of all fee-for-service Claims shall be pursuant to and under OAR Chapter 410, Division 120.

5. Settlement of Accounts

a. If a Member is disenrolled, any RAE Payments received by RAE after the effective date of disenrollment will be considered an overpayment and will be recouped by Health Share from future RAE Payments.

b. Health Share shall have no obligation to make any payments to RAE for any period(s) during which RAE fails to carry out any of the material terms of this Agreement.

c. If RAE requests, or is required by Health Share, to adjust the Service Area or Enrollment Limit or to transfer or reassign Members due to loss of Provider capacity or for other reasons, any delay in executing amendments or completing other obligations pursuant to Exhibit B, Part 4, Section 11, Adjustments in Service Area or Enrollment, may result in recovery of RAE Payments to which RAE was not entitled under the terms of this Agreement.

d. Any payments received by RAE, to which RAE is not entitled under the terms of this Agreement, from Health Share or from any other source shall be considered an overpayment and shall be recovered from RAE.

e. In the event RAE fails to comply with the terms and conditions of this Agreement or Health Share’s policies or procedures, RAE authorizes Health Share to deduct appropriate amounts from future RAE Payments to address such non-compliance, provided, however, the amount of the reduction shall bear a reasonable relationship to the harm caused by such non-compliance. Such RAE Payment deductions may be made in addition to or as an alternative to termination remedies as provided in this Agreement. Before exercising such right, Health Share shall provide RAE with at least thirty (30) days’ prior written notice specifying the amount of the proposed reduction. RAE may dispute the proposed reduction by sending written notice to Health Share prior to the expiration of the thirty (30) day notice period above. If Health Share does not receive a written notice of dispute within the 30-day period, Health Share may exercise its rights under this section. If RAE submits a written notice of dispute with the 30-day period, the parties may engage in a mutually acceptable alternative dispute resolution process or they may exercise any rights provided for in this Agreement,
including those identified in Exhibit D, paragraph 1.

f. Health Share will recover from RAE payments made to RAE for sterilizations and hysterectomies performed where the RAE or its Participating Providers failed to meet the requirements of Exhibit B, Part 2, Section 4.g of the Core Contract, the amount of which will be calculated as described in Exhibit B, Part 9, Section 5.g of the Core Contract.

g. The requirements of this section shall expressly survive the termination of this Agreement, and shall not be affected by any amendment to this Agreement, even if amendment results in modification or reduction of RAE’s Service Area or Enrollment. Termination, modification, or reduction of Service Area does not relieve RAE of its obligation to submit sterilization/hysterectomy documentation for dates of service applicable to Service Areas while they were paid a RAE Payment under this Agreement, nor does it relieve RAE of the obligation to repay overpayment amounts under this section.

6. CCO Risk Corridor. RAE shall support and assist Health Share in the development and subsequent implementation of Health Share policies related to the operation of the CCO Risk Corridors. Specifically, RAE shall fully implement Health Share’s policies related to risk sharing mechanisms in which the RAES may share in higher and lower than adjusted expenses outside of a predetermined target amount for items and services identified in Exhibit C, Section 6 of the Core Contract.

7. Intentionally omitted.

8. Intentionally omitted.

9. Intentionally omitted.

10. Minimum Medical Loss Ratio. This Section 10 is effective only upon CMS's approval of Exhibit C, Section 10 of the Core Contract.

a. Definitions. For purposes of the Minimum Medical Loss Ratio (“MMLR”) methodology and calculations, the definitions set forth in Exhibit C, Section 10.b of the Core Contract shall apply.

b. MMLR Standard. In accordance with CMS 42 CFR 438.8, during each Rebate Period, RAE shall maintain a MMLR of at least 85% for its total Member population and shall submit an annual certified MMLR Rebate Report which validates its compliance with this requirement. For each Rebate Period, if RAE's MMLR for the total Member population is below 85%, RAE shall pay to Health Share the dollar amount which, if added to RAE’s Total Incurred Medical Related Costs for the Rebate Period, would result in a Medical Loss Ratio equal to 85%. Health Share shall confirm with RAE the amount of any payment due to Health
Share pursuant to this Section.

c. MMLR Report. Within one hundred and twenty (120) calendar days after the conclusion of each Reporting Period, RAE shall report its MMLR to Health Share utilizing the Minimum Medical Loss Ratio Rebate Calculation Template (Excel Workbook) and following the Minimum Medical Loss Ratio Rebate Calculation Report Instructions to be provided by Health Share, as well as in accordance with CMS Rules 42 CFR 438.8. When the MMLR Reporting Rebate Calculation Report Instructions do not resolve an issue, the CMS Instructions shall control, except where inconsistent with this Section 10. All information reported by RAE on the MMLR Rebate Report must be for revenues and expenses related to this Agreement.
Exhibit D – Standard Terms and Conditions

1. **Governing Law, Consent to Jurisdiction.** RAE agrees that this Agreement shall be governed, and that RAE consent to legal jurisdiction, in accordance with the provisions of the Core Contract, Exhibit D, Section 1 which shall be incorporated herein by reference except that any claim that arises from or relates to this Contract shall be brought and conducted solely and exclusively within the Circuit Court of the County where the claim arises or relates.

2. **Compliance with Applicable Law.** RAE agrees to comply with applicable law in the performance of its duties and obligations of this Agreement, as expressed in the Core Contract, Exhibit D, Section 2 which shall be incorporated herein by reference.

3. **Independent Contractor**
   
a. The relationship between Health Share and RAE is an independent contractor relationship. Neither RAE nor its Participating Providers, employees or agents are employees or agents of Health Share, except as otherwise specifically stated by written agreement between the parties. Neither Health Share nor its employees or agents are members, partners, employees or agents of RAE. None of the provisions of this Agreement shall be construed to create a relationship of agency, representation, joint venture, ownership, control or employment between the parties other than that of independent parties contracting solely for the purpose of effectuating this Agreement. Nothing contained in this Agreement shall cause either party to be liable or responsible for any debt, liability or obligation of the other party or any third party unless such liability or responsibility is expressly assumed by the party sought to be charged therewith. In all communications with each other and with outside individuals and entities, neither Health Share nor RAE shall hold itself out as being responsible for the debts or activities of the other party. Health Share and RAE shall each maintain its own separate corporate identity.

   b. RAE agrees it shall be subject to the “Independent Contractor” provisions that apply to “Contractor” with respect to work performed under contract or subcontract for the State of Oregon or the federal government as stated in the Core Contract, Exhibit D, Section 3, which shall be incorporated herein by reference.

4. **Representations and Warranties**
   
a. **RAE’s Representations and Warranties.** RAE represents and warrants to Health Share that:

   (1) RAE satisfies, shall comply with, or otherwise meets the representations
and warranties that apply to “Contractor” as stated in the Core Contract, Exhibit D, Section 4;

(2) All Covered Services provided or arranged by RAE shall be provided or arranged by duly licensed, certified or otherwise authorized professional personnel in accordance with (i) the generally accepted medical, dental and/or surgical practices and standards prevailing in the applicable professional community at the time of treatment, (ii) the provisions of Health Share’s quality initiative described in Exhibit B, Part 9 of this Agreement, and (iii) the requirements of state and federal laws;

(3) Each of RAE’s Participating Providers shall maintain in good standing at all times during the term of this Agreement the necessary licenses or certifications required by State and Federal Law to provide or arrange Covered Services to Members;

(4) Unless otherwise specified by RAE and approved by Health Share for specific Participating Providers, each of RAE’s Participating Providers who is a physician shall maintain in good standing at all times during the term of this Agreement medical staff membership and clinical privileges at licensed acute care hospitals in RAE’s service area which have entered into a written agreement with RAE or Health Share to provide hospital services to Members;

(5) RAE is a legal entity duly organized, validly existing and in good standing under the laws of the State or Oregon. Neither the execution and delivery by RAE of this Agreement, nor compliance with any of the material provisions hereof by RAE, (i) will violate, conflict with or result in a breach of any material provision of RAE’s articles of incorporation or bylaws, (ii) will violate any judgment, order or decree of any court or other governmental agency or authority to which RAE or any affiliate of RAE is subject, or (iii) will violate any law, rule, regulation, or ordinance to which RAE or any affiliate of RAE is subject the violation of which would have a material adverse effect on Health Share or the continuation of this Agreement;

(6) RAE shall provide Medically Appropriate services that RAE is obligated to provide, under law or under this Agreement, to a Member covered under this Agreement;

(7) RAE shall not impose on Members premiums or charges that are in excess of the premiums or charges permitted under the Medical Assistance Program;

(8) RAE shall not commit acts to discriminate among Members on the basis of their health status or need for health care services. This includes, but is not limited to, termination of Enrollment or refusal to reenroll a Member,
except as permitted under the Medical Assistance Program, or any practice that would reasonably be expected to discourage Enrollment by individuals whose medical condition or history indicates probable need for substantial future medical services;

(9) RAE shall not misrepresent or falsify any information that it furnishes to CMS, the State of Oregon, OHA, or Health Share, including but not limited any certification, any report required to be submitted under this Contract, encounter data or other information relating to care or services provided to a Member;

(10) RAE shall not misrepresent or falsify information that it furnishes to a Member, Potential Member, or health care Provider;

(11) RAE shall comply with the requirements for Physician Incentive Plans, as set forth in 42 CFR 422.208 and 422.210;

(12) RAE shall maintain a Participating Provider Panel sufficient to ensure adequate capacity to provide Covered Services under this Agreement;

(13) RAE shall follow the accounting principles and accounting standards required by federal or State laws, rule or regulation, or this Agreement;

(14) RAE shall make timely Claims payment to Providers and shall provide timely approval of authorization requests;

(15) RAE shall comply with any of the other applicable requirements of sections 1903(m) or 1932 of the Social Security Act and any implementing regulations; and

(16) RAE has been provided a copy of Health Share’s compliance plan (“Compliance Plan”), and RAE agrees to follow the processes and provisions in such Compliance Plan as the same may be updated, amended, modified or supplemented from time to time in the sole discretion of Health Share, including without limitation, those provisions providing mechanisms for identifying and addressing compliance problems related to RAE’s operations and performance. RAE also agrees to participate in education programs relating to the Compliance Plan.

b. **Warranties cumulative.** The warranties set forth in this section are in addition to, and not in lieu of, any other warranties provided by RAE

5. **[Reserved]**

6. **Funds Available and Authorized; Payments.** RAE understands and agrees that Health Share’s payment for Work performed under this Agreement is contingent on OHA receiving appropriations, limitations, allotments, or other expenditure authority sufficient
to allow OHA, in the exercise of its reasonable discretion, to continue to make payments to Health Share under the Core Contract. As a result, RAE’s payment hereunder from Health Share is contingent upon OHA making anticipated payments to Health Share.

7. **Recovery of Overpayments.** Health Share shall have the right to recoup any and all amounts owed by RAE to Health Share against amounts owed by Health Share to RAE. Health Share’s right to recoup shall include, without limitation, the following amounts owed to Health Share by RAE: (i) amounts owed by RAE due to overpayments or payments made in error by Health Share; (ii) amounts owed by RAE as a result of the outcome of the Member appeals and grievance procedure; (iii) amounts owed by RAE to reflect retroactive deletions of Members based on determinations of Members’ eligibility; and (iv) any amounts owed by Health Share to third parties, including but not limited to OHA and any other state or federal governmental agencies, that are caused by RAE’s failure to comply with the term and conditions of this Agreement or Health Share’s policies and procedures. Before exercising such right, Health Share shall provide RAE with at least thirty (30) days’ prior written notice specifying the amount to be recouped. RAE may dispute the recoupment by sending written notice to Health Share prior to the expiration of the thirty (30) day notice period above. If Health Share does not receive a written notice of dispute within the 30-day period, Health Share may exercise its rights under this section. If RAE submits a written notice of dispute with the 30-day period, the parties may engage in a mutually acceptable alternative dispute resolution process or they may exercise any rights provided for in this Agreement, including those identified in Exhibit D, paragraph 1.

8. [Reserved]

9. **Indemnification.** To the extent permitted by Article XI, Section 7 of the Oregon Constitution and by Oregon Tort Claims Act, RAE shall defend, indemnify and hold harmless Health Share and its directors, officers, employees, affiliates and agents against any claim, loss, damage, cost, expense or liability arising out of or related to (i) RAE’s breach of this Agreement, and (ii) the performance or nonperformance by RAE, its Participating Providers, employees or agents of any Covered Services and other services to be performed or arranged by RAE and its Participating Providers under this Agreement. Health Share shall defend, indemnify and hold harmless RAE and its directors, officers, employees, affiliates and agents against any claim, loss, damage, cost, expense or liability arising out of or related to (i) Health Share’s breach of this Agreement, and (ii) the performance or nonperformance by Health Share under this agreement.

10. **Default; Remedies; and Termination.** Health Share may terminate this Agreement as set forth below.

   a. **Causes for Termination of Agreement by Health Share.** The following shall constitute cause for termination of this Agreement by Health Share.

      (1) **Insolvency by RAE.** RAE becomes insolvent, as reasonably determined
by Health Share. RAE shall have the opportunity to dispute such determination by Health Share by providing reasonable evidence and assurances of financial stability and capacity to perform under this Agreement within fifteen (15) days of Health Share’s determination.

(2) **Failure to Provide Quality Services.** RAE’s failure to arrange or provide Covered Services in accordance with the standards set forth in this Agreement.

(3) **Breach of Material Term and Failure to Cure.** RAE’s breach of any material term, covenant or condition of this Agreement and subsequent failure to cure such breach as provided below.

(4) **Failure to Submit Encounter Data.** RAE’s failure at any time during the term of this Agreement to submit complete Encounter and Pharmacy Data required pursuant to Exhibit B, Part 8, Section 7 of this Agreement.

(5) **Conduct of RAE Owner, Employee or Contractor.** RAE knowingly has a director, officer, partner or person with beneficial ownership interest in RAE or has an employment, consulting or other Subcontractor agreement for the provision of items and services that are significant and material to RAE’s obligations under this Agreement, concerning whom: (i) Any license or certificate required by law or regulation to be held by RAE or Subcontractor to provide services required by this Agreement is for any reason denied, revoked or not renewed; or (ii) Is suspended, debarred or otherwise excluded from participating in procurement activities under Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order; or (iii) Is suspended or terminated from the Oregon Medical Assistance Program or excluded from participation in the Medicare program; or (iv) Is convicted of a felony or misdemeanor related to a crime or violation of Title XVIII, XIX, or XX of the Social Security Act or related laws (or entered a plea of nolo contendere); (v) If OHA or Health Share determines that health or welfare of Members is in jeopardy if this Agreement continues.

b. **Health Share’s Remedies.** If any circumstance described in Section 10.a has occurred, Health Share may, at its option, enforce any or all of the remedies available to it under this Agreement and at law or in equity, including, but not limited to those described below. These remedies are cumulative to the extent the remedies are not inconsistent, and Health Share may pursue any remedy or remedies singularly, collectively, successively, or in any order whatsoever.

(1) Immediate termination of this Agreement, following: (i) written notice from Health Share, (ii) an opportunity for RAE and Health Share to meet and discuss RAE’s breach, and (iii) an opportunity for RAE to cure the
breach, which cure period shall be not less than thirty (30) calendar days.

(2) Deductions from future RAE Payments under Exhibit C, Section 5.e of this Agreement;

(3) Withholding all RAE Payments due for Work that RAE has failed to deliver within any scheduled completion dates or has performed inadequately or defectively;

(4) PMPM deductions under Exhibit C of this Agreement;

(5) Initiation of an action or proceeding for damages, specific performance, declaratory or injunctive relief; and

(6) Exercise of its right of recovery of overpayments under Exhibit D, Section 7 of this Agreement.

c. Health Share’s Termination Without Cause. At its discretion, Health Share may terminate this Contract without cause under any of the following circumstances:

(1) Upon 120 days’ prior written notice to RAE;

(2) Immediately upon written notice to RAE if OHA fails to receive funding, appropriations, limitations, allotments or other expenditure authority sufficient to allow OHA to continue to make full payments to Health Share under the Core Contract; or

(3) Immediately upon written notice to RAE if federal or State laws, regulations, guidelines or CMS waiver terms are modified or interpreted in such a way that Health Share’s purchase or continued use of the Work or Work Products under this Agreement is prohibited; or

(4) Immediately upon written notice to RAE if there is a threat to the health, safety or welfare of any Member under its care; or

(5) Immediately if RAE ceases to be a corporate member in good standing of Health Share.

(6) Immediately upon termination of the Core Contract.

d. RAE’s Termination.

(1) RAE may terminate this Agreement without cause:

   a. Upon 120 days prior written notice to Health Share;
RAE may terminate this Agreement for cause if:

a. Health Share fails to pay RAE any amount pursuant to the terms of this Agreement, net of any reduction for overpayment or other offset, and Health Share fails to cure such failure within fifteen (15) calendar days after delivery of RAE’s notice of such failure to pay or such longer period as RAE may specify in such notice;

b. Health Share commits any material breach or default of any covenant, warranty, or obligation under this Agreement, and such breach or default is not cured within thirty (30) calendar days after RAE’s notice or such period as RAE may specify in such notice;

c. Health Share institutes or has instituted against it insolvency, receivership or bankruptcy proceedings; or

d. The Core Contract terminates for any reason;

e. **Actions Following Notice of Termination.** After providing or receiving notice of termination, RAE shall:

   (1) Submit to Health Share a Transition Plan detailing how RAE will fulfill its continuing obligations under this Agreement and identifying an individual (with contact information) as RAE’s transition coordinator. The Transition Plan is subject to approval by Health Share. RAE shall make revisions to the plan as requested by Health Share. Failure to submit a Transition Plan and obtain written approval of the Transition Plan by Health Share may result in Health Share extending the termination date by the amount of time necessary in order for Health Share to provide a Transition Plan or approve the Transition Plan submitted by RAE. The Transition Plan shall include the prioritization of high-needs Members for care coordination and any other Members requiring high level coordination.

   (2) Submit reports to Health Share every thirty (30) calendar days, or as otherwise agreed upon in the Transition plan, detailing RAE’s progress in carrying out the Transition Plan. RAE shall submit a final report to Health Share describing how RAE has fulfilled all its obligations under the Transition Plan including resolution of any outstanding responsibilities.

   (3) Maintain adequate staffing to perform all functions specified in this Agreement.

   (4) Promptly supply all information requested by Health Share for reimbursement of any claims outstanding at the time of termination.
(5) Promptly make available any signed RAE Provider agreements requested by Health Share for the purpose of accomplishing the Transition Plan.

(6) Cooperate with Health Share to arrange for orderly and timely transfer of Members from coverage under this Agreement to coverage under new arrangements authorized by Health Share. Such actions of cooperation shall include but are not limited to RAE:

   a. Forwarding of all records related to Members, including high-needs care coordination.

   b. Facilitating and scheduling of medically necessary arrangements or appointments for care and services, including arrangements or appointments with Participating Providers for dates of service after the termination date.

   c. Identifying chronically ill, high risk, and hospitalized Members.

   d. Continuing to provide care coordination until appropriate transfer of care can be arranged for those Members in a course of treatment for which a change of providers could be harmful.

(7) Make available (including as applicable requiring Participating Providers to make available), to Health Share, copies of medical, behavioral, dental and case care management records, Member files, and any other pertinent information, including information maintained by any subcontractor, as Health Share deems necessary for effective Care Management of Members. Such records shall be in a usable form and shall be provided at no expense to Health Share or the Member, using a file format and dates for transfer specified by Health Share.

(8) Arrange for the retention, preservation, and availability of all records under this Agreement, including, but not limited to those records related to Member grievance and appeal records, litigation, base data, medical loss ratio data, financial reports, claims settlement information, as required by this Agreement and state and federal laws.

f. **Actions Following Termination.** After the effective date of termination of this Agreement, RAE shall:

   (1) Maintain compliance with all financial requirements set forth in this Agreement, including but not limited to restricted reserves and insurance coverage, for eighteen (18) months following the date of termination, or until Health Share provides RAE written release agreeing that all continuing obligations of this Agreement have been fulfilled, whichever is earlier.
(2) Maintain claims processing functions as necessary for a minimum of eighteen (18) months after the date of termination (or longer if it is likely there are additional claims outstanding) in order to complete adjudication of all claims and appeals.

(3) Assist Health Share with Grievances and Appeals for dates of service prior to the termination date.

(4) Submit financial reporting deemed necessary by Health Share, including but not limited to the statements and reports set forth in Exhibit L of this Agreement, such as the Quarterly Financial Reports and annual AFS, up to the date specified by Health Share, and final reports on the status of any existing third-party liability or personal injury lien cases.

g. **Continuity of Care.** In the event of termination of this Agreement or at the end of the term of this Agreement if the parties do not execute a new Agreement, the following provisions shall apply to ensure continuity of the Work by RAE. RAE shall ensure:

(1) Continuation of services to Members for the period in which Health Share has paid RAE Payments to RAE, including inpatient admissions up until discharge;

(2) Orderly and reasonable transfer of Member care in progress, whether or not those Members are hospitalized;

(3) Timely submission of information, reports and records, including encounter data, required to be provided to Health Share and OHA during the term of this Agreement;

(4) Timely payment of Valid Claims for services to Members for dates of service included in the Agreement year; and

(5) If RAE continues to provide services to a Member after the date of termination, Health Share shall have no responsibility to pay for such services.

h. **Accounting of Payments.** Upon termination, Health Share shall conduct an accounting of RAE Payments paid or payable and Members enrolled during the month in which termination is effective and shall be accomplished as follows:

(1) **Mid-Month Termination or Expiration.** For a termination of this Agreement that occurs during mid-month, RAE Payments shall be apportioned on a daily basis. RAE shall be entitled to RAE Payments for the period of time prior to the date of termination and Health Share shall be
entitled to a refund for the balance of the month.

(2) **Responsibility for Payments/Claims.** RAE is responsible for any and all claims from Participating Providers or other Subcontractors for Covered Services provided prior to the termination date.

(3) **Notification of Outstanding Claims.** RAE shall promptly notify OHA of any outstanding claims for which OHA may owe, or be liable for, a fee-for-service payment(s), which are known to RAE as the time of termination or when such new claims incurred prior to termination are received. RAE shall supply OHA with all information necessary for reimbursement of such claims. Health Share is not responsible for fee-for-service payment(s) for such claims.

(4) **Responsibility to Complete Contractual Obligations.** RAE is responsible for completing submission and corrections to encounter data for Covered Services received by Members during the period of this Agreement. RAE is responsible for submitting financial and other reports required during the period of this Agreement.

(5) **Withholding.** If this Agreement is terminated for any reason and Health Share has not approved a Transition Plan by sixty days before the termination date, then Health Share may withhold RAE Payments due to RAE until Health Share has given written approval to RAE’s Transition Plan.

11. **Limitation of Liabilities**

   a. Neither party shall be liable for incidental or consequential damages arising out of or related to this Agreement. Neither party shall be liable for any damages of any sort arising solely from the termination of this Agreement or any part hereof in accordance with its terms.

   b. RAE shall ensure that Health Share is not held liable for any of the following:

      (1) Payment for RAE’s or any Subcontractor’s debts or liabilities in the event of insolvency; or

      (2) Covered Services authorized or required to be provided under this Agreement.

12. **Insurance.** RAE shall maintain insurance as set forth in Exhibit F of this Agreement.

13. **Access to Records and Facilities.** Exhibit D, Section 13 of the Core Contract shall be Delegated to RAE.

14. **Information Privacy/Security/Access.** Exhibit D, Section 14 of the Core Contract shall
be Delegated to RAE.

15. **Force Majeure.** RAE shall be subject to the rights conferred on “Contractor” as stated in the Core Contract, Exhibit D, Section 15.

16. **Foreign Contractor.** If RAE or any Participating Provider is not domiciled in or registered to do business in the State of Oregon, RAE shall promptly provide to the Department of Revenue and the Secretary of State Corporation Division all information required by those agencies relative to this Agreement.

17. **Assignment of Contract, Successors in Interest**

   a. RAE shall not assign or transfer its interest in this Agreement, voluntarily or involuntarily, whether by merger, consolidation, dissolution, operation of law, or in any other manner, without prior written consent of Health Share, which shall not be unreasonably withheld. Any such assignment or transfer, if approved, is subject to such conditions and provisions as Health Share may deem necessary. No approval by Health Share of any assignment or transfer of interest shall be deemed to create any obligation of Health Share in addition to those set forth in the Contract.

   b. The provisions of this Agreement shall be binding upon and inure to the benefit of the parties, their respective successors and permitted assigns.

18. **Subcontracts**

   a. **RAE’s Subcontracts with Participating Providers.** RAE shall demonstrate and certify to Health Share prior to the Effective Date and upon Health Share’s written request at any time during the term of this Agreement, and in the format specified by Health Share, that its subcontracts with Participating Providers comply with requirements of this Agreement. RAE shall make best efforts to amend any and all of its existing subcontracts with Participating Providers which do not comply with this Agreement and shall provide Health Share with certification thereof at Health Share’s request. Without limiting any other provision of this Agreement, all of RAE’s subcontracts with Participating Providers shall require Participating Providers to look solely to RAE for payment for Covered Services rendered by Participating Providers to Members.

      1) **Participating Provider Information.** RAE shall provide Health Share with a complete list of its Participating Providers, together with the provider specific information required by Health Share, at the time of initial contracting with Health Share and at any other time as required by this Agreement and/or Health Share policies and procedures.

      2) **Notice of Participating Provider Terminations.** RAE shall provide sixty (60) calendar days prior written notice to Health Share of the termination
of any of its Participating Providers; provided, however, that if any Participating Providers are terminated with less than sixty (60) calendar days’ notice, then RAE shall provide written notice to Health Share within five (5) business days of RAE becoming aware of such termination. Notwithstanding the termination of any Participating Providers, RAE shall remain responsible for providing or arranging Covered Services through its remaining Participating Provider and shall remain financially responsible for Covered Services furnished to Members under this Agreement.

(3) **Restriction, Suspension or Termination of Participating Providers.** RAE shall, as warranted, immediately restrict, suspend or terminate its Participating Providers from providing or arranging Covered Services to Members in the following circumstances: (i) the Participating Provider ceases to meet the licensing/certification requirements or other professional standards described in this Agreement; or (ii) Health Share or RAE reasonably determines that there are serious deficiencies in the professional competence, conduct or quality of care of the Participating Provider which affects or could adversely affect the health or safety of Members. RAE shall immediately notify Health Share of any of its Participating Providers who cease to meet the licensing/certification requirements or other professional standards described in this Agreement and RAE’s actions under this Section. If RAE fails to act as required by this Section with respect to its Participating Providers, Health Share shall have the right to immediately prohibit such Participating Providers from continuing to provide Covered Services to Members.

(4) **Compliance with Provisions of this Agreement.** RAE’s subcontracts with Participating Providers shall be in writing. All such subcontracts shall be consistent with the terms and conditions of this Agreement. If this Agreement is amended or modified, all such subcontracts shall be amended or modified within thirty (30) calendar days to be consistent with such amendments or modifications, upon the direction of Health Share.

(5) **Compliance with Requirements of State and Federal Laws.** RAE’s subcontracts with Participating Providers shall comply with the standards of state and federal laws. If there are changes in such requirements, RAE shall make best effort to amend its subcontracts with Participating Providers to comply with such changes within thirty (30) calendar days following notice thereof from Health Share.

(6) **Access by Health Share and Government Agencies to Subcontracts and Books and Records of Participating Providers.** RAE shall make available for inspection, examination and copying by Health Share and Government Agencies during normal business hours (i) its Participating Provider subcontracts and (ii) books and records of its Participating Providers relating to Covered Services provided to Members. Copies of subcontracts
and the books and records of Participating Providers shall be maintained for at least seven years from the close of the fiscal year in which Covered Services were provided.

(7) **RAE’s Responsibility for Providing or Arranging Covered Services.** Notwithstanding the existence of RAE’s subcontracts with its Participating Providers, RAE shall remain responsible for satisfying the obligations of RAE set forth in this Agreement. If any of RAE’s subcontracts with Participating Providers are terminated, RAE shall remain responsible for providing or arranging Covered Services through its remaining Participating Providers and shall remain financially responsible for Covered Services provided to Members under this Agreement.

b. **Required Terms of Subcontracts.** In addition to the other requirements provided in this Agreement and pursuant to applicable law, Covered Services shall be provided primarily by Participating Providers with whom RAE has employed or contracted for the provision of Covered Services. All subcontracts of RAE in connection with this Agreement shall contain the following terms:

(1) Describe adequately the responsibilities of the Participating Provider and RAE in connection with the subcontract;

(2) Require the Participating Provider to comply with the provisions of this Agreement related to billing Members;

(3) Require the Participating Provider to participate in Health Share’s quality initiatives described in Exhibit B, Part 9 of this Agreement;

(4) Require the Participating Providers to provide Covered Services to Members for the period in which Health Share paid RAE Payments for such services;

(5) Have a term of not less than one (1) year, subject to the termination provisions as may be set forth in the subcontract between RAE and the Participating Provider;

(6) Require the Participating Provider to carry insurance as required by Health Share and to provide certificates of insurance to Health Share upon its request; and

(7) Set forth provisions consistent with the provisions of Exhibit D, Section 10 of this Agreement and pertaining to either the terminations of this Agreement or the termination of the subcontract between RAE and the Participating Provider.

19. **No Third Party Beneficiaries.** This Agreement shall not create any rights in any third
parties who have not entered into this Agreement, nor shall this Agreement entitle any such third party to enforce any rights or obligations that may be possess by such third party.

20. Amendments

a. Mutual Amendment. The terms of this Agreement may be amended from time to time in a writing signed by Health Share and the RAE.

b. Notice Amendments. Upon any amendment made to the Core Contract pursuant to Exhibit D, Section 20, Health Share may unilaterally amend this Agreement to the extent it is required to do so to remain in compliance with the terms of the Core Contract by providing sixty (60) calendar days written notice to RAE of the amendment to the Agreement (“Notice Amendment”). Upon receipt of a Notice Amendment, RAE shall promptly give written notice of such amendments to those of its Participating Providers affected by the amendment. RAE may reject Notice Amendments by terminating this Agreement in accordance with Exhibit D, Section 10.d of the Agreement. If no notice of termination is received by Health Share, Notice Amendments shall be binding upon RAE and its Participating Providers at the end of the sixty (60) calendar-day period, and this Agreement shall be deemed amended as of that date, or as of the date specified in the Notice Amendment, even if not signed by the RAE.

The notice period for Notice Amendments required due to the following conditions shall be thirty (30) calendar days:

(1) If Health Share is required to amend this Agreement due to changes in federal or State statute or regulations, or due to changes in Covered Services and CCO Payments under ORS 414.735, and if failure to amend this Agreement to execute those changes in the time and manner proposed in the amendment may place Health Share at risk of non-compliance with federal or State statute or regulations or the requirements of the Legislature or Legislative Emergency Board.

(2) To address budgetary constraints, including those arising from changes in OHA’s funding, appropriations, limitations, allotments, or other expenditure authority limitations.

(3) If OHA’s actuary recalculates CCO Payment Rates under Exhibit C, Section 2.

(4) If the Core Contract is amended to reduce or expand Health Share’s Service Area, reduce or expand Health Share’s Enrollment Limit, or both, and a CCO Payment Rate change is made.

c. Effective Date of Amendments. The effective date of any amendment to this
Agreement shall be the date specified in the mutually signed writing or in the Notice Amendment, as applicable. However, any changes in the CCO Payment rates under ORS 414.735 shall take effect on the date approved by the Legislative Assembly or the Legislative Emergency Board. Any changes required by Federal or State law or regulation shall take effect not later than the effective date of the Federal or State law or regulation.

21. **Waiver.** No waiver or other consent under this Contract shall bind either party unless it is in writing and signed by the party to be bound. Such waiver or consent shall be effective only in the specific instance and for the specific purpose given. The failure of either party to enforce any provision of this Contract shall not constitute a waiver by that party of that or any other provision.

22. **Severability.** The unenforceability or invalidity of any paragraph or subparagraph of any section or subsection of this Agreement shall not affect the enforceability and validity of this balance of this Agreement.

23. **Survival.** The parties agree that, notwithstanding anything else herein to the contrary, any representations and warranties of the parties and those covenants set forth at Exhibit D, Section 4 of this Agreement, and Sections 1, 6, 7, 9, 11, 13, 14, 17, 19, 21 and 22 of this Exhibit D shall survive any termination of this Agreement.

24. **Notices.** All notices required or permitted by this Agreement shall be in writing and may be delivered in person or may be sent by registered or certified mail or U.S. Postal Service Express Mail, with postage prepaid, or by Federal Express or other overnight courier that guarantees next day deliver, or by facsimile transmission, and shall be deemed sufficiently given if served in the manner specified in this Section. The addresses below shall be the particular party’s address for delivery or mailing of notice purposes:

If to Health Share:

Health Share of Oregon
2121 SW Broadway, Suite 200
Portland, OR 97201

If to RAE:

__________________________
__________________________
__________________________

The parties may change the names and addresses noted above through written notice in compliance with this Section. Any notice sent by registered or certified mail, return receipt requested, shall be deemed given on the date of delivery shown on the receipt card, or if no delivery date is shown, the postmark date. Notices delivered by U.S. Postal Service Express mail, Federal Express or overnight courier that guarantees next day delivery shall be deemed given twenty-hour (24) hours after delivery of the notice to the
United States Postal Service, Federal Express or overnight courier. If any notice is transmitted by facsimile transmission or similar means, the notice shall be deemed served or delivered upon telephone confirmation of receipt of the transmission, provided a copy is also delivered via delivery or mail.

25. **Construction.** The provisions of this Agreement are to be interpreted and their legal effects determined as a whole. A court interpreting this Agreement shall give a reasonable, lawful and effective meaning to this Agreement to the extent possible. The rule of construction that ambiguities in a written agreement are to be construed against the party preparing or drafting the agreement shall not be applicable to the interpretation of this Agreement.

26. **Headings.** The headings and captions to sections of this Agreement have been inserted for identification and reference purposes only and shall not be used to construe the meaning or to interpret this Agreement.

27. **Merger Clause.** This Agreement constitutes the entire agreement between the parties on the subject matter hereof. There are no understandings, agreements, or representations, oral or written, not specified herein regarding this Agreement.

28. **Counterparts.** This Agreement and any subsequent amendments may be executed in several counterparts, all of which when taken together shall constitute one agreement binding on all parties, notwithstanding that all parties are not signatories to the same counterpart. Each copy of this Agreement and any amendments so executed shall constitute an original.

29. **Equal Access.** RAE shall provide or arrange for equal access to Covered Services for both male and female Members under 18 years of age, including access to appropriate facilities, services and treatment, to achieve the policy in ORS 417.270.

30. **Media Disclosure.** RAE shall not provide information to the media regarding a recipient of services under this Agreement without first consulting with and receiving approval from the OHA case manager that referred the child or Family. RAE shall make immediate contact with the OHA office when media contact occurs. The OHA office will assist RAE with an appropriate follow-up response for the media.

31. **Mandatory Reporting.** RAE shall immediately report any evidence of child abuse, neglect or threat of harm to DHS Child Protective Services or law enforcement officials in full accordance with the mandatory Child Abuse Reporting law (ORS 419B.005 to 419B.045). If law enforcement is notified, RAE shall notify the referring caseworker within 24 hours. RAE shall immediately contact the local DHS Child Protective Services office if questions arise whether an incident meets the definition of child abuse or neglect. RAE shall comply, and shall require its Participating Providers to comply, with all protective services, investigation and reporting requirements described in any of the following laws:

a. OAR 407-045-0000 through 407-045-0370 (abuse investigations by the Office of
Investigations and Training);

b. ORS 430.735 through 430.765 (persons with mental illness or developmental disabilities);

c. ORS 124.005 through 124.040 (elderly persons and persons with disabilities abuse), and;

d. ORS 441.650 through 441.680 (residents of long term care facilities).

32. OHA Compliance Review. RAE agrees to cooperate and assist Health Share during the course of any OHA compliance review conducted in accordance with the Core Contract, Exhibit D, Section 32. RAE agrees to cooperate to make records and facilities available for compliance review, consistent with the Core Contract, Exhibit D, Section 13.

33. Intentionally omitted.

34. Intentionally omitted.

35. Intentionally omitted.

36. Intentionally omitted.
Exhibit E – Required Federal Terms and Conditions

RAE shall comply and cause all subcontractors to comply with all applicable standards, policies, orders or requirements that apply to “Contractor” as stated in the Core Contract, Exhibit E.
Exhibit F – Insurance Requirements

Prior to performing under this Agreement, RAE shall obtain and maintain, at RAE’s expense, the types of insurance policies described in Exhibit F, Sections 1 through 9 of the Core Contract, with the per occurrence and aggregate limits described in Exhibit F, Sections 1 through 3 of the Core Contract. RAE shall also obtain and maintain privacy and network security coverage providing protection against liability for (a) system attack; (b) denial or loss of service attacks; (c) spread of malicious software code; (d) unauthorized access and use of computer systems; and (e) liability from the loss or disclosure of confidential data with limits of at least $4 million. If RAE has not already acquired such privacy and network security coverage meeting all of the previously-mentioned requirements at the time this Agreement is executed, RAE shall procure such coverage in a reasonable amount of time after execution and as mutually agreed by Health Share. All of the above described insurance policies shall name Health Share as an additional insured, except if self-insured.

RAE shall maintain such insurance policies in full force and effect throughout the duration of this Agreement. Upon Health Share’s request, RAE shall provide Health Share with certificates of insurance that include the name of the insurance company, the effective date of the policy or policies, and the coverage and limits provided. Said insurance shall require thirty (30) days notification to Health Share by the insurance company prior to any change or cancellation.

RAE may fulfill one or more of its insurance obligations herein through a program of self-insurance, provided that RAE’s self-insurance program complies with all applicable laws, provides coverage equivalent in both type and level to that required in this Exhibit F, and is reasonably acceptable to Health Share. RAE shall furnish an acceptable insurance certificate to Health Share for any insurance coverage required by this Agreement that is fulfilled through self-insurance.
Exhibit G – Reporting of Delivery System Network Providers, Cooperative Agreements and Hospital Adequacy

RAE shall cooperate with and assist Health Share to fulfill its obligations under Exhibit G of the Core Contract entitled “Reporting of Delivery System Network Providers, Cooperative Agreements and Hospital Adequacy.” Specifically, RAE shall submit to Health Share, within a reasonable amount of time prior to the dates specified in Exhibit G of the Core Contract, the information and supporting documentation referenced in Exhibit G of the Core Contract necessary for Health Share to prepare DSN Reports.
Exhibit H – Physician Incentive Plan Regulation Guidance

Exhibit H of the Core Contract shall be Delegated to RAE.
Exhibit I – Grievance System

1. RAE shall develop and implement a Grievance System, supported with written procedures, for Members that includes a Grievance process, Appeal process and access to Contested Case Hearings. RAE shall have only one level of appeal for members and members must complete the appeals process with RAE prior to requesting a state Contested Case Hearing. RAE’s Grievance System shall meet the requirements of Exhibit I Sections 1 through 6 of the Core Contract, OAR 410-141-3225 through 410-141-3255 and 42 CFR 438.400 through 438.424. The Grievance System must include Grievances and Appeals related to requests for accommodation in communication or provision of services for Members with a disability or limited English proficiency. RAE shall include in its Grievance and Appeal procedures a process for Grievances and Appeals concerning communication or access to Covered Services or facilities. RAE shall make its Grievance System procedures available to Health Share for compliance review and approval. Upon any change to RAE’s approved Grievance System procedures, Health Share shall submit the changes to OHA for approval. RAE shall permit Health Share to monitor RAE’s performance on an ongoing basis and perform a formal compliance review at least once a year to assess performance, deficiencies, or areas for improvement. RAE shall further cooperate with Health Share by taking corrective action to remediate deficiencies identified by Health Share.

2. RAE shall provide to all its Participating Providers, at the time they enter into a subcontract, its OHA approved written procedures for its Grievance System, as well as the following Grievance, Notice of Adverse Determination, Appeal and Contested Case Hearing procedures and timeframes as described in Exhibit I, Sections 1-6 of the Core Contract.

3. On a quarterly basis, in accordance with OAR 410-141-3255 and 42 CFR 438.416, RAE shall document all Grievances and Appeals using the approved Grievance and Appeal Log supplied by Health Share.

4. RAE shall submit each prepared Grievance and Appeal Log and a quarterly Grievance System Report to Health Share no later than twenty (20) days following the end of each calendar quarter. RAE shall monitor the data collected from the Grievance System on a monthly basis for completeness and accuracy. RAE shall incorporate data collected from monitoring of its Grievance System to analyze its Grievance System, including all Grievances and Appeals data reported by RAE in the Grievance and Appeal Log. The analysis of the Grievance System shall demonstrate how RAE uses data collected by RAE and its sub-delegates, to maintain an effective process for monitoring, evaluating and improving the access, quality and appropriateness of services provided to members. RAE shall address all sections in the Grievance System Report template provided by OHA.

5. RAE shall maintain a record, in a central location for each Grievance and Appeal. The record shall include, at a minimum:
   a. A general description of the reason for the Appeal or Grievance;
b. The member’s name and ID;

c. The date the member, or member’s representative, or provider filed the Grievance or Appeal;

d. Notice of Adverse Benefit Determination;

e. If filed in writing, the Appeal or Grievance;

f. If an oral filing was received, documentation that the Grievance or Appeal was received orally;

g. Records of the review or investigation at each level of the Appeal or Grievance;

h. Notice of resolution of the Grievance or Appeal, including dates for each level; and

i. All written decisions and copies of all correspondence with all parties to the Grievance or Appeal.

6. RAE shall submit to Health Share with the Grievance and Appeal Log, ten (10) sample copies of Notices of Adverse Benefit Determination, and all Notices for ABA and Hepatitis C.
Exhibit J – Reserved
Exhibit K – Reserved
Exhibit L – Solvency Plan and Financial Reporting

A. Overview of Solvency Plan and Financial Reporting

1. Background/Authority

RAE shall maintain sound financial management procedures and demonstrate to Health Share through proof of financial responsibility that it is able to perform the Work required under this Agreement efficiently, effectively and economically and is able to comply with the requirements of this Agreement and OAR 410-141-3340 through 410-141-3395. As part of the proof of financial responsibility, RAE shall provide assurance satisfactory to Health Share that RAE’s provisions against the risk of insolvency are adequate to ensure the ability to comply with the requirements of this Contract.

2. Intentionally omitted.


Health Share follows the Method A-OHA Approval process for its solvency plan and financial reporting. All required RAE financial reporting, as described by the Core Contract, this Exhibit L and Health Share policies and procedures, shall be consistent with the Method A-OHA Approval process, unless another reporting method is approved by Health Share.

4. Intentionally omitted.

B. Method A-OHA Approval of Solvency Plan and Financial Reporting

1. Glossary of Terms

a. **Average Fee-For-Service Liability:** The Average Monthly Fee-For-Service Liability is the cost of Covered Services that are offered by RAE to Members that would be owed to creditors in the event of RAE’s insolvency. These are expenditures for Covered Services for which RAE is at risk and will vary in type and amount. These services may include out-of-area services, primary care services, referral services, and Hospital services. Determination of the cost is based on the usual and customary fee schedule of RAE and is developed for the anticipated Capitated Services Liability. Anticipated monthly non-service liability (such as insolvency insurance, hold harmless contracts liabilities, regulated and non-regulated guarantees liabilities, and other liabilities) are not included.

b. **Corporate Activity:** the financial position of a corporation relating to activities the corporation performs. Includes the OHP Line of Business. If RAE is not a corporation is should regard its total OHP Business as Corporate Activity.
c. **Net Premiums**: calculation obtained from Report L.3.1 which represents RAE’s average OHP Capitation Rate and case rates paid (net of reinsurance premiums paid, HRA and GME payments, minimum MLR Rebate and Health Insurance Provider Fee per Member during the reporting period.

d. **OHP Business**: activities RAE performs that relate to this Agreement.

e. **Quarterly Financial Reports**: financial and utilization information filed quarterly, covering the time periods defined on each report.

2. **Annual Audited Financial Statement**

RAE shall submit audited financial statements ("AFS") to Health Share no later than June 30th following the last day of each calendar year that this Agreement is in effect, except otherwise specified herein. Any RAE that does not observe a fiscal year consistent with the calendar year shall submit AFS to Health Share no later than 180 days following the last day of each fiscal year that this Agreement is in effect. The AFS shall be prepared by an independent accounting firm and shall include, but are not limited to, the following information:

a. **Balance Sheet(s)**. The information specified in Report L.5 shall be included in Audited Yearly Balance Sheet of Corporate Activity or the accompanying notes or schedules to Financial Statements. RAE shall amend the 4th quarter Financial Report for audit adjustments and submit to Health Share no later than June 30th, following the last day of each calendar year that this Contract is in effect.

b. **Statement of Revenue, Expenses and Changes in Fund Balance**. The information specified in report L.6 shall be included in the Audited Yearly Statement of Revenue, Expenses and Changes in Fund Balance or the accompanying Notes to Financial Statements. RAE shall amend prior Quarterly Financial Report L.8 for audit adjustments and submit to Health Share no later than June 30th, following the last day of each calendar year that this Contract is in effect.

c. **Statement of Cash Flow**. The information specified in Report L.9 shall be included in the Audited Cash Flow Analysis for Corporate Activity or the accompanying Notes to Financial Statements. Contractor shall allocate cash flow using the Indirect Method of Accounting, as described by GAAP.

d. A statement of opinion by the independent accounting firm about the financial statements based on the results of their audit;

e. A statement of opinion by an independent actuarial firm about the assumptions and methods used in determining loss reserve, actuarial liabilities and related
items;

f. Statement of changes in RAE’s capital;

g. Notes to financial statements; and

h. Any supplemental information deemed necessary by the independent accounting firm, actuary or Health Share.

The AFS and the accompanying notes shall include information specified in Reports L.5, L.6, and L.9 on the Contract Report Web Site. RAE shall use GAAP to define the information requested.

RAE shall disclose to Health Share within the notes of the AFS any sale, exchange or lease of any property, any lending of money or other extension of credit and any furnishing for consideration of goods, services or facilities between the RAE and any party of interest, excluding regular business operation administrative expenses, such as compensation and bonuses made to personnel. Part of interest is defined as 1) any director, officer, partner, affiliate or employee responsible for management or administration of the RAE, 2) any person who is directly or indirectly the beneficial owner of 5% or more of the net worth of the RAE, 3) any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing 5% or more of the RAE, or 4) an incorporator or member of the RAE entity under applicable state law.

3. **Quarterly Financial Reports.** RAE shall report results of financial operations to Health Share quarterly basis, in the form and according to the timeframes set forth below.

   a. Quarterly Financial Reports include, but are not limited to, the following:

   (1) Report L1: General Information and Certification,

   (2) Report L2: Members Approaching or Surpassing Stop-Loss Deductible,

   (3) Report L3: Restricted Reserves

   (4) Report L4: Key Financial Indicators

   (5) Report L5: Quarterly Balance Sheet of Corporate Activity Corporate Total,

   (6) Report L6: Quarterly Statement of Revenue, Expenses and Changes in Net Assets Corporate Total and OHP Line of Business

   (7) Report L7: Case Flow Analysis Corporate Activity/Indirect Method Corporate Total
(8) Report L8: Corporate Relationships of Contractors

b. Health Share will supply RAE with an Excel spreadsheet containing the Quarterly Financial reports. RAE shall submit the Quarterly Financial Reports to Health Share in an electronic format approved by Health Share.

c. RAE shall submit Quarterly Financial Reports for the 1st, 2nd, and 3rd quarters to Health Share 45 days after the end of each calendar quarter. RAE shall submit the Quarterly Financial Reports for the 4th quarter three months after the end of the calendar quarter, as follows:

<table>
<thead>
<tr>
<th>End of Quarter</th>
<th>Due Date of Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 31st</td>
<td>May 15th</td>
</tr>
<tr>
<td>June 30th</td>
<td>August 15th</td>
</tr>
<tr>
<td>September 30th</td>
<td>November 15th</td>
</tr>
<tr>
<td>December 31st</td>
<td>March 31st</td>
</tr>
</tbody>
</table>

d. RAE shall use GAAP to define the information requested

e. RAE shall immediately notify Health Share of a material change in circumstances from the information contained in the latest-submitted Quarterly Financial Reports. If the material change in circumstances requires restatement of prior Quarterly Financial Reports, RAE shall amend the Quarterly Financial Reports and submit to Health Share within 15 working days of the date the material change is identified.

f. Reports annotated as an annual requirement only will include all data from the prior calendar year and are due on the dates specified on the reports.

4. Annual Reporting Requirements

a. In addition to the quarterly reports described in Section 3, RAE shall submit annually the Audited Financial Statements as described in Subsection 2. If necessary, RAE shall complete:

   (1) Report L9: Audited Annual Balance Sheet of Corporate Activity

   (2) Report L10: Audited Annual Statement of Revenues, Expenses & Changes in Net Assets

These reports will provide an explanation of how the Audited Financial Statements described in Section 2 above reconcile to Reports L5 and L6. Reports L9 and L10 shall be provided to Health Share pursuant to the timelines outlined in Section 2 above.

5. Assumption of Risk/Private Market Reinsurance. RAE assumes the risk for providing the services required under this Contract. RAE shall obtain risk protection in the form of
stop-loss or reinsurance coverage against catastrophic and unexpected expenses related to services to Members.

a. RAE shall submit Report L2, Part I, along with the Quarterly Financial Reports, due May 15th, August 15th, November 15th and March 31st. RAE shall report Members approaching or surpassing the deductible amount of stop-loss or reinsurance. Report L2 contains instructions necessary to complete the form.

b. Within 30 days of signing this Agreement, and thereafter at the time of filing the first Quarterly Financial Report on May 15th, RAE shall report to Health Share on Report L2, Part II, the deductible amounts and the amount and associated type of stop-loss or reinsurance coverage (e.g., hospital, medical, or aggregate coverage), and the dollar amount or percentage of Claim amount whereby responsibility for covering the Claim reverts back to the RAE from the re-insurer.

6. Intentionally omitted.

7. Intentionally omitted.

8. Intentionally omitted.
Exhibit M – Reserved
Exhibit C, Attachment 1 – Payment Rates

I. Payment Rates Effective January 1, 2019
A. Background Information about Health Share of Oregon

A.1. Questions

A.1.a. Describe Applicant's Affiliates as relevant to the Contract

Nonprofit, community-based leadership – Health Share of Oregon is a 501(c)3 nonprofit membership corporation domiciled in Oregon. Our member organizations are our affiliates, which we will refer to as “founding partners,” “partner organizations,” or “partners” throughout this application. Following is a list of our eleven founding partners, which includes every major health care finance or delivery system currently serving Oregon Health Plan (OHP) members in our service area. Together, we are Health Share.

- Adventist Health
- CareOregon, Inc.
- Central City Concern
- Clackamas County
- Kaiser Foundation Health Plan of the Northwest and Kaiser Foundation Hospitals
- Legacy Health
- Multnomah County
- Oregon Health & Science University
- Providence Health & Services and Providence Health Plan
- Tuality Healthcare and Tuality Health Alliance
- Washington County

A.1.b. Is the Applicant invoking alternative dispute resolution with respect to any Provider?

No.

A.1.c. What is the address for the Applicant’s primary office and administration located within the proposed Service Area?

2121 SW Broadway, Suite 200, Portland, Oregon, 97201

A.1.d. What counties are included in this Service Area? Describe the arrangements the Applicant has made to coordinate with county governments and establish written agreements as required by ORS 414.153.

Tri-county collaboration from governance to service delivery – Health Share’s current and desired service area includes the entirety of Clackamas, Multnomah, and Washington counties. Each county holds a seat on Health Share’s Board of Directors, and county staff are involved in both the governance and operation of our coordinated care organization (CCO). We have memoranda of understanding with our three county partners around support for public health point-of-care services and crisis and safety net behavioral health services. Beginning in 2020, Health Share will provide direct funding to the counties from our global budget to support safety net behavioral health and public health services to remain compliant with the requirements set forth in ORS 414.153.

A.1.e. Prior history: (1) Is Applicant the Legal Entity that has a contract with OHA as a CCO as of Jan 1, 2019?

Yes. Health Share’s CCO contract is #143115-11. (2)–(4) Not applicable.

A.1.f. Does this Applicant (or an Affiliate of Applicant) currently have a contract with the OHA as a licensed insurer or health plan third party administrator for any of the following?

<table>
<thead>
<tr>
<th>Applicant or Affiliate</th>
<th>PEBB</th>
<th>OEBB</th>
<th>AMHI (Choice)</th>
<th>Cover All Kids</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Share of Oregon</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>CareOregon</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes*</td>
</tr>
<tr>
<td>Clackamas County</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes**</td>
</tr>
<tr>
<td>Kaiser Permanente</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Multnomah County</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes**</td>
</tr>
<tr>
<td>Providence Health Plan</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Washington County</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes**</td>
</tr>
</tbody>
</table>

*Jackson Care Connect and Columbia Pacific CCOs; Tribal Care Coordination
**Administrator for indigent behavioral health safety net treatment and crisis services
A.1.g. Does the Applicant (or an Affiliate of Applicant) have experience as a Medicare Advantage contractor? Does the Applicant (or an Affiliate of Applicant) have a current contract with Medicare as a Medicare Advantage contractor? What is the Service Area for the Medicare Advantage plan?

Yes, the following affiliates have current Medicare Advantage contracts: CareOregon (Multnomah, Clackamas, Washington, Tillamook, Columbia, and Jackson Counties), Kaiser Permanente (along the I-5 corridor from Cowlitz County, WA, to Linn County, OR), and Providence Health Assurance (Benton, Clackamas, Columbia, Crook, Deschutes, Hood River, Jefferson, Lane, Linn, Marion, Multnomah, Polk, Washington, Wheeler, and Yamhill).

A.1.h. Does Applicant have a current Dual Special Needs Coordination of Benefits Agreement with OHA to serve Fully Dual Eligible Members?

Yes, affiliates Providence Health Assurance and CareOregon Advantage D-SNP plans have current Dual Special Needs Coordination of Benefits agreements with the Oregon Health Authority to serve fully dual eligible members.

A.1.i. Does the Applicant (or an Affiliate of Applicant) hold a current certificate of authority for transacting health insurance or the business of a health care service contractor, from the Department of Consumer and Business Services, Division of Financial Regulation?

Affiliates CareOregon, Kaiser Permanente, and Providence Health Plan hold current certificates of authority for transacting health insurance.

A.1.j. Does the Applicant (or an Affiliate of Applicant) hold a current contract effective Jan. 1, 2019, with the Oregon Health Insurance Marketplace?

Affiliates Kaiser Permanente and Providence Health Plan hold current contracts with the Oregon Health Insurance Marketplace.

A.1.k. Describe Applicant’s demonstrated experience and capacity for engaging Community members and health care Providers in improving the health of the Community and addressing regional, cultural, socioeconomic and racial disparities in health care that exist among Applicant’s enrollees and in Applicant’s Community.

Mission-driven, community-led – Health Share’s organizational mission is to partner with communities to achieve ongoing transformation, health equity, and the best possible health for each individual. Our governance and operating models are specifically designed to engage Health Share members, community members, health and human services stakeholders, health care providers, and more in the governance and operation of our community-based CCO.

As the sole CCO in the tri-county region, we are able to leverage community-wide, payer-agnostic population health data to identify health disparities and needs in our region, so we can work to eliminate them. Our current data driven three-year strategic investment plan, Ready + Resilient, starts with an equity lens (Share Health) and has two goals — Start Strong and Support Recovery.
Health Share employs a Strategic Initiatives team that engages community stakeholders on strategies designed to achieve these goals, which are ultimately aimed at addressing the social determinants of health and achieving health equity. Health Share also employs a Chief Equity & Engagement Officer and a team of staff whose role is to engage with communities and providers to work toward health equity.

Health Share has a long-standing record of working with our community partners to bring programs to Oregon to end the cycle of poverty, eliminate health care disparities, and achieve the triple aim of better care, smarter spending, and healthier people:

**Housing**
- **Frequent Users System Engagement (FUSE)** – In partnership with Multnomah and Clackamas counties, these initiatives work to understand the systemic impacts of housing insecurity on health and criminal justice outcomes and implement cross-system interventions in response. These interventions may include supportive housing or new clinical programming depending on the analysis results and community priorities.
- **Housing is Health** – In the fall of 2016, six of our founding partners launched a housing initiative, providing $22.6 million in funding to Central City Concern (also a founding partner) for a new clinic and 379 units of low-income housing.
- **Regional Supportive Housing Fund (RSHIF)** – RSHIF is a continuation of efforts by the six Housing is Health partners to ensure OHP members who are discharged by facilities funded have immediate access to housing upon discharge.

**Traditional Health Workers**
- **Community Health Worker (CHW) Program Infrastructure** – We invested $3.3 million in ORCHWA to create and sustain an infrastructure that will increase statewide access to culturally specific and community-based CHWs for all Oregonians, regardless of health care system or payer.
- **Doula Business Investment** – A workforce development investment to increase knowledge on creating sustainable solo or collaborative doula practices in the Tri-County region. Additionally, this investment will increase the number of registered doulas of color on the State Traditional Health Worker Registry, enabling Medicaid billing and reimbursement for doula services.

**Referrals for Social Needs**
- **Medical Legal Partnership of Oregon** – Medical Legal Partnerships (MLPs) provide access to legal services that impact health outcomes. Attorneys are generally co-located within clinics, and clinicians refer patients to attorneys for legal services. We sponsored Oregon’s first MLP pilots and funded start-up costs for MLPO, helping to stand up MLPs across the state.
- **Regional Community Health Network** (Project Access NOW) – We are developing an integrated system of services to ensure individual and families have stable and consistent access to health care, social services, and other resources necessary for optimal health.
- **Tri-County 911 Service Coordination Program** (Multnomah County) – We developed and fund this program serving tri-county residents who frequently call 911 for emergency medical services when other health and social services would more appropriately serve their needs.
Foster Care Initiatives

Foster care placement is not always thought of as a SDOH, but it should be. Our data show removal from one’s home and birth family has dramatic long-term consequences for members’ physical and behavioral health. That’s why we invested heavily in developing programs to serve children in foster care:

- **Foster care APC** - created a foster care advanced primary care home model
- **DHS medical liaison** – hired and placed a foster care medical liaison in our local DHS Child Welfare office
- **DHS Referral Manager** – developed a digital platform to ensure our members in foster care get the care they need, when they need it.

Education and Children & Family Services

- **Project Nurture** - A Center of Excellence model for providing integrated maternity care and substance use treatment for pregnant women, this includes each participant working with doulas, some who are cross-trained as Certified Recovery Mentors.

- **Early Learning Hub Partnerships**
  - **Help Me Grow** – SDOH can create access barriers for services like developmental services. In response, we brought Help Me Grow (HMG) to Oregon, a national model for promoting children’s development through early detection of risk for developmental delays and linkages to community-based services through a centralized access point. Nationally, 82% of families report their needs are met by HMG.
  - **Immigrant and Refugee Children** – We supported development of a “Sign up Early for Kindergarten Campaign” that created short videos in 10 languages and hosted Parent Cafés with Hubs and Immigrant/Refugee Organization on developmental milestones and school readiness for different refugee populations.

- **Regional Kindergarten Readiness Network** – We brought together over 60 cross-sector organizations and leaders to redesign how systems work together so that race, class, and disability are no longer predictors of kindergarten readiness and long-term population health.

### A.1. Identify and furnish résumés for the following key leadership personnel:


- **CEO (Interim):** Maggie Bennington-Davis, MD
- **Chief Medical Officer:** Maggie Bennington-Davis, MD
- **Chief Financial Officer:** Larry Soderberg
- **Chief Information Officer:** John Sanders
- **Chief Operations Officer:** Deborah Friedman
- **Chief Equity & Engagement Officer:** Michael Anderson-Nathe
A.1.m. Provide a chart identifying Applicant’s contact name, telephone number, and email address for each of the following:

See attached RFA4690-Health Share of Oregon-Att6-(A)(1)(m) Contacts.

B. Corporate Organization and Structure

B.1.a. Provide a certified copy of the Applicant’s articles of incorporation, or other similar legal entity charter document, as filed with the Oregon Secretary of State or other corporate chartering office.

See attached RFA4690-Health Share of Oregon-Att6-(B)(1)(a) Articles of Incorporation.

B.1.b. Provide an organization chart listing of ownership, Control or sponsorship, including the percentage Control each person has over the organization.

Locally founded, governed, and operated – As a locally founded and governed tax-exempt, nonprofit, charitable corporation, Health Share of Oregon has no “owners.” Our CCO was founded and continues to be governed by eleven nonprofit or government entities serving Oregon Health Plan members in Clackamas, Multnomah, and Washington counties.

B.1.c. Describe any licenses the corporation possesses.

Health Share’s Oregon Business registration number is: 849793-93. This is the sole license Health Share of Oregon possesses.

B.1.d. Describe any administrative service or management contracts with other parties where the Applicant is the provider or Recipient of the services under the contract.

Health Share holds a management services agreement with CareOregon, which currently includes human resources, some financial services, and electronic data interchange. In 2020, we plan to expand this relationship to eliminate duplication and achieve administrative cost savings.

C. Corporate Affiliations, Transactions, Arrangements

C.1.a. Provide an organization chart or listing presenting the identities of and interrelationships between the parent, the Applicant, Affiliated insurers and reporting entities, and other Affiliates. …

See attached RFA4690-Health Share of Oregon-Att6-(C)(1)(a) Corporate Affiliations. See B.1.d. above for information about our management services agreement with CareOregon.
C.1.b. Describe any expense arrangements with a parent or Affiliate organization. Provide detail of the amounts paid under such arrangements for the last two years. Provide footnotes to the operational budget when budgeted amounts include payments to Affiliates for services under such agreements.

Current expense arrangements with affiliates include risk arrangements for purchased health care, quality incentive payments, a management services agreement, and community benefit initiatives. Health Share intends to have the same types of arrangements throughout the duration of the CCO 2.0 contract, although the subcontracts and subcontracted affiliates will differ.

<table>
<thead>
<tr>
<th>Affiliate</th>
<th>Description of Arrangement</th>
<th>Paid in 2017</th>
<th>Paid in 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>CareOregon, Inc</td>
<td>• Risk arrangement for purchased health care</td>
<td>$480,568,497</td>
<td>$744,942,839</td>
</tr>
<tr>
<td></td>
<td>• Quality management incentive</td>
<td>$16,310,099</td>
<td>$17,163,029</td>
</tr>
<tr>
<td></td>
<td>• Management services (HR, IT, Financial)</td>
<td>$1,315,255</td>
<td>$1,297,800</td>
</tr>
<tr>
<td></td>
<td>• Leased employee costs</td>
<td>$6,870,994</td>
<td>$7,526,253</td>
</tr>
<tr>
<td>Clackamas County</td>
<td>• Risk arrangement for purchased health care</td>
<td>$7,851,115</td>
<td>$7,840,369</td>
</tr>
<tr>
<td></td>
<td>• Quality management incentive</td>
<td>$482,898</td>
<td>$634,096</td>
</tr>
<tr>
<td>Kaiser Permanente</td>
<td>• Risk arrangement for purchased health care</td>
<td>$109,610,242</td>
<td>$130,135,658</td>
</tr>
<tr>
<td></td>
<td>• Quality management incentive</td>
<td>$5,193,866</td>
<td>$5,497,635</td>
</tr>
<tr>
<td>Multnomah County</td>
<td>• Risk arrangement for purchased health care</td>
<td>$28,424,362</td>
<td>$40,300,741</td>
</tr>
<tr>
<td></td>
<td>• Quality management incentive</td>
<td>$2,635,686</td>
<td>$1,966,434</td>
</tr>
<tr>
<td></td>
<td>• TC911 Program (EMS utilization reduction)</td>
<td>$346,506</td>
<td>$1,038,027</td>
</tr>
<tr>
<td>Providence Health</td>
<td>• Risk arrangement for purchased health care</td>
<td>$138,676,972</td>
<td>$180,186,933</td>
</tr>
<tr>
<td>Assurance</td>
<td>• Quality management incentive</td>
<td>$5,583,441</td>
<td>$6,117,423</td>
</tr>
<tr>
<td>Providence Health</td>
<td>• CORE Consulting services (analytics)</td>
<td>$760,936</td>
<td>$86,094</td>
</tr>
<tr>
<td>&amp; Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuality Healthcare</td>
<td>• Risk arrangement for purchased health care</td>
<td>$33,793,112</td>
<td>$41,877,265</td>
</tr>
<tr>
<td></td>
<td>• Quality management incentive</td>
<td>$1,754,817</td>
<td>$1,748,543</td>
</tr>
<tr>
<td>Washington County</td>
<td>• Risk arrangement for purchased health care</td>
<td>$7,799,692</td>
<td>$8,581,135</td>
</tr>
<tr>
<td></td>
<td>• Quality management incentive</td>
<td>$814,873</td>
<td>$885,233</td>
</tr>
</tbody>
</table>

C.1.c. Describe Applicant’s demonstrated experience and capacity for: Managing financial risk and establishing financial reserves.

Partnering for optimal financial stability – Health Share has successfully managed financial risk and met financial solvency requirements for service to between one-quarter and one-third of the OHP population since 2012. We obtain capital from three sources: (1) capital contributions from founding partner organizations; (2) a one-time grant agreement with CareOregon at start-up; and (3) dedication of a percentage of Health Share’s OHP capitation payments until we achieved minimum required reserve levels.

C.1.c. Meeting the minimum financial requirements for restricted reserves and net worth in OAR 410-141-3350. Since 2013, Health Share has successfully maintained adequate levels of net worth and reserves — even with a near 50% increase in enrollment in 2018 — through dedication of a percentage of capitation to meeting financial solvency requirements. We are set up to call upon our partner organizations as a secondary source for capital, if necessary. Health Share complies with the financial requirements in OAR 410-141-3350.

D. Subcontracts

D.1a. Please identify and describe any business functions the Contractor subcontracts or delegates to Affiliates.

Currently, Health Share delegates most health plan functions to partners and some administrative functions to CareOregon. See below for future plans.

D.1b. What are the major subcontracts Applicant expects to have?

Optimizing value-based payment and community integration with Health Share 2.0 – In 2020, under a new operating structure that we call Health Share 2.0, we are leveraging the value and strengths of the tri-county’s integrated finance and health care delivery systems (IDSs)—Kaiser Permanente, Legacy Health, OHSU Health System, and Providence Health & Services—and opti-
mizing a best in class integrated community network (ICN), managed by CareOregon, that focuses on integrating and supporting our safety net, oral health, NEMT, and behavioral health systems of care. We will optimize integration through our IDS partners by implementing advanced alternative payment methodologies (qualifying as HCP-LAN Category 4C) with each system. The IDS partners will leverage resources provided by the ICN to fully realize whole person care across all health disciplines. Health Share will also contract with CareOregon for administrative services, including human resources/leased employee services and some services related to electronic data interchange, financial services, customer service, compliance, and production of member materials. We will continue to support county-based community health services through providing financial support for public health and crisis/safety-net behavioral health services.

Our subcontracts will comply with Exhibit B, Part 4, Section 13 of the sample contract. The infographic below illustrates Health Share 2.0.

D.1.b. Please provide an example of subcontracted work and describe how Applicant currently monitors subcontractor performance or expects to do so under the Contract.

Please find attached an example of subcontracted work: RFA4690-Health Share of Oregon-Att6-D1b Subcontracted Work and RFA4690-Health Share of Oregon-Att6-Subcontractor Report.
Monitoring subcontractor performance – Health Share monitors subcontractor performance through a delegation oversight program, incorporating a calendar of audits and required reporting from each subcontractor. We conduct, at a minimum, an annual in-depth programmatic review of subcontractor performance on CMS federal program requirements, quality management programs, and program integrity. We conduct quarterly reviews of grievance notices, notices of adverse benefit determinations, and appeal resolution notices for timeliness and readability. If we identify noncompliance, we require a corrective action plan and increase monitoring of the subcontractor until the noncompliance has been resolved.

Noteworthy delegation oversight performance – Our most recent EQR Compliance Report gave us high-marks for delegation oversight of subcontractors: “While [Health Share] delegates many of its required functions to numerous risk accepting entities (RAEs), it assumes ultimate accountability by conducting comprehensive audits of its subcontractors, as evidenced by oversight policies and audit reports provided. The communication and collaboration with their delegates is exceptional and [Health Share] should also be commended for its monitoring of contracted provider organizations.” We received a perfect “4.00 – Fully Met” score on the EQR of Standard VI – Subcontractual Relationships and Delegation.

E. Third Party Liability
E.1. Informational Questions:
E.1.a. How will Applicant ensure the prompt identification of Members with TPL across its Provider and Subcontractor network?
Health Share analyzes databases and claims data for potential TPL, including Medicare, commercial health insurance, or other types of insurance such as car insurance or workers’ compensation in accordance with Exhibit B, Part 8, Section 16 of the sample contract. When potential TPL is noted, we send an inquiry to the member to determine if liability for payment is the responsibility of a third party. When we identify TPL, we flag claims systems and initiate TPL recovery efforts. We seek recovery of TPL by contacting the member, member representative, provider of service, or responsible third party.

E.1.b. How will Applicant ensure the prompt identification of Members covered by Medicare across its Provider and Subcontractor network?
Upon initial assignment to Health Share and with each enrollment update, we check all members that are flagged in the OHA enrollment files as dually eligible for Medicare and Medicaid against a CMS data system to identify Medicare relationships. That information guides us in assigning the dually-eligible members to providers where Medicare and Medicaid coverage are aligned. Additionally, Health Share has fully implemented coordination of benefits administration (COBA) processes, so we receive and process all Medicare claims for enrolled members.

F. Oversight and Governance
F.1. Informational Questions: Please describe:
F.1.a. Applicant’s governing board, how board members are elected or appointed, how the board operates, and decisions that are subject to approval by a person other than Applicant.
Local, community-based governance – Health Share has a 20-person Board of Directors comprised of representatives of its eleven founding partners and members of the community, in compliance with ORS 414.625 and OAR 410-141-3025. Founding partners appoint representatives to the eleven member director seats; the Community Advisory Council appoints its representative; and the other eight board members are elected by the Board of Directors. The Board meets monthly and complies with all laws relevant to nonprofit corporate governance and CCOs. No decisions are subject to approval by a person, corporation, or entity other than Health Share.

F.1.b. Please describe Applicant’s key committees including each committee’s composition, reporting relationships and responsibilities, oversight responsibility, monitoring activities and other activities performed.
Updated governance to support the goals of CCO 2.0 – In the below diagram of the Health Share 2.0 governance structure, each committee displayed in green is composed of members of Health Share’s Board of Directors. The Community Advisory Council, Clinical Advisory Panel, Pediatric Council, and Behavioral Health Council (displayed in yellow) will include board members as well as relevant community members. All
committees report to the Board. Below is a chart containing a non-exhaustive description of the roles and responsibilities of each committee, council, or panel.

<table>
<thead>
<tr>
<th>Board Committee</th>
<th>Responsibilities (non-exhaustive)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality &amp; Health Outcomes Committee</td>
<td>Clinical alignment, quality assurance, quality improvement, and integration strategy</td>
</tr>
<tr>
<td>Governance &amp; Operational Excellence Committee</td>
<td>Operational oversight, delegation oversight, administrative services agreement oversight, data governance, and governance policies</td>
</tr>
<tr>
<td>Finance &amp; Audit Committee</td>
<td>Global budget management, VBP and financial integration strategy, and financial oversight</td>
</tr>
<tr>
<td>Community Impact Committee</td>
<td>Community investment, health equity strategy, and public policy advocacy strategy</td>
</tr>
<tr>
<td>Clinical Advisory Panel</td>
<td>Identification of metrics and projects improving care delivery, spreading best practices, and providing feedback on CCO operations and benefit management strategies</td>
</tr>
<tr>
<td>Pediatric Council</td>
<td>Development of cross-cutting strategies around pediatric delivery system improvement</td>
</tr>
<tr>
<td>Behavioral Health Council</td>
<td>Development of cross-cutting strategies around behavioral health delivery system improvement</td>
</tr>
</tbody>
</table>

F.1.c. The composition, reporting responsibilities, oversight responsibility, and monitoring activities of Applicant’s CAC.

Health Share’s Board directly charters our Community Advisory Council (CAC). The CAC meets monthly to carry out the duties of the CAC as outlined in ORS 414.627 and our contract. The CAC’s composition is based on a matrix that reflects Health Share member demographics. It hosts public meetings at least four times a year, two of which are held jointly with Health Share’s Board to ensure transparency and accountability to our members and community. Health Share’s Board includes a CAC consumer representative seat that serves as a liaison between the CAC and Board. Health Share intends to add a second CAC representative to the Board in 2020.
Attachment 7: DSN Provider Narrative Report

Methodology - Capacity and Access

1. Describe the methodology used to establish provider capacity for physical, behavioral, and oral health providers. How does Contractor determine the minimum number of providers needed to ensure sufficient access?

Health Share’s provider network includes 4,912 physical health Primary Care Providers; of these, 3,615 serve adults, 691 serve pediatric populations, and 606 are OB/Gynecologists serving women. Health Share includes in its network 3,079 behavioral health practitioners who are distributed among—and sometimes shared between—175 mental health organizations and 100 substance use disorder treatment offices. In addition, there are 53 individual mental health practitioners in Health Share’s behavioral health network. Health Share’s dental health plans contract with 730 Primary Dental Care practitioners, 51 of whom specialize in treating pediatric populations, and 124 of whom are specialists such as endodontists, orthodontists, periodontists and oral surgeons.

Health Share determines the minimum number of providers necessary to ensure that members have sufficient access to care according to the following methods:

Provider to Member Ratios – Health Share’s plan partners establish ratio standards and monitor their contracted networks on a regular basis to ensure that they are adequate to meet members’ needs. Exhibit 1 indicates Health Share’s range of various provider type-to-member ratios as of April 1, 2019. Health Share analyzes contracted capacity limits in the provider network, the number of providers in a given clinic, the ability to meet credentialing and site review standards, and openness to accepting new OHP members to ensure that network adequacy standards are met. For example:

- CareOregon’s initial contract with a PCP requires a minimum of 100 patients per FTE clinical when provider first joins CareOregon. Capacity beyond that is determined by the provider based on several variables that can affect utilization and acuity such as patient age and gender. Other variables include clinic administrative practices such as the use of EHR. Practices with sophisticated information systems may have more capacity.

In addition, each of the four Physical Health plans employ verification resources such as Quest Analytics Adequacy software to validate network adequacy—based on capacity and ratios—in accordance with CMS rules.

Time and Distance Standards – Health Share follows the time and distance standards outlined in OAR 410-141-3220(4) and OAR 410-141-3220 (8). In absence of explicit time and distance parameters in OAR, Health Share uses CMS’ Medicare Advantage Network Adequacy criteria as a measure of sufficient access. Accordingly, the vast majority of Health Share members and providers—both primary and specialty—reside within 30 miles of Health Share’s major urban areas. By plotting Portland as the central point in a circle, a 30 mile radius from that point encompasses all
of Multnomah County and extends well into rural Clackamas and rural Washington Counties. Similarly, Health Share has assessed compliance with the standard of 60 minutes/60 miles for rural members to specialty providers, and found that even members from the furthest reaches of Washington County can access a specialty provider within those time and distance limits. For residents of Clackamas County, only the most remote areas of the County exceed the 60 minute drive time. Ultimately, less than 1% of Health Share members fall outside of the time/distance standards established in OAR, ensuring that well over 90% of Health Share members have access to care.

Regular weekly and monthly analysis of the existing contracted capacity by zip code demonstrates that Health Share’s provider network meets CMS Network Adequacy Standards, ensuring that 90 percent of members (or more) have access to at least one provider/facility, for each specialty type, within established time and distance requirements for that county. For instance:

- In 2018, Kaiser Permanente assessed that its assigned Health Share members can access any type of provider in under 11 minutes or 8 miles, well under the community time and distance standard of 30 minutes/30 miles for an urban area.

In sum, Health Share’s provider network has broad geographic distribution across the tri-county region, and it offers access to both routine and urgent care services within those standards, as well as to 24/7 crisis services through contracts with community-based mental health providers and through relationships with county Local Mental Health Authorities who manage crisis hotlines and mobile crisis units.

Care Integration and Information Access – While ensuring a sufficient number of providers to meet the health care needs of all members in our service area, our integrated care model includes additional features that ensure timely and convenient access, high quality care and positive health outcomes for our members. These features include:

- Ninety-eight percent of members are assigned to a PCPCH as their medical home in which providers deliver preventive services, primary care, care coordination and chronic condition management.
- Continual access to clinical advice and members’ own health records.
- Same-day urgent and emergency care services.
- Physician visits and clinical advice available via telemedicine, telephone and secure email.

Health Share intends to keep its existing capacity limits for Clackamas, Multnomah, and Washington Counties. To date, Health Share is filled to 77% of total capacity, leaving room to grow by more than 90,000 members. Based on the fact that Health Share is the only CCO in those three counties, the FFS population is <20,000 members and the Governor’s 2019-2021 budget predicts 8,000-member growth in this service area, Health Share is well positioned to serve the entire population in this service area.

In addition, Health Share will continue to enhance its capacity to serve members through expansion of the capabilities of its provider network. For example, with CareOregon, five FQHCs are piloting the use of an e-Consult platform, RubiconMD, where providers can ask a national network of over 150 board certified specialists for guidance on diagnosis workups, treatment advice options and interpretation of labs and other diagnostics. These efforts coalesce to improve access to care for
members, reduce the administrative burden of referring when unnecessary and when a face-to-face visit is needed, and provide the proper work up for specialist-consultants.

2. Describe the processes used to develop, maintain and monitor an appropriate provider network that is sufficient to provide adequate access to all services covered under this Contract.

Health Share’s provider network has broad geographic distribution across the tri-county region that ensures timely access to covered benefits and services; meets access standards including distance and travel and wait times; allows for member choice; and provides access to THWs and certified Health Care Interpreters. We will continue to ensure that distribution, proximity and provider array are sufficient to provide adequate access using the following processes:

Develop – Health Share promotes telemedicine and video conferencing for all types of providers, including use of shared portals for providers contracted with plans that manage both physical and dental care, contracting with a national pool of specialists to obtain electronic consultation, offering members video and telephonic visits with primary or specialty health providers, and accessing OHSU’s Oregon Psychiatric Access Line about Kids (OPAL-K) and OPAL-A (a similar line for adult consultations) to ensure psychiatric consultation is available to providers who serve members with co-occurring disorders. Such options allow members easy access to providers, eliminate travel time, promote interdisciplinary care, and increase providers’ ability to serve additional members. Indeed, CareOregon includes in its provider contracts telemedicine services as a payable service in order to provide additional access to specialty providers.

Maintain – We are leveraging the value and strengths of the tri-county’s integrated finance and health care delivery systems (IDS)-Kaiser Permanente, Legacy Health, OHSU Health System, and Providence Health & Services-and optimizing an integrated community network (ICN), managed by CareOregon, which focuses on integrating and supporting our safety net, oral health, NEMT, and behavioral health systems of care. As part of these development and maintenance efforts, Health Share’s IDS partners are each certified as PCPCHs and comply with OAR standards. As of the end of 2018, 97% of Health Share’s members were assigned to a PCPCH (303,000 members). Health Share’s performance on the CCO Incentive Metric, which more heavily weights PCPCHs at higher tiers, is currently at 75%, illustrating the efficacy of these development and maintenance. Health Share also specifically contracts with and invests in PCPCHs across the region, including FQHCs, school-based health centers, health system-based primary care, and other safety net providers.

Health Share also utilizes data, geo-access mapping and a health equity lens to identify opportunities to improve care coordination through culturally specific programs focusing on populations with high rates of disparities, including African American pregnant women, pregnant women with substance use disorders, Latinx women and children, and members with mental illness.

Monitor – Health Share reviews network adequacy on a weekly, monthly, and quarterly basis through both direct monitoring and as part of annual compliance monitoring of delegates. On a weekly basis, capacity reports by zip code and county are produced and analyzed to ensure that there is sufficient capacity to support the membership.

On a monthly basis, the capacity analysis expands to include both provider to enrollee ratios as well as the percentage of contracted providers accepting new OHP members. This process happens at all
levels of Health Share currently and will continue to ensure that both the Integrated Delivery Systems and the Integrated Community Network have sufficient capacity. Additionally, Integrated Delivery Systems and the Integrated Community Network will routinely monitor wait times to appointments for primary care, specialty care, oral health, and behavioral health services, building on CareOregon’s current monthly phone surveys to analyze wait times for new patient appointments to establish care, existing patients needing appointments, and urgent/emergent appointments. Monitoring is prioritized for those services that have historic access concerns based on member feedback or identified through routine monitoring, as well as unassigned members who have not been auto assigned to clinic. Call center performance and accessibility is also monitored utilizing standard metrics such as target service factor of calls answered within 30 seconds and percentage of calls abandoned.

On a quarterly basis, Health Share utilizes CMS time and distance standards to regularly assess and ensure network adequacy, demonstrating that routine travel time or distance to a primary provider or clinic, for each specialty type, does not exceed 30 min/30 mi (urban), or 60 min/60 mi (rural) for 90% of the member population in each service area. In addition, each of the four Physical Health plans employ verification resources such as Quest Analytics to review their performance against established standards. Geomaps are produced for analysis at least on a quarterly basis and are reviewed by delegated network adequacy committees. Deficits are identified by highlighting areas that do not have sufficient coverage in time and distance standards and by performing comparisons between previous and current Network Analysis reports. Grievance data is also analyzed within all service lines, which can present patterns in barriers to access beyond timeliness and distance by plan or provider.

On-call and after-hours provider schedules and logs are reviewed periodically to ensure providers are available or have coverage 24/7, including validating the hours of operation for each provider. Should any network gaps occur due to a sudden fluctuation, Health Share would apply various contingency practices such as paying for services for providers that are not yet contracted, adjusting authorization requirements to ensure continued access and/or utilizing Single Case Agreements while contracts are under negotiation.

Availability of language services are analyzed by reviewing capacity reports that show the number of appointments requested and the number of appointments filled by language. Those reports are reviewed internally and with the vendors. Action plans may include putting the language service provider on a corrective action plan, adding additional capacity, and adding access to alternative interpretive modalities like video interpretation or adding another vendor for interpretation.

3. **Describe how contractor identifies and incorporates the needs of linguistically and culturally diverse populations within its community.**

**Identifies** – Health Share uses data to identify communities with specific outreach and member education needs and develops focused outreach efforts to address those needs. For example, in 2016, we saw dramatic disparities across our member population in the rate of developmental screenings based on language. In response, we spent two years working with culturally specific organizations in our community to develop more culturally and linguistically appropriate Ages and Stages Questionnaires (ASQ)—the most common developmental screening tool. Today, Spanish-, Vietnamese-, and Somali-speaking populations outperform English speakers on the developmental screening metric.
Health Share estimates that 38% of our members come from communities of color and 16% speak a language other than English. In order to ensure that members receive care congruent with their preferred language and communication needs, Health Share ensures that interpreter services are available to members, including during and after hours for consultation and care provision, and that written materials are offered in multiple languages. In addition, 2,547 of Health Share’s providers speak languages other than English.

In 2018, we identified that the Russian speaking population was also experiencing lower than average immunization rates in our community. As a result, we developed a focused print and social media outreach campaign in Russian, which will launch in 2019. We are also working with public health partners on an outreach campaign for both members and providers to address barriers to accessing primary care in general for the Russian-speaking community.

In addition to language services, Health Share also ensures that members receive care in a manner compatible with their cultural health beliefs and practices by:

- Contracting with tribal wellness centers, and notifies American Indian and Alaska Native members about their right to receive care at those clinics.
- Building infrastructure to enable additional utilization of community-based traditional health workers throughout the Health Share system.
- Conducting a Community Health Needs Assessment that informs its Community Health Improvement plan.
- Incorporating 94 sites (of 334 total, or 28%) into its directly-contracted specialty behavioral health provider network which offer services specific to discrete cultural, ethnic or sexual-minority populations; and 99 locations (29.6% of the behavioral health network total) which offer distinct languages other than English.

**Incorporates via Communication** – Health Share recognizes that health is largely impacted by what happens outside of the clinic and that communities do better when they receive services in settings they are familiar with, in the language they prefer, and by people who understand their cultural needs. To that end, we deploy several resources to ensure we engage our members in culturally and linguistically appropriate ways. Health Share and our partner organizations arrange for language assistance from contracted certified and qualified language interpreters to meet the oral interpretation needs of Limited English Proficiency members. These services can be provided face-to-face, telephonically and through online encounters for eligible physical, behavioral and oral health services at no charge to members.

We also proactively translate member materials, including a series of four animated member navigation videos, into six prevalent non-English languages. Provider Directories in which members can search for providers are offered in multiple languages. The member section of our website was translated into Spanish to be culturally and linguistically relevant to the Spanish speaking community and can be displayed in all other prevalent non-English languages. All English notices include a language insert explaining in 15 languages that the member has the right to free interpretation services and written information in the language they speak. Materials are also available in large print and other alternate formats. We also create focused health education materials for communities experiencing language-based disparities that we have identified through data analytics and which are tailored to improve health literacy. Health Share’s member Handbook is available in eight languages.
Health Share partners also offer Meaningful Language Access training to network providers emphasizing patient rights and ensuring that provider offices know how to access interpretation services for our members. Beginning in 2019, we are conducting a series of non-English language focus groups to improve both translation and cultural responsiveness of our member handbooks and member navigation materials. We will update our member materials in response to the feedback from the focus groups.

Health Share holds MOUs with many culturally specific social and support service organizations including:

- Asian Health and Service Center serving multiple Asian communities
- Lutheran Community Services NW serving immigrant and refugee communities
- Native American Rehabilitation Association (NARA) serving Native American/American Indians
- Oregon Health and Science University delivers an intercultural psychiatric program serving refugee, immigrant and non-English speaking communities
- NAMI (National Alliance on Mental Illness) in Clackamas and Washington Counties provides educational and support groups for individuals impacted by mental illness
- The Living Room in Clackamas County serves LGBTQ youth and young adults
- IRCO provides on-site and in-person interpretation and translation in multiple languages and serves immigrants and refugees

4. Describe how Contractor utilizes Grievance and Appeal data to identify and remedy member access issues by geographic area, by provider type, by special needs populations, and by subcontractor or subcontracted activity.

Health Share collects grievance data from all delegated entities quarterly, including our NEMT sub-contractor. This data is analyzed initially for patterns in grievances by plan type (reflecting common subcontracted activities), unique plan partners, service type and category of grievance, which is reported to the Board Quality Committee quarterly. Health Share has identified a set of grievance sub-categories that point to potential equity issues that may be present within a plan, provider network or service type and reflect this to partners and the Board each quarter.

Considering routine grievance trends over time, in tandem with other information about our membership, allows Health Share to identify patterns in access to services and key events that warrant immediate response. If trends are identified that require action, Health Share works with our delegates on a plan for addressing barriers to accessing care. For example, Health Share’s initial NEMT vendor did not perform to expectations which resulted in ongoing quality concerns and high volumes of grievances. Health Share put the vendor on a Corrective Action Plan to remediate the access concerns and provided technical assistance to support addressing the concerns. When improvement was not sufficient, Health Share made the decision to not renew that vendor’s contract once the term expired. Instead, in the year leading up to that expiration, Health Share undertook a deep look at the unique NEMT needs of its members and external stakeholders and developed a new and innovative (first of its kind) model for delivering NEMT. That model is specifically focused on Health Share’s unique member needs and demographics, prioritizes safety, and leverages community resources and modern technology platforms. Additionally, Health Share leverages the quality functions of its
partners who perform ongoing analysis and improvement activities on access grievance data across integrated systems.

**Geographic area.** – Health Share’s data indicates the type of service that is related to a specific grievance which allows us to determine when grievances are related to sub-categories of care, i.e. specialty care, pharmacy, or hospital services within the physical health realm. In addition, grievances may specifically identify member experiences related to excessive wait times and travel distance, or receiving non-emergency medical transportation in a timely manner. In such cases, Health Share can map grievances by member zip code to determine if there are geographic pockets where access appears to be an issue.

**Provider type** – In the ‘Access’ category, provider-related grievances may specifically identify difficulties the member experienced in communicating with the provider, or having access to a provider of the preferred gender. Other grievance categories related to providers include lack of cultural sensitivity, rude or inappropriate treatment from staff, and physical barriers to accessing clinical spaces.

**Grieved second opinions may indicate lack of specialists** – Certain grievances indicate denial of second opinions, which generally occurs when a second opinion is requested out of the provider network. This can be an indication of an insufficient network of specialists to provide the needed services. If we see an increased trend in grievances in the “request for second opinion denied” sub-category, we reach out to our delegated entities to determine if this is a trend or an expected variation based on their contracting activity.

Health Share’s review of second opinion grievances informs us that, at this time, the majority of our members are able to receive seamless second opinions, indicating that Health Share currently has sufficient access to contracted specialty providers:

**Grievances for 2nd Opinion Requests**
Plan type – Health Share further divides grievances by plan type. For example, Health Share compares dental-delegated entities to each other, behavioral health delegated entities to each other, and our physical health delegated entities to each other. This level of comparison provides Health Share with a view of the network among our delegated entities.

If we identify an increase in grievances within a part of our network, we can conduct further reviews and work with our delegates to identify whether this an access issue or some other identified trend. For example, when it was determined that member complaints related to access were trending up in one of our delegates, the delegate created a dashboard that was then shared internally with a Network Adequacy Steering Committee and externally directly with providers. Through tests of change, it was discovered that the creation of an Access Coordinator’s (AC) position to facilitate access to specialists for members was required. The AC works with members to determine and coordinate the specific needs of each member associated with an appointment, which can include but is not limited to transportation needs, interpretation services, and preparation with the member prior to the appointment. The AC reviews every referral before moving it forward to the specialist to ensure that all diagnostic tests, imaging and notes are attached for review, thus creating efficiency for the specialist. Currently the AC role is focused on Orthopedic and Neurology access and referrals and expanding to COPD. Our provider partners indicate that they have a 98% show rate for their appointments managed through our Access Coordinator whereas similar Medicaid plans they work with have a 60% member no show for appointments.

As Health Share proceeds with the new integrated model, comparisons between Integrated Delivery Systems will be available as well as aggregated data across physical, behavioral, and oral health.

Special needs populations – Annually we analyze grievances by race/ethnicity, language and gender, in conjunction with utilization rates of PCP, behavioral health, dental and NEMT services for these demographic groups. Together these data elements highlight where we hear from our members and helps determine if an absence of grievances is an indication of complete satisfaction with care or an inability to access care at all. Identifying barriers in certain communities triggers follow-up with plan partners who undertake further review of clinic-level grievance data and address issues as necessary. The plan partners provide their analysis of grievances, issues and resolutions back to Health Share. Health Share is able to identify other groups of members whose needs might need additional focus. For example, in response to the transition of membership from the FamilyCare CCO, we compared
patterns in grievances for this new population to pre-existing membership to ensure this set of members was not experiencing disproportionate challenges in their care.

5. Describe the data collection methods used to assess timely access to services including member, provider and staff feedback about the provider network and performance, and, when specific issues are identified, the protocols for correcting them.

In order to ensure the broad distribution of and appropriate access to routine, urgent and emergent services across its service area, Health Share and its plan partners have robust monitoring systems that include review of:

- On-call and after hour provider schedules and logs to ensure providers are available or have coverage 24/7
- Allocation of provider appointments including number of appointments held open for same day urgent/emergent care services
- Wait times for new patient appointments to establish care, existing patients needing appointments, and urgent/emergent appointments, including monthly access reporting from behavioral health providers on the availability of routine, urgent and emergent appointments
- Utilization of crisis and walk-in clinics

Health Share also monitors time to first appointment for new enrollees wishing to access primary care and evaluates overall service utilization across all lines of business (physical health, behavioral health and dental care). For instance, the dental plan partners regularly monitor access to care through surveying prospective time-to-third available appointment and retrospective access reports, patient satisfaction and patient/member Press Ganey office visit surveys, and grievances filed due to access issues. The plan partners also validate that ratios and wait times meet requirements. For instance, a number of them conduct regular randomized calls to primary care providers and specialists to learn when the next available appointment is for new and urgent appointments.

In order to ascertain access across its combined system of plan types (behavioral, dental and physical), Health Share regularly reviews utilization rates and performance on quality metrics as proxies for better understanding multiple pieces of the access puzzle. Some measures speak more directly to the availability of services, some to the timeliness of key services in response to specific needs, and others are better indicators of member engagement with their healthcare system.

Health Share uses the following key measures as indicators of access:

- Child and adolescent access to primary care
- Child and adult use of preventive dental services
- ED utilization (as a balancing measure for where there may be lack of access to routine outpatient services)
- Well child visits in the first 15 months of life and childhood immunization rates (AAP-recommended preventive services for infants)
- Adolescent well care visits (recommended annual prevention care for teens 12-21)
- Enrollment in certain tier-level PCPCH-certified clinics (higher certification levels require improved availability—after hours in-person care, 24-hour telephone consultations, etc.)
Timeliness of prenatal care (in first trimester or within 42 days if enrolled after first trimester)
Follow-up after hospitalization (outpatient appointment within 7 days of a psychiatric hospitalization)
DHS assessments (physical, mental and dental health assessments, as age appropriate, within 60 days of entering DHS custody)

Health Share distributes its analysis of all utilization, access, and metric reports via email and newsletters to its plan partners and Board members so that they, in turn, can use it to assess the adequacy of their contracted networks and, when needed, address how they support members in accessing services.

One Plan Partner’s innovation in addressing deficiencies low performance involves aligning financial incentives with metrics, including access and quality. CareOregon’s alternative payment models reward clinics for meeting quality measure benchmarks. In addition, clinics must be a recognized PCPCH to be eligible for participation. Metrics the CCO performs poorly on are prioritized for inclusion in the APM program. In addition, a portion of the quality pool metric received by the CCO is repaid to the network based on the organization’s contribution to the CCO’s success. These financial incentives are used to align network priorities with the CCO priorities.

Addressing Deficiencies in Network Adequacy

6. Provide an evaluation of the prior year’s DSN report, identifying where network deficiencies were discovered, and provide a description of how those deficiencies are being remedied. In the response, please address the following:

The 2018 DSN Report identified three network challenges which are respectively outlined below.

Limited DBT Resources

a. The methodology used to identify barriers and network gaps. DBT is a prior auth service, and UM staff notify supervisors if they are alerted to any difficulties and/or delays with accessing services once authorized. We perform occasional oversight to determine of open authorization numbers to monitor capacity, and conduct conversations with DBT provider who maintain an internal interest/wait list.

b. Immediate short-term interventions to correct network gaps. We also expanded our network to include both fidelity, non-fidelity DBT treatment, and numerous providers who perform DBT informed interventions. This ensures that members who do not meet medical necessity criteria for fidelity DBT treatment have access to DBT informed treatment.

c. Long-term interventions to fill network gaps and resolve barriers. We currently have three full fidelity DBT providers across four locations, three of which who report having standard appointment wait time availability. We have not identified a need for additional fidelity programs at this time. Within our contracted network of providers, there are numerous options for DBT informed treatment.
d. **Outcome measures for evaluating the efficacy of interventions to fill network gaps and resolve barriers.** Because DBT requires prior authorization, UM staff will become alerted to any gaps/barriers from any members, referring providers, and delivering providers when there are access difficulties. UM staff have real-time insight into network access by virtue of the prior authorization process.

e. **Projection of changes in future capacity needs.** This is a growing area of interest--as more members meet criteria for full fidelity DBT, we will continue to rely on both medical necessity criteria as well as provider feedback to understand how to better improve our network of DBT providers. We will also continue to work with DBT providers on program development to expand their services to our members.

f. Ongoing activities for network development based on identified gaps and future needs projection. Health Share's Provider Network Management and UM groups continue to evaluate capacity and access and make adjustments with providers as needed.

**Dental Care Under-Utilization**

a. **The methodology used to identify barriers and network gaps.** In its prior DSN, Health Share noted that less than half of our members utilized their dental care benefit. As a result, Health Share’s Data Analytics team analyzed the low rates of utilization among the adult population, considering demographic characteristics and the geographic distribution of adult members who had not received any dental services. Initially Health Share hypothesized that language or cultural barriers were driving low utilization among certain populations, but data showed that English-speaking Caucasians had the lowest dental utilization rates. Further parsing by age showed that members aged 19 – 35 years had the lowest utilization rates. Geographic analysis showed pockets within the region where adult membership was high but dental utilization was low, suggesting that perhaps physical access barriers existed in those areas. The area around Oregon City (zip code 97045) is home to a large volume of members and consistently showed low utilization rates across adult age groups.

b. **Immediate short-term interventions to correct network gaps.** This data was shared with dental plan leadership, and it encouraged further analysis of their own internal data, including network capacity and access. Health Share’s Dental Joint Operating Committee discussed this data and used it to guide where new clinics should be opened to help improve access to services where utilization is lowest.

c. **Long-term interventions to fill network gaps and resolve barriers.** The dental plans operate secure provider portals through which dental care providers verify member assignment and eligibility, metric and outreach status, and claims history. Providers also use this portal to request case management or care coordination for members, report missed appointments, and find “gap lists” of members who need to be seen in order to reach out to them and schedule appointments.
d. **Outcome measures for evaluating the efficacy of interventions to fill network gaps and resolve barriers.** All dental plan partners regularly monitor access to care through surveying prospective time-to-third available appointment and retrospective access reports, patient satisfaction and patient/member Press Ganey office visit surveys, and grievances filed due to access issues. No service gaps or capacity needs have been identified through these ongoing efforts.

The largest dental plan monitors the number of children ages 0-5 years who have had an oral health intervention in a medical or dental setting, and recently met its metric targets for this population.

e. **Projection of changes in future capacity needs.** Throughout 2018 and Q1 2019 year, the dental plans’ weekly capacity reports indicate that they are operating within capacity. No plan has requested increased capacity.

f. **Ongoing activities for network development based on identified gaps and future needs projection.** Health Share’s Dental Care Plans continue to monitor access to care through surveying prospective time-to-third available appointment and retrospective access reports, patient satisfaction and patient/member Press Ganey office visit surveys, and grievances filed due to access issues.

**ED Over-utilization by Members with SPMI**

a. **The methodology used to identify barriers and network gaps.** In June 2017, OHA released draft specifications for a new disparity measure to enter the CCO incentive set, looking specifically at ED utilization for members experiencing mental illness. Across the state, adults with a mental illness diagnosis [according to the Department of Justice definition of Severe and Persistent Mental Illness (SPMI)] utilize the emergency department for physical health conditions 2-3 times more frequently than adults without a mental health diagnosis.

Health Share affirmed that adults with mental illness in our community use the ED at nearly three times the rate of their counterparts. We then evaluated the capacity of the provider network to serve members with mental illness, and embarked on an analysis of where members with mental illness were geographically located compared to where specialty mental health services are available in our region. That analysis identified three key areas in the region with a large volume of members with mental illness but few specialty behavioral health providers, including the North Portland neighborhood.

With limited access to behavioral health services, Health Share sought to better understand how those members were receiving treatment or support for their mental health conditions. Review of other utilization identified several cohorts within this group, including members who had authorizations for specialty behavioral health programs; those who were receiving medication management only; those engaged in BH services within their primary care facility; and other members not receiving any services at all.
ED utilization for these utilization cohorts of members with mental illness varied significantly. Data from the May 2016 – April 2017 period suggested that ED utilization was highest for members who did not receive specialty mental health support or medication management but did receive BH services in primary care. Among members who were engaged in specialty behavioral health, most members were authorized for a lower level of care; however, members with the highest level of authorization predictably showed the highest ED use rate.

b. **Immediate short-term interventions to correct network gaps.** Health Share provided the above data to both physical and behavioral health plans and providers, who used it to address how the system could work collaboratively to better serve members with mental illness using the ED for physical health conditions. One physical health plan started a collaborative focused on reduction of ED use with key large clinics within their network. One learning session included BH providers and focused on the demographic, diagnostic and utilization characteristics of populations shared between primary care clinics and specialty behavioral health providers.

c. **Long-term interventions to fill network gaps and resolve barriers;** Collectively, our partners understand that meeting the needs of our adult members with mental illness will require a robust spectrum of service options, from intensive community-based treatment modules delivered by clinicians with specialty behavioral health certifications (such as ACT); to embedded behaviorists within primary care that work with the team to deliver comprehensive, whole-person care; to peers, community health workers and navigators that can support members in finding the ideal place to receive the care they need and feel comfortable engaging in. Our behavioral health plans continue to assess adequacy of their network of specialty providers in relation to the needs of the population, including the level of care required for members with severe and persistent mental illness. A regional coordinator for efforts around ED utilization for adults with mental illness has been hired and is currently gathering information from all plan partners to understand what efforts have been successful thus far and where there may be untapped opportunity for further improvement. Health Share is working closely with physical and behavioral health plans to streamline the means of funding embedded behavioral health clinicians, so that more intensive physiological services can be delivered in a single setting and more seamlessly integrated into a single care plan. Dental providers have also begun reviewing the contribution of dental pain to overuse of the ED, and a cohort definition of members using the ED for preventable dental needs within PreManage has been shared among our dental plans.

d. **Outcome measures for evaluating the efficacy of interventions to fill network gaps and resolve barriers.** Because of these efforts, Health Share saw a 7% reduction in ED utilization among adult members with mental illness in 2018, more than twice the expected improvement in a single year. This effort will continue into 2019 and we will continue to use the CCO incentive metric as an indicator of impact, along with engagement in primary care and outpatient mental health services. We would expect a reduction of ED use to be coupled with an increase outpatient care as members receive more preventive support.

e. **Projection of changes in future capacity needs.** We expect a greater demand for behavioral health services integrated into primary care—many members identified by the
DOJ definition of SPMI do not meet criteria for specialty behavioral health programming but would experience improved outcomes with routine mental health support. Embedding this resource in primary care, where members may already be engaged, facilitates access and allows a coordinated team to provide comprehensive care and support a single treatment plan.

f. **Ongoing activities for network development based on identified gaps and future needs projection.** Health Share is working with physical health partners to expand integration of behavioral health services into primary care, to support availability of services in that portion of the spectrum. Conversely, partners are also continuing to fund the model of the Certified Community Behavioral Health Center (CCBHC), which was piloted by two behavioral health providers over the last 3 years. A highlight of this model is the integration of primary care services into the behavioral health clinics, bringing routine preventive care and chronic condition monitoring into the same setting where members have become engaged and established relationships with specialty mental health providers. CCBHCs recognize the interplay of mental illness and physical health conditions, and the synergistic nature of treatment responses—for example, common treatment goals for members with diabetes include improved nutrition and increased physical activity, which are also effective strategies for managing depression. Funding has been identified to maintain existing CCBHCs and support expansion of the model to additional locations.
## Exhibit I

### PROVIDER TYPE TO MEMBER RATIOS

#### PHYSICAL HEALTH

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Providers</th>
<th>Members (N=318,868)</th>
<th>Demographic Notes</th>
<th>Ratio (Members per Provider)</th>
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<tbody>
<tr>
<td>Family Medicine/General Practice</td>
<td>982</td>
<td>318868</td>
<td>Ages 0-65+</td>
<td>325</td>
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<tr>
<td>Naturopath</td>
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<td>1012</td>
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<tr>
<td>Nurse practitioner</td>
<td>1298</td>
<td>193309</td>
<td>Ages 18-65+</td>
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<tr>
<td>Physician assistant</td>
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<td>193309</td>
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<tr>
<td>OB/GYN</td>
<td>606</td>
<td>81153</td>
<td>Women, ages 13-44</td>
<td>134</td>
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#### PH Provider Type: Adult

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Providers</th>
<th>Members</th>
<th>Demographic Notes</th>
<th>Ratio (Members per Provider)</th>
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</thead>
<tbody>
<tr>
<td>Anesthesiology</td>
<td>542</td>
<td>193309</td>
<td>Ages 18-65+</td>
<td>357</td>
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<tr>
<td>Cardiovascular Medicine</td>
<td>240</td>
<td>193309</td>
<td>Ages 18-65+</td>
<td>805</td>
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<tr>
<td>Dermatologist</td>
<td>123</td>
<td>193309</td>
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<tr>
<td>Endocrinologist</td>
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<tr>
<td>Gastroenterologist</td>
<td>141</td>
<td>193309</td>
<td>Ages 18-65+</td>
<td>1371</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>55</td>
<td>18887</td>
<td>Ages 65+</td>
<td>343</td>
</tr>
<tr>
<td>Hematology &amp; Oncology</td>
<td>175</td>
<td>193309</td>
<td>Ages 18-65+</td>
<td>1105</td>
</tr>
<tr>
<td>Internal Medicine (for medical provider types otherwise not identified)</td>
<td>1223</td>
<td>193309</td>
<td>Ages 18-65+</td>
<td>158</td>
</tr>
<tr>
<td>Nutritionist / Dietician</td>
<td>102</td>
<td>193309</td>
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<td>1895</td>
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<tr>
<td>Ophthalmologist</td>
<td>213</td>
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<td>Ages 18-65+</td>
<td>908</td>
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<tr>
<td>Otolaryngologist</td>
<td>111</td>
<td>193309</td>
<td>Ages 18-65+</td>
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<td>Pathology</td>
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<td>193309</td>
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<td>Psychiatry &amp; Neurology</td>
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<td>Pulmonologist</td>
<td>93</td>
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<tr>
<td>Radiology / Imaging</td>
<td>316</td>
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<tr>
<td>Rheumatologist</td>
<td>43</td>
<td>193309</td>
<td>Ages 18-65+</td>
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<tr>
<td>Speech, Language and Hearing Service Providers</td>
<td>238</td>
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<tr>
<td>Surgeons</td>
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<td>Ages 18-65+</td>
<td>284</td>
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<tr>
<td>Urology</td>
<td>102</td>
<td>193309</td>
<td>Ages 18-65+</td>
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#### Hospital

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<th>Provider Type</th>
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<tbody>
<tr>
<td>Emergency Medicine</td>
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<td>Critical Care Medicine</td>
<td>68</td>
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<tr>
<td>Hospitalists</td>
<td>66</td>
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<td>Ages 0-65+</td>
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#### Pharmacy

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<th>Provider Type</th>
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<td>Pharmacists</td>
<td>170</td>
<td>193309</td>
<td>Ages 18-65+</td>
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#### MENTAL HEALTH

#### MH Provider Type: Adult

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<tr>
<th>Provider Type</th>
<th>Providers</th>
<th>Members</th>
<th>Demographic Notes</th>
<th>Ratio (Members per Provider)</th>
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<tbody>
<tr>
<td>MH Licensed Practitioners, Adults: LCSW, LPC, LMFT</td>
<td>261</td>
<td>193309</td>
<td>Ages 18-65+</td>
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<tr>
<td>MH Psychiatrist/PMHNP, Adults</td>
<td>78</td>
<td>193309</td>
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<td>MH Psychologist, Adults</td>
<td>97</td>
<td>193309</td>
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<td>Other QMHPs</td>
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<td>Ages 18-65+</td>
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<tr>
<td>ACT</td>
<td>91</td>
<td>46265</td>
<td>Members with SPMI, ages 18+</td>
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<tr>
<td>MH Inpatient: Adults (4)</td>
<td>652</td>
<td>46265</td>
<td>Members with SPMI, ages 18+</td>
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#### MH Provider Type: Youth

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<th>Provider Type</th>
<th>Providers</th>
<th>Members</th>
<th>Demographic Notes</th>
<th>Ratio (Members per Provider)</th>
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</thead>
<tbody>
<tr>
<td>MH Licensed Practitioners, Youth: LCSW, LPC, LMFT</td>
<td>372</td>
<td>83205</td>
<td>Ages 6-17</td>
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<tr>
<td>MH Psychiatrist/PMHNP, Youth</td>
<td>209</td>
<td>83205</td>
<td>Ages 6-17</td>
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<tr>
<td>MH Psychologist, Youth</td>
<td>96</td>
<td>83205</td>
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<td>867</td>
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<tr>
<td>Other QMHPs</td>
<td>809</td>
<td>83205</td>
<td>Ages 6-17</td>
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<tr>
<td>ABA</td>
<td>150</td>
<td>83205</td>
<td>Ages 6-17</td>
<td>555</td>
</tr>
<tr>
<td>MH Inpatient, Youth</td>
<td>341</td>
<td>83205</td>
<td>Ages 6-17</td>
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<td>Provider Type: Adult</td>
<td>Provider Type: Youth</td>
<td>Provider Type: Specialty</td>
<td>Provider Type: Pediatric</td>
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<tr>
<td>-----------------------</td>
<td>----------------------</td>
<td>----------------------</td>
<td>--------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>SUD Outpatient, Adults (95 facilities)</td>
<td>761 193309 Ages 18-65+ 254</td>
<td>SUD Outpatient, Youth (33 facilities)</td>
<td>260 83205 Ages 6-17 320</td>
<td>General Dentist Practitioner</td>
</tr>
<tr>
<td>SUD Alternative, Adults (acupuncturists)</td>
<td>262 193309 Ages 18-65+ 738</td>
<td>SUD Alternative, Youth (acupuncturists)</td>
<td>206 83205 Ages 6-17 404</td>
<td>Dental Hygienist</td>
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<tr>
<td>Residential Treatment: Adults</td>
<td>315 193309 Ages 18-65+ 614</td>
<td>Residential Treatment: Youth</td>
<td>38 83205 Ages 6-17 2190</td>
<td>Pediatric Dentist</td>
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<td>Withdrawal Management</td>
<td>113 193309 Ages 18-65+ 1711</td>
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<td>Endodontist</td>
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<tr>
<td></td>
<td></td>
<td></td>
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<td>Orthodontist</td>
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<td>Periodontist</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Oral Surgeon</td>
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<tr>
<td></td>
<td></td>
<td></td>
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<td>Denturist</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Acupuncturists</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Chiropractors</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Physical Therapist</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>Occupational Therapist</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
<td>Other Alt Care (respiratory, developmental, rehabilitative, restorative)</td>
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<tr>
<td>MAT</td>
<td>678 193309 Ages 18-65+ 285</td>
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1. Governance and Organizational Relationships

Non-profit, community-based care – Health Share of Oregon is a 501(c)3 non-profit membership corporation. Our member organizations are our affiliates, which we will refer to as “founding partners”, “partner organizations”, or “partners” throughout this application. Health Share’s 11 founding partner organizations are building a new model for health care transformation in service to Oregon Health Plan (OHP) members in the tri-county area. We are calling the new model “Health Share 2.0.” Health Share 2.0 offers members integrated physical and primary care behavioral health from four integrated delivery systems and centrally coordinates all other covered services through a single, easy to navigate entity—CareOregon. Health Share represents a collaboration of our 11 founding partners, which include every major health care finance or delivery system currently serving OHP members in our service area.

Together, we are Health Share.

- Adventist Health
- CareOregon, Inc.
- Central City Concern
- Clackamas County
- Kaiser Foundation Health Plan of the Northwest and Kaiser Foundation Hospitals
- Legacy Health
- Multnomah County
- Oregon Health & Science University
- Providence Health & Services and Providence Health Plan
- Tuality Healthcare and Tuality Health Alliance
- Washington County

Community-wide health care collaboration – Health Share and its unique collaborative model will achieve the triple aim of better care, smarter spending, and healthier people—bringing the value of each partner organization to make the whole better than the sum of its parts. To meet the diverse needs of OHP members in our region, we have created the state's most comprehensive provider network. We are leveraging the value and strengths of the tri-county's integrated finance and health care delivery systems (IDS): Kaiser Permanente, Legacy Health, OHSU Health System, and Providence Health & Services—and optimizing a best in class integrated community network (ICN), managed by CareOregon, that focuses on integrating and supporting our safety net, oral health, NEMT, and behavioral health systems of care.

Local, community-based governance – Health Share has a 20-person Board of Directors comprised of representatives of its 11 founding partners and members of the community, in compliance with ORS 414.625. Founding partners appoint representatives to the 11 member director seats; the Community Advisory Council (CAC) appoints its representative; and the other eight Board members are elected by the Board. The Board meets monthly and complies with all laws relevant to non-profit corporate governance and CCOs.

<table>
<thead>
<tr>
<th>Member Director Seats (11)</th>
<th>Elected Director Seats (9)</th>
</tr>
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<tbody>
<tr>
<td>Adventist Health</td>
<td>Multnomah County</td>
</tr>
<tr>
<td>CareOregon (incl. DCO)</td>
<td>OHSU</td>
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<td>Central City Concern</td>
<td>Providence</td>
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<tr>
<td>Clackamas County</td>
<td>Tuality Healthcare</td>
</tr>
<tr>
<td>Kaiser Permanente (incl. DCO)</td>
<td>Washington County</td>
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<tr>
<td>Legacy Health</td>
<td>Primary Care Director</td>
</tr>
<tr>
<td></td>
<td>Nurse Practitioner Director</td>
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<td>Specialty Care Director</td>
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<td>Behavioral Health Director</td>
</tr>
<tr>
<td></td>
<td>Oral Health Director</td>
</tr>
<tr>
<td></td>
<td>CAC Director</td>
</tr>
<tr>
<td></td>
<td>Community-at-Large Director</td>
</tr>
<tr>
<td></td>
<td>Community-at-Large Director</td>
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</tbody>
</table>

Updated governance to support the goals of CCO 2.0 – In the below diagram of the Health Share 2.0 governance structure, designed to better meet the needs of the OHP Program, each committee displayed in green is composed of members of Health Share’s Board. The CAC, Clinical Advisory Panel (CAP), Pediatric Council, and Behavioral Health Council (displayed in yellow) will include Board members as well as relevant community members. All committees report to the Board.
The relationship of the Governance Structure with the CAC, including how the Applicant will ensure transparency and accountability for the governing body’s consideration of recommendations from the CAC.

Connecting the Board and CAC – Health Share’s Board charters our CAC. The CAC meets monthly to carry out the duties as outlined in ORS 414.627 and our Contract. The CAC hosts public meetings at least every three months or four times a year. Two of the four meetings are joint public
meetings between the CAC and the Board, and serve to strengthen relationships, provide opportunities for discussion and collaboration, and to share their work with each other. At the February 2019 joint CAC/Board meeting, the agenda included Board Committee updates, a review of Health Share’s 2018 accomplishments, and a work session dedicated to the Community Health Improvement Plan (CHP). In this session, community members participated alongside Board and CAC members on providing input into Health Share’s 2019 CHP.

**Ensuring transparency and accountability** – While joint CAC/Board meetings are one mechanism to ensure transparency and accountability, Health Share’s Board has always included a CAC member representative seat serving as a liaison between the CAC and Board. This position is a full Board and CAC member and helps hold both the CAC and Board accountable by sharing regular updates on each body’s work and formally submitting and reporting back on CAC recommendations to the Board and vice versa. The Board not only considers CAC recommendations, but also takes action on them. One example is the CAC’s inclusion of increasing access to community-based, culturally specific community health workers (CHWs) in the 2014-2018 community health plan (CHP), which led directly to Health Share’s $3.3 million investment in infrastructure for the Oregon Community Health Worker Association (ORCHWA) to create a platform for all payers and systems, including CCOs, to meaningfully employ CHWs.

1.a.(3) The CCO Governance Structure will reflect the needs of Members with severe and persistent mental illness and Members receiving DHS Medicaid-funded LTC services and supports through representation on the Governing Board or CAC.

**Representing members with SPMI and members receiving long-term care (LTC) services** – Health Share’s governance structure reflects the needs of members with SPMI and members receiving DHS Medicaid-funded LTC services through the Board and the CAC. Health Share’s Board designates a seat specifically for a mental health or substance use treatment provider in active practice as one way of ensuring the needs of our members with SPMI are connected to our governance. Health Share also has a Board seat for consumer CAC member who helps to bring in member voice and experience including our members with SPMI and in LTC.

Additionally, three of our 11 founding member organizations include Clackamas, Multnomah and Washington Counties. Board members from these counties represent a wide breadth of services and supports provided by the counties including their roles as community mental health programs (CMHPs), Local Mental Health Authorities (LPHAs), and Area Agency on Aging (AAA) and Adults and People with Disabilities (APD) offices connecting members to LTC services and supports.

Health Share’s CAC is designed to reflect our member population and their needs. This includes representatives from the LPHAs in our Service Area and Traditional Health Workers (THWs) (specifically peers and CHWs) that have experience working with members with SPMI. Going forward, we will ensure our CAC has a member specifically representing the needs of members receiving LTC services. Additionally, the Board is chartering a new Behavioral Health Council as part of our Governance Structure. This council will be charged with high-level oversight of Health Share’s behavioral health system and will help to ensure the needs of our SPMI members are elevated and addressed. These combined structures support Health Share in ensuring our Governance Structure reflects the needs of our members including those with SPMI and those receiving DHS Medicaid-funded LTC services.

1.b. Clinical Advisory Panel (recommended page limit ½ page)

1.b.(1) If a Clinical Advisory Panel is established, describe the role of the Clinical Advisory Panel and its relationship to the CCO governance and organizational structure.

**Building provider leadership through a Clinical Advisory Panel (CAP)** – Health Share’s Board will charter a CAP before January 1, 2020 to provide leadership and clinical strategy for Health Share to ensure clinical best practice, maximize implementation across the network, and to leverage the
collective talents and capabilities of our clinical partners. Through a collaborative process, and utilizing both clinical and operational expertise, the CAP will provide Health Share with:

- feasible recommendations regarding optimal resource allocation for integrated services
- strategies to achieve the targeted budget rate of growth
- strategies for new and expanded value-based payment arrangements
- assessment and interpretation of gaps in care for clinical quality measures
- description of existing barriers to quality care
- identification of disparities in health outcomes and strategies to meaningfully reduce adverse health outcomes, among other clinical priorities

CAP membership will include, but not be limited to clinical and operational representation from: our clinician Board members, IDS partners, primary care; Federally Qualified Health Centers (FQHCs); mental health and substance use disorder (SUD) systems, oral health, pediatrics, and public health.

The CAP will reflect learnings from current provider workgroups designed to identify metrics and projects for improving care delivery, spread best practices, and provide feedback on CCO operations and benefit management strategies. Over the last two years, these provider groups have focused on implementing Ready + Resilient strategies—start strong, support recovery, and share health—including expanding implementation of medication assisted treatment (MAT), behavioral health integration, oral health integration.

1.b.(2) If a Clinical Advisory Panel is not established, the Applicant should describe how its governance and organizational structure will achieve best clinical practices consistently adopted across the CCO’s entire network of Providers and facilities.

Not applicable.

1.c. Agreements with Type B Area Agencies on Aging and DHS local offices for APD (APD) (recommended page limit ½ page)

1.c.(1) Describe the Applicant’s current status in obtaining MOU(s) or contracts with Type B AAAs or DHS local APD office.

Memorandums of Understanding (MOUs) with Type B area agencies on aging and DHS local offices for APD – Health Share has an existing MOU with the Area Agencies on Aging and Disability in the Multnomah, Clackamas, and Washington County regions and the Multnomah, Washington, and Clackamas districts of Oregon DHS-Aging and People with Disabilities (collectively “APD/AAAD”). The MOU describes how Health Share will work together collectively with APD/AAAD to expand our mutual ability to address the social determinants of health (SDOH), reduce health disparities, prevent or delay need for long-term services and supports (LTSS), and improve health outcomes for low income and at-risk senior and adults with disabilities. We achieve this through interdisciplinary care coordination, cross-system transitional care practices, and member engagement. Our Tri-County Joint Aging, Disability and Health Steering Committee meets at least quarterly to monitor and advance the activities included in the MOU. This Steering Committee includes a representative of Health Share, health system partners, the Multnomah County ADVSD LTSS program manager, the regional coordinator for the Older Adult Behavioral Health team, District or program managers from the Clackamas and Washington County DHS-APD districts, and leadership staff from both Clackamas County Social Services (CCSS) and Washington County Disability, Aging, and Veterans Services (DAVS).

1.c.(2) If MOUs or contracts have not been executed, describe the Applicant’s efforts to do so and how the Applicant will obtain the MOU or contract.

Not applicable.

1.d. Agreements with Community Partners Relating to Behavioral Health Services (recommended page limit 1 page)

1.d.(1) Describe the Applicant’s current status in obtaining MOU(s) or contract(s) with LMHAs and CMHPs throughout its proposed Service Area.
Existing agreements with LMHAs and CMHPs – Health Share has MOUs or contracts with both the LMHAs and CMHPs in all three counties in our service area, in compliance with ORS 414.153. These agreements ensure the publicly funded mental health and substance use disorder services are appropriately supported, coordinated and funded through Health Share in its role as a CCO, and by each county in its role as the LMHA. Health Share and our LMHA and CMHP partners work closely to ensure a comprehensive and coordinated behavioral health system exists for our members and community. All three counties in our service area are founding partners of Health Share and serve at all levels of governance, including on the Board.

Looking to the future – In the spirit of continuous quality improvement, Health Share and our LMHAs are actively developing additional written agreements for the CCO 2.0 MOU on how to expand and strengthen the relationship between Health Share and LMHA’s in their roles. We anticipate completing this new MOU by January 1, 2020 and will be drafted pursuant to ORS 414.153.

1.d.(2) If MOUs or contracts have not been executed, describe the Applicant’s efforts to do so and how the Applicant will obtain the MOU(s) or contract(s).

Not applicable.

1.d.(3) Describe how the Applicant has established and will maintain relationships with social and support services in the Service Area, such as:

• DHS Child Welfare and Self Sufficiency field offices in the Service Area

Relationships with DHS child welfare and self-sufficiency field offices – Health Share is focused on improving the health and well-being of children in foster care. Through strategic efforts and dedicated staffing, we have established and maintain strong collaborative relationships with all three DHS Districts in our region. Our commitment to children in foster care combined with our strong partnerships with our DHS field offices have allowed us to advance several key initiatives and investments. We have outlined several of them below.

Health Share plans to build upon this success with a continued focus on children in foster care.

• Medical liaisons – Designed to strengthen cross system partnerships with DHS, Health Share funded a Medical Liaison position to prioritize and support the health care needs of children in substitute care through advancing policy, procedures, and practices.

• MindSights – In 2017, we partnered with DHS and a local provider, MindSights, to launch a standardized process and tool, called RAPID, for assessing the needs of children entering foster care in Multnomah County. The results identify initial service needs that inform initial Child Welfare case-planning efforts.

1.d.(3) Oregon Youth Authority (OYA) and Juvenile Departments in the Service Area

Oregon Youth Authority and juvenile justice – Health Share works closely with OYA and County Departments of Behavioral Health, Child Welfare, Community Action, Developmental Disability Services, Juvenile Services, and Self-Sufficiency. We participate in the Pacific Transition Project hosted by OYA, an initiative to explore and enhance the transition process for youth who are transitioning from secure placements back into the community. Additionally, over the past five years, Health Share has built strong partnerships with local child, youth, and family serving systems and services. Our Tri-County Children’s System of Care (SOC) governance structure has become an effective cross system
collaborative effort to identify and address the systemic barriers experienced by children and families in our community. The SOC regularly convenes leadership from several regional child and family serving systems and organizations including Juvenile Justice, Intellectual/Developmental Disabilities, Child Welfare, County Health and Human Services, Special Education and others.

1.d.(3) **Department of Corrections and local Community corrections and law enforcement, local court system, problem solving courts (drug courts/mental health courts) in the Service Area, including for individuals with mental illness and substance abuse disorders**

**Relationships with corrections and law enforcement** – Health Share and the counties have strong partnerships with local law enforcement and community corrections. Investments supporting members experiencing mental health or substance use disorder challenges in the community include partnerships between mental health clinicians and law enforcement:

- In Clackamas County, five mental health clinicians embedded in the Sheriff’s office, respond to crisis calls in the community via 911 to offer crisis assessment, diversion and referral
- QMHP level staff provide jail in-reach to support transitions and attend weekly Mental Health Court and Aid and Assist court dockets
- Peer support specialist in-reach into jails to assist with re-entry planning including housing, access to mental health and substance use disorder providers, coordination with parole and probation, and support to resources to meet basic needs

1.d.(3) **School districts, education service districts that may be involved with students having special needs, and higher education in the Service Area**

**Relationships with schools** – In addition to participation in the Children’s SOC, Health Share’s focus on early life health includes the Regional Kindergarten Readiness Network (RKRN). The RKRN is a collective impact initiative in the tri-county region with over 60 organizations representing health, early childhood, school districts, housing, and communities including the region’s largest school districts and ESDs. Health Share provides backbone support to this effort as well as critical data infrastructure, including a focus on REAL+D analytics, to support redesigning our systems with kids and families at the center, addressing the SDOH and education.

1.d.(3) **Developmental disabilities programs**

**Relationships with developmental disabilities programs** – Health Share has strong, established relationships with the three metro-area community developmental disabilities programs (CDDPs). The three local counties not only manage both the CDDPs but also care coordination for members with significant behavioral health concerns. As Board members and founding partners of Health Share, the counties are able leverage their many roles to ensure close coordination of services for members who have intellectual or developmental disabilities. Behavioral health staff at the counties are co-located in some instances, allowing for immediate care coordination and support to members served in the CDDPs.

1.d.(3) **Tribes, tribal organizations, Urban Indian organizations, Indian Health Services and services provided for the benefit of Native Americans and Alaska Natives**

**Agreements with Urban Indian organizations and programs service Native Americans and Alaska Natives** – Health Share contracts with NARA Northwest, the only Urban Indian Organization (UIO) in our service area, which provides the full-spectrum of physical, behavioral and oral health services to Health Share’s Native American and Alaska Native members. The contract allows an Indian member to choose NARA as their provider if capacity allows. In addition, Health Share contracts and coordinates with five organizational and five individual behavioral health providers who serve Native American and Alaska Native populations. We are committed to ensuring our Native American and Alaska Native members have access to culturally appropriate care. Our ICN, CareOregon, also offers a Tribal Care Coordination Program for all Native American and Alaska Natives on open card and brings this experience to bear in serving Health Share’s Native American
and Alaska Native members as well.

1.d.(3) Housing organizations

Relationships with housing organizations – Health Share and our partners have a long history of engaging with housing organizations. In fact, one of Health Share’s founding partner organizations is Central City Concern (CCC). We have invested in or partnered with the following housing related organizations:

- **Frequent Users System Engagement (FUSE)** – In partnership with Multnomah and Clackamas counties, these initiatives work to understand the systemic impacts of housing insecurity on health and criminal justice outcomes and implement cross-system interventions in response. These interventions may include supportive housing or new clinical programming depending on the analysis results and community priorities.

- **Housing is Health** – In the fall of 2016, six of our founding partners launched a housing initiative, providing $22.6 million in funding to Central City Concern (also a founding partner) for a new clinic and 379 units of low-income housing.

- **Regional Supportive Housing Fund (RSHF)** – RSHF is a continuation of efforts by the six Housing is Health partners to ensure OHP members who are discharged by facilities funded have immediate access to housing upon discharge.

- **A Home for Everyone (AHFE)** – Health Share’s Chief Equity & Engagement Officer serves on the Coordinating Board and committees for A Home for Everyone (AHFE), a multisector initiative responding to the crisis of homelessness in Multnomah County.

- **Home Forward** – The housing authority in Multnomah County committed to providing our most vulnerable neighbors with access to affordable housing and services. Home Forward is an active partner in the Regional Kindergarten Readiness Network, which has led to new partnerships. For example, we have explored data sharing opportunities with Home Forward and the Reynolds School District to better understand the impact of housing issues as they relate to outcomes within the school system, such as school absenteeism, as well as health system outcomes related to utilization and cost.

1.d.(3) Community-based Family and Peer support organizations

Advancing community-based family and peer supports – Health Share has been a leader in promoting and advancing community-based family and peers supports. Health Share contracts with Youth ERA and the Oregon Family Support Network, to provide peer delivered services to members utilizing mental health services. These agencies employ a combined total of 16 full-time Certified Family Support Specialists to support and help members engage with and participate in their children’s Wraparound teams. We also support the Foster Parent Support Network: KEEP Support Program which assists foster parents to communicate and collaborate with DHS.

Health Share provided two years of funding to Providence Swindells Resource Center to train, supervise, and support three Peer Family Navigators to mentor and guide families of children who have special needs, developmental delays or disabilities as these families navigate through the health, education, and community services available to them. These navigators were placed in Providence and St. Vincent’s Children’s Development Institute, as well as a Virginia Garcia primary care clinic. Over the two-year pilot, the navigators had 1,923 encounters with families (891 unique contacts). An independent program evaluation noted that the Family Navigator role “has helped improve the care experience for families and staff at PCDI. Families felt a stronger connection to the
clinic through their relationship with the Family Navigator, they received needed emotional support, and were connected to resources to meet their needs.” Through this pilot, Health Share also funded Swindells to design and implement a training curriculum as a pathway for Family Navigators through the THW Training and Continuing Education Unit Programs. This has been approved by the OHA.

1.d.(3) Other social and support services important to communities served

Additional social and support services partnerships – Health Share recognizes that health is largely impacted by what happens outside of the clinic and that communities do better when they receive services in settings they are familiar with, in the language they prefer, and by people who understand their cultural needs. Towards that end, Health Share holds MOUs with many culturally specific social and support service organizations including:

- **Asian Health and Service Center** serving multiple Asian communities
- **Lutheran Community Services NW** serving immigrant and refugee communities
- **Native American Rehabilitation Association (NARA)** serving Native American/American Indians
- **Oregon Health Science University** delivers an intercultural psychiatric program serving refugee, immigrant and non-English speaking communities
- **NAMI** in Clackamas and Washington Counties provides educational and support groups for individuals impacted by mental illness
- **The Living Room** in Clackamas County serving LGBTQIA youth and young adults
- **Immigrant & Refugee Community Organization (IRCO)** provides on-site and in-person interpretation and translation in multiple languages and serves immigrants and refugees
- **Passport to Languages, Linguava Interpreters** and **Telelanguage** all provide on-site and in-person interpretation and translation in multiple languages

2. Member Engagement and Activation (recommended page limit 1½ pages)

2.a. Describe the ways in which Members (and their families and support networks, where appropriate) are meaningfully engaged as partners in the care they receive as well as in organizational Quality Improvement activities.

**Engaging our members in their care** – Health Share and our partners are committed to ensuring each member and their families and support networks are empowered and encouraged to actively participate in their health care. We believe that member dignity and culture is best respected when members (and their families and support networks) get to choose their provider and care team (as capacity allows) and play an active role in designing their treatment plans. We achieve this goal through the following strategies:

<table>
<thead>
<tr>
<th>Member Engagement Strategy</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual outreach to members to establish care</td>
<td>Welcome calls, completion of an Initial Health Risk Assessment, welcome informational packets</td>
</tr>
<tr>
<td>Provider and care coordinator motivational interviewing tools</td>
<td>Utilization of Motivational Interviewing, Trauma-informed Care, and screenings that address ACE’s</td>
</tr>
<tr>
<td>Electronic reminders to schedule past due chronic disease care</td>
<td>Automated phone calls, emails, texts and letters to schedule appointments</td>
</tr>
<tr>
<td>Reminder texts for preventive screening</td>
<td>Automated phone calls, emails, texts and letters to schedule appointments</td>
</tr>
<tr>
<td>Targeted behavior change marketing</td>
<td>Digital, social media, streaming services, and outdoor marketing around immunizations, effective contraception use, adolescent well-child visits (incl. partnership w/school-based health centers), and more</td>
</tr>
<tr>
<td>Postcards reminding members how to access their benefits</td>
<td>Dental services postcards, annual reminders about member handbooks and provider directories, NEMT postcards, and more</td>
</tr>
</tbody>
</table>
Members provide feedback on care experiences by engaging in organizational quality improvement activities such as quantitative patient satisfaction surveys, grievance reporting, and direct interactions with providers and health plan staff. For example, Wraparound care coordinators in Multnomah, Washington and Clackamas Counties utilize the Wraparound Fidelity Index, Short Version (WIFI-EZ), to solicit feedback from children, adolescents, caregivers and team members on their experiences in Wraparound, outcomes and satisfaction.

2.b. Describe how the Applicant will ensure a comprehensive communication program to engage and provide all Members, not just those Members accessing services, with appropriate information related to benefits and accessing physical health, Behavioral Health and oral health services, including how it will:

### General member communications
- Mailings with care reminder postcards and letters
- Outbound calls
- Text messaging
- Member newsletters
- Member apps
- Member portals
- Social media

Communications describe covered benefits and services and provide information on how members can utilize their OHP benefits and our approach accounts for the SDOH by utilizing multiple methods and types of communication.

### Communication tools for navigating Health Share
- All new members receive a new member welcome packet that includes detailed information about what benefits and services are covered, contact information for accessing assistance with scheduling a first appointment, care schedules for well child visits and immunizations, and links to provider information. Health Share hosts quarterly in-person new member orientation sessions. Our newly redesigned website includes four animated member navigation videos—describing how to navigate the CCO overall, as well as navigating physical, oral, and behavioral health systems of care—transcreated into our service area’s six prevalent non-English languages (pursuant to OAR 410-141-3300).

**GoMobile teams are also deployed throughout the year.** They are a team of health care navigators and health plan assistors who create access for members to the Oregon HealthPlan, Medicare, and their CCO by educating the members and Community Based Organizations (CBO’s) on navigation of these systems by coordinating with OHP enrollment assisters, COA plan agents, Tri-Met, DHS, Social Security, and SNAP to deliver a wrap-around experience. Our intention is to meet members where they naturally gather and build social capital, either churches, grocery stores, the library, waiting rooms in CBO’s, and early learning hubs. The goal is to reduce the need for members and their advocates i.e. case managers, CHW, clinic staff on calling OHA directly and instead engage members with their CCO and their PCP as early and often as needed. This is a great time to assist members with address changes, educate them on transportation and Dental navigation, share their benefits regarding Pharmacy, and ‘how to advocate,’ for themselves at the doctor’s office.

### Importance of engaging members in their care
While encouraging members to be active partners in their health care is a standard of practice for Health Share and our partners, we recognize that not all members have had or currently have the same opportunities and experiences. These opportunities and experiences can have a profound impact on their health and their willingness to engage as active participants in their care. Health Share implements a comprehensive member engagement strategy that leverages multiple modes of communication further outlined below.

### Culturally and linguistically appropriate members engagement
We deploy several resources to ensure we engage our members in culturally and linguistically appropriate ways. We issue translated
written materials into our service area’s six prevalent non-English languages (pursuant to OAR 410-141-3300). All English notices include a language insert explaining in 15 languages that the member has the right to free interpretation services and written information in the language they speak. Materials are also available in large print and other alternate formats. Health Share and our partner organizations arrange for language assistance from contracted certified and qualified language interpreters—Language Services Associates, Passport to Languages, Linguava Interpreters and Telelanguage—to meet the oral interpretation needs of Limited English Proficiency members. These services can be provided face-to-face, telephonically and through online encounters for eligible physical, behavioral and oral health services at no charge to members. We ensure that these services are provided in a timely manner and compliant with the Contract both in Exhibit B, Part 3, Section 2 “Member Rights Under Medicaid” and in Exhibit B, Part 4, Section 2 “Access to Care”.

We also proactively translate member materials, including a series of four animated member navigation videos, into six prevalent non-English languages. The member section of our website was transcreated in Spanish to be culturally and linguistically relevant to the Spanish speaking community and can be displayed in all other prevalent non-English languages.

Provider training: Health Share partners also offer Meaningful Language Access training to network providers emphasizing patient rights and ensuring that provider offices know how to access interpretation for our members. Beginning in 2019, we are conducting a series of non-English language focus groups to improve both translation and cultural responsiveness of our member handbooks and member navigation materials. We will update our member materials in response to the feedback from the focus groups.

Targeting initiatives to populations experiencing disparities: Health Share also uses data to identify communities with specific outreach and member education needs and develops focused outreach efforts to address those needs. For example, in 2016, we saw dramatic disparities across our member population in the rate of developmental screenings based on language. In response, we spent two years working with culturally specific organizations in our community to develop culturally and linguistically appropriate Ages and Stages Questionnaires (ASQ)—the most common developmental screening tool. Today, Spanish, Vietnamese, and Somali speaking populations outperform English speakers on the developmental screening metric.

In 2018, we noticed that the Russian speaking population were experiencing lower than average immunization rates in our community. As a result, we developed a focused print and social media outreach campaign in Russian, which will launch in 2019.

2b. Educate Members on how to navigate the coordinated care approach and ensure access to advocates including Peer wellness and other Traditional Health Worker resources

Educating members on navigating their care – Once members are assigned to Health Share new member onboarding begins with activities such as welcome calls and member centric orientation to OHP benefits and supports. If a member needs care coordination, a care manager reaches out to the member and describes the care coordination process and how to connect to their care team, including THWs when appropriate. Health Share also employs a team of health equity strategists who work with our partners to promote health equity best practices, including the utilization of THWs. In fact, over the last five years of our contract, Health Share has made investments to support CHWs, Peer Wellness and Peer Support Specialists, and doulas. Health Share’s THW Liaison, as outlined in Health Share Attachment 10: THW Integration and Utilization Plan, will collaborate with our partners to build off these investments to increase TWH integration and utilization with a strong member communication component.
2.b. **Encourage Members to use effective wellness and prevention resources and to make healthy lifestyle choices in a manner that is culturally and linguistically appropriate**

Educating members on using wellness and prevention resources – Health Share and our partners provide robust wellness and prevention resources through communication mechanisms described above. Further, we recognize that prioritizing preventive care is difficult for our members in their busy lives. To support them in actively participating in wellness care, we offer incentive programs (such as gift cards) to certain members who engage in preventive care appropriate for their age and conditions.

**Targeted member education campaigns:** Additionally, each year Health Share promotes OHP-related benefits and services through multi-media marketing campaigns, reaching members through community-specific digital, radio, print, direct mail, and outdoor advertising. Health Share also has the unique opportunity—through quality incentive funds—to conduct social marketing campaigns promoting behaviors and specific health services to members and the community at large. 2019 behavior change campaigns aim to address 1) early childhood immunizations (Russian language example at right), 2) diabetes care, and 3) postpartum health, including tobacco cessation, behavioral health and resource needs, immunizations, and more. In 2020, Health Share plans to implement a dental wellness communication campaign focused on promoting annual dental visits for all family members. These communications campaigns are informed by demographic data and transcreated or translated in the prevalent non-English languages spoken by Health Share’s members.

2.b. **Provide plain language narrative that informs patients about what they should expect from the CCO with regard to their rights and responsibilities**

Plain language information on member rights and responsibilities – All new members receive a welcome letter and a member handbook that explains member rights and responsibilities in detail, in compliance with Exhibit B, Part 3 of the model contract. This information is also available on Health Share’s website. In addition, all member communications follow best practices and meet contractual requirements in terms of health literacy, plain language, alternative formats, and more.

2.b. **Meaningfully engage the CAC to monitor and measure patient engagement and activation.**

CAC monitoring of patient engagement and activation – As a mechanism to improve patient engagement via member materials, Health Share's CAC reviews member materials, website content, and other written communication materials and provides input on improvements. The CAC also hosts quarterly CAC meetings open to the public and promotes these meetings on our website, through listservs and email, and through our community partners. These meetings create a venue for members to provide feedback on their experiences and is one more way for the CAC to monitor patient engagement and activation. In the future, staff from Health Share’s Data and Analytics team will work with the CAC to identify the most meaningful patient engagement and activation metrics to review twice annually for feedback and improvement suggestions.

3. **Transforming Models of Care (recommended page limit 1 page)**

3.a. **Patient-Centered Primary Care Homes**

3.a.(1) **Describe Applicant’s PCPCH delivery system.**

Advancing health system transformation through PCPCHs – Health Share supports Health System Transformation by maximizing access to Patient-Centered Primary Care Homes (PCPCHs) through our IDS partners and CareOregon’s Integrated Community Network. Our IDS partners are each certified as PCPCHs and comply with OAR standards. Integral to our PCPCH network is the...
approach to providing care that is integrated and coordinated, patient/family centered, and culturally and linguistically appropriate. This includes supporting a person’s physical, oral, and behavioral health needs, focusing on wellness and prevention, and active management and support of individuals with special health care needs. As of the end of 2018, 97% of Health Share’s members were assigned to a PCPCH (303,000 members). Health Share’s performance on the CCO Incentive Metric, which more heavily weights PCPCHs at higher tiers, is currently at 75%. Health Share also specifically contracts with and invests in PCPCHs across the region, including FQHCs, school-based health centers, health system-based primary care, and other safety net providers.

3.a.(2) Describe how the Applicant’s PCPCH delivery system will coordinate PCPCH Providers and services with DHS Medicaid-funded LTC Providers and services.

Our PCPCHs support interdisciplinary care teams that include care managers, providers, and representatives from LTSS and other relevant agencies to communicate and coordinate care with the PCPCH. Care managers at PCPCHs develop person-centered care plans that include LTSS service needs in the Electronic Health Record and share these care plans with LTC providers and services either electronically, by phone, or through in-person Intensive Care Coordination Conferences when needed.

3.a.(3) Describe how the Applicant will encourage the use of Federally Qualified Health Centers (FQHC), Rural health clinics, migrant health clinics, school-based health clinics and other safety net providers that qualify as Patient-Centered Primary Care Homes.

