Report to Oregon House Committee on Health Care

Health Share of Oregon's Contributions to Transformation of the Oregon Health Plan

Janet L. Meyer, Chief Executive Officer

6/10/2015

This report is in response to questions posed in a letter from Representative Mitch Greenlick, Chair of Oregon's House Committee on Health Care, dated May 18, 2015.

Introduction

This report is in response to questions posed in a letter from Representative Mitch Greenlick, Chair of Oregon's House Committee on Health Care, dated May 18, 2015. The four questions posed in the letter have been organized into three broad topic areas: Structure and Governance (Question #1), Delivery System (Questions #2-3), and Quality Metrics (Question #4). We have also attached three documents that support the Delivery System section: Health Share 1.5 Review, Health Commons Overview, and Transformation Fund Update. For more information about information in this report or its attachments, please contact:

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Structure and Governance

This section addresses the majority of Question #1: "Describe your CCO structure, including the governance structure, the key partners, who bears the risk, the nature of the delivery system, the role of the community advisory council, and your profitability." The description of Health Share's delivery system can be found under the "Delivery System" heading.

THE COLLECTIVE IMPACT MODEL

Health Share's service area is complex. There are 17 hospitals and more than 18,000 providers in our networks. Prior to the formation of coordinated care organizations (CCOs), there were five fully-capitated health plans (covering physical health), three mental health organizations, and eight dental care organizations serving Oregon Health Plan members in the Tri-County area. Health Share is a collaborative of all but one of those managed care entities and the providers in their networks. When Health Share was formed, its founders chose to avoid disrupting the existing provider networks and the good things they were doing. Health Share's founders did not want to create a mega health plan; they wanted to create something transformational—a collective impact organization in Medicaid managed care.

Health Share serves as a "backbone organization" in a collective impact organization. The Collective Impact Model was first described in 2011 by John Kania and Mark Kramer in the *Stanford Social Innovation Review* article titled "Collective Impact." Collective impact suggests that in order to impact

social change, organizations from across sectors must work together toward a shared goal. An organization must meet five criteria in order to be considered a collective impact organization.

1. Common Agenda
2. Shared Measurement System
3. Mutually Reinforcing Activities
4. Continuous Communication
5. Backbone Organization

A backbone organization provides ongoing support to a collective impact initiative through an independent staff dedicated to the initiative.

LEGAL STRUCTURE

Health Share is a private, non-profit corporation that contracts with the State to provide Medicaid coordinated care services to Oregon Health Plan members in Clackamas, Multnomah, and Washington Counties. It is designated with the Internal Revenue Service as a **501c(3) tax exempt charitable organization,** which comes with special requirements. For example, 501c(3) organizations are strictly prohibited from participating in political activities, where other types of non-profit entities are not. In addition, 501c(3) organizations are required to publicly disclose certain financial information that other entities are not required to disclose. This leads to a high level of transparency.

BOARD OF DIRECTORS

Health Share was founded by eleven familiar health care entities that served Oregon Health Plan members in our community prior to the formation of CCOs. Our Board of Directors includes a representative from each of the founding organizations--whose seat is held by the organization rather than the individual--and nine other members who are elected as individuals. The elected board members represent populations that the statute governing CCOs requires and additional populations that Health Share's founders felt were important to have represented.

Each of Health Share's Board members has an equal vote. There is no weighting of votes based on status as a founding organization, size of entity represented, or anything else.

Health Share of Oregon's Board of Directors Roster

Board Member	Representing	Reason for Position
Michael Biermann, DMD	Dentist	Health Share requires dental representative
Ed Blackburn	Central City Concern	Founding Organization
George J. Brown, MD, FACP	Legacy Health	Founding Organization
Patrick Curran	CareOregon	Founding Organization
Tim Fleischmann	Tuality Healthcare	Founding Organization
Joanne Fuller	Multnomah County Health Department	Founding Organization
Jill Ginsberg, MD	Primary Care Provider	Law requires either MD or NP primary care provider; Health Share requires both
W. Gary Hoffman, MD	Specialty Care Provider	Law requires specialty care provider
Marni Kuyl	Washington County Department of Health & Human Services	Founding Organization
Andrew McCulloch	Kaiser Permanente	Founding Organization
Jacqueline Mercer	Addictions Provider	Law requires either mental health or addictions provider; Health Share requires both
Mary Monnat	Mental Health Provider	Law requires either mental health or addictions provider; Health Share requires both
Jean-Claude Provost, NP	Primary Care Provider	Law requires either MD or NP primary care provider; Health Share requires both
Mel Rader	At-Large Member (Upstream Public Health)	
Peter Rapp	Oregon Health & Science University	Founding Organization
Thomas Russell	Adventist Medical Center	Founding Organization
Richard Swift	Clackamas County Health, Housing & Human Services	Founding Organization
Dave Underriner	Providence Health & Services	Founding Organization
Stephen Weiss	Community Advisory Council	Required by law
Ramsay Weit	At-Large Member (Community Housing Fund)	

KEY PARTNERS

As a backbone organization, Health Share partners with many organizations serving our members across our service area. Key partners include all of our board member organizations, community providers, state and local governments, transportation providers, social service organizations, the Healthy Columbia Willamette Collaborative, and many others.

Operational Committees

In addition to our Board of Directors and its subcommittees, Health Share includes key community partners in a number of standing operational and transformational committees and work groups. Regular Committees include:

- Physical Health Joint Operating Committee
- Mental Health Joint Operating Committee
- Dental Health Joint Operating Committee
- Behavioral Health Leadership
- Quality Metrics Workgroup
- REaL Data Team (Race, Ethnicity and Language)
- Data Analysis and Reporting Workgroup
- Cultural Competency Workgroup
- Compliance and Delegation Oversight Committee
- Government Relations Workgroup

Additional ad hoc committees and workgroups are formed on an as needed basis for time-limited initiatives.

