CLARK COUNTY

COMMUNITY HEALTH ASSESSMENT

2015

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Acknowledgements

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Introduction and Background

Clark County Public Health (CCPH) is the local health jurisdiction for Clark County, Washington. The department routinely conducts community health assessments (CHA) by reviewing health status indicators and documenting community health status. In addition to supporting departmental work, the CHAs serve as a resource within the community and benefit overall county government, community organizations, and the general public.

Previous CHA

The previous CHAs for Clark County were instrumental in various aspects of departmental and community work. The three most recent reports include the following:

- Community Assessment, Planning and Evaluation (August 2010)[1] – a broad health indicator report
- Community Report Card 2009 (January 2010)[2] – a report of selected social determinants of health within the community
- Growing Healthier: Planning for a healthier Clark County (April 2012)[3] – a report on aspects of the built environment and health influences through the comprehensive planning process

Some examples of how these past reports were used include departmental and community program planning, grant applications and reporting, and strategic planning.

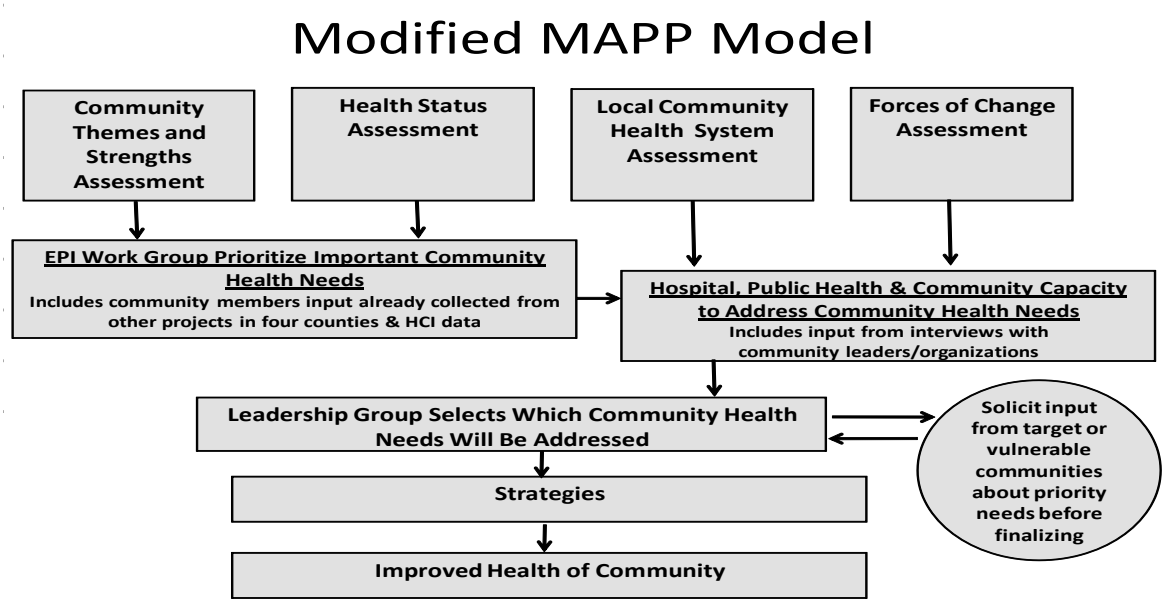
Current CHA

Regional – Healthy Columbia Willamette Collaborative

Through the work of the Healthy Columbia Willamette Collaborative (HCWC), CCPH partnered with other agencies and organizations across the Portland-Vancouver metropolitan area to conduct a regional community health needs assessment. HCWC is comprised of local public health departments, hospitals, and Oregon Coordinated Care Organizations (CCO) within the four counties of Clark County in Washington and Clackamas, Multnomah and Washington counties in Oregon. The multi-sector collaborative was created, in part, to help build efficiencies to fulfill similar needs for community health needs assessments for hospitals, public health departments, and CCOs.

Using a modified version of the Mobilizing for Action through Planning and Partnerships (MAPP)

Figure A. Schematic of the Modified MAPP Model



model (Figure A) developed by the National Association of County and City Health Officials[4], HCWC produced a series of assessment reports that collectively comprise the HCWC's Community Health Needs Assessment.[5-9] The results produced regional findings while maintaining data at the county level wherever possible. A full description of the MAPP model and a compilation of HCWC reports can be found in the Appendix.

Local – Clark County

This Clark County Community Health Assessment report specifically discusses Clark County level results in further detail. A general description of the community and selected social determinants that influence health status are also reviewed. Stemming from the regional HCWC work, data and community input were used to systematically select priority health issues.

About this report

This report documents the community health needs of Clark County, Washington. Because the assessment work was conducted as part of the regional HCWC, relevant information is shared regarding the regional process and results. Selected details are included within the report to provide greater context for the county level information. The full complement of HCWC community health needs assessment work is available for reference in the Appendix.

Description of Community

Geography

Clark County is located in southwestern Washington State along the Columbia River. It is bordered to the north by Cowlitz County and to the east by Skamania County. Along the Washington State-Oregon division of the Columbia River, the county is bordered to the south by Multnomah County (OR) and to the west by Columbia County (OR). The county is a mixture of urban, suburban and rural lands.

Demographics

Total Population and Growth

The total population of Clark County in 2014 was 442,800, making it the 5th most populous county in the state of Washington.[10] The county was the second-fastest growing from 2000 to 2010 with an increase of 80,125 people or 23% of the population.[11]

Geographic distribution

The county population was almost evenly split between incorporated cities and unincorporated areas. In 2014, a total of 232,660 people, or 53% of the population, lived within incorporated cities. The remaining 210,140 (47%) of the population live throughout the unincorporated areas of the county. The map below shows the distribution of the population within the county (Figure B).[10] Vancouver was the largest city with a population of 167,400, or 38% of the county population.

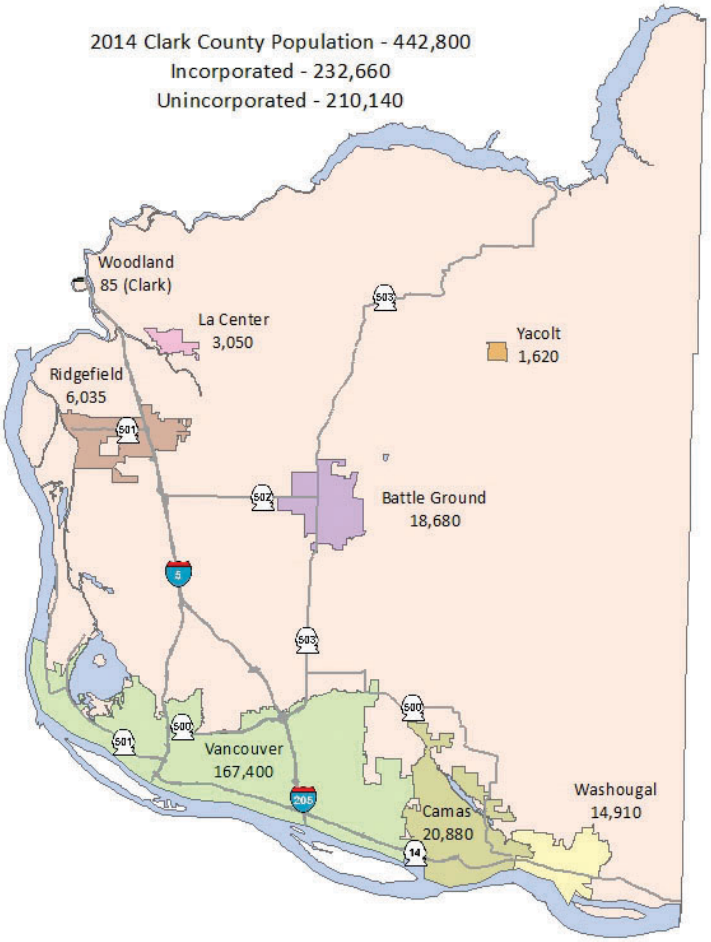
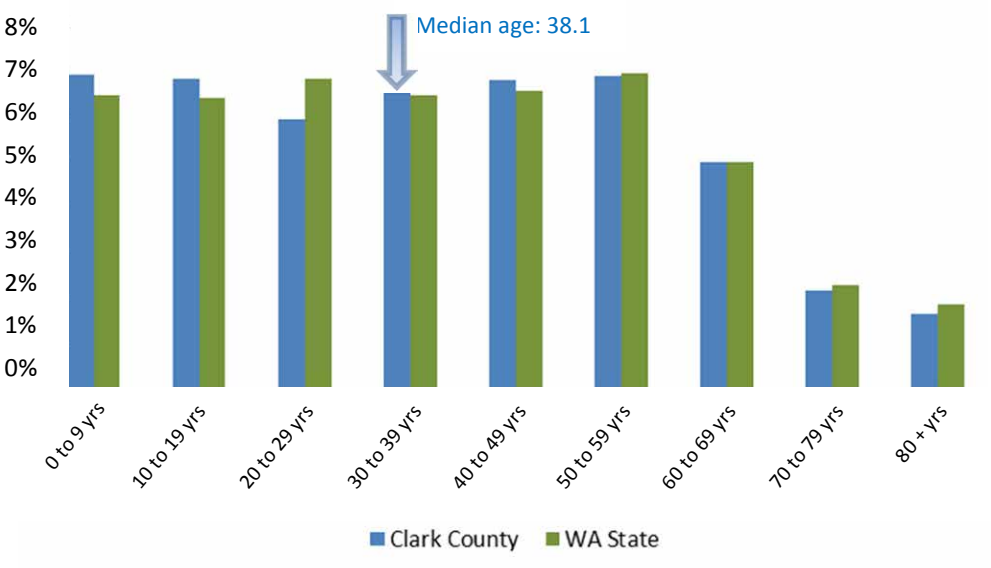


Figure B. Map of Clark County, WA

Figure C. Population by 10-year age-groups, 2014



Population composition

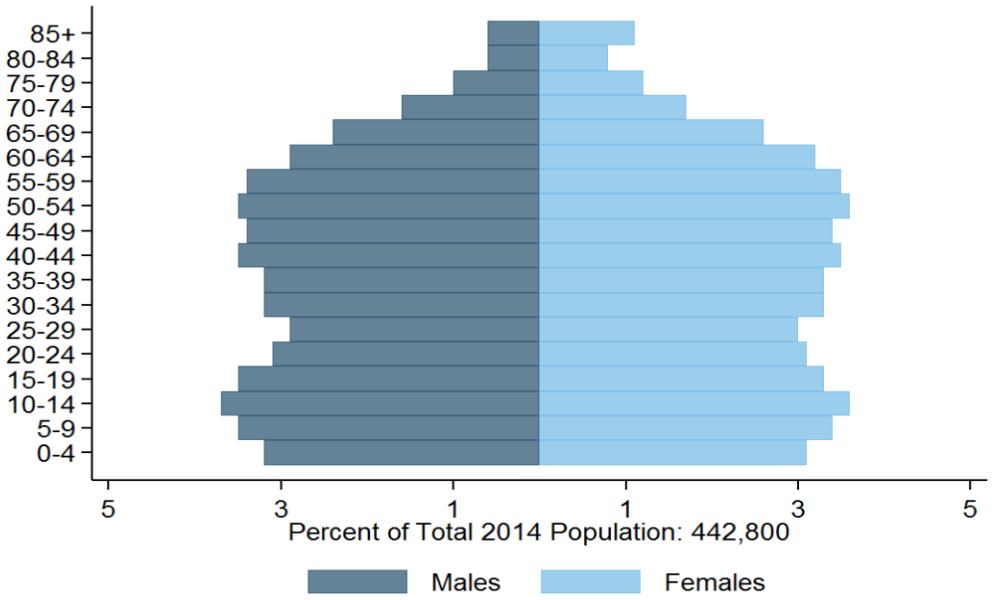
The 2014 county population composition closely mirrors the state population across 10 year age-groups (Figure C). The largest difference is apparent in the young adult age-group of 20-29 year olds. Within the state, 6.8% of the population falls within this age-group while compared to only 5.9% of the county population. The median age was also similar at 38.1 years for Clark County and 38.0 for Washington State.[12]

Table A shows the proportion of county and state populations for select age-groups. Clark County data are similar to Washington State with approximately 6% under 5 years of age, 25% under 18 years of age, and 14% 65 years and older.[12]

Table A. Population by selected age-groups, 2014

	Clark County		Washington State	
	Percent of population	Number of people	Percent of population	Number of people
Under 5 years of age	6.3%	27,766	6.3%	439,593
Under 18 years of age	24.9%	110,048	22.8%	1,591,184
65 years and older	13.6%	60,052	14.0%	978,086

Figure D. Population composition by age and gender, Clark County 2014



The county population is 49.4% male and 50.6% female (Figure D), almost identical to the state with 49.8% male and 50.2% female. When the county population is further broken down by age and gender, differences can be noted particularly in the older age-groups in which there are more females. [12]

Race and Ethnicity

Clark County's population is predominately white, non-Hispanic (85%). Eight percent of the population is Hispanic. Table B below shows the distribution across racial/ethnic groups.[13]

Table B. Population composition by race/ethnicity, Clark County 2013

	Percent of population	Number of people
White	85%	375,289
Hispanic (any race)	8%	37,171
Two or more races	4%	18,585
Asian	4%	18,171
Black	2%	10,319
American Indian/Alaska Native	1%	3,847
Pacific Islander	1%	2,945
Other	3%	14,661

Note: Race groups are non-Hispanic. Hispanic category includes all races. Total may not add to 100% due to rounding.

