2024 CCO Community Health Improvement Plan Progress Report Guidance

This guidance helps Coordinated Care Organizations (CCOs) address contractual requirements for the Community Health Improvement Plan (CHP) Progress Report. The CHP Progress Report requirement is described in **Exhibit K, Section 7, Paragraph l** of the 2024 CCO Contract and in **Oregon Administrative Rule 410-141-3730(10)**.

A. CCO Community Advisory Councils (CACs) are required to annually publish a CHP Progress Report. CCOs should work with their CACs to complete the CHP Progress Report questionnaire on pages 2-3 of this document, which will serve as the annual CHP Progress Report. The questionnaire is due to OHA on or before December 31, 2024. The questionnaire must be submitted via the CCO Portal. (The submitter must have an OHA account to access the portal.) All CCOs must submit a CHP Progress Report in 2024. The reporting period for this progress report is July 1, 2023 to June 30, 2024 for CCOs who are not closing out a CHP. For those CCOs closing out their CHP, the reporting cycle is the entire length of the CHP. If your CCO has multiple CHPs, it must complete a separate questionnaire for each CHP. If your CCO has multiple Service Area contracts, it must submit a separate questionnaire for each contract.

B. Evaluation criteria: The annual CHP Progress Report should document progress made towards the goals, strategies and measures for priority areas as identified in the CHP and include the following:

   (a) Changes in community health priorities, resources, or community assets
   (b) Strategies used to address the health priorities identified in the CHP
   (c) Parties outside and within the community who have been involved creating and implementing strategies used to address CHP health priorities
   (d) Progress and efforts made (including services provided and activities undertaken) to date toward reaching the metrics or indicators for health priority areas identified in the CHP
   (e) Identification of the data used, and the sources and methodology for obtaining such data, to evaluate and validate the progress made towards metrics or indicators identified in the CHP
   (f) Progress of the integration strategies and implementation of the plan for working with programs developed by the Early Learning Council, Early Learning Hubs, the Youth Development Council, and school health providers in the region

CHP Progress Report Questionnaire

1. Please list any changes since July 1, 2023 to community health priorities, goals, strategies, resources, or assets. If your CCO is closing out its CHP, please list the most significant changes during the period of the CHP. Please state whether any of the priorities, goals or strategies will be carried over into the next CHP cycle.

As we close out our 2019-2024 CHP, we reflect on the significant work we have achieved with the partnership of OHA, LPHAs, local hospitals, systems partners, and our community-based partners. The COVID-19 pandemic was traumatic and disruptive to everyone during this time. As Health Share of Oregon, we experienced disruption from the pandemic in our CHP implementation, as we needed to significantly shift our efforts and investments towards emergency responses for our members and local community. Health Share was able to work significantly over the last 5 years to develop our Supportive Housing and Access to Care priority areas. And we settled back into regular rhythms as a CCO despite the pandemic, we worked to develop further our goals and efforts around the remaining priority areas.

In the wake of the 2020 racial uprising, Health Share intentionally responded by creating a health equity statement and seeking to follow it as our guide for our entire Health Share portfolio.
Additionally, we worked to distribute quality funds to culturally specific CBOs serving priority populations with the greatest impact/health disparities (exacerbated during COVID) and refreshed our approach toward funding.

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2. Please list the strategies used since July 1, 2023, to address CHP health priority areas. Please note which of these strategies involve working with programs developed by the Early Learning Council, Early Learning Hubs, the Youth Development Council, and school health providers in the region. If your CCO is closing out its CHP, please list the most successful strategies used during the period of the CHP.

ACCESS TO CARE:

1. **COVID Response**
    a. In response to the unequal impact of COVID on communities of color, Health Share distributed $4.6 million in COVID-19 Impact Support Funds to Community-Based Organizations (CBOs) and Faith-Based Organizations (FBOs) who were then able to continue their operations to keep supporting our most impacted members. In total, 58 CBOs received funds to provide services that directly addressed consequences of the COVID-19 pandemic, i.e., vaccination programs/events, hiring of clinicians of color, developing emergency sites, providing free childcare, and purchasing transportation equipment for food box delivery. Following our initial response in 2020, Health Share focused on addressing health disparities in 2021 and 2022 to ensure our most vulnerable populations have access to COVID vaccinations. In addition to our funding that laid the groundwork for various organizations to develop COVID response programs, Health Share continued to support CBOs with our Public Health Infrastructure to hold hundreds of culturally and geographically specific vaccine clinics. Through our collaborative and targeted approach, we reached people who an otherwise more conventional approach would have left out One of our awarded organizations was quoted the following, “Your funds helped us to reach and exceed our goal set in early 2021, to fully vaccinate 30,000 patients and community members, approximately 5 percent of the population of Washington County”. A year after vaccinations were available, Health Share had the state’s highest CCO vaccination rates in the state and had considerably improved equity. Our vaccine dashboard added pediatric vaccinations and booster

information once those were started and used the same process for improving equitable access.

