Cross Agency Health Improvement Project

☒ **Decision Making Committee:**
Committee has delegated authority to commit each agency to a decision and requires executive leadership approval.

☐ **Advisory Committee:**
Committee provides recommendations and advice only and can be chartered with or without executive leadership approval.

☐ **Informational Committee:**
Committee shares information and best practices and can be chartered with or without executive leadership approval.

Background

The Cross Agency Health Improvement Project (CAHIP) is an innovative partnership involving the highest level of leadership from Oregon Department of Human Services (ODHS) and Oregon Health Authority (OHA) that aims to improve the health of staff, clients and consumers. Steering committee members work across agencies to implement culturally and linguistically appropriate policies to encourage worksite wellness, stress-management, tobacco-free living, and improved nutrition and physical activity among ODHS and OHA staff, clients and consumers. CAHIP uses a collective impact approach, which is a commitment by multiple sectors with a common agenda to solve a specific social issue. Under this model, CAHIP members have mutually reinforcing objectives and track progress using shared metrics. The Oregon Public Health Division's Health Promotion and Chronic Disease Prevention Section serves as the backbone organization for CAHIP.

The CAHIP mission supports the goals of both agencies. For ODHS, improved health outcomes reduce the financial burden on clients, consumers and their families, enabling them to be healthier and more independent. For OHA, CAHIP is aligned with the goals of reducing cost and improving population health. By helping people take care of themselves and manage existing health conditions, CAHIP uses an employee, client and consumer-oriented approach that supports the Triple Aim (better health, better care, lower costs).

ODHS|OHA Workforce Chronic Disease Risk Factors

ODHS and OHA employees are generally similar to Oregonians overall in terms of health, however they have a 25% to 30% higher obesity prevalence than other state agency employees and the general population.[1] Additionally, ODHS|OHA employees without a college degree have a 30% higher prevalence of obesity and are five times as likely to smoke compared to those who are college graduates[2] To address this inequity, CAHIP is committed to creating supportive environments where state employees, volunteers, trainees and interns are empowered to participate in worksite wellness activities and model good health with the clients and consumers they serve.

ODHS|OHA Clients and Consumers

A growing number of Oregonians receive health care, mental health, addictions, SNAP, financial assistance, job training and other services from ODHS and OHA. People with fewer resources, communities of color, people with mental illness, substance use conditions and people with disabilities are overrepresented in the ODHS|OHA client population and experience

- Compared to white non-Latino Oregonians, American Indians and Alaska Natives have a 40% higher obesity prevalence and are nearly 70% more likely to smoke; African Americans have a 25% higher obesity prevalence and more than 40% higher smoking prevalence; Latino/as have an over 25% higher obesity prevalence; and Pacific Islanders have both obesity and smoking prevalence's that are more than

50% higher than those of non-Latino whites. In contrast, Asians have a lower prevalence of smoking (40% lower) and obesity (67% lower) compared to non-Latino whites.[3]

- Oregonians with disabilities have nearly double the smoking prevalence and an 11% percent higher obesity rate compared to people without disabilities.[4]
- People with serious mental illness experience substantial health inequities. They die on average 25 years before those without serious mental illness, and much of this inequity is related to high rates of tobacco use, poor nutrition and low rates of physical activity.[5]
- Lesbian, gay, and bisexual adults in Oregon disproportionately experience tobacco addiction and obesity compared to heterosexual men and women. Bisexual and gay men smoke cigarettes at an 11% and 15% (respectively) higher rate compared to heterosexual men. Lesbian and bisexual women are 25% and 75% (respectively) more likely to smoke cigarettes than heterosexual women. Lastly, lesbian and bisexual women have a 14% and 30% (respectively) higher prevalence of obesity compared to heterosexual women.[6]
- Many of these communities are disproportionately Oregon Health Plan (OHP) members and experience poorer health compared to the average Oregonian. OHP members have a 30% higher prevalence of both smoking and obesity compared to the Oregon population overall.[7]

All Oregonians deserve equal opportunity to support by managing stress, eating well, staying active and living tobacco free regardless of their income, education, ethnicity, physical or developmental ability, or mental health or substance use status. CAHIP recognizes the invaluable role of other statewide efforts that work to improve access to quality housing, educational opportunities, jobs and other social factors that ultimately affect the health of ODHS|OHA employees, clients and consumers.

