Health Share of Oregon

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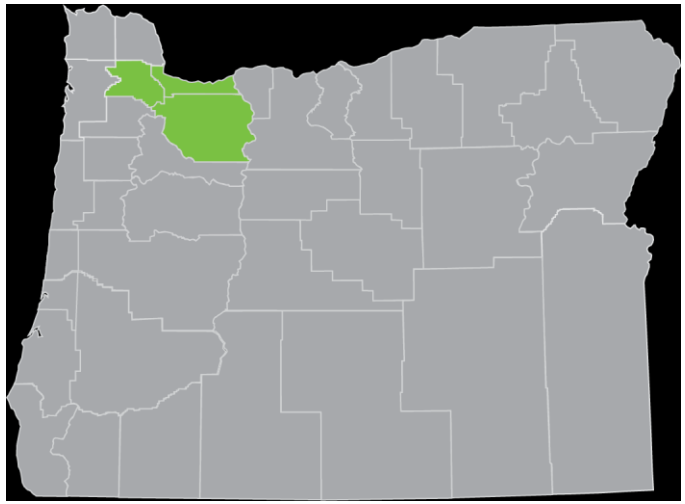
Health Share of Oregon
Service Area & Population Served

April 2015 Enrollment = 251, 706 (21% Increase)



Today	Before ACA Expansion
41% children	55% children
59% adults	45% adults

23% select language other than English
26% unknown language preference

15% African American/African/Asian/PI/AI/AN
36% Unknown Race
20% Hispanic Latino

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Structure and Governance

Health Share was built to serve as an organizational platform to

- support administrative efficiencies,
- enhance community engagement and
- provide a structure to focus transformation and strategic initiatives

Collective Impact Model

- Common Agenda
- Shared Measurement System
- Mutually Reinforcing Activities
- Continuous Communication
- Backbone Organization

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Structure and Governance

Legal Structure

- ❑ Private Non-profit Corporation
- ❑ Tax Exempt Charitable Organization

Board of Directors

- ❑ Eleven Member Directors Representing Founding Organizations
- ❑ Eight Elected Members
- ❑ Community Advisory Council Chair

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Key Partners

Founding Organizations

- Adventist Health
- Legacy
- Kaiser Permanente
- OHSU
- Providence
- Tuality
- CareOregon
- Central City Concern
- Clackamas County
- Multnomah County
- Washington County

Community Providers, Social Service Organizations, Healthy Columbia Willamette Collaborative, Transportation Providers, Dental Plan Partners

Propelled by 18,000 Providers!

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Community Advisory Council

Liaison between staff, leadership, Board of Directors and the public

Monthly half-day public meetings with public comment period

Community Health Needs Assessment and Community Health Improvement Plan

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Community Health Improvement Plan

Priority Areas

- ❑ Behavioral Health
- ❑ Chronic Disease

Health Share funded culturally-specific Community Health Workers and Peer Mentors in culturally-specific community-based organizations to address the two priority issues.

Results are just coming in!

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Risk and Profitability

Like all CCOs, Health Share sub-capitates organizations who are accountable for their assigned population

Model is based on supporting the established provider networks in our community

Health Share meets the OHA requirements for restricted reserves and net worth

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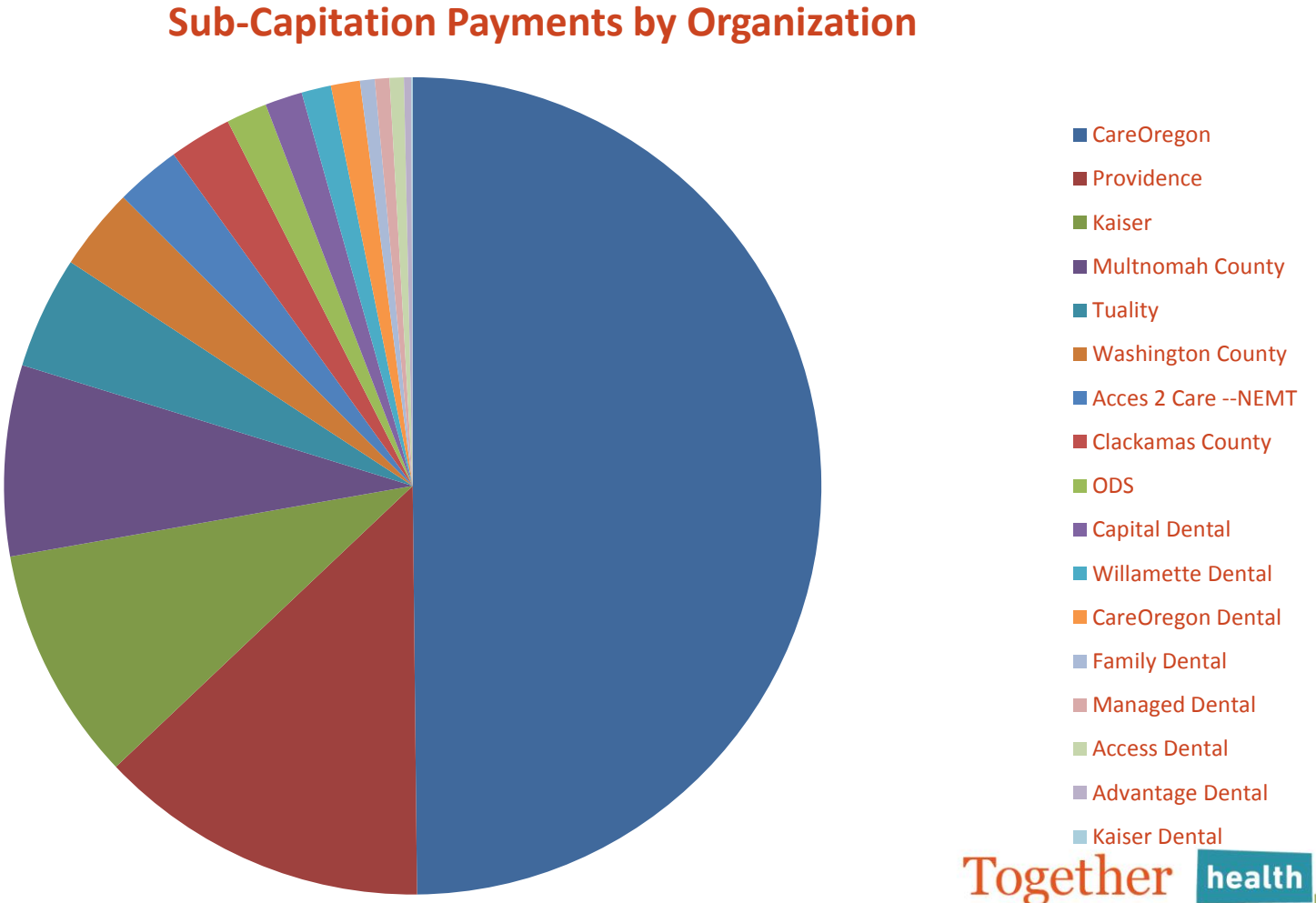
Risk and Profitability