2. **Traditional Health Workers**
    a. In 2024, all Health Share Collaborative partners maintained or increased the number of THWs in their services. For example:
        i. Health Share of Oregon entered two new contracts with THW-employing Community-Based Organizations to deliver culturally congruent Social Emotional Health Services and explore billing Medicaid. These contracts with Adelante Mujeres and The Immigrant and Refugee Community Organization have funded 3 Community Health Workers (CHWs).
    b. The Health Share collaborative provided training and technical assistance (TTA) both in groups and on a 1-on-1 basis, to THWs and THW partners throughout the region. We are supporting THWs and THW-employed CBOs in understanding the OHA certification process; understanding health plan contracting and CHW billing codes, including code changes; and offering guidance on submitting claims. Additionally, we have been supporting clinical partners, including two federally qualified health centers (FQHCs) in understanding the value of integrating THWs into the delivery of health care services.
    c. This last year, the Health Share collaborative reported high utilization of the current THW and CHW workforce. For example:
        i. Providence Health Plan reports that the number of member encounters with THWs in clinical settings increased from 7,576 encounters (from previous report cycle) to 8,003 encounters (current report cycle). Additionally, the number of member encounters with THWs in community-based settings increased from 1,301 encounters to 3,087 encounters.
        ii. Multnomah County Health Center Program reports that members at all sites utilize CHWs to their total capacity. Additional peer positions will be integrated into each site in 2025 to expand capacity.
3. **Health Equity and Culturally Specific Outreach**

    Health Share has further reinforced our dedication to addressing gaps in care by expanding our team's capacity for in-person member engagement at targeted culturally specific community and health events. We are accomplishing this by hiring staff who prioritize member engagement. Our steps to expand the engagement team's capacity have led to a significant increase in interactions with both members and community partners. We continue to maintain our position of moving Health Share toward equity by participating in various activities that put the member experience at the center of our lens:
    a. Health Share continues to work toward creating an umbrella policy specific to CLAS standards. The CHEW (Cultural Humility and Health Equity Workgroup) will be engaged as a strategic place for policy development for the second half of 2023; with an anticipated policy draft for the Health Share Board of Directors, Community Advisory Council (CAC) & CHEW to affirm/adopt during Q1 of 2024. Health Share will also engage plan partners to offer updates about their policies/bylaws and strategic planning from their organizational representatives who serve on the CHEW.
    b. In collaboration with leadership from the Health Equity and Engagement Team, the HS Communications Team and our member navigation team have supported various public-facing events, including several HEET-focused gatherings (BBIC Conference, Community Engagement Brunch, Joint Board/CAC Meeting). Internally, they continue to update and expand the availability of member materials, particularly for non-English speaking members. This strategy will continue to develop as we build our oversight and support of community and member engagement under the leadership of the Chief EDI Officer as the Executive Sponsor of this work. There continues to be a need to ensure that communications, generally led by a dominant lens, are done through an equity and community-centered lens. Thus, the advocacy for equity and community health leadership lens to be centered in our outreach efforts remains strong.

c. Considering the significant impact of the Public Health Emergency unwinding and Medicaid Redetermination, Health Share identified nine Community-Based Organizations (CBO) equipped with OHA Certified OHP Assisters to provide proactive outreach to members affected by the new Redetermination period beginning April 1, 2023. Health Share allocated funding to the nine identified CBOs to support efforts that ensure members have up-to-date information in the state's enrollment system, ensure that members responded to OHA requests for updated eligibility information, and provide coaching to members who are no longer eligible for OHP benefits on how to access medical coverage through other means such as the Oregon Health Insurance Marketplace. Funding for these organizations was explicitly dedicated to outreach to the most vulnerable populations that are traditionally hard-to-reach including but is not limited to the following: Unhoused members, Refugee and Immigrant Communities and Non-primary English speakers. During the period of Redetermination, Health Share held space for progress evaluation and feedback during quarterly Redetermination Learning Collaboratives.

