Appendix B: Methodology

This appendix contains HCWC's overall approach to this study, as well as summaries of our methodology for each area of data collection for this assessment:

Overall Methodology

The HCWC Data Workgroup implemented a mixed methods approach to data collection and analysis, which prioritized community voice and input in the assessment model.

Town Hall Methodology

In June 2018, HCWC hosted a series of Town Hall events across the quad-county region. These events were designed to bring together community leaders and representatives from community-based organizations, to provide feedback on early data findings and illicit conversations about communities to target for listening session outreach. Below are the methods used to collect and analyze the data from these events.

Methods for collecting data

The HCWC Data Workgroup guided the development of the event structure and format. The group decided to host one three-hour meeting in each of the HCWC region counties with invited participants to meet the following goals:

- Gather reactions from community stakeholders to numerical data to include in the CHNA

- Develop a list of considerations for current or future cycles of the CHNA

- Identify a list of populations HCWC should connect with to collect additional information in smaller focus group setting

During the event, participants reviewed numerical data during a gallery walk and then returned to preassigned tables to discuss a series of questions. Gallery walk data was presented on posters and an HCWC representative explained the poster to the participants during a rotation.

Each table discussion was facilitated by a trained HCWC representative and notes where taken by the facilitator on flip charts. Each facilitator was provided just-in-time training in the one hour prior to the event. All written information from the events was collected by the conveners, this included the facilitator flip chart notes and the activity sheets that participants completed identifying assets and barriers.

Methods for analyzing data

All written data from each event was transcribed by convener staff. The information collected from each table was transcribed and coded separately to identify both similarities and differences between tables in the analysis.

Once transcription was complete, the convener staff used a consensus coding model and the qualitative analysis software NVivo to code the data into thematic categories. The data analyzed came from notes taken during the sessions. Two independent coders used a collaborative, open-coding process to analyze the data and ensure reliability (Harry, Sturges, & Klingner, 2005). After the coders came to consensus on the themes, they presented them to

convener staff to ensure the findings resonated with all staff members' experience of the town halls. Once themes were consensus coded, the coders went back to refine the coding to pull out specific participant examples and quotes to contextualize the themes.

Code List (Top 6):
- Siloed Organizational Resources and Funding Strain
- Obtaining Status, Security, Opportunity
- Lack of Cultural Competency
- Mental Health
- Racism
- Transportation

Data limitations

The data collected was limited to amount of information that was collected by each table facilitator, as well as the conversation had by the attendees. There is a selection bias in those who chose to attend the event and provide feedback. While table facilitators were trained and asked to moderate the conversation and allow for all voices to be heard equally, it is impossible to tell if this occurred.

Documentation

Table B-1 shows a sample agenda from one of the events.

Table B-1. Sample Event Agenda.

Time	Topic	Lead
1:05-1:40	**Welcome & Introduction**	**HCWC Representative from County**
1:40-2:45	**Data Gallery** • Attendees will move through the posters with their table group	**Poster Facilitators**
2:45-3:50	**Table Group Discussion** • Small group discussion to answer structured questions	**Table Facilitators**
3:50-4:00	**Thank you & Closing** • Please complete the evaluation!	**HCWC Convener**

Discussion questions

Question 1: Based on your understanding of the poster information, what does the data tell us? What does the data not tell us?

Question 2:

Part 1: Please pick an issue of concern (with barriers) in your community (it can be one you think is surfaced by the data, or not surfaced by the data. ***Follow instructions on guide. You can do as many of these as you have time to fill out during the allotted time. One item per activity sheet.***

Part 2: Please pick an issue of concern (with assets) in our community (it can be one you think is surfaced by the data, or not surfaced by the data. ***Follow instructions on guide. You can do as many of these as you have time to fill out during the allotted time. One item per activity sheet.***

Question 3: What support do you need to connect communities with resources and/or what is making your job difficult?

Question 4: For our community member listening sessions, what *specific communities* do you recommend outreach to?

