



Community Health Improvement Plan

Introduction

Willamette Valley Community Health (WVCH) primarily serves a demographic at or below 138 percent of poverty level (WVCH Service Area Profile, 2013). Those served by WVCH live in Marion (85%) and Polk (15%) counties with a small number of individuals (less than 1%) living in surrounding counties. This Community Health Improvement Plan is an example of priorities set to address needs in the communities where WVCH members reside. The following principals have been identified by the WVCH Community Advisory Council (CAC) as fundamental components of the WVCH Community Health Improvement Plan (CHIP):

- 1) The elimination of health disparities.
- 2) The mobilization of community partners to advance public policy that improves overall public health (use of resources within our counties- sort of covered already)
- 3) Ensuring services provided to community members are inclusive and accessible to all individuals.

Following the expansion of coverage in 2014, the WVCH population grew by approximately 35,000 members to a total of roughly 100,000. *The Marion-Polk County Health Care System Capacity and Access Assessment* (2013) provides the data for Marion and Polk counties, however, the WVCH data below is updated with the new numbers. Willamette Valley Community Health populations are slightly different from the whole of Marion-Polk counties and set the foundation for some of the increased concerns for health disparities in this population. Throughout WVCH, Marion, and Polk counties the population is over 50% female and is primarily Caucasian with English as the first language. The WVCH population has a higher percentage of Hispanic (34.4%) members with Spanish as the first language and also includes African American (1.4%), Native American (<1%) and Asian (1.9%) members. Other languages spoken are Russian and Vietnamese. As a result, health literacy and a culturally sensitive approach is an important focus for all health care interactions and sets a foundation for all of the recommendations within this CHIP.

Willamette Valley Community Health is committed to promoting health equity for all residents of Marion and Polk Counties. In light of this, every strategy outlined in this document has been crafted with the explicit expectation that individuals and organizations executing the Community Health Improvement Plan will work to address existing and emerging health disparities within the community. WVCH also recognizes that cultural competency is a critical component of any Community Health Improvement Plan. The CCO maintains the unambiguous expectation that individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientation and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families and communities and protects and preserves the dignity of each.

Although the median age of residents in Marion and Polk counties are 35 and 37 respectively, the ages of WVCH members is much lower as this health care plan covers approximately 40% of the children within both counties. Fifty-six percent of the WVCH population is under the age of 18, with those 19-64 making up the next largest percentile (40.9%). Elders over 65 within WVCH represent a significantly lower percentage (2%) than elders in Marion (15%) and Polk counties (13%). Most WVCH members

have some education potentially up to a high school diploma and are unemployed (58%). The remaining thirty percent are self-employed or retired.

The composition of the WVCH population certainly shaped the work of the CHIP. The process for the CHIP started October, 2013 with a determination of the needs of the WVCH and Marion-Polk residents. Several documents provided data to explore health issues. The Coordinated Care Organizations (CCO) Incentive Measures baseline data for Willamette Valley Community Health provided a list of areas to prioritize that would improve related scores. The chronic disease statistics comparing the data for the Oregon Health Plan and WVCH provided a ranked health issues list. The Marion and Polk Counties CHIP and CHA documents also provided local resources already being used to address these health issues and any identified gaps.

The objectives of the Community Health Improvement Plan (CHIP) workgroup was guided by several agreements in addition to those objectives laid out by the CAC. The first was to incorporate the Community Health Assessments (CHA) and Community Health Improvement Plans from both Marion and Polk Counties to explore the priorities for both counties. Similarly, an attempt was made to honor the plans already in place within each county to create a coordinated effort and work with or add to the resources already available. A second agreement was to recognize the interconnectivity of the initiatives and their related health conditions. Although this CHIP does focus on specific initiatives to measure a change in the health impact, the workgroup intends the related health initiatives to be explored for the related changes. For example, although obesity is one focus, it is assumed any resources directed to this health issue will also impact improving nutrition, physical activity, and diabetes in the population.

With this in mind the workgroup stratified the different initiatives or health conditions into groups relating to obesity, mental health, substance use, cancer health screening, prenatal care and related health issues, and well child care. The final agreement was to honor the prioritization given to these health issues by the Community Advisory Committee (CAC). This process included presenting the CAC with the list of the health issues, which they then prioritized their top choices for the CHIP focus. These were summarized and guided the focus for the final CHIP. Members of the CHIP workgroup then completed the intervention plans and the full CAC group provided feedback.