4. Language Access

a. Health Share regularly collaborates with Integrated Delivery Systems/Integrated Clinical Networks (IDS/ICN) partners to collect and analyze the provision of language assistance services across the CCO's network. A core component of this process is ingesting and analyzing of interpreter service data that Health Share receives from each physical, behavioral, and dental partner.
In 2023, Health Share engaged Collaborative plan partners to collect information regarding their language access activities and capacity. This collaborative process helped guide the CCO's completion of the 2022 CCO Meaningful Language Access (MLA) Self-Assessment Survey. Health Share passed all "PASS" questions and exceeded the minimum point threshold required by the metric.

b. Health Share has supported Plan Partners in developing their reporting for their clinical systems on the need for and use of language interpreters during clinical care. This data is now reported across all Health Share Members and will continue to be a focus of the MLA Workgroup. We aim to improve the reporting metrics and navigate feedback from members as plan partners gain more experience in using and sharing this data.

c. Health Share materials – which include consent forms, complaint forms, intake forms, notices of rights/denials/loss or decrease in benefits or services forms - are all translated into non-English languages. Other information on programs, activities and additional benefits and/or services are also translated into non-English languages; large print and Braille are made available when requested or indicated as a need for members.

5. Child and Adolescents:

a. Health Share has funded the Autism Assessment Capacity Project (see details below) to address the long wait time for children and families seeking Autism Assessments/Diagnoses. This is a multi-pronged strategy to support families, clinicians and health systems.

b. We continue to meet monthly with the three early learning hubs and the three public health authorities in our region on shared goals and strategies all of which seek to create a seamless regional perinatal continuum of care. We support promotion and expansion of access to Family Connects and other home visiting programs, WIC, and access to culturally specific community-based organizations like IRCO, Adelante Mujeres, Healthy Birth Initiative, etc.

c. We are partnering with the public health authorities again to create a regional behavior change campaign in the Fall of 2024 to increase well child checkups and routine childhood/adolescent vaccinations.

d. The early learning hubs and public health agencies are included in our community health needs assessment and subsequent CHP prioritization and strategies. Additionally, county health staff hold positions on our Community Advisory Council.
e. Health Share partners with our health plan partners, hospitals, and regional youth development organizations to support our Foster Youth population including youth transitioning out of foster care.

SUPPORTIVE HOUSING:

Housing Benefit Pilot:
To align the Health Share collaborative with the state's proposed 1115 Waiver changes for 2023 through 2027, our collaborative committed $15 million towards a targeted demonstration project focused on housing assistance as a benefit that could potentially help up to approximately 6,000 eligible Portland area residents. Our demonstration project utilized flexibilities in Health-Related Services (HRS) and other flexible funds to cover gaps and create a pathway toward stable housing. As described, the Housing Benefit Pilot (HBP) would explore the outcomes and overhead of running a two-year housing support project in the Portland Metro area.

The program was designed to support individuals at vulnerable transition points by connecting them with community-based housing navigators and resources (e.g., rental assistance and move-in support). Health Share contracted with 20 community and government-based organizations with OHSU Health IDS as the Central Benefit Administrator for the housing benefit pilot and other associated services.

Between the program's launch in May 2022 and October 2023, 545 members were enrolled in the pilot. The largest category of member classification types were members exiting SUDS residential programs (*n* = 258), transitioning out of corrections facilities (*n* = 109), and transitioning out of foster care (*n* = 69). Based on preliminary assessment data, rent, utilities, and move-in support were the top three requested types of assistance. Almost half of the assessed members identified needing additional employment services (42%) and food assistance (43%), and over half of the assessed members stated that they were already receiving Oregon SNAP benefits at their enrollment. On average, members were enrolled in the program for nine and a half months. By December 2023, 305 members had exited the program. Of those who left the program, approximately 42% were considered to have graduated, no longer needing the benefit or reaching the end of the benefit period. Additional data tracked during the assessment period included Criminal History, ER visits, other medical concerns, mental health diagnoses, and history of substance abuse.

Health Share is currently working on a comprehensive review of this pilot with Providence's Center for Outcomes Research and Education (CORE) to evaluate this program, which will be made public once it is complete.

