Health Share of Oregon

Community Health Improvement Plan (CHP) Annual Progress Report: 2014-2015

June 22, 2015

Introduction

Over the past 2 years, Health Share of Oregon's Community Advisory Council's Community Health Needs Assessment & Community Health Improvement Plan Committee (CNHA/CHP Committee) has been committed to developing and implementing a community driven process to address physical and behavioral health disparities experienced by communities facing the greatest barriers to receiving the services and support they need to thrive. The committee, led by consumer and community members and supported by Health Share's staff and board, understands that the communities most affected by these disparities must be given the opportunity to identify what is of most concern for them and guides the process of improvement – with those outside of the communities taking a supporting role.

During the first year of implementation of the CHP, Culturally-Specific Traditional Health Workers developed and enhanced relationships within their communities to better connect individuals with culturally relevant supports and services. The CHNA/CHP Committee fully supports and understands the importance of the role of Traditional Health Workers in promoting and enhancing individual and community health and addressing physical and behavioral health disparities. Over the past year, the CHNA/CHP Committee has continued their work to ensure the needs of the community are heard and addressed through involvement with Healthy Columbia Willamette Collaborative's (HCWC) Community Engagement Workgroup, developing relationships with community partners, engaging community partners in the CHP process, reviewing progress of the year one activities, and identifying lessons learned for the development of additional supporting activities.

While there have been challenges during the first year of the CHP implementation, including balancing funding opportunities and time constraints with community identified/community driven needs and activities, the CHNA/CHP Committee has continued to identify ways to ensure the on-going evaluation of needs and activities addressing the physical and behavioral health disparities experienced by Health Share members and their communities.

I am truly inspired by the commitment and dedication of the communities served, the Traditional Health Workers and the organizations with which they work, the Council's CHNA/CHP Committee, and Health Share staff. This annual report demonstrates what's possible when we work together to transform communities. By working together we are creating opportunities to improve systems that truly support movement towards better health for everyone.

Thank you,

Sonja Ervin, CHNA/CHP Committee Chair & Community Advisory Council Member

Executive Summary

Health Share of Oregon's first Community Health Improvement Plan (CHP) was developed following the establishment of a Community Health Needs Assessment, and was formally approved by the Community Advisory Council (Council) on October 1, 2014. This report documents CHP Year 1 activities to demonstrate how Health Share satisfies our CCO contractual requirements while focusing on specific priorities established by our Council. It was written by Health Share staff and edited and approved by the Council's CHNA/CHP Committee.

The Oregon Health Authority provided a Guidance Document to support how every CCO may document its CHP progress. This report is outlined using OHA's recommended guidance. Health Share of Oregon's 2014-2015 Community Health Improvement Plan and Community Health Needs Assessment can be found on our website: http://www.healthshareoregon.org/transforming-health-together/community-health/community-health-needs-assessment.html.

The CHNA/CHP Committee felt that additional work beyond the Healthy Columbia Willamette Collaborative's HCWC was needed, particularly in the area of community engagement. Additional steps to include community voices were integrated into the Committee's plan for developing the CHP.

The Council and Staff prioritized these principles in the CHP process:

- ✓ **Seek input from communities impacted by disparities** about what investments would be most impactful, and matching them to the community's stage of change;
- ✓ **Align investments with transformation activities** underway at Health Share and through Health Share partners;
- ✓ **Measure improvements in health outcomes** for members as a result of investments.
- ✓ **Use the Community Readiness Model,** a process that included interviewing over 40 Health Share members and community stakeholders for input and identification of level of community readiness to address both priority health needs.
- ✓ **Utilize findings from community-led self-assessments** to identify needs and strategies in addition to our CHNA findings.

These principles influenced the focus of Health Share's Community Health Improvement Plan and the first year of activities. Moving forward, the CHNA/CHP Committee and Council will refer to and utilize OHA's Guidance Document as part of its prioritization process.

