Applicants must provide a detailed plan for community engagement according to the required components in the RFA Community Engagement Plan Reference Document, including identified gaps and plans to address gaps. **Applicant’s Community Engagement Plan must be no more than 4 pages (according to the RFA spacing and font restrictions), excluding tables. Tables should be completed in the format provided below and submitted with Applicant’s Community Engagement Plan (narrative).**

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| **Table 1: Stakeholders to be included in the engagement process** |
| **All applicants must complete this full table. Applicants may add rows as needed.** |
| **Part 1a.** List stakeholder types to be included in the engagement process. Applicants must include, at a minimum, plans to engage the following stakeholder types: OHP consumers, community-based organizations that address disparities and the social determinants of health (“SDOH-HE”), providers, including culturally specific providers as available (includes physical, oral, behavioral, providers of long term services and supports, traditional health workers and health care interpreters), Regional Health Equity Coalitions (if present in the service area), early learning hubs, local public health authorities, local mental health authorities, other local government, and tribes. Add additional rows as needed. | **Part 1b.** List specific agencies, organizations and individuals, based on the stakeholder types identified in Part 1.a, with which the applicant will engage. Add additional rows under the stakeholder type as needed. | **Part 1b.** Describe why each listed agency, organization and individual was included. | **Part 1b.** Describe how Applicant plans to develop, maintain or strengthen relationships with each stakeholder and maintain a presence within the community.  |
| **OHP consumers (list in first column below)** |
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| **Community-based organizations that address disparities and SDOH-HE (list in first column below)** |
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| **Providers, physical health, including culturally specific providers as available (list in first column below)** |
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| **Providers, behavioral health, including culturally specific providers as available (list in first column below)** |
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| **Providers, oral health, including culturally specific providers as available (list in first column below)** |
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| **Providers, long term services and supports, including culturally specific providers as available (list in first column below)** |
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| **Providers, traditional health workers, including culturally specific providers as available (list in first column below)** |
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| **Providers, health care interpreters (list in first column below)** |
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|  |  |  |  |
| **Early learning hubs (list in first column below)**  |
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| **Local public health authorities (list in first column below)**  |
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| **Local mental health authorities (list in first column below)** |
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|  |  |  |  |
| **Other local government (list in first column below)** |
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| **Tribes, if present in the service area (list in first column below)**  |
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| **Regional Health Equity Coalitions, if present in the service area (list in first column below)**  |
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| **Add additional stakeholder types here (list in first column below)** |
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| **Add additional stakeholder types here (list in first column below)** |
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| **Add additional stakeholder types here (list in first column below)** |
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| **Add additional stakeholder types here (list in first column below)** |
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| **Table 2: Major activities and deliverables for which the CCO will engage the community** |
| **All applicants must complete this full table.** |
| **Part 2a.** List and describe the five to eight major projects, programs and decisions for which the CCO will engage the community.  | **Part 2b.** Identify the level of community engagement for each project, program and decision. Answers**\*** must be 1) inform/communicate, 2) consult, 3) involve, 4) collaborate, or 5) shared decision-making. Applicant may include more than one level of engagement for each project, program or decision to account for differences among stakeholder groups.  |
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| **\***1. **Inform**: Provide the community with information to assist in their understanding of the issue, opportunities, and solutions. Tools include fact sheets, published reports, media releases, education programs, social media, email, radio, information posted on websites, and informational meetings.
2. **Consult**: Obtain community feedback on analysis, alternatives, and/or decisions. Tools include issue briefs, discussion papers, focus groups, surveys, public meetings, and listening sessions.
3. **Involve**: Work directly with the community throughout the process to ensure that community concerns and aspirations are understood and considered. Applicant provides feedback to the community describing how the community input influenced the decision. Tools include meetings with key stakeholders, workshops, subject matter expert and stakeholder roundtables, conferences, and task forces.
4. **Collaborate**: Partner with the community in each aspect of the process, including decision points, the development of alternatives and the identification of a solution. Tools include advisory committees, consensus building, and participatory decision making.