Table C. Language spoken at home, Clark County 2013

	Percent of population	Number of people
English only	86%	355,654
Language other than English	14%	59,460
Degree of spoken fluency with English if primarily speak another language (n=59,460)		
Speaks English "very well"	59%	35,309
Speaks English less than "very well"	41%	24,151
Language spoken at home if speak English less than "very well" (n=24,151)		
Asian/Pacific Islander	26%	6,338
Indo-European	34%	8,143
Spanish	39%	9,429
Other	1%	241

Note: Total population aged 5 years and older was 415,114.

Languages

In 2013, most county residents aged 5 years and older spoke English at home (86%). Among the residents who spoke a language other than English at home, 41% spoke English less than "very well", relying on other languages (Table C).[14]

Household and Family size

In 2013, there were an estimated 158,778 households in Clark County with an average household size of 2.8. There were 111,361 families in the county with an average family size of 3.3. This compares to an average household size of 2.6 and average family size of 3.2 across Washington State.[14, 15]

Social Determinants of Health

The World Health Organization defines health as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[16] Factors beyond traditional measures of health are often necessary to understand the broader context that influences health. Collectively, these factors are called the determinants of health. According to the Centers for Disease Control and Prevention, "these factors may be biological, socioeconomic, psychosocial, behavioral, or social in nature."[17] Several nationally recognized social determinant of health indicators across these various themes are described in this section.[18]

Economic

Median household income

In 2013, the median household income in Clark County was $57,588. This figure was similar to the $58,405 for Washington State.[19, 20] Median household income is the amount where the income of one half of households is below and one half is above.

Poverty

For Clark County residents, 12.4% of residents and 17.5% of children less than 18 years of age lived in poverty. In Washington State, 14.1% of residents and 18.8% of children less than 18 years of age lived in poverty. About 9% of families in Clark County and Washington State had incomes below the poverty level, 9.1% and 9.5% respectively. Families with children less than 18 years of age were affected more than other families. For instance, there were 15.2% of families with children less than 18 years of age in Clark County and 15.5% in Washington State that lived in poverty (Figure E).[19, 20] For reference, in 2013 the Federal Poverty Level for a family of four was $23,550.[21]

Livelihood security and employment opportunity

Unemployment rate

In 2013, the unemployment rate among the civilian population in Clark County was 8.9%. It was 7.9% throughout Washington State. [19, 20]

Supplemental Nutrition Assistance Program

The Supplemental Nutrition Assistance Program (SNAP), formerly known as food stamps, provides food assistance to residents in need. In 2013, 14.9% of households in Clark County used SNAP benefits during the previous year, similar to the 14.8% of Washington State households.[19, 20]

Transportation

Most county residents commute to work (93.3%). Only 6.7% worked at home. For those commuting, the mean travel time to work was 25.5 minutes. The mean travel time for workers in Washington State was 26.0 minutes.[19, 20]

Figure E. Percent of populations in poverty, 2013

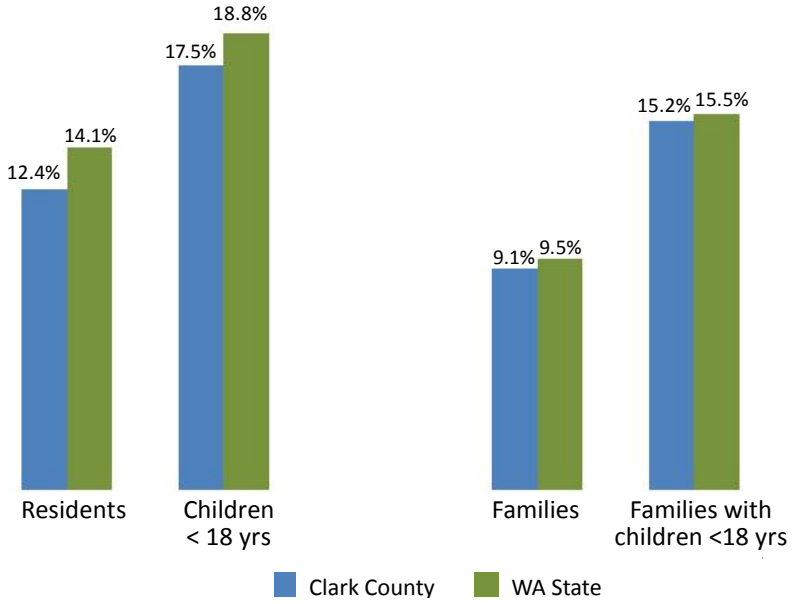
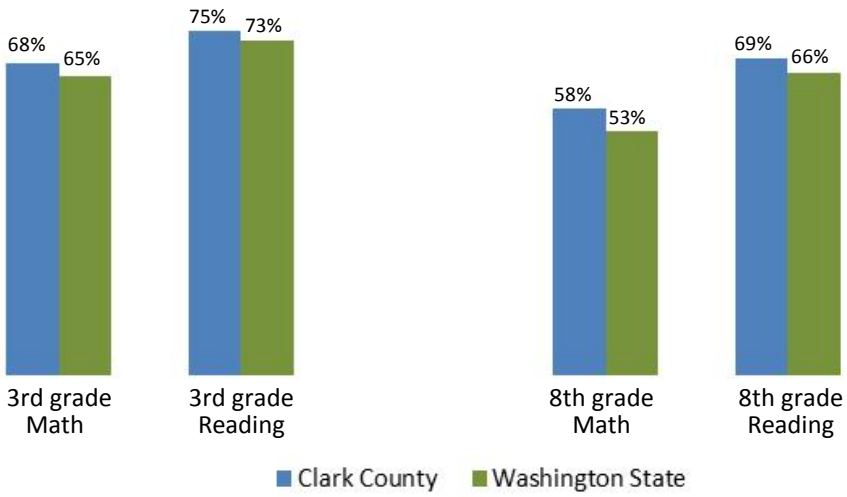


Figure F. Percent of 3rd and 8th grade students passing math and reading standards, 2012-13



School readiness and educational attainment

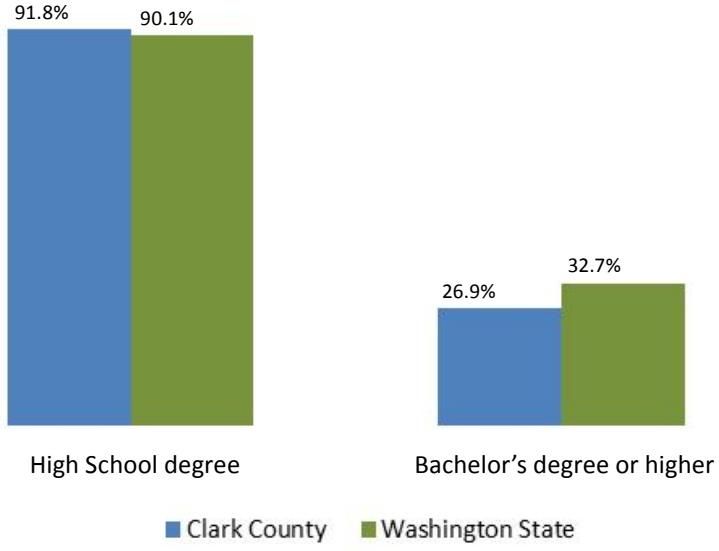
3rd & 8th grade math and reading scores

Student math and reading assessments measure student progress toward educational standards. The percent of Clark County 3rd and 8th grade students that met or exceeded standards during the 2012-13 school year were slightly better than Washington State students (Figure F).[22]

Adults with a bachelor's degree or higher

Educational achievement is recognized as a key factor regarding health. Most Clark County residents aged 25 years and older had graduated from high school or completed equivalent coursework (91.8%). Many fewer residents (26.9%) had college or graduate degrees (bachelor's degree or higher) which was less than the 32.7% in Washington State (Figure G).[14, 15]

Figure G. Percent of population 25 years and older with high school or bachelor's degree, 2013



Availability and utilization of quality medical care

Availability of health care providers varies by discipline. The ratio of providers to population is shown in Table D.[23] Provider presence within the community is one aspect of care coupled in many cases with appointment availability and insurance coverage.

Table D. Ratio of provider availability by type, Clark County, 2012-14

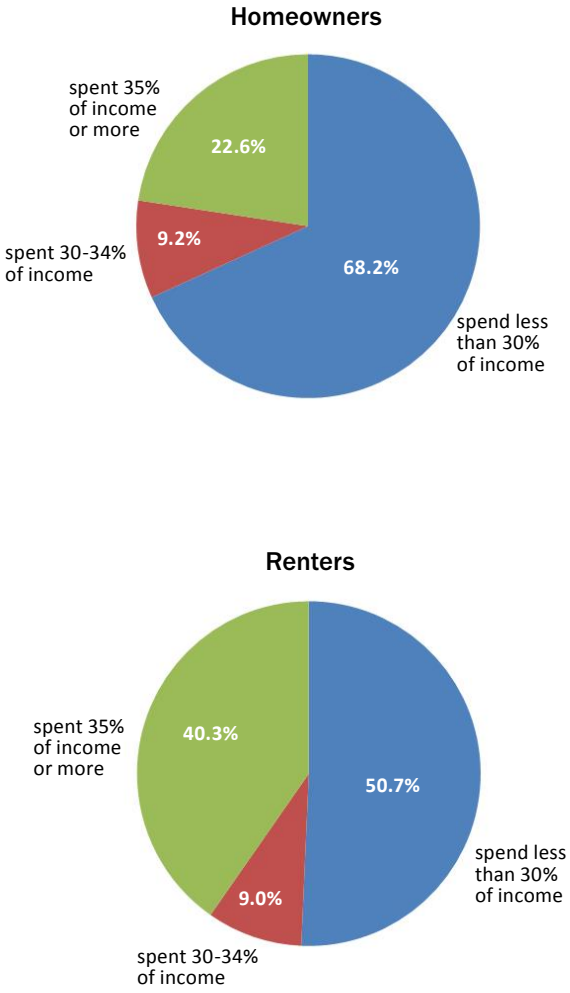
	Ratio
Dentist	1572:1
Mental Health provider	636:1
Primary Care	1469:1

Provider availability varies within the county, and some areas are federally designated as Health Professional Shortage Areas (HPSA). Clark County has the following three HPSA for primary care: (1) Vancouver low income, migrant workers, and homeless population, (2) Camas low income population, and (3) geographic area in the northern portion of the county. For mental health providers, the entire county has a HPSA for migrant/seasonal farmworkers. The county currently has no HPSA for dental providers.[24]

Adequate, affordable, and safe housing

A common measure of housing affordability is whether residents spend more than 30% of their income on housing. Spending more income on housing can stress households. In 2013, more Clark County homeowners spent less than 30% of income on housing compared to renters (68.2% of owners and 50.7% of renters, respectively). There was a larger percent of renters who spent 35% or more of their income on housing costs (40.3%) compared to homeowners (22.6%) (Figures H).[25]

Figure H. Percent of income paid towards housing, Clark County, 2013



County Health Issues

County health issues were identified through the combination of several assessment processes following the MAPP model as modified by HCWC (see Appendix). Information from indicator data and community input was compiled into the Community Health Needs Assessment. The following areas are detailed in this section:

Health Status Assessment
- Indicator Review
- Indicator Prioritization

Community Input on Health Issues
- Phase 1 – Community Themes and Strengths Assessment
- Phase 2 – Local Community Health System and Forces of Change Assessment
- Phase 3 – Community Listening Sessions

Community Health Needs Assessment

To provide greater context for county findings, select portions of the regional methodology and findings are referenced in this report. A complete compilation of HCWC regional assessment reports can be found in the Appendix.[5-9]

Health Status Assessment

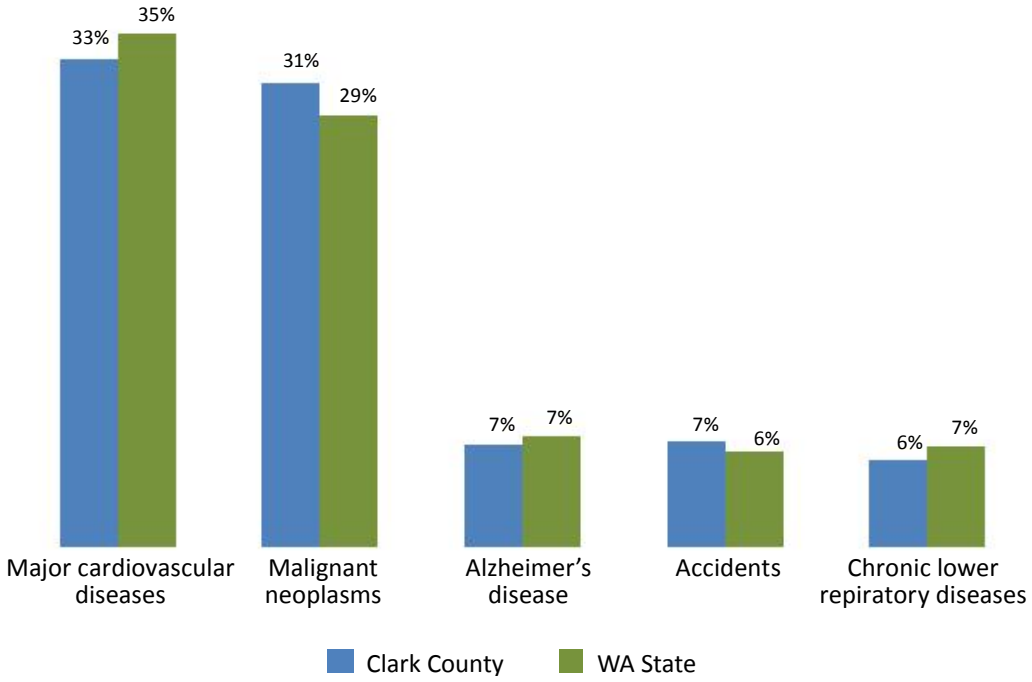
The Health Status Assessment looked at "what do the data tell us about population health." It was comprised of an expansive review of various health outcome and health-related behavior indicators in order to describe the health of the population. Once compiled, indicators were categorized through a prioritization process to identify indicators that had a significant impact on the health of residents.