This report, following OHA Guidance, includes:

1. **2014-2016 CHP Priorities: Behavioral Health & Chronic Disease**
    - **CHP Year 1 Activities**
2. **Strategies for Developing & Strengthening Community Partnerships**
3. **Addressing Health Disparities & Collaboration with Office of Equity and Inclusion**
4. **Community Engagement and Transparency**
5. **What's new for the 2015-2016 CHP**

1. 2014-2016 CHP Priorities: Behavioral Health & Chronic Disease

In April 2014, the Community Advisory Council and Board of Directors approved Behavioral Health and Chronic Disease preventable through physical activity and nutrition as the two priority areas to address in our CHP. The Council and Health Share staff developed the CHP document and subsequent plans in the following months for implementing the CHP's first year activities utilizing one-time resources available through Health Share's Transformation Fund.

Key themes from our interviews with community stakeholders:

Stigma (cultural, family, individual) about behavioral health came up in many interviews.

> *"We … come from a community that has a lot of fear of stigma so people will keep in denial and only when...facing certain problems, that's when they'll be forced to ask for some kind of service, so mostly they do not understand."*

Culturally and linguistically appropriate mental health and addictions services are needed.

> *"There's not enough culturally specific counselors, and if you taught counselors who will be able to support community members and because again if you have a Somali person or a Latino person and the person who's supposed to be counseling is from the dominant culture and don't understand the historical cultural aspect of that individual it makes very very difficult for people to trust."*

Communities want access and support for healthy eating and better nutrition.

> *"What's not working is … just being able to access food, afford foods that they need to eat and just the difficulty of behavior changes and lack of education."*
> *"A lot of people think it's an inevitable thing for us. It's come to the point where people just accept the reality that as you grow older, you will get diabetes, you will get high blood pressure and that's not something that's preventable. It's something that our community has accepted as part of life which is very sad."*

Community stakeholders provided their perspectives toward culturally-specific Traditional Health Workers:

- Many people we interviewed demonstrated awareness of the concept of culturally-specific traditional health workers and indicated very high support.
- Many indicated they felt there were not enough culturally and linguistically specific community health workers available in their communities.
- They indicated there is not enough outreach to multilingual communities and advance notice of activities is not widespread or timely or in languages other than English.
- A recurring theme from the interviews was culturally-specific communities have specific needs the larger health system can't address on its own.
- Suggestions from people we interviewed included we should provide more culturally-specific and culturally responsive education. For example, provide cooking classes featuring recipes the community already cooks.

Based on these themes, the CHNA/CHP Committee and Health Share staff developed a strategy for Year 1 activities. A number of strategies could be developed to reach our goal of addressing health disparities among vulnerable populations impacted by behavioral health issues and chronic disease preventable through physical activity and nutrition. Following many discussions, Health Share developed the Year 1 CHP strategy to achieve our goal of addressing health disparities among vulnerable populations impacted by behavioral health issues and chronic disease preventable through physical activity and nutrition.

Strategy: Resource culturally-specific Community Health Workers and Peer Mentors using one-time Transformation Funds from OHA to achieve our goal of addressing health disparities within our two priority areas.

CHP Priority: Behavioral Health (Mental Health and Addictions)

Objectives

1. Increase the availability of culturally-specific Peer Support Workers to Health Share members who identify as people of color, who speak a preferred language other than English, who identify as LGBTQI, who have a disability or who are young or elderly, or who have been diagnosed with a severe persistent mental illness
2. CBOs train primary care provider teams on peer resources, and referral to Peer Support Workers
3. Culturally-Specific CBOs employ Peer Support Workers to provide education and outreach to communities and individuals about mental health and addictions generally, as well as specific programs and services available to Health Share Members
4. Culturally-Specific CBOs host community discussions about mental health and addictions issues, in order to engage community members in a preventive manner

CHP Priority: Chronic Diseases Preventable through Nutrition and Physical Activity

Objectives

1. Increase the availability of culturally-specific Community Health Workers to Health Share members who identify as people of color, who speak a preferred language other than English, who identify as LGBTQI, who have a disability or who are young
2. Culturally Specific Community Health Workers share information about and lead healthy eating and physical activity groups in their communities
3. CBOs train Community Health Workers on chronic disease outcomes and clinical services related to the CCO's Quality Improvement Plan
4. CBOs train providers on culturally and linguistically appropriate care and Chronic Disease prevention and management in the primary care setting, including how to integrate the use of Community Health Workers into their practice.