Health Share made significant effort in encouraging the use of FQHCs, SBHCs, migrant health clinics, and other safety net providers to strengthen the PCPCH model at a system level. With our partners, Health Share contracts with all FQHCs in its catchment area, and preferentially assigns members to clinics that are certified as Tier 3, 4, or 5 PCPCHs and meet other quality standards and align, to the extent possible, its payment models with the Alternative Payment Methodology (APM) in the FQHC setting, maximizing the impact FQHCs to continue to transform their care model. To encourage the use of school-based health clinics (SBHCs), Health Share developed a social marketing campaign to encourage students to access Adolescent Well Care at their SBHCs.

We engage with FQHCs on key issues such as quality, cost control, policy issues, and provider operations. We also partner with the Oregon Primary Care Association (OPCA) and the Coalition of Community Health Clinics, who primarily serve and support FQHCs, to collaborate on key initiatives including behavioral health integration, value-based payment, and SDOH. We are partnering with OPCA on a primary care behavioral health integration project with the Association of Oregon Community Mental Health Programs to advance value based payment and care in the safety net.

3.b. Other models of patient-centered primary health care

3.b.(1) If the Applicant proposes to use other models of patient-centered primary health care in addition to the use of PCPCH, describe how the Applicant will assure Member access to Coordinated Care Services that provides effective wellness and prevention services, facilitates the coordination of care, involves active management and support of individuals with Special Health Care Needs, is consistent with a patient and Family-centered approach to all aspects of care, and has an emphasis on whole-person care in order to address a patient’s physical, oral and Behavioral Health care needs.

Additional patient-centered primary care models – In addition to PCPCH recognition, many Health Share partner clinics and payers participate in CMS’s Advanced Payment Model, Comprehensive Primary Care Plus (CPC+). CPC+ requires practices to make changes in the way they deliver care in the areas of: 1) Access and Continuity, 2) Care Management, 3) Comprehensiveness and Coordination, 4) Patient and Caregiver Engagement, and 5) Planned Care and Population Health. Partners continue to exceed quality and utilization expectations of this model. Health Share also
partners with seven of the state’s certified community behavioral health clinic (CCBHC) sites to advance the care of the Health Share population with SPMI. CCBHC’s increase access to mental health and addictions treatment, expand the capacity to address opioid use disorder, and enhance utilization of evidence-based practice, care coordination, and integration with physical health. Additionally, Health Share partner organizations serve as faculty for the state Patient-Centered Primary Care Home Institute and other national organizations like the UCSF Center for Excellence in Primary Care to train and support new clinical leadership in foundations of Medical Home transformation.

3.b.(2) Describe how the Applicant’s use of this model will achieve the goals of Health System Transformation. By participating in the multi-payer CPC+ model, Health Share leverages Medicaid, Medicare, and commercial payers to transform the delivery system and support providers in moving further in VBP and increasing risk and shared savings for providing high quality, effective care. Additionally, the CCBHC model of integration will support the transformation of the delivery system to effectively meet the needs of members with SPMI and integrates services to address physical health needs in one, high quality setting.

4. Network Adequacy (recommended page limit 3 pages)
4.a. Evaluation Questions

4.a.(1) How does Applicant intend to assess the adequacy of its Provider Network? Please include specific data points used to inform the assessment and the methodology for how adequacy will be evaluated.

Ensuring adequacy of our provider network to meet member needs – Consistent with Exhibit B, Part 4 and Exhibit G of the model contract, our provider network has broad geographic distribution across the tri-county region that ensures: timely access to covered benefits and services; meets access standards including distance and travel and wait times; allows for member choice; and provides access to THWs and certified Health Care Interpreter. Health Share monitors network adequacy on a weekly, monthly, and quarterly basis through both direct monitoring and as part of annual compliance monitoring of delegates. **On a weekly basis,** Health Share produces capacity reports by zip code and county and analyzes them to ensure that there is sufficient capacity to support the membership.

<table>
<thead>
<tr>
<th>PRIMARY CARE IN 2013</th>
<th>BEHAVIORAL HEALTH IN 2015</th>
<th>DENTAL CARE IN 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 primary care provider for:</td>
<td>1 behavioral health provider for:</td>
<td>1 dentist for:</td>
</tr>
<tr>
<td>1159 people in Clackamas</td>
<td>476 people in Clackamas</td>
<td>1321 people in Clackamas</td>
</tr>
<tr>
<td>725 people in Multnomah</td>
<td>159 people in Multnomah</td>
<td>1094 people in Multnomah</td>
</tr>
<tr>
<td>1110 people in Washington</td>
<td>415 people in Washington</td>
<td>1154 people in Washington</td>
</tr>
</tbody>
</table>

3,4,5 – Based on our most recent Community Health Needs Assessment data

**On a monthly basis,** the capacity analysis expands to include both provider to enrollee ratios as well as the percentage of contracted providers accepting new OHP members. This process happens at all levels of Health Share currently and will continue to ensure that both the IDS partners and the ICN have sufficient capacity. Additionally, partners will routinely monitor wait times to appointments for primary care, specialty care, oral health, and behavioral health services. We prioritize monitoring for those services that have historic access concerns based on member feedback or identified through routine monitoring. We also monitor call center performance and accessibility, utilizing standard
metrics such as target service factor of calls answered within 30 seconds and percentage of calls abandoned.

**On a quarterly basis**, Health Share utilizes OHA time and distance standards to regularly assess network adequacy, demonstrating that 90% of members (or more) have access to at least one provider/facility, for each specialty type, within established time and distance requirements for that county. Health Share produces Geomaps that network adequacy committees review at least quarterly to identify service delivery gaps. Both Health Share and partners analyze grievance data within all service lines. We also review on-call and after-hours provider schedules and logs to ensure providers are available or have coverage 24/7, including validating the hours of operation for each provider.

**We analyze availability of language services** by reviewing capacity reports that show the number of appointments requested and the number of appointments filled by language. If we identify a concern with a language services vendor, responses may include putting the vendor on a corrective action plan, adding additional capacity, and adding access to alternative interpretive modalities like video interpretation or adding another vendor for interpretation.

4.a.(2) **How does Applicant intend to establish the capacity of its Provider Network? Please include specific data points used to inform the assessment and the methodology for how capacity will be evaluated.**

**Establishing the capacity of our provider network** – Health Share has the largest OHP provider network in the tri-county area which includes the full range of physical health, behavioral health and oral health services. That network is largely managed by Health Share’s partners who represent the most well-known and established health systems in the state with proven track records in providing services to OHP enrollees. Further, Health Share and its delivery system partners are state leaders in providing services across the age spectrum, managing a variety of services and specialty types, and understanding the racial/ethnic and linguistic considerations of the members they serve through regular monitoring and routine analysis using CMS Network Adequacy Standards. Health Share’s provider network has broad geographic distribution across the tri-county region. That network offers access to both routine and urgent care services. Additionally, the behavioral health network provides access to 24/7 crisis services through contracts with community-based mental health providers as well as through relationships with county Local Mental Health Authorities who manage crisis hotlines and mobile crisis units.

**Sufficient capacity to support program growth** – Health Share intends to keep its existing capacity limits for Clackamas, Multnomah, and Washington Counties. Right now, Health Share is filled to 77% of total capacity, leaving room to grow by more than 90,000 members. Based on the fact that Health Share is the only CCO in those three counties and the FFS population is <20,000 members and the Governor’s 2019-2021 budget predicts 8,000-member growth in this service area, Health Share is well positioned to serve the entire population in this service area.

Existing capacity limits were set based on extensive analysis of contracted capacity limits in the provider network, the number of providers in a given clinic, the ability to meet a credentialing and site review standards, and openness to accept new OHP members. Existing contracted capacity analysis demonstrates network adequacy meeting CMS time and distance standards, demonstrating that 90 percent of members (or more) have access to at least one provider/facility, for each specialty type, within established time and distance requirements for that county.

**Expanding our network capacity** – Health Share has also worked to expand its capacity to serve members through expansion of the capabilities of its provider network. For example, with CareOregon, five FQHCs are piloting the use of an e-Consult platform, RubiconMD, where providers can ask a national network of board-certified specialists for guidance on diagnosis workups, treatment advice options and interpretation of labs and other diagnostics. All in an effort to improve access to care for the members, reducing administrative burden of referring when not necessary and when a face to face visit is needed providing the proper work up for the specialists.
4.a.(3) How does Applicant intend to remedy deficiencies in the capacity of its Provider Network?

Addressing network deficiencies – If we identify deficiencies in our Provider Network capacity, we take immediate steps to remedy it. This will include developing a list of providers in the specific areas of deficiency (physical health, behavioral health, and oral health), conducting provider outreach and education specific to serving OHP member, and entering into new contracts with willing providers. Additionally, Health Share will work with our Integrated Delivery System partners to expand capacity within our current networks to increase the number of members able to be served within those systems.

In terms of ensuring an adequate culturally responsive network, Health Share works closely with its CAC, Board, providers, and plan partners to identify and close gaps in culturally responsive care providers across physical, behavioral, and oral health to ensure that we are addressing both clinical and cultural barriers to care. We will proactively perform a gap analysis for any expected new membership to identify gaps ahead of the 2020 plan year and establish needed provided contracts in 2019.

4.a.(4) How does Applicant intend to monitor Member wait times to appointment? Please include specific data point used to monitor and how that data will be collected.

Monitoring appointment wait times – We use both prospective and retrospective methods of monitoring member wait time to appointments. We leverage the work with the PCPCHs in our provider network (98% of members are assigned to a PCPCH) to actively monitor empanelment and capacity as well as time to next appointment. We do this by having providers report on their analysis to third next available appointments and aggregating those results across the network to ensure we meet timeliness standards. We also support work between PCPs and specialty providers to implement closed loop referral systems and referral tracking to support members getting access to specialty providers in a timely manner. Health Share also analyzes the results of the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to understand member experience of wait times. Recognizing the health and health care disparities faced by our members of color, we stratify this data by REAL+D in order to uncover any disparities by specific populations. For example, CareOregon used this approach and conducted member focus groups for African American/Black, Latina/Hispanic, Vietnamese, and Russian communities in Portland who have at least one medical visit in the previous 12 months. Findings showed several themes around the challenges of receiving appropriate care including translation services, feeling respected, and understanding benefits. As a result, we expanded language access services, including the addition of a second interpretation vendor, modification of language vendor contracts to include quality metrics, and development and trainings on how to provide meaningful language access.

Case Study: Kaiser Permanente also uses various methods to ensure member needs and expectations are met. Kaiser has an aspirational goal to be in the 90th percentile for Press Ganey Medical Office Visit surveys and CAHPS/METEOR surveys related to member experiences and wait times. In order to meet this target, they have implemented improvements and metrics to track the following areas: increasing virtual visits, increase kp.org appointing, simplifying appointment process, leveraging RN visits, simplifying specialty care referrals, improving walk-in convenience, and filling every available appointment.

4.a.(5) How will Applicant ensure sufficient availability of general practice oral health Providers and oral health specialists such as endodontists? Please provide details on how the full time equivalent availability of Providers to serve Applicant’s prospective Members will be measured and periodically validated.

Health Share’s oral health providers ensure availability of general practice providers and specialists by looking at several factors impacting network capacity. Geographic locations and time and distance standards are measured periodically through reports such as Geo mapping and continuously validated
by reports showing wait times to appointments and complaints about access. General Providers are assigned patient load targets that ensure they are not being overburdened, with more experienced providers typically serving a higher patient count. In addition, some providers utilize the best practice of assessing the time between the referral to a specialist and the receipt of the specialist claim as an indicator of timeliness and we will work to spread this practice. Future reporting will include individual provider FTE levels so that capacity limits can be more closely and accurately measured and validated. This assessment will be performed at least annually.

4.a.(6) Describe how Applicant will plan for fluctuations in Provider capacity, such as a Provider terminating a contract with the Applicant, to ensure that Members will not experience delays or barriers to accessing care.

Health Share’s broad provider network and extensive capacity ensures we can absorb fluctuations in provider membership without compromising care for our members. This was evident by Health Share’s ability to quickly and successfully expanded network capacity to assure the safe transition of membership after another CCO in our service area closed. This success was the result of both expanding existing contracted capacity and contracting with new providers, in addition to providing care management and care coordination support to those members that needed it the most. We worked tirelessly to ensure the safety of the highest need members, particularly those receiving Exceptional Needs Care Coordination, Intensive Care Coordination, Choice, Wraparound or other care management. If there were another significant and unanticipated gap in the provider network, Health Share would develop a contingency plan to bridge any gaps created by a sudden fluctuation in membership including paying for services for out of network providers or adjusting authorization requirements to ensure continued access for members.

5. Grievance & Appeals (recommended page limit 1½ pages)

Please describe how Applicant intends to utilize information gathered from its Grievance and Appeal system to identify issues related to each of the following areas:

5.a. Access to care (wait times, travel distance, and subcontracted activities such as Non-Emergent Medical Transportation).

Utilizing grievance and appeals data to identify access to care issues – Health Share collects grievances and appeals data and uses it to maintain an effective process for monitoring, evaluating, and improving the access, quality, and appropriateness of services provided to members, as per the Sample Contract Exhibit I, and tracks data in accordance with Section 10(g). Specifically, grievance data is collected from all delegated entities quarterly including our NEMT sub-contractor. This data is entered into a database, downloaded into Tableau, and reported to the Quality Committee quarterly. We categorize this data as required by the OHA. The “Access” category and related sub-categories identify provider type and grievances related to excessive wait times and travel distance. These sub-categories are tracked over time and will be analyzed by race/ethnicity and language, which allows us to identify events or trends. If trends are identified that require action, Health Share works with our delegates on a plan for improving the trend. For example, Health Share’s initial NEMT vendor did not perform to expectations which resulted in ongoing quality concerns and grievances. Health Share put the vendor on a Corrective Action Plan to remediate the access concerns and provided technical assistance to support addressing the concerns. When improvement was insufficient, Health Share made the decision to not renew that vendor’s contract once the term expired. Instead, in the year leading up to that expiration, Health Share undertook a deep look at the unique NEMT needs of its members and external stakeholders and developed a new and innovative (first of its kind) model for delivering NEMT. That model is specifically focused on Health Share’s unique member needs and demographics, safety, leveraging of community resources and modern technology platforms. Additionally, Health Share leverages the quality functions of its partners who perform ongoing analysis and improvement activities on access grievance data across integrated systems.

5.b. Network adequacy (incl. sufficient number of specialists, oral health and Behavioral Health Providers).

Health Share further divides grievances by plan type. For example, historically, Health Share compares
our dental-delegated entities to each other, our behavioral health delegated entities to each other and our physical health delegated entities. As we move forward in our new integrated model, comparisons between Integrated Delivery Systems will be available as well as aggregated data across physical, behavioral, and oral health. This provides Health Share with a view of the network among our delegated entities. If we identify an increase in grievances within a part of our network, we can conduct further reviews and work with our delegates to identify whether this an access issue or some other identified trend. For example, when it was determined that member complaints related to access were trending up in one of our delegates, the delegate created a dashboard that was then shared internally with a Network Adequacy Steering Committee and externally directly with providers. Through tests of change, it was discovered that the creation of an Access Coordinator’s (AC) position to facilitate access to specialists for members was required. The AC works with members to determine and coordinate the specific needs of each member associated with an appointment which can include but is not limited to transportation needs, interpretation services, and preparation with the member prior to the appointment. The AC reviews every referral before moving it forward to the specialist to ensure that all diagnostic tests, imaging and notes are attached for review, thus creating efficiency for the specialist. Currently the AC role is focused on Orthopedic and Neurology access and referrals and expanding to COPD. Our provider partners indicate that they have a 98% show rate for their appointments managed through our Access Coordinator whereas similar Medicaid plans they work with have a 60% member no show for appointments.

We also track grievances related to not being able to receive second opinions. This generally occurs when a second opinion is requested out of the provider network. This can be an indication of not enough specialists in the network to provide the needed services. If we see an increased trend in grievances in the “request for second opinion” sub-category denied, we reach out to our delegated entities determine if this is a trend or an expected variation.

5.c. Appropriate review of prior authorized services (consistent and appropriate application of Prior Authorization criteria and notification of Adverse Benefit Determinations down to the Subcontractor level).

Health Share conducts a quarterly review of prior authorized services and comply with the Sample Contract Exhibit I, “Grievance and Appeal System”. We average approximately 8,700 adverse determinations (NOABD) per quarter. Our delegated entities are required to submit a random sample of 10 NOABDs each. We review the notices for compliance with the Sample Contract in Exhibit I, Section 3, “Notice of Adverse Benefit Determinations—Requirements”. If Health Share identifies a concern, a records request is initiated, and a detailed review occurs. We also pull a random sample of the universe of NOABDs on the spreadsheet and request random files. Health Share has developed a NOABD review tool that identifies certain elements that we audit for during each authorization review. One of those elements is the review criteria used and if it is the appropriate criteria for the request. Dates are also checked and counted to ensure timeliness requirements are met.

6. Coordination, Transition and Care Management (recommended page limit 5 pages)

6.a. Care Coordination:

Describe how the Applicant will support the flow of information between providers, including DHS Medicaid-funded LTC care Providers, mental health crisis services, and home and Community-based services, covered under the State’s 1915(i) State Plan Amendment (SPA) for Members with severe and persistent mental illness, as well as Medicare Advantage plans serving Fully Dual Eligible Members, in order to avoid duplication of services, medication errors and missed opportunities to provide effective preventive and primary care.

Currently, Health Share relies on a technological backbone that facilitates information sharing across providers to support care coordination, to reduce duplication of services and medication errors, and to identify opportunities for preventive and primary care. This backbone includes software and data tools such as Care Everywhere, PreManage and Health Share Bridge.
• Care Everywhere provides clinical data, such as allergies, medications, problem lists, medical history, visit summaries, test results and immunization history, and is available to providers who use Epic and other affiliated electronic health systems.

• PreManage provides inpatient and ED information that can be used to schedule follow-up care and support transitions of care among provider settings, and is accessible to all providers in the region.

• Health Share Bridge is our interactive reporting-based tool that contains all of an individual’s claims information and is available to all Health Share providers.

Health Share and its partners within the IDSs and the ICN are committed to supporting the success of OHA’s HIE Onboarding Program (HOP) with Reliance eHealth Collaborative to explore the value proposition and return on investment of this HIE opportunity. The goal will be to expand use of HIE functionality to increase timely access to data across systems, with a focus on integrating behavioral and dental information with physical health information. An additional objective over the course of the engagement will include expanding the offerings of the HIE related to SDOH information as available. The addition of SDOH information will include CAC and provider engagement components to ensure a sensitive and community-informed roll-out in order to ensure a community centered and strengths-based approach.

To minimize gaps in information exchanges, care coordinators share relevant information, including individual care plans, across the health care system and with other organizations involved in meeting a member’s needs. Primary care providers (PCPs), particularly those certified as PCPCH, also play a central role in coordinating the member’s care needs. PCPCH’s and care coordinators both help ensure that all providers involved in a member’s care, including LTC care providers, mental health crisis services and home and Community-based services for members with SPMI, as well as other health plans, such as Medicare Advantage plans serving dual eligible members, are able to exchange clinical and other pertinent information to improve safety, ensure appropriate utilization and identify opportunities to improve health and outcomes. In addition to the strong suite of tools and processes currently in place, we continue to expand our ability to share data and clinical information to further strengthen relationships among systems caring for high risk patient populations.

6.a.(2) Describe how the Applicant will work with its providers to develop the partnerships necessary to allow for access to and coordination with social and support services, including crisis management services, and Community prevention and self-management programs.

Health Share works with our partners and providers to increase access to and coordination with social and support services, including crisis management services and community prevention and self-management programs by convening stakeholders, facilitating discussions and providing funding support for pilot programs. We recognize that in our community, as with most communities across the state, members often engage with numerous service providers and touch multiple social sectors. These partners play a critical role in the lives of so many Health Share members, and include (among others) health, housing, education, child welfare, criminal justice, community-based organizations, or public health. With this in mind, Health Share prides itself on working across multiple organizations and sectors to find better methods of bringing resources closer to those providing care coordination, educating about new or emerging best practices, and creating connections across people who do similar work but perhaps in very different domains.

Caring for children in foster care – One particularly strong example of this work is our focus on improving the systems and supports for children in foster care. Through ongoing partnership and innovation efforts with our providers, Health Share ensures youth who enter DHS custody receive comprehensive and immediate supports. We recognize that for this population, expedited access to care is a top priority and strong relationships with our providers are key to that access. To build those relationships, Health Share convenes providers from our Advanced Primary Care Homes in a learning
collaborative format to learn from one another, establish best practices, and improve care for this vulnerable population. Each month, Health Share partners with regional stakeholders in our three counties to address access barriers and increase coordination of care between the CCO, behavioral health providers, and DHS Child Welfare. Data is used to identify gaps in connections to care, which prompts ongoing quality improvement efforts by Health Share, our providers, and our DHS partners.

**Linking families to services** – As described in section 2, Health Share is working with providers to implement Help Me Grow in our region. When a PCP identifies developmental concerns, one common referral is to Early Intervention/Early Childhood Special Education. Unfortunately, many children do not qualify for services, and providers are left without a clear place to refer members. In these cases, Help Me Grow helps providers connect children and families to a wide array of services including family supports, home visiting programs, parenting classes and other behavioral health supports to address toxic stress and SDOH.

Health Share has very close relationships with the three counties (Clackamas, Multnomah, and Washington) in our service area, and all three counties have membership on our board, committees and workgroups. Health Share works closely with the counties to support and facilitate relationships among the three counties and with physical and oral health providers as well as with community-based organizations to identify priority areas of need and develop and implement targeted solutions. This includes very close integration with these counties' public health efforts, including suicide prevention, elder abuse services and housing development. Since county mental health program funding supports non-health plan activities, such as residential treatment homes/facilities, mental health services in the jail/criminal justice system, walk-in and mobile crisis teams, and supports for schools, Health Share’s close ties with county leaders is essential in helping to identify and support the needs related to crisis management and safety net services within the counties.

**6.a.(3) Describe how the Applicant will develop a tool for Provider use to assist in the culturally and linguistically appropriate education of Members about Care Coordination, and the responsibilities of both Providers and Members in assuring effective communication.**

Health Share requires that all providers use a culturally and linguistically appropriate approach when communicating with and educating members. Health Share convenes the Cultural Competency & Health Equity Workgroup (CHEW), which is charged with advancing equity, diversity and inclusion (EDI) initiatives. CHEW meets quarterly and utilizes a learning collaborative framework to share and spread best practices on culturally and linguistically appropriate services across health plans. The workgroup is made up of key staff charged with advancing equity and promoting policies, practices, and procedures supporting the provision culturally and linguistically appropriate services. **This workgroup will use its learning collaborative format**, which supports sharing of knowledge and joint creation of solutions to create and disseminate this tool for providers that will summarize best practices for assisting in the culturally and linguistically appropriate education of members. This tool will include information about the care team structure, care plans and how they are created in a person-centered way, and how to access care coordination. The tool will also outline the responsibilities of providers and members in ensuring effective communication, be compliant with health literacy standards and be available in multiple formats. Increasingly, we will be incorporating community voices to improve culturally and linguistically appropriate services.

Examples of work undertaken by the CHEW group in the past includes the following:

- **Organizational cultural competency assessments** of plan partners to assess policies and procedures supporting the delivery of culturally and linguistically appropriate services to members
- **Language access strategy** project focused on improving member language access policies and trainings for plan partners and providers
- **Member grievance data disparity analysis** project to improve equitable access to member...
grievance process and enhance staff capacity to identify opportunities to advance equity through member grievance data

- **Member communication translation improvement** project focused on creating best practices for translating member materials

**Case Study: My easy drug system chart (MEDS Chart)** – CareOregon used a human-centered design process to listen to members to determine unmet health care needs. Medications and medication coordination emerged as a significant area of concern. Members were then involved in a design process to create a way to communicate their medication and care coordination needs in a way that would work for them. The MEDS Chart was developed to provide a trauma informed care and social determinant-informed tool for members to manage their medication needs. It is available in 4 non-English languages and is designed to be responsive to any language or literacy level to improve engagement and activation. It is provided to every new member as part of the member handbook.

6.a.(4) **Describe how the Applicant will work with Providers to implement uniform methods of identifying Members with multiple diagnoses and who are served with multiple healthcare and service systems.**

We work to optimize effective data sharing among providers and systems within the network and to establish and promote implementation of uniform methods of identifying members with multiple diagnoses and who are using services across multiple systems, with particular attention to disparities.

In order to identify these members, Health Share uses a combination of analytics, risk stratification, and clinical judgment along with national standards such as HEDIS. These members may also self-identify or be identified by a provider, community partner, or through utilization of services prior to meeting thresholds used in our systematic, data-driven process. Additionally, Health Share proactively targets members who are identified as rising risk and, in the absence of intervention, are likely to meet criteria in the future.

The process for identifying these high-risk members and working with providers includes the following: 1. Identify all major diagnoses using predetermined national definitions such as HEDIS or NQF 2. Determine level of medical complexity based on the number of conditions, overall cost, frequency and recency of visits. 3. Track ‘natural clinical network’ based on the most frequently utilized and most recently utilized providers. 4. Provide clinical data, including a summary of conditions, most recent visits, medical fragility, to providers in the member’s natural network of providers.

6.a.(5) **Describe how Applicant will implement an intensive Care Coordination and planning model in collaboration with Member’s PCPCH and other service providers such as Community Developmental Disability Programs and brokerages for Members with developmental disabilities, that effectively coordinates services and supports for the complex needs of these Members.**

High quality care coordination aligns all providers working with the member to produce optimal health outcomes. The PCPCH is central to care coordination for all members but is particularly important in coordination services and supports for members with developmental disabilities. Children are routinely screened for developmental delays in infancy and early childhood, and development continues to be assessed in older children during routine well child checks. All new members receive an initial health risk screening which gathers information about physical, oral and behavioral health needs. Members with special health care needs who qualify for Intensive Care Coordination (ICC) receive additional outreach about their right to ICC and how to connect to the care team. Once a member enters ICC, an Individualized Care Plan (ICP) is created based on identified needs and in collaboration with the member and the member’s PCPCH.

The ICC care coordinator is at the center of this information sharing which allows the member to experience a collaborative care plan. An example of this is the work by ICC care coordinators to create a robust system of care coordination for members receiving Applied Behavioral Analysis (ABA)
services by bringing together the PCPCH, the ABA providers, developmental pediatricians, and the IDD case workers to provide a seamless spectrum of services for the member. For adults and youth with Intellectual and Developmental Disabilities (IDD), ICC coordinators work with the appropriate case managers from IDD programs or brokerages to identify needs specific to the member and develop an individualized, culturally responsive care plan to address those needs. For children and youth, care coordination includes the PCPCH, the member and family, behaviorists, therapists, specialty providers, the schools or Early Intervention and other community agencies.

6.a.(6) Describe how the Applicant will meet state goals and expectations for coordination of care for Members with severe and persistent mental illness receiving home and Community-based services covered under the State’s 1915(i) SPA and Members receiving DHS Medicaid-funded LTC services, given the exclusion of DHS Medicaid-funded LTC services from Global Budgets.

Health Share provides care coordination for members with SPMI and those receiving LTC services through an individualized, strengths-based, recovery-focused, person-centered approach. The widely acknowledged health disparities seen across the lifespan for members with SPMI require a strong partnership among behavioral health, oral health, and physical health partners. Working collaboratively with members, their natural systems of support, peers, and community providers, the Health Share ICC develops ICPs that include personalized goals for treatment and recovery, plans to address gaps in care, and estimated dates for achieving these goals. The member’s recovery goals serve as the roadmap to determine the least restrictive, most integrated physical, behavioral, oral, and social services and supports available for each member. The ICC coordinator communicates openly and regularly with the member to assure that the services stay aligned with the member’s recovery goals.

Members who are receiving 1915i HCBS (Home and Community-Based Services) in conjunction with their behavioral health services, have individualized care plans created to reflect their needs and to support the request for those additional habilitative services. Consistent with Health Share’s commitment to keeping the member’s voice at the center, care plans are created by a member’s care coordinator and/or service provider, in conjunction with the member and the support system that the member chooses to include in that process. 1915i services are intended to provide habilitative services (above and beyond treatment services) that are necessary to support the individual’s recovery, as they define it, and to maximize their ability to remain healthy and stable in the most integrated, community-based setting possible. Care plans are regularly updated as required by either OHA or the IQA reviewing the plans; they are also updated by the assigned care coordinator whenever the member is moving to a new setting and may require a different range of services to support that transition.

For members receiving DHS Medicaid-funded LTC services, consistent with OAR 410-141-3170, ICC coordinators support the flow of information between disability and aging agency partners, identify supports needed for any transitions, and when necessary provides increased levels of support and care coordination, such as arranging for an Intensive Care Coordination Conference (ICCC) with the member, providers, and any agency that is involved in the member’s care to discuss the specific needs of the member.

6.a.(7) Describe the evidence-based or innovative strategies the Applicant will use within their delivery system network to ensure coordinated care, including the use of Traditional Health Workers, especially for Members with intensive Care Coordination needs, and those experiencing health disparities.

Health Share members often have complex care coordination needs. Given the demographic, diagnostic and social determinant challenges members face—including a high prevalence of trauma and system distrust—traditional approaches to care coordination are necessary but often insufficient to meeting the need. In these instances, highly coordinated trauma-informed care is necessary and the role of THWs are critical in engaging with members to find the best care pathways possible.

One example of a place we have used THWs in a team-based care setting is with our Regional Care Teams (RCTs). These multidisciplinary teams include medical staff, behavioral health staff, CHWs, and pharmacists. The teams are assigned by member’s PCP and do not change over time. This allows
the team, the member, and the provider to become more knowledgeable of each other thus improving the quality of care coordination. It also creates simplicity as the member and provider call one number to access all disciplines. The team works collaboratively via a shared care plan to address all of the member’s needs. The teams also have capacity for different levels of intensity. All RCTs are equipped with both telephonic and community-based staff.

Another example of a community-based staff is the **health resilience specialist**. These specialized care coordinators provide intensive engagement, community connection and care coordination. They address the needs of people with intensive care coordination needs, connecting them with primary care, specialty or behavioral health as appropriate with a heavy reliance on the role of peers and natural supports.

Health Share uses evidenced-based practices and innovative strategies to ensure members receive coordinated care, with a special focus on members who experience health disparities or require ICC. Evidence-based practices include the use of THWs such as CHWs, peers, and doulas to improve care coordination and reduce disparities for vulnerable populations. For example, within our behavioral health system, we make THW and peer supports available to all members whether or not they are engaged in any kind of treatment.

Health Share also utilizes data, geo-access mapping and a health equity lens to identify opportunities to improve care coordination through culturally specific programs focusing on populations with high rates of disparities, including African American pregnant women, pregnant women with substance use disorders, Latinx women and children, and dual members with mental illness.

**6.a.(8) Assignment of responsibility and accountability: The Applicant must demonstrate that each Member has a PCP or primary care team that is responsible for coordination of care and transitions.**

**6.a.(8)(a) Describe the Applicant’s standards that ensure access to care and systems in place to engage Members …not later than 30 days after Enrollment with the CCO.**

Health Share supports member choice in selecting health care providers to manage their physical, behavioral, and oral health care needs and works collaboratively with members to facilitate successful connection with their health care providers. Health Share ensures that all members are assigned to a PCP within 30 days of enrollment with preference to PCPs certified as a PCPCH. At the time of enrollment, each new member receives an initial health risk screening. This information helps identify each member’s individualized care needs, including the appropriate level of care, and is also used to connect members with a care coordinator as appropriate. Members with special health care needs receive special outreach via a letter that informs them of their right to care coordination and includes information on how to connect with the care team. The care team then engages the member in completing an assessment & generating a care plan.

The care coordinator helps the member engage with appropriate physical, behavioral and oral health providers and other support services. Care coordinators share pertinent information with PCPs and other members of the care team to facilitate care coordination and a holistic approach to providing care to each member. As PCPCH providers evolve their ability to optimize care coordination at the site where the member seeks care, Health Share will support them with data and electronic tools to:

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$3.3 Million

**ORCHWA Infrastructure Investment**

We made a 3-year investment in 2018 to develop the necessary infrastructure to support reliable contracting with community-based and culturally specific CHWs. This infrastructure will include:

- A data system
- Payment model development
- TA for health systems, public health, and CBOs
1) prioritize populations for additional supports, 2) ensure disparities are being adequately addressed and 3) use trauma-informed approaches to operationalize these efforts.

6.a.(8)(b) Describe how the Applicant will provide access to primary care to conduct culturally and linguistically appropriate health screenings for Members to assess individual care needs or to determine if a higher level of care is needed.

Health Share recognizes that each member encounter is an opportunity to provide care to our members in a manner that best meets their needs and in culturally and linguistically appropriate ways. We expect all partners, providers and PCPs to provide equitable, understandable, and respectful care to members. In particular, Health Share and our partners will work with the members to identify an appropriate PCP based on identified cultural and linguistic needs. The PCP performs initial health assessments through culturally and linguistically appropriate health screenings, including using interpretation services when appropriate. PCPs collaborate with care coordinators to further assess individual care needs, including transitions to a higher level of care if necessary.

As we continue to develop a culturally and linguistically diverse workforce, using interpretation services whenever necessary, Health Share will work to improve our PCP assignment process to align patients with particular cultural and linguistic needs with clinics serving those needs, if available. We believe this will enhance the ability of special populations, such as racial and ethnic groups, LGBTQIA, and others, to be served by providers who are able to address their specific needs. For members seeking behavioral health services, our online provider directory indicates providers’ specialties such as services for veterans, transgender members, pregnant and postpartum women, or Burmese members.

6.a.(9) Comprehensive Transitional Care: The Applicant must ensure that Members receive comprehensive Transitional Care so that Members’ experiences and outcomes are improved...

6.a.(9)(a) Describe the Applicant’s plan to address appropriate Transitional Care for Members facing admission or discharge from Hospital, Hospice or other palliative care, home health care, adult foster care, skilled nursing care, residential or outpatient treatment for mental health or substance use disorder, the Oregon State Hospital or other care settings...

Health Share’s partners in physical and behavioral health play a central role in coordinating care for members requiring a transition in level of care. Whether a member is an adult, child, or adolescent, is being treated for a physical or behavioral health condition, is being admitted to or discharged from a hospital, home health or hospice care, a skilled nursing facility, adult foster care, residential or outpatient treatment for mental health or substance use disorder or the Oregon State Hospital, care coordinators work collaboratively with members, their support networks, treatment teams, and facility discharge planners to ensure patient safety, to reduce readmission risk, and to improve health outcome. Specific examples of the care coordinators’ role include assessing the following:

- Member’s understanding of their hospitalization
- If they received a discharge plan in their native language
- Readiness for discharge
- Appropriate services in place to reduce risk of readmission

All care coordinators are trained in interpreter access and best practices for engaging members in a culturally and linguistically appropriate manner.
PCPs, particularly those certified as PCPCH, are an integral part of ensuring smooth transitions between levels of care for members by providing clinical information and context upon admission and by providing follow up care once a member is discharged. Health Share has several PCP groups that have transition programs for high-risk populations with special teams that focus on the specific needs of the populations they serve. These include clinics with a high proportion of linguistically or culturally diverse members or members with substance use disorder or mental health conditions. These clinics have special teams that are much more appropriate to the population served and include timely and culturally appropriate transitions and care coordination. Whenever possible and appropriate, care coordinators connect with the member while at the hospital to begin the transition process and collaborate with those on the member’s treatment team (including the member) to ensure a successful transition to the next level of care.

**Specialist transitions team** – The REACH team at OHSU Richmond Clinic, a primary care site designated as an FQHC, is a specialized transitions team is a multidisciplinary onsite team consisting of a nurse, pharmacist, care coordinator, and health resilience specialists. The team triages all hospital discharges and tailors interventions to individual needs, including home visits by the nurse or social worker if needed. The REACH team is closely connected with health plan care coordinators to address any issues that are most easily addressed at the health plan level, such as durable medical equipment requests.

In behavioral health, programs such as Wraparound, ICC, Choice, and Utilization Management provide ICC for members transitioning to or from facility, residential treatment or state hospital care. For youth and adult members being referred to Oregon State Hospital or residential treatment, Wraparound and Choice teams (respectively) are responsible for ICC services, starting from the initial referral, partnering with other health, social and community supports and work throughout the treatment episode to explore options and divert the member to the least restrictive, most integrated setting possible that can safely and effectively meet the needs of the member. This includes partnering with the physical health plan, APD, Home Health, and any other providers who may be necessary to support the member in a successful transition to a less restrictive setting. An example of this coordination may include the coordinator connecting with providers, the member and the facility to ensure the member has an appointment scheduled with their outpatient provider(s) for an assessment within seven days of discharge from a hospital to ensure re-engagement; or to help an unassigned member engage with a transition team to assist in connecting to a new provider at the new level of care, and staying in contact with the member and providers to ensure the appointments occur.

**6.a.(9)(b) Describe the Applicant’s plan to coordinate and communicate with Type B AAA or APD to promote and monitor improved transitions of care for Members receiving DHS Medicaid-funded LTC services and supports, so that these Members receive comprehensive Transitional Care.**

When a member receiving LTC services and supports requires a transition of care, Care Coordinators from the health plan and Type B AAA or APD meet in-person or by phone, and exchange emails to share information and identify needs to support the transition, including the appropriate setting for further care. When indicated, an interdisciplinary care coordination conference, with the providers and agencies involved in the member’s care, is arranged to develop a culturally and linguistically appropriate care plan to address the member’s needs, with additional follow up meetings as necessary.

**Behavioral health care coordinators** assist in coordinating and integrating any mental health and substance use services that may be needed and are actively involved when a member may benefit from placement in a residential treatment setting or foster home that is licensed as behavioral health.

**6.a.(9)(c) Describe the Applicant’s plan to develop an effective mechanism to track Member transitions from one care setting to another, including engagement of the Member and Family Members in care management and treatment planning.**
Health Share is actively working to develop an automated set of metrics to track member transitions between care settings. Currently, we track Follow-up after hospitalization for Mental Illness and hospital readmission rates (which may indicate poorly managed transitions of care). We are currently developing a new measure, Follow-up after Detox, and will continue to expand our ability to track other transitions as well.

Along with the transitions of care measures currently available and under development, Health Share’s partners use a range of electronic medical records (EMRs) and care coordination platforms with the goal that every involved provider can view, access, and edit documents pertaining to the member. Care coordinators identify and track members who are transitioning from one care setting to another and document engagement of the member and family members in care planning as well as communication with the provider, facility or other agency to ensure member needs are met as planned.

### Intensive Transition Teams (ITT) –

Intensive Transition Teams, currently in all three counties, engage with members while in psychiatric inpatient settings, helping to plan for discharge and to engage with and connect members without current outpatient mental health supports. The goal is to connect individuals without current behavioral health supports to community-based specialty behavioral health providers for follow-up and ongoing care. This early engagement and transition program helped **Health Share achieve a 32% increase** in timely follow-up care for members discharging from psychiatric inpatient stays.

In addition to organization-specific EMRs or care coordination platforms, software and communication tools that assist in inter-organization communication are used whenever available, such as Pre-Manage, secure messaging, EDIE, and Care Everywhere. For organizations that cannot share information across EMRs, shared secure tracking documents will be employed, with the goal of every involved provider being able to view, access, and edit the document pertaining to their shared client.

Health Share’s partners have agreed to move forward with expanded HIE functionality in line with OHA’s HIE Onboarding Program. The scale and scope of the expansion will be decided by a HIT Governance Structure in partnership with clinical and operational leadership.

### Standard Transitions Program –

Health Share invested early resources in developing a Standard Transitions Program that built upon Kaiser’s transitional care model and created a standardized discharge document and transition protocol for use in a majority of hospital discharges. The document improved ease of information flow between inpatient and outpatient settings and set a standard of 24 hour post-discharge follow-up call. The phone call was used to determine whether medication reconciliation was needed, as confusion about medications was a key driver of readmissions and poor outcomes.

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**6.a.(10) Individual care plans:**

6.a.(10(a) Describe the Applicant’s standards and procedures that ensure the development of individualized care plans, including any priorities that will be followed in establishing such plans for those with intensive Care Coordination needs, including Members with severe and persistent mental illness receiving home and Community-based services covered under the State’s 1915(i) SPA.

As required by ORS 414.625, Health Share expects that providers and care coordinators use ICPs to address the supportive and therapeutic needs of members requiring ICC, including those with severe and persistent mental illness, and that ICPs reflect member or family preferences and goals to ensure engagement and satisfaction.

ICPs are developed with the member and/or member representatives and care providers to identify areas of supportive and therapeutic need; to map measurable and achievable goals of care to achieve
best possible outcomes in terms of member well-being and safety, and to avoid unnecessary service utilization and costs. The care plans are reviewed regularly to ensure progress is made or adjustments happen as needed to ensure engagement by the member and member family/caregivers.

The development of an individualized care plan begins with the identification of the complex member needs through a review of the member’s health care histories, current functional domains statuses, situational issues and goals. The initial development of the ICP can occur through completion of the new member enrollment screen and needs assessment when a request for services is received by a member/member representative, a provider or from AAA/APD or other community sources. Once the request is submitted, the Care Coordinator reaches out to the member within one business day of receiving the request to continue the process of developing the ICP with the member/member representative input and agreement.

Care coordinators engage the member and their supports, providers, aging and disability agencies, and other community resources in the development of the ICP. Those working on the care plan identify a lead Care Coordinator who initiates a care conference involving all pertinent parties to ensure one ICP is developed and implemented to address the full scope of services and agreed upon goals. ICPs are dynamic and change with the needs of the member. Once care plans are reviewed and aligned, documentation is updated and synchronized in the various electronic tools, such as PreManage, and EMRs where the member’s information is being managed.

6.a.(10)(b) Describe the Applicant’s universal screening process that assesses individuals for critical risk factors that trigger intensive Care Coordination for high needs Members; including those receiving DHS Medicaid-funded LTC services.

Health Share’s screening process for adults begins at the time of enrollment. All adult members receive a culturally and linguistically appropriate health screening within 90 days of enrollment, which gathers information about physical, behavioral, and oral health needs and SDOH. If the screening identifies that the member has certain high-risk triggers, a health risk assessment is conducted also within the same 90-day period. As indicated above, if the member is identified as receiving LTC services or identified as having special needs at enrollment, an assessment is completed within 30 days of enrollment. Additionally, for adults and children, PCPs use evidence-based screening tools appropriate for the age of the member to identify physical, mental health and substance use risks. Highest risk members, such as those with chronic illnesses plus SDOH factors or those in LTC, are referred to the health plan for more intensive care management when appropriate.

6.a.(10)(c) Describe how the Applicant will factor in relevant Referral, risk assessment and screening information from local Type B AAA and APD offices and DHS Medicaid-funded LTC Providers; and how they will communicate and coordinate with Type B AAA and APD offices.

In accordance with Health Share’s existing LTSS MOU, care coordinators reach out to aging and disability agencies to identify any needs for interdisciplinary care coordination conferences (ICCC) based on referral, risk assessment and screening information gathered by the agencies. Anyone on an LTSS member’s care team may request an ICCC. The care team member who requests the ICCC provides information to complete the ICCC Request form and identifies and invites members of the care team, including the member and a support person of their choice.

6.a.(10)(d) Describe how the Applicant will reassess high-needs Members at least semi-annually or when significant changes in status occur to determine whether their care plans are effectively meeting their needs in a person-centered, person-directed manner.

Member ICPs are developed with the member’s specific needs in mind and monitored accordingly. This means that the ICP will contain goals and progress toward goals agreed upon by the member and within specific time frames connected to each goal identified. ICPs are reviewed on a daily, weekly, or monthly basis depending on the specific needs of the member. At any time during this process, when a significant change in status occurs or the member, member representative, provider or care team
requests, the ICP may be reassessed to set new goals and provide additional resources as identified. This continues until all goals are met and the case is closed.

Reassessment occurs at least semi-annually after case closure when no new needs are identified. The case closure date sets a calendar note for follow-up within the six-month period for reassessment needed to ensure no new needs have been identified. Care coordination may also be re-opened at any time based on member need or when requested by the provider, the member, or their representative. If another need arises, members re-engage in care coordination services at which time their health risk is reassessed and a new ICP is developed.

6.a.(10)(e) Describe how individualized care plans will be jointly shared and coordinated with relevant staff from Type B AAA and APD with and DHS Medicaid-funded LTC Providers and Medicare Advantage plans serving Fully Dual Eligible Members.

Once an ICCC has been scheduled, the member and all providers are sent an invitation to attend. A standardized ICP form is used during the ICP that includes the contact information of the care coordinators from the IDS and ICN, the AAA and APD, the LTC provider involved, and the MA plan (if there is one). ICPs are developed with input by all providers, agencies, support services, and the member. ICCCs occur in-person or by teleconference. Once the ICP is developed and agreed upon, it is distributed to all of the participants, including agency staff and LTC providers, and is made available electronically. When progress is made towards goals or any change occurs, this information is updated in the ICP and shared with the team (noted above) to ensure communication occurs to facilitate coordination of services and resources and to reduces redundancies in services provided.

6.a.(11) Describe the Applicant’s plan for coordinating care for Member oral health needs, prevention and wellness as well as facilitating appropriate Referrals to oral health services.

Health Share maintains a “no wrong door” philosophy for care coordination and referral to services. Oral health needs, prevention and wellness activities are identified in multiple ways, including but not limited to initial screenings, providers, plan partners, Health Share, OHA, community agencies, members and their families. Regardless of where a request or referral for oral health services is received, care coordinators from that discipline ensure members are connected with their dental plan for direct outreach, navigation and scheduling. The dental plans also maintain robust networks of primary and specialty dental providers and care coordinators to ensure prevention services and treatment are readily available and highly coordinated for members. In addition, school and community-based oral health wellness and preventive programs are conducted throughout the service area by Dental3, and proactive outreach and visit scheduling are conducted by dental plans to targeted populations such as children aged 0-5, sealant aged children, members with diabetes and pregnant members.

6.a.(12) Describe Applicant’s plan for coordinating Referrals from oral health to physical health or Behavioral Health care.

Health Share’s dental provider networks reach out when they identify an unmet health need in the dental setting. In some cases, the dentist partners directly with the PCP or behavioral health provider, but in many situations, the dental plans are engaged to work across health disciplines to facilitate care coordination on behalf of the member. When other unmet health needs are known or suspected, coordination and collaboration with physical or behavioral health providers are initiated to support the member. In these situations, care coordinators reach out to the PCP or other care coordination partner and work with them to ensure the unmet health needs are assessed, coordinated and addressed. To support this interdisciplinary care coordination, Health Share created a care coordination tool that provides a guide for conducting this level of member support. In addition, CareOregon is currently working on an electronic submission process for oral health providers to request physical and/or behavioral health care coordination services for their members. Health Share and its partners are also committed to supporting the success of OHA’s HOP program with Reliance eHealth Collaborative, whose goal will be to expand use of HIE functionality to increase
timely access to data across systems, with a particular focus on integrating dental and behavioral health information with physical health information.

6.b. Care Integration (recommended page limit 1 1/2 pages)

6.b.(1) Oral Health

Describe the Applicant’s plan for ensuring delivery of oral health services is coordinated among systems of physical, oral, and Behavioral Health care.

Coordinating delivery of oral health services – Health Share’s plan for ensuring delivery of coordinated oral health services constitutes meaningful, collaborative relationships between physical, oral and behavioral Care Management leaders at the member and system levels via Health Share’s bimonthly Care Integration Workgroup, as well as the monthly Clinical Advisory Panel. These groups will provide strategic and operational recommendations for care integration. When oral health needs are identified at any point in the health care system, the region’s care management supervisors know whom to call to ensure those needs are met. While relationships across systems always benefit care coordination, Health Share recognizes that an electronic approach can have a broader reach. To address this system need, CareOregon enabled their physical health providers to submit online physical health providers, but given its success, Health Share recently invested a portion of our Quality Pool earnings to pilot an enhancement of this system so that behavioral health providers can also submit referrals online for dental services. Additionally, in an effort to continuously innovate, Health Share funded CareOregon’s Diabetes Integration Project Collaborative over two years (2018-2020) to improve integrated care for patients experiencing both diabetes and severe and persistent mental illness (SPMI). The grant funds direct service at pilot integration sites in the Portland metropolitan area as well as a cross-disciplinary learning collaborative to build out integration efforts and disseminate learnings across CareOregon’s network.

Case Study: SDOH screening in dental offices – As part of an integrated care delivery system, Kaiser Dental works with their medical partners to identify disparity gaps for dental care through social, economic, and behavioral needs (SEBN) screening at various touch points throughout the system. Any needs identified from these screenings are triaged appropriately and entered into the electronic health record so that all members of a patient’s care team have access to the information and can act on it accordingly. In another case, a dental care coordinator sits on the physical health care coordination team and works closely with all partners to refer and coordinate care for members with unmet physical, behavioral or oral health needs. As we continue to hone in on these best practices for coordinating care across systems, we will expand these efforts across our CCO.

6.b.(1)(b) Describe Applicant’s plan for ensuring that preventive oral health services are easily accessible by Members to reduce the need for urgent or emergency oral health services.

Health Share’s members are assigned to a Primary Dental Provider (PDP) assuring access to oral health providers. Health Share and its dental plans track a broad range of preventive services provided by the PDP networks, including fluoride, sealants, cleanings, oral hygiene instructions and nutritional counseling, and work with their provider networks to increase the provision of these prevention services. Dental providers use treatment plan completion codes and oral health risk scores as a basis for outreach to members with open treatment plans and to set preventive strategies and recall intervals that are tailored to the needs of the individual patient. One plan offers additional preventive services to members through an Oral Health Wellness program for members who have higher risk scores. Other plans do additional outreach, navigation, and in some cases, offer member incentives to special populations such as foster children, members with diabetes, pregnant members, members who have not received a dental service in the past 18 to 24 months, members aged 0-5 years and members with SPMI who may be more likely to seek urgent or emergent care.
Health Share’s dental care organizations are members of Dental3, which provides community-based preventive oral health services in schools and Head Start locations throughout the Health Share service area. A subset of Health Share’s dental plans also contract with school-based health centers that offer prevention services delivered by expanded practice dental hygienists and a school-based program at Faubion K-8 that offers comprehensive dental services with a dentist in a school setting. One of our dental plans also provided funding to the Native American Rehabilitation Association (NARA) to develop and operate culturally specific, mobile dental services in their residential facilities and at community events.

6.b.(2) Hospital and Specialty Services

Describe how the Applicant’s agreements with its Hospital and specialty care Providers will address:

6.b.(2)(a) Coordination with a Member’s Patient-Centered Primary Care Home or Primary Care Provider

Coordinating hospital and specialty services – Health Share requires its hospital providers to communicate and coordinate care with the PCPCH in a timely manner using electronic health information technology such as integrated EHRs and PreManage. Health Share’s unique approach to partnership with Integrated Delivery Systems and the Integrated Community Network supports the promise of integrated care, which incorporates shared information and communication through such HIT tools, providing a distinct advantage in caring for our members and measuring clinical performance. Health Share’s Integrated Delivery System partners fully integrate hospital, specialty, and primary care services across the continuum, managing total cost of care. Adventist, Kaiser Permanente, Legacy Health Systems, OHSU, Providence, and Tuality hospitals are all founding Health Share members, and part of contracted Integrated Delivery Systems within Health Share—managing hospital systems as well as employing their own ambulatory care systems including PCPCH and specialty care networks. Additionally, via Care Everywhere hospital teams can identify PCPCH assignment for members outside their systems and work with partner organizations to address member needs, and even repatriate members when clinically appropriate to assure care plans are followed and reduce duplication of service.

In CareOregon’s ICN, we work with Hospital and specialty providers in coordinating with our PCPCH providers. Coordination with the member’s PCPCH begins with the Initial Health Screening which asks members key questions regarding their health, SDOH, dental and behavioral health needs. When issues are identified, the care coordinator creates a care plan and begins working with the member’s PCPCH. This coordination can occur through many methods including telephone, electronic communication, or via an Interdisciplinary Care Team meeting for members with complex needs. Hospitals and PCPCH’s also have advanced use of the PreManage. Utilization is now widespread in the region and quickly identifies high risk patients with real-time notifications of utilization of hospitals, ED, and now starting to include Skilled Nursing Facilities (SNF). Care coordination occurs across multiple systems include the PCPCH, behavioral health, SNF, and hospital. The use of the PreManage increases efficiency and timeliness of these activities, as well as optimal targeting of high-risk populations by the right point of contact. Additionally, through the use of VBP models, we encourage hospitals to coordinate care for members who are frequent ED utilizers.

6.b.(2)(b) Processes for PCPCH or Primary Care Provider to refer for Hospital admission or specialty services and coordination of care.

Health Share’s partner agreements with Hospital and Specialty providers assure that care can be coordinated efficiently and effectively through the PCPCH. Within Health Shares’ network, the PCPCH and/or specialist can request initial and ongoing care. At times, members can directly access specialty services. All authorization information is available to PCPCH and PCPs so they can stay informed of services their members are receiving. Urgent/Emergent admissions do not require prior authorization. For pre-planned admissions PCPCH or PCPs submit requests for inpatient services. These requests are reviewed for medical necessity and compliance with OHP guidelines for coverage.
Each request is reviewed on its own merit for presence of a contributing co-morbidity or need for a benefit exception. The PCPH has consistent access to care coordination support. We consistently reach out to providers (primary care and behavioral health) to explain how to access care coordination services.

Similarly, each IDS employs its own electronic medical record, with all clinical information present in real-time for all those who participate in the care of our members. As primary care teams guide patients through the entire care continuum, they are able to make appropriate referrals and communicate in real time with specialty and hospital team members.

6.b.(2)(c) Performance expectations for communication and medical records sharing for Hospital and specialty treatments, at the time of Hospital admission or discharge, for after-hospital follow up appointments.

Health Share requires coordination between hospitals, PCPCH, and specialty providers as outlined in the sample contract. Health Share partners receive hospital notification when members are admitted to facilities. This occurs via PreManage whenever possible. Health Share expects our PCP network to communicate and share records between hospital and specialty treatment providers especially at the time of hospital admission and discharge and these responsibilities are identified in the Provider Manual and in provider agreements. The coordination of care and sharing of information is essential to the successful transition of the member from differing levels of care. For providers who utilize Epic, providers receive information regarding a member’s care in the hospital or in specialty treatment utilizing Care Everywhere. This allows for the electronic flow of information between the PCPCH and other providers. Most network providers are utilizing the PreManage to receive real-time notification of admission and discharge from facilities. This is especially important for those clinics who not have Care Everywhere. PreManage allows for the creation of shared care guidelines, which are made visible to all providers within the member’s care team. The care coordination team at the IDS or ICN serves as a bridge for information sharing. They strive to connect all the pieces of the member’s care and often assist the PCPCH, the hospital, and specialty provider in sharing information to optimize the member’s health outcomes.

In 5 years, Health Share was able to achieve a 32% increase in timely follow-up care for members discharging from psychiatric inpatient stays, largely due to the expansion of Intensive Transition Teams (ITT) into each of the 3 counties. In the ITT model, interdisciplinary mental health staff outreach directly in the hospital, helping to connect members without current outpatient mental health supports to community-based specialty behavioral health providers for follow-up and ongoing care. This early engagement and warm hand-off ensured that by 2017 nearly 90% of all members received timely follow-up after discharge from a psychiatric inpatient stay.

6.b.(2)(d) A plan for achieving successful transitions of care for Members, with the PCPCH or Primary Care Provider and the Member in central treatment planning roles.

Within the Health Share network, facility discharge planners work collaboratively with the member’s PCPCH and others of the care team. IDS and ICN care coordinators work with the facility discharge planners to assist in the facilitation of discharge or transitions between levels of care. The care coordinator will assess for transition needs with the member including confirmation of the member’s understanding of their hospitalization, if they received a discharge plan in their native language and readiness for discharge. Care teams are adept at working with the member and their support network in supporting complex members to move to the next level of care—accessing supportive services such as the Recuperative Care Program and other intermediate care options. The care coordinator and facility staff ensure members have appropriate services in place to reduce readmission and improve
health outcomes. Due to the comprehensive and advanced use of the PreManage, many PCPCHs are
notified in real time of discharge from hospital as well. The care coordinator works collaboratively
with the PCPCH ensuring a follow up appointment has been made and addresses other needs the
PCPCH or member might need to assure a successful transition. A care guideline is created within the
PreManage so all providers involved in the members transition are notified of care coordination
efforts across multiple systems.

When a member is discharged to a Skilled Nursing Facility, we work in collaboration with those
facilities and the PCPCH to provide the best care coordination possible. Care coordination teams
from the IDS or ICN, the PCPCH and the SNF are notified that a member has entered a SNF via
PreManage. Transitional care for the member begins at time of admission which ensures ample time
for appropriate discharge planning. When the member is ready for discharge, the care coordination
staff between the health plan and the SNF work together to address any issues including clinical and
utilization management barriers such as needed durable medical equipment. Information is shared
with the PCPCH and follow up appointments with the PCPCH are established upon discharge from
the facility.

**Standard Transitions Program** – Health Share invested early resources in developing a Standard
Transitions Program that was built from Kaiser's transitional care model and created a standardized
discharge document and transition protocol for use in a majority of hospital discharges. The document
improved ease of information flow between inpatient and outpatient settings and set a standard of 24-
hour post-discharge follow-up call. The phone call was used to determine whether medication
reconciliation was needed, as confusion about medications was a key driver of readmissions and poor
outcomes.

Health Share will work with our CAP to assess the current state and will build on our work around
standard transitions in previous years to assure that there are successful transitions of care for
members, with the PCPCH or PCP and the member in central treatment planning roles.

6.c. **DHS Medicaid-funded Long Term Care Services (recommended page limit 2 pages)**

6.c.(1)(a) Describe how the Applicant will: Effectively provide health services to Members receiving DHS
Medicaid-funded LTC services whether served in their own home, Community-based care or Nursing Facility
and coordinate with the DHS Medicaid-funded LTC delivery system in the Applicants Service Area, including
the role of Type B AAA or the APD office

Coordinating DHS Medicaid-funded LTC services – Health Share currently provides health
services to all members, including those receiving DHS Medicaid-funded LTC services. We have a
signed and executed MOU with DHS Medicaid-funded LTSS providers through the tri-county
AAA/APDs that require coordination of care and services for members in LTC. Over the past few
years, we have strategized and developed the aligned Interdisciplinary Care Coordination Conferences
(ICCCs) across all three counties. Our partners utilize Bridge and other analytics tools to identify
members receiving LTSS and with other tools such as PreManage, resulting in members that are
identified as possibly needing LTC services. Communication between our AAA/APDs and our plan
partners’ results in an ICCC and the provision of care and services is agreed upon and provided to the
member.

6.c.(1)(b) Describe how the Applicant will: Use best practices applicable to individuals in DHS Medicaid-
funded LTC settings including best practices related to Care Coordination and transitions of care

Health Share leverages the ICCCs as a best practice to facilitate transitions of care between treatment
settings and to problem solve complex issues to find a resolution. The purpose of these ICCCs is to
gather all care team members from all disciplines that are currently working with the member to
communicate a shared understanding of the member's health and social service needs, including their
preferences, goals, and any concerns about access to needed services. The ICCCs provide a forum to
work collaboratively to address gaps and unmet needs of the member while respecting the member
right to self-determination and the least restrictive intervention. ICCCs may be offered in clinic, at a
social service office, in nursing facilities, residential settings and the member’s home. A call-in option is always available.

Another best practice is our **Regional Cross Systems Transitions Work Group**. This is a multidisciplinary group comprised of physical, behavioral and dental health plan partners along with the APDs, county housing managers, and Project Access Now (PANOW). The purpose of the workgroup is to improve communication, coordination, and collaboration among staff in transitional care roles within the above-mentioned disciplines. This workgroup convened a mini summit on transitions of care in 2018. This summit brought together members of the workgroup as well as emergency responders, community-based providers, nursing facility staff, hospital staff, etc. The purpose of the summit was to tackle barriers to effective care transitions, for example, the homeless, those requiring complex care and services such as DME, or member transitions to and from skilled nursing facilities.

Health Share also convenes a quarterly **Care Integration Workgroup (CIW)**, comprised of delegated plan partners from physical/behavioral/ dental plan providers involved in Care Coordination. The CIW provides a forum for identifying issues related to integration of care and for developing processes, tools and best practices for care coordinators and case managers across all plan partners to facilitate integrated and successful care coordination and transitions for members. The LTSS Innovator Agent and APD Case Managers also attend the CIW to provide trainings, updates on their work and case presentations.

Finally, the **Regional Evidence Based Task Force**, convened under the MOU for LTSS services, has met several times a year to identify and share Evidenced Based Health Programs (EBHP) and Self-Management Education (SME). The group has created an available list of community and health plan partners and agencies and the EBHP and SME they utilize and make available. These programs and practices align with the performance improvement outcomes for Health Share and plan partners serving LTSS members such as Diabetes Management and Prevention.

6.c.(2) Describe how Applicant will use or participate in any of the following models for better coordinating care between the health and DHS Medicaid-funded LTC systems, or describe any alternative models for coordination of care:

6.c.(2)(a) Co-Location: co-location of staff such as Type B AAA and APD case managers in healthcare settings or co-locating Behavioral Health specialists in health or other care settings where Members live or spend time.

All three counties’ AAA/APDs have intake case managers co-located in our acute care hospitals. We also have Transition Coaches in Providence and coming soon to Legacy hospital facilities across the metro area. One of our FQHCs, Virginia Garcia Memorial Health Center (VGMHC) has a health plan care coordinator placed in their clinics for the purpose of care coordination and connecting the members to AAA/APD services as needed.

One of our contracted providers, Cascadia Behavioral Health, has recently opened Cascadia Garlington Health Center in 2018. The Garlington Health Center supports whole health care including mental health services, addiction recovery support, primary care, wellness programs, permanent housing solutions and affordable housing to people of all ages. Similar to VGMHC, the Garlington Health Center’s unique structure allows them to provide coordinated services alongside the APD case manager.

6.c.(2)(b) Team approaches: Care Coordination positions jointly funded by the DHS Medicaid-funded LTC and health systems, or team approaches such as a multi-disciplinary care team including DHS Medicaid-funded LTC representation.

Health Share utilizes a team approach, multi-disciplinary model for ICCCs. The ICCC team members can include health, LTSS, behavioral health, other social services, other community services providers, the member, and their natural supports.

A member’s care plan is developed collaboratively within this model and communicated to the multi-disciplinary care team when changes occur. Staff are trained in Motivational Interviewing, a technique
which encourages member involvement and insight into problem solving, which assists in development of the care plan. Care plan goals and interventions are entered based on the member’s health care needs, including behavioral health, cognitive and functional health, SDOH and psychosocial supports. Higher acuity needs will result in additional contacts per month. Modification to goals, motivation, or priority may occur as health needs change; this is assessed with each contact.

6.c.(2)(c) Services in Congregate Settings: DHS Medicaid-funded LTC and health services provided in congregate settings, which can be limited to one type of service, such as “in home” Personal Care Services provided in an apartment complex, or can be a comprehensive model, such as the Program of All-Inclusive Care for the Elderly (PACE).

Through the work of the MOU and ICCCs, the AAA/APD case managers provide assessment services for members in their home or residential/nursing facility who are in LTSS. They also provide case management services, which may include helping members to obtain in-home personal care services. Providence Elder at Home extends primary care into the home, for the frailest, medically-complex dual eligible members living in our service area, which includes Portland and parts of Yamhill County. This model brings care to the member, when and where they need it and meet them where they are in body, mind and spirit. Additionally, Providence Elderplace, a Program of All-inclusive Care for the Elderly (PACE), is both a health insurance and a health care provider. ElderPlace is a federally recognized program which offers a seamless provision of total care. Members receive regular, frequent contact with an interdisciplinary team of medical and social care providers who coordinate and deliver their care. Frequent contact and a team approach means that Health Share can address even small changes in health and well-being as effectively as larger issues for our members.

Another example is the Recuperative Care and Post Hospitalization Case Management Program (RCP), developed by a partner FQHC, Central City Concern. RCP is a highly effective intervention for members who are homeless that provides care for members transitioning from a hospital setting who are ready for discharge but are homeless and require medical care and support, providing immediate housing, intensive case management and access to primary care onsite. Members also may receive onsite addictions treatment, food support, and care coordination. More than 90% of members admitted to RCP establish with a primary care home while in the program, and 63% discharge from the program to stable housing and with their acute medical condition resolved.

6.c.(2)(d) Clinician/Home-Based Programs: increased use of Nurse Practitioners, Physician Assistants, or Registered Nurses who perform Assessments, plan treatments, and provide interventions to the person in their home, Community-based or Nursing Facility setting.

Through our partner organizations, we contract with providers that treat members in the home setting, facilities, or adult care homes. An example is Housecall Providers, a nationally recognized community-based non-profit serves members whose medical needs cannot be met in a traditional clinical setting. People with multiple chronic illnesses, many of whom have trouble leaving their residential setting, often rely on emergency transport and emergency department (ED) visits and hospitalizations to access even basic health care. These trips take a physical and emotional toll on individuals and their families and are very costly to our health care system. As the largest provider of person-centered, home-based primary care in the Portland metro area, Housecall Providers has grown to serve more than 2,000 patients and families a year through a multidisciplinary, team-based model comprised of Nurse Practitioners, Physician Assistants, Nurses and Social Workers who visit patients in private homes, residential care and nursing facilities, foster homes and medical respite centers and homeless

An independent evaluation of RCP found that only 6% of RCP patients were readmitted to the hospital within 30 days of discharge, compared with a typical 30-day readmission rate of 50% for homeless patients.
shelters. Housecall Providers has expanded services to include in-home palliative care and a hospice program. This continuum of care allows the practice to support patients and families as their needs change, ensuring that they receive the right care, at the right place, at the right time.

Another example is Exceptional Needs Dental Services (E.N.D.S.). E.N.D.S. provides mobile and hospital-based dental services to individuals who are functionally impaired, requiring assistance with Activities of Daily Living (ADL), and are unable to obtain treatment in a traditional dental office setting. E.N.D.S. has been in operation for more than 23 years and has a network of dentists, denturists and expanded practice dental hygienists who provide dental services in over 900 care facilities to over 3,000 patients throughout Western Oregon.

6.d. Utilization management

6.d.(1) Describe how the Applicant will perform the following UM activities … How will the authorization process differ for Acute and ambulatory levels of care

Ensuring effective utilization management – Utilization Management (UM) activities are tailored to address the needs of diverse populations through coordination and collaboration with community partners and care coordination between behavioral health and physical systems in compliance with the Sample Contract Exhibit B, Part 4, Section 11, “Evidence Based Guidelines”. UM program activities include the evaluation of appropriateness of clinical services and treatment, and encourage the highest quality care, including using care coordination to engage APS, DHS, DD, specialty mental health, and physical health providers to gather additional information about the member and supports available through those networks. UM also includes a retrospective review of covered services already rendered or already incurred costs and the use of predictive modeling to identify individuals or populations for disease management or care management programs.

Most ambulatory authorizations are seamless and flow between primary providers to specialty care without the need for an authorization. For certain types of ambulatory care, we conduct prior authorization reviews for certain high risk, high cost diagnostic procedures (such as MRI/CT scans) and certain ambulatory surgeries. This authorization process differs from acute levels of care. For acute levels of care (inpatient), if these are planned admissions, they would have been prior authorized. For those that are admitted via the ED, an initial utilization review is conducted the next business day using nationally accepted evidence-based criteria and concurrent review is conducted regularly on a subset of stays thereafter to ensure continuing care criteria continue to be met.

6.d.(2) Describe the methodology and criteria for identifying over- and under-utilization of services

Health Share utilizes criteria to identify members with special health care needs and, through the Health Share Bridge data management platform, provides health plans access to pre-aggregated data to assist with targeting care management programs. Among the many populations that can be identified in Health Share Bridge are individuals flagged as having serious and persistent mental illness, those with significant chronic conditions, children in (or previously in) foster care, individuals who use emergency or inpatient services, and members belonging to particular rate categories such as aged, blind, and disabled. Physical, dental, and behavioral health plans are required to have a systematic process to assess, coordinate, and provide early intervention and ongoing care coordination for members with special health care needs. Bridge supports each system’s function in reviewing utilization—if those capabilities don’t exist as robustly within the plan—and, more importantly, allows for an entire population view to hone in on particular cohorts or conditions of interest, including disaggregated populations based on Race, Ethnicity or Language. This role is important, as some populations are both relatively small and distributed across multiple partners, so over or under-utilization by these groups could be missed without the aggregate perspective.

We follow several utilization measures such as ED Visits/1000 member months (mm), OP MH/1000 mm, OP substance use disorder/1000 mm, IP Stay non maternity/1000 mm, IP Stay MH Psychiatric/1000 mm, IP Stay SUD/1000 mm, SNF Stay/1000 mm, Primary Care and Specialty
Care/1000/mm as examples. We can further disaggregate this data into demographic or group slicers such as members in LTSS services, members with SPMI, foster care status. Data are then analyzed based on provider specialty to review rates/quantity of service requests for outliers. This analysis can inform policy change, provider education, or potential fraud waste and abuse concerns. For example, by reviewing allergy testing requests from ENT specialist it was determined the quantity requested varied between specialists. After discussions with ENTs and journal/evidence review the medical director determined quantity limits should be put into place. Requests with services under the threshold could be approved without further medical review and over the threshold amount would have medical review. This policy change put in safeguards to prevent overutilization and improved workflows by removing unnecessary barriers to most ENT requests for allergy testing.

Another example of an area where Health Share regularly reviews data to identify over and under-utilization of services and to support the system toward a more coordinated response is the ED/MI Measure. A new quality metric introduced in 2018, ED use for individuals with mental illness identifies individuals with a historic diagnosis of mental illness and tracks their ED utilization for physical health conditions. These data were used to convene partners in developing innovative approaches to reducing ED utilization and finding better clinical models to serve this population. Appropriate engagement in primary settings (PCP, MH and/or SUD treatment) with care coordination decreases acute setting utilization. We are developing network wide goals for engagement and care coordination of this cohort. To begin we will define the cohort (MH, SUD, or both with high acute utilization) and define this cohort’s current engagement rates with PCP, MH, and/or SUD. Later we will define clinic system (PCP, MH, SUD) level goals for engagement of this cohort and will develop the cross-system care coordination pathways and standard practices needed for this cohort.

### 7. Accountability (recommended page limit 1½ pages)

**7.a. Describe any quality measurement and reporting systems that the Applicant has in place or will implement in Year 1.**

Our commitment to quality – Health Share has several mechanisms for quality measurement and reporting in conformance with 42 CFR§438.350, .358 and §457.1250 and Exhibit B, Part 9 of the Sample Contract. Health Share conducts both annual auditing and on-going monitoring of delegated entities to ensure Health Share remains accountable and compliant with performance expectations. Health Share conducts an annual external quality review audit of all delegated entities. We utilize the current CMS protocol as a guide to ensure a fair and consistent process for a compliance review that meets all state and federal rules and will be adapted to include all components of the Sample Contract. Our ongoing monitoring program includes, but is not limited to, quarterly review of denial notices (Notice of Adverse Benefit Determination), random reviews of authorization files, a random review of all grievances submitted, a review of grievance letters to ensure timeliness and appropriate resolution of grievances, and timely submission of reports.

We will also continue our quality measurement and reporting in Year 1 in adherence to Exhibit B, Part 10 of the Sample Contract. Health Share maintains a Transformation and Quality Strategy that complies with all state and federal requirements. Health Share is committed to continuously measuring and improving quality performance across our partner organizations. We collect and analyze health
data from across city borders and county lines to unlock insights that pinpoint problems, guide decisions, customize care, and lower costs. Health Share and our partners employ robust quality measurement and reporting programs including the collection and reporting of HEDIS and CAHPS measures, quality performance oversight committees, specific quality initiatives focused on populations such as pregnant women and children with special health care needs, systems to close gaps in care and increase prevention and wellness activities, programs to reduce ED utilization and improve patient safety, and many other innovative strategies to help achieve the Triple Aim. These partner activities are supported by Bridge, Health Share’s analytics and data delivery platform that is the backbone of our quality measurement and reporting system. Interactive Tableau dashboards, accessed through our SharePoint site, reflect monthly updates to performance on health quality indicators including CCO Incentive Metrics, State Quality measures, and pregnancy outcomes. We actively monitor performance at the plan and provider level, as well as by population demographics. We also implement pilot programs focused on improving quality performance, such as measuring SDOH among our member population.

In the event that there are identified quality concerns, they are escalated to a medical director for review and elevated to the appropriate committees (Compliance, Delegation Oversight, and Peer Review) for assessment of next steps up to and including a corrective action plan and or contract termination. These activities are routinely reviewed by the Quality Committee and reported to the Board.

7.b. Will the Applicant participate in any external quality measurement and reporting programs (e.g. HEDIS reporting related to NCQA accreditation, federal reporting for Medicare Advantage lines of business)?

Health Share’s partners currently collect and report HEDIS and CAHPS measures for internal and external reporting purposes including the Medicare Stars program and NCQA accreditation. Health Share’s network includes two of the highest Medicare Stars performing plans in the state.

7.c. Explain the Applicant's internal quality standards or performance expectations to which Providers and Subcontractors are held.

Health Share enters into contracts with delegated entities that describe the delegated functions and the accountabilities for quality standards and performance expectations. This is achieved through a number of policies that describe contractual and regulatory requirements. Collectively, the contractual obligations and policy guidance ensure accountability by delegates for performance of CCO Contract requirements. These contracts also require delegated entities to report on state required measures. Two corporate policies specifically address the delegated relationship and expectations. The Delegated Functions and Oversight policy establishes the authority of Health Share to delegate specific functions, the process through which that delegation occurs, and establishes the process for oversight of delegated entities. The second policy, Delegated Entity Corrective Action and Sanctions policy, describes the process by which Health Share addresses situations where a delegated entity is non-compliant with Health Share policies and procedures, or does not meet its contractual obligations. Through the auditing and monitoring process, if Health Share identifies areas of noncompliance, Health Share Quality Assurance staff review the areas of noncompliance with Health Share’s Delegation Oversight Committee (DOC). The DOC determines the level of noncompliance and the type of corrective action that is indicated. Health Share then issues the appropriate notification (audit findings, Notices of Inadequate Performance or Contract Noncompliance for example) to the delegated entity and sets an agreed upon timeframe to resolve the area of noncompliance. Health Share tracks the improvement plan monthly through the DOC until it is resolved and closed. In the rare circumstance that a delegated entity does not resolve the issue, or the finding is of an egregious nature, our escalation process is to bring it to the Board’s attention through the Quality Committee of the Board. Health Share’s DOC reports regularly to the Quality Committee of the Board. Through this avenue,
the Board will implement additional corrective action or sanctions if a delegated entity continues to not resolve an issue or the severity of the finding is significant enough that the Board must be apprised. When final resolution occurs, the Quality Committee is informed, and the delegated entity receives the closure notice.

Additionally, our Board will leverage the CAP, CAC, Quality and Health Outcomes Committee, the CCO Incentive Metrics, and other required measures to define the health outcomes targets that will be integrated into our system level delegation agreements with our Integrated Delivery System partners and the Integrated Community Network. Our partners will report on progress against these goals on an annual basis. These outcomes will include but not be limited to the CCO Incentive Metrics and measures that address fundamentals that drive poor outcomes and inequities in the Health Share population such as access to MAT.

The Board will monitor their performance, elevate best practices, and address performance gaps to ensure that there is appropriate attention and oversight of key processes and outcomes to ensure that Health Share supports a culturally responsive health system, works toward health equity, and assures adequate investment and performance in key areas of risk such as the SUD system of care. Health Share’s VBP framework will align with these internal quality standards and performance expectations to ensure that there are meaningful incentives to support achievement of those outcomes.

7.d. **Describe the mechanisms that the Applicant has for sharing performance information with Providers and contractors for Quality Improvement.**

**Sharing information with partners to drive quality improvement** – Health Share Bridge, described above, is the primary mechanism we use to share performance information with partner organizations. We show performance at the plan and provider level, as well as by population demographics, so areas of high and low performance are easily discernible. We also deliver more detailed member-level reporting on priority metric populations and dashboards based on external sources (EHR-based clinical quality data, ALERT data, etc.) to partners via the Bridge site. Other interactive Bridge applications allow partner organizations to explore areas of high cost, identify populations with high clinical risk, or review under- or over-utilization patterns among subsets of the population. Priority populations, including those with a diagnosis of SPMI, those who have had child welfare history, and those in LTSS, are easily identifiable with flags. This suite of tools was specifically designed to allow partners to better understand the experiences of member populations, and by comparing performance to CCO benchmarks or partners across our network, identify areas for improvement and opportunities for sharing best practice.

Using data from **Health Share Bridge**, we also create a monthly newsletter to share real-time quality incentive metrics performance with partners and our Board. The comparative aspect drives performance improvement. We also created a report in 2018—**Measurable Outcomes: A Five-Year Snapshot of Health Share Performance Metrics** (right). This document details our five-year performance on each quality incentive metric and highlights best practices from high-performing partners that helped us achieve success. We published it at our regional convening of more than 200 health care professionals and community leaders in our region and posted it on our website.

Additionally, our IDS partners have their own reporting systems that leverage EHR data and claims data to offer performance information at all levels of their systems. CareOregon leverages a population health data platform to share performance, equity, risk, and over/under utilization data with providers across physical, behavioral, and oral health systems of care.
Health Share also convenes QI and clinical leadership to review measure performance and will leverage the CAP to ensure that clinical strategies achieve performance expectations. Performance information is shared, and strategies are developed to address areas of need. Additional workgroups, with a focus on populations of interest (i.e. children in foster care, Kindergarten Readiness) meet regularly to align QI efforts across the region and share performance. Health Share’s partner organizations also convene their providers and contractors to share performance information and engage in collaborative QI and best practice sharing activities. For example, CareOregon convened PCPCH providers to develop and implement the STOP CRC program in partnership with the Kaiser Permanente Center for Health Research to promote the use of FIT screening, increasing our performance on the CRC Screening inventive metric.

8. Fraud, Waste and Abuse Compliance (recommended page limit ½ page)

8.a. Please describe how Applicant currently engages in activities designed to prevent and detect Fraud, Waste and Abuse.

Activities designed to prevent and detect fraud, waste, and abuse – Health Share operates a Fraud, Waste, and Abuse (FWA) prevention program in compliance with Exhibit B, Part 9 of the Model Contract. Our FWA policies and procedures and those of our plan partners include a detailed Compliance Plan, designated Compliance Officers, required committees, training and education programs, credentialing, and systems to identify potential fraud and other illegal activities. The Health Share Board has appointed a Compliance Officer that provides the Board with periodic reports on compliance and FWA concerns. Health Share and our plan partners utilize claims payment functions to identify outliers or trends that may lead to further investigations and work with the Medicaid Fraud Control Unit as needed. All delegated partners have a significant number of internal audits performed each year for their respective Medicaid business and include evaluations of established controls and incorporate fraud detection components such as identifying overpayments, identifying encounters/services that did not occur, and identifying upcoded services. Health Share has also established a Compliance workgroup, chartered to collaborate in building a coordinated compliance program across organizations and to strengthen the understanding of an effective compliance program that includes fraud and abuse prevention and detection. This workgroup shares best practices and knowledge of relevant state and federal laws and contract requirements.

New employee fraud and abuse prevention training is conducted within 90 days of employment and annually. Health Share compliance staff also attend a quarterly fraud taskforce roundtable with the main objective to provide updates to attendees regarding identified trends in their organizations.

8.b. Please describe how Applicant intends to monitor and audit its Provider Network, Subcontractors, and delegated entities for potential Fraud, Waste and Abuse activities.

Subcontractors and delegated entities are monitored and audited by Health Share directly. In addition, the partners operate their own respective oversight and monitoring programs. Oversight from Health Share and its delegates may include: functional area business owners who work directly with vendors to monitor delegated activities and related performance measures, Delegation Oversight personnel who monitor contracting and provide oversight of the internal business owner and vendor relationships, and an Internal Audit and Compliance function that evaluates the effectiveness of the Delegation Oversight function and ensures delegated entities provide sufficient annual FWA training to their staff and downstream contractors to include available anonymous non-retaliation reporting mechanisms and expectations.

Additional auditing and monitoring is already conducted on an ad hoc basis, if the delegated entity becomes aware of any credible allegation of fraud, waste or abuse. The characteristics of suspicious cases that should be referred are described in the Model Contract, Exhibit B, Part 9, Section 15. Current and continued reporting requirements at a minimum are: monthly OIG/SAM checks; quarterly review, investigation and resolution of complaints and grievances related to fraud, waste or
abuse; and annual submission of their fraud and abuse policies, annual compliance and program
integrity training of their staff, and an annual review of their program integrity according to OHA
contract requirements. We also support FWA prevention through our provider credentialing system
and those of our plan partners.

9. Quality Improvement Program (recommended page limit 1 page)
9a. Please describe policies, processes, practices and procedures you have in place that serve to improve
Member outcomes, including evidence-based best practices, emerging best practices, and innovative
strategies in all areas of Health System Transformation, including patient engagement and activation.

Our comprehensive quality improvement program – Member outcomes and the implementation
of evidence-based best practices and emerging best practices happen at all levels in Health Share.
These activities are guided and overseen by Health Share’s Quality Committee, a subcommittee of
Health Share’s Board. Health Share’s Transformation and Quality Strategy (TQS) highlights work
being led directly by Health Share staff as well as that of our partners. Examples of the projects
referenced in the TQS include:

- Increasing access to behavioral health services through VBP strategies targeting reporting and
  improvement of access measurement and access to specialty behavioral health care in primary
care for children;
- Expanding access to culturally specific THWs, such as access to doulas to increase
  mother/baby bonding and improve outcomes for women and children of color;
- Addressing vaccine hesitancy and improving vaccination rates for children by partnering with
  public health.

Two of Health Share’s Performance Improvement Projects, Medication Assisted Treatment
Expansion and Foster Care RAPID (Relational health, Academic Psychological, Intellectual,
Development) assessment process, are incorporated into the TQS, addressing special health care
needs by supporting access to care for vulnerable populations. Health Share’s partners are actively
engaged in each of these projects within the TQS and are required to participate in the development
and implementation of Health Share’s quality program. Health Share’s Quality Assurance and
Performance Improvement Program policy requires partners to have their own quality strategies and
quality programs.

Health Share also engages our partners in identifying evidence-based and innovative strategies to
address the needs of specific member populations through engagement with clinical and operational
leadership. These strategies are shared in collaborative-style meetings lead by Health Share and our
partners. Last year, Health Share trained 259 clinicians and convened 431 partner meetings to spread
these types of practices.

Case Study: Evidence-based practice for diabetes – To improve performance on the Diabetes
poor control metric, CareOregon partnered with OHSU and Adventist Endocrinology and
developed a Diabetes-Pathway-To-Treat for primary care. We created a diabetes education
program for PCPs and presented the pathways-to-treat content in 4-hour workshops with a multi-
disciplinary education team. We then provided a list of patients most in need of the pathway-to-
treat recommendations to each provider in our network to take action. We also made
endocrinologists available for diabetes case consults to support primary care. Recognizing the
need for a more comprehensive strategy for members with Diabetes, as part of our TQS, Health
Share is using a portion of incentive metric funds to support integrated initiatives being
implemented by culturally specific providers, certified community behavioral health clinics, and
other partners.
9.b. Please describe your experience and plan to emphasize and implement wellness and health improvement activities and practices within your organization for Members and staff, including partners and contracts in place to strengthen this aspect of health care.

**Wellness for members** – All partners offer innovative health and wellness program and members have access either directly or through contract to services like yoga, vouchers for farmers markets, incentives for completing wellness and prevention activities. Members are provided individual outreach, electronic, text, and mailed reminders for wellness and preventative services. For example, our partners have offered gift card incentives for members to complete prevention activities like adolescent well child checks, immunizations, and other screenings. Members can also access wellness services through flexible services, which care coordinators across Health Share’s networks use to order things like gym memberships and healthy cooking classes for members. In the future we will work with our CAC to continue to identify new opportunities and improve on our existing programs.

**Wellness for staff** – Health Share has implemented a variety of wellness and health improvement activities within our benefit structure. We include reimbursement for health and wellness-related expenses, provide an Employee Assistance Program, and wellness resources within health benefits, among other things. We also have a Wellness Committee that puts on contests and events to encourage staff to exercise, eat well, and practice mindfulness and self-care.

9.c. Outline your experience, staffing, policies, procedures, and capacity to collect the necessary electronic and other data that will be required for meeting regular performance benchmarks to evaluate the value of Health Services delivered by your CCO. Describe how CCO accountability metrics serve to ensure quality care is provided and serve as an incentive to improve care and the delivery of services.

Health Share has extensive experience in meeting regular performance targets and benchmarks such as achieving 100% of the CCO Incentive Metric payout for 5 of the last 6 years and reporting on all required HEDIS measures. Health Share has dedicated quality improvement staff at the CCO, delegate, and provider network level to ensure that we have the capacity, policies, and procedure necessary to collect data required to meet performance benchmarks and evaluate our Health Services. Contracts with all delegates outline data collection requirements to support at least monthly performance monitoring and partnerships with clinical systems provide monthly feeds of EHR-based clinical quality data from systems serving 75% of our membership. Per the Sample Contract Exhibit B, Part 10, Health Share has a TQS that drives our quality strategy across all partner organizations and is overseen by the Board Quality Committee.

We have consistently used the CCO Incentive Measures and the statewide PIP metrics as a baseline for assessing the value of the health services and have incorporated them into our value-based payment methodologies to ensure that they serve to improve care and the delivery of services. Population data and performance on all metrics, including financial indicators, utilization rates and key measures for priority populations (such as pregnant women and foster children), are shared through our Health Share Bridge platform. Partners at all levels can view their own rates in comparison to other systems and the CCO, creating a shared platform for transparency and accountability. Through our VBP work, we have incorporated the CCO Incentive Metrics into our payment models and are incorporating more of the CCO accountability metrics in our payment models.

9.d. Describe your policies and procedures to ensure a continuity of care system for the coordination of care and the arrangement, tracking and documentation of all Referrals and Prior Authorization.

Health Share has implemented policies and procedures governing coordination of care and utilization management designed to support a continuum of care that integrates behavioral, oral and physical health services to achieve the objectives of whole person, integrated care aligned with the Sample Contract in Exhibit B, Part 4, Section 1 “Integration and Coordination”. These policies set the expectations for our Integrated Delivery System and Integrated Community Network partners to participate in and support coordination of care activities such as communication and coordination across health care disciplines; the development of infrastructure support for sharing information,
coordinating care and monitoring results; use of evidence-based screening tools, treatment standards and guidelines; and participation in Health Share’s Care Integration Workgroup chartered to support implementation of a system of care approach that is member-driven, community-based and culturally and linguistically appropriate. Health Share requires that partners develop and implement a utilization management program that includes the collection, assessment and monitoring of data, including tracking referrals and prior authorizations, to evaluate the appropriateness of clinical services and treatment, and encourage the highest quality care.

In accordance with the Sample Contract, Exhibit B, Part 4, Section 8 “Care Coordination,” staff use information systems to collaborate with providers, and/or members, and/or member’s representatives to assure that information for the members’ plans of care is available to assure safe transitions across care settings. This occurs for pre-service hospital admissions, inpatient rehabilitation, and the initiation of home health services through PreManage, electronic data exchange, secure email, and fax. Care Managers refer members who may be at-risk for poor health outcomes, or who need assistance with care coordination, transitioning between health care settings, or in accessing community resources, to case management staff. For members whose conditions appear to be deteriorating and who may be able to benefit from palliative care services, members are referred to palliative care programs.

10. Medicare/Medicaid Alignment (recommended page limit ½ page)

10.a. Is Applicant under Enrollment and/or Marketing sanction by CMS? If so, please describe?

Applicant is not under Enrollment and/or Marketing sanctions by CMS.

10.b. Is Applicant currently Affiliated with a Medicare Advantage plan? If no, how will Applicant ensure they are contracted or Affiliated with a Medicare Advantage plan prior to the Effective Date of the Contract?

Yes, Health Share is affiliated with the following Medicare Advantage plans as listed below:

<table>
<thead>
<tr>
<th>Medicare Advantage Plan Name</th>
<th>CMS Number</th>
<th>Medicare Advantage Plan Service Area/Counties</th>
</tr>
</thead>
<tbody>
<tr>
<td>CareOregon Advantage Plus</td>
<td>H5859</td>
<td>Clackamas, Multnomah, Washington</td>
</tr>
<tr>
<td>Providence Medicare Dual Plus (HMO.SNP)</td>
<td>H9047</td>
<td>Clackamas, Multnomah, Washington</td>
</tr>
<tr>
<td>Kaiser Senior Advantage</td>
<td>H9003-001</td>
<td>Clackamas, Multnomah, Washington</td>
</tr>
<tr>
<td>Kaiser Senior Advantage Basic</td>
<td>H9003-006</td>
<td>Clackamas, Multnomah, Washington</td>
</tr>
</tbody>
</table>

11. Service Area and Capacity (not counted towards overall page limit)

11.a. List the Service Area(s) the Applicant is applying for and the maximum number of Members the Applicant is proposing to accept in each area based upon the Applicant's Community health assessment and plan for delivery of integrated and coordinated health, mental health, and substance use disorder treatment services and supports and oral health services.

Health Share is requesting to serve the same Service Area and maintain the same enrollment limits as described in its 2019 Amended and Restated Health Plan Services Contract, #143115-11. (See Service Area table below). Capacity requested for each County in the Service Area reflects OHA approved enrollment limits and allows for the provision of an integrated care model for any projected expansion in membership, specifically with regard to the transition of FFS dual eligible to CCOs and the projected increase in OHP enrollment, as described in the 2019-2021 Oregon Governor’s Budget.

<table>
<thead>
<tr>
<th>Service Area Table</th>
</tr>
</thead>
<tbody>
<tr>
<td>County</td>
</tr>
<tr>
<td>Clackamas County</td>
</tr>
<tr>
<td>Multnomah County</td>
</tr>
<tr>
<td>Washington County</td>
</tr>
</tbody>
</table>

11.b. Does Applicant propose a Service Area to cover less than a full County in any County?

No.

12. Standards Related To Provider Participation (recommended page limit 5 pages)

12.a. Standard #1 - Provision of Coordinated Care Services
INSTRUCTIONS: Submit the information in about each Provider or facility using the DSN Provider Report Template in Excel for all Provider or facility types in Applicant’s Provider Network.

See attached document RFA4690-Health Share of Oregon-Att7-DSN Provider Report Template.

Health Share’s comprehensive, integrated provider network – Health Share’s Delivery Systems Network (DSN) consists of all provider types in all delegated or directly held provider networks that are necessary to ensure adequate capacity and access to all Covered Services for Medicaid and dual eligible members, including providers that address members’ special health care needs (see attached DSN Provider Report for a complete listing of all provider and facility types). Our members can choose from the largest provider network available to individuals and families with OHP coverage, including Adventist Health, Kaiser Permanente, Legacy Health, OHSU, Providence, and Tuality Healthcare, as well as region-wide networks for dental and mental health and substance use care. Our members have greater access than ever to the care they need, when and where they need it, including dental care and support for mental health and addictions.

Outside of the doctor’s office, we work with community partners to lower everyday barriers to good health—like providing rides to the doctor’s office, creating opportunities for peer support, and connecting families with the services their children need most. Health Share’s provider network includes 4,912 physical health PCPs; of these, 3,615 serve adults, 691 serve pediatric populations, and 606 are OB/Gynecologists serving women. Health Share includes in its network 3,079 behavioral health practitioners who are distributed among—and sometimes shared between—175 mental health organizations and 100 substance use disorder treatment offices. In addition, there are 53 individual mental health practitioners in Health Share’s behavioral health network. Health Share’s dental health plans contract with 730 Primary Dental Care practitioners, 51 of whom specialize in treating pediatric populations, and 124 of whom are specialists such as endodontists, orthodontists, periodontists and oral surgeons.

Aligning our provider network with community needs – In August 2018, Health Share, in partnership with its CAC and the Healthy Columbia Willamette Collaborative, released our 2018-2020 Community Health Needs Assessment (CHA). The CHA includes information on the health needs and strengths of the community as well as the top chronic conditions and illness. Health Share utilizes the CHA to plan for future programs and services that best meet the needs of the communities we serve. Also, by comparing each specific community’s top health conditions, according to the current zip codes in which that community predominantly lives, with providers who are culturally-responsive and licensed to treat those top health conditions, Health Share can pinpoint where capacity may need to be enhanced or re-assigned.

Provider network innovation: oral health – Since 2014, Health Share’s dental plan partners and regional community organizations have participated in a collaborative partnership project, Dental3 (D3). The D3 program coordinates and deploys 19 expanded practice dental hygienists and 3 dentists to deliver preventive oral health services in alternative settings including Head Start programs, WIC programs, community centers and schools. In addition, two of the Dental plans deploy dental vans that visit areas with higher membership and lower dental care utilization.

Provider network innovation: school-based health centers – Health Share also innovates to improve access by providing care in non-traditional settings. For example, Health Share partners serve as medical sponsors for school-based health centers (SBHCs) throughout the region. SBHCs provide accessible, comprehensive, and confidential physical and behavioral health services to Oregon youth through public and private partnerships (e.g. schools, health departments, tribes, community providers, hospitals). Additionally, some SBHCs offer weekly preventive dental care via an Expanded Practice Dental Hygienist and a dental assistant who use mobile equipment, as well as dental treatment delivered by a dentist and dental students through mobile dental clinic.

See attached document RFA4690-Health Share of Oregon-Att7-DSN Provider Report Template.
Health Share’s comprehensive, integrated provider network – Health Share’s Delivery Systems Network (DSN) consists of all provider types in all delegated or directly held provider networks that are necessary to ensure adequate capacity and access to all Covered Services for Medicaid and dual eligible members, including providers that address members’ special health care needs (see attached DSN Provider Report for a complete listing of all provider and facility types). Our members can choose from the largest provider network available to individuals and families with OHP coverage, including Adventist Health, Kaiser Permanente, Legacy Health, OHSU, Providence, and Tuality Healthcare, as well as region-wide networks for dental and mental health and substance use care. Our members have greater access than ever to the care they need, when and where they need it, including dental care and support for mental health and addictions.

12.b. Standard #2 – Providers for Members with Special Health Care Needs (recommended page limit 1 page).

Ensuring provider access for members with special health care needs – With our expansive network across the tri-county region, Health Share offers access to the full array of providers and specialists with the skills necessary to care for our most vulnerable members. Health Share utilizes criteria to identify members with special health care needs and provides our partners with access to pre-aggregated data to assist with targeting care management programs. Among the many populations with special health care needs are members who:

- **Have serious and persistent mental illness**: Individuals with serious and persistent mental illness (SPMI) are by definition individuals with special health care needs. For the **66,271 adult members** with severe and persistent mental illness in 2018, Health Share’s provider network included **nine dedicated behavioral health systems** that served the 9,769 who frequently used ED care. These organizations employ 109 prescribers, **1,358 licensed mental health providers**, and at least 72 peers to work with the population of members with SPMI. Care management for these members will be integrated in the Integrated Community Network, across physical health, behavioral health, and dental providers and will be coordinated with Physical Health providers in the Integrated Delivery Systems. Care is managed through interdisciplinary care teams that provide direct member outreach and engagement, coordination of services and care conferences. In order to better serve members with SPMI, Health Share has supported increasing urgent, walk-in, and mobile crisis services, as well as access to Assertive Community Treatment teams and peer-delivered services. There are seven CCBHCs operating in Health Share’s service region, providing an opportunity to determine whether this model achieves improved health outcomes for members with SPMI, using the new quality incentive metric addressing ED utilization of members with mental illness (ED-MI) as a primary measurement.

- **Have multiple chronic illnesses**: Housecall Providers serves people with multiple chronic illnesses who may have difficulty leaving their residential setting. This multidisciplinary, team-based model is comprised of 16 Nurse Practitioners, 6 Physicians, 2 Physician Assistants, and 1 social worker who have served more than 2,000 patients in private homes, residential care and nursing facilities, foster homes, medical respite centers and homeless shelters.

- **Experience significant chronic conditions**: The Table below indicates the proportion of claims in 2018 for members with specific chronic conditions to the specialists who treated them:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Member Count</th>
<th>Provider Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>36,356</td>
<td>5,062</td>
</tr>
<tr>
<td>COPD</td>
<td>6,736</td>
<td>3,587</td>
</tr>
<tr>
<td>Diabetes</td>
<td>20,271</td>
<td>5,577</td>
</tr>
<tr>
<td>ESRD</td>
<td>828</td>
<td>2,274</td>
</tr>
<tr>
<td>CAD</td>
<td>795</td>
<td>898</td>
</tr>
<tr>
<td>SPMI</td>
<td>33,686</td>
<td>7,726</td>
</tr>
<tr>
<td>Hypertension</td>
<td>28,832</td>
<td>3,181</td>
</tr>
</tbody>
</table>

RFA4690-Health Share of Oregon-Att7-Provider Participation and Operations Questionnaire Page 43 of 55
• Have been or currently are in foster care: Health Share has developed three Advanced Medical Homes comprised of specially-trained pediatricians who understand the unique constellation of trauma-induced mental health needs of the 1,570 members in foster care. In addition, five of our largest BH providers\(^1\) partner with their local child welfare offices to prioritize access to and timely completion of mental health assessments for incoming foster children. Among contracted BH providers, nearly 60 licensed professionals hold a post-graduate Certificate in Adoptive and Foster Family Therapy.

• Belong to particular rate categories such as aged, blind and disabled: Of the 38,507 members who were assigned to the rate category of Aged, Blind and Disabled between 1/1/2018 and 4/1/2019, there are 141 gerontologists, 173 psychiatrists, 213 ophthalmologists, and 122 LTC facilities available to serve them.

Members with special health care needs can directly access specialty care through a standing referral from a PCP. Standing referrals, which are reviewed annually and updated as appropriate, provide seamless access to specialty care for any covered service. Plans are required to have a systematic process to assess, coordinate, and provide early intervention and ongoing care coordination for members with special health care needs. In 2017, Health plans provided care management services for over 8,300 members with special health care needs. There were almost 30,000 referral or authorization requests received and 92.4% of those were approved.

Care management staff are expected to coordinate across organizations, to ensure physical, behavioral and oral health needs of members are met. For example, youth who require Intellectual and Developmental Disability (IDD) services have access to intensive care coordinators distributed throughout the network who work with the IDD case workers, the youth, parents/guardians, PCPs, behaviorists, therapists, specialty providers, the schools or Early Intervention and other community agencies to ensure the member is receiving a comprehensive array of services. Similarly, Wraparound is available to members 0-18 who are served by the behavioral health system and one other system, such as Intellectual or Developmental Disabilities, Special Education, Child Welfare, Juvenile Justice, physical health system or substance use disorder system. Wraparound is a collaborative care coordination process that brings together children, family members, friends, service providers and community members to create an individualized plan of care for addressing member’s complex needs.

When we have identified specific populations with unique needs that are not easily met by the traditional health care system, we have developed new and innovative programs. In addition to the examples noted above, we launched a program called Project Nurture to care for expecting mothers with substance use disorders. Members with complex biopsychosocial needs have access to health resilience specialists embedded in primary care. In order to ensure children who are not receiving dental care have access to dental sealants and referrals to dental homes, we created Dental3, a unique collaboration of dental plans, Federally Qualified Health Centers, schools, and Head Start programs to offer screenings and sealants in community settings. The ENDS program provides in-home dental services to home-bound seniors. Health Share also developed an innovative strategy within the behavioral health system to make THW and peer supports available to all members regardless of if they are engaged in any kind of treatment. This allows members to take advantage of this unique and valuable service at any time, but also assures that even if a member should choose to leave treatment, they will not lose access to their peer.

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\(^1\) Mindsights, Lifeworks NW, Options Counseling, Morrison Children and Family Services, and Clackamas County MH.
**12.c. Standard #3 – Publicly funded public health and Community mental health services (recommended page limit 1½ pages)**

**Tri-county collaboration from governance to service delivery** – Health Share serves the entirety of Clackamas, Multnomah, and Washington counties. Each county holds a seat on Health Share’s Board, and county staff are involved in both the governance and operation of our CCO. We have memoranda of understanding with our three county partners around support for public health point-of-care services and crisis and safety net behavioral health services. Beginning in 2020, Health Share will provide direct funding to the counties from our global budget to support safety net behavioral health and public health services.

**12.c.(1) Describe how Applicant has involved publicly funded providers in the development of its integrated and coordinated Application.**

As a locally based, community governed coordinated care organization, community involvement is fundamental to Health Share. Engagement varied from participating in 1 of 8 application drafting workgroups, serving as subject matter experts, providing content review, and authoring sections of the application. We dedicated our March and April Community Advisory Committee (CAC) meetings to further engage our CAC members in the application drafting process. More than 120 community members (illustrated below) participated in development of this Application.

<table>
<thead>
<tr>
<th>Health Share Partner Organizations</th>
<th>Local Health Care Providers</th>
<th>Health Share Governance Bodies</th>
<th>Community Organizations</th>
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</thead>
<tbody>
<tr>
<td>• Adventist Health</td>
<td>• Physical health providers</td>
<td>• Board of Directors</td>
<td>• Oregon Community Health Workers Association (ORCHWA)</td>
</tr>
<tr>
<td>• CareOregon</td>
<td>• Mental health providers</td>
<td>• Community Advisory Council</td>
<td>• Oregon Primary Care Association (OPCA)</td>
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<td>• Central City Concern</td>
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<td>• Mental Health and Addiction Certification Board of Oregon (MHACBO)</td>
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<tr>
<td>• Clackamas County</td>
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<td>• Oregon Health Equity Alliance (OHEA)- our regional health equity coalition</td>
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<tr>
<td>• Kaiser Permanente</td>
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<td>• Multnomah County</td>
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<tr>
<td>• Legacy Health</td>
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<td>• Oregon Health &amp; Sciences University</td>
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<td>• Multnomah County</td>
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<td>• Providence Health &amp; Services</td>
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<td>• Oregon Health &amp; Sciences</td>
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<td>• Tuality Healthcare</td>
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<td>University</td>
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<td>• Washington County</td>
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<td>• Providence Health &amp; Services</td>
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<td>• SUD providers</td>
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<td>• Tuality Healthcare</td>
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<td>• Oral health providers</td>
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<tr>
<td>• Washington County</td>
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<td>• Three Board Committees</td>
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</tbody>
</table>

Health Share is built for collaboration, engagement and partnership that values community involvement. Our governance structure reflects this commitment. The Board is comprised of physical, oral, and behavioral health providers, delivery systems, health plans, county representatives, regional community leaders, and a CAC member. Health Share’s operations ensure authentic engagement in operational and strategic decision-making with our ICN (CareOregon), integrated delivery systems (Legacy Health, OHSU Health System, Kaiser Permanente, and Providence Health & Services), CAC, community partners, county governments, and OHP members.

**12.c.(2) Describe the agreements with counties in the Service Area that achieve the objectives in ORS 414.153(4). If any of those agreements are under negotiation, the Applicant must submit the executed agreement prior to OHA issuing the CCO Contract.**

Health Share holds an MOU with the Area Agencies on Aging and Disability in the Multnomah, Clackamas, and Washington County (AAADs) and the Multnomah, Washington, and Clackamas Districts’ DHS-Aging and People with Disabilities (APD) offices. The parties to the MOU agree to coordinate care and share accountability in the tri-county area for Medicaid and dual eligible

Health Share’s mission is to partner with communities to achieve ongoing transformation, health equity and the best possible health for each individual.
Medicare/Medicaid beneficiaries to prevent or delay need for LTSS and improve health outcomes for low income and at-risk seniors and adults with disabilities.

Health Share has had a long-standing MOU with the counties in their roles as the Local Mental Health Authorities (LMHAs) and Community Mental Health Programs (CMHPs) and addresses the services included in ORS 414.153(4). Health Share has always provided financial support to the county crisis safety net programs, and beginning in 2020, will provide a portion of the global budget directly to the counties to support these programs. An updated MOU will be in place prior to January 1, 2020.

Health Share also holds an MOU with each county Local Public Health Authority (LPHA). The MOU defines roles and responsibilities of Health Share and LPHAs regarding reducing costs in both systems, ensuring shared responsibility for improving population health, and addressing gaps in services for high need uninsured members of the community. LPHA administrators meet monthly with Health Share to discuss progress in three bodies of work: data sharing to support strategic action, health equity, and improve and direct services to special populations. In addition, each County appoints a representative to serve on Health Share’s Consumer Advisory Council which oversees the CCO’s CHA and CHP.

Each County is represented by a founding member director on the Health Share Board, is intimately involved in developing the operational structure of Health Share and supports and promotes Health Share’s efforts to integrate and coordinate care. In addition, each of the Counties participates in the various committees and workgroups operated by Health Share, including the CAC.

**12.c.(3) If Applicant does not have signed agreements with counties, as providers of services or as required by ORS 414.153(4), describe good faith efforts made to obtain such agreements and why such agreements are not feasible.**

Not applicable.

**12.d. Standard #4 – Services for the American Indian/Alaska Native Population (AI/AN) (½ page)**

**12.d.(1) Please describe your experience and ability to provide culturally relevant Coordinated Care Services for the AI/AN population.**

Providing culturally-relevant coordinated care services to the AI/AN population – NARA NW is an Urban Indian Health Provider, a title V urban Indian Health Program, which works closely with Health Share to provide care to qualified patients. NARA NW is the only Indian Health Services/Tribe/Urban Indian Health Program (ITU) provider in this area. NARA provides the full-spectrum of physical, behavioral and dental health services to Health Share’s American Indian and Alaska Native members. That UIO contract permits an Indian member to choose NARA as their provider as long as NARA has capacity to provide services to that member. In addition, Health Share contracts and coordinates with five organizational and five individual behavioral health providers who serve Native American populations in the same way that it works with its other contracted behavioral health providers.

Health Share care coordinators work with NARA NW to ensure members are receiving the frequency and intensity of service that is clinically indicated by the member's level of care. Similarly, all contracted behavioral health providers—including those serving Native American populations—are responsible to coordinate care and the exchange of protected health information with the member’s physical health care provider in order to address physical and behavioral health needs, when indicated. NARA NW was recently awarded designated funds to assist with care coordination.

At the regional level, the Executive Director of NARA NW serves on Health Share’s Board, ensuring that the needs of Native American members and providers are represented in policy-making and program development across all plan types.

Additionally, our partner CareOregon has extensive experience in working with the working with IHS and the nine confederated tribes of Oregon through the Tribal Care Coordination (TCC) team. They provide care coordination support for the tribes in Oregon and those out of state who maintain affiliation with their Oregon tribe. The work is done in collaboration with Tribal Leadership to
coordinate care for members in multiple Tribal Health Centers including but not limited to, Yellow Hawk Tribal Health Center, Warm Springs Health and Wellness Center, Native American Rehabilitation Association, and Klamath Tribal Wellness Center. There is a strong partnership with Oregon Tribal Leadership and participation in the Tribal Clinical Advisory Council. The Tribal Clinical Advisory Council reviews data provided by the TCC team, discusses systematic barriers and provides guidance on changes needed to improve the overall health of Oregon Tribal members.

12.e. Standard #5 – Indian Health Services (IHS) and Tribal 638 facilities (recommended limit 1 page)
12.e.(1) From among the Providers and facilities listed in the DSN Provider Report Template, please identify any that are Indian Health Service or Tribal 638 facilities.

There are no Indian Health Service clinics or Tribal 638 facilities in Health Share’s service area.

12.e.(2) Please describe your experience working with Indian Health Services and Tribal 638 facilities.

- Include your Referral process when the IHS or Tribal 638 facility is not a participating panel Provider.
Health Share’s referral process for members seeking care in IHS or Tribal 638 facilities includes providing the greatest latitude possible for PCPs in decision making for their patients while assuring medical services rendered are consistent with the benefit and are medically appropriate. Although Health Share strongly supports the medical home model of care and encourages members to discuss specialty service needs with their PCP, Health Share delegates nevertheless does allow all members to have direct access to specialists for funded services. Members may access the specialists by calling them directly to make appointments. In addition, referrals originating from an IHS or Tribal 638 facility follows the same process. If needed, Health Share delegates will arrange for non-network specialty care when it is determined that providers are unavailable or inadequate to meet a member’s medical need.

12.e.(2) Include your Prior Authorization process when the Referral originates from an IHS or Tribal 638 facility that is not a Participating Provider.

Authorizations will be issued to those providers based on the member’s benefit package, including applicable rules and policies, as previously stated. If the provider requests a “single case agreement” before the service is provided, care management staff notifies the contract manager, who then secures the agreement based on the urgency of the service need and within the authorization processing timelines.

12.f. Standard #6 – Pharmacy Services and Medication Management (recommended limit 5 pages)
12.f.(1) Describe Applicant’s experience and ability to provide a prescription drug benefit as a Covered Service for funded Condition/Treatment Pairs.

Providing the prescription drug benefit – Health Share’s partner organizations have decades of experience providing prescription drug benefits for OHP-eligible Oregonians. Providers, pharmacies, and pharmacy benefit administrative services staff work together daily to diagnosis, prescribe and dispense medications consistent with the funded condition/treatment pairs and pertinent guideline notes. Health Share monitors the pharmacy benefit through customer service calls, appeals & grievances, and recently through the mental health parity analysis. Health Share will bring identified trends and/or findings to the Quality Committee and the CAP for resolution by creating or sharing best practices and for follow-up.

Prior-authorization (PA) and formulary management are used to confirm drug benefit coverage appropriateness when specific patient, condition/treatment pairs require verification for coverage. In addition, partners take clinical evidence, the prioritized list, and applicable Guidelines Notes into consideration when developing and revising PA criteria. Each of Health Share’s partner organizations has established care coordination pathways that fit their provider workflows for the most vulnerable and high-risk members with a focus on quality and safety initiatives.

12.f.(2) Specifically describe the Applicant’s:

- Ability to use a restrictive formulary as long as it allows access to other drug products not on the formulary through some process such as Prior Authorization.
Health Share’s partner organizations recognize that the formulary for OHP members is a closed formulary and that medications not listed on the formulary will not be allowed at pharmacy point-of-service without PA. When appropriate, prescribers may access these medications by requesting a PA for coverage, for the prescriber can choose an alternative drug product that is available on the formulary. Health Share assures sufficient drug therapy choices are available to meet member needs in congruence with the sample contract Exhibit B, Part 2, Section 4(g)(1) and Section 4(g)(4)(f-g). The clinical criteria for use of non-formulary medications require that formulary medications have been tried and/or another specific medical issue exists that precludes use of a formulary item. Clinical pharmacists involved with clinical policy development for drug use also participate in applying these policies to individual cases and they communicate and assist providers when needed to resolve care coordination and benefit needs. All clinical reviewers participate in annual and/or routine formulary monitoring to review congruence and alignment with the benefit plan requirements, quality goals, and the prioritized list.

Formularies available through Health Share follow the principle of included at least one or more FDA-approved drug products for each therapeutic prescription drug class when these products meet safety, quality and utilization needs. In addition, at least one over-the-counter (OTC) medication is provided for relevant therapeutic prescription drug classes when it an OTC medication is indicated as a treatment option for coverable conditions.

12.f.(2) Formulary development that includes FDA approved drug products for each therapeutic class and at least one item in each therapeutic class of over-the-counter medications sufficient to ensure the availability of covered drugs with minimal prior approval intervention by the providers of Pharmaceutical Services, e.g. pharmacies.

Teams of health care professionals at Health Share’s partner organizations develop and maintain their formularies following their organizational Pharmacy and Therapeutics (P&T) Committee review processes. The formularies all include both FDA-approved prescription drug products and OTC drugs from each therapeutic classes for treatment of funded conditions where applicable. Not all therapeutic classes have agents that are OTC. The goal is to assure sufficient drug therapy choices are available to assure members’ needs are met in the context of available benefits from the program.

12.f.(2) Development of clinically appropriate utilization controls.

UM principles are applied to formulary products to promote value-based utilization in accordance with FDA-approved indications and best practices for funded conditions. Our integrated delivery system models allow us to implement robust drug use management controls and strategies within each partner’s network. This approach enables us to react and adapt UM controls as the evidence for appropriate use and/or cost change emerges. This may mean eliminating UM controls such PA, step therapy, or quantity limits or adding UM controls as warranted with appropriate notification to members and providers. Drug decisions are coordinated within the larger cost context of quality metrics and safety initiatives affecting total-cost-of-care and member/patient experience.

12.f.(3) Ability to revise a formulary periodically and a description of the evidence-based review processes utilized (including how information provided by the Oregon Pharmacy & Therapeutics Committee is incorporated) and whether this work will be subcontracted or performed internally.

Health Share delegates the formulary development, review, revision, and approval processes to our delivery system partners, each of whom has its own internal P&T Committee. This allows each partner’s provider network to engage, support, and participate in formulary decisions at the local and/or regional level where it makes the most sense to meet the needs of the Medicaid population. Each partner reviews all new FDA-approved products and new clinical indications under the authority of their Committee. The partners’ formularies are subject to change at any time based on new drugs to market, best practice updates, changes in regulatory guidance, and/or new recommendations from the Oregon P&T Committee. Formulary placement is guided by a review of major compendia, recommended treatment guidelines, and value-based assessment tools. P&T Committee staff are
trained in evidence-based quality-of-evidence assessment techniques. All of the partners’ P&T Committees meet regularly throughout the year and typically include both practicing physicians as well as pharmacists.

12.f.(3) Describe Applicant’s ability to ensure an adequate pharmacy network to provide sufficient access to all enrollees and how Applicant will communicate formulary choices and changes to the network and other medical professionals and how to make non-formulary, i.e. Prior Authorization, requests.

Health Share engages in continuous evaluation of our provider network to ensure adequate pharmacy coverage for their assigned members. This evaluation includes geographical availability of pharmacies according to CMS’s established network standards. A network adequacy study is available upon request. Each P&T Committee and pharmacy administration team communicates with providers through a variety of methods when significant formulary changes or utilization change strategies (e.g. grandfathering, new starts only, member status, order change forms) occur. Methods of communication include faxing to pharmacies, direct mailings to providers, emails to provider member lists, access to online tools, and e-prescribing. For example, Health Share demonstrated successful pharmacy network adequacy monitoring during the recent transition of members from Family Care to Health Share by ensuring members had a smooth and safe transition without medication interruptions.

12.f.(4) Describe Applicant’s capacity to process pharmacy claims using a real-time Claims Adjudication and Provider reimbursement system and capture all relevant clinical and historical data elements for claims paid in their entirety by the CCO and when the coordination of benefits is needed to bill Third Party Liability (TPL) when the CCO is the secondary coverage.

Pharmacy claims are processed in compliance with NCPDP D.0 standards using a real-time claims processing adjudication system that allows for coordination of benefits billing for primary and secondary payers at point of sale. Dual eligible Medicare part D members are limited to drugs that are excluded from Medicare part D coverage. For members identified as having secondary only coverage with the CCO, the payment system is configured to ensure primary insurance is billed first. Claims that are submitted to the CCO without this information are rejected and given instructions to the pharmacy to “bill primary.”

12.f.(5) Describe Applicant’s capacity to process pharmacy Prior Authorizations (PA) within the required timeframes either with in-house staff or through a Pharmacy Benefits Manager and the hours of operation that prescribers or pharmacies will be able to submit PAs.

Each of Health Share’s partners administers a PA process that is compliant with OAR 410-141-3225 (9)(f), CFR 438.210(d)(3) and section 1927(d)(5)(A) of the Social Security Act. Each organization staffs their PA workflow to meet the required time frames. PAs can be received by fax, phone, and/or mail 24 hours a day, seven days a week. Health Share’s pharmacy networks provide standard pharmacy hours with pharmacies open during the day, evening and weekends as well as some pharmacies providing 24-hour coverage. Health Share provides oversight through audits and delegation oversight activities to assure that this service is provided in a contractually compliant way.

12.f.(6) Describe Applicant’s contractual arrangements with a PBM, including:

Due to the proprietary nature and explicit terms of agreements within our Pharmacy Benefit Management contracts, Health Share is providing a response that includes percentile or dollar figure ranges for each question element. Those ranges are in the summary tables for each portion to follow.

12.f.(6) The contractual discount percentage(s) from Average Wholesale Price (AWP) or the percentage above Wholesale Acquisition Cost (WAC) the Contractor will receive from the PBM including rebate and incentive agreements or other funds received from the PBM by the CCO or any other type of any pricing arrangements between the CCO and PBM not based on a percentage discount from AWP or the percentage above WAC.

<table>
<thead>
<tr>
<th>Discount Percentage from AWP</th>
<th>Effective Percent Range</th>
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<tbody>
<tr>
<td>Brand</td>
<td></td>
</tr>
<tr>
<td>Generic</td>
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</table>
12.f.(6) The dispensing fees associated with each category or type of prescription (for example: generic, brand name, mail order, retail choice 90, specialty).

<table>
<thead>
<tr>
<th>Dispensing Fees</th>
<th>Effective Fee Range</th>
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<tbody>
<tr>
<td>Brand</td>
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<td>Generic</td>
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12.f.(6) The administrative fee to be paid to the PBM by CCO on a quarterly basis including a description of the associated administrative fee for each category or type and a description of the amount and type of any other administrative fees paid to PBM by Contractor.

<table>
<thead>
<tr>
<th>Administrative Fees</th>
<th>Quarterly Estimated Fees*</th>
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<tbody>
<tr>
<td>Claims Administration</td>
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<tr>
<td>Audit Fees</td>
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<tr>
<td>Rebate Administration</td>
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<tr>
<td>E-Prescribing Fees</td>
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*Amounts based upon best estimate membership levels.

12.f.(7) Describe Applicant’s ability to engage and utilize 340B enrolled Providers and pharmacies as a part of the CCO including: Whether Applicant is currently working with FQHCs and Hospitals

Currently, Health Share has many FQHCs, DSH hospitals, and other 340B eligible entities in our provider network. As a CCO, we are not directly involved in 340B activities or services, however, the 340B program is the responsibility of the qualified covered entity (such as the FQHC and hospital system with DSH designation) with oversight by HRSA. At times, at the request of the 340B entities, we have facilitated the sharing of best practices in the interpretation and use of 340B between qualified entities. Only one of our partners, Kaiser Permanente, operates its own pharmacies and warehouses, therefore acting as a direct purchaser of pharmaceuticals with no 340B activity for the Oregon Medicaid population.

12.f.(7) If so, how Applicant ensures the 340B program is delivering effective adjunctive programs that are being funded by the delta between what CCOs pay for their drugs and their acquisition costs

The 340B program is the responsibility of the covered entity (such as the FQHC and hospital system) with oversight by HRSA. As a CCO, Health Share is not involved in evaluating adjunctive programs associated with the 340B program. We believe in the original mandate of 340B provided in the Federal Register, which states that the intent of the 340B program is to permit covered entities “to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services.” We are aware of examples of 340B revenue helping clinics or hospitals financially support their clinic and pharmacy teams to be able to hire initial or more clinical pharmacists and/or expanding or starting pharmacies attached to the clinics or hospitals.

12.f.(7) How the Applicant is evaluating the impact of these adjunctive programs whether they are generating positive outcomes.

We believe the evaluation of these adjunctive programs is the requirement of the FQHC, DSH hospital, HRSA, and the State or Federal process. The impact evaluation should be according to the provisions required of being a qualified entity and/or the governing body within the 340B established HRSA framework.

12.f.(8) Describe Applicant’s ability and intent to use Medication Therapy Management (MTM) as part of a Patient-Centered Primary Care Home.

Health Share performs MTM care for members as a part of PCPCHs as well as through the use of pharmacists in retail setting where needed. We encourage the use of multidisciplinary team models that support providers and pharmacists through appropriate reimbursement methods. In addition, utilization and quality metrics are available in formats usable by clinicians to support PCPCHs in managing the medication needs of their patients.

12.f.(9) Describe Applicant’s ability to utilize E-prescribing and its interface with Electronic Medical Records (EMR).
All of Health Share’s partners meet the CMS standards for EMR/e-prescribing adoption, and our providers are fully compliant. Each partner meets the obligation to make e-Prescribing available through their claims processing systems, allowing providers to e-Prescribe through SureScripts or other technology as pertinent and when desired. Each EMR installation is at different levels of incorporating e-prescribing into their EMR and/or office workflows.

12.f. Describe Applicant’s capacity to publish formulary and Prior Authorization criteria on a public website in a format useable by Providers and Members.

Health Share provides our formulary and prior authorization criteria on our and our partners’ public websites for both members and providers to access. The resources include online search tools in most instances. Members can also seek help by calling the customer service lines to further understand these resources.

12.g. Standard #7 – Hospital Services (recommended limit 4 pages)

12.g.(1) Describe how the Applicant will assure access for Members to Inpatient and outpatient Hospital services addressing timeliness, amount, duration and scope equal to other people within the same Service Area.

Assuring access to inpatient and outpatient hospital services – The major hospital systems in the service area are all founding members of Health Share and are committed to ensuring the success of Health Share. **Health Share has the largest OHP provider network in the state** which includes the full range of physical health, behavioral health and oral health services, therefore Health Share members have services equal to other people in the service area. That network is largely managed by Health Share’s partners who represent the most well-known and established health systems in the state with proven track records in providing services to OHP enrollees. Further, Health Share, its delivery system partners are state leaders in providing services across the age spectrum, managing a variety of services and specialty types, and understanding the racial/ethnic and linguistic considerations of the members they serve. Health Share’s provider network has broad geographic distribution across the tri-county region. That network offers access to the full range of inpatient and outpatient hospital services monitored using network adequacy standards and access standards referenced above in Network Adequacy, Question 4. **Health Share has no gaps in the CMS time and distance standards for Inpatient and Outpatient services in our service area.** Access, timeliness, amount, and scope are all monitored in Network Adequacy reporting and ongoing access evaluation and assessment.

Health Share ensures that there are no prior authorization or concurrent review requirements that create a barrier to access of behavioral health benefits, including inpatient and outpatient hospital services, or that is more restrictive than medical/surgical benefits. We conduct yearly audits and oversight monitoring throughout our networks. Managing the specialty behavioral health network as a part of CareOregon’s ICN will allow for transparency and coordination throughout the system to continue to ensure there is no conflict with parity regulations.

12.g.(1) Describe any contractual arrangements with out-of-state hospitals.

Most often, we utilize Single Case Agreements for a contractual arrangement with an out of state hospital. These agreements are worked collaboratively between the Authorization Department and Contracting to efficiently coordinate the approval of the services and the agreed upon contract rate for a specified length of time.

We currently have an active agreement with Lucile Packard Children’s Hospital. This agreement allows us to pay claims at the negotiated OHA contract rates for members needing services at Lucile Packard Children’s Hospital. We are also in the process of finalizing a contract with Seattle Children’s Hospital. We have previously completed Single Case Agreements with the hospital for members needing services. The new contract would eliminate the need to complete Single Case Agreements.
12.g.(1) Describe Applicant’s system for monitoring equal access of Members to Referral Inpatient and outpatient Hospital services.

On a quarterly basis, Health Share utilizes CMS time and distance standards to regularly assess network adequacy, demonstrating that 90 percent of members (or more) have access to at least one provider/facility, for each specialty type, within established time and distance requirements for that county. Geomaps are produced for analysis at least on a quarterly basis and are reviewed by delegated network adequacy committees. Deficits are identified by highlighting areas that do not have sufficient coverage in time and distance standards and by performing comparisons between previous and current Network Analysis reports. On-call and after-hours provider schedules and logs are reviewed periodically to ensure providers are available or have coverage 24/7, including validating the hours of operation for each provider. These processes happen at all levels of Health Share currently and will continue to ensure that both the Integrated Delivery Systems and the Integrated Community Network have sufficient capacity and access. Additionally, Integrated Delivery Systems and the Integrated Community Network will routinely monitor wait times to appointments for specialty care. Monitoring will be prioritized for those services that have historic access concerns based on member feedback or identified through routine monitoring.

Grievance and complaint data are also analyzed within all service lines. If there is a trend with access to a specific specialty, Provider Services is notified to pursue resolution. The Quality Assurance process monitors grievances related to access issues, looking for trends and addressing individual complaints one by one. QA staff members track member complaints of all types. The QA supervisor monitors the complaints and identifies patterns and trends. Complaint thresholds are established and if they are exceeded, complaints are referred to a Peer Review committee. Peer Review can recommend corrective action or intervention by provider relations specialists to help resolve issues.

12.g.(2) Describe how the Applicant will educate Members about how to appropriately access care from Ambulance, Emergency Rooms, and urgent care/walk-in clinics, and less intensive interventions other than their Primary Care home.

- Procedures for improving appropriate use of Ambulance, Emergency Rooms, and urgent care/walk-in clinics.

Health Share is committed to providing members with the right service, at the right time, in the right place, and in the most integrated, least restrictive setting possible. Our member handbook has a section that encourages members to “Get Care in the Right Place” and describes when and how to seek routine, urgent and emergent care. Our integrated delivery systems will have policies and practices in place via ICC teams prior to January 2020 to meet the requirement for contacting and offering services to members with more than two ED visits in a six-month period. We currently have a broad range of interventions, teams, and tools in place to ensure appropriate use of ambulance transports, EDs, and urgent care/walk in. Such interventions include:

- The Tri-County 911 Service Coordination (TC911) program, which serves Clackamas, Multnomah, and Washington county residents who are using emergency medical services (EMS), including ambulance services, frequently and are heavily burdened by health and social issues. Staff help people find the right care, in the right place through short-term interventions. TC911 evaluations consistently show statistically significant reductions in use of acute care services, maintained connection to outpatient care, and reduced costs among highest cost Medicaid enrollees.

- Multiple programs have care coordination staff located in EDs or working primarily with ED staff to help members access the most appropriate care to meet their needs. Programs include health resilience specialists, ED diversion teams from Lifeworks and Cascadia, hospital-based ED navigators, and Project Respond’s ED response team.
• **Wraparound, Choice Model, and ACT teams are utilizing PreManage** to alert them to members who are seen in the ED.

• **Behavioral health partners use PreManage** to run daily reports for members with two or more readmissions to an ED in a six-month period and then partner with community-based treatment providers to respond while a member is still in the ED, providing interim behavioral health support between ED discharge and first appointment with the member’s provider.

• **Oral health partners use PreManage** for real-time notifications of members who visit the hospital for non-traumatic dental issues. Care coordinators reach out to the member and work with their dental clinic to schedule a dental visit in order to reduce the number of members who go to the hospital for dental issues and to increase the number of members who complete a dental visit after an ED visit. Future plans include spreading the adoption and use of PreManage to our dental providers.

• **Ongoing education** to EDs, urgent care clinics, and members about availability and access to crisis respite beds and urgent mental health walk-in clinics through regular communication about availability. This includes ensuring any barriers regarding discharge and transition to an urgent mental health walk-in clinic are addressed, including transportation.

• **Education of members** for access to urgent care and walk-in clinics through mailers, website information, and care coordination staff interventions.

• Our **Community Paramedicine** program is designed to reduce avoidable and costly hospital readmissions while making sure patients are receiving the care and support they need after they return home from the hospital. An innovative model of care, it involves paramedics working outside of their customary emergency response and transportation roles by treating patients in their homes. Hospitals identify patients who are at high risk for readmission, and paramedics follow up with them to ensure a successful transition from hospital to home.

12.g.(3) Describe how the Applicant will monitor and adjudicate claims for Provider Preventable Conditions based on Medicare guidelines for the following:

• **Adverse Events**

We follow Medicare guidelines for the identification for Adverse Events and Hospital Acquired conditions. Utilization Management teams, in the course of their utilization review may identify from clinical documentation a qualifying event. These are reported as a Quality of Care concern and processed and tracked by Quality Assurance teams. The claims system adjudication is also used to identify events, whether initially identified by the UM team or not, by using Medicare coding methodology.

Health Share delegates monitor and adjudicate claims using several standardized systems. HAC and Adverse Events are built in to our automatic claims DRG pricing system. In addition, our claims pricing product analyzes UB claims for Adverse Event and HAC codes, identifies affected claims and passes through an altered/ lowered DRG payment rate to the claims processing module in the pricing edits steps. Health Share will monitor these events across the CCO and will escalate any concerning trends to the Quality Committee.

12.g.(3) **Hospital Acquired Conditions (HACs).**

The hospitals that use the CMS Inpatient Prospective Payment System DRG apply the CMS hospital acquired conditions (HAC) logic when they are not present on admission. CMS has a list of HAC that they will not pay for. They do this by ignoring the diagnosis that was not present on admission when determining the DRG. When the HAC diagnosis was not present on admission, it assigns a DRG without complication/comorbidity (CC) or major complications/comorbidity (MCC). When the HAC diagnosis was present on admission, it assigns a DRG with complication/comorbidity (CC).
which pays differently for the service provided. Health Share will monitor these events across the CCO and will escalate any concerning trends to the Quality Committee.

**12.g.(4) Describe the Applicant's Hospital readmission policy, and how it will enforce and monitor this policy.**

We follow OAR 410-125-0410 regarding hospital readmissions within 30 days for related conditions and do not cover stays meeting the requirements of the OAR. All inpatient stays are reviewed for medical necessity. All 30 day readmissions are identified by UM RNs and verified by a medical director. Hospital readmissions are be bundled into a single billing when all the following are true:

- Member is on the OHP
- Hospital is paid using DRG methodology
- Readmission is within 30 days of discharge
- Readmission is for a diagnosis that is the same or related to the prior admission

Policy is enforced by denying payment for services that do not meet required criteria for readmission. Readmission rate will be monitored at least monthly through cost and utilization dashboards and through Health Share Bridge and the amount of denials are reviewed at least annually. Provider interventions are developed to improve rates if there are increasing trends. This policy does not include readmissions for a diagnosis that may require episodic acute care hospitalizations to stabilize the medical condition such as (but not limited to) diabetes, asthma, or chronic obstructive pulmonary disease as described in OAR.

**12.g.(5) Please describe innovative strategies that could be employed to decrease unnecessary Hospital utilization.**

We will utilize population health strategies to target readmission. By utilizing data, we will look for subpopulations within our membership for health disparities based on race, ethnicity, language, and geography overlaid with readmission rates. If a disparity is identified as it relates to readmission, we work with community partners and community to address the driver of the issue. To address the issue of unnecessary hospitalization for behavioral health admissions, we have employed numerous innovative strategies, including maintaining crisis stabilization services for members, such as intensive outpatient supports. These services also include:

- Intensive Transition Team
- Assertive Community Treatment teams for individuals with SPMI
- Intensive care coordination
- Peer crisis services
- Behavioral health/law enforcement paired teams

In addition, our ICN utilizes a robust population segmentation model allowing us to segment the entire population to easily identify how our membership is utilizing the health care system. The model contains four cohorts healthy, low risk, rising risk, and high risk. Each of these cohorts are further apportioned into 11 sub segments. This segmentation process allows us the ability to prevent unnecessary hospitalizations at three levels. On the population level, we work to keep our healthy members and communities healthy. This is accomplished by understanding the needs of those in the healthy segments and where they are located geographically. This upstream approach grants us the ability to leverage our community resources such as community-based organizations. We are also able to employ additional population health initiatives such as community benefit or SDOH remediation to keep these members healthy ultimately avoiding unnecessary hospitalization in the future. More immediately, we proactively engage those members in the rising risk segments. These members demonstrate usage of the medical system that indicates they may be moving to more high-risk cohorts but may not currently have had a hospitalization. By proactively enrolling members in care coordination and by addressing their needs, we believe we can avoid hospitalization. We continue to employ robust transition support, especially for those members in the high-risk segments. We strive
to connect these members to the appropriate level of resources (i.e. palliative care) and use the Coleman Care Transitions model to prevent future readmission. By understanding our entire population and by matching the appropriate intervention with the right segment, we can demonstrate a comprehensive system of preventing unnecessary hospitalization from very upstream to immediate readmission prevention.

Another innovative approach to decrease unnecessary hospitalizations for individuals with mental illness is through the hiring of a regional coordinator with Quality Pool earnings. The ED-MI coordinator is tasked with partnering with physical, dental and behavioral health plans to identify strategies to improve care for populations experiencing mental illness, with the goal to reduce ED utilization as well as hospital readmissions.

12.g.(6) Please describe how you will coordinate with Medicare Providers and, as applicable, Medicare Advantage plans to reduce unnecessary ED visits or hospitalization for potentially preventable conditions and to reduce readmission rates for Fully Dual Eligible Members.

Health Share is affiliated with three Medicare Advantage plans. All partners align, coordinate and communicate to reduce unnecessary ED visits. Care management is an essential component of this process because working with the member to identify the “why” identifies the gaps and barriers members perceive exist that circumvents primary care visits. Care management includes communication with the member, conducting a screening and assessment when applicable, and then communicating with the provider to assist the member in gaining access to treatment in the ambulatory care setting. Receiving care in the ambulatory setting provides for wellness, prevention, and treatment related services with the goal of reducing preventable conditions that lead to acute care hospitalizations.

Strategies in place to reduce unnecessary ED visits and potentially preventable inpatient admissions and readmissions include real-time monitoring of ED admits through the PreManage tool, embedded ED navigators and care managers, community access to virtual health, health express as well as urgent care clinics, 24/7 RN advice telephonic intervention, care management, and same day/next day PCP appointments. Interventions include health care education: appropriate site of care, community access to health, PCP assignment and scheduling, behavioral health coordination, scheduling and support, assessment of SDOH and connecting to resources, and multi-disciplinary follow up and ongoing support until the member is comfortable and trusting in their use of the health care system outside of the ED. Health Share’s approach to caring for Medicaid members is not dependent on their Medicare carrier; however, understanding resources available, benefits, and additional support systems through the Medicare plan, and coordinating with those services, is a key component to our execution of the interventions and the holistic approach described above.
Attachment 8 — Value-Based Payment Questionnaire (15 pages)

C. VBP Questions

C.1. Submit two variations of the information in the supplemental baseline RFA VBP Data Template: a detailed estimate of the percent of VBP spending that uses the Applicant’s self-reported lowest Enrollment viability threshold, and a second set of detailed and historical data-driven estimate of VBP spending that uses the Applicant’s self-reported highest Enrollment threshold that their network can absorb.

VBP Data Templates – Please see the attached RFA4690-Health Share of Oregon–Att8-RFA VBP Data Template for the required data template. The three provided CY2020 supplemental baseline RFA VBP Data Template estimates include the following assumptions:

- Alignment with enrollment forecasts and costs in the pro forma required by Attachment 12: Cost and Financial Questionnaire
- Proportional scalability of VBPs based upon the strength of our partners, strong relationships with network and population, and unpredictable member mix if decreases in actual membership take place from the best estimate

Additionally, in order to meet the diverse needs of Oregon Health Plan (OHP) members in our region and the imperatives of CCO 2.0, we have created the state’s most comprehensive provider network. We are leveraging the value and strengths of the tri-county’s integrated finance and health care delivery systems (IDS) — Kaiser Permanente, Legacy Health, OHSU Health System, and Providence Health & Services — and optimizing a best-in-class integrated community network (ICN), managed by CareOregon, that focuses on integrating and supporting our safety net, oral health, non-emergent medical transportation (NEMT), and behavioral health systems of care.

We strongly support the vision of expanding VBPs consistent with the LAN standards set forth by OHA. Many Health Share partners are members of HCP-LAN and were moving in this direction prior to OHA’s adoption of the framework, enabling Health Share to have a baseline of 68% of payments in VBP 2C or higher when the contract takes effect. As demonstrated in our VBP Data Template, this estimate reflects our shift to contracting with IDSs that qualify as LAN 4C payments and the ICN that is integrating key services and systems of care in a way that we have not previously integrated.

Although we are starting from a position of strength in this area, we still have a lot of work to do to continue to advance VBP in our region. Health Share will build upon this strong baseline from year one and focus on:

1. Increasing the number and breadth of VBPs
2. Progressing existing VBPs beyond a LAN 2C status
3. Supporting our IDS partners’ expansion of VBP within the LAN 4C payment category by expanding service categories covered by the IDSs (e.g., specialty behavioral health and dental)
4. Addressing social determinants of health and health equity through VBP
Below is an infographic illustrating our new operating structure — Health Share 2.0.

C.2. Provide a detailed estimate of the percent of the Applicant’s PMPM LAN category 2A investments in PCPCHs and the plan to grow those investments. Applicants must submit the following details:

C.2.a. Payment differential across the PCPCH tier levels and estimated annual increases to the payments

Percent of LAN Category 2A investments in PCPCHs –

More than 98% of Health Share’s members are assigned to a PCPCH recognized Primary Care Provider.
Plan for growing investments in PCPCHs –

Payment differential across the PCPCH tier levels and annual increases –

### Estimated PMPM Payment by Tier

<table>
<thead>
<tr>
<th>PCPCH Tier</th>
<th>PMPM Range</th>
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<tbody>
<tr>
<td>Tier 3 clinics</td>
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<tr>
<td>Tier 4 clinics</td>
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<tr>
<td>Tier 5 clinics</td>
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### Members Assigned to PCPCH by Tier as of Q4 2018

<table>
<thead>
<tr>
<th>Number</th>
<th>Proportion</th>
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C.2b. Rationale for approach (including factors used to determine the rate such as Rural, Urban, or social complexity)

Rationale for our VBP approach –
C.3. Describe in detail the Applicant’s plan for mitigating any adverse effects VBPs may have on health inequities, health disparities, or any adverse health-related outcomes for any specific population (including racial, ethnic and culturally-based communities; lesbian, Gay, Bisexual, transgender and queer (LGBTQ) people; persons with disabilities; people with limited English proficiency; immigrants or refugees and Members with complex health care needs as well as populations at the intersections of these groups. Mitigation plans could include, but shall not be limited to:

Mitigating adverse effects of VBP arrangements – Health Share recognizes the risk related to VBP implementation and its potential impact on particular communities, including racial, ethnic and culturally based communities, LGBTQIA individuals, persons with disabilities, individuals with limited English proficiency, immigrants and refugees, and members with complex health care needs. As we increasingly tie payments to outcome measures and performance targets, we realize achievement of these targets by focusing only on the dominant culture could potentially leave some populations behind. Health Share has historically disaggregated all performance measures by available demographic categories, and we recognize that achievement of considerable improvement for all populations needs to be intentional and addressed through culturally specific interventions. The Health Share model offers an advantageous framework to evaluate and monitor potential adverse impacts of VBPs given our structure of strong community engagement. We will share disaggregated data for specific populations and solicit feedback from our CAP, CAC, and other community stakeholders in our assessment process. Our complex and sizable network, existing analytics platform, experience with risk adjustment, and established processes embedded within our most robust VBPs with our IDS partners equip us for ongoing system evaluation and management.

C.3.a. Measuring contracted Provider performance against their own historical performance rather than national benchmarks when patient mix is more complex;

Measurement approaches to mitigate adverse impacts on specific populations – Health Share recognizes the differences and diversity in our network partners and designs our VBPs with this in mind. As an example, we work to measure performance on several primary care program metrics on a clinic’s own historical performance across the entire program. We recognize that some measures are particularly sensitive to populations with greater medical and social complexity, as seen in validation through our own analysis. Given this, and based on feedback from our clinical network partners, we have measures that focus on individual clinic improvement as opposed to benchmark attainment. Furthermore, Health Share recognizes the necessity to fully support services delivered within the safety net and FQHCs. For all physical and behavioral health providers, the quality
metrics both incentivize and provide a framework for monitoring access, engagement, and health outcomes. Through routine performance monitoring, quality teams evaluate year-over-year performance changes and population changes. Thanks to having five years of existing baseline data, we have a strong platform for evaluating trends and anomalies. Combining such evaluation ensures that we have alignment in our payment models with targets Health Share needs to achieve on CCO Incentive and Accountability metrics.

Culturally specific behavioral health providers – Culturally specific behavioral health providers are eligible for incentive funding related to quality metrics. Metrics include access to services, initiation and engagement, and psychiatric hospital utilization. Culturally specific providers were deeply engaged in the development of these metrics, including helping to identify areas that may exacerbate disparities. Our network of culturally specific providers has performed very well on the final metrics and has displayed the value of the current incentives and capacity-based funding model. In addition, Health Share contracts with culturally specific behavioral health providers on a capacity basis, with additional funding allocated for engaging historically disenfranchised populations. Many members from disenfranchised populations may not engage in behavioral health services due to cultural stigma, historical trauma, poor prior experiences with behavioral health services, or fear of public institutions. For these reasons, efforts to engage populations must be recognized and built into funding models. Capacity-based contracts allow providers to make proactive attempts to engage members in disenfranchised populations and do not penalize providers for failing to engage those members.

C.3.b. Use of risk-adjustment models that consider social and medical complexity within the VBP; and

Risk adjustment models based on medical complexity and social needs – Health Share recognizes and has embraced the value-add of social and medical complexity evaluation tools, both within and aside from VBPs. To mitigate adverse effects of VBP arrangements, we will utilize risk adjustment models that consider medical and social complexity. Health Share has been using robust risk adjustment models based upon medical complexity within VBPs since initial implementation of the CCO program, and we will continue doing so within both new and expanded VBPs throughout the CCO 2.0 program. Health Share leverages these risk adjustment models for almost all member populations/categories of aid served by Health Share, inclusive of those that have documented exclusions from such processes (i.e., dual eligible persons with disabilities and foster children). Health Share also anticipates aligning with and leveraging risk adjustment mechanisms based on assessment of social determinants of health that OHA implements for CCOs. All such risk adjustment and changes in risk profiles allow for provider, regional, and statewide comparisons for member mix and complexity.

