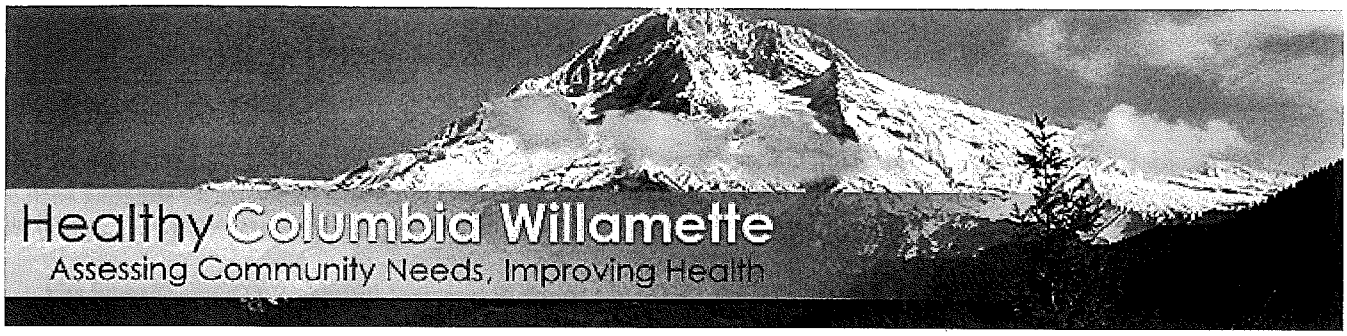

November 2013

Origination of Project

In 2010, local health care and public health leaders began to discuss the upcoming need for several community health assessments and health improvement plans within our region in response to the Affordable Care Act and Public Health Accreditation[1]. They recognized that the most efficient and effective approach would be to create a work group responsible for conducting a region-wide community health assessment for Clackamas, Multnomah, Washington counties (Oregon) and Clark County (Washington).

Members

With start-up assistance from the Oregon Association of Hospitals and Health Systems, the Healthy Columbia Willamette Collaborative (Collaborative) was developed. It is a large public-private collaborative comprised of fourteen hospitals, four local public health departments and two coordinated care organizations in the four-county region. Members include: Adventist Medical Center, Clackamas County Health Division, Clark County Public Health Department, FamilyCare[2], Health Share of Oregon, Kaiser Sunnyside Hospital, Legacy Emanuel Medical Center, Legacy Good Samaritan Medical Center, Legacy Meridian Park Medical Center, Legacy Mount Hood Medical Center, Legacy Salmon Creek Medical Center, Multnomah County Health Department, Oregon Health & Science University, PeaceHealth Southwest Medical Center, Providence Milwaukie Hospital, Providence Portland Medical Center, Providence St. Vincent Medical Center, Providence Willamette Falls Medical Center, Tuality Healthcare/Tuality Community Hospital and Washington County Public Health Division.

Multnomah County Health Department applied for and was given the contract to be the legal entity and neutral convener for the first three-year cycle (June 2012-May 2015).

Vision

Align efforts of hospitals, Coordinated Care Organizations (CCOs), public health and the residents of the communities they serve to develop an accessible, real-time assessment of community health across the four-county region. By combining efforts, the Collaborative hopes to eliminate duplicative efforts; prioritize community health needs throughout the region; facilitate joint efforts for implementing and tracking improvement activities; and improve the health of the community.

Year 1 Achievements (June 2012-May 2013)

The Collaborative completed a comprehensive needs assessment using a modified version of the Mobilizing for Action through Planning Partnerships (MAPP) assessment model[3] using health data and community input to identify the most important community health needs. Community input was collected during three distinct phases of the assessment:

- ***Community Themes and Strengths Assessment (Fall 2012):*** Findings from 62 projects, conducted in the four-county region since 2009, were analyzed for themes about how community members described the most important health issues affecting themselves, their families, and the community.

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1 The federal Affordable Care Act, Section 501(r)(3) requires tax exempt hospital facilities to conduct a Community Health Needs Assessment (CHNA) at minimum once every three years, effective for tax years beginning after March 2012. Through the Public Health Accreditation Board, public health departments now have the opportunity to achieve accreditation by meeting a set of standards. As part of the standards, they must complete a Community Health Assessment (CHA) and a Community Health Improvement Plan (CHIP) every 5 years.

2 FamilyCare and Health Share of Oregon joined the Collaborative June 2013. Coordinated Care Organizations are required by OAR 410-141-3145to conduct a CHNA every three years.