What specific questions do you recommend we ask these community members? (Hopefully in ways, or about things, they haven't been asked before. *Are there issues hidden by data and standard interview/group session questions that we can help bring to light?*)

Listening Session Methodology

In October through December 2018, HCWC hosted 18 listening sessions across the quad-county region. These events were designed to bring together community members to provide feedback on their lived experience. Below are the methods used to collect and analyze the data from these events.

Methods for collecting data

The Data Workgroup guided the development of the event structure and format. The group decided to host listening sessions with priority populations that were identified based on feedback from the town halls, the groups reached during the previous CHNA cycle, and members knowledge and connections with communities that are not typically heard from during outreach exercises.

After the identification of priority populations, Data Workgroup members worked to reach out to organizations across the region that work with the populations. After outreach occurred, and organizations expressed interest in hosting a session, the conveners contracted with the organizations and scheduled the sessions.

Each session was based on the same format, using the facilitation guide outlined below. Hosting organization were asked to provide a facilitator for the session and Data Workgroup members and convener staff supported them as co-facilitators and note-takers as needed. Data was captured at each session by the assigned note takers. Facilitators and note-takers were provided just-in-time training for their roles prior to the sessions.

Methods for analyzing data

All written data from each session was transcribed by convener staff. Each session was transcribed and coded individually before being recoded to identify regional themes.

Once transcription was complete, the convener staff used a consensus coding model and the qualitative analysis software NVivo to code the data into thematic categories. The data analyzed came from notes taken during the sessions. Two independent coders used a collaborative, open-coding process to analyze the data and ensure reliability (Harry, Sturges, & Klingner, 2005). After the coders came to consensus on the themes, they presented them to convener staff to ensure the findings resonated with all staff members' experience of the listening sessions. Once themes were consensus coded, the coders went back to refine the coding to pull out specific participant examples and quotes to contextualize the themes. The individual listening session reports were shared with each hosting organization, who shared the reports with participants, to ensure their experiences were captured. This feedback was incorporated into the listening session reports that followed.

Code list:

- Access to Health Care
- Community Spaces and Support
- Concerns for Safety
- Discrimination and Racism
- Family Welfare
- Financial Barriers
- Geographical and Cultural Isolation
- Language Barriers
- Representation
- Transportation

Data limitations

The data collected was limited to amount of information that was collected by note-takers, with some sessions having more robust notes available for analysis than others. Hosting organizations recruited participants and those who attended the session self-selected. Participants may have also be influenced to participate by the incentive which was provided ($25 gift card).

Documentation

Table B-2 lists each of the 18 listening sessions, the host organization, date, county, and number of participants.

Table B-2. Listening Sessions.

Priority Population	Hosting Organization	Date of Session	County of Session	Participants
Elderly (65+) LGBTQ persons	Cascade AIDS Project – Aging Well	10/24/18	Multnomah	17
Middle Eastern	Iraqi Society of OR	10/27/18	Multnomah	16
People with Mental Health Concerns	NAMI Clackamas County	10/18/18	Clackamas	8
Youth of Color	Momentum Alliance	10/27/18	Multnomah	11
LGBTQ Homeless Youth	Outside In	10/24/18	Multnomah	12
Hispanic/Latinx	Adelante Mujeres	11/13/18	Washington	17
Elderly (65+) Low-Income	Friendly House	11/16/18	Multnomah	11
Farmworkers	Plaza Del Robles	11/16/18	Clackamas	10
People of Color with Housing Concerns	Central City Concern	11/17/18	Multnomah	19

Priority Population	Hosting Organization	Date of Session	County of Session	Participants
Slavic	Church	11/18/18	Clark	11
Rural	Southwest Washington ACH	11/19/18	Clark	10
Pacific Islander	Pacific Islander Coalition	11/26/18	Multnomah	16
Hispanic/Latinx	Latino Network	11/27/18	Multnomah	14
Arabic		11/30/18	Washington	9
Military Connected	Veterans of Foreign Wars	12/1/18	Washington	10
Elderly (65+) Rural	Estacada Community Center	12/5/18	Clackamas	6
Youth	AntFarm	12/5/18	Clackamas	10
Elderly Low-Income	Community Partnership for Affordable Housing	12/7/18	Washington	10

Facilitation guide

HCWC INTRODUCTION

Welcome and thank you for joining us for a Healthy Columbia Willamette Collaborative (HCWC) community Listening Session event. We are delighted to have you join us today as we work collectively to gather information for our 2019 Community Health Needs Assessment.