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Risk and Profitability

CCO profitability is difficult to measure across CCOs

Earning a profit is not a goal of Health Share and surpluses at Health Share or at partner plans must be used in a specific manner

Health Share's retained earnings in 2014 was 1.1% of premium ($15 million)

Change in Health Share's Minimum Net Worth Requirement was 1.5%

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Transformation

Fundamental Changes to the Way Care is Delivered:

- ❑ Shared Data
- ❑ Health Commons Project
- ❑ Transformation Fund Portfolio
- ❑ Pay for Performance

Fundamental Changes to the Way Care is Financed

- ❑ Outpatient Case Rates and Treat to Target
- ❑ Actuarial and Global Budget Policies

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Integration
Physical/Mental/Substance Use Disorders

Clinical Integration

- ❑ Project Nurture
- ❑ SAMHSA Grants at NARA and Cascadia to fund integration of primary care into specialty mental health
- ❑ Cascadia Co-located Urgent Care Services at OHSU Richmond
- ❑ Many Patient Centered Primary Care Homes are incorporating Behaviorists in the primary care clinic

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Integration
Physical/Mental/Substance Use Disorders

Financial Integration:

- ❑ Less progress and an abundance of caution
- ❑ Risk of disruption of the complex relationships between Medicaid funded specialty mental health services, community mental health programs and the local mental health authority functions
- ❑ New psychiatric emergency services model and the need to develop a recovery oriented system of care has prompted new definitive conversations around financial integration

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Quality Metrics

Currently on track to meet 15 of 17 improvement targets!

Including two we missed last year!

“Worst Performance” is defined as those metrics that have the largest gap between current performance and the statewide benchmark

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Quality Metrics

Screening, Brief Intervention and Referral to Treatment

Challenges:

- Clinical Workflow
- Billing Issues
- Competing Measures/Clinical Evidence

Actions Taken:

- EMR “Builds”
- Investments in Behaviorist Model
- OHA’s SBIRT Coordinator
- Sharing Best Practices To Review and Refine Workflows

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Quality Metrics

Adolescent Well Child Visit

Challenges:

- ❑ Challenging population to engage
- ❑ Confidentiality

Actions Taken:

- ❑ Learning collaborative with clinical partners and the Oregon Pediatric Improvement Partnership
- ❑ Development and delivery of gaps in care reports
- ❑ Incentive cards
- ❑ Leveraging scheduled sports physicals or sick visits
- ❑ Culturally specific community based traditional health workers

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Quality Metrics

Assessments for Members in DHS Custody

Challenges:

- ❑ Identification of children in foster care
- ❑ Child Welfare is focused on safety and permanency
- ❑ Foster Parents need more support!
- ❑ Regional inconsistencies
- ❑ Small numbers

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Quality Metrics

Assessments for Members in DHS Custody

Actions Taken:

- ❑ Plan Partners funded a centralized dedicated staff position focused on developing systems to improve coordination for this population
- ❑ Frequent collaborative meetings with DHS staff and leadership across all three counties
- ❑ Member navigator resource
- ❑ Plan Partners have examined their coordination and clinical practices and identified primary points of contact
- ❑ Best practice models under evaluation for possible future development
- ❑ Clinical champions identified in high volume practices

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