Utilizing OHA’s pediatric health complexity model – Despite gains in pediatric primary care homes, there is a need to better support children with health complexity (combination of physical health and social risk factors). The term “health complexity” is a variable that describes the degree to which a child has both medical and social complexity. This is important, as children with high social complexity would benefit from different resources than those with medical complexity. The children with both high social and medical complexity are some of our most vulnerable children. Several social determinants of health put our pediatric population at risk, particularly those with chronic medical conditions. OHA in conjunction with the Oregon Pediatric Improvement Partnership is in the process of piloting a pediatric health complexity model. This model accounts for both:

1. **Medical complexity** – The Pediatric Medical Complexity Algorithm (PMCA) is a tool that accounts for utilization of services, diagnoses, and the number of body systems impacted over a
three-year lookback. It divides children into three categories (complex chronic, non-complex chronic, and children without chronic disease).

2. **Social complexity** – The Center of Excellence on Quality of Care Measure for Children with Complex Needs (COE4CCN) has identified 18 different social complexity factors associated with worse health outcomes and increased costs. OHA was able to get data on 12 of these children and family social risk factors. Many of these factors are ACES (Adverse Childhood Experiences).

We will explore use of this data as it is available and refined in development of new VBP models to assess the enhancement of payments for providers taking care of our most complex children. This model will allow these providers to hire resources and staff that will help these children and families receive the care they need in a trauma-informed and culturally competent manner.

**Tools to support risk stratification based on medical complexity** – As outlined in the health information technology (HIT) response (Attachment 9), Health Share also offers all partners access to Health Share Bridge, our analytics and data delivery platform that is the backbone of our quality measurement and reporting system. Interactive Tableau dashboards, accessed through our SharePoint site, reflect monthly updates to performance on health quality indicators and access to tools like our patient stratification application. This tool makes risk-stratified population data easily available to all active Health Share partners to inform both member-level and population-level decision-making. This tool allows users to create unique patient lists of their assigned membership across numerous domains of utilization and engagement, including emergency department (ED) visits, inpatient admissions, skilled nursing facility stays, specialist visits, observations stays, intensive care unit (ICU) stays, cost, 7-day readmits, 30-day readmits, and behavioral health visits. The tool also has the ability to combine the above utilization factors with stratification for individuals on medications, including high-risk medications. Additionally, the tool has three native risk models to identify patients with high risk. Those models include Health and Human Services “Hierarchical conditions category” (HHS-HCC) risk, the Center for Medicare and Medicaid Services “Hierarchical conditions category” (CMS-HCC), and the Charlson/Deyo risk score. Finally, the patient stratification application includes an INSIGHT Risk score, allowing users to stratify their population based on a combined social risk score determined by variables unique to the patient’s zip code.

**C.3.c. Monitoring number of patient that are “fired” from Providers.**

**Monitoring member re-assignment and quality data** – Health Share monitors our provider network for signs of providers selectively choosing or dismissing members from their practices through several different mechanisms, and ensures compliance with applicable policies, procedures, and Oregon Administrative Rule 410-141-3080. We monitor the number of patients reassigned from individual PCPs as well as quality metric denominators for indications that members are no longer within the practice. Significant deviations from baseline data will trigger additional monitoring or investigation as indicated.

**Monitoring grievances** – Health Share also receives quarterly grievance reports from our partner organizations. Health Share received only one complaint from a member dismissed by a provider during the entirety of 2018. Using this data, Health Share can identify if there is an increase in members being dismissed from providers and can determine if there was an increase due to VBP. We also review Quality of Care grievances. This category of grievances tells us about the member’s experience and their perception of the care they are or are not receiving. We have also developed our unique “Equity” category of grievances. Examples of sub-categories we have reviewed include provider bias barrier, member not treated with respect, language or cultural barriers or lack of
cultural sensitivity, interpreter services not available, and member neglect. If we identify a trend in these categories, Health Share partner organizations will reach out to the provider’s clinic and conduct an investigation into the cause of the increase in fired patients. Health Share partner organizations have conducted root cause analysis in the past as needed for investigating concerns.

Focusing PCP assignment on culturally appropriate providers – In addition to continuing to develop a culturally and linguistically diverse workforce and utilizing interpretation services whenever necessary, Health Share will work to improve our PCP assignment process to align patients with particular cultural and linguistic needs with clinics serving those needs, if available. This will enhance our ability to serve special populations — such as racial and ethnic groups, LGBTQIA, and others — through providers who are able to address their specific needs.

C.4. Describe in detail the new or expanded, as previously defined, care delivery area VBPs the Applicant will develop in year one and implement in year two.

Expanding VBP within our new collaborative model –
New and expanded VBP arrangements by year 2 –
C.5. Provide a detailed plan for how the Applicant will achieve 70% VBP by the end of 2024, taking into consideration the Applicant’s current VBP agreements. The plan must include at a minimum information about:

C.5.a. The service types where the CCO will focus their VBPs (e.g. primary care, specialty care, Hospital care, etc.)

C.5.b. The LAN categories the CCO will focus on for their payment arrangements (e.g. mostly pay for performance, shared savings and shared risk payments, etc.)

Plan for achieving 70% VBP by the end of 2024 –
Achieving 50% and 60% VBPs in years 3 and 4 —
Achieving 70% VBP by 2024 –

Achieving 25% of LAN 3B by 2024 –

Assistance for providers –
Attachment 8, Value Based Payment Data Template

Template redacted per Attachment 4, Disclosure Exemption Certificate.
Health Share supports and believes in value-based care and continuing improvement of patient outcomes. We actively participate and support OHA’s and OHPB’s efforts to advance delivery of healthcare to Oregonians using optimized HIT tools and support. Health Share currently participates in and uses the Emergency Department Information Exchange (EDIE) and participates in the Prescription Drug Monitoring Program (PDMP) Integration Initiative. We do not expect any challenges or obstacles in signing the HIT Commons MOU and fulfilling its terms. We are already active members of HITOC, HITAG, HIT Commons, and other collaborative bodies, and we intend to maintain an active engagement with OHA through these forums. The following table represents our current commitment and engagement to HIT Commons and other HIT groups in Oregon.

<table>
<thead>
<tr>
<th>Organization</th>
<th>Members</th>
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<tbody>
<tr>
<td>HIT Commons</td>
<td>Several of the current HIT Commons Governance Board members are from either Health Share or one of our partner organizations.</td>
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<tr>
<td></td>
<td>- Andy Zechnich MD – Providence (as a hospital system representative)</td>
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<tr>
<td></td>
<td>- David Russell – Adventist (as a hospital system representative)</td>
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<tr>
<td></td>
<td>- John Sanders – Health Share (as a CCO representative)</td>
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<tr>
<td></td>
<td>- Amit Shah MD – CareOregon (as a CCO physician representative)</td>
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<tr>
<td></td>
<td>- Mary Monnat – LifeWorks (as a Behavioral Health representative)</td>
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<tr>
<td></td>
<td>- Paul Lewis MD – Multnomah County (as a county Public Health representative)</td>
</tr>
<tr>
<td>HITAG</td>
<td>- John Sanders – Health Share</td>
</tr>
<tr>
<td></td>
<td>- Nate Corley – CareOregon (representing Jackson Care Connect and Columbia Pacific CCO)</td>
</tr>
<tr>
<td>HITOC</td>
<td>Health Share partners actively contribute to HITOC and its statewide HIT planning.</td>
</tr>
<tr>
<td></td>
<td>- Amy Henninger MD – Multnomah County Health Department</td>
</tr>
<tr>
<td></td>
<td>- Mali Boynay – Legacy Health</td>
</tr>
<tr>
<td></td>
<td>- Valerie Fong – Providence</td>
</tr>
<tr>
<td></td>
<td>- Cort Garrison – OHSU</td>
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B. Support for EHR Adoption
B.1. Evaluation Questions (recommended page limit 5 pages)

For each evaluation question, include information on Applicant’s current operations, what Applicant intends to arrange by the Contract Effective Date, and Applicant’s future plans. When answering the evaluation questions, please include in a narrative as well as a roadmap that includes activities, milestones and timelines.

Community-wide health care leadership with Health Share 2.0 – Health Share of Oregon and its unique collaborative model will achieve the triple aim of better care, smarter spending, and healthier people – bringing the value of each partner organization to make the whole better than the sum of its parts. In order to meet the diverse needs of Oregon Health Plan (OHP) members in our region, we have created the state’s most comprehensive provider network. Under a new operating structure that we call Health Share 2.0, we are leveraging the value and strengths of the tri-county’s integrated finance and health care delivery systems (IDS) — Kaiser Permanente, Legacy Health, OHSU Health System, and Providence Health & Services — and optimizing a best-in-class integrated community network (ICN), managed by CareOregon, that focuses on integrating and supporting our safety net, oral health, NEMT, and behavioral health systems of care.
Health Share’s commitment to widespread use and adoption of EHRs — Health Share and our partner organizations are committed to the widespread use and adoption of electronic health records (EHRs) across physical, behavioral, and oral health providers throughout the state. In fact, our IDS partners have already fully adopted EHRs throughout their systems. This commitment is rooted in the fundamental understanding that health IT, and specifically EHRs, enable transparency to patients, present clinically relevant data to providers at the point of care, and ultimately streamline patient care to support health care affordability and accountability through actions and analytics. A 2016 landscape scan in Oregon's Health Systems Transformation Report found that 78.4% of eligible CCO providers had already adopted certified EHRs and, as of 2015 (the last year data were available), Health Share’s performance on the EHR Meaningful Use quality measure met state targets at 74%. Across the state, a variety of drivers increased EHR adoption, especially financial incentives related to Meaningful Use. With this incentive program, other motivating factors, and new ways of incentivizing EHR adoption to all care providers, we will continue to promote and measure care coordination effectiveness and monitor the use of EHRs within our plan. We will report on EHR use and proliferation throughout our networks on a routine basis and continually look for ways to improve sharing of relevant clinical data to improve our members’ health outcomes.

The Office of the National Coordinator for Health IT’s (ONC) Meaningful Use and subsequent Merit Based Incentive Program (MIPS)/Electronic clinical quality measure (eCQM) program, working in parallel with Oregon’s CCO incentive measures and technical assistance programs, have had a positive and transformative impact on EHR use in Oregon. As requirements and expectations expand to encompass population health management and analytics, as well as data exchange to facilitate care and prevent unnecessary costs, providers will need increasingly sophisticated tools and services that support these capabilities while streamlining workflows. This may include implementing, changing, or upgrading EHRs or more fully utilizing existing systems to meet these challenges. Health Share will support providers in adopting tools and optimizing systems and processes necessary to realize benefits to both their practices and our members. One way we will support our providers in adopting tools and EHRs is described below in a first-of-its-kind proposed HIT Governance Structure, which will serve as a cross-functional group chartered to oversee these important goals and objectives.

![Proposed Health Share HIT Governance Structure](image-url)
**EHR Adoption Steering Group** – Under Health Share’s HIT Governance Structure, we will establish and sponsor a multi-sector EHR Steering Group comprised of representatives from physical, behavioral, and oral health tasked to help expand EHR adoption among these provider types. This group will:

- Partner with OHA on environmental scans to establish baselines of EHR use among physical, behavioral, and oral health providers
- Use baseline data to create realistic EHR adoption targets, referencing benchmarks from other comparable regions by provider type
- Articulate and champion the value proposition for EHR adoption
- Leverage existing and new strategies among entities to expand on behavioral health and oral health adoption
- Evaluate and support technical assistance opportunities
- Oversee work targeted specifically towards behavioral and oral health EHR adoption

Through this HIT Governance Structure, we will align EHR-related provider contract terms with Oregon’s PCPCH requirements for participating providers and encourage participation in these programs. Similarly, we will seek parity with EHR-related requirements in CMS programs as they align with OHA requirements to simplify administration for providers and encourage adoption of emerging standards. Health Share participates in and actively works with the State PCPCH program toward increasing tier levels across primary care groups, using 5B PCPCH standards to help incentivize clinics to use EHRs. An example of this is one of our IDS partners using VBP to help incentivize clinics to become tier 4 or higher, which includes EHR adoption.

**B.1.a. How will Applicant support increased rates of EHR adoption among contracted physical health Providers?**

Realizing the value of EHR adoption among physical health providers – Currently our IDS partners and CareOregon providers offer and extend Epic EHR tools to contracted physical health providers that offer a variety of features to streamline the care experience for members and providers. For example, an Epic community connect bundle often includes a patient portal for members (i.e., MyChart) and CareEverywhere HIE functionality for providers.

Strategies for increasing rates of EHR adoption among physical health providers that will be arranged by January 2020 – By contract effective date, Health Share will establish a strong and collaborative Board Governance Committee to develop the structure, charters, and overall strategic plan for the proposed HIT Governance. This group will develop a plan for phase one discovery, make resource recommendations, and engage in ongoing evaluation and improvement.

Proposed strategy for promoting EHR adoption among physical health providers through the life of the contract – To further EHR adoption over the course of the next CCO contract, we will base our approach on a solid understanding of the specific provider challenges and value propositions for those few organizations that have not yet adopted EHR systems. Our strategies to promote EHR adoption will include advocating for and educating organizations on the value of EHR adoption both to their internal organizations as well as the broader value of participation at a regional level. We will reduce barriers by offering opportunities to leverage investments in larger systems (i.e., Epic community connect) and by consulting with organizations to help them with system selections, RFAs, evaluations, workflow design, and sharing other known best practices. We will promote the benefits of EHR adoption by clearly articulating the value and improvement of care delivery through electronic record and data exchange methods. Examples of this value include data integration between entities such as diagnostic and ancillary services, providing quicker and more convenient results information through integration with HIE, and automation of metrics needed for VBP. We will also evaluate EHR adoption within our VBP contracts.
# Roadmap for Increasing EHR Adoption among Physical Health Providers

## Year One

<table>
<thead>
<tr>
<th>Activities</th>
<th>Milestones</th>
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<tbody>
<tr>
<td>Establish and charter the multi-organization HIT Governance Structure to lead and be accountable for making and monitoring recommendations regarding the EHR adoption efforts across Health Share</td>
<td>By 2020: Establish HIT Governance Groups</td>
</tr>
<tr>
<td>Conduct environmental scans to assess prevalence, versions, and capabilities of EHRs in our networks</td>
<td>Q1 2020: determine environmental scan method and level of detail for reporting Q2 2020: all delivery systems have completed scan and responses are compiled</td>
</tr>
<tr>
<td>Analyze the members and activities corresponding to non-EHR practices</td>
<td>Q3 2020: complete analysis of populations and claims</td>
</tr>
<tr>
<td>Create a ranked set of provider organizations that we will target for EHR adoption support.</td>
<td>Q4 2020: combine with survey data to assess EHR users; complete ranked list of providers to target for support</td>
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## Year Two

<table>
<thead>
<tr>
<th>Activities</th>
<th>Milestones</th>
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<tbody>
<tr>
<td>Assess the role of contracting, VBP, quality metrics program, and other EHR-relevant programs to promote adoption</td>
<td>Q1 2021: strategy for use of programs to promote adoption</td>
</tr>
<tr>
<td>Prioritize regions and/or provider types for outreach based on areas of greatest need</td>
<td>Q1 2021: build prioritized list for outreach</td>
</tr>
<tr>
<td>Develop tailored value propositions and business cases for EHR-adoption or enhanced functionality</td>
<td>Q2 2021: high priority practices engaged</td>
</tr>
<tr>
<td>Establish a resource/advisory workgroup within our Governance Structure to provide workflow and technical assistance to provider groups</td>
<td>Q2 2021: governance structure in place</td>
</tr>
<tr>
<td>Deliver up-to-date functionality and workflows of current EMRs to include foundational and best practice standards within the EMRs to include recommended treatment guidelines, decision support, and best practices at the point of care</td>
<td>Q3 2021: engagements have begun with selected practices</td>
</tr>
<tr>
<td>Offer consultative services for care management and patient care navigation</td>
<td>Q4 2021: engagements have begun with selected practices</td>
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## Years Three - Five

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<thead>
<tr>
<th>Activities</th>
<th>Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess the range of incentives and support we are offering in regards to the progress made on adoption</td>
<td>Q2 2022: assessment delivered to Health Share partners</td>
</tr>
<tr>
<td>Support an overall EHR Planning and Technical Services Extension Program. Start by assessing how support can be directed to increasing the more complete and meaningful use of EHRs in place</td>
<td>Q2 2022: plan proposed</td>
</tr>
<tr>
<td>Provide accessibility across diverse platforms, computers, smartphones, and digital mobile devices</td>
<td>Q2 2023: selected practices have implemented</td>
</tr>
<tr>
<td>Implement population management tools such as patient registries and workflows</td>
<td>Q3 2023: selected practices have implemented</td>
</tr>
<tr>
<td>Provide data sharing across provider systems, assuring a continuum of care for patients that provides visibility for providers caring for that patient, regardless of service location</td>
<td>Q4 2023: selected practices have implemented</td>
</tr>
<tr>
<td>Incorporate system alerts on abnormal results, negative trends, and potential drug interactions</td>
<td>Q2 2024: selected practices have implemented</td>
</tr>
</tbody>
</table>
While our goal by the end of the contract is to have all providers on electronic records systems, we realize that it may not be possible to overcome all the disincentives a specific provider may face. We expect that our rate of provider adoption will meet or exceed comparable regional or national rates.

**B.1.b. How will Applicant support increased rates of EHR adoption among contracted Behavioral Health Providers?**

Realizing the value of EHRs among behavioral health providers – In a survey of 275 contracted behavioral health agencies conducted in 2017, Health Share found that 83% reported the presence of an EHR, though roughly half of these providers report only partial implementation. Over 90% of respondents reported using EHRs to capture patient information such as demographics, clinical encounters, care plans, and diagnosis. 80% or less reported access to discharge/transfer reports, emergency department alerts, medications, lab results, and allergy information. These findings imply that in addition to spreading EHR adoption among providers not already using them, there may be unrealized value in converting to a more capable EHR platform or leveraging functionality that has not yet been implemented.

The automatic and rapid receipt of outside information has been a significant factor in EHR adoption in other disciplines, and the survey results indicate behavioral health programs greatly value some of the same capabilities with emphasis on different content. Top EHR vendors have started to focus more on behavioral health and some IDS partners have begun to extend their EHRs to behavioral health providers with success.

**Strategies for increasing rates of EHR adoption among behavioral health providers that will be arranged by January 2020** – By contract effective date, Health Share will have identified and chartered the Governance Structure we will use to refine our HIT strategies, identify resources, and operationalize those initiatives.

**Proposed strategies to increase EHR adoption among behavioral health providers through the life of the contract** – Health Share’s strategy will examine the drivers, enablers, and barriers that influence EHR use and shape solutions accordingly. Some providers may benefit from workflow optimization to use their EHR more efficiently or to more effectively document and improve upon key performance measures. Others may need help in increasing automation or improving data quality of claims submissions, and still others would benefit from improved electronic information exchange with hospitals, physical health providers, or oral health providers.

Under the Health Share 2.0 structure for the delivery of behavioral, physical, and oral health, we have the opportunity to work directly with all contracted providers to understand current needs. We will also work to develop VBP options that support both clinical care and workforce development as well as enhanced and consistent use of HIT to support the needs of members who cross providers and service domains regularly. Central to this work will be ensuring behavioral health providers have access to the tools needed for care coordination and to enable them to participate in VBP arrangements that support Health Share’s pursuit of the triple aim.
# Roadmap for Increasing EHR Adoption among Behavioral Health Providers

## Year One

### Activities
- Conduct environmental scans to assess prevalence, versions, and capabilities of EHRs in our behavioral health networks
- Analyze the members and activities corresponding to non-EHR practices
- Bring behavioral health leaders, including those from the region’s CCBHCs, together to share experiences on journeys to EHR adoption, the value they have realized, and the opportunities they see going forward
- Create a ranked set of behavioral health provider organizations guided by values of HIT Governance Structure that we will target for EHR adoption support
- Determine how Health Share or our ICN/IDS networks can offer financial or other support for EHR adoption
- Work with our partners to educate behavioral health providers about benefits that result from investments made in the physical health EHR space

### Milestones
- **Q1 2020**: determine environmental scan method and level of detail for reporting
- **Q2 2020**: complete analysis of populations and claims
- **Q3 2020**: learning session held and ranked list drafted
- **Q4 2020**: programs proposed

## Year Two

### Activities
- Develop tailored gap analyses and adoption business models to better help non-EHR practices overcome barriers and understand the behavioral health functionality of EHRs in physical health settings
- Work with the HIT Commons to expand use of EDIE to inpatient behavioral health facilities
- Work with the HIT Commons to expand direct EDIE/PreManage connections to behavioral health EHRs
- Explore workflow opportunities to increase automation of claims submission

### Milestones
- **Q2 2021**: selected practices engaged
- **Q2 2021**: proposal delivered
- **Q3 2021**: proposal delivered
- **Q4 2021**: selected practices engaged

## Years Three - Five

### Activities
- Evaluate and reassess adoption program performance to date, adjust as needed
- Work to maximize behavioral health EHR capabilities to incorporate and present physical health data
- Work to set up behavioral health EHRs to submit quality measures to the CQMR
- Expand EHR extension offerings to behavioral health entities, capitalizing on physical health learnings and successes
- Focus on the capabilities of behavioral health EHR systems to properly document and manage substance use disorder information, including evaluating access controls and limits on external disclosures

### Milestones
- **Q2 2022**: report delivered to governance group
- **Q3 2022**: selected practices engaged
- **Q1 2023**: selected practices engaged
- **Q2 2023**: program(s) in place
- **Q2 2024**: guidance document and support program in place for data exchange and external access
As it ties into our HIE strategies, we will work with our behavioral health providers to identify the physical/dental health information they find relevant for their practices. As we determine suitable HIE methods for this data, we will also identify if and how the behavioral health EHR systems are able to receive, incorporate, and present this data to providers.

**B.1.c. How will Applicant support increased rates of EHR adoption among contracted oral health Providers?**

**Realizing the value of EHRs among oral health providers** – As noted above, as requirements related to EHR adoption expand to encompass population health management, as well as data exchange to facilitate care and prevent unnecessary costs, providers will need increasingly sophisticated tools and services that support these capabilities while streamlining workflows. This may include implementing, changing, or upgrading EHRs, or more fully utilizing the systems they have to meet these challenges. Health Share is prepared to not only support providers in adopting the tools, but also to optimize the systems and processes necessary to realize benefits to both their practices and our members.

Health Share has experience working with multiple dental care organizations (DCOs) to provide coordinated oral health care to our members. For example, CareOregon Dental supports the use of APM and quality pool dollars for EHR implementation and upgrading. Their focus is on electronic dental records systems within our primary dental provider network with an emphasis on adoption, transition, and/or upgrading to fully integrated EHR with co-located medical-dental providers where the medical and dental record is fully combined into a single health record for the patient.

Specific to our work, the funded OHIP projects support the use of integrated Epic EMR. Currently 4 out of 5 OHIP partners use the integrated EHR, with the last partner scheduled to transition to the Epic Wisdom dental module in fall 2019. Virginia Garcia’s OHIP deliverables include developing an Epic scrubbing tool and toolkit to be shared with OCHIN’s Wisdom Collaborative and CareOregon Dental providers.

**Strategies for increasing rates of EHR adoption among oral health providers that will be arranged by January 2020** – By contract effective date, Health Share will have identified and chartered the Governance Structure we will use to refine our HIT strategies, identify resources, and operationalize those initiatives, including approaches to governing oral health strategies.

**Proposed strategies to increase EHR adoption among oral health providers through the life of the contract** – Under the Health Share 2.0 model, we are integrating the oral health benefit and DCO contracts into a single integrated community network (ICN) administered by CareOregon. The ICN will tightly align oral health delivery systems with safety net and behavioral health systems in
order to reduce complexity for members and providers. As a result, we will increase our ability to make regional investments to support clinical integration and EHR adoption in systems that have historically lagged behind physical health.

Health Share will engage with DCOs to learn how they support EHRs within their networks and identify opportunities where we can support expansion on EHR technology adoption and use.

**Roadmap for Increasing EHR Adoption among Oral Health Providers**

<table>
<thead>
<tr>
<th>Year One</th>
<th>Milestones</th>
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<tbody>
<tr>
<td><strong>Activities</strong></td>
<td></td>
</tr>
<tr>
<td>Work with DCOs to assess current provider use</td>
<td>Q3 2020: assessment complete</td>
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<tr>
<td>state and to identify ways of measuring adoption</td>
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</table>

<table>
<thead>
<tr>
<th>Year Two</th>
<th>Milestones</th>
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</thead>
<tbody>
<tr>
<td><strong>Activities</strong></td>
<td></td>
</tr>
<tr>
<td>Expand existing electronic referral processes</td>
<td>Q1 2021: in place for selected practices</td>
</tr>
<tr>
<td>between physical and oral health providers</td>
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</tr>
<tr>
<td>Understand current state use of EDIE/PreManage</td>
<td>Q2 2021: assessment complete</td>
</tr>
<tr>
<td>within DCO landscape, including use cases and</td>
<td></td>
</tr>
<tr>
<td>opportunities</td>
<td></td>
</tr>
<tr>
<td>Promote further use of EDIE for emergency</td>
<td>Q2 2021: implementation program in place</td>
</tr>
<tr>
<td>department and urgent care event notifications</td>
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</tr>
<tr>
<td>for oral health-related diagnoses</td>
<td></td>
</tr>
<tr>
<td>Explore expansion of current pilots within some</td>
<td>Q4 2021: implementation program in place</td>
</tr>
<tr>
<td>Health Share DCOs using PreManage for high-risk</td>
<td></td>
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<tr>
<td>oral health conditions and/or members</td>
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<thead>
<tr>
<th>Years Three - Five</th>
<th>Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activities</strong></td>
<td></td>
</tr>
<tr>
<td>Require electronic exchange of clinical information for EHR-related quality measurements</td>
<td>Q1 2022: contracts in place based on agreed-upon plan</td>
</tr>
<tr>
<td>Explore closed-loop electronic referrals and/or reauthorization's for dental specialty services</td>
<td>Q3 2022: plan in place</td>
</tr>
<tr>
<td>Identify opportunities for how EHR systems in oral health settings can be augmented to better support care coordination and information sharing with primary care providers</td>
<td>Q1 2023: assessment delivered</td>
</tr>
<tr>
<td>Work with DCOs on contracting opportunities to incorporate EHR adoption and use within existing value-based payment arrangements</td>
<td>Q1 2024: contract structures supporting EHRs drafted</td>
</tr>
</tbody>
</table>

**B.1.d. What barriers does Applicant expect that physical health Providers will have to overcome to adopt EHRs? How do you plan to help address these barriers?**

**Potential Barriers to EHR Adoption for Physical Health Providers** – Startup or implementation costs are often the first barrier to EHR adoption that providers identify, as well as ongoing costs of software and services in order to maintain these systems and their content. In addition, early iterations of EHRs resulted in more time spent by clinicians on charting, which is often cited as a concern for providers when considering an EHR.

**Health Share’s plan to address these barriers** – These barriers may be mitigated through economies of scale, leveraging current investments from our partners to offer lower cost and lower maintenance options. Health Share currently funds the use of PreManage for all of our enrolled members. PreManage has proven so effective that we are committed to creating a sustainability model to ensure all contracted providers continue to have access to this program. Partnering with OHA’s HIE Onboarding Program (HOP) program is another tremendous opportunity to help address start-
up costs for the segment of HIE covered by use of a centralized HIE such as Reliance. We will explore the best options for providing resources for practices choosing to use peer-to-peer exchange methods.

An additional benefit of using established systems in a shared environment is the amount of refined content and experience with workflows built up over time. The EHR adoption resources offered through our new HIT Governance Structure will facilitate providers from partner organizations sharing best practices to reduce overhead and streamline charting. As service offerings such as Epic Community Connect can be so useful for promoting adoption, we will work to allay the concerns of some providers about any potential loss of autonomy from sharing EHR infrastructure and workflow elements.

To help address these barriers and potential concerns about using shared systems, we will work with EHR providers to clearly articulate where providers can collaborate on system governance and configuration as well as what integration development roadmaps are available for adding future capabilities.

**Roadmap for Addressing Barriers to EHR Adoption for Physical Health Providers**

<table>
<thead>
<tr>
<th>Year One</th>
<th>Milestones</th>
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<tbody>
<tr>
<td><strong>Activities</strong></td>
<td><strong>Milestones</strong></td>
</tr>
<tr>
<td>Understand the specific adoption barriers experienced by our providers</td>
<td>Q3 2020: barriers identified in assessment report</td>
</tr>
<tr>
<td>Identify priority providers for increasing EHR adoption</td>
<td>Q4 2020: prioritized list delivered</td>
</tr>
<tr>
<td>Perform a detailed gap assessment for our prioritized providers</td>
<td>Q4 2020: gap assessment incorporated in prioritized list</td>
</tr>
<tr>
<td>Work within our HIT governance model to define the support and incentives that can be offered either by Health Share or our partners</td>
<td>Q4 2020: support and incentives program(s) identified</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Years Two - Five</th>
<th>Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activities</strong></td>
<td><strong>Milestones</strong></td>
</tr>
<tr>
<td>Work within our HIT governance model to define the support and incentives that can be offered either by Health Share or our partners</td>
<td>Q4 2021: assessment of program effectiveness and proposed changes</td>
</tr>
<tr>
<td>Q4 2022: assessment of program effectiveness and proposed changes</td>
<td></td>
</tr>
<tr>
<td>Q4 2023: assessment of program effectiveness and proposed changes</td>
<td></td>
</tr>
</tbody>
</table>

Strategies to address barriers are also described in more detail in outlined in Subsection (a) above.

**B.1.e. What barriers does Applicant expect that Behavioral Health Providers will have to overcome to adopt EHRs? How do you plan to help address these barriers?**

**Potential barriers to EHR adoption for behavioral health providers** – When asked in our 2017 survey described above, behavioral health providers without EHRs at Health Share stated that the cost and the small size of their programs were the top barriers, followed by lack of technical infrastructure and staffing. Another often cited barrier for some providers is concern about electronic information sharing and associated privacy regulations such as 42 CFR Part 2.

**Approaches to address barriers for behavioral health providers** – Barriers related to cost of EHR adoption and the small size of many behavioral health providers could be mitigated by emphasis on the use of cloud or "software as a service" EHR offerings, which have lower implementation costs and require little to no local technical support. Health Share will examine the workforce and technical assistance resources needed to enable behavioral health providers to adopt and use these tools. We will work with our partners to gather and present EHR market information to providers that have not
yet adopted EHRs. This adoption support assistance can also include providing direct vendor experience or knowledge, assessment of migration requirements, privacy and security advice, and consulting on workflow transitions. We will also work to leverage partners and service providers offering shared multi-disciplinary EHRs, which provide added benefits in enabling access to information from physical health providers and facilities (with appropriate authorization).

**Roadmap for Addressing Barriers to EHR Adoption for Behavioral Health Providers**

**Year One**

<table>
<thead>
<tr>
<th>Activities</th>
<th>Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understand the specific adoption barriers experienced by our providers</td>
<td>Q2 2020: assessment based on environmental scan and learning session</td>
</tr>
<tr>
<td>Identify priority providers for increasing EHR adoption</td>
<td>Q2 2020: list drafted</td>
</tr>
<tr>
<td>Work within our HIT governance model to define the support and incentives that can be offered either by Health Share or our partners</td>
<td>Q3 2020: programs proposed</td>
</tr>
</tbody>
</table>

**Years Two - Five**

<table>
<thead>
<tr>
<th>Activities</th>
<th>Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perform a detailed gap assessment for our prioritized providers</td>
<td>Q2 2021: high priority practices engaged</td>
</tr>
<tr>
<td>Advocate and partner with stakeholders to educate behavioral health providers on how organizations can and have addressed these concerns</td>
<td>Q2 2021: integrated in provider engagement plan</td>
</tr>
<tr>
<td>Incorporate the privacy topic into our HIE strategy to address concerns about ensuring patient privacy</td>
<td>Q1 2022: integrated in HIE strategy</td>
</tr>
<tr>
<td>Support OHA sponsored activities, such as the Behavioral Health Information Sharing Advisory Group</td>
<td>Support throughout contract term</td>
</tr>
</tbody>
</table>

Additional strategies for addressing barriers to EHR adoption among behavioral health providers are outlined in our roadmap descriptions in Subsection (b) above.

**B.1.f. What barriers does Applicant expect that oral health Providers will have to overcome to adopt EHRs? How do you plan to help address these barriers?**

**Potential barriers to EHR adoption for oral health providers** – For Health Share and many other CCOs, contracts with oral health providers are managed through DCOs rather than directly with providers. DCOs often contract with multiple CCOs and have traditionally been effective in areas such as compliance and reporting that emphasize EHR use. However, DCOs have been guarded about direct CCO engagement with providers to help with quality or performance opportunities. Additionally, DCOs have historically had challenges extracting data from their provider EHRs.

**Approaches to address barriers for oral health providers** – We will work with DCO leadership to identify how best to approach specific providers/groups to advance their use of EHRs. We will work to see how our DCO contracting can be aligned to reinforce incentives for EHR adoption. There also may be synergies with our HIE and quality reporting efforts that we can leverage to address these barriers with both providers and Health Share. Aligning DCO contract terms with national programs such the Merit-Based Incentive Payment System may help minimize overhead for providers and for internal operations and data analytics. We will work with OHA and HIE vendors to explore these opportunities.

Given that DCOs often work with multiple CCOs, we will also collaborate with other CCOs on encouraging EHR adoption among selected DCO providers and aligning EHR-related requirements to manage administrative impacts.
### Roadmap for Addressing Barriers to EHR Adoption for Oral Health Providers

#### Year One

<table>
<thead>
<tr>
<th>Activities</th>
<th>Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engage with DCO partners to understand the specific adoption barriers experienced by our providers</td>
<td>Q3 2020: assessment complete</td>
</tr>
<tr>
<td>Identify priority providers for increasing EHR adoption</td>
<td>Q4 2020: priority list drafted</td>
</tr>
</tbody>
</table>

#### Years Two - Five

<table>
<thead>
<tr>
<th>Activities</th>
<th>Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perform a detailed gap assessment for our prioritized providers</td>
<td>Q3 2021: assessment delivered for high priority practices</td>
</tr>
<tr>
<td>Work within our HIT governance model to define the support and incentives that can be offered either by Health Share or CareOregon as the ICN network administrator responsible for the oral health network</td>
<td>Q4: 2021: incentive program(s) defined</td>
</tr>
<tr>
<td></td>
<td>Q4 2022: incentive program(s) evaluated and adjusted</td>
</tr>
<tr>
<td></td>
<td>Q4 2023: incentive program(s) evaluated and adjusted</td>
</tr>
</tbody>
</table>

Strategies to address barriers are also described in more detail in our roadmap descriptions outlined in Subsection (c) above.

**B.2. Informational Questions (recommended page limit 2 pages)**

**B.2.a. What assistance you would like from OHA in collecting and reporting EHR use and setting targets for increased use?**

Health Share would like to understand what sources of adoption information may already exist within state-owned systems. The statewide provider directory program may be an example of a potential data source with a standardized approach across the state. Through this work, OHA could provide a standardized and trusted source of adoption rates by types of providers and geographies, along with an ability to drill down to specific providers that are not leveraging certified EHR technology. Given the current high adoption rate among most provider types in our region, we would like to partner with OHA to define EHR adoption targets. OHA could play a valuable role in bringing DCO and CCO leadership together around EHR adoption approaches, set common expectations, and identify opportunities to combine efforts or standardize/simplify requirements.

**B.2.b. Please describe your initial plans for collecting data on EHR use, and setting targets for increased use by contracted physical health Providers. Include data sources or data collection methods.**

Health Share will collect data on and set targets for EHR adoption and the meaningful use of EHRs by leveraging our EHR Adoption Steering Group (first described in response to B.1.a.) to motivate and share best practices. This group will:

- Explore our current data collection effort for the DSN provider directory to encompass additional information on EHR capabilities and adoption rates
- Create common EHR adoption targets, referencing benchmarks from other comparable regions
- Examine claims data and workflows for Health Share and for our partners to see if markers exist that can identify submissions coming from non-EHR practices
- Look within our quality reporting and information exchange programs to identify where we are not getting electronic data out of EHRs
- Leverage our compliance oversight and audit processes to identify and document extent of EHR use
Work to identify national and statewide benchmarks and comparison data for us to use in setting appropriate targets

B.2.c. Please describe your initial plans for collecting data on EHR use, and setting targets for increased use by contracted Behavioral Health Providers. Include data sources or data collection methods.

In addition to what is described in response to question B.2.b., Health Share’s integrated care network administrator, CareOregon, will work with an industry-leading provider data quality service organization to incorporate EHR usage questions into quarterly provider data gathering and validation. These will flow into a data warehouse for analysis and reporting.

We will also leverage claims data and Quest Analytics as data sources for this work. The behavioral health EHR market has a few large vendors (e.g., Netsmart) that we can approach to see what information is available about adoption rates that will help us to set appropriate, realistic targets for increased use.

B.2.d. Please describe your initial plans for collecting data on EHR use, and setting targets for increased use by contracted oral health Providers. Include data sources or data collection methods.

In addition to what is described in response to question B.2.b., Health Share will work with DCO leadership to collect EHR information from their network providers. This will include a survey of providers’ ability to exchange data and integrate with EDIE/PreManage and HIE services. This may include leveraging our service provider for gathering provider data utilized in physical and behavioral health areas. We will leverage claims data and Quest Analytics as data sources for this work.

C. Support for Health Information Exchange (HIE)

C.1. Evaluation Questions (recommended page limit 8 pages)

C.1.a. How will Applicant support increased access to HIE for Care Coordination among contracted physical health Providers?

Health Share’s collaborative structure allows us to offer capabilities from our partner organizations to increase access to HIE for care coordination among physical health providers. These partners, including both integrated delivery systems and CareOregon, have made significant investments in electronic health records (EHRs), software hosting and development, vendor management, and information exchange competencies. These investments allow for sharing complex, actionable, and relevant data in compliance with state and federal security standards (HIPAA, 42 CFR, HITECH, others). Today, Health Share’s integrated delivery system partners provide fully integrated health information exchange capabilities for all providers within their networks. The IDSs serve more than 30% of Health Share members today.

Our integrated community network administrator, CareOregon, supports increased access to HIE for care coordination among contracted physical health providers by utilizing Carequality, CommonWell, EDIE/PreManage, and CareEverywhere with community providers and skilled nursing facilities to further support transitions of care. Additionally, we collect social determinants of health, member demographic, and electronic health record information within a member/patient-centric data set capable of rapid expansion across our networks.

C.1.a. Please describe your strategy, including any focus on use cases or types of Providers, any HIE tool(s) or HIE methods included, and the actions you plan to take.

Strategy for increasing access to HIE for care coordination – To improve HIE adoption and use by providers to support care coordination, we will approach HIE on two main fronts: 1) PreManage (CMT Collective Platform) for ED notification and care management of high-need patients and 2) standards-based clinical exchange methods for all providers and their clinical workflows.

In year one, Health Share will establish an HIT Governance Structure that will focus on identifying care coordination efforts that could be improved by increased information availability and HIE, including care transitions (i.e., hospital discharge), referrals, and coordination across health care provider types (e.g., between a physical health provider and a behavioral health provider).
Using stakeholder input provided through our Community Advisory Council (CAC) and other partner organizations, we will assemble and rank workflows to identify early targets for promoting HIE. This work will result in the creation of a Regional HIE Plan to guide Health Share’s HIE promotion efforts and a Health Share regional work plan called for by the HOP program. Especially for coordination between provider types, we will identify and rank the types of information needed for care coordination to ensure consistency with HIPAA’s “minimum necessary” standard. We will also aim to minimize “information overload” for our receiving providers. This assessment will focus on what summaries are clinically valuable and how that information can be exchanged and presented. We will also develop value propositions and build return-on-investment cases based on improving these processes.

CareOregon will also monitor and enhance its existing capability for physical health providers to request dental services through its provider portal and continue to provide technical assistance to physical health providers while partnering to improve their workflows at the point of care.

An early and key goal of our HIE program in years two through five will be to determine the exchange technology or method that best suits different types of partner workflows. While Epic CareEverywhere is widely adopted by our larger provider groups, we want to determine the availability and ongoing affordability of different HIE methods. We will also determine the value of having a centralized community database as offered by Reliance HIE. Many of our provider groups may benefit from the range of service offerings that are available from Reliance. This evaluation will include identifying the value of analytics services and data feeds for providers in our region from a centralized clinical repository.

Also in Year 2, we intend to provide provider HIE Technical Assistance under the HIT Governance Structure to offer necessary support to providers interested in adopting or expanding their use of HIE. We will provide assistance in identifying data sharing methods and HIE vendors most suitable for their situation.

Roadmap for Increasing HIE Access for Physical Health Providers

<table>
<thead>
<tr>
<th>Year One</th>
<th>Activities</th>
<th>Milestones</th>
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<tbody>
<tr>
<td></td>
<td>Establish and charter the multi-organization HIT Governance Structure to</td>
<td>By 2020: Establish HIT Governance</td>
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<tr>
<td></td>
<td>lead and be accountable for making and monitoring recommendations</td>
<td>Groups</td>
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<td>regarding the HIE adoption efforts across Health Share</td>
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<tr>
<td></td>
<td>Renew PreManage license coverage for the entire Health Share member</td>
<td>Q2 2020: Contracted completed</td>
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<tr>
<td></td>
<td>population</td>
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<tr>
<td></td>
<td>Identify and prioritize initial HIE use cases</td>
<td>Q3 2020: Initial set completed</td>
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<td></td>
<td>Prepare initial HOP regional workplan</td>
<td></td>
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<tr>
<td></td>
<td>Survey and assemble inventory of EHRs and HIE capabilities</td>
<td>Q3 2020: CCO plan completed</td>
</tr>
<tr>
<td></td>
<td>Identify pilot example use cases and participating organizations</td>
<td>Q4 2020: Inventory completed</td>
</tr>
<tr>
<td></td>
<td>Identify Epic Connect partners and their suite of offerings</td>
<td>Q4 2020: have working plan</td>
</tr>
<tr>
<td></td>
<td>Determine available CCO funding and resources for HIE support</td>
<td>Q4 2020: Service options documented</td>
</tr>
<tr>
<td></td>
<td>Determine how to add HIE to contracting and VBP programs</td>
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<th>Year Two</th>
<th>Activities</th>
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<td>Determine how to add HIE to contracting and VBP programs</td>
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<tr>
<td>Survey and assess options for HIE adoption and usage metrics</td>
<td>Q1 2021: Have metrics set identified</td>
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<tr>
<td>Establish and charter HIE Technical Assistance workgroup</td>
<td>Q2 2021: First planning meeting</td>
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<tr>
<td>Develop standardized HIPAA guidance and framework for HIE and data exchange</td>
<td>Q2 2021: Have reference material available</td>
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<tr>
<td>Assess prioritized provider organizations for adoption of Epic Connect</td>
<td>Q2 2021: Governance structure in place</td>
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<tr>
<td>Start integration of CareOregon referral platform to provider EHRs</td>
<td>Q3 2021: Prioritized list ready for implementations</td>
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### Years Three - Five

**Activities**

- Reassess and refocus CCO offerings, support, resources, and TA based on adoption metrics evaluation  
  **Milestones**  
  Q1 2022: Current gap analysis completed

- Begin concerted efforts to integrate SDOH information and explore integrations with community organizations  
  **Milestones**  
  Q1 2022: Opportunity assessment document complete

- Begin characterizing and documenting support for extending Epic CareEverywhere to non-Epic organizations  
  **Milestones**  
  Q1 2022: Project team assembled

- Develop and incorporate clinical data feeds into CCO bulk data distributions to provider organizations  
  **Milestones**  
  Q2 2023: Initial high-priority clinical data identified

1. **Supporting the HOP program:** Health Share and its partners are committed to supporting the success of OHA’s HOP program with Reliance eHealth Collaborative to explore the value proposition and return on investment of this HIE opportunity. The goal of this initiative will be to expand use of HIE functionality to increase timely access to data across systems, with a particular focus on integrating behavioral and oral information with physical health information. An additional objective over the course of the engagement will include expanding the HIE offerings related to social determinants of health information (SDOH) as available. We will include CAC and provider input as we consider the addition of SDOH information to ensure a sensitive and community-informed rollout. We will also explore how we can work with Reliance and other vendors to lower ongoing costs for our network providers, including those participating in the HOP.

2. **Providing PreManage licenses to providers:** For the past several years, Health Share has (along with OHA) funded PreManage licenses and access for our entire regional population. We have also allocated earned quality funds specifically to support HIE. We are setting up governance and processes to evaluate how this investment will be extended in the future, consistent with our commitment to expanding regional information exchange. We will combine available funding and explore the development of incentives within contracting or risk arrangements that reward participation in HIE. Where possible, we will work to better integrate PreManage into EHRs so its availability to providers is expanded and more efficient.

3. **Advocating for use of Epic’s CareEverywhere platform:** Where appropriate, we will advocate for expanded use of Epic’s CareEverywhere platform that allows providers to securely share patient information (lab and imaging results, EKG tests, historical diagnoses, event notifications, follow-up alerting) initiated by patients or providers across care teams. Our IDS partner organizations are already successfully using CareEverywhere, Carequality, and CMT PreManage for exchange of clinical data among providers and care managers. This approach also applies to CareOregon’s network providers, since many use or can adopt OCHIN’s Epic instances. A majority of Oregon provider organizations currently use CareEverywhere, among them Adventist, Asante, Bend Memorial, Kaiser Permanente, Legacy Health, OCHIN, OHSU, Providence Health and Services, Salem Health, Samaritan Health Services, Tuality, Mid-Columbia Medical Center, Sky Lakes Medical Center, and the Portland Clinic.
Adopting or integrating with Epic provides access to a large part of our physical health data network, along with a range of very useful analytics and coordinated care tools.

4. Integration into Epic for providers utilizing Reliance HIE: For those organizations using Reliance HIE, we will promote its integration into Epic and other EHRs. We will forge links between Epic and non-Epic organizations using the range of available methods and standards. The assessments described above will help determine what is most suitable for the specific use cases and organizational readiness. These options include Carequality/CommonWell, eHealthExchange, Direct, and Reliance HIE. As its availability and use becomes more widespread, we will start developing pilot trial implementations of exchange using the Fast Healthcare Interoperability Resources (FHIR) interface standards. These standards allow our providers and partners to share patient data securely between systems in order to ensure effective delivery of care for our members.

5. Supporting bulk data exchange: Distinct from clinical messaging, we also consider bulk data exchange to have a strong role in our information exchange strategy. Health Share will support these efforts in multiple ways, including:

- Delivery of complete sets of claims data to provider organizations based on their actual member relationships. This will allow each organization to combine claims with their clinical data so they have a complete view of a member’s care. It will also help them further develop their own analytics environments.
- Delivery of standardized extract files to payers in support of quality metric reporting (NCQA HEDIS, CMS) and compilation of adjudicated claims data within our enterprise data warehouse (EDW) to evaluate cost and utilization, support quality improvement dashboards, and support integrated reporting.
- Contribution of member data for community-based initiatives via regional entities such as Oregon Health Care Quality Corporation and Reliance, as well as any provider organizations who wish to participate in the exchange of data to benefit patients and members. This will include exchange of SDOH information as it becomes available.

6. Support for tri-directional provider referrals: CareOregon intends to create functionality for providers from across the continuum of Health Share’s physical health provider networks to request service navigation and/or care coordination services from oral and behavioral health providers. They will evaluate use cases whereby these referrals occur via an automated or ‘closed-loop’ mechanism. In years three through five, we will expand the above functionality to be multi-directional (behavioral health and oral providers to send referrals to physical health as well as to one another). We are confident this navigation and referral system will support and augment more robust HIE development and encourage participation. Within the HIT Governance Structure, we will measure HIE use and re-evaluate strategies and tools on an annual basis.

C.1.b. How will Applicant support increased access to HIE for Care Coordination among contracted Behavioral Health Providers? Please describe your strategy, including any focus on use cases or types of Providers, any HIE tool(s) or HIE methods included, and the actions you plan to take.

Increasing access to HIE for care coordination among behavioral health providers – We understand how critical health information sharing is to ensuring effective care management across physical health and behavioral health and to supporting behavioral health integration efforts. We are committed to working with our behavioral health provider network as well as our CAC and clinical advisory panel to identify opportunities for expanding HIE and information sharing among all provider types.

Strategy for Increasing Access to HIE for Care Coordination – Our HIE expansion efforts
outlined above for physical health will be applied as much as possible with our behavioral health provider networks. Health Share’s Board of Directors has allocated funds in the Ready + Resilient strategic portfolio to support HIE adoption in behavioral health in line with OHA’s HOP program ambitions. Our contracted behavioral health providers vary widely in their HIE needs, as well as in their capability to develop the necessary infrastructure and workflow to support health information exchange. Epic does not have a large penetration in the behavioral health market, so most of our efforts will center on employing appropriate standards-based exchange methods that integrate with the behavioral health EHRs used by our behavioral health providers.

As part of our HIT Governance Structure’s focus on HIE promotion, we will establish a sub-group to focus specifically on behavioral health workflows and will determine whether a mediated HIE approach like Reliance adds value that will offset costs. Based on our considerable knowledge of the region’s care coordination and information sharing needs, we are strongly encouraged by OHA’s commitment to use the HOP program to emphasize adoption and use by behavioral health providers, and we will work to ensure the program’s success. For many smaller providers, portal-based access to HIE will be most practical and can be supported by Reliance and the HOP. We will also examine in detail the role of direct messaging and other methods for cross-sector physical health-behavioral health referrals. We will inventory our behavioral health provider EHR systems to determine how well they support direct and other standards.

We would like to better integrate substance use disorder information to the extent possible given the regulations regarding the confidentiality of substance use disorder patient records (42 CFR Part 2). One of the main limitations reported by behavioral health providers is concern and lack of knowledge around compliance and records exchange. We intend to establish resources to support behavioral health providers with information exchange including providing better information and assessments of what exchange is available given the particular combination of data type, regulation, and patient consent. The HIT Governance will assign this work through a sub group.

As described in our response for physical health providers above, Health Share will explore use of a cross-system referral platform to facilitate referrals across care domains.

Roadmap for increasing access to HIE for Behavioral Health Providers

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<tr>
<th>Year One</th>
<th>Activities</th>
<th>Milestones</th>
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<tr>
<td></td>
<td>Establish and charter the multi-organization HIT Governance Structure</td>
<td>Q4 2019: Structure and membership identified</td>
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<tr>
<td></td>
<td>Identify and prioritize initial BH HIE use cases</td>
<td>Q3 2020: Priority list drafted</td>
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<tr>
<th>Years Two - Five</th>
<th>Activities</th>
<th>Milestones</th>
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<tr>
<td></td>
<td>Convene BH focus groups to tailor CCO HIE adoption efforts for BH providers</td>
<td>Q3 2021: First workgroup session</td>
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<tr>
<td></td>
<td>Develop HIE implementation templates or project plans with large BH EHR vendors such as Netsmart</td>
<td>Q4 2021: Draft documentation complete</td>
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<td></td>
<td>Begin concerted efforts to standardize handling of SUD and member consent in our HIE settings</td>
<td>Q1 2022: Workgroup starts</td>
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<td></td>
<td>Start integration of CareOregon referral platform into BH EHR workflows</td>
<td>Q1 2022: Workplan developed</td>
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Reassess and refocus CCO offerings, support, resources, and TA based on progress towards adoption metrics

Q1 2022: Metrics evaluation completed

C.1.c. How will Applicant support increased access to HIE for Care Coordination among contracted oral health Providers? Please describe your strategy, including any focus on use cases or types of Providers, any HIE tool(s) or HIE methods included, and the actions you plan to take.

Increasing access to HIE for care coordination among oral health providers – As with Behavioral Health, we will adapt our basic HIE approach to maximize the integration of our Dental Health provider network. As with most CCOs, our dental providers come into our network through five contracted dental care organizations (DCOs). Some DCOs have already taken steps to set up capable dental HIEs. In these cases, we will consider an approach similar to OHA’s Network of Networks as we work to link up connectivity nodes. We look forward to interacting with our DCO colleagues to integrate them into our regional work plan.

We will establish a subgroup within our HIT Governance Structure focused on oral health information exchange. This group will examine what types of information will be useful to exchange. While there are many dental workflow opportunities to use physical health data — for example, gaps in care coaching during time with the hygienist — clearly dental providers do not need or want all the available physical health data. Our assessment of this area will focus on data needed to fuel high-priority workflows, evaluating the abilities of the dental EHR to hold and display that data, and to explore the HIE methods supported by those vendor systems.

As described above, we will explore referral coordination and facilitation across all provider types via use of the current tool hosted by Health Share’s ICN partner, CareOregon.

Roadmap for increasing access to HIE for Oral Health Providers

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<th>Year One</th>
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<tr>
<td><strong>Activities</strong></td>
<td><strong>Milestones</strong></td>
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<tr>
<td>Establish and charter the multi-organization HIT Governance Structure</td>
<td>Q4 2019: Structure and membership identified</td>
</tr>
<tr>
<td>Engage with DCOs on provider HIE adoption status and opportunities</td>
<td>Q2 2020: First set of meetings held</td>
</tr>
<tr>
<td>Identify and prioritize initial Oral Health HIE use cases</td>
<td>Q3 2020: Priority list drafted</td>
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C.1.d. How will Applicant ensure access to timely Hospital event notifications for contracted physical health Providers? Please describe your strategy, including any focus on use cases or types of Providers, which HIE tool(s), and the actions you plan to take.

Increasing access to timely hospital event notification for physical health providers – Health Share and its partners have been active participants in the implementation of both the EDIE and PreManage platforms. This has included paying for subscriptions covering the entire CCO population and participating in learning collaboratives at the state and local level to improve workflows and
standardize information contained in these tools to strengthen community collaboration.

CMT EDIE/PreManage will remain the primary notification method used with our contracted physical health providers to coordinate care for patients with a recent hospital event. Building on a successful array of current use cases, we intend to expand the availability and aligned use of PreManage. We currently use PreManage to:

- Retrieve daily reports which identify our members with inpatient admissions and/or discharges in order to enroll them into care coordination teams to connect and provide transitional support
- Use pre-established population risk segments to generate specific reports based off of ADT notification to proactively prioritize outreach to those members and coordinate care across physical, behavioral, and oral health systems as well as community partners
- Upload CCO metrics and STARS/HEDIS measures to PreManage as flags for our population and share this with our community partners to proactively outreach and address our members’ gaps in care
- Optimize and continue to promote the use of care recommendations to spread shared care plans across the continuum of care (PCP, IP, ED, behavioral health, etc.)
- Promote use of Prescription Drug Monitoring Program (PDMP) data to help address substance use disorder and meet CCO targets for opioid prescribing

These tools offer all of Health Share’s partners a rich set of near real-time information related to critical moments of member transition. Although both IDS and ICN partners have been working with EDIE/PreManage in different ways, aligning around and sharing best practices will be a priority, particularly for high-priority populations and transitions.

We will continue to be active in the many statewide and regional EDIE/PreManage forums, where we widely share our success stories and lessons learned and provide feedback to CMT about system enhancements based on experience using the platform.

**Roadmap for Ensuring Access to Notifications for Physical Health Providers**

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<th>Year One</th>
<th>Activities</th>
<th>Milestones</th>
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<tr>
<td></td>
<td>Establish and charter the multi-organization HIT Governance Structure</td>
<td>By 2020: Establish HIT Governance</td>
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<td></td>
<td>Renew PreManage license coverage for the entire Health Share member population</td>
<td>Q2 2020: Contract completed</td>
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<td>Survey and assemble inventory of EHRs and capabilities for integrating notifications</td>
<td>Q3 2020: Inventory completed</td>
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<td>Extend and standardize flagging of high-risk or other cohorts for Care Coordination notifications</td>
<td>Q4 2020: Initial set of cohorts identified</td>
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<th>Year Two</th>
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<tr>
<td></td>
<td>Complete development of sustainability model for PreManage funding</td>
<td>Q1 2021: Funding model identified</td>
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<td></td>
<td>Identify and prioritize organizations not currently using PreManage</td>
<td>Q2 2021: Prioritized list available</td>
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<tr>
<td></td>
<td>Start setup and distribution of PreManage data feeds to provider organizations</td>
<td>Q2 2021: High value data identified</td>
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<td></td>
<td>Start offering technical assistance and other support to get providers connected to PreManage</td>
<td>Q3 2021: Prioritized provider list prepared</td>
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<th>Years Three - Five</th>
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C.1.e. How will Applicant ensure access to timely Hospital event notifications for contracted Behavioral Health Providers? Please describe your strategy, including any focus on use cases or types of Providers, which HIE tool(s), and the actions you plan to take.

Ensuring access to timely hospital event notification for behavioral health providers – As noted above, Health Share has historically ensured that all members are entered into PreManage and that this access is prioritized to the behavioral health provider network. Health Share has historically funded behavioral health provider access to PreManage to enable interested organizations to use timely hospital event notifications. In the past two years we have seen a significant increase in engagement of these tools within the behavioral health community as all of Health Share’s largest BH providers are now actively engaged with PreManage. Health Share is committed to continuing to offer PreManage to contracted behavioral health providers to coordinate care for patients with complex needs. As in Physical Health, we intend to build on our current successful workflows, which generally are built around notification of specifically designated care coordinators who then proceed to outreach to members or other providers once notification is received. Examples of successful uses of PreManage in this area include:

- In alignment with CCO 2.0 cohort definitions, we will expand use of embedded staff into points of care where members have been identified via HIT as having been admitted with a substance use disorder diagnosis as primary or secondary (i.e., members with 2 or more admissions to an ED within a rolling 6-month period, members with a readmission to inpatient psychiatric care, and other emerging cohorts to be developed in partnership with behavioral health and Primary Care clinics).
- Place peer support in the ED for engagement of members in the ED who are there secondary to a substance use disorder-related issue or an overdose and will rely on HIT to identify those members.
- Use of PreManage cohort offerings for individuals identified as falling in the denominator for the ED/Mental Illness quality incentive metric. Because the measure focuses on individuals who have a historical mental health diagnosis and are visiting the ED for a physical health concern, the need for timely HIE and event notification will be pivotal in helping to integrate systems and ensure aligned approaches and clinical accountability.

Roadmap for Ensuring Access to Notifications for Behavioral Health Providers

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<th>Year One</th>
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<td></td>
<td>Establish and charter the multi-organization HIT Governance Structure</td>
<td>Q4 2019: Structure and membership identified</td>
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<td></td>
<td>Identify and prioritize high-value BH notification use cases</td>
<td>Q3 2020: Prioritized list drafted</td>
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<td>Extend and standardize flagging of high-risk or other cohorts for Care Coordination notifications</td>
<td>Q4 2020: Standard set of cohorts developed</td>
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<tr>
<td></td>
<td>Identify and prioritize BH organizations not currently using PreManage Governance Structure</td>
<td>Q1 2021: Prioritized list completed</td>
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<td></td>
<td>Start offering TA and other support to get BH providers connected to PreManage</td>
<td>Q3 2021: TA mechanisms available</td>
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Develop notification implementation templates or documentation for larger BH EHR vendors such as Netsmart

Reassess availability of notifications and refocus CCO offerings, support, resources, and TA based on progress of prioritized providers

Q4 2021: Work team has engaged with vendors
Q1 2022: Current gap analysis completed

C.1.f. How will Applicant ensure access to timely Hospital event notifications for contracted oral health Providers? Please describe your strategy, including any focus on use cases or types of Providers, which HIE tool(s), and the actions you plan to take.

Expansion of PreManage access and capability among oral health providers – Health Share’s dental partners have started to adopt PreManage as a tool to receive event notification and provide timely care coordination. To support further adoption of this important tool, we will expand on our current use of cohorts developed via PreManage (ED admits and discharges) with chief complaints and ICD10 codes that we receive in near-real time via email notifications. For example:

- Non-emergency dental issues within ED — our care coordinators will engage the member’s clinic if assigned (or locate and assign a clinic if none exists) and initiate an appointment for that member
- Member outreach — perform member outreach for members in order to identify opportunities to reduce further ED visits
- Provider oversight — track and monitor providers in our oral health networks to ensure they are receiving and acting on real time email notifications via PreManage

Roadmap for Ensuring Access to Notifications for Oral Health Providers

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<td>Establish and charter the multi-organization HIT Governance Structure</td>
<td>Q4 2019: Structure and membership identified</td>
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<td></td>
<td>Identify and prioritize high-value oral health notification use cases</td>
<td>Q3 2020: Priority list drafted</td>
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<td>Engage with DCOs on provider PreManage adoption options</td>
<td>Q2 2020: First round of meetings complete</td>
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<td>Extend and standardize flagging of high-risk or other cohorts for CareCoordination notifications</td>
<td>Q4 2020: Standard set of cohorts developed</td>
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<td></td>
<td>Identify and prioritize oral health organizations not currently using PreManage Governance Structure</td>
<td>Q1 2021: Prioritized list completed</td>
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<tr>
<td></td>
<td>Start offering TA and other support to get oral health providers connected to PreManage</td>
<td>Q3 2021: TA mechanisms available</td>
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<td></td>
<td>Reassess availability of notifications and refocus CCO offerings, support, resources, and TA based on progress of prioritized providers</td>
<td>Q1 2022: Current gap analysis completed</td>
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C.1.g. How will Applicant access and use timely Hospital event notifications within your organization? Please describe your strategy, including any focus areas and methods for use, which HIE tool(s), and any actions you plan.

Use of timely event notification within Health Share – As noted above in the physical, behavioral, and oral health sections, we will continue to use PreManage as a foundational element of our population health and event notification efforts. It will be used within and across Health Share to:

- Identify gaps in care, which can manifest as ED or inpatient admissions, and address those gaps via partnerships between our care coordination team and network providers
• Align care needs to the proper facilities – as members arrive in ED or inpatient facilities for non-critical care, we redirect those encounters to occur in oral, behavioral, or outpatient physical care facilities
• Trigger care coordination outreach to members based on their ED or hospital usage and help them to locate alternate facilities for care based on the acuity and type of need

We actively engage providers across our physical, behavioral, and oral health networks both electronically and in person to promote the value of PreManage content through education and also by embedding clinically relevant information within PreManage, completing care guidelines and creating access for our members.

Additionally, data extracts from the CMT platform provide enhanced and timely information allowing us to perform analytics on key populations and to provide a vehicle for more aligned cohort definition and management in real time. In the near future, we plan to not only expand the use of messaging from PreManage, but also develop data feeds about our members, their care teams, and their inpatient experience. We will apply our data analytics tools to these data feeds and improve our assessment of member risk and ED utilization.

Roadmap for Health Share access and use of Notifications

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<tr>
<td>Establish and charter the multi-organization HIT Governance Structure</td>
<td>Q4 2019: Structure and membership identified</td>
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<tr>
<td>Renew PreManage license coverage for the entire Health Share member population</td>
<td>Q2 2020: Agreement reached</td>
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<tr>
<td>Engage with DCOs on provider PreManage adoption options</td>
<td>Q2 2020: First round of meetings complete</td>
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<tr>
<td>Extend and standardize flagging of high-risk or other cohorts for CareCoordination notifications</td>
<td>Q4 2020: Standard set of cohorts developed</td>
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<tr>
<td><strong>Activities</strong></td>
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<tr>
<td>Complete development of sustainability model for PreManage funding</td>
<td>Q2 2021: Funding model determined</td>
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<tr>
<td>Establish data feeds from CMT to Health Share in order to feed analytics and data distribution processes for our ICN/IDS partners</td>
<td>Q1 2021: Initial delivery completed</td>
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<tr>
<td>Complete an analytical evaluation of the impact of using PreManage on CCO utilization and quality metrics</td>
<td>Q4 2024: Program analysis completed</td>
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C.2. Informational Questions (recommended page limit 2 pages)

C.2.a. What assistance you would like from OHA in collecting and reporting on HIE use and setting targets for increased use?

Health Share would benefit from assistance from OHA related to HIE use and setting targets for increased use of HIE in several ways. First, we would like to understand what information may already exist within state systems, including how it is collected and at what cadence. We would like to partner with OHA on setting meaningful targets for increased use of HIE. We look forward to continued participation from OHA on the HIE onboarding program, beyond the currently defined ‘Phase 1’ (i.e., long-term care services, social services, other providers). We would also like OHA to work with Washington on interstate HIE integration. Additionally, we would like OHA through the HIT Commons to support Reliance integration with OneHealthPort. We recommend that OHA differentiate between region(s) and provider types when setting targets to align with differentiating
challenges around the state and to focus resources on areas of greatest potential impact. Finally, we would like OHA to provide guidance on the definition of “use” of an HIE.

**C.2.b. Please describe your initial plans for collecting data on HIE use, and setting targets for increased use by contracted physical health Providers. Include data sources or data collection methods.**

Health Share currently collects data on HIE penetration and use from within our IDS systems and portions of CareOregon’s ICN. On an ongoing basis, we work to collect and track information around data exchange from across all of Health Share’s partners. We will augment that quantitative tracking data with qualitative data to better understand how clinicians are using HIE at or near the point of care and use this supplemental information to target areas for improvement. We will receive and review regular reports of volume and exchange between systems.

In order to support the development of a more robust monitoring capacity and assure regional promotion, Health Share’s HIT Governance Workgroup will:

- Collect data from external HIE vendors and combine this with existing data from our partners (i.e., smaller and/or in-house developed systems, which may have a smaller market footprint)
- Set targets related to HIE adoption and measurement of HIE use with input from hospital systems, outpatient clinics, dental facilities, behavioral health facilities, care coordinators, and others health professionals in order to identify areas of greatest need
- Automate the collection and distribution of usage metrics, including performance against established use targets and progress towards addressing emerging areas of need

**C.2.c. Please describe your initial plans for collecting data on HIE use, and setting targets for increased use by contracted Behavioral Health Providers. Include data sources or data collection methods.**

Our plans for behavioral health will be similar to those outlined above for physical health. Within our behavioral health network there are some larger vendor exchange platforms (e.g., Netsmart) that can offer use data for the tracking of provider exchange activity. Some individual EHR systems can provide logged event information triggered at some point of the workflow when records are exchanged. We will determine these capabilities during our environmental EHR and HIE inventories that we will perform in year one.

As described previously, we successfully use CMT EDIE and PreManage for many HIE key use cases. We intend to work directly with CMT to better measure this activity, determine our providers’ current usage state, identify gaps relative to key workflows, and have this inform our choice of suitable targets.

Since we have such a diverse provider and system environment, an early part of our plans will be to assemble and automate the collection and visualization of usage data so it can inform our process improvement and change management efforts around HIE.

**C.2.d. Please describe your initial plans for collecting data on HIE use, and setting targets for increased use by contracted oral health Providers. Include data sources or data collection methods.**

Our plans for oral health are also similar to those outlined above for physical health and behavioral health. As described previously, our DCO partners have made significant progress in linking their providers within a dental HIE. We intend to work closely with these colleagues to determine the information available that describes HIE use — both within the oral health network and with respect to any other outside systems.

Since referrals are a key HIE use case for oral health and other types of providers, we will also examine these processes for measureable data markers that can be used quantitatively to track provider HIE use.

Similar to behavioral health, appropriate target setting will likely vary according to workflow and use case. While this is subject to our HIT governance process, it is likely that initial measurement and
target setting will look at HIE for oral health post-hospital or ED notification, referral, and follow-up.

D. Health IT for VBP and Population Health Management

D.1. Informational Questions: (recommended page limit 3 pages)

D.1.a. If Applicant will need technical assistance or guidance from OHA on HIT for VBP, please describe what is needed and when.

Health Share and its partners would benefit from technical assistance from OHA, including:

1) Increased **best practice sharing** across CCOs related to VBP administration (especially within specific domains such as maternity, hospital/inpatient, children’s health, etc.), population health management, HIE implementation, and integration of non-health-related information (social determinants and community level data)

2) Continued refinement and analytic use of member level clinical data (QRDA) for measures such as diabetes and hypertension control

3) Assistance through continued data sharing agreements with OHA/state data sources to increase use of **social risk information**, which will help guide smart investments in system integration, health equity, social determinants of health, and prevention

D.1.b. What plans do you have for collecting and aggregate data on SDOH&HE, that may be self-reported or come from providers rather than be found in claims? Can you match demographic and SDOH&HE-related data with claims data?

Collecting and aggregating social determinants of health data is critical to shifting both interventions and investments within the Health Share 2.0 model. This data is often not available through traditional methods of data collection for health plans (claims), though the access and availability of this information is increasing. The expansion of this work and further alignment within Health Share will be a major focus over the next five years, particularly as SDOH will become an element of future VBP requirements for CCOs and as CCOs will be required to begin tracking and reporting on the use of traditional health worker (THW) services across the network. One component of our investment in Oregon Community Health Workers Association (ORCHWA) to support building a holistic infrastructure is to identify an IT Platform that will aid in tracking activities of and work with THW's. Staff dedicated to THW integration and utilization efforts will develop methodology to capture a baseline of THW utilization, relying on data such as provider surveys, EHR encounter reports, and tracking activities reported in grant-funded contracts.

We collect and aggregate SDOH data in a number of ways at varying levels of Health Share, including through EHRs, member and provider surveys, and provider intake documentation that captures information not typically used for claims payment but gives insight into social determinants impacting a member’s health. Current engagement with school districts and early learning HUBs will offer opportunities to collect additional information on our school-aged members, such as barriers to attendance that may also be barriers to receiving appropriate health services. Although the majority of data is collected at the IDS and provider levels, Health Share is committed to enhancing system-wide data with more of this information as it becomes available. The following are examples of our work in this space:

**Social Service Resource Locator** – Our partner Kaiser Permanente is developing a Social Service Resource Locator (SSRL) that will be a regional tool shared across Health Share partner organizations to connect members to community resources that effectively address their SDOH-HE needs. The SSRL will provide automated bi-directional communication between referring health care organizations and community social service agencies, helping to prioritize follow-up based on real-time data and facilitate closed-loop referrals.

**Z-Codes** – For numerous delivery systems on the Epic medical record platform, 2018 enhancements
related to the social determinants of health will be aimed at tracking ten specific domains — alcohol use, tobacco use, financial resource strain, depression, stress, food insecurity, transportation, physical activity, violence, and social connection — through the use of ICD-10 diagnosis codes in the Z55-Z65 series (Z codes). We have already seen considerable increase in the use of these codes, and there is interest and alignment among partner organizations around increasing the use of these codes further to track need (and the correlation between need and outcomes) more closely. This method of data capture will allow Health Share and its partners to have a more accurate perspective on member needs related to SDOH and will be incorporated into analytic initiatives, population health planning, and strategic investment.

**PRAPARE** — Currently underway within our integrated community network, administered by CareOregon, is a two-year initiative where federally qualified health centers (FQHCs) are developing workflows, data collection, and protocols for PRAPARE (Protocol to Respond to and Assess Patient Assets, Risks, and Experiences), a national standard tool designed to identify and address social factors contributing to patients’ health experiences and outcomes. Some FQHCs and county health departments on OCHIN Epic are already using components of PRAPARE (for example, to screen for food insecurity) enabling them to:

- Connect patients to relevant community resources
- Segment patient populations to direct clinic resources
- Compare risk across patient panels
- Direct advocacy and investment efforts by identifying inequity and need

**Oregon Pediatric Improvement Partnership** — Health Share has also been an active participant with OHA and Oregon Pediatric Improvement Partnership (OPIP) in receiving and understanding pediatric social risk data. This project, which leverages various state data systems to create social risk scores for children based on both parent and child social complexity factors, builds from literature on adverse childhood events (ACEs) and work more broadly related to pediatric complexity, social risk, and high health care costs. Health Share has hosted numerous conversations about the risks and benefits of having this data, with a specific focus on the historical use of data with vulnerable populations, issues related to consent for data use, and health equity. Health Share plans to use this information to identify geographic and clinic locations that have high social risk not otherwise identified through claims or other “traditional” sources of information. These analyses will facilitate both additional resource allocation and options to integrate social services across delivery networks to maximize investment in social determinants interventions.

**Foster Care Referral Manager** — Health Share will also continue to play an active role in tracking referrals and non-clinical information for vulnerable populations, specifically including children in foster care. Health Share has invested in a Referral Manager platform in recent years to help with coordination related to the quality measure aimed at getting quick assessments for children entering foster care. However, the tracker also serves as a place for Child Welfare, CCO staff, and our partner organizations to highlight critical changes in a child’s life, such as changes in home or school placement (one of the most difficult elements to track for these children).

**Population Builder** — Health Share has recently developed a Population Builder tool that can quickly highlight utilization, costs, and diagnoses for particular groups of interest, whether defined by traditional health-related categories such as HEDIS value sets, utilization history or diagnoses, or by characteristics linked to demographics or available SDOH information (such as manually generated lists of individuals in a particular housing or education program). This tool allows for easy comparison to a statistically “matched” cohort of members to highlight differences and drive insight. For example,
this methodology can quickly generate an analysis highlighting differences in cost, utilization, and demographic composition between individuals with diagnoses for both diabetes and depression compared to those with only diabetes or only depression. If further information is available about involvement in supported housing programs, additional cohorts can be compared to understand program impact. This supports data-driven decisions about system and clinical investments that will both improve care and lower costs and will prove invaluable in the next phase of CCO work.

For any data sources that are not directly aligned with Medicaid reporting and the use of unique patient identifiers, Health Share has the capability to perform reliable, statistically sound patient matching within Health Share’s enterprise data warehouse. This data can then be shared across partners through routine data-sharing mechanisms, including monthly data feeds, SFTP, and Health Share Bridge, the CCO's analytics and data sharing platform.

**D.1.c. What are some key insights for population management that you can currently produce from your data and analysis?**

Key insights from the Health Share Bridge analytics platform – Health Share and its partners have made substantial investments in data and analytics to support a number of population management strategies and outreach programs over the past five years.

The center of our analytics efforts is Health Share Bridge. This combination of enterprise data warehouse, security model, and Tableau analytics interfaces offer our partners within physical, behavioral, and oral health settings views of their assigned populations, member lists, and the ability to see performance across organizations for regional benchmarking and the identification of best practices. The tools within Bridge have been developed to support metric improvement efforts, patient risk stratification and member assignment exploration, and cost analysis, all within a unique security model that ensures maximum transparency with excellent data security features. Daily enrollment files ensure that our partners can only see patient information they are entitled to see, yet retains the ability to see aggregate performance across organizations, which is in line with Health Share’s philosophic orientation toward the importance of data sharing and transparency.

Our efforts for population health management focus on identifying members who would warrant additional outreach based on gap lists or under-utilization, identifying individuals who have frequent visits to emergency rooms or multiple hospital admits or readmissions, and early identification of members who have a rising risk profile and may warrant additional outreach and engagement. These analyses enable our delivery system partners to work on addressing key triple aim objectives within the scope of their networks and provider relationships while also sharing best practices that can be adopted system-wide as appropriate.

In addition to these key network and population management insights, Health Share regularly leverages our analytics capacity at the regional level to address complex population health challenges. This includes active data sharing in support of development of community health needs assessments. These analyses often highlight issues that may not meet an intervention threshold within any particular delivery system but which, when viewed system-wide, represent significant challenges and costs for...
the region’s Medicaid system, which warrant collective intervention. This function has proven critical to Health Share’s model and has been identified as a strength of having analytics focused on numerous levels of Health Share structure.

A few examples of insights that drove action include analysis of:

- **DHS Diagnoses and Utilization**: Diagnostic and demographic make-up of children in the child welfare system to show the higher prevalence of chronic conditions and trauma
- **Developmental Screening Disparities**: Significant disparities related to developmental screening rates for non-English or non-Spanish speaking young children
- **School District Opportunity Overlap**: Differences in Medicaid enrollment within regional school districts (to highlight prime opportunities for cross-system partnerships)
- **Novel MAT Engagement Measure**: Variation in rates of “high” Medication Assisted Treatment (MAT) engagement across delivery systems based on point of initial contact and diagnoses (to identify variation in effectiveness of referral pathways leading to high MAT engagement)
- **ED/MI Analysis**: Rate of engagement within the specialty behavioral health system for individuals who have mental health diagnoses and utilize emergency department services
- **Language-Based Primary Care Disparities**: We identified consistently low levels of primary care engagement with Russian-speaking members, which led to targeted interventions to encourage primary care engagement
- **Opioid Use Disorder Partnership**: Prevalence of Opioid Use Disorder and treatment to help drive Clackamas Public Health Department’s service expansion strategy
- **Early Learning Hub Overlap Analysis**: Demographics and metric performance by race, ethnicity, and spoken language of 0-17 year-old population to provide regional Early Learning Hubs with information on the low-income population in their service area
- **Multnomah County Refugee Population Profile**: Utilization and cost patterns of recent refugees to Multnomah County to help identify and respond to disparities
- **School-Based Health Center Analysis**: Population served by school-based health centers to understand relative impact on performance metrics, engagement, and utilization to support further promotion of SBHC services

These insights represent only a portion of the types of analysis that Health Share has produced and shared with partners (community and clinical) to help drive aligned transformation efforts over the last six years. Health Share’s deliberate resourcing of analytics and our philosophical approach to community partnership through data has served a crucial role in helping community-based organizations and other key system partners better understand their intersections with the Oregon Health Plan and have consistently identified areas for collaboration across sectors.

**D.2. Evaluation Questions (recommended page limit 15 pages)**

**D.2.a. Describe how Applicant will use HIT to administer VBP arrangements (for example, to calculate metrics and make payments consistent with its VBP models). Include in your description how Applicant will implement HIT to administer its initial VBP arrangements and how Applicant will ensure that it has the necessary HIT as it scales its VBP arrangements rapidly over the course of 5 years and spreads VBP arrangements to different care settings.**
Plans for supporting VBP arrangements – Health Share’s strategic roadmap and governance oversight efforts for HIT will be closely aligned with the requirements for CCO 2.0 as they relate to VBP expansion. These requirements call for increasing annual payments delivered via a VBP arrangement, starting at 20% and escalating to 70% by 2024. To meet these goals, Health Share will start by optimizing our existing partnerships with the major integrated health care delivery systems in the tri-county area by implementing advanced alternative payment methodologies (population-based payments, LAN category 4C) within each system. Each IDS will manage total cost of care within their systems for both physical health (medical) and behavioral health services delivered in a primary care setting.

Health Share’s established analytics platform, Health Share Bridge, will play a central role in monitoring performance and accountability of our partners. Bridge is ideally situated to provide a baseline level of population health and performance information to all partners. Bridge is the result of significant investments in analytics and data infrastructure to develop a validated, secure, and reliable metrics, financial, and population health tracking program. Data and measures — both claims-based and clinically based — are shared via the platform, which securely aggregates and reflects performance (via Tableau interface) from all system partners. The tools embedded in Health Share Bridge reflect performance at the network, provider group, or individual provider level based on member assignment information updated daily. The system is capable of attributing members to particular clinics (PCPCH assignment) and can also track members as they move from one Health Share network to another.

Health Share has calculated, based on historical expenditures and proposed capitation arrangements, that the CCO is already meeting Year 1 and Year 2 VBP thresholds through IDS expansion and accompanying quality metrics accountability. In order to achieve the HIT goal to support the year one and year two VBP expectations, we will ensure that the IDS systems have the data, tools, and access to metrics reporting needed to report this work successfully.

In years one and two, Health Share’s integrated community network (ICN), managed by CareOregon, will administer and ensure continued improvement of VBP models with the contracted providers in the ICN, as well as develop the analytics and population health infrastructure needed to optimize the specialty behavioral health, oral health, and NEMT systems that the ICN is administering for the entirety of Health Share’s member population. Supporting these functions through HIT to ensure clear measures of quality are validated and accessible will be a primary focus. CareOregon’s existing vendor (Valiant) provides a Web-based method for providers to document activities, assess performance against metrics, and automate integration within our claims system for VBP administration and accounting.

Our HIT priorities for the first two years include maintenance of provider attribution information; redesigning the system’s assignment paradigm to align around our new Health Share 2.0 structure; the shifted responsibility of specialty behavioral health, dental health, and NEMT services to the ICN administered by CareOregon; and training partners on the use of these tools. Additionally, we will work with partners to strengthen our ability to collect and report on the use of THW services across the network in alignment with OHA’s requirements.

Starting in 2021 (year two), OHA’s VBP expectations require more sophisticated approaches to paying for hospital or maternity services. We will develop additional HIT and analytic support to ensure that both CareOregon and our IDS partners’ systems have this capacity either internally or with external...
support from Health Share. We will continue this HIT support, adjusting data delivery, analytic tools, and technical support to deliver effectively on OHA’s expectations for these critical areas of care.

In years three and four, we will focus on developing HIT support for OHA’s VBP payment priorities: hospital, maternity, children’s health, pharmacy, behavioral health, and oral health. CareOregon’s ICN will support integration of behavioral health and oral health benefit administration on behalf of the broader network in partnership with Health Share, through the provision of data to behavioral health providers to ensure accurate panel management and improvement on key quality measures. We will also continue HIT strategies to hit the 70% VBP target by 2024.

In year five and beyond, we will pursue further integration of NEMT and SDOH event capture and benefit administration for non-health care provider entities. Developing and improving the HIT capacity to ensure accountability and measurement of these systems will be critical to monitoring the health and functioning of these efforts as they relate to VBP models.

**Tools to Support VBP Arrangements:** Many of our partners currently employ tools to support VBP, either for bundled payments related to particular conditions or for management of primary care needs. For example, CareOregon uses Valiant, a leading third-party software to enter into value-based contracts and administer and monitor them effectively. This software allows us to build payment arrangements, administer payments, monitor performance metrics, and adjust payments based on performance in one place. The system generates claims based on contract terms (membership, risk level, program pay rates) and can be modified for varying VBP. Having the payment in claim form allows processing with existing claims processing software and operations.

CareOregon currently uses Valiant to manage payments for PCPM, CPC+, and IBH programs. This move away from manual checks and integrating VBP payments into claims processing operations greatly reduced processing time for payments. A Provider Data Submission function allows providers to enter performance data on their contract deliverables. This allows a record of performance and associated payment to exist in one system. CareOregon is exploring expanding use of the Provider Data Submission function to all tracks in PCPM, CPC+, and IBH programs.

**D.2.b. Describe how Applicant will support contracted Providers with VBP arrangements with actionable data, attribution, and information on performance. Include in your description, plans for start of Year 1 as well as plans over the 5 year contract, including activities, milestones, and timelines.**

Providing actionable data for contracted providers with VBP arrangements – Health Share Bridge currently contains an automated and secure data delivery mechanism via SharePoint that improves significantly upon traditional SFTP and secure e-mail pathways. We routinely use this data-sharing mechanism to share timely metric performance directly with partners, including monthly and year-to-date member lists for priority measures. One example is the quarterly interactive dashboard reflecting immunization status for members currently in the CCO metric denominator as well as children under age two who may populate our denominator in the future. Providing timely attribution data and actionable, prospective information on performance has been a key feature of Health Share’s model during the first round of CCO contracting, and that priority will be reinforced in CCO 2.0.

In the first two years of the CCO 2.0 contract, Health Share will prioritize data delivery to our IDS partners via Health Share Bridge. This includes milestones such as provisioning key users within these systems, identifying streamlined and enhanced data delivery offerings, and training partners on the use of available tools. Bridge contains several analytic “applications” that allow users to do self-service
analytics related to population stratification, PMPM cost analysis, metric performance, population assignment, and demographic exploration. For example, the Community Care application presents current performance on all CCO incentive metric and state quality measures to partners at all levels (health plans, clinic systems, clinic locations, and individual providers) and allows partners to interactively explore their performance by various attributes of the measure population to identify disparities and opportunities for quality improvement within their network. Additional tools are available for specific projects and population health initiatives (e.g., pregnancy outcomes) and these tools will also be shared broadly with all engaged partners.

In years two to five, Health Share will work closely with IDS partners and CareOregon to enhance internal capacities to best manage VBP expectations as those VBP expectations increase. This will include enhancing Bridge as needed for regional offerings of value to all service types, working with partners to deliver timely and actionable data related to specific priority populations as strategically aligned with the VBP expectations of CCO 2.0, and incorporating critical SDOH information to enhance population analyses and interventions delivered outside of traditional healthcare settings.

**Roadmap for Providing Data to Providers with VBPs**

<table>
<thead>
<tr>
<th>Years One - Two</th>
<th>HIT Goals and Milestones</th>
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</thead>
<tbody>
<tr>
<td><strong>VBP Area Priority</strong></td>
<td><strong>IDS: Data Delivery to partners via Health Share Bridge</strong></td>
</tr>
<tr>
<td><strong>Q3 2020:</strong> Clearly define desired data from partners</td>
<td></td>
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<tr>
<td><strong>Q4 2020:</strong> Reconfigure needed data flows to automate VBP data delivery</td>
<td></td>
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<tr>
<td><strong>2021, continual:</strong> Refinement based on governance priorities and emerging population health needs</td>
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| **ICN: Support Inpatient 2C or Higher** |
| **Q3 2020:** Work with hospitals and VBP team to define data needed for Inpatient 2C capabilities |
| **Q4 2020:** IP 2C data support in place to monitor and refine VBP arrangement |

| **ICN: Add MAT 2C or Higher for Behavioral Health** |
| **Q3 2020:** Define data needs for VBP arrangement to support MAT access goals |
| **Q4 2020:** Data is available for ICN to track payment arrangement for 2C MAT administration in Primary Care and Specialty BH settings |

| **IDS: Expand BH in Primary Care** |
| **Q2 2020:** Work with IDS systems to define measures of BH integration to support VBP and ensure accountability for integrated BH services |

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<thead>
<tr>
<th>Years Three – Five</th>
<th>HIT Goals and Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>VBP Area Priority</strong></td>
<td><strong>ICN: Expand Hospital to 3A, 3B, and 4B levels</strong></td>
</tr>
<tr>
<td><strong>Q4 2024:</strong> Multiple iterations of VBP data provision and measure provision to ensure successful path to 4B payment of IP service within ICN</td>
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| **ICN: Expand Primary Care to 3A-3B level** |
| **Q4 2022:** Ensure data and measures in place to allow Primary Care payment to reach level 3A or higher |
| **Q4 2024:** Ensure data and measures in place to allow Primary Care payment, inclusive of specialty care, to reach level 3A or higher |

| **ICN: Expand BH payment for Community BH services** |
| **Q4 2022:** Support expansion of BH VBP (including data delivery and quality measures) to enable 2C or more |

| **IDS: Continue expanding BH in primary care and providing data via Bridge** |
| Ongoing throughout years 3-5 |
D.2.b.(1)  Timely (e.g., at least quarterly) information on measures used in the VBP arrangement(s) applicable to the Providers

Health Share and its partners at the IDS and ICN level can produce, utilize, and share regular data, at least quarterly, on VBP measures and performance with providers. In most instances this data will be available more frequently than quarterly. Health Share Bridge provides monthly updated metrics information, supported by daily updates of enrollment for the entire population. This allows IDS and ICN partners to view membership information in near-real time, while claims reflect the most recent monthly delivery. As most quality measurement necessitates continuous enrollment, traditional claims “lag” may be appropriate for overall system performance on an annual basis. However, to improve performance, Health Share also supplements annual rolling twelve-month views with regular “year-to-date” performance reporting, reflecting the member level status on key performance metrics. These reports are intended to drive quality improvement efforts and are balanced against year-end reporting to provide a suite of data that our partners have found useful.

For measures of clinical quality extracted from EMRs, Health Share’s partners — particularly within the IDSs — have access to both patient level and aggregated data. However, Health Share goes beyond most CCOs and collects this data from all reporting partners monthly. Currently Health Share gets this data monthly from providers who serve roughly 75% of our assigned membership. This frequency of reporting is administratively difficult and requires a significant investment of personnel and HIT resources but has proven effective in helping align efforts on metric performance; it will be a critical model to effectively maintain and enhance VBP efforts over the course of Health Share 2.0 contract.

While the exact structures and frequency of data delivery differ across organizations, Health Share will include a baseline expectation in contracts with IDS/ICN systems to support their provider networks in our move toward additional VBP models. Health Share will offer supplemental supports to ensure that each system is developing appropriate structures and avenues for important information sharing.

D.2.b.(2) Accurate and consistent information on patient attribution

Population-wide data in Health Share Bridge – As VBP models are expanded, additional focus and continual refinement will be needed to ensure that performance and risk are attributed accurately. Each Health Share partner has a method for accurately tracking patient attribution to care providers. One example is the Population Explorer tool in Health Share Bridge, our self-serve analytics platform that is updated daily with current enrollment and assignment data. Our data sharing model allows each partner to leverage this tool to view patient attribution across all parts of the system (regardless of health care system, payer, or geography), giving insight into interdependencies not only across physical, oral, and behavioral health benefit administrators, but also between primary care and primary behavioral health providers. This information is displayed not only in aggregate (to show, for example, which behavioral health providers see the greatest proportion of a primary care provider’s panel) but also at the individual member level to identify other providers for care coordination purposes. The attribution features of this tool are well-suited to supporting cross-system collaboration focused on a population of interest (e.g., identifying the plan and provider partnerships serving the greatest number of our members in foster care).

Primary Care – Health Share and its partners will continue to refine patient attribution methodologies. Currently patient attribution is largely understood at the level of assigned primary care provider and continuing that approach will be a key component of the HIT roadmap. Health Share staff currently spend considerable resources ensuring that providers are accurately attributed to the individual, clinic, and clinic systems in which they practice. Patients assigned to primary care settings
thus have their information included in performance tracking and monitoring for these levels of system assignment.

**Behavioral Health** – Additionally, Health Share has created a unique algorithm to convert behavioral health prior-authorization information into a “behavioral health assignment” field, which more fairly attributes patient responsibility to behavioral health providers. We validate these lists with providers to ensure the methodology has a high level of accuracy, with the aim of aligning providers’ sense of their patient panel with ours. This will continue to be a critical element as behavioral health contracting and risk shifts to CareOregon’s integrated community network, but Health Share will work with the ICN to ensure that this critical structure is not lost for analytic and VBP purposes.

**Oral Health** – Many Health Share members receive a primary dental provider (PDP) assignment. However, because this practice is not universal across DCOs, these data elements have not been incorporated into Health Share Bridge. With consolidation of dental contracts moving to CareOregon’s ICN, we will explore standardizing patient attribution to dental providers.

**D.2.b.(3) Identification of specific patients who need intervention through the year, so the Providers can take action before the year end.**

There are a variety of tools used by Health Share and our partners to identify specific patients throughout the year to intervene, take action, and improve health outcomes.

These tools include Health Share Bridge applications, predictive analytics focused on high and rising-risk populations, and PreManage, which Health Share will continue to support as a regional HIT resource for all our partners. For VBP and performance tracking, Health Share and our partners produce various forms of “year to date” reports, which generate gap lists of patients eligible for intervention but who have not yet been engaged. These tools provide all levels of the system with actionable data, including patient identifiers, most recent system-contacts, and other key demographic information. These enhanced gap lists move beyond a simple numerator compliant flag and offer providers and systems the ability to stratify their outreach efforts based on patients’ need and engagement with the system.

All reports generated at the Health Share level are shared via Health Share Bridge, using an automated data distribution process within SharePoint subscriptions and within Health Share’s PHI security model. Reports generated by the IDS and ICN systems are delivered internally through EMR functionality, SFTP, or other secure channels as most appropriate.

**D.2.c. Describe other ways the Applicant plans to provide actionable data to your Provider Network. Include information on what you currently do, what you plan to do by the start of the Contract (Jan. 1, 2020), and what you intend to do in the future. Please include a narrative as well as a roadmap that includes activities, milestones and timelines.**

Health Share’s current practices for providing actionable data to our provider network – Currently Health Share expends considerable resources to serve as a data and information hub for providers and other regional partners. This includes provision of information provided by OHA and generated by Health Share through claims and other forms of data collection.

Health Share also parses apart and passes along any critical information received from OHA related to unique populations or opportunities as identified by the State (children in foster care, Immunization data, etc.). With the addition of the IDS model, the vertically integrated delivery systems will be both recipients of and users of data provided. As such, Health Share has developed monthly claims extracts that are provided to each risk-bearing entity, but which can also be offered to providers as determined strategically appropriate and legally permissible. These extracts include all services rendered over a 15-month period to every individual assigned to the receiving entity, including those services delivered if the member was previously assigned to a different delivery network or provider. This information
removes information that is not legally permitted to be shared, but aims to provide partners with the maximum available information to support organization-level analytics and program evaluation.

Because of Health Share’s well-organized EDW and capacity to track member movement and engagement across multiple systems, Health Share is regularly asked by providers and network partners to share lists of cohorts involved in particular programs or to provide analysis on program effects for very specific programs. Examples of this include providing physical health utilization, diagnoses, and aggregated costs for individuals who have been engaged with CCBHC programs, children engaged in school-based health center services, foster care medical homes, or individuals involved in Long Term Care programming. Due to restrictions around 42 CFR Part 2, Health Share has historically also been a central repository for substance use disorder-related information. Given Health Share and network’s increased focus on improving the substance use disorder system of care, Health Share has been a critical partner to providers and systems alike in both understanding and improving that system through data sharing and creative analyses.

CASE STUDY: School District Geomapping - In partnership with the Early Learning Hubs, Health Share has geocoded its entire membership into school district catchment areas. Using this information, analytics are able to “pivot” toward different demographic or geographic lenses which support deeper community partnership and reflect shared population priorities. This information would allow Health Share to develop strategies with particular elementary schools to highlight the number of OHP members in the catchment area, their ages, their engagement with the health system (exploring for inequities in access or cultural appropriateness), and other key variables. Because of Health Share’s flexible data architecture, this information can be passed to IDS and ICN partners as part of large data feeds, inclusive of more traditional member characteristics, or placed on public-facing webpages for broader consumption.

Health Share’s plans for providing actionable data to our provider network by January 2020 – As noted above, Health Share currently provides considerable amounts of actionable data to partners and is a leader among CCOs in this regard. Health Share was an early partner with Providence CORE to develop monthly data deliveries reflective of metric performance, costs, and utilization. and that set of tools was ultimately adopted by OHA to support other CCOs. The CCO has since evolved its actionable data delivery mechanisms to ensure that monthly files reflecting the prior 15 months of encounters for each assigned member are shared with partners, including Integrated Delivery Systems, to support their population management approaches. This allows each system to understand not only those services provided by their network but also the services received in the other systems (physical, oral, or behavioral respectively). In addition, monthly reports related to year-to-date metric performance; measures and member lists related to performance improvement projects; and initiatives within the Ready + Resilient strategic plan are shared to accompany each organization’s access to Health Share Bridge. By the beginning of 2020, Health Share will work to clarify the need for enhanced data feeds currently provided to each of our partners and to reorient assignment and patient attribution information to reflect the CCO’s new structure. Additionally, through the CCO’s enhanced governance, structure groups will be chartered to ensure timely delivery of the most critical information needed to succeed on the goals within this RFA and within the CCO’s strategic plan.

Health Share’s plans for providing actionable data to our provider network over the course of the CCO 2.0 contract – Over the course of the five-year CCO contract, Health Share will work with partners to constantly understand the data needs within each network (at the system and provider level), to supply tools and support to each network to develop its own internal capacity to track CCO
or network-specific priorities, and to have the actionable data needed to track performance more closely.

In addition to the delivery mechanisms above inherent to Health Share Bridge, which will be tailored to support the VBP roadmap among IDS and ICN partnerships, Bridge also offers both networks and providers information related to the full array of patient experience in the system. Tools focused on showing encounters over time across primary care, specialty, NEMT, dental, inpatient, emergency department, and other domains are easily organized and viewed in the secure portal.

### Roadmap for Providing Other Actionable Data to Providers

#### Years One – Two

<table>
<thead>
<tr>
<th>Activities</th>
<th>Milestones</th>
</tr>
</thead>
</table>
| Deliver data to IDS and ICN partners via Health Share Bridge | **Q1 2020**: Provision users from new IDS partners into Bridge security model, offer training and TA  
**Q1 2020**: Updated metrics information to reflect new partnerships and incorporate new measures  
**Q3 2020**: Clearly define desired data from partners  
**Q4 2020**: Reconfigured needed EDI flows to automate VBP data delivery  
**Q1 2021, continual**: Refinement based on governance priorities and emerging population health needs |
| Consistent provision of PIP data | **Q1 2020**, on-going: Data delivery to partner networks and providers related to aligned performance improvement projects (PIPs), including OHA-provided data |
| Refine attribution information for provider assignment | **Q3 2020**: Refine behavioral health assignment information to reflect longer-term organizational affiliation and SUD provider assignment  
**Q3 2021**: Agree upon and implement standard PDP assignment collection and attribution |
| Sharing quality metric performance data | **Q1 2020**: Refine year-to-date reporting to ensure reflects new IDS partnerships and member assignment  
**Q1 2121**: Enhanced data feeds based on feedback from IDS and ICN partners, reflective of new metrics and identified problem areas in metric performance |
| Sharing program evaluation data | **Q1 2020** and on-going: Continue to share data related to program evaluation for promising practices through new QHOC structure, including both quantitative and qualitative evaluation for early-life health, behavioral health, and equity initiatives; SDOH over time |
| Sharing data across cross sectors | **Q1 2020**: Continue and expand data sharing agreement with local public health organizations  
**Q4 2021**: Share available and allowable cross-sector data related to early-life health strategies, school district partnerships, and routinely collected SDOH information from OHA, CLARA, and Social Service Resource Locator for particular aligned improvement initiatives |

#### Years Three – Five

<table>
<thead>
<tr>
<th>Activities</th>
<th>Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhance metric performance data</td>
<td><strong>Q4 2024</strong>: Continued sharing and refinement of sharing model related to VBP/Quality Metric model — including new measure specifications and actionable member lists to drive outreach, engagement, and performance improvement</td>
</tr>
<tr>
<td>Enhance collection and evaluation of SDOH information</td>
<td><strong>Q4 2024</strong>: Based on strategic initiatives related to SDOH investment, integrate and provide analysis on key areas of SDOH investments, including outcomes of those investments and potential ROI of the investments</td>
</tr>
</tbody>
</table>
D.2.d. Describe how you will help educate and train Providers on how to use the HIT tools and data that they will receive from the CCOs.

Health Share Bridge is a powerful set of tools built upon a significant EDW infrastructure. In order to optimize its use, we have dedicated staff resources to maintain it and educate users. Health Share offers monthly trainings on the system for new and existing users and has staff available to provide individual sessions for interested parties. Project and program leads are able to request Bridge demonstrations for their meetings, which often lead to new organizations and users connecting to Bridge. We maintain a Bridge user-monitoring dashboard for internal use to keep informed of who is accessing which Bridge tools. We use that information to enhance tools and engage users. A repository of training materials is available on our SharePoint site, allowing end users to receive support on their own time. We plan to revisit our approach to Bridge training and technical assistance through annual end user surveys, which will inform future analytic developments and training offerings.

Health Share’s structure closely ties Quality Improvement and Analytic efforts with the intent of making data and analysis present in most activities. This means that Bridge tools and analyses performed on behalf of particular programs are brought to meetings of leadership or steering committees in order to support decision making or self-service analyses as Health Share aims to foster aligned but individualized improvement efforts within the system. Depending on the improvement effort, Health Share will continue to build in processes to ensure that the data provided is easily understood and that tools are optimized for end users. Recent examples of this include the creation of MAT engagement dashboards, which show the percentage of patients involved in MAT services who are “highly engaged.” The dashboards have been created to reflect differences among individual physicians and clinics and have been a powerful reference for medical and system leadership to promote improvement within individual systems. Health Share partner staff are regularly invited to attend meetings with network and provider leadership to explain data tools, data sharing opportunities, and analyses to drive collective improvement and decision making.

D.2.e. Describe the Applicant’s plans for use of HIT for population health management, including supporting Providers with VBP arrangements. Include in the response any plans for start of Year 1 as well as plans over the 5-year contract, including activities, milestones, and timelines.

Plan for use of HIT for population health management – Health Share’s data and analytics resources are seen as a regional asset for both providers and community partners. Many of the analytic insights shared above were developed in response to requests from partners who sought a more complete view of their population. These analyses help partners make strategic decisions aimed at improved outcomes and community engagement, and Health Share’s access to well-organized and comprehensive information consistently proves valuable in these areas. We plan to expand on that success moving into CCO 2.0 by strengthening our governance process, tightening our focus on the success of VBP programs, and incorporating data available through unique cross-sector partnerships into a more holistic view of our membership.

Roadmap for Use of HIT for Population Health Management

<table>
<thead>
<tr>
<th>Years One - Two</th>
<th>Activities</th>
<th>Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Inventory risk stratification approaches among partner organizations,</td>
<td>Q2 2020: Convene partners to share pop health analytic best practices and</td>
</tr>
<tr>
<td></td>
<td>identify best practices and centralize distribution of that information as</td>
<td>risk modeling approaches Q4 2020: Use full inventory of risk models in use</td>
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<tr>
<td></td>
<td>appropriate</td>
<td>to identify additional models to build into Bridge Q2 2021: Incorporate</td>
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<tr>
<td></td>
<td></td>
<td>new models into Bridge trainings and applications as determined by group</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q3 2020: Create user experience and needs survey</td>
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<tr>
<td></td>
<td>Gather partner input about future Bridge</td>
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</tr>
</tbody>
</table>

RFA4690-Health Share of Oregon-Attr9-Health Information Technology Questionnaire
enhancements and training needs

Q4 2020 & 2021: Compile, analyze and develop strategic priorities for enhancements from survey
Q4 2020: Identify opportunities for additional resourcing of training as needed

Enhance BH Composite scoring methodology

Q2 2020: Refine accuracy and availability of provider data related to current composite scoring
Q3 2020: Additional scoring available for SUD detox, residential, OP, and MAT programs

<table>
<thead>
<tr>
<th>Years Three – Five</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activities</strong></td>
</tr>
<tr>
<td>Refine Patient Stratification and other Bridge applications based on stakeholder feedback</td>
</tr>
<tr>
<td>Continue to engage with stakeholders to gather feedback on Bridge user experience as new priorities arise</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Milestones</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2 2023: Patient Stratification refinements completed</td>
</tr>
<tr>
<td>Q4 2022, 2023, 2024: Feedback on Bridge collected from stakeholders</td>
</tr>
</tbody>
</table>

D.2.e. Describe how Applicant will do the following:

**D.2.e.(1) Use HIT to risk stratify and identify and report upon Member characteristics, including but not limited to past diagnoses and services, that can inform the targeting of interventions to improve outcomes?**

Health Share will continue to offer all partners access to Health Share Bridge, our analytics and data delivery platform that is the backbone of our quality measurement and reporting system. Currently, interactive Tableau dashboards, accessed through our SharePoint site, reflect monthly updates to performance on health quality indicators and access to tools like our Patient Stratification application. This tool makes risk-stratified population data easily available to all active Health Share partners to inform both member-level and population-level decision-making. This tool allows users to create unique patient lists of their assigned membership across numerous domains including ED Visits, IP Admits, SNF Stays, Specialist Visits, Observations Stays, ICU stays, Cost, 7-Day Readmits, 30-Day Readmits, and Behavioral Health Visits. The tool also has the ability to combine the above utilization factors with stratification for individuals on medications, including high-risk medications. Additionally, the tool has three native risk models to identify patients with high risk. Those models include Health and Human Services “Hierarchical conditions category” (HHS-HCC) risk, the Center for Medicare and Medicaid Services “Hierarchical conditions category” (CMS-HCC), and the Charlson/Deyo risk score. Finally, the Patient Stratification Application includes an INSIGHT Risk score based on a combined social risk score determined on variables unique to the patient’s zip code.

As users generate their unique algorithms to stratify their population, a patient list is provided. The list includes demographic and contact information, as well as summary data indicating the relative cost, utilization, and engagement of the cohort as identified by the user, as well as information about primary care, IDS/ICN and behavioral health provider assignment, overall costs, ED visits, and other counts of utilization. This list can be securely downloaded for import into analytic tools or to provide to care managers.

Within the tool itself, users can also select individual patients to see a comprehensive history of that patient’s last 15 months of physical, behavioral, and oral health claims, displayed graphically to reveal insights into each person’s history of service utilization over that time. This graphical interface identifies patient engagement across utilization types, as well as the provider and date of service. The tool also provides the most recent pharmacy claim information indicating near-current medications.

**D.2.f. What are your plans to provide risk stratification and Member characteristics to your contracted Providers with VBP arrangements for the population(s) included in those arrangement(s)?**

Data is currently shared with providers related to risk stratification. As mentioned above, the Patient Stratification tool presents customized lists of members stratified by user-selected risk categories. Patient lists can be downloaded by the user or provided by Health Share via SharePoint secure SFTP.
Health Share and its partners plan to leverage the collective analytic capability of IDS and ICN partners by convening regular learning sessions about risk models currently in place to identify best practices among our partners to spread regionally and develop those models within Bridge so they can be utilized by all partners and as members move throughout the system. Centralizing some of this stratification information will allow providers across the spectrum of physical, behavioral, and oral health to access the patient information easily through a familiar distribution process.

D.2.g. Please describe any other ways that the Applicant will gather information on, and measure population health status and outcomes (e.g., claims, clinical metrics, etc.).

The behavioral health system is pursuing two main paths in moving toward tracking outcomes and value-based care: composite scoring and outcomes-informed care.

Health Share’s composite scoring model calculates a single composite score measuring quality processes and outcomes for each behavioral health agency by pulling in multiple metrics from different data sources via current technology. The composite score for mental health outpatient case rate agencies launched in 2018 after a multi-year collaborative process with the provider association and the three counties (putting us ahead of the curve for value-based payments). The first round of incentive payments based on top scores were distributed in early 2019. We are near completion of composite scoring systems for substance use detoxification, residential, outpatient, and medication-assisted treatment programs - the result of another collaboration with providers and the counties - and anticipate launch in late 2019 or early 2020. We anticipate using these composite scores as an overall picture of agency health and performance, and as a guide for structuring values-based payments in the future. While case rates represented a significant change from the fee-for-service model, in both how we track data and make payments and moving toward a more holistic and values-based approach, composite scoring represents yet another significant change in promoting improved population health, as opposed to simply tracking encounters of unknown quality.

Our outcomes-informed care endeavor of the last several years contractually obligated providers to use A Collaborative Outcomes Resource Network (ACORN) or other validated tools to measure patient outcomes, with the intent that this would ultimately inform values-based payments as well. ACORN is a measure of patient and clinician engagement, which tracks self-reported data from each clinical session and tracks clinical alignment over time. The data can be viewed by the client, the clinician, or in aggregate by clinical supervisors or across a behavioral health organization to look for trends in patient engagement or clinician performance.

D.2.g. Describe Applicant’s HIT capabilities for the purposes of supporting VBP and population management. Again, please provide plans for start of Year 1 as well as plans over the 5-year contract, including activities, milestones, and timelines. Include information about the following items:

Health Share currently has a strong analytic infrastructure and has been a leader among CCOs in data delivery, metric performance monitoring, and cross-sector partnerships around data sharing. This success is due both to pre-existing and underlying technology and workforce, and due to investments to centralize flexible analytics capacity to leverage data about the entire region’s Medicaid population in service to OHA’s health system transformation goals in CCO 1.0. Moving forward, the commitment to HIT will be heightened by codifying decisions through a new governance structure. That process will identify priority improvements to HIT capabilities, a few of which are already identified below.

### Development of HIT capabilities for supporting VBP and population management

<table>
<thead>
<tr>
<th>Year One</th>
<th>Activities</th>
<th>Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Sources:</strong></td>
<td>Enhance eCQM collection from across CCO network, particularly to support member level reporting</td>
<td>Q2 2020: Evaluate population reporting requirements for CQMs</td>
</tr>
</tbody>
</table>

RFA4690-Health Share of Oregon-Attr9-Health Information Technology Questionnaire   Page 36 of 42
thresholds

**Dissemination of Analytics:** Explore capability of embedding dashboards on webpage for greater community partner engagement and access to data

<table>
<thead>
<tr>
<th>Year Two</th>
<th>Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activities</strong></td>
<td><strong>Milestones</strong></td>
</tr>
<tr>
<td><strong>Data Sources:</strong> Enhance eCQM collection from across CCO network, particularly to support member level reporting thresholds</td>
<td><strong>Q2 2021:</strong> Evaluate population reporting requirements for CQMs</td>
</tr>
<tr>
<td><strong>Data Sources:</strong> Continue monitoring opportunities to support broader collection of SDOH information at point of service and broadly across community partnerships</td>
<td><strong>Q1-Q3 2021:</strong> Identify and engage priority clinics</td>
</tr>
<tr>
<td><strong>Analytic Tools:</strong> Expand capability for geospatial analysis</td>
<td><strong>Q1-Q2 2021:</strong> Develop and pilot measures</td>
</tr>
<tr>
<td><strong>Dissemination of Analytics:</strong> Pilot use of public-facing dashboards for community partners</td>
<td><strong>Q4 2021:</strong> SDOH information is collected</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Years Three – Five</th>
<th>Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activities</strong></td>
<td><strong>Milestones</strong></td>
</tr>
<tr>
<td><strong>Data Sources:</strong> Continue with eCQM collection, refinement, and incorporation</td>
<td>Annually Q4: Reporting thresholds surpassed annually, valid data incorporated into meaningful improvement efforts</td>
</tr>
<tr>
<td><strong>Data Sources:</strong> Incorporate critical SDOH information to enhance population analyses and interventions delivered outside of traditional healthcare settings</td>
<td>Q4 2023: Infrastructure in place to support SDOH data integration and delivery</td>
</tr>
</tbody>
</table>

*D.2.g.(1) Data sources: What data sources do you draw on – for example, if you incorporate clinical quality metrics, what data do you collect and how? How often do you update the data? How are new data sources added? How do you address data quality?*

Health Share currently relies primarily on claims and enrollment information to identify populations of interest (including children entering foster care and pregnant women), as well as monitor their ongoing care and health outcomes. We collect enrollment feeds from OHA daily and claims from our partner organizations monthly. We incorporate data around the existing five CCO incentivized Clinical Quality Measures (CQMs), which are delivered to Health Share via SFTP each month. Most data is reported at the clinic level, but some includes member-level and has been combined with encounter data to better understand the outcomes of health services, especially for members with diabetes. Health Share developed a platform to identify children entering DHS custody daily, both from enrollment changes and notifications from DHS directly. This platform supports the coordination of initial assessments upon entering custody, but also identifies a population of children with unique health care needs, whose ongoing care and outcomes we monitor. We also ingest quarterly deliveries of ALERT data from OHA, which support our work on the incentive metric focused on 2-year-olds as well as our strategic priorities around kindergarten readiness and our collaboration with public health on understanding vaccination patterns and potential access barriers across the tri-county region.
When we determine that there is a new data source that can yield beneficial clinical or other data such as social determinants of health data, we identify the source, format, and frequency from the target data source. New data sources are introduced in a test environment where analytics staff can view the format, generate descriptive statistics on the information, and manipulate the data to optimize blending with existing data sources. Data quality is assessed based on the cleanliness and completeness of the data, as well as the representativeness of the population that is reflected in the data source. If a disproportionately small member sample is included, we may not use this as a data source to evaluate population health outcomes.

Since we use claims data throughout Health Share, we have developed data quality processes starting in our EDI systems and continuing as it flows into specialized databases used for reporting. Significantly, we compare two views of the claims information — one from the pure X12 EDI messaging used in submissions to OHA, and one from APAC-formatted claims data sets our partners provide to Health Share directly. As opposed to the X12 transactional systems, the APAC summaries contain additional information and are typically generated by partner analytics systems.

D.2.g.(2) Data storage: Where do you store data (e.g., enterprise data warehouse)?

We store data in our transactional EDI systems and in the Health Share Bridge enterprise data warehouse (EDW). The transactional SQL Server databases contain information needed for Health Share business operations. This is where we keep the authoritative member enrollment and demographics databases, which, along with many other data sources, are also stored in our industrial-grade EDW based on technology from the vendor Health Catalyst. This data platform is highly capable and versatile for our analytics and data processing needs. We run the EDW in a Microsoft Azure secure cloud environment, and the data is replicated between multiple development, test, production, and backup systems.

Our IDS partners also have their own, and often multiple, data platforms for their member’s data. Most of these use Epic for their EHR along with Epic’s Clarity and Cogito/Caboodle EDWs. CareOregon is in the process of implementing a high-end data warehouse from the vendor Arcadia. Several of the larger provider organizations in CareOregon’s network have their own data warehouses for their business and clinical intelligence purposes. Health Share slices available data according to the active members at a provider organization and provides copies or regular data feeds to them.

D.2.g.(3) Tools:

D.2.g.(3)(a) What HIT tool(s) do you use to manage the data and assess performance?

We use industry standard tools, processes, and practices for managing data and assessing performance:

<table>
<thead>
<tr>
<th>Tool</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enterprise Data Warehouse</td>
<td>Unified database to hold integrated, cleaned, and curated data for analysis and reporting purpose (e.g., integrated claims and enrollment data)</td>
</tr>
<tr>
<td>Data Marts</td>
<td>Cleaned and curated data for analysis and reporting related to a particular department or business group (i.e., Finance Data Mart)</td>
</tr>
<tr>
<td>Tableau</td>
<td>Provides an analyst ability to visualize large quantity of data and perform exploratory analysis; enables analysts to present his/her findings in easily digestible and shareable format</td>
</tr>
<tr>
<td>SAP Business Objects</td>
<td>Reporting and analysis software tool for reporting from Epic Clarity data marts</td>
</tr>
<tr>
<td>Python</td>
<td>Open source statistical processing tool which is used by researchers and developers to develop advance models and for machine learn problems</td>
</tr>
<tr>
<td>Microsoft SSIS</td>
<td>Extract-Transform-Load (ETL) tool primarily used for extracting data from Microsoft SQL Server databases and loading data into Enterprise Data Warehouse and Data Marts</td>
</tr>
</tbody>
</table>
IBM Datastage (ETL) | Extract-Transformation-Load (ETL) tool used for extracting data from IBM databases and loading data into Enterprise Data Warehouse and Data Marts
---|---
Microsoft SSAS | Analysis services tool for analysts/developers to develop reporting cubes which could be used for slicing and dicing large quantity of aggregated data
SQL Stored Procedures | Used to insert/update/delete/retrieve data from SQL Server repositories; allows developer to build reusable and performance tuned code and algorithms for retrieving large amount of data from a SQL Server repository
SSRS | Reporting tool used for creating and distributing reports from MS SQL Server database repositories including enterprise data warehouse and data marts

**D.2.g.(3)(b) What analytics tool(s) do you use? What types of reports do you generate routinely (e.g., daily, weekly, monthly, quarterly)?**

Health Share and our partners use leading analytics and data visualization tools to produce a variety of dashboards and reports, both ad hoc and regularly on a daily, weekly, monthly, quarterly, and annual basis. These reports help track and monitor the business processes of Health Share, reporting for financial and utilization measurement, and reporting for clinical outcome and quality. Examples of reports include weekly enrollment reports to monitor enrollment trends, quarterly YTD metric reports to identify members meeting metric denominator criteria but not numerator criteria, and quarterly diabetic member lists to support care coordination for high risk members. Our analytics tools include:

**Analytics Tools**

<table>
<thead>
<tr>
<th>Tool</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tableau</td>
<td>Provides an analyst ability to visualize large quantity of data and perform exploratory analysis; enables analysts to present findings in easily digestible and shareable format</td>
</tr>
<tr>
<td>Stata</td>
<td>Statistical software for data science used by researchers for complex statistical analysis</td>
</tr>
<tr>
<td>R</td>
<td>Open source statistical processing tool which is used by researchers and developers to develop advance models and for machine learn problems</td>
</tr>
<tr>
<td>SAS</td>
<td>Statistical software for data science used by researchers to perform complex statistical analysis as well as for creating analysis dataset and distributing reports.</td>
</tr>
<tr>
<td>ArcGIS</td>
<td>Provides interactive maps and geocoding capability to facilitate location-based analysis to find patterns in utilization demand, which are driven by geo location.</td>
</tr>
</tbody>
</table>

**D.2.g.(4) Workforce: Do you have staff (in-house, contractors or a combination) who can write and run reports and who can help other staff understand the data? What is your staffing model, including contracted staffing?**

Health Share operates with a relatively small analytics team, which supports the analytics capabilities at the IDS and ICN levels. Multiple analysts can write and run reports from the CCO’s EDW, and Health Share Bridge is structured to allow self-service analytics and list generation to share with partners. Additionally, each partner has robust data and reporting teams, which Health Share convenes on a regular basis. Between Health Share and its partners, we have over 50 permanent data and analytics staff members managing our HIT and databases, assuring data quality, developing reports, conducting statistical analyses, developing predictive models, and performing other data/analytics functions. This does not include workforce dedicated to helping other staff understand the use of data for quality improvement initiatives or workflow development, which might benefit from or be strongly involved with the data. We subcontract to outside vendors if specialized skills not currently located in-house are needed, often for program evaluation and outcomes monitoring.

**D.2.g.(5) Dissemination: After reports are run, how do you disseminate analysis to Providers or Care Coordinators in your network? How do you disseminate analysis within your organization?**

Health Share report dissemination and partner engagement – Health Share uses an enterprise Tableau server to deliver analytics to stakeholders. This is generally in the form of interactive dashboards published onto the Bridge server, with varying levels of user access based on project affiliation and security settings determined by organization type and level. For instance, some partners have access to all data contained in Health Share applications, including PHI and financial information.
Others are able to see a limited set of tools (non-financial) but PHI specific to their populations. Health Share shares access to most of these tools with local public health partners, who have broad access but are unable to see most financial and PHI information.

We also deliver CCO reports and datasets to Health Share Bridge users via SharePoint’s secure delivery platform. This tool allows active Bridge users to access large sets of data in a secure setting that requires dual-factor authentication, enables bi-directional document exchange, and provides active notification when new reports are published. This addition has drastically reduced the amount of SFTP and secure-email exchange, while also helping Health Share track who is accessing the information.

We report performance outcomes to Health Share’s Board, the Board-level Quality Committee, each partner organization, and numerous stakeholder groups through a monthly newsletter and other publications. Health Share intentionally reports comparative performance across partner organizations to motivate improvement and identify and spread best practices across our region. We also embed quality analysts on all project teams to provide data and quality improvement support.

To share quality performance with stakeholders and the broader public, Health Share produces an Annual Report and community health plan progress report. We also published five-year transformation and metrics (pictured right) summary reports in 2017 and 2018. The reports are shared through Health Share’s quarterly stakeholder newsletter, website, social media, and list-servs and at CAC and Board meetings, community events, and annual regional convening.

**Partner report dissemination and provider engagement –** IDS partners and CareOregon employ a variety of tools and strategies to flexibly disseminate analyses to providers across their delivery system meet the needs of the data consumer. Reports, analyses, dashboards, and scorecards are disseminated to providers, care coordinators, executives, and analysts through methods such as secure web portal, secure email, mobile devices, and directly embedded in Epic. Examples of delivery paths include:

- Tableau event dashboards set up to notify users when events meet specific thresholds
- SSRS reports based on criteria for follow-up on services (MHAs, Treatment Plans, and other critical services) as well as drive level of care renewals from our information system (Evolv)
- Business Objects directly embedded into our Epic EMR, allowing direct access to information housed in our data warehouse for clinical decision support

Moving forward, and in hopes of fulfilling our vision as a community data and analytics hub, Health Share would like to embed more public-facing interactive dashboards on our webpage or webpages for specific initiatives. This approach can quickly offer analytics to community partners who are working with the CCO on strategies related to poverty, equity, and community improvement, without necessitating the sharing of member specific data. We hope to begin exploring this capability in year one of the contract, with refinement and improvement in future years.

**Internal Health Share staff report dissemination –** Most Health Share staff can access Health Share Bridge for the purpose of receiving and reviewing reports, and for exploring data through Bridge Applications. Health Share’s Analytics Team is embedded in numerous organizational projects and supports project managers and initiative leads, as well as CCO leadership, to ensure that data is front
and center in strategic decision-making. End users are able to subscribe to SharePoint notifications providing alerts when new content is available as well as system status updates.

**D.2.g.(6) Effectiveness: How will you monitor progress on your roadmap and the effectiveness of the HIT supports implemented or to be implemented?**

We will monitor roadmap progress and effectiveness of implemented HIT supports by reporting on progress (and barriers) to HIT roadmap within Heath Share’s governance structure. Initially, Health Share will establish an HIT oversight structure with workgroups to guide both HIE strategy rollout and data/analytic governance. These workgroups will have a direct reporting relationship and accountability to the roadmap through Health Share’s Board-level committee structure. Given the strength of the relationship between Health Share’s ambitions related to VBP and the HIT roadmap, the interrelatedness of these workgroups and the required metrics for achieving VBP improvement, accountability structures will maintain HIT’s roadmap status as a high priority across Health Share and both IDS and ICN leadership.

**D.2.g.(7) Addressing challenges: What challenges do you anticipate related to HIT to support VBP arrangements with contracted Providers, including provider-side challenges? How do you plan to mitigate these challenges? Do you have any planned projects or IT upgrades or transitions that would affect your ability to have the appropriate HIT for VBP?**

Among the many challenges that arise from the ambitions, timelines, and goals of CCO 2.0 are finding methods to engage providers who are not yet under VBP arrangements in OHP-specific initiatives. Providers struggle with accessing multiple systems for analytics and tend to be willing to do so only when the need is high and when they are incentivized. This means that although strong tools can be developed at Health Share (IDS or ICN level), getting providers to engage in using those tools can be a significant challenge. As noted above, training on the use of tools and providing specific feedback as problems arise can be difficult. Additional challenges include other topics addressed here: patient and provider attribution, particularly as it relates to specialty services or service domains (such as dental) that do not have the same robust standards of data and attribution that the PCPCH model has embedded in physical health. These attribution challenges make it difficult to accurately track certain specialty services, their outcomes, and the many system touches that arise as part of complex episodes of care. Although Health Share and partners are well-prepared to address these complexities due to the significant investment in both technology and workforce to support the region’s Medicaid strategy, we are aware that they will present challenges to both the data infrastructure and use of analytics that were not as prominent during the first phase of CCOs. We are not bound to any IT upgrades that would negatively impact our plans for implementing HIT for VBP.

Additional challenges will include evaluating the effectiveness of clinical interventions and investments, particularly as it relates to SDOH and health equity. Often these systems lack significant data and reporting infrastructure, making the evaluation of implementation and outcomes. In the past, Health Share has contracted with external vendors for these more sophisticated analyses and that method has been effective, though labor and resource intensive. Over time, as Health Share moves toward supporting the Collective Impact efforts of our partners, the ability to evaluate — both qualitatively and quantitatively — the return on investment, improvement in quality, or impacts on population health of these innovative approaches will be increasingly important.

To mitigate the challenges listed above, Health Share IDS and ICN partners will work closely over the next five years to be responsive to system changes, align efforts, and avoid duplication. A strength of Health Share’s 2.0 model is the clear accountability across IDS and ICN systems and the ability to build from “like” models of care delivery and risk acceptance toward a common goal. We anticipate that best practices in HIT and population management as they relate to VBP for particular domains such as maternity, inpatient, behavioral health, or pharmacy can be leveraged collectively and invested in regionally to raise the overall standard of practice. Health Share has a history of participating in
statewide learning collaboratives and with the Transformation Center to understand best practices of other CCOs. We pride ourselves on sharing successes and offering replicable solutions to other CCOs. We will play a strong leadership role across the state in showing how a complex system can use HIT and collaboration to shift how services are delivered to members and communities.
### B. Support for EHR Adoption

#### Multidisciplinary

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<tr>
<th>Activity</th>
<th>By 2020</th>
<th>2020</th>
<th>2021</th>
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<tr>
<td>Establish and charter the multi-organization HIT Governance Structure</td>
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<td>to lead and be accountable for making and monitoring recommendations</td>
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<td>regarding the EHR adoption efforts across Health Share</td>
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<tr>
<td>Conduct physical and behavioral health EHR environmental scans</td>
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<td>Analyze the members and activities corresponding to non-EHR practices</td>
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<td>in our networks</td>
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<td>Establish a resource/advisory workgroup within our Governance Structure</td>
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<td>to provide workflow and technical assistance to provider groups</td>
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#### Physical Health

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<tr>
<td>Create a ranked set of provider organizations that we will target for</td>
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<td>EHR adoption support</td>
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<td>Assess the role of contracting, VBP, quality metrics program, and other</td>
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<td>EHR-relevant programs to promote adoption</td>
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<td>Prioritize regions, and or provider types for outreach based on areas of</td>
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<td>Develop tailored value propositions and business cases for EHR-</td>
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<td>adoption or enhanced functionality</td>
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<td>Deliver up to date functionality and workflows of current EMRs to</td>
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<td>include foundational and best practice standards within the EMRs to</td>
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<td>include recommended treatment guidelines, decision support, and best</td>
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<td>practices at the point of care</td>
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<td>Offer consultative services for care management and patient care</td>
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<td>Assess the range of incentives and support we are offering in regards</td>
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<td>Support EHR planning and technical extension programs and services and</td>
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<td>start to assess how support can be directed to increasing the more</td>
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<td>complete and meaningful use of EHRs in place</td>
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<td>Implement population management tools such as patient registries and</td>
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<td>workflows</td>
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<td>Provide accessibility across diverse platforms, computers, smartphones</td>
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<td>and digital mobile devices</td>
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### Support for EHR Adoption

**By 2020**

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**B. Support for EHR Adoption**

**Provide data sharing across provider systems, assuring a continuum of care for patients that provides visibility for providers caring for that patient, regardless of service location**

**Incorporate system alerts on abnormal results, negative trends, and potential drug interactions**

**Behavioral Health**

- Bring behavioral health leaders, including those from the region’s CCBHCs, together to share experiences on journeys to EHR adoption, the value they have realized and the opportunities they see going forward
- Create a ranked set of behavioral health provider organizations guided by values of HIT Governance Structure that we will target for EHR adoption support
- Determine how Health Share or our ICN/IDS networks can offer financial or other support for EHR adoption
- Work with our partners to educate behavioral health providers about benefits that result from investments made in the physical health EHR space
- Develop tailored gap analyses and adoption business models to better help non-EHR practices overcome barriers and understand the behavioral health functionality of EHRs in physical health settings
- Work with the HIT Commons to expand use of EDIE to inpatient behavioral health facilities
- Work with the HIT Commons to expand direct EDIE/PreManage connections to behavioral health EHRs
- Explore workflow opportunities to increase automation of claims submission
- Evaluate and reassess adoption program performance to date, adjust as needed.
- Work to maximize behavioral health EHR capabilities to incorporate and present physical health data
- Work to set up behavioral health EHRs to submit quality measures to the CQMR

**Selected practices implemented**

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**E. Support for EHR adoption**

- Educational materials and provider outreach plan in place
- Proposal delivered
- Proposal delivered
- Selected practices engaged
- Selected practices engaged
- Selected practices engaged
- Selected practices engaged

**Proposal delivered**

**Selected practices engaged**
### B. Support for EHR Adoption

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</table>

#### Expand EHR extension offerings to behavioral health entities, capitalizing on physical health learnings and successes
- Focus on the capabilities of behavioral health EHR systems to properly document and manage substance use disorder information, including evaluating access controls and limits on external disclosures

#### Oral Health
- Work with DCOs to assess current provider use state, and to identify ways of measuring adoption
- Understand current state use of EDIE/PreManage within DCO landscape, including use cases and opportunities
- Expand existing electronic referral processes between physical and oral health providers
- Promote further use of EDIE for emergency department and urgent care event notifications for oral health related diagnoses
- Explore expansion of current pilots within some Health Share DCOs using PreManage for high risk oral health conditions and/or members
- Require electronic exchange of clinical information for EHR-related quality measurements
- Explore closed loop electronic referrals and/or reauthorization’s for dental specialty services
- Identify opportunities for how EHR systems in oral health settings can be augmented to better support care coordination and information sharing with primary care providers
- Work with DCOs on contracting opportunities to incorporate EHR adoption and use within existing value-based payment arrangements

#### Physical Health
- Understand the specific adoption barriers experienced by our providers
- Identify priority providers for increasing EHR adoption
B. Support for EHR Adoption

**Barriers and plans to address**

### Behavioral Health
- Perform a detailed gap assessment for our prioritized providers
- Work within our HIT governance model to define the support and incentives that can be offered either by Health Share or our partners
- Understand the specific adoption barriers experienced by our providers
- Identify priority providers for increasing EHR adoption
- Work within our HIT governance model to define the support and incentives that can be offered either by Health Share or our partners
- Advocate and partner with stakeholders to educate behavioral health providers on how organizations can and have addressed these concerns
- Incorporate the privacy topic into our HIE strategy to address concerns about ensuring patient privacy
- Support OHA sponsored activities, such as the Behavioral Health Information Sharing Advisory Group

### Oral Health
- Engage with DCO partners to understand the specific adoption barriers experienced by our providers
- Identify priority providers for increasing EHR adoption
- Perform a detailed gap assessment for our prioritized providers
- Work within our HIT governance model to define the support and incentives that can be offered either by Health Share or CareOregon, as the ICN network administrator responsible for the oral health network

### By 2020

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<tr>
<td>C. HIE Program</td>
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<tr>
<td>Governance</td>
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<tr>
<td>Establish and charter the multi-organization HIT Governance Structure</td>
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<td>HIE steering Workgroup chartered</td>
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<td>Determine funding/resourcing</td>
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<td>Determine how to add HIE adoption to partner contracting</td>
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<td>Determine how to add HIE adoption into our VBP programs</td>
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<tr>
<td>Establish data sharing policies and principles</td>
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<td>HIE Technical Assistance Workgroup</td>
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<td>Gather and disseminate information about sharing methods and vendors</td>
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<td>Offer Selection and implementation support</td>
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<td>Provide workflow and HIPAA consulting</td>
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<tr>
<td>Reassess HIE Program success and readjust efforts</td>
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<td>Oral health focus efforts and workgroup</td>
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<tr>
<td>Behavioral Health focus efforts and workgroup</td>
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<tr>
<td>Set targets for adoption</td>
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<td>Work with OHA to define targets</td>
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<tr>
<td>Planning</td>
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<tr>
<td>Inventory of EHRs and HIE capabilities</td>
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<td>Identify HIE adoption and usage measurements</td>
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<tr>
<td>Work with DCOs on measures</td>
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<td>Work with BH EHR vendors to identify measures of use</td>
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<td>Work with CMT on PreManage and EDIE use and adoption tracking</td>
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<td>Identify comparable adoption benchmarks</td>
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<td>Stakeholder engagement</td>
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<td>Engagement Areas</td>
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<td>Engage with DCOs</td>
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<td>Identification and prioritization of use cases</td>
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<tr>
<td>Determine example pilot use cases and participating organizations</td>
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<tr>
<td>Construct tailored workplans and business cases for prioritized providers</td>
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<tr>
<td>HIE Onboarding Program</td>
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<td>Complete initial regional workplan</td>
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<td>Complete contracting and initial scheduling with Reliance</td>
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<td>Establish claims and enrollment data feeds to Reliance</td>
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<td>Support portal-access clients</td>
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<td>Explore setting up direct EHR integrations with Reliance</td>
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<td>Explore SDoH connections through Reliance</td>
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<td>PreManage for HIE and Notifications</td>
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<td>Renew licensing support for Health Share members</td>
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<td>Identify sustainability/funding model for PreManage</td>
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<td>Assess missing organizations that need notifications</td>
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<td>Offer TA to contract with CMT and adopt the use for CareCoordination</td>
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<td>Care Coordination</td>
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<td>Contribute to regional and state-wide best-practice forums</td>
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<td>Extend use of care recommendations for care coordination</td>
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<td>Notifications</td>
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<td>Extend and standardize flagging of high-risk or metrics-gap cohorts for care coordination</td>
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<td>Set up and distribute data feeds from EDIE/Premanage to provider analytics teams</td>
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<td>Epic Connect and CareEverywhere</td>
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<td>Determine who can provide Epic Connect - eg Legacy, OCHIN, OHSU etc and determine their scope of offerings</td>
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<td>Assess prioritized providers for Epic adoption</td>
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<td>Prepare value proposition cases for Connect</td>
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<td>Support implementation and adoption efforts</td>
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<tr>
<td>Characterize and document how CareEverywhere can be extended to non-Epic EHRs</td>
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<td>Bulk Data Exchanges</td>
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<td>Improve member attribution for primary and specialty providers</td>
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<td>Develop standardized HIPAA justification framework to support exchange</td>
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<td>Determine and standardize subject mart data deliveries - eg. Metrics reporting, Risk assessment</td>
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<td>Incorporate Clinical with Claims into distributed data feeds</td>
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<td>Support submission of eCQMs to the CQMR</td>
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<td>Pilot FHIR interfaces</td>
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<td>Referrals using CareOregon platform</td>
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<td>Extend to BH</td>
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<td>Integrate referrals with SDoh/ Social Service Resource Locator platform</td>
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<td>Standardize information needed for effective referral by workflow</td>
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### Data Provision for VBP in alignment with VBP Strategy timeline

**Define partner data needs for quality metric performance (will start before 2020)**

**Data flows automated**

**Continued refinement and enhancement of data delivery (PDSA)**

### Support Inpatient 2C or Higher VBP within ICN

**Work with hospitals and ICN to define data needed for Inpatient 2C capabilities**

**Inpatient 2C data and metrics support in place to monitor and refine VBP arrangement**

**Continued refinement and enhancement of data delivery (PDSA)**

### Expand Hospital to 3A, 3B and 4B Levels within ICN

**Begin planning process to expand capacity, including current state assessment**

**Multiple iterations of IP VBP data and measure provision to ensure successful path to 4B**

### Add MAT 2C or Higher for Behavioral Health

**Define data needs for VBP arrangements to support CCO's MAT access goals**

**Data is available for ICN to track payment arrangements for 2C MAT in PCP and BH settings**

**Continued refinement and enhancement of data delivery (PDSA)**

### Expand BH in Primary Care Settings

**for BH services delivered under 4C arrangement (will start before 2020)**

**Share necessary data, metrics of accountability to support VBP**

**Continued refinement and enhancement of data and measures for accountability (PDSA)**

### Expand Primary Care to 3A-3B Level

**Define needed data and measures to support 3A or higher in Primary Care**

**Data and measures in place to support 3A**

**Define needed data and measures to allow PCP and specialty at 3A**
<table>
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<tr>
<th>Data and measures in place to allow PCP and specialty care payments at 3A or higher</th>
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<tr>
<td>Expand BH Payment for Community BH Services</td>
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<tr>
<td>Define VBP model and data needs to support 2C or more across network</td>
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<td>Data and measures in place to support 2C</td>
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<td>Continue to refine payment model and VBP outcomes</td>
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<td><strong>Data delivery to IDS and ICN partners via Health Share Bridge</strong></td>
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<td>Provision new Bridge users, training and technical assistance</td>
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<td>Update Metrics information to reflect new partnerships and incorporate new measures as available</td>
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<td>Define additional data feeds to support Population Health Initiatives from partners</td>
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<td><strong>Provision of Performance Improvement Project (PIP) Data</strong></td>
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<td>Data delivery to partner networks and providers for aligned performance improvement projects</td>
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<td><strong>Refine Attribution Information for Provider Assignment</strong></td>
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<td>Refine BH assignment information to reflect longer-term organizational affiliation and SUD provider assignment</td>
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<td>Agree upon and implement standard PDP Assignment collection and attribution</td>
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<td><strong>Sharing Program Evaluation Data</strong></td>
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<td>Through QHOC share available program evaluation data related to SDOH and other strategic investments</td>
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<td><strong>Cross Sector Data Sharing</strong></td>
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<tr>
<td>Maintain and expand data sharing agreements with local public health organizations</td>
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<td>Inventory high priority data re: early-life health, school districts, SDOH from local resources</td>
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<td>Collect and utilize available cross-sector data to support SDOH and other strategic investments</td>
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<td><strong>Risk Stratification Tools</strong></td>
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<td>Convene partners to share pop health analytics best practices and risk stratification approaches</td>
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<tr>
<td>Inventory promising local and national risk stratification methods</td>
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<tr>
<td>Identify and create priority additions to Patient Stratification tool to include these methods and build alignment around use</td>
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<td>Improve process for Bridge feedback, stakeholder training, and identification of priority build areas</td>
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<td>Create and implement user experience and needs survey</td>
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<td>Compile, analyze and develop strategic priorities for enhancements</td>
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<td>Identify opportunities for training program enhancements</td>
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<td>Perform annual user experience and needs survey</td>
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<td><strong>Composite Score in Behavioral Health</strong></td>
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<td>Refine accuracy and availability of provider data behind scoring</td>
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<td>Develop scoring and data for substance use detox, residential,</td>
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<td>outpatient and MAT programs</td>
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<td><strong>Data Sources</strong></td>
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<td><strong>Enhance eCQM collection</strong></td>
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<td>Evaluate population reporting requirements for eCQM against</td>
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<td>current reporting capabilities</td>
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<td>Identify and engage with priority clinics not yet reporting</td>
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<td>Work with CQM workgroup to develop and pilot new CCO measures</td>
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<td>Valid data integrated and available for OHA reporting</td>
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<td><strong>Explore opportunities to collect and share SDOH information</strong></td>
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<td>efforts, Education, Child Welfare, Social pediatric risk tools, etc., to incorporate into Bridge</td>
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<td><strong>Analytic Tools</strong></td>
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<td>Expand CCO capacity re: Geomapping (ArcGIS) through training and vendor technical assistance</td>
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<td><strong>Dissemination of Data</strong></td>
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<td>partners, including data source and security, technology requirements</td>
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<td>Identify high priority opportunities for public sharing</td>
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<td>Pilot specific dashboards/visualizations on webpage</td>
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<td>Refine and repeat process to increase visibility</td>
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TITLE: DELEGATED FUNCTIONS AND OVERSIGHT

DEFINITION(S):
Delegation: The assignment of responsibility or authority to another entity to carry out specific activities or perform certain administrative or operational functions on behalf of the delegating organization.

Delegation Agreement: A mutual agreement between a delegating organization and its Delegated Entity that specifies the activities and reporting responsibilities delegated. A contract entered into between Health Share and the Delegated Entity is considered to be the Delegation Agreement.

Delegated Entity: An entity with which Health Share has entered into a written agreement to perform certain functions required under, or governed by, the Health Plan Services Contract, federal and/or state regulations that would otherwise be the responsibility of Health Share.

Delegation Audit: An annual evaluation of a Delegated Entity’s capacity to perform delegated activities using established criteria.

Health Plan Services Contract (CCO Contract): Contract entered into between Health Share of Oregon and the Oregon Health Authority pertaining to the administration of the Oregon Health Plan Medicaid program.

PURPOSE:
To establish the authority of Health Share of Oregon (Health Share) to delegate specific functions to other entities and the process through which that delegation occurs.

To establish the annual process for monitoring performance of Delegated Entities.

POLICY:
I. Health Share may subcontract work to be performed under the CCO Contract, and may delegate specific responsibilities to qualified entities. Health Share oversees and retains accountability for any functions and responsibilities that it delegates to any entity. When a business need has been established for delegation of functions, appropriate Health Share staff shall follow the guidelines outlined in this policy.

II. Pre-delegation assessments are conducted prior to entering into a Delegation Agreement to assess the organization’s ability to perform the functions identified in the proposed Delegation Agreement. If deficiencies are identified, the organization must submit a plan of correction that is acceptable to and approved by Health Share prior to entering into a Delegation Agreement.

III. Health Share shall conduct an annual Delegation Audit of Delegated Entities to ensure compliance with Health Share policies, requirements of the CCO Contract, Oregon Administrative Rules and all other related state and federal rules and regulations relevant to the functions delegated. If deficiencies are found, the organization must submit a plan of correction that is acceptable to and approved by Health Share.
IV. If Health Share amends the Delegation Agreement to include additional activities less than 12 months prior to the annual Delegation Audit date, a pre-delegation evaluation must be performed for the additional duties.

V. A Delegation Agreement must be in place prior to any delegated activities being performed. The Delegation Agreement includes a business associate agreement consistent with privacy requirements for protected health information.

PROCEDURE:

I. Health Share performs a pre-delegation assessment of the organization's ability to perform the specific functions to be delegated. At a minimum, the pre-delegation assessment includes:
   - Review of relevant policies and procedures;
   - An assessment of the organization's administrative, operational and staffing capabilities and past performance record;
   - An evaluation of the organization's processes and systems related to each delegated function;
   - Site visits and/or pre-delegation meetings, as needed; and
   - An evaluation of the organization's programs and compatibility with Health Share policies related to the delegated function(s) under consideration.

II. Results of the pre-delegation assessment are documented and retained by the Director, Compliance and Quality Assurance and a summary is presented to the Delegation Oversight Committee. A recommendation is provided to the Committee to proceed with delegation, proceed with stipulations, or deny the Delegation Agreement.