For the period of July – September 2014, we developed a Request for Proposals to invite Community-Based Organizations (CBOs) with culturally-specific programs to apply for funds to support Year 1 Activities of our CHP.

More than 30 CBOs submitted proposals, which were reviewed through a multi-step process including a review panel comprised of Community Advisory Council members and representatives from each County. This process resulted in new partnerships with 4 community-based organizations and coalitions. In September 2014, Health Share entered into formal partnerships with: Northwest Family Services, Center for Intercultural Organizing, North by Northeast Community Health Center, and Familias en Accion. These organizations worked in collaboration with additional organizations (for example, Northwest Family Services partnered closely with NAMI Clackamas County), and also met together monthly with Health Share staff to support collaboration and co-learning throughout the year.

With the primary strategy being to resource culturally-specific THWs, Health Share established the following eight objectives for our two CHP priorities. CBOs developed and implemented plans designed to achieve these activities during the period of September 1, 2014 to June 30, 2015. The following four pages describe their work using both quantitative and qualitative data to report their outcomes during the project period. While these projects will be completed in 2015, the impact of their activities and the establishment of relationships and programs continues.

Health Share is immensely grateful to the individuals we worked with at each of our four collaborative partnerships. Thank you to our lead organizations:

Behavioral Health Emphasis: Northwest Family Services

Clackamas & Multnomah Counties. Hispanic/Latino community focus. Northwest Family Services and the National Alliance on Mental Health Illness –Clackamas County collaboratively invested in programs designed to provide education and outreach in the Latino and LGBTQI communities through peer resources, peer support workers. They hosted culturally-specific discussions on mental health and addiction issues with culturally-specific and competent staff.

Metric	Target	Progress toward Target
# of patients assigned to/served by Peer Support Specialists	80	**On track to meet target:** 67patients served by Peer Support Specialist
# of Peer Support Specialists trained and certified	20	**Close to target**: 17 trained and certified as of March 2015
# of trainings held and number of participants at each event	Various targets depending on training topic	**Exceeding target:** Train the trainer 1 class. 7 participants Mental Health PSS training 1 class. 10 participants Mental health First Aid-Spanish 2 classes. 38 participants Compartiendo Esperanza workshops- 4 Familia a Familia-1 class. 23 Families
# of community presentations delivered	18	**Exceeding target:** 29 presentations delivered as of March 2015

NWFS Participant Story: *"Working to feed and keep a roof over my children was my drive. I have always wanted the best for my family and provided the way that I could. The day to day routine, the children fighting, the bills, the calls from their school, life, got to be too much and I was overwhelmed by hopelessness. I never saw myself in this situation, this was not the life I thought I would be living. My husband was now out of the picture and all the children had was me, but who did I have? I had tried to seek help but I always left feeling worse, not understanding the language, feeling that I was at fault for my situation.*

I was referred to Northwest Family Services, and really did not know much about the program. What I did know is that the lady that called me spoke Spanish like me….it was her native language. She agreed to meet me at my home, and she listened. She listened to me talk and cry for more than two hours in our first meeting. I felt heard. She asked me when I had last had a physical, and I told her I could not remember but that I needed to schedule one. She asked me if she could help me schedule it, and in less than ten minutes I had an appointment where she agreed to accompany me. I cannot express in words the support that I felt from a complete stranger. I have had more than ten "appointments" with her and I have shared with her my greatest fears, the anger I have been harboring, and this feeling of impotence. Although I thought I was protecting my children from my inner turmoil, I did not realize the impact it had also had on them. I am currently continuing to see a mental health therapist who speaks Spanish, and my children are all receiving support from an amazing therapist that I can communicate with. My family is everything to me, and I am thankful for the light that Northwest Family Services has provided for me. I notice changes in myself, but more importantly in my children. I can now hug my oldest child."

