

Appendix A: HCWC Leadership Group and Workgroups

This report was prepared by Comagine Health (formerly HealthInsight) convener staff: Meghan Haggard, Maria Danna, Jennifer Hendrickson and Karen Drill. Special thanks to the Data Workgroup participants Eva Hawes, Erin Jolly, Kathleen Lovgren, Chris Goodwin, Kristine Rabii, Maria Tafolla, Marilou Carrera, Anna Menon, Katherine Galian, Diana Netter, Jesse Gelwicks, and Dr. Frank Franklin, who volunteered to provide feedback on initial drafts.

Acknowledgements

Each organization and individual listed below provided important contributions to this HCWC 2019 Community Health Needs Assessment. Their efforts, expertise and commitment to communities they serve made this report possible.

Community Partners

Town Hall Organization Participants

ASAC	Oregon AIDS Education & Training Center
City of Lake Oswego	Oregon Community Health Workers Association
Clackamas Behavioral Health Division	Oregon Dairy and Nutrition Council
Clackamas County Aging Services Advisory Council	Oregon Food Bank
Clackamas County Community Action Board	Oregon Health Equity Alliance
Clackamas County Disaster Management	Oregon Office on Disability and Health
Clackamas County Public Health Division	Oregon Oral Health Coalition
Clackamas County Social Services	Planned Parenthood
Clackamas Workforce	Project Access NOW
Clark County Community Services	Providence ElderPlace
Clark County Public Health	Providence Health and Services
Coalition of Community Health Clinics	Quest Center for Integrative Health
Kaiser Permanente	Society of St. Vincent de Paul
Legacy Health	Vibrant Future Coalition/NW Family Services
Micronesian Islander Community	YMCA of Columbia Willamette
NAYA Family Center	
Northwest Family Services	

Community Listening Session Hosts

Adelante Mujeres

AntFarm

Cascade AIDS Project – Aging Well

Central City Concern

Community Partnership for Affordable
Housing

Estacada Community Center

Faith Organization in Multnomah County

Friendly House

Individual Facilitators, Arabic Community

Individual Facilitator, Farmworkers

Iraqi Society of Oregon

Latino Network

Momentum Alliance

NAMI, Clackamas County

Outside In

Pacific Islander Coalition

SW WA Accountable Community of Health

Veterans of Foreign Wars

Workgroups

The collaborative worked together in a variety of areas on this project. HCWC has deep appreciation for all member organization staff who volunteered their time and expertise to help tell part of the community story. Listed below are the workgroups that were part of the collaborative.

Communications Workgroup

- Chris Goodwin, Clark County Public Health
- Gianoux Knox, Oregon Health & Science University (OHSU)
- Philip Mason, Clackamas County Health, Housing and Human Services
- Rachel Burdon, Kaiser Permanente
- Brian Willoughby, Legacy Health
- Gerald Ewing, Tuality Healthcare
- Rebecca Naga, Health Share of Oregon

Stakeholder Engagement Workgroup

- Ed Hoover, Adventist Health Portland
- Susan Berns-Norman, Clackamas County Health, Housing and Human Services
- Kirsten Ingersoll, Clackamas County Health, Housing and Human Services
- Erin Jolly, Washington County Public Health
- Michael Anderson-Nathe, Health Share of Oregon
- Mariotta Gary-Smith, Health Share of Oregon
- Daesha Ramachandran, Health Share of Oregon
- Kristen Brown, Providence Health and Services
- Maria Tafolla, Health Share of Oregon (and also a member, formerly of FamilyCare)
- Kamar Haji-Mohamed, Family Care (prior to closing)

Data Workgroup

- Anna Menon, Clackamas County Health, Housing and Human Services
- Ayni Amir, IRCO
- Celia Higuera, Oregon Community Health Workers Association (ORCHWA)
- Chris Goodwin, Clark County Public Health
- Claire Smith, Multnomah County Health Department