III. Health Share monitors Delegated Entities on an on-going basis and performs a formal Delegation Audit annually to assess performance of the Delegated Entity in accordance with 42 CFR 438.230.
   A. The annual review may be composed of elements that are universal to all Delegated Entities as well as elements that are specific to each Entity.
   B. The annual audit process will follow the same general process as the pre-delegation assessment described in I above.
   C. Upon completion of the audit, a draft report with findings is presented to the Delegation Oversight Committee for review or revision.
   D. When approved, the draft report is provided to the Delegated Entity, which has 5 business days to review and comment prior to the report being finalized.

IV. Upon identification of areas of non-compliance or inadequate performance, Health Share notifies the Delegated Entity and may require submission of a plan of corrective action depending on the severity of the issue identified. The Delegation Oversight Committee is accountable for on-going monitoring of plans of corrective action submitted by Delegated Entities.
V. A summary of plans of corrective action and their status is submitted to the Quality Committee of the Health Share Board of Directors on a quarterly basis or as needed to inform the Committee of areas of non-compliance or inadequate performance by Delegated Entities. The Quality Committee may request additional information be presented by the Delegated Entity to ensure the prompt and adequate resolution of deficiencies.

VI. Health Share staff submits a summary of annual Delegation Audits to the Quality Committee to inform them of the status of each Delegated Entity’s performance.

VII. Health Share retains ultimate accountability for any functions or responsibilities it delegates.

REFERENCE:
CORP-05 Delegated Entity Corrective Action and Sanctions Policy

| Department: Compliance and Quality Assurance | Author: Barbara Carey, Director, Compliance and Quality Assurance |
| Effective Date(s): August 2013 | Review Frequency: Every 2 years |
| Revision Date(s): December 2015, November 2016, February 2019 | |

Marni Kuyk, Chair 3/20/19

Maggie Bennington-Davis, MD Date 3/20/2019
Interim Chief Executive Officer
TITLE: ACCESS TO CARE

DEFINITION:

**Health Plan Services Contract:** Contract entered into between Health Share of Oregon and the Oregon Health Authority pertaining to the administration of the Oregon Health Plan Medicaid program.

**Member:** An Oregon Health Plan client assigned to Health Share of Oregon.

**Risk Accepting Entity (RAE):** An entity that holds a fully capitated contract with Health Share of Oregon to provide services as defined in the Health Plan Services Contract for Coordinated Care Organizations between the Oregon Health Authority and Health Share of Oregon.

PURPOSE:
To ensure all Health Share of Oregon (Health Share) Members have an ongoing source of primary physical health care, and access to dental, mental health and substance use disorders care appropriate to the Members’ needs.

To ensure all services provided to Members are culturally and linguistically appropriate, geographically available as close as possible to where Members reside, and to the extent necessary and available, offered in nontraditional settings that are accessible to families, diverse communities and underserved populations.

POLICY:

I. Health Share requires that each RAE maintain a provider network that meets standards of timely access to care and services, taking into account the urgency of the need for services in accordance with the requirements of the Health Plan Services Contract and Oregon Administrative Rules. RAEs shall develop a provider network that delivers access to high quality care, that is geographically dispersed, that assures access to integrated and coordinated care provided in linguistically and culturally appropriate settings, and that includes access to a primary care team that is responsible for coordination of Members’ care.

II. RAEs are responsible for the development and implementation of an access plan that establishes and monitors access to all covered services, including access to urgent and emergent care including post-stabilization services; determines delivery system capacity for their provider network; manages risk in times of reduced participating provider capacity; identifies populations in need of interpreter services and populations in need of accommodation under the Americans with Disabilities Act.

III. Behavioral health RAEs are responsible for an emergency response system of services needed to respond to mental health crises, including but not limited to a crisis hotline, mobile crisis team, walk-in/drop-off crisis center and respite or short-term stabilization.
IV. Dental health RAEs are responsible for ensuring Members have access to emergency dental services and urgent care services for emergency dental conditions.

V. RAEs are required to monitor appointment accessibility and after-hours access within their provider networks to ensure Members have access to appropriate clinical care 24 hours a day, 7 days a week.

VI. RAEs shall comply with the requirements of Title II of the Americans with Disabilities Act and Title VI of the Civil Rights Act by assuring communication and delivery of covered services to Members who have difficulty communicating due to a disability, or limited English proficiency, or diverse cultural and ethnic backgrounds. RAE shall maintain written policies and procedures regarding accessibility of services, including provision of certified or qualified interpreter services, and provision of coordinated services which are culturally appropriate.

VII. RAEs shall regularly track Member utilization of urgent and emergent care and take action to reduce and improve the appropriate utilization of these services through actions including but not limited to:
- Individual counseling with the member
- Education of members regarding appropriate access to the following services:
  - Emergency Rooms
  - Urgent care centers
  - Walk in clinics
  - Non-traditional health care workers
  - Patient Centered Primary Care Home or primary care provider
  - Behavioral health providers
  - Dental care providers.
- Implementation of innovative strategies to decrease unnecessary utilization.

VIII. RAEs are responsible for implementing a monitoring and reporting system that demonstrates Members have equal access to covered services, including routine, urgent and emergent services in accordance with the Health Plan Services Contract.

IX. RAEs shall provide Members with access to a second opinion from a qualified provider to determine medically appropriate services. If RAE cannot arrange for a second opinion from a provider participating in their network, RAE shall arrange for the Member to obtain the second opinion from a non-participating provider at no cost to the Member.

X. If a RAE is unable to provide necessary services to Members within its existing provider network, RAE shall cover those services out of network for the Member for as long as RAE is unable to provide them within network.
REFERENCES:
Health Plan Services Contract
OAR 410-141-3120, 3140, 3160, 3220
OAR 410-123-1000 through 410-123-1640

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Executive Signature

Date

7/13/16
TITLE: NONDISCRIMINATION

DEFINITIONS:

Delegated Entity: An entity with which Health Share has entered into a written agreement to perform certain functions required under, or governed by, the Health Plan Services Contract, federal and/or state regulations that would otherwise be the responsibility of Health Share.

Health Plan Services Contract (CCO Contract): Contract entered into between Health Share of Oregon and the Oregon Health Authority pertaining to the administration of the Oregon Health Plan Medicaid program.

Member: An Oregon Health Plan client assigned to Health Share of Oregon.

PURPOSE:
To ensure that Health Share of Oregon (Health Share) Members receive all benefits and services to which they are entitled without discrimination, to advance equity and reduce health disparities, and to ensure that Members’ rights are protected as specified under the law.

POLICY:
I. Health Share of Oregon does not exclude, deny benefits to, or otherwise discriminate against any Member on the grounds of race, color, or national origin, religion, sex, sexual orientation, gender identity/expression, protected veteran’s status, genetic information, or on the basis of disability or age, participation in, or receipt of the services and benefits under any of Health Share’s programs and activities, whether carried out by Health Share directly or through a Delegated Entity, contractor or any other entity with which Health Share arranges to carry out its programs and activities.

II. Health Share acts, and requires Delegated Entities to act, in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973; Title II of the Americans with Disabilities Act of 1990; the Age Discrimination Act of 1975; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Section 1557 of the Affordable Care Act; and the Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at Title 45 Code of Federal Regulations (CFR) Parts 80, 84, 86 and 91, and 28 CFR Part 35.

III. Health Share’s notice of nondiscrimination is communicated to Members and other interested persons through multiple methods, including but not limited to the Member handbook and on Health Share’s website or through Delegated Entities.

IV. If assistance or communication aids for impaired hearing, vision, speech, or manual skills are needed by Members, Health Share and Delegated Entities will make reasonable accommodations and provide auxiliary aids and services. Such aids and services include, but are not limited to:
- Qualified sign language interpreters
- Large print materials
- Text telephones (TTYs)
- Captioning
V. Health Share requires Delegated Entities to take reasonable steps to assure that Members with limited English proficiency are provided meaningful access to health care services, programs and activities. Reasonable steps may include the provision of language assistance services, such as oral language assistance or written translations. Delegated Entities must offer a qualified interpreter when oral interpretation is a reasonable step to provide an individual with limited English proficiency with meaningful access.

VI. Health Share assures that all Members with sensory or speech impairment are able to receive notices, including nondiscrimination and notices concerning benefits or services, or information concerning waivers of rights or consent to treatment, regardless of their disability in the alternative format requested.

VII. Health Share has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by the U.S. Department of Health and Human Services regulations (45 C.F.R. Part 84), implementing Section 504 of the Rehabilitation Act of 1973 as amended (29 U.S.C. 794). Section 504 states, in part, that "no otherwise qualified disabled individual...shall solely by reason of his/her disability, be excluded from participation in, be denied benefits of, or be subject to discrimination under any program or activity receiving federal financial assistance..." as referenced in the Oregon Health Authority Health Plan Services Contract.

VIII. These rules shall be liberally construed to protect the substantial rights of interested persons to meeting appropriate due process standards and assure Health Share’s compliance with Section 504 of the Rehabilitation Act of 1973 and associated regulations.

IX. Members wishing to file a discrimination complaint with Health Share may submit it to the Civil Rights Coordinator:
    Sr. Manager of Compliance and Quality Assurance
    2121 SW Broadway Suite 200
    Portland, OR 97201
    (503) 416-4962

X. A Member who files a discrimination complaint may pursue other remedies including filing with:
    Office for Civil Rights
    U.S. Department of Health and Human Services
    2201 Sixth Avenue - M/S: RX-11 Seattle, WA 98121-1831
    Voice Phone: (800) 368-1019
    Fax: (206) 615-2297
    TDD: (800) 537-7697
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<th>Department: Quality</th>
<th>Author: Barbara Carey, Manager, Compliance and Quality Assurance</th>
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<td>Effective Date(s): March 2015</td>
<td>Review Frequency: Every 2 years</td>
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TITLE: MEMBER AND POTENTIAL MEMBER EDUCATION, INFORMATION, AND MARKETING MATERIALS REVIEW PROCESS

DEFINITIONS:

Education and Information Materials: Any materials that provide information to Health Share of Oregon members or potential members about Oregon Health Plan or Medicaid benefits, or significant changes in benefits; providers and provider sites; or significant changes in programs or services pursuant to Subcontractor’s contract with Health Share that affect the member’s ability to access care or services.

Health Plan Services Contract (CCO Contract): Contract entered into between Health Share of Oregon and the Oregon Health Authority pertaining to the administration of the Oregon Health Plan Medicaid program.

Marketing materials: Materials that are produced in any medium by a Coordinated Care Organization or on behalf of a Coordinated Care Organization by its subcontractors and that can reasonably be interpreted as intended to compel or entice a potential member to enroll in that particular Coordinated Care Organization.

Member: An Oregon Health Plan member assigned to Health Share of Oregon.

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

Potential Member: An individual who meets the eligibility requirements to enroll in the Oregon Health Plan but has not yet enrolled with a Coordinated Care Organization.

Risk Accepting Entity (RAE): An entity that holds a fully capitated contract with Health Share of Oregon to provide services as defined in the Health Plan Services Contract between the Oregon Health Authority and Health Share of Oregon.

Subcontractor: RAE or other organization contracted with or doing business on behalf of Health Share of Oregon

PURPOSE:

To ensure all Member and Potential Member Education and Information Materials and Marketing Materials meet the requirements of the CCO Contract and Oregon Administrative Rules, and to define the process by which materials developed by Subcontractors of Health Share of Oregon (Health Share) are submitted to Health Share for review.
POLICY:

I. Health Share is accountable to OHA through the CCO Contract to ensure that materials developed for Health Share Members or Potential Members are consistent with federal and state regulations including OAR 410-141-3270, OAR 410-141-3280, and OAR 410-141-3300.

II. Health Share is required to submit certain Member and Potential Member Education and Information Materials and Marketing Materials produced by itself or by its Subcontractors to OHA for approval prior to distribution.

III. Subcontractors shall submit all Education and Information Materials and Marketing Materials, meeting the definitions above, to Health Share for review, and Health Share shall be responsible for obtaining OHA approval, if necessary. Subcontractors shall not submit Education and Information Materials or Marketing Materials directly to OHA.

IV. Health Share shall be responsible for producing the Member ID Card and Member Handbook for all Members assigned to Health Share. No Subcontractor shall produce a Member ID Card or Member Handbook for Health Share Members with the exception of Kaiser Permanente. Health Share Members assigned to Kaiser Permanente and Kaiser Permanente Dental will receive a Kaiser Permanente card in addition to their Health Share Member ID Card.

V. In addition to materials which require review and approval by OHA, Health Share reserves the right to submit any materials produced by itself or a Subcontractor to OHA for consultation purposes only, if Health Share believes it needs guidance as to whether the materials require OHA review and approval.

VI. Health Share reserves the right to reasonably require Subcontractor to alter the language or design of material based on OHP rules and regulations or Health Share policy and guidelines, prior to submission to OHA or distribution to Health Share Members.

VII. Health Share shall provide to each Subcontractor, for informational purposes only, copies of or access to all material, in any form, produced and provided to Health Share Members served by Health Share.

VIII. Subcontractors shall provide to Health Share, for informational purposes only, copies of or access to other materials not meeting the definition of Education and Information Materials or Marketing Materials, in any form, provided to Health Share members.

PROCEDURE:

I. Subcontractors shall submit any Member Education and Informational Materials and Marketing materials to the Health Share Communications Specialist for review:
   A. The materials must follow and be consistent with all pertinent statutes, rules, policies, and procedures related to Member Education and Information Materials and Marketing Materials, including intent, reading level, and font size.
Health Share of Oregon
Policy Number COMM-01

B. Subcontractors shall submit information regarding audience and distribution methods with materials.

II. Within ten (10) business days after receipt of materials, the Health Share Communications Specialist will review the materials and notify the submitter of any concerns that will or may prevent approval of the material by Health Share or OHA, if required. If concerns are present, Subcontractor will be provided an opportunity to revise the materials, as suggested or required, and resubmit to the Health Share Communications Specialist.

III. Within three (3) business days after materials are reviewed by Health Share, the Communications Specialist will submit those materials to OHA for review as required, or for consultation purposes, with an accompanying OHP Materials Submission and Approval Form for each document. In accordance with their procedures, OHA will review submitted materials within ten (10) business days.

A. If OHA responds to Health Share with suggested edits to submitted materials, the Communications Specialist will review those edits with Subcontractor and jointly determine the next course of action, to include agreeing on which suggested edits will be incorporated into the material and which will not.

B. If any revisions are required by OHA or Health Share, the Subcontractor shall make those revisions and resubmit the materials to the Communications Specialist. The Communications Specialist shall resubmit the revised materials to OHA for review along with a new OHP Materials Submission and Approval Form for each document. That process will continue, if needed, until final approval is obtained from OHA.

C. When final approval of materials is received from OHA, the Communications Specialist shall inform Subcontractor and provide Subcontractor with an approval code supplied by the OHA. That approval code must be printed on the approved material.

IV. Health Share maintains a tracking system to ensure the procedures in this policy are followed and the material review process moves forward in a timely and efficient manner.

V. Subcontractors shall provide the Health Share Communications Specialist with a single point of contact for receipt and distribution of materials. That single point of contact shall be the only individual authorized to submit and/or communicate with the Communications Specialist regarding communications materials unless other arrangements are made with the Communications Specialist.

OTHER RELATED INFORMATION:
Health Share of Oregon Co-Branding Policy
Health Share of Oregon Co-Branding Guidelines
REFERENCES:
OAR 410-141-3270 Coordinated Care Organization Marketing Requirements
OAR 410-141-3280 Coordinated Care Organization Potential Member Information Requirements
OAR 410-141-3300 Coordinated Care Organization Member Education and Information Requirements

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<th>Author: Ashlen Strong, Director Public Policy and Communications</th>
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<td>Review Frequency: Every 2 years</td>
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Subject: Access to Care

Objective:

I. To ensure that each Tuality Health Alliance (THA) Oregon Health Plan (OHP) member has access to a primary care provider (PCP) or patient centered primary care home (PCPCH) offering high quality care, located geographically near members’ residence, assuring integrated and coordinated care provided in linguistically and culturally appropriate settings, and offering accessible nontraditional settings for families, diverse communities and underserved populations as needed.

II. To ensure that THA maintains an adequate network of providers in Washington County to provide members with access to primary care providers, specialty care providers, pharmacies, hospitals, vision, and ancillary services.

Definitions:

Primary Care Provider (PCP): a person or entity formally designated as primarily responsible for coordinating ongoing healthcare services that are appropriate to the member needs.

Patient Centered Primary Care Home (PCPCH): a model of primary care that has received attention in Oregon and across the country for its potential to advance the “triple aim” goals of health reform: a healthy population, extraordinary patient care for everyone, and reasonable costs, shared by all. PCPCHs achieve these goals through a focus on wellness and prevention, coordination of care, active management and support of individuals with special health care needs, and a patient and family-centered approach to all aspects of care. PCPCHs emphasize whole-person care in order to address a patient and family’s physical and behavioral health care needs.

Policy:

I. Access to Primary Care
   a. THA providers shall not discriminate between THA OHP members and non-THA OHP members.

   b. If a THA OHP member does not choose a PCP/PCPCH within thirty (30) days of enrollment, THA will assign a PCP/PCPCH to him/her. THA will assist members in selecting or changing a PCP/PCPCH upon request. Refer to THA Policy I-4: Primary Care Provider (PCP)/Patient Centered Primary Care Home (PCPCH) Selection for detailed guidelines.
Subject: Access to Care

c. Credentialed PCP/PCPCH’s who meet the THA OHP member threshold requirements may close to THA OHP members, but remain open to other patients.

d. Credentialed PCP/PCPCH’s will be required to re-open to THA OHP members if their THA OHP member assignments fall below the required threshold based upon the number of days the provider works.

e. THA providers will have their THA OHP member threshold requirements adjusted based on the number of days they work:
   i. Four (4) days per week: is full-time 150 THA OHP member threshold
   ii. Three (3) days per week: is part-time 80% THA OHP member or 120 THA OHP member threshold
   iii. Two (2) days per week: is part-time 60% THA OHP member threshold or 90 THA OHP member threshold

f. THA monitors the provider network at least monthly to ensure adequate service capacity and compliance with access guidelines.

g. Any PCP/PCPCH closing to OHP THA members but not meeting the applicable THA OHP member threshold, THA will furnish a written request to open their availability for THA OHP assignments. If the provider does not respond, the PCP/PCPCH will be administratively opened for assignments and members will be assigned up to the required threshold. These incidents will be reported to the THA Quality Management Committee (QMC).

h. For any PCP/PCPCH not accepting THA OHP members as patients, the THA Provider Relations will conduct a phone survey to verify if the PCP/PCPCH is open for non-THA OHP members. Findings will be reported to the THA QMC.

i. THA providers who meet THA OHP member thresholds may remain closed to assignment of new THA OHP members. PCP/PCPCH’s may accept family members of existing THA OHP members or THA OHP members referred by other providers.

II. Access for Members with a disability, limited English proficiency, or diverse cultural and ethnic backgrounds

In accordance with American with Disabilities Act Title II, Civil Rights Act Title VI, as well as Federal and State regulations and statutes, providers must provide appropriate accommodations for THA OHP members with disabilities, having limited English proficiency, or are from diverse cultural and ethnic backgrounds.
Subject: Access to Care

a. Providers shall ensure THA OHP members are provided with appropriate accessible equipment and features including:
   • Street level access or accessible ramp into the facility;
   • Wheelchair access to the examination room;
   • Wheelchair access to the lavatory;
   • Doors with levered hardware or other special adaptations for wheelchair access;
   • Wheelchair access to operate elevators;
   • Features to distinguish between elevator floor numbers for members with vision impairment; and
   • Communication/Interpreter Services.

b. THA OHP members with hearing impairments have access to the TTY line for phone communication by calling 800-753-2900.

c. Providers shall ensure THA OHP members are provided with a qualified or certified interpreter as needed. Refer to THA Policy I-2: Interpreter Services for detailed information.

d. Providers shall ensure THA OHP members are provided with culturally appropriate coordinated services as needed. Refer to THA Policy 6-5: Cultural Competency for detailed information.

III. Scheduling Care
   a. Routine Appointments
      All THA providers must schedule routine care appointments within four weeks of the appointment request.

   b. Emergency Care and Urgent Care
      Members with emergency needs shall be seen immediately or referred to the Emergency Department. Members with urgent needs are encouraged to be seen within 72 hours or as indicated in the initial screening. Refer to THA Policy 1-6: Emergency Care and Urgent Care for more detailed information.

IV. Access Monitoring and Audits
   a. The THA Provider Relations monitors plan membership and the provider network on a monthly basis to ensure service capacity.

   b. The THA Complaints and Grievances Subcommittee compile and review
Subject: Access to Care

complaints regarding access on a bi-monthly basis. A threshold of three access complaints against a single provider entity results in an onsite visit and completion of a site survey which addresses scheduling, calendaring, access to appointments, etc.

c. Annually, or more often as required, THA Provider Relations completes an after-hours access audit.
   • THA Provider Relations will perform the After-Hours/Access Survey according to THA Policy X-5: Site Reviews.
   • THA Provider Relations may conduct random re-audits during the year to monitor for compliance.
   • Access noncompliance issues will be forwarded to the THA Medical Director for development of a corrective action plan. Access noncompliance is officially monitored by the THA Medical Director and THA QMC.

d. When a need is identified for additional providers, suggested additions to the THA network will be presented to the THA leadership team for approval and recommendations. The need for additional providers may be identified by members, THA network providers or their clinical staff, or THA staff.

References: 42 CFR 438.206(b)
2 CFR 438.208(b)
Health Share of Oregon Policy QUAL-10: Access Standards
Health Share of Oregon RAE Participation Agreement
OAR 409-055-0000
OAR 410-141-3160
OAR 410-141-3220

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Revised:
- September 1998
- October, 1999
- December 2000
- January 2002
- June 2003
- December 2005
- January 2007
- October 2009
- December 2011
- November 2013
- July 2014
- December 2016
- June 2017
- April 2018
Subject: Member Grievances

Objective:

I. To ensure Tuality Health Alliance (THA) members have access to a comprehensive process for submitting grievances regarding services they received through THA.

II. To ensure that THA members receive a timely and appropriate resolution to any grievances by an appropriate means of communication (e.g., telephone call or written communication).

III. To ensure THA member confidentiality throughout any grievance process.

Definition:

Grievance: oral or written expression of dissatisfaction with any aspect of THA- or provider-related operations, activities, or behaviors that pertain to the availability, delivery, or quality of care filed at any time.

Grievance and appeal system: the processes to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.

Policy:

I. A THA member, member's authorized representative, or member's provider on behalf of the member, may file a grievance with any THA staff member.

II. Upon receipt of a grievance, THA will assist the member with any reasonable assistance in completing forms and taking other procedural steps related to filing and resolution of a grievance. THA will provide members with interpreter services or TTY/TTD capabilities as needed.

III. A THA member, member’s authorization representative, or member’s provider on behalf of the member, may withdraw a grievance at any time.

IV. THA will protect employees and members from retaliation, retribution, or any form of harassment for requesting, or considering requesting, an appeal or a contested case hearing.

V. A THA member, member’s authorization representative, or member’s provider on behalf of the member, may request an expedited review of their grievance.

V. THA documentation, review, and resolution process includes the following:
   a. Upon receipt of a grievance, and in a manner that is consistent with THA confidentiality requirements, the appropriate THA staff will investigate all
Subject: Member Grievances

aspects of the grievance and document the investigation/actions/resolution in the THA Grievance database.

- Non-clinically related provider specific grievances will be investigated by THA Provider Relations.
- Clinical related grievances will be investigated by THA Nurse Case Management Team and/or THA Medical Director, as appropriate.

b. The THA member must authorize disclosure or release of information if there is a need to discuss their grievance with providers not involved with the grievance. An authorization to release information related to the grievance does not constitute authorization to disclose medical information unrelated to that grievance. If the grievance is alleged to be a quality of care issue, THA has the right to use member information for purposes of resolving the grievance and for health oversight purposes without a signed release from the member.

c. Within five (5) business days, THA will acknowledge receipt of or resolve the grievance to the member, member’s authorized representative or the member’s provider on behalf of the member.

d. Should THA be unable to resolve the grievance within five (5) business days, the member, member’s authorized representative or the member’s provider on behalf of the member, will be provided a written notice informing them of the reason for the delay.

e. All grievances will be resolved within thirty (30) business days from the date of grievance receipt.

f. Notification of the resolution may be made orally or in writing, depending upon the method in which the original grievance was received:
   - Written grievances will be resolved in writing including review of each aspect of the grievance.
   - Oral grievances will be resolved orally including review of each aspect of the grievance.

g. Should the member, member’s authorized representative, or member’s provider on behalf of the member, be dissatisfied with the grievance resolution, the grievance may be presented to the Department of Health and Human Services Client Services Unit at (800) 273-0557 or Oregon Health Authority’s Ombudsperson at (503) 947-2347.
Subject: Member Grievances

VI. All grievances are reported to Health Share of Oregon for review quarterly.

VII. THA Medical Management Manager monitors the grievance system for:
   a. Review of completeness, accuracy and timeliness of documentation;
   b. Compliance with written procedures for receipt, disposition, and documentation;
   c. Compliance with applicable Oregon Health Plan rules; and
   d. To evaluate access, provider service, clinical care, or other THA service to members for improvement.

VIII. At least quarterly, THA Medical Management Manager reports grievance trends to the THA Quality Management Committee (QMC) for monitoring, modification, disciplinary action, or quality improvement.

IX. If indicated, THA Medical Management Manager and/or other appropriate THA staff will provide training on identified quality improvement needs.

X. THA maintains all grievance records for a minimum of seven (7) years.

References: 42 CFR 438.400 through 438.414
             OAR 410-141-3225 to OAR 410-141-3255
             Oregon Health Authority Coordinated Care Organization Contract
             Health Share of Oregon-Tuality Health Alliance Contract

Formulated: October 1993
Reviewed: February 2013
Revised
May 1995
January 2000
February 2002
May 2004
September 2011
September 2014
June 2015
November 2016
March 2018
Subject: Cultural Competency

Objective:

I. To ensure that all Tuality Health Alliance (THA) members are treated in a manner that respects their cultural background and beliefs.

II. To promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

III. To ensure that THA encourages cultural sensitivity among all staff and providers.

Definition:

Cultural competence: the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientation and other diversity factors in a manner that recognizes, affirms and values the worth of individuals, families and communities, and protects and preserves the dignity of each. Operationally defined, cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attributes used in appropriate cultural settings to increase the quality of service, thereby producing better outcomes.

Policy:

I. THA staff actively engages in efforts to promote the delivery of services in a culturally competent and equitable manner to all members, including members with limited English proficiency and diverse cultural and ethnic backgrounds.
   a. THA provides written or audio operational and educational materials in English and Spanish, and any other language upon request.
   b. THA providers are provided monthly rosters indicating member’s preferred languages.
   c. THA provides annual education to THA providers on the provision of culturally competent care to members.

II. Following Standards on Culturally and Linguistically Appropriate Services (CLAS):
   a. THA provides language assistance services, including bilingual staff and interpreter services, at no cost to each member with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
Subject: Cultural Competency

b. THA will provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

c. THA will assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

d. THA will make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

III. THA has the following systems in place to identify and address the needs of diverse populations and to meet Federal regulations:

a. THA reviews Division of Medical Assistance Programs demographic reports monthly to identify members with alternative language needs.

b. In communicating with members, members are notified of and/or asked if they prefer alternate information formats and alternate language documents.

c. Employees are required to complete annual training on cultural competence.

References: OAR 410-141-3220
Oregon Health Authority Coordinated Care Organization Contract

| Formulated: | February 2000 |
| Reviewed:    | July 2002, October 2013 |
Subject: Interpreter Services

Objective:
To ensure that Tuality Health Alliance (THA) provides Interpreter Services that meet the communication needs of members who do not speak English as a primary language or who, otherwise, require alternate forms of communication due to sensory impairment.

Definitions:
Limited English Proficient (LEP): members who do not speak English as their primary language and who have a limited ability to read, write, speak or understand English may be LEP and may be eligible to receive language assistance for particular type of service, benefit or encounter.

Prevalent: a non-English language determined to be spoken by a significant number or percentage of members that limited English proficient.

Policy:
I. Access to qualified Interpreter Services is provided by telephone, electronically, or in person, within THA provider offices and/or the THA administrative office.

II. During normal business hours, THA provides access to qualified interpreters who can translate in the primary language of each LEP members.

III. After normal business hours, on weekends, and holidays, telephone or electronic interpreter services are available.

IV. A minor child is not to be used as an interpreter. Family members or friends should only be used as adjunctive interpreters if this is the member’s preference.

V. THA shall monitor the prevalent language needs of its membership semi-annually.

References:
42 CFR: 438.10
42 CFR: 438.100(b)
ORS 411.970
OAR: 410-141-3320
Oregon Health Authority Coordinated Care Organization Contract
Health Share of Oregon-Tuality Health Alliance Contract

Formulated: February 1995
Reviewed: July 2010
June 2012
February 2014
February 2016
Revised: May 1995
April 1999
Subject: Interpreter Services
**POLICY:**
Providence Health Assurance (PHA) and Providence Health Plan (PHP), collectively known as Providence, ensure that all commercial and Oregon Health Plan (OHP) members are treated in a manner that respects their cultural background and beliefs. Providence encourages cultural sensitivity and ensures that services provided are in a culturally appropriate manner to all individuals, including those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities.

**DEFINITION:**

**Cultural and Linguistic Competence:**
A set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals that enables effective work in cross-cultural situations (Adapted from Cross, 1989).

**Cultural Sensitivity:**
Awareness that one group's habitual actions and patterns of thought cannot be assumed to be the same as those of people from other societies or cultures.

**Culture:**
Integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious or social groups (Adapted from Cross, 1989).

**Competence:**
Implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors and needs presented by consumers and their communities (Adapted from Cross, 1989).

**Health Literacy:**
The degree to which individuals have the capacity to obtain, process and understand basic health information needed to make appropriate health decisions regarding services needed to prevent or treat illness.

**Prevalent Non-English Language:**
Providence incorporates all languages identified by Section 1557 of the Affordable Care Act. Additionally, PHA includes all non-English languages that are identified as
Cultural and Linguistic Competency

the preferred written language by the lesser of either: 5 percent of the CCO’s total OHP enrollment; or 1,000 of the CCO’s members.

APPLIES TO:
All Providence Health Plan, Providence Health Assurance and Providence Plan Partners caregivers including contracted physicians, vendors and delegated entities.

REFERENCES:
Attachment A: Culturally and Linguistically Appropriate Services (CLAS) Standards
OAR 410-141-3220 (9) (a)-(e)
OAR 410-141-3300
OAR 410-141-3320 (1) (k)-(l), (1) (p)
ORS 411.970
42 CFR 438.10 (a)-(d)
OPS 11: Discrimination Related Grievances
QM 220 Clinic On-site Review Program
Section 1557 of the Affordable Care Act

PROCEDURE:
I. Providence staff actively engages in efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

II. Providence accepts as policy the National Standards on Culturally and Linguistically Appropriate Services (CLAS), as appended herein, that are mandated by the Federal requirements for all recipients of Federal Funds. (Standards 5, 6 and 7).

A. Standard 5
Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
Cultural and Linguistic Competency

Providence is required to provide interpreter services that are culturally appropriate to individuals who are considered non-English speaking.

B. Standard 6
Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

Providence follows the guidance for those members identified as having a “Prevalent Non-English Language” and provides both interpreter services and written materials in the primary language upon request.

C. Standard 7
Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

Providence only uses certified interpreter services.

D. Standard 8
Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Providence offers these services upon request.

III. Providence’s network of practitioners provides the capability of meeting the member’s cultural, racial, ethnic and linguistic needs and preferences.

IV. PHA utilizes Clinic On-site Review Program (CORP) for OHP to evaluate a provider’s office at an initial site review. Providers must score 100% on the site review. If the resulting score is less than 100%, corrective action is required and providers are re-audited to ensure 100% passing score is achieved. Provider sites may be reviewed in the annual CORP program as part of a random sample chosen each year for subsequent reviews. Site review includes whether the following accommodations are in place:

A. Disabled parking spaces
B. Wheelchair access to and within the office
C. Provisions for non-English speaking patients that includes when possible, a written privacy policy in alternative languages.

D. Provisions for visually and/or hearing impaired patients.
<table>
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<tr>
<th>Subject: Cultural and Linguistic Competency</th>
<th>Department: Regulatory Compliance, Risk Management and Government Affairs</th>
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<tr>
<td>Original Effective Date: 10/13</td>
<td>Date(s) Reviewed/Revised: 03/14, 01/16, 12/17, 12/18</td>
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<td>Approved By: Chief Compliance and Risk Officer</td>
<td>Number: RA 76</td>
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**Attachment A**

National Standards on Culturally and Linguistically Appropriate Services (CLAS)

**Standard 1**
Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

**Standard 2**
Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices and allocated resources.

**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.

**Standard 4**
Educate and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

**Standard 5**
Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

**Standard 6**
Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

**Standard 7**
Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

**Standard 8**
Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.
Cultural and Linguistic Competency

Standard 9
Establish culturally and linguistically appropriate goals, policies and management accountability, and infuse them throughout the organization’s planning and operations.

Standard 10
Conduct ongoing assessments of the organization’s CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

Standard 11
Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

Standard 12
Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

Standard 13
Partner with the community to design, implement and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

Standard 14
Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent and resolve conflicts or complaints.

Standard 15
Communicate the organization’s progress in implementing and sustaining CLAS to all stakeholders, constituents and the general public.
**POLICY:**
Providence Medicare Advantage Plans will provide no cost interpreter services to all non-English speaking, limited English proficient, and hearing impaired beneficiaries for call center services.

**APPLIES TO:**
Providence Public Programs Operations, Providence Medicare Advantage Plans Members

**REFERENCES:**
2018 Medicare Marketing Guidelines, Section 80.1
42 CFR 422.111 (h)(1), 423.128 (d) (1)

**PROCEDURE:**
Language Interpretation for Member Calls:

Providence Medicare Advantage Plans will have interpreter services available within eight (8) minutes of reaching the Customer Relations Specialist (CRS). The CRS will also inform callers that interpreter services are free.

Contact the following approved Providence Oregon interpreter service agency to request telephonic interpreter services.

- Linguava at (888) 870-7450
  - Cost Center number 62885908
- Passport to Languages at (844) 437-2432
  - Cost Center number 62885908

The CRS will provide the following information:
- Self-identification as an employee of Providence Medicare Advantage Plans
- Patient Name
- Language Required
- Providence Medicare Advantage Plans member ID number
The CRS will then assist the member by conferencing with the interpreter.

TTY Line for Hearing Impaired Members:
Providence Medicare Advantage Plans has a TTY line available at 711. A TTY relay operator will be available within seven (7) minutes of the time of answer. When a relay call from a hearing impaired member is received, just like any call, the CRS will indicate it is a relay call and document the conversation in a Customer Service Inquiry (CSI).
Procedures Number: CS10001
Title: TTY/TDD Access

Department: Customer Service  Applies To: Administrative ☑
CareOregon (Medicaid) ☑ and/or  CareOregon Advantage (Medicare) ☑
OHC ☑ CareOregon Affiliated CCOs ☑

Author: David Lima  Approved By: Karen Mattila
Effective Date: 01/01/2010  Revision Date:

**POLICY:** It is the policy of CareOregon to have the capability to communicate with its perspective and existing members who are hearing or speech impaired. CareOregon uses state relay services in lieu of having in-house TTY/TDD equipment.

**DEFINITIONS:**
TTY/TDD – (Telecommunications Device for the Deaf/Teletypewriter) A user terminal with keyboard input and printer or display output used by the hearing and speech impaired.

**PROCEDURES**
The caller contacts CareOregon by calling Oregon Relay Service. The state relay attendant calls the CareOregon customer service phone line where the call is answered by a customer service representative.

**RELATED DOCUMENTS**
- Chapter 3 Medicare Marketing Guidelines *(Rev. 91; Issued: 08-07-09; Effective/Implementation Date: 08-07-09) 40.12 Use of TTY Numbers*
- Oregon Administrative Rule 410-141-0220 Oregon Health Plan Prepaid Health Plan Accessibility (6e)
- NCQA, MA14 - Element G
POLICY
CareOregon Customer Service utilizes various tools in order to provide service to our members in their primary languages. CSR’s utilize the CyraCom Language Line, which has telephone interpretation services available for all languages.

PROCEDURES
Currently CSR’s place a conference call to CyraCom Language Line for telephone interpretation services.

The Cyra Com Language Line is listed in Shoretel under *CyraCom Language Line (1-800-481-3293). The CareOregon Customer Service client ID is 501013528 and PIN 5414.

RELATED DOCUMENTS
Interpreter-CyraCom Job Aid
410-141-0220 Oregon Health Plan Prepaid Health Plan Accessibility
Interpreter Service Requests

Overview

CareOregon no longer coordinates interpretation services for members’ medical appointments. For covered services we contract with our preferred vendor, Passport to Languages (PTL). Providers work with PTL directly for coordination of services, and PTL is also where the provider will send their claim.

Interpreter services are provided for the following:

- Visits to the Doctor’s office.
- Ancillary services and hospital visits (examples: surgery, therapy, testing).
- Provider to contact Passport to Languages for cancelled appointments, clinical/facility closures or they will be responsible for charges. (PTL would prefer a 24 hour notification when possible)
- Face to face services over 8 hours in length must be accompanied by an itemized (detailed) documentation.
- Prospective COA members in their home when they have a scheduled appointment with a Health Plan Consultant/Broker. The broker should coordinate this with PTL.

CareOregon does not cover medical interpreter services for provider administrative services such as scheduling appointments, relaying test results or communicating over the phone.

**Exception:** Phone interpretation for a CareOregon Dental member is covered. However, CyraCom is used for this type of interpretation. See the CyraCom Job Aid for more information.

Requests for interpreter services are handled by Passport to Languages (PTL). Providers are able to fax their requests for Interpreter Services directly to PTL by using the Interpreter Request Form (IRF) available in the CareOregon website (Provider/Policy Forms & Policies/Miscellaneous forms). Providers can also access PTL’s online system to request and confirm an interpreter. [www.passporttolanguages.com](http://www.passporttolanguages.com)
Occasionally, a request will come from a provider or member for Interpreter services. These should be directed to PTL for handling.

Providers should be using PTL as their primary resource for Interpreter services, however, CareOregon has an agreement with IRCO interpreter services as back up or if requested.

**Requests:**

**Urgent**

Urgent requests are defined as less than two business days before the scheduled appointment. Advise the provider they can call PTL directly to schedule all urgent requests. Ph# 503-297-2707
Non-Urgent requests are defined as more than two business days between the request and the scheduled appointment. If appointment is more than two days out direct the provider to fill out the IRF and fax it over to PTL. If provider does not have internet access, CSR should fax or mail a blank form. Provider may call PTL directly to schedule an interpreter.

It is the provider’s responsibility to complete and fax form directly to PTL using the fax number indicated on the form.

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**Confirmations:**

Provider Calling for Confirmation

All confirmations will be sent from PTL. Give the provider the phone number to PTL for direct dial or warm transfer the call. They can also be referred to their website portal for confirmation. passporttolanguages.com.

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**Cancellations:**

Provider calling to cancel

Provider calls to cancel a previously scheduled interpreter request. Encourage provider to contact PTL directly, either through direct dial or warm transfer.

**Note:** Passport to Languages is under *PTL on Shoretel

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**Call Tracking**

- Call Codes: Interp Svcs, Request for Interp Svcs
- Close call with Issue Resolution: **All- Information/Education Provided**
1.0 Policy Statement

1.1 Interpreter services are provided during all hours of operation at no cost to members/patients, their medical decision makers, personal representative and those providing support to the patients’ care.

1.2 Members/patients are informed of their right to receive interpreter services at no cost to them, how to access interpreter services, and how to address and file complaints pertaining to interpreter services.

1.3 Kaiser Foundation Health Plan, Kaiser Foundation Hospitals, and Northwest Permanente, P.C. adheres to state and federal laws, regulations and contractual agreements requiring health care organizations to provide interpreter services.

2.0 Purpose

2.1 To ensure that interpreter services are available at all administrative and clinical points of contact where the need of interpreter services can reasonably be anticipated.

2.2 To define a process to monitor compliance with various state and federal requirements surrounding the provision of qualified interpreter services.

3.0 Scope/Coverage

This document describes Policies and Procedures for Kaiser Foundation Health Plan, Kaiser Foundation Hospitals, and Northwest Permanente, P.C. Foundation Health Plan.

4.0 Definitions

4.1 Professional Contract Interpreters – A company that provides interpreter services with whom Kaiser Permanente contracts to provide spoken and/or sign language services. Professional contracted interpreters must demonstrate proficiency in the source and target language, including medical terminology as appropriate. Professional contracted interpreters must also have training in interpreter ethics, standards of practice, and be bound by agreements to protect personal health information.

4.2 Certified Sign Language Interpreter – An individual who holds one of the following certifications:

- RID (Registry of Interpreters for the Deaf); National Interpreter Certification (NIC); NIC is replacing CI (Certificate of Interpretation), CT (Certificate of Transliteration) and CSC (Comprehensive Skills Certificate) as the new standard; but CI, CT and CSC are still valid and accepted.
- NAD (National Association for the Deaf) Advanced (Level IV), or Master (Level V); ACCI (American Consortium of Certified Interpreters) Levels IV and V.

4.3 Health Plan – Kaiser Foundation Health Plan

4.4 Interpreting – The act of listening to something in one language (the source language) and orally conveying the same message and information into another language (the target language). See also “Sign Language Assistance Services” below.
4.5 KFH – Kaiser Foundation Hospitals

4.6 **Limited English Proficient (LEP) Person** – An individual who does not speak English as his/her primary language and who has limited ability to read, write, speak, or understand English.

4.7 **NWP** – Northwest Permanente, P.C., Physicians and Surgeons, Permanente Dental associates

4.8 **Point of Contact** – An instance where a member/patient and/or their medical decision maker accesses administrative or clinical services, either in person or via telephone, from Health Plan, KFH, or NWP.

4.9 **Professional/Dedicated Staff Interpreter** – An individual employed to provide spoken and/or sign language services at his or her job. Professional/Dedicated staff interpreters must demonstrate proficiency in the source and target language, including medical terminology as appropriate. Demonstration of proficiency will be via a valid and reliable assessment tool selected by the employer. Professional/Dedicated staff interpreters must also have training in interpreter ethics and standards of practice and be bound by agreements to protect personal health information. Professional/Dedicated staff interpreters must have National Board of Certification for Medical Interpreters (NBCMI) or Certification Commission for Healthcare Interpreters (CCHI) within 6 months of hire/transfer. They must have Oregon Health Authority Health Care Interpreter Certification within 12 months of hire/transfer.

4.10 **Qualified Bilingual Staff/Status (QBS) Level 1** – An eligible bilingual employee who has demonstrated conversational proficiency in English and the target language. A QBS Level 1 employee uses his or her language skills within two distinct roles:

4.10.1 Performs his or her regular duties in a language other than English with simple, non-clinical information (for example, a Spanish speaking receptionist who performs his or her job in Spanish).

4.10.2 May be called upon to interpret simple, non-clinical information between a co-worker and a patient elsewhere (for example, a Spanish-speaking registration representative in one department is called to interpret for a patient at the registration desk in another department).

4.10.3 Demonstrates interpreter ethics, conduct, and confidentiality that adopt and apply, in full, the standards of practice promulgated by the California Healthcare Interpreters Association, the National Council on Interpreting in Healthcare, or the RID Code of Ethics.

4.11 **Qualified Bilingual Staff/Status (QBS) Level 2** – An eligible bilingual employee who has demonstrated intermediate to advanced conversational proficiency in English and the target language, including healthcare/medical terminology. A QBS Level 2 employee uses his or her language skills within two distinct roles:

4.11.1 Performs his/her regular duties in a language other than English (for example, a Spanish-speaking medical assistant in the OB/GYN department who performs his or her job in Spanish).

4.11.2 May be called upon to interpret for someone else in clinical encounters familiar to the QBS employee where understanding of healthcare/medical terminology/concepts is required (for example, a Spanish-speaking medical assistant in the OB/GYN department who is called to interpret for a patient and the provider within the OB/GYN department).
4.11.3 Demonstrates confidentiality and adheres in full to the standards developed by the California Healthcare Interpreters Association, the National Council on Interpreting in Healthcare, or the RID Code of Ethics.

4.12 Interpreter – An individual who has met the standards to be a health care interpreter. An interpreter may be a professional interpreter who is hired as a Health Plan, KFH, or NWP employee, an independent contractor or a Professional Healthcare Interpreter hired through a contracted vendor.

4.13 Sign Language Interpreter Services – Interpreter services for someone who is deaf or has hearing loss or who has a speech disability and who primary means of communication is sign language.

4.14 Sight Translation – The act of reading out loud from a document written in one language into another language.

4.15 Spoken Language/Preferred language – The language/dialect which a patient self-discloses as the language/dialect he/she prefers to use when accessing and receiving healthcare services.

4.16 Target Language – The preferred language spoken by the patient/member, and his/her medical decision makers and/or those providing support to the patient’s care.

4.17 Telecommunication Relay Service – A free public service for communication between voice users and persons who are deaf, hard-of-hearing, deaf-blind and speech-disabled using Text telephones (TTYs) or PCs via the internets. Such service provides trained communication assistants who complete all calls and stay on the line to relay text messages over a TTY device (to persons who are deaf, hard of hearing, or who have speech disabilities) and verbally (to the hearing party). Dial 711 to access relay services in Oregon and Washington.

4.18 TTY – Text Telephone. A TTY device enables persons who are deaf, have hearing loss, or who have a speech disability use of a text telephone to communicate by typing messages and receiving written response instead of talking and listening. See above “Telecommunication Relay Service”.

4.19 Video Remote Interpreting (VRI) – A video telecommunication service that uses devices such as web cameras or videophones to provide sign language or spoken language interpreting services. This is done through a remote or offsite interpreter.

4.20 Taglines – A short statement in multiple languages that informs members, patients and caregivers about the availability of language assistance services.

5.0 Provisions

5.1 Planning for Services

5.1.1 All staff using clinical or non-clinical systems and interacting with members/patients note when the member language preference fields are not filled in and take responsibility to gather and input the following data:

5.1.1.1 Spoken language preference in medical encounters;
5.1.1.2 Written language preference and/or alternative format needs;
5.1.1.3 Whether the member/patient requires an interpreter.
5.1.2 The NW Region’s most common non-English languages among Health Plan members are:
- Spanish
- Russian
- Vietnamese
- Cantonese
- Mandarin

5.2 Notification of Availability of Language Assistance Services

5.2.1 Members and patients are informed that interpreter services are available at no charge to them during all hours of operations at all points of contact. Members and patients are informed that for services and/or departments that provide services 24 hours a day, 7 days a week, language services are also provided 24 hours a day, 7 days a week.

5.2.2 Health plan informs members of the availability of free language assistance via notice in the Member Orientation Guide, Medical and Dental directories, new member welcome kits, Evidence of Coverage, and other outreach materials.

5.2.2.1 The notice describes how members may seek assistance from Health Plan in arranging interpreter services at administrative and clinical points of contact.

5.2.3 KFHP, KFH and NWP inform members/patients of the availability of free language assistance via notices posted at key entrances of all facilities, admitting departments, and emergency departments.

5.2.4 Notices of the availability of language assistance services at no cost to the member/patient are posted at KFH facilities include the telephone number and TTY number.

5.2.5 Entities subject to this policy include Taglines in Vital Documents to inform members and patients on the availability of language assistance services, including interpreter services.

5.2.5.1 The Taglines describe how members may seek assistance from Health Plan in arranging qualified interpreter services at administrative and clinical points of contact.

5.3 Offer of Interpreter Services

5.3.1 Any member/patient who expresses a preference for a non-English language including Sign language or demonstrates a need for interpreter services is offered interpreter services 24 hours a day, 7 days a week at all administrative and clinical points of contact during all hours of operation at no cost to the member/patient. For departments that are open 24 hours a day, 7 days a week, language assistance is provided 24 hours a day, 7 days a week.

5.3.2 The offer of interpreter services is made to a companion/caregiver who is involved in care decisions for a member/patient and needs to communicate with the provider regarding those care decisions. The use of interpreter services in such encounters must be documented in the patient’s chart. In addition, a note should be included that language assistance services were provided to the member/patient’s companion or caregiver.
5.3.3 The offer of interpreter services is made even in the situations when a member/patient is accompanied by someone who may be capable to interpret for the member/patient.

5.3.4 In situations where a member or patient refuses the offer of interpreter services and insists on using an adult family member or friend, the offer of interpreter and service and refusal by the member/patient is to be documented in the medical record or health plan file, as applicable. KFHP, KFH and NWP reserve the right to use interpreter service to ensure meaningful communication takes place.

5.3.2 Every reasonable attempt is to be made to meet the member’s request of his/her preferred mode of interpreter services.

5.4 Arranging for Interpreter Services

5.4.1 For appointments scheduled in advance, the need for interpreter services is documented at the time the appointment is scheduled.

5.4.2 For unscheduled encounters, every reasonable attempt is to be made to arrange for interpreter services in a timely manner, as described in section 5.5.

5.5 Timely Delivery of Interpreter Services

5.5.1 Spoken/Sign Language assistance services are provided during all hours of operation to avoid the effective denial of the service, benefit, or right at issue or the imposition of an undue burden on or delay in important rights, benefits, or services to the LEP person. For departments that are open 24 hours a day, 7 days a week, language assistance is provided 24 hours a day 7 days a week.

5.5.2 If face-to-face interpreter services are not available or feasible, phone or video interpreter services should be used and/or considered before the appointment is rescheduled.

5.6 Use of Family and Friends as Interpreters

5.6.1 The use of adult family and friends as interpreters is strongly discouraged; member/patients have to be informed of their right to interpreter services at no cost and be informed how to obtain interpreter. In situations where a member/patient insists on using an adult family member or friend, the “Get care in your language” document is given to the member/patient (the document is available in Spanish, Russian, and Vietnamese) and the offer of interpreter services and refusal by the member/patient is to be documented by entering the dot phrase “interpreter opt out.” If the member/patient does not want interpreter services for future appointments, staff is to enter in demographic information that member/patient does not want an interpreter. If the patient does want interpreter service for future appointments, the indicator of interpreter service continues to be “yes.”

5.6.2 Cases in which the patient’s diagnosis, condition, procedure and/or care plan are of complex and/or sensitive nature may cause providers or staff to request interpreter services to participate in the encounter despite the patient’s preference to use an adult family member or a friend. In such situations, the circumstances leading to the override of the patient’s preference are documented in the medical record.
5.6.3 Minor children are prohibited from interpreting except in extraordinary situations such as medical emergencies where any delay could result in harm to a member/patient, and only until an interpreter is available. Use of a minor child for interpreting under these circumstances should be documented in the medical record.

5.6.4 Kaiser Permanente is prohibited from asking members/patients to provide or bring their own interpreters to an Administrative or Clinical Point of Contact.

5.7 Types of Interpreters Available

5.7.1 Only the services of interpreters competent in medical terminology in both the source and target language are used during medical encounters. These resources include:
- Professional Healthcare Staff Interpreter;
- Contracted Interpreter (in person or telephone);
- Qualified Bilingual Staff
- Bilingual providers who have taken a language assessment to demonstrate their language proficiency in the target language

5.7.2 The specific method for providing interpreter services chosen for a particular point of contact depends on the nature of the encounter as well as the readily available services in the language needed.

5.7.3 Bilingual staff without Qualified Bilingual Staff certification are prohibited from using their language skills in administrative and medical points of contact.

5.8 Documenting Use or Refusal of Interpreter Services

5.8.1 When an interpreted encounter is complete, use of an interpreter is documented in the medical record or health plan file. Documentation must include the type of interpreter used and the interpreter’s name and unique identifying number (e.g. Name of vendor and Interpreter ID, Name of QBS and Employee ID # or NUID).

5.8.2 In situations where a member/patient insists on using an adult family member or friend, the “Get care in your language” document is given to the member/patient (the document is available in Spanish, Russian, Vietnamese and Cantonese) and the offer of interpreter services and refusal by the member/patient is to be documented by entering the dot phrase “interpreter opt out.”.

5.9 Sight Translation

5.9.1 Sight translation of documents used during patient visits may be provided in person, through a spoken/sign language assistance resource, or, is appropriate, through a telephone interpreter.

5.9.2 If an interpreter accompanies a member/patient to an administrative or clinical point of contact, the interpreter will sight translate relevant information and forms not available in the target language used during the course of the visit in the presence of clinical or relevant staff so that they can answer questions and/or clarify information.
5.9.3 If an administrative or clinical encounter involves documents not available in the patient’s preferred language, and an interpreter cannot be secured for in-person sight translation in a timely manner, providers or staff may read the document(s) used during the visit to a contracted telephone interpreter service, for interpretation for the member.

5.10 Review of Member Grievances
Research and respond to all grievances submitted by members, patients or their advocates related to language assistance. Meet all regulatory and internal guidelines for responding to and resolving grievances. Identify root cause and/or opportunities to improve language services and the member experience.

5.11 Confidentiality
5.11.1 All individuals providing interpreter services to members and patients from Health Plan, KFH, and NWP protect confidentiality of member/patient information.

5.11.2 All professional interpreters who are contracted to provide interpreter services to Health Plan members and patients sign confidentiality statements and are bound by Health Plan, KFH, and NWP standards for the protection of personal health information.

6.0 Appendices
6.1 Standards for Interpreter Services
6.1.1 Qualified Bilingual Staff
6.1.1.1 NW Interpreter and Translation Services Department is responsible for determining the process to conduct proficiency assessments for staff seeking to qualify as Qualified Bilingual Staff/Status Level 1 or Qualified Bilingual Staff/Status Level 2.

6.1.1.2 Those designated as QBS 1 or 2 are not authorized to provide language assistance services beyond the scope of their qualifications and language skills.

6.1.1.3 NW Interpreter and Translation Services Department is responsible for outlining the processes by which staff may obtain QBS.

6.1.1.4 Bilingual staff may obtain QBS certification by obtaining a passing score on the QBS language assessment and completion of applicable QBS training.

6.1.1.5 QBS training includes education on ethics, conduct and confidentiality.

6.1.1.6 QBS are not eligible for pay differential for their bilingual status, unless they are hired into a job code that explicitly requires bilingual skills. Likewise, QBS are not required to use their bilingual skills.

6.1.2 Contract Interpreters
6.1.2.1 The NW Interpreter and Translation Services Department is responsible for selecting contract interpreters.
6.1.2.2 Any organization contracted to provide professional interpreter services to members/patients must have processes in place to assess the proficiency of the interpreters they provide and to ensure the quality of the interpreter services they provide.

6.1.2.3 Any individual contracted to provide interpreter services must demonstrate:

6.1.2.3.1 Proficiency in both the target and source languages.

6.1.2.3.2 A fundamental knowledge in both languages of healthcare terminology and concepts relevant to healthcare delivery system; and

6.1.2.3.3 Education and training in standards of practice, interpreting ethics, conduct and confidentiality.

7.0 References and Resources

7.1 NW Interpreter Intranet Site
7.2 Title VI of the Civil Rights Act of 1964 (Title VI)
7.3 Title III of the Americans with Disabilities Act
7.4 ORS 413.550, 836-053-10033, 836-053-1190
7.5 Oregon Telecommunications Relay Services
7.6 Federal Executive Order 13166
7.7 Washington State Health Care Authority Interpreter Services
7.8 Washington Relay
Attachment 10 — RFA Community Engagement Plan Narrative (4 pages)

A. General Component: To be addressed via narrative descriptions and Tables 1 and 2

A.1. Identify stakeholders (Table 1) to be included in the engagement process, which will include:

A.1.a. Identification of stakeholder types to be included in the engagement process.
A.1.b. Identification of agencies, organizations and individuals, based on the stakeholder types in Part 1a.

See attached RFA4690-Health Share of Oregon-Attr10-RFA Community Engagement Table 1

A.2. Five to eight major projects, programs, or decisions (Table 2) for which the CCP will engage the community. The Applicant will include:

A.2.a. A list and description of the five to eight major project or decision the CCO will engage the community.
A.2.b. The level of community engagement for each project, program, or decision.

See attached RFA4690-Health Share of Oregon-Attr10-RFA Community Engagement Table 2

A.3. Describe (via narrative) the process for members (both CAC and non-CAC members), health care providers, other service delivery partners, and other stakeholders to provide input that will inform CCO decision-making;

Our commitment to incorporating community input into decision-making - Health Share’s community based, collaborative governance and operating model is specifically designed to foster stakeholder engagement and consensus driven decision-making. In addition to serving on Health Share’s Board of Directors, leaders from our partner organizations, local government, clinicians, community leaders, and consumers will serve on our Clinical Advisory Panel and Pediatric and Behavioral Health Advisory Councils—all of which report to the Board along with the Community Advisory Council (CAC), ensuring direct community and stakeholder input into decision-making. Both clinical and administrative representatives from our Integrated Delivery System and clinical care delivery partners support CCO operations by co-leading and participating in operating councils where policy changes are implemented and process improvements are operationalized. Additionally, we convene hundreds of workgroups, committees, collaboratives, and advisory council meetings each year to ensure community input into decision-making and operations. Our CAC, Community Health Assessment (CHA), and Community Health Improvement Plan (CHP) will be developed and operated in accordance with Exhibit N of the Model Contract.

Public meetings - In accordance with ORS 414.627, House Bill 4018, and Exhibit N of the Contract, Health Share and our CAC host quarterly public meetings, semi-annual public joint CAC/Board meetings, and public engagement at Board meetings where substantive decision-making occurs. Public meetings include opportunities for public comment, and we use a form to record comments and track accountability. The Board and CAC solicit public testimony to aid decision-making. Additionally, we use public meetings to collect community input on specific topics. For example, we invited community members to participate alongside Board and CAC members to provide input into Health Share’s 2019 CHP at our February 2019 joint CAC/Board meeting.

Community engagement activities - Health Share hosts community engagement activities to solicit community input including forums such as conducting new member orientations and public listening sessions. We also participate in community events and workgroups (like Early Learning Hubs, School Based Health Center Alliances, housing groups) throughout our service area. One clear example is listening sessions and town halls Health Share hosted during the tri-county member transition of 2018. We held community sessions in each county of our service area for community members (including OHP members, community partners, providers, and even OHA staff). Health Share provided up-to-date information and collected...
community input to inform decision-making on provider networks and contracting.

Health Share has developed vast and deep relationships within our local communities as evidenced by Table 1 in RFA4690-Health Share of Oregon-Att10-RFA Community Engagement Plan Tables. Health Share is committed to continuing this level of community engagement in CCO 2.0.

**A.4. Describe (via narrative) how the Applicant will ensure the member voice is elevated**

Our commitment to ensuring member voices are heard and considered - At Health Share, we believe member voice and experience are at the center of what we do. The CAC is one mechanism for ensuring member voice is elevated to the CCO governance level, and Health Share is excited to expand CAC consumer representation on our Board to two seats. The CAC oversees development of our CHA and CHP, including extensive community and member engagement to identify the strengths, needs, and priorities of our communities and to develop strategies to address them. Our 2018 CHA development process included 29 community listening sessions and over 3,000 completed surveys. As primary liaisons between our Board and our members, the CAC played a pivotal role in developing Health Share’s mission statement and values. During the aforementioned public CAC and Board meetings, we encourage members to attend and share public comment. Our partners have also created mechanisms to elevate member voice throughout our network, and we routinely begin Board meetings with member stories highlighting successes or areas of opportunity within our health systems. Many partner organizations convene their own consumer advisory councils to advise them on policies, programming, and funding decisions. For example, CareOregon has a consumer advisory group as well as several clinical advisory panels, and all three of our LMHA/LPHA county partners engage members on advisory boards.

**A.5. Describe (via narrative) potential barriers to community engagement and how the Applicant will address these barriers. The applicant will include:**

<table>
<thead>
<tr>
<th>Known or Anticipated Barriers</th>
<th>Mitigation Strategies</th>
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<tbody>
<tr>
<td>Child care</td>
<td>Provide free childcare for key community engagement events including public CAC meetings</td>
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<tr>
<td>Transportation</td>
<td>Alternate location of public engagement activities (CAC Meetings, New Member Orientations, etc.) throughout all three counties in Health Share’s service area, provide transportation assistance that could include: bus/transit tickets or cab vouchers, and select locations close to public transportation.</td>
</tr>
<tr>
<td>Accessibility of event spaces</td>
<td>Adopt clear criteria for selecting meeting locations that are ADA accessible. Hold meetings in community-based locations when possible. Vary meeting times, including evenings and weekends, to accommodate needs of members.</td>
</tr>
<tr>
<td>Language barriers</td>
<td>Provide free interpreter services for key community engagement events including public CAC meetings.</td>
</tr>
<tr>
<td>Literacy and numeracy levels</td>
<td>Ensure member materials are at a 6th grade reading level or below, using 12 point font or larger and ensure closed captioning at key public meetings.</td>
</tr>
<tr>
<td>Hetero-dominance and gender</td>
<td>Adopt standard practice of sharing gender pronouns. Ensure access to gender-neutral...</td>
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</tbody>
</table>
A.6. Describe (via narrative) the plan to ensure continual quality improvement of the high-level plan throughout the life of the contract, including how quality improvements will be shared back with engaged stakeholders and the larger community.

Continual quality improvement and information sharing - Health Share will ensure continual quality improvement of our Community Engagement Plan through regular monitoring, evaluation and reporting activities. Health Share’s Chief Equity and Engagement Officer will be responsible for high-level oversight of the Community Engagement Plan and will provide annual updates on Health Share’s compliance with the plan to the CAC and the Community Impact Committee of the Board. Oversight activities will include conducting annual community partner evaluations with organizations listed in Health Share’s Community Engagement plan as well as quarterly reviews of the plan with Community Engagement staff. These annual evaluations will assess the level of partnership, partnership successes and challenges, and offer partners an opportunity to provide feedback on how to strengthen the relationship. We will identify quality improvement opportunities and share these with our community partners. Additionally, Health Share will include findings from our Community Engagement Plan report in our Annual and CHP progress reports. These reports are shared through Health Share’s quarterly stakeholder newsletter, website, and social media, at the CAC and Board meetings, community events, numerous list-servs, and an annual regional convening.

B. CAC Component: To be addressed via narrative description

B.1. The Applicant will describe its Community Advisory Council as follows:

B.1.a. An Applicant that is not an existing CCO …

Not Applicable

B.1.b. An Applicant with one or more existing CACs will describe its current CAC structure and role(s) and, if applicable, its plans for adapting its CAC structure based on a new or adjusted CCO service area….

Community Advisory Council structure - In accordance with ORS 414.627 and Exhibit N, the Board charters Health Share’s CAC, which is comprised of representatives from the community and each county government in our service area. At least 51% of our CAC members represent consumers. We recruit, interview, and recommend new CAC members who are then approved and appointed by a selection committee comprised of equal numbers of county representatives and Board members. The CAC serves as the primary liaison between the community and the Board, and is key to collecting and responding to community input both through public meetings and development of the CHA and CHP. The CAC is charged with: overseeing the development of a CHA and CHP; identifying and advocating for preventive care practices; publishing an annual CHP report; serving as the liaison between members and Health Share; and providing feedback on Health Share’s strategic plans. Beginning in 2020, the CAC will play a critical role in advising the Board Community Impact Committee on investments designed to address the social determinants of health and health equity.

B.1.b. A description of how it defines its population

Health Share’s member population are OHP members and Cover All Kids enrollees living in Clackamas, Washington and Multnomah County. CAC membership needs are determined using a similar process to the CAC Member Assessment and Recruitment Matrix provided by OHA.

B.1.b. Any planned changes to CAC recruitment and engagement strategies to align CAC membership with that population and with CHP priorities

restrooms for public meetings.

Use various adult learning theories such as popular education. Ensure facilitation is trauma-informed, equity-centered, and uses inclusive practices.

Offer consumer CAC Members monthly stipends and food for their participation in CAC meetings.

Communicate meeting dates and times on various platforms such as social media, community partner list-servs, and use on flyers.

Offer various platforms for community to provide feedback in public meetings including CAC public meetings. Demonstrate accountability to our members by having mechanisms in place to respond to feedback during meetings.
Health Share will reassess member demographics under the new contract and, if necessary, add members to ensure the CAC reflects our member population. We will also pair member demographics with a skills inventory based on priorities from Health Share’s CHP and the CHP Guidance Report. *B.1.c. All Applicants will describe how they will meaningfully engage OHP consumer representatives on the CCO board, and how they will meaningfully engage tribes and/or tribal advisory committees (if applicable).* Health Share’s current bylaws designate a CAC consumer seat on the Board, and we will add a second CAC consumer seat in 2020. As mentioned above, the CAC and the Board hold joint meetings twice a year to strengthen relationships and dialogue about Health Share’s strategies to meet community and member needs. In recognition that all land is indigenous land, Health Share has relationships with Indian Health Services providers and CBOs serving our Native communities. For example, CareOregon provides care coordination for Indian Health Services statewide; one of our Community at Large Board seats is held by the CEO of Native American Rehabilitation Association (NARA), and one of our CAC members works for the Northwest Portland Area Indian Health Board (NPAIHB).  

*B.1.d. All Applicants will describe strategies for collaborating with CACs from other CCOs that have overlapping services areas. Include strategies to ensure best use of local capacity and resources to avoid overtaxing the community (for example, if the same county, community-based organizations or OHP consumers being asked to participate in more than one CAC or more than one CHA/CHP process).* Health Share shared a service area with another CCO for five years and found multiple ways to collaborate and maximize capacity and resources. The primary example is through our participation in the Healthy Columbia Willamette Collaborative. This 15-member coalition of hospital community benefit programs, LPHAs, and CCOs serving the four county regions of Clackamas, Multnomah, and Washington counties in Oregon and Clark County in Washington collaborates to conduct a regional CHA. The impetus behind this partnership is to maximize resources and avoid overtaxing community partners by having one coordinated regional CHA as opposed to 15 individual assessments. The CHA includes extensive community engagement done in partnership with CBOs, RHECs, OHP consumers, CAC members, and other key community stakeholders. Although our experience as the single community-based CCO in our service area has improved health system and community engagement across the region, we are prepared to collaborate with new entrants to our community if necessary.  

*C. Description of CAC/CHP component: To be addressed via narrative description and completed Tables 3-5.*  

*C.1. Table 3 describing engagement activities with other agencies in the service area that have responsibility for developing community health assessments and community health improvement plans.* See attached RFA4690-Health Share of Oregon-Att10-RFA Community Engagement Tables  

*C.2. Table 4 describing engagement activities with social determinants of health and health equity (SDOH-HE) partners for developing community health assessments and community health improvement plans.* See attached RFA4690-Health Share of Oregon-Att10-RFA Community Engagement Tables  

*C.3. Table 5 describing how the applicant will select subsequent year (2021) community social determinants of health spending priorities (“SDOH-HE”) by March 15, 2020 to meet the CCO SDOH-HE spending requirements.* See attached RFA4690-Health Share of Oregon-Att10-RFA Community Engagement Tables  

*C.4. Describe (via narrative) how the Applicant’s strategy for health-related services (HRS) community benefit initiatives will link with the Applicant’s CHP.*  

*C.4.a. Please describe how HRS Community benefit investment decisions will be made, including the types of entities eligible for funding, how entities may apply, the process for how funding will be awarded, the role of the CAC (and Tribes/tribal advisory committee if applicable) in determining how investment decisions are made, and how HRS spending will align with CHP priorities.* Health Share’s HRS community benefit investments will comply with OAR 410.141.3150, target community-level initiatives improving population health and health care quality, but not limited to members. Health Share proposes to use the same process developed for SDOH-HE spending for HRS Community Benefit Investment decisions. This includes types of entities eligible for funding, how entities apply, how the process for funding happens and the role of the CAC in funding decisions.
RFA Community Engagement Plan Tables

Applicants must provide a detailed plan for community engagement according to the required components in the RFA Community Engagement Plan Reference Document, including identified gaps and plans to address gaps. **Applicant’s Community Engagement Plan must be no more than 4 pages (according to the RFA spacing and font restrictions), excluding tables.** Tables should be completed in the format provided below and submitted with Applicant’s Community Engagement Plan (narrative).

**Table 1: Stakeholders to be included in the engagement process**

*All applicants must complete this full table. Applicants may add rows as needed*

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<th>Part 1a. List stakeholder types to be included in the engagement process.</th>
<th>Part 1b. List specific agencies, organizations and individuals, based on the stakeholder types identified in Part 1a, with which the applicant will engage. Add additional rows under the stakeholder type as needed.</th>
<th>Part 1b. Describe why each listed agency, organization and individual was included.</th>
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<tbody>
<tr>
<td>OHP consumers (list in first column below)</td>
<td>Health Share’s Community Advisory Council (CAC)</td>
<td>With at least 51% consumer membership, our CAC serves as the voice and representation of our OHP consumers.</td>
<td>The CAC will continue to be charged with: overseeing the development of a CHA and CHP; identifying and advocating for preventative care practices; publishing an annual CHP report; serving as a liaison between members and Health Share; and providing feedback on Health Share’s strategic plans. Health Share’s Council hosts quarterly public meetings and is one vehicle for community engagement.</td>
</tr>
<tr>
<td>OHP consumers</td>
<td>Abigail Lawrence</td>
<td>Abigail serves on both our CAC and our Board of Directors. She serves as the liaison between the CAC and Board to ensure two way communication, transparency and accountability. Abigail is one of our member consumer representatives.</td>
<td>Abigail will be maintaining seats on our Council and Board. She will support the onboarding of a second Council/Board member and will be involved in the recruitment of more OHP consumers for our Council. Abigail serves as one way to engage consumer voice in our processes and helps us remain connected to direct consumer needs.</td>
</tr>
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</table>

Abigail Lawrence

Health Share’s Community Advisory Council (CAC)
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**OHP consumers**

Parent Advisory Councils of Clackamas, Multnomah and Washington County Early Learning Hubs

Each of our three Early Learning Hub partners have parent advisory councils, made up of a diverse group of parents, including OHP members. They are an already organized body that is a great resource for community engagement for Health Share. They are deeply connected community members with important wisdom and insights.

Health Share has funded several trainings for parents and caregivers in partnership with these councils. The most recent was our Big Feelings parent conference, which addressed Early Childhood Mental Health as well as parental mental health.

**OHP Consumers**

Central City Concern

Central City Concern has a Health Service Advisory Committee (HSAC) with 12-15 members who can be current or recent consumers (within the last 3 years) of CCC. Health Share is committed to collaborate with communities and CCC represents a clear connection to fulfil that mission.

Our CAC has indicated they would like to get feedback on the CHP from other partners that have consumer advocates. We will seek input from their advisory council members. Building this relationship will help us maintain a presence with the population they serve such as those affected by homelessness and addictions.
### Table 1: Stakeholders to be included in the engagement process

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</thead>
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<td>OHP consumers</td>
<td>CareOregon Community Advisory Board (COCAB)</td>
<td>COCAB advises CareOregon’s Tri-County health improvement by hearing from our members, conducting focus groups and listening sessions, reviewing community health needs and advising on member-centric initiatives. COCAB meets the requirements of a CCO Community Advisory Council with 51% Consumer and 49% Community Partner membership.</td>
<td>Our CAC has indicated they would like to get feedback on the CHP from other partners that have consumer advocates. We have initiate outreach to the Council’s coordinators. The goal is to engage with this Council during the development of the 2019 CHP strategies. This will extend a broader reach of member voice in our CHP strategies.</td>
</tr>
<tr>
<td>OHP consumers, Providers</td>
<td>Multnomah County Health Department Adult Mental Health and Substance Abuse Advisory Council (AMHSAAAC)</td>
<td>AMHSAAAC is comprised of consumers, advocates, mental health and addiction providers, public partners and family members. It makes recommendations to the Mental Health and Addiction Services Division.</td>
<td>Health Share has initiated contact with County staff that supports the Advisory Council. The goal is for Council to provide feedback on future CHP strategies. First step will be to attend one of monthly Council’s meetings and determine the level of future engagement. This Council will support us in being responsive to consumers, advocates, mental health and addiction provides in Multnomah County.</td>
</tr>
<tr>
<td>OHP consumers, Providers</td>
<td>Washington County Behavioral Health Council</td>
<td>The Behavioral Health Council addresses prevention, intervention and treatment issues of adults and children with mental health, alcohol and drug addiction, gambling or other areas related to behavioral health. Membership includes consumers.</td>
<td>Staff will initiate outreach to County staff in order to establish a relationship with the Council in order to provide feedback to future CHP strategies. First steps include; participating in one of the monthly meetings, and establish future level of engagement. This Council will support us in being responsive to the needs of adults and children accessing Behavioral Health services in the Washington County service area.</td>
</tr>
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<tbody>
<tr>
<td><strong>OHP consumers, Providers</strong></td>
<td>Clackamas County, Mental Health and Addictions Council (MHAC)</td>
<td>Advisory body to the Clackamas County Board of County Commissioners and the Director of the Clackamas County BH Division on community needs, gaps in services, barriers and priorities related to providing mental health and addictions services in the county. Membership includes consumers.</td>
<td>Our CAC has indicated they would like to get feedback on the CHP from other partners that have consumer advocates. First steps include; participating in one of the monthly meetings, and establish future level of engagement. This Council will support us in being aware of potential gaps in services and barriers faced by consumers in Clackamas County.</td>
</tr>
<tr>
<td><strong>OHP consumers</strong></td>
<td>Clackamas County Developmental Disabilities Council</td>
<td>Advises the Director of HHS, Director of Social Services and the DD Program Manager in planning. Membership includes a minimum of five (5) families and/or persons with Intellectual Disabilities and Developmental Disabilities (ID/DD) or fifty percent (50%), whichever is greater.</td>
<td>Our CAC has indicated they would like to get feedback on future CHP strategies from consumers with an intellectual or developmental disability. First steps include; participating in one of the monthly meetings, and establish future level of engagement. This Council will help Health Share stay aware of potential barriers in care faced by consumers with intellectual and development disabilities.</td>
</tr>
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</table>

### Community-based organizations that address disparities and SDOH-HE (list in first column below)

| CBO | Oregon Food Bank | The Oregon Food Bank’s mission is to eliminate hunger and its root cause. One of our new CHP strategies focuses on food access. Health Share’s Council will invite stakeholders to provide feedback for CHP strategies including the Oregon Food Bank. | Health Share staff has initiated outreach with key staff from the Oregon Food Bank. Oregon Food Bank will be presenting current strategies for addressing food access at a future Council Meeting. Building this relationship will help us shape food access strategies in our upcoming. |

<p>| <strong>Part 1a.</strong> List stakeholder types to be included in the engagement process. | <strong>Part 1b.</strong> List specific agencies, organizations and individuals, based on the stakeholder types identified in Part 1a, with which the applicant will engage. Add additional rows under the stakeholder type as needed. | <strong>Part 1b.</strong> Describe why each listed agency, organization and individual was included. | <strong>Part 1b.</strong> Describe how Applicant plans to develop, maintain or strengthen relationships with each stakeholder and maintain a presence within the community. |</p>
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<td><strong>CBO</strong></td>
<td>Village Gardens</td>
<td>Village Gardens builds neighborhood economic and food resilience through leadership development, employment opportunities and a community-based food system model. One of Health Share’s CHP priorities includes food access and we see this organization as a potential partner in addressing food access in our region.</td>
<td>Health Share staff will initiate outreach to the organization as part of the stakeholder engagement around building Food Access strategies to begin in 2020. Building a relationship with this organization will help us strengthen our awareness and responsiveness to food access barriers and opportunities.</td>
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<td>Eca-Etabo Wasongolo</td>
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<tr>
<td><strong>CBO</strong></td>
<td>Zenger Farms</td>
<td>Zenger Farm is a non-profit farm and wetland in outer southeast Portland dedicated to promoting sustainable food systems, environmental stewardship, community development and access to good food for all. One of Health Share’s CHP priorities includes food access and we see this organization as a potential partner in addressing food access in our region.</td>
<td>Health Share staff will initiate outreach to the organization as part of the stakeholder engagement around building Food Access strategies to begin in 2020. Building a relationship with this organization will help us strengthen our awareness and responsiveness to food access barriers and opportunities in the SE Portland service area.</td>
</tr>
<tr>
<td></td>
<td>Mike Wenrick</td>
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<tr>
<td><strong>CBO</strong></td>
<td>Urban Gleaners</td>
<td>Urban Gleaners is a non-profit whose mission is to reduce food waste and eliminate hunger. One of Health Share’s CHP priorities includes food access and we see this organization as a potential partner in addressing food access in our region.</td>
<td>Health Share staff will initiate outreach to the organization as part of the stakeholder engagement around building Food Access strategies to begin in 2020. Building a relationship with this organization will support us in strengthening our awareness and responsiveness to food access barriers and opportunities in Multnomah County.</td>
</tr>
<tr>
<td></td>
<td>Tracey Oseran</td>
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<td><strong>CBO</strong></td>
<td>Q Center</td>
<td>The Q Center contributed in the last CHA report by facilitating listening sessions with their stakeholders. The Q Center serves as the largest community center in the Pacific Northwest for the LGBTQ2SIA+</td>
<td>Health Share staff will maintain this relationship for future opportunities in the next CHA or CHP cycle in Fall of 2020. This organization helps us maintain awareness on the LGBTQ2SIA communities in our service area.</td>
</tr>
<tr>
<td></td>
<td>Cameron Whitten</td>
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| CBO | Ant Farm  
Kathy Cancilla | Ant Farm contributed to our last CHA report by facilitating listening sessions with their members and continues to participate as part of the current HCWC collaborative effort. | Health Share staff will continue to look for opportunities to collaborate with them in the next CHA or CHP cycle in Fall of 2020. This organization supports our connection with youth in the Clackamas County service area. |
| CBO | Ecumenical Ministries of Oregon-Russian  
Oregon Social Services  
Jan Musgrove Elfers | This organization has two programs one serving the Russian population in the tri-county and the other addressing food access. Both programs may be a good stakeholder to inform CHP strategies. | Health Share staff will initiate outreach with agency to identify potential partnerships to provide feedback in future CHP strategies addressing food access and Social Connection. This will help us remain responsive to the community this agency supports. |
| CBO | NAYA- Native American Youth and  
Family Center | NAYA worked with us on the last CHA report by facilitating listening sessions with their members. We continue to collaborate with them on CHA and CHP activities. | Health Share staff will continue to look for opportunities to collaborate with NAYA for our next CHA or CHP cycle. This organization supports our connection with the Native American community. |
| CBO | Momentum Alliance  
Emily Lai | This organization collaborated with us by facilitating Community listening sessions for HCWC collaborative CHA development. | Health Share staff will continue to collaborate with agency leadership to identify opportunities to support CHP strategies around Social Connection. This will help us remain aware of current barriers faced by the youth population around Social Isolation. |
| CBO | APANO- Asian Pacific American  
Network of Oregon  
Chi Nguyen | This community partner contributed to our CHA by facilitating Community listening sessions for HCWC collaborative with a focus on the Asian and Pacific Islander population. | Health Share staff will continue to work with agency leadership to identify opportunities to support future CHP strategies around Social Connection with the Iraqi community. This will help us maintain an awareness of current barriers faced by the Asian Pacific Islander community around Social Isolation. |
| CBO | El Programa Hispano  
Edith Molina | Collaborated on the last CHA report by facilitating listening sessions with the Latinx community in SE Portland. | Health Share staff continue to work with agency leadership to identify opportunities to support CHP strategies. This will help us maintain an awareness of current barriers faced by the Latinx community around Social Isolation. |
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<td>CBO</td>
<td>Urban League of Portland Nkenge Harmon Johnson</td>
<td>Contributed in the last CHA report by facilitating listening sessions with their members.</td>
<td>Health Share staff will continue to engage agency leadership to support CHP strategies around Social Connection. This will assist us in maintaining our awareness of current barriers faced by the African American community.</td>
</tr>
<tr>
<td>CBO</td>
<td>Oregon Latino Health Coalition Olivia Quiroz</td>
<td>This organization is a potential partner in supporting CHP strategies around Social Connection for Latinx community living in Tri-County.</td>
<td>We will initiate outreach to identify opportunities to support CHP strategies around Social Connection by Spring of 2020.</td>
</tr>
<tr>
<td>CBO</td>
<td>Cascade AIDS Project</td>
<td>CAP collaborated with us to host listening sessions to their communities for the last HCWC CHA.</td>
<td>Health Share staff will continue to find opportunities to collaborate in the next CHA or CHP. This organization supports our connection with those living with HIV in our community.</td>
</tr>
<tr>
<td>CBO</td>
<td>NAMI- National Alliance of Mental Illness (Clackamas)</td>
<td>NAMI contributed in the last CHA report by facilitating listening sessions with their members and continues to participate in the HCWC collaborative activities.</td>
<td>Health Share staff will continue to look for future partnership opportunities in the next CHA or CHP cycle in Fall of 2020. This organization supports our connection with those living with a mental health condition in our community.</td>
</tr>
<tr>
<td>CBO</td>
<td>Friendly House Vaune Albanese</td>
<td>Friendly House contributed in the last CHA report by facilitating listening sessions with their members and continues to support as part of the current HCWC collaborative.</td>
<td>No further engagement needed at this moment agency will be recruited in the next CHA cycle to facilitate listening sessions in their community. This agency serves as community center for seniors and you located in NW Portland.</td>
</tr>
<tr>
<td>CBO</td>
<td>Aging Services Advisory Council</td>
<td>This community partner participates in the HCWC Collaborative community engagement activities use to develop our CHA.</td>
<td>No further engagement needed at this moment agency will be recruited in the next CHA cycle to facilitate listening sessions in their community. They help us maintain connection to older adults, people with disabilities and veterans in Multnomah County.</td>
</tr>
<tr>
<td>CBO</td>
<td>Sandy Adult Center</td>
<td>This community partner participates in the HCWC Collaborative community engagement activities use to develop our CHA.</td>
<td>No further engagement needed at this moment agency will be recruited in the next CHA cycle to facilitate listening sessions in their community. This agency helps us maintain connection to older population around social cohesion and social connectivity to seniors Clackamas County.</td>
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<td><strong>CBO</strong></td>
<td>Molalla Community Center</td>
<td>This community partner participates in the HCWC Collaborative community engagement activities use to develop our CHA.</td>
<td>No further engagement needed at this moment agency will be recruited in the next CHA cycle to facilitate listening sessions in their community. This agency helps us maintain connection to older population around social connectivity with the senior population in Clackamas County.</td>
</tr>
<tr>
<td><strong>CBO</strong></td>
<td>Disability Aging and Veterans Services</td>
<td>This community partner participates in the HCWC Collaborative community engagement activities use to develop our CHA.</td>
<td>No further engagement needed at this moment agency will be recruited in the next CHA cycle to facilitate listening sessions in their community. This agency helps us maintain connection to older population around social connectivity with the senior population in Washington County.</td>
</tr>
<tr>
<td><strong>CBO</strong></td>
<td>Disability Arts and Culture</td>
<td>This community partner participates in the HCWC Collaborative community engagement activities use to develop our CHA.</td>
<td>No further engagement needed at this moment agency will be recruited in the next CHA cycle to facilitate listening sessions in their community. This agency helps us maintain connection to the disabilities community through arts and building social cohesion.</td>
</tr>
<tr>
<td><strong>CBO</strong></td>
<td>Disability Justice Leaders Collaborative</td>
<td>This community partner participates in the HCWC Collaborative community engagement activities use to develop our CHA.</td>
<td>No further engagement needed at this moment agency will be recruited in the next CHA cycle to facilitate listening sessions in their community. This agency help us remain connected to the disability community and helps us remain responsive to the needs of this population.</td>
</tr>
<tr>
<td><strong>CBO</strong></td>
<td>We Can Do Better</td>
<td>This community partner participates in the HCWC Collaborative community engagement activities use to develop our CHA.</td>
<td>No further engagement needed at this moment agency will be recruited in the next CHA cycle to facilitate listening sessions in their community. This agency is a statewide health care advocacy organization; this helps us maintain awareness of statewide advocacy needs.</td>
</tr>
<tr>
<td><strong>CBO</strong></td>
<td>Elders in Action</td>
<td>Contributed in the last CHA report by facilitating listening sessions with the focus on the older adult population</td>
<td>No further engagement needed at this moment agency will be recruited in the next CHA cycle to facilitate listening sessions in their community. This agency support with advocacy for the older adults and helps us remain responsive to the needs of this population.</td>
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<td><strong>CBO</strong></td>
<td>Highland Christian Center</td>
<td>This community partner participated in the HCWC Collaborative community engagement activities use to develop our CHA by conducting listening sessions with the African American community.</td>
<td>No further engagement needed at this moment agency will be recruited in the next CHA cycle to facilitate listening sessions in their community. This is a place of worship for culturally specific population and helps us remain responsive to the needs of this population.</td>
</tr>
<tr>
<td><strong>CBO</strong></td>
<td>The Intertwine Alliance</td>
<td>This community partner facilitated listening sessions with their members in the HCWC Collaborative community engagement activities use to develop our CHA.</td>
<td>Health Share believes this organization can assist us in developing strategies to tackle social isolation. We will work with them as we develop our new CHP.</td>
</tr>
<tr>
<td><strong>CBO</strong></td>
<td>Liberation Street Church</td>
<td>This community partner facilitated listening sessions with their members in the HCWC Collaborative community engagement activities use to develop our CHA.</td>
<td>Begin outreach specifically around CHP strategy addressing Social connection in fall of 2020. Organization focus on the houseless community in Portland.</td>
</tr>
<tr>
<td><strong>CBO</strong></td>
<td>Lifeline Connections</td>
<td>This community partner facilitated listening sessions with their members in the HCWC Collaborative community engagement activities use to develop our CHA.</td>
<td>Initiate outreach specifically around CHP strategy addressing Social connection in fall of 2020. Organization focuses on substance use treatment center and serves population in the Pacific NW. This helps us remain aware of the needs of this population</td>
</tr>
<tr>
<td><strong>CBO-Provider</strong></td>
<td>Lifeworks Northwest</td>
<td>This community partner facilitated listening sessions with their members in the HCWC Collaborative community engagement activities use to develop our CHA.</td>
<td>Health Share will initiate conversations with key leadership of the organization to engage them in CHA or CHP development by Summer 2020. Mental Health Provider in Tri-County area.</td>
</tr>
<tr>
<td><strong>CBO</strong></td>
<td>Oregon Foundation for Reproductive Health</td>
<td>This community partner facilitated listening sessions with their members in the HCWC Collaborative community engagement activities use to develop our CHA.</td>
<td>No further engagement needed at this moment agency will be recruited in the next CHA cycle to facilitate listening sessions in their community. Agency helps us remain aware of advocacy needs around reproductive health.</td>
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<th>Oregon Public Health Institute</th>
<th>This community partner facilitated listening sessions with their members in the HCWC Collaborative community engagement activities use to develop our CHA.</th>
<th>Initiate outreach with partner to establish conversation of future engagement beyond CHA and CHP report by Summer 2020. Agency helps us maintain awareness of any public health advocacy needs and best practices.</th>
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<td>Provider</td>
<td>Veterans Affairs Hospital</td>
<td>This community partner facilitated listening sessions with their members in the HCWC Collaborative community engagement activities use to develop our CHA. They focused specifically on Veterans.</td>
<td>No further engagement needed at this moment agency will be recruited in the next CHA cycle to facilitate listening sessions with the Veterans community. Provider helps us remain connected to the needs of the Veteran community.</td>
</tr>
<tr>
<td>CBO</td>
<td>Oregon Spinal Cord Injury</td>
<td>This is a community-based agency serving the disability community and providing education around spinal cord injuries.</td>
<td>Health Share staff currently supports agency around strategic support and Community Health Worker training/alignment</td>
</tr>
<tr>
<td>CBO</td>
<td>Project Access NOW Linda Nilsen</td>
<td>Health Share has been supporting the development of a Regional Community Health Network (RCHN) operated by PANOW that is working to strengthen an integrated system of services to connect individuals and families to consistent access to health care, social services and other resources supporting SDOH-HE.</td>
<td>Health Share is a funder of this initiative and serves as a member of the RCHN Leadership Team. We will continue to support this effort in our region. A Health Share staff member serves on the Governing Board of PANOW/RCHN as well.</td>
</tr>
<tr>
<td>CBO</td>
<td>Help Me Grow Oregon Hannah Lobingier</td>
<td>Health Share and our ELH partners have been supporting the development of Help Me Grow, a national model for promoting children’s optimal development through early detection of young children at risk for developmental delays and link them to appropriate community-based services through a centralized access point.</td>
<td>Health Share is a funder of this initiative and serves on the Help Me Grow Advisory Committee with a broad and diverse group of cross-sector stakeholders. This Advisory Committee meets quarterly and is an excellent vehicle for community engagement. We will continue to support this effort in our region.</td>
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<td>CBO</td>
<td>Adelante Mujeres Bridget Cooke</td>
<td>Adelante Mujeres provides holistic education and empowerment opportunities to low income Latina women and their families to ensure full participation and active leadership in the community. This is a newer relationship for Health Share that has happened because of the Network. This has been an effective way of strengthening Health Share’s relationships in the LatinX community.</td>
<td>Member of Health Share’s Regional Kindergarten Readiness Network, which is addressing the Social Determinants of Health and Education for children and families in our region and will be an effective vehicle for cross-sector community engagement, system alignment/improvement and advocacy. Several of Adalante Mujeres’ staff members attend monthly meetings of the Network at Health Share. We plan to become more involved in their initiatives going forward.</td>
</tr>
<tr>
<td>CBO</td>
<td>All Born In/NW Down Syndrome Association Angela Jarvis-Holland</td>
<td>This organization creates and nurtures a loving and inclusive community celebrating every person with a disability. Through their joining the Network, we have had the benefit of deep expertise from the lived experience of the disability community.</td>
<td>Member of Health Share’s Regional Kindergarten Readiness Network, which is addressing the Social Determinants of Health and Education for children and families in our region and will be an effective vehicle for cross-sector community engagement, system alignment/improvement and advocacy. Their Executive Director attends monthly meetings of the Network at Health Share and is a powerful advocate and ally. Health Share has been a Sponsor of All Born In’s large Annual Conference for the past 3 years and several staff members have attended this event.</td>
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<td>CBO</td>
<td>Children's Institute</td>
<td>Through advocacy, research, policy, and practice, Children's Institute works to ensure that young children have the programs and services they need to nurture their love of learning and prepare them for success in school and beyond. This is a long-standing relationship for Health Share and it has continued to strengthen over the years. We sit on a number of Advisory Committees and other groups with their staff.</td>
<td>Member of Health Share’s Regional Kindergarten Readiness Network, which is addressing the Social Determinants of Health and Education for children and families in our region and will be an effective vehicle for cross-sector community engagement, system alignment/improvement and advocacy. A Children’s Institute staff member is a very active member at monthly meetings of the Network, specifically with the Systems Alignment Workgroup. Health share has also funded Children’s Institute to place a culturally specific CHW in Earl Boyles Elementary School.</td>
</tr>
<tr>
<td>CBO</td>
<td>Greater Than</td>
<td>The mission of Greater Than is to support and empower students from poverty-impacted communities to thrive in school, college and career. This is a newer relationship for Health Share, and it continues to grow quickly. Their staff have joined the Design Team of the Network and taken an active role in the Network’s Data and Metrics Workgroup. They are an important key community partner doing effective place-based collective impact in a school catchment area where many of Health Share’s members reside, and likely attend.</td>
<td>Member of Health Share’s Regional Kindergarten Readiness Network, which is addressing the Social Determinants of Health and Education for children and families in our region and will be an effective vehicle for cross-sector community engagement, system alignment/improvement and advocacy. In addition to very active participation in the Network, Health Share has had a number of meetings with this organization along with the superintendent of the Reynolds School District and Home Forward to explore a data sharing partnership to strategize better ways to target resources to students. Health Share has sponsored their Annual Event – Rising – for the last 2 years and we see them as strong partners.</td>
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<td>CBO</td>
<td>Immigrant and Refugee Organization</td>
<td>The Immigrant and Refugee Community Organization (IRCO) serves the holistic needs of immigrants, refugees, and mainstream community members in Oregon and SW Washington. As a community-based organization, we empower children, youth, families and elders from around the world to build new lives and become self-sufficient. Health Share is deeply committed to health equity and sees its strong relationship with IRCO as critical to this aim.</td>
<td>Member of Health Share’s Regional Kindergarten Readiness Network, which is addressing the Social Determinants of Health and Education for children and families in our region and will be an effective vehicle for cross-sector community engagement, system alignment/improvement and advocacy. Health Share is also collaborating with IRCO, Early Learning Multnomah and Multnomah Early Childhood Program to conduct world cafes with refugee population to learn from and inform our work around developmental screening and referral/follow-up.</td>
</tr>
<tr>
<td>CBO</td>
<td>Latino Network</td>
<td>A Latino-led education organization, grounded in culturally specific practices and services that lifts up youth and families to reach their full potential. This is a newer relationship for Health Share that has happened because of the Network. Their commitment to equity aligns well with Health Share’s.</td>
<td>Member of Health Share’s Regional Kindergarten Readiness Network, which is addressing the Social Determinants of Health and Education for children and families in our region and will be an effective vehicle for cross-sector community engagement, system alignment/improvement and advocacy. Latino Network’s staff attend monthly meetings of the Network at Health Share. This has been an effective way of strengthening Health Share’s relationships in the LatinX community and we are looking to create a much stronger relationship with them going forward.</td>
</tr>
<tr>
<td>CBO</td>
<td>Oregon Center for Children and Youth with Special Health Care Needs (OCCYSHN)</td>
<td>OCCYSHN is Oregon's <a href="#">Title V</a> public health agency for children and youth with special health care needs (CYSHCN). We identify and address issues affecting this population. We share a commitment to serving Health Share’s members with have special health care needs.</td>
<td>Member of Health Share’s Regional Kindergarten Readiness Network, which is addressing the Social Determinants of Health and Education for children and families in our region and will be an effective vehicle for cross-sector community engagement, system alignment/improvement and advocacy. Their Executive Director is very active in the Network’s Mapping the Money workgroup and attends monthly meetings.</td>
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<td>CBO</td>
<td>Self Enhancement Inc.</td>
<td>Self Enhancement, Inc (SEI) is dedicated to guiding underserved youth to realize their full potential. Working with schools, families, and partner community organizations, SEI provides support, guidance, and opportunities to achieve personal and academic success. SEI is a trusted community partner in N. Portland and Health Share is working hard to strengthen and align our work. This is a newer relationship for us.</td>
<td>Member of Health Share’s Regional Kindergarten Readiness Network, which is addressing the Social Determinants of Health and Education for children and families in our region and will be an effective vehicle for cross-sector community engagement, system alignment/improvement and advocacy. Several of SEI’s staff have joined the Network Convening’s and panel discussions over the last year. We plan to more deeply engage with them going forward.</td>
</tr>
<tr>
<td>CBO</td>
<td>United Way of the Columbia-Willamette</td>
<td>UW’s mission is to invest in our region’s kids so they are free from poverty and free to reach their potential. Their priority is addressing the root causes of poverty and in doing so, putting racial equity at the center of their work. This is a longstanding and growing partner of Health Share’s. UW’s footprint in the metro region, along with their focus on addressing poverty and racial equity make them a natural partner for Health Share in our SDoH/HE work.</td>
<td>Member of Health Share’s Regional Kindergarten Readiness Network, which is addressing the Social Determinants of Health and Education for children and families in our region and will be an effective vehicle for cross-sector community engagement, system alignment/improvement and advocacy. UW houses Early Learning Multnomah, one of Health Share’s primary partners. We meet twice monthly with staff from UW/ELM regarding a wide variety of topics from developmental screening to early childhood mental health consultation. We plan to continue to collaborate closely with them on our aligned projects and goals. OCF was an initial investor (one of 5) in the Kindergarten Readiness Network and they continue to be very active members.</td>
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<td>CBO</td>
<td>Clackamas Workforce Partnership</td>
<td>A nonprofit organization that serves as an advocate for workforce development within Clackamas County and the State of Oregon. Addresses critical workforce, educational, and training challenges, and develop a skilled workforce that meets the needs of businesses and strengthens the local economy of Clackamas County. Employment and workforce development issues are important social determinants of health. This new partnership represents a new and exciting sector that Health Share is collaborating with.</td>
<td>Member of Health Share’s Regional Kindergarten Readiness Network, which is addressing the Social Determinants of Health and Education for children and families in our region and will be an effective vehicle for cross-sector community engagement, system alignment/improvement and advocacy. CEO of Clackamas Workforce Partnership serves as Chair of the Early Learning Hub of Clackamas County, which Health Share staff also sits on. This person has also been active attending monthly meetings at Health Share of the Mapping the Money Workgroup of the Network.</td>
</tr>
<tr>
<td>CBO</td>
<td>Metropolitan Family Services</td>
<td>MFS is a non-profit that helps people move beyond the limitations of poverty, inequity and social isolation. This is a newer partnership with Health Share and our two organization’s share many similar goals related to addressing the SDoH/HE such as poverty, and racism.</td>
<td>Member of Health Share’s Regional Kindergarten Readiness Network, which is addressing the Social Determinants of Health and Education for children and families in our region and will be an effective vehicle for cross-sector community engagement, system alignment/improvement and advocacy. MFS staff sit on the Governance Council of the Early Learning Hub of Clackamas County that meets monthly. Health Share staff also sit on this group that has afforded growing opportunities for partnership.</td>
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<td>CBO</td>
<td>Child Care Resource and Referral (CCR&amp;R)</td>
<td>CCR and R’s mission is to strengthen our community by supporting early childhood professionals, providing leadership in the field and by promoting access to high quality child care experiences for all children and families inclusive of every race, ethnicity, language, gender, age, ability or income level. Access to quality childcare and workforce development of this sector are critical social determinants of health. Health Share has a well-established relationship with CCR&amp;R of Multnomah County and have worked with them on a number of committees and projects over the years.</td>
<td>Member of Health Share’s Regional Kindergarten Readiness Network, which is addressing the Social Determinants of Health and Education for children and families in our region and will be an effective vehicle for cross-sector community engagement, system alignment/improvement and advocacy. Health Share staff meet regularly with Executive Director through the Governance Council of Early Learning Multnomah at monthly meetings. We have also collaborated on a number of trainings and continuing education events for providers related to Early Childhood Mental Health.</td>
</tr>
<tr>
<td></td>
<td>Christine Waters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CBO</td>
<td>Swindles Family Resource Center</td>
<td>Swindells Resource Center of Providence Child Center supports parents and caregivers of children who have special needs, developmental delays or disabilities. This is a strong and well-established relationship of Health Share’s. We have funded several pilot projects here very successfully including Help Me Grow and the Peer Family Navigator Project.</td>
<td>Member of Health Share’s Regional Kindergarten Readiness Network, which is addressing the Social Determinants of Health and Education for children and families in our region and will be an effective vehicle for cross-sector community engagement, system alignment/improvement and advocacy. Health Share staff meet bi-monthly with Swindell’s staff on a number of shared projects including Help Me Grow, Peer Family Navigators, and training opportunities. They are one of our strongest regional partnerships.</td>
</tr>
<tr>
<td></td>
<td>Hannah Lobingier</td>
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<td><strong>CBO</strong></td>
<td>Social Venture Partners Lauren Johnson</td>
<td>SVP practices venture philanthropy – a model that mimics venture capital investing to make social impact. Currently focused on ensuring children living in poverty have access to high quality preschool. SVP’s focus on children living in poverty is aligned with Health Share’s strategic goals. This is a strong partnership of Health Share’s.</td>
<td>Member of Health Share’s Regional Kindergarten Readiness Network, which is addressing the Social Determinants of Health and Education for children and families in our region and will be an effective vehicle for cross-sector community engagement, system alignment/improvement and advocacy. SVP was an initial investor (one of 5) in the Kindergarten Readiness Network and they continue to be very active members.</td>
</tr>
<tr>
<td><strong>CBO</strong></td>
<td>Oregon Community Foundation Mary Louise McClintock Abby Bush</td>
<td>Oregon Community Foundation puts donated money to work in Oregon – more than $100 million in grants and scholarships annually. Since 1973, OCF grant making, research, advocacy and community-advised solutions have helped individuals, families, businesses and organizations create charitable funds to improve lives for all Oregonians. This is a newer partner of Health Share’s over the last year. There is much common ground and many opportunities to align some of our resources and funding for bigger impact.</td>
<td>Member of Health Share’s Regional Kindergarten Readiness Network, which is addressing the Social Determinants of Health and Education for children and families in our region and will be an effective vehicle for cross-sector community engagement, system alignment/improvement and advocacy. OCF was an initial investor (one of 5) in the Kindergarten Readiness Network and they continue to be very active members. Health Share staff serves as a member of OCF’s Early Childhood Funders Collaborative that meets quarterly.</td>
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<td>CBO</td>
<td>Oregon Pediatric Improvement Partnership</td>
<td>The Oregon Pediatric Improvement Partnership (OPIP) is a public/private partnership dedicated to building health and improving outcomes for children and youth. OPIP’s interest in pediatric health complexity and risk stratification is of growing interest to Health Share and our partners.</td>
<td>Member of Health Share’s Regional Kindergarten Readiness Network, which is addressing the Social Determinants of Health and Education for children and families in our region and will be an effective vehicle for cross-sector community engagement, system alignment/improvement and advocacy. OPIP meets quarterly with Health Share staff on a variety of issues ranging from pediatric risk stratification to language disparities in developmental screening. They also attend several of our standing committees such as the Young Child Wellness Council.</td>
</tr>
<tr>
<td>CBO</td>
<td>Reach Out and Read</td>
<td>ROR give young kids a foundation for success by incorporating books into pediatric care and encouraging families to read aloud together. ROR is an important organization that bridges the worlds of primary care and early childhood education. Health Share has a well-established relationship with this organization.</td>
<td>Health Share participates on the ROR state advisory board and is invested in early life health efforts. Health Share funded ROR to do an inventory of tri-county clinics that were implementing ROR and identify TA that was needed.</td>
</tr>
<tr>
<td>Youth Advocacy</td>
<td>Oregon Foster Youth Connection (OFYC)</td>
<td>OFYC empowers current and former foster youth to share their voice and to be heard in key decisions affecting children and youth in foster care. With peer support, leadership skills, and civic engagement, these inspiring youth take the lead in improving their own lives and the lives of thousands of kids in Oregon’s foster care system.</td>
<td>Health Share invites OFYC youth advocates participating on steering committees and workgroups that impact youth in care. OFYC has participated in Health Share’s Foster Care Advanced Primary Care Learning Collaborative, the Foster Care Medical Home Alignment Workgroup, and in early explorations of Pediatric Health Complexity. Health Share staff meet quarterly with OFYC on these various initiatives.</td>
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RFA4690-Health Share of Oregon- Att10- RFA Community Engagement Plan Tables
### Table 1: Stakeholders to be included in the engagement process

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<tr>
<td>Providers</td>
<td>Health Share’s Clinical Advisory Panel (CAP)</td>
<td>The CAP will be set up under Health Share’s new structure and chartered to provide strategic and collective leadership on clinical transformation work towards Health Share’s goal of achieving the Triple Aim. The CAP will include leadership from our partner and provider organizations to ensure alignment on clinical transformation efforts and other regional priorities.</td>
<td>Health Share will charter and launch this CAP and develop shared clinical priorities for the tri-county region. These groups will meet on a regular basis to achieve their goals and priorities.</td>
</tr>
<tr>
<td>Providers</td>
<td>Health Share’s Pediatric Council</td>
<td>The Pediatric Council will be set up under Health Share’s new structure to monitor the strategic, clinical, financial, operational aspects of the child-serving system. Membership will include pediatric leaders across sectors and delivery systems all working to improve the quality of care for children in our region.</td>
<td>Health Share will charter and launch this Council and develop shared clinical priorities for the tri-county region. These groups will meet on a regular basis to achieve their goals and priorities.</td>
</tr>
<tr>
<td>Providers</td>
<td>Health Share’s Behavioral Health Council</td>
<td>The Behavioral Health Council will be set up under Health Share’s new structure to strategize and monitor the Behavioral Health impacts and opportunities of the new organizational structure. It will focus on the strategic, clinical, financial and operational aspects of shifting the Behavioral Health benefit to the Integrated Community Network, as well as partner accountability for integrating Behavioral Health into Primary Care.</td>
<td>Health Share will charter and launch this Council and develop shared clinical priorities for the tri-county region. These groups will meet on a regular basis to achieve their goals and priorities.</td>
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**Table 1: Stakeholders to be included in the engagement process**

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<td>Providers</td>
<td>Health Share’s Council of Clinical Advisors</td>
<td>This group is comprised of oral, physical, and behavioral health providers working in the prenatal and early childhood space. They are a cross-discipline, cross-health plan advisory group to Health Share.</td>
<td>This group currently meets bi-monthly and would be a natural and existing venue to get engagement from these stakeholders.</td>
</tr>
<tr>
<td>Providers</td>
<td>Coalition of Community Health Clinics Janelle Mellor</td>
<td>The Coalition is a hub for 15 Federally Qualified Health Centers (FQHCs) and Community Sponsored Clinics (CSC’s) that come together as strategic partners in the region working to achieve the Triple Aim, in part, by building a stronger primary and specialty care delivery network and working toward health equity.</td>
<td>Health Share has provided technical assistance and training for the Coalition. Health Share staff will continue to discuss future opportunities of engagement; such as supporting the Health Equity Program (Healthier Together). This program serves as a vehicle to train providers serving our members in the Tri-County region and supports us in maintaining a strong relationship with our service providers.</td>
</tr>
<tr>
<td>Providers</td>
<td>Virginia Garcia Gil Munoz</td>
<td>Virginia Garcia is one of the largest health centers in Washington County and has an active Patient Advisory Council that can further provide feedback around our CHP strategies.</td>
<td>Health Share staff will outreach to leadership that supports the Patient Advisory Council by January 2020. Connection to other advisory councils will extend our knowledge to better understand member needs in the Washington County.</td>
</tr>
<tr>
<td>Providers</td>
<td>Wallace Medical Concern Lisa Cline</td>
<td>Wallace Medical Concern has an active Board represented of consumer voice that can further provide feedback around our CHP strategies in representation of the SE Portland Community.</td>
<td>Health Share staff will initiate outreach to leadership that supports the Patient Advisory Council by January 2020. Connection to other advisory councils will extend our knowledge to better understand member needs in the SE Portland service area.</td>
</tr>
<tr>
<td>Providers</td>
<td>Outside In Patricia Patron</td>
<td>Outside In contributed in the last CHA report by facilitating listening sessions with their members and continues to participate as part of the current HCWC collaborative.</td>
<td>We plan to engage them in next CHA or CHP report specifically around their Patient Advisory Council. Building connection to other advisory councils will extend our knowledge to better understand our youth population.</td>
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<td>Providers</td>
<td>Foster Care Medical Homes</td>
<td>These providers offer Foster Care Medical Home models of primary care for children engaged with state systems and have been active partners in Health Share’s efforts to transform care for our kids in foster care.</td>
<td>Health Share has worked with these clinics over the past four years to develop and implement advanced primary care models. Health Share continues to convene clinical and administrative leadership from clinics to continue to refine and integrate the model of care.</td>
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<tr>
<td></td>
<td>Hillsboro Pediatrics</td>
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<td></td>
<td>Terrie Molin, Randall Children’s Pediatrics</td>
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<td></td>
<td>Christian Huber OHSU General Pediatrics</td>
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<td></td>
<td>Tam Grigsby Metropolitan Pediatrics</td>
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<tr>
<td></td>
<td>Resa Bradeen</td>
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**Providers, behavioral health (list in first column below)**

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<th>Behavioral Health Provider</th>
<th>TriCounty Behavioral Health Providers Association Sarah Buckley</th>
<th>This group convenes providers for building infrastructure and advocacy for specialty BH providers in the region.</th>
<th>Health Share meets bi-monthly with this group for operational and transformational efforts in BH.</th>
</tr>
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<tr>
<td>Behavioral Health Provider</td>
<td>Alliance of Culturally Specific Providers Pierre Morin</td>
<td>This group convenes monthly; representatives from the county Behavioral Health plans attend the meeting to get feedback about continued enhancement of culturally specific BH services.</td>
<td>Health Share and county representatives will continue to meet bi-monthly with this group.</td>
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<tr>
<td>Psychological Evaluation Services</td>
<td>Mindsights</td>
<td>This provider administers the RAPID assessment to children entering foster care in Multnomah County. The RAPID is an enhanced mental health assessment designed for the population.</td>
<td>Health Share funds the RAPID through a unique set of billing codes. Health Share, Mindsights, Multnomah County, and District 2 DHS continue to meet monthly to review processes and build pathways to ongoing services and supports.</td>
</tr>
<tr>
<td>Behavioral Health Provider</td>
<td>Clackamas County Behavioral Health</td>
<td>As the current BH plan, meet weekly to address integration of BH services in primary care, primary care in specialty BH and moving forward, an integrated BH benefit with the county supporting specialty populations such as high-risk adults and children and their families.</td>
<td>Weekly, initially and then monthly ongoing engagement between the county and Health Share-CareOregon to address access and expansion as it relates to the integration of BH benefits and the BH services overall.</td>
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<tr>
<td>Behavioral Health Provider</td>
<td>Multnomah County Behavioral Health</td>
<td>As the current BH plan, meet weekly to address integration of BH services in primary care, primary care in specialty BH and moving forward, an integrated BH benefit with the county supporting specialty populations such as high-risk adults and children and their families.</td>
<td>Weekly, initially and then monthly ongoing engagement between the county and Health Share-CareOregon to address access and expansion as it relates to the integration of BH benefits and the BH services overall.</td>
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<tr>
<td>Behavioral Health Provider</td>
<td>Washington County Behavioral Health</td>
<td>As the current BH plan, meet weekly to address integration of BH services in primary care, primary care in specialty BH and moving forward, an integrated BH benefit with the county supporting specialty populations such as high-risk adults and children and their families.</td>
<td>Weekly, initially and then monthly ongoing engagement between the county and Health Share-CareOregon to address access and expansion as it relates to the integration of BH benefits and the BH services overall.</td>
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*Providers, oral health (list in first column below)*
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<td>Oral Health Provider</td>
<td>Dental 3 (D3)</td>
<td>Collaborative of partners to further oral health with the goal of reaching community that may not otherwise seek care.</td>
<td>Health Share is working in partnership with D3 to increase aligned efforts and address disparities in oral care.</td>
</tr>
<tr>
<td>Oral Health Provider</td>
<td>CareOregon Dental</td>
<td>CareOregon dental plan’s mission is to cultivate individual well-being and community health through partnerships, shared learning and innovation. They will be a contracted dental care organization.</td>
<td>CareOregon will play a leadership role in supporting the Dental Operating Committee and community engagement with members.</td>
</tr>
<tr>
<td>Oral Health Provider</td>
<td>Kaiser Permanente Dental</td>
<td>Kaiser Permanente Dental’s mission is to improve the health of their members and the communities in which they serve and will be contracted as a Dental Care Organization. Kaiser Permanente Dental is also an integrated delivery system integrating dental and medical care for members.</td>
<td>Kaiser Permanente will participate in the Dental Operating Committee and support community investments in the community such as dental service days, providing care to members and other low-income community members in the communities in which they live.</td>
</tr>
<tr>
<td>Oral Health Provider</td>
<td>ODS</td>
<td>ODS, or MODA, will be contracted with Health Share as a Dental Care Organization.</td>
<td>Health Share will engage ODS and their leadership team to participate in the Dental Operating Committee.</td>
</tr>
<tr>
<td>Oral Health Provider</td>
<td>Willamette Dental Group</td>
<td>Willamette Dental Group’s mission is to deliver proactive patient care through a partnership with our patients to stop the disease-repair cycle by means of evidence-based methods of prevention and treatment. Willamette will be contracted as a dental care organization with Health Share, and is an integrated delivery system.</td>
<td>Willamette Dental will participate in the Dental Operating Committee with Health Share and will serve as an extension of our dental partners with their work in the community.</td>
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Providers, long term services and supports (list in first column below)
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<td>Long Term Care Services and Supports System</td>
<td>Multnomah County Aging, Disability and Veteran Services Division Lee Girard</td>
<td>We have a signed MOU with this agency.</td>
<td>Health Share has included our community partners in our Care Integration Workgroup. This has strengthened our relationship with AAA/APD and our partners. Since including them, our Intensive Care Coordination Conferences have increased &amp; we have plan partners that are now implementing these conferences. We expect our relationships to continue with these increased activities.</td>
</tr>
<tr>
<td>Long Term Care Services and Supports System</td>
<td>Washington County Disability, Aging &amp; Veteran Services Sia Lindstrom</td>
<td>We have a signed MOU with this agency.</td>
<td>Health Share has included our community partners in our Care Integration Workgroup. This has strengthened our relationship with AAA/APD and our partners. Since including them, our Intensive Care Coordination Conferences have increased &amp; we have plan partners that are now implementing these conferences. We expect our relationships to continue with these increased activities.</td>
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<tr>
<td>Long Term Care Services and Supports System</td>
<td>Clackamas County Social Services Division Brenda Durbin</td>
<td>We have a signed MOU with this agency.</td>
<td>Health Share has included our community partners in our Care Integration Workgroup. This has strengthened our relationship with AAA/APD and our partners. Since including them, our Intensive Care Coordination Conferences have increased &amp; we have plan partners that are now implementing these conferences. We expect our relationships to continue with these increased activities.</td>
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<td>Long Term Care Services and Supports System</td>
<td>Clackamas County APD Jillian Johnson</td>
<td>We have a signed MOU with this agency.</td>
<td>Health Share has included our community partners in our Care Integration Workgroup. This has strengthened our relationship with AAA/APD and our partners. Since including them, our Intensive Care Coordination Conferences have increased &amp; we have plan partners that are now implementing these conferences. We expect our relationships to continue with these increased activities.</td>
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<td>Washington County APD</td>
<td>We have a signed MOU with this agency.</td>
<td>Health Share has included our community partners in our Care Integration Workgroup. This has strengthened our relationship with AAA/APD and our partners. Since including them, our Intensive Care Coordination Conferences have increased &amp; we have plan partners that are now implementing these conferences. We expect our relationships to continue with these increased activities.</td>
</tr>
<tr>
<td>Long Term Care Services and Supports System</td>
<td>Oregon Wellness Network (OWN)</td>
<td>OWN is a division of Oregon’s Association of Area Agencies on Aging and Disabilities. OWN is serving as a central hub for our region providing a centralized, coordinated model for service provision by incorporating uniform logistical practices for recruitment, referral, enrollment, marketing, quality assurance, and evaluation for SDOH services such as self-management and education programs and social services.</td>
<td>Health Share has started to build a partnership with this group focused on the availability and coordination of DPP in our region. We hope to strengthen our partnership through this process to increase access to these supports for our communities.</td>
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Providers, traditional health workers (list in first column below)

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<th>CBO</th>
<th>Oregon Community Health Worker Association (ORCHWA)</th>
<th>ORCHWA supports culturally specific community-based Community Health Workers (CHWs) and Community Education Workers (CEWs), which is an integral part of our workforce. They are a trusted community-based organization that supports, employs, advocates, and aids in advancing the CHW workforce.</th>
<th>Current engagement in multiple capacities with ORCHWA. Health Share is an active investor and has provided investment initially in the Warriors of Wellness program and currently in year two of a two-year investment. This partnerships supports us in maintain a presences with culturally specific community-based organizations in the tri-county region.</th>
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### Table 1: Stakeholders to be included in the engagement process

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| Peer Delivered Services | Oregon Family Support Network (OFSN)  
Sandy Bumpus  
Youth ERA (YE)  
Desiree Bansile | OFSN and YE provide peer-delivered Family Support Specialists and Youth Support Specialists respectively. | Health Share contracts with OFSN and YE to provide peer specialists for youth and families engaged in Wraparound services, as well as to support youth and family members who participate in the regional System of Care governance committees. |
| Peer-run organization (CBO), consumers | 4th Dimension Recovery Center  
Tony Vezina | They are a trusted community-based organization that supports, employs, advocates, and provides support to peers in recovery and mentorship. | Health Share engages with 4th Dimension, at minimum quarterly to discuss how to support recovery peer efforts for young people. Health Share has also engaged 4th Dimension in reviewing and contributing to creation of an RFA for peers under the BH Investment and will continue to deepen relationship with regular communication. |
| CBO, consumers | Regional Peer Facilitation Center  
Eric Martin | They are a trusted community-based organization that supports, employs, advocates, and aids in advancing the recovery peer workforce – specifically in the area of providing education and information to peers. | Health Share engages with Eric Martin as a content expert in the peer workforce. Health Share is working to solidify investment in the Regional Peer Facilitation Center to support peer workforce development. Health Share will continue to have regular communication with the Center to deepen relationship and stay abreast to current workforce efforts, barriers, etc. |

### Providers, health care interpreters (list in first column below)

| Interpreters Association | OHCIA – Oregon Health Care Interpreters Association  
Susy Molano | Oregon Interpreters Association supports Oregon’s interpreters by facilitating interpreter training and advocating for this profession within Health Systems. | Currently, a staff member of the Health Equity team serves in OHCIA’s Pacific NW Advisory Group. We plan to maintain that seat. The Advisory Council remains closely connected with Health Interpreters in our service area and supports us in maintain awareness of potential language access barriers faced by our members. |

### Early learning hubs (list in first column below)
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<td>Early Learning Hub</td>
<td>Early Learning Hub of Clackamas County</td>
<td>Health Share serves on the Governance Council of the Hub and meets monthly with the regional hubs together. We have identified shared regional goals and initiatives to improve health and education outcomes for the children and families in our region we are both serving. The Hubs are critical partners in our community engagement work.</td>
<td>Health Share works very closely with our hubs on a variety of projects, including funding Help Me Grow Liaisons in each hub/county. We serve on their governance councils and have identified shared goals and initiatives that we will work on jointly. We meet at least twice a month with them on a variety of shared projects. Health Share provides them with Data Snapshots of their Medicaid members, which helps them with their strategy development and reporting.</td>
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<tr>
<td>Early Learning Hub</td>
<td>Early Learning Washington Co.</td>
<td>Health Share serves on the Governance Council of the Hub and meets monthly with the regional hubs together. We have identified shared regional goals and initiatives to improve health and education outcomes for the children and families in our region we are both serving. The Hubs are critical partners in our community engagement work.</td>
<td>Health Share works very closely with our hubs on a variety of projects, including funding Help Me Grow Liaisons in each hub/county. We serve on their governance councils and have identified shared goals and initiatives that we will work on jointly. We meet at least twice a month with them on a variety of shared projects. Health Share provides them with Data Snapshots of their Medicaid members, which helps them with their strategy development and reporting.</td>
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<td>Early Learning Hub</td>
<td>Early Learning Multnomah</td>
<td>Health Share serves on the Governance Council of the Hub and meets monthly with the regional hubs together. We have identified shared regional goals and initiatives to improve health and education outcomes for the children and families in our region we are both serving. The Hubs are critical partners in our community engagement work.</td>
<td>Health Share works very closely with our hubs on a variety of projects, including funding Help Me Grow Liaisons in each hub/county. We serve on their governance councils and have identified shared goals and initiatives that we will work on jointly. We meet at least twice a month with them on a variety of shared projects. Health Share provides them with Data Snapshots of their Medicaid members, which helps them with their strategy development and reporting.</td>
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<td><strong>Local public health authorities (list in first column below)</strong></td>
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| Clackamas County Public Health | Clackamas County Public Health Department  
Rich Swift  
Philip Joyner-Mason | Health Share collaborates with our LPHA in multiple ways to strengthen our alignment and impact in our communities. We meet monthly with PH directors, serve on their Public Health Advisory Board, participate in CHP committees, have county reps on our CAC to ensure CHP alignment, and fund a regional initiative on vaccine hesitancy. | We will continue our current efforts and expand funding to LPHAs for their contributions to the health of our communities. Currently, one county staff serves as part of our CAC and provides essential advocacy and connection to the Clackamas County community and their needs. |
| Multnomah County Public Health | Multnomah County Health Department  
Rachael Banks  
Natasha Smith | Health Share collaborates with our LPHA in multiple ways to strengthen our alignment and impact in our communities. We meet monthly with PH directors, participate in CHP committees, have county reps on our CAC to ensure CHP alignment, and fund a regional initiative on vaccine hesitancy. | We will continue our current efforts and expand funding to LPHAs for their contributions to the health of our communities. Currently, one county staff serves as part of our CAC and provides essential advocacy and connection to the Multnomah County community and their needs. |
| Washington County Public Health | Washington County Health Department  
Marni Kuyl  
Tricia Mortell | Health Share collaborates with our LPHA in multiple ways to strengthen our alignment and impact in our communities. We meet monthly with PH directors, participate in CHP committees, have county reps on our CAC to ensure CHP alignment, and fund a regional initiative on vaccine hesitancy. | We will continue our current efforts and expand funding to LPHAs for their contributions to the health of our communities. Currently, one county staff serves as part of our CAC and provides essential advocacy and connection to the Washington County community and their needs. |
| **Local mental health authorities (list in the first column below)** | | | |
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<td>LMHA</td>
<td>Clackamas County Behavioral Health Mary Rumbaugh</td>
<td>As the current BH plan, meet weekly to address integration of BH services in primary care, primary care in specialty BH and moving forward, an integrated BH benefit with the county supporting specialty populations such as high-risk adults and children and their families.</td>
<td>Weekly, initially and then monthly ongoing engagement between the county and Health Share-CareOregon to address access and expansion as it relates to the integration of BH benefits and the BH services overall.</td>
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<tr>
<td>LMHA</td>
<td>Multnomah County Behavioral Health Ebony Clarke</td>
<td>As the current BH plan, meet weekly to address integration of BH services in primary care, primary care in specialty BH and moving forward, an integrated BH benefit with the county supporting specialty populations such as high-risk adults and children and their families.</td>
<td>Weekly, initially and then monthly ongoing engagement between the county and Health Share-CareOregon to address access and expansion as it relates to the integration of BH benefits and the BH services overall.</td>
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<td>LMHA</td>
<td>Washington County Behavioral Health Kristen Burke</td>
<td>As the current BH plan, meet weekly to address integration of BH services in primary care, primary care in specialty BH and moving forward, an integrated BH benefit with the county supporting specialty populations such as high-risk adults and children and their families.</td>
<td>Weekly, initially and then monthly ongoing engagement between the county and Health Share-CareOregon to address access and expansion as it relates to the integration of BH benefits and the BH services overall.</td>
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*Other local government (list in the first column below)*
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<td>K-12 School Districts</td>
<td>Beaverton School District&lt;br&gt;North Clackamas School District&lt;br&gt;Portland Public Schools District&lt;br&gt;Reynolds School District&lt;br&gt;Tigard Tualatin School District&lt;br&gt;Northwest Regional Education Service District&lt;br&gt;Clackamas Education Service District</td>
<td>These districts have an interest in addressing the SDOH and education of the families they serve.&lt;br&gt;They are interested in the importance of going upstream and of early childhood education.</td>
<td>Member of Health Share’s Regional Kindergarten Readiness Network, which is addressing the SDOH and Education for children and families in our region and will be an effective vehicle for cross-sector community engagement, system alignment/improvement and advocacy.&lt;br&gt;Several of these districts also serve on the Regional System of Care Governance Structure that Health Share is convening.&lt;br&gt;We have recently met with several superintendents to present the kinds of data we track, and to determine whether there may be joint projects to work on in the future.</td>
</tr>
<tr>
<td>Department of Human Services</td>
<td>Districts 2, 15, 16</td>
<td>Health Share works closely with Child Welfare in these districts, all of whom have an interest in addressing family stability, and the social determinants of the health of the families they serve. Health Share works closely with Child Welfare across our region to support innovative approaches and aligned strategies to advance care for children in foster care. Collaborations include Foster Care Medical Home, Referral Manager (a web-based care coordination platform), and the DHS Medical Liaison.</td>
<td>Member of Health Share’s Regional Kindergarten Readiness Network, which is addressing the SDOH and Education for children and families in our region and will be an effective vehicle for cross-sector community engagement, system alignment/improvement and advocacy.&lt;br&gt;Health Share continues to fund these innovative programs and will launch a second DHS Medical Liaison position in 2019.&lt;br&gt;These districts are also involved in the Regional System of Care Structure that Health Share convenes.</td>
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| City Government | Portland Children’s Levy  
Meg McElroy | The Portland Children’s Levy (PCL) grants funds through a competitive application process. Funded programs must be cost effective and achieve positive results for children.  
This is a strong and growing partnership of Health Share’s. We share strategic goals around improving the SDOH and Health Equity among the children in our region | Member of Health Share’s Regional Kindergarten Readiness Network, which is addressing the SDOH and Education for children and families in our region and will be an effective vehicle for cross-sector community engagement, system alignment/improvement and advocacy.  
PCL staff attend monthly meeting of the Network. They also attend other committees convened by Health Share having to do with Early Childhood Mental Health Consultation, Young Child Wellness Council, and others. |
| Tribes, if present in the service area (list in first column below) |  |  |  |
| N/A |  |  |  |
| Regional Health Equity Coalitions, if present in the service area (list in first column below) |  |  |  |
| Regional Health Equity Coalition | Oregon Health Equity Alliance,  
Zeenia Junkeer | OHEA is a collective effort of regional and state partners who seek to make Oregon a more equitable place for all. OHEA seeks to enact smart policies to improve our regional and statewide health and wellbeing through public policy, legislation, and policies that govern our workplaces, schools and communities.  
Health Share’s deep commitment to health equity makes this a natural partnership. | Member of Health Share’s Regional Kindergarten Readiness Network, which is addressing the SDOH and Education for children and families in our region and will be an effective vehicle for cross-sector community engagement, system alignment/improvement and advocacy.  
Their Executive Director meets monthly at Health Share as part of the Network’s Anti-Racism and Trauma-informed organizational Change Workgroup. We plan to become more involved in OHEA’s work going forward.  
We currently work with OHEA, but will formally join and actively participate in their meetings and initiatives. |
<p>| Add additional stakeholder types here (list in first column below) |  |  |  |</p>
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<td>Early Childhood System Partner</td>
<td>WIC Program (Women, Infants and Children) Julie Reeder</td>
<td>WIC works to ensure optimal nutrition and lifelong health for every Oregon family. WIC serves many of Health Share’s members and shares a vision of health equity and the importance of providing support to families.</td>
<td>Member of Health Share’s Regional Kindergarten Readiness Network, which is addressing the SDOH and Education for children and families in our region and will be an effective vehicle for cross-sector community engagement, system alignment/improvement and advocacy. WIC staff attend monthly meetings at Health Share at several of our standing committees including the KR Network and the Young Child Wellness Council.</td>
</tr>
<tr>
<td>Early Childhood System Partner</td>
<td>Portland State, Center for the Improvement of Child and Family Services Beth Green</td>
<td>The Center partners and collaborates with agencies, non-profits, community partners, professionals, scholars, parents and youth on transformative, system changing projects that increase practice effectiveness. The Center is a strong partner in much of our work. Their deep knowledge of child and family systems improvement is critical to many of our projects.</td>
<td>Member of Health Share’s Regional Kindergarten Readiness Network, which is addressing the SDOH and Education for children and families in our region and will be an effective vehicle for cross-sector community engagement, system alignment/improvement and advocacy. Staff attend monthly meetings at Health Share for the Network and we contracted with them to do an early evaluation of the first year of the network. We may engage them again in future evaluation work, as needed.</td>
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<td>Housing Coalition</td>
<td>A Home for Everyone (AHFE) Marc Jolin Ryan Diebert Joshua Bates</td>
</tr>
<tr>
<td>Housing Partner</td>
<td>Home Forward</td>
</tr>
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<td>Housing Partner</td>
<td>Central City Concern</td>
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**Table 2: Major activities and deliverables for which the CCO will engage the community**

*All applicants must complete this full table.*

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<th>Part 2a. List and describe the five to eight major projects, programs and decisions for which the CCO will engage the community.</th>
<th>Part 2b. Identify the level of community engagement for each project, program and decision. Answers* must be 1) inform/communicate, 2) consult, 3) involve, 4) collaborate, or 5) shared decision-making. Applicant may include more than one level of engagement for each project, program or decision to account for differences among stakeholder groups.</th>
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<tr>
<td><strong>Disparities and SDOH Spending Plan</strong> – Health Share plans to engage our community on our SDOH-HE spending plan and HRS-CB investments, inclusive of Health Share’s Housing investments. This will be done in partnership with our CAC and other stakeholder groups noted in Table 1.</td>
<td>Consult, Collaborate</td>
</tr>
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<td>Note: The level of engagement for each project may include elements/products included at the INFORM level, but it is essential to the integrity of our community engagement practices that all of our projects go beyond “inform: to more substantial engagement through consultation and collaboration.</td>
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<tr>
<td><strong>Community Health Needs Assessment (CHA)</strong> – Health Share is contractually required to complete a CHA every 5 years and takes a collaborative approach to meet this requirement. Health Share is an active leader on the Healthy Columbia Willamette Collaborative (HCWC). The Collaborative includes 15 hospitals, representation from each of the three county health departments, and includes two community partners – Oregon Health Equity Alliance and Oregon Community Health Worker Association. The community engages in decision-making that informs focus areas of the CHA, including marginalized communities.</td>
<td>Consult, Collaborate, Shared Decision-Making</td>
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<td><strong>Community Health Improvement Plan (CHP)</strong> – The CHP is the action plan based on the CHA identified needs for the tri-county region. The CHP support strategies intended to benefit the broader community with a particular focus on marginalized communities.</td>
<td>Collaborative, Shared Decision-Making</td>
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### Regional Kindergarten Readiness Network – Health Share’s strategic priorities of Early Life Health, Behavioral Health and Health Equity converge in the Regional Kindergarten Readiness Network. We know that many of the factors contributing to Kindergarten Readiness are, in fact, the Social Determinants of Health and Education. Continuing to operate in silos is not working and not bringing about the health and education outcomes we want. To that end, Health Share is convening – and serving as the backbone organization for - a 60+ organization, cross sector network intentionally to ensure meaningful engagement with a wide array of community groups. Our goal is to work together differently to redesign how systems work together so that race, class, and disability are no longer predictors of Kindergarten Readiness. There are currently 5 Workgroups in the Network: Systems Alignment, Mapping the Money, Anti-Racist and Trauma-Informed Organizational Change, Data/Metrics and the Design Team.

### Early Learning Hub Partnerships – future collaborative work – Health Share is investing in Help Me Grow, a collaborative project with the three early learning hubs. Our goal is to jointly build a centralized access point to a triaged menu of services and supports for children at risk of developmental or behavioral delays. We are also jointly working on projects to improve services and supports to immigrant and refugee children. This work can serve as a springboard/blueprint for future regional collaborative work.

### PH Partnerships – Vaccine Hesitancy and future collaborative work – Health Share is investing in a collaborative project with the three county public health departments on a multipronged approach to addressing vaccine hesitancy. This can serve as a springboard/blueprint for future regional collaborative work.

### Partnerships with Housing Authorities and School Districts – We have had several meetings with school districts and housing authorities to explore partnering to share data to better inform and create targeted interventions and strategic investments to address the social determinants of health and education.

### Foster Care System Alignment – Health Share funds advanced primary care medical homes to support child populations who have experienced early adversity and trauma and who are engaged with child serving systems (Child Welfare, Juvenile Justice, Intellectual/ Developmental Disabilities). The steering committee collaborated to design, support a yearlong learning collaborative, and has evolved into a standing system alignment group that continues to refine and integrate the model of care.

<table>
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<th>Level of Engagement</th>
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<td>Early Learning Hub Partnerships – Help Me Grow</td>
<td>Consult, Involve, Collaborate, and Shared Decision-Making</td>
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<td>PH Partnerships – Vaccine Hesitancy</td>
<td>Consult, Involve, Collaborate, and Shared Decision-Making</td>
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<td>Partnerships with Housing Authorities and School Districts</td>
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<td>Foster Care System Alignment</td>
<td>Consult, Collaborate</td>
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* 1. **Inform**: Provide the community with information to assist in their understanding of the issue, opportunities, and solutions. Tools include fact sheets, published reports, media releases, education programs, social media, email, radio, information posted on websites, and informational meetings.

2. **Consult**: Obtain community feedback on analysis, alternatives, and/or decisions. Tools include issue briefs, discussion papers, focus groups, surveys, public meetings, and listening sessions.

3. **Involve**: Work directly with the community throughout the process to ensure that community concerns and aspirations are understood and considered. Applicant provides feedback to the community describing how the community input influenced the decision. Tools include meetings with key stakeholders, workshops, subject matter expert and stakeholder roundtables, conferences, and task forces.

4. **Collaborate**: Partner with the community in each aspect of the process, including decision points, the development of alternatives and the identification of a solution.

   Tools include advisory committees, consensus building, and participatory decision-making.

5. **Shared decision-making**: To place the decision-making in the hands of the community (delegate) or support the actions of community initiated, driven and/or led processes (community driven/led). Tools include delegated decisions to members of the communities impacted through steering committees, policy councils, strategy groups, Community supported processes, advisory bodies, and roles and funding for community organizations.
### Table 3: Collaboration with other agencies in the service area that have responsibility for developing community health assessments and community health improvement plans

All applicants must complete this full table. Applicants may add rows as needed.

**Part 1.** Applicants with an existing CCO CHA and CHP will submit their most recent CHA and CHP with the community engagement plan.

**Part 2.** List of all local public health authorities, non-profit hospitals, other CCOs that share a portion of the service area, and any federally recognized tribe in the service area that is developing or has a CHA/CHP. Add additional rows as needed.

**Part 3.** The extent to which each organization was involved in the development of the Applicant's current CHA and CHP. Answers must be a) competition and cooperation, b) coordination, c) collaboration, or d) not applicable (NA).

**Part 4.** For any organization that is a collaborator for a shared CHA and shared CHP priorities and strategies, the applicant will list the shared priorities and strategies.

**Part 5.** For any organization that is not a collaborator for a shared CHA and shared CHP priorities and strategies, the applicant will describe the current state of the relationship between the applicant and the organization(s), including gaps.

**Part 6.** For any organization that is not a collaborator for a shared CHA and shared CHP priorities and strategies, the applicant will take to address gaps prior to developing the next CHA and CHP, and the dates by which the applicant will complete key tasks.

**Part 7.** Applicants without an existing CHA and CHP or that intend to change their service area will demonstrate that they have reviewed CHAs and CHPs developed by these other organizations. List the health priorities from existing plans.

### Local public health authorities (list in this column below)

<table>
<thead>
<tr>
<th>Clackamas County Public Health</th>
<th>Collaboration</th>
<th>Health Equity and trauma informed Access to care Chronic conditions Housing Education Food access</th>
<th>NA</th>
<th>NA</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multnomah County Public Health</td>
<td>Collaboration</td>
<td>Health Equity and trauma informed Access to care Housing Education Food access Social isolation</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Washington County Public Health</td>
<td>Collaboration</td>
<td>Health Equity and trauma informed Access to care Chronic conditions Housing Education Food access</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

**Non-profit hospitals (list in this column below)**

| Adventist Medical Center | Coordination | NA | We work collaboratively to develop a regional CHA that we each use to inform our individually tailored CHAs and CHPs. | Health Share is convening this stakeholder group to develop strategies and agreements to move towards collaboration. Key activities and dates include: formalize a charter and policy for regional community health investments by Dec. 31, 2020; create a regional strategic investment fund to support shared CHP priorities by Dec. 31, 2020 | NA |

<p>| Kaiser Sunnyside Medical Center | Coordination | NA | We work collaboratively to develop a regional CHA that we each use to inform our individually tailored CHAs and CHPs. | Health Share is convening this stakeholder group to develop strategies and agreements to move towards collaboration. Key activities and dates include: formalize a charter and policy for regional community health investments by Dec. 31, 2020; create a regional strategic investment fund to support shared CHP priorities by Dec. 31, 2020 | NA |</p>
<table>
<thead>
<tr>
<th>Medical Center</th>
<th>Coordination</th>
<th>NA</th>
<th>We work collaboratively to develop a regional CHA that we each use to inform our individually tailored CHAs and CHPs.</th>
<th>Health Share is convening this stakeholder group to develop strategies and agreements to move towards collaboration. Key activities and dates include: formalize a charter and policy for regional community health investments by Dec. 31, 2020; create a regional strategic investment fund to support shared CHP priorities by Dec. 31, 2020</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaiser Westside Medical Center</td>
<td>Coordination</td>
<td>NA</td>
<td>We work collaboratively to develop a regional CHA that we each use to inform our individually tailored CHAs and CHPs.</td>
<td>Health Share is convening this stakeholder group to develop strategies and agreements to move towards collaboration. Key activities and dates include: formalize a charter and policy for regional community health investments by Dec. 31, 2020; create a regional strategic investment fund to support shared CHP priorities by Dec. 31, 2020</td>
<td>NA</td>
</tr>
<tr>
<td>Legacy Emanuel Medical Center</td>
<td>Coordination</td>
<td>NA</td>
<td>We work collaboratively to develop a regional CHA that we each use to inform our individually tailored CHAs and CHPs.</td>
<td>Health Share is convening this stakeholder group to develop strategies and agreements to move towards collaboration. Key activities and dates include: formalize a charter and policy for regional community health investments by Dec. 31, 2020; create a regional strategic investment fund to support shared CHP priorities by Dec. 31, 2020</td>
<td>NA</td>
</tr>
<tr>
<td>Legacy Good Samaritan Medical Center</td>
<td>Coordination</td>
<td>NA</td>
<td>We work collaboratively to develop a regional CHA that we each use to inform our individually tailored CHAs and CHPs.</td>
<td>Health Share is convening this stakeholder group to develop strategies and agreements to move towards collaboration. Key activities and dates include: formalize a charter and policy for regional community health investments by Dec. 31, 2020; create a regional strategic investment fund to support shared CHP priorities by Dec. 31, 2020</td>
<td>NA</td>
</tr>
<tr>
<td>Legacy Meridian Park Medical Center</td>
<td>Coordination</td>
<td>NA</td>
<td>We work collaboratively to develop a regional CHA that we each use to inform our individually tailored CHAs and CHPs.</td>
<td>Health Share is convening this stakeholder group to develop strategies and agreements to move towards collaboration. Key activities and dates include: formalize a charter and policy for regional community health investments by Dec. 31, 2020; create a regional strategic investment fund to support shared CHP priorities by Dec. 31, 2020</td>
<td>NA</td>
</tr>
<tr>
<td>Legacy Mount Hood Medical Center</td>
<td>Coordination</td>
<td>NA</td>
<td>We work collaboratively to develop a regional CHA that we each use to inform our individually tailored CHAs and CHPs.</td>
<td>Health Share is convening this stakeholder group to develop strategies and agreements to move towards collaboration. Key activities and dates include: formalize a charter and policy for regional community health investments by Dec. 31, 2020; create a regional strategic investment fund to support shared CHP priorities by Dec. 31, 2020</td>
<td>NA</td>
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</tr>
<tr>
<td>Legacy Salmon Creek Medical Center</td>
<td>Coordination</td>
<td>NA</td>
<td>We work collaboratively to develop a regional CHA that we each use to inform our individually tailored CHAs and CHPs.</td>
<td>Health Share is convening this stakeholder group to develop strategies and agreements to move towards collaboration. Key activities and dates include: formalize a charter and policy for regional community health investments by Dec. 31, 2020; create a regional strategic investment fund to support shared CHP priorities by Dec. 31, 2020</td>
<td>NA</td>
</tr>
<tr>
<td>Oregon Health &amp; Science University</td>
<td>Coordination</td>
<td>NA</td>
<td>We work collaboratively to develop a regional CHA that we each use to inform our individually tailored CHAs and CHPs.</td>
<td>Health Share is convening this stakeholder group to develop strategies and agreements to move towards collaboration. Key activities and dates include: formalize a charter and policy for regional community health investments by Dec. 31, 2020; create a regional strategic investment fund to support shared CHP priorities by Dec. 31, 2020</td>
<td>NA</td>
</tr>
<tr>
<td>PeaceHealth Southwest Medical Center</td>
<td>Coordination</td>
<td>NA</td>
<td>We work collaboratively to develop a regional CHA that we each use to inform our individually tailored CHAs and CHPs.</td>
<td>Health Share is convening this stakeholder group to develop strategies and agreements to move towards collaboration. Key activities and dates include: formalize a charter and policy for regional community health investments by Dec. 31, 2020; create a regional strategic investment fund to support shared CHP priorities by Dec. 31, 2020</td>
<td>NA</td>
</tr>
<tr>
<td>Providence Milwaukie Hospital</td>
<td>Coordination</td>
<td>NA</td>
<td>We work collaboratively to develop a regional CHA that we each use to inform our individually tailored CHAs and CHPs.</td>
<td>Health Share is convening this stakeholder group to develop strategies and agreements to move towards collaboration. Key activities and dates include: formalize a charter and policy for regional community health investments by Dec. 31, 2020; create a regional strategic investment fund to support shared CHP priorities by Dec. 31, 2020.</td>
<td>NA</td>
</tr>
<tr>
<td>-------------------------------</td>
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<td>-------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>----</td>
</tr>
<tr>
<td>Providence Portland Medical Center</td>
<td>Coordination</td>
<td>NA</td>
<td>We work collaboratively to develop a regional CHA that we each use to inform our individually tailored CHAs and CHPs.</td>
<td>Health Share is convening this stakeholder group to develop strategies and agreements to move towards collaboration. Key activities and dates include: formalize a charter and policy for regional community health investments by Dec. 31, 2020; create a regional strategic investment fund to support shared CHP priorities by Dec. 31, 2020.</td>
<td>NA</td>
</tr>
<tr>
<td>Providence St. Vincent Medical Center</td>
<td>Coordination</td>
<td>NA</td>
<td>We work collaboratively to develop a regional CHA that we each use to inform our individually tailored CHAs and CHPs.</td>
<td>Health Share is convening this stakeholder group to develop strategies and agreements to move towards collaboration. Key activities and dates include: formalize a charter and policy for regional community health investments by Dec. 31, 2020; create a regional strategic investment fund to support shared CHP priorities by Dec. 31, 2020.</td>
<td>NA</td>
</tr>
<tr>
<td>Health Share of Oregon</td>
<td>Att10</td>
<td>RFA Community Engagement Plan Tables</td>
<td></td>
<td></td>
<td></td>
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<tr>
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<td>--------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Providence Willamette Falls Medical Center</strong></td>
<td>Coordination</td>
<td>NA</td>
<td>We work collaboratively to develop a regional CHA that we each use to inform our individually tailored CHAs and CHPs.</td>
<td>Health Share is convening this stakeholder group to develop strategies and agreements to move towards collaboration. Key activities and dates include: formalize a charter and policy for regional community health investments by Dec. 31, 2020; create a regional strategic investment fund to support shared CHP priorities by Dec. 31, 2020</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Tuality Healthcare</strong></td>
<td>Coordination</td>
<td>NA</td>
<td>We work collaboratively to develop a regional CHA that we each use to inform our individually tailored CHAs and CHPs.</td>
<td>Health Share is convening this stakeholder group to develop strategies and agreements to move towards collaboration. Key activities and dates include: formalize a charter and policy for regional community health investments by Dec. 31, 2020; create a regional strategic investment fund to support shared CHP priorities by Dec. 31, 2020</td>
<td>NA</td>
</tr>
</tbody>
</table>

**Current coordinated care organizations, as of 2019 (list in this column below)**

N/A

**Federally recognized tribes that have or are developing a CHA/CHP (list in this column below)**

N/A
** Competition and Cooperation: ** Loose connections and low trust; tacit information sharing; ad hoc communication flows; independent goals; adapting to each other or accommodating others’ actions and goals; power remains with each organization; resources remain with each organization; commitment and accountability only to own organization; relational time frame short; low risk and reward.

b) **Coordination:** Medium connections and work-based trust; structured communication flows and formalized project-based information sharing; joint policies, programs and aligned resources; semi-interdependent goals; power remains with parent organizations; commitment and accountability to parent organization and project; relational time frame medium and based on prior projects; medium risk and reward.

c) **Collaboration:** Dense interdependent connections and high trust; frequent communication; tactical information sharing; systems change; pooled and collective resources; negotiated shared goals; power is shared between organizations; commitment and accountability to network first, community and parent organization; relation time frame long (3 years or more); high risk and reward.

d) **Not applicable**

** If the applicant does not have a current CHA and CHP, the applicant will enter not applicable (NA).

*** Engagement activities must begin by March 31, 2020 and applicant will report on progress through the June 2020 CCO CHP progress report.
<table>
<thead>
<tr>
<th>All applicants must complete Part 1.</th>
<th>Applicants with an existing CHA and CHP must complete Parts 2, 3 and 4. Applicants that intend to change their service area must also complete Parts 2, 3, and 4.</th>
<th>Applicants without an existing CHA and CHP or that intend to change their service area must complete Parts 2a and 4a.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Part 1.</strong> List of organizations that address the social determinants of health and health equity in the applicant’s service area. Add additional rows as needed.</td>
<td><strong>Part 2.</strong> Applicants with an existing CHA and CHP will describe existing partnerships with each identified organization, including whether the organization contributed to the applicant’s current CHA and CHP.</td>
<td><strong>Part 3.</strong> Applicants with an existing CHA and CHP will describe gaps in existing relationships with identified organizations.</td>
</tr>
<tr>
<td><strong>Part 4.</strong> Applicants with an existing CHA and CHP will describe the steps the applicant will take to address the identified gaps prior to developing the next CHA and CHP and the dates by which the applicant will complete key tasks for engagement.**</td>
<td><strong>Part 2a.</strong> Applicants without an existing CHA and CHP or that intend to change their service area will demonstrate that they have reviewed community partnerships in place for other LPHA/non-profit hospital/tribal/CCO CHAs and CHPs in the service area. For each organization listed in Part 1, the applicant will document the organization’s level of involvement in developing any other CHAs or CHPs by entering one of these responses: a) The organization was explicitly involved in developing one or more CHAs or CHPs; b) The organization was not explicitly involved in developing a CHA or CHP; c) unknown.</td>
<td><strong>Part 4a.</strong> Applicants without an existing CHA and CHP or that intend to change their service area will describe the steps the applicant will take to form relationships and secure participation by each organization prior to developing the first or next CHA and CHP, and the dates by which the applicant will complete key tasks for engagement.**</td>
</tr>
</tbody>
</table>
### All tribes that are present in the service area (list in this column below). If no tribe is present in the service area, note there are none.