A little background on how we got here. In 2011, leaders from the hospitals systems and public health departments came together to figure out how to better collaborate to produce a regional Community Health Needs Assessment. When coordinated care organizations were formed in 2012, they joined the collaborative as well. These leaders include: Health Share, Providence, Kaiser Permanente, Legacy, OHSU, Adventist, Tuality, PeaceHealth and the Public Health Departments of Clackamas, Multnomah, Washington, and Clark Counties. Now in our third cycle, the collaborative has published two regional assessments of the health of our communities. In order to complete these assessments, we have looked at what the numbers tell us and what the community tells us.

We appreciate your willingness to participate and answer questions about your community experience. We recognize that you may be asked questions from different groups. Part of the goal of HCWC is to attempt to limit duplicative outreach. By working together as a collaborative, we strive to ensure your time is respected, questions are relevant, and information is collected and shared back in a coordinated and transparent manner.

The information from each of the completed regional Needs Assessments (CHNA's) has been used by HCWC member organizations to develop and implement improvement plans. For example, the 2016 CHNA information from last cycle established housing concerns as a high priority area of focus for HCWC member organizations. In fall of 2016, six health organizations participating in HCWC announced they would invest 21.5 million dollars towards the Housing is Health Initiative through Central City Concern.

The Housing is Health Initiative aided Central City Concern in building a new health care clinic and 379 units of new housing in North and East Portland. Prior to that, information from the first CHNA in 2013 identified opioids as an area of concern for the region. HCWC supported the establishment of a workgroup focused on opioids that has continued working across the region since that time.

SESSION INTRODUCTION

We are excited to hear from each of you about your experiences. By being here today and sharing your experiences, you are helping to improve the health of your community. We're hoping to learn about community experiences, so your concerns can be addressed by HCWC partners. Your voice matters. This information will be used by HCWC members and community partners, who will be developing strategies based off the information you provide to better serve your communities.

Please note that this session is being recorded by note-takers and the information gathered will be used by HCWC in the upcoming July 2019 Community Health Needs Assessment. We may capture direct quotes but those won't be tied to you personally. We are committed to sharing what we learn.

Okay, we have a little over an hour to talk. I'd like to start with a creative activity. Here's paper and crayons. Start by thinking about your community. People might think of "community" in different ways. Maybe it's family, or maybe it's neighbors, or maybe it's coworkers or friends. For the next 5 minutes, draw a picture that represents **your community**.

> *Pause, give people ~5 minutes to draw. Facilitator should draw too.*

So let's go around in a circle—tell me your name, and tell us something about your drawing. I'll start.

> *Facilitator introduces self, models talking about community. Then everyone goes in a circle, introducing self and saying a few words about their community.*

Thank you. So you all told us your name and told us something about how you see your community. That leads into what we're going to talk about next: the health of your community. This is going to be an informal discussion. We want to hear about your ideas, experiences and opinions. Everyone's comments are important. They might be similar or very different, but they all should be heard. The goal today is to hear from everyone.

CONTEXT

What we were hoping to talk about today is: ***What makes a healthy community?***

> *PAUSE, for thought time, not answers. Be sure attendees understand that.*

That's a difficult question, because it involves two ideas. First, there's ***HEALTH***. What do we mean by health? Do we mean freedom from disease? Having enough to eat? Feeling generally good about life? Being financially healthy?

> *PAUSE, for thought time, not answers. Be sure attendees understand that.*

Then there's the idea of **COMMUNITY**. What do we mean by community? Are we talking about each one of you, individually? Are we talking about your friends and family? Your neighborhood? Your church? Your racial or ethnic group? Your city or town? Maybe you feel part of multiple communities, or maybe you identify primarily with one community.

We're not going to define these things for you. They are for you to decide.

QUESTION 1: VISION. Now take a minute to think about your community or communities.

How can you tell if your community is healthy?