- Diana Netter, Legacy Health
- Erin Jolly, Washington County Public Health
- Eva Hawes, Washington County Public Health
- Dr. Frank Franklin, Multnomah County Health Department
- Gianou Knox, OHSU
- Jesse Gelwicks, Kaiser Permanente
- Joseph Ichter, Providence Health and Services
- Katherine Galian, Clark County Public Health
- Kathleen Lovgren, Clark County Public Health
- Kristine Rabii, Tuality Healthcare
- Maria Tafolla, Health Share of Oregon
- Marilou Carrera, Oregon Health Equity Alliance
- Mary Rita Hurley, Our House of Portland
- Peter Morgan, Adventist Health Portland

HCWC Leadership Group Members 2018–2019

- Daesha Ramachandran, Health Share of Oregon
- David Hudson, Clark County Public Health
- Dawn Emerick, Clackamas County Health, Housing and Human Services
- Dr. Jennifer Mensik, Oregon Health and Science University
- Ed Hoover, Adventist Health Portland
- Dr. Frank Franklin, Multnomah County Health Department
- Gianou Knox, Oregon Health & Science University
- Jessica Guernsey, Multnomah County Health Department
- Jewell Sutton, Tuality Healthcare
- Joe Ichter, Providence Health and Services
- Kamesha Robinson, Legacy Health
- Kim Leathley, Tuality Healthcare
- Lauren Foote-Christensen, Legacy Health
- Maria Tafolla, Health Share of Oregon
- Meghan McCarthy, PeaceHealth SW Medical Center
- Michael Anderson-Nathe, Health Share of Oregon
- Molly Haynes, Kaiser Permanente
- Pamela Mariea-Nason, Providence Health and Services
- Pei-Ru Wang, Multnomah County Health Department
- Peter Morgan, Adventist Health Portland
- Phytusin Myint, Washington County Public Health
- Rujuta Goankar, Kaiser Permanente
- Tricia Mortell, Washington County Public Health

Descriptions of Leadership Group and Workgroups

Leadership Group

The Leadership Group is the steering committee and main decision-making body for the HCWC. It has final say on budget decisions and other issues that affect work scope and deliverables. The Leadership Group is comprised of one to two members from each organization that are either direct decision-makers for their organization, or who have a direct report line to those in the organization with that authority. They come to the table to oversee the process, vet new opportunities, solve problems, and ensure the process meets the needs of the collaborative while keeping its focus on the community.

Subgroups are formed to participate in more hands-on portions of the community health needs assessment creation and work.

Data Workgroup

The Data Workgroup is in charge of telling the data story. It was decided early on that the qualitative and quantitative data would be done concurrently to ensure the goal of raising community voice was achieved.

This group developed data frameworks, made decisions regarding scope and worked with all other groups to ensure an equity lens was rigorously applied to the process. Members also participated in developing Town Hall and Listening Session frameworks and processes.

Communications Workgroup

This group was started at the beginning of cycle three to develop communications for suggested use regarding cycle two's 2016 report. The group's charge was to focus on key messaging and develop preliminary presentations and talking points for circling back to the community. Additionally, they developed summaries of information from the 2016 report for suggested use for internal and external stakeholders (key points).

Late in the cycle, this group merged with the Stakeholder Engagement Workgroup since these two workgroups no longer needed to be separate once the Cycle Two circle back was completed.

Now merged with the Stakeholder Engagement Workgroup, this group focused on developing outreach and presentation materials that may be needed/requested by the community when the Cycle Three report is completed.

Stakeholder Engagement Workgroup

This Workgroup's main charge is to circle back with the community member organizations and community members touched in the previous cycle to ensure they were aware the report was published, address any questions, and make presentations to groups who were interested in knowing more.

Significant time, outreach, and effort were involved. This group also took the initial PowerPoint framework created by the Communications Workgroup and added to it based on experience and feedback. Scripting was added, and workgroup members often presented to CBOs and/or supported other presenters. See merged charter beginning on following page.