The resulting CHIP focuses on four health indicators 1) Obesity Prevention and Intervention, 2) Tobacco Prevention and Cessation, 3) Depression Screening and Treatment, and 4) Access to Early Prenatal Care. These indicators and associated strategies are outlined in the following pages.

The principals mentioned throughout this document will continue to guide the development of WVCH policies and procedures to ensure that the needs of all community members are addressed. WVCH recognizes that it is imperative not only to support the concepts and ideals of community-wide health equity, but to work actively to achieve that aim. These efforts will be significantly bolstered by the implementation of the WVCH Community Health Improvement Plan, which will serve as a mechanism for WVCH and its community partners to continuously examine community performance as it relates to healthy equity and cultural competency.

Depression

Overview:

Each year 6.7% of adults in the U.S. experience a major depressive disorder¹. Women are at an increased risk of depression across their lifespan along with people who are unemployed or low socio-economic status, people with a family history of depression, people with a chronic medical disease, and those with a psychiatric disorder². Addressing depression in the primary care setting is one of the 17 CCO incentive measures.

By focusing on improving the approach to screening, treating and resource used for depression in Marion and Polk Counties, WVCH also hopes to impact the cascade of related behavioral health issues such as Attention Deficit Disorder, PTSD, Bipolar Disorder, and Schizophrenia. Suicide prevention may also be impacted with improved coordination of services. These measures will be tracked as additional variables of interest, however, depression will be the focused measure for this report.

Strategy:

This CHIP strategy aims to increase engagement of physical health providers for

- depression screening
- treatment
- appropriate referral

In creating models for collaborative care for individuals experiencing or at risk of depression, we are in line with HealthyPeople2020 Objectives (MHMD-5 and MHMD-11). HealthyPeople2020 Objective MHMD-5 is to increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral and MHMD-11 to increase depression screening by primary care providers³. The long term goals for WVCH include a primary care system that is routinely screening for depression and appropriately recognizing signs and symptoms. The overall theme for this strategy is to improve the collaboration between physical health and behavioral health providers.

Steps include:

1. Assess the knowledge, awareness and capacity of primary care providers to screen, treat, and refer appropriately for depression care.
2. Develop a cross-discipline training aimed at educating primary care providers as an in-person training and webinar format in order to allow for flexibility in provider schedules

¹ National Institute of Mental Health (2014) Retrieved from, http://www.nimh.nih.gov/health/topics/depression/index.shtml?utm_source=BrainLine.orgutm_medium=Twitter#part4

² Depression Screening and Follow-Up Plan Guidance Document

³ HealthyPeople2020 (2014) Retrieved from, <http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=28>

3. Invite providers to the training(s).
4. Develop a post-assessment to gauge the effectiveness of the training.

Short Term Goals:

A primary objective of the WVCH Community Health Improvement Plan is to advance the integration of healthcare services. WVCH recognizes that fragmentation of community resources can render even the most robust programs ineffective. Additionally, engaging the public health system will allow for continuity of information and referral to mutual clientele. The treatment of depression necessitates a well-developed understanding of differential diagnostics to identify symptoms when they are often presented to the PCP as somatic complaints, i.e., insomnia, headaches, fatigue. Goals address support the plan for a stronger integration.

- 1) Identify training needs to increase effectiveness of primary care physicians' identification and treatment of individuals with depression

To ensure the proper place to begin enhancing PCP knowledge of Depression identification and treatment, WVCH will facilitate a pretest opportunity, prior to January 1st 2015, for physical health care providers who are part of the system. The preassessment will determine current baseline for

- Knowledge of signs and symptoms of depression
- Knowledge of treatment options and effective therapeutic dosages
- Those PCP screening and/or billing for depression screening

- 2) Engage behavioral health prescribers to provide the training.

WVCH will use the results of this pretest to inform behavioral health prescribers in developing educational materials/training at the appropriate level.

Prior to the pre-assessment results, WVCH will utilize a strategy that promotes awareness of and communication between physical, behavioral and public health providers. This parallel process will enable the community to develop and maintain momentum relating to improved outcomes for individuals experiencing depression while crafting a robust model to ensure long term viability.

Medium-Term Goals:

Develop flexible training to be offered to physical health prescribers using pretest results will be used to inform development of future initiatives.

To accomplish the medium term goals, WVCH will

- Identify behavioral health prescribers to develop a training and resource manual
- Provide support and promotion for in-person training

- Develop a webinar from the training to be accessible ongoing
- Develop a post-assessment to measure improvements and areas of continued need

Long Term Goals:

- 1) By increasing knowledge and communication for and between WVCH physical health, behavioral health and public health providers, an overall reduction in physical and behavioral level-of-care needs for residents of Marion and Polk counties who experience symptoms of depression is anticipated.