Behavioral Health Emphasis: Center for Intercultural Organizing

Washington County. Community focus includes Asian/Pacific Islander, Latino, and people from war torn regions of Africa & Middle East. The Margins to Mainstream project is a collaboration centering around developing and employing a trained base of immigrant and refugee "wellness life guides," or traditional health workers/organizers—assisted and supported by a team of social service agencies, community based organizations, and health care providers—that aid newcomers in acquiring the facilitative and communicative skills necessary to interact, understand, and cope with their needs in relation to their adopted environment, and work collaboratively toward institutional change.

Metric	Target	Progress toward Target
# of Wellness Life Guides	16	**Exceeding target:** 20 trained and 4 receive a stipend to lead cohorts.
# of Health Share members participating in intercultural group process work	20	**Exceeding target:** 80 participants involved in the intercultural group process work (Note: not all are necessarily Health Share members)
# of group process workshops offered	6	**On track to meet target:** 4 ongoing cohorts as of March 2015, with two more planned
# of community specific events held on mental health and addictions issues and number of participants attending	6	**On track to meet target:** 4 events held as of March 2015, with two more planned

CIO's Story: *Our Iraqi Life Guide Muwafaq Alkattan (pictured left) has gone beyond the expectations of our life guides and has set new standards. He has not only changed his cohort sessions to bi-weekly to meet the needs of the group but has also started case management with cohort participants to support their skill building of systems navigation into US society. The Life Guide has also referred four participants for individual therapy sessions with our consultant Anya Valsamakis, MSW. Our Somali Community Wellness Cohort Leader Kaltun Caynan (pictured right), had an extremely successful first cohort session, where over 20 community members attended. The initial meeting was so successful, the participants requested the meetings be held twice a month, not once. It has exposed the needs of the community, and the gaps the Somali refugee community is currently going through.*

Chronic Disease Emphasis: North by Northeast Community Health Center

Multnomah County. Focus on and African-American communities. The project supports ongoing inclusion of Community Health Workers (CHWs) in efforts to improve the health of African-American patients and eliminate health disparities. CHW helps patients identify barriers to health improvement, set goals, understand medication regimens and adhere to follow-up plans.

Metric	Target	Progress toward Target
# of patients assigned to Community Health Worker	20	**Exceed target:** Decision made as of January, 2015 to include all hypertensive patients on CHW panel; 114 patients assigned, with 145 patient encounters as of March 2015
# of "Clinical Topics for CHWs" trainings held and # of attendees	2 trainings; 24 participants	**Exceed target:** 1training offered to 25 participants as of March 2015. New class beginning in May with 10 participants registered.
# of barber shops participating in "Cuts and Checks" program	4	**On track to meet:** Decision made to have 4 barbershops participating. 3 barbershops currently participating. Additional shop will be participating by end of grant
# of referral relationships established with community organizations	3	**On track to meet target:** 2 referral partnerships as of March 2015
# of health education classes held and number of participants	3+ on Hypertension Diabetes	**On track to meet target:** Monthly hypertension, diabetes and pre-diabetes classes scheduled with 8-12 participants per class.

NxNE's Story: *We first met John (name has been changed) in 2010 when he needed the blood pressure medications he'd run out of when he lost his health insurance. Over the past four years, John's blood pressure has been up and down, and he hasn't always been able to get to his appointments.*

We knew we could do better for him and enlisted the help of Sharetta Butcher, our Community Health Worker. Sharetta stayed in close touch with John and arranged for him to get free bus tickets so he could get to his medical visits more easily.

Things really hit close to home when one of John's co-workers had a heart attack while at work. John asked Sharetta if she could pay them a visit at his job to check everyone's blood pressure and talk about staying healthy. Last month she did just that. John said he feels proud to be helping his coworkers and is making his own health a higher priority.

Chronic Disease Emphasis: Familias en Acción

Clackamas, Washington & Multnomah Counties. Hispanic/Latino. Project goals are to provide a culturally-specific Community Health Worker program, Senderos Hacía su Salud/Pathways to Your Health, for Hispanic members of Health Share by partnering with several clinics.