Table A-1. Data Workgroup Plan for Operationalizing Equity.

CHNA Development Phases	Because we recognize...	We will strive to...	By...
<p>Governance & Decision Making</p>	<ul style="list-style-type: none"> • That decision-making power is not always explicitly articulated • We must operate in an open and transparent manner to safeguard and deepen the trust of all stakeholders in the system, as well as to foster accountability 	<ul style="list-style-type: none"> • List organizations with decision-making power • Name constraints/limitations of decision-making power • Ensure every community member who participates in work groups has the same decision-making power as other workgroup members 	<ul style="list-style-type: none"> • Defining terms (i.e., power) frequently and how they influence the group
<p>Community & Stakeholder Engagement</p>	<ul style="list-style-type: none"> • That historical abuses and mistrust of health care and research institutions influence how people may participate (or not) in the HCWC • Community members are often asked to volunteer their wisdom and lived experience and that this information is not an accessory but central to a community needs assessment • Community and individual participation is critical to eliminating health disparities, and that active participation may necessitate going beyond invitation and encouragement 	<ul style="list-style-type: none"> • Design intentional strategies to engage communities and demonstrate the integrity and transparency embedded in our core values. • Compensate community members for their participation on the work groups • Actively review potential barriers to participation, assess low turnout events • Discuss experiences of inclusion in engagement process with community leaders 	<ul style="list-style-type: none"> • Inviting more community members to the Data Workgroup at every step • Compensating community members for their input • Considering meeting time and attendance • Investigating why current community members are not attending Data Workgroup meetings

<p>Methods development</p>	<ul style="list-style-type: none"> • Continuous data collection, including stratification by racial and ethnic subgroups, and other disparity variables is one way to monitor disparities and to adapt strategies to address them. 	<ul style="list-style-type: none"> • Articulate clear and transparent methods that are designed to enable iterative, rapid adaptation, and incremental evolution to meet current and future needs of stakeholders. • Routinely and systematically integrate demographic and social factors into all analytics and decision-making processes 	<ul style="list-style-type: none"> • Developing methods that focus on strengths, not just needs. • Identifying and acknowledging limitations of methods. • Being clear about describing methods and how they were chosen.
<p>Data collection</p>	<ul style="list-style-type: none"> • That historically underrepresented communities experience interview fatigue. • Dominant culture institutions often possess or have access to considerable information about historically underrepresented/ oppressed communities 	<ul style="list-style-type: none"> • Seek to answer questions about the community from information that has already been shared in existing community reports. • Refrain from pulling data for the sake of it – we will have clear answers to the who, what, why. 	<ul style="list-style-type: none"> • Identifying priority populations • Holding mutually beneficial Listening Sessions, e.g., providing opportunities for community organizations to learn about accessing funding. • Improving outreach and participation for a broader perspective and reach. • Using existing data (i.e., leading w/race). • Determining an inclusive data collection process.

<p>Data analysis</p>	<ul style="list-style-type: none"> • That dominant culture organizations prioritize numerical data. 	<ul style="list-style-type: none"> • Integrate narrative and qualitative information and use it to inform quantitative data analysis 	<ul style="list-style-type: none"> • Making data actionable and accessible • Mapping SDOH to Health Outcomes (including racism)
<p>Development of final product</p>	<ul style="list-style-type: none"> • All should benefit from the public good derived from the HCWC and that the HCWC Needs Assessment has not historically been designed to be useful for community members • Community engagement plays an essential role in operationalizing value • Accessibility cannot be determined by those providing access, but must be measured by those attempting to access. • The narratives we choose to create, share and perpetuate are products of power • Narratives of underrepresented communities often emphasize a deficit narrative 	<ul style="list-style-type: none"> • Ensure accessibility will be executed in different ways to reach different audiences, understanding that diverse communities have different needs. • Contains information that is useful to multiple community stakeholders • Create a report that is easy to navigate and share • Create an online portal to selectively view information that is most important to the reader • Accessible in multiple languages and formats • Ensure community members participate in the development of the needs assessment narrative • Use language intentionally, focusing on an asset-based narrative 	<ul style="list-style-type: none"> • Determining how to integrate SDOH, quantitative, and qualitative data together. • Identifying the audience and purpose of the report • Determining what an asset-based narrative look likes.