> *Probes:*
> *What does health look like in your community?*
> *What does health feel like in your community?*
> *Maybe you feel part of multiple communities, does health feel or look the same in each one?*
> **Instructions: Ensure participants know this is where we want discussion. Capture ideas on flip chart.**

QUESTION 2: CHALLENGES. We've talked about what a healthy community looks like. Now let's talk about what's not there to support community health.

What gets in the way of your community being healthy?

> *Probes:*
> *Can you give some examples of challenges your community faces?*
> *Do you ever notice disparities, or unfairness, between what your community has and what other communities have or experience?*
> **Instructions: Ensure participants know this is where we want discussion. Capture ideas on flip chart.**

QUESTION 3: STRENGTHS. So, you've told us what a healthy community looks like and what the challenges are in your community. Let's explore this idea a little more. Communities have certain **resources** that can help them be healthy. It might be programs. It might be a park or a community center. It might be a really great teacher at your local school. It might be a local business or a local organization that helps people be healthy.

My question for you is:

What's currently working? What are the resources that currently help your community to be healthy?

> *Probes:*
> *What are the strengths within your community?*
> *If someone was new to your community, and looking for resources, where would you tell them to go?*
> *How do these resources help your community to be healthy?*

Instructions: Ensure participants know this is where we want discussion. Capture ideas on flip chart.

QUESTION 4: NEEDS. So, you've now shared with us what a healthy community looks like, as well as what the challenges and strengths are in your community. Now let's talk about how we can improve your community for the future.

What is needed? What more could be done to help your community be healthy?

> *Probes:*
> *What are sources of stress or tension in your community?*
> *What do you think is important to address to improve the health of your community?*
> *Instructions: Ensure participants know this is where we want discussion. Capture ideas on flip chart.*

Conclusion:

We've come to the end of our time together today. We greatly appreciate your contributions and sharing your thoughts, thank you again for participating in the session. As we mentioned at the beginning, HCWC will be compiling this information with other information to create a Community Health Needs Assessment which will be released in July 2019. HCWC is committed to sharing that report with participants through our organization. If you have any questions after this session, please let us know and we will connect with HCWC to get them answered.

Population Health Methodology

Overview

An important part of the CHNA is the collection and analysis of population morbidity and mortality burdens. To this end, the Data Workgroup developed a robust methodology for collecting and analyzing this data.

Methods for collecting data

Data was collected from the Oregon Public Health Assessment Tool (OPHAT), Community Health Assessment Tool (CHAT) - Washington, and the Oregon State Cancer Registry. The convener was granted direct access to OPHAT and CHAT through partnership agreements with Clackamas and Clark counties, respectively.

Cancer mortality and morbidity information is not available in OPHAT for Oregon counties, therefore the convener collected summarized data on cancer morbidity and mortalities for the Oregon counties from the Oregon State Cancer Registry.

The convener's data scientist collected the necessary data for analysis from each system:

- Mortality by race and ethnicity, per county
- Morbidity by race and ethnicity, per county
- Cancer mortality and morbidity by race and ethnicity, per county

Methods for analyzing data

The data scientist analyzed the data at both the county and regional level for multiple time periods, data was age-adjusted and analyzed by race and ethnicity when that information was available.

The Data Workgroup determined that one-year periods were not appropriate for analyzing Morbidity and Mortality. A five-year period was used for the mortality analysis (2012-2016) and a three-year period for the morbidity analysis (2014-2016). Periods were selected based on data available with more historical data being available for mortality analysis than for morbidities.

Age-adjusted rates are adjusted to the projected 2000 U.S. population. The weights have not been recalculated based on the actual 2000 Decennial Census population because the National Center for Health Statistics still uses the original weights.

The population weights by age group are show in Table B-3.

Table B-3. Population Weights.

Age Group	Weight
Under 1 year	0.013818
1 to 4 years	0.055316
5 to 14 years	0.145563
15 to 24 years	0.138646
25 to 34 years	0.135575
35 to 44 years	0.162614
45 to 54 years	0.134835
55 to 64 years	0.087249
65 to 74 years	0.066035
75 to 84 years	0.044841
85 years and over	0.015509

The age-adjusted rates were analyzed by race and ethnicity for mortalities: White Non-Hispanic; Black Non-Hispanic; Hispanic; Asian Non-Hispanic; Pacific Islander Non-Hispanic; Native American Non-Hispanic; and Two or More Races Non-Hispanic. The White Non-Hispanic population was used as a reference population to determine statistical significance. Statistical significance was determined using a 95% Confidence Interval. The age-adjusted rates were also analyzed for disparities in sex using a rate ratio to determine statistical significance.

