CORE | Center for Outcomes Research and Education

OHA Transformation Center CHA/CHP Learning Collaborative: Resourcing a Shared CHA & CHP

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Presented by:

Bentley Moses, MPH (they/them), Program Manager

Kate Marsi, MSW, MPH (she/her), Research Associate

Zoom Logistics

- This session will be recorded
- Private chat or email Tom Cogswell (thomas.cogswell@dhsoha.state.or.us) with any Zoom issues
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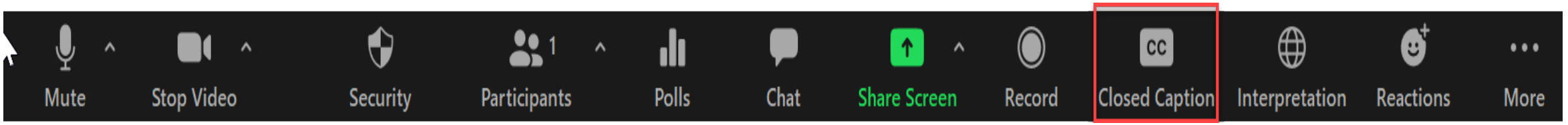

Learning Collaborative Goals

- Support CCOs and their CHA/CHP partners in creating shared community health assessments & health improvement plans

- Provide a space for learning collaborative participants to discuss operational challenges, successes and best practices

About CORE

An independent team based in Portland, Oregon within the Providence Health System

30+ scientists, researchers, and data experts with a vision for a brighter future.

Our Mission: To drive meaningful improvements in health and health equity through collaborative research, evaluation, analanalytics, and strategic consulting.

We work to inform and inspire a healthier, more equitable world!

Intro: Center for Outcomes Research and Education

Bentley Moses
(they/them)

Kate Marsi
(she/her)

Participant Introductions

- In the chat, please share:
  - Name
  - Pronouns
  - Title
  - Organization

- Favorite thing about spring

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Presentation Objectives

- Review learnings from environmental scan and key stakeholder interviews on shared CHA/CHP work
- Discuss themes, lessons learned
- Share examples and resources

OHA Definition of Shared CHA/CHP Work

- For CCOs, OHA has defined a shared CHP and CHA as one shared CHA document and one shared CHP document for the required entities.
- This can include separate documentation to fulfill an entity's state or federal requirements.
- Collaborating on CHA/CHP work is not always the same as a having a fully shared CHA/CHP.

Key Requirements: Nonprofit Hospital

Controlling Authority / Guidance	✓ Patient Protection and Affordable Care Act (ACA) ✓ Internal Revenue Services (IRS)
Jurisdiction/Service Area	✓ Hospital service area, geographic, target populations
Frequency	✓ Every 3 years
Community Engagement	✓ Include broad community input ✓ Include high need populations
Overview of Requirements	✓ Identify and assess health needs of community served
Required Methods	✓ Definition of community served by hospital, demographics, health care facilities/resources, primary and chronic disease needs
Unique Considerations	✓ IRS review (versus health professionals) ✓ Style and documents vary widely ✓ Fines and possible revocation of 501(c) 3 status if not completed adequately.

Key Requirements: CCO

Controlling Authority / Guidance	✓ CCO contract with Oregon Health Authority ✓ OAR 410-141-3730, ORS 414.575, ORS 414.577, ORS 414.578
Jurisdiction / Service Area	✓ Community served by CCO
Frequency	✓ At least every 5 years
Community Engagement	✓ MUST be shared with local public health authority and hospitals ✓ MUST engage list of partners, including representatives from populations with disparities
Overview of Requirements	✓ CAC and collaborative partners oversee process ✓ Must drive improved health of community served (triple aim)
Required Methods	✓ Identify health disparities ✓ Include SDOH-E factors
Unique Considerations	✓ CAC and consumer involvement implicit in process ✓ Broad organization and population focus ✓ Beyond Medicaid population served