<p>Dissemination</p>	<ul style="list-style-type: none"> • That sometimes institutions fail to return to communities and share the final outcome of projects 	<ul style="list-style-type: none"> • Present information from the report in person to groups in the community 	<ul style="list-style-type: none"> • Exploring report dissemination avenues • Sharing data back with the community • Developing a presentation template (video, etc.)
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Project Charter: HCWC Data Workgroup

OVERVIEW

Project title: Data Workgroup

Project: HCWC Member Institutions

Lead: Meghan Haggard (with support from workgroup members as appropriate)

Staff support: Maria Danna, Jennifer Hendrickson, Karen Drill and Zoe Larson

Kickoff date: March 21, 2017

DESCRIPTION

Project Aim and Goals:

- Develop a product timeline for 2019 Community Health Needs Assessment (CHNA) by September 30, 2017.
- Use a mixed methods data collection approach to gather and analyze information for the 2019 CHNA.
- Embed resonance checks with the community through qualitative data collection methodology.
- Collect and analyze data for the 2019 CHNA by February 2019.
- Collaborate with the Stakeholder Engagement Workgroup to build relationships with community-based partners through the 2019 CHNA. Combine group meetings as appropriate.
- Provide quarterly updates to the Leadership Group on progress.

Description:

The Data Workgroup is responsible for:

- Collecting, and informing the analysis of data for the 2019 CHNA cycle
- Ensuring processes and values align with the HCWC vision and mission, including the identification and analysis of Social Determinants of Health affecting community health outside of healthcare
- Leading the aggregation of information
- Identification of themes within the data
- Identification of priority health issues
- Development of a report outline

The Data Workgroup will consist of subject matter experts in qualitative, quantitative, and/or mixed methods data collection and analysis. The Data Workgroup will identify project team focus areas as needed throughout the process. Community members will be actively engaged in the process.

HealthInsight/Q Corp is responsible for report writing and editing.

The Data Workgroup will meet twice monthly for two hours per meeting, project teams will meet more frequently as needed.

*BOUNDARIES*Includes:

- CCOs, Hospitals, and Public Health have differing needs that should be reasonably addressed.
- Reasonable data collection from each HCWC partner to produce the 2019 CHNA.
- Coordination with other HCWC workgroups to complete the stated goals and objectives of the collaborative in creating the 2019 CHNA.

Excludes:

- This is a collaborative CHNA and will not meet all individual stakeholder needs.
- The process cannot address the needs of each organizational CHIP.

MAJOR TASK SCHEDULE

Note: Final project timeline will be collaboratively developed once workgroup has active project stakeholder participation. Dates listed are intended for discussion and revision.

Table A-2. Original Schedule for Major Tasks.

TASK	START	END
Update framework to be used for the data collection process	May 2017	June 2017
Complete a data gap analysis	June 2017	August 2017
Update or develop data collection protocols	July 2017	October 2017
Identify priority populations/areas for data collection	September 2017	October 2017
Collect and analyze data	November 2017	December 2018
Develop report framework	October 2018	December 2018
Review report drafts and provide feedback	January 2019	April 2019

PROJECT TEAM

Table A-3. HCWC Project Team.