The strategies outlined in this document focus primarily on efforts to enhance the awareness and availability of effective identification and treatment of depression. While these are important components of any improvement plan, building a stronger alliance between physical health and behavioral health prescribers, up to and including opportunities to co-house, is a long term goal.

- 2) Integrate depression screening into physical health-care settings.

Outcomes Measurements:

- 1) Increase the percent of primary care physicians screening for depression

Dataset: CCO Incentive Measure data (when available)

Subset:

Baseline: when available

Improvement Target: Five percentage point increase over baseline

Re-measurement: when available

Access to Early Prenatal Care (women who access prenatal care in the first trimester)

Overview:

Early and adequate prenatal care is important for the health of the mother and her baby. Late prenatal care has been linked to increased risks of low-birth-weight babies, premature births and sometimes death of mother and baby.⁴

⁴Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department for Health and Human Services.

Prenatal services. <http://www.mchb.hrsa.gov/programs/womeninfants/prenatal.htm>

Preventing one infant from needing care for an unplanned complication or premature birth at the NICU saves approx. \$12,000 to \$25,000 dollars based on DRG 795 (normal newborn) as opposed to DRG 793 (Neonate with significant issues). Ensuring women receive early prenatal care will minimize the cost downstream for labor and delivery, NICU stay, and specialist visits. Reaching the benchmark of 69.4% of women who begin prenatal care in the first trimester will have a significant positive impact for WVCH members throughout their lifespan.

This CHIP priority aligns with existing local, state and national health priorities. Locally, increasing access to early prenatal care has been a focus of the Prenatal Taskforce serving women from Marion and Polk counties. The Oregon Health Improvement plan strategy to target resources to improve child and student health (birth through higher education) to support improved education outcomes aligns with this CHIP strategy along with the Oregon Benchmark #40 Prenatal Care. Nationally, early prenatal care is a Healthy People 2020 objective.

Table 1: Targets and benchmarks for early prenatal care

	<i>WVCH 2011*</i>	<i>OR CCO Average 2011*</i>	<i>All OR Births 2011**</i>	<i>WVCH Improvement Target*</i>	<i>CCO benchmark*</i>	<i>Healthy People 2020</i>
% of women who start prenatal care in first trimester	57.1%	65.3%	75.1%	60.1%	69.4%	77.9%

*Oregon Health Authority: Expanded Baseline Data for CCO Incentive Measures May 16 2013

**Oregon Health Authority on-line:

<http://public.health.oregon.gov/BirthDeathCertificates/VitalStatistics/birth/Pages/index.aspx>

The WVCH Community Advisory Council’s Community Health Assessment (2013) revealed that unlike Polk County (77.6%), women living in Marion County (71.7%) are less likely to access first trimester prenatal care than the state average (75.9%). Recent changes to the healthcare system, including Cover Oregon and the expansion of the Citizen-Alien Waived Emergency Medical package now called CAWEM Plus or CWX will help to ensure coverage of prenatal care; however barriers to accessing care in a timely manner still exist. Oregon Health Authority has found that the main reasons women cite for not accessing prenatal care as early as they wanted include⁵:

- I didn’t have enough money or insurance to pay for my visits – 42.3%
- I didn’t have my Oregon Health Plan or Medicaid card – 37.9%
- The doctor or my health plan would not start care as early as I wanted – 31.7%
- I couldn’t get an appointment when I wanted one – 40.4%

⁵Oregon Health Authority. 2011 PRAMs results. Oregon Birth data on-line.

<http://public.health.oregon.gov/HealthyPeopleFamilies/DataReports/prams/Pages/9899q1list.aspx><http://public.health.oregon.gov/BirthDeathCertificates/VitalStatistics/birth/Pages/index.aspx>

Experience at Marion County Health Department has identified other barriers to early care: Women who are between insurances, or move to the area after the first trimester have a more difficult time finding a community provider willing to assume care. Additionally, offices may be booked out six weeks or more and unable to see any new prenatal client promptly.

Oregon Mother's Care (OMC) is an Oregon Health Authority program intended to improve access to early prenatal care as well as quick access for those in the 2nd or 3rd trimester. OMC advocates assist pregnant women with the OHP application, track the approval of the application, schedule a prenatal care appointment, and provide referrals to community services. The Oregon Health Authority's OMC objective is for women to obtain prenatal care within the first trimester or prenatal care within 14 days of OMC contact for 2nd and 3rd trimester births.