FOOD ACCESS, CHRONIC CONDITIONS, SOCIAL CONNECTIONS:

1. **Heat Wave and Climate Devices**
    a. In response to frequent adverse climate events, Health Share has taken several steps to mitigate the risks and health disparities experienced by our most vulnerable members.
        i. **Climate Dashboard:** In response to the 2021 heat dome, Health Share has been proactively utilizing our Climate Dashboard to provide lists of members who may be at risk during adverse climate events. The lists generated by Health Share are customizable based on various demographic and health conditions that increase vulnerability to heat, smoke, and power

outages. Health Share and our delivery networks have utilized these lists internally to identify and appropriately distribute climate support based on an equitable approach.

ii. **Heat Mapping Report: Through** Collaboration with the Tri-Counties and CAPA Strategies, we generated a heat mapping report for the Portland Metro region, showing how heat is distributed throughout the city. This project identified small climate pockets that can have a variance of temperature upwards of 17 degrees around our region at the same time. Health Share has since utilized the heat mapping tool generated by this report internally to reach members who are both heat-sensitive due to chronic conditions and residing in a heat-vulnerable area. Further, since publishing this report, Health Share has been contacted by city officials from one of the identified high-risk communities who wanted to understand the report better and look for a solution to address heat disparity in their community. This affected population is primarily Latinx and has a proportionally high number of mobile homes that are not well adapted to climatization. Through collaboration between city officials and Multnomah County's weatherization program, we identified existing funds that could be utilized to treat vulnerable homes residing in this community. This collaboration between all parties resulted in 36 air conditioning units installed between April and June 2024 for qualifying low-income homes.

iii. **Climate Devices:** Outreach conducted by Health Share Integrated Delivery Systems/Integrated Clinical Networks (IDS/ICN) allowed Health-Related Service (HRS) funding to support the purchasing and delivery of climate devices to climate-vulnerable households. Devices purchased fell into one of the following categories: Air conditioners, Air Filtration Devices, Replacement Filters, Heaters, Mini-Refrigerators, and Portable Power supplies. From July 1, 2022 to June 30, 2024 Health Share was able to procure over a thousand Air Conditioner units through HRS funding. The Climate Health-Related Social Needs (HRSN) benefit, introduced in March 2024, expanded and accelerated the delivery of equipment by Health Share IDS/ICN. During the reporting period of April-August, approximately 2,405 climate devices were delivered via HRSN Covered benefit to members; air conditioners were the largest category delivered with 1,064 units. The distribution of HRSN climate benefit recipients was the greatest with individuals who were homeless or at risk of becoming homeless with approximately 56% of the spread; individuals who are transitioning to dual Medicaid and Medicare coverage were the second largest category at 36% of all devices delivered.

2. Health Share has done significant work to align with the goals and strategies of **Raise Up Oregon:**
    a. OBJECTIVE 7: All families have access to support for their physical, social, emotional, behavioral, and oral health and OBJECTIVE 11: Families have access to high-quality, culturally, and linguistically responsive birth-to-five pediatric health care services.
    b. Supported a Well Visit and Immunization campaign in the summer of 2023
    c. Behavioral and Social Emotional Health – Aligned with the Social-Emotional Health metric. We have funded:

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3. Please indicate which of the following partners were involved in creating and implementing strategies to address CHP priorities since July 1, 2023 (select all that apply). If your CCO is closing out its CHP, please indicate which of the following partners were involved at any point during the period of the CHP.

- ☒ CCO tribal liaison
- ☒ Federally Recognized Tribes of Oregon
- ☒ Indian Health Care Providers
- ☒ Culturally specific organizations

- ☒ Early Learning Hub
- ☐ Early Learning Council
- ☐ Youth Development Council
- ☒ Federally Qualified Health Centers
- ☒ Hospitals
- ☒ Local public health authority
- ☒ Local mental health authorities and community mental health programs
- ☒ Physical, behavioral, and oral health care providers
- ☒ Representatives from populations who are experiencing health and health care disparities
- ☐ School nurses, school mental health providers and other individuals representing child and adolescent health services such as those listed in ORS 414.578
- ☒ Social determinants of health & equity partners
- ☐ Local government
- ☒ Traditional health workers

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4. If applicable, identify any gaps in making connections to the key players listed above.

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5. For CHP priorities related to children or adolescents (prenatal to age 24), describe how the CHP activities improve the coordination of effective and efficient delivery of health care to children and adolescents in the community.

SOCIAL CONNECTION:

1. To support Kindergarten Readiness and social emotional health we have funded:
    a. **Workforce Development for Contracted Behavioral Health**
        i. Provide stipends &/or scholarships for continuing education and/or internship placement to support workforce skills and to incentivize being placed in a setting to support children birth
        ii. Support group training(s) on evidence-based modalities and needed supporting materials.
    b. **Workforce Development for Integrated Behavioral Health**
        i. Sustained the Integrated Behavioral Health Learning Collaborative, including an 8-part webinar series in 2024 and a half-day in-person learning session on implementing issue-focused interventions in the context of IBH and Primary Care.
    c. Workforce Development for Primary Care
        i. Funded Primary Care Provider Training focused on improving workforce knowledge and skills to address Social-Emotional Health and provide clinically recommended follow ups aligned with EPSDT. This training includes talking about social-emotional health, including anticipatory guidance, considering administering secondary assessments, brief counseling strategies, and referring to behavioral health supports when deemed clinically appropriate