Indicator Review

Leading Causes of Death

Leading causes of death were examined for Clark County and Washington State.[26] In 2010, the top five leading causes of death were the same in Clark County and Washington State. Figure I displays county and state data as the percent of all deaths. The top two categories – major cardiovascular disease and malignant neoplasms –represented two-thirds of all deaths. The top five categories combined represent 84% of all deaths.

Figure I. Top Five Leading Causes of Death, by percent of all deaths (2010)



Note: Malignant neoplasms includes all cancer types; Major cardiovascular disease includes heart disease and stroke. All other causes of death represent about 16% of all deaths.

Table E. Top Ten Leading Causes of Death and subcategories, Clark County, 2010

	RATE		RATE
Major cardiovascular diseases	197.7	Alzheimer's disease	42.7
Diseases of heart	144.9	Accidents (unintentional Injury)	41.5
Cerebrovascular diseases	38.6	Non-transport accidents	32.7
Malignant neoplasms (cancers)	181.4	Chronic lower respiratory diseases	35.5
Trachea, bronchus and lung cancer	50.4	Diabetes mellitus	20.8
Lymphoid hematopoietic/related tissue cancer	18.3	Intentional self-harm (suicide)	17.7
Breast cancer	13.5	Influenza and pneumonia	10.2
Colon, rectum and anus cancer	13.3	Pneumonia	9.7
Prostate cancer	11.9	Parkinson's disease	9.3
Pancreas cancer	10.6	Nephritis, nephrotic syndrome and nephrosis	7.2

Note: Death rates are per 100,000 age-adjusted to US Standard Population.

Table E shows the top ten leading causes of death and the respective rate per 100,000. To further detail the leading causes of death, the large, overarching categories (e.g., malignant neoplasms) were examined. For each of the categories listed, subcategories were reviewed for more specificity per condition. For instance, the broad category of malignant neoplasms was separated into the most prevalent specific cancer types. The top ten subcategories are also displayed in Table E.

Mortality indicators
Other noteworthy mortality indicators within the county were identified and reviewed to supplement the leading causes of death described previously.[26] Some indicators such as diabetes-related deaths, for example, are comprised of multiple causes of death where diabetes was a contributing factor of death. Overall, indicators range from larger, primary categories such as all cancer deaths to more specific categories such as lung cancer deaths for instance. Therefore, not all indicator categories are mutually exclusive in nature.

Behavioral indicators
Health-related behavior indicators of adults and youth were also analyzed.[27, 28] The review included indicators of the prevalence of risk and protective factors such as smoking or physical activity, prevalence of health conditions such as emotional health, prevalence of preventive health measures such as cancer screening, and measurement of health care access.

Additional indicators
For a more comprehensive review, additional indicators related to cancer incidence, maternal and child health and health insurance were also included.[29, 30]

Indicator Prioritization

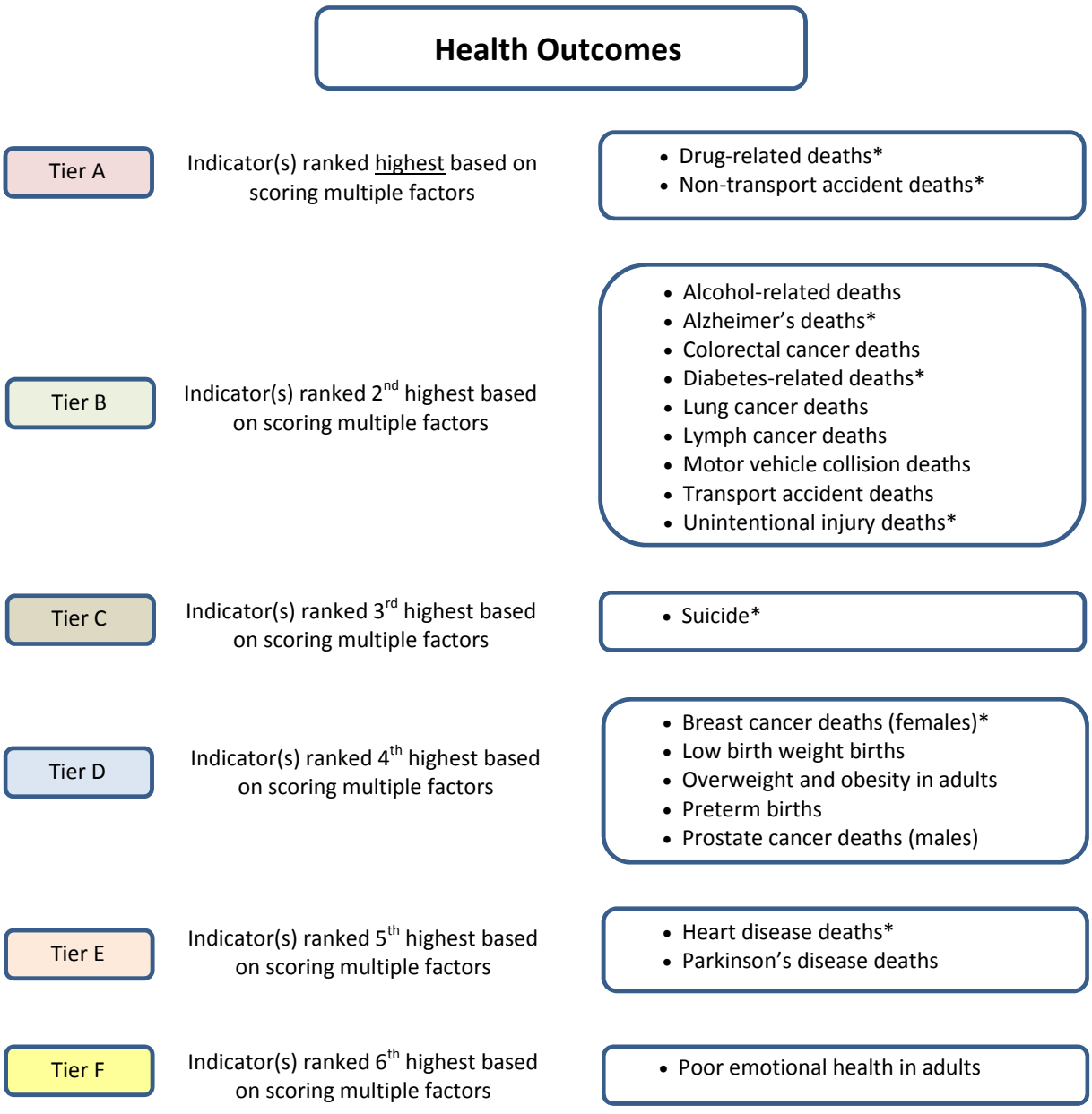
Indicators for health outcomes and health-related behaviors were scored and ranked based on the HCWC prioritization matrix. For each indicator, six elements were reviewed to systematically identify the top health outcomes and health-related behaviors. The six predetermined criteria included racial/ethnic disparities, gender disparities, comparison to the state value, trend over time, magnitude of the population affected, and severity of associated health consequences. The highest scoring indicators were those that showed significant disparities, a worsening trend, poor performance compared to state values, impact on many people, and/or had severe consequences.

Figures J and K show the county's highest ranking health outcomes and health behaviors by level or tier. Each tier shows either a single indicator or a group of indicators (when multiple indicators scored

the same based on the prioritization matrix). Within each tier, indicators are listed in alphabetical order. Higher tiers would generally be considered worse and may need attention before other tiers.

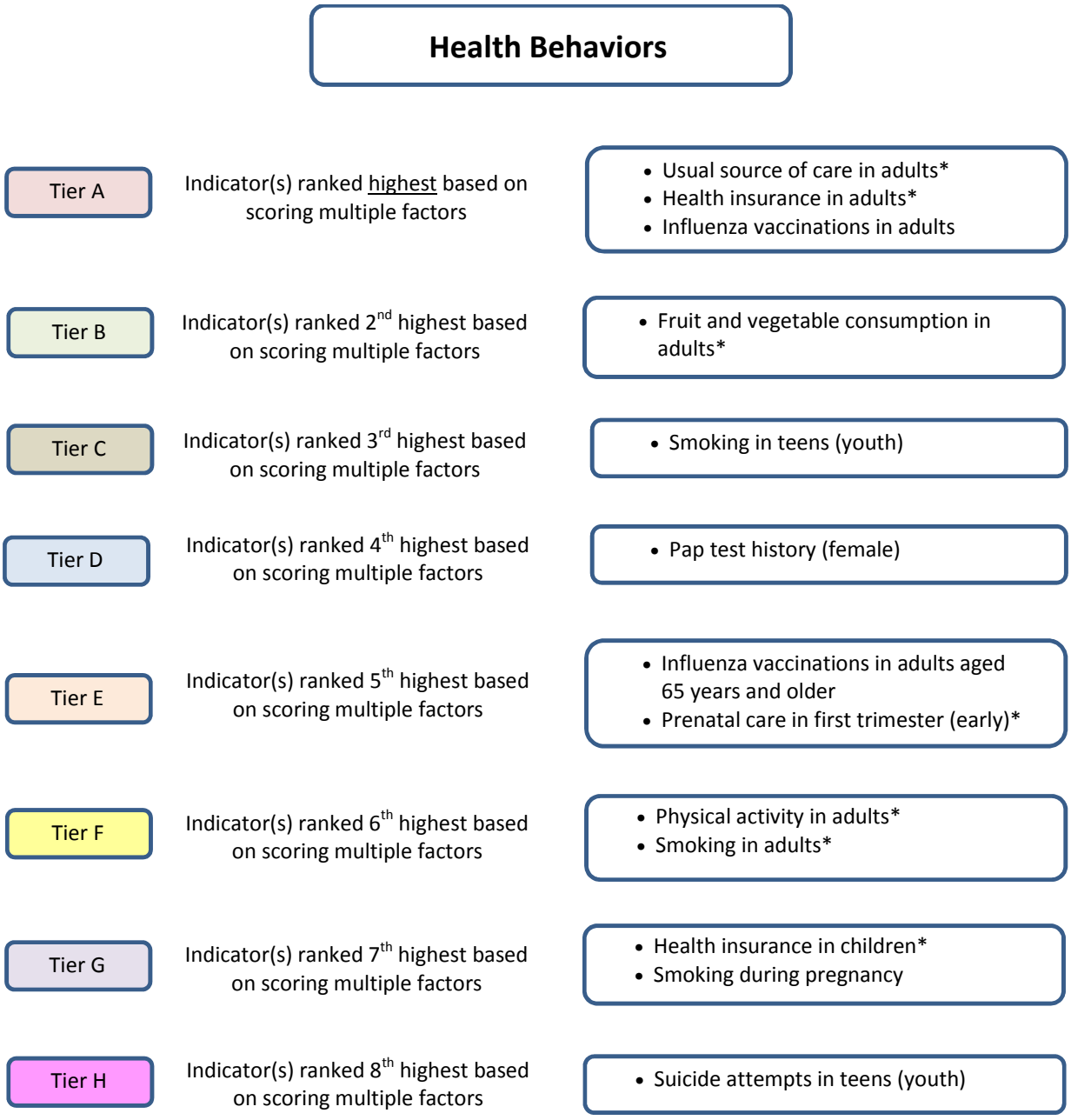
Whereas Figures J and K display the tier grouping based on the prioritization matrix, Tables F and G show specific data for the indicators. Indicators are displayed in the same tier groupings as Figures J and K. County rates are shown per indicator and category (e.g., gender, race). Trend over time and how the rate compares to the Washington State rate are noted. Statistically significant differences are documented when evident. Indicators that were also

Figure J. Clark County's highest ranking health outcomes (see Table F for data).
Higher tiers would generally be considered worse and may require attention before other tiers.



Notes: Indicators are listed in alphabetical order within tier.
Death rates are per 100,000 age-adjusted to US Standard Population.
*Indicators were also top-ranked regional indicators.

Figure K. Clark County's highest ranking health (see Table G for data).
Higher tiers would generally be considered worse and may require attention before other tiers.



Notes: Indicators are listed in alphabetical order within tier.
Incidence rates are per 100,000 of the population at risk. Adult behavior data are a percent of the population at risk. Youth behavior data are a percent of student enrollment (e.g., 10th grade).
*Indicators were also top-ranked regional indicators.

Table F. Clark County Top Ranked Health Outcome Indicators
Higher tiers would generally be considered worse and may require attention before other tiers.