5. **Shared decision-making**: To place the decision-making in the hands of the community (delegate) or support the actions of community initiated, driven and/or led processes (community driven/led). Tools include delegated decisions to members of the communities impacted through steering committees, policy councils, strategy groups, Community supported processes, advisory bodies, and roles and funding for community organizations.
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| **Table 3: Engagement with other agencies in the service area that have responsibility for developing community health assessments and community health improvement plans** |
| **All applicants must complete this full table. Applicants may add rows as needed.** |
| **Part 1.** **Applicants with an existing CCO CHA and CHP will submit their most recent CHA and CHP with the community engagement plan.** |
| **Part 2.** List of all local public health authorities, non-profit hospitals, other CCOs that share a portion of the service area, and any federally recognized tribe in the service area that is developing or has a CHA/CHP. Add additional rows as needed. | **Part 3.** The extent to which each organization was involved in the development of the Applicant's current CHA and CHP. Answers**\*** must be a) competition and cooperation, b) coordination, c) collaboration, or d) not applicable (NA).**\*\*** | **Part 4.** For any organization that is a collaborator for a shared CHA and shared CHP priorities and strategies, the applicant will list the shared priorities and strategies.**\*\*** | **Part 5.** For any organization that is not a collaborator for a shared CHA and shared CHP priorities and strategies, the applicant will describe the current state of the relationship between the applicant and the organization(s), including gaps. | **Part 6.** For any organization that is not a collaborator for a shared CHA and shared CHP priorities and strategies, the applicant will describe the steps the applicant will take to address gaps prior to developing the next CHA and CHP, and the dates by which the applicant will complete key tasks.**\*\*\*** | **Part 7.** Applicants **without an existing CHA and CHP or that intend to change their service area** will demonstrate that they have reviewed CHAs and CHPs developed by these other organizations. List the health priorities from existing plans. |
| **Local public health authorities (list in this column below)** |  |
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| **Non-profit hospitals (list in this column below)** |  |
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| **Current coordinated care organizations, as of 2019 (list in this column below)** |  |
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| **Federally recognized tribes that have or are developing a CHA/CHP (list in this column below)** |  |
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| **\***1. Competition and Cooperation: Loose connections and low trust; tacit information sharing; ad hoc communication flows; independent goals; adapting to each other or accommodating others’ actions and goals; power remains with each organization; resources remain with each organization; commitment and accountability only to own organization; relational time frame short; low risk and reward.
2. Coordination: Medium connections and work-based trust; structured communication flows and formalized project-based information sharing; joint policies, programs and aligned resources; semi-interdependent goals; power remains with parent organizations; commitment and accountability to parent organization and project; relational time frame medium and based on prior projects; medium risk and reward.
3. Collaboration: Dense interdependent connections and high trust; frequent communication; tactical information sharing; systems change; pooled and collective resources; negotiated shared goals; power is shared between organizations; commitment and accountability to network first, community and parent organization; relation time frame long (3 years or more); high risk and reward.