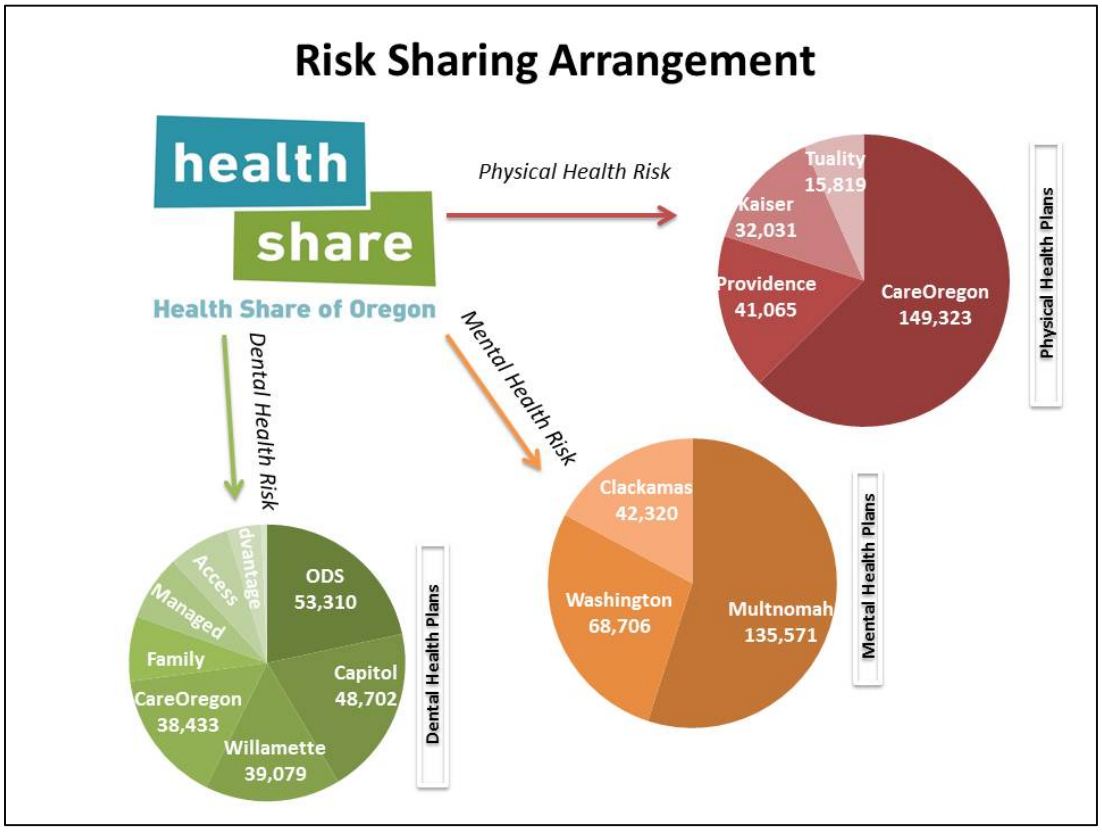
RISK SHARING

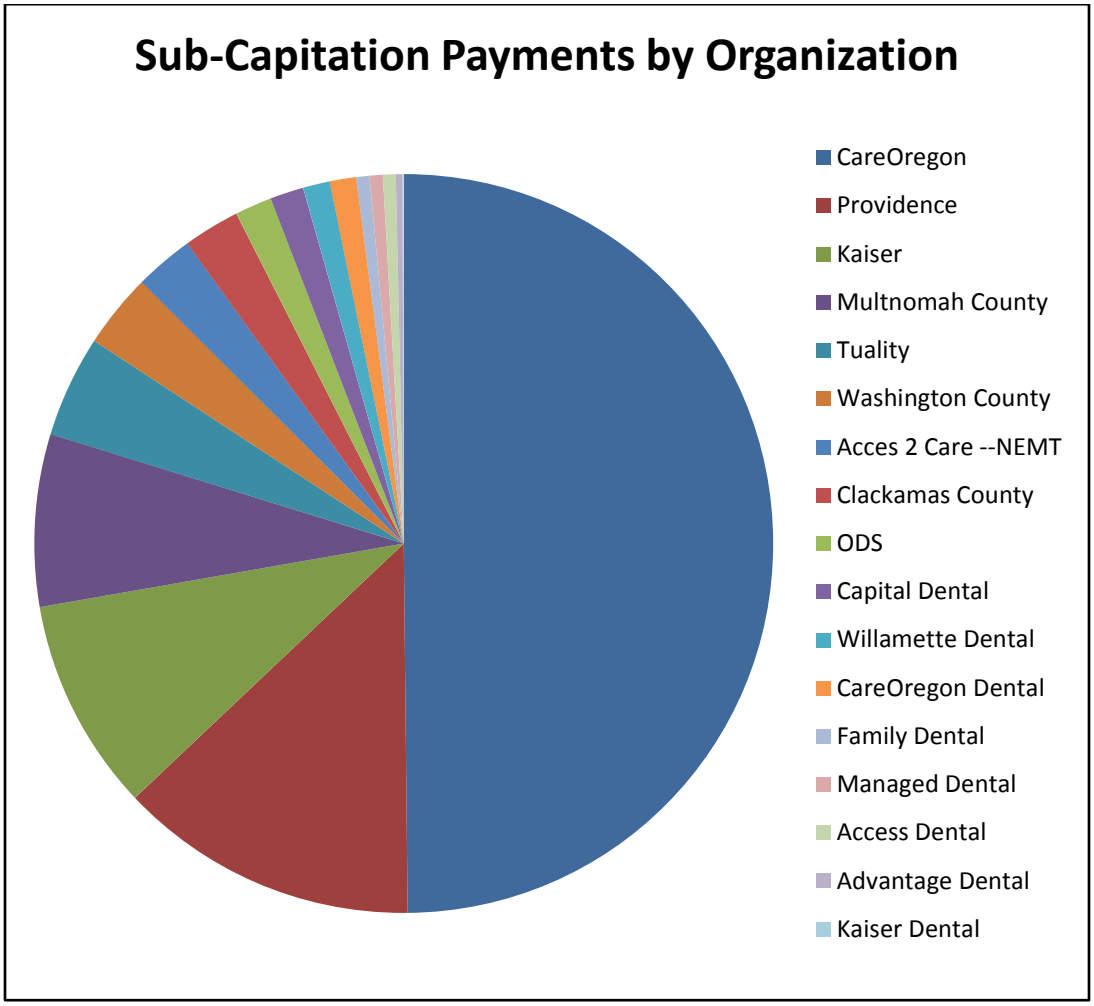
Like all CCOs, Health Share sub-capitates delegated entities to bear risk for the health of its members. Our risk sharing model is based on supporting the established provider networks in our community. Just as the Legislature required CCOs to maintain the stability of the state's dental networks by mandating that CCOs contract with existing Medicaid dental care organizations, Health Share maintained stability in the existing networks in our community by subcontracting with existing plans to bear risk for all types of health care.

Health Share's sub-capitated entities include four physical health managed care entities, three mental health managed care entities, and nine dental managed care entities:

Physical Health	Mental Health	Dental Health
CareOregon	Clackamas County	Access Dental
Kaiser Permanente	Multnomah County	Advantage Dental
Providence	Washington County	Capitol Dental Care
Tuality Health Alliance		CareOregon Dental
		Family Dental
		Kaiser Dental
		Managed Dental
		ODS Dental
		Willamette Dental

Each member chooses or is assigned to one of the networks in each category. There are 108 possible combinations of health networks for our members, and Health Share coordinates services across them and provides centralized customer service and non-emergency transportation services.





COMMUNITY ADVISORY COUNCIL

Health Share's Community Advisory Council functions primarily as a liaison between its staff leadership and Board of Directors and the public. The Council holds monthly half-day public meetings in various locations around Health Share's service area. Each meeting includes a public comment period. Council Chair, Steve Weiss, serves on the Board of Directors and provides a report from the Board to the Council each month and vice versa. Health Share's CEO also provides a monthly update to the Council during the public meeting.

Member	Representing
Steve Weiss (Chair)	OHP Member
Dalila Sarabia (Vice Chair)	OHP Member
Ronda Harrison (Secretary)	OHP Member (Parent)
Amy Anderson	OHP Member
Ebony Clarke	Multnomah County
Glendora Claybrooks	OHP Member
Gary Cobb	Community Member
Sonja Ervin	Community Member
Erin Mowlds	Washington County
Dr. Ryan Skelton	Community Member
Lyla Swafford	OHP Member
Claire Weiss	Clackamas County

In addition to this liaison function, the Council is instrumental in guiding Health Share's community health needs assessment (CHNA) and community health improvement plan (CHP). Through the CHNA, the Council identified Behavioral Health and Chronic Disease Preventable through Physical Activity and Nutrition as the two priority areas to address in the current CHP. Health Share funded the CHP's first year activities utilizing one-time resources available through the Transformation Fund provided by the 2013 Legislature. Health Share's CHP funds culturally-specific Community Health Workers and Peer Mentors in culturally-specific community-based organizations to address the two priority issues.

PROFITABILITY

CCO profitability is difficult to measure across CCOs for a number of reasons: not all CCOs are non-profit organizations; the Oregon Health Authority does not collect financial data from CCOs in a uniform manner; and the relative size of CCOs' enrollment can skew the numbers.

Non-Profit Status and Related Policies

As noted above, Health Share is a non-profit organization. Earning a profit is not a goal of Health Share's, and surpluses must be used in a specific manner.

The OHA does not require an overall minimum medical loss ratio (MLR)—i.e., the ratio of premium spent on covered services to premium spent on administration—of CCOs. However, Health Share has adopted a minimum MLR for its subcontracted managed care entities. Each service type has a different minimum MLR, and Health Share aims for an aggregate minimum MLR of 92%. Health Share itself withholds only 0.9% for operational costs and 0.9% to meet financial solvency requirements from the CCO capitation payments. If a subcontracted managed care entity does not attain its minimum MLR, Health Share requires them to use those funds for one of three things: 1) increasing restricted reserves to the maximum allowed by Health Share policies; 2) increasing network capacity; or 3) increasing provider payments.

The OHA requires all CCOs to retain a certain amount in restricted reserves and net worth. Health Share also sets a minimum and maximum restricted reserves amount for its subcontracted managed care entities, so that we can meet our financial commitments in down times but none of our partners are amassing trapped equity that could be better used to improve the overall health care system.

Lack of Uniformity in CCO Financial Reporting

The OHA does not collect financial information from CCOs in a uniform fashion. Health Share reports the aggregate medical and administrative cost allocations of each of its subcontracted managed care entities to the OHA. Some other CCOs are allowed to report payments to subcontracted managed care entities as capitation payments—essentially counting all payments to managed care entities as medical expenses, rather than accounting for the administrative costs at the subcontractor level. Neither practice is better, but the reporting requirements ought to be uniform for all CCOs to improve comparisons across CCOs.