Tier	Health Outcome Indicators[26, 27, 30]	County Rate (2010)	Gender (2006-2010)		Race/Ethnicity (2005-2009)					Trend	Compare to state	WA rate (2010)
			Male	Female	W	B	A	AI/AN	H			
A	Drug-related deaths*	12.6	17.4	11.1	14.6	--	--	--	--	Worse	Same	13.7
	Non transport accidents deaths*	32.7	33.6	20.6	25.1	32.9	--	--	--	Worse	Same	28.4
B	Alcohol-related deaths	8.1	13.0	6.7	10.0	--	--	--	--	No	Same	11.2
	Alzheimer's deaths*	42.7	34.9	45.6	42.2	--	--	--	--	No	Same	43.6
	Colorectal cancer deaths	13.3	18.4	12.6	16.4	--	--	--	--	No	Same	14.1
	Diabetes-related deaths*	83.0	108.6	69.7	90.3	165.7	115.0 (API)	--	90.1	No	Same	75.2
	Lung cancer deaths	50.4	57.7	44.0	53.1	68.1	32.6 (API)	--	--	No	Same	46.8
	Lymph cancer deaths	18.3	22.7	15.0	19.8	--	--	--	--	No	Same	17.0
	Motor vehicle collision deaths	8.2	12.0	4.3	8.7	--	--	--	--	No	Same	7.8
	Transport accident deaths	8.8	13.1	4.7	9.4	--	--	--	13.2	No	Same	8.9
	Unintentional injury deaths*	41.5	46.7	25.3	34.5	41.3	33.7 (API)	--	34.6	No	Same	37.3
C	Suicide*	17.7	23.0	7.1	14.1	--	--	--	--	No	Same	13.8
D	Breast cancer deaths (females)*	24.1	n/a	Female only	22.4	--	--	--	--	No	Same	21.2
	Low birth weight births	6.4%	5.7% (baby)	6.4% (baby)	6.1	9.7	8.9 (A)	--	5.7	Worse	Same	6.3%
	Overweight and obesity in adults	61.8%	71.6%	56.6%	65.3%	--	38.1% (A)	--	57.0%	No	Same	61.3%
	Preterm births	10.1%	10.8% (baby)	9.7% (baby)	9.9%	14.9%	11.8% (A) 15.0% (NH/PI)	10.4	11.0%	No	Same	10.0%
	Prostate cancer deaths (males)	29.3	Male only	n/a	26.8	--	--	--	--	No	Same	23.2
E	Heart disease deaths*	144.9	197.5	118.8	164.7	195.0	133.5 (API)	--	140.7	Improve	Same	150.5
	Parkinson's disease deaths	9.3	13.3	6.5	10.5	--	--	--	--	No	Same	7.8
F	Poor emotional health in adults	11.4%	8.1%	12.0%	9.8%	--	--	--	--	No	Same	10.4%

Notes: Indicators are in listed in alphabetical order within tier. Death rates are per 100,000 age-adjusted to US Standard Population. Incidence rates are per 100,000 of the population at risk. Adult behavior data are a percent of the population at risk. Youth behavior data are a percent of student enrollment (e.g., 10th grade). Race/Ethnicity includes White-non Hispanic (W), Black-non Hispanic (B), Asian-non Hispanic (A), American Indian or Alaskan Native-non Hispanic (AI/AN), and Hispanic (H-any race). Sub-categories of Asian-non Hispanic are listed where available: Asian (A), Asian Pacific Islander (API), Native Hawaiian/Pacific Islander (NH/PI). Values noted in red are statistically significant. Values without enough data to report are blank. *Indicators that were top-ranked regional indicators.

Table G. Clark County Top Ranked Health-Related Behavior Indicators
Higher tiers would generally be considered worse and may require attention before other tiers.

Tier	Health-Related Behavior Indicators[27, 28, 30]	County Rate (2010)	Gender (2006-2010)		Race/Ethnicity (2006-2010)					Trend	Compare to state	WA rate (2010)
			Male	Female	W	B	A	AI/AN	H			
A	Usual source of care in adults*	77.3%	70.2%	81.4%	77.6%	--	--	--	47.2%	No	Same	78.5%
	Health insurance in adults*	85.2%	85.0%	89.0%	89.0%	--	--	--	61.8%	No	Same	85.0%
	Influenza vaccinations in adults	37.5%	32.4%	42.3%	--	--	--	--	--	--	Worse	43.0%
B	Fruit and vegetable consumption in adults*	21.7% (2009)	18.1%	29.5%	23.8%	--	--	--	--	No	Worse	25% (2009)
C	Smoking in teens (youth)	13.7%	14.8%	14.1%	14.3%	18.5%	6.3% (A) 15.5% (NH/PI)	26.6%	12.9%	No	Same	12.7%
D	Pap test history (female)	80.9% (2010)	n/a	Female only	78.1%	--	--	--	--	--	Same	80.7% (2010)
E	Influenza vaccinations in adults aged 65 years+	69.1%	70.0%	71.4%	71.2%	--	--	--	--	No	Same	69.8%
	Prenatal care in first trimester (early)*	76.3%	n/a	Female only	76.3%	70.7%	78.0% (A) 71.2% (NH/PI)	66.2%	66.9%	No	Worse	80.1%
F	Physical activity in adults*	55.2% (2009)	56.3%	53.0%	54.8%	--	--	--	53.6%	No	Same	53.6% (2009)
	Smoking in adults*	17.1%	17.9%	15.5%	16.8%	--	--	--	11.9%	Improve	Same	14.9%
G	Health insurance in children*	92.8% (2009-11)	--	--	--	--	--	--	--	No	Same	93.5% (2009-11)
	Smoking during pregnancy	12.0%	13.4% (baby)	13.2% (baby)	14.2%	14.8%	2.8% (A) 12.3% (NH/PI)	--	5.2%	Improve	Worse	9.2%
H	Suicide attempts in teens (youth)	7.2%	6.8%	9.0%	6.5%	--	--	--	--	Improve	Same	7.2%

Notes: Indicators are in listed in alphabetical order within tier. Death rates are per 100,000 age-adjusted to US Standard Population. Incidence rates are per 100,000 of the population at risk. Adult behavior data are a percent of the population at risk. Youth behavior data are a percent of student enrollment (e.g., 10th grade). Race/Ethnicity includes White-non Hispanic (W), Black-non Hispanic (B), Asian-non Hispanic (A), American Indian or Alaskan Native-non Hispanic (AI/AN), and Hispanic (H-any race). Sub-categories of Asian-non Hispanic are listed where available: Asian (A), Asian Pacific Islander (API), Native Hawaiian/Pacific Islander (NH/PI). Values noted in red are statistically significant. Values without enough data to report are blank. *Indicators that were top-ranked regional indicators.

Community input on health issues

Input was sought through various community engagement activities to elicit thoughts and perspectives about community health needs. Community input was obtained through a three-part phased approach. Phase 1 and Phase 2 identified health needs through review of previous work and feedback from key community representatives. Phase 3 validated findings about health concerns directly with community members.

Phase 1 - *Community Themes and Strengths Assessment: What does the community identify as health issues?*

For the first phase, community engagement projects conducted since 2009 that related to health were reviewed to identify the most important health issues affecting community members, their families, and the community.[5]

Across the region, the 62 projects reviewed dated back to 2009 and included 38,000 participants. There were 12 Assessment projects examined for Clark County. The top health-related themes specific to the county are shown in Figure L. Each of these topics was also identified as a top theme within the region. There were two additional themes identified in the region but not specifically in Clark County. The health issues identified through this phase were also documented in the current health status assessment.[6]

Phase 2 - *Local Community Health System & Forces of Change Assessment: What is the capacity to address the health issues?*

The second phase of community engagement involved interviewing and surveying stakeholders and community representatives.[7] Examples of respondents included service agency staff, community organization directors, and representatives from distinct culturally identified communities (e.g., low income, ethnic groups). This phase solicited stakeholder feedback on the identified health issues resulting from Phase 1 as well as from the health status assessment. Stakeholders were asked to prioritize previously identified health issues and add any others they thought were missing. In addition, they were asked to describe their organizations' capacity to address these health issues and any outside influences that might affect the ability to address them (e.g., funding, political environment).

Figure L. Phase 1
Clark County top health-related themes

Social environment
Access to affordable health care
Equal economic opportunities
Housing
Access to healthy food
Education
Chronic disease
Mental health and substance abuse
Safe neighborhood
Poverty

Additional themes identified in the region but not specifically Clark County:
Early childhood/youth
Transportation options

Note: Ranked by how many assessments the theme was identified in.

There were 126 stakeholder participants in the region, and 58 participated on behalf of Clark County. Issues selected by at least 30% of respondents were regarded as prioritized health issues. The same five health issues were priorities in Clark County and the region. Stakeholders within Clark County, however, also prioritized cancer and oral health. The Clark County prioritized health issues are shown in Figure M.

Figure M. Phase 2
Clark County Prioritized Health Issues

Access to health care
Cancer†
Chronic disease
Culturally competent services/data
Mental health
Oral health†
Substance abuse

Note: † topics identified for Clark County and not for the region.

Phase 3 - *Community Listening Sessions: Do community members feel "we have it right"*

The third phase of community engagement vetted earlier findings with community members through community listening sessions.[8] During these sessions, community members were asked whether they agreed with the issues that were identified through the previously conducted community engagement efforts and health status assessment. Participants were asked to add to the list the health issues that they thought were missing or not identified in the previous work. Finally, participants voted for what they thought were the most important issues from the expanded list.

There were 14 community listening sessions held with uninsured and/or low-income community members living in the four-county area. A total of 202 individuals participated including some for whom English was not their native language and interpreters were available. Because of the relatively small number of participants, results were not available for each individual county but rather presented for the region. Though results are not county specific, there was a fair amount of agreement across sessions on the important health issues. Figure N lists the most important health issues for the region. These issues were consistent with findings in the previous Clark County assessments described above.

Figure N. Phase 3
Most Important Health Issues (region)

Mental health and mental health services
Chronic disease and related health behaviors
Substance abuse
Access to affordable health care
Oral health and access to oral health services

Community Health Needs Assessment

The compilation of the indicator data from the health status assessment and the three phases of community engagement comprise the community health needs assessment findings.[5-9] Some health issues identified through the community input process coincided with the health indicator data while other health issues were identified only through one part of the process.

Overall, nine broad community health issues, or health focus areas, were identified across the four-county region. Clark County identified the same nine community health issues and also added the specific categories of "Aging-related issues" and "Immunization" based on the county assessment findings. Therefore, there were 11 health issues identified for Clark County. Table H shows the 11 health issues for Clark County and displays which assessment each was identified through (listed in alphabetical order).

Table H. Clark County health issues identified by community members or population data

Health Issue	ASSESSMENT IDENTIFIED IN			
	HSA	Phase 1-CTSA	Phase 2-LCHS & FoC	Phase 3-Listening Sessions
Access to health care	Yes	Yes	Yes	No
Aging-related issues†	Yes	No	No	No
Cancer	Yes	Yes	Yes	No
Chronic disease (related to physical activity & healthy eating)	Yes	Yes	Yes	Yes
Culturally competent services/data collection	ND	No	Yes	No
Immunization†	Yes	No	No	No
Injury	Yes	No	No	No
Mental health	No	Yes	Yes	Yes
Oral health	ND	No	Yes	Yes
Sexual health	Yes	No	No	No
Substance abuse	Yes	Yes	Yes	Yes

Notes: ND=no data available. †denotes topics identified for Clark County and not for the region. HSA was the Health Status Assessment. Phase 1-CTSA was Community Themes and Strengths Assessment. Phase 2-LCHS & FoC was the Local Community Health Systems and Forces of Change Assessment.

Priority Health Issues

Selecting Priority Health Issues

In order to better focus attention on specific health issues, HCWC developed a standard selection tool for identifying priority health issues. This tool was used for each county and the region to objectively show the most significant community health issues.[9]

To be selected as a priority area, the health issue needed to be identified by the following criteria:

- Was identified by at least two of the three community engagement activities (i.e., Community Themes & Strengths Assessment, Local Community Health System & Forces of Change Assessment, and Community Listening Sessions);
- Was identified as a health issue (with indicators) through the Health Status Assessment‡
- Was one of the top five most expensive issues in the metropolitan statistical areas in western U.S.‡
- Has shown to improve as a result of at least one type of evidence-based practice‡

Note: ‡ Considered also if data were not currently available.

The Clark County selection tool incorporated the 11 identified health issues (Table I). Three of these health issues met all the selection criteria and were therefore deemed priority health issues for potential action. These same three areas were also selected as priority health issues for the region. Figure O shows the priority health issues for Clark County (in alphabetical order).

Figure O. Clark County Priority Health Issues

Access to health care
Behavior health (combination or mental health and substance abuse categories)
Chronic disease (related to physical activity and health eating)

Table I. Selection Tool: Clark County Community Health Issues

	Oral Health	Substance Abuse	Mental Health	Chronic Disease: nutrition, physical activity	Chronic Disease: cancer	Sexual Health	Injury	Access to affordable health care	Culturally-competent data/services	Immunization	Aging-related issues
Was the issue identified by community members or population data?											
1. Community Themes & Strengths Assessment: Is the issue one of the 10 most frequently mentioned[1]? (community input)	No	Yes Combined with mental health	Yes Combined with substance abuse	Yes Includes cancer Yes Access to healthy food	Yes Included in chronic disease	No	No	Yes	No	No	No
2. Health Status Assessment: Is the issue identified as one of prioritized health issues? (population data)	Do not have data	Yes Adults who smoke Teens who smoke Alcohol-related deaths Drug-related deaths	No	Yes Adults doing regular physical activity Adult fruit/vegetable consumption Diabetes-related deaths	Yes Adults who smoke Teens who smoke Colorectal cancer deaths Lung cancer deaths Lymphoid cancer deaths	Yes Pap test history	Yes Motor vehicle collision deaths Non-transport accident deaths Transport accident deaths Unintentional injury deaths	Yes Adult with an usual source of health care Adults with health insurance Mothers receiving early prenatal care	Do not have data	Yes Influenza vaccination rate	Yes Alzheimer's disease deaths Unintentional injury deaths
3. Local Community Health System & Forces of Change Assessment: Is the issue one of the most frequently identified?[2] (community input)	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No	No

[1] Of the 10 most frequently mentioned issues, only those that are health outcomes and health behaviors were considered. Social determinants of health, (e.g., poverty) were not included in this assessment because they are outside the reach of the Local Community Health System.