<table>
<thead>
<tr>
<th>Tribe</th>
<th>Presence and Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N/A</td>
</tr>
</tbody>
</table>

### All regional health equity coalitions (RHECs) that are present in the service area (list in this column below). If no RHEC is present in the service area, note there are none.

<table>
<thead>
<tr>
<th>RHEC</th>
<th>Presence and Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oregon Health Equity Alliance- OHEA</td>
<td>Currently serves as part of the Data and Communications workgroup for the HCWC collaborative in charge of developing the next CHA. We are currently in the process of becoming a formal member. Submit necessary paperwork and payment to become OHEA organizational member by Summer of 2019. Identify further opportunities of collaboration by early Spring of 2020.</td>
</tr>
</tbody>
</table>

### Local government, including counties

<table>
<thead>
<tr>
<th>County</th>
<th>Presence and Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clackamas County</td>
<td>Currently serves as part of the Data and Communications workgroup for the HCWC collaborative. CHP staff serves as part of our CAC and therefore contribute to our CHP by representing Clackamas County. No existing gaps.</td>
</tr>
<tr>
<td>Multnomah County</td>
<td>Currently serves as part of the Data and Communications workgroup for the HCWC collaborative. CHP staff serves as part of our CAC and therefore contribute to our CHP by representing the Multnomah County. No existing gaps.</td>
</tr>
<tr>
<td>Washington County</td>
<td>Currently serves as part of the Data and Communications workgroup for the HCWC collaborative. CHP staff serves as part of our CAC and therefore contribute to our CHP by representing Washington County.</td>
</tr>
</tbody>
</table>

**Organizations that address the four key domains of social determinants of health* (list in this column below).**

<p>| Oregon Food Bank | Did not contribute to the existing CHP but Food Access has been identified as a priority for 2019 CHP. | Working to formalize and build relationship for future CHP collaboration around Food Access. | Seek outreach with Council and staff to align on food access strategies activity to begin winter 2019 and plan by Spring 2020 |
| Village Gardens | Did not contribute to the existing CHP but Food Access has been identified as a priority for 2019 CHP. Village Gardens has been identified as a potential partner whose mission is to build food resilience in the Multnomah County areas. | Working to establish a partnership with the organization around supporting Food Access strategies | We will invite the organization to be a part of stakeholder engagement around Food Access strategies. Conversations begin in early 2020. |
| Zenger Farm | Did not contribute to the exiting CHP but Food Access has been identified as a priority area for our 2019 CHP. | Working to establish and build relationship for future CHP collaboration around Food Access strategies | We will begin to invite the organization to be a part of stakeholder engagement around Food Access strategies. Conversations to begin in early 2020. |</p>
<table>
<thead>
<tr>
<th>Organization</th>
<th>Did not contribute to the existing CHP but Food Access has been identified as a priority for 2019 CHP. Urban Gleaners has been identified as a potential partner whose mission is to distribute food in over 40 sites in the Portland Metro Area to those most in need.</th>
<th>No formal relationship or partnership established with the organization</th>
<th>We will begin to initiate outreach of potential stakeholder engagement around Food Access strategies. Conversations to begin in early 2020.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central City Concern (CCC)</td>
<td>Contributed in the last CHA report by facilitating listening sessions with their members. Housing is a priority for 2019 CHP; CCC is seen as a partner for future development of strategies.</td>
<td>Housing is a priority for 2019 CHP; CCC is seen as a partner for future development of strategies.</td>
<td>Recruit CCC as a partner to establish Housing strategies for 2019 CHP by early summer of 2019.</td>
</tr>
<tr>
<td>Ecumenical Ministries of Oregon-Russian Oregon Social Services</td>
<td>Was not a contributor to the last CHA or CHP. No formal relationship or partnership established with the organization. Organization has two programs one serving the Russian population in the tri-county and the other address food access both programs can support future CHP strategies. Health Share staff will initiate outreach with agency to identify potential partnerships to provide feedback in future CHP strategies addressing food access and Social Connection.</td>
<td>Organization has two programs one serving the Russian population in the tri-county and the other address food access both programs can support future CHP strategies. Health Share staff will initiate outreach with agency to identify potential partnerships to provide feedback in future CHP strategies addressing food access and Social Connection.</td>
<td></td>
</tr>
<tr>
<td>Q Center</td>
<td>Contributed in the last CHA report by facilitating listening sessions. The Q Center serves as the largest community center in the Pacific Northwest for the LGBTQ2SIA+ communities and allies. We currently do not have an extended relationship beyond the CHA.</td>
<td>We currently do not have an extended relationship beyond the CHA.</td>
<td>We will initiate outreach for future alignments and opportunities in Fall of 2020.</td>
</tr>
<tr>
<td>Organization</td>
<td>Contribution</td>
<td>Existing Gaps</td>
<td>Notes</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>---------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Traditional Health Workers (THWs) affiliated with organizations listed in OAR 410-141-3145 (list in this column).</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oregon Community Health Worker Association</td>
<td>Contributed to the last CHA report by facilitating listening sessions with their members and continues to support as part of the current HCWC collaborative.</td>
<td>Currently no existing gaps</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Culturally specific organizations and organizations that work with underserved or at-risk populations (list in this column below).</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NAYA- Native American Youth and Family Center</td>
<td>Contributed to the last CHA report by facilitating listening sessions with their members.</td>
<td>Determine future engagement in next CHA or CHP report.</td>
<td>Outreach to partner to discuss potential partnerships around CHP strategies addressing Social Connection for the Native American community by Fall of 2020 CHA or CHP report by Summer 2020.</td>
</tr>
<tr>
<td>IRCO- Immigrant and Refugee Community Coalition</td>
<td>Contributed in the last CHA report by facilitating listening sessions with their members and continues to support as part of the current HCWC collaborative.</td>
<td>Potential partner in supporting CHP strategies around Social Connection for member’s immigrant and refugee populations.</td>
<td>Work with leadership to identify opportunities to support CHP strategy around Social Connection by Fall of 2020 with the immigrant and refugee communities.</td>
</tr>
<tr>
<td>Adelante Mujeres</td>
<td>Contributed in the last CHA report by facilitating listening sessions with their members and continues to support as part of the current HCWC collaborative.</td>
<td>Further partnership is possible due to CHP strategy addressing Food Access and Social Connection among the Latinx.</td>
<td>Initiate outreach with agency leadership by Fall of 2020.</td>
</tr>
<tr>
<td>Momentum Alliance</td>
<td>Community Partner engaged with upcoming CHA report by facilitating Community listening sessions for HCWC collaborative.</td>
<td>Potential partner in supporting CHP strategies around Social Connection for the transition age youth populations.</td>
<td>Begin outreach with leadership to identify opportunities to support CHP strategy around Social Connection by Fall of 2020 with the transition age youth populations.</td>
</tr>
<tr>
<td>Community Partner</td>
<td>Engagement with CHA report and future strategies</td>
<td>Stakeholder Engagement and Support</td>
<td>Additional Notes</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>--------------------------------------------------</td>
<td>-----------------------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td>Latino Network</td>
<td>Community Partner engaged with upcoming CHA report by facilitating Community listening sessions for HCWC collaborative with a focus on the Latinx population.</td>
<td>Potential partner in supporting CHP strategies around Social Connection for Latinx populations living in Multnomah.</td>
<td>Launch stakeholder engagement with leadership to identify opportunities to support CHP strategies around Social Connection by Fall of 2020.</td>
</tr>
<tr>
<td>APANO- Pacific Islander Coalition</td>
<td>Community Partner engaged with upcoming CHA report by facilitating Community listening sessions for HCWC collaborative with a focus on the Pacific Islander population.</td>
<td>Potential partner in supporting CHP strategies around Social Connection for Pacific Islander member populations.</td>
<td>Launch outreach with leadership to identify opportunities to support CHP strategies around Social Connection by Fall of 2020.</td>
</tr>
<tr>
<td>El Programa Hispano</td>
<td>Contributed in the last CHA report by facilitating listening sessions with their members.</td>
<td>Potential partner in supporting CHP strategies around Social Connection for Latinx members living in SE Portland.</td>
<td>Launch stakeholder engagement with leadership to identify opportunities to support CHP strategies around Social Connection by Fall of 2020.</td>
</tr>
<tr>
<td>Urban League of Portland</td>
<td>Contributed in the last CHA report by facilitating listening sessions with their members.</td>
<td>Potential partner in supporting CHP strategies around Social Connection for African American community.</td>
<td>Reach out to leadership to identify opportunities to support CHP strategies around Social Connection by Fall of 2020.</td>
</tr>
<tr>
<td>Familias en Accion</td>
<td>Did not contribute to the last CHA or CHP.</td>
<td>Potential partner in supporting CHP strategies around Social Connection for Latinx community living in Tri-County.</td>
<td>Follow-up with leadership to identify opportunities to support CHP strategies around Social Connection by Spring of 2020.</td>
</tr>
<tr>
<td>Organization</td>
<td>Contribution to CHA or CHP</td>
<td>Potential Partner Role</td>
<td>Outreach Strategy</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>---------------------------</td>
<td>------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Oregon Latino Health Coalition</td>
<td>Did not contribute</td>
<td>Potential partner in supporting CHP strategies around Social Connection for Latinx community living in Tri-County.</td>
<td>Initiate outreach to leadership to identify opportunities to support CHP strategies around Social Connection by Spring of 2020.</td>
</tr>
<tr>
<td>Other organizations (list in this column below).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cascade AIDS Project</td>
<td>Contributed</td>
<td>no existing gaps</td>
<td>N/A</td>
</tr>
<tr>
<td>NAMI- National Alliance of Mental Illness (Clackamas)</td>
<td>Contributed</td>
<td>no existing gaps</td>
<td>N/A</td>
</tr>
<tr>
<td>Project Access Now</td>
<td>Contributed</td>
<td>no existing gaps</td>
<td>N/A</td>
</tr>
<tr>
<td>Virginia Garcia</td>
<td>Did not contribute</td>
<td>Virginia Garcia is one of the largest health centers in Washington County and has an active Patient Advisory Council that can further provide feedback around our CHP strategies.</td>
<td>Initiate outreach to facilitator and leadership that supports the Patient Advisory Council by January 2020.</td>
</tr>
<tr>
<td>Wallace Medical Concern</td>
<td>Did not contribute</td>
<td>Wallace Medical Concern has an active Board represented of consumer voice that can further provide feedback around our CHP strategies in representation of the SE Portland Community.</td>
<td>Initiate outreach to facilitator and leadership that supports the Consumer Board by January 2020.</td>
</tr>
<tr>
<td>Community Partner</td>
<td>Engagement Status</td>
<td>Existing Gaps</td>
<td>Action Plan</td>
</tr>
<tr>
<td>-------------------------------------------</td>
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<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Clackamas County Health Centers</td>
<td>Did not contribute to the last CHA or CHP.</td>
<td>No gaps</td>
<td>Initiate outreach to facilitator and leadership that supports the Community Health Council by January 2020.</td>
</tr>
<tr>
<td>Outside In</td>
<td>Contributed to the last CHA report by facilitating listening sessions with their members and continues to support as part of the current HCWC collaborative.</td>
<td>No gaps</td>
<td>Initiate outreach to facilitator of the Patient Advisory Council by January 2020.</td>
</tr>
<tr>
<td>Friendly House</td>
<td>Community Partner engaged with upcoming CHA report by facilitating Community listening sessions for HCWC collaborative.</td>
<td>No gaps</td>
<td>N/A</td>
</tr>
<tr>
<td>NW Pilot Project</td>
<td>Community Partner engaged with upcoming CHA report by facilitating Community listening sessions for HCWC collaborative.</td>
<td>No gaps</td>
<td>N/A</td>
</tr>
<tr>
<td>Aging Services Advisory Council</td>
<td>Community Partner engaged to facilitate Community listening sessions for HCWC collaborative to support the next CHA report.</td>
<td>No gaps</td>
<td>N/A</td>
</tr>
<tr>
<td>Sandy Adult Center</td>
<td>Community Partner engaged to facilitate Community listening sessions for HCWC collaborative to support the next CHA report.</td>
<td>No gaps</td>
<td>N/A</td>
</tr>
<tr>
<td>Community Partner</td>
<td>Engagement &amp; Collaboration</td>
<td>Potential Opportunities/Outcomes</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>----------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Molalla Community Center</td>
<td>Community Partner engaged</td>
<td>no existing gaps</td>
<td></td>
</tr>
<tr>
<td></td>
<td>to facilitate Community</td>
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<td>the next CHA report.</td>
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<tr>
<td>Disability Aging and Veterans Services</td>
<td>Community Partner engaged</td>
<td>no existing gaps</td>
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<td></td>
<td>to facilitate Community</td>
<td>N/A</td>
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<td>the next CHA report.</td>
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<tr>
<td>Disability Arts &amp; Culture Project</td>
<td>Community Partner engaged</td>
<td>This is a potential partner in supporting CHP strategies around Social Connection for</td>
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<tr>
<td></td>
<td>to facilitate Community</td>
<td>members with a disability.</td>
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<td>listening sessions for HCWC</td>
<td>Launch outreach with leadership to identify opportunities to support CHP strategy around Social</td>
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<td>collaborative to support</td>
<td>Connection by Fall of 2020.</td>
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<td>the next CHA report.</td>
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<tr>
<td>Disability Justice Leaders Collaborative</td>
<td>Community Partner engaged</td>
<td>Further partnership opportunity to support Access to Care CHP strategy for members with a disability.</td>
<td></td>
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<td></td>
<td>to facilitate Community</td>
<td>Connect with organizational leadership to identify opportunities of collaboration around Access to Care.</td>
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<td>listening sessions for HCWC</td>
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<td>the next CHA report.</td>
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<tr>
<td>Allies for a Healthier Oregon</td>
<td>Community Partner engaged</td>
<td>no existing gaps</td>
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<td></td>
<td>to facilitate Community</td>
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<td>the next CHA report.</td>
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<tr>
<td>Coalition of Community Health Clinics</td>
<td>Contributed to the last CHA</td>
<td>Determine partnership beyond CHA and CHP. Further, identify partnerships with the Coalition of</td>
<td></td>
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<tr>
<td></td>
<td>report by facilitating</td>
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<td></td>
<td>listening sessions with</td>
<td>Community Health Clinics to incorporate member voice representation through the FQHC’s Patient</td>
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<td>their Federally Qualified</td>
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<td>Health Centers (FQHC’s)</td>
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<td>network.</td>
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<tr>
<td>Organization</td>
<td>Contributions</td>
<td>Identified Gap</td>
<td>Next Steps</td>
</tr>
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<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Elders in Action Commission</td>
<td>Contributed to the last CHA report by facilitating listening sessions with a focus on the older adult population.</td>
<td>No existing gap identified.</td>
<td></td>
</tr>
<tr>
<td>Highland Church</td>
<td>Contributed to the last CHA report by facilitating listening sessions with a focus on the African American population.</td>
<td>No existing gap identified.</td>
<td></td>
</tr>
<tr>
<td>The Intertwine Alliance</td>
<td>Contributed to the last CHA report by facilitating listening sessions with their members.</td>
<td>Potential partner to support Social Connection strategy in 2019 CHP.</td>
<td>Begin outreach specifically around CHP strategy addressing Social connection in fall of 2020.</td>
</tr>
<tr>
<td>Liberation Street Church</td>
<td>Contributed to the last CHA report by facilitating listening sessions with their members.</td>
<td>Potential partner to support Social Connection strategy in 2019 CHP.</td>
<td>Begin outreach specifically around CHP strategy addressing Social connection in fall of 2020.</td>
</tr>
<tr>
<td>Lifeline Connections</td>
<td>Contributed to the last CHA report by facilitating listening sessions with their members.</td>
<td>Potential partner to support Social Connection strategy in 2019 CHP.</td>
<td>Initiate outreach specifically around CHP strategy addressing Social connection in fall of 2020.</td>
</tr>
<tr>
<td>LifeWorks Northwest</td>
<td>Contributed to the last CHA report by facilitating listening sessions with their members.</td>
<td>Determine future engagement in next CHA or CHP report.</td>
<td>Initiate conversations with key leadership of the organization to establish further engagement in CHA or CHP report by Summer 2020.</td>
</tr>
<tr>
<td>Oregon Foundation for Reproductive Health</td>
<td>Contributed to the last CHA report by facilitating listening sessions with their members.</td>
<td>No existing gaps at this moment.</td>
<td></td>
</tr>
<tr>
<td>Oregon Public Health Institute</td>
<td>Contributed to the last CHA report by facilitating listening sessions with their members.</td>
<td>Determine future engagement in next CHA or CHP report.</td>
<td>Initiate outreach with partner to establish future engagement beyond CHA or CHP report by Summer 2020.</td>
</tr>
<tr>
<td>Veterans Affairs Hospital</td>
<td>Contributed to the last CHA report by facilitating listening sessions with focus on the Veterans population.</td>
<td>No existing gap identified.</td>
<td></td>
</tr>
<tr>
<td>Washington County Mental Health and Addictions Advisory Council</td>
<td>Contributed to the last CHA report by facilitating listening sessions with a focus on populations accessing Mental Health and Addiction services in Washington County.</td>
<td>Opportunity to connect this advisory Council with our Council in order to further incorporate Washington County member voice.</td>
<td>Initiate outreach to facilitator of the Advisory group by early 2020.</td>
</tr>
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<td>-------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
</tr>
<tr>
<td>Washington County Public Health Advisory Council</td>
<td>Contributed to the last CHA report by facilitating listening sessions with the Washington County community.</td>
<td>Opportunity to connect this advisory Council with our Council in order to further incorporate Washington County member voice.</td>
<td>Initiate outreach to facilitator of the Advisory group by early 2020.</td>
</tr>
</tbody>
</table>

*The four key domains of social determinants of health are economic stability, education, neighborhood and built environment, and social and community health.

**Engagement activities must begin by March 31, 2020 and applicant will report on progress through the June 2020 CCO CHP progress report.

**Table 5: Assessment of existing social determinants of health priorities and process to select Year 1 social determinants of health priorities**

All applicants must complete this full table to describe how the applicant will identify social determinants of health (“SDOH-HE”) priorities to meet the CCO SDOH-HE spending requirements. Housing must be included as one of the SDOH-HE spending priorities.

<table>
<thead>
<tr>
<th>Part 1. List of existing SDOH-HE CHP priorities* in applicant's proposed service area from its own CHP or other existing CCO, local hospital, local public health authority and/or tribal CHPs, if applicable. Add additional rows as needed.</th>
<th>Part 1a. Source for priority (i.e. which CHP it came from).</th>
<th>Part 1b. Whether priority describes a health outcome goal (i.e. addressing food insecurity to address obesity as a health issue) or priority populations (i.e. addressing early childhood education for children as a priority population) or other.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to safe, affordable and supportive housing</td>
<td>Health Share CHA, LPHA CHPs, local hospital CHPs and CareOregon</td>
<td>Addressing housing to address health outcomes</td>
</tr>
</tbody>
</table>

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**RFA4690-Health Share of Oregon- Att10- RFA Community Engagement Plan Tables**

Page 54 of 57
<table>
<thead>
<tr>
<th>Social Isolation/connection</th>
<th>Health Share CHA and LPHA CHPs</th>
<th>Addressing social isolation/connection to improve health outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to inclusive and accessible physical, behavioral and oral health care</td>
<td>Health Share CHA, LPHA CHPs and local hospital CHP – Adventist, KP, Prov.</td>
<td>Addressing access to care to improve health outcomes</td>
</tr>
<tr>
<td>Access to healthy, affordable and culturally relevant food</td>
<td>Health Share CHA, LPHA CHPs and local hospital CHPs</td>
<td>Addressing food security to improve health outcomes</td>
</tr>
<tr>
<td>Access to high quality, identify affirming and trauma-informed education</td>
<td>Health Share CHA and LPHA CHPs</td>
<td>Addressing access to education for children as a priority population with attention to communities facing disparities</td>
</tr>
<tr>
<td>Medical Legal Partnership</td>
<td>Health Share CCO Priority</td>
<td>Addressing access to legal support on issues such as housing, utilities, education and employment, income support, family law, child welfare and more to address SDOH.</td>
</tr>
<tr>
<td>Safe neighborhoods</td>
<td>Health Share CHA and LPHA CHPs</td>
<td>Addressing safe neighborhoods to improve health outcomes</td>
</tr>
<tr>
<td>Living Wage Jobs/Economic opportunity</td>
<td>Local hospital CHPs</td>
<td>Addressing poverty to improve health outcomes.</td>
</tr>
<tr>
<td>Transportation</td>
<td>LPHA CHPs and local hospital CHPs</td>
<td>Addressing access to transportation to improve health outcomes</td>
</tr>
<tr>
<td>Children’s Social and Emotional Learning (ACES)</td>
<td>CareOregon</td>
<td>Addressing ACEs in children to improve long term health outcomes</td>
</tr>
</tbody>
</table>
Part 2. Description of process through which the applicant will identify and vet SDOH-HE priorities in line with CHP priorities for submission to OHA by March 15, 2020. This must include, timelines, milestones, methods for vetting selected priorities with community partners (such as those described in Table B, Part 1) and CAC, and planned actions to clarify and define CCO housing priority in line with statewide priority.

- Process may also include planned actions to identify additional community-based SDOH-HE priorities from CHP priorities.
- If housing has not been identified as a priority in existing CHPs, note that housing must still be selected as an SDOH-HE priority. Consider adding the housing priority in alignment with either a health outcome goal or priority population identified in Part 1b.

By July 30, 2019, Health Share’s Community Impact Committee will approve a proposal for the development of Health Share’s Disparities and Social Determinants of Health Spending Implementation Plan (D&SDOH Spending Implementation Plan) inclusive of defining Health Share’s housing priority.

By August 30, 2019, Health Share will convene a SDOH-HE Spending Plan Oversight group to develop and oversee a community engagement process to develop Health Share’s D&SDOH Spending Implementation Plan. Oversight group members may include: CAC members, staff, board or board committee members, Community Impact Committee and Advisory Committee members, Community-based partners, health plan partners/Community Benefit staff, local public health authority staff, OHP consumers, Regional Health Equity Coalition members, and more.

By September 15, 2019, the SDOH-HE Spending Plan Oversight group will develop a community engagement process (which may include surveys, public listening sessions, stakeholder interviews and more) to solicit input into the selection and vetting of potential SDOH-HE investments to inform Health Share’s D&SDOH Spending Implementation Plan.

By January 30, 2020, Health Share staff will have completed an infrastructure/capacity gaps analysis on selected SDOH-HE spending priorities to incorporate into our D&SDOH Spending Implementation Plan.

By January 30, 2020, Health Share will implement the community engagement process developed by the SDOH-HE Spending Plan Oversight group and use community input to inform the development of the D&SDOH Spending Implementation Plan.

By January 30, 2020 Health Share’s CAC and Community Impact Committee will have reviewed and provided feedback on an initial draft of the D&SDOH Spending Implementation Plan.

By February 4, 2020, Health Share staff and health plan partners will have vetted Health Share’s draft D&SDOH Spending Implementation Plan by key leaders within Health Share’s founding member organizations.

By February 12, 2020, Health Share staff will have completed a final draft of the D&SDOH Spending Implementation Plan.

By February 28, 2020, Health Share Board of Directors and CAC will have formally approved and adopted Health Share’s D&SDOH Spending Implementation Plan.

By March 5, 2020, Health Share staff will submit Health Share’s D&SDOH Spending Implementation Plan to OHA

NOTE: Please see the below diagram for a visual map of this work.

*Applicants must include description of housing priority if already identified in CHPs. (e.g. housing overall, housing for targeted populations).

**The four key domains of social determinants of health are economic stability, education, neighborhood and built environment, and social and community health. Refer to the Social Determinants of Health and Health Equity Glossary reference document.
Social Determinants of Health & Health Equity
Spending Plan Process

Community Impact Advisory Committee approves proposal for development of SDOH-HE spending plan and recommends to Community Impact Committee

Community Impact Committee (CIC) approves proposal for development of SDOH-HE spending

SDOH-HE Oversight Group develops community engagement plan

Sept. – Dec. 2019:
- Community engagement completed
- CCO infrastructure/capacity gaps analysis completed
- Socialize plan with key stakeholders and incorporate feedback

Present at January CAC meeting for approval

Present at January CI Advisory Committee for approval

Submit SDOH-HE spending plan to OHA

Complete final draft of SDOH-HE spending plan

Approve SDOH-HE spending plan at joint Board/CAC meeting

Health Share launches SDOH-HE Oversight Group
Community Health Improvement Plan

October 1, 2014

Health Share of Oregon
208 SW 5th Avenue, Suite 400
Portland, OR 97204
Table of Contents

Acknowledgements.................................................................................................................. 3
Executive Summary.................................................................................................................. 4
Community Health Needs Assessment Findings....................................................................... 7
Alignment of the CHP with Health Share Activities related to Behavioral health and Chronic Disease:
Culturally-Specific Traditional Health Workers...................................................................... 7
  Alignment with Health Share Goals and Activities ................................................................. 8
  Traditional Health Worker Strengths...................................................................................... 9
  Peer Support Services Outcomes............................................................................................ 9
  Community Health Workers Outcomes.................................................................................. 10
  Table 1 - Behavioral Health Activities At Health Share ...................................................... 13
  Table 2 - Chronic Disease Prevention Activities At Health Share ........................................ 14
The Community Readiness Model........................................................................................... 15
  Table 3 - The Tri-Ethnic Center’s Stages of Community Readiness ..................................... 17
  Table 4 - Community Readiness Score for Mental Health & Addictions............................... 20
  Table 5 - Community Readiness Score for Chronic Disease that is Impacted by Physical Activity and 
  Nutrition.................................................................................................................................... 29
Objectives: Behavioral Health.................................................................................................. 36
  Table 6 - Behavioral Health Driver Diagram ........................................................................ 37
Objectives: Nutrition and Physical Activity-related Chronic Disease........................................ 40
  Table 7 - Chronic Disease Driver Diagram........................................................................... 42
  Table 8 - Health Share of Oregon – Top 20 Chronic Conditions Diagnoses Among Non-ACA Expansion 
  Member Population (all ages, as of April 2014).................................................................... 43
  Table 9 - Count of Members Diagnosed by Race and Ethnicity ............................................ 44
  Table 10 - Per-Member Per-Year Cost by Diagnosis and Race/Ethnicity............................... 45
  Table 11 - Top Conditions Identified by Race, Ethnicity, and Gender ...................................... 46
Acknowledgements

We would like to acknowledge and extend thanks to the Community Advisory Council, particularly the Community Health Needs Assessment Committee, who with the exceptional leadership of Sonja Ervin, the Committee Chair, and committee members Joseph Lowe, Tab Dansby and Ronda Harrison, has for the last year engaged in a process to identify the population health issues Health Share will address through 2017. Board member Mel Rader has served as an excellent liaison from the committee to our Board of Directors. Elena Weisenthal, Assefash Melles, Omar Carillo, and Rebecca Naga facilitated our use of the Community Readiness Model, which allowed us to hear directly from our diverse communities about what needs we should focus on related to culturally specific traditional health worker services. The people they interviewed provided rich information that will influence our work from here on out, and we thank them for sharing their knowledge and perspectives. As always, we would like to thank our Members, our reason for being!
Executive Summary

Background

The legislation that created Coordinated Care Organizations (CCOs) to provide services to Oregon Health Plan (OHP) beneficiaries in Oregon included provisions requiring that the CCOs’ Community Advisory Councils, composed of a majority of Oregon Health Plan members, oversee a Community Health Needs Assessment (CHA) and Community Health Improvement Plan (CHP) every three years.

The purpose of the CHA and CHP is to reduce health disparities, promote health equity, and improve overall population health in the region served by the CCO. This Improvement Plan supports strategies that are intended to benefit the broad Tri-County community with particular focus on issues that disproportionately impact our Members, and is funded through State of Oregon Transformation Funds, which are dedicated to innovative projects aimed at improving integration and coordination of care for Medicaid patients.

Community Health Needs Assessment Findings

Health Share of Oregon’s Board of Directors approved two Community Health Needs to be prioritized and addressed through our Community Health Improvement Plan:

- Behavioral Health- Mental Health and Substance Use Disorders; and
- Chronic Disease preventable through physical activity and nutrition

Alignment of the CHP with Health Share activities related to Behavioral health and Chronic Disease: Why Culturally-Specific Traditional Health Workers?

Health Share needed to determine activities to which we would devote one-time Transformation Funds from OHA to address Chronic Disease and Behavioral Health in our Community Health Improvement Plan. In this process we considered following principles to be essential to our activities:

1. Seek input from communities impacted by disparities about what investments would be most impactful, and matching them to the community’s stage of change;
2. Align investments with transformation activities underway at Health Share and through Health Share partners;
3. Measure improvements in health outcomes for members as a result of investments.

The choice of implementing Traditional Health Worker activities through Health Share’s CHP supports our work to eliminate health disparities, allows us to facilitate culturally and linguistically appropriate care, and aligns with performance measures that are only achievable through coordination of services and resources throughout our community.

Behavioral Health and Chronic Disease prevention and management are enormously influenced by the social determinants of health: employment, housing, education, environment, opportunities for physical activity and nutrition, and most importantly, social support and empowerment. This is one of the
reasons that the Health Share Community Advisory Council Mental Health and Addictions Committee prioritized Peer Delivered Services when they made recommendations on what should be contained in the CHP.

As Health Share begins to implement more prevention and health promotion activities in addition to addressing the needs of people with multiple chronic conditions and people already engaged in medical care, traditional health workers can provide an important bridge between the environments in which our members live, work, play and learn, and the clinical systems in which they receive health care.

Based on the organizational assessments for Cultural Competence and Health Equity conducted by Health Share’s Cultural Competence Workgroup, we know that recruiting and retaining a culturally diverse health care workforce to serve our communities is a goal shared by many of the organizations serving Health Share members. Investing resources in culturally-specific traditional health workers is one step Health Share can take to contribute to diversifying the workforce that serves our members.

Finally, achieving Transformation Plan metrics and CCO Performance Measures pertaining to the elimination of disparities in Chronic Conditions and coordination of care for people with Severe Persistent Mental Illness are contingent upon community-based support for our members.

The Community Readiness Model

In order to learn in which aspects of the Traditional Health Worker model to invest, we conducted key stakeholder interviews following the Community Readiness Model process, which was created by the Tri-Ethnic Center for Prevention Research at Colorado State University and is based on Stages of Change model from the addictions and recovery disciplines. The Community Readiness Model is a multidimensional model that integrates a community’s culture, resources, and level of readiness into the design of interventions. Readiness is defined by the Tri-Ethnic Center “as the degree to which a community is prepared to take action on an issue.” ¹

This model was selected by the committee because of its ability to identify the level of readiness of a community to address issues, which helps to support Health Share’s identification of health improvement activities and alignment with impacted communities.

Based on the objectives created based on this input from our communities, we will issue a request for proposals from Community Based Organizations, to provide culturally-specific traditional health worker services, training and outreach to meet objectives specific to the community’s level of readiness.

Implementation of the Community Health Improvement Plan will focus on achieving the following objectives:

Behavioral Health Objectives

- Increased availability of culturally-specific Peer Support workers to Health Share members who identify as people of color, who speak a preferred language other than English, who identify as LGBTQ, who have a disability or who are young or elderly
- Community Based Organizations train primary care provider teams on peer resources, and referral to Peer Support workers
- Culturally-Specific Community Based Organizations employ Peer Support workers to provide education and outreach to communities and individuals about mental health and addictions generally, as well as specific programs and services available to Health Share Members
- Culturally-Specific Community Based Organizations host community discussions about mental health and addictions issues, in order to engage community members in a preventive manner
- Reduce disparities in utilization of Mental Health and Addictions services by members who identify as people of color & who speak a preferred language other than English
- Increase diabetes screening rates for members with Severe Persistent Mental Illness (SPMI)
- Decrease hospitalization rates for members with SPMI
- Increase follow-up after hospitalization for Mental Illness Rates for members with SPMI
- Development of Health Share ability to conduct disparities-sensitive analysis of members diagnosed with SPMI

Chronic Disease Objectives

- Increased availability of culturally-specific Community Health Workers to Health Share members who identify as people of color, who speak a preferred language other than English, who identify as LGBTQ, who have a disability or who are young
- Culturally Specific Community Health workers share information about and lead healthy eating and physical activity groups in their communities
- Community Based Organizations train Community Health Workers on chronic disease outcomes and clinical services related to the CCO’s Quality Improvement Plan
- Community Based Organizations train providers on culturally and linguistically appropriate care and Chronic Disease prevention and management in the primary care setting, including how to integrate the use of Community Health Workers into their practice
- Community Based Organizations employ Community Health Workers to conduct culturally-specific health needs assessments with Health Share Members
- Decreased chronic disease outcomes disparities based on Quality Improvement Plan metrics
Community Health Needs Assessment Findings

Health Share of Oregon’s Board of Directors approved two Community Health Needs to be prioritized and addressed through our Community Health Improvement Plan:

- Behavioral Health- Mental Health and Substance Use Disorders; and
- Chronic Disease preventable through physical activity and nutrition

Of people who are eligible for Medicaid in the tri-county area, according to Providence’s Center for Outcomes Research and Education’s Tri-County Service Profile of 2013:

- 11% have been diagnosed with diabetes
- 28.8% have been diagnosed with high blood pressure
- 21.8% have been diagnosed with high cholesterol
- 43% have been diagnosed with depression or anxiety

Additionally, eight separate community-led self-assessments indicated that Chronic Disease, Mental Health, and Substance Abuse were a priority in the African American, Immigrant and Refugee, Native American/Alaska Native, Asian and Pacific Islander, and Latino/Hispanic communities.

The companion document to this Community Health Improvement Plan, the Community Health Needs Assessment provides detail about the process and data that informed the choices of Chronic Disease and Behavioral Health as Health Share’s priorities.

Alignment of the CHP with Health Share Activities related to Behavioral health and Chronic Disease: Culturally-Specific Traditional Health Workers

Health Share needed to determine activities to which we would devote one-time Transformation Funds from OHA to address Chronic Disease and Behavioral Health in our Community Health Improvement Plan. In this process we considered the following principles to be essential to our activities:

1. Seek input from communities impacted by disparities about what investments would be most impactful, and matching them to the community’s stage of change;
2. Align investments with transformation activities underway at Health Share and through Health Share partners;
3. Measure improvements in health outcomes for members as a result of investments.

To gather input from communities and target investments to the appropriate level of readiness for change, the committee chose to use a modified version of the Community Readiness Model, which is described in detail in the following section of this plan.
In order to align investments with activities underway at Health Share, and ensure improvements in outcomes are able to be measured, staff proposed the following criteria for inclusion in the CHP:

- Member data related to the investment are able to be disaggregated by Race, Ethnicity and Language, and outcomes are being tracked and analyzed by Health Share
- Community based activities can influence Health Share activities and improve outcomes
- Health Share data and findings can influence the development of Community Based Activities.

Based on these criteria, one of the most promising foundations upon which to build an improvement plan is through the incorporation of Culturally-Specific Traditional Health Workers into Health Share’s model of care.

Alignment with Health Share Goals and Activities

The choice of implementing Traditional Health Worker activities through Health Share’s CHP supports our work to eliminate health disparities, allows us to facilitate culturally and linguistically appropriate care, and aligns with performance measures that are only achievable through coordination of services and resources throughout our community.

Behavioral Health and Chronic Disease prevention and management are enormously influenced by the social determinants of health: employment, housing, education, environment, opportunities for physical activity and nutrition, and most importantly, social support and empowerment.

As Health Share begins to implement more prevention and health promotion activities in addition to addressing the needs of people with multiple chronic conditions and people already engaged in medical care, traditional health workers can provide an important bridge between the environments in which our members live, work, play, and learn, and the clinical systems in which they receive health care.

Based on the organizational assessments for Cultural Competence and Health Equity conducted by Health Share’s Cultural Competence Workgroup, we know that recruiting and retaining a culturally diverse health care workforce to serve our communities is a goal shared by many of the organizations serving Health Share members. Investing resources in culturally-specific traditional health workers is one step Health Share can take to contribute to diversifying the workforce that serves our members.

The choice to focus on Traditional Health Workers also allows us to align and collaborate with the work of our Regional Health Equity Collaborative, the HOPE Coalition (now named Oregon Health Equity Alliance or OHEA), which has chosen to focus on Traditional Health Workers as an aspect of Workforce Diversity and Cultural Competency, one of five priorities in its Five Year Plan. The other HOPE priorities being: Chronic Disease and Other Illness Factors, Access to Health Care, Mental Health/Substance Abuse/Addictions, and Improved Data Collection & Analysis.

The HOPE Coalition is a regional partnership of communities of color, health advocates and policy makers working together to create and implement a five-year plan to increase health equity in Clackamas, Marion, Multnomah and Washington Counties. By bringing together...
community voice and experience around the most pressing health equity issues in the region, this partnership is a unique vehicle for driving regional change and making true advances toward health equity.

Grounded in the belief that local communities understand their own needs best, the HOPE Coalition also met with grassroots community leaders and community based organizations to surface their priorities and sustainable solutions for remediating systemic barriers to better health and creating relevant policy change.

**Traditional Health Worker Strengths**

Health Share’s Community Health Improvement Plan resources culturally-specific Community Health Workers and Peer Mentors, who, working in conjunction with Patient Centered Primary Care Homes, bring the following assets and skills to our health systems:

- Close ties to the community
- Cultural competence
- Engagement of patients in disease self-management
- Continuity of communication between provider and patient
- Increased access to preventive care
- Improved compliance with prescribed care
- Enhanced social support
- Addressing the major determinants of health

**Peer Support Services Outcomes**

Locally, we have organizations that have invested in evaluation of peer support services that have shown early positive results. Since 2009, Health Share’s partner organization, Clackamas County Behavioral Health Division, has made significant investments in Peer Support Services to serve the Behavioral Health needs of people in Clackamas County. Evaluation of those investments has shown that Peer Delivered Services have resulted in the following:

- 3118 people served with 1:1 and drop-in group peer services
- 87% Engagement Rate (3 appointments in a 6 week period)
- 80% report improved overall wellness
- 77% report improved quality of life
73% report an increase in natural supports

48% feel accepted in the community

58% report that would have returned to a higher level of care if not for peer delivered services

Early analysis of cost savings data related to Peer Delivered Services in Clackamas County is extremely positive, with high returns on investment accrued by the Jail and Child Welfare in addition to reduced use of the Emergency Room.

**Community Health Workers Outcomes**

Oregon has a long and successful history of using Community Health Workers. In a 2010 study of the Salud program at One Community Health in Hood River, Oregon, the 400 case-managed diabetic patients averaged greater than 10 Hba1c at the outset of the program, and reduced this to 7.8 in one year.

Additionally, the program produced stellar maternal child health results for patients, with greater than 90% 1st trimester entry into prenatal care, and ½ the rate of low birth weight babies than the Oregon Community Health Center average. (Volkman & Castanares, 2010)

Other outcomes achieved through the incorporation of Community Health Workers into the model of clinical care are outlined below:

**Utilization management:**

Presbyterian Hospital in New York State hired CHWs to work with ER triage nurses. The CHWs redirected patients to primary care clinics and increased awareness about the importance of primary care. By the end of the three-year intervention period, the following outcomes had been achieved:

- The rate of broken primary care appointments dropped from 50% to 11%;
- Non-urgent adult ER visits decreased by 42%; and
- The percentage of patients keeping their first primary care appointment stood at 89%.

**Increased access to preventive care:**

For more than 20 years, Kaiser Permanente Hawaii employed CHWs to increase access to preventive care for their Plan X5 Medicaid clients. These CHWs provided information, advice about using Kaiser services, and referrals for basic services such as food and housing. They also case managed plan members who are at high risk because of pregnancy, diabetes, or asthma. One study of this program revealed the following results:

- Plan x5 members used more preventive services than commercial group members;
- They made more visits to nurse practitioners and fewer visits to specialists than other members; and
- Their use of ambulatory care was similar to that of commercial members. (Knobel, 1992).
Enhanced patient-provider communication:
CHWs can function as “cultural brokers” between the patient and clinic, which can lead to increased understanding and acceptance on the part of both providers and patients (Volkman & Castañares, 2011). They translate complicated information about medical regimens into language which patients can understand (Giblin, 1989), and can elicit more complete information about symptoms and risk factors, leading to more accurate diagnoses and more appropriate care (Castañares, 1992, personal communication).

Improved compliance with prescribed care:
CHWs have been shown to effectively explain diet, exercise and medication regimens in terms which patients can understand, which allows them to improve rates of compliance with care. (Witmer, 1995). For example, CHWs who work with high-risk populations to improve control of hypertension have been shown to increase the number of patients that keep appointments and who comply with prescribed regimens (Rosenthal et al., 2011).

Improved chronic disease management:
Hypertension: A study by researchers at Johns Hopkins University revealed that a five-year intervention by CHWs was associated with a twofold increase in the percentage of controlled hypertensive patients (from 38% to 79%). The treatment group also experienced a 35% decrease in hospitalization and a 65% decrease in mortality from uncontrolled hypertension (Levine et al., 1992). In a more recent literature review of CHW effectiveness in the care of people with hypertension, significant improvements in blood pressure, self-management behaviors, and health care utilization were found (Brownstein et al., 2007).

Diabetes: CHW interventions involving home visits, group sessions, and/or joint provider-CHW visits, compared to control groups with usual care and access to educational materials, showed significant positive outcomes in 6 of 8 studies reviewed, including improvements in HbA1c and improved self-reports of dietary changes (Institute for Clinical & Economic Review, 2013). In Hood River, Oregon, CHWs support over 400 diabetic patients, reducing their average HbA1c from >10 to 7.8 in 1 year (Volkman & Castanares, 2010).

Enhanced social support:
There is overwhelming evidence that social and emotional support can help to protect against a number of health issues (Reblin & Uchino, 2008), including depression and poor perinatal outcomes (Jackson, 2007). The high level of trust that CHWs are able to establish with patients allows them to provide informal one-on-one counseling and to create and facilitate social support groups.

Educating the health care system about community norms and needs:
CHWs educate providers and administrators about the health needs of communities and help increase cultural competency (Rosenthal, 2011; Smedley et al., 2002; Witmer et al., 1995).

Under a contract with the Oregon Health Sciences University (OHSU), from 1993-1995 CHWs from La Familia Sana, Inc. in Hood River facilitated workshops for medical and nursing students. CHWs taught the students about traditional Mexican folk illnesses such as empacho and mal de ojo. They also helped the students look beyond their class and culture to understand other people’s ways of viewing health and illness.
Improved patient and community empowerment:
CHW interventions have been associated with increases in empowerment at the individual, organizational, and community levels (Wiggins, 2012). Empowerment is independently associated with improved self-reported health and decreased depressive symptoms (Wallerstein, 2006).

Addressing the social determinants of health:
As community members with knowledge of health issues and the health care system, CHWs are uniquely situated to mobilize their communities to address the root causes of ill health (Wiggins and Borbón, 1998). Many studies have found evidence that CHWs are able to organize communities to address the social and structural issues that traditional health care providers are often unable to address (Ingram et al., 2013; Eng & Young, 1992). The true “value-added” from the CHW model comes when CHWs are encouraged to use their unique abilities to address the major determinants of health (Wiggins and Borbón, 1998).

Return on investment (ROI):
Many CHW activities save money. When CHWs connect community members to primary care homes or other lower cost medical services, they often prevent the usage of higher cost medical services like the emergency room. When CHWs help patients manage chronic disease and access preventive services, they help achieve long-term savings for both patients and health systems. Return on investment calculations for CHW programs range between $2.28 to $4.80 for every dollar spent on CHWs (Angus et al., 2012). A CHW program in Baltimore has produced an average savings of $2,245 per patient per year and a total savings of $262,080 for 117 patients (Angus et al., 2012).
Table 1 - Behavioral Health Activities At Health Share
○ = alignment with CHP
Table 2 - Chronic Disease Prevention Activities At Health Share

- **Activitie**s Related to Chronic Disease at Health Share
  - **Culturally Specific Community Health Worker Pilot Project:** Support people to make lifestyle changes and find resources to manage and prevent Hypertension and Diabetes
  - Transformation Fund Project: Healthy Homes Asthma Program
  - **Healthy Columbia Willamette:** Breastfeeding Benefits Standardization
  - CCO Performance measure: HbA1c Poor Control
  - Transformation Plan Metric (Exhibit K) Quality Improvement Plan to Reduce Disparities in Chronic Disease
  - Transformation Fund Project: Bringing Health Home - Public Health Nurses in housing complexes facilitating Chronic Disease Self-Management
  - CCO Performance metric: Controlling High Blood Pressure
  - **Performance Improvement Project:** Improve Screening rates for Diabetes for People with SPMI

O = alignment with CHP
The Community Readiness Model

In order to learn in which aspects of the Traditional Health Worker model to invest, we conducted key stakeholder interviews following the Community Readiness Model process, which was created by the Tri-Ethnic Center for Prevention Research at Colorado State University and is based on Stages of Change model from the addictions and recovery disciplines. The Community Readiness Model is a multi-dimensional model that integrates a community’s culture, resources, and level of readiness into the design of interventions. Readiness is defined by the Tri-Ethnic Center “as the degree to which a community is prepared to take action on an issue.” 2

The main components of our Community Readiness process were as follows:

1. Adapting the Community Readiness Model survey instrument to Health Share’s specific health priorities: are (1) mental health and addictions and (2) nutrition and physical activity related chronic diseases.
2. Streamlining the Community Readiness model to accommodate our limited timeframe and resources.
3. Identifying, contacting, and arranging to interview community members. We chose to interview people from communities disproportionately impacted by health disparities, and sought to interview consumers and community leaders who identify with the following communities: African American; Latino/Hispanic; Native American/Alaska Native; Asian & Pacific Islander; Immigrants & Refugees; and the Slavic community.
4. Interviewing a total of 40 consumers and community leaders.
5. Transcribing the audio recordings of the interviews.
6. Scoring the interviews to determine the community’s stage of readiness according to the Community Readiness Model’s anchored rating scales.
7. Analyzing the interviews for common themes and key observations.
8. Reporting the results.

III. Methods

III.A. Adaptation of the Community Readiness Survey Instrument

The Community Readiness Model provides a set of 36 generic questions that are mapped to six dimensions of community readiness. These questions were adapted to Health Share’s identified priorities: (1) mental health and addictions and (2) nutrition and physical activity related chronic diseases. Some questions were tailored to be even more specific and elicit responses related to the use of culturally specific peer support services for mental health and addiction and the use of community health workers for work related to chronic diseases. Additionally, for some questions we added specific prompts, follow up questions, and definitions of terms. The questions were adapted by the consultant with feedback provided by Health Share staff members, Community Health Needs Assessment committee members, and the persons hired to conduct the interviews.

In order to further streamline the process and elicit the information that would be most useful to the Community Health Improvement Plan process, we excluded all but one question related to Dimension C: Leadership, as we felt the questions would not yield new information. As a result, we still collected information on community leaders (see Appendix E) but did not score Dimension C.

Three interview instruments were created (see Appendices A, B, and C):

- Mental Health and Addictions, with 25 multi-part questions.
- Chronic Disease, with 27 multi-part questions.
- A combined instrument with both sets of questions for community members interviewed about both issues.

Each interview instrument includes introductory and closing scripts. A set of instructions for recording the interviews and tips for conducting the interviews was created and distributed to the interviewers.

**III.B. Recruitment of Community Members for Interviews**

We chose to interview people from communities disproportionately impacted by health disparities, and began searching for consumers and community leaders who identify with the following communities: African American; Latino/Hispanic; Native American/Alaska Native; Asian & Pacific Islander; Immigrants & Refugees; Slavic community.

Health Share staff reached out to more than 75 community organizations and individuals in order to identify potential stakeholders for these interviews. We focused on reaching out to people who identify as youth, with the disability community, and with the LGBTQ community. We wanted to place special focus on hearing from people within these communities because during the Community Health Needs Assessment process we were unable to find many self-led community assessments of health needs.

Our Community Health Improvement Plan (CHP) is primarily focused on identifying opportunities to integrate Traditional Health Workers into systems of care providing behavioral and physical health services, so we also sought to locate individuals who have received and/or provided traditional health work. These include peer support specialists, health navigators, community health workers, doulas, etc.

Additionally, our Community Advisory Council advised Health Share to seek out and obtain input from Health Share Members to learn about their needs for inclusion and emphasis. From July – September 2014, additional outreach to Health Share members took place, resulting in a total of 40 interviews with community stakeholders. Among those 40 interviews, 31 were Health Share members or came from households with Health Share members.

**III.C. The Interviews**

Forty community members were interviewed in 38 interview sessions. Two interviews were conducted as joint interviews with two individuals at the same time. Four different interviewers conducted the interviews at community locations. Two of the interviews were conducted in Spanish using interpreters.

The audio of all the interviews were digitally recorded with the participants’ consent.
Fourteen persons were interviewed using the mental health and addictions instrument, nine persons were interviewed using the chronic disease instrument, and seventeen persons were interviewed with the combined instrument, for a total of 31 persons asked the mental health and addictions questions and 26 persons asked the chronic disease questions.

III.D. Transcribing, Scoring and Analyzing the Interviews

All recordings were transcribed as accurately as possible.

The transcribed interviews were scored using the Tri-Ethnic Center’s anchored rating scales for the five dimensions that we chose (out of six possible dimensions). Each interview was scored individually and then an average was calculated for each dimension using the scores for all the interviews. An overall stage of readiness score was calculated by averaging the stage of readiness for each dimension. Scores were calculated for the mental health and addictions and chronic disease separately.

### Table 3 - The Tri-Ethnic Center’s Stages of Community of Readiness

<table>
<thead>
<tr>
<th>Score</th>
<th>Stage of Community Readiness</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No Awareness</td>
<td>Issue is not generally recognized by the community or leaders as a problem (or it may truly not be an issue).</td>
</tr>
<tr>
<td>2</td>
<td>Denial / Resistance</td>
<td>At least some community members recognize that it is a concern, but there is little recognition that it might be occurring locally.</td>
</tr>
<tr>
<td>3</td>
<td>Vague Awareness</td>
<td>Most feel that there is a local concern, but there is no immediate motivation to do anything about it.</td>
</tr>
<tr>
<td>4</td>
<td>Preplanning</td>
<td>There is clear recognition that something must be done, and there may even be a group addressing it. However, efforts are not focused or detailed.</td>
</tr>
<tr>
<td>5</td>
<td>Preparation</td>
<td>Active leaders begin planning in earnest. Community offers modest support of efforts.</td>
</tr>
<tr>
<td>6</td>
<td>Initiation</td>
<td>Enough information is available to justify efforts. Activities are underway.</td>
</tr>
<tr>
<td>7</td>
<td>Stabilization</td>
<td>Activities are supported by administrators or community decision makers. Staff are trained and experienced.</td>
</tr>
<tr>
<td>8</td>
<td>Confirmation / Expansion</td>
<td>Efforts are in place. Community members feel comfortable using services, and they support expansions. Local data are regularly obtained.</td>
</tr>
<tr>
<td>9</td>
<td>High Level of Community Ownership</td>
<td>Detailed and sophisticated knowledge exists about prevalence, causes, and consequences. Effective evaluation guides new directions. Model is applied to other issues.</td>
</tr>
</tbody>
</table>

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The transcribed interviews were also analyzed using standard qualitative methods. The transcript answers were combined into a master document organized by topic. The consultant reviewed the master document to identify patterns, trends, and anomalies within the responses.

*Technical Note:* The interviews were transcribed as accurately as possible, but it is not always possible to get the exact language used for each response. The interview excerpts used in this report have been stripped of words such as “um,” and “you know.” Excerpts may be truncated for clarity and focus. At times words were inserted in brackets to facilitate reading and add clarity.

**IV. Communities Represented**

Below is a summary of the 40 stakeholders that were interviewed. Among these individuals, 30 self-identified as either being a Health Share member or caring for family members with Health Share or OHP benefits:

- African American Community Health Worker from Multnomah County based in NE Portland who runs a Patient Wellness Council and has experience using OHP.
- African American Community Health Worker from Multnomah County employed by a local FQHC who is also a trained doula and provides breastfeeding classes, with a focus on people with substance use and the formerly incarcerated.
- Latina Breastfeeding Peer Counselor from Multnomah County who is in training to become a doula and is a leader of a local breastfeeding coalition.
- Native American woman from Washington County identifying as a youth and challenged by disability who has Health Share benefits.
- Refugee from Somalia who is a recognized leader of immigrant refugee justice issues who lives in Multnomah County and serves the metro region in his leadership role.
- Chuukese Pastor and community health worker from Micronesia who provides culturally-specific services throughout the tri-county region.
- Latino peer support mentor for Latinos in recovery who lives and works in East Multnomah County.
- Caucasian woman who is a supervisor of peer support services program with over 20 years of direct experience serving and living in Clackamas County.
- Slavic community leader of Russian descent who lives in and serves Clackamas County.
- Latina youth from Multnomah County involved with a volunteer community health organization promoting healthy eating in her neighborhood who has Health Share benefits.
- Spanish speaking mother of four from Mexico who is obese with hypertension and identifying as someone with mental health disabilities, uninsured with four children covered by OHP.
- Spanish speaking mother of three from Mexico who identifies as someone with mental health disabilities, also uninsured with three children covered by OHP. These two mothers are trained volunteer community health workers who are currently unemployed.
- Vietnamese community mental health therapist from Clackamas County who specializes in serving Vietnamese refugees and immigrants for over 14 years.
- Bhutanese/Khmer refugee who is a community mental health therapist from Multnomah County who specializes in serving refugees with trauma for over 10 years.
- African American man with HIV identifying with LGBTQ community who provides peer support services and chronic disease self-management services throughout the tri-county region.
Ugandan immigrant who provides culturally-specific peer navigation and medical case management services to people with chronic conditions from the African and African-American community.

Burmese case manager providing culturally-specific services supporting newly resettled refugees within the tri-county region.

Iraqi community activist and refugee advocate from Washington County who is a practicing psychiatrist focused on supporting refugees from Africa and the Middle East.

African American peer support specialist who oversees a housing program for women in recovery returning to the community following incarceration.

African American and Native American adult student who has received and provided peer recovery services and who has been incarcerated, identifying as having a mental health disability.

A Muslim woman who identifies as Malaysian and who grew up in Singapore currently living in Washington County.

A young woman living in Multnomah County who identifies with the Somali-Bantu community.

Ethiopian immigrant identifying as part of the Oromo community who lives in Multnomah County.

Congolese immigrant youth from Multnomah County identifying with mental health disability.

Sudanese immigrant from Clackamas County.

Somali immigrant identifying with the Beaverton and Portland refugee community who lives in Washington County.

Congolese immigrant from Washington County.

African American youth from Multnomah County identifying with homeless/unhoused community, mental health community, LGBTQI community, and African community.

Caucasian woman with physical disabilities from Multnomah County.

Somali immigrant from Multnomah County identifying broadly with the African immigrant and refugee community.

Community health worker and trained peer support specialist with ties to African American and Native American community, LGBTQI, and recovery community from Multnomah County.

Vietnamese community health worker from Multnomah County.

Immigrant from Iraq who lives in Clackamas County identifying with the Middle Eastern community and people with physical health disabilities.

Latina from Washington County identifying with mental health disability who has children covered by Health Share.

African American woman from North Portland/Multnomah County.

Caucasian woman with physical disabilities and chronic disease from Clackamas County.

African American youth with developmental disability identifying with LGBTQI community.

We met our goal of interviewing people representing African American; Latino/Hispanic; Native American/Alaska Native; Asian & Pacific Islander; Immigrants & Refugees; Slavic communities, and 30% of those we interviewed self-identified with the youth, LGBTQ, and/or disability community. Slightly more people from Multnomah County were interviewed than from Clackamas or Washington County.

The people who were interviewed were asked to identify natural leaders within their community who they trust and rely on for access to information about behavioral health and/or chronic disease concerns. In our work to transcribe the interviews we identified:
• 32 specific organizations or programs that are trusted by stakeholders for chronic disease
• 6 community leaders and 4 community plans related to chronic disease prevention efforts
• 60 specific organizations or programs that are trusted by stakeholders for mental health and/or addictions issues
• 22 community leaders and 46 community plans or active programs related to mental health and/or addiction support.

Technical Notes:

• Two of these interviews were conducted with two persons at the same time.
  ○ One of the joint interviews was scored as one interview because both interviewees were from the same communities and neighborhood and one of the interviewees dominated the conversation. Both interviewees were in agreement for most, if not all, of the questions.
  ○ For the other joint interview, it was clear in the audio recording which person was speaking, each interviewee answered almost all questions separately, and the interviewees were from different communities. These interviews were scored separately.
• One interviewee did not identify as a person of color but is from a county underrepresented in the interviewee pool, and supervises peer support specialists and peer navigators. This interview represented an outlier in terms of scoring. The scores for this interview were not included in the total scoring and overall stage of readiness. Comments from this interviewee are included in the results section because the content is relevant and represents a unique (for this pool) geographic perspective.
• For one interview that used the combined instrument, there was not enough time to complete the Chronic Disease portion of the interview (the interviewees were also asked the Mental Health & Addictions questions). This interview was not scored, however, comments from these interviewees may be included in the results section.
• Due to a technical error when the interview instruments were adapted, questions representing the last dimension, Resources Related to the Issue, were not asked to every interviewee. Only five of the participants for mental health and addictions answered these questions. The calculation of the scores reflects this. These scores were included in the Overall Stage of Readiness Score.
• Due to technical error, the audio recording for two of the interviews is missing parts of each interview. The interviewers were able to reconstruct the salient answers for the missing audio and this was used to score the interviews.

V. Mental Health and Addictions Results

V.A. Dimensions, Scores, and Stages of Readiness

Interviews were scored and the stage of readiness calculated for each dimension, as well as calculating an overall stage of readiness score as discussed in the Methods section.

Table 4 - Community Readiness Score for Mental Health & Addictions

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Total Score</th>
<th>Stage of Readiness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category</td>
<td>Score (average for all interviews)</td>
<td>Stage</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>------------------------------------</td>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>Community Efforts (programs, activities, policies, etc.)</td>
<td>5.1</td>
<td>Preparation</td>
</tr>
<tr>
<td>Community Knowledge of the Efforts</td>
<td>3.5</td>
<td>Vague Awareness / Preplanning</td>
</tr>
<tr>
<td>Community Climate</td>
<td>4.8</td>
<td>Preparation</td>
</tr>
<tr>
<td>Community Knowledge About the Issue</td>
<td>4.1</td>
<td>Preplanning</td>
</tr>
<tr>
<td>Resources Related to the Issue (people, time, money, space, etc.)</td>
<td>4.8</td>
<td>Preparation</td>
</tr>
<tr>
<td><strong>Overall Stage of Readiness (averaged across all dimensions)</strong></td>
<td><strong>4.5</strong></td>
<td><strong>Preplanning / Preparation</strong></td>
</tr>
</tbody>
</table>

According to the Community Readiness Model, the goal of strategies for the communities in the Preplanning stage is to “raise awareness with concrete ideas to combat the condition.” The goal of strategies for the communities in the Preparation stage is to “gather existing information with which to plan strategies.” These goals can help inform the development of appropriate peer support services to address mental health and addictions issues.

The Community Readiness Handbook states, “To move ahead, readiness on all dimensions must be at about the same level – so if you have one or more dimensions with lower scores than the others, focus your efforts on strategies that will increase the community’s readiness on that dimension or those dimensions first. Make certain the intensity level of the intervention or strategy is consistent with, or lower than, the stage score for that dimension. To be successful, any effort toward making change within a community must begin with strategies appropriate to its stage of readiness.” The lowest scored dimensions for mental health and addictions is community knowledge of efforts and community knowledge of the issue. This is supported in the thematic analysis of the interviews: community education was a repeated theme.

**V.B. Themes from Interviews**

**Mental Health and Addictions: Concern, Knowledge, and Feelings**

Most people interviewed said that mental health and addictions issues in their communities were very concerning, and when asked to rate the concern in their communities on a scale of 1-10, most interviewees who gave a number chose a rating of 8 or higher.

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4 Community Readiness Handbook


6 All the scales used in the interview questions use 1 as the lowest level and 10 as the highest (whether it is concern, knowledge, usefulness, etc.).
One interviewee said, “I think it is a big concern for folks but there’s so much stigma surrounding it. So I think if you were to talk to people on an individual basis they might be like, ‘Oh, it’s not that much of a concern’ but in reality it is, when you see it played out...”

One interviewee said, “In the African American community I’m kind of split on that because I believe there is some awareness, so I would probably be somewhere around a 6, however, I also feel that a lot of it is denied or kind of ignored and so on that I would probably say like a 3 which is a great concern to me.”

Not all interviewees interpreted this denial as a lack of concern however, “I think when I’m talking about the black community, African American community, I think that we would probably be a 10. Did you want the reason why? It’s been culturally a pattern in our lives as African Americans that we don’t talk about our issues and problems so there’s a lot of mental health issues around depression that people in our community deal with that’s never addressed as well as using drugs and alcohol to offset that.”

For mental health issues in particular, denial, stigma (cultural and/or familial), and lack of education or knowledge, were common themes. Some interviewees felt that communities had more knowledge of addiction issues compared to mental health issues, and that addiction issues were somewhat more acceptable in their communities compared to mental health issues. Multiple interviewees brought up that alcohol and drugs were used to deal with mental health issues that went unaddressed.

One interviewee said, “I think in the Native American community which is oftentimes as well the impoverished community, mental health and addictions is a very great concern and I think that potentially they aren’t privileged to have the knowledge about mental health, so it turns into addictions. I don’t know if you talked to people in the community that they would say mental health is a great concern in the Native American community but I think that’s mostly because there’s so little knowledge shared about it in the community around mental health but that there’s definitely a lot of negative coping mechanisms that lead to addictions and people just don’t know how to put that into words.”

A common theme was that there was generally knowledge and some support for addictions issues, whereas there was a great need for more education in their communities around mental health.

One interviewee said, “I feel like we do great with the addiction but I don’t see much for mental health. When we say mental health I mean like your everyday diagnosis or you know a diagnosis of a mental health issues like depression. . . I feel that for me, raised in the African American community, the black church community, if you say that you’re depressed it’s like you’re not trusting God enough to help you through whatever struggle you’re going through ... so I don’t think there’s really places that offer mental health service for the African American community to be...”

Another common theme is that persons only become concerned and/or educated about mental health and addictions issues when they or family members are in crisis. One interviewee said,
“We ... come from a community that has a lot of fear of stigma so people will keep in denial and only when...facing certain problems, that's when they'll be forced to ask for some kind of service, so mostly they do not understand.”

Some interviewees just feel that their communities’ needs are not a priority for mainstream institutions, “I think the overall feeling for a lot of community members that are in need is that they're forgotten, that their needs are not on the top of the list or prioritized, and that no one really cares. I think that's kind of it, that they're a forgotten invisible population of people that no one really cares about.”

Mental Health and Addictions: Needs / Improvements/ Barriers

The community needs cited and improvement suggested are:

- More education for individuals and the communities, particularly around mental health issues.
- More outreach and information dissemination, about mental health and addiction information generally, as well as specific programs and services available.
- Removal of the stigma around mental health and addictions issues, and encourage more community discussion.
- Culturally specific services.
- Services specifically for the elderly.
- Services specifically for youth.
- Improved access to mental health and addiction services and programs before individuals and families are in crisis.
- Use a person-centered approach to deliver services.
- Employ more people from communities being served.

Community education to disseminate information, start conversations, and remove stigma, was commonly suggested as a great place to start. One interviewee said, “I think educating people about mental health and what that is in the community is a good place to start.”

A Latina-identified Health Share member from Washington County said that “trying to access mental health services with OHP is really hard... The only way I was actually able to stabilize was landing in a hospital. I couldn’t get an appointment when I was going into a mental health crisis.”

Another interviewee explained the connections between stigma and community education, “I don't think everyone ... identifies with mental health and what that looks like and so I feel like if they don’t, if they can't identify with it, they don’t know how to address it, and so I think education is a big piece that's missing in the community. I think people struggle that a label of mental health means you're crazy for lack of better words and so I think that there’s that barrier because people aren't educated ... I also think that just from growing up in different cultures, different... just being brought up in a different culture, I think mental health has a different stigma for different people like it was a sign of weakness or it was something you didn’t talk about as far as how I grew up...”

Access to mental health services in languages other than English was another commonly stated need. Cultural differences between generations of immigrants due to assimilation, was also repeated as a
need to be addressed. One interviewee said, “There is a lot of issue regarding the language... and also regarding access to care access ...in my community ... there's an elderly population of the age now that they need more even more services. In the same token, the youngsters, the youngest ones who might be understood and understand the language very well but then they absolutely have no idea where they're coming from, that's the issue as well. And sometimes they fall through the cracks cuz there's no services available to them as well.”

Improving access to services before crisis or problems with the law or other institutions was repeated by multiple interviewees: “You know, it wasn’t like an advertisement, it wasn't like, ‘oh you need the Oregon Health Plan, you can sign up here’ you know it was like ‘oh, you're in trouble, these are your options.’ You know what I mean? And so it took me being involved in the correctional system or getting DHS involved with my children for me to know that ‘okay, I've got some issues and I'm gonna have to do something about it and now I have some options.’”

“I think that a lot of people often feel that they’re not the priority. They feel that some sort of...like you have to set up a goal plan and you have to meet those goals in order to continue receiving services and I feel like a lot of people feel more like a cog in the wheel and they’re just going through a set of programs instead of the priority is this person and we’re trying to help them reach their goals. It's more of ‘well we need funding so we have to have you do this and this and this and this and this’ and it starts to feel less and less like it has anything to do with you and more and more about um a business continuing to be a business.”

Many barriers to accessing mental health and addictions services were cited throughout the interviews. Many of these barriers are interrelated. These barriers include:

- Not enough services, long waits.
- Not knowing what or where services are available or how to access services.
- No or limited services that are linguistically and culturally specific.
- Problems using interpretation services, especially for mental health services.
- Inability to acknowledge the issue due to lack of knowledge, stigma, and/or other cultural issues, and therefore care is not sought.
- The bureaucracy and administrative hurdles of getting into care and staying in care.
- Lack of medical coverage.
- Undocumented status.
- Being screened out of available services due to serious mental illness or active addictions.
- Racial oppression.
- Homelessness.

When asked how the community gets access to the physical and mental health services that are available, a common response was that no services are available, or there is no knowledge of available services. One interviewee responded, “The only thing I know is that you have to look for help, but the big question is where?”

Another interviewee stated, “Access, I think is sometimes hard for people cuz they just don’t know. And
organizations aren't always the best communicators as well.”

“There's not enough culturally specific counselors, and if you taught counselors who will be able to support community members and because again if you have a Somali person or a Latino person and the person who's supposed to be counseling is from the dominant culture and don't understand the historical cultural aspect of that individual it makes very very difficult for people to trust.”

“...Mostly it's relying on interpretation services. There is now a good chance that the certification process that will improve because unfortunately there's a lot being missed in the interpretation, but anyway, that's the way to access...For the mental health services it's more difficult you know interpretation cannot help all the time when it comes to issues it's about language.”

“Unable to be transparent and say I need help because it's been like we're supposed to be strong people. [In the] African American community you’re supposed to be strong people and so you end up carrying things. So instead of saying ‘hey this is really breaking down my body cuz I'm carrying this’ or ‘I'm struggling with ___’”

“Sometimes it's hard to get health coverage because people are afraid if they have a legal record that they'll be denied coverage or that they will be turned in or something or they, I mean there's people who have a really hard time filling out papers so that can be frustrating or they just don't know what's available...getting access that can be one thing that's the hardest because first you have to introduce the idea, the concept to people and whenever it becomes bureaucratic, whenever it gets stuck somewhere, or whenever there's a problem that arises, it can really turn someone off from the situation because there’s a lot of these people who ... aren't very used to it .... the system doesn't work for them essentially.”

Peer Support: Awareness

Most interviewees had difficulty citing culturally specific peer support services that are available in the community. Some interviewees could not think of any, some only a few places. Many interviewees said there is not enough peer support services, although the need is high.

“Yea I can say that there's zero. We don't have any formal peer support services for the family members. Of course we have our traditional ways of dealing with these issues and mostly it's about denial of course and providing support indirectly ... So when we provide support to each other its not the appropriate scientific or academic services.”

When asked to use a scale from 1-10 to how aware are people in your community of peer support services to address mental health and addictions issues, the answered ranged across the scale from 1 up to 8, with the average around 5.
A sentiment that was repeated is represented in this comment, “I would say like 5 because how they can know something that hasn’t been provided to them, you know what I mean?” Others thought there were some services, but that the community often isn’t made aware of those services and programs, “Very little awareness, there needs to be a whole lot more messaging toward that.”

Others felt there were some community members who were “in the know,” usually those who worked in the field and/or had personal or familial experiences with mental health or addictions issues. “I think the few wellness specialists out there that are African American are very aware of it so maybe they have been through that themselves so they know how to support people in that.”

Peer Support: Strengths

The strengths of peer support as described by the interviewees were as follows:

- Shared understanding of common culture, community, language, values, and/or history.
- Shared or common experiences; lived experiences.
- Honest, open, non-judgmental support.
- Meeting the person where they are – both physically (e.g. going to court) and in their readiness for treatment or recovery.
- More availability (e.g. non-business hours) than other types of services.
- Ability to help navigate multiple, complex systems that often have emotionally fraught implications (e.g. DHS Child Protective Services)
- Bringing awareness, “starting the conversation.”

“Is that the people who are providing the service are people who have walked through exactly what they’re trying to help the next person walk through. They’re saying ‘this is what I’ve done, this is what worked for me, I’ve been where you’re at, and so if you’d like, I can help you walk through this and this is what we can try’ so being able to identify with someone and it’s not just feeling like someone who was taught what to say or who did some research and or that has the education behind it but doesn’t have the experience, like being able to identify with the person you’re working with gives you a level of trust...”

“I think in the Native Community having peer support is massively important to have other Native Americans because there are things that are part of the culture that people who grew up outside of the culture have a really really hard time understanding the concept when it comes to even basic philosophy, finding...Native Americans often find very different value than other communities so I think that it’s important...

“. having someone who’s not going to judge you, someone who you can identify with, someone who you can see as a result of the choices that they’ve made that this is what works.”

“The strengths is that its the people... because they want to help and they know how to help you know like I seen provider, he keep on a schedule from 8-4 in the office but there it’s 24 hours a day and peer support is ready those 24 hours so it’s very helpful.”

Peer Support: Barriers, Needs, and Improvements
The following were the barriers, needs, and suggested improvements specific to peer support around mental health and addiction issues:

- A need for more peers and peer support programs.
- More culturally and linguistically specific peer support services for specific groups.
- Utilize persons with lived experiences for peer support.
- Ability to work with people in a preventative mode instead of in crisis.
- Training for potential peers.
- Mentor / support peers to become mental health and addiction professionals.
- Centralized services – one stop shopping.
- Trust the community and existing organizations.
- Creating coalitions of organizations and/or peers that are doing culturally specific peer support.
- Raising awareness in communities about existing peer support services and programs.
- Getting people to services if there is cultural stigma or other barriers.
- Funding!

A general feeling was that more peers and peer support programs were needed. “That we have more of them. I believe that if we had more peers I think that would be helpful. So, finding the funding…”

“... maybe it might be teens that are homeless that you're looking at that population and teens of color and you know maybe there’s abuse or maybe you’re looking at incarcerated women or men ... because really crazy stuff happens to people when they're incarcerated and there's a lot of mentally ill people there and people that have addictions that guide them there in the first place. So I think even if you looked at the incarcerated population so that when they do return out into the world, that their needs are met and that they have a good support system…”

“...I do feel like it's changing but more needs to happy. Many people in my community [African American, LGBTQI] and that I know and see – more just needs to happen to make that change. Not just going to be overnight.”

“... I think the issues for me is that's not enough culturally specific services available for immigrant refugees and people of color so that's a really big issue for me and culturally specific providing means to me means that people... the agencies and individuals who are from the community [are] running those programs, so meaning that the immigrant refugee organization is led and based on the immigrant refugee population and people of color find those programs ... we don't have enough services available from those perspectives.”

“There's not nearly enough peer-wellness specialists that are really of many different ethnicities or even languages so maybe looking at now we're starting to see bigger populations of Somali folks, Russians, or Vietnamese, just looking at those different populations that really aren't being served well in those aspects.”

“I've talked to several individuals that I've work with that identify with that and say it's a struggle for them to sit down with someone who has absolutely no idea, who's never been through DHS involvement,
that's never been incarcerated due to their addiction or mental health and they go, 'Whoa. Wow you're a college graduate but you've never had any of this so how do you understand?' and that's a struggle for them.”

One interviewee brought up the desire for more peers to in order to work with people in a preventative mode instead of in crisis, “We're always dealing with the emergencies, we're not doing enough frontloading so that's why it's really really important to adapt these programs if we were working with people before they got to crisis cuz when they get to crisis, there's nothing, I mean there's just absolutely nothing...Transportation, you know companionship, people who can talk about what the doctor just said in a meaningful way that they hear what the doctor said and they understand it cuz the doctors are doing better with you know speaking culturally where people understand that there's a lot to be done.”

“What could improve the situation is actually in providing training, we do not have training ... so at the end of the day it's an issue of funding to provide the training to expand service.” “There's so many different populations you can work with to create peer specialist or advocates in those fields that could really become leaders in their communities and you start to empower people in that way to you know to take a path towards healing really but there also does need to be professional mental health consultants that are culturally appropriate for folks. Because people like to see reflections of themselves. And I know that's not stressed enough, I know that we live in Oregon where it's a very white population in some aspects and it its changing but as far as providers go, it still is not nearly where it should be.”

“I think that different organizations like Health Share or CCOs or hospital systems don't trust the community members or ... nonprofits enough to know that they know their community so I think that they need to tap into the resources that are already there and local nonprofits know what's going to work for their communities. . . let the community speak for itself.”

When asked if peer support services are not accessible to certain people in your community, for example, individuals of a certain age group, ethnicity, income level, geographic region, etc, groups with no or limited access include:

- People outside of Portland – lack of culturally appropriate services in other areas of the counties.
  - East Portland / Gresham was specifically discussed
- Undocumented immigrants, who have difficulty accessing services and who may have specific mental health issues.
- Refugees, who may have specific mental health issues.
- People who speak languages other than English.
- Youth.
- Women with children and addiction issues.
- Persons who don’t / can’t leave the house: women (in some cultures), elderly, disabled

“Geographic region I would probably say would be the biggest thing. It's kinda difficult for me to get out there because there's only two NARA locations and they're both in Portland and they have specific uses
so if I wanna see the doctor, I have to go really really really really far and really really early in the morning.”

“In the Latino community it’s hard...even if they got insurance, medical, there’s no service like right now for a woman to go to a treatment only if she speaks English, if she does not speak English it’s outside, you know, left out which is you know, and same thing for men, you know in Oregon...I hear one Latino treatment and I send some guys who were there and it’s only one, like they’ve got 14 beds...we are thousands outside...even if they’ve got insurance or a health plan, there’s no service for the Latino, no bilingual facility or culture of people who can address the problem.” “Also with women. If we weren’t prosecuting women that were heavy in their addiction, if we were really working with them to coordinate serves to help support them to get through that hard time instead of just removing their children, we wouldn’t see women repeatedly having baby after baby to try to replace the ones that they lost because they were removed... women that are in the middle of their addiction really need a place to go to where they can receive comprehensive whole-person care where they can receive holistically so if we could really do a better job of providing services to them.”

“We need them for the youths. For the mothers in the house who are not coming out - you know this is our culture [Iraqi refugee] the woman will be in the house and they will not go out, they need outreach to them in the community.”

All the interviewees that were asked if there a need to expand these peer support services to address mental health and addictions issues, said yes, there was a need to expand peer support services to address mental health and addictions issues. “The funding isn’t adequate.”

“I think the [peer support] model is amazing, but there’s not a lot of funding for it. But it’s well needed.”

**VI. Chronic Disease**

**VI.A. Dimensions and Scores**

Interviews were scored and the stage of readiness for each dimension was calculated, as well as an overall stage of readiness as discussed in the Methods section.

**Table 5 - Community Readiness Score for Chronic Disease Impacted by Physical Activity and Nutrition**

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Total Score (average for all interviews)</th>
<th>Stage of Readiness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Efforts (programs, activities, policies, etc.)</td>
<td>4.8</td>
<td>Preparation</td>
</tr>
<tr>
<td>Community Knowledge of the Efforts</td>
<td>3.8</td>
<td>Preplanning</td>
</tr>
<tr>
<td>Community Climate</td>
<td>4.4</td>
<td>Preplanning / Preparation</td>
</tr>
<tr>
<td>Community Knowledge About the Issue</td>
<td>4.3</td>
<td>Preplanning</td>
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</table>
According to the Community Readiness Model, the goal of strategies for the communities in the Preplanning stage is to “raise awareness with concrete ideas to combat the condition.” This goal can help inform the development of appropriate peer support services to address mental health and addictions issues. The lowest scored dimensions for chronic disease that is impacted by physical activity and nutrition are community knowledge of efforts and resources related to the issue. The thematic analysis of the interviews support this. Most interviewees felt community members were aware of the issue but did not know what programs and services are available to address chronic disease or that resources to aid behavior change are lacking in their communities.

**VI.B. Themes from Interviews**

**Chronic Disease: Concern, Knowledge, and Feelings**

- Physical Activity

Most people interviewed said that lack of physical activity in their communities was concerning. When asked to rate the concern in their communities on a scale of 1-10, most interviewees who gave a number chose a rating of 7 or higher, although four interviewees rated the concern as a five or lower.

> “Culturally, people think of physical activity in the lifestyle here in this context as a luxury; you have a luxury to go and run to do physical activity whereas back home, physical activity is survival. So people do that based on how they're living within culture. To tie it to health, as a need for dealing with our health, it's not really on the radar for our communities as they really don't see it tied directly to health.”

> “As a doula I work with moms and I worked for seven years in an elementary school where 80% of the population was Latino and noticed that a lot of children spend time watching TV in their houses along with adopting food habits from this country [which] contribute to obesity and not being very active. Some kids play soccer but they don't find a place to practice so they tend to stay home and watch TV, families feel their kids are safer that way, so all those factors contribute.”

> “So probably the younger generation, because most of us here are first generation immigrants but probably the second generation that are growing up now, they have some awareness of physical activity.”

A Health Share member said during her interview that “I have high blood pressure and I’m just figuring that out and learning about having it even though I’ve had it for years. I didn’t know you could get a heart attack and die, I didn’t know that stuff.”

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Healthy Eating

When asked how much of a concern is unhealthy eating in this community on a scale of 1-10, interviewees were divided. Half of the respondents said 9 or higher, and half said 2 or 3, with one person saying 5.

“I think it is very concerning, because as I said, we see the negative impact right away in the first generation. We see how that makes us sick, we are more vulnerable, than another member of another community... Coming here and starting eating the diet that is prevalent here, that is making us sick. And also the family is working and that contributes. Get fast food and stop eating the way we ate from our countries. That change happened very fast.”

“This varies from family to family. There are some families that are still interested in their traditional meals so they go to African stores and buy African food and cook it which is healthier. And some families tend to pick up on the lifestyle of the new community ... or they going for fast foods and eating unhealthy and some of this is related to when they get jobs and they don't have time to cook so they get something which is already made and are not good for them so it's kind of a two way thing.”

“If there are [efforts] a lot of us don't know about them.”

When asked, “using a scale from 1-10, how knowledgeable are community members about chronic disease can be impacted through physical activity and healthy diet,” respondents said 7 or lower.

“I've seen the changes through second generation, children are being physically active, their children might be open to that but I'm not seeing that in necessarily the first generation which can be a burden to a second generation, you know when mom has a chronic disease, the kid has to support the mom.”

“I think they may have heard the information but it is not something that is constant or being reinforced all the time. I mean sometimes the terms that people use when giving information people doesn't really understand so maybe language that is more clear and really like, ‘so what are you are eating right now’ in a week, and being sure they are getting information. Even for me sometimes it is hard to understand like ‘protein’ and ‘carbohydrates’ and all those things. So just make it easier. So see what they have, they are already good, and work toward building from there.”

Chronic Disease: General Needs / Improvements / Barriers

The community needs and suggested improvement from interviewees include:

- Addressing social determinants of health and root cases, e.g. racism, poverty, which can then enable behavior change.
- For immigrant communities, address assimilation issues that lead to unhealthy eating and lack of physical activity, as well as cultural differences related to food and exercise.
- Make fresh healthy food more financially and geographically accessible.
- Fast food should be less accessible in impoverished neighborhoods.
- Better nutrition and access to physical activity in schools.
- More information available to the communities in the communities.
• Staff that speak the language instead of relying on interpretation services.

“It’s a very high concern but I think I would frame the question instead of focusing on physical activity, I think there’s a much broader issue why there is huge disparities between the people of color, even refugees, on chronic diseases such as diabetes and high blood pressure and I think a lot has to do with ... access to health food and so there’s a broader social issues ... racial issues of oppression people face on this issue can confuse that battle. ...”

“For Latino communities it is a lot about sharing what we eat. That is huge. So instead of preparing a meal and eating at home, it becomes more about going out, but we go to those places that is not very healthy. You don’t see very many families coming together and going for a hike or something like that. More sedentary activities.”

“I think it is very concerning, because as I said, we see the negative impact right away in the first generation. We see how that makes us sick, we are more vulnerable, than another member of another community... Coming here and starting eating the diet that is prevalent here, that is making us sick.”

Barriers to healthy diet and exercise include:

• Cultural reasons.
• Financial reasons; poverty.
• Habits.
• Limited opportunities.
• Lack of linguistically and culturally appropriate services, programs, opportunities.
• No knowledge of current efforts – lack of information dissemination, e.g. Oregon Trail program with farmer’s markets.
• For immigrants, different habits, environments, circumstances, opportunities compared to home country.
• Chronic disease has been normalized or thought of as inevitable in families and/or communities.
• Not a priority – basic needs or sending money to family in home country are a priority.
• Lack of time. Days are filled working enough to pay the bills.

“There’s almost zero opportunities in our communities. The only one thing that I can think of is when a certain organization, usually churches, organize some kind of sports event so the youth would come together and play basketball or volleyball for a period of time but that’s about it. There’s no real organized activity.” “I think the barrier is it would be great if more people had employees who spoke our language. Language is a big one, especially for older adults. ... Language is a big deal and in terms of just understanding culture, you know since this is all for a larger purpose...there’s still a lot of stigma I think with people who come from Russia and live here in the United States...I think larger community doesn’t necessarily understand the background and I know that it’s not easy for seniors to interact with other seniors, seniors who are Russian or Ukrainian for example, they tend to interact only with people from their own country.”
“They may not have diabetes. An older person might say ‘I have that sugar.’ ‘My mom had it, my auntie had it, my dad had it,’ so it’s also in a sense it’s like it’s okay to have it cuz it’s a norm in our family. Then here you are saying it’s not normal. My grandma may have lived to 75, my mom may live till 70, so I’m thinking living to 70 is gonna be a great age because of what I know. But if I’m living a healthy life, I’ve got until 95. I short change myself 15 years because of lifestyles and not having the basics of information.”

“What’s not working is … just being able to access food, afford foods that they need to eat and just the difficulty of behavior changes and lack of education.”

“A lot of people think it’s an inevitable thing for us. It’s come to the point where people just accept the reality that as you grow older, you will get diabetes, you will get high blood pressure and that’s not something that’s preventable. It’s something that our community has accepted as part of life which is very sad.”

“I think they know a lot but I think there’s a lot of myths that they know about it too. Like having high blood pressure is hereditary so it’s accepted. So that’s another hard thing to see in your community that people are dying so young but it’s almost like it’s accepted cuz they have high blood pressure, oh they died of a heart attack. But the preventable piece they don’t talk about. So it’s almost accepted that we are the way we are around chronic disease.”

“If you’re asking me if there’s enough culturally specific information or education programs addressing those issues, I don’t think so, I don’t think there’s enough.”

Community Health Workers: Awareness

“I think this [Community Health Workers] just started. I mean, excuse me, with a specific name it just started. We have been community health workers for years, years, helping each other out. Like I said the older generation helping, used to do births, having a doula, I mean it’s been called doula but it was ‘so and so’s’ mom would come over hand help that person deliver her baby. So it’s been a lot of community type health work within the community that goes on there…so the community health workers, we’ve have them in the community, they’ve been here for years but now we have a name that’s called a community health worker so now it’s almost a sense of validation of what we’ve done.”

“Yea, the community health workers at Urban League are working on that, they’ve done… they’ve graduated two classes and they are working in the community… I think they are based out of Urban League and so they’re doing a lot of canvassing the communities, working in the community centers, working with churches, anywhere they can get in to talk to people about chronic diseases. Again trying to just work on the inequity of the health disparities that we find in our communities that’s their mission, that’s their goal.”

Many of the community members we interviewed didn’t know about any community health workers. Among our consumer interviews, “I don’t know” and “I wouldn’t know about that,” were common
answers when asked about efforts to help people in the community or about community health workers specifically.

“Not that I know of in Clackamas County...Maybe in Multnomah County...Our community is about 150,000 people between Washington, Multnomah, Marion, those three counties primarily...I can’t speak to the larger community but I can tell you as far as I know we don't have anybody who speaks Russian in Clackamas County that does health promotions.”

“I don't really know about Latino. I know about African American but I don't know about Latino.”

Community Health Workers: Strengths

When asked to describe the community’s attitude about using culturally specific community health workers to address chronic disease preventable through physical activity and nutrition, using a scale of 1–10, all respondents said 8 or higher, and half said 10.

“You can never get enough of culturally specific community health workers or health information.”

“Grassroots, you know it’s very natural, it’s the community does it but the lack of resources make it impossible to do it on a larger scale.”

“It’s bringing more awareness of how people eat especially when we're thinking about diabetes cuz it's just so prevalent. People are getting diabetes diagnosis younger and younger in our community and so it's really raising the awareness and people seem to be very conscious, there's a lot of conversations about it.”

"I like Stanford [the Stanford School of Medicine Chronic Disease Self-Management Program] because Stanford talks about you have an action plan and you start small. You think big and you start small ... I think it’s an excellent way of getting that conversation started, I notice we're using materials from them in the community of faith ... I like Stanford and I'm trained in it and I wanna take Stanford into the community because I see that people are open to talking about chronic disease in that way and so I see that the people are open to it and so I'm happy...” “I work in the field of HIV and I've found that they're more receptive when I talk about chronic disease versus HIV. And in chronic disease, we can name HIV and talk about how it is a manageable disease and that takes some of the sting out of the stigma, it takes some of the stigma out of HIV and ... normalizes it. And I think the more that we do that, the more success we'll have in the community in addressing HIV and how we see people who are HIV in the black community...”

Interviewees from a variety of communities spoke of church efforts.

“I know that for our church ... we've done some things to kind of ask the people to make better food choices for the sake of our children and because you know we, I, personally see it as also very important for our spiritual health to be physically healthy. So I know of that effort. Also our church has made it part of their, kind of our ethic, how we do community gatherings. Right now we are moving away from the traditional way we do foods which is bringing as much food as you can you know and right now we're
trying to limit it…"

“I think if the larger community was more willing to support culturally appropriate services, I think anything’s possible.”

“I think it will be really useful but I think it needs to come from an institution that people trust.”

Community Health Workers: Barriers, Needs, and Improvements

- Lack of resources / funding.
- Not enough culturally and linguistically specific community health workers.
- Not enough outreach, notice of activities is not widespread or timely or in languages other than English.
- Differences within communities, religious or ethnic.
- Provide culturally specific education, e.g. cooking classes that feature recipes the community already cooks.

“Back to resources, we can only do so much with what we have.”

“Show us how to cook them... Like if there were some cooking piece component where someone could really come Tuesday and Thursday ... over at [a clinic in North Portland] and do a cooking demonstration on something around southern cooking, how to make it taste good and be really great for a diabetic person. It’s culture specific. If there were something like that, that would be great.”

“Oh yes! ...if you’re saying that what we’re eating is causing these things -- high blood pressure, diabetes -- these chronic issues, then we need them financially to be more accessible to be able to purchase them.”

“I think part of it is we can’t wait for people to come to us; we need to go and see if they need our help. When I came for example here to Clackamas County, I remember people saying ‘oh wow, that’s so cool you speak Russian, we don’t really have a lot of Russian clients’ and I said that’s interesting because we have at least 30,000 [Russian] people in Clackamas County. And part of it was as I started to go out and meet with people...just the other day I was at a meeting with Slavic families and literally next day we had three referrals at the agency.. and these referrals .. this one child has not had medical insurance so we got her with medical insurance ... another child who go get social security for disability, we got her mom to complete the SSI form ... and all of it was because somebody who spoke their language and happened to be at their meeting. I was that person.”
“The biggest challenge is the language. People don't feel comfortable to walk into a place where you can't communicate.”

Objectives: Behavioral Health

Goal: Identify and eliminate health care disparities in Physical and Mental Health outcomes for people diagnosed with Severe Persistent Mental Illness, people who identify as People of Color, and people who speak a preferred language other than English.

Strategy: Work with Culturally Specific community based organizations and behavioral health providers and community based organizations, to support the use and availability of Culturally-Specific Peer Support Services for Health Share Members, with outcomes tracked by Race, Ethnicity and Language, and attention to young people, people with disabilities and people identifying as LGBTQ.
**Table 6 - Behavioral Health Driver Diagram**

Culturally-Specific Peer Mentors Reduce Disparities in Outcomes for Members with SPMI and Increase use of Behavioral Health Services

**Aim**
- Eliminate racial, ethnic and language-based disparities in use of services to address Mental Health and Substance Use Disorders and improve health outcomes for people diagnosed with Severe Persistent Mental Illness among culturally-specific communities.
  - Supporting and expanding availability of Culturally-Specific Peer Mentors
  - Collaborating more effectively with peer support services organizations and culturally-specific organizations
  - Increasing understanding of health disparities among Health Share’s members

**Primary Drivers**
- Culturally-specific Peer Mentors

**Secondary Drivers**
- Improve partnerships between Primary Care and Behavioral Health practices and Peer Mentors
- Enhance focus on Culturally-Specific Peer Mentors, LEP members, LGBTQI, youth, and people with disabilities

**Specific Changes to Test**
- Culturally-specific Peer Mentors support members to make lifestyle changes and find resources to improve their health
- Behavioral Health and Primary Care practice teams identify and provide referrals connecting members to Peer Mentors
- Improve collaboration between culturally-specific CBOs, Peer Services CBOs and Health Share provider practices
- Support culturally and linguistically appropriate care teams through education
- Enhance Peer Mentors’ knowledge of health system transformation outcomes measures

**Disparities sensitive Outcome Measures**
- Improve quality: Increase diabetes screening rates for Members with SPMI from baseline (x%) to (x%)
- Improve experience: Increase follow-up after Hospitalization for Mental Illness Rates for members with SPMI from baseline (x%) to (x%)
- Increase rate of Addictive services use by members who identify as people of color & who speak a preferred language other than English from (x%) to (x%)
- Increase rate of mental healthcare services use by members who identify as people of color & who speak a preferred language other than English from (x%) to (x%)
- Decrease costs: Decrease hospitalization rates for members with Severe Persistent Mental Illness from baseline (x%) to (x%)

**Process Measures**
- Member data on polity-time cohort of members diagnosed with SPMI is analyzed by Race, Ethnicity and Language
- Use disparities data to enhance SPMI quality improvement initiative on screening for diabetes

**Health & Healthcare Disparities Data Analysis**

**Disparity analysis implementing best practices**

**Focus on Behavioral Health services use and improved outcomes for people with SPMI**

**CBOs provide training on Health Transformation outcomes measures to Peer Mentors**

**CBOs provide training to primary care and behavioral health practices about culturally-specific Peer Mentors and integrating peer workforce into care teams**

**Develop and refine a set of standard agreements upon measurable disparities outcomes**

**Optimize analysis of behavioral health outcomes and member utilization data**

**Implement a Quality Improvement Plan to address healthcare disparities for members diagnosed with SPMI**
### Objectives:

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<tbody>
<tr>
<td>Recommendation of CAC Mental Health and Addictions Committee: Expand Peer Support Services</td>
<td># of Culturally-Specific Peer Support workers available for referral to Health Share members who identify as people of color, who speak a preferred language other than English, who identify as LGBTQ, who have a disability or who are young or elderly</td>
<td>4</td>
<td>To be developed in 2015, based on the findings of the Culturally-specific community led self assessments conducted by CBOs in 2014</td>
<td>TBD in 2016</td>
</tr>
<tr>
<td>Referrals by Health Share providers to peers for members who identify as people of color, LGBTQ, who speak a preferred language other than English, who have a disability or who are young or elderly</td>
<td>Target # of referrals TBD, based on the peers services proposed - could be high or low “touch” depending on the complexity of the population served</td>
<td></td>
<td>To be developed in 2015, based on the findings of the Culturally-specific community led self assessments conducted by CBOs in 2014</td>
<td>TBD in 2016</td>
</tr>
<tr>
<td># of Culturally-Specific CBO-Sponsored Community Dialogues focused on decreasing stigma of Mental Health and Addictions, and increasing community knowledge of services available to Health Share Members</td>
<td>10</td>
<td></td>
<td>To be developed in 2015, based on the findings of the Culturally-specific community led self assessments conducted by CBOs in 2014</td>
<td></td>
</tr>
<tr>
<td>Community Based Organizations employ Peers to conduct culturally-specific health needs assessments with Health Share Members</td>
<td># of culturally-specific community-led self assessments conducted by June 30, 2015</td>
<td>4</td>
<td>To be developed in 2015</td>
<td>To be developed in 2016</td>
</tr>
<tr>
<td>Recommendation of CAC Mental Health and Addictions Committee: Increase the use of Mental Health and Addictions Services</td>
<td>Service Utilization Rate of members who identify as people of color or who speak a preferred language other than English</td>
<td>Increase use of mental health and addictions services to match rate of general population</td>
<td>TBD in 2015</td>
<td>TBD in 2016</td>
</tr>
<tr>
<td>Health Share Transformation Fund Project: Future Generations Collaborative</td>
<td>Increase ability to share learnings about trauma informed process, and spread practices developed by FGC to other groups</td>
<td># Organizations involved in collaborative: 8 # orgs financially supported through collaborative: 4 # elders and natural helpers trained &amp; working in community: 18</td>
<td>TBD in 2015</td>
<td>TBD in 2016</td>
</tr>
<tr>
<td>CCO Performance Improvement Project</td>
<td>PIP: Diabetes screening rates for members with SPMI (who identify as people of color or with a language preference other than English)</td>
<td>Meet or exceed benchmark rate for for HbA1C completed and LDL-c screenings completed for Health Share members</td>
<td>TBD in 2015</td>
<td>TBD in 2016</td>
</tr>
<tr>
<td>Health Share Transformation Plan Metric</td>
<td>Hospitalization Rates for members with SPMI who identify as people of color or with a language preference other than English</td>
<td>Reduce rates by 10% for overall SPMI population, eliminate disparities based on R/E/L</td>
<td>TBD in 2015</td>
<td>TBD in 2016</td>
</tr>
<tr>
<td>CCO Performance Measure</td>
<td>Follow-Up after hospitalization for Mental Illness Rates for members with SPMI who identify as people of color or with a language preference other than English</td>
<td>Benchmark=68%</td>
<td>TBD in 2015</td>
<td>TBD in 2016</td>
</tr>
</tbody>
</table>
Objectives: Nutrition and Physical Activity-related Chronic Disease

Goal: Identify and eliminate disparities in Nutrition and Physical Activity related Chronic Disease outcomes for Health Share Members who identify as People of Color, speak a preferred language other than English, identify as LGBTQ, or have disabilities

Strategy: Work with Culturally-Specific community based organizations and the Oregon Community Health Worker Association, to support and expand the use and availability of Culturally-Specific Community Health Workers available for referral to Health Share Members

Strategy: Improve Health Share’s ability to conduct health and healthcare disparities data analysis

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Culturally Specific Community Health Workers support members to improve conditions in their families and neighborhoods, make lifestyle changes and find resources to manage and prevent chronic conditions</td>
<td># of Culturally-Specific Community Health Workers available to Health Share members who identify as people of color, who speak a preferred language other than English, who identify as LGBTQ, who have a disability or who are young</td>
<td>4 FTE</td>
<td>To be developed in 2015, based on the findings of the Culturally-specific community led self assessments conducted by CBOs in 2014</td>
<td>To be developed in 2016</td>
</tr>
<tr>
<td>Culturally-Specific Community-Based Organizations provide trainings to Community Health Workers on nutrition and physical activity related chronic disease and clinical services related to Health Share’s Quality Improvement Plan</td>
<td># Contracts in place with Community Based Organizations to train Community Health Workers</td>
<td>1</td>
<td>To be developed in 2015, based on the findings of the Culturally-specific community led self assessments conducted by CBOs in 2014</td>
<td>To be developed in 2016</td>
</tr>
<tr>
<td>Initiative</td>
<td>Metric Description</td>
<td>Target Range or Frequency</td>
<td>Development Timeline</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>---------------------------</td>
<td>----------------------</td>
<td></td>
</tr>
<tr>
<td>Culturally Specific Community Health workers share information about and lead healthy eating and physical activity groups in their communities</td>
<td># of members who set personal goals around healthy eating and physical activities, as captured by Community Health Workers in pre and post assessment forms</td>
<td>TBD, based on the community members that the CHWs propose to engage with (could be high or low “touch” members, a range could be between 20 and 50 people per CHW per month)</td>
<td>To be developed in 2015, based on the findings of the Culturally-specific community led self assessments conducted by CBOs in 2014</td>
<td></td>
</tr>
<tr>
<td>Community Based Organizations employ Community Health Workers to conduct culturally-specific health needs assessments with Health Share Members</td>
<td># of culturally-specific community-led self assessments conducted by June 30, 2015</td>
<td>4</td>
<td>To be developed in 2016</td>
<td></td>
</tr>
<tr>
<td>Culturally-Specific Community-Based Organizations provide trainings to Primary Care Providers about culturally-specific traditional health workers and integrating the workforce into care teams</td>
<td># Contracts in place with Community Based Organizations to train Providers</td>
<td>1</td>
<td>To be developed in 2015, based on the findings of the Culturally-specific community led self assessments conducted by CBOs in 2014</td>
<td></td>
</tr>
<tr>
<td>Disparities Sensitive data analysis plan is created to improve Health Share’s ability to identify and eliminate health and health care disparities among our members</td>
<td># of disparities-sensitive measures identified that Health Share can utilize to identify, track, and reduce healthcare disparities.</td>
<td>Improvement to measures or positive change in utilization of disparities-sensitive measures</td>
<td>To be developed in 2015</td>
<td></td>
</tr>
<tr>
<td>CCO Quality Improvement Plan: Reduce an avoidable disparity in a chronic condition impacting a specific member population defined by Race, Ethnicity or Language by 10%</td>
<td>Submit plan to OHA prior to July 1; plan objectives to be finalized by Quality Mgmt Council in June 2014.</td>
<td>Specific improvement using a disparities-sensitive measure, TBD July 2014</td>
<td>To be developed in 2015</td>
<td></td>
</tr>
</tbody>
</table>

To be developed in 2016 |
Table 7 - Chronic Disease Driver Diagram

Culturally-specific Community Health Workers Reduce Chronic Disease Disparities

**Aim**
Identify and eliminate disparities in nutrition and physical activity-related chronic disease outcomes among culturally-specific communities by:

- Supporting and expanding Culturally-Specific Community Health Workers
- Collaborating more effectively with culturally-specific organizations
- Increasing understanding of health disparities among Health Share’s members

**Primary Drivers**
- Culturally-specific Community Health Workers
  - Process Measure: # of Culturally-specific CHWs available to members identifying as people of color
- Collaboration with Culturally-Specific Organizations
  - Process Measure: # of Culturally-specific organizations in contract with Health Share

**Secondary Drivers**
- Implement Culturally-specific CHW Pilot Project
- Improve partnerships with health providers and CHWs
- Enhance focus on LEP members, LGBTQI, youth, and people with disabilities
- Improve collaboration between culturally-specific CBOs and Health Share partners
- Support cultural and linguistically appropriate care teams through education
- Enhance CHWs knowledge of nutrition and physical activity-related chronic diseases

**Specific Changes to Test**
- Culturally-specific CHWs support members to make lifestyle changes and find resources to improve their health
- Health providers identify and provide referrals connecting members to CHWs
- CBOs provide culturally-specific training on nutrition and physical activity-related chronic disease to CHWs
- CBOs provide training to health care providers about culturally-specific CHWs and integrating workforce into care
- Develop and refine a set of standard agreed upon measurable disparities-sensitive outcomes
- Optimize data analysis of nutrition and physical activity related chronic diseases through using Local Public Health data, Healthy Columbia Willamette, provider data, and member utilization data
- Implement a Quality Improvement Plan to address specific healthcare disparity

**Disparities-sensitive Outcome Measures**
- Improve quality: % improvement in specific health outcomes (BP control and other measures among impacted members)
- Improve experience: CAHPS survey, % improvement in engagement
- Decrease costs: % reduction in ER visits, other cost reduction measures

**Health & health care disparities data analysis**
- Process Measure: Disparity Quality Improvement Plan is implemented; # of members in project
- Disparity analysis plan utilizing best practices
- Focus on nutrition and physical activity-related chronic disease focus
- Develop specific quality improvement initiatives
Identifying Disparities: Top Chronic Conditions Identified By Member Race and Ethnicity

The tables below contain information that supports our ability to observe differences in rates of diagnosis of chronic conditions among our members by race and ethnicity. Most of these conditions are related to the two areas of focus for the CHP.

Table 8 - Health Share of Oregon - Top 20 Chronic Conditions Diagnoses Among Non-ACA Expansion Member Population (all ages, as of April 2014)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Count of Diagnosed Members</th>
<th>Percent of Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>21953</td>
<td>13.7%</td>
</tr>
<tr>
<td>Obesity</td>
<td>19286</td>
<td>12.0%</td>
</tr>
<tr>
<td>Asthma</td>
<td>17861</td>
<td>11.1%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>11548</td>
<td>7.2%</td>
</tr>
<tr>
<td>Tobacco Use</td>
<td>11337</td>
<td>7.1%</td>
</tr>
<tr>
<td>Depression</td>
<td>9753</td>
<td>6.1%</td>
</tr>
<tr>
<td>Attention Deficit Disorder (ADD)</td>
<td>6880</td>
<td>4.3%</td>
</tr>
<tr>
<td>Post-Traumatic Stress Disorder (PTSD)</td>
<td>5631</td>
<td>3.5%</td>
</tr>
<tr>
<td>Schizophrenia (Schizo)</td>
<td>4276</td>
<td>2.7%</td>
</tr>
<tr>
<td>Chronic Ischemic Heart Disease (CIHD)</td>
<td>3408</td>
<td>2.1%</td>
</tr>
<tr>
<td>Chronic Kidney Disease (ESRD)</td>
<td>2999</td>
<td>1.9%</td>
</tr>
<tr>
<td>Chronic Liver Disease/Cirrhosis (Liver)</td>
<td>2964</td>
<td>1.8%</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>2602</td>
<td>1.6%</td>
</tr>
<tr>
<td>Hepatitis C (HepC)</td>
<td>2297</td>
<td>1.4%</td>
</tr>
<tr>
<td>Chronic Bronchitis</td>
<td>2200</td>
<td>1.4%</td>
</tr>
<tr>
<td>Chemical Dependency</td>
<td>1906</td>
<td>1.2%</td>
</tr>
<tr>
<td>Chronic Coronary Heart Disease (CHF)</td>
<td>1005</td>
<td>0.6%</td>
</tr>
<tr>
<td>Hemophilia</td>
<td>623</td>
<td>0.4%</td>
</tr>
<tr>
<td>Hiv/Aids</td>
<td>459</td>
<td>0.3%</td>
</tr>
<tr>
<td>Cystic Fibrosis</td>
<td>18</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>160,492</strong></td>
<td></td>
</tr>
</tbody>
</table>
Below, Tables 9 and 10 outline the same chronic conditions with our members as identified by race and ethnicity. Table 9 portrays the count of members diagnosed with a chronic condition, which can help to show differences in diagnosis that can be attributed to a health disparity. For example, 14.7% of African American members are diagnosed with asthma, while 11.9% of Caucasians are diagnosed with asthma. Note: chronic conditions diagnoses among our Hispanic members appears very low. Part of this is attributed to 80% of our Hispanic members being under 18; many of these chronic diseases emerge in adulthood.

<table>
<thead>
<tr>
<th>Count of Members Diagnosed</th>
<th>African American (N=15,143)</th>
<th>AI/AN (N=1,326)</th>
<th>Asian (N=11,217)</th>
<th>Caucasian (N=75,883)</th>
<th>Hispanic (N=37,738)</th>
<th>Health Share (N=152,050)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>2417</td>
<td>152</td>
<td>2450</td>
<td>12049</td>
<td>1412</td>
<td>19086</td>
</tr>
<tr>
<td>Obesity</td>
<td>1997</td>
<td>185</td>
<td>493</td>
<td>9325</td>
<td>5724</td>
<td>18844</td>
</tr>
<tr>
<td>Asthma</td>
<td>2225</td>
<td>184</td>
<td>781</td>
<td>9003</td>
<td>3769</td>
<td>17166</td>
</tr>
<tr>
<td>Diabetes</td>
<td>1176</td>
<td>105</td>
<td>1304</td>
<td>5967</td>
<td>967</td>
<td>9873</td>
</tr>
<tr>
<td>Tobacco Use</td>
<td>1524</td>
<td>164</td>
<td>213</td>
<td>8319</td>
<td>491</td>
<td>11297</td>
</tr>
<tr>
<td>Depression</td>
<td>1015</td>
<td>131</td>
<td>490</td>
<td>6254</td>
<td>864</td>
<td>9234</td>
</tr>
<tr>
<td>Attention Deficit Disorder (ADD)</td>
<td>625</td>
<td>97</td>
<td>74</td>
<td>4337</td>
<td>907</td>
<td>6582</td>
</tr>
<tr>
<td>Post-Traumatic Stress Disorder (PTSD)</td>
<td>670</td>
<td>112</td>
<td>266</td>
<td>3609</td>
<td>416</td>
<td>5400</td>
</tr>
<tr>
<td>Schizophrenia (Schizo)</td>
<td>507</td>
<td>55</td>
<td>231</td>
<td>2728</td>
<td>155</td>
<td>3766</td>
</tr>
<tr>
<td>Chronic Ischemic Heart Disease (CIHD)</td>
<td>291</td>
<td>27</td>
<td>298</td>
<td>1976</td>
<td>188</td>
<td>2870</td>
</tr>
<tr>
<td>Chronic Kidney Disease (ESRD)</td>
<td>322</td>
<td>26</td>
<td>345</td>
<td>1467</td>
<td>162</td>
<td>2410</td>
</tr>
<tr>
<td>Chronic Liver Disease/Cirrhosis (Liver)</td>
<td>196</td>
<td>33</td>
<td>229</td>
<td>1935</td>
<td>343</td>
<td>2840</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>270</td>
<td>36</td>
<td>112</td>
<td>2046</td>
<td>77</td>
<td>2590</td>
</tr>
<tr>
<td>Hepatitis C (HepC)</td>
<td>297</td>
<td>30</td>
<td>85</td>
<td>1746</td>
<td>75</td>
<td>2290</td>
</tr>
<tr>
<td>Chronic Bronchitis</td>
<td>214</td>
<td>29</td>
<td>79</td>
<td>1549</td>
<td>73</td>
<td>1995</td>
</tr>
<tr>
<td>Chemical Dependency</td>
<td>165</td>
<td>51</td>
<td>15</td>
<td>1439</td>
<td>87</td>
<td>1815</td>
</tr>
<tr>
<td>Chronic Coronary Heart Disease (CHF)</td>
<td>149</td>
<td>10</td>
<td>75</td>
<td>697</td>
<td>46</td>
<td>1001</td>
</tr>
<tr>
<td>Hemophilia</td>
<td>83</td>
<td>8</td>
<td>41</td>
<td>359</td>
<td>66</td>
<td>578</td>
</tr>
<tr>
<td>Hiv/Aids</td>
<td>83</td>
<td>5</td>
<td>15</td>
<td>310</td>
<td>20</td>
<td>452</td>
</tr>
<tr>
<td>Cystic Fibrosis</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>14</td>
<td>1</td>
<td>18</td>
</tr>
</tbody>
</table>
Table 10 - Per-Member Per-Year Cost by Diagnosis and Race/Ethnicity

<table>
<thead>
<tr>
<th>Per-Member Per-Year Cost by Diagnosis</th>
<th>African American (N= 15,143)</th>
<th>AI/AN (N= 1,326)</th>
<th>Asian (N= 11,217)</th>
<th>Caucasian (N= 75,883)</th>
<th>Hispanic (N=37,738)</th>
<th>Health Share (N = 152,050)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>$12,516</td>
<td>$17,631</td>
<td>$4,697</td>
<td>$11,311</td>
<td>$8,804</td>
<td>$10,491</td>
</tr>
<tr>
<td>Obesity</td>
<td>$7,938</td>
<td>$8,914</td>
<td>$4,311</td>
<td>$8,551</td>
<td>$2,103</td>
<td>$6,182</td>
</tr>
<tr>
<td>Asthma</td>
<td>$7,916</td>
<td>$12,959</td>
<td>$6,881</td>
<td>$9,299</td>
<td>$3,178</td>
<td>$7,412</td>
</tr>
<tr>
<td>Diabetes</td>
<td>$15,640</td>
<td>$20,341</td>
<td>$5,265</td>
<td>$13,743</td>
<td>$8,318</td>
<td>$12,362</td>
</tr>
<tr>
<td>Tobacco Use</td>
<td>$11,183</td>
<td>$14,804</td>
<td>$6,637</td>
<td>$10,230</td>
<td>$7,173</td>
<td>$10,078</td>
</tr>
<tr>
<td>Depression</td>
<td>$11,397</td>
<td>$14,689</td>
<td>$6,595</td>
<td>$10,978</td>
<td>$7,897</td>
<td>$10,392</td>
</tr>
<tr>
<td>Attention Deficit Disorder (ADD)</td>
<td>$4,565</td>
<td>$8,834</td>
<td>$4,729</td>
<td>$6,113</td>
<td>$3,384</td>
<td>$5,480</td>
</tr>
<tr>
<td>Post-Traumatic Stress Disorder (PTSD)</td>
<td>$9,925</td>
<td>$15,603</td>
<td>$6,035</td>
<td>$11,559</td>
<td>$7,970</td>
<td>$10,703</td>
</tr>
<tr>
<td>Schizophrenia (Schizo)</td>
<td>$11,132</td>
<td>$14,411</td>
<td>$6,524</td>
<td>$10,583</td>
<td>$10,872</td>
<td>$10,476</td>
</tr>
<tr>
<td>Chronic Ischemic Heart Disease (CIHD)</td>
<td>$24,883</td>
<td>$25,950</td>
<td>$7,624</td>
<td>$15,771</td>
<td>$12,804</td>
<td>$15,752</td>
</tr>
<tr>
<td>Chronic Kidney Disease (ESRD)</td>
<td>$33,178</td>
<td>$34,810</td>
<td>$9,560</td>
<td>$20,518</td>
<td>$25,917</td>
<td>$21,417</td>
</tr>
<tr>
<td>Chronic Liver Disease/Cirrhosis (Liver)</td>
<td>$19,095</td>
<td>$36,097</td>
<td>$11,550</td>
<td>$18,144</td>
<td>$11,293</td>
<td>$16,946</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>$27,587</td>
<td>$24,296</td>
<td>$11,023</td>
<td>$18,066</td>
<td>$13,682</td>
<td>$18,891</td>
</tr>
<tr>
<td>Hepatitis C (HepC)</td>
<td>$21,845</td>
<td>$38,444</td>
<td>$10,215</td>
<td>$15,988</td>
<td>$16,611</td>
<td>$16,763</td>
</tr>
<tr>
<td>Chronic Bronchitis</td>
<td>$28,309</td>
<td>$19,513</td>
<td>$7,877</td>
<td>$18,848</td>
<td>$14,941</td>
<td>$19,799</td>
</tr>
<tr>
<td>Chemical Dependency</td>
<td>$24,187</td>
<td>$31,860</td>
<td>$21,923</td>
<td>$16,879</td>
<td>$12,795</td>
<td>$17,828</td>
</tr>
<tr>
<td>Chronic Coronary Heart Disease (CHF)</td>
<td>$44,442</td>
<td>$57,776</td>
<td>$35,732</td>
<td>$25,069</td>
<td>$17,694</td>
<td>$28,876</td>
</tr>
<tr>
<td>Hemophilia</td>
<td>$78,571</td>
<td>$25,762</td>
<td>$82,531</td>
<td>$41,634</td>
<td>$33,732</td>
<td>$49,600</td>
</tr>
<tr>
<td>Hiv/Aids</td>
<td>$35,236</td>
<td>$32,779</td>
<td>$28,538</td>
<td>$32,829</td>
<td>$28,636</td>
<td>$32,753</td>
</tr>
</tbody>
</table>

Amounts highlighted in red in Table 10 denote the highest costs for that diagnosis by race/ethnicity of Health Share members. It is helpful to analyze cost data by race and ethnicity because it provides another layer of understanding about how much of a burden chronic diseases are for our members who people of color. Nationally, African Americans and Native Americans tend to have the highest burden of chronic disease. We can see through Health Share cost data that there are high costs associated with providing care to some of our members, with a clear pattern of higher costs in some conditions. High costs can be associated with diseases that are costly to treat and are often the result of complex social and medical needs. These diseases tend to result in higher mortality; for example, End Stage Renal Disease is incurable and can result from diabetes, hypertension, and obesity. These data help us better understand how significant health disparities impact African Americans and Native Americans in particular.
Table 11 - Top Conditions Identified by Race, Ethnicity, and Gender

Hypertension Prevalence by Race, Ethnicity and Gender (All)

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>35.40%</td>
<td>31.61%</td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td>20.92%</td>
<td>25.51%</td>
</tr>
<tr>
<td>Asian</td>
<td>38.63%</td>
<td>39.22%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>21.44%</td>
<td>18.41%</td>
</tr>
<tr>
<td>Not Hispanic or Unknown</td>
<td>21.65%</td>
<td>16.11%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>30.89%</td>
<td>27.49%</td>
</tr>
</tbody>
</table>
Diabetes Prevalence by Race, Ethnicity and Gender (All)

- African American
- American Indian or Alaska Native
- Asian
- Hispanic
- Not Hispanic or Unknown
- Grand Total

**Female**
- Caucasian (F): [Data]
- Asian (F): [Data]
- Hispanic (F): [Data]
- Not Hispanic or Unknown (F): [Data]
- Grand Total (F): [Data]

**Male**
- Caucasian (M): [Data]
- Asian (M): [Data]
- Hispanic (M): [Data]
- Not Hispanic or Unknown (M): [Data]
- Grand Total (M): [Data]
Health is all around us: at the doctor’s office and at home, at the dinner table and the grocery store, among families and friends, at school, at the park, and beyond.

Health Share’s 2018-2020 Community Health Needs Assessment (CHNA) considers our region’s health with this idea front and center. To understand how to better serve communities throughout the region, including our 320,000 members, we looked beyond claims and demographic data and into the complex interplay between the health system and real life. We also reconsidered how we present information about the region’s diverse communities, focusing on elevating community strengths, leading with equity, and being transparent about the limitations of our data.

Our last CHNA, published in 2014, catalyzed innovative and impactful improvements in the quality and type of care available to our members. For example, our work to support traditional health workers—including community health workers and peers—originated in the findings of the 2014 CHNA.

From there, we committed in our 2014 Community Health Improvement Plan (CHP) to better utilize the traditional health worker workforce. We then provided small grants to support the Oregon Community Health Workers Association (ORCHWA) in deploying a cohort of culturally relevant community health workers. This partnership eventually led to Health Share investing $3.3 million in ORCHWA so they could develop an infrastructure that supports community health workers throughout the region.

Our hope is that this CHNA leads to even more innovation and positive impacts throughout our region. We invite our partners within and outside of the health care system to join us in advancing our vision of a healthy community for all. This is truly an opportunity to co-design and coordinate our actions in service to community health.

Sincerely,

Janet L. Meyer  
Chief Executive Officer  
Health Share of Oregon

Michael Anderson-Nathe  
Chief Equity and Engagement Officer  
Health Share of Oregon
More Than Numbers

Guiding principles in our 2018-2020 Community Health Needs Assessment

INFORMATION FOR ALL
To expand our reach outside the health care community, we emphasized visual storytelling and an approachable voice throughout this report.

A HOLISTIC APPROACH
Our health is shaped by where we live, how we grow up, and how much support is available to us. These are the social determinants of health, and they factor strongly into how Health Share understands and responds to the health needs of our members.

CONNECTION AS FUNDAMENTAL
Research repeatedly demonstrates that social connection strongly influences health. Isolation often surfaces as a key health issue in the communities we serve—indicating that one of the most powerful ways to build health for all is to support social connection.

A STRENGTHS-BASED NARRATIVE
We know that the communities we serve are strong, vibrant, and resilient. Part of our work to advance equity has involved reconsidering how we present data in a way that does no harm. To promote a strengths-based narrative, we chose to present data about communities of color independently from one another rather than in comparison.

GAPS IN OUR KNOWLEDGE
We are committed to being open about what we do not know. Although we analyzed multiple data sources and created new ones, limitations remain in what we know about what our communities need, with particular gaps in information about gender, disability, and other intersecting identities.
What is a Community Health Needs Assessment?

At least every five years, Health Share of Oregon, in partnership with its Community Advisory Council and the Healthy Columbia Willamette Collaborative, undertakes a Community Health Needs Assessment (CHNA). Through an ongoing process of community engagement, a CHNA helps health care organizations plan for future programs and services that best meet the needs of the communities they serve.

**SPECIFICALLY, A CHNA HELPS TO:**

- Describe the overall health of a community, including community strengths, resources, top illnesses, and chronic conditions
- Identify the health needs of a community and pinpoint key gaps in services, particularly those related to social determinants of health such as housing, education, poverty, and employment
- Highlight areas of potential action and resources needed to remedy the health and health care disparities a community faces

Community Health Needs Assessments play a critical role in pursuing and achieving health equity. By combining the learnings from community engagement and the findings of the CHNA, practitioners and policy makers are better equipped to direct resources and services to people and communities experiencing the greatest disparities in health and health care. This is often captured in a Community Health Improvement Plan (CHP). When done well, CHNAs can help create pathways to health for all families and communities.
Methods

Key data sources

Health Share is a member of the Healthy Columbia Willamette Collaborative (the Collaborative), a regional public-private partnership comprised of 15 hospitals, four health departments, and the region’s coordinated care organizations in Oregon's Clackamas, Multnomah, and Washington counties, and in Clark County, Washington. The findings in Health Share’s 2018 CHNA are heavily influenced by the Collaborative’s most recent CHNA, conducted in 2016. Detailed methods of this assessment can be found in the Collaborative’s final report.

To assess the health needs of the region’s many communities, the Collaborative performed a comprehensive study of data, drawing from a variety of sources, including:

- CCO/Medicaid Data (claims data)
- Hospital data
- Population health data
- Online survey results
- Listening sessions
- Local Community Health System and Forces of Change Assessment (assets mapping)
- Community engagement projects

Data limitations

The Collaborative’s 2016 CHNA relied on a number of data collection strategies to yield a robust snapshot of the region’s health needs. However, gaps in data made it difficult to tell the complete story of the entire community. Below are several data limitations impacting this report’s ability to comprehensively illustrate our community’s health needs:

Secondary data: The data in this report is predominantly from secondary sources, meaning our report draws on information that was designed and collected for a different purpose. Additionally, because of time lags between when much of the data was collected and when it became available for analysis, the data may reflect past health needs more accurately than present health needs.

Claims data: We recognize that claims data only tells part of the story of a community’s health and how people use the health care system. Health and health care happen outside of the exam room, but claims data reflects the health care use and health needs only of those members who have sought and received care.

Social identity and lived experience measures: The primary data sources for this report did not include certain measures of social identity or lived experience that we know to be linked to increased health disparities and structural inequities. Nor does the data reflect the significant health disparities and strengths that exist at the intersections of many of these identities. For example, we do not have information on how many people in our community identify as gender fluid/non-binary or LGBTQ*, are unstably housed, are immigrants or refugees, or are living with disabilities.

As stewards of public resources, members of the community, and people dedicated to advancing social justice, we are committed to calling out where and when communities are overlooked. Our aim is to be transparent in these limitations while continuing to acknowledge, challenge, and improve how we collect and use data about communities most impacted by structural inequality. With a more complete picture, we will be better able to change historic and ongoing practices within the health system that continue to make some communities and their needs less visible.

To this end, Health Share conducted a Photovoice project in 2016 to capture the lived experiences of trans and queer communities of color in the tri-county region, acknowledging the scarcity of information about the health and health care needs and experiences of the lesbian, gay, bisexual, transgender, queer, intersex, asexual, and two-spirit (LGBTQIA2) community. This project is an example of Health Share’s commitment to making communities most impacted by oppression more visible.
Our Members

320,348 members

128,241 (40%) under 18

49,097 (15%) have not used services in the last 15 months

7,399 (5.8% of youth) in foster care

Data from Health Share claims as of June 2018

= 8,000 people
**GENDER**
- 55% Female
- 45% Male

Note: Collected data is limited to binary gender identity and inaccurately reflects members who identify as transgender, two-spirit, and otherwise outside of the gender binary.

**RACE/ETHNICITY**

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>41% Unknown</td>
<td></td>
</tr>
<tr>
<td>37% Caucasian</td>
<td></td>
</tr>
<tr>
<td>9% Hispanic</td>
<td></td>
</tr>
<tr>
<td>5% Black/African American</td>
<td></td>
</tr>
<tr>
<td>6% Asian, Pacific Islander or Native Hawaiian</td>
<td></td>
</tr>
<tr>
<td>1% Other ethno-racial identities</td>
<td></td>
</tr>
<tr>
<td>1% Native Americans and Alaska Natives</td>
<td></td>
</tr>
</tbody>
</table>

Note: Health Share lacks ethno-racial identity data for approximately 40% of our members. Race/ethnicity data comes from OHP applications. All data from Health Share claims as of June 18, 2018, unless otherwise noted.

**HEALTH CARE UTILIZATION IN THE LAST 12 MONTHS**

The #1 reason members sought care was for routine, preventive health services:
- 6 in 10 (60%) of members had a primary care visit
- 4 in 10 (38%) of members had a dental visit
- 1 in 10 (11%) of members received behavioral health services

**LANGUAGE**

16% of members speak a language other than English.

Our members speak over 68 languages, from Urdu to Croatian.

The most frequently spoken languages are English, Spanish, Russian, and Vietnamese.

**MAP OF CURRENT HEALTH SHARE MEMBERS JUNE 2018**

- Clackamas County
  - 62,009 Members | 20% of Health Share members
- Washington County
  - 85,638 Members | 27% of Health Share members
- Multnomah County
  - 170,311 Members | 54% of Health Share members

About 1 percent of Health Share members have zip codes outside of the tri-county area due to special circumstances or data entry errors.

**TRI-COUNTY MEDICAID ENROLLMENT AGES 0-17 JULY 2018**

- 0-2,000 Members
- 2,000-4,000 Members
- 4,000-6,000 Members
- 6,000+ Members
Foundations of a Healthy Community

Our health is shaped by where we live, how we grow up, and how much support is available to us. These are the social determinants of health, and they include factors like housing, education, the built environment, employment, social support networks, and access to health care.

In 2016, the Healthy Columbia Willamette Collaborative engaged community members across Clackamas, Clark, Multnomah, and Washington counties in a survey and a series of listening sessions to identify the most important characteristics of a healthy community. Community members reported that the following have the greatest impact on community health.

Connection as a determinant of health

“The work of creating health is the work of creating connection.”

– DIDI PERSHOUSE

Research repeatedly demonstrates that social connection strongly influences health. Feeling connected to a community was one of the strengths identified in the community engagement data in this CHNA. The Full Frame Initiative defines social connection as “the degree to which a person has and perceives a sufficient number and diversity of relationships that: allow them to give and receive information, emotional support, and material aid; create a sense of belonging and value; and foster growth.” Investing in social connectedness – between individuals and within communities – can be a powerfully protective force in nurturing health for all.
Social connections—both in clinical and community settings—help people learn about the resources available to them.¹

Strong social cohesion is linked to increased neighborhood safety for people living in low-income public housing.¹

Social cohesion is correlated to higher rates of physical activity and lower risk for obesity among children, regardless of where they live.¹
Access to safe, affordable, and supportive housing

Housing is a key social determinant of health that often underlies individual and community health disparities. Safe, affordable, and supportive housing is correlated to improved access to health care and reduced exposure to injury, communicable disease, and violence. Poor-quality or substandard housing can be unhealthy or unsafe and is associated with chronic health issues such as asthma. Access to safe, affordable housing impacts some communities, including people of color, those living with disabilities, and the LGBTQIA2 community, more than others.

OCCUPIED HOUSING UNITS WITH ONE OR MORE SUBSTANDARD CONDITIONS
(% of owner-renter occupied housing units)

<table>
<thead>
<tr>
<th></th>
<th>Clackamas</th>
<th>Multnomah</th>
<th>Washington</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>37%</td>
<td>42%</td>
<td>37%</td>
</tr>
</tbody>
</table>

Access to inclusive & accessible physical, behavioral, and oral health care

Culturally responsive, accessible, and high-quality medical care can help people live longer, healthier lives. Access to medical care integrates many factors, many of which are difficult to measure at the system level. One factor that impacts access is the ratio of providers to community members in an area. A 2008 Evidence Review reported that states with a lower ratio of patients to primary care physicians have better health outcomes, including decreased cancer, heart disease, and stroke mortality. Low-income communities, communities of color, people living with disabilities, and the LGBTQIA2 and immigrant and refugee communities often experience additional barriers to access in health care services that further amplify regional variations in access to care.

<table>
<thead>
<tr>
<th>PRIMARY CARE IN 2013</th>
<th>BEHAVIORAL HEALTH IN 2015</th>
<th>DENTAL CARE IN 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 primary care provider for:</td>
<td>1 behavioral health provider for:</td>
<td>1 dentist for:</td>
</tr>
<tr>
<td>1159 people in Clackamas</td>
<td>476 people in Clackamas</td>
<td>1321 people in Clackamas</td>
</tr>
<tr>
<td>725 people in Multnomah</td>
<td>159 people in Multnomoh</td>
<td>1094 people in Multnomah</td>
</tr>
<tr>
<td>1110 people in Washington</td>
<td>415 people in Washington</td>
<td>1154 people in Washington</td>
</tr>
</tbody>
</table>
Access to healthy, affordable, and culturally relevant food

The ability to access fresh, affordable, and culturally relevant foods is a cornerstone of individual and community health, especially for low-income communities, people living with disabilities, and communities of color. People in these communities are disproportionately impacted by the effects of food deserts, limited access to culturally relevant food options, and chronic health conditions such as diabetes and hypertension.

PERCENT OF CENSUS TRACTS DESIGNATED AS FOOD DESERTS

<table>
<thead>
<tr>
<th></th>
<th>Clackamas</th>
<th>Multnomah</th>
<th>Washington</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>17%</td>
<td>13%</td>
<td>15%</td>
</tr>
</tbody>
</table>

Access to high-quality, identity-affirming trauma-informed education

Education is a strong predictor of health outcomes. Much of our formative years are spent in the school environment. A healthy, safe, identity-affirming academic environment promotes social cohesion, healthy self-concept, and increased mental well-being. Additionally, these environments increase health-promoting behaviors, self-advocacy, and life expectancy while also reducing stress. High-quality educational experiences are not equally accessible to all communities in the tri-county region – income, ethno-racial identity, primary language, and disability status are all associated with disparities in access to education.

EDUCATION INDICATORS

<table>
<thead>
<tr>
<th>Children ages 3-4 years enrolled in public or private preschool or nursery school (%)</th>
<th>Clackamas</th>
<th>Multnomah</th>
<th>Washington</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>45%</td>
<td>50%</td>
<td>46%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Students proficient in reading (%)</th>
<th>Clackamas</th>
<th>Multnomah</th>
<th>Washington</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>72%</td>
<td>64%</td>
<td>71%</td>
</tr>
</tbody>
</table>

Safe neighborhoods

Where we live is deeply linked to how well we live. Housing quality, access to services, and proximity to playgrounds, schools, libraries, and parks are all associated with individual and community health. Some communities are disproportionately impacted by poor air and water quality, proximity to hazardous waste, and a lack of basic infrastructure such as sidewalks and paved roads.
Top Chronic Conditions & Illnesses*

The following data is drawn from medical claims. It gives a snapshot of the top reasons people have received care and the top chronic conditions or illnesses diagnosed and monitored by Health Share and FamilyCare between 2012 and 2015.

This data only reflects those who sought care for health issues. Low prevalence of a diagnosis may indicate lack of engagement in health care, rather than lower prevalence of the condition. In this section, we examine these top conditions by ethno-racial identity to focus attention on how health differs within communities of color, who are often most impacted by health disparities. Because comparing communities of color with each other can lead to harmful comparisons, we have reported each of these health conditions for each ethno-racial community on its own.

We recognize that by adopting an ethno-racial approach, we are prioritizing a racial equity analysis to these top chronic conditions and illnesses. We are doing so with the hopes of the following:

1. Shining a light on the structural and systematic racism and discrimination experienced by communities of color, and the connection between racism, discrimination, and health
2. Providing data for community-based organizations to use in program design and funding to respond to these disparities
3. Modeling an approach to health equity work that decenters white/Caucasian experiences by not comparing communities of color to white communities

Making the Invisible, Visible

Health Share recognizes that life is lived at the intersections of multiple identities and is committed to improving how we capture and use data that reflects this. See page 4 for more information on how we are working to make community needs more visible.

* Population: Adults (19 and older) and youth (0-18) who are enrolled in the Oregon Health Plan (OHP) and assigned either to FamilyCare or Health Share of Oregon, the two CCOs serving the tri-county region until January 2018. Time period: Utilization between April 1, 2014, and March 31, 2015. Diagnosis between March 31, 2012, and March 31, 2015. Data inclusion criteria: Diagnostic codes derived from administrative Medicaid claims data. Unduplicated count of patients.
Top Health Conditions

Because tri-county and even state-level data is difficult to find for several of the top chronic conditions, the following prevalence estimates are pulled from national data sources as a comparison point for our claims data.

### Adults

**HYPERTENSION/HIGH BLOOD PRESSURE**
National average

- 32% ~1 in 3 adults

**DIABETES**
National prevalence

- 9%

**DEPRESSION**
National prevalence

- 8%

### Youth

**ASTHMA**
National prevalence

- 8%

**ADD/ADHD**
National prevalence

- 9%

**PTSD**
National prevalence

- 4%

Top Health Conditions for Native Americans and Alaska Natives

For Native American and Alaska Native members, the leading health issue for adults in all three counties was hypertension. For youth, ADD was the top condition in Clackamas and Multnomah counties, and asthma was the top condition in Washington County.
**Top Health Conditions for Asians and Pacific Islanders**

For Asian and Pacific Islander members, hypertension was the top health condition among adults, and asthma was the most prevalent condition among youth across all three counties.

**Top Health Conditions for Black/African Americans**

For black/African-American members, hypertension was the top health condition among adults and asthma was the most prevalent condition among youth across all three counties.
Top Health Conditions for Latinos

For Latino members, hypertension was the top health condition among adults and asthma was the most prevalent condition among youth across all three counties.

Top Health Conditions for White/Caucasians

For white/Caucasian members, hypertension was the top health condition among adults. For youth, asthma was the most prevalent condition in Multnomah and Washington counties and ADD was most prevalent in Clackamas County.
What’s Next?

Health Share’s Community Health Improvement Plan

This CHNA serves the purpose of describing the overall health of our community. It is based on both quantitative data (public health, Medicaid, and hospital data) and qualitative feedback (listing sessions, community surveys, etc.). Combined, this data captures the top chronic illnesses and conditions experienced by our communities as well as community input on what makes a healthy community.

Using the information in this CHNA, the Community Advisory Council will develop a Community Health Improvement Plan (CHP) to serve as a roadmap for how Health Share can meet the identified needs of the community. The Council will partner with Health Share staff to engage the community and our members to determine how Health Share prioritizes and responds to the identified health needs from the CHNA. Some of the questions that will guide this process include:

- What are the best strategies for response to the identified needs and strengths in the CHNA?
- Are there communities that are not represented and, if so, what can we do to capture that information in the community health improvement plan?
- Of the priorities listed here, which ones are communities interested in addressing?
- How can we continue to make the health needs of communities most impacted by structural inequality more visible?
- Where is the work already being done to address these priorities, and how can Health Share leverage or support those efforts?

Health Share is committed to engaging our communities throughout the development of our CHP. Indeed, we recognize that it is only through true partnership and engagement that real change will come.
About Health Share

Health Share is Oregon’s largest coordinated care organization, providing health care for more than 300,000 residents.

OUR VISION
A healthy community for all

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

OUR FOUNDERS
Health Share was founded and continues to be governed by 11 health and social services organizations serving OHP members:

• Adventist Health
• CareOregon
• Central City Concern
• Clackamas County
• Kaiser Permanente
• Legacy Health
• Multnomah County
• Oregon Health & Science University
• Providence Health & Services
• Tuality Healthcare
• Washington County

Health Share works closely with community, state, and local governments, health advocacy groups, communities of color, and social service agencies to help address social determinants of health in a person-centered, culturally relevant way.

Health Share, along with all of our partners, works within our community to improve the ways that members, providers, and health care delivery systems interact with one another and to connect our members with the services they need to be healthy.

Our health as individuals and as a region depends not just on the medical system, but also on the resources available to each of us in our communities. We are committed to making the health delivery system responsive to the needs of those we serve, and we are committed to strengthening partnerships with others outside the health care system to reach a mutual goal of ensuring the healthiest and most productive life possible for everyone.
Acknowledgements

HEALTH SHARE COMMUNITY ADVISORY COUNCIL

LAKEESHA DUMAS
Consumer Engagement Coordinator
Multnomah County

PHILIP MASON-JOYNER
Operations Manager,
Clackamas County Public Health Division

BEN SOLHEIM
Community-Based Program Administrator,
ColumbiaCare Services, Inc

CANDACE JIMENEZ
NW Portland Area Indian Health Board

ABIGAIL J. LAWRENCE
Community Advocate, NxNE Clinic

OLIVIAH WALKER
Senior Policy Analyst/ Community Engagement Liaison,
Multnomah County Public Health Department

MARIA HERMSEN
Program Manager
Youth M.O.V.E Oregon

WEST LIVAUDAIS
OHSU Office of Disability & Health

NATASHA SMITH
EPS Project Specialist, Multnomah County Public Health Department

ERIN JOLLY
Senior Program Coordinator, Health Equity, Planning & Policy Program,
Washington County Public Health

MAYRA MERINO RENDON
OHP Assister,
NW Family Services

2016 HEALTHY COLUMBIA WILLAMETTE COLLABORATIVE

Adventist Health Portland*
Clackamas County Public Health Division*
Clark County Public Health
FamilyCare Health

Kaiser Permanente Sunnyside and Westside Hospitals*
Legacy Health*
Multnomah County Public Health*
Oregon Health & Science University (OHSU)*

PeaceHealth Southwest Medical Center
Providence Health & Services*
Tuality Healthcare*
Washington County Public Health Division*

2016 HEALTHY COLUMBIA WILLAMETTE COLLABORATIVE

Adelante Mujeres
Adult Mental Health and Substance Abuse Advisory Council
Allies for a Healthier Oregon
Ant Farm
Calvary Church
Central City Concern
Clackamas County Public Health Advisory Committee
Clackamas Service Center
Coalition of Community Health Clinics
Elders in Action Commission
El Programa Hispano
FamilyCare Community Advisory Council
Free Clinic of SW Washington

Hacienda CDC
Health Share of Oregon Community Advisory Council
Highland Church & Highland Access, Reentry and Recovery Program
Immigrant and Refugee Community Organization
The Intertwine Alliance
Latino Network
Liberation Street Church
Lifeline Connections
LifeWorks Northwest
Multnomah County Health Equity Initiative
Native American Youth Association
National Alliance on Mental Illness (Clackamas)

OHSU Richmond Clinic
Health Literacy Committee
Oregon Community Health Worker Association
Oregon Health Equity Alliance
Outside In
Oregon Foundation for Reproductive Health
Oregon Public Health Institute
Project Access NOW
Q Center
Urban League of Portland
Veterans Affairs Hospital
Washington County Mental Health and Addictions Advisory Council
Washington County Public Health Advisory Council

*Original founding partners of Health Share of Oregon
Sources


Health Share's mission is to partner with communities to achieve ongoing transformation, health equity, and the best possible health for each individual.