Health Share's 2014 Revenue Utilization as Percent of Premiums

Health Share's 2014 surplus is reflected in the table below. In order to show Health Share's revenue utilization in a way that is not skewed by the size of its enrollment, we are presenting these numbers as a percent of premiums (less the hospital tax reimbursement).

Health Share of Oregon
2014 Corporate Revenue Utilization

Percent of Premiums (less HRA)		Premium Utilization
91.8%		OHP Member Medical Expenses
	88.5%	OHP Member Medical Expenses
	2.0%	Subcontracted Entity ACA MLR Recoupment Reserves
	1.3%	Subcontracted Entity Retained Reserves
7.1%		Administrative Costs (CCO & Subcontracted Entities)
1.1%		CCO Retained Earnings
1.5%		Change in CCO Minimum Net Worth Requirement

Health Share retained 1.1% of its premiums as a surplus in 2014. However, the minimum net worth requirement imposed by the State amounted to 1.5% of Health Share's 2014 premiums. In other words, 100% of the surplus went toward State mandated increases in Health Share's net worth and restricted reserve requirements.

As for 2015, there is no way to predict profitability at this time because the State is currently revising the 2015 rates, and we have yet be told whether any new rates will be applied retroactively.

Delivery System

This section addresses part of Question #1 ("describe the nature of the delivery system") and the entirety of Questions #2-3:

- Describe what you are doing that will fundamentally change the way health care is delivered and financed in your community and specifically how this progress will be measured and when will results be broadly evident.
- Describe specific efforts underway that integrate physical, mental, and behavioral health.

NATURE OF THE DELIVERY SYSTEM

Physical Health

The underlying delivery systems in Health Share's physical health networks range from a highly integrated staff model to Physician Hospital Organizations to contracted network models. Each physical health plan partner operates a unique (proprietary) primary care panel for population health

management. Each physical health delivery system takes full risk at either the organizational or provider level.

Behavioral Health

The delivery system for specialty mental health and addictions is based on a combination of larger "full service" community based providers as well as culturally specific providers and a statewide provider network for subspecialty services. Provider payments reflect the wide variety of services rendered and populations served. Risk is shared with providers and plan partners for certain services, but the majority of risk is held at the subcontracted managed care entity level. Most providers serve clients across the service area (i.e., in all three counties).

Dental Health

The delivery system for dental benefits reflects the variety of dental plans operating in the service area at the time SB 1580 was enacted. This includes two highly integrated staff model plans, networks based on federally qualified health clinics and contracted network models utilizing private practice dentists.

INTEGRATION OF PHYSICAL AND BEHAVIORAL HEALTH

While Health Share cannot take responsibility for most of these efforts, the CCO finances a large portion of services provided by partner organizations that are integrating physical and behavioral health services. Health Share is fortunate to be in an area where providers are moving forward with clinical integration. The following are examples:

- Health Share has sponsored Project Nurture which integrates treatment for addictions with prenatal care at a residential treatment facility (which brings a Nurse Midwife to the facility for prenatal care) and at a Midwifery Clinic (which brings addictions counselors to the clinic for addictions treatment)
- Lifeworks and Virginia Garcia have a long-standing reciprocal relationship with co-located behaviorists for which they won a national award at the National Council for Behavioral Healthcare this spring
- NARA and Cascadia both won SAMHSA grants funding integration of primary care into specialty mental health services (the only two in Oregon to do so), allowing exploration of clinical and financial models; Cascadia's model with Outside In's FQHC is a mobile model serving several clinic locations and homeless clients
- OHSU's Richmond Clinic and Cascadia have co-located urgent care services at a Cascadia urgent walk-in site, serving all people, all ages, all types of urgent health needs whether physical or behavioral
- Providence has hired over 20 PhD psychologists for behavioral health services in its primary care settings
- DePaul and Legacy entered into a new partnership for integrated services, addictions and primary care
- Central City Concern has internal integration efforts well underway, including dental
- Multnomah and Clackamas counties have both had behaviorists in their primary care clinics for some time

Our community has made less progress on financial integration. Health Share is proceeding with an abundance of caution because there is a risk that disruption of the complex relationships between Medicaid funded specialty mental health services, community mental health programs, and the local mental health authority (LMHA) functions provided by Clackamas, Multnomah and Washington counties could destabilize any part of the system. Our community relies on county LMHAs to provide crisis services (for ALL people, regardless of health coverage or payer); this includes mobile crisis outreach and walk-in mental health services. Also LMHAs oversee the processes to protect people who are involuntarily held/hospitalized/transported or interacting with the criminal justice system. These LMHA functions are necessarily intertwined with specialty mental health services, so abruptly dismantling county Medicaid services would also disrupt those safety net services provided by the county LMHA. The process of financial integration must be thoughtful and thorough, with constant attention to unintended consequences.

FUNDAMENTAL CHANGES TO THE WAY CARE IS DELIVERED

The CCO model has already produced results that have fundamentally changed the way that health care is delivered in our service area. A few examples follow.

Shared Data

Health Share has implemented a uniquely transformative system-wide data sharing platform that allows providers to monitor health information about their patients across multiple care settings. For example, even though Clackamas County served Medicaid members in county run clinics for years prior to the advent of CCOs, Health Department staff could not see utilization data for their patients across the physical health, mental health, and dental health arenas within their own system. Now, a provider in one of their primary care clinics can see when her patient has been treated for a mental health condition or had a dental assessment and follow up as appropriate.

Further, partner health systems are able to identify systemic service gaps. One example is that through this platform, Health Share was able to identify a trend of low utilization of adolescent well child visits in the Slavic community. After identifying this trend, Health Share deployed a culturally-specific Community Health Worker to educate the community about the importance of the preventive service. Progress is measured through qualitative analysis of increased functionality of the platform, and the results are already evident to providers in our networks.

Health Commons Project

Please see the attached “Health Commons Overview” for more information about interventions funded by Health Share’s Health Commons Grant. The interventions were evaluated throughout the grant period and up-scaled where appropriate. Progress was measured in the way required by the funder of the Grant, the CMS Innovation Center. The Grant has driven fundamental changes to the way care is delivered in a number of ways. Just to name a few: hospital discharge planning has become more integrated with community providers; frequent callers to 911 have been identified and now receive services in the community; and clinicians have been embedded in a high needs low income housing community. Multiple interventions were successful enough that Health Share or its partners have elected to sustain the programs moving forward.

Transformation Fund Portfolio

Please see the attached "Transformation Fund Update" for more information about interventions funded by the State Transformation Fund. This Portfolio focuses on eight key areas for transformation in our community:

- Strengthening primary care capacity
- Engaging members
- Enhancing community health integration
- Health information
- Addictions
- Behavioral Health
- Oral health
- Vulnerable populations

One example of how each of these interventions has changed the way care is delivered in our community is that they involve partnership and communication between providers that is unprecedented. For example, OHSU psychiatrists are telementoring primary care providers in psychiatric medication management in different types of clinics all across Oregon. Another example is that prenatal services are being delivered in the addictions treatment setting and addictions treatment services are being integrated in a midwifery clinic.

The OHA requires CCOs to evaluate utilization of these funds. Transformation will be broadly evident as the interventions are up-scaled and spread across provider networks and care settings.

Pay for Performance

The implementation of the CCO incentive metrics has changed the focus of providers in our community. Prior to implementation of the metrics, providers were not focused on depression screening or ensuring that children in DHS custody received screenings. Now, they are working with an intent focus on these populations. Progress is measured by the OHA, and we have already seen substantial improvement on a number of metrics. More information about CCO incentive metrics is below.

FUNDAMENTAL CHANGES TO THE WAY CARE IS FINANCED

Health Transformation itself has fundamentally changed the way that Medicaid services are financed. CCOs are paid a single global budget to manage almost all Medicaid services for a population of members. CCOs are responsible for deciding, with our communities, how we allocate those resources to providers and are completely on the hook for staying within that budget. This is substantially different from Medicaid financing in most states and from Oregon's previous financing model.