[2] Results are from interviews (N=34) and surveys (N=24) for Clark County unless otherwise noted. Issues identified by at least 30% of surveys/interviews combined were included.

Table I. Selection Tool: Clark County Community Health Issues continued

	Oral Health	Substance Abuse	Mental Health	Chronic Disease: nutrition, physical activity	Chronic Disease: cancer	Sexual Health	Injury	Access to affordable health care	Culturally-competent data/services	Immunization	Aging-related issues
4. Community Listening Sessions: Is the issue in the 5 most frequently identified health issues? (community input)	Yes	Yes	Yes	Yes	No	No	No	Yes	No	No	No
Is the issue a driver of health care costs in the region?											
5. Is the issue one of the top five most expensive in the metropolitan statistical areas in western U.S.[3]?	Do not have data	Yes Combined with mental health	Yes Combined with substance abuse	Yes Diabetes	Yes Cancer	No	Yes Includes all trauma related disorders	Do not have data	Do not have data	No	Yes Includes all trauma related disorders (if falls are included)
Is the issue something that the Local Community Health System can influence?											
6. Is the issue a priority identified in the National Prevention Strategy[4]	No	Yes Preventing drug abuse and excessive alcohol use Tobacco free living	Yes Mental and emotional well-being	Yes Active living Healthy eating	No	Yes Reproductive and sexual health	Yes Injury and violence free living	No	No	No	Yes Injury and violence free living (if falls are included)
7. In what setting are the evidence-based practices to address this issue?[5] (Community Guide/HCI)	Community	Policy Healthcare Community	Healthcare Community	Policy Healthcare Community	Policy Healthcare	Policy Healthcare	Policy Community	Policy Healthcare Community	Research gap	Policy Healthcare Community	Policy Healthcare Community
		MET	MET	MET				MET			

[3] Medical Expenditure Panel Survey, Household Component , Agency for Healthcare Research and Quality, 2010 data

[4] The Affordable Care Act created the National Prevention Council and called for the development of the National Prevention Strategy to realize the health and economic benefits of prevention for all Americans. Seven priority health issues are identified, along with evidence-based strategies across multiple sectors that are likely to improve health.

[5] Evidence-based practices have been identified by the CDC Community Guide or Healthy Communities Institute. They have been categorized into policy, healthcare and community settings.

Addressing Priority Health Issues

CCPH and other HCWC member organizations agreed to collaborate on two health improvement strategies related to the Behavioral Health and Chronic Disease priority health issues through participation in and support of the HCWC Community Health Improvement Teams (C-HIT). The focus of the C-HITs has been improving behavioral health by preventing prescription opioid related overdoses and deaths through changes in prescription opioid practices and preventing chronic disease through the promotion of breastfeeding/ expression of breast milk.[31]

The third priority health issue identified was Access to Affordable Health Care. Recognizing the many existing efforts to improve access, no direct strategy was developed for this priority health issue.

To supplement the HCWC work, CCPH may want to consider complementary health improvement strategies around these two priority health issues or develop additional strategies for other health issues identified within Clark County.

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APPENDIX

Healthy Columbia Willamette Collaborative Regional Health Issues

APPENDIX

Materials used in this Appendix were taken directly from Healthy Columbia Willamette Collaborative reports. Full reports are also available through HCWC directly (see contact information below).

HEALTHY COLUMBIA WILLAMETTE COLLABORATIVE ACKNOWLEDGEMENTS

Note: Community Themes and Strengths Assessment[a], Health Status Assessment[b], Local Community Health System and Forces of Change Assessment[c], Community Listening Sessions[d], Year One Progress Brief[e], Year Two Progress Brief[f]

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Healthy Columbia Willamette Collaborative Regional Health Issues

Healthy Columbia Willamette Collaborative Members

The following 21 agencies and facilities comprise the 13 member organizations of the Healthy Columbia Willamette Collaborative:

Adventist Medical Center
Clackamas County Health Division
Clark County Public Health
FamilyCare
Health Share of Oregon
Kaiser Sunnyside Hospital
Kaiser Westside 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
Washington County Public Health Division

INTRODUCTION AND BACKGROUND

Vision

The Healthy Columbia Willamette Collaborative's vision is to: 1) align efforts of non-profit hospitals, coordinated care organizations, 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; 2) eliminate duplicative efforts; 3) lead to the prioritization of community health needs; join efforts to implement activities and monitor progress; and 4) improve the health of the community.

Collaborative Origin

In 2010, local health care and public health leaders in Clackamas, Multnomah, and Washington counties in Oregon and Clark County in Washington began to discuss the upcoming need for several community health assessments and health improvement plans within the region in response to the Affordable Care Act and Public Health Accreditation[1]. They recognized these requirements as an opportunity to align the efforts of hospitals, public health and the residents of the communities they serve in an effort to develop an accessible, real-time assessment of community health across the four-county region. By working together, they would eliminate duplicative efforts, facilitate the prioritization of community health needs, enable joint efforts for implementing and tracking improvement activities, and improve the health of the community.

Members

With start-up assistance from the Oregon Association of Hospitals and Health Systems, the Healthy Columbia Willamette Collaborative was developed. It is a large public-private collaborative currently comprised of 15 hospitals, four local public health departments, and two Coordinated Care Organizations (Oregon only) in the four-county region.

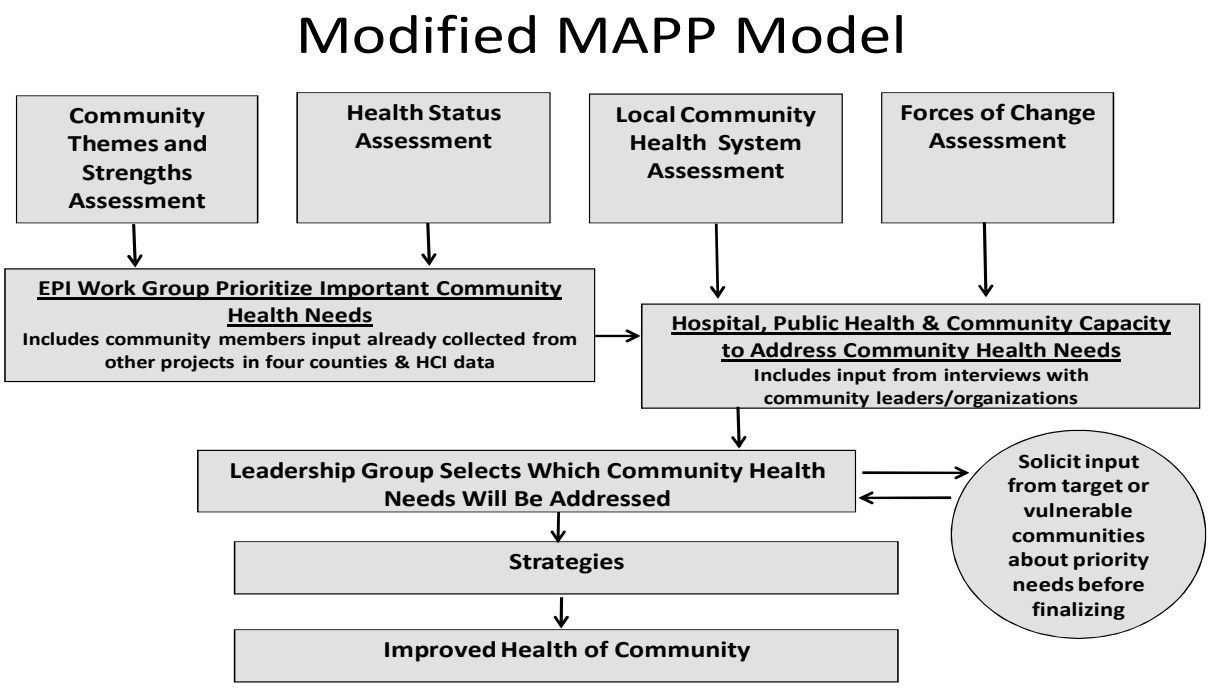
Assessment Model

The Collaborative used a modified version of the Mobilizing for Action through Planning and Partnerships (MAPP) assessment model[2]. See Figure 1. The MAPP model uses health data and community input to identify the most important community health issues. This assessment will be an ongoing, real-time assessment with formal community-wide findings every three years. Community input on strategies and evaluation throughout the three-year cycle will be crucial to the effort's effectiveness.

[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).

[2] MAPP is a model developed by the National Association of County and City Health Officials (NACCHO)

Figure 1. Schematic of the Modified MAPP Model



Five phases of this assessment model were completed between August 2012 and April 2013:

The Community Themes and Strengths Assessment (Fall 2012)
This first assessment involved reviewing 62 community engagement projects that had been conducted in the four-county region since 2009. Qualitative responses from community members participating in 62 projects were analyzed for themes about health issues they identified as the most significant to the community, their families, and themselves.

The Health Status Assessment (Fall 2012)
The second assessment was conducted by epidemiologists from the four county health departments with representatives from two hospital systems acting in an advisory capacity. This workgroup systematically 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 analysis used the following criteria for prioritization: disparity by race/ethnicity, disparity by gender, a worsening trend, a worse rate at the county level compared to the state, a high proportion of the population affected, and severity of the health impact.

The Local Community Health System Assessment & Forces of Change Assessment (Winter 2013)
The third and fourth assessments were combined, and involved interviewing and surveying 126 stakeholders. This assessment was designed to solicit stakeholder feedback on the health issues resulting from the first two assessments listed above. Stakeholders were asked to add and prioritize health issues they thought should be on the list, as well as describe their organizations' capacity to address these health issues.

Community Listening Sessions (Spring 2013)
The next phase is not a formal MAPP component, but was added to ensure the findings from the four assessments resonated with the local community. Fourteen community listening sessions were held with uninsured and/or low-income community members living in Clackamas, Clark, Multnomah and Washington counties. More than 100 organizations and local businesses helped recruit for these discussions so that members of a variety of culturally-identified communities and geographic communities would be reached. In all, 202 individuals participated. During these meetings, community members were asked whether they agreed with the issues that were identified through the four assessments. Participants were also asked to add to the list the health issues that they thought were missing. Next, participants voted for what they thought were the most important issues from the expanded list.

COMMUNITY THEMES AND STRENGTHS ASSESSMENT

Purpose

The broad goal of the Community Themes and Strengths Assessment was to identify health-related themes from recent projects engaging community members of Clackamas, Multnomah and Washington counties in Oregon and Clark County in Washington.

Conducting the Community Themes and Strengths Assessment served three purposes: 1) to increase the number of community members whose voices could be included; 2) to prevent duplication of efforts and respect the contributions of community members who have already shared their opinions in recent projects; and 3) to utilize the extensive and diverse community engagement work that local community-based organizations, advocacy organizations, and government programs have already done.

Community Themes and Strengths Assessment findings combined with the findings of the other three MAPP assessment components and the community listening sessions provided the Collaborative's Leadership Group with information necessary to select the community health needs and improvement strategies within the four-county region.

Methodology

The Community Themes and Strengths Assessment, the first of four major components of MAPP, was an analysis of findings from recently conducted health-related community assessment projects conducted in Clackamas, Multnomah, and Washington counties in Oregon and Clark County in Washington State.

Between September and December 2012, the Collaborative identified community assessment projects conducted within the four-county region. Four criteria were used for inclusion in the "inventory" of assessment projects that would be used to identify community-identified themes. The assessment project needed to: 1) be designed to explore health-related needs, 2) have been completed within the last three years (since 2009), 3) have a geographic scope within the four-county region, and 4) engage individual community members in some capacity, as opposed to only agency-level stakeholders.

Community assessment projects were identified by: 1) contacting individual community leaders, community-based organizations, public agencies and Healthy Columbia Willamette Collaborative leadership members to solicit their recommendations for projects to include in the inventory; 2) conducting numerous Internet searches, which consisted of using a Google search engine and by examining hundreds of organizational websites across the four-county region and; 3) including recent community assessment projects that had already been identified through the Multnomah County Health Department's 2011 Community Health Assessment. At the end of this report, tables in four appendices describe the assessment projects included in this inventory; the participants for each project (as described by each project's authors); and the health-related themes found from each project. In all, 62 community assessment projects' findings were included in the "inventory" of assessments.

This inventory includes large-scale surveys, PhotoVoice[3] projects, community listening sessions, public assemblies, focus groups, and stakeholder interviews. Not only did their designs vary, the number and included participants were quite different. For example, one project engaged a small group of Somali elders while another was a massive multi-year process engaging thousands of members of the general public. Collectively, these projects' findings paint a picture of what people living in the four-county area say are the most pressing health issues they and their families face. Although there is not a scientific way to analyze these findings as a whole, it was possible to identify frequently-occurring themes across these projects.

Findings

The most frequently-arising themes in the four-county region were identified through a content analysis of the findings from the assessment projects. Below, each theme is defined using descriptors directly from the individual projects. Issues are categorized either as "important" or as a "problem." In Table 1, these themes

[3] PhotoVoice is a process by which people can identify, represent, and enhance their community by taking photos to record and reflect their community's strengths and concerns.

are listed in the order of how frequently they arose in the four-county region, as well as the order they occurred in each county.

