

# Transformation Plan Element #4

## Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP)

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### **Transformation Plan Guidance and Technical Assistance**

Oregon Health Authority's technical assistance is designed to provide Coordinated Care Organizations (CCOs) with guidance on specific areas each plan should address; examples of approaches and outcomes that can help inform discussions and strategies as the CCO develops its plan; other resources and additional technical assistance available to CCOs; and staff assistance to answer specific questions through an assigned OHA contact. Please call or email your OHA Transformation Plan contact if you need assistance with a particular subject or item.

### **Overview**

Oregon's Coordinated Care Organizations (CCOs) are charged with preparing a strategy to develop a Community Health Assessment (CHA) and adopting an annual Community Health Improvement Plan (CHIP) consistent with 2012 Oregon Laws, Chapter 8 (Enrolled SB 1580), Section 13. This guidance is intended to clarify the importance and purpose of the CHA and CHIP, and to provide basic information about how the assessment and planning processes may be conducted. This information is intended to assist CCOs in identifying strategies for developing their CHA and CHIP, with the recognition that each CCO should tailor its approach to the unique needs and characteristics of the communities in its service area.

CCO responses to Transformation Plan Element 4 should be explicitly linked to Plan Elements 6, 7 and 8. Reducing health disparities, promoting health equity, and improving overall population health is the central purpose of any health assessment and health improvement planning effort.

### **Background**

The CHA and the CHIP comprise two critical components of an important and emerging transformation process to examine the health of defined populations, to assess the assets in a community that can be used to improve the health of that population, and to encourage engagement across organizations to improve health. As a part of the transformation of the health system in Oregon, CCOs are being asked to collaboratively engage in this systematic approach to assessing the health of the populations they cover and the communities those populations live in, and planning to improve the health of those communities by addressing health disparities.

This systematic approach to health improvement has gained importance nationally. As a result of the adoption of the Patient Protection and Affordable Care Act (PPACA), the federal government is in the process of developing rules that require non-profit hospitals to develop and maintain community health needs assessments, and has encouraged collaboration between hospitals, public health, and others toward this end.

The national accreditation movement being promoted by the Centers for Disease Control and Prevention and the Public Health Accreditation Board is encouraging state and local public health authorities to engage in the development of community health assessments and health improvement plans as a best practice in public health. There are also long-standing statutory

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requirements and best practices in Oregon that ensure local public health authorities and mental health authorities engage in population-level assessment and planning processes. As a result, there are opportunities for synergy and collaboration on both health assessments and health improvement plans, particularly at the community, to ensure that all partners in health system transformation come together to improve the health of the public in Oregon. (See Table 1 for a list of key plans.)

CCOs should consider these CHA and CHIP precedents as opportunities for collaboration in the development of a strategy for their contractually required CHA and CHIP. CCOs are encouraged to explore partnerships that draw on the strengths of partner organizations that are skilled in conducting health assessments and knowledgeable about health disparities in their communities, and CCOs are encouraged to avoid the duplication of effort, data collection, or community engagement where doing so would not directly result in a health benefit to the public or a vulnerable population.

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**Table 1 - List of Key Plans**

<b>Requirement</b>	<b>Responsible Entity</b>	<b>Requiring Entity</b>	<b>Legal Authority</b>	<b>Due Date</b>
Community Health Assessment; Community Health Improvement Plan	Coordinated Care Organization	Oregon Health Authority	SB 1580 (2011)	Strategy to complete due at the start of the second CCO Contract period
Community Health Needs Assessments	Non-profit hospitals	Internal Revenue Service	Announcement 11-52	Every three hospital tax years
Annual Plan	Local Public Health Authorities	Oregon Health Authority	ORS 431.385	Annually, not later than May 1 or a time agreed upon between the State and the LPHA
Community Health Assessment; Public Health Agency Strategic Plan; Community Health Improvement Plan	State and Local Public Health Authorities	Public Health Accreditation Board	Not applicable	Optional, but not less than every 5 years for accredited authorities
Local Community Mental Health Plan	Local Mental Health Authorities	Oregon Health Authority	ORS 430.630 (9)(b)	At time intervals established by the State
Other Special Local or Regional Health Improvement Plans	Regional governments or collaborations	Varies	Varies	Varies

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### **Definitions**

**Community Prevention:** Prevention of disease or injury before it occurs or reoccurs in the person.

**Clinical Prevention:** Early detection and treatment of disease or injury.

**Community Health Assessment:** Community health assessment is a systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community.

**Community Health Improvement Plan:** A community health improvement plan is a long-term, systematic effort to address public health problems on the basis of the results of community health assessment activities and the community health improvement process.

**Evidence-Based:** Supported by the current peer-reviewed scientific literature.

### **References/Resources**

- [Oregon's State Health Profile \(Statewide Health Assessment and List of Indicators\)](#)
- [Oregon's Public Health Strategic Plan](#)
- [IRS Publication 11-52 on Non-profit Hospital Community Health Needs Assessments](#)
- [Public Health Accreditation Board](#)
- [The Guide to Community Preventive Services](#)
- [Community Health Assessment aNd Group Evaluation Tool](#)
- [Mobilizing Action through Partnerships and Planning](#)

### **Components**

1. **Community Health Assessment**
2. **Community Health Improvement Plan**

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## 1. Community Health Assessment

### **OHA Expectations**

CCOs are strongly encouraged to review and build on existing or ongoing health assessment work in the communities they serve. Many local public health authorities and the Public Health Division are engaged in health assessment efforts. Some non-profit hospitals have also started to engage in health assessment activities. OHA also expects that CCOs work collaboratively with other partners in their communities to carry out the community health assessment activities in a replicable fashion and with data that is available to the entire community.