The purpose of restructuring health care financing models is usually to drive clinical transformation. As noted above, Health Share is heavily invested in supporting our provider networks' ability to improve clinical practices and achieve the Triple Aim, regardless of provider payment reforms. The following are examples of fundamental changes to the way services are financed.

Outpatient Case Rates and Treat to Target

Payment models are moving away from *paying for volume* to *paying for value*. There is growing consensus that a definition of *value* should include the following three characteristics:

1. The services are effective in achieving individual **outcomes** or system-wide outcomes;
2. The services are more **cost-effective** than alternatives;
3. The services are **lean**, meaning that waste (excess costs) have been removed through process improvement activities.

Health Share's behavioral health managed care entities are using a case rate payment model for outpatient mental health services and a quality management performance fund incentive program to support mental health providers in transitioning to value-based payment.

Outcomes based care includes measuring outcomes for every client. Providers use a treat to target, team-based approach to achieve clear and measureable successes at the client level. The client, with support of their care team, identifies their care goals, both clinical and personal. Outcome tools relevant to the clinical goals are used to collect baseline information and measurable targets are set. Professional and self-care plans are developed, and frequent measurement is made. If the client is not meeting their targets, the care plan and self-care plans are changed.

Case rate payments provide flexibility to the provider and client in the type, frequency and duration of services provided to assist the client in meeting their goals, to ensure that mutually established treatment outcomes are met. 2014 was a transition year from fee-for-service to case rates. Providers were paid a monthly "capacity payment" or budget. Case rates went into effect January 1, 2015. Reports have been developed and are being produced to monitor the financial impact of case rates. There will be "truing-up" process starting in 2016 which will be the best measure the results.

Actuarial and Global Budget Policies

As discussed above, Health Share has adopted Actuarial and Global Budget Policies to which it holds its subcontracted managed care entities and providers accountable. These policies establish minimum and maximum reserves requirements, minimum medical loss ratios, and more. Performance on these policies is shared with the Board. If a managed care entity fails to perform, then Health Share holds it accountable per contract requirements. Prior to the formation of Health Share, managed care entities in our community were not subject to these policies. They were able to hold back significant net income in reserves or increase their net worth rather than ensuring surplus funds were reinvested in health services for low income Oregonians. Not all CCOs hold themselves to these standards. This change has already been accomplished in our community, among Health Share's subcontracted managed care entities.

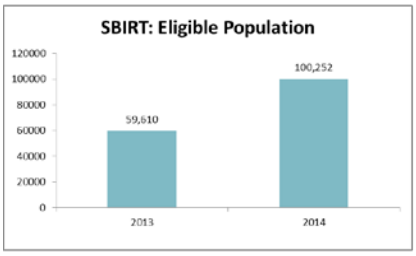
Quality Measures

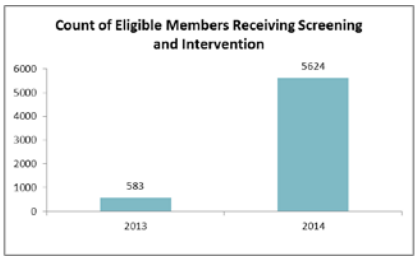
This section addresses Question #4: "Identify the three (3) quality measures on which your CCO recorded the worst performance and describe what actions have been implemented to improve performance in those areas."

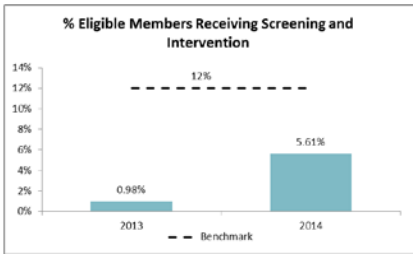
OVERVIEW

Health Share is on track to meet its improvement target for fifteen of the seventeen CCO incentive metrics in 2014 (final measurement will be reported later this month). Last year, Health Share met 13 of the 17 improvement targets—enough to earn 100% of available incentive funds. For the purposes of this report, Health Share has defined its "worst performance" as those metrics that have the largest gap between Health Share's current performance and the statewide benchmark. Under that definition, the three metrics on which Health Share performed the worst are: Screening, Brief Intervention, and Referral to Treatment (SBIRT), Adolescent Well Child Visits (AWV), and Screenings for Children in DHS Custody (DHS Custody).

SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT (SBIRT)







Challenges

Clinical Workflow: All clinics implementing the SBIRT process need to design their workflow specifically for this screening. This means dedication of process improvement resources, electronic medical record builds, and the dedication of clinical champions to ensure the process is being carried out consistently and successfully as well as identifying problems along the way. Depending on the clinic, this workflow involves many members of the primary care team including front desk/reception, Medical Assistants, PCP and behavioral health practitioner. The change in workflow represents a significant shift in practice and continues to take time to implement.

Billing Issues: Many systems chose to implement the SBIRT workflow across all patients rather than limiting it to OHP members. This presents new challenges, as other insurers may not reimburse for the assessment or will require co-pays from individuals who did not ask for this screening and who may not have needed it in the first place. In response, many organizations performed the screening as a zero-dollar service, meaning they would perform the service but not seek monetary reimbursement for it. Building this into the electronic medical record workflow took time and resources.

Claims based measure: In order to ensure the CCOs are getting credit for improving performance some clinical partners needed to manually review all relevant claims to ensure that they would count, as their previously developed billing and coding systems were unable to adjust quickly enough to ensure success, even when the workflow and clinical best practice has been established. This burden increased provider resistance to adopting the measure.

Competing Measures: Clinics usually serve patients from many insurance types including commercial, Medicare, Medicaid and uninsured. The SBIRT measure was initially only applicable to the CCO population. Therefore, the development of new workflows, clinical trainings, quality assurance processes, and referrals to treatment represented an additional lift to clinics already working within many competing priorities and incentive programs.

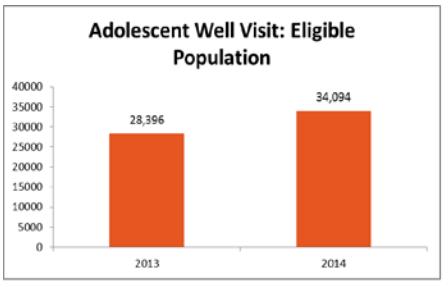
Clinical Evidence: As a relatively new measure the evidence behind the benefit of this screening was unproven, leaving room for skepticism among providers about the effectiveness and benefit of the process.

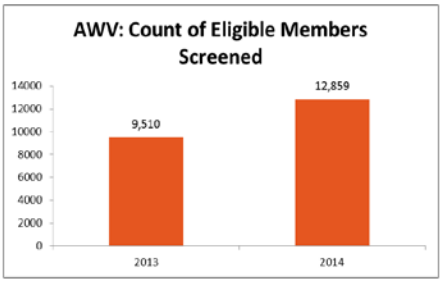
Changing Populations: The ACA expansion greatly increased our adult population and therefore the denominator for this measure. Additionally, CCOs are now being asked to provide this screening to adolescents as well as adults. This will require new tools and the need to address new confidentiality and billing issues. At this point many providers have implemented the screening tool, are aware of the prevalence of alcohol and drug concerns in the Medicaid population, and are seeing the benefits of the new workflow. Unfortunately, the significant amount of time and attention each clinic system has used to implement the required workflows makes them less willing and eager to adopt other new metrics proposed by the Metrics and Scoring Committee.