Social environment:
- Issues identified as important: sense of community, social support for the community, families, and parents, equity, social inclusion, opportunities/venues to socialize, spirituality
- Issue identified as problems: racism

Equal economic opportunities
- Issues identified as important: jobs, prosperous households, economic self sufficiency, equal access to living-wage jobs, workforce development, economic recovery
- Issue identified as problems: unemployment

Access to affordable health care
- Issues identified as important: access for low income, uninsured, underinsured, access to primary care, medications, health care coordination
- Issue identified as problems: emergency room utilization

Education
- Issues identified as important: culturally relevant curriculum, student empowerment, education quality, opportunity to go to college, long term funding/investment in education
- Issues identified as problems: low graduation rates, college too expensive

Access to healthy food
- Issues identified as important: Electronic Benefit Transfer-Supplemental Nutrition Assistance Program (EBT-SNAP) benefits, nutrition, fruit and vegetable consumption, community gardens, farmers' markets, healthy food retail, farm-to-school
- Issue identified as problems: hunger

Housing
- Issues identified as important: affordability, availability, stability, tenant education, healthy housing, housing integrated with social services/transportation
- Issues identified as problems: evictions, homelessness

Mental health & substance abuse treatment
- Issues identified as important: access for culturally-specific groups and LGBTQI community, counseling, quality and availability of inpatient treatment, prevention
- Issues identified as problems: depression, suicide, drug/alcohol abuse

Poverty
- Issues identified as important: basic needs, family financial status
- Issues identified as problems: cost of living, daily struggles to make ends meet

Early childhood/youth
- Issues identified as important: child welfare, youth development and empowerment, opportunities for youth, parental support of student education experience
- Issues identified as problems: lack of support for youth of all ages, child protection services

Chronic disease
- Issues identified as important: chronic disease support, management and prevention
- Issues identified as problems: obesity, smoking

Safe neighborhood
- Issues identified as important: public safety, traffic/pedestrian safety
- Issues identified as problems: crime, violence, police relations

Transportation options
- Issues identified as important: equitable access to public transportation, transportation infrastructure investments
- Issues identified as problems: bus is too expensive, limited routes for shift workers

Table 1. Top Health-Related Themes by Region and County*

Region 62 Assessment Projects	Clackamas (OR) 29 Assessment Projects	Clark (WA) 12 Assessment Projects	Multnomah (OR) 42 Assessment Projects	Washington (OR) 28 Assessment Projects
• Social environment	• Access to affordable health care	• Social environment	• Social environment	• Social environment
• Equal economic opportunities	• Social environment	• Access to affordable health care	• Equal economic opportunities	• Access to affordable health care
• Access to affordable health care	• Housing	• Equal economic opportunities	• Access to healthy food	• Equal economic opportunities
• Education	• Equal economic opportunities	• Housing	• Education	• Mental health & substance abuse
• Access to healthy food	• Mental health & substance abuse	• Access to healthy food	• Housing	• Education
• Housing	• Access to healthy food	• Education	• Access to affordable health care	• Housing
• Mental health and substance abuse	• Education	• Chronic disease	• Mental health & substance abuse	• Chronic disease
• Poverty	• Civic engagement	• Mental health & substance abuse	• Chronic disease	• Safe neighborhood
• Early childhood/ youth	• Chronic disease	• Safe neighborhood	• Poverty	• Early childhood/youth
• Chronic disease	• Culturally competent care	• Poverty	• Early childhood/youth	• Access to healthy food
• Safe neighborhood	• Transportation options		• Civic engagement	
• Transportation options	• Safe neighborhood			

*Ranked by how many assessments the theme was identified in.

The information learned through this compilation of assessment projects showed that when the participants were asked questions about health, community and well-being, they were likely to describe basic needs and social determinants of health[4] rather than specific health conditions. Most of the social determinants prioritized in Table 1 require more than a local response. For instance, "equal economic opportunities/employment" is directly affected by the national economy. This does not mean that the issue isn't critical, only that it needs to be brought to the attention of those with the reach and authority to have an impact. Local responses could address components of the issue. For example, the Collaborative could choose to support targeted work force development programs that help chronically under-employed populations become gainfully employed, particularly for those populations with significant health disparities.

The health issues (other than the social determinants of health) identified were chronic disease, mental health, and substance abuse. These issues were also prioritized through epidemiological study and organizational stakeholder interviews. (For more information, see *Health Status Assessment: Quantitative Data Analysis*

[4]As defined by the World Health Organization, the social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.

Methods and Findings. May 2013, and *Local Community Health System and Forces of Change Assessments: Stakeholders' Priority Health Issues and Capacity to Address Them.* June 2013.)

Limitations

It is likely that there are important community assessment projects not represented in this inventory; ones that have been completed after the analysis, ones we did not know about or could not find through our search methods, and ones that are being conducted currently. Our intent is to be looking for this community work on an ongoing basis so that this regional assessment can continue to be informed by the health-related work conducted by other disciplines, organizations, and community groups within the region.

The intent is not to rely solely on this first inventory of assessments to represent the community's voices. It is one step in community engagement. As discussed earlier in this report, interviews and surveys with 126 agency stakeholders and listening sessions with 202 community members are also being done. Additionally, community engagement will continue throughout the three-year cycle to inform the development, implementation and evaluation of strategies, as well as to help the Collaborative identify additional community health needs to be considered for the next cycle (2016).

Resources

The following resources are referenced above and may be useful for background information:

- New Requirements for Charitable 501(c) (3) Hospitals under the Affordable Care. Internal Revenue Service. Available from: http://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/New-Requirements-for-501(c)(3)-Hospitals-Under-the-Affordable-Care-Act
- Public Health Accreditation. Public Health Accreditation Board. Available from: http://www.phaboard.org/
- Mobilizing for Action through Planning and Partnerships (MAPP). National Association of County and City Health Officials. Available from: http://www.naccho.org/topics/infrastructure/mapp/
- Healthy Columbia Willamette regional website. Healthy Columbia Willamette Collaborative. Available from: http://www.healthycolumbiawillamette.org.

HEALTH STATUS ASSESSMENT

Epidemiology Workgroup

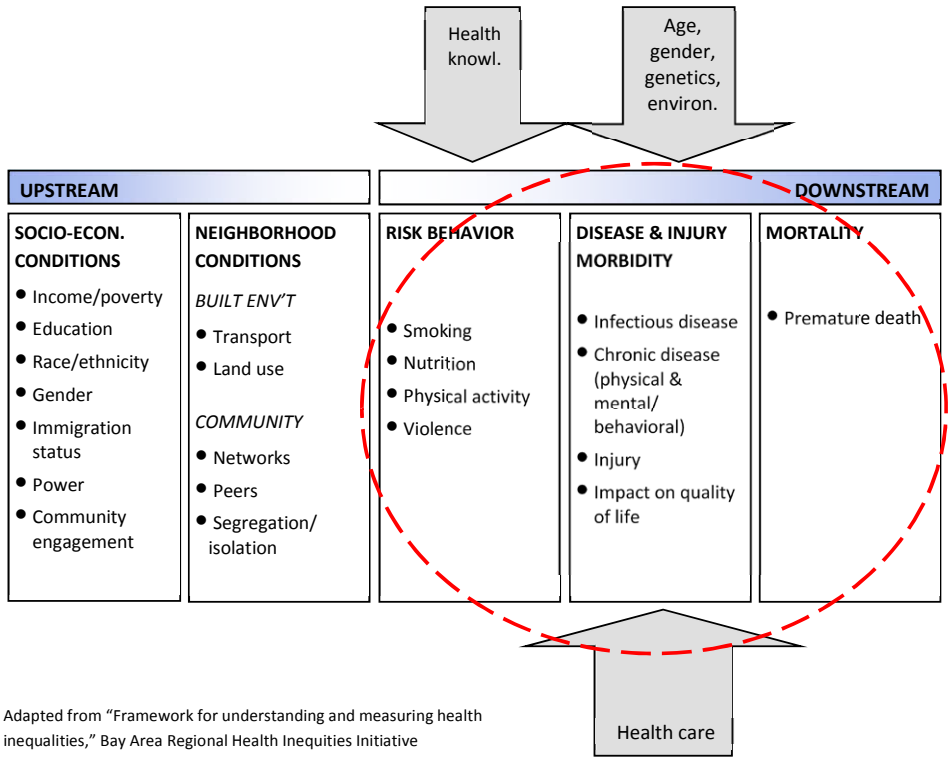
The Collaborative's Epidemiology Workgroup (Workgroup) was established to develop and implement a systematic approach to screening and prioritizing quantitative population health data to satisfy the community health status assessment component of MAPP.

The Workgroup consists of epidemiologists from the four county health departments with representatives from two hospital systems acting in an advisory capacity. The broad goal of the health status assessment was to systematically analyze quantitative population health-related behavior and outcome data to identify important health issues affecting each of the four counties as well as the four-county region. Health status assessment findings combined with the findings of the other three MAPP assessment components would provide the Collaborative's Leadership Group with information necessary to select health priorities and improvement strategies within the communities they serve.

Methodology

The health status assessment, one of four major components of MAPP, requires a systematic examination of population health data to identify health issues faced in the community. Figure 2 shows a conceptual framework connecting upstream determinants of health with downstream health effects. The health status assessment focused on health outcomes and behaviors contained in the red circle. While recognizing the importance of socioeconomic and other societal conditions as determinants of population health outcomes, the Workgroup focused its initial analytic efforts on health behaviors and health outcomes. After identifying broad community health issues, the Workgroup will assist the Leadership Group in examining contributing social determinants of health as it identifies strategies to address the health issues.

Figure 2. Continuum of Health Determinants and Health Outcomes



Adapted from "Framework for understanding and measuring health inequalities," Bay Area Regional Health Inequities Initiative

The Workgroup created a list of health indicators that were analyzed and prioritized systematically based on a predetermined set of criteria. Health indicators were placed on the list if they were 1) assigned a "red" or "yellow" status (indicating a health concern) on the Healthy Communities Institute (HCI) web site[5] for the four counties, 2) identified as important indicators by public health and other local experts, or 3) a top ten leading cause of death in one of the counties. Data for all health indicators were available at the county level through state government agencies and include vital statistics, disease and injury morbidity data, or survey data (adult or student).

Workgroup members conducted literature reviews and examined other nationally recognized prioritization schemes to identify examples of robust methods for screening and prioritizing quantitative population health measures. The Workgroup adapted a health indicator ranking prioritization worksheet developed for use with maternal/child health data in Multnomah County Health Department[6]. This worksheet met the needs of the regional community health status assessment by establishing prioritization criteria against which health indicator data were evaluated objectively and consistently. All criteria were weighted equally. The highest score meant a health indicator had a disparity by race/ethnicity, a disparity by gender, a worsening trend, a worse rate at the county level compared to the state, a high proportion of the population affected, and a severe health consequence. County-level scores were averaged for the region to generate regional scores per indicator. Once scored, the health indicators were ranked relative to one another for each county as well as for the four-county region as a whole.

To make the results of this analysis more meaningful to the Leadership Group and easier to incorporate into the other MAPP assessment components, the Workgroup clustered health indicators where there were natural relationships between them. This allowed health indicators to be understood as broader health issues within the community. For example, indicators of nutrition and physical exercise were grouped with indicators of heart disease and diabetes-related deaths into a health issue focused on nutrition and physical activity-related chronic diseases. The resulting health issues will be used by the Leadership Group, in combination with findings from the other MAPP assessments, to develop health improvement strategies.

Findings

Using the criteria scoring, each county's top ten ranked health-related behavior and health outcome indicators were identified (Table 1 and Table 2). Indicators that are "starred" are those that were on the regional list of top health indicators. Overall population rates can be found in Appendix 4. Indicators with the same score tied in rank which created a list of more than ten indicators in some cases.

The regional score for each indicator was the average of the four individual county scores. In most cases, scores were fairly close to one another across counties. The top ten ranked health-related behavior and health outcome indicators for the four-county region were identified (Table 3). Again, indicators with the same score tied in rank which created a list of more than ten indicators in some cases. Due to lack of available data, many fewer health-related behaviors were available for regional scoring.

[5] The Collaborative contracted with Healthy Communities Institute, a private vendor, to purchase a web-based interface with a dashboard displaying the status of each of the four counties data in terms of local health indicators. The Collaborative regional HCI web site can be accessed at www.healthycolumbiawillamette.org.

[6] The Multnomah County Health Department referenced the Pickett Hanlon method of prioritizing public health issues.