4. Not applicable
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| **\*\***If the applicant does not have a current CHA and CHP, the applicant will enter not applicable (NA). |
| **\*\*\***Engagement activities must begin by March 31, 2020 and applicant will report on progress through the June 2020 CCO CHP progress report. |

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| **Table 4: Engagement with social determinants of health and health equity (SDOH-HE) partners for CHA and CHPs****Applicants may add rows as needed.** |
| **All applicants must complete Part 1.** | **Applicants with an existing CHA and CHP must complete Parts 2, 3 and 4. Applicants that intend to change their service area must also complete Parts 2, 3, and 4.** | **Applicants without an existing CHA and CHP or that intend to change their service area must complete Parts 2a and 4a.** |
| **Part 1.** List of organizations that address the social determinants of health and health equity in the applicant’s service area. Add additional rows as needed. | **Part 2.** Applicants **with an existing CHA and CHP** will describe existing partnerships with each identified organization, including whether the organization contributed to the applicant's current CHA and CHP. | **Part 3.** Applicants **with an existing CHA and CHP** will describe gaps in existing relationships with identified organizations.  | **Part 4.** Applicants **with an existing CHA and CHP** will describe the steps the applicant will take to address the identified gaps prior to developing the next CHA and CHP and the dates by which the applicant will complete key tasks for engagement.**\*\***  | **Part 2a.** Applicants **without an existing CHA and CHP or that intend to change their service area** will demonstrate that they have reviewed community partnerships in place for other LPHA/non-profit hospital/tribal/CCO CHAs and CHPs in the service area. For each organization listed in Part 1, the applicant will document the organization's level of involvement in developing any other CHAs or CHPs by entering one of these responses: a) The organization was explicitly involved in developing one or more CHAs or CHPs; b) The organization was not explicitly involved in developing a CHA or CHP; c) unknown.  | **Part 4a.** Applicants **without an existing CHA and CHP or that intend to change their service area** will demonstrate that they have reviewed community partnerships in place for other LPHA/non-profit hospital/tribal/CCO CHAs and CHPs in the service area by describing the steps the applicant will take to form relationships and secure participation by each organization prior to developing the first or next CHA and CHP, and the dates by which the applicant will complete key tasks for engagement.**\*\***  |
| **All tribes that are present in the service area (list in this column below). If no tribe is present in the service area, note there are none.** |   |
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| **All regional health equity coalitions (RHECs) that are present in the service area (list in this column below). If no RHEC is present in the service area, note there are none.** |   |
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| **Local government, including counties** |  |  |  |  |  |
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| **Organizations that address the four key domains of social determinants of health\* (list in this column below).** |   |
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| **Traditional Health Workers (THWs) affiliated with organizations listed in OAR 410-141-3145 (list in this column).** |   |
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| **Culturally specific organizations and organizations that work with underserved or at-risk populations (list in this column below).** |   |
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| **Other organizations (list in this column below).** |   |
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| **\***The four key domains of social determinants of health are economic stability, education, neighborhood and built environment, and social and community health. |
| **\*\***Engagement activities **must** begin by March 31, 2020 and applicant will report on progress through the June 2020 CCO CHP progress report. |

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| **Table 5: Assessment of existing social determinants of health priorities and process to select Year 1 social determinants of health priorities**  |
| **All applicants must complete this full table to describe how the applicant will identify social determinants of health (“SDOH-HE”) priorities to meet the CCO SDOH-HE spending requirements. Housing must be included as one of the SDOH-HE spending priorities.**  |
| **Part 1.** List of existing SDOH-HE CHP priorities**\*** in applicant's proposed service area from its own CHP or other existing CCO, local hospital, local public health authority and/or tribal CHPs, if applicable. Add additional rows as needed. | **Part 1a.** Source for priority (i.e. which CHP it came from). | **Part 1b.** Whether priority describes a health outcome goal (i.e. addressing food insecurity to address obesity as a health issue) **or** priority populations (i.e. addressing early childhood education for children as a priority population) **or** other. |
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| **Part 2.** Description of process through which the applicant will identify and vet SDOH-HE priorities**\*\*** in line with CHP priorities for submission to OHA by March 15, 2020. This must include, timelines, milestones, methods for vetting selected priorities with community partners (such as those described in Table B, Part 1) and CAC, and planned actions to clarify and define CCO housing priority in line with statewide priority.- Process may also include planned actions to identify additional community-based SDOH-HE priorities from CHP priorities. - If housing has not been identified as a priority in existing CHPs, note that housing must still be selected as an SDOH-HE priority. Consider adding the housing priority in alignment with either a health outcome goal or priority population identified in Part 1b. |
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|  **\***Applicants must include description of housing priority if already identified in CHPs. (e.g. housing overall, housing for targeted populations). |
| **\*\***The four key domains of social determinants of health are economic stability, education, neighborhood and built environment, and social and community health. Refer to the Social Determinants of Health and Health Equity Glossary reference document. |