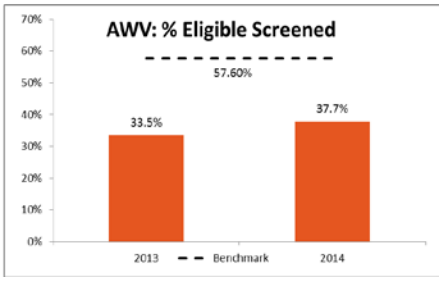
Actions taken to improve

- Partners invest in EMR builds to streamline workflow
- Partners invest in behaviorist model among some clinic systems
- Some systems work with groups like Oregon Primary Care Association (OPCA) and the Addiction Technology Transfer Center to help review and refine workflows
- Strong engagement with SBIRT coordinator through Oregon Health Authority for problem-solving and feedback
- Promote use of SBIRT as an important tool to drive integration
- Participation on multiple SBIRT-focused state workgroups, sharing best practices

ADOLESCENT WELL CHILD VISIT







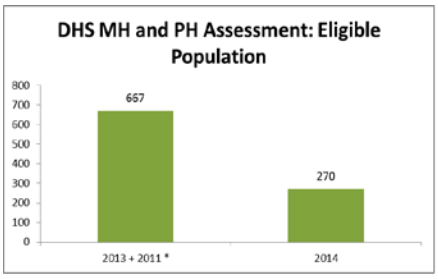
Challenges

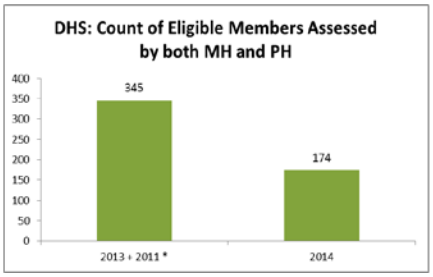
Health Share recognizes the importance of providing regular care for our adolescent population. This is important both to ensure good health currently and to provide youth with the tools necessary to proactively engage in their healthcare as they enter adulthood. This measure has proven difficult for a number of reasons. Adolescents are frequently not eager to engage in primary care assessments when they are healthy. Many adolescents cite confidentiality concerns and prefer not to discuss topics such as sex or drugs if it can be avoided. It has also been difficult for some groups to gain alignment among providers on the importance of getting "healthy" kids in to the clinic every year for this kind of discussion and evaluation. Those clinics that focused on this metric reported initial difficulties identifying and engaging with their adolescent population who are in need of this assessment.

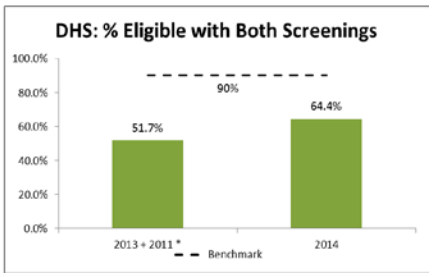
Actions taken to improve

- Health Share learning collaborative with numerous clinical partners and the Oregon Pediatric Improvement Partnership (OPIP) focused on engaging youth and getting the most out of these visits
- Development of gaps in care reports by health plans partners and some clinic systems
- Incentive cards used to motivate youth to schedule and attend these appointments
- Strategy among many organizations to use scheduled sports physicals (frequently required for children in school athletics) or sick visits into adolescent well visits, focusing on a broader range of topics but still meeting the need for the original appointment.
- A pilot was launched utilizing community based traditional health workers targeted at adolescents in communities with identified disparities. Program evaluation results are pending.

DHS CUSTODY







Challenges

Identification of foster children: Accurately identifying these children through standard CCO enrollment data is very difficult. OHA provides a list to CCOs of kids who appear to have recently entered foster care, though only about 50% of the children on that list end up qualifying for the measure. An additional delay in access to integrated care is the Medicaid enrollment process. The Oregon Medicaid Management Information System currently auto enrolls all foster children into CCOg coverage and open card for medical. A staff person at each branch must manually enroll the child in a medical plan if appropriate. There are several steps in this enrollment process, creating potential for delay and error. Per conversations with DHS partners, open card historically allowed for increased flexibility for children who changed foster homes early in placement, provided time to identify if private insurance coverage existed, and allowed the longer term foster parent to select a provider/plan most convenient to them. The process from caseworker entry of custody into ORkids to enrollment in medical can take a week or longer.

Child Welfare is focused on safety and permanency: *The 2013 Child Welfare Data Book* reports on several key data points for entry, placement stability, demographics, length of stay, and permanency outcomes. Child Welfare does not generally prioritize the required health assessments. Nor should they necessarily given the above listed priorities. This is space that Health Care Systems and CCOs are better suited to support. In addition to improved health and wellbeing, a heightened and improved focus on supporting the special health needs of children in foster would contribute to key outcomes like placement stability, length of stay, Permanency, etc.

Foster Parents need more support: Foster Parents do not have sufficient support to meet the complex needs of the children in their homes. Child Welfare places responsibility for scheduling health assessments on Foster Parents. Foster Parents are also asked to attend, participate, or facilitate a number of appointments, meetings, visits, and activities for a foster child in their home. A foster parent's schedule can quickly become unmanageable. Add to that the significant emotional and frequently behavioral needs of kids who have recently experienced trauma and removal from their home of origin, and it becomes less surprising that some needs go unmet, or that placements fall through. These are complex children with complex needs that even two parent homes with no other children (a rarity in foster care) struggle to support. Health systems that better recognize and care for the unique needs of foster children and foster families could provide some of the much needed support.

Tracking progress: Third, despite these assessments being required by Oregon Administrative Rule, DHS offices in our area were not consistently tracking follow through of the physical health and dental components of this measure. There was a higher focus on the mental health assessment but even that portion was inconsistent. Similarly, as the measure required assessments from both mental and physical health providers it proved difficult to track success at the CCO level without additional dedicated resources.

Small numbers: In the first year of this measure CCOs statewide had very few children in the denominator. This made it difficult for some clinics to dedicate the resources needed to provide the additional care coordination, referrals and assessment follow-up that would be indicated based on clinical need.

Regional Inconsistencies: Health Share spans three counties and three Child Welfare systems. Early process improvement work found that each of these DHS systems operated differently, with different positions, tracking processes and resources dedicated to this work. Creating a single best practice would have been very difficult within Health Share's structure but it was considerably more challenging given the differences at the DHS offices.

Actions taken to improve

- Health Share and partners developed a dedicated staff position focused exclusively on developing systems to improve coordination and assessment frequency for this population. This has not only helped improve performance on the measure, it also creates a critical link within the CCO to understand the system of care for these children, promote and advocate for their needs, and to start conversations across the network about how our system can respond more effectively to the healthcare needs—not simply the assessment needs—of this important population. This position has become a strong point of advocacy for the need of primary care to attend to Adverse Childhood Events (ACEs) as well as a more trauma-informed system of care.

- Frequent meetings with DHS staff and leadership across all three counties, ranging from weekly to monthly. Topics include workflow, policies and practices, and potential data sharing arrangements.

- Use of member navigator: Health Share and FamilyCare worked together to create informational brochures to provide foster parents with a member navigation resource within each CCO. This person can be contacted by caseworkers, providers or foster parents with any questions related to this important population and attempts to ease any administrative barriers to receiving timely care.

- All of our health plan partners have examined their coordination and clinical practices around foster children. They have identified individuals who serve as the primary point of contact for any questions or referrals and these individuals are also actively tracking success, problem-solving for foster parents. Many providers are starting to identify clinical champions who would like to enhance the system of care for this vulnerable population and other vulnerable children who may not have entered the foster care system but who experience high risk nonetheless.

- A workgroup of health plan partners has been meeting regularly to discuss challenges with this measure, system improvements that could support better performance, and changes to the system of care supporting this population. This group is exploring the development of a shared care management notification system to provide cross-system information exchange and member tracking for the foster care population—possibly to extend to other high priority populations.

Health Share of Oregon 1.5
Summary Report

June 10, 2015

Executive Summary

This report documents a set of strategies and tactics undertaken by Health Share in partnership with subcontracted managed care entities, providers, and community-based organizations during 2014-2015. The primary intention of the portfolio of project work referred to as "Health Share 1.5" is to achieve the Triple Aim by making incremental improvements in our integrated health system to improve the lives of our Medicaid population. We labeled these strategies "Health Share 1.5" to reflect the transition from Health Share's start-up phase and the need to follow through on a set of responsibilities undertaken through both the CMMI Grant and the Transformation Funds, both of which sunset June 2015. This report does not include Health Share's work under our Foundational Strategies, which include a range of critical and ongoing functions such as IT and health equity, nor the on- going operational and contractual obligations we hold as a Coordinated Care Organization.

This report uses the framework of continuous improvement to evaluate and enhance our performance. We account for our performance in each of the three areas of strategic focus, highlighting outcomes and the path forward for the portfolio, including what is being sustained and what is complete. We see the Health Share 1.5 portfolio of work as progress toward the vision of "Health Share 2.0" – a longer range strategic plan with targeted aims that provoke innovation and change to transform health care for our Medicaid population and achieve the Triple Aim.