Table 2. Top Ranked Health Outcomes by County

Clackamas (OR)	Clark (WA)	Multnomah (OR)	Washington (OR)
• Non-transport accident deaths ★	• Non-transport accident deaths ★	• Non-transport accident deaths ★	• Suicide ★
• Chlamydia incidence rate ★	• Drug-related deaths ★	• Chlamydia incidence rate ★	• Breast cancer incidence rate
• Suicide	• Colorectal cancer deaths	• Diabetes-related deaths ★	• Parkinson's disease deaths
• Breast cancer deaths ★	• Lung cancer deaths	• Alcohol-related deaths	• All cancer incidence rate
• Adults who are obese ★	• Lymphoid cancer deaths	• Drug-related deaths ★	• Heart disease deaths ★
• Ovarian cancer deaths	• Diabetes-related deaths ★	• Early syphilis incidence rate	• Chlamydia incidence rate ★
• Chronic liver disease deaths	• Alzheimer's disease deaths ★	• Chronic liver disease deaths	• Unintentional injury deaths ★
• Heart disease deaths ★	• Unintentional injury deaths ★	• Breast cancer deaths ★	• Non-transport accident deaths ★
• Drug-related deaths ★	• Alcohol-related deaths	• Breast cancer incidence rate	• Ovarian cancer deaths
• Adults who are overweight	• Transport accident deaths	• All cancer deaths ★	• Adults who are obese ★
• Prostate cancer deaths ★	• Motor vehicle collision deaths	• All cancer incidence rate	• Chronic liver disease deaths
		• Heart disease deaths ★	
		• HIV incidence rate	
		• Suicide ★	
		• Unintentional injury deaths ★	
		• Tobacco-linked deaths	

Table 3. Top Ranked Health-Related Behaviors by County

Clackamas (OR)	Clark (WA)	Multnomah (OR)	Washington (OR)
• Adults doing regular physical activity ★	• Adults with a usual source of health care ★	• Adults with a usual source of health care ★	• Adult fruit & vegetable consumption ★
• Adults who binge drink: males ★	• Adults with health insurance ★	• Adults with health insurance ★	• Adults doing regular physical activity ★
• Adult fruit & vegetable consumption ★	• Influenza vaccination rate	• Mothers receiving early prenatal care ★	• Adults with health insurance ★
• Children with health insurance ★	• Adult fruit & vegetable consumption ★	• Adults who binge drink: female	• Children with health insurance ★
	• Teens who smoke	• Adults who binge drink: males ★	
	• Pap test history	• Adult fruit & vegetable consumption ★	
	• Influenza vaccination rate for adults aged 65+	• Adults doing regular physical activity ★	
	• Mothers receiving early prenatal • care ★	• Adults who smoke ★	
	• Adults doing regular physical activity ★		
	• Adults who smoke ★		

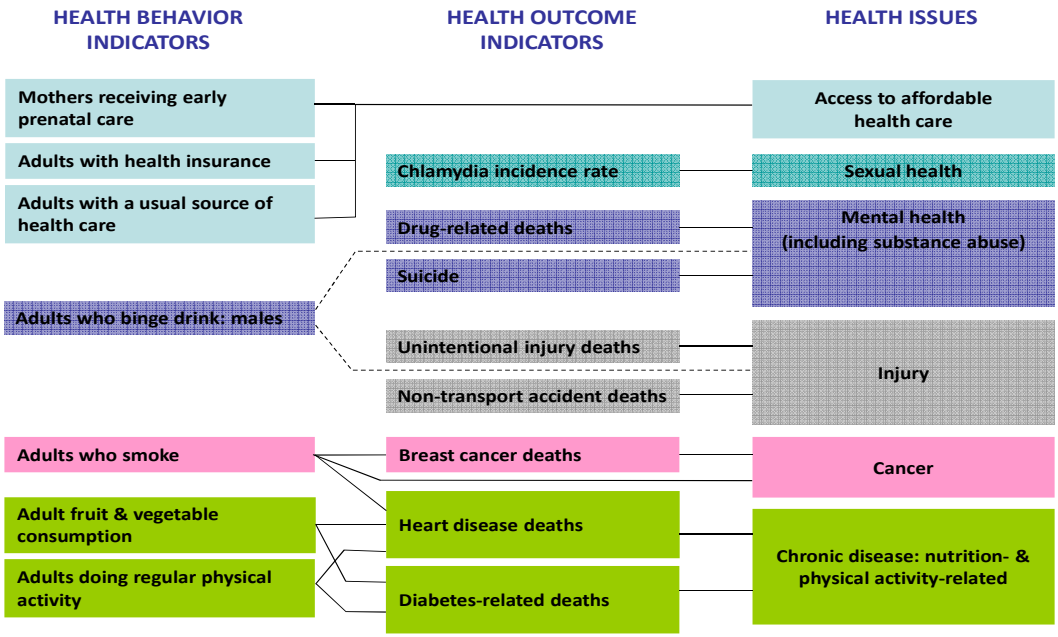
★Health outcomes and health-related behavior indicators that were top-ranked for the region (see Tables 2 & 3).

Table 4. ★Top Ranked Health-Related Behavior and Health Outcome Indicators in the Region

Health Behaviors	Health Outcomes
• Adult fruit & vegetable consumption • Adults doing regular physical activity • Adults with health insurance • Adults with a usual source of health care • Adults who binge drink: males • Mothers receiving early prenatal care • Adults who smoke	• Non-transport accident deaths • Suicide • Chlamydia incidence rate • Breast cancer deaths • Heart disease deaths • Unintentional injury deaths • Drug-related deaths • Diabetes-related deaths
The following indicators ranked lower and were not considered for regional action:	
• Children with health insurance	• Prostate cancer deaths • Alzheimer's disease deaths • Adults who are obese • All cancer deaths

The strongest consideration for regional action was given to the highest scoring health behavior and health outcome indicators listed in Table 3 (above the shaded section). These indicators showed significant disparities, a worsening trend, poor performance compared to state values, impact many people, and/or had severe consequences. These indicators were combined into six broader health issues for community discussion (Figure 3). Although other indicators were in the top scoring for the region, those with lower scores were not considered as strong for regional action. These indicators are listed in the shaded section of Table 3.

Figure 3. Top Ranked Health Behaviors, Health Outcomes, and Health Issues in the Region



Note: Solid lines represent a strong evidence base for the relationship and dotted lines represent a suggested relationship.
The identified health issues were substantiated by a parallel assessment of community themes and strengths, a separate MAPP component that explored existing evidence of community input around health issues. (For more information, see *Community Themes and Strengths Assessment: Important Health Issues Identified by Community Members, March 2013.*)

Quantitative Data Limitations

There are limitations to keep in mind when using quantitative data. The following lists describes limitations specific to this analysis.

Data collection

Each source of data—whether a national survey, vital records or any other source—has its own limitations. For example, health behavior data included in this assessment were based on answers from self-reported national surveys, and therefore may be affected by recall or response bias. There were over ten data sources from two states analyzed in this community health needs assessment. We strongly recommend reviewing known limitations from each data source (see Data Sources section) before interpreting the data for your county.

Granularity

The data available for this assessment were largely unavailable at the zip code level, and thus were analyzed at the county level. Analyzing indicators at the county level allowed application of the prioritization criteria in a consistent manner.

Data availability

The initial list of health outcome and behavior indicators reflected data that was available to each of the four counties. Consequently, it was evident that this selection was not able to assess certain important health areas. Thus, these areas with data gaps are not represented by the quantitative analysis findings. Health behavior data was limited because few counties had these data available. Youth, mental health and oral health data were very limited or not available at all.

Statistical analysis

Results based on certain criteria were suppressed when statistical analysis was unstable due to low counts. In order to ensure a reliable analysis, indicators were removed from consideration if fewer than four of the criteria were available. Health behavior indicators were only considered for regional analysis if they were evaluated by two or more counties.

Rate Comparison

For purposes of comparison across geographic areas in the Appendix tables, age-adjusted rates should be used. Age-adjusted rates were calculated using the US 2000 Standard Population. Although age-adjusted rates may not reflect the actual burden of disease or risk factor in a population, they are necessary for comparisons between rates. When age-adjusted rates are not available, crude rates (number of events/population) are available and describe the burden in the given area though do not account for demographic differences between the areas. Rates that are not age-adjusted (e.g., crude rates) should not be compared to age-adjusted rates.

Data Sources

Oregon

- American Community Survey, U.S. Census Bureau. Available from: http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml
- Centers for Disease Control and Prevention. National Center for Health Statistics. Available from: http://wonder.cdc.gov/
- Oregon Health Authority, Public Health Division. Center for Health Statistics. Oregon Behavioral Risk Factor Surveillance System. Available from: https://public.health.oregon.gov/BirthDeathCertificates/VitalStatistics/Pages/index.aspx
- Oregon Health Authority, Public Health Division. Center for Health Statistics. Oregon Vital Statistics. Available from: https://public.health.oregon.gov/BirthDeathCertificates/VitalStatistics/Pages/index.aspx

- Oregon Health Authority, Public Health Division. Oregon State Cancer Registry (OSCaR). Available from: http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Cancer/oscar/Pages/index.aspx
- Oregon Health Authority, Public Health Division. HIV/STD/TB Program. Available from: http://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/DiseaseSurveillanceData/Pages/index.aspx
- Oregon Student Wellness Survey. Available from: http://www.oregon.gov/oha/amh/pages/student-wellness/index.aspx
- VistaPHw: Software for Public Health Assessment in Oregon.

Washington

- American Community Survey, U.S. Census Bureau. Available from: http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml
- Washington State Department of Health. Center for Health Statistics. Washington Behavioral Risk Factor Surveillance System. Available from: http://www.doh.wa.gov/DataandStatisticalReports/HealthBehaviors/BehavioralRiskFactorSurveillanceSystemBRFSS.aspx
- Washington State Department of Health. Center for Health Statistics. Washington State Vital Statistics. Available from: http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/Publications.aspx
- Washington State Department of Health. Washington State Cancer Registry. Available from: https://fortress.wa.gov/doh/wscr/WSCR/
- Washington State Department of Health. Communicable Disease Epidemiology. Communicable Disease Surveillance Data. Available from: http://www.doh.wa.gov/DataandStatisticalReports/DiseasesandChronicConditions/CommunicableDiseaseSurveillanceData.aspx
- Washington State Healthy Youth Survey. Available from: http://www.askhys.net/
- Community Health Assessment Tool (CHAT) [Computer software for public health assessment], Washington State Department of Health.

Resources

The following resources are referenced above and may be useful for background information:

- New Requirements for Charitable 501(c) (3) Hospitals under the Affordable Care. Internal Revenue Service. Available from: http://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/New-Requirements-for-501(c)(3)-Hospitals-Under-the-Affordable-Care-Act
- Public Health Accreditation. Public Health Accreditation Board. Available from: http://www.phaboard.org/
- Mobilizing for Action through Planning and Partnerships (MAPP). National Association of County and City Health Officials. Available from: http://www.naccho.org/topics/infrastructure/mapp/
- Healthy Columbia Willamette regional website. Healthy Columbia Willamette Collaborative. Available from: www.healthycolumbiawillamette.org.
- Pickett Hanlon method of prioritizing public health issues. University of Chicago School of Public Health. Available from: http://www.uic.edu/sph/prepare/courses/ph440/mods/bpr.htm.

LOCAL COMMUNITY HEALTH SYSTEMS AND FORCES OF CHANGE ASSESSMENT

Purpose

The purpose of the Local Community Health System and Forces of Change Assessment was to learn the most important health issues facing the clients of stakeholder organizations across Clackamas, Multnomah, and Washington counties in Oregon and Clark County in Washington, as well as the organizations' capacity to address those needs. The assessment was designed to also collect input about the current opportunities and threats to the "local community health system" (LCHS).

The LCHS is the network of organizations that contributes to the health of a community. LCHS stakeholders include public health authorities, community based organizations, hospitals, health care providers, and advocacy groups. A LCHS can also include stakeholders working to address social determinants of health—housing, education, employment, and other factors—and could expand to include less obvious contributors to the community's health. Examples include media companies that can participate in health promotion efforts and grocery stores that influence what types of food are available.

Findings from the Local Community Health System and Forces of Change Assessment were used in conjunction with the results from the Community Themes & Strengths Assessment, Health Status Assessment, and Community Listening Sessions to guide the Healthy Columbia Willamette Collaborative's selection process of community health issues it will work to address.

Methodology

Between January and March 2013, 126 stakeholder organizations were interviewed (n=69) and surveyed (n=57). The stakeholders play primary roles of the LCHS in Clackamas, Multnomah, and Washington Counties in Oregon and Clark County, Washington.

For the scope of this first cycle of the Healthy Columbia Willamette community needs assessment, the list of stakeholders engaged was driven by the Community Health Needs Assessment (CHNA) requirements for non-profit hospitals and Coordinated Care Organizations set forth by the Internal Revenue Service and the Oregon Health Authority respectively.

The Internal Revenue Service and the Oregon Health Authority identify the following stakeholder groups that should be engaged during the CHNA process: 1) people with special knowledge of, or expertise in public health; 2) federal, tribal, regional, state, local, or other departments/agencies; and 3) community members and/or agencies that represent or serve medically underserved/underinsured/uninsured populations, low income populations, communities of color, populations with chronic disease issues, aging populations, the disability community, the LGBTQI[7] community, and populations with mental health and/or substance abuse issues. A complete list of interviewed and surveyed stakeholder organizations is in Appendix 5.

Interview questions were informed by Healthy Columbia Willamette members' experiences—hospitals conducting CHNAs and local health departments completing community health assessments. Members also reviewed resources available from the National Association of County and City Health Officials (NACCHO) MAPP Clearinghouse. The interview tool is in Appendix 6.

[7] Lesbian, Gay, Bisexual, Transgender, Questioning or Queer, and Intersex

Stakeholders were asked about:

- The health of the populations they serve;
- The list of important health issues identified through the Community Themes and Strengths and Health Status Assessments (i.e., access to health care, sexual health, mental health & substance abuse, injury, cancer, and chronic disease);
- Health issues that should be added to the list;
- Their opinions on the three most important health issues;
- Their current work to address important health issues;
- The work they would like to be doing in the future to address important health issues;
- Opportunities and threats to their current capacity to do this work; and
- Resources that would help their organization continue or expand their capacity.

Information learned from the interviews was used to develop an online survey, and in turn, information learned from the survey informed a second analysis of interview notes to find themes that may not have been recognized the first time. This iterative process was used to ensure that the ideas generated by participants were not overlooked due to a methodological process. See Appendix 7 for the online survey tool.

Findings

Stakeholder organizations that participated in interviews and surveys described the important health issues facing community members and what is currently being done to improve the health of the community. Stakeholders participating in interviews and surveys indicated that they served primarily:

- Medically underserved, uninsured, and underinsured populations;
- Communities of color;
- Children and youth;
- The disability community; and/or
- Populations with mental health and/or substance abuse issues.

Of those organizations reporting that they work with communities of color, American Indians/Alaska Natives and Hispanics/Latinos were the most common populations they mentioned. Of those who work with populations that speak limited English, Spanish and Russian were the most commonly spoken languages. See Appendix 8 for more information on the populations served by the participating stakeholder organizations.

The Community's Health

During the interviews participants were asked, "How healthy is the population/community you serve compared to the larger population?" More than half of the interviewees did not think the community they served was as healthy as the larger population.

