

Community Health Assessments and Community Health Improvement Plans

Guidance for Coordinated Care Organizations

Coordinated Care Organizations are responsible for improving the health of the community they serve, including the health of socially and culturally diverse populations as well as individual member outcomes. Upon establishment of a CCO, its Community Advisory Council (CAC) will be responsible for conducting a community health assessment and designing, implementing and annually updating a community health improvement plan. The CAC will collaborate with the local public health authority, local mental health authority, hospital system and professionally and culturally diverse community-based organizations to develop a shared health assessment and improvement plan that serves as a strategic population health and health care system service plan for the community served by the CCO.

The community health assessment adopted by the CAC needs to be transparent and available to the public in both process and results. The health assessment will be conducted using standard guidance from the Oregon Health Authority and will describe the scope of the activities, services and responsibilities that the CCO considers upon implementation of the improvement plan.

The elements defined in the plan may include, but are not limited to:

1. Evaluation and development of public and private resources, capacities and metrics needed to support ongoing community health assessment activities and population health priorities
2. Health policy
3. System design
4. Outcome and Quality Improvements¹
5. Integration of service delivery¹
6. Workforce development

Through its community health assessment, the CCO identifies health disparities associated with race, ethnicity, language, health literacy, age, disability, gender, sexual orientation, geography, occupation or other factors in its service areas². A CCO and its Community Advisory Council will work with OHA to develop meaningful baseline data on health disparities.

The process for conducting community health assessments will generally be as follows:

¹This may also include information on approaches to coordinate care across the spectrum of services, as well as to encourage prevention and health promotion to create healthier communities and community health needs, resources and barriers to care, and typical patterns of health care utilization.

² The CHA is expected to be analyzed in accordance with OHA's race, ethnicity and language data policy when fully implemented.

Community Health Assessments and Community Health Improvement Plans for CCOs

- A) CCOs are not expected to generate new data during their first year of operation. To avoid duplication, the community health assessment should draw on existing resources. CCOs are encouraged to build upon, coordinate with, or take the place of the community health assessments required in community mental and behavioral health, public health and hospital system benefit reporting, as well as socially and culturally diverse research conducted by community-based organizations. See Appendices A and B of this document, and the Community Health Assessment/Community Health Improvement Plan section of the CCO Request for Applications.
- B) The Oregon Health Authority has assembled relevant resources used in current Community Health Assessments performed by local public health agencies, mental health agencies, hospitals, etc.
- C) CCOs will be encouraged to begin discussions with OHA (Public Health, Addictions and Mental Health, Office of Equity and Inclusion, etc.) and local community partners like hospitals, public health, mental health, AAAs, socially and culturally diverse community-based organizations, disabilities advocates, etc. to augment information posted on the website mentioned in Appendix A with additional information (even if qualitative rather than quantitative) on health status and health disparities.
- D) Based on A), B) and C) above, CCOs will assess whether their provider networks and points of access are sufficient to meet the health needs of all local communities, identify where capacity to cover the health care needs of the CCO enrollees is under- or over-developed, and make plans to strengthen or adjust network capacity as needed beyond the state minimum standards. This assessment should include communities of race, ethnicity, language, health literacy, age, disability, gender, sexual orientation, geography, and occupation who may experience provider network access differently than the general population.
- E) The community health assessment should include an examination of the health status and health needs of diverse populations such as racial and ethnic communities, tribal members, the elderly population, people with disabilities, LGBT populations, and those currently uninsured and underinsured. Upon identifying the health disparities that create barriers for individuals accessing care, the CCO will establish priorities for addressing these disparities and develop a preliminary community health improvement plan. The health improvement plan will serve as a strategic population health, health care system and health services plan for the community served by the CCO to realize the ultimate goals of health system transformation – better health, better care and lower costs – and eliminate the disparities.
- F) As a part of periodic updating of the health assessment and improvement planning, CCOs will be responsible for publishing an annual report on the progress of implementing the community health improvement plan. The report should describe the scope of the activities, services, progress made in meeting performance measures, and a description of the progress made on health indicators as defined in the community health improvement plan. If there has been no progress, the CCO should

note this. The annual report should also document when and why a plan has been revised based on monitoring.

The activities, services and responsibilities defined in the plan may include, but are not limited to:

1. Evaluation and development of public and private resources, capacities and metrics needed to support ongoing community health assessment activities and population health priorities as noted above and with enhancements reflecting updated health assessment and improvement planning
2. Health policy
3. System design
4. Outcome and quality improvement
5. Integration of service delivery
6. Workforce development

G) The community health improvement plan may include consultation with the Oregon Health Authority to develop surveys and research regarding the health needs and disparities within the CCO's service area. A revised community health improvement plan, reflecting this additional information and revised priorities for addressing health disparities, would need to be submitted to the Oregon Health Authority approximately six months after implementation.