Metric	Target	Progress toward Target
# of patients referred to the program and number of patients enrolled	120 referred; 90 enrolled	**On track to meet target:** 113 referred and 68 enrolled as of March 2015
# of trainings provided and number of participants at each event (broken down by multiple training topics and types)	Various targets depending on training topic	**On track to meet target:** • 2 Walk With Ease Trainings – 26 participants • 4 Empoderate Trainings – 78 participants • 3 Cultural Competency Trainings - 86 participants • 2 Online Cultural Competency Trainings – 58 participants • 1 Monthly Support group - 56 participants • 1 Children's food class – 25 participants • 7 CHW classes & presentations • 1 Seed to Supper Event - 6 participants
# of participants who complete Tomando Control de su Salud course	30	**On track to meet target:** Three classes were offered, one each in Multnomah, Clackamas and Washington counties.

Familias en Accion's Story: *We recently had a married couple stop by our office asking for assistance in using their new Health Share insurance. They are currently receiving services at Providence; one has hypertension and the other diabetes. In the past, the couple had insurance through work. But they recently lost their jobs and they were accepted into OHP/Health Share. They have been going to their doctor appointments, they exercise, eat healthy and follow the providers instructions. But their key barrier was not understanding how to use their new health insurance.*

The couple had been struggling to pay for their own medications, glucometer, lancets and test strips. The couple and the community health worker called Health Share and Providence and identified their benefits, which covered the cost of the medications, glucometer, lancets and test strips. The clients are now aware of the preferred pharmacy and have also learned that transportation is available. They did not know that they could receive dental services and Familias is working on scheduling the first dental appointment. The couple has been very excited to learn about all of the services available to them through Health Share.

2. Strategies for Developing & Strengthening Community Partnerships

Beyond the two CHP priorities, Health Share staff and Council continue to develop and implement strategies for strengthening community partnerships. We document below areas of collaboration and work that are not technically among our CHP priority areas, but are part of community health improvement activities nonetheless.

Early Learning Councils

Health Share has been and continues to actively partner with all three Early Learning Councils in the tri-county region. Each Early Learning Council is separate and unique and requires that our relationship and involvement be catered to their needs. Our work with Early Learning Washington County (the name of their Early Learning Council) is quite robust and includes the Chief Equity & Engagement Officer serving on their Steering Committee as well as Health Share's Maternal Child Family Program Manager serving on various workgroups where she brings her content expertise. This group is actively working on developing a strategic plan to achieve their three early learning goals of: 1) children are ready for Kindergarten and reading at grade level by 3rd grade; 2) families are healthy, stable & attached; and 3) services are coordinated, efficient & effective, and Health Share is an active participate in the strategic planning process including attending the Early Learning Washington County Steering Committee retreat in January 2015.

Our work with Early Learning Multnomah County (Multnomah County's Early Learning Council) includes the Chief Equity & Engagement Officer participating on their Investors Council committee. This committee is the steering committee for the council and is currently working on solidifying their Hub goals, reviewing and modifying metrics related to this work, and focusing on systems development, alignment, and coordination. Part of this work includes ensuring we have the right systems at the right table and we fully understand the resources available for Early Learning in Multnomah County. Towards this end, the ELM has been working on conducting a resource inventory of currently engaged partners.

Our work with Clackamas County Early Learning Council includes the Chief Equity & Engagement Officer serving on the Advisory Committee for the Clackamas Early Learning Hub (ACCEL) with the charge of ensuring achievement of their three hub goals of: 1) increase Kindergarten readiness; 2) increase family stability, and 3) increase system coordination and efficacy. Health Share staff attend ACCEL meetings on a regular basis and just participated in their Early Learning Council celebration and year one action planning retreat in April 2015.

Part of this work includes encouraging a collaborative approach to the tri-county ELCs work in partnership with the two CCOs in the region (Health Share of Oregon and FamilyCare). We have been advocating for convening all the key players to come to the same table to develop a coordinated approach to ASQs and have received buy-in for this effort from all the partners and are just waiting for someone from the State Early Learning Division to pull this meeting together (at the request of the ELCs). We look forward to the synergy and potential success this focused effort will have.

Finally, Health Share anticipates even further collaboration and coordination between Health Share and all three Early Learning Councils as one of our strategic initiatives moving forward aligns well with the goals of Early Learning Councils and helps Health Share work upstream in our population with the ultimate goal of improving the health of our members.