2. Autism Assessment Capacity Project (AACP): Health Share is funding the AACP to address the long wait times families with young children are experiencing to get an Autism Assessment/Diagnosis. We are funding two staff positions at OHSU but serving all health systems in our region) and are working on 4 areas of improvement:
    - Family-Level Support: Help Me Grow is expanding its autism alerts. Bilingual Peer Family Navigators are available to help families access services, compile paperwork, and provide emotional support while they wait for an assessment. This project is scheduled to expand incrementally to be available to all families

with children ages 0 – 5 in our region.

- Clinician Level Support: We are training a cohort of primary care providers to be able to diagnose clear-cut cases of autism via a two-day training and ongoing ECHO series.
- System Level Support: We are investigating Alternative Payment methodologies to support clinics conducting Autism assessments in primary care. We have also contracted with a business consultant to conduct a feasibility study of a multi-health system centralized Autism Assessment Center.

3. Health Share convenes the EveryStep Leadership Council monthly, to discuss ways to improve and advance best practices around care for youth in foster care. In 2024 we have approved a new local health system to be funded to adopt the EveryStep model. Currently, all 5 of our health plans offer Every Step clinic.

4. Help Me Grow (HMG) is a strong example of the impact of collaboration on outcomes for families navigating complex developmental and behavioral health needs. Last year, HMG served 1,378 children, 65% of whom were children of color. HMG averaged 3.5 calls per family to provide developmental support and ensure families had access to community resources – including a partnership with Connect Oregon to receive referrals through the Unite Us platform. HMG liaisons (Peer Support Specialists) in the three counties serve Native American families, as well as immigrant and refugee families. HMG increased trainings on anti-bias, motivational interviewing, and Autism 101 to be better equipped to serve Oregonian families

5. What activities is the CCO doing for children or adolescents (prenatal to age 24)?
    a. Health Share continues to convene a Children's Health Advisory Council to identify regional priorities and guide strategy development of programs and services to support this age population.
    b. Health Share convenes the Children's System of Care for the region.
    c. Health Share is working to expand the Healthy Birth Initiative to Clackamas and Washington counties to better serve the African and African American community.
    d. Use of the RAPID assessment is fully implemented in two of the three metro area counties with the third county considering implementation later this year. In 2022, 278 youth received a RAPID assessment.
    e. Health Share and plan partners implemented and evaluated a "Safe Beginnings" program at all the Project Nurture clinics, providing pregnant members with SUD access to a pre-approved menu of items to support

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6. In the table below or through supplemental documentation, please list and/or reference progress in meeting all CHP metrics and indicators. Please include data sources for all metrics. Please refer to the example below in *italics.*

Strategy	Measure	January 2023 (baseline)	2024 (most recent data)
Access to Care	Primary Care Utilization - Adults	208.2 visits per 1k member months	193.6 visits per 1k member months
Access to Care	Primary Care Utilization - Children	202.2 visits per 1k member months	209.3 visits per 1k member months
Access to Care	Primary Care Utilization – Health Share Overall	206.4 visits per 1k member months	199.9 visits per 1k member months
Access to Care – Language Access	Interpreter Service Reporting- Percent of visits with interpretation provided by an OHA certified or qualified interpreter	3.80%	7%

	for members with a "interpreter needs" flag in MMIS		
Access to Care – Traditional Health Workers	FTE (full-time only) reported by HSO plan partners, by THW type: CHW, PSS, PHN, PWS, Birth Doula, ALL	**CHW:** 152 **Doulas:** 19 **Peer Support Specialists:** 186 **Peer Wellness Specialists:** 36 **Navigators:** 33	**CHW:** 221 **Doulas:** 82 **Peer Support Specialists:** 227 **Peer Wellness Specialists:** 52 **Navigators:** 58

HRSN Covered Population	Air Conditioner	Air Filtration Device	Replacement Filters	Heaters	Mini-refrigerators	Portable power supply
Homeless or at-risk of becoming homeless	657	231	235	61	17	66
Discharged from an IMD	33	15	13	5	0	1
Released from carceral setting	8	4	5	1	1	0
Involved with child welfare	87	32	27	4	6	10
Transitioning to dual status	279	297	288	12	4	6
Total	**1064**	**579**	**568**	**83**	**28**	**83**