3 MAPP is a model developed by the National Association of County and City health Officials (NACCHO)

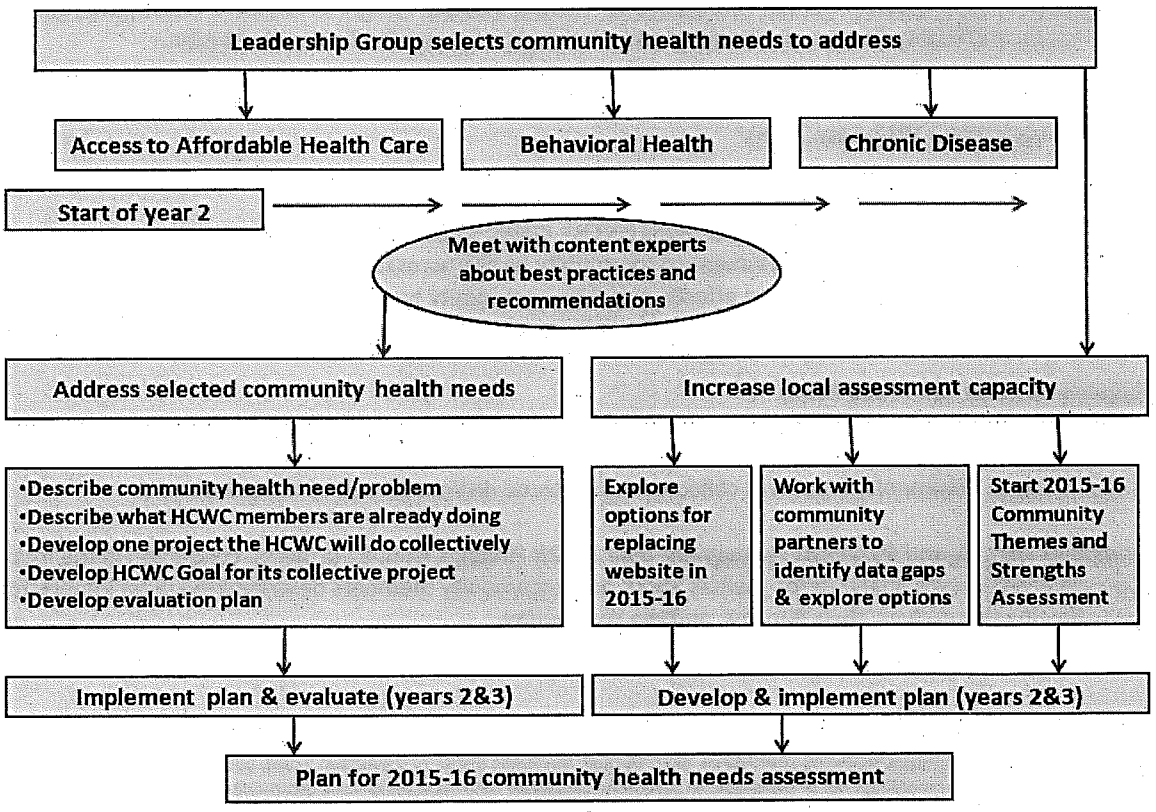
- ***The Health Status Assessment (Fall 2012):*** Epidemiologists from the four county health departments analyzed quantitative population health-related behavior and outcome data to identify important health issues affecting each of the four counties as well as the region. More than 120 health indicators (mortality, morbidity and health behaviors) were examined.
- ***The Local Community Health System Assessment & Forces of Change Assessment (Winter 2012):*** Interviewed and surveyed 126 stakeholder organizations to understand the community health system's capacity to address identified needs.
- ***Community Listening Sessions (Spring 2013):*** Conducted 14 community listening sessions with 202 individuals in the four-county region to ask community members to tell us about their health needs.

These assessments, led to identification of top health needs in the region. These needs are (in alphabetical order):

- Access to affordable health care
- Behavioral health —focusing on preventing suicide and prescription opiate misuse
- Chronic disease –focusing on promoting breast milk/feeding and preventing/reducing tobacco use.

Year 2 Primary Objectives (June 2013-May 2014)

- To engage content experts and community stakeholders to help identify, develop, and implement collective strategies to address prioritized health needs.
- To work with community partners in order to identify data gaps in the community health needs assessment and explore options on how to begin filling these gaps.
- To explore ways to increase local assessment capacity.
- To implement a communication plan about HCWC process, findings, and opportunities to become involved.



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