School-Based Health Providers

Health Share recognizes the vital role that School Based Health Centers (SBHCs) fulfill in ensuring the health of our youth. SBHCs serve as centers for excellence in adolescent health and have the trust and relationships with this population allowing them to provide high quality and culturally responsive care in settings where youth are, thereby reducing barriers to access and limiting school absence. Additionally, SBHCs provide additional resources and support through on-site care coordination for young people in school settings.

Health Share has worked with SBHCs in the following ways in 2014 – 2015:

- Health Share's Chief Equity & Engagement Officer is a member of the Washington County School Based Health Center steering committee. This group meets on a regular basis to coordinate and oversee SBHC services in Washington County.
- Health Share is an active participant in workgroup convened by Multnomah County to develop an Alternative Payment Model for SBHCs. This workgroup includes key players from SBHCs from the tri-county region, people from the Oregon School Based Health Center office, Oregon School Based Health Center Alliance, and both CCOs.

Local Public Health Authority

Health Share works closely with Multnomah, Clackamas, and Washington county public health authorities and has a written Agreement signed by both Health Share and public health leadership, which recites specific terms for ongoing collaboration and coordination.

In 2014-2015 Health Share worked with our LPHA in the following areas:

- There is LPHA representation on Health Share's Community Advisory Council and our Community Health Needs Assessment/Community Health Improvement Plan Committee.
- Health Share staff participates in Washington County Public Health Division's Community Health Improvement Plan's three committees: Suicide Prevention Council, Access to Care Committee, and Chronic Disease Prevention Committee.
- Health Share partners with our LPHA through formal ongoing involvement in the Healthy Columbia Willamette Collaborative, a four-county regional collaborative effort to conduct a Community Health Needs Assessment. This collaborative involves public health departments, hospital systems, and CCOs within the Clackamas, Clark, Multnomah, and Washington County region.
- Health Share's Chief Equity & Engagement Officer serves on Clackamas County's Public Health Advisory Committee
- Health Share partners with Clackamas County on the OHA grant funded opportunity: Building Sustainable Relationships for Community Health. This collaborative effort is focused on creating sustainable systems and relationships to enhance Chronic Disease Self Management course on pre diabetes, diabetes, and hypertension.
- Health Share and our LPHA partners convene quarterly to discuss ongoing partnership and areas of collaboration opportunities.

Hospital Systems

Al six hospital systems in Health Share's service area serve as founding Member Organizations and serve on our Board of Directors. We also work with our region's hospital systems through formal ongoing involvement in the Healthy Columbia Willamette Collaborative, a four-county regional collaborative effort to conduct a Community Health Needs Assessment. This collaborative involves public health

departments, hospital systems, and CCOs within the Clackamas, Clark, Multnomah, and Washington County region.

Housing & Homelessness

Health Share of Oregon has been a member of the Home For Everyone (HFE) Coordinating Board since the fall of 2014. The HFE Coordinating Board was chartered by the Portland/Gresham/Multnomah County Continuum of Care as a product of the 2013 plan, *A Home for Everyone: A United Community Plan to End Homelessness in Multnomah County.* The goal of this group is to develop and recommend key strategies to end homelessness in Multnomah County. The HFE Coordinating Board brings together key leaders from various sectors including health and workforce development to address homelessness.

3. Addressing Health Disparities & Collaboration with OEI

Developing a framework for collecting, stratifying, and analyzing data

Addressing and eliminating health and healthcare disparities is essential to improving the quality of care for all our members, and is a foundational strategy for Health Share. Health Share determined to improve its approach identifying health disparities by establishing a Disparity Data Analysis & Reporting Team part of implementing an evidence-based framework for stratifying and analyzing member race, ethnicity, and language (REaL data), as well as other important data elements about our member population to effectively and competently identify health disparities.