House Bill 3650 requires that local public health and mental health authorities, community based organizations and hospital system(s) help shape CCO operations to address the health needs of communities within the CCO's service area. This community needs assessment will be achieved through a collaboration of all agencies and stakeholders. Each CCO is required to contract with the counties in its service area and to coordinate with these counties regarding local public health, mental health and primary care (where the county operates primary care clinics – e.g. Multnomah and Tillamook Counties), unless such an agreement is not feasible.

Both the original legislation and the Oregon Health Policy Board's CCO Implementation Proposal emphasize the importance of strong and diverse community representation in CCO governance. Each CCO must include representatives of the community at large on its governing board, and must also establish a Community Advisory Council to ensure that policy considerations and implementation reflect community perspectives and values. Community representation as described above will have a key role in assuring that CCO resources and activities are directed appropriately to improve shortcomings and reduce disparities in health identified during the community needs assessment.

Framework

Community Health Assessment and Community Health Improvement Plan

This framework provides guidance on the process of designing and documenting the CCO's community health assessment and community health implementation plan. The initial year's assessment and implementation plan processes should be completed by July 1, 2013 and the annual report completed by August 1, 2013:

- The OHA Contact for both the community health assessment and the community health implementation plan is Tricia Tillman (tricia.tillman@state.or.us) of the Office of Equity and Inclusion.
- CCOs are expected to collaborate with community partners to provide any additional and relevant perspectives or information to help identify health disparities in the CCO's service area.
- OHA will assist CCOs in:
 - Identifying and analyzing available data
 - Developing a preliminary identification of health disparities
 - Developing plans for gathering additional information and performing analyses on identifying more accurately and completely the significant health disparities in the CCOs service area
 - Developing a community health improvement plan for the first year's operation, to be amended based on further information gathered and analyzed in subsequent years
- The community health assessment is expected to be analyzed, at a minimum, in accordance with OHA's race, ethnicity and language data policy. (see appendix C)

This stepwise assessment and plan guidance is based on the National Association of County and City Health Officials community-driven strategic planning process for improving community health called the Mobilizing for Action through Planning and Partnerships (MAPP) process.

Phase 1: Community Engagement

Diverse community engagement and partnership development are an essential first (and ongoing) phase of the assessment and health improvement plan. This phase identifies who should be involved in the process and how the partnership will approach and organize the process.

Documentation:

- Demographic summary, at a granular level sufficient to represent community diversity, of the assessment and health improvement planning partners, including which assessment partners are part of the CCO Community Advisory Council, to be identified by the signing of the CCO contract

Community Health Assessments and Community Health Improvement Plans for CCOs

- Demographic summary of community members engaged as participants in the assessment and health improvement planning process
- Decision making process – Identifying who has final authority to approve the assessment and adopt the plan
- Identify CCO framework for embedding health equity and the elimination of health disparities in the Health Improvement
- Document coaching/consulting with OHA staff in Public Health Division, Office of Equity and Inclusion, and Health Analytics
- Identify the mechanism for on-going dialogue and community engagement throughout the Community Health Assessment, Community Health Improvement Plan, and ongoing assessments/future plan updates

Phase 2: Visioning

The visioning phase is a collaborative and creative approach that leads to a shared community vision and common values.

Documentation:

- Explain the process for identifying (including community members engaged in) the CCO health assessment and improvement plan's vision and values
- Vision and values statement

Phase 3: Assessment

The assessment phase provides a comprehensive picture of a community in its current state using both qualitative and quantitative methods to help communities analyze health issues through multiple lenses.