FUNCTION	REPRESENTATIVE	ORGANIZATION
Project Facilitator/Lead	Meghan Haggard	HealthInsight/Q Corp
Project Staff	Maria Danna	HealthInsight/Q Corp
Project Staff	Jennifer Hendrickson	HealthInsight/Q Corp
Project Staff – Intern	Zoe Larson	HealthInsight/Q Corp
Project Analyst	Karen Drill	HealthInsight/Q Corp Consultant
	Anna Menon	Clackamas County Public Health
	Celia Higuera	Oregon Community Health Workers Association
	Chris Goodwin	Clark County Public Health
	Claire Smith	Multnomah County Public Health
	Dianna Netter	Legacy
	Dr. Daesha Ramachandran	Health Share
	Erin Jolly	Washington County Public Health
	Eva Hawes	Washington County Public Health
	Dr. Frank Franklin	Multnomah County Public Health
	Gianou Knox	Oregon Health & Science University
	Jesse Gelwicks	Kaiser Permanente
	Joseph Ichter	Providence Health & Services
	Katherine Galian	Community Action
	Kathleen Lovgren	Clark County Public Health

	Marilou Carrera	Oregon Health Equity Alliance
	Mary Rita Hurley	Our House of Portland
	Peter Morgan	Adventist Health

Project Charter: HCWC Communications/Stakeholder Engagement Workgroup

OVERVIEW

Project title: Communications and Stakeholder Engagement Workgroup

Project sponsor: HCWC member institutions

Co-chair(s): Ed Hoover, Chris Goodwin

Staff support: Maria Danna and Jennifer Hendrickson, HealthInsight

Kickoff date: July 16, 12:30-1:00 p.m.

DESCRIPTION

Project Aims and Goals

- To begin, in Cycle 3, so prepare for the other goals and aims listed once the report is released
- To organize key communication points for internal and external partners regarding the HCWC CHNA to our Collaborative members. Those members will take that information to their individual organizations to get approval and use as determined by their processes [Communications/Marketing/Legal/Other departments] (as done in Cycle 2)
- To develop any communications needed for further community engagement and/or follow up post Town Halls and Listening Sessions
- To build and strengthen community relationships and connections through collecting, organizing and packaging information
- To build systems and structures for sharing 2019 CHNA information with the community
- To develop a system to organize, track, disseminate, and collect information from 2016 and 2019 cycles
- To learn from this process and determine areas where there are gaps to address
- To support the work of the Data Workgroup and the larger collaborative as applicable

Description

Two groups were combined for the last half of the Cycle 3 work (Communications and Stakeholder Engagement Workgroups (SEW)). This was done as the circle back from Cycle 2 (2016 CHNA) was completed by the SEW and the SEW's future work had synergistic overlap with the Communications Workgroup.

This combined group is responsible for:

- Reporting back to community stakeholders our findings from Cycle 3 CHNA and how our stakeholders are using this information to inform their community and public

- health work via CHIPs (Community Health Improvement Plans) or other work
- Building and maintaining community relationships for the next cycle (Cycle 4 CHNA)
 - Developing Leadership Group presentations to external stakeholders regarding the HCWC Collaborative and the CHNA (Cycle 3/2019) as requested by community partners and organizations
 - Key communication recommendations/highlights from the 2019 CHNA (Cycle 3) -- internal and external stakeholder communication (for use/review by Collaborative member communications departments)
 - Other communications functions as determined appropriate by the Leadership Group
 - Collaboration with other workgroups as relevant

Project Risks

- Low engagement by workgroup members
- Not enough input from appropriate stakeholders
- Lack of ability for all 12 organizations to agree on sharing or using communications pieces created
- Timeline constraints
- Lack of representation of different HCWC entity types
- Product inaccessible to the communities we reach out to

Boundaries

Includes:

- Stakeholder groups surveyed and interviewed in HCWC CHNA cycle
- Stakeholder groups TBD/outreach for 2019 cycle
- Evaluation of community stakeholder input (dissonance, areas of concern, etc. to inform 2019 process).

Concern: CCOs, Public Health, and Hospitals have differing needs that should be reasonably addressed.

Excludes:

- The Stakeholder Engagement and Communications Workgroup will not be the only members responsible for presentations and feedback collection

Concern: Cannot address the needs of each organizational CHIP.

This is a collaborative CHNA, and will not meet all individual stakeholder needs.