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CCOs may choose, but are not required to, use existing models for health assessment, such as the Mobilizing Action for Planning and Partnerships (MAPP) or Community Health Assessment and Group Evaluation (CHANGE) tool. CCOs may modify these methods or use other innovative approaches to developing health assessments. If a CCO's approach to developing a CHA and CHIP would or does substantially meet requirements for federal ACA and national PHAB requirements, and the CCO worked with the Local Public Health Authorities and Local Mental Health Authorities that oversee the jurisdictions where their members reside, the CCO requirements to develop a CHA and CHIP will be considered to be met by OHA.

#### **Measurement Methodology**

- The CCO should ensure timely completion of the community health assessment and ensure participation of non-CCO representatives in the health assessment process to achieve the baseline CHA requirements.

#### **Baseline**

At a minimum, the completed CHA should include:

- Demographic information regarding the population of covered lives and the communities in which they live, at a minimum including data regarding age, race, ethnicity, language, gender, LGBT identification, family size, disability status, employment, housing, and overall health. This information should be at a granular level sufficient to represent community diversity, of the partners involved in planning the assessment and health improvement plan effort.
- An examination of the health status and health needs of diverse populations community health assessment is expected to be analyzed, at a minimum, in accordance with OHA's race, ethnicity and language data policy
- Health indicators that reflect the leading causes of disease, injury, and death in Oregon, including but not limited to tobacco, obesity, heart disease and stroke, intentional and unintentional injuries, suicide, prescription drug abuse, and mental health conditions
- Indicators that reflect the leading drivers of health care costs within the Medicaid population, including but not limited to hospitalization rates, emergency department utilization, inadequately managed chronic disease, poor mental health, prescription drug use, dialysis, and prenatal and maternity care
- Data regarding health and socio-economic disparities (including those listed in the first bullet above) within the CCO population and/or between the CCO population and other communities
- An assessment of the assets available in the community to meet the physical, mental, and oral health and prevention needs of the CCO population and the communities in which they live
- Evidence of engagement of a range of stakeholders and the use of a variety of data sources in identifying disparities, prioritizing disparities for targeting in the CHIP, and developing an approach to evaluating the success of the CHIP in addressing prioritized disparities

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### **Transformative Activity**

The CCO should establish a systematic approach to using the CHA findings to ensure a common understanding of the community's health across partner organizations. The approach should be used to guide investments and health improvement efforts that reflect the community's needs and diverse community priorities, perspectives and values.

### **Improvement Metric**

- The CCO should describe how it will use the health assessment to monitor the leading cause of disease and injury and monitor health disparities in its community over 5 years.

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## **2. Community Health Improvement Plan**

### **OHA Expectations**

Similar to the CHA expectations, CCOs are strongly encouraged to review and build on existing or ongoing health improvement plan work in the communities they serve. Many local public health authorities are engaged in health improvement planning efforts. OHA expects that CCOs work collaboratively with other partners in their communities to develop the health improvement plan. CCOs may choose, but are not required to, use existing models for developing health improvement plans. Strategies identified in the plan should be evidence-based or evidence-informed and there should be a clearly accountable organization or group for each strategy with a clear timeline for change.

### **Measurement Methodology**

- The CCO should ensure timely completion of the community health improvement plan to achieve the baseline CHIP.

### **Baseline**

At a minimum, the completed CHIP should reflect:

- A clear connection to the findings from the CHA and engagement of diverse stakeholders
- A clear prioritization of the CCO population health needs and disparities and the total community health needs and disparities, and approaches that will be taken to address those needs and disparities
- Strategies and actions beyond patient health education that will be undertaken by the CCO and other partners to transform health outcomes in the community, including:
  - Evidence-based community and clinical preventive approaches, such as those found in the US Preventive Health Services Task Force's Guides to Community and Clinical Preventive Services
  - Community policy changes to create safer and healthier social and physical environments
  - Strategies that reduce health disparities and promote health equity

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- Linkages between CCO efforts and other community partner efforts to improve health
- Plans for sustaining investment in health improvement approaches (e.g. alternative payment methodologies to fund non-clinical and community interventions)
- Consideration of the need to enhance the skills and numbers of people in the workforce essential to health system transformation and to improve cultural competence and diversity
- Clear metrics or milestones that would indicate progress over time toward the goals in the CHIP

#### **Transformative Activity**

The CHIP should identify strategies to address the prioritized findings from the CHA through evidence-based community and/or clinical preventive approaches. These strategies should reflect consideration of, but are not limited to—

- Community interventions that include policy changes to address drivers of poor health in the social, physical, or informational environments of CCO clients (e.g., lack of opportunity for physical activity contributing to obesity or marketing of unhealthy food products to children)
- Quality improvement strategies to ensure access to and delivery of clinical prevention health services through patient-centered primary care homes
- Patient engagement (through PCPCHs or patient-centered primary care teams) in the integration and coordination of care through the CCO's overall transformation plan
- The patient-centered primary care team (with the patient as a team member) in a management role in the integration and coordination of care according to best practices and patient preferences
- Enhancing the skills and numbers of people in the workforce essential to health system transformation, including non-traditional health workers

#### **Improvement Metric**

- The CCO should describe how it will ensure the use the health improvement plan to reduce the leading cause of disease and injury and reduce health disparities and improve health equity in its community over 5 years.