This team has drafted and tested a multiple step procedure for analyzing and interpreting data, which includes engaging impacted communities in sharing and making meaning of the data to be culturally responsive in our reporting methods and to more effectively collaborate with community members experiencing disparities. Health Share is using this new procedure to update the Health Share member data included in the 2014 CHNA and CHP. It involves taking six steps:

1. Identify and state data need. (Example: What is the prevalence of diabetes among Health Share members stratified race/ethnicity and preferred language?)
2. Identify the population and dataset.
3. Perform an accuracy check by checking data with others and comparing with external data, if possible.
4. Interpret the data by writing a draft statement describing what the data shows.
5. Collaborate to make meaning of the data by identifying appropriate communities, such as the Community Advisory Council, Cultural Competence & Health Equity Workgroup, Community-based organizations or other external stakeholder groups we work with.
6. Prepare how the data will be shared using a strengths-based approach and acknowledging feedback or consultation with impacted communities.

Collaboration with OEI

Health Share is immensely grateful for the ability to collaborate with multiple staff working at the Office of Equity and Inclusion on health equity issues. We would not be where we are in equity work without our partnership with OEI. We collaborate with OEI in too many ways to count, but examples include:

- OEI staff Policy Analyst Emily Wang is a member of our Cultural Competence & Health Equity Workgroup, which is focused on working on systems-wide improvements related to implementing the CLAS (Culturally and Linguistically Appropriate Services) Standards newly revised by HHS in 2012 among our Health Plan Affiliates.
- Health Share staff participate on OEI's Health Equity Policy Committee, OEI's Health Care Interpreter Learning Collaborative, and on OEI's Cultural Competence Continuing Education Curriculum Approval Committee.
- OEI's Health Equity Program Manager Carol Cheney and Training Coordinator Charniece Tisdale provided Health Share with an All Staff Training on Health Equity and Social Determinants of Health in 2015.
- Three Health Share staff are graduates of OEI's Developing Equity Leadership through Training & Action (DELTA) Program.
- OEI staff has asked Health Share to attend meetings periodically to collaborate on several opportunities and issue areas related to addressing health disparities and promoting health equity.

4. Community Engagement and Transparency

Health Share satisfies the requirements outlined in ORS 414.627 by holding open meetings of our Council, which are publicized on our website and include public comment time. Our Council promotes public comment through community forums (entitled "Conversations with Health Share) held in each county. Council business, including agendas and minutes, are available on our website. Board minutes are available to the public upon request.

Community Advisory Council Involvement and Role in CHNA/CHP

The CHNA/CHP Committee contributed well over 500 hours to develop our CHNA and CHP Year 1. This group and the Council as a whole impacted and improved Health Share's process, especially with regard to how we engaged with communities impacted by disparities (see below).

How we engaged with communities impacted by disparities

The Council and the CHNA/CHP Committee impacted and improved Health Share's CHP development, especially with regard to how we engaged with communities impacted by disparities. Initially we interviewed 20 community stakeholders and Health Share members under a short timeline. The Council reviewed the input we gathered and requested Health Share take more time to engage with more consumers impacted by disparities. As a result we interviewed 20 more people, with more representation of communities from Clackamas & Washington Counties, more Health Share members, and more people identifying as LGBTQI, living with disabilities, immigrants and refugees.

5. Moving Forward: What's next for Year 2 of our CHP?

The CHNA/CHP Committee reconvened in early 2015 to begin reviewing progress and developing a plan for Year 2 - 2015-2016. The group revised its Charter and recruited new members, and reflected on the successes of the first year process and identified areas for improvement moving forward. Beginning in May 2015, the CHNA/CHP Committee began to review and provide feedback on updated data about Health Share Members about their chronic health conditions. The desired outcome of these activities are to begin to implement a process for analyzing data to identify disparities in health status that is culturally responsive and engages impacted community members as part of the process of understanding the data and developing strategies to address them.

The Committee recognizes a holistic, integrated approach is necessary to address health disparities and that physical health and behavioral health needs are not separate issues for individuals, so they should not be separated in strategies that are meant to coordinate care among our population. The committee is discussing the role of social determinants of health, such as housing and food security. Additionally, since our CBO partner activities did not include an emphasis on addictions and substance use disorders, Year 2 activities will likely involve an increased focus on this area of behavioral health. Health Share staff and Council members will be closely involved with our regional CHNA partnership, the Healthy Columbia Willamette Collaborative, during 2015-2016.

Please visit our website for updated information on our Community Health Needs Assessment and Community Health Improvement Plan.