Collective Impact: Building on the Tobacco Control Integration Project

From 2010 to 2012, the Tobacco Control Integration Project (TCIP) was an innovative partnership among OHA's Tobacco Prevention and Education Program and all ODHS|OHAOHA divisions and programs with the goal of reducing tobacco use inequities among Oregonians with fewer resources. TCIP championed many successes related to creating tobacco-free policies and promoting tobacco cessation protocols.

This model of collaboration inspired the development of CAHIP, which continues to carry the work of TCIP with broader goals around reducing the main risk factors contributing to the development of chronic diseases – including tobacco use, nutrition, physical activity and stress–for ODHS|OHA employees, clients and consumers.

- **Common agenda**: support policies and protocols that promote worksite wellness, stress management, tobacco free living, improved nutrition and physical activity.
- **Shared measurement:** data on employee, client and consumer health outcomes to track progress.
- **Mutually reinforcing activities:** carried out by all steering committee members.
- **Continuous communication:** to build trust, assure mutual objectives and create a common motivation.
- **Backbone organization:** Oregon Public Health Division, Health Promotion Chronic Disease Prevention.

Objectives

ODHS|OHA Workforce

Nearly 12,000 staff, including employees, volunteers, trainees and interns, work for ODHS and OHA. These staff represent a diverse range of roles and as a workforce they are leading the way to model good health for the clients and consumers they serve. Some state staff are healthier than others. Research shows that workers with fewer resources experience negative health outcomes due to having a high workload, low perceived control

over their performance and minimal influence in leadership decisions.[8] One way that ODHS and OHA leadership can reduce employee stress is by transparently communicating organizational changes that affect the workforce. CAHIP recognizes that staff are healthier when they are meaningfully engaged and supported by their organization as well as when they have access to culturally and linguistically appropriate resources to support strengthening family relationships, gaining financial literacy skills and finding help buying a home.

Improving the health of all ODHS|OHA staff reflects good stewardship of public dollars by reducing employee health care costs and absenteeism; increasing employee retention and morale; and ensuring the delivery of high-quality services. The CAHIP steering committee will vet, champion, support and inform potential ODHS|OHA wellness policies to be considered by the Shared and Central Services Policy Committee and will provide support for the successful implementation of wellness initiatives impacting the health of ODHS|OHA staff.

Goals

- Reduce tobacco use prevalence among ODHS|OHA staff by five percent.
- Reduce obesity among ODHS|OHA staff.
- Increase ODHS|OHA employee participation in the Employee Assistance Program and self management programs that include but not limited to the Oregon Tobacco Quit Line; Living Well with Chronic Conditions; Tomando Control de Su Salud; Better Choices, Better Health; Walk with Ease; and the Diabetes Prevention Program.

ODHS|OHA Clients and Consumers

In 2013, ODHS and OHA served almost 1,400,000 people These Oregonians bear a disproportionate burden of chronic disease. This health inequity corresponds with many factors prevalent among those served by ODHS and OHA including lower incomes, lower educational attainment, communities of color, people with disabilities, and people with mental health or substance use conditions. CAHIP recognizes that by having sufficient food, stable housing, access to quality health care and educational opportunities to find jobs, ODHS|OHA clients and consumers stress, live tobacco free, have and be physically active. Due to the number of clients and consumers and the inequity of health outcomes, CAHIP is poised to have a large statewide impact.

Goals

- Reduce tobacco use among Oregon Health Plan members by ten percent.
- Reduce obesity among Oregon Health Plan members [2015 Medicaid BRFSS data].

Authority

The Cross Agency Health Improvement Project Steering Committee will develop joint workplans and advise ODHS and OHA on best practices. Agency organizational units are responsible for implementing their individual agency workplans and completing agreed upon objectives.