In year one, the expectation is that CCOs will use multiple existing data sources rather than develop and implement new assessment tools (see appendix A):

- Census tracts most closely aligned with CCO service area - demographic breakdown of CCO service (ACS data, Census data)
- Review quantitative data on a broad array of health indicators, including quality of life, behavioral risk factors, and other social determinant of health measures that reflect a broad definition of health across the dimensions of diversity identified above
- Review qualitative information on how communities perceive their health and quality of life concerns as well as their knowledge of community resources and assets
- Measure how well public health and health system partners collaborate to provide public health services based on a nationally recognized set of performance standards
- Examination of the health status and health needs of diverse populations such as racial and ethnic communities, tribal members, the aged, people with disabilities, LGBT populations, and the currently uninsured and underinsured
- Conduct an environmental scan of positive and negative external forces that impact the promotion and protection of the public's health

Documentation:

- Assessment plan – explain criteria used to select data for analysis

Community Health Assessments and Community Health Improvement Plans for CCOs

- Provide a summary of the demographics of the CCO service area at a granular level sufficient to represent community diversity
- List quantitative clinical and community health data sources chosen for analysis
- List qualitative clinical and community health data sources chosen for analysis
- List data sources (qualitative and quantitative) that delineate the health inequities experienced by diverse populations in the CCO service area, such as racial and ethnic communities, tribal members, the aged, people with disabilities, LGBT populations, and the currently uninsured and underinsured
- Document any use of Public Health Accreditation Board standards and measures
- Document process for (including community members engaged in) conducting an environmental scan

Phase 4: Analysis

Use the information gathered from the above assessments to determine the strategic issues a community must address in order to reach its vision.

Documentation:

- Summarize findings from qualitative and quantitative data that inform the CCOs strategic clinical and community health priorities
- Explain the process for (including community members engaged in) narrowing data findings into strategic priorities
- Explain the process for (including community members engaged in) identifying priority community health disparities
- Provide brief analysis of key findings that relate to strategic priorities for promoting both community health and health equity

Phase 5: Community Health Improvement Plan

The Community Health Improvement Plan should specify goals, objectives, strategies, budget, and leadership for each of the strategic issues identified in the previous phase.

Documentation:

- Explain the process for (including community members engaged in) identifying priority community health improvement strategies
- Explain goals, objectives, strategies, budget, and leadership for each of the strategic health improvement priorities identified
- Identify how health improvement strategies have been tailored to respond to priority health inequities
- Plan for addressing clinical aspects of community health improvement in CCO (Clinical Advisory Panel, utilization and diagnosis data, budget, appropriate hours of operation, provider network, provider location, language access, HR, public health and community partnerships, contracting, cultural competency, workforce with expertise in health equity issues, Health Care Interpreters, key staff assigned to advance this work)

Phase 6: Continuing assessment and quality improvement

Describe your plan and methods for evaluating and improving the community's health assessment and health improvement plan.

Documentation:

- Explain how the CCO will continue to maintain and deepen diverse community engagement in the CHA and the CHIP over time
- List qualitative and quantitative data sources to be developed for future community health assessments
- Explain the process for how the CCO will deepen its understanding of causes, effects and solutions to health inequities in the CCO membership and the local community, including uninsured and underinsured, over time
- Identify any plans for collecting more granular data over time, with the goal of devising solutions to the health problems impacting each of the diverse populations in the CCO service area

**Appendix A:
Existing community health assessment and community health improvement plan activities in Oregon**

(Note: There are already a number of existing web pages with pertinent data and resources available for CCOs to utilize in their community health assessment and improvement plans. Please See Appendix B.)

Required in:	Conducted by:	Frequency	Brief Description
Local Public Health Annual Plan (AP) Contact: Tom R. Engle, Office of Community Liaison	In statute and required of all local health authorities http://public.health.oregon.gov/PROVIDERPARTNERRESOURCES/Pages/lhd-annual-plan.aspx	All plans due Dec. 1 st . This Plan covers the period July 1, 2012 – June 30, 2013.	The AP is an opportunity for the LPHA (Local Public Health Authority) to describe for both the state public health agency and the local community the goals and strategies to fulfill statutory, contractual, and locally driven obligations. The local dialogue and the discussion with the state are important aspects of the AP process.  AP_2012-2013_Appendices.doc
Public Health Accreditation Contact: Lydia Emer, Performance Improvement Manager	Voluntary for state, local, tribal and territorial health departments, though all LHDs in OR are expected to be accredited by 2015. Right now 15 counties are in the process of accreditation. http://public.health.oregon.gov/ProviderPartnerResources/Pu	Five-year status granted by Public Health Accreditation Board (PHAB)	Standards in 12 domains: <ul style="list-style-type: none"> • Ten Essential Services of Public Health • Governance and Administration Prerequisites: <ul style="list-style-type: none"> • The Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) are two of the three pre-requisites for accreditation at all levels of the public health system (state, local and Tribal). Both must be conducted every 5 years, and are considered to be "living" documents. See PHAB Standards and Measures Version 1.0 Overview.