Key Requirements: Public Health

Controlling Authority / Guidance	✓ Public Health Accreditation Standards & Measures (Public Health Accreditation Board) ✓ Public Health Modernization ORS 431.131
Jurisdiction / Service Area	✓ State or county
Frequency	✓ Every 5 years
Community Engagement	✓ Participate in or lead collaborative process with agencies outside health department ✓ Include populations with high health risk
Overview of Requirements	✓ Multiple types of data (primary, secondary, qualitative, quantitative, etc.) ✓ Documentation of methods
Required Methods	✓ Include SDOH, health disparities, epidemiology fundamentals, qualitative and quantitative data, health disparity data
Unique Considerations	✓ Previously voluntary if seeking public health accreditation ✓ Professionals already immersed in population health assessment

CHA/CHP Learning Collaborative Workshop Series

Resourcing 3/29, 11:30-1	Governance 5/17, 11:30-1	Timelines/Cycles September 2022
Community Engagement November 2022	Tribal Engagement February 2023	Sustainability & Dissemination April 2023

CHA/CHP Staffing and Resourcing

Staffing and resourcing for convening, facilitation, and community engagement

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Stakeholders and Partners

- Collective impact on this scale requires appropriate resourcing
- Dedicating protected staff capacity and expertise is critical. Relationships, workflows, processes, evaluation all hinge on proper staffing support.
- Work slows significantly without sufficient designated staff time, especially from a lead or convening entity.

Convener Models

Backbone Entity

Convening organization funded to lead work (typically a 501©3)

- Part-time or full-time employee convening work
- Staff time paid for by grants or by contributions from partners
- CBO lead model can be a value-add

CCO Lead, hospital, or LPHA lead

One organization designates staff to lead coordination of shared CHA/CHIP work

- One organization accountable to lead
- Partnering organizations contribute in-kind staff time
- In Oregon: CCO or Hospital. Nationally: often LPHA.

Hospital/CCO Co-Lead

CCO and hospital partner both fund coordinating staff

- Provide shared facilitation model
- Staff designated at each org work closely
- In some cases, hospitals paid to support collaborating LPHA staff time

Staffing Considerations

- Important to have funded, designated staff time for project coordination
- LPHA participation is critical. CCOs/hospitals consider funding LPHA staff time for project period.
- Identify gaps are in each partner organization's capacity and resources. Leverage each organizations strengths, access, and resources to fill in the gaps.

Agreements and Accountability between Organizations

- Develop clear, written working agreements (e.g., MOUs, DSAs, etc.) early in the process. Review and revise with every cycle.
- Clearly outline commitments from each organization, including roles and expectations.
- Protect staff time, in-kind time, and other resources designated to support shared CHA/CHIP

Example Staffing - Overviews

- 1.0 FTE coordinator funded by LPHA, hiring 1.0 FTE analyst. Consultant support for community engagement, analysis.
- 1.0 FTE coordinator funded by CCO. Consultant hired for strategy, community engagement.
- 0.5 FTE-2.0 staff time coordinator housed at 501c3. Funded by CCO, Hospital, or grants. Consultant hired to help establish backbone organization or provide expertise for community engagement.
- Shared in-kind coordination across Hospital, CCO (typically less than 1.0 FTE per organization). Community engagement led by CCO/Hospital.

Example A: Deschutes/Crook/Jefferson - Central Oregon Collaborative RHIP

- Regional work convened and driven by CCO.
- Staff donated in-kind by counties – leadership, epidemiologists.
- Health system donates survey results
- Community engagement included focus groups, phone survey. Focused on LPHA, CCO communities.

- **Resourcing more staff time extremely helpful, especially for community engagement**
- **Staff were doing work in addition to their normal job responsibilities (1 staff at CCO, 1 at LPHA)**

Example B: Clatsop, Columbia, and Tillamook Counties - Columbia Pacific CCO

- **Biggest challenge is alignment of process (hospitals are on 3 year cycle, CCO/LPHA on 5)**
- **Surveys/community engagement take about 18 months, sometimes overlap between cycles**

- CCO leads and drive CHA/CHIP process, backbone for work, funds most work
- Hospital donates time in-kind, supports community engagement process
- CCO staff responsible for community partnerships and CAC work integral to CHA/CHIP work
- Worked with consultant for community engagement process

Example C: Jefferson Regional Health Alliance – All In For Health

- Jefferson Regional Health Alliance (JRHA) is a 501©3, convenes the work. Approx. 0.5 FTE dedicated time to project.
- Additional staffing/leadership from board (CCOs, LPHAs). Core group of 5-7 individuals.
- Community engagement led by JRHA, took about 6 months.