Lower Costs: Address Critical Populations and Redesign Payment Models

The 7 strategies in this focus area each aim toward the long term impact of reducing the cost of health care. These include the portfolio of projects under the Health Commons Grant, quality and performance improvement plans, and developing or implementing innovative care and payment models. A common theme for these projects is a focus on specific populations needing enhanced care coordination or other delivery-systems level changes to influence how our members access and use healthcare services.

Sustaining the Innovations

Advances in systems to pair cost-reducing activities with innovative models have been termed "disruptive innovation," and it is well recognized that such disruption it is a necessary component to creating a high-performing health care system. However, the benefits from innovation do not come from the initial disruption, but from the implementation of routine, sustaining innovations that can accumulate benefit over time. The hallmark of a transformed healthcare system may not be a series of disruptive innovations, but the integration of a sustained set of innovations that ultimately become routine, which may accrue the benefits from years of implementation. Our partners are sustaining these innovations:

- **The Health Commons Grant**, a portfolio of complex interventions tested and implemented over three years with $17.1m from CMMI, is primary among these disruptive innovations that are now moving forward in sustaining patterns that will become part of routine healthcare for our Members. As envisioned three years ago when the grant was first received, each of the five primary interventions have a clear path for sustainability and spread.
- **The Advanced Primary Care Model** development will continue through the support of the CareOregon's Health Resilience Program and expand to integrate care transitions.
- **Wraparound Coordination** is being provided to children with serious emotional and behavioral disorders, grounded in System of Care principles. The Behavioral Health RAEs are implementing Wraparound consistently, ensuring that any child living in any community within Health Share's service region will have a similar experience and have access to a similar array of services.

Key Outcomes

Outcomes for Health Commons grant funded projects are significant and are documented extensively at www.healthcommonsgrant.org (Projects include Standard Transitions, CTrain, ITT, the Health Resilience Program, the CCC's Health Improvement Project, Tri-County 911, and the Skin Care Clinic at Bud Clark Commons.

Advanced Primary Care Collaborative built on the CMMI work to develop 7 multi-disciplinary teams based in primary care clinics. These teams are skilled to support patients with complex bio-psychosocial needs.

Children with special needs are prioritized through the regional implementation of the Children's Wraparound initiative and improved relationships through planning for the integration of Targeted Case Management funds supporting cost-effective public health programs.

Outpatient mental health case rates were implemented, resulting in a regional payment model that supports a transition from volume-based payment to a value- and outcomes-based model of care.

Completed or operational projects

- ✔ **Implementation of outpatient mental health case rates** was successful.
- ✔ **Diabetes & Hospital performance improvement projects (PIPs)** are completed and future PIPs will be designed and implemented as part of Health Share's operational responsibilities.
- ✔ **Integrating Targeted Case Management:** Over the last year, Health Share has worked closely with OHA and our partnering counties and OHSU on the expected integration of county-leveraged funds that support case management for children with special needs as wells as for people living with HIV or AIDS. While significant progress has been made, OHA has delayed the integration date beyond July 1, 2015. Health Share will continue to move forward working with OHA and our partners to achieve integration on OHA's timeline as part of our operational responsibilities.
- ✔ **Addressing health disparities through Quality & Performance Improvement Plans:** Every CCO needs to develop quality improvement plans to address health disparities and to conduct specific performance improvement projects. This year we strengthened our approach to analyzing data in order to better identify disparities while focusing on how we can better care for African Americans with hypertension. We will continue to work on this important improvement initiative every year as part of our foundational commitment to health equity and to fulfilling our promise to the Oregon Health Authority and to our Members in our CCO contract and Transformation Plan.

Better Care: Improve Access & Capacity and Promote Integration

The 6 strategies in this focus area all aim to have the long term impact of assuring that our members are receiving better care. Much of this work has to do with operationalizing structures that support integration across complex and differing systems as well as assessing and improving capacity and access to integrated services that meet our Members' needs.

Sustaining the Innovations

Our partners are sustaining these innovations:

- **Health Commons Grant: Standard Transitions, CTraIn, Tri-County 911** are among the projects that are being sustained beyond the CMMI grant. Additional information on these projects is available through www.healthcommonsgrant.org.

Completed or Operational Projects

- Successful integration of NEMT
- Integration of the adult mental health residential benefits has been postponed until 2017; the initial implementation planning phase is complete
- Successful integration of Member Navigator into Customer Service team

Continuing through Health Share 2.0

Project ECHO will continue at Health Share under a proposal included for Board consideration as part of the Capacity and Access strategy. We are proposing continuing support for a clinic focused on psychiatric medication management and explore adding another clinic focused on developmental delays. We will continue working with OHA and other partners to seek support and spread for the model beyond our pilot.

Align Care Management (Emergency Department Information Exchange): Health Share is proposing to continue to collaborate on tri-county use, structure and implementation around the EDIE platform via PreManage. We will continue to convene regional work groups to align efforts with our plan partners and delivery system.

Key Outcomes

Standard Transitions (CMMI Grant) met the original goals for the program and continued conversation around a standard discharge documentation and follow-up process after a psychiatric hospitalization appears to be solidifying.

Aligning care management through the Implementation of the Emergency Department Information Exchange (EDIE) reduced communication barriers and began to optimize multi-system care coordination.

Member Outreach and On-Boarding piloted new ways to onboard new patients in primary care. It also resulted in development of a Member Navigator position at Health Share. This role has evolved to be the primary point of contact for members with questions about population specific benefits including foster kids, children who access residential behavioral service programs and transgender members

Project ECHO implementation resulted in highly attended weekly tele-mentoring clinic sessions focused on upskilling providers and impacting specific patient cases, with a focus on psychiatric medication management.

Non-Emergent Medical Transportation (NEMT) was successfully integrated in collaboration with FamilyCare and RideToCare, which supports 8,500 unique Health Share Members, averaging over 105,000 transportation legs and 55,000 calls every month. 99.7% of all transports are complaint free.

Better Health: Prevent High Risk Behavior and Redesign Delivery System

The 9 strategies in this focus area all aim to have the long term impact of assuring better health outcomes for our members. Several projects were short term, one-time investments utilizing Transformation Funds. Others represent larger scopes of work and are aspects of a larger transformational change within our delivery system.

Sustaining the Innovations

Our partners are sustaining these innovations:

- **Healthy Homes** expansion to Clackamas and Washington County will be sustained through Targeted Case Management funds sourced by the state and counties, which will become integrated into Health Share's global budget forthcoming.
- **The Future Generations Collaborative** has a clear plan for being sustained through Multnomah County general funds and additional national and local foundation grants.
- **Regional Behavioral Health Promotion-Prevention** will be sustained through the new website, an established speakers bureau, and operational support by our county partners. Our county partners continue to seek sustainable funding for the regional coordinator role supporting this work.
- **Dental 3** activities will be sustained by the supporting Dental Health Plans, coordinating community-based dental activities and managing school-based dental sealant efforts.

Completed or operational projects

- Integration of self-management in supportive housing – Clackamas tested programs at four supportive housing communities and will continue exploring future partnerships
- Substance Use Disorder systems improvements will be addressed through other projects and efforts
- Mental Health Clinical Care improvements was completed through treat to target training in support of case rates
- Provider education on addictions will continue to be offered via initiatives in support of Project Nurture and HCWC Opioid Reduction plans
- Strengthening patient centered primary care homes is a strategic initiative of our physical health plan partners

Continuing through Health Share 2.0

Project Nurture is a project that will continue to evolve through our Prevention Strategy, and represents disruptive innovation that will require ongoing evaluation and testing through our two initial pilot projects and possible expansion.

Key Outcomes

Healthy Homes, an evidence-based public health program that improves early asthma interventions for children, was expanded to provide access to our members living in Washington and Clackamas Counties with technical assistance from Multnomah County.

By investing in the Future Generations Collaborative, we strengthened relationships with the Native American Community and contributed toward the training and certification of 31culturally-specific Community Health Workers, multiple community-based events and education, and were involved in building community capacity to address historical trauma and implement a culturally appropriate community action plan for reducing the impact of substance use on pregnancy in local Native American communities.

160+ primary care providers received continuing education in addictions and substance use in March at a day-long CME event, resulting in the growth of local expertise and strengthened connections between primary care and behavioral health.

New website GetTrainedToHelp.com was launched to coordinate regional learning and registration for first aid trainings for mental health and suicide prevention to further behavioral health promotion and prevention in our community.