Attachment 10 — Social Determinants of Health and Health Equity (14 pages)

A. Community Engagement
A.1. Evaluation Questions
A.1.a. Did Applicant obtain Community involvement in the development of the Application?

Our commitment to community engagement – Yes, as a locally based, community-governed coordinated care organization, community involvement is fundamental to Health Share of Oregon. Stakeholder engagement varied from participating application workgroups, serving as subject matter experts, providing content review, and authoring sections of the application. We dedicated our March and April Community Advisory Committee (CAC) meetings to engage our CAC members in the application drafting process. More than 120 community members (illustrated below) participated in the development of this application. As an example of stakeholder input informing this application, our community partners suggested we use an RFP process in order ensure a transparent and equitable process to award funds for social determinants of health and health equity (SDOH-HE) spending. This input has been incorporated into our application.

Health Share Partner Organizations
- Adventist Health
- CareOregon
- Central City Concern
- Clackamas County
- Kaiser Permanente
- Legacy Health
- Multnomah County
- Oregon Health & Sciences University
- Providence Health & Services
- Tuality Healthcare
- Washington County

Local Health Care Providers
- Physical health providers
- Mental health providers
- SUD providers
- Oral health providers

Health Share Governance Bodies
- Board of Directors
- Community Advisory Council
- Three Board Committees

Community Organizations
- Oregon Community Health Workers Association (ORCHWA)
- Oregon Health Equity Alliance (OHEA), our regional health equity coalition
- Mental Health and Addiction Certification Board of Oregon (MHACBO)
- Oregon Primary Care Association (OPCA)

Health Share is built for collaboration, engagement, and partnership that values community involvement. Our governance structure reflects this commitment. The Board of Directors (Board) is comprised of physical, oral, and behavioral health providers, delivery systems, health plans, county representatives, regional community leaders, and a CAC member. Health Share’s operations ensure authentic engagement in operational and strategic decision-making with our integrated community network (CareOregon), integrated delivery systems (Legacy Health, OHSU Health System, Kaiser Permanente), CAC, community partners, and OHP members.

Building upon six years of successful community engagement, Health Share is elevating SDOH-HE as we work to advance the triple aim of better health, smarter spending, and healthier people. Health Share’s Board recently approved a new organizational and governance structure to accelerate our investments in SDOH-HE. Through the creation of a strategic investment fund, Health Share will direct approximately 0.5% (as reflected within our pro forma) of our annual global budget to upstream and public health investments and community-wide strategies to address SDOH-HE. We will work with the OHA in its HB 4018 rulemaking
process around defining the “portion” of net revenue or surplus reserves that must be invested to address SDOH-HE and will allocate at least the minimum level of funding required by the rule.

A.1.b. Applicant will submit a plan via the RFA Community Engagement Plan for engaging key stakeholders, including OHP consumers, Community-based organizations that address disparities and the social determinants of health, providers, local public health authorities, Tribes, and others, in its work.

See RFA4690-Health Share of Oregon-Att10-RFA Community Engagement Plan.

B. Social Determinants of Health and Health Equity (SDOH-HE) Spending, Priorities, and Partnership

B.1. Informational Questions

B.1.a. Does Applicant currently hold any agreements or MOUs with entities that meet the definition of SDOH-HE partners, including housing partners? If yes, please describe the agreement.

Yes, since its inception, Health Share has achieved substantial inroads through agreements and MOUs with strategic SDOH-HE partners including multiple arrangements with a variety of housing partners which already set us on the path toward addressing OHA’s housing priority. Health Share’s CAC played a pivotal role in this through their work on our Community Health Needs Assessment (CHA) and Community Health Improvement Plan (CHP), which has driven our strategic initiatives and community investments. Health Share understands our ability to impact SDOH-HE depends on engaging in and fostering cross-sector partnerships. We have invested in and engaged with a wide variety of stakeholders who share our dedication to addressing SDOH-HE. Below are examples of agreements and MOUs we have in place:

- **Frequent Users System Engagement (FUSE)** – In partnership with Multnomah and Clackamas counties, these initiatives work to understand the systemic impacts of housing insecurity on health and criminal justice outcomes and implement cross-system interventions in response. These interventions may include supportive housing or new clinical programming depending on the analysis results and community priorities.

- **Housing is Health** – In the fall of 2016, six of our founding partners launched a housing initiative, providing $22.6 million in funding to Central City Concern (also a founding partner) for a new clinic and 379 units of low-income housing.

- **Regional Supportive Housing Impact Fund (RSHIF)** – RSHIF is a continuation of efforts by the six Housing is Health partners to ensure OHP members who are discharged by facilities funded have immediate access to housing upon discharge.

- **A Home for Everyone (AHFE)** – Health Share’s Chief Equity & Engagement Officer serves on the Coordinating Board and committees for A Home for Everyone (AHFE), a multisector initiative responding to the crisis of homelessness in Multnomah County.

- **Medical Legal Partnership of Oregon** – Medical Legal Partnerships (MLP) provide access to legal services that impact health outcomes. Attorneys are generally co-located within clinics, and clinicians refer patients to attorneys for legal services. We sponsored Oregon’s first MLP pilots and funded start-up costs for MLPO, helping to stand up MLPs across the state.

- **Local Public Health Authority (LPHA) partnership** – We hold MOUs with our three LPHAs with a focus on sharing and using data across systems, improving care and direct services to individuals and families, and collaborating for health equity and community health. We recently funded and convened our three LPHAs to develop a joint behavior change marketing campaign to combat vaccine hesitancy in the tri-county region, and beginning in 2020, public health services will be funded with a percentage of Health Share’s global budget.
• **Community Health Worker (CHW) Program Infrastructure** (Oregon Community Health Worker Association (ORCHWA)) – We invested $3.3 million in ORCHWA to create and sustain an infrastructure that will increase statewide access to culturally specific and community-based CHWs for all Oregonians, regardless of health care system or payer.

• **Foster Care Initiatives (DHS)** – Foster care placement is not always thought of as a SDOH, but it should be. Our data show removal from one’s home and birth family has dramatic long-term consequences for members’ physical and behavioral health. That’s why we invested in creating a foster care advanced primary care home model, hiring and placing a foster care medical liaison in our local DHS Child Welfare office, and developing a digital platform to ensure our members in foster care get the care they need, when they need it.

• **Early Learning Hub Partnerships** (Tri-county Early Learning Hubs)
  - Help Me Grow – SDOH can create access barriers for services like developmental services. In response, we brought Help Me Grow (HMG), a national model for promoting children’s development through early detection of risk for developmental delays and linkages to community-based services through a centralized access point, to Oregon. Nationally, 82% of families report their needs are met by HMG.
  - Immigrant and Refugee Children – We supported development of a “Sign up Early for Kindergarten Campaign” that created short videos in 10 languages and hosted Parent Cafés with Hubs and immigrant/refugee organizations on developmental milestones and school readiness for different refugee populations.

• **Regional Kindergarten Readiness Network** – We brought together over 60 cross-sector organizations and leaders to redesign how systems work together so that race, class, and disability are no longer predictors of kindergarten readiness and long-term population health.

• **Regional Community Health Network** (Project Access NOW) – Through a contractual agreement, we’re funding RCHN to develop an integrated system of services to ensure individuals and families have stable and consistent access to health care, social services, and other resources necessary for optimal health.

• **Tri-County 911 Service Coordination Program** (Multnomah County) – We developed and fund this program serving tri-county residents who frequently call 911 for emergency medical services when other health and social services would more appropriately serve their needs.

**Working with providers to address SDOH-HE** – Our clinical service providers are also integral to addressing SDOH-HE. Through contracts, MOUs, and agreements, Health Share funds clinical service providers to address the SDOH for high-risk populations such as children in foster care (Foster Care Medical Homes), pregnant women with substance use disorders (Project Nurture), and children with developmental/behavioral delays (Peer Family Navigators).

**B.1.b. Does Applicant currently have performance milestones and/or metrics in place related to SDOH-HE? These milestones/metrics may be at the plan level or Provider level. If yes, please describe.**

**Approach to assessing effectiveness of SDOH-HE initiatives** – Yes, Health Share measures performance on addressing SDOH-HE through building infrastructure to evaluate performance on SDOH-HE interventions, measuring outcomes of initiatives, disaggregating population health data and health care quality metrics by demographic characteristics, and supporting community and provider-level performance improvement initiatives through our partner organizations.

Health Share’s investment in the Regional Community Health Network (outlined above) supports implementation of the Pathways Community HUB model. The HUB model has three principles:

1) **Find:** Identify individuals at greatest risk and assess their health, social, and behavioral health...
risk factors

2) **Treat:** Ensure that each identified risk factor is assigned a pathway to address the risk factor with an evidence-based or best-practice intervention

3) **Measure:** Confirm that the risk factor has been successfully addressed. The measurement component of the HUB model utilizes a nationally defined set of metrics related to SDOH-HE. Health Share’s investment in the RCHN supports the development of an information platform to capture and track these metrics.

Health Share’s Ready + Resilient (R+R) strategic initiatives include interventions designed to address SDOH-HE (many listed above), and each initiative includes performance milestones and metrics. All agreements for organizations receiving R+R funding include performance evaluation through a mix of qualitative and quantitative milestones and/or metrics. Funding recipients submit quarterly reports on outcomes, progress, and barriers.

As an example of the types of milestones and metrics we require of funded entities, we’ve included a sample of those required for the ORCHWA investment described above:

<table>
<thead>
<tr>
<th>Deliverable</th>
<th>Metric</th>
<th>Milestone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selection and implementation of a <strong>Health Information Technology (HIT)</strong> system to track CHW activities and outcomes</td>
<td>- HIT system utilized, by ORCHWA and partner organizations employing CHWs, to track CHW activities and outcomes</td>
<td>- HIT system selected</td>
</tr>
<tr>
<td>Increase ORCHWA’s capacity to provide <strong>technical assistance (TA)</strong> and support to health systems and CBOs using CHWs</td>
<td>- ORCHWA has capacity to provide TA to health systems on promising practices for integrating and utilizing CHWs</td>
<td>- ORCHWA website includes a TA section with resources and promising practices</td>
</tr>
<tr>
<td></td>
<td>- ORCHWA has provided TA to CBOs or Health Systems</td>
<td>- ORCHWA has developed training modules on CHW integration, supervision, and support</td>
</tr>
<tr>
<td>Expand <strong>tri-county culturally-specific collaborative</strong> network of CBOs that employ CHWs</td>
<td>- Increase number of contracts with culturally specific CBOs employing CHWs</td>
<td>- Potential CBOs identified</td>
</tr>
</tbody>
</table>

In addition, Health Share’s analytics platform, Health Share Bridge, allows us to disaggregate population health data based on demographic characteristics, including REAL+D. This has led to multiple discoveries of gaps in services and health inequities experienced by our members, which we were then able to address through community interventions. For example, when we discovered that non-English speakers had lower rates of development screenings, we realized that we needed to trans-create the Ages and Stages Questionnaire (ASQ) into prevalent non-English languages. Doing this led to a more than three-fold increase in timely developmental screenings for our members.

We will build upon this success and create SDOH-HE specific dashboards to track and measure the impact of our SDOH-HE investments. These metrics will be developed in partnership with our CAC, the Community Impact Committee of our Board, and other key stakeholders and in alignment with recommendations coming from the SDOH-HE Measurement Workgroup OHA is convening.

One of Health Share’s many strengths is the diversity and breadth of our partners’ efforts. Following are highlights of several partner initiatives and metrics related to addressing SDOH-HE:

- CareOregon is developing a health equity component for its primary care payment model, which will incentivize clinics to reduce health disparities and provide culturally responsive, inclusive, and trauma-informed care. CareOregon is also piloting this model within pediatric clinics focused heavily on SDOH-HE, ACEs, and resiliency. These initiatives include process and outcome performance milestones and metrics.
• Multnomah County’s Racial and Ethnic Approaches to Community Health (REACH) program has SDOH-HE metrics focused on built environment, food access, physical activity, and access to clinical and community programs. The Joint Office on Homeless Services (JOHS) monitors the homeless service system and reports on metrics tied to number of people newly homeless, average length of time homeless, placements and retention into permanent housing, emergency shelter usage, and more.
• Legacy Health Systems has adopted a metric to measure hospital readmissions for people of color in order to identify and address systemic inequities driving poorer health outcomes.
• Kaiser Permanente invests in a comprehensive community partnership integration approach supporting members with issues such as housing and transportation. In addition to metrics such as readmission and ED usage, additional goals are to decrease no show rates and self-reported social barriers to accessing care and self-reported emotional health.

B.1.c. Does Applicant have a current policy in place defining the role of the CAC in tracking, reviewing and determining how SDOH-HE spending occurs? If yes, please attach current policy. If no, please describe how Applicant intends to define the role of the CAC in directing, tracking, and reviewing SDOH-HE spending.

Health Share recognizes the pivotal role the CAC plays in guiding CCO decision-making. Health Share’s $3.3 million investment in ORCHWA stemmed from the CAC’s decision to prioritize culturally specific and community-based CHWs in Health Share’s first CHP. We will create a policy defining the role of the CAC in tracking, reviewing, and determining how SDOH-HE spending occurs. This policy will outline the role the CAC plays in developing our SDOH-HE priorities via their work on the CHP, active participation in developing Health Share’s Disparities and Social Determinants of Health Spending Implementation Plan, submitting their recommendation to the board, and tracking and monitoring initiatives selected. This policy will be in place by January 2020.

B.1.d. Please describe how Applicant intends to award funding for SDOH-HE projects, including:

Health Share’s collaborative model will create a platform to address SDOH-HE through the development of a strategic investment fund supporting upstream and public health investments and community-wide strategies to address SDOH-HE. This fund will be governed by policies and procedures developed by the Community Impact Committee of the Board, the CAC, and additional key stakeholders and then adopted by the Board. The strategic investment fund will use a collective impact investment model to align and leverage the resources and investments of our founding partner organizations to achieve maximum community impact.

B.1.d.(1) How Applicant will guard against potential conflicts of interest

Health Share, as a locally based nonprofit 501(c)3 charitable organization, uses a conflict of interest policy as a systematic mechanism for disclosing and evaluating actual and potential conflicts in any transaction or arrangement in order to avoid real or perceived conflicts. This policy applies to our Board and staff members, and it covers conflicts or potential conflicts regarding investments or transactions, business ownership, goods or services, and other circumstances. We will build on this foundation and develop policies specifically to guard against potential conflicts of interest related to our SDOH-HE spending. Health Share staff will be responsible for monitoring for compliance; any undisclosed conflicts uncovered will result in ineligibility for funding. Strategies included in this new policy will likely include requiring applicants and reviewers to sign a conflict of interest agreement, including criteria addressing potential conflicts in SDOH-HE applications, and restricting review of proposals and decision-making on investments to individuals without any conflicts of interest.

B.1.d.(2) How Applicant will ensure a transparent and equitable process

Health Share proposes to use a Request for Proposals (RFP) process to award SDOH-HE investments. Utilizing an RFP approach will ensure a transparent and equitable process by informing the community of our intent to award funds, the areas of SDOH-HE we intend to fund, and amounts available. We will outline the application process (including screening, evaluation, and...
selection procedures) and expectations of awardees. We will ask that applicants outline an evaluation approach to support tracking effectiveness of investments over time. This RFP process will be designed and implemented by Health Share’s Community Impact Committee with input from the CAC. The Board of Directors will approve and oversee the RFP process and its implementation.

B.1.d.(3) How Applicant will demonstrate the outcome of funded projects to Members, SDOH-HE partners, and other key stakeholders in the Community

Health Share will produce and disseminate yearly reports on our SDOH-HE spending that include a list of awardees, amount of funds received, description of project(s), and associated timelines. The yearly report will include qualitative and quantitative performance milestones and outcomes for each project as proposed by the awardee. Currently Health Share creates an Annual Report that includes information about community investments, as well as short videos that highlight specific initiatives. We share these productions on our website, in our quarterly stakeholder newsletter, and on social media platforms. We also produce a quarterly progress reports on R+R initiatives, which include performance evaluation through a mix of qualitative and quantitative measures, for our Board.

B.1.e. For the statewide housing priority only: please provide proposed metrics for assessing the impact of investments in this area.

Health Share’s focus on supportive housing – In order to achieve the deepest impact in housing investments, supportive housing is a key focus for Health Share. With the recent passage of the Affordable Housing Bond and pending investments at the state level, there are more funds than ever for housing production along with a need for long-term stable funding and supportive services that make supportive housing successful. This is why six of our founding partners invested $22.6 million in the Housing is Health initiative, and their commitment continues through the Regional Supportive Housing Impact Fund. Additionally, Health Share will target housing partnerships to invest in services for people with the most complex health needs and communities disproportionately impacted by homelessness. Health Share proposes the following metrics for assessing our investments:

<table>
<thead>
<tr>
<th>Category</th>
<th>Outcome Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Housing Retention</strong></td>
<td>Length of time a member remains in their supportive housing unit</td>
</tr>
<tr>
<td><strong>Health Outcomes</strong></td>
<td>Improved outcomes on physical and behavioral health by member based on regular assessment and analysis:</td>
</tr>
<tr>
<td></td>
<td>- Substance use disorder treatment initiation and completion</td>
</tr>
<tr>
<td></td>
<td>- Engagement in primary care/prevention services</td>
</tr>
<tr>
<td></td>
<td>- Engagement in mental health treatment</td>
</tr>
<tr>
<td></td>
<td>- Chronic disease medication utilization</td>
</tr>
<tr>
<td><strong>Health Care Utilization</strong></td>
<td>Reduced use of emergency programs and residential facilities:</td>
</tr>
<tr>
<td></td>
<td>- Inpatient psych utilization</td>
</tr>
<tr>
<td></td>
<td>- Detox and SUD residential treatment</td>
</tr>
<tr>
<td></td>
<td>- Emergency department utilization</td>
</tr>
<tr>
<td></td>
<td>- Inpatient utilization</td>
</tr>
<tr>
<td></td>
<td>- Transitions directly from acute care services to supportive housing</td>
</tr>
<tr>
<td><strong>Homelessness</strong></td>
<td>Reduced homelessness, especially among those individuals and families who have special needs and would benefit from a supportive housing intervention</td>
</tr>
</tbody>
</table>

2. Evaluation Questions

2.a. Please describe the criteria Applicant will apply when selecting SDOH-HE partners.

Health Share will collaborate with our CAC and other community stakeholders to develop a comprehensive list of criteria for these investments. The Community Impact Committee will approve the final criteria. We will consider utilizing the following criteria, though additional criteria may be added through our collaborative process: partners with a demonstrated track record of impacting health disparities, health equity, and SDOH; projects aligning with Health Share’s CHP and strategic priorities; projects that leverage other SDOH investments, including those of our county or hospital CHPs; organizations using a framework of evidence-based and evidence-lived
practices (Health Share defines “evidence-lived practices” as community wisdom based on lived experience); initiatives with positive impacts on quality of care and reductions in ED utilization; projects aligning with statewide priorities; and projects that comply with Health Related Services.

2.b. Please describe how Applicant will broadly communicate the following information to the public and through its network of partners: its SDOH-HE spending priorities, the availability of funding for projects, how interested parties can apply for consideration, and the project selection process.

Health Share will promote our SDOH-HE spending priorities and RFP opportunities through multiple methods to notify community partners of our spending priorities, funding availability, the process to apply for consideration, and the selection process. We will post opportunities on our website, utilize press releases, send notices to our stakeholder listserv, promote opportunities on our and our partners’ social media platforms, and use CAC and community stakeholder networks to engage a broad base of interested organizations. Community outreach will include listservs of partners serving marginalized communities to ensure funding opportunities reach diverse communities.

2.c. Please describe how Applicant will track & report SDOH-HE expenses & outcomes, including technological capacity & process for sharing & collecting data, financial systems, & methods for data collection.

Tracking and reporting expenses and outcomes – All community partners who receive funding from Health Share submit quarterly reports documenting progress on deliverables and outcomes. Staff produce quarterly dashboards for Health Share’s Board on program investments and outcomes. Given the length of time it takes to impact outcomes related to SDOH-HE, Health Share use a combination of process and outcome metrics to measure the effectiveness of SDOH-HE investments. We will adjust these accordingly based on the work of the OHA SDOH-HE Measurement Workgroup.

Outside of traditional encounter-based expenditures, the primary focal point for financial reporting of SDOH activities is within Health-Related Services (HRS). These include both member-specific flexible services, as well as community benefit initiatives funded via larger strategic investments. Both types of HRS are included in current financial reports on a quarterly and annual basis. Community benefit expenses are captured at a financial program or project level, as these are not a member-specific expense. Most are larger-scale strategic investments, focused on specific populations and/or a specific SDOH criterion. For each project, annual financial reporting captures criteria such as costs, rationale, any evidence-based best practices, measurable outcomes, target populations, length of initiative, and returns on investments. Health Share captures flexible services expenditures in a manner that attributes the costs and activities to individual members, similar to encounter data.

Technological capacity – To assist with HRS data collection, Health Share subscribes to the Community-Linked Assistance Referrals Assessment (CLARA) regional technology platform capturing fields such as member ID, date of service, cost, and service category for flexible services. CLARA is administered by Project Access Now, a SDOH/HE Partner. Health Share’s partners are also advancing technology to track SDOH-HE data, including:

- Health Share’s FQHCs are implementing the PRAPARE screening tool to capture data on the SDOH-HE needs of their patients. PRAPARE is available in most major electronic health record (EHR) platforms and in over 10 languages. It is the most widely used tool in safety-net clinics nationwide. The data will assist providers in defining and documenting the social complexity of their patients, transform care with integrated services and community partnerships to meet the needs of their patients, and enable the clinics to advocate for change in their communities.
Health Share’s physical and behavioral health partners are increasing their efforts at capturing SDOH needs of our patients within EHRs through the use of ICD-10 diagnosis codes in the Z55-Z65 series (Z codes) reflecting SDOH-HE needs. Documenting these Z codes in the EHR allows us to quantify and monitor the primary barriers and needs of our population. Health Share will make strategic pushes for broader use of codes in certain categories (e.g., housing) to support data-driven approaches to improvement and upstream impact.

Kaiser Permanente is developing a Social Service Resource Locator (SSRL) that will be a regional tool across Health Share partners to connect patients to community resources that effectively address their SDOH-HE needs. The SSRL will provide bi-directional communication between health care organizations and community social service agencies, helping to prioritize follow-up based on real-time data and facilitate closed-loop referrals.

In the future, Health Share will align any new SDOH-HE reporting criteria implemented by OHA, including activities related to implementing SDOH-HE risk adjustment factors.

2.d. Applicant will submit a plan for selecting Community SDOH-HE spending priorities in line with existing CHP priorities and the statewide priority on Housing-Related Services and Supports via the RFA Community Engagement Plan, as referenced in section A.

See attached RFA4690-Health Share of Oregon-Att10-RFA Community Engagement Plan.

C. Health-Related Services (HRS)

C.1. Informational Questions

C.1.a. Please describe how HRS Community benefit investment decisions will be made, including the types of entities eligible for funding, how entities may apply, the process for how funding will be awarded, the role of the CAC (and Tribes/tribal advisory committee if applicable) in determining how investment decisions are made, and how HRS spending will align with CHP priorities.

Health Share’s HRS community benefit investments will comply with OAR 410.141.3150 focusing on community-level initiatives improving population health and health care quality. Health Share proposes to use the same process developed for SDOH-HE spending for HRS Community Benefit Investment decisions as referenced in Section B above. This includes types of entities eligible for funding, how entities apply, how the process for funding happens, and the role of the CAC in funding decisions.

D. Community Advisory Council membership and role

D.1. Informational Questions

D.1.a. Please identify the data source(s) Applicant proposes to use when defining the demographic composition of Medicaid Members in the Applicant’s Service Area.

Health Share uses enrollment data provided by OHA through the membership assignment process to determine the demographics of our member population. Health Share uses a process of applying a REAL+D analysis along with geo-mapping and analytics technology to understand the geographic distribution and makeup of our members. This information guides the composition of our CAC in order to ensure our CAC reflects the communities we serve.

D.2. Evaluation Questions

D.2.a. Applicant will submit a plan via the RFA Community Engagement Plan, as referenced in Section A, for engaging CAC representatives that align with CHP priorities and membership demographics, how it will meaningfully engage OHP consumer(s) on the CCO board and describe how it will meaningfully engage Tribes and/or tribal advisory committee (if applicable)...

See attached RFA4690-Health Share of Oregon-Att10-RFA Community Engagement Plan

E. Health Equity Assessment and Health Equity Plan

E.1. Informational Questions

E.1.a. Please briefly describe the Applicant’s current organizational capacity to develop, administer, and monitor completion of training material to organizational staff and contractors, including whether the Applicant currently requires its Providers or Subcontractors to complete training topics on health/Health Equity.
Advancing health equity in our community – Health Share has been a leader among CCOs in advancing health equity. We hired an executive level Chief Equity & Engagement Officer who provides organization-wide oversight and leads, develops, supports, and monitors all organization-wide activities related to health equity, serving as the single point of accountability. Additionally, Health Share invests in three dedicated FTEs focused on advancing health equity by developing, administering, and monitoring equity-related trainings as well as developing and implementing our organizational health equity plan. This team also offers equity-related technical assistance and trainings for our partners and community. Past internal trainings have included health equity; social determinants of health, power, and privilege; transgender competency 101 and 201; poverty and classism; implicit bias and structural racism; decolonizing data; trauma-informed care; adverse childhood events; disability and mental health awareness; and more. In 2015, Health Share collaborated with local community leaders and experts in transgender health to plan and host a provider training on serving our transgender members. In 2018, Health Share health equity staff provided external trainings on Health Equity and Self-Care for People of Color to our partner organizations and hosted a daylong CME training on the intersections of behavioral health and communities of color. Health Share is excited to work with our partners to accelerate and expand our health equity efforts to include organizational equity audits, enhanced equity trainings and the development of health equity plans. While our current delegation contracts do not require our providers or subcontractors to complete trainings on these topics, we will include these requirements in our delegation contracts moving forward.

E.1.b. Please describe Applicant’s capacity to collect and analyze REAL+D data.

Health Share invested early in our capacity to collect and analyze REAL+D data to identify and target interventions to eliminate disparities. Health Share has robust systems, staff, and procedures to support disparities analysis. We maintain REAL+D fields in our enterprise data warehouse and populate those fields with REAL+D data from OHA enrollment files. Health Share has long been a collaborative partner with OHA for improving the utility of REAL+D data. Health Share’s equity and engagement and data analytics staff created a standard process to stratify our member enrollment data by REAL+D. This process includes best practices in community engagement such as partnering with impacted communities to understand disparities data, identify specific problems, and co-create strategies to address identified challenges. As noted above, this process was used to direct Health Share’s work on developmental screenings and led to improvements in developmental screening rates among populations experiencing disparities. Health Share is expanding its data capacity for REAL+D by creating disparity dashboards with specific focus areas or populations such as early childhood. Health Share’s Early Life dashboard displays a range of information about our members aged 0-18 years, namely the demographic composition of the population (including medical complexity and foster care status), geographical distribution (by zip code and school catchment area), and rates on key metrics indicating engagement in routine preventive care. These views will allow partners to identify disparities in access to preventive services and make connections between the primary care clinic systems and school districts that mutually serve our child and adolescent populations.

E.2. Evaluation Questions (Health Equity Assessment)

E.2.a. Please provide a general description of the Applicant’s organizational practices, related to the provision of culturally and linguistically appropriate services. Include description of data collection procedures and how data informs the provision of such services, if applicable.

Health Share identifies prevalent non-English languages spoken by members through monitoring
demographic data supplied through OHA enrollment files. We translate or trans-create member materials, including our website, handbooks, postcards, member navigation videos, targeted behavior change marketing campaigns, and more into prevalent non-English languages. We also ensure our partners are appropriately translating into non-English languages through a member materials review process. In addition, we employ Spanish-speaking customer service staff, and our customer service representatives and contracted providers are trained in accessing oral interpretation services in any non-English language. All of Health Share’s network provider directories include language access and culturally specific services (including LGBTQIA) information.

Health Share’s compliance infrastructure ensures Health Share staff, partner organizations, and providers throughout our networks comply with CLAS standards and expectations in law and contract. The Compliance Officer and compliance team conduct routine audits throughout our networks. The Board-level Quality Committee oversees these audits.

Cultural Competency & Health Equity Workgroup (CHEW) – CHEW meets quarterly and utilizes a learning collaborative framework to share and spread best practices on culturally and linguistically appropriate services across health plans. The workgroup includes key staff charged with advancing equity and promoting policies, practices, and procedures supporting culturally and linguistically appropriate services. Examples of work undertaken by this group in the past include:

- **Organizational cultural assessments** of plan partners to assess policies and procedures supporting the delivery of culturally and linguistically appropriate services to members
- **Language access strategy project** focused on improving language access policies and trainings for partners
- **Member grievance data disparity analysis project** to improve equitable access to member grievance process and enhance staff capacity to identify opportunities to advance equity through member grievance data
- **Member communication translation improvement project** focused on creating best practices for translating member materials

**Data and disparities** – Our early investments in data analytics and in building organizational capacity to advance health equity have positioned Health Share as a leader in this space. In addition to our work on standardizing our organizational practices on stratifying our data by REAL+D and our current work on creating disparity dashboards, one of our Transformation and Quality Strategy initiatives focuses on creating mechanisms to make disparities data actionable by our partners. This effort includes sharing data in ways that compel action and providing technical assistance in translating data into actionable interventions. Developing disparities dashboards by specific populations is the start of this work. We are also using data to build community profiles for special populations as a mechanism for expanding our knowledge of the disparities and experiences faced by our members. Our interactive electronic dashboards allow both internal staff as well as external provider partners to stratify CCO incentive metric performance by gender, language, and race. We use internal analyses from this data to develop new interventions if inequities are identified. Moving forward, we are exploring how to incorporate information from the OHA/OPIP Health Complexity dataset to account for social inequities as well.

**E.2.b. Please describe the strategies used to recruit, retain, and promote at all levels, diverse personnel and leadership that are representative of the demographic characteristics of the Service Area.**

Health Share and our partners recognize the value and advantage of a diverse workforce and, accordingly, we work to recruit a staff representative of our service area. Beyond increased creativity, productivity, and employee performance, a diverse workforce assists us with ensuring culturally and linguistically appropriate services for our members.
Recruiting a diverse workforce – Our efforts to recruit a diverse workforce include actively monitoring the demographics and representation of our current workforce. Health Share enlists the services of a firm specializing in affirmative action/equal employment opportunity, and assists in the development of annual affirmative action plans. These plans are used to assess the effectiveness of recruitment efforts across all job groups. We also realize the role clear and accessible job descriptions play in recruiting a diverse workforce, and we have employed numerous strategies in developing job descriptions such as listing language requirements or preferences, including lived experience in lieu of education, using accessibility software like Textio to remove bias from job description wording, and more. Job opportunities are promoted on sites and listservs reaching diverse communities including veterans and people with disabilities.

Retaining and promoting a diverse workforce – Retaining a diverse workforce requires attention to competitive compensation, professional development opportunities, and active promotion of an inclusive workplace culture that supports a diverse workforce. Health Share conducts an annual compensation review for all positions and adjusts salaries as appropriate to remain competitive. We also invest in employee professional development by providing opportunities to attend local and national conferences and workshops, webinars, and additional skills training opportunities. Health Share intentionally works to cultivate a workplace culture that values employee diversity. We offer equity, diversity, and inclusion (EDI) trainings and lunch-and-learn sessions to raise awareness of EDI. As Health Share employees, we operate with a set of guidelines and values that drives our work together. One of these values is believing health equity is achievable and requires deliberate action on our part. Our guidelines for dialogue are posted in our meeting rooms and provide foundational agreements for engaging in the work of advancing EDI efforts within our organization and programs. We include EDI efforts in our employee performance evaluations as another mechanism for encouraging a workplace culture that supports diverse personnel.

E.2.c. Please describe how Applicant will ensure the provision of linguistically appropriate services to Members, including the use of bilingual personnel, qualified and certified interpreter services, translation of notices in languages other than English, including the use of alternate formats. Applicant should describe how services can be accessed by the Member, staff, and Provider, and how Applicant intends to measure and/or evaluate the quality of language services.

Bilingual personnel and oral interpretation services – Health Share employs bilingual (Spanish) customer service staff, and customer service representatives and contracted providers are trained in accessing qualified and certified oral interpretation services in any non-English language. We use Language Services Associates as our oral interpretation vendor. All partners and providers are also required to offer free oral interpretation services to members. All of Health Share’s network provider directories include language access information, and we print members’ preferred language on their member ID cards to facilitate providers’ (including pharmacists’) ability to connect them with appropriate oral interpretation services.

Assuring access to translated and alternate format materials – Per OAR 410-141-3300, Health Share identifies prevalent non-English languages and alternate formats preferred by members through monitoring demographic data supplied through OHA enrollment files. We translate or trans-create member materials, including our website, handbooks, postcards, member navigation videos, targeted behavior change marketing campaigns, required notices, and more into prevalent non-English languages. In 2017, we created four member navigation videos to provide information about navigating the health care system in a more accessible format for all members. Our member materials are also available in alternate formats, and we offer information about obtaining alternate
formats and languages on all materials. We also ensure that our partners are appropriately translating materials into non-English languages through a member materials review process.

**Evaluating translation and interpretation services** – Health Share scored a “Fully Met” on availability of services, which includes accessibility of materials, on our most recent External Quality Review. In order to ensure compliance with member accessibility standards, we conduct annual onsite audits of partners that include ensuring the review policies/procedures and member correspondence such as Notices of Adverse Benefit Determination and Notices of Appeal Resolution are available in alternate formats (including non-English languages, Braille, large print, or audio). If Health Share identifies a partner organization is not providing linguistically appropriate services, we develop a corrective action plan and monitor the partner until they are fully compliant. In 2019, we will undergo a community and language-specific focus group process to review our member materials for cultural and linguistic responsiveness. We will share resulting best practices throughout our networks.

**E.2.d. Please describe how Applicant will ensure Members with disabilities will have access to auxiliary aids and services at no cost as required in 42 CFR 438.10, 42 CFR part 92, and Section 1557 of the Affordable Care Act. Response should include a description of how Applicant plans to monitor access for Members with disabilities at all contracted providers.**

Health Share employs various methods to ensure members with disabilities have access to auxiliary aids and services at no cost to them. Members with speech or hearing disabilities have access to 711 for Telecommunications Relay Services to assist with accessing customer service. We provide member materials in audio versions or Braille, provide verbal assistance through our customer service line, and our website and digital materials are screen reader accessible. Health Share utilizes closed captioning services at public CAC meetings and provides materials in large print format. Health Share enforces policies and procedures internally and with delegates to ensure members with disabilities have access to auxiliary aids at no cost.

As mentioned above, Health Share conducts annual audits of partner organizations to ensure compliance of the requirements and access to provider offices for members with disabilities. Health Share plan partners and providers conduct onsite audits of high-volume providers, and Health Share reviews a random sample of reports during our oversight audit. We also review quarterly grievance reports submitted from our partners. Specifically, we review the “access” category grievances to monitor and assess if the partner organization is out of compliance. Any findings instigate a corrective action plan that is monitored until it is resolved.

Health Share provides specific education on Section 1557 compliance to staff and to partner organizations through Health Share’s Compliance Workgroup. Health Share continually addresses this requirement during annual staff compliance training.

**E.3. Requested Documents**

See attached RFA4690-Health Share of Oregon-Att10-Language Policies.

**F. Traditional Health Workers (THW) Utilization and Integration (3 pages)**

**F.1. Informational Questions**

F.1.a. Does Applicant currently utilize THWs in any capacity? If yes, please describe how they are utilized, how performance is measured and evaluated, and identify the number of THWs (by THW type) in the Applicant's workforce.

**Partnering with traditional health workers** – Health Share utilizes the THW workforce in various capacities and accordingly is invested in building THW capacity. Health Share continues to invest in programs and efforts that support and advance workforce diversification of peers, doulas, and community health workers and has made a sizable investment in the development of infrastructure to support integration and system contracting for community-based CHW services. Health Share acknowledges and values the role THWs play, as social supports and as part of a clinical care team,
in increasing access for marginalized communities, providing culturally responsive services, and in reducing health disparities by providing both clinical and community-based services. Demonstrated through intentional investments, integration, and utilization of each of the five worker types, Health Share continues to strive toward increasing OHP member access to health care and social services with impacts reaching the broader community. Health Share currently holds the CCO seat on the OHA THW Commission and its Payment Models Sub-Committee. Health Share is dedicated to supporting THW-led professionalization of the workforce and identification of living wage and sustainable funding for community and clinic-based THWs. Health Share also supports increased health system and provider awareness, identification, and engagement in opportunities to enhance infrastructure that support clinics and other system partners to reliably contract for community-based THWs. In 2018, we published a video about the importance of developing infrastructure to support community-based community health workers.

**Programs utilizing, integrating, and supporting THWs** – THWs enhance social supports and connectivity for members with expertise that spans across sectors, from providing birthing support to supporting community members with substance use disorder (SUD). Health Share provides access to and partners with THWs through the following initiatives:

<table>
<thead>
<tr>
<th><strong>Doulas</strong></th>
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<tbody>
<tr>
<td><strong>Doula Business Investment</strong></td>
<td>A workforce development investment to increase knowledge on creating sustainable solo or collaborative doula practices in the tri-county region. Additionally, this investment will increase the number of registered doulas of color on the State Traditional Health Worker Registry, enabling Medicaid billing and reimbursement for doula services.</td>
</tr>
<tr>
<td><strong>IDS Doula Services</strong></td>
<td>Health Systems have clinic/system-based doulas on staff to support women through the pregnancy and/or birthing episode.</td>
</tr>
<tr>
<td><strong>Project Nurture</strong></td>
<td>A Center of Excellence model for providing integrated maternity care and substance use treatment for pregnant women with SUD has each participant working with doulas, some of whom are cross-trained as Certified Recovery Mentors.</td>
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<tr>
<th><strong>Community Health Workers</strong></th>
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<tr>
<td><strong>CHWs</strong></td>
<td>CHWs are employed by health systems or contracted through community-based organizations and are imbedded directly in clinics, including FQHCs, to support member engagement, increase access to social determinant related services, increase member access to healthcare services, provide chronic disease management education and support, and facilitate group education, walking groups, and cooking classes. Additionally, Health Share and partners are collaborating with community-based organizations to contract for culturally specific community-based services including education, advocacy, connection to resources, and chronic disease management support.</td>
</tr>
<tr>
<td><strong>Oregon Community Health Worker Association (ORCHWA) Infrastructure Investment</strong></td>
<td>As noted above, Health Share is investing in ORCHWA to create an infrastructure allowing systems to reliably contract for culturally specific community-based CHWs. This investment supports expansion of the culturally specific CHW network, development of clinical CHW curriculum, creation of opportunities for CHW workforce development, development of promising practices and technical assistance to support health systems integration of CHWs, and building communities of practice for CHWs and their supervisors.</td>
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<thead>
<tr>
<th><strong>Patient Health Navigators</strong></th>
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<tbody>
<tr>
<td><strong>Patient Health Navigators</strong></td>
<td>Directly employed staff work to support members and member families in navigating health systems, at times as part of integrated care teams.</td>
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<tr>
<td><strong>Peers</strong></td>
<td>Peers are housed in Hooper Detox Stabilization Center to support patients’ connection and warm handoff to ADFC transitional housing. Through this program, successful graduates that meet appropriate criteria are able to train and serve as peers.</td>
</tr>
<tr>
<td><strong>Peer Support Specialists</strong></td>
<td>Peers support individuals in meeting court-mandated obligations, treatment, engagement, maintaining sobriety, and attending appointments and court hearings. They directly assist with supportive services and crisis interventions alongside clinical staff.</td>
</tr>
<tr>
<td><strong>Diversion Program</strong></td>
<td>Located at Swindells Resource Center, Family Support Specialists provide mentorship and</td>
</tr>
<tr>
<td><strong>Family Support Specialist</strong></td>
<td></td>
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</table>
help guide families of children who have special needs, developmental delays, or disabilities in navigating health, educational, and community services.

<table>
<thead>
<tr>
<th>Tri-County Peer Facilitation Center</th>
<th>The center builds capacity of workforce, including diversity of trained peers.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional Behavioral Health Collaborative</td>
<td>This collaborative focuses on addressing behavioral health challenges and improving the BH system with a focus on expanding member access to SUD peers.</td>
</tr>
</tbody>
</table>

**Performance measurement and evaluation** – Reporting for THW worker types varies across programs, systems, and partners and includes both qualitative and quantitative quarterly reporting, surveying of members working with or served by THWs, encounter data, assessment of identified social needs being addressed with the support of THW services, tracking impact of cost of care by those engaged with THWs, number of Care Steps and individual patient encounters per month, tracking and measurement of plan of care with goals and outcomes, tracking cost and inappropriate utilization – specifically ED utilization and/or hospitalizations, and reduced recidivism.

THWs are a relatively newly recognized workforce, so there is limited infrastructure within health systems to support even minimum standardization of data collection around THW activities. This makes accurate tracking of THWs within our system difficult. Health Share and partners are dedicated to identifying and addressing barriers to integration of THWs, including working collaboratively to create systems that appropriately capture the work of THWs while allowing the workforce to maintain fidelity to their model. The THW count below is underreported.

<table>
<thead>
<tr>
<th>THW Type</th>
<th>Number of THWs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doulas</td>
<td>18</td>
</tr>
<tr>
<td>Community Health Workers</td>
<td>206</td>
</tr>
<tr>
<td>Patient Health Navigators</td>
<td>45</td>
</tr>
<tr>
<td>Peers (including Peer Wellness Support, Peer Support Specialists, Certified Recovery Mentors)</td>
<td>127</td>
</tr>
</tbody>
</table>

**F.1b. If Applicant currently utilizes THWs, please describe the payment methodology used to reimburse for THW services, including any alternative payment structures.**

As the THW workforce and the systems they operate in are diverse, the infrastructure to fully support THWs must also be diverse. Currently there are varying approaches to payment or reimbursement for THW services. Health Share and partners are currently using the following payment methodologies: alternative payment models and value-based payment arrangements where payment is tied to contractually required reports that include quantitative and qualitative measures, braided funding, bundled fee-for-service, fee-for-service, direct employment where THWs are considered part of the operating budget, grants and contracts, and unpaid volunteers.

**F.2. Evaluation Questions**

**F.2.a. Please submit a THW Integration and Utilization Plan which describes:**

See attached RFA4690-Health Share of Oregon-Att10-RFA THW Integration and Utilization Plan.

**F.3. Requested Documents**

See attached RFA4690-Health Share of Oregon-Att10-RFA THW Integration and Utilization Plan.

**G. Community Health Assessment and Community Health Improvement Plan**

**G.1. Evaluation Questions**

**G.1.a. Applicant will submit a proposal via the RFA Community Engagement Plan, referenced in Section A, describing how it intends to engage key stakeholders, including OHP consumers, Providers, local public health authorities, including local health departments, Tribes, Community-based organizations that address disparities and the social determinants of health, and others, in its work…**

See attached RFA4690-Health Share of Oregon-Att10-RFA Community Engagement Plan.
Attachment 10 — THW Integration and Utilization Plan (5 pages)

Health Share of Oregon acknowledges the expertise and value traditional health workers (THWs) bring to the community. THWs are rooted in connection to the community, and their use enables a person-centered approach. Their lived experience, passion and foundation of relationship building contribute to their ability to help marginalized communities reach their highest health outcomes.

For THWs to work at the top of their scope of practice, health systems must take an intentional approach to creating environments that allow for smooth integration onto clinical care teams, system and clinic understanding of how to leverage THW services, and the provision of effective supervision (as applicable and in accordance with THW Commission Best Practices). Health Share is committed to building holistic infrastructure that fosters successful integration and increases member access to and engagement with THWs. To further support incorporation of THWs and community voice, Health Share will ensure THW representation on the Community Advisory Council (CAC).

Proposed plan for integrating THWs into the delivery of services

No single approach to integration or payment methodology meets the needs for all THW worker types. Therefore, infrastructure investments must account for these differences, in part by including stakeholders and experts in the infrastructure development and by promoting use of promising practices for each worker type. Additionally, provider and system knowledge of the scopes and expertise THWs provide is fundamental to the successful integration of THWs in service delivery. Health Share’s plan for integrating THWs will leverage our current experience and investments, Health Share's comprehensive Integrated Community Network and Integrated Delivery Systems, our new THW Liaison position, and the support of community partners, like the THW Commission, the Oregon Community Health Worker Association, and more.

Our Experience - Health Share leverages the THW workforce in various capacities to improve the health outcomes and experiences of our members. We have and will continue to make investments in building capacity and infrastructure to advance THW integration and utilization. Over the years, our investments in THWs have focused on peers, doulas, and community health workers (CHWs). As of the end of 2018, Health Share has almost 400 THWs working with our members and provider partners. This number is likely an underestimate of the utilization of these services since the structure and methodology for capturing this type of information is still very new.

Supporting ORCHWA and Statewide Alignment - In 2015, Health Share’s CAC used the Community Health Improvement Plan (CHP) to prioritize investments that would ensure members had access to culturally specific and community-based CHWs. This prioritization led to a $3.3 million Health Share investment in the Oregon Community Health Worker Association (ORCHWA) to develop a much-needed infrastructure to support employment of and access to culturally specific and community-based CHWs. Working together with ORCHWA, we are investing in:

- Technical assistance for health plans, systems, governments, and other groups wanting to access CHWs
• Mechanisms to enable health systems to reliably purchase/contract CHW services
• Information technology platforms to track CHW efforts and measure outcomes
• CHW workforce development activities

We are confident this infrastructure investment will do more to connect OHP members statewide with culturally specific, community-based health care than any specific outreach effort and will eventually serve as a model for creating access for all other types of THWs. Health Share will use lessons learned from this investment as we work with our partners to advance integration and utilization of THWs.

**THW Advisory Committee** - Effective integration and increased utilization of THWs requires capacity from each of our partners in our Integrated Delivery Systems, within our Integrated Community Network, and from provider groups and community-based organizations. Health Share will convene a THW Advisory Committee comprised of community-based organizations (e.g. peer-run organizations, doula advocacy and education organizations, CHW advocacy and education organizations, and patient health navigator representation), Integrated Delivery System and Integrated Community Network representatives, providers interested in utilizing THWs, and public health programs who already employ THWs. The goal of THW Advisory Committee will be to collaborate with Health Share’s THW Liaison to surface challenges and barriers, and develop solutions for increasing the utilization of THWs in Health Share’s service area. The THW Advisory Committee will work to address challenges including, but not limited to the following:

**Year One (2020)**

- Define methodology to capture baseline data on use of THW services in order to comply with OHA’s THW Minimum Reporting Requirements and Exhibit N of the Contract
- Develop a process to improve tracking of THW workforce integration over time
- Plan for provider/system education including both effective utilization of THW services and existing opportunities for reimbursement
- Define process to track and manage THW Policy Rubric Requirements
- Prioritize the highest need areas where existing payment models are a significant barrier to THW utilization

**Year 2-3 (2021 - 2022)**

- Develop recommendations and advocate for including THWs in scope for services meeting billing requirements
- Create process to identify barriers to integration and solutions to address barriers
- Track payment methodologies used to reimburse for THW services
- Develop recommendations on standard payment models to address gaps in service
- Track promising/best practices being used in clinical and community-based settings
- Define effective collaboration between public/population health and clinical THW interventions
- Develop and implement systems to track member satisfaction

**Year 3-5 (2022 - 2024)**

- Develop process to ensure appropriate and timely access to THWs for members
Identify recommended ratio of THWs to members
Develop clinical work flows or educational materials for members to access THW services
Identify metrics to demonstrate ROI
Identify and recommend sustainable payment methodologies accounting for the full range of THW services

Health Share’s THW Liaison position will coordinate the THW Advisory Committee. Health Share’s Board will approve THW Advisory committee recommendations, and all partners will be responsible for complying with approved recommendations.

**Proposed plan to communicate to Members about the benefits and availability of THW services**

Health Share will communicate to members about the benefits and availability of THW services through member outreach efforts, including member orientation sessions and the member handbook. When enrolled in Health Share, individuals receive a member handbook that introduces them to health plan benefits, including the covered THW benefit. Moving forward, Health Share will include a description of each THW worker type and instructions of how to access THW services. Health Share hosts new member orientations to support members in navigating their benefits and will include information of the THW benefit, including instructions of how members access THW services (when developed). The THW Liaison, in collaboration with the THW Advisory Committee, will develop workflows and educational materials identifying the process by which a member could access clinic or community-based THW services. Additionally, the THW Liaison will increase system and provider awareness and promotion of THW services through provider education. Health Share will contractually require all plan partners to communicate with members regarding the THW benefit, this may include but is not limited to providing information through; new member welcome calls, member materials, communication with provider representatives, development of a THW promotion campaign, and/or at community events. Health Share and partners will ensure customer service representatives have the appropriate knowledge to assist members with accessing THWs.

**Plan to increase THW utilization**

Health Share will increase utilization of THWs through member outreach efforts as described above, increasing workforce capacity that will enable a larger number of members to access services, and advancing system awareness to improve THW integration. Responsibly increased utilization of THWs requires assurance of adequate capacity of the workforce to meet member needs. The THW Liaison, in collaboration with the THW Advisory Committee and partners, will utilize existing information from workforce specific assessments, THW Commission Best Practices, and workforce specific surveys to inform infrastructure investments that allow for seamless access to THW service providers.

Health Share and partners will continue to invest in and expand existing efforts that support THWs as outlined in Health Share Attachment 10 SDOH and HE Questionnaire. This includes investments in professional development of the THWs, promotion of THWs on the THW State Registry, investing in THW collaborative efforts and workforce-run organizations. The THW Liaison and THW...
Advisory Committee will identify baseline utilization rates of THW services as well as recommended ratio of THWs to members and Health Share and partners will strive to meet recommended ratio to allow for an increase in member utilization. Additionally, the THW Liaison, THW Advisory Committee, and community engagement and outreach staff will develop clinic in-reach and member outreach strategies that to enhance THW utilization.

**Plan to implement THW Commission Best Practices**

Health Share is an active member of the OHA THW Commission as well as the Office of Equity and Inclusion (OEI). Health Share currently holds the CCO seat on the THW Commission including serving on its Payment Models Sub-Committee, and serves on the Health Equity Committee of the Oregon Health Policy Board staffed by OEI. This enables us to remain up-to-speed on THW best practices. The new THW Liaison position will be responsible for ensuring THW Commission Best Practices that are currently in development are included in the work of the THW Advisory Committee, and in consultation with OEI as needed, on advancing THW integration and utilization.

**Proposed plan to measure baseline utilization and performance over time**

Health Share will require our Integrated Delivery Systems and the Integrated Community Network to collaborate with Health Share’s THW Liaison position to ensure THW tracking and reporting is completed in alignment with the reporting requirements as outlined in Exhibit N of the Contract and as directed by OHA’s THW Minimum Reporting Requirements template. Measurement of baseline utilization and performance over time would include a phased roll out by worker type, as there is a variance of network data capacity. Measurements will include the following practices:

- Tracking THW activities and required reporting in grant funded contracts
- Surveying of the provider network and members working with THWs
- Tracking claims data and EHR encounter reports for FFS reimbursed THWs
- Reporting on VBP contracts

In addition to measuring baseline utilization and performance over time, the THW Advisory Committee will track, promote and report on payment methodologies implemented by providers for THW services. Additional measurement to be implemented in phases will include the following:

- Recommending investments in infrastructure that allows for multiple payment methodologies
- Highlighting benefits of different methodologies for different worker types to encourage spread of best practices/promising practices related to payment models
- Supporting the creation of payment/reimbursement infrastructures within plan partner systems to support both clinical and community-based THW programs
- Identifying and advancing the use of a PMPM specific for THW services

**Proposed plan to utilize the THW Liaison position to improve access to Members and increase recruitment and retention of THW’s in its operations**

Health systems across the country are in the beginning stages of incorporating THWs as a valued component of a care team. The THW Liaison will be a pivotal component of Health Share’s plan to advance integration, increase member utilization of, and access to THW services. In order to maximize on this investment, Health Share will collaborate with other stakeholders including the THW workforce, community-based organizations, THW advocacy organizations, health systems, and governmental entities to address existing structural barriers. These barriers include a lack of; flexible and sustainable funding models; a framework that enables reimbursement for the broad range of THW services; an advanced understanding of scope of THW roles; workflows for accessing THW services;
billing methodologies that meet the need for each worker type; minimum necessary standardization for reporting; and mechanisms to support professional advancement of the THW workforce.

Health Share and partners envision leveraging the THW Liaison position in four main ways:

**Education**
- Educate and connect provider network on role and scope of THWs, including referral process
- Educate provider network on community resources and promising practices to employ, supervise, support, and integrate clinic and community-based THWs, this would incorporate THW Commission Best Practices
- Create member awareness of available THW benefit and how to access covered services

*Effective education of systems will increase THW retention and potentially create opportunities for workforce advancement. All education activities will promote fidelity to each THW model.*

**Liaise & Align**
- Track regional and statewide efforts to integrate and promote work with THWs
- Ensure alignment between regional and national efforts to integrate THWs
- Serve as liaison between OHA and CCO, including THW Commission engagement to remain informed on all relating policies and ORS
- Serve as liaison for THW advocacy organizations, hubs, and members
- Collaborate with public health to promote utilization of THWs

**Metrics & Evaluation**
- Aid in building language and THW related deliverables into contracts
- Assess formula to calculate THW need in systems
- Evaluate consistencies and inconstancies in utilization of THW’s and help plans make goals to include THW’s, identify baseline utilization and track performance over time
- Track and promote funding models being employed to reimburse for THW services
- Track and report on all THW related contractual requirements outlined in the CCO 2.0 contract
- Incorporate evidence of regional & national consensus on process and outcome indicators to evaluate THW programs (applicable when information is available)

**Integration**
- Recruit THWs to system and lead learning collaborative to aid in workforce retention; with specific attention to culturally and linguistically specific THWs
- Work with partners and the THW Advisory Committee to:
  - Compile and promote promising practices, for all THW worker types to support integration
  - Work with systems to explore additional opportunities to increase integration
  - Provide oversight and support of building infrastructure to support THW integration
  - Ensure contractual obligations are met such as; data collection, encounter submission of THWs
Community-wide health care leadership – Health Share of Oregon and its unique collaborative model will achieve the triple aim of better care, smarter spending, and healthier people—bringing the value of each partner organization to make the whole better than the sum of its parts. To meet the diverse needs of Oregon Health Plan (OHP) members in our region, we have created the state's most comprehensive provider network. We are leveraging the value and strengths of the tri-county’s integrated finance and health care delivery systems (IDS)—Kaiser Permanente, Legacy Health, OHSU Health System, and Providence Health & Services—and optimizing a best-in-class integrated community network (ICN) managed by CareOregon, that focuses on integrating and supporting our safety net, oral health, NEMT, and behavioral health systems of care.

Building on the success of Health Share 1.0: Health Share 1.0 aligned behavioral health services that previously existed in silos across the three counties. During CCO 1.0, Health Share moved to a consolidated and streamlined process to benefit both members and behavioral health providers. We accomplished this by consolidating and aligning policies and procedures, utilization criteria, program intake and access standards, and ultimately, all behavioral health funding within Health Share’s behavioral health benefit called Pathways. Moving into CCO 2.0, we recognize that our ambitions for a high-functioning behavioral health system of care are not yet fully realized.

Integrated physical, behavioral, and oral health services under Health Share 2.0: In CCO 2.0, we will fully integrate the behavioral health benefit within physical health and will provide behavioral health benefits in accordance with Exhibit M to the sample contract. To accomplish this goal, we will continue to consolidate contracts, investments, and improvement strategies within the ICN administered by CareOregon. This integration will be further supported by direct input and collaboration with the IDSs. A key mechanism for supporting integration is the delivery of behavioral health services in the primary care setting to: 1) improve accessibility of services and offer them in places where many patients will be receiving numerous other services; and 2) ease the access challenges inherent to the specialty behavioral health system by enabling people to receive lower level services in settings outside of those designed for treating individuals with more acute issues and in need of highly specialized services. Additionally, by fully integrating the behavioral health benefit under Health Share 2.0, we will now be able to pay for unique programs that span physical, behavioral, and oral health needs, such as Project Nurture, Foster Care Medical Homes, and behavioral health services delivered in primary care settings. We are in the process of conducting ongoing meetings between CareOregon and the three counties on the transition of the specialty behavioral health benefit and network as well as monthly meetings with the IDSs on alignment of payment of behavioral health services within primary care. We expect a smooth transition, with no disruption to members or providers in 2020.

A.1. How does Applicant plan to ensure that Behavioral Health, oral health and physical health services are seamlessly integrated so that Members are unaware of any differences in how the benefits are managed?

Realizing the promise of CCOs with Health Share 2.0 – Health Share is proud of the work we have done over the past several years to integrate behavioral health services into primary care medical homes and primary care services into behavioral health homes, using the primary care behavioral health (PCBH) model endorsed by the Oregon Health Authority, PCPCH standards, Primary Care Payment Reform Collaborative, and SAMHSA.

Seamless integration of physical, behavioral, and oral health benefits – Beginning in 2020, Health Share will fully integrate behavioral, physical, and oral health benefits for our members through a newly designed Integrated Community Network (ICN) administered by CareOregon. Our members
will have a seamless experience in accessing all covered benefits because CareOregon’s ICN will administer member services, care coordination, grievance and appeals, translation and interpretation support, and member engagement activities for all covered benefits, and members will access assistance related to all their health care needs through the single ICN. CareOregon will administer specialty behavioral health and oral health networks in a manner that provides seamless access for all members across our Integrated Delivery System (IDS) partners: Kaiser Permanente, Legacy Health, OHSU Health System, and Providence Health & Services. Our IDS partners will provide integrated and often co-located physical and primary care behavioral health services, which will be covered without members or providers having to go outside their IDS to receive services or payment. We recognize that member behavioral health needs can often be met in primary care settings with adequate supports and will ensure these services are available across the ICN and IDS networks. This will be in addition to our current specialty behavioral health network and means Health Share members will, over time, have hundreds more locations, organizations, and providers able to provide meaningful, ongoing behavioral health treatment.

A.2. How will Applicant manage the Global Budget (as defined in ORS 414.025) in a fully integrated manner meaning that Applicant will not identify a pre-defined cap on Behavioral Health spending, nor separate funding for Behavioral Health and physical health care by delegating the benefit coverage to separate entities that do not coordinate or integrate?

Managing the global budget in a fully integrated manner – As noted above, Health Share will manage a fully integrated behavioral, oral, and physical health benefit with no delegation of risk or benefit management to an entity outside of Health Share’s coordinating partner organizations. The behavioral health benefit will not be carved out or managed separately from other benefits. Health Share members will have a choice of fully integrated networks, including behavioral health services offered in a primary care setting, across our IDS partners or through the ICN. The IDS partners are fully capitated for all integrated behavioral health and physical health spending, and Health Share will centrally coordinate specialty behavioral health benefits for members through CareOregon’s ICN.

Health Share’s Board and its Finance & Audit Committee will oversee the global budget management for the organization, which allows for one global budget, with focus on an overall or combined medical benefit ratio. While Health Share does track revenue by its designated category (e.g. physical, mental health, oral health, substance use disorder (SUD)), we ensure that funding of services is not driven by this allocation, but rather by need. Within the global budget, Health Share is able to shift funds based on community need and utilization drivers. For example, Health Share invests in increased SUD medication-assisted treatment (MAT) which has a positive impact on emergency department (ED) and inpatient utilization. Health Share intends to expand this commitment to addressing the behavioral health needs of our members through investment, increased accountability for outcomes, value-based payments to providers, and through partnership with the Oregon Health Authority in the rate-setting process.

Investments in behavioral health system improvements – Health Share 2.0’s fully integrated structure will allow our Board, our Community Advisory Council (CAC), and our community partners to prioritize and invest in behavioral health system improvements in alignment with OHA priorities. For example, SUDs are one of the largest drivers of medical expenses in our community yet are chronically underfunded in OHA’s rate-setting process. By combining the benefits, Health Share will be able to more appropriately allocate dollars to the services that benefit members most while also managing the overall global budget.
In addition to a current $6.2 million behavioral health capacity investment portfolio, Health Share has historically supported increased funding for behavioral health through significant investments made in the Unity Center and targeted investments to seed innovative care models such as Project Nurture (an integrated SUD and maternity care model) and Wheelhouse (a hub-and-spoke model for spreading medication-assisted treatment capacity throughout the community).

A.3. How will Applicant fund Behavioral Health for its Service Area in compliance with the Mental Health Parity and Addiction Equity Act of 2008?

Compliance with mental health parity – Health Share completed a full mental health and SUD parity analysis during 2018 and will enter the 2020 contract with no outstanding findings. Behavioral health funding for the service area is currently and will continue to comply with the Mental Health Parity and Addiction Equity Act of 2008. Health Share ensures that there are no prior authorization or concurrent review requirements that create a barrier to access of behavioral health benefits or that are more restrictive than medical/surgical benefits. We conduct yearly audits and oversight monitoring throughout our networks. Managing the specialty behavioral health network as a part of CareOregon’s ICN will allow for transparency and coordination throughout the system to continue to ensure there is no conflict with parity regulations. In addition, we continuously assess network adequacy through our Provider Network Management Workgroup, which has combined physical and behavioral health teams, ensuring that standards are aligned and providers are treated consistently.

A.4. How will Applicant monitor the need for Behavioral Health services and fund Behavioral Health to address prevalence rather than historical regional spend? How will Applicant monitor cost and utilization of the Behavioral Health benefit?

Tracking the need for behavioral health services – Health Share is changing its structure to increase integration of behavioral health services in primary care and with other physical health services. This means more behavioral health services and funding are being managed in a global manner and not as a budget carve out. In addition, specialty behavioral health services will be centrally managed by CareOregon’s ICN, which is responsible for the largest portion of our membership. In doing so, resources will be allocated by the needs of members, not historical spend. To ensure resources are provided based on needs, Health Share has developed several ways to monitor the need for behavioral health services. We have refined our tracking and monitoring process to promote access to high-quality, timely behavioral health services, and to respond more effectively when we identify barriers to access. Our analytics platform, Health Share Bridge, allows partners throughout our networks to identify members diagnosed with serious and persistent mental illness (SPMI) and analyze gaps in services, disparities, and health outcomes based on SPMI status. We also require providers to report on access to both mental health and substance use treatment monthly and offer at least three referrals to members who cannot be seen within required timeframes. In addition to monthly provider access reports, we monitor access complaints for trends in overall capacity and availability of services. Health Share also requires monthly access reporting for both mental health and SUD treatment providers in our network. We monitor our network against these standards monthly and develop interventions to connect members to needed services identified through the monitoring process. Interventions include SBIRT and depression screenings in primary care, coordination with criminal justice, and others. Our Network Committee continuously reviews applications for additional providers and offers contracts to add needed capacity.
Utilization of the behavioral health benefit is monitored on an ongoing basis primarily through two platforms: 1) The aforementioned Bridge analytics tool which ties together member demographics and all services a member is receiving (including physical and oral), and 2) The dedicated PHTech claims and authorization administration system which provides real-time information and reporting on all behavioral health authorizations and claims. The PHTech platform has been built to aid in administering the behavioral health benefit and offers reporting that is accessible to both Health Share and our specialty mental health and substance use provider network.

**Funding behavioral health to address prevalence** – Health Share’s Board in consultation with its Finance & Audit Committee and Clinical Advisory Panel (CAP), will oversee global budget management for the organization, which allows for one global budget with focus on an overall or combined medical benefit ratio. While Health Share does track revenue by its designated category (i.e. physical, mental health, SUDs), we ensure that funding of services is not driven by this allocation, but rather by need. Within the global budget, Health Share is able to shift funds based on community need and utilization drivers. There is no cap or separate standalone budget for behavioral health services. Services are funded based on current utilization and prevalence targets—limited by the overall budget and medical benefit ratio rather than a discrete behavioral health medical benefit ratio. When overall funding becomes a limiting factor, we look for interventions to reduce utilization of high-cost, low-value services rather than limiting access or reducing payment to providers.

A.5. **How will Applicant contract for Behavioral Health services in primary care service delivery locations, contract for physical health services in Behavioral Health care service delivery locations, reimburse for the complete Behavioral Health Benefit Package, and ensure Providers integrate Behavioral Health services and physical health services?**

**Delivering behavioral health care in primary care settings** – Health Share will partner with the major integrated health care finance and delivery systems in the tri-county area (OHSU Health Services, Kaiser Permanente, Legacy Health, and Providence Health & Services), referred to as our IDS partners, to provide integrated behavioral health services delivered in primary care settings. We use advanced alternative payment methodologies (population-based payments, LAN category 4C) with our IDS partners to incentivize further integration of behavioral and physical health services, as well as oral health services. Additionally, Health Share members will have access to a comprehensive, diverse group of providers and partners across physical health, specialty behavioral health, oral health, and NEMT, focused on integration across settings through CareOregon’s ICN providers.

**Delivering primary care in behavioral health settings** – Health Share supports three certified community behavioral health centers (CCBHCs) in the tri-county service area. The CCBHCs provide nursing, peer, and wellness staff for health screening, care coordination, and engagement activities for members. The staff have worked to develop a team-based approach to identifying clients who are at risk for health complications, utilizing emergency services at high rates, and inpatient care. These services are vital within a behavioral health setting, which is where our members with SPMI receive their services. These members are often under-engaged in treatment for physical health concerns that lead to worsening of mental health symptoms, worsening of total health outcomes, and early mortality.

**Reimburse for the complete behavioral health benefit package** – Health Share supports an integrated, team-based model of behavioral health services in primary care and offers an alternative payment model to clinics that can demonstrate a minimum Tier 3 patient-centered primary care home (PCPCH) certification and integrated behavioral health consultation. Funding for both integrated and co-located behavioral health services in primary care comes from the global budget and allows clinics and clinic systems to have only one integrated contract. This includes internal medicine, family practice, and pediatric primary care, as well as school-based health centers. Health Share is moving to a payment model for its PCPCH clinics that requires integrated behavioral health services and has a target of serving members in a PCPCH in order to receive enhanced alternative payments.
Ensuring providers are integrating primary care and behavioral health services – Health Share has a demonstrated record of innovation and support for new models of care through pilot funding, alternative payments, and technical assistance, and will continue these practices into 2020 and beyond. Health Share is also currently funding integrated care pilots across the network to inform and support expansion of integrated care:

- Behavioral health treatment services within primary care with an allowed set of behavioral health codes to be billed by licensed clinicians
- Medical services to be provided in a culturally specific behavioral health setting assisting refugees
- Mental health and psychological evaluation for transgender members receiving gender confirmation surgery at a medical facility
- Sustainable, long-term funding and expansion of CCBHCs

Monitoring cost and utilization – Health Share Bridge serves as a community resource for monitoring cost and utilization across the CCO. It provides insight and metrics into PMPM payments and costs, member utilization, trends in provider service provision, and can be used to provide regular reports or to respond to ad hoc utilization requests. These tools offer CCO staff and health systems views into expenses and utilization by specific diagnoses or service types and increasingly provide information to behavioral health providers about members assigned to them, including their utilization across the system (physical health, oral health, NEMT). These tools will be enhanced to include greater visibility into behavioral health services provided in primary care settings as the system strives to provide care that is more integrated.

A.6. How will Applicant ensure the full Behavioral Health benefit is available to all Members in Applicant’s Service Area?

Ensuring access to the full behavioral health benefit in the tri-county region – Health Share currently provides the full behavioral health benefit in our service area (Clackamas, Multnomah, and Washington Counties). We will continue to serve this region and deliver the behavioral health benefit to all members in the area. Most covered behavioral health services are available from providers located within the tri-county region. We provide access to members whose needs cannot be met with the community-based services in the local area through contracts with statewide service providers, such as licensed residential programs. Health Share contracts with treatment providers to offer a full local continuum of care, including all levels of community-based services for children and adults, supported housing, respite care, subacute, psychiatric residential treatment, SUD treatment, withdrawal management treatment, and a variety of specialty programs. In addition to traditional treatment interventions, Health Share recognizes the important role of THWs (inclusive of peers) in supporting, connecting, and assisting members in their recovery.

Supporting access to behavioral health services through care coordination – Health Share has multiple robust care coordination programs that assist members in accessing services and removes barriers to access, such as the Intensive Transition Team (ITT) and Intensive Care Coordination teams. In addition, care coordination teams proactively identify and provide outreach to members who may need additional support. When transportation is a barrier, Health Share works to ensure that members have access to the health-related services benefit or coordinates with our contracted NEMT provider to offer access to services across the region.

A.7. How will Applicant ensure timely access to all Behavioral Health services for all Members?

Ensuring timely access to behavioral health services – To ensure all members have timely access to all behavioral health services, we require providers to report on access monthly and to offer at least three referrals to members who cannot be seen within required timeframes. This process provides critical information about capacity and availability of routine services in our continuum of care, for both mental health and SUD treatment. Our Network Committee continuously reviews applications
for additional providers and offers contracts to add needed capacity whenever available. For levels of care that require prior authorizations or concurrent review, we monitor turnaround times to ensure adherence to timelines and to prevent delays to treatment. In 2019, Health Share expanded on efforts to measure access in our specialty behavioral health provider network and now defines access as the third next available appointment—a recognized standard that goes beyond simply measuring time to intake appointments. We intend to continue this practice into 2020.

**Provider incentives to promote timely access to care** – We use regular provider access monitoring to develop strategies for expanding our provider network, promoting transparency of appointment availability, and informing incentive payments to providers. We incentivize providers to ensure rapid access to care through a composite scoring on key metrics. Providers demonstrating consistent and timely access for members are eligible for incentive payments. This aligns funding with prompt access to services and incentivizes investments in provider capacity.

**A.8. How will Applicant ensure that Members can receive Behavioral Health services out of the Service Area, due to lack of access within the Service Area, and that Applicant will remain responsible for arranging and paying for such out-of-service-area care?**

**Ensuring access to behavioral health services outside our service area** – As noted above, most covered behavioral health services are available within our service area. Health Share’s care coordination and utilization management teams work closely together to ensure that members have access to any services that may be out of area. The care coordination team refers members to the most appropriate level of care, and when that is not available in the local community, they work with the member to identify a resource out of the area. If a provider is out of network, Health Share will obtain a contract or single-case agreement and will pay claims in a timely manner to the provider. We maintain many out-of-area contracts for specialty behavioral health services, such as substance use residential programs. The care coordination team stays in regular contact with members and providers during out-of-area treatment episodes, including assisting with discharge planning to facilitate a safe and successful transition back to the member’s community. When members are already out of the area before the need for services arises, Health Share is responsible for payment of medically necessary services provided in accordance with our prior authorization policies and provides retrospective clinical reviews for payment where prior authorization was not sought by the out-of-area provider. We maintain a streamlined authorization process for transportation outside of or returning to the service area to minimize delay in treatment or discharge.

**A.9. How will Applicant ensure Applicant’s physical, oral and Behavioral Health Providers are completing comprehensive screening of physical and Behavioral Health care using evidence-based screening tools?**

**Ensuring the completion of comprehensive screening for physical and behavioral health** – Health Share conducts a standardized initial health risk screening for all newly enrolled members. We implemented this assessment process across all networks to ensure consistent application of the screening. The screening tool includes questions regarding chronic health conditions, emergency room utilization, mental health, tobacco use, oral health needs, vision needs, and the member’s primary language. The screening provides a rapid assessment of members who have high-risk areas and who may benefit from additional support to navigate the system of care. Health Share via contract requires behavioral health providers to conduct comprehensive mental health and substance use assessments, inclusive of screenings for physical and oral conditions. In addition, Health Share’s oral health providers use a medical and oral health history form to screen for health concerns during every comprehensive oral evaluation and routinely screen for blood pressure, dental caries, and periodontal disease with the goal of addressing potential health issues before they become serious. Furthermore, diabetes screening, including HbA1c, will be developed and implemented in oral health settings.
Evidence-based screening tools for behavioral health needs – Many of the CCO quality incentive metrics focus on implementation of evidence-based tools to screen for behavioral health needs in primary care settings, including early childhood development (ASQ tool), depression (PHQ, EPDS), and risky substance use (AUDIT/DAST or CRAFFT tools). As benchmarks for these measures continue to increase, Health Share partners will work to expand these best practices across clinical networks and provide screening services in more culturally responsive ways. Our behavioral health network providers regularly utilize ASAM, The Columbia Suicide Severity Rating Scale, and the Child and Adolescent Needs and Strengths assessment tools. Additionally, our providers conduct post-partum depression screening in pediatric settings. Other screening tools being used include ASQ, MCHAT, GAD 7 or SCARED, CRAFFT, PHQ-2/PHQ-9, AUDIT C, EDPS and GAD7 for post-partum women.

Given the importance of these incentive measures, our physical, oral, and behavioral health partners continue to look for opportunities to support efforts across domains, which not only improves performance but fosters delivery of more integrated, comprehensive care to members. The ED utilization for members with mental illness metric has encouraged behavioral health providers to engage members around the intersection of their behavioral health and physical health needs, resulting in a significant reduction of ED utilization for this population. The new oral evaluation for members with diabetes metric will support engagement in routine chronic condition management services in primary care as well as oral health. Oral health providers also consistently screen for tobacco use among patients—a critical focus area for all three domains. In partnership with Multnomah County, DHS District 2, and Mindsights, we implemented the RAPID (Relational, Academic, Psychological, Intellectual, Developmental) assessment tool for children entering foster care, that identifies several domains or needs and makes robust child-specific recommendations for care and services.

A.10. How will Applicant ensure access to Mobile Crisis Services for all Members to promote stabilization in a Community setting rather than arrest, presentation to an Emergency Department, or admission to an Acute Care Psychiatric Hospital, in accordance with OAR 309-19-0105, 309-019-0150, 309-019-0242, and 309-019-0300 to 309-019-0320?

Our commitment to stabilization in the community – Health Share has a long-standing partnership with Clackamas, Multnomah, and Washington Counties and has consistently contributed financially to support seamless 24/7 access to crisis services for all members at all times. The three counties maintain robust crisis systems with a variety of crisis supports, including 24/7 telephonic crisis intervention and mobile crisis response. These supports are available to all community members regardless of their insurance status, age, where they present, or their level of acuity. This approach of integrated, braided funding that combines Health Share resources with multiple other county funding streams ensures mobile crisis access for the Health Share membership. All three county partners have completed sequential intercept mapping and work closely with local law enforcement. Each county operates Health Share supported programs that pair behavioral health clinicians with officers for community-based responses that are timely, appropriate to the circumstance, and promote community safety. Health Share has supported the State in meeting Oregon Performance Plan measures for crisis services and is in compliance with OAR 309-019-0105, 309-019-0150, 309-019-0242, and 309-019-0300 to 309-019-0320. Under Health Share’s new structure in 2020, which will provide direct funding

Over the past 5 years, Health Share has continuously exceeded the benchmark for depression screening and SBIRT (61% rate increase), as well as improving on developmental screening rates (247% rate increase), primarily through focus on improving access for members who do not speak English.
and support for the regional safety net system, all three counties will share required State reporting
data related to mobile crisis responsiveness and utilization. Monitoring of this reporting will allow
Health Share to ensure mobile crisis services are accessible. Reporting includes response time and
diversion opportunities from the criminal justice system and acute care.

**Funding of crisis services** – Health Share believes in funding crisis services in a capacity model
whereby Medicaid dollars are braided with non-Medicaid and county general funds to support a stable
and high-functioning crisis system. This results in Health Share making a direct and significant
investment in the safety net system across the region, including crisis services. Members have access
to both mobile crisis supports and a range of facility-based options that serve as viable alternatives to
EDs or jail.

Three behavioral health urgent care centers are available to serve members in crisis and to provide
interventions prior to acute episodes to prevent escalation. Health Share supports and
contributes to local funding for crisis stabilization services for members, such as intensive outpatient supports as an alternative to inpatient care or EDs. These services include:

- ED diversion services – peer navigator and behavioral health clinician respond to youth
  presenting in the ED with behavioral health symptoms.
- Intensive Transition Teams (ITT) – short-term intensive care coordination that supports
  members admitted to inpatient psychiatric care to connect with ongoing behavioral health
  services in the community.
- Assertive community treatment teams for individuals with SPMI-intensive and highly
  integrated treatment intervention that is community-based with the goal of reducing
  unnecessary emergency room visits and higher levels of care.
- ED liaisons – social workers housed at Psychiatric Emergency Services at the Unity Center
  who assist and stabilize members to be discharged back into the community.
- Walk-in urgent mental health centers – located in each county, where members presenting in
  the community who have made contact with law enforcement can be brought, instead of the
  ED or jail.
- Peer crisis services – Peers are available to respond to where members present including in
  the community, jail, ED, or crisis centers.
- Behavioral health/law enforcement paired teams – each county provides mental health
  clinicians who respond with law enforcement, with the goal of diverting from jail and the ED.

Together, these services support members receiving services in the least restrictive setting possible,
minimizing the use of EDs or arrest as a primary intervention.

**A.11. Describe how Applicant will utilize Peers in the Behavioral Health system.**

**Incorporating peers in behavioral health service delivery** – Health Share believes that
incorporating lived experience both in the design and delivery of behavioral health care is critical to
meeting the needs of members. For example, Washington County’s Hawthorn Walk-in Center, an urgent behavioral health care program, incorporated peer input in all aspects of the workflow, facility, and service delivery design of the center. Peers are also primary staff at the center, offering supports to individuals and their families who come to the center in crisis. Likewise in Clackamas County, peers are available through walk-in clinics or a simple call to member services which will assist in referring to a variety of contracted peer providers, regardless of enrollment in behavioral health services. Health Share and our partners are also active participants in OHA’s Regional Behavioral Health Collaborative that has identified strengthening the peer service delivery network in our region as a top priority.

Examples of how peer services are made available to Health Share members – Peers are central to Health Share’s behavioral health system of care and are available in a variety of locations and settings. We are continually building our network of peer supports as it is an essential service within a high-functioning behavioral health system of care. Health Share-supported peer programs include:

- Peer Drop-in Centers: Clackamas County’s The Living Room for LGBTQIA members, Multnomah County’s Luke Dorf’s Northstar program, and Washington County’s Comfort Zone
- Peer Recovery Mentors: available in outpatient and residential programs, juvenile services, and community corrections
- MetroPlus Association of Addiction Peer Professionals (MAAPPS): addiction peer association serving the tri-county region
- Family Partners in Wraparound
- Family to Family classes and support through NAMI
- Peers integrated into Older Adult programs
- Substance use peer led recovery centers
- Peers integrated into outpatient mental health services
- Peer crisis supports integrated into crisis teams
- IMPACT program at OHSU
- Project Nurture for pregnant women with SUDs

Peers and SUD treatment and recovery programs – Health Share believes peer-based recovery support services for people with SUDs are important for the Portland area tri-county health care system. To achieve the most effective and efficient deployment of resources toward building peer-based recovery support services, Health Share engaged consultants at Aspire Inc. to conduct an environmental scan of peer delivered services (PDS) for SUD treatment and services in the tri-county area. They conducted the work in early 2016 and included interviews with key stakeholders, an extensive survey to peers and peer supervisors, a national literature search, and a daylong think tank. Their efforts culminated in a thorough report on the state of PDS in the tri-county area including 36 recommendations for increasing the capacity of PDS. These recommendations are informing Health Share’s behavioral health investments.

**A.12. How will Applicant ensure access to a diversity of integrated community supports that mitigate SDOH-HE, increase individuals’ integration into the community, and ensure all Members access to Peer services and networks?**

Integrating behavioral health services and addressing the social determinants of health (SDOH) – Health Share has a long-standing history of collaborating with numerous community partners and Clackamas, Multnomah, and Washington Counties to collectively address SDOH that impact our members across our service area. We leverage our partnership with the local public and mental health authorities to understand the diversity and uniqueness of these communities. Flexible and health related services are another way Health Share provides access to a diversity of community supports that can mitigate SDOH. Through our established partnership with Project Access NOW, Health Share members have access to a wide range of individual flexible services that can address food
insecurity, transportation not covered by NEMT, housing supports (including eviction prevention and short-term rental assistance), child care, gym memberships, and a wide range of services and activities that promote improved health outcomes.

**Health Share has a long history of including peer supports as an integral component for members with behavioral health conditions.** Peer services are available where members are served. This includes co-locating peer mentors within juvenile departments, jails, provider agencies, EDs, and crisis centers. Health Share has developed, sustains, and is expanding peer drop-in centers for both mental health and SUDs. These centers serve as access points into a diverse network of peer services. Additionally, we support a number of programs that provide members access to unique and integrated community supports. We will continue to make investments in similar programs throughout the new contract. Some examples include:

- **Project Nurture**: Provides integrated maternity care and substance use treatment during pregnancy and the first year post-partum.
- **Noble House**: A partnership between Washington County Housing Authority and Washington County Behavioral Health that provides housing supports for individuals transitioning out of the state hospital.
- **Health Resiliency Specialists**: Community-based, specialized care coordinators that provide intensive engagement, community connection and care coordination (deployed through Health Share’s ICN). They address the needs of people with complex needs, connecting them with primary care, or specialty or behavioral health as appropriate, with a heavy reliance on the role of peers and natural supports.
- **Foster Care Medical Homes**: A foster care advanced primary care home model with multiple clinics in the region and in alignment with best practices. The model supports children in child welfare custody, intellectual and disability placements, and is expanding to support those with juvenile justice involvement. (Though it should be, foster care placement is not always thought of as a social determinant of health. Our data show that removal from one’s home and birth family has dramatic long-term consequences for members’ physical and behavioral health—just one reason we invest heavily in this program.)
- **Foster Care DHS Medical Liaisons**: A medical liaison grant position in DHS District 2, and funded by Health Share. The position supports a variety of alignment and coordination activities between DHS and health care systems.
- **RAPID (Relational, Academic, Psychological, Intellectual, Developmental)**: A partnership with Multnomah County, DHS District 2, and Mindsights, for use of a specialty assessment tool for children entering foster care.
- **Tri-County 911 Service Coordination Program**: Works with frequent users of the emergency medical services system and includes dedicated peer support services.

**B. Billing System and Policy Barriers to Integration (recommended page limit 2 pages)**

**B.1. Please describe Applicant’s process to provide Warm Handoffs, any potential barriers to ensuring Warm Handoffs occur and are documented, and how Applicant plans to address them.**

*Process for providing warm handoffs* – Health Share provides warm handoffs across multiple settings. All warm handoffs include clear referral pathways, direct communication channels, and facilitating clinical information sharing between providers. Our care coordinators facilitate warm handoffs based on the mode that works most effectively for the members, including meeting with members directly in their care settings. Health Share believes a trauma-informed approach and reinforcing trusted provider relationships is imperative for success.

*Intensive transition teams* – An example of how Health Share supports warm handoffs from acute psychiatric inpatient settings are our ITTs that are Health Share funded programs embedded in each
county in the CCO service area. ITT is a short-term intensive care coordination program that supports members admitted to inpatient psychiatric care to connect with ongoing behavioral health services in the community after discharge. ITT engages members who are not already affiliated with a behavioral health provider, assesses member needs and preference, completes the initial plan of care, and provides consultation and coordination support to the hospital social workers as they make referrals for the member’s discharge plan. Following the member’s discharge from the hospital, ITT provides personalized outreach to the member to address barriers to care, including coordination with NEMT, use of flexible services to provide a phone or to address other barriers to care, coordination with providers for bridge medications, referral to needed services and supports, assistance rescheduling appointments, and telephonic and in-person support to members. ITT uses PreManage to receive notifications of enrolled member admission to EDs.

ITT maintains relationships with providers throughout the continuum of care (outpatient, intensive outpatient, assertive community treatment (ACT), intensive case management (ICM), respite, community assessment and treatment center (CATC), etc.) to ensure clear referral pathways and successful transitions for members. ITT collaborates with the addictions benefit coordination (ABC) team as appropriate to support members with dual diagnosis. ITT’s primary focus is on connection to behavioral health services; however, they also coordinate regularly with primary care and oral health providers, other care coordination teams, social service agencies, and natural supports to ensure successful transitions and to improve long-term engagement and outcomes for members.

An overview of the effectiveness of ITT during a 3-year period in the current CCO contract cycle across the Health Share service area is demonstrated below:

**Intensive Transition Team Program Evaluation | Key Findings**

- **ITT Clients are highly medically complex:** ITT clients had mental illness at rates as high as 20 times the typical Medicaid population and an average of three chronic health conditions.

- **Outpatient behavioral health visits are increased:** ITT clients in all counties saw increases in connection with outpatient behavioral health services following engagement with ITT compared to prior, where Clackamas County clients had the largest increase. Working with Washington County increased the likelihood of having an outpatient behavioral visit.

- **Inpatient mental health admission are reduced:** ITT clients in Multnomah and Washington counties had significantly reduced inpatient mental health admissions following enrollment with ITT compared to prior, while Clackamas County had minimal impact. Again, working with Washington County was a key factor that decreased the likelihood of having an inpatient mental health 30 days following enrollment.

- **Changes in utilization is reflected in costs:** Medical costs generally reflected the changes in utilization—costs for outpatient behavioral health services were increased and costs for inpatient mental health were decreased.

**Tracking warm handoffs** – Warm handoffs are documented in electronic health records (EHRs) that include transition information, as well as within our care coordination platforms. Internal documentation and tracking of the warm handoff process allow us to measure elements such as the development and implementation of individualized care plans, in-person interventions such as attending provider appointments for support and member advocacy, interdisciplinary care team meetings including those attended by providers, and successful transitions from hospital to home.

**Barriers to warm handoffs** – Barriers to facilitating warm handoffs include time and staffing resources on behalf of providers, distrust that can exist between the member and elements of the health care delivery system, cumbersome health information exchange, and unavailability of appropriate services that meet the member’s needs. To address these barriers, our partners provide
technical support to specialty behavioral health and primary care providers to support smooth transitions. Health Share also encourages warm handoffs by utilizing an alternative payment model that supports non-encounterable services such as warm handoffs (and crisis interventions in the primary care clinic).

B.2. How does Applicant plan to assess for need and utilization of in-home care services (behavioral health services delivered in the Member’s home) for Members?

Assessing for need and utilization of in-home care services  – A need for in-home services may be identified by medical providers, behavioral health providers, partners with state and local aging and disability services, developmental disability services, and county representatives with the Older Adult Behavioral Health Initiative who participate in care and system coordination meetings throughout the region. Health Share may also identify a need for in-home services for members hospitalized in inpatient gero-psychiatric units and make referrals to mental health providers who provide these services. Community-based and in-home behavioral health services are a critical component of Health Share’s behavioral health system. Using data from Health Share Bridge, we generate a list of members who are enrolled in long-term care services and identify need for in-home services via metrics like ED visits, inpatient admits, and other indicators of high utilization. Health Share also requires behavioral health providers to conduct a comprehensive mental health assessment, which includes assessment of the most appropriate setting for treatment services.

Ensuring access to in-home services  – These services are available through a variety of teams including (but not limited to): assertive community treatment (ACT), case management for individuals with SPMI, crisis services, home health, and home-based stabilization services. To ensure that in-home behavioral health services are available to members who need them, we are expanding our network of providers offering these services and increasing access and geographical availability. In 2018, 8% of the Health Share members who received behavioral health services received them in their place of residence.

B.3. Please describe Applicant’s process for discharge planning, noting that discharge planning begins at the beginning of an Episode of Care and must be included in the care plan. Discharge Planning involves the transition of a patient's care from one level of care to the next or Episode of Care. Treatment team and the patient and/or the patient’s representative participate in discharge planning activities.

Focus on care coordination throughout transitions of care  – Transitions of care of any kind are stressful for members and challenging for providers. We focus on care coordination during these periods and view transitions as opportunities to: (a) strengthen care coordination relationships, (b) assure that the goals of the member remain at the center of the planning process, and (c) ensure effective discharge planning begins when care starts. Our expectation of behavioral health providers is that treatment is individualized, has measurable goals in collaboration with the member or member representative, and clinical documentation reflects treatment goals, measures, progress in treatment, and discharge planning. Depending on the specific settings and services involved in the transition and the unique needs of the member, we use a number of tools, workgroups, member-specific care planning meetings, and care coordination staff across the integrated delivery systems. Multi-disciplinary team meetings, intensive care coordination conferences, and use of care coordination staff (Choice, Wraparound, and ICC) facilitates communication among members, their support system, community partners, and care coordination staff at all involved organizations. Progress or lack of progress in treatment are both measures that affect discharge planning—whether for termination or transition to another treatment provider. Through the course of treatment, care coordination teams work with providers to identify members who have higher or lower care needs and help identify resources for next steps. We encourage the current provider to coordinate with the new provider by sharing information necessary to ensure continuity of care. Transitions of care are planned collaboratively with members, their support systems, and treatment teams to ensure safety, reduce readmission or relapse risk, and improve health outcomes.
For members requiring higher levels of care, this transition is facilitated by Wraparound care coordinators, Choice care coordinators, ICC staff, or our ITT to ensure that the connection is made with a new provider and to honor the member’s perspective in a culturally and clinically responsive manner. For youth and adult members being referred to long-term care, Oregon State Hospital, or residential treatment, Wraparound and Choice teams (respectively) are responsible for intensive care coordination services, starting at the time of the initial referral. Care coordinators partner with other health, social and community supports to explore options to assure the least restrictive, most integrated setting possible that can safely and effectively meet the needs of the member. We ensure methods exist to transfer a member from one provider to another in a culturally responsive manner, honoring the member’s choice. This may include face-to-face meetings with the member prior to discharge or transition between providers, and coordinating the transfer of responsibility for the member’s ongoing care and continuing treatment and services. All care coordinators are trained in interpreter access and best practices for engaging members.

B.4. Please describe Applicant's plan to coordinate Behavioral Health care for Fully Dual Eligible Members with Medicare providers and Medicare plans, including ensuring proper billing for Medicare covered services and addressing barriers to Fully Dual Eligibles accessing OHP Covered Services.

Coordinating behavioral health care for fully dual eligible members – Health Share provides the same level of care coordination for dual eligible members regardless of Medicare plan affiliation. In addition, many dual eligible members access the full continuum of behavioral health services through our specialty behavioral health network. Health Share’s integrated delivery systems with Medicare Advantage plans provide a structured Model of Care for all fully dual eligible members.

Billing for Medicare services – To best leverage limited Medicaid funding, Health Share requires that provider’s bill all other sources first, including Medicare. When available and appropriate, we make efforts to work within the network of the member’s primary payer and ensure secondary payments meet the full Medicaid rates when those are higher than Medicare. In limited instances and in the interest of member access, Health Share provides waivers to Medicaid providers who are not able to bill Medicare to see dual eligible members. In these instances, Health Share will pay the provider at their full Medicaid rates. This is most often done to provide in-home behavioral health care in rural areas for members with complex or unique care requirements and ensures we are able to meet the behavioral health care needs of our members.

Addressing barriers to access for dual eligible members – Health Share also ensures that dual eligible members have full access to the NEMT benefit to reduce any barriers this population may have in accessing care. Fully dual eligible members have the same open access to our specialty behavioral health provider network as any other Health Share member.

C. MOU with Community Mental Health Program (CMHP) (recommended page limit 6 pages)

C.1. Describe how Applicant plans to develop a comprehensive Behavioral Health plan for Applicant’s Service Area. Please include dates, milestones, and Community partners.

Collaborating with our partners to develop a comprehensive Behavioral Health Plan – Health Share closely partners with Clackamas, Multnomah, and Washington Counties in their roles as the Local Mental Health Authorities (LMHAs) and Community Mental Health Programs (CMHPs). Health Share has had a long-standing memorandum of understanding (MOU) with the counties, and an updated MOU will be in place prior to January 1, 2020. Each of the three counties is a founding member organization of Health Share and holds a seat with reserved powers on our Board of Directors and seats on various advisory committees throughout our organization. Health Share has always provided financial support to the county crisis safety net programs, and beginning in 2020, will provide a portion of the global budget directly to the counties to support these programs.

Development of the Behavioral Health Plan: As part of the MOU agreement, Health Share will engage with the three counties, our Board, CAC, CAP, and community stakeholders to develop a new comprehensive Behavioral Health Plan for the service area in accordance with Exhibit M, Section 3,
subsections a(6) and a(7) of the sample contract. We will begin to develop the comprehensive
Behavioral Health Plan beginning in January 2020, and it will be completed per OHA requirement
on or prior to December 31, 2020. This process will be directly informed by and contribute to the
development of the Community Health Improvement Plan to ensure that there is direct alignment
with the larger plan and specific focus areas in the behavioral health system of care and safety net.
We will charter a Behavioral Health Council, directly responsible for development and oversight of
the Behavioral Health Plan. This Council will be chartered prior to the contract period to oversee and
prioritize performance and outcomes expectations for the Behavioral Health System of Care. The
Council will focus on the strategic, clinical, financial and operational aspects of shifting the behavioral
health benefit to the Integrated Community Network, as well as partner accountability for integrating
behavioral health into primary care. The committee will include Board members, clinicians, and key
community partners. Council membership will be determined by the Governance Committee and the
Board to ensure that membership reflects the needs of the population, supports the development of
strategies to address disparities, and links the behavioral health system to physical and oral health as
well as SDOH service providers. In addition, the Behavioral Health Plan will be developed in
coordination with many local community partners, which will meet quarterly at a minimum. The
Council will meet monthly and report to Health Share’s Board with progress.
Additionally, the Board will include in the MOU agreement funding and outcome metrics for County
Based Safety Net and Community Support Services that are best provided through the LMHA
and CMHPs. For example, each of the counties, with Health Share, has made significant investments
in ensuring that there are programs that support and serve culturally specific communities. These
programs will continue to be developed, directly supported, and expanded across physical and oral
health where possible. The updated MOU will be approved by the Board and in place prior to the
Contract start date of January 1, 2020. The Quality and Health Outcomes Committee will conduct
ongoing oversight and ensure alignment with input from the Behavioral Health Council, CAC, and
CAP. Health Share will engage with numerous community organizations in the process to develop the
new comprehensive Behavioral Health Plan. Health Share understands that to create a comprehensive
Behavioral Health Plan that supports multiple systems across the region, we must include the
following stakeholders in this process including schools, hospitals, corrections, law enforcement, first
responders, child welfare, DHS, public health/Local Public Health Authority, and peers.
Together, Health Share and the counties have worked to continually develop the local system of care
that encompasses prevention activities, an array of treatment services, local public health authorities,
recovery supports to maintain a behavioral health safety net, and strategies to address health disparities
for children, youth, adults, and older adults. Health Share and the LMHAs meet multiple times monthly
to collaborate and coordinate to identify service needs, develop strategies to fund and support efforts and to

C.2. Describe how Applicant plans to collaborate and coordinate with the Local Mental Health Authority in the
development of the CHP. Please include dates and milestones.

Collaborative development of the Community Health Improvement Plan (CHP) – In
development of the CHP, Health Share closely partners with Clackamas, Multnomah, and Washington
Counties in their roles as the LMHAs, CMHPs, and LPHAs. The current CHP is already under
development and will be approved by Health Share’s Board in August 2019. By June 30, of each
subsequent year, Health Share will submit an update to the CHP in collaboration with the LMHAs.
Together, Health Share and the counties have worked to continually develop the local system of care
that encompasses prevention activities, an array of treatment services, recovery supports to maintain
a behavioral health safety net, and strategies to address health disparities for children, youth, adults,
and older adults. Health Share and the LMHAs meet multiple times monthly to collaborate and
coordinate to identify service needs, develop strategies to fund and support efforts and to
operationalize care coordination and access to services. This partnership is well established and has been in place since the initial development of Health Share in 2012.

**Health Share and the LMHAs partner in planning for the behavioral health needs of the community**, as seen in the LMHAs’ participation in the development of the Health Share’s 2014 and 2018-2020 community health assessment and health improvement plans. These plans include a strong emphasis on behavioral health. Health Share previously participated in the development of the LMHA’s biennial implementation plans and will participate in the development of the upcoming 2019-2021 biennial plan. The collaboration and shared responsibility for the system of care between Health Share and the LMHAs is codified in a formal MOU between Health Share and each county. In addition, each county has a seat on Health Share’s Board with the chair currently being a county representative.

Health Share uses the comprehensive information contained within the current Community Health Assessment (CHA) based on the most recent Healthy Columbia Willamette Collaborative CHA. This is the regional entity supported by Health Share to conduct our regional (Clackamas, Multnomah, and Washington Counties in Oregon, and Clark County in Washington) CHA. The collaborative includes representatives from each of the counties as well as Health Share and the community benefit departments of the hospital systems in the region. The CHA is a 3-year process that includes extensive community engagement. We use this extensive CHA as the basis from which our CHP is developed. Health Share’s CAC actively advises Health Share on the incorporation of the CHA into our operational practice. Currently the CAC is working on developing a new CHP in response to the CHA. There will be continued engagement with various stakeholders, including coordination with the LMHAs as they have an active role in the development of local CHPs. The CHP provides a broad platform and vision for Health Share to improve the health of our members. This includes behavioral health and the most recent CHP which had significant emphasis on improving the behavioral health system of care, including:

- Improving follow-up after hospitalization for mental illness
- Increasing screening of individuals with SPMI and co-occurring diabetes
- Expanding culturally specific treatment and peer support services
- Identifying and eliminating health care disparities in physical and mental health outcomes for people diagnosed with SPMI
- Expand peer support services
- Reducing hospitalization rates for individuals with SPMI
- Engaging in a media campaign to reduce mental health stigma
- Increase the use of mental health and addiction services
- Eliminate barriers to services, such as transportation
- Increase access to 24-hour crisis services

The next CHP will continue to include a strong emphasis on behavioral health. Following the implementation of the plan, the three LMHAs in partnership with Health Share, will assess the concurrent efforts that should align and compliment the comprehensive Behavioral Health Plan.

**C.3. Describe how Applicant plans to collaborate and coordinate with the Local Mental Health Authority in the development of the local plan. Please include dates and milestones.**

**Development of the local plan** – Health Share closely partners with Clackamas, Multnomah and Washington County in their roles as the LMHAs and Community Mental Health Program (CMHPs). Together, Health Share and the counties have worked to continually develop the local system of care that encompasses prevention activities, an array of treatment services, recovery supports to maintain a behavioral health safety net, and strategies to address health disparities for children, youth, adults,
and older adults.

We will engage and support the LMHAs in development of a comprehensive local plan for the delivery of mental health services for children, families, adults, and older adults. Health Share will partner with the LMHAs to create a blueprint to provide mental health services that are directed by and responsive to the needs of individuals in our community. The local plan will be developed in coordination with many regional partners, and this group will meet quarterly at minimum. We will prioritize the needs of the LMHAs in developing their local plans and will align milestones with the requirements of each county. The local plans will be completed per the requirements of each local LMHA. In partnership with the LMHAs in Health Share’s service area, each local plan will identify ways to:

- Coordinate and ensure accountability for all levels of care
- Maximize resources for consumers and minimize administrative expenses
- Provide supported employment and vocational opportunities for consumers
- Determine the most appropriate service provider among a range of qualified providers
- Ensure that appropriate mental health referrals are made
- Address local housing needs for persons with mental health disorders
- Develop a process for discharge from state and local hospitals and transition planning between levels of care
- Provide peer support services, including drop-in centers
- Provide transportation supports
- Coordinate services among the criminal and juvenile justice systems and local mental health programs

Priority areas for the local plans will be identified through:

- Stakeholder input generated through existing partnerships and venues
- Community listening sessions
- Data analysis, including assessing the ethnic, age-specific, cultural and diversity needs of the population
- Member input including consumers, advocates, and families
- Physical, oral, and behavioral health provider input
- CAC input
- Feedback from the OHA

Our goal is to ensure any plan that is developed is closely aligned with other plans to ensure minimal duplication of effort and the broadest scope possible. For this to be successful, the plans should complement efforts already underway with current CHPs, regional behavioral health collaboratives, existing strategic plans, and Health Share’s Ready + Resilient (R+R) initiative.

C.4. Does Applicant expect any challenges or barriers to executing the written plan or MOU extension with the Local Mental Health Authority? If yes, please describe.

We do not anticipate any barriers to executing a written plan or MOU, given that the three counties are founding partners of Health Share and participate extensively in the governance and operation of the CCO. There were no significant challenges or barriers to executing current MOUs.

D. Provision of Covered Services (recommended page limit 6 pages)

D.1. Please provide a report on the Behavioral Health needs in Applicant’s Service Area.

Behavioral health needs in the tri-county region – Health Share has been a CCO since 2012 and has served the entire tri-county CCO Medicaid population since early 2018. In 2018, 18% of the Health Share membership received behavioral health services through Health Share’s specialty behavioral health network. The large majority of these members (74%) received services through our providers contracted via value-based payment arrangements (case rates). Health Share has great expertise in the area of evaluating the behavioral health needs of the tri-county area. Prior to being founding members of Health Share, the three local counties managed the mental health benefit for Medicaid. Our combined experience of over 45 years has allowed us to understand the provider network strengths,
areas of development and priorities for the future, such as expanding behavioral health services offered in primary care settings and building capacity for Applied Behavioral Analysis.

**Understanding behavioral health needs of our population:** The table below presents a summary of the most prevalent behavioral health conditions among Health Share members in 2018:

<table>
<thead>
<tr>
<th>Diagnosis (Adults)</th>
<th># of Members</th>
<th>% of Adult Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUDs</td>
<td>21,562</td>
<td>11.60%</td>
</tr>
<tr>
<td>Depressive disorders</td>
<td>21,495</td>
<td>11.50%</td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>18,123</td>
<td>9.70%</td>
</tr>
<tr>
<td>Stress reaction and adjustment disorders</td>
<td>14,126</td>
<td>7.60%</td>
</tr>
<tr>
<td>Psychotic disorders, Schizoaffective disorders, Schizophrenia</td>
<td>6,474</td>
<td>3.50%</td>
</tr>
<tr>
<td>Bipolar disorders</td>
<td>5,207</td>
<td>2.80%</td>
</tr>
<tr>
<td>Childhood-onset disorders</td>
<td>4,111</td>
<td>2.20%</td>
</tr>
<tr>
<td>Personality and impulse disorders</td>
<td>2,599</td>
<td>1.40%</td>
</tr>
<tr>
<td>Other mental health</td>
<td>1,960</td>
<td>1.10%</td>
</tr>
<tr>
<td>Behavioral-driven physiological disorders</td>
<td>1,407</td>
<td>0.80%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis (Children Under 18)</th>
<th># of Members</th>
<th>% of Child Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress reaction and adjustment disorders</td>
<td>6,973</td>
<td>5.80%</td>
</tr>
<tr>
<td>Childhood-onset disorders</td>
<td>6,671</td>
<td>5.50%</td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>4,249</td>
<td>3.50%</td>
</tr>
<tr>
<td>Depressive disorders</td>
<td>4,206</td>
<td>3.50%</td>
</tr>
<tr>
<td>Other mental health</td>
<td>776</td>
<td>0.60%</td>
</tr>
<tr>
<td>SUDs</td>
<td>615</td>
<td>0.50%</td>
</tr>
<tr>
<td>Behavioral-driven physiological disorders</td>
<td>408</td>
<td>0.30%</td>
</tr>
<tr>
<td>Personality and impulse disorders</td>
<td>261</td>
<td>0.20%</td>
</tr>
<tr>
<td>Psychotic disorders, Schizoaffective disorders, Schizophrenia</td>
<td>244</td>
<td>0.20%</td>
</tr>
<tr>
<td>Bipolar disorders</td>
<td>90</td>
<td>0.10%</td>
</tr>
</tbody>
</table>

**Additional trends in SUD needs** – Approximately 9,700 Health Share members (37% of members with SUD) have diagnoses for two or more substances. Members with SUD for one substance have ED rates about twice the average Health Share member. For members with SUD for two or more substances, ED rates are 4 times the Health Share average.

**Methods to better understand Health Share member behavioral health needs** – Health Share utilizes numerous strategies to continually better understand the behavioral health needs of our members and to enhance our network as needed to best meet these needs. Health Share has long provided a full range of behavioral health services in our service area and has adapted to build both capacity and new services as the needs of our membership change. For example, we have made investments in increasing the capacity of our provider network to provide MAT to be responsive to both our community and our membership. We have also conducted numerous inquiries across our membership to better understand the needs of our members, such as the Life Course Health Study, a survey sampling of over 10,000 Health Share members that found 43% of participants had experienced four or more adverse childhood events, a clear indicator for the need for trauma-informed
care across our networks. Another significant finding was that 41% of our members had experienced homelessness at some point in their lives, highlighting the importance of tying behavioral health services to housing supports.

**Findings from our Community Health Needs Assessment (CHA)** – The 2018 CHA included 29 community listening sessions and over 3,000 completed surveys. Some of our findings included:

- Two of the top three chronic conditions among youth are ADD/ADHD and PTSD
- Depression is one of the top three chronic conditions for adults
  - Our African American members experience higher rates of depression than the national average
  - Suicide was identified as a priority health issue based on the population data on mortality.
- Alcohol-induced and drug-induced deaths emerged as top mortality indicators in the population health data. Non-transport accidents, which included accidental overdose deaths, also ranked high in the population mortality data. Risky health behaviors included high rates of binge drinking; smoking; and alcohol, marijuana, and vaping, and e-cigarette use specifically among youth.

Health Share’s first CHP included addressing behavioral health needs of our members (inclusive of mental health and substance use) as one of the top community health priorities. This resulted in Health Share funding community-based organizations utilizing traditional health workers (THWs) to address behavioral health needs. Two examples are:

- Northwest Family Services (NWFS) – who partnered with the National Alliance of Mental Health Illness in Clackamas County to invest in programs designed to provide education and outreach in the Latino and LGBTQIA communities through peer resources and peer support workers with an emphasis on mental health and addictions.
- Center for Intercultural Organizing (CIO) – who invested in their Margins to Mainstream project that developed and employed immigrant and refugee “wellness life guides” or THWs that aided newcomers in acquiring the facilitative and communicative skills necessary to interact, understand and cope with their needs in relation to their adopted environment, and work collaboratively toward institutional change.

**Using data to target member needs**: Health Share utilizes multiple sources of data to enhance our understanding of our member needs, such as conducting analysis of NEMT trips which offers a window into where members receive services and where additional capacity may be needed. Additionally, we enhance our understanding of demand by measuring the unmet need in our community. We identify members with a secondary diagnosis of mental health or SUD but no history of treatment to create a more robust provider network. Heath Share monitors ED utilization data via the regional Emergency Department Information Exchange (EDIE) to understand which emergency visits can be better served in a community behavioral health setting. Using this information, we are able to evaluate the needs of our members and work to ensure adequate service delivery. Health Share quickly added service providers in key areas as the need presented. For example, in 2018, Health Share expanded our behavioral health service provider network by adding over 50 new providers in response to FamilyCare’s closure. We continue to identify areas of need through data analysis, access reports and service utilization to determine the adequacy of our provider network.

**Geographic access challenges**: Additionally, the ED-MI measure encouraged a new review of the adequacy of the behavioral health network in 2017. The Provider Network Management Workgroup reviewed reports of the geographic distribution of members identified with mental health conditions (according to the DOJ definition) in relation to the locations and number of behavioral health services providers, identifying three key geographic areas within our service area where the ratio of provider
resource to membership was particularly low. Of the members with mental health conditions in these regions engaged in specialty behavioral health services, the majority (65%) were receiving lower levels of care and showing moderate ED use (70 visits/1000 mm), while members with the highest level of service had nearly twice the ED utilization rate (143 visits/1000mm). Further analysis revealed that 68% of the full cohort of adult members with mental health conditions were engaged in specialty behavioral health services, while another 30% were receiving support in primary care, either through medication management or embedded behaviorist services. This demonstrated the important role that primary care plays in supporting the needs of members with mental illness, which encouraged partners across the behavioral and physical network to review the spectrum of services available to this group of members.

Meeting the cultural and linguistic needs of our members: Beyond meeting the known need of members with an existing behavioral health diagnosis, we understand that culturally responsive, accessible, and high-quality medical care helps members live longer, healthier lives. Because historically marginalized populations can be under-represented in assessments of need, Health Share (in collaboration with our regional county community mental health programs) provides funding for culturally specific providers that includes additional support for outreach and engagement activities for culturally specific populations. This allows providers who best know their communities to identify underserved members and provide additional access that may otherwise go unmet. This is in addition to dedicated funding for culturally specific behavioral health services.

D.2. Please provide an analysis of the capacity of Applicant’s workforce to provide needed services that will lead to better health, based on existing Behavioral Health needs of the population in Applicant’s Service Area.

Behavioral health workforce capacity: Health Share’s behavioral health workforce functions in a wide range of settings including prevention programs, community-based programs, FQHC’s, inpatient facilities, integrated delivery systems, emergency rooms, psychiatric emergency rooms, criminal justice systems, and schools. The workforce consists of case managers, psychiatrists, psychologists, social workers, advanced practice psychiatric nurses, marriage and family therapists, addiction counselors, professional counselors, psychiatric rehabilitation specialists, and peer support specialists. Per Health Share’s 2019 Q1 roster report, we have 4,615 direct service professionals in our contracted specialty behavioral health network. This reflects significant efforts in 2018 to contract with over 50 new behavioral health provider organizations to meet the needs of our increased membership. Access to behavioral health services considers many factors, many of which are difficult to measure at the system level. Low-income communities, communities of color, people living with disabilities, LGBTQIA, and immigrant and refugee communities often experience additional barriers that further amplify regional variations in access to care.

Behavioral health workforce rate study: Health Share does not have a workforce shortage in behavioral health, but chronic underfunding of the behavioral health benefits has led to workforce retention and development issues. In 2017, Health Share engaged a private consultant to complete a mental health and SUD market rate study, working with providers in Clackamas, Multnomah, and Washington Counties. The goal of the rate study was to determine what investments would be required to stabilize the behavioral health system’s workforce in the tri-county region in order to improve quality and bend the cost curve of Health Share members with behavioral health conditions. During the course of our work, Health Share collected salary, benefit, and other cost data from 15 provider organizations; benchmark wage data from the 2016 Oregon Wage Information Report; benchmark benefits data from the U.S. Department of Labor Bureau of Labor Statistics; and detailed provider rate data from current provider contracts. These data were analyzed and incorporated into a model that enabled us to compare current wages and benefits to benchmark data, compare both sets of figures to current reimbursement rates, and run multiple scenarios to determine how to close identified gaps. This market rate analysis has informed Health Share’s behavioral health rate structure.
and provided the impetus for multiple initiatives to improve the capacity and stability of the behavioral health and SUD provider network.

**Expanding access to behavioral health care in primary care settings:** Additionally, to increase access to care, Health Share is expanding our ability to meet members’ behavioral health needs in primary care settings. **All contracted primary care settings will have an option to bill behavioral health codes for licensed behavioral health clinicians working in primary care offices.** These codes have historically been restricted to providers with behavioral health contracts. This will be additive to the current specialty behavioral health network and means Health Share members will, over time, have hundreds more locations, organizations, and providers able to provide meaningful, ongoing behavioral health treatment.

**Use of reporting to inform network expansion:** Health Share requires regular access reporting for all contracted medium to large specialty behavioral health providers in our region. We use this information in the development of strategy for expansion of our provider network, to inform provider network decision making, to promote transparency of appointment availability, and as part of our composite score incentive payments to providers. This aligns funding with prompt access to services and incentivizes investments in provider capacity.

In 2019, Health Share expanded on these efforts to measure access in our specialty behavioral health provider network and now defines access as the third next available appointment, a recognized standard that goes beyond simply measuring time to intake appointments. The chart below provides a current example of our access reporting for our largest specialty behavioral health case rate clinics. Creating meaningful progress in expanding access to behavioral health services in our region requires collaboration with providers, enforcing contract standards, and matching increased funding to those services and locations most in need. Our public reporting of access data will increasingly identify areas we can improve most and guide future partnerships and incentives.

**D.3. How does Applicant plan to work with Applicant’s local communities and local and state educational resources to develop an action plan to ensure the workforce is prepared to provide Behavioral Health services to Applicant’s Members?**

Preparation of our workforce to provide behavioral health services to all members – Health Share's R+R strategic investment plan includes a strategy around supporting recovery, which entails both short- and long-term investments in the regional behavioral health provider network’s workforce to address current need and build future capacity for years to come. This strategic plan was developed in concert with local community behavioral health providers representing the needs of the behavioral health workforce. Health Share recognizes the need to work with local educational programs to ensure our workforce is prepared to meet the needs of our members. To this end, representatives of both Health Share and our contracted provider network participated in a planning session in 2018 with the School of Social Work at Portland State University (PSU). The goal of this session was to communicate the needs of the community to the school so they could ensure that students were prepared for community-based work. In addition, Health Share is working with Portland Community College (PCC) to develop a program to train culturally specific peer mentors to upskill and obtain certification as certified alcohol and drug counselors. Health Share has partnered with the Tri-County Behavioral
Health Providers Association to sponsor diversity, equity and inclusion trainings that will enhance the entire community provider network to be more responsive to our members of color and other underserved communities. This investment and commitment to developing the behavioral health workforce will continue in Health Share’s new contract cycle.

**D.4. What is Applicant’s strategy to ensure workforce capacity meets the needs of Applicant’s Members and Potential Members?**

**Ensuring workforce capacity** – Health Share’s strategy to ensure workforce capacity to meet the needs of members recognizes that capacity can be defined in multiple important ways. First, it refers to the number of providers available to offer routine outpatient services such as counseling and medication management. Second, it refers to the types of expertise and backgrounds present in the provider network itself, designed to understand emerging clinical and social challenges and to provide meaningful, evidence-based approaches to improve outcomes and offer a positive member experience.

**Sufficient number of providers to offer routine outpatient services** – To ensure our network contains a sufficient number of providers to offer routine outpatient services, our primary strategy is to increase the ability for primary care providers to offer behavioral health supports within the primary care practice. This includes therapeutic and medication management services, often for shorter duration and focused on specific clinical challenges identified in that setting. Historically, a constant tension for the CCO has been the challenge of ensuring adequate access in specialty behavioral health settings while ensuring that transitions back to primary care from the behavioral health system were successful. As primary care expertise and capability increases, we believe that capacity will expand in the specialty behavioral health arena, offering increased expertise for those who need it most.

**Provider expertise related to unique populations and clinical needs** – To ensure sufficient expertise around unique populations and clinical needs, Health Share has made a number of investments to support the community and the providers who strive to meet the community’s needs. These investments have offered targeted support to leverage the amazing talent in our network to share best practices and expertise, allowing for spread and increased capacity:

- **SUD provider investments**: Health Share is currently soliciting proposals from contracted SUD providers to fund a Per Member Per Year (PMPY) investment with the following key objectives: workforce retention, staff development, care coordination, and improved member care or member experience in care. Providers who receive these grant funds will have identified key outcomes that will be monitored by Health Share to ensure success. Funding may be used to support the following activities:
  - Development of staff retention activities
  - Staff training in a clinical model
  - Training and implementation of treatment model
  - Implementation of evidence-based clinical services serving focus populations
  - Development of supports such as peer delivered services
  - Capacity building (i.e., expenses related to recruitment, hiring and training of staff before they begin encountering services)
  - Technology upgrades to improve workforce productivity

- **Oregon Community Health Worker Association (ORCHWA)**: A Health Share investment to create an infrastructure that allows systems to reliably contract for community-based community health workers (CHWs). This investment supports expansion of the culturally specific CHW network and development of clinical CHW curriculum, while creating opportunities for CHW workforce development in order to increase marginalized communities’ access to health care and social-determinant related support and services.
• **Wheelhouse**: A Health Share created and funded program that provides workforce support to specialty addictions and behavioral health providers by providing medication-assisted treatment (MAT) education programs. A primary goal of Wheelhouse is to expand meaningful access to buprenorphine in the behavioral health and primary care networks across Clackamas, Multnomah, and Washington Counties. It is an adapted model of a “hub and spoke” network, which connects outpatient MAT providers (“spokes”) to a specialized “community hub” that has advanced experience with MAT. The hub is available for consultation, clinical guidance, and technical assistance, as well as direct patient care.

• **Learning collaboratives**: Community learning events that facilitate the spread of best practices and encourage network cohesion. Wheelhouse convened a seven-session learning collaborative series (October 2017 through November 2018) covering topics such as: foundations of MAT, client engagement and retention, cultural awareness in SUD treatment, and quality standards for MAT services. Each participating spoke received individualized technical assistance as they created and broadened their MAT programs. A second learning collaborative focused on expanding MAT access in primary care will begin in May 2019.

In response to these efforts, there has been an increase in Drug Addition Treatment Act-waivered (DATA-waivered) providers at all participating spoke agencies and an increase in activity levels of providers who were already waivered. Specific to one of the largest organizations in the program, since January 2018, over 200 clients at Hooper have elected maintenance buprenorphine upon treatment completion. Health Share will continue to monitor and expand the number of providers in our region that have been DATA-waivered to ensure this newly trained workforce maintains its capacity to serve our members.

**Minimizing administrative burden on providers** – Additionally, Health Share seeks to minimize the administrative burden we place on behavioral health providers, encouraging them to channel resources into direct service staff rather than administrative FTEs. One of the ways Health Share seeks to streamline administrative burden and encourage greater access is to promote the use of case rate payment systems that allow us to provide immediate authorization of services with limited or no pre-authorization requirements. Over 92% of Health Share’s current specialty behavioral health authorizations were approved in this fashion. With the coming increased integration of behavioral health services provided in primary care settings, an ever-greater number of behavioral health services will be provided in this fashion.

**D.5. What strategies does Applicant plan to use to support the workforce pipeline in Applicant’s area?**

**Supporting the behavioral health workforce pipeline in the tri-county area** – Health Share is committed to supporting the workforce pipeline in our region. For example, Health Share is funding a grant to PCC to increase the number of underrepresented substance abuse counselors in the community. This funding supports the creation of two new cohorts and represents truly expanded capacity that is additive to the existing PCC alcohol and drug counselor training program. The program provides:

- Full scholarship support to 20 students per year through 2021 who are seeking the Alcohol and Drug Counseling AAS Degree or Addiction Studies Certificate. Priority for scholarship recipients are African American students; secondary are other underrepresented students
- Professional development activities and cohort support
- Professional certification fees for degree and certificate completers
- Course materials
- School-related financial needs that may be a barrier to degree completion

Health Share is also committed to expanding the use of THWs and individuals with lived experience
to enhance the network of service delivery. This has been demonstrated through substantial expansion of peer delivered services.

D.6. How will Applicant utilize the data required to be collected and reported about Members with SPMI to improve the quality of services and outcomes for this population? What other data and processes will Applicant collect and utilize for this purpose?

Health Share uses the data required to be collected and reported about members with SPMI (Health Share uses the DOJ definition of SPMI) to improve the quality of services and outcomes in the following ways:

**Health Share Bridge provider and membership analytics database:** Health Share merges members’ SPMI status, enrollment, cost, and utilization data in our Bridge Analytics Applications to visualize this population demographically and geographically to better understand how service use occurs. This data is made available to integrated delivery systems, providers, and community partners via Health Share Bridge so that all types of providers—not just behavioral health providers—are able to leverage data to inform care coordination focused on the unique needs of members diagnosed with SPMI. We hold monthly Bridge trainings for providers and care coordination teams that include examples of how to stratify membership to better identify and serve those with the most complex behavioral health needs. Health Share will continue to present this approach to the larger provider community and has already done so at the Regional Behavioral Health Clinical Directors meeting and the Tri-County Providers Association.

**Emergency Department Mental Illness (ED-MI) Disparity Measure:** Improving the quality of care for members with SPMI is the focus of Health Share’s quality improvement efforts for the ED MI disparity measure. In addition to identifying members with SPMI in Bridge, monthly reports are sent to partner organizations to encourage quality improvement (QI) activities to reduce ED utilization. The member level data includes information on behavioral health diagnosis, physical health conditions, ED visit count, and diagnoses from ED visits, chronic conditions flags, primary care assignment, and behavioral health provider assignment.

**ED learning collaborative:** Health Share provides key primary care and behavioral health providers reports of shared members who qualify for the DOJ’s definition of SPMI. These reports create the opportunity for providers to know shared members and develop workflows to improve care. Providers have prioritized reviewing those shared clients with the highest ED utilization rates with attention to determining how to best meet their complex needs. Similar reports are delivered to our seven area CCBHCs, who attend to both the physical health and behavioral health outcomes for the population.

**PreManage:** Health Share compliments OHA’s funding for PreManage and ensures behavioral health providers have access to this tool at no cost. Providers use PreManage to obtain real-time alerts for ED utilization, admissions, and discharges. Health Share and partner organizations use PreManage for alerts and as a care coordination and communication tool with EDs and clinic systems. Care coordination teams build cohorts within PreManage to monitor their members to ensure avoidable ED visits are minimized and that connections to care are supported. Health Share acts as a central point of contact for behavioral health providers to assist with onboarding this technology into their practices and expects the majority of our specialty behavioral health network will make direct use of this platform to assist with caring for members diagnosed with SPMI.

D.7. What Outreach and/or collaboration has Applicant conducted with Tribes and/or other Indian Health Care Providers in Applicant’s Service Area to establish plans for coordination of care, coordination of access to services (including crisis services), and coordination of patient release?

**Outreach to tribes and Indian health care providers** – Health Share collaborates closely with Native American Rehabilitation Association of the Northwest (NARA NW), an Urban Indian Health Provider and a Title V urban Indian Health Program. NARA NW is the only Indian Health Services/ Tribe/ urban Indian health program (UIHP) provider in our service area. NARA NW provides the
full-spectrum of physical, behavioral, and oral health services to Health Share's American Indian and Alaska Native members. The UIHP contract permits an Indian member to choose NARA as their provider as long as NARA has capacity to provide services to that member. It is Health Share's responsibility to assess and work with NARA NW to develop network capacity for these patients.

**Health Share care coordinators work with NARA NW** to ensure members are receiving the frequency and intensity of service clinically indicated by the member's level of care. Similarly, all contracted behavioral health providers—including those serving Native American populations—are responsible to coordinate care and facilitate the exchange of health information with the member's physical health care provider to address physical and behavioral health needs, when indicated. NARA NW was recently awarded designated funds to assist with care coordination.

At the regional level, the Chief Executive Officer of NARA NW serves on Health Share's Board, ensuring that the needs of Native American members and providers are represented in policy making and program development. NARA also participated in the creation of the current Health Share Pathways behavioral health network and system of care. Additionally, the Integrated Community Network, administered by CareOregon, has extensive experience in working with the IHS and the nine confederated tribes of Oregon through the Tribal Care Coordination (TCC) team. This team provides care coordination support for the tribes in Oregon and those out of state who maintain affiliation with their Oregon tribe.

**E. Covered Services Components (recommended page limit 36 pages)**

**E.1 SUD (recommended page limit 2 pages)**

**How will Applicant support efforts to address opioid use disorder and dependency?**

**Opioid use disorder (OUD) programs** – Health Share recognizes the detrimental impact the opioid epidemic has had on our community, members, and their families. Health Share, in cooperation with Multnomah, Washington, and Clackamas Counties, has developed a comprehensive continuum of specialty care for SUD services, addressing OUD and dependence. In addition, Health Share and county partners participate in several opioid workgroups. These workgroups are both at individual county levels as well as the regional metropolitan level. The workgroups bring together partners from public health, community mental health programs, law enforcement, and primary care and behavioral health providers to develop strategies to address the opioid epidemic.

**Case Study: Opioid Prescribing Support** – Kaiser Permanente, one of our IDS partners, created its **Opioid Use Improvement (OUI) program** in response to the opioid epidemic. The OUI leverages Kaiser Permanente’s integrated care delivery system with a partnership between medical care providers and pharmacy. To aid PCPs in opioid management decisions, Kaiser created the Support Team Onsite Resource for Management of Pain (STORM). This team includes physicians, pharmacists, nurses, and social workers. STORM resources include pain support, mental health resources and Pharmacy Alert Services (PAS). An urgent consultation phone line was created to support PCPs with advice on tapering or converting opioids, use of adjuvant medications, and in interpreting results from urine drug screens. Assistance is provided with referrals to the Pain Clinic and Addiction Medicine when appropriate. PAS staff proactively review members using opioids and work with clinicians to address possible concerning behaviors related to the use of controlled substances. Through these efforts, Kaiser significantly reduced the use of opioids among our members while providing the most effective and appropriate treatment.
E.1.a. How will Applicant provide, in a culturally responsive and linguistically appropriate manner, SUD services to Members, including outpatient, intensive outpatient, residential, detoxification and MAT services?

Culturally responsive SUD services – Health Share contracts with a large network of substance use providers for an array of services, including outreach and engagement, prevention, outpatient, intensive outpatient, residential, detoxification, and MAT services. Peer services are included at all levels of care. Culturally specific services are available throughout the network. Providers have developed culturally specific services for member populations including older adults; LGBTQIA individuals; people living with HIV/AIDS; African American men, women, and children; Burmese adults; Spanish speaking Latinx; and Middle Eastern and Native American members. Translation services are available when needed, with the goal that members receive services in their first language.

**Case Study: Culturally specific SUD program** – Central City Concern’s Imani Center provides culturally specific and responsive Afrocentric approaches to mental health and SUD treatment, peer support, and case management. The Imani Center consists of African American leadership and staff who provide group and individual supports and pro-social activities in a culturally safe environment, allowing participants to authentically engage and address barriers.

**SUD care coordination:** SUD care coordination is provided throughout the full range of physical and behavioral health services, coordinating and locating access in primary care, behavioral health settings, and high-risk venues (EDs, detox, jails, crisis clinics, needle exchange programs, unspecified rural areas, community para-medicine teams). An example of engaging at risk members is through the addiction benefit coordinator team that includes staff specializing in OUDs, people living with HIV, and LGBTQIA, African American, and Spanish speaking populations. Addiction benefit coordinators conduct in-reach into area ED and detox centers.

E.1.b. How will Applicant provide culturally responsive and linguistically appropriate alcohol, tobacco, and other drug abuse prevention and education services that reduce SUDs risk to Members?

**Alcohol, tobacco, and other drug abuse prevention and education** – Health Share believes SUDs can be prevented and must be treated as a chronic health condition, through strengthening individuals’ lives through prevention, education, outreach, treatment, and recovery. Prevention and education efforts are provided throughout the community, including through collaboration with the local mental health and public health authorities, schools, community-based programs, and community organizations, with a focus on reaching underserved populations. Health Share strives to provide prevention and education services in culturally responsive ways including providing the education in alternative languages and/or formats and ensuring that educational programs are conducted by individuals that reflect our diverse community. Prevention and education activities are often provided by county staff; each county has initiatives in place to hire staff that are reflective of our local communities to enhance our cultural responsiveness. Health Share also works in partnership with community organizations that specialize in cultural populations to deliver these education and prevention efforts in a culturally and linguistically responsive manner. Many of these services are delivered by people who belong to, and are trusted by, those communities. Examples of specific education and prevention efforts related to alcohol, tobacco, and other SUDs include:

**Case Study: Prenatal SUD screening** - Kaiser Permanente, one of our IDS partners, conducts a screening and risk assessment for substance abuse and alcohol at the first prenatal visit (within the first 12 weeks), using their prenatal intake questionnaire. The information is documented in HealthConnect, and the appropriate intervention is implemented. Additionally, clinicians screen pregnant women for tobacco use and provide pregnancy tailored counseling to those who smoke.
<table>
<thead>
<tr>
<th><strong>Prevention Activity</strong></th>
<th><strong>Description</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinicians embedded in schools</td>
<td>Health class presentations on use of alcohol, tobacco, and other substances</td>
</tr>
<tr>
<td>Community presentations</td>
<td>Mental Health 101 presentations address risks and education on support services through Wheelhouse</td>
</tr>
<tr>
<td>Outreach to youth-based activities</td>
<td>After-school programs for at-risk youth (Sun Schools and PreventNet Sites)</td>
</tr>
<tr>
<td>Tobacco education in outpatient, DUII, and residential treatment programs</td>
<td>Smoking cessation groups offered in various settings</td>
</tr>
<tr>
<td>Close collaboration with public health’s prevention efforts</td>
<td>Participation in the Tri-County Opioid Safety Coalition</td>
</tr>
<tr>
<td>Social media and web content</td>
<td>Facebook messages, health messages, information about accessing supports such as smoking cessation classes, online prevention educational information</td>
</tr>
<tr>
<td>Promotional materials in primary care settings</td>
<td>Brochures, posters, questionnaires</td>
</tr>
<tr>
<td>Targeted member outreach</td>
<td>Phone and in-person outreach to members identified as smokers who also have an inpatient or ED visit, chronic health condition, or are pregnant</td>
</tr>
<tr>
<td>Member Handbook</td>
<td>Smoking cessation program information provided to all members in the member handbook</td>
</tr>
</tbody>
</table>

Providers in our network commonly utilize **screening, brief intervention, and referral to treatment (SBIRT)**, to screen members who identify high-risk drinking or drug use and to provide counseling and referrals to treatment. Health Share provided significant education and training across our provider networks on the use of this tool. Additionally, members are routinely screened for tobacco use at primary care visits as well as specialist visits, admission to hospitals, and oral health visits, and are offered resources for tobacco cessation. Health Share’s **addiction benefit coordinators** also provide culturally specific prevention and education to members at risk in the community as well as those presenting in EDs. Community partners (such as needle exchange sites), jails, and domestic violence shelters are critical outposts for disseminating prevention and education materials and referrals. To ensure cultural responsivity, many coordinators specialize in and belong to the communities that they work with, including coordinators for African American, LGBTQIA, and Spanish speaking populations. In addition, Health Share is currently implementing a program in partnership with PCC to train addiction counselors to serve underserved communities. Our first cohort will enroll in the fall of 2019.

**E.1c. How will Applicant inform Members, in a culturally responsive and linguistically appropriate manner, of SUD services, which will include outpatient, intensive outpatient, residential, detoxification and MAT services?**

**Informing members of available SUD services** – Health Share informs our members in a culturally responsive and linguistically appropriate manner about SUD services (including outpatient, intensive outpatient, residential, detoxification, and MAT services) through multiple forums, beginning with our prevention and education efforts (as outlined above). In addition, Health Share makes all member materials available consistent with Exhibit B, Part 3 of the sample contract and OAR 410-141-3300. Members receive a member handbook upon enrollment with instructions on how to access SUD services, which is available in prevalent non-English languages and alternate formats. We have also
posted on our website an animated, trans-created behavioral health system navigation video in Spanish, Vietnamese, Russian, Arabic, Somali, and Chinese, to help members understand how to navigate both mental health and SUD services.

Members can also learn about available SUD services through Health Share’s online provider directory, which allows them to identify a level of care and any specialty services they may need (i.e. language, cultural specificity, co-occurring mental health needs, etc.) and geographic locations. Members can access SUD services and addiction care coordination through contacting our centralized member call center. Through our call center, members can obtain consultation and referrals for treatment options, often in their primary language. Translation and qualified health are interpreter services are also made available through our member call center. Additionally, care coordinators provide in-depth, individualized education to members about services that are available to them through their OHP coverage.

County-based crisis lines – To promote a “no wrong door” approach, Health Share also supports county-based crisis lines to ensure referrals and resources are up to date and accurate across the service area, allowing members, community partners, referents from the health care system, child welfare, and criminal justice to access accurate treatment information. Crisis line staff are trained in providing a culturally responsive interaction and appropriate interpretation is provided. Addiction benefit coordinators stationed throughout the community provide client-centered care coordination services ranging from referral to side-by-side engagement to warm handoffs to providers.

E.1.d. In collaboration with local providers and CMHPs, ensure that adequate workforce, Provider capacity, and recovery support services exist in Applicant’s Service Area for individuals and families in need of opioid use disorder treatment and recovery services. This includes: sufficient up to date training of contracted Providers on the PDMP, prescribing guidelines, buprenorphine waiver eligibility, overdose reversal, and accurate data reporting on utilization and capacity.

Ensuring access to care for members with OUD – Health Share’s integrated delivery systems work closely with CMHPs and local providers to provide a culturally responsive and linguistically appropriate workforce, provider capacity, and recovery support services across the tri-county region. These partnerships include the Local Alcohol and Drug Planning Committee (LADPC), the Tri-County Behavioral Health Providers Association (TCBHPA), the MetroPlus Association of Addiction Peer Professionals (MAAPS), Tri-County Opioid Safety Coordinating Committee, and educational institutions to identify needs for workforce and recovery support services.

Supporting provider capacity and training: One of Health Share’s primary community collaborations to address both expansion of the MAT workforce and capacity, as well as providing technical support and training for MAT providers, is the Wheelhouse Model. The Wheelhouse Model is a hub and spoke initiative for spreading MAT capacity throughout the community. The Wheelhouse Model began with a focus on increasing MAT services available through specialty behavioral health providers and supports the MAT workforce through:

- Increased collaboration among existing providers
- Onboarding of new MAT providers, including training regarding MAT prescribing guidelines and technical assistance for buprenorphine waiver eligibility
- Expanded MAT access across the tri-county area
- Reduced barriers to access by providing same-day/next-day appointments
- Offering MAT services in detox and ambulatory settings

As a result of the efforts implemented under the Wheelhouse Model, Health Share has played a role in decreasing stigma and increasing acceptance of MAT as an evidence-based tool to support recovery. Since 2017, we have observed a 67% increase in the number of providers trained to support MAT services.
**Investing to provide MAT in primary care settings:** Health Share is investing $1 million in 2019 to expand access to MAT in primary care settings through bi-monthly learning collaboratives for primary care clinic teams, establishing community standards for patient stratification and escalation, and building a support network for newly DATA waived prescribers.

**Tri-County Opioid Safety Coalition:** The Tri-County Opioid Safety Coalition, in which Health Share, CMHPs, and local providers participate, has a clear mission to decrease opioid misuse and harms by coordinating the efforts of the public health, medical, payer, and patient communities. Goals of the group include supporting statewide efforts to implement safer prescribing practices including promotion of the PDMP use guidelines as a provider community standard, as well as improving access to timely treatment including MAT and social support. A result of these efforts along with Health Share's participation in OHA's statewide Performance Improvement Project, we have seen a 45% reduction in opioid prescriptions per Health Share member from 2016 to 2018.

**Ongoing provider training efforts:** Health Share worked with our provider network in the summer of 2018 to conduct an organizational self-assessment of readiness to implement recognized best practices including PDMP use, Naloxone co-prescribing, and overdose prevention. This self-assessment guided Health Share’s technical assistance and training plan to assist providers with the adoption of evidence-based, culturally responsive best practices. Health Share additionally convened the full spectrum of substance use stakeholders in our community to co-develop our SUD Best Practice Guidelines. Health Share maintains these guidelines on our website and is building requirements regarding evidence-based MAT into substance use provider contracts. Additionally, training on a variety of topics relevant to opioid use and OUD providers is available to providers via website, informational packets, and group or individual settings. Topics include training on how to use the PDMP, chronic and acute opioid prescribing guidelines, naloxone co-prescribing and opportunities for DATA waiver training.

**Data reporting on utilization and capacity:** As referenced in Section D2, Health Share requires contracted providers to report on intake availability which provides data on capacity and access. Additionally, Health Share has created a MAT Dashboard within our Bridge analytics platform that identifies individuals with an OUD diagnosis and their treatment engagement as well as Naloxone prescriptions for overdose reversal.

**E. i.e. Coordinate with Providers to have as many eligible Providers as possible be DATA Waived so they can prescribe MAT drugs.**

Supporting workforce ability to prescribe MAT – Health Share supports the development of an expanded MAT provider network throughout the region. In 2018, we focused on a collaborative learning program for specialty behavioral health providers, and in 2019 a similar collaborative learning program is scheduled for primary care providers. The goals of these collaborative training programs are to increase the number of DATA waived prescribers and to increase the number of members each prescriber is managing. The specialty behavioral health prescriber program has demonstrated success with the number of Health Share members receiving a MAT prescription from a prescriber participating in this program, increasing more than four-fold from 26 in 2017 to 110 in 2018. The number of MAT prescribers has increased by 67% from 170 to 284 from 2017 to 2018. The increase in MAT prescribing capacity has
been possible through a combination of training, technical support, prescriber peer support and operational support. In addition to learning collaboratives, technical support is offered to assist practices with developing and implementing policies and procedures, workflows, and referral pathways between primary care and substance use treatment providers.

**E.1.f. Coordinate care with local Hospitals, Emergency Departments, law enforcement, EMS, DCOs, certified Peers, housing coordinators, and other local partners to facilitate continuum of care (prevention, treatment, recovery) for individuals and families struggling with opioid use disorder in their Community.**

Care coordination support for members with OUD – Care coordinators throughout the system (physical, behavioral, and oral health) provide care coordination support to providers and members, including helping members understand treatment options, facilitating transitions between levels of care, and assisting with housing placement for members and their families struggling with OUD. Our care coordinators support care coordination across multiple care settings including hospitals and EDs as well as within the community. Addiction benefit coordinators work closely with jail discharge planners to coordinate transitions from jail to treatment and with Tri-County 911 (TC911) for high utilizers of EMS services and are stationed in several local hospital EDs to provide consultation and care coordination. Health Share also works with county public health departments, Tri-County Health Officer, local providers, hospital systems, the recovery community, and other stakeholders to generally address OUDs and substance use.

**Collaboration with corrections, juvenile services, law enforcement, and sobering centers:**

Health Share and our partners strategically assign care coordinators to systems such as community corrections, juvenile services, law enforcement, and sobering centers to both provide linkages across systems and to connect with members who initially present in those systems. For example, in Washington County, a SUD care coordinator spends much of their time physically located at the community corrections department where they work with parole and probation officers to identify individuals who would benefit from additional care coordination. Additionally, care coordinators collaborate with housing coordinators and partner housing organizations such as Central City Concern to identify supportive or other housing settings for members in need of stable housing to support recovery. We also provide access to services through certified peers and work to coordinate these services within the member’s continuum of care. We also have collaborated with DCOs and the State of Oregon to develop and implement acute prescribing guidelines across our dental network. To reduce new cases of OUD, particular attention is currently being focused on reducing opioid prescriptions in dental settings for adolescents.

**Coordination with hospitals and EDs:** Health Share also provides access and technical support to providers in utilizing PreManage, which enables providers and hospitals/EDs to effectively coordinate care related to recent inpatient and ED admissions. Health Share convenes regular provider collaboratives to provide standards of care guidance, develop best practices, and identify opportunities for providers to facilitate transitions of care across the continuum. Any member can be referred to SUD-specific care coordination services if necessary. Effective, person-centered care coordination includes the creation and strengthening of partnerships with community partners and providers, assuring that the member’s voice is at the center of the plan, and the use of EMRs and other technology (including but not limited to PreManage and Bridge).

**E.1.g. Additional efforts to address opioid use disorder and dependency shall also include:**

- **Implementation of comprehensive treatment and prevention strategies**

Additional programs focused on OUD – Health Share has implemented chronic opioid prescribing guidelines, acute prescribing guidelines, and tapering plans as well as encouraged non-pharmacological pain care as a prevention strategy. Education and training is available for providers, including individualized feedback about opioid prescribing patterns. Comprehensive treatment (including the full range of ASAM services) is available throughout the tri-county service.
area, including providers who specialize in culturally specific and underserved communities. Health Share's Practice Guidelines’ Values and Principles include: individuals are to be served in the most normative, least restrictive, least intrusive, most cost-effective level of care appropriate to their diagnosis and current symptoms, degree of impairment, level of functioning, treatment history, individual voice and choice, and extent of family and community supports.

**Partnering with public health departments** – In addition, Health Share partners closely with public health departments to implement opioid use prevention, education and awareness strategies. Much of this work centers on overdose death prevention, and Health Share’s community partners have been instrumental in distributing Naloxone kits within the community to ensure the resource is available wherever our members may present. We have engaged in significant educational campaigns with community partners that work with our members who are at high risk of opioid use. This includes community corrections, law enforcement, and crisis centers. By educating probation officers, law enforcement, and crisis staff, we are better able to identify members with treatment needs and connect them to services. Another strategy is to place peer recovery mentors in locations where individuals at risk of opioid use are often present, such as housing programs, jails, and juvenile services. These peer recovery mentors support members in accessing treatment services.

**E.1.g. Care coordination and transitions between levels of care, especially from high levels of care such as hospitalization, withdrawal management and residential**

Care coordination and transitions for members with OUD – For members with OUD who are transitioning out of higher levels of care (hospitals, detox, and/or residential), care coordinators support transitions to a range of needed services—including intensive outpatient, ongoing MAT, outpatient with supportive housing, peer services, primary care, and any other specialties (i.e., OB/GYN, etc.)—all of which can be provided in a culturally and linguistically appropriate setting. Three of the largest acute care organizations in the Health Share network have already or are in the process of implementing programs for patients who have been hospitalized and require treatment for OUD. Hospitalized patients with OUD are able to begin treatment with MAT while admitted to the hospital and have pathways for seamless transitions to the appropriate level of OUD treatment once they are discharged from the hospital.