- **A collective impact initiative of this level, complexity, and scope would benefit from more robust staffing and funding options**
- **More staff time is needed for ongoing sustainability**

Example D: Austin/Travis County, TX

- LPHA leads and convenes the work in alignment with Accreditation
- 1.0 FTE coordinator, time from a manager, and hiring a 1.0 analyst for CHA/CHIP
- Community engagement centers and uplift existing organizational and community assessments, builds community engagement from there.
- Consultants supported data collection, analysis

- **Extremely important to fully staff this work. Austin/Travis County continuing to hire to meet capacity needs.**
- **Be flexible, creative in working with partners to look at options for how to do the work. Share power with community organizations, uplift their work.**

Example E: Oregon CCO

- **Additional staff time would be beneficial to model to fully support development, workgroups, community engagement**
- **More funding needed to fully sustain and build out efforts**

- Backbone entity has 2.0 FTE dedicated to dedicated to fostering the conditions of collective impact
- All partners responsible for voicing their specific needs, working to incorporate these into shared documents
- Community engagement covers CCO service area, LPHA service area, Hospital service area. Led by backbone entity, supported by partners.

Example F: Oregon CCO

- CCO convenes and leads work in close partnership with Hospital
- CCO subsidized the FTE of public health epidemiologist. Created a CHA that was more population health focus
- CCO led community engagement, worked with early learning council and CAC.

- **Smaller region meant resourcing model was better fit to size**
- **Community partners very engaged, allowed for effective community-led decision making from community engagement**

Breakout Groups: Staff and Facilitation Resourcing

- In breakout groups, discuss:
  - How have you resourced staff and facilitation your CHA/CHP work?
  - What has worked well, what pitfalls have you encountered?
  - What examples from today might you want to apply to your organization?
- You are facilitating your own group:
  - Choose a spokesperson to share out learnings to larger group
  - Pick 1-2 key examples from your group and share back.

Tribal Engagement – key learnings from CCO work

- Dedicate staff time and resources specifically for Tribal engagement
- Resourcing Tribal liaisons can increase engagement
- Relationship building takes time – dedicate resources for relationship development in advance of CHA/CHP work
- Dedicate resources/staff time to learn Tribal priorities, assessment activities

Epi Support for Data Collection and Community Engagement

- All interviewees highlighted how important it is to work with partner LPHAs (epidemiologists) for this work. LPHA epidemiologists can help groups understand population demographics and proportions needed to get a representative sample of community populations.

- Not all LPHAs have epidemiologists on staff. There may be organizations in your region who can support this. Consider:
  - Local universities in your region may have epidemiologists or research scientists on staff who can assist with development and analysis.
    - University of Oregon, Oregon State, OHSU, Portland State, Southern Oregon, Western Oregon, Eastern Oregon are a few examples.

- Consulting groups who have research scientists or epidemiologists can also be a good option for outsourcing some of this work.
- Data collection and synthesis can take up a lot of time and resources in this work – consider how you are resourcing (staff, funding) this appropriately

Discussion

How have group with shared CHA/CHPs resourced epidemiology, data collection, and synthesis?

Hospitals: how much do you typically allocate for community benefit to support this work?

What other sorts of funding (foundations, federal support, etc) have you used to support capacity?

Jamboard link: https://jamboard.google.com/d/1SsC4Cf3F1GzjZUdwk6PfqwnZs21tVtfrSDlYptw_22Y/edit?usp=sharing

Consultants

- Healthy Columbia Willamette Collaborative (Clark, Washington, Clackamas, Multnomah, Washington counties) outsource all their CHA/CHIP work. For their 2019 CHA, they used CoMagine.