Oral Health services are reaching 1000+ kids in Head Start through screening and fluoride varnish applications provided by Dental 3, a collaborative of six Dental Health Plans. Additionally, Saving Smiles Clackamas County extended its Saturday dental service hours to provide services to more than 400 additional patients.

HEALTH COMMONS OVERVIEW

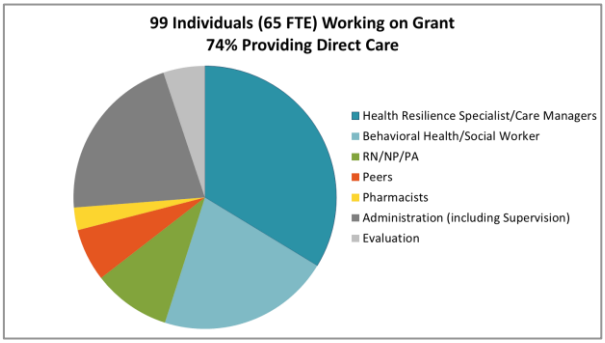
The Health Commons Grant, an award of $17.3 million over three years from the CMS Innovation Center, has been a springboard for Health Share of Oregon to create a regional system to better serve the high-acuity adult Medicaid population in Clackamas, Multnomah, and Washington Counties. Through the implementation and expansion across the region of five complementary interventions, we have improved care coordination, developed enhanced systems for learning and collaboration, and created a sustainable system of care. In less than three years, we have served over 13,000 individuals, 4,000 of whom received complex care management services through one of our high-intensity interventions.

KEY OUTCOMES

Collaboration Across Competitors: Launched in September 2012, the same month that Health Share incorporated as a Coordinated Care Organization, the Health Commons Grant provided an early platform for the CCO's four Medicaid Managed Care Plans, three county-based Medicaid Mental Health Organizations, six hospital systems, and hundreds of providers to rally around a common goal – achieving the triple aim for Health Share's highest-cost, highest-acuity adult members. After nearly three years, the grant has helped demonstrate the power of this multi-organizational, multi-sectorial collaboration.

Better Health, Lower Costs: Although we continue to monitor our progress and refine our understanding of the data, our preliminary results show decreases in emergency department and inpatient utilization and increases in utilization of primary care and behavioral health care as well as improved patient and provider satisfaction. The Providence Center for Outcomes Research & Education (CORE) has been evaluating each of the interventions and producing detailed outcomes reports. They are available on the Health Commons website at www.HealthCommonsGrant.org/reporting.

New Workforce Deployed: The Health Commons Grant employed almost 100 health workers in the tri-county region, and nearly three-quarters of those individuals have provided direct services to members. This new workforce is comprised of staff whose home bases remain in hospitals and primary care clinics but whose reach extends beyond the walls of the health care system to home and community settings.



PROGRESS AND SUSTAINABILITY PLANS

As we close the grant on June 30, 2015, we are proud to report that all of our interventions have firm sustainability plans. Below are the summaries of our successes.

Standard Transitions: The Standard Transitions intervention built a standard discharge summary into Legacy and Providence's electronic health records. It also created a standard workflow to ensure that the inpatient care teams at these hospitals as well as the primary care teams at Legacy, Providence, and Multnomah County clinics know exactly who is responsible for each step in the care process after a patient discharges. OHSU is in the process of implementation, and it is also being spread to Adventist and Tuality. The community conversation around a standard discharge documentation and follow-up process after a psychiatric hospitalization appears to be solidifying, and the Health Commons Grant is aiding in convening those conversations as appropriate. For more information, contact Melinda Muller at MMuller@lhs.org.

ED Guide: The ED Guide program put non-traditional health care workers in Providence emergency departments to help patients with non-acute needs find the most appropriate place to get care. Based on evaluation results from CORE, the program implemented targeted program modifications in order to improve their return on investment, and Providence is committed to sustaining this work beyond June 2015. For more information, contact Jillian Schrupp at Jillian.Schrupp@providence.org.

CTraIn: The Care Transitions Innovation (CTraIn) is an intervention that provides high-intensity support to high-utilizing patients who are discharged from the hospital. This program helps patients transition from inpatient to outpatient care, provides pharmacist support to increase medication adherence, and links patients to resources to meet psychosocial needs. It has been a springboard of learning for intensive work in the Care Management and Pharmacy arenas at OHSU and Legacy hospitals where it is in operation as well as to our larger community partners. With funding from CareOregon, both organizations plan to sustain this program as a part of larger Care Management operational restructuring. The New Directions program at OHSU, which employs two social workers embedded in the ED who work with frequent ED utilizers with mental health challenges, has merged with CTraIn at OHSU. For more information, contact Honora Englander at EnglandH@ohsu.edu.

ITT: The Intensive Transition Teams (ITT) intervention provides transitions support specifically for patients who have had a psychiatric hospital admission, deploying mobile crisis support specialists who can meet patients at the hospital and then follow them throughout their transition to outpatient care. The program began in Washington County and needed to be modified during implementation in Clackamas and Multnomah Counties to address differences in county environments. In Clackamas County, this involved working closely with Peer Support Specialists. Having an aligned CCO metric focused on ensuring follow-up care after a mental health crisis helped catalyst support for this intervention. Clackamas, Multnomah and Washington Counties have agreed to continue funding the program. For more information, contact Jeffrey Anderson at JeffreyAnd@co.clackamas.or.us.

Health Resilience Program: The Health Resilience Program provides multidisciplinary support to high-utilizing patients to help them build health literacy, address psychosocial needs, and overcome barriers to health. Health Resilience Specialists employed by CareOregon are embedded in primary care clinics as well as other high-touch locations, such as Hooper Detox, throughout the region, but they spend the majority of their time connecting with patients in the community. The program was launched initially in three pilot clinics and has spread to sixteen sites. Both CareOregon and Providence have agreed to continue funding the Health Resilience Program after the grant ends. Central City Concern's Health Improvement Program merged with the Health Resilience Program. For more information, contact Rebecca Ramsay at RamsayR@careoregon.org.

Tri-County 911 Service Coordination Program: The Tri-County 911 Service Coordination Program (TC911) employs four social workers who help address the needs of frequent 911 callers. The Multnomah County EMS office launched the program in response to needs identified by emergency response providers, but the team now works with providers and clients across Clackamas, Washington, and Multnomah Counties. Health Share, in collaboration with FamilyCare, is sustaining this program after June 2015. For more information, contact Alison Goldstein at Alison.J.Goldstein@multco.us.

The Skin Care Clinic at Bud Clark Commons: Bud Clark Commons (BCC) is a facility located in Portland's Old Town that provides drop in, temporary and permanent housing for the chronically homeless population. It is operated by Transitions Projects and Home Forward. Given the prevalence of injection drug use related skin infections experienced by the BCC population, an onsite Skin Care Clinic was established through a partnership with Multnomah County Health Department as the service provider. The primary goals of the Skin Care Clinic are to evaluate and treat skin and soft tissue injuries and infections (as well as other clinical issues), improve patients' connection with primary care providers, improve health outcomes, and reduce inappropriate emergency department utilization. The Skin Care Clinic team includes Nurse Practitioners, Physician Assistants, and Community Health Workers. It opened at the BCC in March 2014 and has provided more than 1,500 clinic visits for over 600 individuals. Central City Concern's will be sustaining the Skin Care Clinic beginning in July 2015. In order to maintain provider continuity and a focus on public health, CCC will continue contracting with Multnomah County to staff the clinic. For more information, contact Carol Casciato at Carol.J.Casciato@multco.us.

ADDITIONAL KEY LEARNINGS

Better Understanding of Our Members' Lives: Perhaps the most profound impact of the Health Commons Grant is what we have learned about those we are trying to help. Early on as the new staff was engaging with the "high utilizing" members targeted by the interventions, we heard life stories hugely burdened by troubled childhoods and early lives, recurrent violence, multiple struggles with relationships, time spent in the corrections systems, homelessness and joblessness, as well as increasing isolation and marginalization.

CMMI allowed us to use some of our evaluation funding to have CORE do a formal qualitative study of the life experiences of members enrolled in our high-intensity interventions. Interviews were open ended, with the inquiry being not much more than "tells us about your life." Some went as long as 3.5 hours. All were summarized to allow key themes to emerge. A formal analysis of the themes is being prepared, but the overall picture that emerges of what has happened to so many of those who come to us for care is deeply sobering.