Community Health Assessments and Community Health Improvement Plans for CCOs

Required in:	Conducted by:	Frequency	Brief Description
	blicHealthAccreditation/Pages/index.aspx		<ul style="list-style-type: none"> • CHA appears in Domain 1: Conduct and disseminate assessments focused on population health status and public health issues facing the community. The CHIP appears in Domain 5: Develop public health policies and plans, specifically Standard 5.2: Conduct a comprehensive planning process resulting in a Tribal/state/community health improvement plan. Expectations are more focused on documentation of broad collaboration and information sharing rather than distinct methodologies or frameworks.
<p>501(c)(3) status for hospital organization³</p>	<p>The Community Health Needs Assessment (CHNA) requirements are among several new requirements that apply to section 501(c)(3) hospital organizations under section 501(r), which was added to the Code by section 9007(a) of the ACA Pub. L. No. 111-148, 124 Stat.119, enacted March 23, 2010.</p> <p>(http://www.irs.gov/charities/charitable/article/0,,id=203109,00.html.)</p>	<p>CHNA must be conducted at minimum once every 3 years, effective for tax years beginning after March 23, 2012.</p>	<p>CHNA for a hospital facility in a written report that includes a description of:</p> <ol style="list-style-type: none"> 1) The community served by the hospital and how it was determined. 2) The process and methods used to conduct the assessment, including sources, dates of the data, other information used in the assessment, the analytical methods applied to identify community health needs, information gaps impacting the hospital’s ability to assess the health needs of the community they serve, and identify other organizations or third parties they collaborated with in conducting a CHNA, if applicable. 3) How the hospital organization took into account input from persons, particularly individuals with expertise in public health, or those providing input as leaders or representatives, or organizations that represent the broad interests of the community served by the hospital facility including a description of when and how the organization consulted with these persons.

³ Resources: Internal Revenue Code for community needs an assessment conducted by hospitals (see Internal Revenue Bulletin 2011- 52) and follows the community health assessment best practices recommended by the U.S. Centers for Disease Control and Prevention and required by PHAB.

Community Health Assessments and Community Health Improvement Plans for CCOs

Required in:	Conducted by:	Frequency	Brief Description
			<p>4) All of the prioritized community health needs identified through the CHNA, as well as a description of the process and criteria used in prioritizing such health needs.</p> <p>5) The existing health care facilities and other resources within the community available to meet the community health needs identified through the CHNA.</p> <p>6) The needs identified in the CHNA that the hospital intends to address, the reasons those needs were selected, and the means by which the hospital will undertake to address selected needs.</p>

Appendix B: Resources

See Community Health Assessment Resources website (contents of which shown below):

<https://cco.health.oregon.gov/Pages/ResourcesCHA.aspx>

Community Health Assessment Resources

The Oregon Health Authority has identified information that may be useful to CCO applicants when developing the initial Community Health Assessment and Community Health Improvement Plan. This information is provided as a resource only. This list will be updated as new information is identified. CCO Applicants are encouraged to identify and incorporate additional information in their community health assessment and improvement plan development processes.

OHA will be providing guidance shortly to help inform the Community Health Assessment and Improvement Plan process and structure.

State Department Websites

- Health.Oregon.gov
- [Oregon Health Authority - CCO related materials and presentations](#)
- [Office for Oregon Health Policy and Research](#)
 - [Coordinated Care Organizations and CMMI Applicants](#)
 - [Research and Data Unit](#)
- [Public Health - Public Health and Health System Transformation](#)
- [Office of Equity and Inclusion - Oregon Health Equity Data](#)
- [Oregon Health Plan](#)

Reports and Data

Addictions and Mental Health

- [Local population-based assessment](#) (based on CDC priorities)
- [Oregon's Epidemiological Data on Alcohol, Drugs, Mental Health and Gambling County Measures](#) (based on the Student Wellness Survey and Oregon Healthy Teens Survey)
- [Public Health data on county tobacco profiles](#) (based on the Oregon Behavioral Risk Factor Surveillance System (BRFSS) data)

County Specific Reports

- [County Health Rankings](#) (by the Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute)
- [Health Indicators Warehouse](#) (by National Center for Health Statistics)
- [Community Health Status Indicators](#) (by DHS to provide information for improving community health)
-  [CCO Developmental Disabilities Services in Oregon](#)
- [DHS and OHA County Fact Sheets](#)
- [Oregon County Demographics Base Statistics](#) (uninsurance rate by region and FPL)

Community Health Assessments and Community Health Improvement Plans for CCOs

-  [2010 Oregon Health Professions: Occupational and County Profiles](#)
- [County level information on chronic diseases and related risk factors](#) (from BRFFS)