**Project Nurture:** Through Project Nurture, Health Share has also established payment models in women’s health that support integration of obstetrics care with SUD treatment. These payment models include integration of behavioral health services, services to address social complexities, and the utilization of peer support specialists, doulas, and other THWs, as well as, complex case management.

**E.1.g. Adherence to Treatment Plans**

Treatment plans – Health Share monitors engagement and adherence to evidence-based treatment through consistent, client-centered care coordination efforts, including a strong commitment to the inclusion of certified recovery mentors and other peers, and the use of a variety of tools including person-centered planning and motivational interviewing. One example is the use of medication possession ratio (MPR) data. MPR is the ratio of the number of days for which a member has medication on hand divided by the total days in the measurement period and is a widely accepted metric for treatment adherence for patients participating in MAT. Health Share has begun providing MPR reports to providers that segment patient populations by adherence and risk levels, enabling providers to proactively manage assigned members with OUD through a population health lens.

**E.1.g. Increase rates of identification, initiation and engagement**

Identifying OUD and engaging members – By increasing the number of DATA waived providers who have the training to identify OUD along with the ability to treat appropriately, rates of OUD identification will increase, along with increased rates of initiation and engagement in MAT. Data analysis of all Health Share members with OUD showed that 28% receive no treatment at all and only
58% get at least one prescription for MAT. Of those who receive MAT, only about half are highly engaged in MAT (defined as medication possession at least 75% of the time for a minimum of 30 days). Health Share’s target is for at least 70% of all members with OUD to receive MAT, with the ultimate goal for members to be highly engaged in MAT therapy whenever possible.

**E.1g. Reduction in overdoses and overdose related deaths**

Health Share is actively promoting the harm-reduction philosophy of treating OUD. This approach is strongly encouraged with all MAT providers as well as providers prescribing chronic opioid therapy. Additionally, naloxone is routinely covered without any restrictions and is available through the public health system, and at some key high-risk facilities in the community, such as the network’s largest inpatient withdrawal management facility. A promising practice in Clackamas County is the Project Hope Team—a collaboration with Community Paramedics and Fire along with a peer recovery mentor who follows up with individuals who have had an overdose and received naloxone by a first responder.

**E.1g. Fewer readmissions to the same or higher level of care**

Reduction in readmissions – Health Share is focused on increasing MAT engagement across all settings and has developed unique metrics to monitor member engagement in MAT. Health Share has seen initial promising correlations between high MAT member engagement and lower inpatient utilization, including readmissions to higher levels of care. Members with OUD who receive evidence-based MAT and care coordination to connect them with ongoing care are more likely to achieve desired recovery outcomes. Health Share works to prevent unnecessary readmissions through the initiation of MAT in inpatient settings, subacute withdrawal management, and residential treatment. Active engagement with addiction benefit coordinators and provider-level care coordination within EDs assists members to access the least restrictive and most appropriate care available. Current efforts to increase the number of primary care providers that can continue treatment in the community will improve warm handoffs and prevent interruptions in care. Health Share is committed to supporting the expansion of recovery-focused supportive housing as it is an essential factor for stability and long-term recovery.

**E.2. Prioritize Access for Pregnant Women and Children Ages Birth through Five Years (recommended page limit 6 pages)**

Prioritizing access to behavioral health services for pregnant women and children 0-5 – Early life health has been a top priority for Health Share since it became a CCO in 2012. Since then, our approach to ensure the next generation of Oregonians is healthy and productive has only grown in sophistication. In the beginning, like most CCOs, Health Share zeroed in on a specific population of OHP members known as “high utilizers”—those who developed poor health outcomes as adults, requiring multiple medical interventions. But Health Share wanted to know what caused these members to develop poor health outcomes to begin with. Through a project called the Life Study, Health Share learned what many had suspected: people are better served by changing the question from “what’s wrong with you?” to discovering “what has happened to you?” This shift was a critical step in acknowledging and addressing the early-life trauma, adverse childhood experiences (ACEs), and SDOH that form a pathway to poor health for many OHP members.

Ready + Resilient – Health Share used its learning from the Life Study (and its various programs over the past six years) to develop its current strategic investment plan, R+R, a long-term roadmap to support the well-being of children, families, and communities through prevention support
for recovery, and focused investment in health equity. When it comes to early life health, Health Share's goal is that children are ready for kindergarten, and families are connected to the health and social resources they need to thrive. By investing in early life health and social resources, we prevent bigger issues down the road. We also know that every child's needs are different, and many children are falling through the cracks of the current, fragmented system.

Innovative Initiatives focused on Early Life Health and SDOH – To address these issues, Health Share is building on multiple Early Life Health initiatives, including promoting effective contraception use, promoting screening of pregnant women for behavioral health and social resource needs, and partnering with Early Learning Hubs, community organizations and families to promote kindergarten readiness, improving services for foster children, and developing an infrastructure for supporting families through a national model called Help Me Grow.

E.2.a. How will Applicant ensure that periodic social-emotional screening for all children birth through five years is conducted in the primary care setting? What will take place if the screening reveals concerns?

Supporting developmental and social-emotional screening for children birth to 5 years – Health Share’s primary care providers proactively screen children using evidence-based screening tools, including the Ages and Stages Questionnaire (ASQ-3) to support the “Developmental Screening in the First 36 Months of Life” metric. The Modified Checklist for Autism in Toddlers (M-CHAT) is used to screen for autism. In addition to these standard developmental screening tools, Health Share will work with its primary care provider network to develop and implement standardized processes to routinely perform social-emotional screening for all children under 5 years of age. Providers will be encouraged to adopt evidence-based screening tools such as the ASQ-3, Social and Emotional (ASQ-SE), or the Pediatric Symptom Checklist. Providers conduct outreach to ensure all children receive developmental screening. When the screening identifies developmental and behavioral delays, the child and family receive follow up from the treating provider. Follow up includes referral to and coordination of resources, to ensure that at-risk young children get connected to services as early as possible so they can be ready for kindergarten.

Connecting children to early intervention/early childhood services – While developmental screening is important, we know that what happens after screening is even more critical. When providers identify developmental concerns, one common primary care referral is to early intervention/early childhood special education. Unfortunately, many children do not qualify for services, and families are left without developmental supports. This led Health Share to invest in one of the many building blocks that make up our Start Strong early life health strategy: Help Me Grow.

Help Me Grow is a national model that creates a system of collaboration across early childhood and health sectors to ensure that children at risk for developmental delays receive the services they need. Help Me Grow connects children and families to a wide array of services including family supports, home visiting programs, parenting classes and other behavioral health supports to address toxic stress and SDOH. Help Me Grow is housed at Swindells Resource Center of Providence Health and Services, and implemented in partnership with the Early Learning Hubs of Clackamas, Multnomah, and Washington Counties, and the OHA Maternal Infant Early Childhood Home Visiting Program.
The regional Help Me Grow system:

- Provides information, support and outreach to families, community organizations, and health care providers
- Manages a centralized phone line connecting families and clinicians to culturally relevant clinical, educational and community resources
- Tracks referrals and closes feedback loops with primary care referrals
- Provides ongoing data collection and analysis to help identify gaps in resources and barriers to care

In addition to funding Help Me Grow at Swindells, Health Share funds liaisons in each county who act as developmental specialists, compiling and building upon existing resources to maintain a regional early childhood database, and providing promotional activities in the community. Health Share provides education and training of best practices tools and resources for community-based maternal child health focused partners to support referrals and coordination of need.

Ready + Resilient early childhood efforts — In 2018, as part of Health Share’s R+R early childhood portfolio, we surveyed 16 primary care practices representing over 50 clinics about their current practices and ambitions related to childhood screenings. Almost 60% of respondents currently screen for social and emotional well-being; over 20% of clinics that do not currently screen expressed interest in developing capacity in this area. We believe this is representative of providers more broadly and of the emerging recognition that social and emotional well-being play a significant role in child health outcomes.

An exciting example of our efforts to ensure that social-emotional screening for all children—birth through five years—is conducted in the primary care setting, is the Multnomah County Health Department pilot creating a Maternal Child Medical Home (MCMH) program that integrates Maternal Child Health Community Health Nurses and CHWs into Patient-Centered Medical Home Teams at the East County Health Center. The MCMH focuses on Latino families through a) engaging Latina prenatal members at the East County Health Center; b) working with members and the community to develop the service model; and c) developing the workforce to provide trauma-informed, culturally responsive coordinated care. MCMH care coordination includes prenatal, developmental, and adverse ACEs screenings; and a menu of clinical, group, home visiting, and behavioral health services. When screenings identify concerns, services are customized to meet child and family needs, improve health outcomes, and optimize family and community health and resiliency.

E.2.b. What screening tool(s) to assess for adverse childhood experiences (ACES) and trauma will be used? How will Applicant assess for resiliency? How will Applicant evaluate the use of these screenings and their application to developing service and support plans?

Screening for ACES and trauma — Health Share places a high value on screening for factors that may negatively affect the growth, development, health, and social and educational outcomes for infants and children. Health Share supports offering evidence-based screening for adverse childhood events to pregnant women and to parents/guardians of children ages 0-5. Health Share also acknowledges that screening for ACEs without appropriate referral pathways, resources, and supports for providers and families could be unhelpful. As such, Health Share works closely with primary care and behavioral health providers who routinely care for these members and develop standardized workflows that include screening for ACEs, trauma, and resilience as well as identification of referral resources and supports. When clinically indicated, additional tools for screening children include The Whole Child Assessment (WCA) or the Survey of the Well-Being of the Young Child. The results of these screening tools are documented in the patient’s health record. Additionally, resilience is reviewed based upon scoring of the above-mentioned screening tools and use of the Family Assessment Form (FAF), which is a research-validated tool. The FAF covers five protective factors, including parental...
resilience, social connections, concrete support in times of need, knowledge of parenting and child development, and social and emotional competence of children.

**Self-assessment of needs (SAN) pilot in Multnomah County** – Multnomah County Health Department’s Maternal Child Medical Home Program is piloting a self-assessment of needs (SAN) tool. The SAN tool was specifically designed around trauma-informed principles (counter to most dominant culture screening tools that can be re-traumatizing for members in the application of the tool). It was culturally adapted through a rigorous process that solicited feedback from diverse stakeholders. In practice, the SAN tool is used as a collaborative assessment between the member and community health worker (CHW). Most of the SANs are completed together with the member and the CHW who helps explain services with which the member may be unfamiliar.

**Partnering with OHA and the Oregon Pediatric Improvement Partnership** – In addition to offering routine screening at health care visits, Health Share will engage with OHA and the Oregon Pediatric Improvement Partnership to explore use of pediatric health complexity data that combines medical and social complexity to stratify children by level of risk. The social risk factors consider trauma and ACEs. Health Share has engaged with the community about this data and discussed the risks and benefits of using it at both the population and individual level. We see opportunity to identify geographic and clinic locations that have high social risk that may otherwise not be identified through claims or traditional sources of information. Health Share will work with providers and community organizations to interpret the data and consider what types of clinical and social service supports are needed for children and families with high health complexity, and how to best allocate limited resources across the region.

**E.2.c. How will Applicant support Providers in screening all (universal screening) pregnant women for Behavioral Health needs, at least once during pregnancy and post-partum?**

**Universal screening of pregnant women for behavioral health needs** – Health Share has been a leader in promoting the importance of maternal and early child health through innovative programming and screening for social needs. We will continue to support providers in following the American College of Obstetrics and Gynecology’s recommendation that all women are screened for mood and emotional well-being in the perinatal and postpartum periods. Health Share’s networks of primary care providers have access to technical assistance and support, which is provided by CareOregon and our IDS partners. By focusing specifically on maternal child health practice coaching, Health Share ensures that screenings related to mood and emotional well-being are completed when indicated and that corresponding follow up for behavioral health services occurs. One example of this effort is Health Share’s participation in the development of the Oregon Family Well-Being Assessment (FWBA). We provided leadership and resources toward the development and refinement of this comprehensive questionnaire, which was created in collaboration with the Oregon Perinatal Collaborative’s Subcommittee on Maternity Model of Care. The goals of the tool are to:

1. **Connect pregnant women with clinical and community resources** they need to address mental health concerns, SUDs, domestic violence, basic resource needs and other support services; and

2. **Understand the behavioral health resource needs of our clinics, clinical systems and communities** in order to make strategic investments in the integration of behavioral health services into maternity care.

The FWBA is currently used at all Providence maternity clinics; a modified version is used at all Women’s Healthcare Associates clinics. We continue to promote adoption of the tool. Health Share has convened and facilitated an implementation committee to support use and spread of the tool within multiple practices in our region. Another example is Multnomah County Health Department’s practice to assess all prenatal and postpartum members for depression. The Maternal Child Medical Home Program CHWs also observe members for indications of depression, and results are
documented in the member’s medical record.

Maternal child health collaboratives – CareOregon is hiring a maternal child health innovation specialist, modeled after the success of the primary care innovation specialist model, but focused on maternal child health in the primary care and OB clinical settings. This person will provide clinic-based one-on-one coaching and technical assistance. They will create Maternal Child Health Collaboratives specifically designed to facilitate, disseminate, and share best practices, workflows, and staffing models for improving screenings, referrals, and warm handoffs to behavioral health. These venues support action planning and accountability through quality improvement monitoring and data transparency that directly motivates and equips our primary care providers to increase their levels of medical home status.

Supporting screenings through HIT/HIE – Health Share’s integrated delivery systems incorporate data sharing with providers who serve pregnant women, including data fields from screening tools to capture behavioral health and SDOH. This includes support and expansion of HIE tools where appropriate, including optimizing Care Everywhere and EMR tools, as well as PreManage for timely support and care coordination for pregnancy complications and/or outcomes. Health Share providers use evidence-based screening tools appropriate for their populations, including consideration of cultural and linguistic needs.

E.2.d. How will Applicant ensure that clinical staff providing post-partum care is prepared to refer patients to appropriate Behavioral Health resources when indicated and that systems are in place to ensure follow-up for diagnosis and treatment?

Ensuring appropriate referrals to behavioral health resources for post-partum mothers – Health Share’s IDS partners integrate behavioral health into primary care and OB clinical settings. This integration will include value-based payment (VBP) models that incentivize postpartum care screenings, follow-up/interventions, resources for postpartum support, and timely access to behavioral health services. Health Share has met improvement targets for the CCO incentive measure around timely prenatal care for the last 5 years, even as the target has gone above 90%. While this measure looks only at a sample of women experiencing pregnancy throughout the measurement year, it is representative of the engagement our clinical system has with the 3,000 to 4,000 pregnant women we have served each year. This includes screening and preventive care services through primary care clinics as well as with obstetricians and gynecologists, and ensures that even those members who do not enroll in the CCO until later in their pregnancy are monitored and supported prior to delivery.

Targeting interventions – In doing annual chart reviews to look for evidence of prenatal care, our partners confirm that many pregnant women are also engaged in SUD treatment, are experiencing mental health conditions, or have difficulty accessing preventive care due to a lack of transportation or childcare supports. This metric has driven our system to expand timely outreach to women as soon as we (and they) know they are pregnant, improving our performance from 60% to over 90% over time and embedding best practices into the workflows of women’s health and primary care clinics throughout the region. To support this work, Health Share has built a pregnancy dashboard that gives early indication of pregnancy and expected date of delivery from enrollment and claims data. This allows partners to reach out to women and support them through their third trimester and even help schedule timely postpartum follow-up care. When providers identify behavioral health needs, they engage members in care coordination. Care coordinators create individualized care plans that outline issues, goals, and interventions. Interventions include, but are not limited to, telephonic support, consultation, and referral as well as in-person assessment and behavioral health system navigation.

Aligning social risk and behavioral health screenings – Even though this measure is no longer being incentivized starting in 2019, we will still gather data around this embedded best practice. The work our partners have done to achieve such notable improvement has laid a foundation for an aligned
strategy around social risk and behavioral health screening, regardless of where a woman may have her first contact with our clinical system during pregnancy. The current shift in focus toward postpartum care opens opportunities to more routinely screen for and support the social and behavioral needs of new mothers that most directly impact the well-being of their child. This includes screening for postpartum depression and a return to tobacco or substance use after a chosen abstinence during pregnancy.

Doulas and supporting maternal behavioral health – Another important connection between maternity and behavioral health systems is the inclusion of THWs. Doulas are an integral and effective workforce in providing culturally specific and supportive services to pregnant and newly parenting women. Doulas provide care coordination, outreach and direct services, coaching and social support, cultural mediation, education, and referral to behavioral health treatment when needed. To that end, Health Share is investing in the doula workforce to increase knowledge about how to create sustainable solo or collaborative doula practices in the tri-county region. Additionally, this investment will increase the number of registered doulas of color on the state THW registry, which enables Medicaid billing and reimbursement for doula services.

E.2.e. How will evidence-based Dyadic Treatment and treatment allowing children to remain living with their primary parent or guardian be defined and made available to families who need these treatments?

Access to dyadic treatment services – Health Share has an existing network of behavioral health outpatient and day treatment providers that are available to children and families. Our goal is to provide services in the least restrictive environment possible for children in need of medically necessary treatment. One such treatment is dyadic developmental psychotherapy—an evidence-based, empirically validated and effective family therapy treatment for children with reactive attachment disorder and complex trauma. When needed or requested, families receive care coordination and assistance with connecting to the provider or resource best suited to meet member needs, including referrals to dyadic treatment. Health Share provides access to this treatment modality by contracting with many specialty behavioral health providers that focus on serving our youngest members. In addition, Health Share has invested in developing programs that support keeping families together. One high-risk population for family separation is pregnant women with SUDs. To support this population, we developed Project Nurture, an integrated maternity care and substance use treatment program. Our evaluation of the program found that 93% of Project Nurture participants had long-term custody of their infant at program exit versus being placed into temporary custody through Child Welfare. This outcome is significantly higher than other published rates and was a key successful outcome of a program that was recently incorporated into the governor’s proposed budget for statewide spread.

E.2.f. How will Applicant ensure that Providers conduct in-home Assessments for adequacy of Family Supports, and offer supportive services (for example, housing adequacy, nutrition and food, diaper needs, transportation needs, safety needs and home visiting)?

Conducting in-home assessments and connecting members to supportive services – Health Share implements multiple programs that involve providers conducting in-home assessments for the adequacy of family supports and that aim to connect members with supportive services that address health needs as well as the SDOH such as housing supports, access to healthy food, baby care items, transportation, and safety. These programs are described in the sections below.

In-home assessment of family support needs: Addressing our members’ most pressing basic needs such as food, transportation, and housing is a critical component of our regional strategy. As part of our commitment to providing high quality, patient-centered care, we have developed processes to identify and address SDOH—such as food insecurity, inadequate housing, and financial hardship—that affect members’ health and leverage the EHR to stratify data at both the member and population level. This assessment of need is conducted in the member’s home. For example, at Health Share’s
IDS Kaiser Permanente, patient navigators are embedded within primary care and EDs to identify the SDOH needs using a Kaiser Permanente screening tool called Your Current Life Situation (YCLS). Responses to the YCLS are translated into ICD-10 social diagnostic codes (Z-codes) and entered into the EHR. Care navigators use this information to help find and, when possible, provide resources to meet members’ SDOH needs by connecting members with specific service providers such as housing supports. Additionally, at Health Share’s partner Providence Health & Services, all maternity clinics use the Oregon Family Well-Being Assessment that identifies social needs.

**In-home behavioral health services:** Health Share encourages and incentivizes providers to conduct in-home assessments and services on a full range of psychosocial needs of children and families. Assessments include understanding the social determinants that are impacting health, safety, and well-being and assessing the supportive services each family needs including food, housing, clothing, transportation, and other needs for daily living. Health Share care coordinators work in collaboration with members and providers to address needs and reduce barriers to treatment access. Health Share also provides education to providers and members regarding the availability of health-related services such as individual flexible services funding, which is used to address barriers created by unmet social needs. Health Share’s integrated care network administered by CareOregon will incentivize behavioral health providers to deliver in-home services to members when indicated.

**Home visiting program supports:** Health Share supports a home visiting program for our members. Home visiting staff use various evidence-based models and culturally-specific approaches depending on program and client needs to conduct an in-home assessment process to address local health and socioeconomic disparities faced by mothers, children, and families. Home visiting screening tools include the Home Violence Screening Questionnaire; PHQ-9 (depression); SCRIPT, which incorporates the 5-As (smoking); ASQ and ASQ-SE (developmental screening), Nursing Prenatal Assessment form, Nursing Postpartum Assessment form, Client Strengths and Goals form, Social Needs Questionnaire, Health and Health-related Behaviors Questionnaire, and Medical Screening Reference Tables. Collectively, these tools assess the following categories and risk/protective factors:

- Environment, including housing and living situation, gun safety, phone, smoke alarm, exposure to lead, pets in the home, and car safety needs
- Basic needs, including health insurance and medical home status, social service/community resource needs, transportation, and support/involvement from other agencies
- Psychosocial, including mental health, depression/anxiety, suicidal ideation/attempts, feelings about pregnancy, family relationships/support, father-of-baby involvement, self-assessed stress and toxic stress, family violence, cultural considerations, history of sexual abuse, and body image/self-esteem
- Physiological, including general health, family health history, pre-existing conditions, prior birth outcomes, obstetric history and experience, immunizations, physical illness, dental health, special needs, and medications
- Health-related behaviors, including nutrition, pre-pregnancy weight, vitamins/folic acid, substance use, tobacco exposure (active/passive), STD/HIV risk assessment, last grade completed, literacy/learning preference, communications/special needs, breastfeeding plans, and newborn care

**Long-standing county partnerships:** Health Share’s long-standing collaborative relationship with our county public health entities enhances the continuum of care and support for pregnant women and young families. For example, Health Share supports the county partner operated **Nurse Family Partnership for first time mothers, a best practice in post-partum care and support.** These mothers are seen throughout pregnancy and for the first two years of their child’s life, with care often provided in the home. Physical and behavioral health care for child and mother are high priorities, as are connection to resources in the community for other needs such as schooling, work, food, clothing,
and housing. Education is a large component of this program with time spent on health care education, teaching families to advocate for themselves, learning to manage their own complex health needs, and availability of care coordination through Health Share.

*Tri-county public health and early learning hubs:* Additionally, the Tri-County Public Health and Early Learning Hubs are collaborating for a robust and integrated referral system for families needing support and services. Through a coordinated referral system, providers have one location to share with families where they can find the services that best match their needs. This referral system links families to both county-led programs and other community-based programs. In-home assessments are part of the work of multiple nursing programs such as the Nurse Family Partnership and *Cacoon* as well as peer support programs such as *Healthy Families* and *Other Mother*. These programs provide direct education on topics like nutrition, parenting, child development, oral health, vaccinations, and a myriad of issues important to family health and well-being.

**E.2g. Describe how Applicant will meet the additional Complex Care Management and evidence-based Behavioral Health intervention needs of children 0-5, and their caregivers, with indications of ACEs and high complexity.**

**Addressing care management and behavioral health needs of children 0-5 and their families**

Health Share has a deep understanding of the impact of ACES and the support needed for our youngest members. Staff and providers have received training about ACES to understand the implications for our members. As a result, Health Share will focus on developing internal resources to provide support for providers delivering specialty case management. Health Share has moved to contracts with pediatric and family practice providers via alternative payment methodologies to include case management and behavioral health supports for pediatric patients identified as complex or at-risk.

**Project Nurture:** Our program supporting pregnant women who currently have a SUD. Health Share has also established payment models in women’s health that support the integration of maternity care with SUD treatment. These payment models include the integration of behavioral health services to address social complexities, and the use of peer support specialists, doulas and other THWs.

**R+R strategic investment portfolio:** Health Share has a significant focus on supporting children with complex needs, including those who benefit from behavioral health interventions. We think broadly about populations of children with higher levels of ACE exposure and behavioral needs both at the clinical and community level. In addition to *Project Nurture*, we have developed Foster Care Medical Homes, which are designed to provide complex care management and evidence-based behavioral health interventions for children in foster care. We are expanding this model to support other high-risk pediatric populations with complex behavioral and social support needs (e.g. intellectual and developmental disabilities, juvenile justice, immigrant, and refugee populations). Over the last year, we have worked with District 2 DHS to develop an enhanced assessment for children entering foster care in Multnomah County. The assessment measures ACEs and makes recommendations across multiple life and health domains for caregiving, services and treatment. One outcome of this assessment is improving the identification of the most appropriate behavioral health interventions and referral to services as quickly as possible. When providers identify behavioral health risk through routine screening, they can connect families with *Help Me Grow*, a model that creates a single point of entry to a menu of services and supports for members and families at risk for developmental or behavioral issues. This includes connections to home visiting programs, parenting education, relief nurseries, developmental support, culturally specific family supports, and behavioral health supports like Parent Child Psychotherapy and Parent Child Interaction Therapy. We recognize the important role that community organizations play to strengthen and support families and address social determinants. Through our *Regional Kindergarten Readiness Network*, we are increasing partnerships with community organizations and working with
stakeholders across sectors to build more aligned, trauma-informed systems so that navigating the systems themselves is not a re-traumatizing experience for families, and that care management supports are well coordinated and not duplicative.

**E.2.h. How will Applicant ensure children referred to the highest levels of care (day treatment, subacute or PRTS) are able to continue Dyadic Treatment with their parents or primary caregivers whenever possible?**

Continuing dyadic treatment – Health Share’s integrated community network, administered by CareOregon, will ensure that all children who are referred to the highest levels of mental health treatment are assigned a care coordinator (Wraparound or ICC). The care coordinator is responsible for coordinating care for the child and family while communicating with treatment providers and other key partners such as DHS. This process ensures that family members or primary caregivers are actively involved in the treatment process whenever possible. Family voice and choice is a key principle of this work. Care coordinators will work with family members or primary caregivers to problem solve around barriers to engagement in continued Dyadic Treatment, including identifying resources for transportation, such as using non-emergency medical transportation and arranging for childcare. Care coordination staff also have access to strategically deploy flexible funding to address barriers and ensure continuity of dyadic treatment.

**E.2.i. Describe Applicant’s annual training plan for Applicant’s staff and Providers that addresses ACEs, trauma-informed approaches and practices, tools and interventions that promote healing from trauma and the creation/support of resiliency for families.**

Staff and provider training on ACES and trauma-informed care – Health Share offers all staff a set of required and optional internal training opportunities throughout the year focused on equity, social determinants, and health disparities. We include a training on ACEs and trauma-informed care.

**CCO-wide commitment to advancing health equity and trauma-informed approaches** – Health Share has been a leader among CCOs in advancing health equity and trauma-informed approaches. We have hired an executive level Chief Equity & Engagement Officer who provides organization-wide oversight and leads, develops, supports and monitors all organization-wide activities related to health equity, serving as the single point of accountability. Additionally, Health Share's investment includes three dedicated FTEs with a focus on advancing health equity and community engagement, inclusive of developing, administering, and monitoring equity-related trainings, and the development and implementation of our organizational health equity plan and measurements. This team also offers equity-related technical assistance modules and trainings for health plans, delivery systems, and community partners. Below is a list of equity and trauma-informed-related trainings we have offered in the past.

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<tr>
<th>Foundations of Health Equity</th>
<th>Power and Privilege</th>
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<td>Transgender Competency 101</td>
<td>Transgender Competency 201</td>
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<tr>
<td>Poverty and Classism</td>
<td>Implicit Bias and Structural Racism</td>
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<td>Decolonizing Data</td>
<td>Microaggressions and Active Bystander</td>
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<td>Data and Disparities</td>
<td>Health Equity and SDOH</td>
</tr>
<tr>
<td>Trauma-Informed Care</td>
<td>Adverse Childhood Experiences</td>
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<tr>
<td>Disability Awareness</td>
<td>Mental Health Awareness</td>
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<td>Unnatural Causes video series</td>
<td>Immigrant and Refugee Experience</td>
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As part of our work supporting the Foster Care Medical Home model, Health Share provides funding to multiple organizations (Hillsboro Pediatrics, Legacy Randall Children’s, Metropolitan Pediatrics, and OHSU General Pediatrics) to specifically **provide a trauma-informed community education.** Examples include:

- Trauma-informed parenting coaching/workshops for caregivers
- Trauma-informed care training to all medical home staff and providers
- Foster care population health and children’s systems navigation for medical home staff
• Support for staff who may experience vicarious trauma

Through R+R, we plan to offer more trainings specific to trauma-informed care, ACEs, equity, SDOH, and health disparities as these have been identified as high interest topics among our provider community.

**E.3. Care Coordination (recommended page limit 12 pages)**

**E.3.a. Describe Applicant’s screening and stratification processes for Care Coordination, specifically:**

**E.3.a.(1) How will Applicant determine which enrollees receive Care Coordination services?**

Identifying members in need of care coordination services – Health Share uses a variety of methods to determine those members with behavioral health or SUD conditions who would benefit from more formalized care coordination. Members can be referred into care coordination through several avenues:

- **Health risk screening:** An initial health risk screening is sent to all adult members within 90 days of enrollment (30 days for members receiving LTC/LTSS). This screening asks key questions regarding health, social determinates, oral health, and mental health.

- **Analytics:** Through a combination of predictive analytics, risk stratification, clinical judgment, community input, and member choice, we can identify members in need of care coordination. Stratification is conducted to ensure that our members receive not only care coordination but also specific interventions tailored to their needs. For example, there is a cohort within the rising risk segment that is specific to members with comorbid behavioral health and medical issues and in need of care coordination.

- **Referral:** Members can self-refer to care coordination or be referred by a provider, community partner, family member or caregiver.

- **Automatic referral:** Members with identified special health care needs are automatically referred to care coordination and receive outreach via a letter that informs them of their right to care coordination, including information regarding how to reach the care coordination team.

Health Share proactively outreaches to members who have been identified as having behavioral health or SUD risk based on the sources above. These members are often not connected to their primary care provider and have been identified as needing specific behavioral health supports.

**E.3.a.(2) How will Applicant ensure that enrollees who need Care Coordination are able to access these services?**

Ensuring access to care coordination services – Health Share ensures access to care coordination by making the referral process easy, and by expanding awareness of the services and referral process. We also ensure we have adequate numbers of care coordinators to meet member needs. Additionally, we ensure access to care coordination by educating members in multiple ways about services available. Members are notified about care coordination services through the welcome packet they receive at enrollment and in the member handbook. Members with identified special health care needs receive special outreach via a letter that informs them of their right to care coordination and are given information regarding how to reach the care coordination team. Members, providers, or other individuals involved in a member’s care can access and request care coordination by calling one centralized customer service line. We proactively reach out to providers to explain care coordination services and the referral process. Providers are a key avenue for identifying members needing care coordination since they are required to screen members for adequacy of supports for the family in the home. When risk factors are identified, the provider refers the member to the care coordination team. Care coordinators are dedicated by clinic and providers can call customer service or the care coordination team directly to access their care coordinator.

**Care Coordination Needs Assessment** – Health Share conducts a needs assessment at the time of referral to ensure appropriate care coordinator assignment and prioritization. The Care Coordination Assessment (CCA) is a comprehensive review of potential needs. Based on the CCA, special emphasis
is placed on connecting a member with a compatible care coordinator. If a member’s primary presenting condition is either mental health or SUD related, a designated care coordinator will have commensurate experience. Health Share will ensure review of the potential need for long-term services and supports and make referrals if appropriate.

Provider screening for adequacy of family supports – Additionally, providers are a key avenue for identifying members needing care coordination since they are required to screen members for adequacy of supports for the family in the home (e.g., housing adequacy, nutrition/food, diaper needs, transportation needs, safety needs and home visiting). When risk factors are identified, the provider refers the member to the care coordination team. Care coordinators are dedicated by clinic and we encourage providers to call customer service or the care coordination team directly to access their care coordinator.

E.3.a.(3) How will Applicant identify enrollees who have had no utilization within the first six months of Enrollment, and what strategies will Applicant use to contact and assess these enrollees?

Reaching members with no utilization during their first six months of enrollment – The PCPCH is at the center of Health Share’s approach to member engagement and population management. Not all members will need regular engagement with the specialty behavioral health system, so screening in the primary care settings is key to identifying people who need additional behavioral health supports. Health Share Bridge, as well as the population management tools within each of Health Share's IDS and ICN partners, routinely generate lists of members who have not engaged in care and are appropriate for outreach and engagement. Health Share’s ICN, CareOregon, has also invested in a care coordination platform capable of conducting population segmentation analysis. Through this process, we identify members in a series of cohorts who appear to need additional support. Care coordinators proactively outreach via phone to these members and attempt to engage them in care coordination. Members with no engagement or utilization in their first 6 months of enrollment are identified through analytics and are included in this process for focused outreach. Our ICN CareOregon also conducts member outreach at local social service providers, such as homeless shelters and resource centers for members experiencing homelessness. Referrals to care coordination can be made by these teams and can identify members otherwise unconnected to care and not easily reached by phone or mail.

B. How does Applicant plan to complete initial screening and Assessment of Intensive Care Coordination (ICC) within the designated timeline? (May submit work flow chart if desirable).

Initial assessment of intensive care coordination (ICC) – Health Share mails an initial health risk screening (HRS) to all adult members at the time of enrollment. This screening asks key questions regarding health, social determinates of health, oral health needs, and mental health needs. If the member does not send back the HRS within 14 days, a second outreach attempt is made prompting the member to call customer service to complete the HRS via the telephone. Additionally, any time the member accesses care coordination services or call member services for other matters, staff are trained to take the opportunity to engage the member in the completion of a HRS if they have not done so already.

Members with special health care needs who may qualify for ICC receive outreach via a letter that informs them of their right to care coordination. They are given information regarding how to reach the care coordination team. When the member connects to the care coordination team, a care coordinator completes a care coordination assessment and generates a care plan. Additional outreach phone calls will be made to members with special health care needs to encourage engagement in care coordination.
E.3.c. **Please describe Applicant’s proposed process for developing, monitoring the implementation of and for updating Intensive Care Coordination plans.**

**ICC care planning process** – Health Share’s integrated delivery system care coordinators develop an individualized care plan that is used to actively manage the member’s care during the care coordination process. The assigned care coordinator develops the care plan that is based on: 1) Health risk screenings; 2) Health risk assessment; 3) Population segmentation and analysis; 4) Clinic needs assessment; and 5) Chart review. The care plan is developed in consultation with 1) The member and caregiver (as appropriate and if able); 2) the member’s PCP; 3) the member’s behavioral health provider; 4) other providers and community partners working with the member; and 5) any other individual involved in the member’s care as indicated by the member.

Care coordinators are responsible for monitoring members who may have identified ICC needs. They review monthly reports of these members and engage with multi-disciplinary teams. Health Share reviews and reassesses care plans on a semi-annual basis, at minimum, or more frequently as requested or indicated by a change in health status. Care plan information is shared among providers via EHRs or other mechanisms as supported by the applicable provider.
E.3.d. How does Applicant plan to provide cost-effective integrated Care Coordination (including all health and social support systems)?

Efficient and integrated care coordination – Health Share has provided cost-effective care coordination during its time as a CCO. To streamline access, in 2018, CareOregon created regional care teams, which are staffed with all health disciplines including nurses, behavioral health staff, pharmacists, oral health access coordinators, housing case managers, respiratory therapy, as well as operational staff such as health care coordinators and triage coordinators. This model has proven successful and will continue to be enhanced in 2020, when additional care coordination services for Health Share members is transitioned to CareOregon. Members are assigned to the appropriate level care coordinator based on their individual needs and different levels of intervention required. As such, we have both telephonic and community-based staff to address the needs of members.

As referrals come into the care coordination team, both proactively and reactively, the team triages the referral and delegates to the appropriate team members for the required level of care coordination. This creates greater efficiency and matches the member's need with the right discipline and the right level of intervention. For some members, needs can be managed over the phone by a care coordinator. For others, a nurse or behavioral health staff is needed to support the member (also by phone). This process allows us to reserve the community-based staff for those members with the highest need. It also allows us to manage more volume throughout the care coordination team as all staff are working together via a common care plan.

Health Share’s ICN CareOregon, which will be providing care coordination for Health Share members under Health Share 2.0, recently invested in a process of population analysis and segmentation. This is done with a combination of the John’s Hopkins’ Adjusted Clinical Group (ACG) score, as well as finding similarities in patterns of utilization that cluster members into cohorts. This process provides insight into how members are using the health care system and allows us to create precise workflows for each segment. Not all needs or referrals are created equal, and this process allows us to direct the care coordinator to work most efficiently based on the data presented via the segmentation model. For example, a member who appears uncoordinated in our model is likely not receiving primary care services consistently, so the care coordinator will know to establish this connection first. Or, if the member falls into our SPMI segment, the behavioral health coordinator will manage that referral and make sure the member is assessed for specialty mental health needs. By understanding our population better, we are able to work much more efficiently.

CareOregon has also implemented a robust care coordination platform that has dramatically increased efficiency. The platform has given us greater access to comprehensive and tested assessments, it works under strict workflows to improve efficiency and avoid errors, and it allows the care coordination team to work off a common care plan, dramatically reducing duplication of services or wasted time reassessing. The platform delivers a care plan to the provider portal so the provider is aware of what is happening for the member and we are able to deliver secure messages directly to the provider’s EMR (when authorized). For those providers who cannot receive secure messaging, we use the provider portal to communicate the care plan and we generate a care plan via PreManage for those members with acute needs.

E.3.e. What is Applicant’s policy for ensuring Applicant is operating in a way guided by person-centered, Culturally Responsive and trauma-informed principles?

Person-centered, culturally responsive, trauma-informed care and coordination – Health Share has adopted the principle of keeping the needs of the member first and foremost. Health Share and its partners train all care coordination staff in trauma-informed care, person-centered care, and cultural responsiveness. This training is provided at time of employment and readressed as needed. In addition, teams are trained regarding culturally responsive supports, language access, health disparities, and unconscious bias. The organization provides comprehensive behavioral health services that
include peer support specialists who can provide advocacy and voice for our members. This model ensures individuals receive member-centered, trauma-informed services focused on improving health by tailoring services to specific needs. The model includes internal and external referral workflows to trauma-informed behavioral health, substance abuse, enabling services, oral health, pharmacy, lab, etc., which results in warm-handoffs between behavioral health care and other services and empowers patients.

This philosophy is guided by and reinforced by individual personnel policies within Health Share and plan partners for providing culturally responsive, trauma-informed service delivery. For example, Washington County staff operate under three separate policies: Cultural Responsiveness, Trauma-informed Approach and language regarding adopting person-centered approaches in job descriptions. This is just one example of how this approach is reinforced among individuals supporting Health Share members.

Health Share is focused on trauma-informed screening, service delivery, and staff education/training/support. Trauma-informed care is applied universally to every individual through the adoption of a treatment mindset and therapeutic approach that asks, “What happened to you?” versus “What’s wrong with you?” We emphasize a focus on individual rights and choice to maximize autonomy and empowerment, as well as support from peers, evidence-based/promising practices, and collaboration between provider and individual. Staff education/training/support is centered on achieving this approach through reinforcing the promotion of a trauma-informed environment within all aspects of the organization.

Finally, Health Share places great emphasis on delivery of culturally responsive services. We maintain a network of culturally specific providers and regularly work on training staff and providers on implicit bias. Health Share and our partners strive to employ staff that reflect our community to ensure that the needs of all members are considered.

E.3.f. Does Applicant plan to delegate Care Coordination outside of Applicant’s organization? How does Applicant plan to enforce the Contract requirement if Care Coordination delegation is chosen?

Health Share does not delegate care coordination outside of the partner organizations that make up Health Share. In Health Share 2.0, our partner, CareOregon, will provide care coordination services for all Health Share members. Health Share has an outstanding record of delegation oversight. On our most recent external quality review, we received a perfect score of 4.00 and “fully met” with no findings in the category of Subcontracts and Delegation. Under “Overall Strengths”, the report states: “While [Health Share] delegates many of its required functions to numerous risk accepting entities (RAEs), it assumes ultimate accountability by conducting comprehensive audits of its subcontractors, as evidenced by oversight policies and audit reports provided. The communication and collaboration with their delegates is exceptional and [Health Share] should also be commended for its monitoring of contracted provider organizations.” We will continue to enforce all contract requirements through strict adherence to our delegation oversight responsibilities.

E.3.g. For Fully Dual Eligibles, describe any specific Care Coordination partnerships with your Affiliated Medicare Advantage plan for Behavioral Health issues.

Care coordination partnerships for dual eligibles – Health Share’s partners CareOregon and Providence have D-SNP Medicare Advantage plans, and Kaiser has a Medicare Advantage plan. Care coordination teams are fully trained in best practices for working with the dually eligible population including the behavioral health benefits provided to these members. The local community health providers are closely tied to the care coordination teams and participate in weekly interdisciplinary care team meetings as well as bi-monthly case conferences to consult about complex member issues. All Medicare members also have after-hours nurse advice line access. This information is shared with the care coordination teams so they can follow up on non-urgent issues or those that resulted in an ED visit.
Dually eligible members have the same access to ICC as all other members. Members with behavioral health conditions are identified in several ways. The health risk assessment (HRA), which is sent to all dually eligible members has questions to indicate behavioral health needs. When needs are identified, a care coordinator works with the member to address the behavioral health concern and connect them to the appropriate level of care. In addition, any time a member enters into care coordination an assessment is initiated, where a more detailed evaluation is conducted for behavioral health. Any positive indication of behavioral health needs triggers the creation of a care plan with issues, goals, and interventions. Interventions include but are not limited to telephonic support, consultation, and referral as well as in-person assessment and behavioral health system navigation. An example of coordination available for dually eligible members is our embedded care coordinators at the Psychiatric Emergency Services at Unity Center. We coordinate care between Unity, specialty behavioral health, and primary care for discharge planning and follow up care. To reduce duplicative efforts, these identified needs are shared with our Medicare Advantage plans serving dual eligible members as well as state case managers and LTC/LTSS providers.

**E.3.b. What is Applicant’s strategy for engaging specialized and ICC populations? What is Applicant’s plan for addressing engagement barriers with ICC populations?**

**Engaging specialized and ICC populations** – Health Share has implemented ICC teams within all three counties in the tri-county service area, with a focus on serving children and youth under the age of 17 with complex health needs and multi-system involvement. Health Share has expanded these efforts with the rollout of the Applied Behavioral Analysis (ABA) benefit, and enrolls all members receiving ABA treatment into ICC.

One successful strategy for engagement is targeted in-reach into pediatric clinics, explaining the role of ICC and how to refer members. In the new CCO contract period, Health Share will build on our existing successful strategies for ICC engagement to enroll additional member populations, such as members with SPMI who will receive ICC support to address housing needs. As ICC is offered to these additional member populations, Health Share will engage in outreach and education efforts to ensure that the community partners that support these members in the community are aware of ICC availability. Health Share also conducts member outreach at local social service providers, such as homeless shelters. Referrals to care coordination can be made by these teams and can identify members otherwise unconnected to care and not easily reached by phone or mail. Members with special health care needs receive special outreach via a letter that informs them of their right to care coordination. They are given information regarding how to reach the care coordination team. When the members connects to the care coordination team, a care coordination assessment is completed and a care plan generated. Health Share will ensure review of the potential need for long-term services and supports and identify appropriate members for referrals to long-term services and supports. Finally, we proactively outreach to members identified through data sources such as claims and the ED information exchange, as well as members identified by community partners that are not connected to care.

**Utilizing THWs and peer supports** – Another innovative strategy within our behavioral health system to engage specialized populations is the use of THWs and peer supports. For example, peers are available to all members regardless of whether or not they are engaged in any kind of formal treatment. Members can take advantage of this valuable service at any time, and even if a member chooses to leave treatment, they do not lose access to their peer. Health Share prioritizes the utilization of culturally and linguistically appropriate THWs inclusive of peers. Health Share’s THW Integration and Utilization Plan includes a THW Liaison position that will collaborate with our partners on advancing THW integration and member utilization of THWs within Health Share’s networks. This work will include enhancing member communications about the benefits and availability of THW services; advancing THW Commission best practices; measuring baseline utilization and performance
over time; and integrating THWs in clinic and community-based settings. These efforts help meet hard to reach members with multiple avenues into engagement and care coordination.

E.3.i. Please describe Applicant’s process of notifying a Member if they are discharged from Care Coordination/ICC services. Please include additional processes in place for Members who are being discharged due to lack of engagement.

**Ongoing care coordination support** – Whether a member engages in care coordination fully, sporadically, or care coordination is not an identified need, members will always have access to care coordination services when and if needed. This allows continuity of care for members and for the care coordinators to truly know a member, their history and current needs. The initial care plan that was created for the member will stay with the member record as long as they are a member of Health Share. This allows the care coordination team to pick up where they left off if/when the member comes back into care coordination. Ideally, members have been prepared for closure through direct communication from care coordinators and agreement that care coordination goals have been achieved. In this situation, our care coordinators notify the member upon closure from an episode of care coordination services either through a face-to-face meeting or a telephone conversation. If the closure is due to lack of engagement or response, the care coordinator makes multiple attempts to connect with the member via phone. If there is no response, we send a letter to the member indicating the closure from care coordination services, and we provide information on how to access the care coordination team if needed in the future. This is done judiciously depending on the need of the member and risk factors. Continued outreach may occur if significant risk factors are present. Regardless, members who have formally received ICC may be re-engaged for care coordination services if another need arises, at which time their health risk is reassessed, and the care plan is updated.

E.3.j. Describe Applicant’s plans to ensure continuity of care for Members while in different levels of care and/or episodes of care, including those outside of Applicant’s Service Area. How will Applicant coordinate with Providers across levels of care?

**Ongoing support for continuity of care** – Health Share members have access to and receive the necessary primary care, specialty care, mental health, SUD, and oral care services whether the member receives those services within or outside of Health Share’s service area. When Health Share members require services that are not available within Health Share’s service area, Health Share ensures that members receive all necessary services and that providers are compensated for those services. Health Share provides care coordination for children and youth who are receiving behavioral rehabilitation services, children, youth and adults receiving psychiatric residential treatment services, and youth and adults receiving alcohol and drug residential services regardless of location. Should the member choose to remain in the community in which they have been receiving treatment services, Health Share works with the Oregon Health Authority to transfer enrollment. Health Share care coordinators work closely with DHS, OYA, and other community partners throughout the time members are receiving care out of the service area. Health Share’s care coordinators are responsible for a care plan that remains with the member throughout their treatment episode, documenting all transitions and follow up. This allows for continuity as members may change providers, levels of care, or move out of the area and then return.

An example of how Health Share ensures continuity of care across levels of care both within and outside of the CCO service area, are our ITTs. This short-term intensive care coordination program, locally deployed in each county, supports members admitted to inpatient psychiatric care to connect with ongoing behavioral health services in the community after discharge. ITT engages members who are not already affiliated with a behavioral health provider, assesses member needs and preference, completes the initial plan of care, and provides consultation and coordination support to the hospital social workers as they make referrals for the member’s discharge plan. Following discharge from the hospital, ITT provides personalized outreach to the member to address barriers to care, including coordination with NEMT, use of flexible services to provide a phone or to address
other barriers to care, coordination with providers for bridge medications, referral to needed services and supports, assistance rescheduling appointments, and telephonic and in-person support to members. ITT uses PreManage to receive notifications of enrolled member admission to EDs.

**ITT maintains relationships with providers throughout the continuum of care** (outpatient, intensive outpatient, Assertive Community Treatment (ACT), Intensive Case Management (ICM), respite, Community Assessment and Treatment Center (CATC), etc.) to ensure clear referral pathways and successful transitions for members. ITT collaborates with the Addictions Benefit Coordination (ABC) team as appropriate to support members with dual diagnosis. ITT’s primary focus is on connection to behavioral health services; however, they also coordinate regularly with primary care and oral health providers, other care coordination teams, social service agencies, and natural supports to ensure successful transitions and to improve long-term engagement and outcomes for member.

**E.3.k. How will Applicant manage discharge planning, knowing that good discharge planning begins from the moment a Member enters services?**

Supporting smooth transitions of care — Health Share recognizes that transitions of care including discharges/transitions of any kind (particularly between treatment settings, treatment providers, etc.) can be stressful for the member and challenging for providers and support systems. Accordingly, we focus heavily on care coordination during these periods and view transitions as opportunities to: (a) strengthen care coordination relationships and (b) assure that the goals of the member remain at the center of the planning process. We recognize the importance of appropriate transitional care for both youth and adult members admitted for an episode of care and that effective discharge planning begins when care starts. Health Share’s expectation of all behavioral health providers is that treatment is individualized, has measurable goals identified in collaboration with the member or member representative, and clinical documentation reflects identified treatment goals, measures, progress in treatment and discharge planning.

Depending on the specific settings and services involved in the transition and the unique needs of the member, Health Share uses a number of tools, workgroups, member-specific care planning meetings, and care coordination staff across the integrated delivery systems. Multi-disciplinary team meetings, intensive care coordination conferences, and use of care coordination staff in the Choice, Wraparound, utilization management, and ICC programs, create close “real-time” communication between the member, their support system, community partners (Adults & Persons with Disabilities, schools, and community corrections) and care coordination staff at all of the involved organizations. Progress or lack of progress in treatment are both measures that affect discharge planning—whether for termination or transition to another treatment provider. Through the course of treatment, Care Coordination teams work with providers to identify members who have higher or lower care needs and help identify resources for next steps. We encourage the current provider to coordinate with the new provider, sharing information necessary to ensure continuity of care. Discharges and transitions of care are planned collaboratively with members, their support systems, and treatment teams to ensure patient safety, reduce readmission or relapse risk, and improve health outcomes.

**For members requiring higher levels of care, this transition is facilitated by Wraparound care coordinators, Choice care coordinators, ICC staff, or our ITTs** to ensure that the connection is made with a new provider and to ensure that the member’s perspective is honored in a culturally and clinically responsive manner. For youth and adult members being referred to Long Term Care, Oregon State Hospital, or residential treatment, Wraparound and Choice teams (respectively) are responsible for intensive care coordination services, starting at the time of the initial referral. Care coordinators from these programs partner with other health, social and community supports to explore every option to assure the least restrictive, most integrated setting possible that can safely and effectively meet the needs of the member.
We ensure methods exist to transfer a member from one provider to another in a culturally responsive manner, honoring member choice. This may include face-to-face meetings with the member prior to discharge or transition between providers and coordinating the transfer of responsibility for the ongoing care and continuing treatment and services. All care coordinators are trained in interpreter access and best practices for engaging members.

We assign care coordinators to members upon admission to:

- Psychiatric acute care settings
- OSH/SCIP/SAIP
- Subacute
- PRTS
- OYA facilities
- SRTF/RTF(H)
- Behavior Rehabilitation Services (BRS)

The intensive care coordinator works with the treatment team on transition and discharge planning and assists in the facilitation of discharge or transitions between levels of care. This includes:

- Contacts with the member in the month prior to discharge and within the week of discharge
- Warm Handoff for the member between any care coordinator and other relevant care providers during the transition of care and discharge planning
- Transition meeting and transition plan with description of how treatment and supports will continue including medication management services. The meeting is held 30 days prior to discharge or as soon as possible
- Post-transition meeting of the Interdisciplinary Team for those members requiring ongoing intensive care coordination, within 14 days, to ensure care is continued and gaps are addressed
- Contact with member post-discharge to ensure members maintain access to appropriate services

The care coordinator documents all activity in the member’s care plan, consults with other disciplines as needed, and provides appropriate documentation to the providers. When indicated care coordinators will also document care guidelines in PreManage.

### E.3.1. What steps will Applicant take to ensure Care Coordination involvement for ICC Members while they are in other systems (e.g., Hospital, subacute, criminal justice facility)?

**Ensuring care coordination involvement for ICC members while in other systems – Health Share ensures that ICC members have access to care coordination services while they are receiving care in other systems. We support continuity of care and work to coordinate transitions of care. Health Share assigns members to care coordinators upon admission to intensive facility-based services. Care coordinators work with the treatment team on transition planning and assist in the facilitation of discharge or transitions between levels of care. Whenever possible and appropriate, the care coordinator connects with the member and/or family in their current placement or level of care to begin facilitating the transition process. The care coordinator identifies needs and barriers for the member when transitioning to home or another facility, such as housing resources for members with unstable housing. The care coordinator stays involved in the member’s care to ensure a smooth transition and that members needs are met. We update post-transition member care plans as needed.**

**Justice-involved members** – Although OHP benefits are suspended when a member enters the criminal justice system, we have strong partnerships within this system across the tri-county region, including with the county community mental health programs, and have educated them on how to connect to the care coordination when the member is discharge from the criminal justice system.

**Members receiving DHS Medicaid-funded LTC services** – For members receiving DHS Medicaid-funded LTC services, consistent with OAR 410-141-3170, ICC coordinators support the flow of information between disability and aging agency partners, identify supports needed for any transitions, and when necessary provides increased levels of support and care coordination, such as arranging for an Intensive Care Coordination Conference (ICCC) with the member, providers, and
any agency that is involved in the member’s care to discuss the specific needs of the member. When a member receiving LTC services and supports requires a transition of care, care coordinators collaborate with APD to share information and identify needs to support the transition, including the appropriate setting for further care. When indicated, an interdisciplinary care coordination conference, with the providers and agencies involved in the member’s care, is arranged to develop a culturally and linguistically appropriate care plan to address needs, with additional follow up meetings as necessary.

Transitions among behavioral health treatment settings – Behavioral health programs such as Wraparound, ICC, ITT, Choice, and Utilization Management provide ICC for members transitioning to or from facility, residential treatment or state hospital care. For youth and adult members being referred to Oregon State Hospital or residential treatment, Wraparound and Choice teams (respectively) are responsible for ICC services, starting from the initial referral, partnering with other health, social and community supports and work throughout the treatment episode to explore options and divert the member to the least restrictive, most integrated setting possible that can safely and effectively meet the needs of the member. This includes partnering with the physical health plan, APD, Home Health, and any other providers who may be necessary to support the member in a successful transition to a less restrictive setting. An example of this coordination may include the coordinator connecting with providers, the member and the facility to ensure the member has an appointment scheduled with their outpatient provider(s) for an assessment within seven days of discharge from a hospital to ensure re-engagement; or to help an unassigned member engage with a transition team to assist in connecting to a new provider at the new level of care, and staying in contact with the member and providers to ensure the appointments occur.

E.3.m. Describe how Applicant will ensure ICC Care Coordinators will maintain the 15:1 caseload requirement.

The ICC Care Coordination Platform provides operational metrics to indicate caseload size and activity occurring with members identified for ICC. The ICC supervisors will diligently assess caseloads on a weekly basis and ensure that caseload size requirements are met. Health Share will adopt this requirement into policy and will hire additional care coordinators to meet this new ratio.

E.3.n. Which outcome measure tool for Care Coordination services will Applicant use? What other general ways will Applicant use to measure for Care Coordination?

Measuring and tracking outcomes of care coordination programs – Health Share currently uses several methods to monitor and evaluate our care coordination programs. These methods include gathering and analyzing data on caseload distribution, length of time a member is actively in care coordination, member conditions, and transitions of care. We generate reports to determine efficacy of the care coordination activities. We are committed to population health and works diligently to monitor the overall health of our population. Using data analytics to combine a variety of data sources, we are able to identify the geographic location of our members and their utilization of health care services. We can also identify health disparities that exist within our communities and those subpopulations that are disproportionately affected thus producing poor health outcomes. By using this valuable information, we can pull multiple levers to close health disparity gaps within specific subpopulations and geographic locations. One example is leveraging our community benefit dollars to support targeted populations with specific goals for reducing disparities. We also utilize our population segmentation model to identify outcomes and opportunities at both the population and the individual levels. This model uses cluster analysis combined with numerous data point to paint a picture of how members are utilizing the health care system. The clusters or segments produced indicate that a subset of the population is using the health care system in a specific and similar way. The model provides us with four main cohorts; healthy, low risk, rising risk, and high risk. It also provides us with 11 additional segments within the cohorts for a more granular view.

We utilize the segmentation information in many ways. First, care coordinators are trained to tailor their assessment of need based on the member’s segment. For example, if a member is extremely
complex, the care coordinator knows to ensure that a medication reconciliation has been completed and to identify any specialists working with the member and prioritize this coordination. We know for members who fall into this category are likely to have multiple and complicated medications as well as have multiple providers. We also use this model to understand the changes in our entire population. Each month we refresh the model and track the movement of members across segments. We analyze this movement to determine what created the shift and how we might learn from this change. We also update individual care plans of members who move up in their risk category (i.e. from rising risk to high risk). Finally, we overlay this information with location of our membership to identify “hot spots” of members to target specific community interventions or to foster more targeted relationships with our community-based organizations. Other metrics tracked include:

- Number of goals met during a care coordination episode
- Care coordinator productivity including answer rates for calls into care coordination teams
- Depending on the population, specific tools may be utilized to assess outcomes and progress.

For example, in our Wraparound programs, care coordinators complete the WFI-EZ and CANS (Child and Adolescent Needs and Strengths) assessments at regular intervals.

We are working to identify an outcome measure tool for care coordination in 2020. The Behavioral Health Advisory Council will prioritize the development of such a tool with the recognition that care coordination is a means to help achieve care goals. We will consider the Care Coordination Measure Atlas in development of the tool.

**E.3.0. How will Applicant ensure that Member information is available to Primary Care Providers, specialists, Behavioral Health Providers, care managers and other appropriate parties (e.g., caregivers, Family) who need the information to ensure the Member is receiving needed services and Care Coordination?**

Sharing member information among providers and families as needed – Health Share’s integrated delivery systems notify primary care providers, specialty behavioral health providers and others, including family members involved in a member’s care, that the member has been enrolled into a care coordination program. Care plans developed include provider input and are shared with providers upon request and throughout the care coordination process. Providers, caregivers, members, and family members are invited to participate in care plan meetings as appropriate. Use of a care coordination platform and a shared/integrated care plan allows providers to better participate in care planning and care coordination activities. This care plan is available via the provider portal. In addition, we can send them secure messages to providers’ EMRs for greater ease of communication. We also use the PreManage application to communicate critical information related to ED visits and associated care plans to providers. Health Share will continue to expand its already extensive processes to gather and distribute data and information to its partner organizations and providers. Consistent with HIPAA and 42 CFR Part 2 regulations, we identify member-provider relationships and transfer as much information as possible between primary care, specialty care, and behavioral health organizations. This considers specific provider needs and ranges from delivery of raw claims data to presenting refined analytics metrics provided on our Bridge analytics platform.

**E.4. Severe and Persistent Mental Illness (SPMI) (recommended page limit 6 pages)**

**E.4a. How will Applicant work with OHA, other state agencies, and other state funded or operated entities to identify areas where treatment and services for adult Members with SPMI can be improved?**

Health Share is a committed partner to the OHA and other state agencies, such as DHS to continue to identify areas where treatment and services for members with SPMI can be improved. Health Share was an active participant in the Regional Behavioral Health Collaborative and continues to be an active participant in the Regional Tri-County Behavioral Health Collaborative. We recognize the unique needs of members with SPMI, many of them with long treatment histories in the Oregon State Hospital and have built capacity in the behavioral health system of care to meet their needs while being an active participant in how to continually improve treatment and services.
Identifying opportunities to improve treatment and services for adult members with SPMI – Health Share currently participates in and will continue to participate in workgroups created by OHA-Health System Division, including monthly Choice meetings, Behavioral Health Director meetings and the Regional Tri-County Behavioral Health Collaborative. These are important venues to understand the priorities of OHA and ensure alignment with program priorities and development. For example, the WFI-EZ is a tool used by member and families receiving Wraparound services to provide feedback about their experience with the Wraparound process, but there is no corresponding tool in the Choice program for adults to provide feedback about their experience. To bridge this gap, Choice program staff meet weekly with county mental health adult systems of care staff and community mental health program (CMHP) staff from involuntary commitment, post commitment, older adult behavioral health, and crisis services. Choice staff also attend monthly meetings with OHA-HSD as well as monthly meetings with all the contracted ICM and ACT supervisors to determine areas of improvement in serving the adult SPMI population and to provide oversight and case consultation. In addition, we leverage information available through several sources (CAC and workgroup meetings, quality metrics and analytics, program evaluations, grievances/appeals/complaints, and member and provider satisfaction surveys, among others) to help identify themes, areas of concern, and information gaps related to service delivery.

E.4.b. How will Applicant provide oversight, Care Coordination, transition planning and management for Members receiving Behavioral Health services, including Mental Health Rehabilitative Services, Personal Care Services and Habilitation Services, in licensed and non-licensed home and Community-based settings, to ensure individuals who no longer need placement in such settings are transitioned to a Community placement in the most integrated Community setting appropriate for that person?

Ensuring individuals are transitioned to community placement in integrated settings – Health Share implements oversight, care coordination, transition planning, and management activities to ensure that members receiving mental health rehabilitative services, personal care services, and habilitation services are transitioned to the most integrated care setting that meets their needs.

**Oversight and management of behavioral health services:** Health Share’s partnership with the counties facilitates close coordination with the county residential coordinators who monitor licensed residential programs. Choice care coordinators, along with County residential staff, provide direct oversight and meet monthly with mental health providers and residential treatment facility staff to discuss member needs and least restrictive levels of care for members. To this end, we discuss whether members can live independently, even if they require medication and meal assistance. With ACT and 1915i support, many members are able to live in their own apartments or in supportive housing utilizing personal care habilitative services. Choice provides direct oversight of personal care services/supports for members to continue to assess the effectiveness and level of supports needed to maintain in an integrated community setting. Incident reports, another tool for monitoring residential services, document the residential events that relate to health and safety situations and are a tool for monitoring providers and identifying quality improvement and training opportunities. These reports come directly to the counties who partner with care coordinators to address concerns. These reports also indicate whether a current level of care is not a good match for the member. Our care coordinators partner with county residential staff to address incidents and member needs.

**Individualized care coordination:** Health Share takes an individualized, strengths based, recovery focused, person-centered, culturally responsive, and trauma-informed approach to all care coordination efforts, working collaboratively with members, their natural supports, peers, and community providers to help the member identify and articulate their goals for treatment, recovery, and housing. The member’s recovery goals serve as the roadmap for helping determine the least restrictive, most integrated living situation available for each member. Health Share collaborates and coordinates with all partners in our community who may be able to provide appropriate housing
options (i.e., veteran services, aging and disability services, Housing Authority, homeless service providers, etc.) to our members. Our partnership with the counties provides a natural connection with these services and agencies to support our community members. Health Share uses a care coordination approach to support matching our member’s needs with the most appropriate housing using highly skilled staff in Choice, Wraparound and ICC teams. These staff seek to understand and advocate for member preference for housing while providing education about housing options in the community.

**Transition planning:** To support member transitions between care settings, our care coordinators continually assess the member’s needs for supports for licensed residential care or habilitative services and actively work to connect individuals to the right level of care as the member’s needs change. The least restrictive option is always sought, often with unique ancillary supports provided to the individual for the maximum possibility of success. We also coordinate carefully with our county residential services coordinators to identify opportunities as they arise to facilitate transitions. Intentional, team-based planning meetings are held regularly to discuss services and strategies to keep our members in the community over the long term. Staffings occur regularly as it is the highest priority that members are connected to the right level of care as rapidly as possible. Examples of services provided include:

- Rental assistance to increase housing options matched to client need
- Exceptional needs care coordination to assure access to appropriate housing placements and the development of supports to increase success in the community
- Referral and facilitated connection to community mental health programs
- Facilitating 1915(i) habilitative supports
- Transition planning management to assure the most efficient utilization of the licensed and non-licensed residential treatment services

**E.4.c. How will Applicant ensure Members with SPMI receive ICC support in finding appropriate housing and receive coordination in addressing Member’s housing needs?**

Ensuring members with SPMI receive housing support – Health Share uses a variety of methods to identify members with SPMI who would benefit from ICC support to assist with addressing housing issues. Care coordinators identify members where housing issues contribute to the reason for higher levels of care. These staff are able to make direct referrals to community partners, including those affiliated with our local Continuum of Care to assist with addressing the complex housing issues our members face. Additionally, our crisis programs and other providers, with whom we closely coordinate, may refer members for additional support and coordination of care.

**Process for addressing housing needs:** Many of our ICC coordinators are experts in local housing options and many have developed relationships with local landlords and housing authority staff. These individuals coordinate with members, their identified support systems, and their community providers to help identify the housing situation that would best suit the member’s needs and wishes and assist the member in navigating the various systems pertaining to their needs (i.e., mental health housing, VA, APD LTSS, foster homes, supported/ive living situations, rental assistance programs, etc.). Our care coordinators also assist members in accessing all available services that would assist them in creating the most integrated, least restrictive living situation (i.e., 1915i services, Personal Care Assistance services, ACT/ICM, Home Health, etc.).

**Monitoring of homeless members:** To ensure that the housing needs of our members with SPMI are met, we will continue to engage in systematic monitoring of members who are homeless. First, the housing status of individuals served in Choice is already tracked and reported frequently. We use this data to monitor trends in homelessness among our highest need members. Second, the counties participate in annual homelessness counts in the metro-area. This information is incorporated into strategic planning and priority focus areas for both the county staff and Health Share activities.

**Ensuring housing needs are met through ICC:** We know that just because a person has housing, this does not mean it is an ideal match to our member’s needs. To ensure that overall housing needs
are addressed, we will use several methods through our ICC program. First, we will use the data on homelessness to identify new programs and services that can provide support to individuals with SPMI. For example, Central City Concern’s new recuperative care program will be opening shortly and provides supported housing for individuals with SPMI who are discharging from inpatient care and are homeless. Staff will work closely with residents to assist them in transitioning to appropriate housing in the community. Another way we will ensure housing needs are met is by specifically focusing on housing in ICC team meetings. The ICC care coordinators are closely connected to county residential staff which ensures housing needs are addressed. For example, in Washington County the county residential staff attend team meetings with the ICC staff and are able to identify individuals whose current housing is not a good match to the individual’s needs or desires. This ensures ICC staff and county residential staff work collaboratively in attending to the housing needs of individuals with SPMI. Finally, we will continue to identify individuals who need ICC services and attend to housing through an ongoing needs assessment of the member. ICC team supervisors will monitor attention to housing through individual supervision, team meetings and staff performance reviews.

**E.4.d. How will Applicant assist Members with SPMI to obtain housing, Supported Housing to the extent possible, consistent with the individual’s treatment goals, clinical needs, and the individual’s informed choice?**

Assisting members with SPMI to obtain supportive housing – We ensure that our care coordination staff and network adopt a client-centered, strengths-based, culturally responsive and trauma-informed approach in all services provided. This includes a foundational belief in member choice. As stated above, each member’s recovery goals serve as the roadmap for helping determine the least restrictive, most integrated living situation available for each member. This also includes educating members about their options so that they may make a fully informed decision about their treatment and housing opportunities. By keeping the member’s desires and choice at the center of all care coordination and treatment planning, we are better able to meet the needs of our members. We collaborate and coordinate with all partners in our community who can provide appropriate housing options (i.e., veteran services, aging and disability services, Housing Authority, homeless service providers, etc.) to our members. We will continue to support our care coordinators and treatment providers in attending to housing needs through supervision, contract language, and chart reviews.

**Collaboration with our provider network to ensure housing needs are met:** In addition to the care coordination supports described in the previous section, Health Share works closely with our contracted provider network to ensure that the housing needs of members with SPMI are met. This is done in a variety of ways including:

- Case management around housing supports as part of outpatient services for members with SPMI
- Expansion of supported housing programs throughout the metro area by leveraging existing Choice funding with Medicaid dollars for various housing programs
- Assisting providers in developing new supported and supportive housing programs, including helping to mitigate public opposition, such as the Clover Court development in Washington County
- Multnomah County’s partnership with HomeForward, Join, and other agencies to create opportunities for institutionalized members to step down to independent living through a unique Section 8 grant. This grant focuses on institutionalized members in various settings, such as the psychiatric state hospital, acute care, jail, or structured housing. HomeForward and Join have offered to provide support regarding finding apartments and assisting with apartment retention
- Use of Health Related Services to fund housing related expenditures such as eviction prevention and first and last rental deposits
- Participating in and supporting the development of new affordable housing related to the recent Metro bond which will bring thousands of new affordable housing units to our area. County
behavioral health staff are engaged in development meetings and advocating for the needs of our Health Share members. These new units will add additional choice and options for our members.

E.4.e. How will Applicant ensure ACT services are provided for all adult Members with SPMI who are referred to and eligible for ACT services in accordance with OAR 309-019-0105 and 309-019-0225 through 309-019-0255?

Ensuring provision of ACT services for adult members with SPMI – Health Share funds an ACT program liaison in each county in our service area to ensure ACT services are provided by our ACT providers per rule and ACT provider contracts. Health Share ensures that all members who are (a) interested in ACT, and (b) meet criteria for ACT services, will be given the opportunity to meet with an ACT provider in their community to both learn about the ACT program and to determine if ACT can meet their needs. A particular population focus for ACT services is the subset of members whose SPMI has led them to struggle with making effective connections to a set of services that meets their needs, thereby leading to a decline in their overall health and satisfaction. Upon receiving a referral, the ACT provider meets with the member for a screening within two weeks of the referral. When services are approved, a comprehensive assessment and treatment plan is developed that includes mental health services, medication management services, supported employment, housing needs, and other SDOH.

Process for ensuring access: Health Share’s methods for assuring access to ACT services for all eligible, interested members include: outreach to Oregon State Hospital and other acute care and residential settings; Choice Model care coordinators’ regular attendance at staffings and interdisciplinary meetings involving members being referred to ACT; and monthly meetings between Health Share and ACT providers to discuss referrals and any system or program challenges. Frequency of meetings vary based on the acuity level of the member, with monthly meetings at minimum for lower acuity members, up to weekly or more often as needed for members in the highest levels of care. In addition, we have also created a broad spectrum of other high-level, individualized, community-based services across our region, including ICM, Forensic ACT, and specialized ACT-like programs that have been developed to meet the needs of specialized populations. It is our plan to continue to explore creative, culturally specific ways to use the philosophy and multi-disciplinary approach of the ACT model, to best meet the needs of our entire membership.

Monitoring and oversight: We are committed to the effectiveness of a fidelity ACT program, and to assuring that any member who meets criteria for ACT—and is interested in this very specific style of service—will be able to access it in a timely fashion. Specific timeliness requirements concerning access to ACT services (including response time for the initial referral, the initial screening, and the start of services) are monitored by both the ACT providers and Health Share to assure that any changes in those requirements are incorporated into the ACT programs’ processes. Monthly meetings with ACT providers include review of timeframes to assure adherence to all relevant timelines. Health Share is committed to meeting the requirements of the Oregon Performance Plan that recommends the number of ACT slots as determined by adult population. For example, in 2019, Multnomah County’s adult population is 634,229, which would correlate with a need for 317 ACT slots. Currently there are over 352 ACT slots available in Multnomah County.

E.4.f. How will Applicant determine (and report) whether ACT team denials are appropriate and responsible for inappropriate denials. If denial is appropriate for that particular team, but Member is still eligible for ACT, how will Applicant find or create another team to serve Member?

Ensuring members that are eligible for ACT receive ACT – Health Share will continue to work collaboratively with all our ACT providers to gather data about admission criteria, denials to the program, closures, and effectiveness. This includes collecting reports from ACT contractors about denials to ensure they are appropriate and consistent with current contracts and OARs. When there are concerns about denials, we reach out to OCEACT, as OHA’s subject matter expert on these issues.

Monitoring and reporting denials for ACT: Health Share monitors denials and associated reasons
for each denial through collecting detailed reports from ACT contractors. Denial information is reported quarterly to OCEACT by all fidelity ACT teams. On an individual basis, Health Share reaches out to our ACT teams on a regular basis (weekly, monthly, or more often as needed). ACT teams provide weekly and/or monthly reports outlining current census, pending referrals, and denials (with reasons, and explanations about next steps for each member that declined services). Each ACT team has multiple approaches to clients who are denied ACT services, from providing a warm handoff to the appropriate service provider, to providing information and attempting outreach and engagement.

**Referrals to alternative programs:** In the event that an ACT provider denies a member who has been approved for ACT services, Health Share will work closely with the ACT provider to understand the specific factors that led to the denial (i.e., capacity, geography, conflict of interest, etc.). Depending on the response of the provider and the individualized needs of the members, Health Share will do any or all of the following:

- Contact the members to determine the preferred service and provider.
- Refer the member to an alternative program if the reason for the denial is capacity.
- Refer the member to one of our broad array of intensive community-based teams if clinically appropriate and preferred by the member.

Concurrently, we will work with the denying provider to address the capacity issue or develop increased capacity in the system through the addition of new ACT teams or redistribution of resources. Should the provider have capacity and the member is clinically appropriate for the service and desires the service, the denial will be addressed as a formal grievance against the provider. Health Share may consider it a contractual compliance issue as well and respond accordingly.

**Assessing the need for ACT capacity:** Health Share will continually assess the need for additional ACT capacity to serve our members. One way this is accomplished is by proactively addressing capacity requirements in contract and ensuring compliance to this standard. At the time of this application, we have been able to meet the needs of all members who have requested/required ACT services, within our current capacity. That said, Health Share will continue to assess the needs of our membership with input from our members, the CAC, providers, and community partners. Health Share will continue to build a resilient, responsive, accessible service spectrum to meet the needs of members whose SPMI requires that highest level of community-based services.

**E.4g. How will Applicant engage all eligible Members who decline to participate in ACT in an attempt to identify and overcome barriers to the Member’s participation as required by the Contract?**

**Overcoming barriers to member participation in ACT** – Health Share takes a person-centered, individualized, strengths-based, culturally responsive and trauma-informed recovery model approach to care coordination and service provision. Health Share pursues active outreach and engagement with members who have declined services that have been offered to them, including (but not limited to) to ACT services. All outreach is grounded in building a respectful, therapeutically sound relationship with the member, which serves as the foundation for care coordination efforts using all avenues of communication (face-to-face, phone, email, text, etc.). Care coordinators rely on the relationships they have built with all partners in the member’s support system (behavioral, physical, and oral health providers, natural systems of support, peers, etc.). Peers are particularly effective in outreach to members who have been hesitant to engage in treatment services (ACT services included) and offer to assist the member in developing a person-centered plan that assists the member in clarifying their goals. Other partners involved in those outreach efforts include community treatment providers and other community partners such as the Area Agency on Aging, APD, and IDD.
Community-based outreach: Health Share implements community-based outreach for ACT programs in two primary ways: 1) educational outreach to providers and community partners about the ACT model, referral process, admission criteria, etc.; and 2) client-specific outreach for people who the ACT team has approached but who have declined services and are still struggling in the community. For the former, ACT teams regularly reach out to community partners and offer to meet with them about the ACT system, present to their staff about what ACT is and how to access services, and get feedback about how the program is working. For the latter (client-specific outreach and engagement), ACT teams can and do continue to make face-to-face contact with members in the community who have declined ACT services, but still appear to meet criteria. These outreach and engagement efforts have no specific time or frequency limit; ACT teams can (and do) reach out multiple times over months or longer—essentially, until the member either no longer appears to need that level of support, or clearly tells the team that they don’t wish to be approached at this time. Our approach is based primarily on respectfully meeting each member “where they are,” and this applies to any member who has chosen not to engage in ACT services. Consistent with all care coordination, staff working with members are always checking in, inviting the member to explore what is working for them and what is not, and offering the broadest range of services and supports to meet the member’s needs. Health Share is committed not to “overcoming” a member’s refusal of offered services, but rather, making sure that every effort is being made to fully understand what recovery means for each member. With this understanding, we work collaboratively to match services and supports that are going to help members in reaching their goals.

**Member outreach example** – An example of the unique, tenacious, individualized work that ACT teams can do is the story of a middle-aged gentleman who had moved in and out of various levels of residential care until he eventually became homeless. He was accepted by ACT, and the team spent months reaching out to him and literally and figuratively, met him where he was—sleeping on the streets, too confused to accept any referrals for any sort of services. He drifted in and out of respite and rehab services for over a year, and after 16 months of outreach efforts by the ACT team, he was willing to consider moving into an adult foster home, where he has now been living successfully for eight months; he remains actively engaged with his ACT team.

**E.4.h. How will Applicant provide alternative evidence-based intensive services if Member continues to decline participation in ACT, which must include Care Coordination?**

Providing alternative, evidence-based intensive services – When a member declines participation in ACT, Health Share’s ACT program liaisons are notified by the ACT program. This notification prompts care coordination efforts which includes outreach attempts via telephone and in-person, with the goal of better understanding barriers to the member’s participation. ACT teams have also developed unique approaches to meet the needs of the communities they are serving, including how to serve members who have been referred, but have declined ACT services. Health Share requires this active outreach and engagement in ACT provider contracts and provides the commensurate funding to support this work. ACT providers will work with the member to get them connected with whatever level of type of outpatient care they are willing to accept at that point and will often ask permission to follow up with the member to see how they are doing. They will also follow up with the assigned treatment provider to see if the member connected with services and will confirm that the provider understands they can contact the ACT team when they feel the member might be more amenable.

Providing alternative intensive services: To provide alternative intensive services to members who have declined ACT services, Health Share maintains a broad service array of intensive, community-based services for individuals with SPMI. Many of these services are evidence-based and all are well established in the community. Through the avenues of care coordination and peer outreach, Health
Share may refer members declining ACT to multiple evidence-based intensive services, such as: ICM, IDDT, strengths-based case management, Forensic Assertive Community Treatment, ITTs, and supported/ive housing programs. Care coordination occurs at multiple levels to ensure member needs are met. We maintain a broad array of care coordination staff including Choice, Utilization Management, and ICC. These staff quickly connect with individuals to assess their unique needs and desires and assist in navigating options and advocating for their desired treatment.

E.4.i. How will Applicant work with Secure Residential Treatment Facilities (SRTFs) to expeditiously move a civilly committed Member with SPMI, who no longer needs placement in an SRTF, to a placement in the most integrated Community setting appropriate for that person?

Supporting member transitions to integrated community settings from SRTFs – Health Share fully understands and supports every person’s right to reside in the least restrictive, most integrated setting available to them that best meets clinical needs while simultaneously considering other factors that may influence that process, such as PSRB jurisdictional issues and the direction of a guardian. Health Share also understands that SRTFs are intended to be part of a treatment continuum, and not long-term housing. As such, discharge planning from SRTFs begins at the time of admission to a facility, if not before. All individuals who have been admitted to a SRTF through the civil commitment process are assigned a Choice care coordinator. Staff coordinate closely with those members and providers, with an emphasis on addressing the treatment issues that contributed to the member being placed in a secure setting. The goal of care coordinators is to assure that the member and the treatment team are working collaboratively on the treatment goals that have been identified to address specific clinical concerns. Care coordinators maintain close contact with SRTF providers to assure that as soon as the treatment goals have been met, the member is given the option to move to the most appropriate, least restrictive setting (RTF/RTH, AFH, supported housing, etc.). The care coordinators work with the member and treatment team to identify the next housing option while stabilization is still occurring, so that there is not an unnecessary delay in transitioning out of the service. There may be times when a member no longer requires a secure setting, but still wishes to participate in the level of treatment provided in an RTF/RTH. In these cases, the care coordinator partners with other residential providers in transitioning the member from a secure treatment setting to lower levels of care. Each member situation will be addressed individually, with the member’s wishes at the forefront in all decisions (again, taking into account other relevant factors such as PSRB or guardian).

E.4.j. How will Applicant work with housing providers and housing authorities to assure sufficient supportive and Supported Housing and housing support services are available to Members with SPMI?

Assuring sufficient supportive housing and housing support services for members with SPMI – The tri-county area, like many areas of the state, is desperately lacking in affordable housing units. Health Share, in partnership with the counties, is able to leverage relationships with both public and private sector partners involved in the development of housing options to ensure the housing that is built will meet the complex needs of SPMI members. This is especially critical with the recent passing of multiple housing bonds. Health Share along with the county partners have already begun discussions with housing authorities to advocate on behalf of our members and consider opportunities for partnership in supported/ive housing development. For example, the behavioral health director in Washington County is currently participating in Metro bond supportive housing planning meetings with the housing authority as well as the cities of Beaverton and Hillsboro. This provides a venue for advocacy to develop units supports specific to the needs of our members with SPMI. Health Share also works closely with county partners who are involved in housing development (housing authorities, developers, community partners) to leverage the broadest possible variety of funding opportunities and resources to support the development of supported/ive housing and are committed to assuring that the member voice is heard at these same tables.

The role of peers: Health Share is committed to looking for opportunities for peers and peer-run
partner agencies to play a prominent role in the development and ongoing support of housing projects. Supported/ive housing is a particularly effective system in which to incorporate peers, as it is intended to be the most resilient of our housing options. Services and supports are provided at the request of members, and treatment services are not a requirement for residency. Peers offer a unique, essential opportunity for support for members who may choose not to participate in any treatment services, but still benefit from the alliance formed with a peer.

**E.4.k. Provide details on how Applicant will ensure appropriate coverage of and service delivery for Members with SPMI in acute psychiatric care, an emergency department, and peer-directed services, in alignment with requirements in the Contract.**

Ensuring appropriate coverage and service delivery for members with SPMI – Health Share has the most comprehensive contracted provider network and service array to support members with SPMI in the State of Oregon. We ensure appropriate coverage and service delivery for members through monitoring the adequacy of our provider network on an ongoing basis and by monitoring quality of care across providers and treatment settings.

**Acute psychiatric care:** With multiple inpatient psychiatric units for children, adults, and older adults in our network, Health Share is able to meet the needs of our members with SPMI. Health Share currently contracts with most local inpatient providers and is working with non-contracted providers to ensure high quality service provision for our members served within these units. Our care coordination and utilization management staff understand that inpatient care is one service within a continuum of treatment and strives to assist with transitions to lower levels of care appropriate to each member’s needs. Members admitted to acute care who are not currently engaged in behavioral health services are assigned to an ITT at the time of admission to the hospital. ITT’s goal is to provide in-reach into the hospital setting to connect directly with the member and assist in transitioning from the hospital into outpatient or residential services that meet the member’s needs and wishes. For members who are currently receiving care coordination through Health Share’s integrated delivery systems (i.e., Choice, Wraparound, ICC, Health Resilience Specialist, etc.), the care coordinator will work directly with the member and the treatment team at the hospital. For members who are currently enrolled in services, care coordinators ensure the behavioral health provider engages directly with the hospital to develop a discharge plan. Consistent with contractual requirements, we cover emergency inpatient services when members are admitted to inpatient units that are not part of our network and/or are outside of our local area. In these situations, we assist hospitals in the steps to receive payment and provide care coordination to assist in connecting the member to local services.

**EDs:** Frequently, members with SPMI will go to the emergency room to receive care for either a behavioral health condition or a medical concern. Our network includes many EDs accessible to our members as well as two specialized Psychiatric Emergency Services (PES) programs available at Providence and Unity. Health Share provides payment for these services while working diligently to develop alternatives to EDs for our members with SPMI. Health Share is equally committed to working collaboratively at the front door (First Responders) as we are to the back door (discharge from inpatient). There are a broad range of options and partners that are involved with the member who is being served through the ED. These include system navigators, peers, care coordinators, health resilience workers, and ED Diversion teams for both member and adults. We partner with EMS, 911, first responders, and acute care partners in a number of collaborative meetings and workgroups to both hear the needs and observation of our partner systems, as well as the voice of our members who are accessing those systems. Our goal is to develop new (and expand existing) low-barrier, easy-to-access alternatives to the ED and/or inpatient settings, such as respite beds, wraparound-style in-home services, and the sub-acute Crisis and Treatment Center (CATC). Health Share care coordinators are also closely involved with members who present to an ED or who are admitted to an acute care inpatient unit. The integrated delivery system provides timely authorization of services...
as well as guidance with less restrictive options such as respite care and sub-acute.  

**Acute care follow up:** In the past 5 years, we achieved a 32% increase in timely follow-up care for members discharging from psychiatric inpatient stays, largely due to the expansion of Intensive Treatment Teams (ITT) into each of the three counties. In the ITT model, interdisciplinary mental health staff outreach directly in the hospital, helping to connect members without current outpatient mental health supports to community-based specialty behavioral health providers for follow-up and ongoing care. This early engagement and warm handoff ensured that by 2017, nearly 90% of all members received timely follow-up after discharge from a psychiatric inpatient stay.  

**Peer directed services:** Health Share values peer services and one of our core values is “member voice and experience are at the center of what we do.” This is reflected in our commitment to the expertise and input of peers and people with lived experience, informing all of the work we do. The role of peers is seen as equally essential to both our members, and our staff and organization as a whole. Our acknowledgement of the essential and unique nature of the peer partnership is seen in our support of a model that invites members to engage in peer services of any kind, regardless of whether or not they choose to engage in treatment services. Health Share, in collaboration with county partners has developed and funds peer support in virtually all levels of care including: crisis services including respite and sub-acute, outpatient services including ACT and ICM, detox and substance use residential, peer drop-in centers, and warm lines.

**E.5. Emergency Department (recommended page limit 2 pages)**

**E.5.a. How will Applicant establish a policy and procedure for developing a management plan for contacting and offering services to each Member who has two or more readmissions to an Emergency Department in a six-month period?**

**Right service, right time, right place –** Health Share is committed to providing members with the right service, at the right time, in the right place, and in the most integrated, least restrictive setting possible. This commitment extends to ensuring a reduction in unnecessary emergency room usage. Health Share’s current plan partners have existing policies and procedures today for responding to members with high utilization of ED visits. To address high utilization of the ED, Health Share has implemented a broad range of interventions, teams, and tools that are employed to assure that members who are seeking non-emergent services in an ED setting are supported and receive assistance in exploring other options that are available to the member. Such interventions include:

- Care coordination staff are sited in the EDs, or work primarily with ED staff in the Metro area (i.e., Health Resilience Specialists, ED Diversion teams from Lifeworks and Cascadia, CATS teams, Project Respond’s ED Response team, etc.)
- Wraparound, Choice Model, and ACT teams are utilizing Pre-Manage to alert them to members who are seen in the ED
- Care Team information within EDIE accurately reflects any community providers who may be of assistance when a member is seen in the ED
- Triage Coordinators run daily reports from PreManage for members with multiple visits to an ED in a six-month period and partner with community-based treatment providers to respond while a member is still in the ED and provide interim behavioral health support between ED discharge and first appointment with the member’s provider. These interventions can also include a peer navigator, mental health intensive transition provider or an addiction benefit coordinator
- Ongoing education to EDs and members about availability and access to crisis respite beds and urgent mental health walk-in clinics through regular communication about availability. This includes ensuring any barriers regarding discharge and transition to an urgent mental health walk-in clinic are addressed, including transportation
• Continued work with providers to expand same day access appointments to establish care following an ED visit for non-established members or follow up appointments within 7 days (or sooner) for established members

Creating alignment on policies and procedures to contact members with multiple ED visits in a six-month period: While each Health Share partner has innovative programs to respond to members utilizing the ED at a relatively high frequency, we can further the goal of alignment in our management plan for contacting and offering services to these members. The Behavioral Health Advisory Council and the Quality Health Outcomes Committee will be responsible, in partnership with the integrated delivery systems, hospital partners and counties for developing policies and procedures, and analytics that address the management plan for meeting the requirement for contacting and offering services to members with more than two ED visits in a six-month period. This collaborative effort will align policies and procedures across Health Share.

E.6. Oregon State Hospital (recommended page limit 1 page)

E.6.a. How will Applicant coordinate with system partners as needed regarding Oregon State Hospital discharges for all adult Members with SPMI?

Coordinating with the Oregon State Hospital and county Choice programs – Health Share coordinates with and financially supports each of the county’s Choice programs, who use skilled care coordinators to assist members who are discharging from Oregon State Hospital (OSH). The care coordinators attend interdisciplinary team meetings at OSH, refer members to multiple housing options, offer and refer for behavioral health services, and provide creative solutions using a Person-centered Planning approach. Care coordinators collaborate effectively with OSH and community partners so that members may discharge to the least restrictive level of care that is clinically appropriate. Health Share and the Choice programs participate in monthly meetings with OSH and OHA/HSD to discuss system issues, barriers to discharge and methods for improving discharge planning to decrease hospital lengths of stay and improve transitions to community treatment providers. In addition, the Choice programs meets monthly with OSH and OHA/HSD to discuss and review specific members who may need additional coordination to safely and quickly discharge to community treatment options. A care coordinator is assigned when a high-needs member is identified, often at the point of commitment, admission to licensed residential settings, or upon receiving a long-term care referral. The care coordinator works with all individuals involved in the member’s care including but not limited to: acute care social worker (if member is in an inpatient unit), LMHA/CMHP, commitment investigator/monitor, Choice contractor, guardian (if applicable), member and any other individual identified by the member as a support (e.g. family), peers, certified recovery mentors, etc., PCP, and other providers. The care coordinator participates as part of the member’s OSH care team and is an active participant in assisting with LTC planning, coordination with the county Choice contractor (if outside of the Health Share region), attendance at the monthly IDTs at OSH, Ready to Transition meetings and discharge/transition planning. The care coordinator remains in place to facilitate discharge and transition out of OSH and into the most appropriate, independent, and integrated community-based settings. They also ensure the member’s needs are met, including placement in the appropriate setting and level of care, the providers (medical, behavioral health, and oral health) and treatment team are in place for continuity of medication and treatment, and the members have access to ACT services or another service for those who decline ACT.

E.6.b. How will Applicant coordinate care for Members receiving Behavioral Health treatment while admitted to the State Hospital during discharge planning for the return to Applicant’s Service Area when the Member has been deemed ready to transition?

Continuity of Care for members admitted to the state hospital during discharge planning – Health Share believes that discharge planning should begin upon admission and keeping community providers engaged throughout the admission is important. For this reason, we employ seasoned care
coordinators who are involved in a member’s care throughout their stay at the State hospital, even if they are not currently assigned to Health Share due to their admission. Health Share knows that continuity of care and maintaining existing treatment relationships is important, especially as our members enter the state hospital. Our care coordinators in each county’s Choice Programs work closely with established providers (including peers) to assess supportive employment, supportive housing, and other recovery-focused endeavors throughout the time the member in in the state hospital. The care coordinators use a person-centered planning approach to further determine member choices. The care coordinators work to facilitate communication with all individuals involved in the member’s care including the OSH staff and existing community treatment providers. The goal is to respect client choice while ensuring appropriate community supports are in place. Often this includes a transition of care to ACT upon discharge or adding supports to existing services.

E.7. Supported Employment Services (recommended page limit 1 page)

E.7.a. How will Applicant ensure access to Supported Employment Services for all adult Members eligible for these services, in accordance with OAR 309-019-0275 through 309-019-0295?

Supporting recovery through employment opportunities – Health Share continues to ensure that contracts for Supportive Employment are in place with providers offering rehabilitative services to Health Share members with SPMI diagnoses. This eliminates barriers to receiving services and provides that the highest number of eligible members who express interest in employment receive Supportive Employment services in a timely manner. Contracts for supportive employment cover the full cost of employing Employment Specialists to ensure that agencies can scale their programs to need and will not need to place eligible members on waitlists. Supported Employment Services are based on IPS (Individual Placement and Support), an evidence-based practice with services to promote rehabilitation and return to productive employment. All supported employment providers employ a team approach to engage and retain clients in treatment and provide the supports necessary to ensure success at the workplace. Services include:

- Focus on competitive employment
- Time-unlimited follow-along supports
- Integration of supported employment and mental health services
- Zero exclusion criteria (no one is screened out because they are not ready)
- Jobs tailored to individuals
- Rapid job searches
- Benefits counseling, to assure that members understand the impact of gaining employment on their eligibility for benefits such as Medicaid and Social Security
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Health Share maintains the following requirements of all contractors to ensure that they are operating in accordance with OAR 309-019-0275 through 309-019-0295:

- Providers will maintain a Certificate of Approval to provide behavioral health services.
- Providers will place 50% of individuals served in competitive employment.
- Services coordination/case management will be provided to all consumers served.
- Providers will maintain fidelity in the “fair implementation range” with the Individual Placement and Support (IPS) model and continually strive toward high fidelity.
- Providers will be reviewed annually for fidelity by the Oregon Supported Employment Center of Excellence and will submit fidelity review results to the CCO on an annual basis.
- Providers will submit Supported Employment information to the State of Oregon including:
  - All individuals who received supported employment in the reporting quarter;
  - Individuals who received supported employment services who are employed in competitive integrated employment; and
  - Individuals who discontinued receiving supported employment services and are employed in competitive integrated employment; and
Individuals who received supported employment services as a part of the Assertive Community Treatment program.

- Health Share regularly reviews providers to ensure they are referring members to supported employment services when appropriate. In addition, we receive fidelity review scores for our providers and monitor for compliance with contract requirements regarding fidelity.

**E.8. Children’s System of Care (recommended page limit 2 pages)**

**E.8.a. What Community resources will Applicant be using or collaborating with to support a fully implemented System of Care?**

Collaboration with community partners – To support a fully implemented System of Care (SOC), Health Share and the tri-county SOC will continue to collaborate with all formal child-serving systems, including Child Welfare, Juvenile Justice, Development Disabilities, Education, Primary Care and other community partners. In addition, Health Share and the tri-county SOC will use the following resources to implement the SOC and ensure that the core values are upheld:

- Contracts are in place with OFSN, Youth ERA, Latino Network, and NAMI to recruit member and family members to assure family and member voice in SOC governance
- Technical assistance provided by PSU’s SOC Institute, OHA, and the Statewide SOC Steering Committee
- Collaboration with Kindergarten Readiness Network to increase the impact of the SOC
- Community partnerships will continue to meet identified system needs, including upcoming statewide dual diagnosis (Mental Health and I/DD) training funded by Health Share
- Continued funding of 1.5 FTE dedicated to supporting SOC work in both administrative and facilitation capacities
- Meetings will continue to be held in locations that are non-intimidating and publicly accessible, with food and childcare provided to promote participation

**E.8.b. Please provide detail on how Applicant will utilize the practice level workgroup, advisory council, and executive council.**

Health Share has a strong and established structure for the practice level workgroup, advisory council, and executive council. The practice level workgroup (PLWG) collects and reviews barriers identified by SOC members and professionals. If the barrier is at the practice level, the group works with the member or system partner to address the barrier directly. If the barrier is systemic and impacting a large group of members, the PLWG completes an assessment of the barrier’s qualities, impact, causes, and potential solutions. This information is then communicated to the Advisory Council (AC) via an Issue Brief. Membership for this group includes member, family, and professionals in a supervisory position from across the tri-county region. This group meets monthly. The AC works on a strategic plan and addresses system level barriers referred by the PLWG. Members attempt to resolve the issue or refer to the Executive Council (EC) for further action. Membership for this group includes member, family, and professionals at a management level from child serving agencies and culturally specific organizations from across the region. At least 51% of the membership is made up of members and families. The EC is a group of leaders and decision makers who have authority to make funding and policy decisions. The EC sets the strategic direction for the SOC and resolves barriers received from the AC at the policy, finance, and design level. The EC interfaces with OHA and the Statewide SOC Steering Committee to make recommendations for state level policy changes.

**E.8.c. How does Applicant plan to track submitted, resolved, and unresolved barriers to a SOC?**

Addressing and resolving barriers – Health Share has 1.5 FTE of support staff for the tri-county SOC. Support staff attend all tri-county SOC meetings, and track barriers as they are processed by the Practice Level Workgroup, Cultural Responsiveness Workgroup, Advisory Council, and Executive Council. Established processes to track barriers include:
E.8.d. What strategies will Applicant employ to ensure that the above governance groups are comprised of Member, families, DHS (Child Welfare, I/DD), special education, juvenile justice, Oregon Youth Authority, Behavioral Health, and Member and Family voice representation at a level of at least 51 percent?

Family voice and representation – Health Share SOC support staff are responsible for recruitment and retention of membership for the governance groups. The SOC charter guides the work and outlines the systems to be represented. This includes 51% member and family representation in addition to participation from DHS (Child Welfare, I/DD), special education, juvenile justice, the Oregon Youth Authority, and behavioral health. Executive leadership gives verbal commitment to provide appropriate staff to attend the Practice Level and Advisory Committees. Support staff are drafting a membership MOU where leadership will formalize their commitment. Support staff prioritize the recruitment of professionals from formal systems to the EC by leveraging relationships with other system partners to identify potential members. Once agency and/or system leadership is actively participating in the SOC at the Executive level, we work with these members to assign staff from their agencies to also attend the PLWG and AC.

Youth and family serving organizations – Member and family are recruited via partnerships with member and family serving organizations. OFSN, NAMI, Youth ERA, and Latino Network are contracted to recruit member and family. These organizations facilitate support groups in the community and recruit from those meetings. They also do outreach to member and families referred by organizations participating in SOC meetings. Additionally, consideration is currently being given to participating in a pilot assessment project on family voice representation in systems of care. To retain current membership Health Share currently uses or commits to developing numerous continuous onboarding strategies including membership binders, new member orientations, clear tracking documents provided in a timely manner, surveys to evaluate member experience, in-meeting relationship building, financial stipends for member and family, and peer support during meetings.

E.9. Wraparound Services (recommended page limit 4 pages)

E.9.a. Provide details on how Applicant plans to ensure administration of the Wraparound Fidelity Index Short Form (WFI-EZ)?

Health Share’s Wraparound and SOC site lead and SOC program coordinator currently meet with Wraparound program supervisors and coaches monthly. A standing agenda item of these meetings is WFI-EZ compliance and data evaluation. Twice annually, we review all enrolled member, and over the course of one month, offer WFI-EZ surveys to all Wraparound teams where the member has been enrolled for over six months and has not previously completed the tool. Wraparound teams discuss completing the WFI-EZ a month in advance and then are given time following the next Wraparound meeting to complete the surveys, often with the support of member and family partners. This approach has been effective in ensuring that every member/family enrolled in Wraparound is offered a survey as well as increasing our survey return rates. Every care coordinator has time allocated specifically for completing the WFI-EZ as well as time with a certified Wraparound coach where use of the tool is a required topic. Coaches also use WFI-EZ data in both individual and group coaching to highlight strengths and provide tailored coaching for improvement in areas identified by the tool.

We use a standardized survey distribution, collection, and data entry process to ensure that member, families, and Wraparound program staff have consistent experiences and understanding of the
process. We plan to continue this process and approach.

**E.9. b. How will Applicant communicate WFI-EZ and other applicable data to the System of Care Advisory Council?**

Health Share SOC staff and Wraparound program supervisors remain active members of the regional SOC Advisory Council and will work with the council chairs to determine what WFI-EZ and other Wraparound program data is most useful to be brought to the group. Wraparound supervisors aggregate data from TMS Wrap track and other sources (determined by Council chairs and program supervisors) and present it to the Regional Advisory Council on a bi-annual basis. Health Share SOC staff and Wraparound supervisors provide data as requested to the Regional Advisory Council when it can be of help with work on specific barriers.

**E.9. c. How does Applicant plan to receive a minimum of 35 percent response rate from member?**

We currently exceed the 35% response rate and has increased WFI-EZ return rates over the past two years. We will establish current system baseline metrics in May 2019. Our goal for 2019 is a 50% return rate. We will continue to keep WFI-EZ compliance and data evaluation as a standing agenda item in our monthly Wraparound standardization and consultation work group that includes Wraparound program supervisors, Wraparound coaches, Health Share’s Wraparound and SOC site lead, and Health Share’s SOC program coordinator (with quarterly attendance by Youth ERA and OFSN). Response rate of the WFI-EZ is a standing agenda item on the Wraparound standardization and consultation work group. Strategies to achieve our goal will be developed with Wraparound supervisors, Members and Family partners, and Wraparound coaches.

**E.9. d. How will Applicant’s Wraparound policy address:**

**E.9.d.(1) How Wraparound services are implemented and monitored by Providers?**

Ensuring the integrity of Wraparound in our community – Health Share, in partnership with counties, ensures the implementation of Wraparound services for members and their families. This is governed by our OHA approved SOC/Wraparound Initiative policy that was developed in partnership with the community and is reviewed by stakeholders annually. Each county has employed Wraparound care coordinators, coaches, and supervisors that appropriately match the need of each county’s unique population. This model ensures that staff delivering Wraparound are embedded in the community they are serving to leverage local partnerships and address local needs. Health Share holds the contracts for providers who employ family and youth partners working directly with Wraparound members and families, and delegates peer positions to each county as needed. Health Share contracts with Youth Era for Wraparound Youth Partners and the Oregon Family Support Network for Wraparound Family Partners. The centralized contract for peer supports allows for culturally specific Wraparound peer support partners to operate in all three counties and better meet the needs of the community. Health Share, in partnership with the counties, has created an expansive Wraparound program overseen by dedicated Health Share and county staff. Health Share has a dedicated Wraparound site lead and a SOC program coordinator who convene monthly meetings of the Wraparound Supervisors and Coaches to evaluate and improve our program, ensure consistent delivery of fidelity Wraparound, and monitor services across our region. Health Share continues to evaluate WFI-EZ fidelity outcomes biannually to identify strengths and areas for targeted coaching as well as using the Oregon Wraparound Team Meeting Observation Measure with all Wraparound providers. Wraparound programs across the counties use the same documentation and eligibility criteria to ensure a consistent Wraparound experience for all members. We have also developed a transition protocol for when members move between counties whereby a member stays with the county and Wraparound care coordinator they started with unless they specifically ask to transition services to the new county. The meetings regularly include representatives from Youth ERA and OFSN to ensure peer voice is consistently present in all work related to Wraparound. The Health Share site lead serves as a centralized hub to convey information/data/outcomes to OHA and the
larger SOC governance structure. Health Share actively engages with PSU for ongoing technical assistance. We conduct yearly audits of Wraparound files to ensure compliance to fidelity standards. Health Share gathers regular reporting data on the current staffing ratios employed by each county, data on the population served, outcomes of the Wraparound planning process and the ability of Wraparound to meet member’s cultural and linguistic needs.

E.9.d. (2) How Applicant will ensure Wraparound services are provided to Members in need, through Applicant’s Providers?

Providing Wraparound services to members most in need – Wraparound supervisors and coaches conduct numerous outreach activities, (Wraparound 101) to various stakeholders in each community. Targeted outreach includes presentations to DHS (Child Welfare/Self Sufficiency) Developmental Disabilities, primary care, school staff, supported employment, Early Learning Hubs, judges, juvenile departments, mental health agencies and other child serving systems. Through focused educational outreach, families are identified alongside their system partners and referred for Wraparound. While Wraparound is often accessed through professionals involved in child serving systems, our county partners have created a low barrier referral process and screening criteria allowing member, families, or natural supports to self-refer to Wraparound. We seek ways to intentionally engage under represented populations through culturally specific outreach. Wraparound Review Committees are held independently in each of the three counties to ensure that localized needs are being met. Health Share values family and member voice at the Wraparound Review process and concerted efforts have been made to ensure that families and members are invited to participate in the review process. Currently Multnomah County offers a weekly Wraparound Review Committee and both Clackamas and Washington counties offer Wraparound Review Committee bi-monthly. Health Share honors the OHA Wraparound criteria, and all members who are in Secure Children’s Inpatient Program (SCIP), Secure Adolescent Inpatient Program (SAIP), SAGE Youth Residential Program or Psychiatric Residential Treatment Services (PRTS) are offered Wraparound at the time of program admission. Additionally, we have created criteria to ensure that members with high needs across the system of care are identified and screened for Wraparound as well as specialized early childhood criteria to address the unique needs of member’s ages 0-5.

E.9.e Describe Applicant’s plan for serving all eligible member in Wraparound services so that no member is placed on a waitlist. Describe Applicant’s strategy to ensure there is no waitlist for member who meet criteria.

Creating and supporting Wraparound capacity – We ensure there are no waitlists for members eligible for Wraparound services in the three counties partnering with Health Share. Across the tri-county region, there is capacity to provide Wraparound services to more than 400 members and families. Supervisors work with care coordinators and coaches on caseload capacity to ensure we meet the needs of any member eligible for services. We deploy an approach designed for members who have complex emotional, behavior, and social needs who typically require care coordination support across multiple child serving systems. The Wraparound programs have standardized regional criteria based on OHA’s eligibility standards to prioritize and offer Wraparound to member who are enrolled in SCIP, SAIP, SAGE or PRTS. The intentional eligibility criteria and screening process ensure that members in the highest levels of mental health care are offered Wraparound. ICC is regularly provided to members with intensive mental health needs to ensure care coordination is offered prior to the Wraparound. Wraparound supervisors monitor caseload sizes monthly to ensure fidelity. Clackamas, Multnomah and Washington County assess the workforce to determine if additional FTE are needed to serve all eligible members. We have consistently maintained enough staffing to keep caseloads well below the cap of 15 members per care coordinator because we recognize that best practices require lower caseload size.

E.9.f Describe Applicant’s strategy to ensure that Applicant has the ability to implement Wraparound services to fidelity. This includes ensuring access to Family and Member peer support and that designated roles are held
Policies and procedures have been developed and adopted that align with Wraparound best practices and ensure services are delivered to fidelity. Each county partnering with Health Share has Wraparound supervisor and coach positions filled by two different individuals. Supervisors provide clinical and administrative supervision to care coordinators especially as it relates to agency policies and procedures. Coaches have expertise in Wraparound and provide intentional support to care coordinators to further develop their skills and increase expertise in the Wraparound process. Additionally, coaches observe team meetings, utilizing the Team Observation Measure (TOM) during all phases of the Wraparound process to offer feedback and targeted coaching. Supervisors bi-annually track fidelity outcome scores using WrapTrack and compare program scores to national fidelity averages. All three counties are consistently demonstrating outcomes above national averages in all fidelity indices. Coaches also use WFI-EZ (Wraparound Fidelity Index) survey data to develop individualized group and one-on-one coaching.

**Family and peer support partnerships** – Health Share holds contracts with Youth ERA and Oregon Family Support Network (OFSN) to ensure access to peer supports. Additionally, Multnomah County holds a contract with the National Alliance on Mental Illness (NAMI) to provide family peer support. The peer partner agencies are well integrated into all three counties’ delivery of Wraparound services and can begin at the time of referral and continue throughout the entire Wraparound process. We also incorporate peer support within agency meetings and group consultations. All three Wraparound programs receive technical assistance and ongoing training through partnership with the Systems of Care Institute (SOCI). Care coordinators and peer service providers attend training in Wraparound. Supervisors and coaches also receive targeted training. Care coordinators attend quarterly regional coaching sessions. Coaches across the region meet regularly with SOCI and engage in a monthly learning collaborative. A cultural considerations workgroup provides consultation and recommendations on documents and culturally appropriate processes. This ensures cultural and linguistic perspectives are considered and met.
A. Evaluate CCO Performance to inform CCO-specific profit margin beginning in CY 2022

A.1. Does Applicant have internal measures of clinical value and efficiency that will inform delivery of services to Members? If so, please describe.

Community-wide health care leadership – Health Share of Oregon and its unique collaborative model will achieve the triple aim of better care, smarter spending, and healthier people — bringing the value of each partner organization to make the whole better than the sum of its parts. In order to meet the diverse needs of Oregon Health Plan (OHP) members in our region, we have created the state’s most comprehensive provider network. We are leveraging the value and strengths of the tri-county’s integrated finance and health care delivery systems (IDS) — Kaiser Permanente, Legacy Health, OHSU Health System, and Providence Health & Services — and optimizing a best-in-class integrated community network (ICN), managed by CareOregon, that focuses on integrating and supporting our safety net, oral health, non-emergent medical transportation (NEMT), and behavioral health systems of care.

Harnessing data to drive delivery system improvement – Health Share and its partner organizations track a variety of both clinical and efficiency measures and have structures in place to regularly review the measures and identify performance opportunities. These measures include hospital admission and readmission rates, emergency department utilization rates, infection rates, screening rates, specialty referral rates, all quality incentive metrics, and disease registry tracking. Health Share convenes committees that include providers, clinical management, and others to review data and discuss trends, cost, utilization patterns, and areas of concern in order to identify improvement opportunities.

For example, Health Share worked with key clinical and operational leaders to develop a unique measure: identifying people who were highly engaged in Medicaid Assisted Treatment (MAT) for Opioid Use Disorder (OUD). We needed to design a unique measure for MAT engagement because traditional approaches to measuring substance use disorder (SUD) system engagement, such as initiation and engagement in treatment, are not sensitive to the frequency and consistency required of real engagement in MAT programs, which includes daily dosing or consistent prescribing of medications. We developed a measure that allowed providers from all areas of the system to understand the proportion of Health Share members they serve who struggle with OUD and are highly engaged, moderately engaged, or poorly engaged in medication assisted treatment. Then, we used the measure to identify members’ point of first diagnosis with OUD and the proportion of them who became highly engaged in treatment — allowing us to identify a significant gap in engagement for people initially diagnosed in emergency and inpatient settings. We then analyzed levels of engagement against cost data to arrive at an estimate of potential savings associated with moving individuals from poor engagement to high engagement. This analysis led to a strategic investment targeted at broader provider trainings in MAT and will be used to support further investment in increasing MAT engagement.

Another example of using internal measures to improve service delivery is CareOregon’s use of its population segmentation tool to target care management and other clinical support services to those members classified as “Rising Risk.” This approach identifies members’ needs and what services will be most effective at addressing those needs. It also helps to ensure we are engaging the members who are most able to be impacted. For example, if a member requires behavioral health coordination, then CareOregon reaches out and provides those services. We track the percentage of Rising Risk members engaged in services over time and use the measure as a key indicator of clinical
value and efficiency.

A.2. What tools does the Applicant plan to deploy to identify areas of opportunity to eliminate waste and inefficiency, improve quality and outcomes, and lower costs?

Health Share and its partner organizations use a multitude of tools to identify and eliminate waste and inefficiency, improve quality and outcomes, and lower costs, and we plan to implement more tools as needed. Currently we use analytic tools to monitor variations in costs, utilization, and outcomes; perform evaluation and management auditing; study physician utilization patterns; track key metrics such as admits, emergency department (ED) utilization, referrals, and imaging orders; and generally follow up on unusual practices identified through the prior authorization process.

We have extensive analytics capabilities at multiple levels within Health Share. Health Share employs a robust data platform from Health Catalyst that flexibly supports data aggregation, distribution, and reporting specifically for quality, outcomes, and utilization measures. Our IDS partners are using Epic Clarity, Cojito, and Caboodle tools that are tightly integrated with their electronic health record (EHR) systems. In many cases these are augmented by specialized data warehouse and analysis packages. Our ICN partner CareOregon employs an enterprise data warehouse from Arcadia to take data from multiple sources and provide a range of outcomes and cost dashboards that are used to minimize inefficiency.

Eliminating waste and inefficiency – In addition to reviewing and analyzing data, we also have payment integrity programs that include identification of other primary payers, coordination of benefits, and claims editing tools to ensure that Medicaid is the payer of last resort and claims are paid appropriately.

In addition to performing reviews after the fact, we also take steps to prevent waste and inefficiency from happening in the first place. We engage members early by coordinating care; sharing data to reduce duplicative services; focusing on wellness and prevention to avoid chronic conditions; implementing chronic condition programs to provide quality care to those requiring complex treatment; providing alternative ways for members to access care such as through phone, email, video, retail clinics, and mobile health vehicles; and tightly managing pharmacy costs through formulary management and prescribing practices.

Improving quality and lowering costs – One example of an analytic tool we have used to improve quality and lower costs is Health Share’s recently developed Population Builder tool. The Population Builder can quickly highlight utilization, costs, and diagnoses for particular groups of interest — whether defined by traditional health-related categories such as Healthcare Effectiveness Data and Information Set (HEDIS) value sets, utilization history, or diagnoses, or by characteristics linked to demographics or available social complexity information (such as manually generated lists of individuals in a particular housing or education program). This tool allows for easy comparison to a statistically “matched” cohort of members to highlight differences and drive insight. This comparison will be invaluable in identifying health disparities for our members. For example, this methodology can quickly generate an analysis highlighting differences in cost, utilization, and demographic composition between individuals with diagnoses for both diabetes and depression compared to those with only diabetes or only depression. This will allow us to customize our interventions and services to obtain maximum impact. If further information is available about involvement in supported housing programs, additional cohorts can be compared to understand program impact. This supports data-driven decisions about system and clinical investments that will both improve care and lower costs and will prove invaluable in the next phase of CCO work.

A.3. Does the Applicant have a strategy to use Health-Related Services to reduce avoidable health care services utilization and cost? If so, please describe.
Strategic use of Health-Related Services to reduce avoidable utilization and cost – Health Share has adopted a population health strategy leveraging Health-Related Services (HRS) at both the member and the systems level. Health Share’s strategy for using HRS to reduce avoidable and unnecessary emergency room visits, readmissions, and other services that create waste and unnecessary costs in our health care system is through both flexible services and community benefit initiatives. Health Share uses a systemic approach to identify and support member needs at the individual and family level through the use of the flexible funds via the regional Community-Linked Assistance Referrals Assessment (CLARA) platform. Subsequently, by capturing resource and social needs at the member level we are then able to aggregate social needs at the hyper-local, partner, and ultimately regional level to identify trends and areas ripe for systemic intervention using HRS community benefit funds. The level of sophistication with which we can execute this strategy will greatly improve in Health Share 2.0 with the implementation of Social Services Resource Locator tool — closing the CLARA referral loop for fulfillment of individual social needs and tying outcomes back to an EHR — and an improved community-based process for HRS community benefit initiative investments with the Health Share Strategic Investment Fund, led by our Community Advisory Council and Community Impact Committee.

Health-Related Services: meeting members where they are – The Health Share strategy to reduce costs and unnecessary utilization through flexible funding is twofold: (1) empower those directly engaging with members and patients with responsibility for identifying and ordering flexible services and (2) provide those front-line caregivers with a centralized portal to easily order flexible services from contracted community partners.

Through a coordinated effort, Health Share partners train providers and care coordination staff on the purpose of flexible services and how they may request flexible services on behalf of a member in the event other community resources are not available and the member may otherwise use avoidable or unnecessary health care services. IDS and ICN care coordinators determine whether members need flexible services on a case-by-case basis by assessing member circumstances, the potential utilization of services, and what supports are available in the community. The most common issues identified by our care coordinators and providers are financial strain, housing insecurity, and food insecurity. By addressing these social determinants of health, the members and care teams are able to focus on whole health, quality of life, health equity, and well-being while encouraging treatment plan engagement and adherence.

Since 2016, Health Share has leveraged a technology platform, CLARA, to procure and track flexible services and items for our members. CLARA captures the majority of data elements required by OHA, including those which indicate affiliated health-related outcomes for members. Health Share established a Flexible Services Workgroup to ensure all who procure and administer flexible services and supports for their members have a forum to share best practices, identify effective, flexible services strategies to support or remove barriers to achieving members’ health, and remain current and compliant with state and federal policies. The Workgroup also reviews historical and current data represented in monthly CLARA reports which allows it to identify the most frequently utilized categories of flexible services as well as member populations that seem to benefit most from certain flexible services or items, e.g., houseless members who have had a recent surgery may require hotel vouchers so they can heal in a warm, dry place. Most recently, the Workgroup endeavored to define intermediate and high-level outcomes related to certain flexible services investments. These efforts allowed Health Share to strategically promote to providers and care coordinators those health-related services that appear to have the greatest impact on member health and well-being.
Health-Related Services: addressing housing needs to improve health and reduce health care costs – Housing is critical for members’ health and helps to reduce avoidable utilization of services. Our partner CareOregon helps members secure safe temporary and long-term housing supports. Care coordinators help members apply for Section 8 housing, recover/replace identity documentation, cover application fee costs and rehousing costs, place rental deposits, and request temporary rental assistance and temporary housing placements. They also work with a medical legal partnership (MLP) program to provide legal assistance to members who face legal barriers to obtain or maintain housing, which includes eviction prevention supports. CareOregon contracts with Health Share partner Central City Concern for post-hospitalization medical care and intensive case management for housing assistance through the Recuperative Care Program. CareOregon assists with long waitlists by providing temporary housing for a safe and hygienic place to recover before a space opens at RCP.

Health-Related Services: strategic investments – While the use of flexible services is ideal for member-level initiatives, the use of community benefit initiatives allows Health Share to invest in regional strategies to reduce avoidable health care services utilization and cost. Health Share’s strategy related to community benefit initiatives is more fully explained in question A4 and should be referred to for context. An HRS community benefit initiative that successfully demonstrates reduced avoidable health care services utilization and cost is the TC911 program, which is highlighted below:

Health Related Services: TC911, meeting unmet social needs that drive costly 911 calls – The Tri-County 911 Service Coordination Program (TC911) serves residents who are using emergency services frequently and are heavily burdened by health and social issues. Social workers help people find the right care in the right place through short-term interventions. TC911 evaluations have consistently shown significant reductions in acute care costs and utilization among high-risk Medicaid members.

- 3,078 referrals
- 1,187 unique people served
- $1.2 million in annual program costs
- $10,644 average savings per member/year among Medicaid members
- $2.8 million in calculated ROI annually to serve 350 Health Share members

A.4. What is the Applicant’s strategy for spending on Health-Related Services to create efficiency and improved quality in service delivery?

Strategy for using Health-Related Services to create efficiency and improve quality – Health Share has adopted a population health strategy leveraging Health-Related Services at both the member and the systems level. Health Share’s strategy for using HRS to create efficiency and improved quality in service delivery is primarily through community benefit initiatives — community-level interventions focused on improving population health and health care quality. Historically this has been grounded in a life-course and population framework as exemplified in Health Share’s Ready + Resilient (R+R) strategic investment portfolio. This work has focused on three key areas impacting OHP membership: early life health, behavioral health, and health equity. Across these three domains we have made a number of investments aimed at improving efficiency and quality, including, among other initiatives, Help Me Grow (a resource to connect families and providers to community supports for childhood development), Foster Care Medical homes (to
address the specific health care needs of children in child welfare), and Project Nurture (innovative programming to support pregnant women struggling with addiction).

Moving forward we will continue to make regional investments in this way, aligning with the CCO’s Community Health Improvement Plan, Community Advisory Council and other regional entities using community benefit resources through a Collective Impact lens. We will make these regional investments through the Board-governed Strategic Investment Fund, which is discussed in more detail in questions C1-4 below.

**A.5. What process and analysis will the Applicant use to evaluate investments in Health-Related Services and initiatives to address the Social Determinants of Health & Health Equity (SDOH-HE) in order to improve the health of Members?**

**Evaluating investments in Health-Related Services** – Health Share is committed to evaluating all its investments and assuring the wise stewardship of public resources. To that end we have developed robust evaluative processes for HRS community benefit initiatives throughout our tenure, and have worked on developing sophisticated mechanisms to value the effectiveness of HRS flexible spending.

Health Share’s HRS community benefit investments currently are primarily in the R+R strategic investment portfolio. The evaluation of R+R strategic investments is guided by Health Share’s Monitoring and Evaluation Outcomes Workgroup (MEOW). This framework asks three key questions about investments: “What did we do?”, “How well did we do it?”, and “Is anyone better
off?”. These questions allow for both monitoring and evaluation methods.

- **What did we do?** Monitoring the implementation of each tactic. Examples of monitoring include tracking the progress of Regional Kindergarten Readiness Network (RKRN) implementation and tracking the number of MAT prescribers over time.

- **How well did we do it?** Evaluating fidelity, satisfaction, and collaboration. Examples of this type of evaluation include tracking the level of fidelity of Help Me Grow using national implementation metrics and tracking the level of collaboration within the RKRN network.

- **Is anyone better off?** Evaluating health and system outcomes over the course of the investment and beyond. Examples include tracking the ED utilization of Wheelhouse participants, the 30-day readmission rates of participants in the Community Paramedic program, and the percentage of Project Nurture participants who have long-term custody of their infants at program exit.

The MEOW workgroup meets monthly to guide the allocation evaluation resources to accomplish a full evaluation of R+R outcomes. Examples of resources allocated to date include a partnership with Portland State University to evaluate the level of collaboration within the RKRN and the allocation of internal analytics resources to staff an MAT data workgroup that defined MAT initiation and engagement. Monitoring and evaluation reporting occurs through quarterly reports to the board (high-level summaries of progress, challenges, and potential adjustments), data dashboards (an MAT dashboard and an Early Life Health dashboard have been developed to date), and initiative-specific reports (e.g., a Foster Care Medical Home annual report and the Project Nurture evaluation report). Health Share is well-poised to track broader community health investments using a similar structure. The framework of the MEOW workgroup and the questions it asks can be used within a larger Health Share Quality Health Outcomes Committee.

**Evaluating Health-Related Services: flexible services spending** – Health Share partners’ adoption and utilization of flexible spending have increased exponentially throughout the last five years. Initially evaluative processes have focused on process measures — counting dollars and identifying trends for resources needs. With the implementation of the Social Services Resource Locator (SSRL), we aim to achieve the correlation between addressing social needs and achieving positive health and life outcomes for our members.

SSRL will be offered to staff and providers, to members, caregivers and family members, and to the community. The enterprise-wide SSRL integrates clinical and social care, supported by data integration and partnership with community. This integration is achieved through three elements — Resource Directory, Community Partner Network, and Technology Platform — identifying member-level social needs which can then be tied back to member-level health outcomes data. At the member level, this will allow care team members to identify the success of various interventions for individuals and families, and at the macro level, data can be aggregated to identify changes to population health correlated with meeting social needs. Once this data is captured, we will implement systemic processes to incorporate it into the larger planning process for continued improvement in strategic investing.
Evaluating initiatives to address social determinants of health – Health Share designed a community-driven process to evaluate and prioritize investments in SDOH-HE. Outlined in Health Share Attachment 10 — Community Engagement Plan Table 5 — Health Share is convening a workgroup to develop our Disparity and Social Determinants of Health Spending Implementation plan. This plan will guide Health Share’s investments in SDOH-HE starting in 2021. This workgroup may include CAC members, staff, board, or board committee members; Community Impact Committee and Advisory Committee members; community-based partners; health plan/community benefit partners; local public health authority staff; OHP consumers; Regional Health Equity Coalition members; and more. This group will be charged with developing and implementing a community engagement process (which may include surveys, public listening sessions, stakeholder interviews, and more) to solicit input into the selection and vetting of potential SDOH-HE investments to be included in Health Share Disparities and Social Determinants of Health Spending Implementation plan. Ultimately, this plan will be vetted and approved at Health Share’s February 2020 joint CAC and Board meeting.

Currently, all community partners who receive funding from Health Share submit quarterly reports documenting progress on deliverables and outcomes. Staff produce quarterly dashboards for Health Share’s Board to report on program investments and outcomes. Given the length of time it takes to impact outcomes related to SDOH-HE investments, Health Share will use a combination of process and outcome metrics to measure the effectiveness of SDOH-HE investments in the long term. We will adjust these according to the work of the OHA-convened SDOH-HE Measurement Workgroup.

B. Qualified Directed Payments to Providers

B.1. Does Applicant currently measure, track, or evaluate quality or value of Hospital services provided to its enrollees? If so, please describe.

Health Share understands and supports the goal of OHA to design and implement a new system for distributing Qualified Directed Payments to hospitals, and will align with the necessary criteria for evaluating hospital performance and distributing related funding once the final process is available from OHA and ready for implementation in 2020. Until then, Health Share will continue to expand the monitoring of quality and value of hospital services for the purposes of monitoring member care, meeting performance improvement targets, and distributing payments to hospitals via incentive metrics and value-based payments (VBPs).

Health Share measures and tracks hospital services system-wide provided to its enrollees, which include the plan all-cause readmission rate (PCR); prevention quality indicator (PQI) 01: diabetes; PQI 05: chronic obstructive pulmonary disease admission rate; PQI 08: congestive heart failure admission rate; PQI 15: adult asthma admission rate; short-term complication admission rate; and mental health follow-up after hospitalization. Health Share evaluates the performance of hospital services by tracking the measures in relation to primary care providers insofar as preventing PQI services and readmissions. Measures such as these will be critical in measuring and monitoring the progress and success of Health Share’s expansion of VBP arrangements with Integrated Delivery Systems.

Within specific hospital value-based payment arrangements, CareOregon’s ICN measures quality metrics related to Hospital Acquired Infection Composite Measure, Reducing Revisits for Frequent ED Users, and HCAHPS surveys related to patients receiving explanation of medications from hospital staff. Current data sources and definitions are as follows:
<table>
<thead>
<tr>
<th>Measure</th>
<th>Data Source</th>
<th>Definition/Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Acquired Infection Composite Measure</td>
<td>CMS Hospital Compare</td>
<td>Count of HAI measures (CAUTI, CLASBI, SCIFF, MRSA) where target is met (must meet at least 3 of 4 targets to meet the composite measure)</td>
</tr>
<tr>
<td>Reducing Revisits for Frequent ED User</td>
<td>Claims</td>
<td>Percent of individuals who have 5 qualifying ED visits at the same facilities, who subsequently visit the ED of the same facility within 30 days of the 5th visit</td>
</tr>
<tr>
<td>All-Cause Readmission</td>
<td>Claims</td>
<td>Percent of inpatient visits returning as an acute care inpatient within 30 days of date of initial discharge</td>
</tr>
<tr>
<td>HCAHPS: Staff Always Explained Medicines</td>
<td>CMS Hospital Compare</td>
<td>Percent of patients who said hospital staff “always” told them what their medication was for and possible medication side effects on HCAHPS survey</td>
</tr>
</tbody>
</table>

These VBPs currently operate on a pay-for-reporting structure, with plans to move towards a pay-for-performance incentive withhold in 2020. An additional hospital quality pay-for-performance VBP program already monitors and incentivizes metrics such as:

- Standardized health care-associated infection ratio
- Total cost of care population-based PMPM index (NQF 1604)
- Total resource use population-based PMPM index (NQF 1598)
- All-cause readmission
- HCAHPS
- ED utilization rates

Another example within Health Share is how Providence evaluates clinical quality, appropriateness, and value in key areas of inpatient and outpatient hospital services. The following metrics are part of Providence’s Key Indicator Report:

- ED utilization and ED readmission within 7 days of initial visit
- All-cause inpatient readmissions within 30 days of inpatient discharge, as well as unplanned 30-day readmission
- ED utilization for individuals experiencing mental illness
- C-section rate
- Diagnostic imaging services
- Ambulatory surgery services
- Inpatient length of stay

Providence monitors medical and pharmacy utilization data at specified intervals throughout the year, and a full analysis is completed and reviewed by the Medical Expense Management Committee (MEMC) at least annually. Performance is compared to state or national benchmarks. When benchmarks are unavailable, internal thresholds are developed, taking into consideration regional differences related to standards of care. MEMC develops and recommends appropriate interventions when variations from standards of care are identified. In addition, Providence monitors and conducts case reviews on adverse clinical outcomes; however, due to low numbers, this is monitored and tracked across all lines of business.

C. Quality Pool Operation and Reporting
C.1. Does the Applicant plan to distribute Quality Pool earnings to any public health partners or non-clinical providers, such as SDOH-HE partners or other Health-Related Services Providers? If so, please specify the types of organizations and providers that will be considered.

Proven history of Quality Pool success and community investment – Health Share has a proven history of success related to Quality Pool measures and has consistently invested the funds to support both on-going performance improvement and our community outside of clinic walls. Significant portions of the transformative efforts highlighted in this application stem from these deliberate strategic investments and reflect our commitment to recognizing the importance of
SDOH and equity in the lives of our members and their community. Moving forward into CCO 2.0, Health Share, our Board of Directors, and partner organizations have renewed their commitment to making investments in SDOH-HE and clinical innovation to support member engagement.

As the Quality Pool funds shift into a global budget withhold, the mechanism by which these investments are made to address SDOH-HE and upstream community supports may change to ensure 1) the funding stream is more predictable and sustainable than quality pool earnings have been historically and 2) the timing of these investments are not necessarily paired with the timing of the quality metrics program.

Currently, 15% of earned Quality Pool funds are directed toward these types of regional strategic investments, and that approach will continue while Health Share’s Board of Directors and partner organizations work to create a broader strategic investment fund which will leverage aligned investment from partners’ community benefit funding and committed funds from the CCO’s global budget intended to address upstream issues and SDOH-HE.

As mentioned above, we have developed a community-driven process to vet and prioritize SDOH-HE investments. Health Share’s Attachment 10 — Social Determinants of Health and Health Equity — outlines a process for awarding funds for SDOH-HE investments, including eligibility criteria. In addition to those criteria, SDOH-HE partners must meet the definition of a SDOH-HE partner as defined by OHA’s Social Determinants of Health and Health Equity Glossary:

Community-based entities delivering services and policy and systems change to address the social determinants of health and health equity, including non-profit, non-Medicaid billing, community-based social and human services organizations; culturally specific organizations; local public health authorities; local government and governments-associated entities; Tribes; Early Learning Hubs; local housing authorities; and Regional Health Equity Coalitions.

Quality Pool distributions to support SDOH-HE and HRS – Health Share outlines our Quality Pool distribution strategy in narrative C4. Part of that strategy is the allocation of anticipated quality dollars from monthly capitation payments to a Board-governed strategic investment fund. That fund is dedicated to investments that improve health care quality across the region or have a collective community impact — upstream investments, community strategies that address social determinants of health and equity, and public health investments. We will primarily invest in community-based organizations and public health partners.

Health Share has a track record of successful Quality Pool investments and strategic partnerships. For example, Health Share’s dental partners have used their annual Quality Pool funds to invest in Dental3, a regional collaborative organization with participation from all of Health Share’s dental partners that works with schools, federally qualified health centers (FQHCs), and Head Start programs to provide oral health screenings and dental sealants in community settings.

Health Share also uses Quality Pool earnings to fund Early Learning Hubs, Department of Human Services (DHS) Child Welfare, Community-Based Organizations (CBOs), and Emergency Medical Service providers.

Additionally, Health Share used Quality Pool earnings from 2016 to work with our region’s public health departments and community mental health programs on two social marketing campaigns last year — one in partnership with school-based health centers (SBHCs) encouraging high school students to access adolescent well care visits at their SBHCs, and another focused on destigmatizing behavioral health treatment. Given the success of those campaigns, Health Share is collaborating with the three local public health authorities in our community on three new behavior change
campaigns — on-time vaccines, diabetes treatment, and OHP-covered postpartum care benefits, including depression, immunizations, tobacco cessation, and more. These campaigns use targeted messaging to find Health Share members where they are — searching the Internet, listening to music streaming services, or engaging in social media — and encourage them to access immunizations, diabetes treatment, and postpartum care.

C.2. How much of the Quality Pool earnings does the Applicant plan on distributing to clinical Providers, versus non-clinical providers? Please discuss the approach as it relates to SDOH-HE partners, public health partners, or other Health-Related Services Providers.

Quality Pool investments in improving clinical quality and community health – Health Share outlines our Quality Pool distribution strategy in narrative C4. Approximately 85% of the anticipated quality bonus funds received each year will be distributed to clinical providers to reward past performance and/or incentive future performance. Approximately 15% will be allocated to a Strategic Investment Fund for investments in regional health care quality improvement activities, Health-Related Services community benefit initiatives, and activities to address social determinants of health and health equity. These earnings are distributed to a mix of both clinical and non-clinical providers.

Health Share invests all of its Quality Pool earnings in initiatives to improve the health of its members and the broader community, whether through improved performance on the quality metrics or transformational initiatives that aim to address the root causes of poor health. Depending on the metric, Health Share works with those deemed most likely to impact performance on the metric. In some cases, this means funding clinical providers; in other cases, it means funding non-clinical providers such as peers to walk alongside members as they seek care. In still other cases, offering members their own incentives, such as gift cards for teens to seek adolescent well care, is the most effective strategy. OHA’s metrics program has been foundational in helping Health Share align efforts around particular metrics, as well as the population of interest inherent in each metric. For instance, efforts initially focused on Developmental Screening, Foster Care Assessments, or Effective Contraceptive Use led to broader strategies around health equity, the intersection of CCOs and Child Welfare, and maternal child health respectively. This regional commitment to both metric performance and population health will persist going forward.

Past Quality Pool community investments – Health Share has used Quality Pool earnings to invest in strategic priorities set by our Board, including our Ready + Resilient strategic investment plan, which has three strategic foci: Start Strong (early life health), Support Recovery (behavioral health), and Share Health (health equity). Past initiatives funded with Quality Pool dollars include:

- Establishing Project ECHO in Oregon
- Developing infrastructure that supports community health workers (CHWs) and the health system’s ability to access culturally specific community-based CHWs
- Embedding staff within DHS Child Welfare to serve as liaisons to the medical community
- Creating curriculum to train Peer Family Navigators
- Developing Help Me Grow, a single regional access point for supports and services for families and children needing support for developmental, behavioral, and other social supports
- Establishing a regional Kindergarten Readiness Network
- Providing funding for the Regional Community Health Network (RCHN) that links CBOs and health systems to better meet the social needs of community members

Health Share partner-funded initiatives Quality Pool dollars with non-clinical providers:

- A highly successful “Friendship Line” for older adults
- Suicide prevention efforts
Infrastructure and staffing to screen members for social needs

Funding books through “Reach Out and Read” to support providers’ emphasis on the developmental importance of reading to children

Partnering with Youth Villages on emergency department diversion efforts for children

C.3. How much of the Quality Pool earnings does the Applicant plan on investing outside its own organization? On what would Applicant make such investments?

Outside investment of Quality Pool funds – Historically, Health Share distributes over 99% of Quality Pool earnings to either outside community organizations or Health Share partners as incentive payments. A small portion, typically less than 1%, of earnings support strategic investment functions such as convening cross sector groups, monitoring outcomes, and promoting regional health equity initiatives. Health Share does not retain any Quality Pool funds for CCO reserves. Health Share’s Quality Pool distribution strategy is outlined in narrative C4. Moving forward, the plan is to utilize a similar approach. Health Share and its Board understand the responsibility of public stewardship and the real impact potential of innovation funds. We recognize that these funds can support clinical behavior as well as the systems and interventions that are critical to our members’ success but may not always fall within the health care system itself. As such, a driving value of our work is to ensure that money leaves the CCO and returns to the community to spark real improvement in the services, supports, and systems that are most important to our members’ well-being.

Health Share’s policy governing these resources states that the Quality Pool earnings are to be used to support the ongoing achievement of the incentive quality metrics. It also states that investments must be in alignment with: Health Share’s strategic objectives as identified by the Board of Directors; the Community Health Improvement Plan, public health, or cross-sector (e.g., social service) initiatives; and/or for other purposes identified by Health Share management, the Quality Committee, or the Board of Directors.

In developing proposals for investment of Quality Pool earnings, we have and will continue to use the following guiding principles:

• Be based on strong partner alignment and engagement
• Have a regional utility and address pervasive problems or small, high-risk populations
• Be supportive of objectives of clinical alignment and integration of behavioral, oral, and physical health
• Be supportive of practice transformation efforts for whole person care
• Be reflective of coordinated care model key elements
• Be a catalyst that leads to sustainability, demonstrating the impact of investment to transform care delivery
• Be innovative in the development of payment models that challenge and support practices in transforming care

C.4. How will the Applicant decide and govern its spending of the Quality Pool earnings?

Health Share allocates Quality Pool earnings in two distinct ways: (1) distributed to Health Share’s IDS partners (Kaiser Permanente, Legacy Health, OHSU Health System, and Providence Health & Services) and our ICN partner (CareOregon) to use for incentive payments to providers and (2) allocated to a strategic investment fund governed by Health Share’s Board of Directors.

Approximately 85% of the funds received each year are passed through to the IDS’s and CareOregon. Those partners use the funds for the following purposes:

• Reward high-performing providers who helped Health Share meet or exceed targets
• Support lower-performing providers through infrastructure development, such as technical assistance, funding of staff positions, and other such assistance as identified by provider or Health Share
• Incentivize continued performance
• Help build performance capacity for those providers striving to achieve better performance
• Demonstrate a proactive and consistent approach to distribute funds to align with the metrics based on forward investment

The plans for the specific uses of those funds is governed by Health Share’s Board Quality and Finance Committees and is ultimately approved by Health Share’s full Board of Directors.

Health Share allocates approximately 15% of the funds to Health Share’s strategic investment fund. However, this fund is not actually funded with the quality funds when received (which are received all at once and vary year to year based on performance) but instead are funded from an allocation of the monthly capitation payment that approximates 15% of anticipated quality bonus funds. This lends certainty to the budget and timing for these investments. Governed by Health Share’s Board, this fund allows Health Share to make investments that are aligned with community benefit investments from our hospital system partners and made through strong relationships with community-based organizations, our three county partners, and the health delivery systems. The funds will be dedicated to investments that have a collective community impact, including upstream investments and community strategies that address social determinants of health, equity, and public health investments. All policies, procedures, and payments are overseen by Health Share’s governance structure, all of which report up to and require approval from the Board.

C.5. When will Applicant invest its Quality Pool earnings, compared with when these earnings are received?

Timing of Quality Pool investments – Using early estimates, Health Share’s Quality Committee begins reviewing proposals for estimated funding in the spring, and on average 85% the funds are distributed to partners based on their proposals and performance within a month of receipt by Health Share. Approved proposals for investment include a mix of prospective and retrospective payments for the purposes of incentive payments, strategic investments, and other health care quality improvement activities. Health Share utilizes the remaining 15% of recent funds for more strategic regional investments in health care quality improvement, Health-Related Services community benefit initiatives, SDOH investments, and pilot projects, some of which do require longer timelines for proper development, implementation, and effectiveness. Health Share identifies such investments and allocates all available funding to strategic initiatives within 12 months or less of receipt of funds, often on sizable initiatives that span three years or more for completion. Thus, Health Share does not maintain any Quality Pool funds for the purpose of reserves. We feel that this approach is advantageous for two primary reasons: 1) maintaining good stewardship in utilizing OHP funds in a strategic manner and 2) recognizing that certain investments (such as those related to SDOH) take longer to develop and be impactful than one-time funding. These initiatives require staged investments based upon achievement of established milestones toward strategic goals.
Competing needs to invest money as quickly as possible and invest in long-term community solutions – Developing truly transformative solutions to complex problems is not always easy to do quickly, especially when an organization values effective engagement with affected communities and true collective impact approaches. As an example, Health Share identified significant disparities in developmental screening rates based on language. We engaged with organizations serving immigrants and refugees, primary care, Early Intervention/Early Childhood Special Education (EI/ECSE), home visiting, and childcare providers to learn what might be driving these disparities. That led to engaging with families and staff to make cultural and linguistic adaptations to the developmental screening tool. Now we are hosting meetings with different linguistic and cultural groups to identify what kinds of messages resonate with different communities that promote child development. Authentically engaging with communities takes time and makes our work better.

C.6. Does the Applicant have sufficient cash resources to be able to manage a withhold of a portion of its Capitation Payments?

Health Share will have sufficient cash resources to manage a quality pool withhold within our system.

D. Transparency in Pharmacy Benefit Management Contracts

D.1. Please describe the PBM arrangements Applicant will use for its CCO Members.

Health Share’s IDS and ICN partners each contract with a separate pharmacy benefit manager (PBM). For that reason, we itemized the responses to certain questions in Section D by partner. Detailed specifics pertaining to the PBM arrangements have been included within responses to the Attachment 7 questionnaire, as requested.

CareOregon will use its current contract with OptumRX, Inc. to provide PBM services.

Kaiser Permanente operates its own pharmacies and warehouses, and therefore acts as a direct purchaser of pharmaceuticals.

Legacy Health System has partnered with PacificSource to provide administration of pharmacy benefits. PacificSource will use its current contract with CVS Health to provide PBM services including pharmacy network management, claims adjudication, rebate contracting, specialty pharmacy, and mail-order pharmacy.

OHSU Health System has partnered with OHSU PBM Services to provide administration of pharmacy benefits for OHSU Health System members including but not limited to claims processing, formulary management, supplemental rebates, a nationwide pharmacy network, and development of utilization management guidelines.

Providence Health Assurance (PHA) serves as its own pharmacy benefit administrator.

D.2. Does Applicant currently have a “no-spread” arrangement with its PBM? If not, please describe the steps the Applicant will take to ensure its contracts are compliant with these requirements and the intended timing of these changes. If changes cannot be made by January 1, 2020, please explain why and what interim steps Applicant will take to increase PBM transparency in CY 2020. (In order for an extension in the timeline to be considered, Applicant must show it is contractually obligated to use non-compliant PBM and shall provide OHA a copy of PBM agreement as justification along with a plan to ensure compliance with transparency requirements at the earliest date possible).
D.3. Does the Applicant obtain 3rd party market checks or audits of its PBM arrangement to ensure competitive pricing? If not, does the Applicant have a plan to receive this analysis? If so, how often are these analyses performed, what is done with this third party data and what terms inside of your PBM contract allow this analysis to have power for the CCO to ensure its pharmacy contract remains competitive?

D.4. Does the Applicant plan to use the Oregon Prescription Drug Program to meet the PBM transparency requirements?

Health Share does not plan to use the Oregon Prescription Drug Program to meet the PBM transparency requirements.

E. Alignment Preferred Drug Lists (PDLs) and Prior Authorization Criteria

E.1. Does Applicant currently publish its PDL? If not, please describe the steps the Applicant will take to ensure its PDL is publicly accessible concurrent or in advance of the Year 1 Effective Date for prescribers, patients, dispensing pharmacies, and OHA.