- Columbia Pacific CCO (Clatsop, Columbia, Tillamook Counties) used Cognitive Edge to develop community engagement instrument, collect the stories, facilitate community outreach process.

- Jefferson Regional Health Alliance used a consultant to support the development of their backbone entity All In For Health: Health Resources in Action https://hria.org/. JRHA is now working with another group to review their CHA/CHIP strategy: CoCreative https://www.wearecocreative.com/

Breakout Groups: Consultants

- How have people used consultants for staffing, resourcing work?
- What has worked well, what are the limitations?
- What part of your CHA/CHP process benefitted most from consultants?
- You are facilitating your own group:
  - Choose a spokesperson to share out learnings to larger group
  - Pick 1-2 key examples from your group and share back.

Summary

Fully resource staff – especially for community engagement

When possible, support funding partner participation (LPHAs, Tribes)

Consultants can support temporary capacity when staff funding is not available or take on larger sections of work

Next Steps

- Join OHA CHA/CHIP Learning Collaborative Basecamp
  - Homework is to get this set up, connect, and troubleshoot with OHA if needed

- Next presentation is Governance in May – we will have co-presenters speaking on their experiences with governance of CHA/CHIP work

- Reminder – if you're wanting to get into detailed work on CHA/CHIP, connect with Healthier Together Oregon in Action (web page)

Questions?

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Resources and Examples

- **Oregon-based consultants with CHA/CHP related experience (non-exhaustive list)**
  - Coalition of Communities of Color https://www.coalitioncommunitiescolor.org/ **Community driven engagement, health equity expertise.**
  - Northeast Oregon Network https://www.neonoregon.org/consulting/
  - Oregon Health Equity Alliance https://www.oregonhealthequity.org/ **Community driven engagement, health equity expertise.**
  - Oregon Public Health Institute https://ophi.org/
  - Oregon Office of Rural Health https://www.ohsu.edu/oregon-office-of-rural-health / Oregon Rural Practice-based Research Network https://www.ohsu.edu/oregon-rural-practice-based-research-network
  - OHA Program Design and Evaluation https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/PROGRAMDESIGNANDEVALUATIONSERVICES/Pages/index.aspx
  - The Rede Group http://redegroup.co/
  - CORE https://oregon.providence.org/our-services/c/center-for-outcomes-research-and-education-core/

Resources and Examples

- **Austin/Travis County, TX**
  - Mutually owned CHIP process includes LPHA, hospitals, and community partners. Utilized MAPP framework, Community Themes and Strengths Assessment, Austin Public Health System assessment. Conducted on 5 year cycle, 2017 is an update to the 2012 assessment. Returning to 3 year cycle to align with hospital CHNA.
  - www.austintexas.gov/communityhealthplan

Resources and Examples

- **NACCHO resources on CHA/CHIP work, including engaging partners** – NACCHO's best practices for aligning strategies across organizations include defining a purpose, building relationships, aligning timelines where possible, communicating regularly, and using a neutral convener.
  - www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment
  - Includes NACCHO MAPP process. www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment/mapp
  - NACCHO MAPP redesign
    - In a February 2021 webinar, NACCHO described its process to evolve Mobilizing for Action through Planning and Partnerships (MAPP). This webinar outlined the evolution process; significant updates to the framework, including the revised phases and assessments; approaches to center health equity and community power building; and future tools and resources.
    - Listen to the recording here: https://bit.ly/3k08ohD and view the slides here: www.naccho.org/uploads/downloadable-resources/MAPP-Evolution-Webinar-Slides-2.16.21_final.pdf.

Resources and Examples

- **National Network of Public Health Institutes** – CHA and CHIP technical assistance resources.
  - nnphi.org/relatedarticle/community-health-assessment-cha-and-community-health-improvement-chip-initiatives
  - Case study document sharing how Health Institutes can serve as neutral conveners for CHA/CHIP work. nnphi.org/wp-content/uploads/2015/08/CommunityHealthAssessmentandImprovementPlanning-TheUniqueContributionOfPublicHealthInstitutes.pdf