Delivery System / Providers

- [Oregon Primary Care Office Health Professional Shortage Area Designations Page](#)
- [HRSA Health Professional Shortage Area Finder](#)
- [Hospitals - New Requirements for 501\(c\)\(3\) Hospitals Under the Affordable Care Act](#)

Developmental Disabilities Services

-  [CCO Developmental Disabilities Services in Oregon](#)

Health Equity

-  [Communities of Color in Multnomah County: An Unsettling Profile](#), a report outlining the disparities experienced by various racial/ethnic populations, by the Coalition of Communities of Color in partnership with Portland State University
- [Reports on the Asian Pacific Islander, Latino and Native American Communities in Multnomah County](#), by the Coalition of Communities of Color
-  [State of Black Oregon](#), a 2009 Report by the Urban League of Portland outlining disparities in outcomes, including health, for African Americans
-  [Oregon Enumeration of Migrant and Seasonal Farmworkers 2002](#)
-  [Oregon Health Authority Health Equity Brief](#)
- [Oregon Health Authority Oregon Racial and Ethnic Data](#)
- [Key Indian Health Issues](#), Northwest Portland Area Indian Health Board
-  [Oregon's Uninsured: Analysis of the 2008 American Community Survey](#), by the Oregon Health Authority and the Office for Oregon Health Policy and Research
- [Demographic Profile of Hispanics in Oregon 2010](#), by Pew Hispanic Center
- [Minority Health - National](#), by the Kaiser Family Foundation
- [Minority Health - Oregon](#), by the Kaiser Family Foundation
- [State of Equity Report – Demographic Data](#), by the Oregon Health Authority
- [State of Equity Report – Local Diversity](#), by the Oregon Health Authority
-  [Putting Women's Health Care Disparities On The Map](#), by the Kaiser Family Foundation

Race, Ethnicity and Language Data Collection

-  [OHA/DHS Race Ethnicity Language Data Collection Policy](#)
-  [DHHS REAL Data Standards](#)
-  [Creating a Voluntary Standard for Collecting Race and Ethnicity Data](#), Quality Corp

Individuals who are Dually Eligible for Medicare and Medicaid

-  [Oregon Listening Session with Dually Eligible Individuals - Final Report, February 2012](#)
-  [Fact Sheet on Individuals who are Dually Eligible in Oregon](#)

Long Term Care Supports and Services for Individuals who are Aged or have Physical Disabilities

Community Health Assessments and Community Health Improvement Plans for CCOs

-  [Overview of the APD/AAA service delivery system](#)
-  [Local LTC field office \(APD/AAA\) contacts](#)
-  [APD/AAA service delivery system map](#)
-  [Glossary of terms for LTC and CCOs](#)
- [OHA/DHS Guidance on CCO/LTC Memorandum of Understanding](#)
-  [OHA/DHS Strategic Framework for Coordination and Alignment between Coordinated Care Organizations and Long Term Care, February 10, 2012](#)
-  [DHS Report for House Bill 5030 \(2011\) Budget Note on Oregon's Long Term Care System, January 2012](#)
- [Older American Act funded area plans and demographic reports](#)
-  [County data on individuals receiving Medicaid long-term care benefits, by living settings](#)

Public Health

- [Public Health County Leaders and Community Health Advisory Committee assessment of needs and directional opportunities for local health organizations](#)
- [Community Planning](#)
- [Community Health Assessment Clearinghouse](#)
-  [Community Health Assessment - Key Messages](#)
-  [Understanding types of community health assessments](#)
-  [Public Health Accreditation and Health System Transformation - Important Messages](#)
- [Community Liaison for Local Health Departments](#)
- [Local Public Health Annual Plan](#)
- [Accreditation and Quality Improvement](#)
- [Performance Management Program](#)
- [Oregon Health Status Data](#)
-  [Public Health and Coordinated Care Organizations](#)
- [Public Health and Primary Care](#)

Rural Health

- [Oregon Rural Communities Explorer](#) (this site is also applicable for urban areas)
- [Oregon Office of Rural Health Data Home Page](#)

Other Resources

Additional Resources

- [American Community Survey Data](#) (Census Data)
- [UDS Mapper](#)
- [Dartmouth Atlas of Health Care](#)

Example Models

- [Carolina Health Assessment](#)
- [NACCHO - Community Health Assessment and Health Reform](#)

Community Health Assessments and Community Health Improvement Plans for CCOs

- [Stories from the Field](#) - Examples from rural and urban communities across the country