Data is suppressed based on the requirements of the data source, with data from OPHAT and CHAT suppressed when numerator is 5 or below and data from the Oregon State Cancer Registry suppressed when it is 10 or below.

Data limitations

Morbidity data is not available by race and ethnicity for Clark County, Washington. Race and ethnicity information was not consistently available between Oregon and Washington and, therefore, was not analyzed regionally for morbidities.

Hospital Discharge Data Methodology

Overview

The Data Workgroup determined that it was important to analyze data from each of the organization types participating in the collaborative to address issues that affect the health system. The Hospital Discharge files for each hospital were determined to be the best source of data about hospital access and usage by the community.

Sample

The descriptive analysis of emergency department (ED) and inpatient primary diagnoses included patient visits between January 1, 2016, and December 31, 2016, and was based on primary diagnosis at discharge. Patient-level hospital discharge data were provided to the convener from:

- Adventist Medical Center Portland
- Legacy Emmanuel Medical Center
- Legacy Good Samaritan Medical Center
- Legacy Mount Hood Medical Center
- Legacy Salmon Creek Medical Center
- Kaiser Foundation Hospital Westside
- Kaiser Foundation Hospital Sunnyside
- Oregon Health & Science University
- PeaceHealth
- Providence Milwaukie Hospital
- Providence Portland Medical Center
- Providence St. Vincent Medical
- Providence Willamette Falls Medical Center
- Tuality

The ED and inpatient analytic samples overall and by county are provided in Tables B-4 and B-5, and only include patients with a primary diagnosis and insurance type reported at discharge.

Table B-4. Total ED Visits by County: 2016.

County	N	%
Clackamas	61,512	17.0%
Clark	71,934	20.0%
Multnomah	156,524	43.5%
Washington	70,165	19.5%
All	**360,135**	**100.0%**

Table B-5. Total Inpatient Stays by County: 2016.

County	N	%
Clackamas	19,838	14.2%
Clark	16,635	11.9%
Multnomah	52,068	37.4%
Washington	50,665	36.4%
All	**139,206**	**100.0%**

Methods for analyzing data

Descriptive analyses of emergency department utilization and inpatient utilization for a select list of conditions were based on patients' primary diagnosis at discharge.

The conditions analyzed were identified by reviewing the ambulatory care sensitive conditions that were analyzed in the previous CHNA and conditions which aligned with HCWC member priorities. The list was narrowed to the top 12 conditions of interest for this analysis.

The codes used for identifying the conditions were based on the CMS Chronic Condition Warehouse and HEDIS Value Sets for the identified conditions. Codes were reviewed by an ICD coding expert employed by the convener.

Data limitations

Data from Legacy hospitals and PeaceHealth did not include a unique identifier for each patient, the analysis included some duplicate records. The data was a point in time of usage of the emergency department and inpatient stays, data was not collected or analyzed regarding the usage of outpatient services for the chronic conditions identified.

Documentation

Table B-6 shows the ICD-10 codes used in data collection.

Table B-6. Code Set.