Health Share provides our PDLs and prior authorization criteria on both our and our partners’ public websites for both members and providers to access. The resources include online search tools in most instances. Members can also seek help by calling the customer service lines to further understand these resources.

E.2. Does Applicant currently publish its pharmacy coverage and Prior Authorization criteria concurrently with or in advance of changes made? If not, please describe the steps the Applicant will take to ensure its pharmacy coverage and PA criteria are both publicly accessible for prescribers, patients, dispensing pharmacies, and OHA and updated in a timely manner.

Each of Health Share’s partners engages in continuous evaluation of their own provider network to ensure adequate pharmacy coverage for their assigned members. This evaluation includes geographical availability of pharmacies according to CMS’s established network standards. A network adequacy study is available upon request.
Yes, our prior authorization criteria are posted on each partners’ website after each Pharmacy & Therapeutics Committee (P&T) meeting when proposed changes have been reviewed and approved by the P&T committees. The partners’ websites are all easily accessible from Health Share’s website. Each P&T committee and pharmacy administration team communicates with providers through a variety of methods when significant formulary changes or utilization change strategies (e.g., grandfathering, new starts only, member status, order change forms) occur. Methods of communication include faxing to pharmacies, direct mailings to providers, emails to provider member lists, access to online tools, and e-prescribing. In the event that members will be negatively affected by formulary or PA criteria changes, impacted members and their prescribing providers are notified in advance of changes made.

E.3. To what extent is Applicant’s PDL aligned with OHA’s fee-for-service PDL? Please explain whether and how supplemental rebates or other financial incentives drive differences in the Applicant’s PDL as compared to the fee-for-services PDL

PDL alignment – Upon review of the Myers and Stauffer report, Health Share partners’ PDLs are mostly aligned with each other and with the FFS Medicaid formulary today. Health Share aligns our formularies with the OHA’s goals of benefit coverage, cost, quality, and safety obligations and is producing significant pharmacy trend reduction. We are not fully aligned with OHA’s fee-for-service (FFS) PDL in order to manage costs to meet the annual cost growth target. Our focus is on promoting the most cost-effective options within therapeutic classes and generic products to drive down the lowest purchase price. The differences in alignment are among the few brand drugs with significant state supplemental rebates, such as insulin and inhaler drug categories. Our formularies also have oncology, specialty, and rare disease state medications that are not on the FFS formulary.

Supplemental rebates and other financial incentives – The minimal supplemental rebates made available to CCOs do not drive formulary placement. Evidence-based decision-making and safety are paramount in selecting the most cost-effective quality treatment. Our P&T committees allow local providers and specialists to participate throughout their P&T processes. These important provider inputs help to prioritize formulary decision-making, which is vital in implementation staging.

E.4. Does the Applicant plan to fully align its PDL with the fee-for-service PDL? If not, please describe exceptions.

Health Share will meet the OHA requirements to work together with the other CCOs and OHA to align our PDLs in specific drugs and drug categories. Health Share fully supports lowering drug costs while ensuring we are meeting quality and safety obligations and improving our member experience.

F. Financial Reporting Tools and Requirements

F.1. Does Applicant or any Affiliate of Applicant currently report on NAIC health insurance forms? If so, please describe the reporting company or companies and its relationship with Applicant.

Health Share does not currently report on any NAIC health insurance forms as the current corporate structure and commitments do not require such reporting. Health Share does, however, have a number of affiliated partners that have experience in NAIC reporting, including CareOregon for their Medicare line of business, as well as Kaiser Foundation Health Plan of the Northwest, Providence Health Assurance, and Providence Health Plan for multiple lines of business. Health Share also purchases administrative support services for accounting and financial services, and the service provider has the capability and currently completes relevant NAIC reporting.

F.2. Does the Applicant currently participate and file financial statements with the NAIC?

Health Share does not currently participate and file financial statements with the NAIC.

F.3. Has Applicant prepared a financial statement which includes a RBC calculation? If so, please submit.

Health Share does not currently complete financial statements inclusive of a Risk Based Capital calculation, thus cannot submit such historical financial statements. Health Share does, however,
have a number of affiliated plan partners that prepare financial statements that include RBC calculations, including CareOregon, Kaiser Foundation Health Plan of the Northwest, Providence Health Assurance, and Providence Health Plan.

**F.4. Does the Applicant currently have experience reporting in SAP either directly or through any Affiliate of Applicant?**

Health Share does not currently report in accordance with SAP standards as the current corporate financial statements and accounting principles are in accordance with GAAP. Health Share does however have a number of affiliated plan partners that have experience reporting in SAP, including CareOregon, Kaiser Foundation Health Plan of the Northwest, Providence Health Assurance, and Oregon Health Sciences University. Health Share also purchases administrative support services for accounting and financial services, for which the provider of said services does have the experience reporting in SAP.

**F.5. Does the Applicant seek an exemption from SAP and NAIC reporting for 2020? If yes, please explain in detail (a) the financial hardship related to converting to SAP for the filing, and (b) Applicant’s plan to be ready to use SAP in 2021.**

Health Share does not anticipate the need for an SAP and NAIC reporting exemption for 2020, with the understanding that minimum RBC requirements at an RBC of 200% are not required to be met until the third quarter of 2021 as itemized within the RFA evaluation of pro forma financial statements.

**F.6. Please submit pro forma financial statements of Applicant’s financial condition for three years starting in 2020, using Enrollment, rates and cost projections that presume Applicant is awarded a Contract under this RFA. If OHA expects there may be more than two CCOs in Applicant’s Service Area, OHA may require Applicant to submit additional pro forma financials based on the expected number of CCOs. OHA will evaluate Applicant’s pro forma financials to assure that they provide a realistic plan of solvency. See the RFA Pro Forma Reference Document and UCAA Supplemental Financial Analysis workbook template for a complete description of the requirements and deliverables. The pro forma workbook templates and required supporting documents are excluded from the page limit.**

Completed attachments include the Pro Forma workbook (NAIC Form 13H), the NAIC Biographical Affidavit (NAIC Form 11), the UCAA Supplemental Financial Analysis Workbook, and three years of Audited Financial Statements. Audited financial statements include fiscal years ending 2015, 2016, and 2017, as fiscal year 2018 audited financial statements have not been completed at the time of the application due date. The Pro Forma and Supplemental Financial Analysis workbooks include the following enrollment assumptions: 1) full enrollment of the tri-county region, 2) a low threshold of 62% of the tri-county regional membership, and 3) a high threshold of 125% of the tri-county regional membership. The low threshold of 62% is based on an enrollment assumption of approximately 199,000, which is consistent with Health Share’s fourth quarter of 2017 enrollment for CCO-A only, which is the point in history wherein Health Share operations reflected two CCOs in the tri-county region as well as reasonably stabilized enrollment. The high threshold of 125% is based on an enrollment assumption of approximately 400,100, which is consistent with the current contractually stated and RFA requested capacity for Health Share.

**G. Accountability to Oregon’s Sustainable Growth Targets**

**G.1. What strategies will the Applicant employ to achieve a sustainable expenditure growth year over year?**

Commitment to achieving sustainable expenditure growth – In a commitment to the goal of achieving sustainable rate of expenditure growth, Health Share is committed to significant revisions and optimization to our operations. This includes optimizing partnerships with the major integrated health care finance and delivery systems in the tri-county area, by implementing advanced alternative payment methodologies of a LAN category 4C with each system. Each integrated delivery system will manage the total cost of care within their systems for both physical health care and integrated behavioral health services that are delivered in a primary care setting. Health Share anticipates this greater shift of working more directly with integrated delivery systems in the first two years of CCO
2.0 will provide additional supports towards achieving the targeted annual rate of growth, as well as targets for utilization of VBPs. The shift of population health risk for total cost of care to the actual delivery systems will drive cost containment for the entire Health Share system.

CareOregon’s ICN will include a comprehensive, diverse group of providers and partners across physical health, specialty behavioral health, oral health, and non-emergent transportation, focused on integration across the disciplines and supporting safety net systems of care. ICN contracts will include value-based payment strategies that include cost of care incentive metrics for primary care and risk sharing agreements that incentivize providers to outperform the sustainable growth rate. Additional strategies to manage costs include:

- Managing transitions across systems
- Using PreManage workflow support to smooth transitions of care and reduce ED utilization
- Partnering with PCPs and specialists to improve outcomes for high risk patients
- Optimizing the network by focusing membership on high value clinic systems
- Optimizing specialty referrals using the Rubicon e-consult tool
- Managing the pharmacy benefit through the formulary and medication and utilization management
- Implementing a “Prometheus-Like” tool and payment integrity efforts to identify and reduce potential waste and cost inefficiencies

Reduced cost growth through supporting behavioral health integration – Our increased focus on behavioral health, physical health, and oral health integration is another key strategy for reducing cost growth. Health Share will manage a fully integrated behavioral, oral, and physical health benefit with no delegation of risk or benefit management to an entity outside of Health Share’s coordinating partner organizations. The behavioral health benefit will not be carved out or managed separately from other benefits. Health Share members will have a choice of fully integrated networks, including behavioral health services offered in a primary care setting, across our IDS partners or through the ICN. The IDS partners are fully capitated for all integrated behavioral health and physical health spending, and Health Share will centrally coordinate specialty behavioral health benefits for members through the ICN administered by CareOregon. For example, greater integration will reduce the numbers of untreated substance use conditions, which have historically had higher than average physical health care costs. Substance use disorder focal areas will include maternal child health integration and pregnant women, based on the Project Nurture model. The county partners will also continue to work with CareOregon and IDS colleagues to identify and engage shared populations into specialty behavioral health care. Systems where individuals with behavioral health conditions frequently present include Community Corrections, Juvenile Services, Child Welfare, Law Enforcement, and Housing Services. The counties have close connections to these systems and will continue to partner with them to connect members into needed services.

Reduced cost growth through strategic use of VBPs – Health Share’s focus on adding and expanding the use of VBPs throughout the five years of CCO 2.0 will also play a critical role in achieving a sustainable rate of growth, beyond those areas outlined above. Health Share recognizes that key service delivery categories must be addressed by year 5, for both achieving sustainable rate of growth and VBP payment targets. Thus, focus areas will include areas such as alignment of FQHC members and hospital partners, PCPCHs, children’s care, maternal health, and pharmacy costs. Historically high-cost growth service categories such as hospital and pharmacy are key to sustainable growth. To that point, Health Share intends to leverage multiple VBPs for hospital care, inclusive of pay-for-performance and shared risk models.
Utilization of care coordination for providing efficient and effective health care – Consistent with the name and premise of a CCO, Health Share uses many types of care coordination throughout its networks. Health Share intends the design to improve patient experience and outcome — and minimize inefficiency — for care within physical, behavioral, or oral care domains, as well as for transitions between domains. Where most appropriate, centralized care coordination has been centralized at Health Share, been established and operated by our ICN or IDS partners, or has been kept closer to care delivery and operated by provider organizations within our network. Health Share has and will continue to standardize or align these care coordination efforts.

G.2. How will the CCO allocate and monitor expenditures across all categories of services?

Health Share’s Board and its Finance & Audit Committee will oversee the global budget management for the organization, which allows for one global budget with focus on an overall or combined medical benefit ratio. While Health Share does track the revenue by its designated category (e.g., physical, mental health, oral health, substance use disorders), we ensure that funding of services is not driven by this allocation, but rather by need. Within the global budget, Health Share is able to shift funds based on community need and utilization drivers. Health Share has used this ability to reallocate funds in the current contract as makes sense for partners, providers, and/or members. Examples of this include reallocating capitation for the substance use disorder benefit to the regional behavioral health system of care (“Pathways”) to be managed in coordination with mental health. Another example is Health Share’s current integrated behavioral health pilot, reallocating capitation to allow for a single contract for clinics with embedded behavioral health clinicians. Health Share 2.0’s fully integrated structure will allow our Board, our Community Advisory Council, and our community partners to prioritize and invest in behavioral health and SDOH system improvements in alignment with OHA priorities.

Health Share will allocate dollars and risk at the global budget level to the different systems of care based upon assigned populations. Each system of care will determine the best use of their global budget based upon member need, with consideration for sharing and implementing best practices. Health Share will monitor system spending across the different categories of service and population. Primary monitoring will be via mechanisms such as claims-based analytical systems, financial statements and performance indicators, and claims and financial dashboards. Health Share will also have the ability to monitor spending at the combined level for all systems of care, for regional and statewide comparisons.

Health Share has historically leveraged risk adjustment factors within payment models, driven upon chronic conditions, which has proven effective in informing how our global budget is allocated as well as how our membership is changing. Health Share anticipates that such methodologies may be expanded to also include adjustment factors for SDOH markers within subset populations. Health Share has also continued its commitment to protecting the community safety net system, ensuring that necessary funding is committed up front to that system. Thus, distribution of the total global budget is better allocated based upon a balance of need, strategic direction, and quality of care when merged with VBPs.

When care is fragmented, it makes it hard to see the complete picture of what is driving costs. CCO 2.0 and the combining of behavioral and physical health financial responsibility and claims payment will allow us to see a complete picture of a patient’s utilization patterns. We believe that the integrated financing and payment will enable us to more accurately determine where we have barriers to care or inequities to address. Cost and utilization reporting by service type and category of aid, constructed from integrated data sources, will be monitored to identify and categorize differences from expected results. Where possible, such monitoring will closely follow the methods
and reporting formats used by OHA to evaluate experience and inform VBP development. This would include tools such as Prometheus or Prometheus-like potentially avoidable cost identifiers, service category mapping logic, and SDOH risk stratifiers. Another tool will be utilization of experience studies that show a systematic issue will be addressed through appropriate methods, including contracting, utilization management, optimal site of service, and early intervention to prevent exacerbation of conditions.

G.3. What strategies will the Applicant utilize related to Value-Based Payment arrangements to achieve a sustainable expenditure growth?

Health Share and our partners are national leaders in VBP development, implementation, and adoption and will continue the commitments, efforts, and successes we saw in CCO 1.0. Health Share also supports the vision of expanding VBP contracting in a manner that is consistent with the LAN standards set for by OHA. Many Health Share member organizations are members of the LAN and have been moving in this direction prior to adoption by OHA, enabling Health Share to start out with a strong baseline of payments in VBP 2C or higher. **Health Share is already poised to achieve a 68% VBP threshold in 2020, well above initial requirements for CCO 2.0.** In the coming years, Health Share’s VBP focus areas will include the addition or expansion of VBPs in service categories such as Primary Care (includes PCPCH), Pediatrics, Hospital Services, Maternity Care (with and without Substance Use Disorder), Behavioral Health (includes Medication Assisted Treatment), NEMT, and Oral Health. Health Share is also moving towards a significant shift in integration, contracting with highly integrated finance and delivery systems for medical and integrated behavioral health services.

As previously stated, Health Share is committed to significant revisions and optimization to our operations. This includes shifting to direct contracting and optimizing partnerships with the major integrated health care finance and delivery systems in the tri-county area, by implementing advanced value-based payment methodologies (LAN category 4C) with each system. Each integrated delivery system will manage the total cost of care within their systems for both physical health care and integrated behavioral health services that are delivered in a primary care setting, while being held accountable for integrated quality incentive metrics as part of total compensation.

Value-based payment arrangements will allow us to experiment with different care models, hold providers and hospitals accountable, and fund interventions that may not be associated with traditional fee for service health care. Providers are at different levels of readiness to accept financial risk. We will continue to employ a withhold methodology with both provider and hospital as an VBP in some cases, with the goal of moving to more advanced VBPs such as episode bundles, results-based pharmaceutical contracting, and integration of community resources to address SDOH. Years 1 and 2 of CCO 2.0 will include focusing on hospital and behavioral health, such as VBP programs directed at substance use disorder specific to maternal health, and enhance MAT services delivered in primary care. The Health Share five-year VBP strategy also includes focusing on expanding on VBP progress in CCO 1.0 and the first two years of CCO 2.0, which means addressing service areas such as PCPCH, maternity health, integrated behavioral health, and children’s health — all with the goal of achieving the 70% VBP target and utilizing LAN category 2C or higher VBP arrangements.

**Tools to support VBP** – As outlined in the HIT response (Attachment 9), Health Share also offers all partners access to Health Share Bridge, our analytics and data delivery platform that is the backbone of our quality measurement and reporting system. Interactive Tableau dashboards, accessed through our SharePoint site, reflect monthly updates to performance on health quality indicators and access to tools like our Patient Stratification application. As outlined in the VBP response (Attachment 8), Health Share currently uses and intends to continue expanding the use of
data analytics to support mitigating adverse impacts of VBPs and leverage risk adjustment factors for both chronic conditions and SDOH factors in developing VBP rates.

### G.4. What strategies will the Applicant utilize to contain costs, while ensuring quality care is provided to Members?

As anticipated with a network comprised of multiple highly integrated delivery systems, such strategies will be numerous and diverse in detail. However, the goal of Health Share is to work collaboratively across all partners to leverage best practices in population health management. Examples of strategies being utilized and/or pursued include but are not limited to the following:

- **Align and support statewide measurements and processes**, such as the Prometheus potentially avoidable costs tool, social determinants of health member risk profiling, and integrating approved quality metrics into provider incentive payments
- **Increase emphasis on evidence-based SUD treatment**, which will improve clinical outcomes and reduce overall costs over time
- **Reduce NEMT costs** by developing a provider network with sufficient coverage to provide services closer to the residences of our members
- **Improve care coordination** through continued use of regional care teams — these teams address social determinants of health and barriers to care
- **Control pharmacy costs** through two main mechanisms: 1) formulary management and 2) development of clinical programs that will increase quality and reduce costs
- **Maximize Hepatitis C treatment** for qualified patients, and develop treatment pathways for asthma, COPD, and diabetes
- **Engage physicians in total cost of care initiatives**, which includes evaluation of both cost and quality outcomes
- **Use VBP strategies** to incorporate integrated, coordinated health care with focused attention on health equity, social determinants of health, and PCPCH delivery systems
- **Implement VBPs** that overlap with community partners as well in order to maximize better care, better culture, and better health at a lower cost
- **Utilize administrative best practices** for evaluation of claims to ensure that payments are appropriate, bills are correct, and inappropriate use is flagged
- **Identify members at risk** of increasing severity or whose care pattern suggests difficulty in managing their care to help address the most complex patients whose care disproportionately impacts the total costs of care
- **Utilize provider quality incentive payments** based upon metrics beyond paid statewide metrics, such as access to care and member engagement, in an effort to identify providers and specific areas with the greatest opportunity for improvement

### G.5. Has the Applicant achieved per-Member expenditure growth target of 3.4% per year in the past? Please specify time periods.

Health Share, as with all of the Oregon Health Plan, has realized challenges in historically achieving the 3.4% rate of growth target when looking at it on a full-cost per-member basis. Health Share has been significantly challenged by several factors in recent years making this target especially difficult. Most notable among these challenges is the increase in member risk during the redetermination catch-up process, the release of expensive specialty drugs, costly pharmaceutical price increases, and an increase in mandated member benefits. However, when adjusting for the change in member risk, Health Share’s trend for 2017 decreases from 7.0% to 0.9% and the average per-member trend for the most recent two years decreases from 6.3% to 2.7%, as shown below.
Member risk was calculated using CDPS with Rx 6.2 methodology, concurrent acute weights, and monthly eligibility; uses 13 diagnosis codes; excludes maternity, lab, and radiology claims; and requires 3 months of enrollment.

The final actual rate of growth is not final to date for 2018, but Health Share is optimistic about coming in under 3.4% on an unadjusted basis. The transition of over 100,000 relatively less risky members to Health Share in early 2018 helped bring down the per-member cost trend, the factors noted above that were particularly challenging 2015 through 2017 have become less impactful, and the many programs and interventions Health Share and its affiliates have developed and implemented are also helping to bring down the per-member cost trend. Health Share is committed to achieving the sustainable rate of growth and will continue to optimize its many programs, practices, and payment models to deliver quality care to members at a rate affordable to the State.

### H. Potential Establishment of Program-wide Reinsurance Program in Future Years

Due to the optimization of the Health Share model in partnering with the major integrated health care delivery systems and CareOregon’s integrated community network, Health Share primarily relies upon the reinsurance policies of those systems to cover their assigned populations and risk. For that reason, the responses to all questions in Section H were itemized by system partner where relevant.

#### H.1. What type of reinsurance policy does the Applicant plan on holding for 2020? Please include the specifics. (e.g. attachment points, coinsurance, etc.)

CareOregon expects that the future reinsurance policy to look similar to what is currently in place for CY2019 (January through December). Attachment point is $500,000, and coinsurance is 90%. Eligible expenses are based on physical health fee-for-service claims paid, and specifically exclude sub capitation and/or administration amounts. The current policy is also subject to "lasers," where identified high-cost members (typically 8-12 members each year) are subject to higher attachment points ranging from $600,000 to $1,000,000. Please note that CareOregon has separate policies for our Medicaid and Medicare populations.

Kaiser Foundation Health Plan of the Northwest is self-insured and has a guarantee agreement with Kaiser Foundation Health Plan, Inc. and subsidiaries and Kaiser Foundation Hospital, which meets the regulatory requirements of the Oregon Department of Consumer and Business Services.

The current policy for Legacy Health Systems has an attachment point of $500,000, and coinsurance of 90% (10% retained by PacificSource) up to $5 million, and 100% coinsurance beyond $5 million.

Providence Health Assurance has specific reinsurance coverage for Oregon Health Plan members. As of 2019, the specifics are $275,000 attachment point with a 90% coinsurance and $5,000,000 maximum. All services are included except physician visits. The program is medically underwritten by a third party. There are two current patients who are lasered.

OHSU Health System will hold a policy for 2020 that will be similar to what is in place for 2019. They will begin the renewal for their 2020 policy in September with a January 1 effective date. Current policy specifics:

- **Claims Basis:** Incurred in 12 months and paid in 21 months
- **Covered Membership:** Oregon Health Plan Medicaid Members
- **Coverage Overview:**
  - Comprehensive Coverage
  - 90% of $725,000 in excess of $275,000 per covered person
100% of $4,000,000 in excess of $1,000,000 per covered person

**H.2. What is the Applicant's reasoning for selecting the reinsurance policy described above?**

Reinsurance coverage for CareOregon is a risk mitigation strategy to protect CCO financial reserves from catastrophic cost events. CareOregon carefully analyzes coverage options, premium costs, and estimated recoveries to evaluate projected net costs. Projected net costs are then considered in tandem with the organization's ability/desire for risk tolerance.

The Providence logic for these specifics:

- Reasonable premium to expected recovery rate
- $275,000 reflects about the 3rd standard deviation in log-transformed claims experience and therefore best reflects the outlier experience we are trying to protect against
- $5,000,000 limit is well beyond the annual maximum exposure ever experienced by PHA
- Physician claims are fairly predictable so we do not need to seek protection
- Drugs administered, in any location, are covered
- The cost of lasers is highly predictable (e.g., Factor VIII drugs) so no need for protection from them (we would spend more on coverage than expected recoveries due to carrier administration and margin)

Kaiser Foundation Health Plan of the Northwest is self-insured within its own integrated systems, and the current structure meets the regulatory requirements of the Oregon Department of Consumer and Business Services.

For Legacy Health System, our reasoning is the result of careful analysis of years of multi-line of business work. It is important to us to have flexibility and not need to purchase a policy on top of a state program for reinsurance.

OHSU Health System has partnered with our current reinsurance carrier for 16 years. This long-term relationship allows our reinsurer to fully understand our membership and the associated risk of those members. OHSU Health System has built strong relationships with our reinsurer that allows the staffs of both entities to work well together to manage our highest acuity membership in the most cost effective and patient-centered way. Financially, our long-term relationship with our reinsurer allows OHSU Health System to obtain a policy that provides us leverage to create policy specifications that best meet the cost containment needs of the Alliance. Additionally, there is also an experience refund included in the policy.

**H.3. What aspects of its reinsurance policy are the most important to the Applicant?**

Health Share considers the following aspects as the most important factors in any reinsurance coverage:

- Attachment points (risk mitigation)
- Net reinsurance costs/premium to expected recovery ratios (financial sustainability)
- Reinsurer quality of service
- Best price of premiums with minimal or no lasering

Value added services: Transplant Management, Consultative Care, Cancer Services Network, Provider Negotiations, and exceptional customer service.

**H.4. Does existing or previous reinsurance contract allow specific conditions or patients to be excluded, exempted, or lasered out from being covered?**

CareOregon reinsurance coverage does allow specific conditions or members. It is very common to
laser hemophiliacs and transplant candidates. Rare chronic diseases are now being lasered due to emerging breakthrough therapies.

For Providence Health Assurance, conditions are not excluded but specific patients can be lasered with specific limits to each laser (e.g., a member up to $1,000,000 in cost. Costs after $1,000,000 are covered by reinsurance).

Kaiser Foundation Health Plan of the Northwest is self-insured within its own integrated networks, thus exclusions, exemptions, and lasering are not applicable.

For Legacy Medical Group, a specific member or member's condition can be lasered out but not all costs associated with a condition across the book of business. Our contract terminates at the end of the calendar year.

While OHSU Health System has had prior policies that have allowed exclusions or lasering, because of our long-term relationship with our carrier and the long-term data they are able to analyze for our membership, our current contract has no exemptions, exclusion, or lasers.

H.5. Is Applicant able to leave or modify existing reinsurance arrangements at any time or is Applicant committed to existing arrangements for a set period of time? If so, for how long is Applicant committed to existing arrangements? Are there early cancelation penalties?

CareOregon policies are constructed to be in effect for each calendar year. Premium costs and estimated recoveries are based on YTD (12 months) activity. It is likely that if the organization were required to terminate a policy before the 12-month coverage period, the financial outcome would be that the CCO incurred higher per member per month costs than necessary. Our current policy through our current reinsurer does not have "cancellation" policies, but that does not mean that a future policy would not.

Providence contracts are annual and, while we pay premium on a member month basis, we are obligated for the entire year. Future contracts could be written with a specific termination date if known.

Kaiser Foundation Health Plan of the Northwest is self-insured within its own integrated networks and committed as such in perpetuity, as the arrangements are not subject to cancellation.

The Legacy contract terminates at the end of the calendar year. We make decisions about reinsurance contracts annually.

The current OHSU Health System policy is in place for renewable 12-month periods. The policy does include a Material Change provision, which allows for a 31-day advance written notice to cancel if the reason meets the Material Change standard. OHSU Health System is committed to our current policy through 2019.

I. CCO Solvency Standards and OHA Tools to Regulate and Mitigate Insolvency Risk

I.1. Please describe Applicant’s past sources of capital.

Health Share has historically sourced necessary operating capital from three primary sources, two of which were only used during start-up operations:

1. Capital contributions from founding partner organizations
2. A one-time grant agreement with CareOregon, the basic details of which are included within the footnotes of Health Share’s audited financial statements
3. Dedication of a percentage of Health Share’s OHP capitation payments

The third method has been the long-term operational source. This methodology is consistent with CCO rate setting, wherein a portion of the non-medical component of CCO rates includes risk reserve contributions when deemed actuarially sound.

I.2. Please describe Applicant’s possible future sources of capital.
Health Share anticipates two primary future sources for necessary capital:

1. Dedication of a percentage of Health Share’s OHP capitation payments
2. Capital calls resulting in an infusion of funds from Health Share’s eleven founding partner organizations, as outlined within corporate bylaws

I.3. What strategies will the Applicant use to ensure solvency thresholds are maintained?

Since year two as a CCO, Health Share has successfully forecasted and managed the maintenance of adequate and prudent levels of reserves, solely leveraging a reasonable and prudent percentage of capitation. Health Share has not required additional capital infusions from founding partner organizations after inception. This approach to capital has proven to be sufficient for Health Share, even when experiencing drastic changes to the corporate book of business to the magnitude of a near 50% increase. Health Share realized instant and significant membership, revenue, and expense increases in both 2014 with the ACA expansion and 2018 with the closing of another CCO in Health Share’s region.

Thus, Health Share is confident that current strategies will prove to be sufficient moving forward, using a percentage of capitation as a primary source and a secondary safety net of partner organization capital calls.

I.4. Does Applicant have a parent company, Affiliate, or capital partner from which Applicant may expect additional capital in the event Applicant becomes undercapitalized? If so, please describe.

Health Share of Oregon has eleven founding partner organizations that are committed to the financial support of Health Share, inclusive of capital calls, capital contributions, and contributions to risk reserves. This commitment is codified within our corporate bylaws.

J. Encounter Data Validation Study

J.1. Please describe Applicant’s capacity to perform regular Provider audits and claims review to ensure the timeliness, correctness, and accuracy of Encounter Data.

To meet regulatory and customer requirements, we audit and report on the industry standard performance measures of financial accuracy, processing accuracy, and payment incident accuracy. Once claims are finalized, we are responsible for extracting dental and medical encounter data weekly and combining with other data sources. The encounter data is validated and formatted, and clean data is submitted to the Oregon Health Authority (OHA) via 837 and NCPDP file format within required timeframes.

J.2. Does Applicant currently perform any activities to validate Claims data at the chart level that the claims data accurately reflects the services provided? If yes, please describe those activities.

Chart review for encounter data accuracy is delegated to the IDS’s and ICNs and is part of the annual delegation oversight audit process. Health Share compliance and IT staff review policy, procedure, and supporting documentation of each IDS and ICN partner’s chart audit process, and issue findings and corrective actions if the activities are insufficient to ensure the accuracy of submitted encounter data.

Health Share regularly scores well on the EQR and ISCA auditing that is conducted by OHA via their third party contractors.

Partners utilize a variety of methodologies to perform ongoing chart reviews and validate proper billing and coding. Partner SIU departments, coding compliance departments, appeals and grievance departments, and quality assurance departments, among others, have processes to review charts to ensure claims data accurately reflects the services provided.

For example, CareOregon utilizes a suite of processes, including but not limited to:

• The Payment Integrity Committee perform chart reviews when investigating suspected provider overpayment concerns
• The Audit & Compliance Department may perform limited chart reviews when investigating
suspected fraud or potential noncompliance concerns reported through EthicsPoint (our FWA hotline reporting mechanism) or when suspected fraud or noncompliance is reported directly to the A&C Department

- The Pharmacy Department’s Clinical Coordinator performs medication chart reviews for high-risk members
- The Grievance Department performs chart reviews (on an as-needed basis) upon receipt of a grievance clinical complaint
- The Behavioral Health Team performs chart reviews when evaluating contracted clinic operations
- The Quality Assurance Team has a clinical chart review process that is initiated when a Quality of Care concern is reported by internal employees
- The Quality Assurance Department performs post-service chart reviews for claim denials appealed by providers

As another example, Providence Health Assurance performs activities to validate claims data in several ways:

- The SIU requires chart documentation and performs chart abstraction to investigate allegations of fraud waste or abuse
- The Risk Adjustment Program (HCC) obtains chart documentation to validate the diagnosis codes for services reported as HCCs in encounter data
- The Coding Compliance function audits chart notes as a part of the Clinical Editing System provider appeal process to determine if the services documented were billed and denied appropriately
- The SIU also conducts the Medicaid Data Validation function, pulling a sample of a broad range of types of services to ensure they are appropriately documented in the medical record
- Healthcare Services Care Coordination Medical Management Nurses will audit chart notes on provider appeal of claim denials for violations of medical policy
- If provider bills an unlisted code both the Healthcare Services nurses and Pharmacy department technicians will review chart notes for accurate coding and to determine appropriate claims payment
- For high dollars over $15,000, claims are routed for review to ensure services are appropriately documented and paid
Attachment 12, Question F, Biographical Affidavits (NAIC Form 11)

All Biographical Affidavits (NAIC Form 11) redacted per Attachment 4, Disclosure Exemption Certificate.
Attachment 12, Question F, Pro Forma Workbook Templates (NAIC Form 13H)

Pro Forma Workbook Templates (NAIC Form 13H) redacted per Attachment 4, Disclosure Exemption Certificate.
Attachment 12, Question F, UCAA Supplemental Financial Analysis Workbook Template

UCAA Supplemental Financial Analysis Workbook Template redacted per Attachment 4, Disclosure Exemption Certificate.
Attachment 13 — Attestations

Applicant Name:  Health Share of Oregon

Authorizing Signature:  Maggie Bennington-Davis, MD

Printed Name:  Maggie Bennington-Davis, MD

Instructions: For each attestation, Applicant will check “yes,” or “no.” A “yes” answer is normal, and an explanation will be furnished if Applicant’s response is “no.” Applicant must respond to all attestations. If an attestation has more than one question and Applicant’s answer is “no” to any question, check “no” and provide an explanation.

These attestations must be signed by a representative of Applicant.

Unless a particular item is expressly effective at the time of Application, each attestation is effective starting at the time of Readiness Review and continuing throughout the term of the Contract. Each section of attestations refers to a questionnaire in an Attachment, which may furnish background and related questions.

A. General Questions Attestations (Attachment 6)

1. Contract
   a. Is Applicant willing to enter into a Contract for 2020 in the form of Appendix B?
      ☑ Yes  ☐ No
      If “no” please provide explanation: ________________________________
   b. Is Applicant willing to satisfy Readiness Review standards by September 30, 2019?
      ☑ Yes  ☐ No
      If “no” please provide explanation: ________________________________

2. Subcontracts
   a. Is Applicant willing to hold written agreements with Subcontractors that clearly describe the scope of work?
      ☑ Yes  ☐ No
      If “no” please provide explanation: ________________________________
   b. Is Applicant willing to provide to OHA an inventory of all work described in this Contract that is delegated or subcontracted and identify the entity performing the work?
      ☑ Yes  ☐ No
      If “no” please provide explanation: ________________________________
   c. Is Applicant willing to provide to OHA unredacted copies of written agreements with Subcontractors?
      ☑ Yes  ☐ No
      If “no” please provide explanation: ________________________________
3. Third Party Liability and Personal Injury Lien
   a. Is Applicant willing to identify and require its Subcontractors and Providers to identify and promptly report the presence of a Member’s Third Party Liability?
      ☑ Yes  ☐ No
      If “no” please provide explanation: ________________________________

   b. Is Applicant willing to document all efforts to pursue financial recoveries from third party insurers?
      ☑ Yes  ☐ No
      If “no” please provide explanation: ________________________________

   c. Is Applicant willing to report and require its Subcontractors to report all financial recoveries from third party insurers?
      ☑ Yes  ☐ No
      If “no” please provide explanation: ________________________________

   d. Is Applicant willing to provide and require its Affiliated entities and Subcontractors to provide to OHA all information related to TPL eligibility to assist in the pursuit of financial recovery?
      ☑ Yes  ☐ No
      If “no” please provide explanation: ________________________________

4. Oversight and Governance
   a. Is Applicant willing to provide its organizational structure, identifying any relationships with subsidiaries and entities with an ownership or Control stake?
      ☑ Yes  ☐ No
      If “no” please provide explanation: ________________________________
B. Provider Participation and Operations Attestations (Attachment 7)

1. General Questions

a. Will Applicant have an individual accountable for each of the operational functions described below?

- Contract administration
- Outcomes and evaluation
- Performance measurement
- Health management and Care Coordination activities
- System coordination and shared accountability between DHS Medicaid-funded LTC system and CCO
- Behavioral Health (mental health and addictions) coordination and system management
- Communications management to Providers and Members
- Provider relations and network management, including credentialing
- Health information technology and medical records
- Privacy officer
- Compliance officer
- Quality Performance Improvement
- Leadership contact for single point of accountability for the development and implementation of the Health Equity Plan
- Traditional Health Workers Liaison

☑ Yes □ No
If “no” please provide explanation: ________________________________

b. Will Applicant participate in the Learning Collaboratives required by ORS 442.210?

☑ Yes □ No
If “no” please provide explanation: ________________________________

c. Will Applicant collect, maintain and analyze race, ethnicity, and preferred spoken and written languages data for all Members on an ongoing basis in accordance with standards jointly established by OHA and DHS in order to identify and track the elimination of health inequities?

☑ Yes □ No
If “no” please provide explanation: ________________________________
d. Will Applicant (i) authorize the provision of a drug requested by the Primary Care Physician (PCP) or Referral Provider, if the approved prescriber certifies medical necessity for the drug such as: the formulary’s equivalent has been ineffective in the treatment or the formulary’s drug causes or is reasonably expected to cause adverse or harmful reactions to the Member and (ii) reimburse Providers for dispensing a 72-hour supply of a drug that requires Prior Authorization?

☑ Yes ☐ No

If “no” please provide explanation: ________________________________


e. Will Applicant comply with all applicable Provider requirements of Medicaid law under 42 CFR Part 438, including Provider certification requirements, anti-discrimination requirements, Provider participation and consultation requirements, the prohibition on interference with Provider advice, limits on Provider indemnification, rules governing payments to Providers, and limits on physician incentive plans?

☑ Yes ☐ No

If “no” please provide explanation: ________________________________


f. Will Applicant ensure that all Provider, facility, and supplier contracts or agreements contain the required contract provisions that are described in the Contract?

☑ Yes ☐ No

If “no” please provide explanation: ________________________________


g. Will Applicant have executed Provider, facility, and supplier contracts in place to demonstrate adequate access and availability of Covered Services throughout the requested Service Area?

☑ Yes ☐ No

If “no” please provide explanation: ________________________________


h. Will Applicant have all Provider contracts or agreements available to OHA in unredacted form?

☑ Yes ☐ No

If “no” please provide explanation: ________________________________


i. Will Applicant’s contracts for administrative and management services contain the OHA required Contract provisions?

☑ Yes ☐ No

If “no” please provide explanation: ________________________________
j. Will Applicant establish, maintain, and monitor the performance of a comprehensive network of Providers to ensure sufficient access to Medicaid Covered Services, including comprehensive behavioral and oral health services, as well as supplemental services offered by the CCO in accordance with written policies, procedures, and standards for participation established by the CCO? Participation status will be revalidated at appropriate intervals as required by OHA regulations and guidelines.

☑ Yes ☐ No

If "no" please provide explanation: __________________________________________

k. Will Applicant have executed written agreements with Providers (first tier, downstream, or related entity instruments) structured in compliance with OHA regulations and guidelines?

☑ Yes ☐ No

If "no" please provide explanation: __________________________________________

l. Will Applicant have executed written agreements with Local Mental Health Authorities throughout its Service Area, structured in compliance with OHA regulations and guidelines?

☑ Yes ☐ No

If "no" please provide explanation: __________________________________________

m. Will Applicant develop a comprehensive Behavioral Health plan in collaboration with the Local Mental Health Authority and other Community partners?

☑ Yes ☐ No

If "no" please provide explanation: __________________________________________

n. Will Applicant coordinate and collaborate on the development of the Community health improvement plan (CHP) under ORS 414.627 with the Local Mental Health Authority's comprehensive local plan for the delivery of mental health services (ORS 430.630)?

☑ Yes ☐ No

If "no" please provide explanation: __________________________________________
o. Will Applicant, through its contracted Participating Provider Network, along with other specialists outside the network, Community resources or social services within the CCO’s Service Area, provide ongoing primary care, Behavioral Health care, oral health care, and specialty care as needed and will guarantee the continuity of care and the integration of services as described below?

- Prompt, convenient, and appropriate access to Covered Services by Members 24 hours a day, 7 days a week;
- The coordination of the individual care needs of Members in accordance with policies and procedures as established by the Applicant;
- Member involvement in decisions regarding treatment, proper education on treatment options, and the coordination of follow-up care;
- Effectively addressing and overcoming barriers to Member compliance with prescribed treatments and regimens; and
- Addressing diverse patient populations in a linguistically diverse and culturally competent manner.

☐ Yes  ☐ No
If “no” please provide explanation:

p. Will Applicant establish policies, procedures, and standards that:

- Ensure and facilitate the availability, convenient, and timely access to all Medicaid Covered Services as well as any supplemental services offered by the CCO;
- Ensure access to medically necessary care and the development of medically necessary individualized care plans for Members;
- Promptly and efficiently coordinate and facilitate access to clinical information by all Providers involved in delivering the individualized care plan of the Member while following Timely Access to Services standards;
- Communicate and enforce compliance by Providers with medical necessity determinations; and
- Do not discriminate against Medicaid Members, including providing services to individuals with disabilities in the most integrated Community setting appropriate to the needs of those individuals.

☐ Yes  ☐ No
If “no” please provide explanation:
q. Will Applicant have verified that contracted Providers included in the CCO Facility Table are Medicaid certified and the Applicant certifies that it will only contract with Medicaid certified Providers in the future?
☑ Yes ☐ No
If “no” please provide explanation: ____________________________________________________________

r. Will Applicant provide all services covered by Medicaid and comply with OHA coverage determinations?
☑ Yes ☐ No
If “no” please provide explanation: ____________________________________________________________

s. Will Applicant have an Medicare plan to serve Fully Dual Eligibles either through contractual arrangement or owned by Applicant or Applicant parent company to create integrated Medicare-Medicaid opportunities during the contract period? [Plan can be a Dual Special Needs Plan or MA plan that offers low premiums and integrated Part D medications options].
☑ Yes ☐ No
If “no” please provide explanation: ____________________________________________________________

t. Will Applicant, Applicant staff and its Affiliated companies, subsidiaries or Subcontractors (first tier, downstream, and related entities), and Subcontractor staff be bound by 2 CFR 376 and attest that they are not excluded by the Department of Health and Human Services Office of the Inspector General or by the General Services Administration? Please note that this attestation includes any member of the board of directors, key management or executive staff or major stockholder of the Applicant and its Affiliated companies, subsidiaries or Subcontractors (first tier, downstream, and related entities).
☑ Yes ☐ No
If “no” please provide explanation: ____________________________________________________________

u. Is it true that neither the state nor federal government has brought any past or pending investigations, legal actions, administrative actions, or matters subject to arbitration involving the Applicant (and Applicant’s parent corporation, subsidiaries, or entities with an ownership stake, if applicable) or its Subcontractors, including key management or executive staff, or major shareholders over the past three years on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services?
☑ Yes ☐ No
If “no” please provide explanation: ____________________________________________________________
2. Network Adequacy
   a. Is Applicant willing to monitor and evaluate the adequacy of its Provider Network?
      ✔ Yes  □ No
      If “no” please provide explanation: ____________________________________________

   b. Is Applicant willing to remedy any deficiencies in its Provider Network within a specified timeframe when deficiencies are identified?
      ✔ Yes  □ No
      If “no” please provide explanation: ____________________________________________

   c. Is Applicant willing to report on its Provider Network in a format and frequency specified by OHA?
      ✔ Yes  □ No
      If “no” please provide explanation: ____________________________________________

   d. Is Applicant willing to collect data to validate that its Members are able to access care within time and distance requirements?
      ✔ Yes  □ No
      If “no” please provide explanation: ____________________________________________

   e. Is Applicant willing to collect data to validate that its Members are able to make appointments within the required timeframes?
      ✔ Yes  □ No
      If “no” please provide explanation: ____________________________________________

   f. Is Applicant willing to collect data to validate that its Members are able to access care within the required timeframes?
      ✔ Yes  □ No

   g. Is Applicant willing to arrange for Covered Services to be provided by Non-Participating Providers if the services are not timely available within Applicant’s Provider Network?
      ✔ Yes  □ No

3. Fraud, Waste and Abuse Compliance
   a. Is Applicant willing to designate a Compliance Officer to oversee activities related to the prevention and detection of Fraud, Waste and Abuse?
      ✔ Yes  □ No
      If “no” please provide explanation: ____________________________________________

b. Is Applicant willing to send two representatives, including the Applicant's designated Compliance Officer and another member of the senior executive team to attend a mandatory Compliance Conference on May 30, 2019?

☑ Yes  □ No

If “no” please provide explanation: __________________________________________

C. Value-Based Payment (VBP) Attestations (Attachment 8)

1. Have you reviewed the VBP Policy Requirements set forth in the VBP Questionnaire?

☑ Yes  □ No

If “no” please provide explanation: __________________________________________

2. Have you reviewed the VBP reference documents linked to the VBP Questionnaire?

☑ Yes  □ No

If “no” please provide explanation: __________________________________________


☑ Yes  □ No

If “no” please provide explanation: __________________________________________

4. Will you begin CCO 2.0 – January 2020 – with at least 20% of your projected annual payments to your Providers under contracts that include a Value-Based Payment component as defined by the Health Care Payment Learning and Action Network's (LAN's) “Alternative Payment Model Framework White Paper Refreshed 2017” (https://hcp-lan.org/apm-refresh-white-paper/), Pay for Performance category 2C or higher and the OHA Value-Based Payment Roadmap Categorization Guidance for Coordinated Care Organizations?

☑ Yes  □ No

If “no” please provide explanation: __________________________________________

5. Do you permit OHA to publish your VBP data such as the actual VBP percent of spending that is LAN category 2C or higher and spending that is LAN category 3B or higher, as well as data pertaining to your care delivery areas, Patient-Centered Primary Care Home (PCPCH) payments, and other information about VBPs required by this RFA? (OHA does not intend to publish specific payments amounts from an Applicant to a specific provider.)

☑ Yes  □ No

If “no” please provide explanation: __________________________________________
6. Do you agree to develop mitigation plans for adverse effects VBPs may have on health inequities, health disparities, or any adverse health-related outcomes for any specific population (including racial, ethnic and culturally-based communities; LGBTQ people; persons with disabilities; people with limited English proficiency; and immigrants or refugees and Members with complex healthcare needs, as well as populations at the intersections of these groups) and to report on these plans to OHA annually?

☑ Yes  ☐ No

If “no” please provide explanation: ____________________________________________

7. Do you agree to the requirements for VBP targets, care delivery areas and PCPCH clinics for years 2020 through 2024, as set forth in the VBP Questionnaire?

☑ Yes  ☐ No

If “no” please provide explanation: ____________________________________________

8. Do you agree to the requirements for VBP data reporting for years 2020 through 2024, as set forth in the VBP Questionnaire?

☑ Yes  ☐ No

If “no” please provide explanation: ____________________________________________

9. Should OHA contract with one or more other CCOs serving Members in the same geographical area, will you participate in OHA-facilitated discussions to select performance measures to be incorporated into each CCO’s VBP Provider contracts for common Provider types and specialties?

☑ Yes  ☐ No

If “no” please provide explanation: ____________________________________________

10. If, after the discussion described in the previous question, OHA informs you of the Provider types and specialties for which the performance measures apply, will you incorporate all selected measures into applicable Provider contracts?

☑ Yes  ☐ No

If “no” please provide explanation: ____________________________________________
D. Health Information Technology (HIT) Attestations (Attachment 9)

1. HIT Roadmap
   a. Does Applicant agree to participate in an interview/demonstration and deliver an HIT Roadmap with any refinements/adjustments agreed to with OHA during Readiness Review, for OHA approval?
      ☑ Yes  □ No
      If “no” please provide explanation: ____________________________

   b. Does Applicant agree to provide an annual HIT Roadmap update for OHA approval to include status/progress on CCO-identified milestones, and any adjustments to the HIT Roadmap; as well as participate in an annual interview with OHA?
      ☑ Yes  □ No
      If “no” please provide explanation: ____________________________

2. HIT Partnership
   a. Does Applicant agree to participate in the HIT Commons beginning 2020, including agreeing to do all of the following:
      • Maintaining an active, signed HIT Commons MOU and adhering to its terms,
      • Paying annual HIT Commons assessments, and
      • Serving, if elected, on the HIT Commons Governance Board or one of its committees?
      ☑ Yes  □ No
      If “no” please provide explanation: ____________________________

   b. Does Applicant agree to participate in OHA’s HIT Advisory Group, (HITAG), at least once annually?
      ☑ Yes  □ No
      If “no” please provide explanation: ____________________________

3. Support for EHR Adoption
   a. Will Applicant support EHR adoption for its contracted physical health Providers?
      ☑ Yes  □ No
      If “no” please provide explanation: ____________________________
b. Will Applicant support EHR adoption for its contracted Behavioral Health Providers?
   ☑ Yes ☐ No
   If "no" please provide explanation: ________________________________

c. Will Applicant support EHR adoption for its contracted oral health Providers?
   ☑ Yes ☐ No
   If "no" please provide explanation: ________________________________

d. During Year 1, will Applicant report on the baseline of EHR adoption among its
   contracted physical health Providers, set Improvement Targets, and provide supporting
detail about its implementation approach?
   ☑ Yes ☐ No
   If "no" please provide explanation: ________________________________

e. During Year 1, will Applicant report on the baseline of EHR adoption among its
   contracted Behavioral Health Providers, set Improvement Targets, and provide
   supporting detail about its implementation approach?
   ☑ Yes ☐ No
   If "no" please provide explanation: ________________________________

f. During Year 1, will Applicant report on the baseline of EHR adoption among its
   contracted oral health Providers, set Improvement Targets, and provide supporting detail
   about its implementation approach?
   ☑ Yes ☐ No
   If "no" please provide explanation: ________________________________

g. Will Applicant report to the state annually on which EHR(s) each of its contracted
   physical health Providers is using, by means of definitions and data sources agreed upon
during Readiness Review? Will reports include product and vendor name, version, and, if
applicable, certification year the ONC Certification (CHPL) number for Certified EHR
Technology? See https://chpl.healthit.gov/ and
Certified EHR Technology.
   ☑ Yes ☐ No
   If "no" please provide explanation: ________________________________
h. Will Applicant report to the state annually on which EHR(s) each of its contracted Behavioral Health Providers are using, by means of definitions and data sources agreed upon during Readiness Review? Will reports include product and vendor name, version, and, if applicable, certification year the ONC Certification (CHPL) number for Certified EHR Technology? See https://chpl.healthit.gov/ and https://www.healthit.gov/topic/certification-ehrs/2015-edition for more information about Certified EHR Technology.

☑ Yes ☐ No

If “no” please provide explanation: ________________________________________________________________

i. Will Applicant report to the state annually on which EHR(s) each of its contracted oral health Providers is using, by means of definitions and data sources agreed upon during Readiness Review? Will reports include product and vendor name, version, and, if applicable, certification year the ONC Certification (CHPL) number for Certified EHR Technology? See https://chpl.healthit.gov/ and https://www.healthit.gov/topic/certification-ehrs/2015-edition for more information about Certified EHR Technology.

☑ Yes ☐ No

If “no” please provide explanation: ________________________________________________________________

4. Support for HIE

a. Will Applicant ensure access to timely Hospital event notifications for its contracted physical health Providers? If there are costs associated with ensuring access to timely Hospital event notifications for contracted Providers, will the Applicant be responsible for those costs?

☑ Yes ☐ No

If “no” please provide explanation: ________________________________________________________________

b. Will Applicant ensure access to timely Hospital event notifications for its contracted Behavioral Health Providers? If there are costs associated with ensuring access to timely Hospital event notifications for contracted Providers, will the Applicant be responsible for those costs?

☑ Yes ☐ No

If “no” please provide explanation: ________________________________________________________________

c. Will Applicant ensure access to timely Hospital event notifications for its contracted oral health Providers? If there are costs associated with ensuring access to timely Hospital event notifications for contracted Providers, will the Applicant be responsible for those costs.

☑ Yes ☐ No

If “no” please provide explanation: ________________________________________________________________
d. Will Applicant use Hospital event notifications within the CCO, for example to support Care Coordination and/or population health efforts?

☑ Yes ☐ No
If “no” please provide explanation: ________________________________

e. Will Applicant support access to health information exchange that enables sharing patient information for Care Coordination for its contracted physical health Providers?

☑ Yes ☐ No
If “no” please provide explanation: ________________________________

f. Will Applicant support access to health information exchange that enables sharing patient information for Care Coordination for its contracted Behavioral Health Providers?

☑ Yes ☐ No
If “no” please provide explanation: ________________________________

g. Will Applicant support access to health information exchange that enables sharing patient information for Care Coordination for its contracted oral health Providers?

☑ Yes ☐ No
If “no” please provide explanation: ________________________________

h. During Year 1, will Applicant report on the baseline of HIE access and use among its contracted physical health Providers (inclusive of Hospital event notifications and HIE for Care Coordination), set Improvement Targets, and provide supporting detail about its implementation approach?

☑ Yes ☐ No
If “no” please provide explanation: ________________________________

i. During Year 1, will Applicant report on the baseline of HIE access and use among its contracted Behavioral Health Providers (inclusive of Hospital event notifications and HIE for Care Coordination), set Improvement Targets, and provide supporting detail about its implementation approach?

☑ Yes ☐ No
If “no” please provide explanation: ________________________________
j. During Year 1, will Applicant report on the baseline of HIE access and use among its contracted oral health Providers (inclusive of Hospital event notifications and HIE for Care Coordination), set Improvement Targets, and provide supporting detail about its implementation approach?
   ☑ Yes  ☐ No
   If “no” please provide explanation: ________________________________

k. Will Applicant report to the state annually on which HIE tool(s) each of its contracted physical health Providers is using, using definitions and data sources agreed upon during Readiness Review?
   ☑ Yes  ☐ No
   If “no” please provide explanation: ________________________________

l. Will Applicant report to the state annually on which HIE tool(s) each of its contracted Behavioral Health Providers is using, using definitions and data sources agreed upon during Readiness Review?
   ☑ Yes  ☐ No
   If “no” please provide explanation: ________________________________

m. Will Applicant report to the state annually on which HIE tool(s) each of its contracted oral health Providers is using, using definitions and data sources agreed upon during Readiness Review?
   ☑ Yes  ☐ No
   If “no” please provide explanation: ________________________________


   a. For the initial VBP arrangements, will Applicant have by the start of Year 1 the HIT needed to administer the arrangements (as described in its supporting detail)?
      ☑ Yes  ☐ No
      If “no” please provide explanation: ________________________________

   b. For the planned VBP arrangements for Years 2 through 5, does Applicant have a roadmap to obtain the HIT needed to administer the arrangements (as described in its supporting detail)?
      ☑ Yes  ☐ No
      If “no” please provide explanation: ________________________________
c. By the start of Year 1, will the Applicant provide contracted Providers with VBP arrangements with timely (e.g., at least quarterly) information on measures used in the VBP arrangement(s) applicable to the Providers?

☐ Yes  ☐ No

If “no” please provide explanation: ________________________________

d. By the start of Year 1, will the Applicant provide contracted Providers with VBP arrangements with accurate and consistent information on patient attribution?

☐ Yes  ☐ No

If “no” please provide explanation: ________________________________

e. By the start of Year 1, will the Applicant identify for contracted Providers with VBP arrangements specific patients who need intervention through the year, so they can take action before the year end?

☐ Yes  ☐ No

If “no” please provide explanation: ________________________________

f. By the start of Year 1, will the Applicant have the capability to risk stratify and identify and report upon Member characteristics, including but not limited to past diagnoses and services, that can inform the targeting of interventions to improve outcomes?

☐ Yes  ☐ No

If “no” please provide explanation: ________________________________

g. By the start of each subsequent year for Years 2 through 5, will the Applicant CCO provide risk stratification and Member characteristics to your contracted Providers with VBP arrangements for the population(s) included in the arrangement(s) in place for each year?

☐ Yes  ☐ No

If “no” please provide explanation: ________________________________

E. Social Determinants of Health and Health Equity (SDOH-HE) Attestations (Attachment 10)

1. Social Determinants of Health and Health Equity Spending, Priorities, and Partnership

a. Is Applicant willing to direct a portion of its annual net income or reserves, as required by Oregon State Statute and defined by OHA in rule, to addressing health disparities and SDOH-HE?

☐ Yes  ☐ No

If “no” please provide explanation: ________________________________
b. Is Applicant willing to enter into written agreements with SDOH-HE partners that describe the following: any relationship or financial interest that may exist between the SDOH-HE partner and the CCO, how funds will be distributed, the scope of work including the domain of SDOH-HE addressed and the targeted population, whether CCO will refer Members to the SDOH-HE partner, the geographic area to be covered, how outcomes will be evaluated and measured, and how the CCO will collect and report data related to outcomes?

☑ Yes  ☐ No
If “no” please provide explanation: ______________________________________

c. When identifying priorities for required SDOH-HE spending, is Applicant willing to designate, define and document a role for the CAC in directing, tracking and reviewing spending?

☑ Yes  ☐ No
If “no” please provide explanation: ______________________________________

d. Is Applicant willing to align its SDOH-HE spending priorities with the priorities identified in the Community Health Improvement Plan and its Transformation and Quality Strategy, and to include at least one statewide priority (e.g. housing-related services and supports, including Supported Housing) in addition to its Community priorities?

☑ Yes  ☐ No
If “no” please provide explanation: ______________________________________

2. Health-related Services

a. Is Applicant willing to align HRS Community benefit initiatives with Community priorities from the CCO’s Community Health Improvement Plan?

☑ Yes  ☐ No
If “no” please provide explanation: ______________________________________

b. Is Applicant willing to align HRS Community benefit initiatives with a designated statewide priority should OHA require it?

☑ Yes  ☐ No
If “no” please provide explanation: ______________________________________
c. Is Applicant willing to designate, define and document a role for the CAC when
determining how Health-Related Services Community benefit initiatives decisions are made?

☐ Yes   ☐ No

If “no” please provide explanation: __________________________________________

3. Community Advisory Council membership and role
   a. Is the Applicant willing to provide to OHA an organizational chart that includes the
      Community Advisory Council, and notes relationships between entities, including the
      CAC and the Board, how information flows between the bodies, the CAC and Board
      connection to various committees, and CAC representation on the board?

☐ Yes   ☐ No

If “no” please provide explanation: __________________________________________

4. Health Equity Assessment and Health Equity Plan
   a. Is Applicant willing to develop and implement a Health Equity Plan according to OHA
      guidance, which includes a plan to provide cultural responsiveness and implicit bias
      education and training across the Applicant’s organization and Provider Network? See

☐ Yes   ☐ No

If “no” please provide explanation: __________________________________________

   b. Is Applicant willing to include in its Health Equity Plan at least one initiative using HIT
to support patient engagement?

☐ Yes   ☐ No

If “no” please provide explanation: __________________________________________

   c. Is Applicant willing to adopt potential health equity plan changes, including
      requirements, focus areas and components, based on OHA plan review feedback and,
      when applicable, based on guidance provided by the Oregon Health Policy Board’s
      Health Equity Committee?

☐ Yes   ☐ No

If “no” please provide explanation: __________________________________________
d. Is Applicant willing to designate a single point of accountability within the organization, who has budgetary decision-making authority and health equity expertise, for the development and implementation of the Health Equity Plan?

☑ Yes  □ No

If “no” please provide explanation: __________________________________________________________

e. Is Applicant willing to faithfully execute the finalized Health Equity Plan?

☑ Yes  □ No

If “no” please provide explanation: __________________________________________________________

f. Is Applicant willing to a) ask vendors for cultural and linguistic accessibility when discussing bringing on new HIT tools for patient engagement and b) when possible, seek out HIT tools for patient engagement that are culturally and linguistically accessible?

☑ Yes  □ No

If “no” please provide explanation: __________________________________________________________

5. Traditional Health Workers (THW) Utilization and Integration

a. Is Applicant willing to develop and fully implement a Traditional Health Workers Integration and Utilization Plan?

☑ Yes  □ No

If “no” please provide explanation: __________________________________________________________

b. Is Applicant willing to work in collaboration with the THW Commission to implement the Commission’s best practices for THW integration and utilization?

☑ Yes  □ No

If “no” please provide explanation: __________________________________________________________

c. Is Applicant willing to fully implement the best practices developed in collaboration with the THW Commission?

☑ Yes  □ No

If “no” please provide explanation: __________________________________________________________

d. Is Applicant willing to develop and implement a payment strategy for THWs that is informed by the recommendations from the Payment Model Committee of the THW Commission?

☑ Yes  □ No

If “no” please provide explanation: __________________________________________________________
e. Is Applicant willing to designate an individual within the organization as a THW Liaison as of the Effective Date of the Contract?
   - Yes ☑  No ☐
   If “no” please provide explanation: ________________________________________________________________

f. Is Applicant willing to engage THWs during the development of the CHA and CHP?
   - Yes ☑  No ☐
   If “no” please provide explanation: ________________________________________________________________

g. For services that are not captured on encounter claims, is Applicant willing to track and document Member interactions with THWs?
   - Yes ☑  No ☐
   If “no” please provide explanation: ________________________________________________________________

6. Community Health Assessment and Community Health Improvement Plan
   a. Is Applicant willing to partner with local public health authorities, non-profit Hospitals, any CCO that shares a portion of its Service Area, and any Tribes that are developing a CHA/CHP to develop shared CHA and CHP priorities?
      - Yes ☑  No ☐
      If “no” please provide explanation: ________________________________________________________________

   b. Is Applicant willing to align CHP priorities with at least two State Health Improvement Plan (SHIP) priorities and implement statewide SHIP strategies based on local need?
      - Yes ☑  No ☐
      If “no” please provide explanation: ________________________________________________________________

   c. Is Applicant willing to submit its Community Health Assessment and Community Health Improvement Plan to OHA?
      - Yes ☑  No ☐
      If “no” please provide explanation: ________________________________________________________________

   d. Is Applicant willing to develop and fully implement a community engagement plan?
      - Yes ☑  No ☐
      If “no” please provide explanation:
F. Behavioral Health Attestations (Attachment 11)

1. Behavioral Health Benefit

   a. Will Applicant report performance measures and implement Evidence-Based outcome measures, as developed by the OHA Metrics and Scoring Committee, and as specified in the Contract?
      - Yes [ ] No [ ]
      If "no" please provide explanation: ________________________________

   b. Will Applicant work collaboratively with OHA and its partners to implement all of the requirements in Exhibit M of the Contract?
      - Yes [ ] No [ ]
      If "no" please provide explanation: ________________________________

   c. Will Applicant be fully responsible for the Behavioral Health benefit for Members beginning in CY 2020?
      - Yes [ ] No [ ]
      If "no" please provide explanation: ________________________________

   d. Will Applicant manage the Global Budget (as defined in ORS 414.025) in a fully integrated manner? Fully integrated manner means that Applicant will not sub-capitate any Provider or entity for Behavioral Health services separately from physical health services nor will Applicant enter into any Value-Based Payment arrangements under which Behavioral Health spending is tracked separately from physical health services.
      - Yes [ ] No [ ]
      If "no" please provide explanation: ________________________________

   e. Will Applicant report on the information and data specified in the Performance Expectations section as specified in the Contract and submit an annual report to OAH for review and approval?
      - Yes [ ] No [ ]
      If "no" please provide explanation: ________________________________

   f. Will Applicant have sufficient resources, including technological, financial, Provider and workforce, to integrate the Behavioral Health benefit with oral and physical health care benefits?
      - Yes [ ] No [ ]
      If "no" please provide explanation: ________________________________
g. Will Applicant ensure the provision of cost-effective, comprehensive, person-centered, Culturally Responsive, and integrated Community-based Behavioral Health services for Members?

☐ Yes  ☐ No

If "no" please provide explanation:

h. Will Applicant provide oversight, Care Coordination, transition planning and management of the Behavioral Health needs of Members to ensure Culturally Responsive and linguistically appropriate Behavioral Health services are provided in a way that Members are served in a most natural and integrated environment possible and that minimizes the use of institutional care?

☐ Yes  ☐ No

If "no" please provide explanation:

i. Will Applicant follow Intensive Care Coordination standards as identified in OAR 410-141-3160/70?

☐ Yes  ☐ No

If "no" please provide explanation:

j. Will Applicant ensure Members have access to Referral and screening at multiple health system or health care entry points?

☐ Yes  ☐ No

If "no" please provide explanation:

k. Will Applicant use a standardized Assessment tool, to adapt the intensity and frequency of Behavioral Health services to the Behavioral Health needs of the Member?

☐ Yes  ☐ No

If "no" please provide explanation:

l. Will Applicant work collaboratively to improve services for adult Members with SPMI as a priority population? Will Applicant make significant commitments and undertake significant efforts to continue to improve treatment and services so that adults with SPMI can live and prosper in integrated Community settings?

☐ Yes  ☐ No

If "no" please provide explanation:
m. Will Applicant ensure Members have timely access to all services under the Behavioral Health benefit in accordance with access to service standards as developed in Appendix C, the Administrative Rules Concept Document, under OHPB #17?

☐ Yes  ☐ No

If “no” please provide explanation: ____________________________________________

n. Will Applicant have an adequate Provider Network to ensure Members have timely access to Behavioral Health services and effective treatment in accordance with the Delivery System and Provider Capacity section of the Contract?

☐ Yes  ☐ No

If “no” please provide explanation: ____________________________________________

o. Will Applicant establish written policies and procedures for Prior Authorizations, in compliance with the Mental Health Parity and Addiction Equity Act of 2008, and be responsible for any inquiries or concerns and not delegate responsibility to Providers?

☐ Yes  ☐ No

If “no” please provide explanation: ____________________________________________

p. Will Applicant establish written policies and procedures for the Behavioral Health benefit and provide the written policies and procedures to OHA by the beginning of CY 2020?

☐ Yes  ☐ No

If “no” please provide explanation: ____________________________________________

q. Will Applicant require mental health and substance use disorder programs be licensed or certified by OHA to enter the Provider Network?

☐ Yes  ☐ No

If “no” please provide explanation: ____________________________________________

r. Will Applicant require Providers to screen Members for adequacy of supports for the Family in the home (e.g., housing adequacy, nutrition/food, diaper needs, transportation needs, safety needs and home visiting)?

☐ Yes  ☐ No

If “no” please provide explanation: ____________________________________________
s. Will Applicant ensure Applicant’s staff and Providers are trained in recovery principles, motivational interviewing, integration, and Foundations of Trauma Informed Care (https://traumainfoundedoregon.org/tic-intro-training-modules/)?

☑ Yes □ No

If “no” please provide explanation: __________________________________________

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t. Will Applicant ensure Providers are trained in Trauma Informed approaches and provide regular periodic oversight and technical assistance to Providers?

☑ Yes □ No

If “no” please provide explanation: __________________________________________

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u. Will Applicant require Providers, in developing Individual Service and Support Plans for Members, to assess for Adverse Childhood Experiences (ACEs) and trauma in a Culturally Responsive and Trauma Informed framework and approach?

☑ Yes □ No

If “no” please provide explanation: __________________________________________

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v. Will Applicant ensure Behavioral Health services are Culturally Responsive and Trauma Informed?

☑ Yes □ No

If “no” please provide explanation: __________________________________________

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w. Will Applicant assume responsibility for the entire Behavioral Health residential benefit by the beginning of CY 2022?

☑ Yes □ No

If “no” please provide explanation: __________________________________________

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x. Will Applicant include OHA approved Behavioral Health homes (BHHs) in Applicant’s network as the BHHs qualify in Applicant’s Region?

☑ Yes □ No

If “no” please provide explanation: __________________________________________

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y. Will Applicant assist Behavioral Health organizations within the delivery system to establish BHHs?

☑ Yes □ No

If “no” please provide explanation: __________________________________________
z. Will Applicant utilize BHHs in their network for Members to the greatest extent possible?

☑ Yes  ☐ No

If “no” please provide explanation: ____________________________

aa. Will Applicant provide a full psychological evaluation and child psychiatric consultation for children being referred to the highest levels of care (day treatment, subacute or PRTS)?

☑ Yes  ☐ No

If “no” please provide explanation: ____________________________

2. MOU with Community Mental Health Program (CMHP)

a. Will Applicant enter into a written memorandum of understanding (MOU) with the local Community Mental Health Program (CMHP) in Applicant’s Region by beginning of CY 2020, in accordance with ORS 414.153?

☑ Yes  ☐ No

If “no” please provide explanation: ____________________________

b. Will Applicant develop a comprehensive Behavioral Health plan for Applicant’s Region in collaboration with the Local Mental Health Authority and other Community partners (e.g., education/schools, Hospitals, corrections, police, first responders, Child Welfare, DHS, public health, Peers, families, housing authorities, housing Providers, courts)?

☑ Yes  ☐ No

If “no” please provide explanation: ____________________________

c. Will Applicant coordinate and collaborate on the development of the Community health improvement plan (CHP) under ORS 414.627 with the local Community Mental Health Program (CMHP) for the delivery of mental health services under ORS 430.630

☑ Yes  ☐ No

If “no” please provide explanation: ____________________________
3. Provisions of Covered Services – Behavioral Health

a. Will Applicant provide services as necessary to achieve compliance with the mental health parity requirements of 42 CFR § 438, subpart K and ensure that any quantitative treatment limitations (QTLs), or non-quantitative treatment limitations (NQTLs) placed on Medically Necessary Covered Services are no more restrictive than those applied to fee-for-service medically necessary covered benefits, as described in 42 CFR 438.210(a)(5)(i)?

☑ Yes ☐ No
If “no” please provide explanation: ________________________________

b. Will Applicant assume accountability for Members that are civilly committed and are referred to and enter Oregon State Hospital; be financially responsible for the services for Members on waitlist for Oregon State Hospital after the second year of the Votnickt, with timeline to be determined by OHA; and be financially responsible for services for Members admitted to Oregon State Hospital after the second year of the Votnickt, with timeline to be determined by OHA?

☑ Yes ☐ No
If “no” please provide explanation: ________________________________

c. Will Applicant reimburse for covered Behavioral Health services rendered in a primary care setting by a qualified Behavioral Health Provider, and reimburse for covered physical health services in Behavioral Health care settings, by a qualified medical Provider?

☑ Yes ☐ No
If “no” please provide explanation: ________________________________

d. Will Applicant ensure Members receive services from Non-Participating Providers for Behavioral Health services if those services are not available from Participating Providers or if a Member is not able to access services within the timely access to care standards? Will Applicant remain responsible for coordinating Behavioral Health services with Non-Participating Providers and reimbursing for services?

☑ Yes ☐ No
If “no” please provide explanation: ________________________________

e. Will Applicant ensure continuity of care throughout episodes of care and provide Intensive Care Coordination and general Care Coordination as specified in the Contract?

☑ Yes ☐ No
If “no” please provide explanation: ________________________________
4. **Covered Services Component – Behavioral Health**

a. Will Applicant establish written policies and procedures for an emergency response system, including post-stabilization care services and Urgent Services for all Members on a 24-hour, 7-day-a-week basis consistent with OAR 410-141-3140 and 42 CFR 438.114? Will the emergency response system provide an immediate, initial or limited duration response for emergency situations or potential Behavioral Health emergency situations that may include Behavioral Health conditions?

☑ Yes  ☐ No

If “no” please provide explanation: ________________________________

b. Will Applicant ensure access to Mobile Crisis Services for all Members in accordance with OAR 309-019-0105, OAR 309-019-0150, 309-019-0242, and 309-019-0300 to 309-019-0320 to promote stabilization in a Community setting rather than arrest, presentation to an Emergency Department, or admission to an Acute psychiatric care facility?

☑ Yes  ☐ No

If “no” please provide explanation: ________________________________

c. Will Applicant establish written policies and procedures for a Quality Improvement plan for the emergency response system?

☑ Yes  ☐ No

If “no” please provide explanation: ________________________________

d. Will Applicant collaboratively work with OHA and CMHPs to develop and implement plans to better meet the needs of Members in Community integrated settings and to reduce recidivism to Emergency Departments for Behavioral Health reasons?

☑ Yes  ☐ No

If “no” please provide explanation: ________________________________

e. Will Applicant work with Hospitals to provide data on Emergency Department (ED) utilization for Behavioral Health reasons and length of time in the ED? Will Applicant develop remediation plans with EDs with significant numbers of ED stays longer than 23 hour?

☑ Yes  ☐ No

If “no” please provide explanation: ________________________________
f. Will Applicant establish a policy and procedure for developing a management plan for contacting and offering services to each Member who has two or more readmissions to an ED in a six-month period?

☐ Yes ☐ No

If “no” please provide explanation: ____________________________

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g. Will Applicant make a reasonable effort to provide Covered Services on a voluntary basis and consistent with current Declaration for Mental Health Treatment as provided at: http://www.oregon.gov/oha/amh/forms/declaration.pdf in lieu of involuntary treatment?

☐ Yes ☐ No

If “no” please provide explanation: ____________________________

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h. Will Applicant establish written policies and procedures describing the appropriate use of Emergency Psychiatric Holds consistent with ORS 426 and alternatives to involuntary psychiatric care when a less restrictive voluntary service will not meet the Medically Appropriate needs of the Member and the behavior of the Member meets legal standards for the use of an Emergency Psychiatric Hold?

☐ Yes ☐ No

If “no” please provide explanation: ____________________________

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i. Will Applicant assure that any involuntary treatment provided under the Contract is provided in accordance with administrative rule and statute, and coordinate with the CMHP Director in assuring that all statutory requirements are met? Will Applicant also work with the CMHP Director in assigning a civilly committed Member to any placement and participate in circuit court hearings related to planned placements, if applicable?

☐ Yes ☐ No

If “no” please provide explanation: ____________________________

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j. If Applicant identifies a Member, over age 18 with no significant nursing care needs due to a general medical condition, Acute medical condition or physical disorder, is appropriate for Long Term Psychiatric Care (State Facility level of care), will Applicant request a LTPC determination from the OHA LTPC reviewer?

☐ Yes ☐ No

If “no” please provide explanation: ____________________________
k. If Applicant identifies a Member, age 18 to age 64, with no significant nursing care needs due to a general medical condition, Acute medical condition or physical disorder of an enduring nature, is appropriate for LTPC, will Applicant request a LTPC determination from the applicable HSD Adult Mental Health Services Unit, as described in Procedure for LTPC Determinations for Members 18 to 64, available on the Contract Reports Web Site?

☑ Yes  ☐ No

If “no” please provide explanation: ____________________________________________

l. If Applicant identifies a Member, age 65 and over, or age 18 to age 64 with significant nursing care needs due to a general medical condition, Acute medical condition or physical disorder of an enduring nature, is appropriate for LTPC, will Applicant request a LTPC determination from the State hospital-NTS, Outreach and Consultation Service (OCS) Team as described in Procedure for LTPC Determinations for Member Requiring Neuropsychiatric Treatment, available on the Contract Reports Web Site?

☑ Yes  ☐ No

If “no” please provide explanation: ____________________________________________

m. For the Member age 18 and over, will Applicant work with the Member to assure timely discharge and transition from LTPC to the most appropriate, independent and integrated Community-based setting possible consistent with Member choice?

☑ Yes  ☐ No

If “no” please provide explanation: ____________________________________________

n. Will Applicant authorize and reimburse Care Coordination services, in particular for Members who receive ICC, that are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are provided to Members receiving care through licensed Community treatment programs? Will Applicant authorize and reimburse for ICC services, in accordance with standards identified in OAR 410-141-3160-70?

☑ Yes  ☐ No

If “no” please provide explanation: ____________________________________________

o. Will Applicant ensure that any involuntary treatment provided under the Contract is provided in accordance with administrative rule and statute and coordinate with the CMHP Director in assuring that all statutory requirements are met? Will Applicant work with the CMHP Director in assigning a civilly committed Member to any placement and participate in circuit court hearings related to planned placements, if applicable?

☑ Yes  ☐ No

If “no” please provide explanation: ____________________________________________
p. Will Applicant provide Acute Inpatient Hospital Psychiatric Care for Members who do not meet the criteria for LTPC?

☑ Yes ☐ No

If “no” please provide explanation: 

q. Will Applicant ensure that all Members discharged from Acute Care Psychiatric Hospitals are provided a Warm Handoff to a Community case manager, Peer bridger, or other Community provider prior to discharge, and that all such Warm Handoffs are documented?

☑ Yes ☐ No

If “no” please provide explanation: 

r. Will Applicant ensure that all Members discharged from Acute Care Psychiatric Hospitals have linkages to timely, appropriate behavioral and primary health care in the Community prior to discharge and that all such linkages are documented, in accordance with OAR provisions 309-032-0850 through 309-032-0870?

☑ Yes ☐ No

If “no” please provide explanation: 

s. Will Applicant ensure all adult Members receive a follow-up visit with a Community Behavioral Health Provider within seven (7) days of their discharge from an Acute Care Psychiatric Hospital?

☑ Yes ☐ No

If “no” please provide explanation: 

t. Will Applicant reduce readmissions of adult Members with SPMI to Acute Care Psychiatric Hospitals?

☑ Yes ☐ No

If “no” please provide explanation: 

u. Will Applicant coordinate with system Community partners to ensure Members who are homeless and who have had two or more readmissions to an Acute Care Psychiatric Hospital in a six-month period are connected to a housing agency or mental health agency to ensure these Members are linked to housing in an integrated Community setting, Supported Housing to the extent possible, consistent with the individual’s treatment goals, clinical needs and the individual’s informed choice?

☑ Yes ☐ No

If “no” please provide explanation: 

v. Will Applicant ensure coordination and appropriate Referral to Intensive Care Coordination to ensure that Member's rights are met and there is post-discharge support? If Member is connected to ICC coordinator, will Applicant ensure coordination with this person as directed in OAR 410-141-3160-3170?

☑ Yes ☐ No

If “no” please provide explanation: ________________________________

w. Will Applicant work with OHA and the CMHPs to ensure that Members who are discharged from Acute Care Psychiatric Hospitals are discharged to housing that meets the individuals’ immediate need for housing and work with Acute Care Psychiatric Hospitals in the development of each individual’s housing assessment?

☑ Yes ☐ No

If “no” please provide explanation: ________________________________

x. Will Applicant establish a policy and procedure for developing a management plan for contacting and offering services to each Member who has two (2) or more readmissions to an Acute Care Psychiatric Hospital in a six-month period?

☑ Yes ☐ No

If “no” please provide explanation: ________________________________

y. Will Applicant work with OHA, other state agencies, and other state funded or operated entities to identify areas where treatment and services for adult Members with SPMI can be improved?

☑ Yes ☐ No

If “no” please provide explanation: ________________________________

z. Will Applicant coordinate services for each adult Member with SPMI who needs assistance with Covered or Non-covered Services?

☑ Yes ☐ No

If “no” please provide explanation: ________________________________

aa. Will Applicant provide oversight, Care Coordination, transition planning and management for Members receiving Behavioral Health services, including Mental Health Rehabilitative Services and Personal Care Services, in licensed and non-licensed home and Community-based settings, ensuring that individuals who no longer need placement in such settings are transitioned to a Community placement in the most integrated Community setting appropriate for that person?

☑ Yes ☐ No

If “no” please provide explanation: ________________________________
bb. Will Applicant provide Utilization Review and utilization management, for Members receiving Behavioral Health Services, including Mental Health Rehabilitative Services and Personal Care Services, in licensed and non-licensed home and Community-based settings, ensuring that individuals who no longer need placement in such setting transition to the most integrated Community setting, Supported Housing to the extent possible, consistent with the individual’s treatment goals, clinical needs, and the individual’s informed choice?

☑️ Yes ☐ No

If “no” please provide explanation: ____________________________________________

cc. Will Applicant encourage utilization of Peer-Delivered Services (PDS) and ensure that Members are informed of their benefit to access and receive PDS from a Peer Support Specialist, Peer Wellness Specialist, Family Support Specialist, or Youth Support Specialist as applicable to the Member’s diagnosis and needs?

☑️ Yes ☐ No

If “no” please provide explanation: ____________________________________________

dd. Will Applicant ensure that Members with SPMI receive Intensive Care Coordination (ICC) support in finding appropriate housing and receive coordination in addressing Member’s housing needs?

☑️ Yes ☐ No

If “no” please provide explanation: ____________________________________________

e. Will Applicant ensure Members with SPMI are assessed to determine eligibility for ACT?

☑️ Yes ☐ No

If “no” please provide explanation: ____________________________________________

ff. Will Applicant ensure ACT services are provided for all adult Members with SPMI who are referred to and eligible for ACT services in accordance with OAR 309-019-0105 and 309-019-0225 through 309-019-0255?

☑️ Yes ☐ No

If “no” please provide explanation: ____________________________________________

gg. Will Applicant ensure additional ACT capacity is created to serve adult Members with SPMI as services are needed?

☑️ Yes ☐ No

If “no” please provide explanation: ____________________________________________
hh. Will Applicant, when ten (10) or more of Applicant's adult Members with SPMI in Applicant's Service Area are on a waitlist to receive ACT for more than thirty (30) days, without limiting other Applicant solutions, create additional capacity by either increasing existing ACT team capacity to a size that is still consistent with Fidelity standards or by adding additional ACT teams?

☑ Yes ☐ No

If "no" please provide explanation: ________________________________

If Applicant lacks qualified Providers to provide ACT services, will Applicant consult with OHA and develop a plan to develop additional qualified Providers? Will lack of capacity not be a reason to allow individuals who are determined to be eligible for ACT to remain on the waitlist? Will no individual on a waitlist for ACT services be without such services for more than 30 days?

☑ Yes ☐ No

If "no" please provide explanation: ________________________________

ii. Will Applicant ensure all denials of ACT services for all adult Members with SPMI are based on established, evidence-based medical necessity criteria; reviewed, recorded and compiled in a manner that allows denials to be accurately reported out as appropriate or inappropriate; and follow the Notice of Adverse Benefit Determination process for all denials as described in the Contract?

☑ Yes ☐ No

If "no" please provide explanation: ________________________________

jj. Will Applicant be responsible for finding or creating a team to serve Members who have appropriately received a denial for a particular ACT team but who meet ACT eligibility standards?

☑ Yes ☐ No

If "no" please provide explanation: ________________________________

kk. Will Applicant be responsible for engaging with all eligible Members who decline to participate in ACT in an attempt to identify and overcome barriers to the Member’s participation?

☑ Yes ☐ No

If "no" please provide explanation: ________________________________
II. Will Applicant require that a Provider or care coordinator meets with the Member to discuss ACT services and provide information to support the Member in making an informed decision regarding participation? Will this include a description of ACT services and how to access them, an explanation of the role of the ACT team and how supports can be individualized based on the Member’s self-identified needs, and ways that ACT can enhance a Member’s care and support independent Community living?

☑ Yes ☐ No

If “no” please provide explanation: ________________________________

mm. Will Applicant provide alternative evidence-based intensive services if Member continues to decline participation in ACT, which must include coordination with an ICC?

☑ Yes ☐ No

If “no” please provide explanation: ________________________________

nn. Will Applicant report the number of individuals referred to ACT, number of individuals admitted to ACT programs, number of denials for the ACT benefit, number of denials to ACT programs, and number of individuals on waitlist by month?

☑ Yes ☐ No

If “no” please provide explanation: ________________________________

oo. Will Applicant ensure a Member discharged from OSH who is appropriate for ACT shall receive ACT or an evidence-based alternative?

☑ Yes ☐ No

If “no” please provide explanation: ________________________________

pp. Will Applicant document efforts to provide ACT to individuals who initially refuse ACT services, and document all efforts to accommodate their concerns?

☑ Yes ☐ No

If “no” please provide explanation: ________________________________

qq. Will Applicant offer alternative evidence-based intensive services for individuals discharged from OSH who refuse ACT services?

☑ Yes ☐ No

If “no” please provide explanation: ________________________________
rr. Will Applicant ensure a Member discharged from OSH who is determined not to meet the level of care for ACT shall be discharged with services appropriate to meet their needs?

☑ Yes    ☐ No

If “no” please provide explanation: ________________________________

ss. Will Applicant coordinate with system partners as needed regarding Oregon State Hospital discharges for all adult Members with SPMI in accordance with OAR 309-091-0000 through 0050?

☑ Yes    ☐ No

If “no” please provide explanation: ________________________________

tt. Will Applicant ensure access to Supported Employment Services for all adult Members eligible for these services, in accordance with OAR 309-019-0275 through 309-019-0295? ("Supported Employment Services" means the same as "Individual Placement and Support (IPS) Supported Employment Services" as defined in OAR 309-019-0225.)

☑ Yes    ☐ No

If “no” please provide explanation: ________________________________

uu. Will Applicant work with local law enforcement and jail staff to develop strategies to reduce contacts between Members and law enforcement due to Behavioral Health reasons, including reduction in arrests, jail admissions, lengths of stay in jails and recidivism?

☑ Yes    ☐ No

If “no” please provide explanation: ________________________________

vv. Will Applicant work with SRTFs to expeditiously move civilly committed adult Members with SPMI who no longer need placement in an SRTF to a Community placement in the most integrated setting, Supported Housing to the extent possible, consistent with the individual’s treatment goals, clinical needs, and the individual’s informed choice?

☑ Yes    ☐ No

If “no” please provide explanation: ________________________________
ww. Will Applicant provide Substance Use Disorder (SUD) services to Members, which include outpatient, intensive outpatient, medication assisted treatment including Opiate Substitution Services, residential and detoxification treatment services consistent with OAR Chapter 309, Divisions 18, 19 and 22, and OAR Chapter 415 Divisions 20, and 50?

☐ Yes  ☐ No

If “no” please provide explanation: ______________________________________

xx. Will Applicant comply with Substance Use Disorder (SUD) waiver program designed to improve access to high quality, clinically appropriate treatment for opioid use disorder and other SUDs, upon approval by Centers for Medicare and Medicaid Services (CMS)?

☐ Yes  ☐ No

If “no” please provide explanation: ______________________________________

yy. Will Applicant inform all Members using Culturally Responsive and linguistically appropriate means that Substance Use Disorder outpatient, intensive outpatient, residential, detoxification and medication assisted treatment services, including opiate substitution treatment, are Covered Services consistent with OAR 410-141-3300?

☐ Yes  ☐ No

If “no” please provide explanation: ______________________________________

zz. Will Applicant participate with OHA in a review of OHA provided data about the impact of these criteria on service quality, cost, outcome, and access?

☐ Yes  ☐ No

If “no” please provide explanation: ______________________________________

5. Children and Youth

a. Will Applicant develop and implement cost-effective comprehensive, person-centered, individualized, and integrated Community-based Child and Youth Behavioral Health services for Members, using System of Care (SOC) principles?

☐ Yes  ☐ No

If “no” please provide explanation: ______________________________________

b. Will Applicant utilize evidence-based Behavioral Health interventions for the needs of children 0-5, and their caregivers, with indications of Adverse Childhood Experiences (ACEs) and high complexity?

☐ Yes  ☐ No

If “no” please provide explanation: ______________________________________
c. Will Applicant provide Intensive Care Coordination (ICC) that is Family and youth-driven, strengths based and Culturally Responsive and linguistically appropriate and abide by ICC standards as set forth in Appendix C, Administrative Rules Concept under OHPB #24 and in accordance with the ICC section in the Contract? Will Applicant abide by ICC standards as forth in Appendix C, Administrative Rules Concept, under OHPB #24, and in accordance with the ICC section in the Contract?

☐ Yes ☐ No
If “no” please provide explanation: ________________________________

d. Will Applicant provide services to children, young adults and families of sufficient frequency, duration, location, and type that are convenient to the youth and Family? Will Services alleviate crisis while allowing for the development of natural supports, skill development, normative activities and therapeutic resolution to Behavioral Health disorders and environmental conditions that may impact the remediation of a Behavioral Health disorder?

☐ Yes ☐ No
If “no” please provide explanation: ________________________________

e. Will Applicant adopt policies and guidelines for admission into Psychiatric Residential Treatment Services (PRTS), Psychiatric Day Treatment Services (POTS) and/or Intensive Outpatient Services and Supports?

☐ Yes ☐ No
If “no” please provide explanation: ________________________________

f. Will Applicant ensure the availability of service, supports or alternatives 24 hours a day/7 days a week to remediate a Behavioral Health crisis in a non-emergency department setting?

☐ Yes ☐ No
If “no” please provide explanation: ________________________________

g. Will Applicant encourage utilization of Peer-Delivered Services (PDS) and ensure that Members are informed of their benefit to access and receive PDS from a Peer Support Specialist, Peer Wellness Specialist, Family Support Specialist, or Youth Support Specialist as applicable to the Member’s diagnosis and needs?

☐ Yes ☐ No
If “no” please provide explanation: ________________________________
h. If Applicant identifies a Member is appropriate for LTPC Referral, will Applicant request a LTPC determination from the applicable HSD Child and Adolescent Mental Health Specialist, as described in Procedure for LTPC Determinations for Members 17 and Under, available on the Contract Reports Web Site?

☐ Yes  ☐ No

If “no” please provide explanation: __________________________________________________

i. Will Applicant arrange for the provision of non-health related services, supports and activities that can be expected to improve a Behavioral Health condition?

☐ Yes  ☐ No

If “no” please provide explanation: __________________________________________________

j. Will Applicant coordinate admissions to and discharges from Acute Inpatient Hospital Psychiatric Care and Sub-Acute Care for Members 17 and under, including Members in the care and custody of DHS Child Welfare or OYA? For a Member 17 and under, placed by DHS Child Welfare through a Voluntary Placement Agreement (CF 0499), will Applicant also coordinate with such Member’s parent or legal guardian?

☐ Yes  ☐ No

If “no” please provide explanation: __________________________________________________

k. Will Applicant ensure a CANS Oregon is administered to a Member who is a child or youth and the data is entered into OHA approved data system according to the eligibility and timeline criteria in the Contract?

☐ Yes  ☐ No

If “no” please provide explanation: __________________________________________________

l. Will Applicant have funding and resources to implement, to fidelity, Wraparound Services?

☐ Yes  ☐ No

If “no” please provide explanation: __________________________________________________

m. Will Applicant enroll all eligible youth in Wraparound and place no youth on a waitlist?

☐ Yes  ☐ No

If “no” please provide explanation: __________________________________________________
n. Will Applicant screen all eligible youth with a Wraparound Review Committee in accordance with Wraparound Services as described in the OHA System of Care Wraparound Initiative (SOCWI) guidance document found at the link below and in Wraparound Service OARs? http://www.oregon.gov/oha/hsd/amh/pages/index.aspx.

☑ Yes ☐ No

If “no” please provide explanation:

o. Will Applicant establish and maintain a functional System of Care in its Service Area in accordance with the Best Practice Guide located at https://www.pdx.edu/ccf/best-practice-guide including a Practice Level Workgroup, Advisory Committee and Executive Council with a goal of youth and Family voice representation to be 51 percent?

☑ Yes ☐ No

If “no” please provide explanation:

p. Will Applicant have a functional SOC governance structure by the beginning of CY 2020 that consists of a practice level work group, advisory council, and executive council?

☑ Yes ☐ No

If “no” please provide explanation:

q. By end of CY 2020, will Applicant have written Charters and new Member handbooks for Practice Level Work group, Advisory Council and Executive Council?

☑ Yes ☐ No

If “no” please provide explanation:

G. Cost and Financial Attestations (Attachment 12)

1. Rates

Does Applicant accept the CY 2020 Rate Methodology appended to Attachment 12?

☑ Yes ☐ No

If “no” please provide explanation:

2. Evaluate CCO performance to inform CCO-specific profit margin

a. Does Applicant agree to performance and efficiency evaluation being used to set profit margins in CCO capitation rates?

☑ Yes ☐ No

If “no” please provide explanation:
b. Does Applicant agree to accept the CCO 2.0 capitation rate methodology as described in the Oregon CY20 Procurement Rate Methodology document and also accept the performance evaluation methodology and its use in setting CCO-specific profit margins?
☑ Yes  ☐ No
If “no” please provide explanation: ____________________________

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c. Does Applicant agree to report additional data as needed to inform the performance evaluation process, including data on utilization of Health-Related Services?
☑ Yes  ☐ No
If “no” please provide explanation: ____________________________

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d. Is Applicant willing to have OHA use efficiency analysis to support managed care efficiency adjustments that may result in adjustments to the base data used in capitation rate development to further incentivize reductions in Waste in the system?
☑ Yes  ☐ No
If “no” please provide explanation: ____________________________

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3. Qualified Directed Payments to Providers

a. Is Applicant willing to make OHA-directed payments to certain Hospitals within five Business Days after receipt of a monthly report prepared and distributed by OHA?
☑ Yes  ☐ No
If “no” please provide explanation: ____________________________

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b. Is Applicant willing to report to OHA promptly if it determines payments to Hospitals will be significantly delayed?
☑ Yes  ☐ No
If “no” please provide explanation: ____________________________

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c. Is Applicant willing to exclude the portion of OHA-directed payments for provider tax repayment when negotiating alternative or Value-Based Payment reimbursement arrangements?
☑ Yes  ☐ No
If “no” please provide explanation: ____________________________

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d. Is Applicant willing to provide input and feedback to OHA on the selection of measures of quality and value for OHA-directed payments to Providers?

☑ Yes   ☐ No

If “no” please provide explanation: 

__________________________

4. Quality Pool Operations and Reporting

a. Does Applicant agree to having a portion of capitation withheld from monthly Capitation Payment and awarded to the Applicant based on performance on metrics based on the Quality Incentive Pool program?

☑ Yes   ☐ No

If “no” please provide explanation: 

__________________________

b. Does Applicant agree to report to OHA separately on expenditures incurred based on Quality Pool revenue earned?

☑ Yes   ☐ No

If “no” please provide explanation: 

__________________________

c. Does Applicant agree to report on the methodology it uses to distribute Quality Pool earnings to Providers, including SDOH-HE partners and public health partners?

☑ Yes   ☐ No

If “no” please provide explanation: 

__________________________

d. Does Applicant have a plan to evaluate contributions made by SDOH-HE and public health partners toward the achievement of Quality Pool metrics?

☑ Yes   ☐ No

If “no” please provide explanation: 

__________________________

5. Transparency in Pharmacy Benefit Management Contracts

a. Will Applicant select and contract with the Oregon Prescription Drug Program to provide Pharmacy Benefit Management services? If yes, please skip to section 5. If not, please answer parts b-f of this question.

☐ Yes   ☑ No

If “no” please provide explanation: Health Share does not plan to contract with the Oregon Prescription Drug Program to provide PBM services.
b. Will Applicant use a pharmacy benefit manager that will provide pharmacy cost pass-through at 100% and pass back 100% of rebates received to Applicant?

☑ Yes  ☐ No

If “no” please provide explanation: __________________________________________________________

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c. Will Applicant separately report to OHA any and all administrative fees paid to its PBM?

☑ Yes  ☐ No

If “no” please provide explanation: __________________________________________________________

---

d. Will Applicant require reporting from PBM that provides paid amounts for pharmacy costs at a claim level?

☑ Yes  ☐ No

If “no” please provide explanation: __________________________________________________________

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e. Will Applicant obtain market check and audits of their PBMs by a third party on an annual basis, and share the results of the market check with the OHA?

☑ Yes  ☐ No

If “no” please provide explanation: __________________________________________________________

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f. Will Applicant require its PBM to remain competitive with enforceable contract terms and conditions driven by the findings of the annual market check and report auditing?

☑ Yes  ☐ No

If “no” please provide explanation: __________________________________________________________

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6. Alignment Preferred Drug Lists (PDLs) and Prior Authorization Criteria

a. Will Applicant partner with OHA on the goal of increasing the alignment of CCO preferred drug lists (PDL) with the Fee-For-Service PDL set every year by OHA?

☑ Yes  ☐ No

If “no” please provide explanation: __________________________________________________________

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b. Will Applicant align its PDL in any and all categories of drugs as recommended by the P&T committee and as required by OHA?

☑ Yes  ☐ No

If “no” please provide explanation: __________________________________________________________
c. Will Applicant post online in a publicly accessible manner the Applicant's specific PDL with coverage and Prior Authorization criteria in a format designated by OHA and update the posting concurrently or before any changes to the PDL or coverage/PA criteria become effective?

☑ Yes ☐ No
If “no” please provide explanation: ___________________

7. Financial Reporting Tools and Requirements

a. Is Applicant willing to partake of all financial, legal and technological requirements of the National Association of Insurance Commissioners (NAIC) in whatever capacity necessary to file its financial information with OHA under NAIC standards?

☑ Yes ☐ No
If “no” please provide explanation: ___________________

b. Will Applicant report its required financial information to OHA on the NAIC's Health Quarterly and Annual Statement blank ("Orange Blank") through the NAIC website as described in this RFA, under NAIC standards and instructions?

☑ Yes ☐ No
If “no” please provide explanation: ___________________

c. Will Applicant report its financial information to OHA using Statutory Accounting Principles (SAP), subject to possible exemption from SAP for 2020 as described in this RFA?

☑ Yes ☐ No
If “no” please provide explanation: ___________________

d. Will Applicant file the financial reports described in this RFA, including Contract Exhibit L and supplemental schedules with the instructions referenced in this RFA?

☑ Yes ☐ No
If “no” please provide explanation: ___________________

e. Is Applicant willing to resubmit its pro forma financial statements for three years starting in 2020, modified to reflect the Enrollment expected assuming other CCOs that may operate in Applicant’s Service Area?

☑ Yes ☐ No
If “no” please provide explanation: ___________________
f. Does Applicant commit to preparing and filing a Risk Based Capital (RBC) report each year based on NAIC requirements and instructions?
   - Yes  [ ] No  [ ]
   If "no" please provide explanation: ____________________________

g. Is Applicant willing to submit quarterly financial reports including a quarterly estimation of RBC levels to ensure financial protections are in place during the year?
   - Yes  [ ] No  [ ]
   If "no" please provide explanation: ____________________________

h. Is Applicant willing to have its RBC threshold evaluated quarterly using a proxy calculation?
   - Yes  [ ] No  [ ]
   If "no" please provide explanation: ____________________________

i. If Applicant’s estimated RBC falls below the minimum required percentage based on the quarterly estimation, is Applicant willing to submit a year-to-date financial filing and full RBC evaluation?
   - Yes  [ ] No  [ ]
   If "no" please provide explanation: ____________________________

8. Accountability to Oregon’s Sustainable Growth Targets

a. Does Applicant commit to achieving a sustainable growth in expenditures each calendar year (normalized by membership) that matches or is below the Oregon 1115 Medicaid demonstration project waiver growth target of 3.4%?
   - Yes  [ ] No  [ ]
   If "no" please provide explanation: ____________________________

b. Does Applicant similarly commit to making a good faith effort towards achievement of future modifications to the growth target in the waiver?
   - Yes  [ ] No  [ ]
   If "no" please provide explanation: ____________________________

c. Does Applicant agree that OHA may publicly report on CCO performance relative to the sustainable growth rate targets (normalized for differences in membership)?
   - Yes  [ ] No  [ ]
   If "no" please provide explanation: ____________________________
d. Does Applicant agree that OHA may institute a Corrective Action Plan, that may include financial penalties, if a CCO does not achieve the expenditure growth targets based on the current 1115 Medicaid waiver?

☑ Yes ☐ No

If “no” please provide explanation: __________________________________________

9. Potential Establishment of Program-wide Reinsurance Program in Future Years

a. Will Applicant participate in any program-wide reinsurance program that is established in years after 2020 consistent with statutory and regulatory provisions that are enacted?

☑ Yes ☐ No

If “no” please provide explanation: __________________________________________

b. Will Applicant use private reinsurance contracts on only an annual basis so as to ensure ability to participate in state-run program if one is launched at the start of a calendar year?

☑ Yes ☐ No

If “no” please provide explanation: __________________________________________

c. Does Applicant agree that implementation of program-wide reinsurance program will reduce capitation rates in years implemented as a result of claims being paid through reinsurance instead of with capitation funds?

☑ Yes ☐ No

If “no” please provide explanation: __________________________________________

10. CCO Solvency Standards and OHA Tools to Regulate and Mitigate Insolvency Risk

a. Is Applicant willing to have its financial solvency risk measured by Risk Based Capital (RBC) starting in 2021?

☑ Yes ☐ No

If “no” please provide explanation: __________________________________________

b. Is Applicant willing to achieve a calculated RBC threshold of 200% by end of Q3 of 2021 and thereafter to maintain a minimum RBC threshold of 200%?

☑ Yes ☐ No

If “no” please provide explanation: __________________________________________
c. Is Applicant willing to report to OHA promptly if it determines that its calculated RBC value is or is expected to be below 200%?

☑ Yes ☐ No

If “no” please provide explanation: ____________________________

d. Is Applicant willing to report to OHA promptly if it determines that its actual financial performance departs materially from the pro forma financial statements submitted with this Application?

☑ Yes ☐ No

If “no” please provide explanation: ____________________________

e. Will Applicant maintain the required restricted reserve account per Contract?

☑ Yes ☐ No

If “no” please provide explanation: ____________________________

11. Encounter Data Validation Study

a. Is Applicant willing to perform regular chart reviews and audits of its encounter claims to ensure the Encounter Data accurately reflects the services provided?

☑ Yes ☐ No

If “no” please provide explanation: ____________________________

b. Is Applicant willing to engage in activities to improve the quality and accuracy of Encounter Data submissions?

☑ Yes ☐ No

If “no” please provide explanation: ____________________________

H. Member Transition Plan (Attachment 16)

1. Is Applicant willing to faithfully execute its Member Transition Plan as described in Attachment 16?

☑ Yes ☐ No

If “no” please provide explanation: ____________________________
Attachment 14 — Assurances

Applicant Name:  Health Share of Oregon

Authorizing Signature:  [Signature]

Printed Name:  Maggie Bennington-Davis, MD

Instructions: Assurances focus on the Applicant’s compliance with federal Medicaid law and related Oregon rules. For each assurance, Applicant will check “yes,” or “no.” A “yes” answer is normal, and an explanation will be furnished if Applicant’s response is “no”. Applicant must respond to all assurances. If an assurance has more than one question and Applicant’s answer is “no” to any question, check “no” and provide an explanation.

These assurances must be signed by a representative of Applicant.

Each assurance is effective starting at the time of Readiness Review and continuing throughout the term of the Contract.

1. **Emergency and Urgent Care Services.** Will Applicant have written policies and procedures, and oversight and monitoring systems to ensure that emergency and urgent services are available for all Members on a 24-hour, 7-days-a-week basis? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers’ compliance and take any Corrective Action necessary to ensure Provider compliance?  (See 42 CFR 438.114 and OAR 410-141-3140]

   - [ ] Yes  [ ] No

   If “no” please provide explanation:

2. **Continuity of Care.** Will Applicant implement written policies and procedures that ensure a system for the coordination of care and the arrangement, tracking and documentation of all Referrals and Prior Authorizations to other Providers? Will Applicant follow Intensive Care Coordination (ICC)/ENCC standards and Care Coordination standards, including transition meetings, as directed in OAR 410-141-3170? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers’ compliance and take any Corrective Action necessary to ensure Provider compliance?  [See 42 CFR 438.208 and OAR 410-141-3160]

   - [ ] Yes  [ ] No

   If “no” please provide explanation:

3. Will Applicant implement written policies and procedures that ensure maintenance of a record keeping system that includes maintaining the privacy and security of records as required by the Health Insurance Portability and Accountability Act (HIPAA), 42 USC § 1320-d et seq., and the federal regulations implementing the Act, and complete Clinical Records that document the care received by Members from the Applicant’s Primary Care and Referral Providers? Will Applicants communicate these policies and procedures to Participating Providers, regularly monitor Participating Providers’ compliance with these policies and procedures and take any Corrective Action necessary to ensure Participating Provider compliance? Will Applicants document all monitoring and Corrective Action activities? Will such policies and procedures will ensure that records are secured, safeguarded and stored in accordance with applicable Law?  [See 45 CFR Parts 160 – 164, 42 CFR 438.242, ORS 414.679 and OAR 410-141-3180]

   - [ ] Yes  [ ] No

   If “no” please provide explanation:
4. Will Applicant have an ongoing quality performance improvement program for the services it furnishes to its Members? Will the program include an internal Quality Improvement program based on written policies, standards and procedures that are designed to achieve through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas and that are expected to have a favorable effect on health outcomes and Member satisfaction? The improvement program will track outcomes by race, ethnicity and language. The Applicant will communicate these policies and procedures to Providers, regularly monitor Providers’ compliance and take any Corrective Action necessary to ensure Provider compliance. [See OAR 410-141-0200]

☑ Yes   ☐ No
If “no” please provide explanation: ________________________________

5. Will Applicant make Coordinated Care Services accessible to enrolled Members? Will Applicant not discriminate between Members and non-Members as it relates to benefits to which they are both entitled including reassessment or additional screening as needed to identify exceptional needs in accordance with OAR 410-141-3160 through 410-141-3170? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers’ compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.206 to 438.210; and OAR 410-141-3220]

☑ Yes   ☐ No
If “no” please provide explanation: ________________________________

6. Will Applicant have written procedures approved in writing by OHA for accepting, processing, and responding to all complaints and Appeals from Members or their Representatives that are consistent with Exhibit I of the Appendix B “Sample Contract”? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers’ compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.228, 438.400 – 438.424]

☑ Yes   ☐ No
If “no” please provide explanation: ________________________________

7. Will Applicant develop and distribute OHA-approved informational materials to Potential Members that meet the language and alternative format requirements of Potential Members? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers’ compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.10; OAR 410-141-3280]

☑ Yes   ☐ No
If “no” please provide explanation: ________________________________
8. Will Applicant have an on-going process of Member education and information sharing that includes appropriate orientation to the Applicant provided in the Member handbook or via health education, about the availability of intensive Care Coordination Care Coordination for Members who are aged, blind and/or disabled, or are part of a prioritized population, and appropriate use of emergency facilities and urgent care? Will Applicant will communicate these policies and procedures to Providers, regularly monitor Providers’ compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.10; and OAR 410-141-3300]

☑ Yes  □ No

If “no” please provide explanation: __________________________________________

9. Will Applicant have written policies and procedures to ensure Members are treated with the same dignity and respect as other patients who receive services from the Applicant that are consistent with Appendix B, Core Contract? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers’ compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.100, ORS 414.635 and OAR 410-141-3320]

☑ Yes  □ No

If “no” please provide explanation: __________________________________________

10. Will Applicant provide Intensive Care Coordination (otherwise known as Exceptional Needs Care Coordination or ENCC) to Members who are Aged, Blind or Disabled; Members with high health needs or multiple chronic conditions; Members receiving Medicaid-funded long-term care or long-term services and supports or receiving Home and Community-Based Services (HCBS) under the state’s 1915(i), 1915(j), or 1915(k) State Plan Amendments or the 1915(c) HCBS waivers, or Behavioral Health priority populations in accordance with OAR 410-141-3170? Will Applicant ensure that Prioritized Populations, who sometimes have difficulty with engagement, are fully informed of the benefits of Care Coordination? Will Applicant ensure that their organization will be Trauma Informed by January 1, 2020? Will Applicant utilize evidence-based outcome measures? Will Applicant ensure that Members who meet criteria for ENCC receive contact and service delivery as required in OAR 410-141-3170? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers’ compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.208]

☑ Yes  □ No

If “no” please provide explanation: __________________________________________
11. Will Applicant maintain an efficient and accurate billing and payment process based on written policies, standards, and procedures that are in accordance with accepted professional standards, OHP Administrative Rules and OHA Provider Guides? Will Applicant and its Providers or Subcontractors will not hold Members responsible for debt incurred by the Applicant or by Providers if the entity becomes insolvent? Will Applicant have monitoring systems in operation and review the operations of these systems on a regular basis. The Applicant will communicate these policies and procedures to Providers, regularly monitor Providers’ compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 447.46]

☑ Yes  ☐ No
If “no” please provide explanation: ________________________________

12. Will Applicant participate as a trading partner of the OHA in order to timely and accurately conduct electronic transactions in accordance with the HIPAA electronic transactions and security standards? Has Applicant executed necessary trading partner agreements and conducted business-to-business testing that are in accordance with accepted professional standards, OHP Administrative Rules and OHA Provider Guides? Will Applicant have monitoring systems in operation and review the operations of these systems on a regular basis? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers’ compliance and take any Corrective Action necessary to ensure Provider compliance? [See 45 CFR Part 162; OAR 943-120-0100 to 943-120-0200]

☑ Yes  ☐ No
If “no” please provide explanation: ________________________________

13. Will Applicant maintain an efficient and accurate system for capturing Encounter Data, timely reporting the Encounter Data to OHA, and regularly validating the accuracy, truthfulness and completeness of that Encounter Data based on written policies, standards, and procedures that are in accordance with accepted professional standards, CCO and OHP Administrative Rules and OHA Provider Guides? Will Applicant have monitoring systems in operation and review the operations of these systems on a regular basis? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers’ compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.242; and the Contract]

☑ Yes  ☐ No
If “no” please provide explanation: ________________________________

14. Will Applicant maintain an efficient and accurate process that can be used to validate Member Enrollment and Disenrollment based on written policies, standards, and procedures that are in accordance with accepted professional standards, OHP Administrative Rules and OHA Provider Guides? Will Applicant have monitoring systems in operation and review the operations of these systems on a regular basis? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers’ compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.242 and 438.604; and Contract]

☑ Yes  ☐ No
If “no” please provide explanation: ________________________________
15. **Assurances of Compliance with Medicaid Regulations**

Item 15 of this Attachment 14 has ten assurances of Compliance with Medicaid Regulations. These Assurances address specific Medicaid regulatory requirements that must be met in order for the Applicant to be eligible to contract as a CCO. For purposes of this section and the federal Medicaid regulations in 42 CFR Part 438, a CCO falls within the definition of a “managed care organization” in 42 CFR 438.2. This section asks the Applicant to provide a brief narrative of how the Applicant meets each applicable Assurance. The Applicant must provide supporting materials available to the OHA upon request.

Please describe in a brief narrative how Applicant meets the standards and complies with the Medicaid requirements cited in the Medicaid Assurances in Item 15:


b. Medicaid Assurance #2 – 42 CFR § 438.207 Assurances of adequate capacity and services.

c. Medicaid Assurance #3 – 42 CFR § 438.208 Coordination and continuity of care.

d. Medicaid Assurance #4 – 42 CFR § 438.210 Coverage and authorization of services.


g. Medicaid Assurance #7 – 42 CFR § 438.228 Grievance and Appeal systems.

h. Medicaid Assurance #8 – 42 CFR § 438.230 Subcontractual relationships and delegation.

i. Medicaid Assurance #9 – 42 CFR § 438.236 Practice guidelines.

j. Medicaid Assurance #10 – 42 CFR § 438.242 Health information systems.
1. Assurances of Compliance with Medicaid Regulations

Item 15 of this Attachment 14 has ten assurances of Compliance with Medicaid Regulations. These Assurances address specific Medicaid regulatory requirements that must be met in order for the Applicant to be eligible to contract as a CCO. For purposes of this section and the federal Medicaid regulations in 42 CFR Part 438, a CCO falls within the definition of a “managed care organization” in 42 CFR 438.2. This section asks the Applicant to provide a brief narrative of how the Applicant meets each applicable Assurance. The Applicant must provide supporting materials available to the OHA upon request.

Please describe in a brief narrative how Applicant meets the standards and complies with the Medicaid requirements cited in the Medicaid Assurances in Item 15:


Health Share scored a Fully Met in all the elements of the Availability of Services standard on our most recent EQR completed by HSAG. Our delegated entities have aligned processes that include access surveys to ensure availability of member appointments, geo-mapping to identify areas that need further providers and review of complaints and grievances on a routine basis.

b. Medicaid Assurance #2 – 42 CFR § 438.207 Assurances of adequate capacity and services.

The availability of services score, mentioned above, includes a review of capacity and services which was Fully Met. Our delegated entities regularly geo-map to identify geographical areas that may need an increase in capacity for specialized services. The DSN analysis and report submitted with this RFA response indicates that Health Share has access to expand our network as membership increases.

c. Medicaid Assurance #3 – 42 CFR § 438.208 Coordination and continuity of care.

In the most recent EQR audit, HSAG found that Health Share Fully Met this sub-element by establishing a bi-monthly Care Integration Workgroup. That Workgroup is a regular forum for sharing best practices that all Health Share delegated entities are required to attend. In addition, HSAG noted our employment of two care navigators who facilitate coordination and continuity of care as well as our funding of community health workers that are embedded in medical practices to assist members with social service needs.

HSAG validated that our use of Health Share Bridge (our data analytics tool) is used to assist our delegated entities with coordinating services furnished to members across our network. Health Share Bridge clearly represented its value as a tool for sharing robust member data and coordinating care. Each delegated entity can access all payer claims and enrollment files in the system in order to view services members have received, including types of services and frequencies of visits (e.g. how many times the member presented in an emergency room). That information allows for greater care coordination through the ability to better assess a member’s needs and create appropriate follow-up planning.

d. Medicaid Assurance #4 – 42 CFR § 438.210 Coverage and authorization of services.

Health Share Fully Met this standard in its most recent EQR. In HSAG’s file review, they found that the average turnaround time for all decisions is well under 14 days with four out of five record review samples revealing decisions made and communicated by the next day after the request was made. HSAG also reviewed our provider agreement, which states that Health Share will not provide incentives to deny, limit or discontinue services for members.
   Health Share Substantially Meet this standard in the most recent EQR. A file review of the behavioral health provider network showed evidence that nine of the 10 records met timeliness and verification standards.

   Health Share has a Confidentiality policy, a Code of Conduct, and several HIPAA policies that dictate appropriate disclosures that ensure the confidentiality of all processes related to the protection of Member information and data.

g. Medicaid Assurance #7 – 42 CFR § 438.228 Grievance and Appeal systems.
   Health Share Fully Met this standard in its recent EQR on the basis of providing robust policies and procedures on our oversight of delegated entities for activities that have been delegated. As part of that review, HSAG verified that Health Share had robust processes for how determinations of deficiencies identified in an audit are made and how a corrective action plan for improvement is initiated, including identifying specific remedies to address unsatisfactory performance. In addition, the performance of each our delegated entities is reviewed and monitored annually. A notification letter is sent to the delegated entity stating our intent to conduct an annual evaluation of its capacity to perform delegated activities using established criteria and includes a list of documents and case files that will be reviewed.

h. Medicaid Assurance #8 – 42 CFR § 438.230 Subcontractual relationships and delegation.
   Health Share Fully Met this standard on its most recent EQR on the basis of a thorough review of our contracts with delegated entities, our annual formal audits of those entities and our oversight policies and procedures.

i. Medicaid Assurance #9 – 42 CFR § 438.236 Practice guidelines.
   All of Health Share’s delegated entities utilize practice guidelines for evaluating medically/clinically appropriate decisions. Health Share monitors those decisions by reviewing the guidelines being used during oversight audits, appeals and hearings. We are currently working to improve our processes to ensure delegated entities are disseminating these guidelines to providers and members when requested.

j. Medicaid Assurance #10 – 42 CFR § 438.242 Health information systems.
   Health Share Fully Meets the Information Systems Capabilities Assessment in nine of the eleven sub-elements resulting in an overall score of Fully Met in our most recent EQR. That provides assurance that our health information systems can and do provide the information necessary to support our providers and to oversee our delegated entities.
Attachment 15 — Representations

Applicant Name: Health Share of Oregon

Authorizing Signature: Maggie Bennington-Davis, MD

Printed Name: Maggie Bennington-Davis, MD

Instructions: For each representation, Applicant will check “yes,” or “no.” On representations, no particular answer is normal, and an explanation will be furnished in all cases. Applicant must respond to all representations.

These representations must be signed by a representative of Applicant.

Each representation is effective starting at the time of Readiness Review and continuing throughout the term of the Contract.

1. Will Applicant have an administrative or management contract with a contractor to manage/handle all staffing needs with regards to the operation of all or a portion of the CCO program?

☑ Yes □ No

Explanation: Health Share of Oregon will have an administrative services contract with CareOregon for management of all of its Human Resources needs.

2. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the systems or information technology to operate the CCO program for Applicant?

☑ Yes □ No

Explanation: Health Share of Oregon will have an administrative services contract with CareOregon for management of a portion of the systems and information technology used to support its operations.

3. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the claims administration, processing and/or adjudication functions?

☑ Yes □ No

Explanation: Health Share of Oregon will have a management contract with CareOregon, OHSU Health System, Legacy Medical Group, and Kaiser Permanente for performance of all claims administration, processing and/or adjudication functions.

4. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the Enrollment, Disenrollment and membership functions?

☑ Yes □ No

Explanation: Health Share of Oregon will have an administrative services contract with CareOregon for performance of all of the Enrollment and Disenrollment functions and a portion of membership functions.
5. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the credentialing functions?

☑ Yes   ☐ No

Explanation: Health Share of Oregon will have a management contract with CareOregon, OHSU Health System, Legacy Medical Group and Kaiser Permanente for performance of all credentialing functions.

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6. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the utilization operations management?

☑ Yes   ☐ No

Explanation: Health Share of Oregon will have a management contract with CareOregon, OHSU Health System, Legacy Medical Group and Kaiser Permanente for performance of all utilization operations management.

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7. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the Quality Improvement operations?

☑ Yes   ☐ No

Explanation: Health Share of Oregon will have a management contract with CareOregon, OHSU Health System, Legacy Medical Group and Kaiser Permanente for performance of a portion of the Quality Improvement operations, with the exception of those operations that cannot be delegated per the CCO Contract.

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8. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of its call center operations?

☑ Yes   ☐ No

Explanation: Health Share of Oregon will have an administrative services contract with CareOregon for performance of a portion of its call center operations.

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9. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the financial services?

☑ Yes   ☐ No

Explanation: Health Share of Oregon will have an administrative services agreement with CareOregon for performance of a portion of the financial services.
10. Will Applicant have an administrative or management contract with a contractor to delegate all or a portion of other services that are not listed?

☑ Yes  ☐ No

Explanation: Health Share of Oregon will have an administrative services agreement with CareOregon for delegation of a portion of other services that are not listed. Those services will be some member communications/materials and administration of flexible services.

11. Will Applicant will have contracts with related entities, contractors and Subcontractors to perform, implement or operate any aspect of the CCO operations for the CCO Contract, other than as disclosed in response to representation 1-10 above?

☑ Yes  ☐ No

Explanation: Health Share will have contracts with related entities and Subcontractors to perform, implement or operate certain CCO operations for the CCO Contract other than those disclosed in responses 1-10 above. Those contracts include: 1) CareOregon for administration of NEMT operations, a portion of behavioral health operations and dental operations; 2) Clackamas, Multnomah and Washington Counties for administration of a portion of behavioral health services, including mobile crisis services.

12. Other then VBP arrangements with Providers, will Applicant sub-capitate any portion of its Capitation Payments to a risk-accepting entity (RAE) or to another health plan of any kind?

☑ Yes  ☐ No

Explanation: A portion of Health Share of Oregon’s sub-capitation to CareOregon will be for other than a VBP arrangement. All other sub-capitation provided to Health Share risk-accepting entities (i.e. OHSU Health System, Legacy Medical Group and Kaiser Permanente) will be VBP arrangements.

13. Does Applicant have a 2019 CCO contract? Is Applicant a risk-accepting entity or Affiliate of a 2019 CCO? Does Applicant a management services agreement with a 2019 CCO? Is Applicant under common management with a 2019 CCO?

☑ Yes  ☐ No

Explanation: Health Share of Oregon does have a 2019 CCO contract. Health Share of Oregon is not a risk-accepting entity or Affiliate of a 2019 CCO. Health Share of Oregon does not have a management services agreement with a 2019 CCO. Health Share of Oregon is not under common management with a 2019 CCO.
Attachment 16 — Member Transition Plan (10 pages)

2. Plan Contents

2.a. Coordination between Transferring and Receiving CCOs

Coordination between transferring and receiving CCOs – To ensure the safe and orderly transition of members, Health Share will cooperate with a transferring or receiving CCO to achieve a successful transition for members during the Open Enrollment period. **Health Share has significant experience with large-scale transitions of members from one CCO to another.** In early 2018, Health Share managed the transition of more than 100,000 members to our CCO over a six-week period. That process allowed Health Share to refine the tools and systems necessary to ensure more seamless continuity of care, especially for those members at risk for serious detriment to their physical, behavioral, or oral health. During that process, Health Share worked proactively and collaboratively with the other CCOs to ensure members transitioned successfully, especially the most vulnerable populations.

**Collaborative process to support coordination:** If we are notified that our service area is a Choice Area, we would implement similar processes based on our learnings from the 2018 transition. First, we would identify our Chief Medical Officer as our single point of contact to work with the other CCO. This person would reach out to the other CCO to establish an open line of communication and to set up, at a minimum, bi-weekly meetings to plan for the transition. Those meetings would begin with addressing the need for **data sharing agreements** and would serve to delineate roles and responsibilities between the transferring and receiving CCOs. In these meetings, key staff from the two CCOs would agree on processes for sharing data related to prior authorizations (PA) and ongoing services and discuss how to communicate with providers and members. The participants in these meetings would also discuss provider assignment and matching and would triage any issues related to members’ continuity of care and customer support.

**Policies and procedures to support member transitions:** The collaborative process outlined above would be used to develop procedures and workflows associated with supporting transferring members between CCOs as outlined in the sections below. These procedures and workflows would address data sharing agreements and data validation processes, processes for sharing member PA history, processes related to sharing information on provider matching and assignment, strategies to ensure continuity of care during the transition, and collaborative approaches to customer support, among other topics. Collaborative customer support could include public meetings convened by CCOs as well as detailed procedures for referring members back and forth between CCOs to address member confusion about plan assignment and other member needs. More details on how Health Share will support these functions is outlined in the sections below.

**Procedures to address high-risk members:** Collaboratively with the other CCO, we would also work to develop **specific procedures to mitigate negative impacts on our highest risk members.** These procedures may include higher-touch outreach to at-risk members, coordination between care coordinators assigned to these members at the outgoing and receiving CCO, collaboration with providers actively providing services to these members, and case conferences with members, providers, and family members. We will work with other CCOs to document these procedures and to share this information with members as needed. Working with our Clinical Advisory Panel (CAP) and our Community Advisory Council (CAC), Health Share’s participants on this team would address and/or escalate any issues related to members in the following categories:

- Prioritized populations
- Medically fragile children
- Breast and Cervical Cancer Treatment Program members
- Members receiving CareAssist assistance due to HIV/AIDS
- Members receiving services for end stage renal disease (ESRD), prenatal or postpartum care, transplant services, radiation, or chemotherapy services
- Members discharged from the Oregon State Hospital or Medicaid-funded residential Behavioral Health programs in the last 12 months
- Members participating in Oregon’s CMS-approved 1915(k) and 1915(c) programs accessing home and community-based services (HCBS)

2.b. Transferring CCOs with Outgoing Members

Supporting transitions for outgoing members – When Health Share received an increase of 100,000 new members in 2018, we developed processes and procedures to ensure our new members would immediately receive the same high-quality care for which Health Share is known across the state. While that transition related to incoming members, during an Open Enrollment period under CCO 2.0 we would leverage our learnings from this experience to execute a transfer plan for outgoing members as well.

2.b.(1) Data Sharing

Data sharing to support member transitions – One of our key learnings from the 2018 transition was related to the transition of member-specific data. Health Share believes very strongly that protecting members’ privacy is of the utmost importance. During the 2018 transition, we identified early in the process that we would need access to member-level information in order to ensure a safe and orderly transition. However, in this instance, we did not immediately know which members would ultimately be transitioned to our CCO. We knew the majority of members would transition to Health Share, but some members would transition to a third CCO while others would lose eligibility prior to the effective date of the transition. In order for both the transferring CCO and Health Share, as the receiving CCO, to be confident that members’ privacy would be protected, we needed OHA to identify the members for us. To protect member privacy during an upcoming transition, we would hope to collaborate with OHA to develop procedures to protect member information in the same way.

Developing a data sharing plan: During an Open Enrollment period, Health Share would work collaboratively with OHA and other CCOs to establish a plan for sharing data between CCOs that protects members’ privacy and also enables a smooth transition of members between CCOs. We will collaboratively establish data sharing agreements with the other CCO as needed, prioritizing member safety along with privacy during the process. This plan would include detailed processes for sharing member data, detailed data elements to be shared, timing of data exchanges, and testing processes to test data sharing protocols before open enrollment.

Shared data elements: Health Share would ensure that OHA and the receiving CCO have the following information on all transitioning members.

<table>
<thead>
<tr>
<th>Type of Member Data</th>
<th>Data Element</th>
</tr>
</thead>
<tbody>
<tr>
<td>Historical claims data</td>
<td>Claims data on services received, including:</td>
</tr>
<tr>
<td></td>
<td>- Medical care (primary and specialty)</td>
</tr>
<tr>
<td></td>
<td>- Behavioral health care</td>
</tr>
<tr>
<td></td>
<td>- Oral health care</td>
</tr>
<tr>
<td></td>
<td>- Prescriptions</td>
</tr>
<tr>
<td></td>
<td>- Ambulance transports</td>
</tr>
<tr>
<td></td>
<td>- Non-emergency medical transportation (NEMT)</td>
</tr>
<tr>
<td>Diagnosis information</td>
<td>Chronic condition flags, where appropriate, using national condition definitions</td>
</tr>
</tbody>
</table>
based on denominators for HEDIS, NQF, or other such organization’s condition-related metrics

### Risk scoring
- Level of medical complexity based on the number of conditions, overall cost, frequency, and recency of visits

### Provider information
- Assigned primary care provider (PCP)
- Assigned primary dental provider (PDP), when available
- Behavioral health provider, when available

### Prior authorizations
- Authorization data

### NEMT
- List of NEMT rides already scheduled

### Inpatient data
- Current inpatient census

### Flags on priority populations
- OHA’s prioritized populations
- Medically fragile children
- Breast and Cervical Cancer Treatment Program members
- Members receiving CareAssist assistance due to HIV/AIDS
- Members receiving services for end stage renal disease (ESRD), prenatal or postpartum care, transplant services, radiation, or chemotherapy services
- Members discharged from the Oregon State Hospital or Medicaid-funded residential Behavioral Health programs in the last 12 months
- Members participating in Oregon’s CMS approved 1915(k) and 1915(c) programs accessing home and community-based services (HCBS)
- Members receiving exceptional needs care coordination
- Members receiving intensive care coordination
- Members receiving Choice services
- Members receiving Wraparound services
- Members receiving other care management services
- Members with imminently scheduled procedures

### Formatting and transmittal methods
We regularly send and receive large quantities of personal health and personally identifiable information (PHI and PII) via our SFTP or secure SharePoint site. Our preferred data sharing approach for claims data would be to send all historical APAC-formatted claims for the last 12 months in a delimited flat file format with an accompanying data dictionary via a mutually agreed upon HIPAA-compliant transmittal method such as SFTP. We are also able to send data in an Epic format. During an Open Enrollment period, files would be loaded in raw form into a staging area using SQL Server Integration Services. Additionally, as we learned during the 2018 transition, some care coordination files are most easily shared via secure emails between care coordinators, and we have that capability as well.

### Staffing and resource plan
Health Share’s IT team would be staffed to support the generation and secure transmission of these files, as well as provide any technical assistance to the receiving CCO regarding the file contents. Health Share’s partners in our integrated delivery systems (IDS) and our integrated community network (ICN) would also dedicate care coordination and other support staff to ensure the member transition is accomplished in a safe and orderly manner.

### 2.b.(2) Provider Matching
**Supporting provider matching** – Health Share currently receives and stores in our data warehouse up-to-date information about each member’s assignment to a primary care provider (PCP) as well as to a primary dental provider (PDP) and behavioral health provider when available. We identify members’ behavioral health providers based on authorization data that indicates where a member is receiving behavioral health services and at what level. During an Open Enrollment period, we would share information on providers serving each member, along with all of the other data elements listed in the section above, with a receiving CCO. The historical claims data includes information on ongoing relationships with specialty care providers. Prioritized populations, including members with high
complexity or demonstration of immediate need for continuity of services, would be prioritized in the transition process.

Working with providers to identify assigned members: Where there is network overlap with another CCO, Health Share would work with our provider partners to identify assigned members who would be impacted by the transition prior to the Open Enrollment period, and we would execute a validation process afterward to ensure that all transitioning members were reassigned back to the correct providers. When we executed a similar process in 2018, we validated and improved the assignment data that we received from another CCO by working directly with our provider partners. In some instances, we discovered that the transitioning members’ assigned providers in the data file we received were not the providers that the members had been seeing based on their claims history and validation with our provider network. In these cases, we were able to more accurately assign those members to the PCP where their care was established.

2.b.(3) Continuity of Care
Supporting continuity of care for transitioning members – To support transitioning members’ continuity of care during an Open Enrollment period, Health Share would begin by providing a receiving CCO with the data elements listed above in our response to question 2.b.1, which would include data on existing prior authorizations for services, member diagnosis information, information on chronic conditions, and treating providers assigned to members. Through our care coordination teams, we would ensure face-to-face or telehealth-supported meetings with our members and their families and coordinate the transfer of responsibility for the member’s ongoing care and continuing treatment and services to the receiving CCO’s care coordination team. We will also reach out to providers treating transitioning members to inform them of the upcoming transition and how to obtain support on ongoing care needs for their patient populations.

Continuity of care for high-risk populations: Working in partnership with our CAP and the Care Coordination Supervisors at Health Share’s IDS and ICN, Health Share’s Chief Medical Officer would closely oversee transitions for high-risk member populations, ensuring the necessary staffing would be available and, whenever appropriate, allowing for a “warm handoff” to the receiving CCO. High-risk populations would include:

- Prioritized populations
- Medically fragile children
- Breast and Cervical Cancer Treatment Program members
- Members receiving CareAssist assistance due to HIV/AIDS
- Members receiving services for ESRD, prenatal or postpartum care, transplant services, radiation, or chemotherapy services
- Members discharged from the Oregon State Hospital or Medicaid-funded residential Behavioral Health programs in the last 12 calendar months
- Members participating in Oregon’s CMS-approved 1915 (k) and 1915 (c) programs for individuals who have met institutional level of care requirements in order to access Home and Community-Based Services (HCBS) under these federal authorities

Data on care management: While ensuring privacy and the security of members’ PHI, we would also share case management files, care coordination files, or behavioral health care plans currently in place (as appropriate). We would share these files through secure FTP with the other CCO. With our 2018 transition experience, we also used secure email to transfer care coordination files between individual care coordinators as needed.

Member prior authorizations: To ensure members transitioning to another CCO are able to
undergo procedures already authorized, we would work with OHA and the other CCO to share data required to ensure those procedures are not interrupted and the medications are seamlessly provided. We would rely on our 2018 experience to streamline the process. The data file layout for authorization history has already been developed and validated in the transition of members from the CCO closure. For large-scale transfers the data would be shared via SFTP site. For smaller or individual transfers, we would use secure email to transfer authorization history. Regardless of the volume of members, any transfer requires a request from OHA or the receiving CCO, with clear list of members for whom records/PA information is being requested.

In our 2018 experience, we received new members whose authorization history was unclear or incomplete. We were able to create a process to ensure transition of care benefits was applied to all received members. This process involved an identifier put into the authorization system to remove authorization barriers for those members whose authorization history was not provided.

2.c. Member/Provider Outreach for Transition Activities

Member and provider outreach to support member transitions – Through our prior experience completing a large member transition, we developed several methods to effectively communicate and coordinate with our members and providers.

Member outreach: Health Share’s robust customer service teams would act as first point of contact for any member questions during an Open Enrollment period. We would also update our website with information for members about the transition. As described in section 2.b.3 above, care coordinators would proactively engage members who are at risk for adverse health outcomes to ensure continuity of care. For members with SPMI or discharging from an acute care psychiatric hospital, Health Share will follow the warm handoff process as required by OAR 30-032-0860. Through our care coordination teams, we would ensure face-to-face meetings with members, either in-person or through the use of telehealth, and coordinate the transfer of responsibility for the member’s ongoing care and continuing treatment and services.

As part of the 2018 transition, we conducted the following activities to ensure that members had the information they needed to continue accessing care:

- Four open houses for members
- Welcome call center for members
- Standardized customer service talking points across our system
- Multiple provider-specific (physical and behavioral health) open houses
- Member and provider-specific webpages
- Search engine marketing to drive individuals seeking information about the member transition to the webpages
- Member and provider-specific handouts (including “school backpack insert” for parents of kids with OHP coverage)
- Custom outreach to behavioral health providers, hospitals (in partnership with the Oregon Association of Hospitals and Health Systems), NEMT providers, etc.
• Community outreach and materials for OHA regional outreach coordinators, community partners, application assisters, etc.
• Custom welcome and ID card letters to incoming members
• Coordinated mailings/language with OHA
• Media outreach: multiple op-eds in the Oregonian, Portland Observer, Basic Rights Oregon listserv, etc.
• Social media ads and outreach messages to key populations

We will evaluate the need for these functions to support the CCO 2.0 transition and will work collaboratively with the other CCO to implement these member services. We are aware that any large-scale transition such as the member transition that would occur during an Open Enrollment period can be disruptive to members and has the potential to create significant member confusion. We would therefore employ similar tactics as we did in 2018 to minimize that disruption and confusion as much as possible for both our members and our providers.

Provider outreach: In addition to the activities listed above, during an Open Enrollment period, Health Share would rely on existing channels for communicating and coordinating with our providers. Our IDSS (Legacy, Kaiser, OHSU Health System, and Providence) and ICN (CareOregon) use regular team meetings and provider portals and newsletters to communicate with their provider networks. As we did in the 2018 transition, we would remind our providers that the benefits package for the Oregon Health Plan is the same, regardless of which CCO a member is assigned. If providers have patients that they are concerned about, we would encourage them to proactively reach out to us to ensure that their patients’ needs are met. As we become aware of members who are transitioning to another CCO, we will reach out to providers treating transitioning members that have an ongoing treatment plan to inform them of the upcoming transition and how to obtain support on ongoing care needs for their patient populations.

Monitoring member complaints: Additionally, as we did in 2018, we would proactively monitor member complaints to ensure safety and experience are not jeopardized. We would review both volume and complaint type weekly to note trends that need to be addressed. In 2018, Health Share developed an early identification system to ensure that any member access issues were quickly identified and escalated to leadership if they could not be resolved.

2.d. Receiving CCOs with Incoming Members
2.d.(f) Data Sharing
Supporting data sharing for incoming members – To ensure that Health Share is able to provide members with a safe and orderly transition, especially for the most vulnerable members transitioning
to a new CCO, Health Share would need to receive the same member data elements as described above in section 2.b.1. As also mentioned in section 2.b.1, we are able to send and receive large quantities of personal health and personally identifiable information (PHI and PII) via our SFTP or secure SharePoint site. During an Open Enrollment period, the transferring CCO would load files in raw form into a staging area using SQL Server Integration Services. As a receiving CCO, we would verify data to ensure that all members whose data appears in the file are found in our most recent enrollment data from OHA, so we know the member successfully transferred and that it is appropriate for us to receive and process their PHI. Using record control totals, we would verify that all transferred records were received, were properly loaded, appear in the format we expected, and are complete and comprehensive (e.g., no column errors or missing data). We would flag all data from the transferring CCO and integrate it into our data warehouse, where our existing algorithms and calculations allow for further validation (e.g., diagnosis and procedure codes will run through the Milliman Grouper, metric performance and utilization rates will be calculated, etc.).

Once the data is integrated into our data warehouse, we publish it on Health Share Bridge, our web-based analytics platform. All of Health Share’s partners as well as many of our providers have access to Health Share Bridge and would have access to all of their members’ historical claims information from the transferring CCO. We also use Health Share Bridge as a tool internally to support smaller providers. During the 2018 transition, we worked closely with providers to validate that the members they anticipated transitioning did in fact transition.

2.d.(2) Provider Matching

Supporting provider matching for incoming members – During an Open Enrollment period, Health Share would incorporate data from a transferring CCO regarding a member’s most recent assignment to a PCP, PDP, and behavioral health provider. Because of the depth and breadth of our provider network, the vast majority of members who were engaged in care and transitioned to Health Share in 2018 were already seeing in-network providers. For example, only about 4% needed to change their PCP. This is also true for the specialty provider network since we contract with all of the major specialty providers in the region. We would create a quality check by engaging providers prior to the transition to pull their assigned member lists. That would enable us to verify the same members are reassigned after the transition and create a reassignment process to correct any assignments that were incorrect.

Out-of-network providers: If members are seeing out-of-network providers, we will reach out to those providers to see if they are interested in joining our network or work to establish single case agreements when out-of-network care is planned or underway. If they do not contract with us or enter into a single case agreement, we will work with those providers and impacted members to establish care with an in-network provider that is located conveniently to the member and meets their needs. Also, our members always have the freedom to select new providers from our vast network.

2.d.(3) Continuity of Care

Supporting continuity of care for incoming members – In our 2018 experience with CCO membership transfer, Health Share worked with both contracted and non-contracted providers to ensure members’ care was not disrupted while members searched for and established relationships with new providers as needed. During an Open Enrollment period, Health Share would employ similar approaches to ensure that members’ continuity of care is not disrupted. The first critical step would be to ensure that members’ providers are in-network. That process is described in section 2.d.2 above. In the 2018 transition, we went above and beyond requirements and honored members’ PAs for physical health services for 90 days and for behavioral health services for 180 days to make sure that members had sufficient time to find and establish care with new providers as needed. For the CCO 2.0 transition, we will comply with the timeframes established in the Transition of Care Requirements.
established under OAR 410-141-3061(5-6).

**Ensuring continuity of care for prescription drugs:** In 2018, one of our key strategies to ensure the safe transition of members with complex conditions was to focus on medication needs. Health Share worked with pharmacy staff in our network to ensure minimal medication disruptions for all existing medications. We carefully reviewed our formularies and pharmacy network against the exiting CCO’s formulary and network to ensure they overlapped. In one case, our ICN, CareOregon, did not contract with Walgreens but worked with their PBM to expand access to Walgreens pharmacies during the transition. Members who transitioned were able to fill their prescriptions at Walgreens; we proactively reached out to them by letter and phone, and coordinated with their PCP to transition medications to a contracted pharmacy. This approach assured that no members went without needed medications and made the transition as smooth as possible for members. Separately, to prevent disruptions in medication coverage, pharmacy staff from Health Share partners provided transition coverage of members’ active medications that required prior authorization. We will employ similar strategies to ensure continuity of care for prescription drugs in accordance with OAR 410-141-3061 in future member transitions.

**Transitions for members with complex care coordination needs:** For transitioning members with complex care coordination needs — particularly those receiving Exceptional Needs Care Coordination, Intensive Care Coordination, Choice, Wraparound, or other care management — and for high-risk members identified in the RFA, Health Share would arrange to staff the cases and, whenever possible, allow for a “warm handoff” between the transferring CCO and Health Share. Additionally, care coordination teams assess for care coordination needs such as provider access, social determinant of health issues, or coordination with multiple providers. Care coordinators create a care plan, document it in the care management platform, and share it with the PCP to address any issues uncovered. The care team then works with the member and providers to ensure a smooth transition.

**2.d.(4) Member/Provider Outreach for Transition Activities**

**Member and provider outreach to support member transitions** – We have several ways we routinely and effectively communicate and coordinate with our providers and members that we employ to welcome new members to Health Share. We also communicate broadly with community stakeholders, many of whom work closely with our members and serve as trusted outlets for information.

**Member outreach:** As described in section 2.c, our robust customer services teams will act as first point of contact for any member questions. We will welcome new members, answer questions, review benefits, or take and respond to complaints. Systems are configured to send welcome packets and ID cards to all new members. In our 2018 experience transitioning a large group of members, we created a custom welcome packet, specific to the member transition. We also welcomed members through specific phone messaging and scripts recognizing the change they were experiencing, as well as through the stand-up of a temporary New Member Welcome Center to ensure we could accommodate the increase in call volume. We would also create a custom webpage with information for members about the transition, and use search engine marketing techniques to make sure individuals seeking information about Health Share or the transition found the transition webpage. In the event that we experience another large influx of members during Open Enrollment, we will deploy similar tactics to welcome new members.
Another way we would outreach to members would be to work with our GoMobile team of health care navigators and health plan assistor who educate members and community-based organizations (CBOs) on navigation of the health care and other social service systems such as DHS, Social Security, and SNAP to deliver a wrap-around experience. With this program, we meet members where they naturally gather and build social capital, including churches, grocery stores, the library, waiting rooms in CBOs, and early learning hubs. During a CCO transition, we would want to encourage members and their advocates to engage with Health Share and their PCP as early and often as needed.

**Outreach to high-risk members:**
For members who are at risk for adverse health outcomes, including those identified in Attachment 16 to the RFA, care coordinators will proactively outreach to these members to ensure continuity of care. For example, for members with SPMI or discharging from an acute care psychiatric hospital, Health Share will follow the warm handoff process as required by OAR 309-032-0860. Through our care coordination team, we will ensure that face-to-face meetings with the patient occur, either in-person or through the use of telehealth, and that coordination and the transfer of responsibility for the patient’s ongoing care and continuing treatment and services are executed.

**Continuity of provider assignment:** We will make every effort to assign transferring members to the same PCP they are currently engaged with, provided they are in-network. We will also work to establish care for those members with their current behavioral health and dental providers. Additionally, we will make outreach attempts to welcome the member to Health Share and fill in any gaps in the data regarding medical provider assignments and care needs. If a member is assessed as needing care coordination, that member will be immediately triaged into care coordination. For members seeing out-of-network providers, we will follow the process outlined in section 2.d.2.

**Provider outreach:** During an Open Enrollment period, Health Share would rely on existing channels for communicating and coordinating with our providers, as we would if Health Share were the transitioning CCO. We would also create a custom webpage with information for providers about the transition, and use search engine marketing techniques to make sure individuals seeking information about Health Share or the transition found the transition webpage. We would also host town hall style
meetings for providers to provide more information. Our IDSs (Legacy, Kaiser, OHSU Health System, and Providence) and ICN (CareOregon) use regular team meetings and provider portals and newsletters to communicate with their provider networks. As we did in the 2018 transition, we would remind our providers that the benefits package for the Oregon Health Plan is the same, regardless of which CCO a member is assigned. If providers have patients that they are concerned about, we would encourage them to proactively reach out to us to ensure that their patients’ needs are met. We will also reach out to providers treating transitioning members to inform them of the upcoming transition and how to obtain support on ongoing care needs for their patient populations.