Currently there are three OMC providers in Marion County located at Marion County Health Department, Silverton Hospital and Stayton Hospital. Women learn about OMC through word-of-mouth or by provider referral. Pregnant women who apply for Oregon Health Plan through OMC benefit from the program's ability to fast-track applications and obtain coverage. Although there are no OMC sites in Polk County, residents of Polk County are served oftentimes through one of the Marion County sites.

Short Term Goals:

Primary objectives of the WVCH Community Health Improvement Plan are to insure integration and equitable and timely access to healthcare services. This strategy will focus efforts on the CWX and WVCH population. Infants born to mothers on CWX will become WVCH members after birth. Improvement of this measure for the combined CWX and WVCH population should improve the measure for the community as a whole.

Short term goal #1: Conduct an assessment of the current prenatal care system serving CWX and WVCH women in Marion and Polk Counties, including: prenatal care providers, referral mechanisms, assistance with OHP applications, and communications between providers and with the public. This assessment will identify gaps and opportunities to enhance collaboration and communication.

Short term goal #2: Increase communications between obstetrical care providers, Oregon Mothers Care, and Local Health Departments to maximize use of this service.

Short term goal #3: Obtain commitment by obstetrical care providers serving WVCH clients to take new 1st, 2nd and 3rd trimester prenatal clients on referral from OMC and Local Health Departments.

Medium-Term Goals:

Medium term goal #1: Create a plan for addressing gaps and opportunities identified through the prenatal care system assessment.

Medium term goal #2: Increase the percent of women receiving first trimester prenatal care.

Long Term Goals:

Long term goal #1: Implement the plan for addressing gaps and opportunities identified through the prenatal care system assessment.

Long term goal #2: Decrease the rate of low birth weight infants.

Outcomes Measurements:

- 2) Increase the percent of WVCH women who start prenatal care in the first trimester (or within 42 days of coming on plan)

Dataset: WVCH CCO Incentive Measures

Subset: Timeliness of Prenatal Care

Baseline: 57.1%

Improvement Target: 60.1%

Re-measurement: June 2014

- 3) Increase the percent of Marion County women who receive first trimester prenatal care

Dataset: OHA Vital Statistics

Subset:

Baseline: 71.7% (2012)

Improvement Target: 77.9% (HP2020)

Re-measurement: Annually with upload of new vital statistics data

- 4) Increase percent of Polk County women who receive first trimester prenatal care

Dataset: OHA Vital Statistics

Subset:

Baseline: 77.6% (2012)

Improvement Target: 77.9% (HP2020)

Re-measurement: Annually with upload of new vital statistics data

- 5) Decrease percent of low birth weight infants born in Marion County

Dataset: OHA Vital Statistics

Subset:

Baseline: 5.0% (2012)

Improvement Target: 4.6%

Re-measurement: Annually with upload of new vital statistics data

- 6) Decrease percent of low birth weight infants born in Polk County

Dataset: OHA Vital Statistics

Subset:

Baseline: 5.2% (2012)

Improvement Target: 4.8%

Re-measurement: Annually with upload of new vital statistics data

Obesity Prevention/Intervention

Overview:

“The estimated annual medical cost of obesity in the U.S. was \$147 billion in 2008 U.S. dollars; the medical costs for people who are obese were \$1,429 higher than those of normal weight.”⁶

While poor food choices and lack of physical activity are behaviors leading to overweight and obesity, many social and economic factors such as food insecurity, food deserts, lack of streets and sidewalks, and lack of rural parks are well known correlates. Efforts to decrease the prevalence of obesity, therefore, must focus on primary and secondary prevention, as well as evidence based weight loss strategies for those identified as overweight and obese.

Nutrition and physical activity play a large role, not only in weight management, but in chronic disease prevention and self-management. A healthful diet and active lifestyle can reduce risk for conditions such as heart disease, diabetes, osteoporosis, and high blood pressure. Therefore the impact of obesity prevention is far reaching in accomplishing CCO incentive measures.

While overweight and obesity, crosses social and economic boundaries, disparities do exist. In the United States, those most at risk for obesity are middle-aged adults and women of color.⁷

Marion and Polk County, Community Health Improvement work, coordinated by the county health departments, have prioritized obesity prevention and intervention as key strategies for improving health. The implementation plans includes primary and secondary prevention. Specifically, the Plans address policy and system development through projects like the Healthy Corner Store initiative and development of corporate wellness policies. The plans promote implementation of a simple, yet broadly disseminated education and outreach program called 5210, which challenging communities to engage in healthy lifestyles.