Conditions	ICD-10 Codes
Asthma	DX J44.0, J44.1, J44.9, J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998,J45.90
Chronic Heart Failure	I42.0, I42.1, I42.2, I42.3, I42.4, I42.5, I42.6, I42.7, I42.8, I42.9, I43, I50.1, I50.20, I50.22, I50.23, I50.30, I50.32, I50.33, I50.40, I50.42, I50.43, I50.810, I50.811, I50.812, I50.813, I50.814, I50.82, I50.83, I50.84, I50.89, I50.9
Chronic Liver Disease/Cirrhosis	K76.89, K76.9, K76.3, K76.0, K74.69, K74.60, K70.31, K70.30, K70.9, K70.2, K70.0, K75.89, K75.9, K75.0, K71.10, K71.9, K71.6, K70.10, K70.11, K73.0, K73.1, K73.2, K73.8, K73.9, K74.0, K74.1, K74.2, K74.3, K74.4, K74.5, K75.4, K71.6, K71.9, K75.0, K75.9, K75.89, K76.3, K76.9,K74.69
Chronic Obstructive Pulmonary Disease (COPD)	J410, J411, J449, J441, J440, J418, J42, J439, J479, J471, J449, J209, J210, J218
Depression	F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.75, F31.76, F31.77, F31.78, F31.81, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.9, F34.1, F43.21, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.75, F31.76, F31.77, F31.78, F31.81, F34.1, F43.21
Diabetes	E08.00, E08.01, E08.10, E08.11, E08.21, E08.22, E08.29, E08.311, E08.319, E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359, E08.36, E08.39, E08.40, E08.41, E08.42, E08.43, E08.44, E08.49, E08.51, E08.52, E08.59, E08.610, E08.618, E08.620, E08.621, E08.622, E08.628, E08.630, E08.638, E08.641, E08.649, E08.65, E08.69, E08.8, E08.9, E09.00, E09.01, E09.10, E09.11, E09.21, E09.22, E09.29, E09.311, E09.319, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E09.36, E09.39, E09.40, E09.41, E09.42, E09.43, E09.44, E09.49, E09.51, E09.52, E09.59, E09.610, E09.618, E09.620, E09.621, E09.622, E09.628, E09.630, E09.638, E09.641, E09.649, E09.65, E09.69, E09.8, E09.9, E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.3211, E10.3212, E10.3213, E10.3219, E10.3291, E10.3292, E10.3293, E10.3299, E10.3311, E10.3312, E10.3313, E10.3319, E10.3391, E10.3392, E10.3393, E10.3399, E10.3411, E10.3412, E10.3413, E10.3419, E10.3491, E10.3492, E10.3493, E10.3499, E10.3511, E10.3512, E10.3513, E10.3519, E10.3521, E10.3522, E10.3523, E10.3529, E10.3531, E10.3532, E10.3533, E10.3539, E10.3541, E10.3542, E10.3543, E10.3549, E10.3551, E10.3552, E10.3553, E10.3559, E10.3591, E10.3592, E10.3593, E10.3599, E10.36, E10.37x1, E10.37x2, E10.37x3, E10.37x9, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.10, E11.11, E11.21, E11.22, E11.29, E11.311, E11.319, E11.3211, E11.3212, E11.3213, E11.3219, E11.3291, E11.3292, E11.3293, E11.3299, E11.3311, E11.3312, E11.3313, E11.3319, E11.3391, E11.3392, E11.3393, E11.3399, E11.3411, E11.3412, E11.3413, E11.3419, E11.3491, E11.3492, E11.3493, E11.3499, E11.3511, E11.3512, E11.3513, E11.3519, E11.3521, E11.3522, E11.3523, E11.3529, E11.3531, E11.3532, E11.3533,

Coordinated Care Organization Methodology

Overview

The Data Workgroup determined that it was important to analyze data from each of the organization types participating in the collaborative to address issues that affect the health system. Due to the mid-cycle closure of FamilyCare Coordinated Care Organization, that left Health Share of Oregon as the single entity from which to receive this data. Health Share hosts a data tool for their partners known as Bridge. Because Bridge 2.0 was still in development, data were requested directly from Health Share of Oregon.

Methods for collecting data

Aggregated, unduplicated data for Health Share of Oregon members were requested for the calendar years 2016 and 2017 using the same ICD-10 codes referenced earlier in Table B-6. Members were included in the aggregated file if the condition was diagnosed in any position on the claim (1–13) and occurred one or more times during the year of inquiry.

Member age was calculated at the end of each inquiry period (December 31 in 2016 and 2017). County, race, and gender were based on the most recently known value. Subpopulation data were suppressed if the count was low (< 10).

Methods for analyzing data

Data were analyzed descriptively by race and gender, comparing the calendar years 2016 and 2017.

Data limitations

The data did not allow for a lookback period and is a point-in-time count of certain conditions and should not be compared to previous analyses done by HCWC.