Membership, Roles & Responsibilities

Full CAHIP Steering Committee

Regular participants in the CAHIP steering committee include:

- ODHS Aging and People with Disabilities
- ODHS Child Welfare
- ODHS Human Resources
- ODHS Office of Equity and Multicultural Services ODHS|OHA HR - Shared Services
- ODHS Operations
- ODHS Self Sufficiency
- ODHS Vocational Rehabilitation

- OHA Communications
- OHA Medical Assistance Programs
- OHA Office of Equity and Inclusion
- OHA Health Systems Division/Office of Health Policy and Analytics
- OHA Operations
- OHA Oregon State Hospital
- OHA Public Health
- Public Employees Benefits Board/Oregon Educators Benefits Board
- Service Employees International Union

CAHIP Steering Committee members will:

- Ensure that the CAHIP workplan is culturally appropriate and addresses health inequities.
- Champion the development and implementation of the workplan.
- Vet and provide input on possible ODHS or OHA policies to be considered by the Shared and Central Services Policy Committee.
- Create workgroups in their organizational units to identify specific targets for policy and procedural change.
- Approve use of staff time and other the resources necessary for workgroup projects within their organizational units.
- Work with other steering committee members to develop an overall CAHIP workplan that is evidence-based and consistent with CAHIP goals.
- Be designated by the director or equivalent and given authority to speak on behalf of their organizational unit.
- Have access to their organizational unit's leadership to accurately represent their agency's point of view and to solve CAHIP workgroup issues within their unit.
- Have the authority within their organizational unit to commit the unit to CAHIP workplan activities.
- Actively collaborate with venues such as the OHA Transformation Center to identify opportunities for partnership and collaboration with CCOs around identifying interventions and maximizing impact.

CAHIP Workgroup

Regular participants in the CAHIP workgroup will include:

- ODHS Facilities
- ODHS Human Resources
- ODHS Operations
- OHA Central Operations
- OHA Health Systems Division
- OHA Oregon State Hospital
- OHA Public Health Division
- Public Employees Benefits Board

CAHIP Workgroup members will:

- Develop an overall CAHIP workplan that is evidence-based and consistent with CAHIP goals for Steering Committee approval.
- Identify priority policy areas.
- Develop policy proposals for Steering Committee approval.
- Develop policy communication and implementation plans for ODHS and OHA Leadership Teams.

Public Health Division

OHA Public Health Division will:

- Staff the Steering Committee.

- Provide support and assistance to each organizational unit and the Steering Committee about evidence-based interventions to address CAHIP goals.
- Provide updates to the Shared and Central Policy Committee twice each year or as requested.
- Collaborate with steering committee members to draft workplans.

Deliverables

Policy and procedural changes implemented within each OHAODHS organizational unit to:

- Reduce tobacco use and exposure to secondhand smoke among staff, clients and consumers.
- Improve nutrition and increase physical activity among staff, clients and consumers.

Relationship to Other Governance Groups

CAHIP staff and provide updates to the CAHIP Steering Committee Shared and Central Services Policy Committee twice each year or as requested.

Meeting Schedule and Meeting Support

The Cross Agency Health Improvement Project (CAHIP) Full Steering Committee (see current roster) will meet biannually. The CAHIP Work Group will meet four times per year.

Meeting materials are distributed via email before and between meetings and hard copies are available at each meeting. CAHIP staff provide the meeting support.

Charter Review & Modification

The CAHIP Charter will be reviewed and modified annually.

Signatures

Project Sponsor(s):
ODHS/OHA Shared and Central Services Policy Committee Chairs

Project Lead:
HPCDP Program Analyst, Trisha Brennan

Sponsoring Manager:
HPCDP State Policy, Systems & Environmental Change Manager, Luci Longoria, MPH

Approved: 07/10/2014
Revised: 12/28/2020

References

[1] Oregon Behavioral Risk Factor Surveillance System of State Employees, 2016
[2] 2012 Oregon Behavioral Risk Factor Surveillance System of State Employees, 2016
[3] Oregon Behavioral Risk Factor Surveillance System Race Oversample Dataset 2015-2017

[4] Oregon Office on Disability and Health. Major Behavior Risk Factors and Chronic Conditions Among Oregonians with Disabilities. Portland, OR: Oregon Health & Science University; 2019. Available from http://www.ohsu.edu/xd/research/centers-institutes/oregon-office-on-disability-and-health/data-statistics/

[5] Parks J. et al. Morbidity and Mortality in People with Serious Mental IllnessCdc-pdfExternal. National Association of State Mental Health Program Directors Medical Directors Council. Alexandria, VA; 2006.

[6] Oregon Behavioral Risk Factor Surveillance System, combined 2014-2017 dataset.

[7] Oregon Behavioral Risk Factor Surveillance System, 2017.

[8] Kuper H, Marmot M. Job strain, job demands, decision latitude, and risk of coronary heart disease within the Whitehall II study. J Epidemiol Community Health 2003;57:147–153.