Prevalence of Overweight and Obesity⁸

Marion County

Adults who are Obese 28.6 Percent

Adults who are Overweight 36.5 Percent

Teens who are Obese 11.6 Percent

Teens who are Overweight 14.8 Percent

Low Income Preschool Obesity 18.5 Percent

Polk County

Adults who are Obese 29.1 Percent

Adults who are Overweight 37.1 Percent

Teens who are Obese 15.9 Percent

⁶ *Overweight and Obesity*. (2014, March 28). Retrieved April 9, 2014, from Centers for Disease Control and Prevention website: <http://www.cdc.gov/obesity/data/adult.html>

⁷ *Nutrition and Weight Status*. (2013, November 13). Retrieved April 9, 2014, from Healthy People 2020 website: <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=29>

⁸ *Community Health Needs Assessment*. (2013). Retrieved April 9, 2014, from Salem Health website: <http://www.salemhealth.org/community/home.php>

Teens who are Overweight 17.6 Percent
Low Income Preschool Obesity 13.5 Percent

The WVCH implementation strategy for addressing overweight and obesity integrates and builds upon the work that is happening in Marion and Polk Counties. The CCO will join the Marion County Community Health Improvement Partnership and work collaboratively with Polk County Health Department Leaders to support local obesity prevention efforts. Additionally, WVCH will continue to promote Primary Centered Primary Care Home (PCPCH) proliferation across its provider network, as this certification requires providers to track BMI in the medical record of each patient. This information will be used to support and leverage resources and programs that exist within the community to decrease the prevalence of overweight and obesity.

Short-Term Goal: (by June 30, 2015)

1. Willamette Valley Community Health will participate in the Marion County CHIP
2. Develop a reimbursement mechanism that allows nutrition and physical activity guidance as a billable service.
3. Health departments will convene a population-based community-wide health assessment that includes WVCH as well as other key partners.
4. Develop a tool kit(s) to assist those identified as overweight or obese or at risk for overweight or obesity. The tool kit may include, free web-based nutrition and physical activity resources, a referral guide to evidence based weight management programs available in Marion and Polk Counties, the 5210 Challenge, and other evidence-based tools.

Medium-Term Goal: (by June 30, 2016)

1. Increase the proportion of primary care providers that are certified for Stage One Meaningful Use. This Certification ensures that providers to document BMI at each visit.
2. Health Departments support policy and system change to prevent obesity by convening county-wide community health improvement planning workgroups.

Long-Term Goal: June 30, 2020

Reduce the proportion of adults and teen in Marion and Polk Counties who are obese by 3% by 2020.

Tobacco Prevention and Cessation

Overview:

Tobacco use poses an immense burden to residents of Marion and Polk counties. Smoking has been causally linked to a myriad of diseases including cancer, heart disease, lung disease, and low birth weight and is the leading cause of preventable death and disease in Oregon⁹.

The burden of tobacco consumption disproportionately affects populations with low socioeconomic status. In Oregon, the prevalence of tobacco use amongst low income residents represents a significant and unacceptable health disparity. Oregon Medicaid clients are nearly twice as likely to smoke as adults in general and subsequently more likely to experience poor health outcomes¹⁰. Not only is this disparity an alarming public health issue, it also represents a significant drain to the healthcare system. Direct Medicaid costs relating to smoking consume approximately 10 percent of total Medicaid expenditures in Oregon¹¹. Reducing tobacco use amongst Oregon residents is a critical component of the state's effort to achieve the Triple Aim of improved population health, better care, and lower costs.

This CHIP strategy aligns with existing state, local and national health priorities. The HealthyPeople2020 Objective is to, "Reduce illness, disability, and death related to tobacco use and secondhand smoke exposure." State and local health departments strive to meet this objective through Tobacco Prevention and Education Program funding (TPEP). Utilizing existing TPEP expertise in partnership with the new service delivery model demonstrated by Coordinated Care Organizations will accelerate the ability to meet the HealthyPeople2020 objective.

Short Term Goals:

- 1) Maximize communication and coordination in order to leverage existing community tobacco cessation resources. With changes in budget and reorganization of workforce, WVCH recognizes that fragmentation of community resources can render even the most robust programs ineffective, which is why a primary objective of the WVCH Community Health Improvement Plan is to assess for the gaps or strengths in services while advancing integration of tobacco prevention and cessation services.