While we can be extremely proud of what we have accomplished as a health care community in these last three years, the personal stories of those who have been touched by the grant remind us that we still have a lot to learn and a lot to do before we can say we have "transformed health care" for those we serve.

Project: Strengthening Primary Care Capacity

Advanced Primary Care	
Description	Build on Health Commons grant work to create clinic-based multidisciplinary teams skilled to help manage patients with complex medical and non-medical socio-behavioral issues (focus: patients with avoidable ED/inpatient hospital use)
Partners	Adventist, Central City Concern Old Town Clinic, Legacy (Good Samaritan, Randall Children's), Multnomah County Northeast, OHSU Richmond, Providence PMG Northeast
Status	Created 7 teams, held 5 cross-site learning sessions, defined program descriptions and metrics
Sustainability	In discussion to continue support as part of the Health Resilience Program (CareOregon)
Project ECHO	
Description	Tele-mentoring program that connects primary care providers with a specialist team to upskill providers and give input on specific patient cases (focus: psychiatric medication management)
Partners	OHSU: Telemedicine Department & Specialist Team *lead* Adventist, Legacy, Multnomah County, Neighborhood Health, OHSU, Virginia Garcia, Mid-Columbia Medical Center, Yellowhawk Tribal Health Center
Status	Weekly clinic sessions since September 4th, great attendance (~18 a week), high provider satisfaction, exploring possibility of adding a second clinic
Sustainability	In conversations with Oregon Health Authority re: potential for state support and spread of model

Project: Engaging Members

Engaging Members	
Description	Increase new member access by changing workflows so clinic staff are working at the top of their license (increase role of RN in patient visits); Develop and pilot a new Member Navigator role to assist members with complex needs
Partners	Member Navigator at Health Share; Pilot clinics include Clackamas County, Neighborhood Health, and Virginia Garcia
Status	Member Navigator hired; clinic pilots underway
Sustainability	Health Share operating budget; TBD

Project: Enhancing Community Health Integration

Healthy Homes	
Description	Spread evidence based Healthy Homes Asthma Intervention Program – Community Health Nurse and Community Health Worker provide home visits to identify and remove asthma triggers in the home. Also provides supplies (pillow/bed covers, vacuums) for families and works with housing partners.
Partners	Clackamas and Washington Counties (technical assistance from Multnomah County)
Status	Formed teams in Clackamas and Washington Counties who are now serving families; cross county collaboration
Sustainability	Targeted Case Management funding
Future Generations Collaborative	
Description	Decrease substance impacted pregnancy by supporting the Collaborative to develop and implement a culturally appropriate community action plan for reducing the impact of substance use on pregnancy in local Native American populations; build community capacity through addressing historical trauma in the Native American population.
Partners	Multnomah County, NARA, NAYA, Native Wellness Institute
Status	Monthly FGC meetings, community contracts in place, qualitative evaluation completed, multiple trainings offered, grant proposal submitted to Northwest Health Foundation and awarded, planning for culturally-specific Community Health Worker training, spreading learnings re: trauma informed care
Sustainability	County general fund, other grant sources
Chronic Disease Self-Management in Supportive Housing	
Description	Integrate chronic disease management supports in four targeted supportive housing environments (e.g. implement the Stanford University chronic disease self-management program; embed community health nurse at housing sites)
Partners	Clackamas County, four supportive housing sites
Status	Hosted two Living Well with Chronic Conditions courses, introduced Public Health Nurse to residents who organizes healthy/active events and refers patients to community health resources, made community space improvements made at housing
Sustainability	TBD
Community Health Improvement Plan	
Description	Support community based organizations employ Community Health Workers and Peer Support Specialists to work with members with chronic disease and behavioral health issues
Partners	Chronic Disease (CHWs): Familias en Acción and North by Northeast ; Behavioral Health (Peers): Center for Intercultural Organizing and Northwest Family Services
Status	Projects launched, staff hired, CBOs developing relationships with provider organizations, grantees meet monthly to share learnings
Sustainability	No clear funding strategy beyond grants

Warriors of Wellness	
Description	Build a model through which CCOs and health systems can partner with Community Health Worker (CHW) programs to improve health and decrease health disparities among communities of color in the Portland metro area (Multnomah, Washington, and Clackamas counties). WOW is a collection of community-based organizations focused on addressing chronic disease prevention and management and mental well-being through culturally-specific interventions within their communities.
Partners	Kaiser Permanente Northwest, Oregon Community Health Worker Association, Community Capacitation Center of Multnomah County Health Department, Urban League of Portland, NAYA Youth and Family Center, Immigrant & Refugee Community Organization, Catholic Charities El Program Hispano, and Northwest Family Services
Status	Contract pending
Sustainability	TBD

Project: Health Information

Leveraging Health Information Technology	
Description	Improve Health Share's data aggregation, analysis, and reporting solution that informs transformation/strategic initiatives
Partners	Center of Outcomes Research and Education (CORE)
Status	Enhanced reports are available to inform decision-making and determine effectiveness of programs
Sustainability	N/A
Improving Community Care Coordination through Information Sharing	
Description	Convene partners to align existing efforts in order to optimize multi-system care coordination through the Emergency Department Information Exchange (EDIE) platform
Partners	Health Share partners implementing EDIE, Oregon Health Leadership Council
Status	Regional work session meetings will begin in December
Sustainability	Health Share to staff as long as needed

Project: Addictions

Project Nurture	
Description	Improve care for pregnant women with substance use; pilot integration of prenatal services in the addictions treatment setting and integration of addictions treatment services in a midwifery clinic.
Partners	Pilot 1: CODA/OHSU Family Medicine; Pilot 2: Legacy Midwifery/Lifeworks NW; DHS Child Welfare
Status	CODA/OHSU pilot has started seeing patients and Legacy/Lifeworks pilot is finalizing their contract and plan to see patients within the next month. Complex model to develop due to challenges with integration.
Sustainability	TBD
Provider Addictions Education	
Description	Upskill Primary Care Providers in basic knowledge of addictions medicine and treatment modalities as well as knowledge of local treatment resources
Partners	Central City Concern, OHSU/Northwest Addiction Technology Transfer Center *leads* CODA, Kaiser, Legacy, OHSU, Volunteers of America
Status	Developing curriculum, planning for all day CME event on March 6, 2015; presenting at local grand rounds and conferences
Sustainability	Project builds local expertise in the community

Project: Behavioral Health

Regional Behavioral Health Promotion/Prevention	
Description	Develop a regional approach to community level behavioral health promotion/ prevention activities that promote positive behavioral health and well-being
Partners	Clackamas, Multnomah and Washington Counties
Status	Hired regional coordinator, developing outreach materials, developing web-based registration platform, creating centralized registry for all certified trainers in the region for ASIST, Mental health First Aid, and QRP.
Sustainability	TBD

Project: Oral Health

Saving Smiles	
Description	Engage patients who have not been receiving dental services and to increase the number of patients receiving dental services in Clackamas County. There are two components to this project including 1) a dental fair to kick-off outreach and promotion of services and 2) pilot offering dental clinics on Saturdays to expand dental access in Clackamas County.
Partners	Clackamas County, OHSU, volunteer dentists, community college students, North West Family Services, local area social service entities, veterans' programs.
Status	Contract executed in March 2015
Sustainability	TBD
Head Start Fluoride Varnish Program	
Description	Expand provision of oral health education , risk assessments and application of fluoride varnish for children in Head Start and Early Head Start programs in the Portland Tri-County area.
Partners	Dental 3 partners, Head Start and Early Head Start programs, Neighborhood Health, Oregon Oral Health Coalition
Status	Contract executed in March 2015
Sustainability	TBD

Project: Vulnerable Populations

Corrections Health Assessment Team	
Description	Embed a Community Health Nurse in the Assessment and Referral Center to provide physical health assessments and support clients recently released from jail stabilize while they are awaiting primary care appointments and other needed health services. Clients will be supported by a cross-departmental Health Assessment Team including a Community Health Nurse, Community Health Worker, Corrections Counselor, Psychiatric NP Lead, and Parole or Probation Officer
Partners	Multnomah County Health Department–Corrections Health, Multnomah County Department of Community Justice, Lifeworks
Status	Contract pending
Sustainability	County General Fund