Steps: WVCH will facilitate a community-wide survey published prior to January 1st 2015

The coordination of tobacco cessation services necessitates a well-developed understanding of existing community resources. To ensure organizations have the proper foundation in place to begin enhancing cross organizational linkages, the survey will identify the following:

- Existing cessation services

⁹ <http://public.health.oregon.gov/preventionwellness/tobaccoprevention/documents/medicaidburden.pdf>

¹⁰ Behavioral Risk Factor Surveillance System (BRFSS) 2007, Consumer Assessment of Healthcare Providers and Systems (CAHPS) 2007.

¹¹ <http://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Documents/medicaidburden.pdf>

- Counseling
 - The number of trained employees or contractors in evidence-based smoking cessation services
- Pharmacotherapy Options
- Current and emerging utilization and participation trends
 - Counseling
 - Pharmacotherapy
 - Prevalence
- Prominent Consumer Barriers
 - Education
 - Access
 - Subpopulations disproportionately affected (could be a qualitative measure)
- Prominent Health System Barriers
 - Reimbursement
 - Health Information Technology
 - Awareness

2) WVCH will use the results of this assessment to craft a comprehensive and coordinated approach to tobacco prevention and cessation in Marion and Polk counties.

Prior to the survey results, WVCH will utilize a strategy that promotes awareness of known tobacco cessation services available to the community. This parallel process will enable the community to develop and maintain momentum relating tobacco prevention and cessation while crafting a robust plan that will ensure long term viability.

The interim plan focuses on the following:

- Develop an effective referral network for participating organizations to direct patients towards cessation services. A prime example of a growth opportunity is to increase the number of referrals for WVCH tobacco users to the Salem Health Freedom from Smoking Program, a counseling service that is provided to OHP members free of charge.
- Engage local healthcare providers and encourage them to discuss tobacco cessation strategies with their patients at every opportunity.
- Promote delivery models that support the co-location of physical and behavioral health specialists.

Medium-Term Goals:

Once published, the WVCH assessment of community tobacco prevention & cessation services will serve as a blueprint for community leaders to develop and enhance system-wide linkages. The document will be used as a starting point for WVCH to:

- Identify individuals to champion community tobacco cessation and prevention efforts
- Engage clinics to participate in pilot projects

- Implement selected evidence based practices

Long Term Goals:

WVCH CHIP has made it a goal to support local and statewide policies that reduce tobacco consumption. The strategies outlined in this document focus primarily on the development of programs that seek to enhance the awareness and availability of preventative and cessation services. While these are important components of any improvement plan, further reducing the prevalence of tobacco use amongst residents of Marion and Polk counties will ultimately necessitate a multi-level approach that includes public policy development.

Outcomes Measurements:

- 7) Increase the percent of WVCH members who report that their provider always or usually offers tobacco cessation support during office visits.

Dataset: Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Subset: Questions 48-50

Baseline: 2014 WVCH CAHPS

Improvement Target: Five percentage point increase over baseline

Re-measurement: 2016 CAHPS

- 8) Decrease the prevalence of tobacco use in both Marion and Polk counties by five percentage points

Dataset: Behavioral Risk Factor Surveillance System BRFSS

Subset: Tobacco Use among Adults

Baseline: 2006-2009 BRFSS

Improvement Target: Five percentage point decrease over baseline

Re-measurement: 2016 BRFSS

- 9) Decrease the prevalence of tobacco use amongst WVCH members by five percentage points

Dataset: CAHPS

Subset: Question 47

Baseline: 2014 WVCH CAHPS

Improvement Target: Five percentage point decrease over baseline

Re-measurement: 2016 CAHPS

- 10) Increase utilization of Oregon Tobacco Quit Line in both Marion and Polk counties

Dataset: Oregon Tobacco Quit Line Dashboard Reports

Subset: Unique Tobacco Users (Callers)

Baseline: 2013 Quit Line Utilization

Improvement Target: 50 percent increase in number of unique callers
Re-Measurement: 2016 Oregon Quit Line Dashboard Report

11) Cessation services utilized by WVCH members

Dataset: WVCH Claims

Subset: Counseling and Pharmacotherapy Claims

Baseline: 2013 Claims per 1,000mm

Improvement Target: five percentage point increase

Re-Measurement: CY 2016

12) Publishing inventory and analysis of community tobacco prevention & cessation services by January 1st 2015.