> There are still too many health disparities, not enough breastfeeding, too many people who are overweight, too many people who smoke, and not enough focus on prevention.

> It's clear that our population of folks is struggling much more than the general population. They have a higher level of health challenges that come with poverty, struggling with basic health care. Often homeless populations are in those situations because they have health issues. It creates a vicious cycle that spirals downwards.

> There are a lot of barriers to good health because of a lack of cultural competency in provider settings. Many [people] experience discrimination and consequently put off care, making them less healthy in the long run.
>
> There is an "immigrant paradox" where new immigrants are healthier and the longer they are in the US, the less healthy they become.
>
> [It] depends. Children? Yes. Adults? No—[due to] lack of specialists, lack of mental health care, lack of programs to educate about wellness, and often adults have chronic conditions.
>
> We know that Native American, African American, Latino, Asian Pacific Islander, and low-income communities fare worse than Non-Hispanic Whites with chronic conditions and have increased illnesses across the board. We've spent time enumerating the health inequities; a lot of it is understood.

An Iterative Process to Identify Health Issues

During interviews, stakeholders were asked to review the list of health issues that were identified through the first two assessments of the Healthy Columbia Willamette Collaborative's CHNA. The first assessment, The Community Strengths and Themes Assessment, looked at recently conducted local community engagement projects; the second assessment, The Health Status Assessment looked at the epidemiological data to describe the current health status of the community. *(Community Themes and Strengths Assessment: Important Health Issues Identified by Community Members.* July 2013 and *Health Status Assessment: Quantitative Data Analysis Methods and Findings.* July 2013*)*

These two assessments had complementary findings with both the qualitative data and the quantitative data describing similar health issues in the community. The only community health issue that was not identified during both assessments was "injury." Injury was identified through the Health Status Assessment and included deaths due to falls and accidental poisoning deaths—including drug overdoses. The list of health issues discussed during the stakeholder interviews (in alphabetical order) included:

- Access to health care
- Cancer
- Chronic disease
- Injury
- Mental health & substance abuse
- Sexual health

Stakeholders were asked, *"After looking over this list, is there any health issue, specifically a health outcome or behavior--that you are surprised to not see? If so, what is it and why do you think it's important? "*

As a result, the most common health issues stakeholders added to the list included domestic violence and oral health. Although not mentioned as frequently as domestic violence or oral health, the need to develop culturally competent services and collect culturally competent data was discussed by several stakeholders. These issues were added to the survey for two reasons: 1) addressing racial/ethnic health disparities is a top priority for all Healthy Columbia Willamette Collaborative members, and 2) the lack of data available for the Health Status Assessment made it challenging to assess indicators stratified by race/ethnicity.

During the interviews, mental health and substance abuse were grouped together as one health issue. Many stakeholders suggested that mental health and substance abuse be separated into two issues for the "voting" process because both are important problems that are distinct from one another and have unique interventions. Consequently, these two issues were separated on the survey and in the findings presented in Table 1. Because "mental health & substance abuse" was one issue during the interviews, it was not possible to determine, in all

cases, whether there was more importance placed on mental health or substance abuse. For the analysis, if an interviewee selected "mental health & substance abuse" as one of their top three health issues, their response was separated into two votes; one each for mental health and substance abuse. Their other four votes were kept resulting in their having four votes in total.

The majority of stakeholders participating in interviews said that the two health issues, "injury" and "sexual health" were not clear. They suggested that these categories needed to be described better by listing the data or indicators that were included. In response to this feedback, both health issues were described. "Injury" was separated into two categories: falls and poisoning/overdose. "Sexual health" was further clarified to include HIV, Syphilis, and Chlamydia, stemming from the epidemiological data. This feedback from the interviews was used to compile the answer choices on the survey:

- Access to Health care
- Cancer
- Chronic Disease
- Culturally Competent Services/Data
- Domestic Violence
- Falls
- Mental Health
- Oral Health
- Poisoning/Overdose
- Sexual Health (HIV, Syphilis, Chlamydia)
- Substance Abuse
- Other_____

An additional health issue, "perinatal health," emerged from the following write-in survey responses: "women's health," "family health," "reproductive health," "prenatal health," "maternal health," "maternal and child health," "pre-conception health," "healthy pregnancy," "birth outcomes," and "Fetal Alcohol Spectrum Disorders." After a second study of interview notes, answers that corresponded to this "perinatal health" category were classified and were taken into consideration when identifying health issues prioritized by the interview and survey participants.

Prioritized Health Issues

Issues that were selected by at least 30% of survey and/or interview responses combined were regarded as prioritized health issues. In the four-county region, these were (in alphabetical order):

- Access to health care
- Chronic disease
- Culturally competent services/data
- Mental health
- Substance abuse

These five health issues were the priorities all four counties. Stakeholders working in Clark County, Washington also prioritized cancer and oral health.

Stakeholders were asked to identify age groups that were at high risk for each of their top health issues. However, stakeholders only differentiated high risk populations among persons aged 45-64 years and 65+ years for chronic disease and cancer. This finding is consistent with national trends as the Centers for Disease Control and Prevention cites that "about 80% of older adults have one chronic condition, and 50% have at least two."

Table 5. Top Prioritized Health Issues from Stakeholder Organizations by Region and County

Region	Clackamas (OR)	Clark (WA)	Multnomah (OR)	Washington (OR)
Access to Health care • 72% of interviews • 67% of surveys	**Access to Health care** • 69% of interviews • 80% of surveys	**Access to Health care** • 79% of interviews • 59% of surveys	**Access to Health care** • 73% of interviews • 74% of surveys	**Access to Health care** • 73% of interviews • 78% of surveys
Mental Health • 64% of interviews • 67% of surveys	**Mental Health** • 53% of interviews • 73% of surveys	**Mental Health** • 65% of interviews • 59% of surveys	**Mental Health** • 57% of interviews • 55% of surveys	**Mental Health** • 56% of interviews • 67% of surveys
Chronic Disease • 65% of interviews • 35% of surveys	**Chronic Disease** • 67% of interviews • 37% of surveys	**Chronic Disease** • 71% of interviews • 41%of surveys	**Chronic Disease** • 69% of interviews • 37% of surveys	**Chronic Disease** • 69% of interviews • 29% of surveys
Substance Abuse • 64% of interviews • 26% of surveys	**Substance Abuse** • 53% of interviews • 17% of surveys	**Substance Abuse** • 65% of interviews • 34% of surveys	**Substance Abuse** • 57% of interviews • 19% of surveys	**Substance Abuse** • 56% of interviews • 19% of surveys
Culturally Competent Services/Data • 6% of interviews • 33% of surveys	**Culturally Competent Services/Data** • 7% of interviews • 40% of surveys	**Cancer** • 32% of interviews • 3% of surveys	**Culturally Competent Services/Data** • 8% of interviews • 39% of surveys	**Culturally Competent Services/Data** • 7% of interviews • 41% of surveys
Oral Health • 10% of interviews • 12% of surveys	**Cancer** • 22% of interviews • 3% of surveys	**Oral Health** • 15% of interviews • 17% of surveys	**Perinatal Health** • 20% of interviews • 3% of survey	**Cancer** • 22% of interviews • 4% of surveys
Domestic Violence • 4% of interviews • 17% of surveys	**Oral Health** • 11% of interviews • 10% of surveys	**Culturally Competent Services/Data** • 0 interviews • 31% of surveys	**Cancer** • 18% of interviews • 3% of surveys	**Domestic Violence** • 2% of interviews • 19% of surveys
Cancer • 17% of interviews • 2% of surveys	**Domestic Violence** • 2% of interviews • 17% of surveys	**Domestic Violence** • 9% of interviews • 9% of surveys	**Oral Health** • 10% of interviews • 8% of surveys	**Perinatal Health** • 18% of interviews • 0 surveys
Perinatal Health • 14% of interviews • 4% of surveys	**Perinatal Health** • 18% of interviews • 0 surveys	**Sexual Health** • 12% of interviews • 3% of surveys	**Domestic Violence** • 2% of interviews • 13% of surveys	**Oral Health** • 11% of interviews • 7% of surveys
Sexual Health • 12% of interviews • 2% of surveys	**Sexual Health** • 9% of interviews • 3% of surveys	**Perinatal Health** • 9% of interviews • 3% of surveys	**Sexual Health** • 12% of interviews • 3% of surveys	**Sexual Health** • 9% of interviews • 4% of survey

Opportunities to Address Prioritized Health Issues

Stakeholders were also asked about their current work on the health issues they prioritized. The most frequently described types of work being done to address the prioritized health issues[13] include:

- Collaborate with others to identify strategies to address health issues.
- Help clients navigate the health care/social service system.
- Work to coordinate care.
- Provide services to individuals.
- Advocate for policy change within the community.

[13] Access to health care, mental health, chronic disease, substance abuse, culturally competent services/data, oral health (Clark County), and Cancer (Clark County)

Stakeholders described the type of work they would like be doing to address the prioritized health issues. The work described fell into four categories: 1) programs and operations, 2) topic-specific advocacy groups and policies, 3) partnerships to promote health and address disparities, and 4) advocacy for funding-system change.

Programs and Operations:

- Utilize networks of clinics to provide comprehensive referrals, treatment, and services (specific to behavioral health).
- Integrate oral health services into community health clinics.
- Support patient navigators for vulnerable patients with, or at risk for, cancer.
- Train health care providers to work with vulnerable patients with, or at risk for, cancer.
- Develop health education activities for culturally specific and vulnerable populations to increase cancer awareness, prevention, and treatment (e.g., tribes, disability community, communities of color, etc.).
- Develop health education activities to increase awareness on how oral health is related to other health outcomes.

Support topic-specific advocacy groups and policies:

- Support community efforts to promote the use of fluoridation treatment in the public water system.
- Develop coalitions focused on chronic disease awareness, prevention, and policy interventions (like a soda tax).
- Support policies that address the social determinants of health.
- Focus on prevention, early intervention, increased screenings for young populations, and school-based interventions.
- Support policy and practice for standardized collection of race, ethnicity, language, and disability data; and require culturally-competent, continuing education for health researchers.

Partnerships to promote health and address disparities:

- Support coalitions comprised of culturally specific organizations.
- Promote understanding and acceptance of marginalized communities.
- Fund organizations that do culturally specific work.
- Develop partnerships between culturally specific organizations and health care providers to find concrete ways to serve low income populations and communities of color.

Advocacy for funding-system change:

- Increased availability of services through changing the funding/reimbursement streams, and by providing services related to social determinants of health (job training, housing, etc).
- Learn from the CCO model to inform the transformation of the mental health system.

Limitations

An iterative approach was used to identify important health issues from which stakeholders were asked to prioritize (see page 5). As a result, those stakeholders participating in interviews did not have the opportunity to "vote for" or select health issues that were not on the original list or that they did not think of themselves. The stakeholders taking the survey benefited from the thinking of those interviewed because the additional health issues identified during the interviews were included on the list from which they were asked to select their top three most important. It is unknown how or if interviewees would have "voted" for different health issues if they were provided with the expanded list from the survey.

The issues from both the interviews and surveys results were included on the list of health issues from with community listening sessions participants "voted." (*Community Listening Sessions: Important Health Issues and Ideas for Solutions.* July 2013)

Resources

The following resources are referenced above and may be useful for background information:

- New Requirements for Charitable 501(c) (3) Hospitals under the Affordable Care. Internal Revenue Service. Available from: http://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/New-Requirements-for-501(c)(3)-Hospitals-Under-the-Affordable-Care-Act
- IRS Form 990, Schedule H, Part V. Available from: http://www.irs.gov/pub/irs-pdf/f990sh.pdf
- Notice and Request for Comments Regarding the Community Health Needs Assessment Requirements for Tax-exempt Hospitals. Available from: http://www.irs.gov/pub/irs-drop/n-11-52.pdf
- Oregon Administrative Rule 410-141-3145, Community Health Assessment and Community Health Improvement Plans. Available from: http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_410/410_141_3000-3430.html
- Community Health Assessments and Community Health Improvement Plans, Guidance for Coordinated Care Organizations. Available from: https://cco.health.oregon.gov/Documents/resources/CHA-guidance.pdf
- Public Health Accreditation. Public Health Accreditation Board. Available from: http://www.phaboard.org/
- Mobilizing for Action through Planning and Partnerships (MAPP). National Association of County and City Health Officials. Available from: http://www.naccho.org/topics/infrastructure/mapp/
- CDC Chronic Disease Prevention and Health Promotion, Healthy Aging. Available from: http://www.cdc.gov/chronicdisease/resources/publications/AAG/aging.htm
- Healthy Columbia Willamette regional website. Healthy Columbia Willamette Collaborative. Available from: http://www.healthycolumbiawillamette.org

COMMUNITY LISTENING SESSIONS

Purpose

The purpose of these discussions was to learn what low-income and uninsured residents of the four-county region feel are the most important issues affecting their health, their families' health, and the community's health. In addition, the groups were held to solicit ideas about how to address these health needs.

Methodology

During March and April of 2013, 14 community listening sessions were conducted in Clackamas, Multnomah, and Washington Counties in Oregon and Clark County, Washington. In total, 202 individuals participated, sharing their opinions with one another about important community health issues and how the community's health can be improved. A list of the locations, dates, and number of participants is in Appendix 9.

Recruitment

In advance of the listening sessions, recruitment flyers were developed by hospital members of the Collaborative and translated into Spanish, Russian, and Somali by health department members. They were distributed to organizations, community networks, and community-accessible locations to be posted or handed out. Flyers specified that low-income/no income and/or uninsured adults were the intended participants, and advertised locations and times for sessions, as well as the provided food, childcare, and $25 gift card incentives. Examples of the recruitment flyers are in Appendix 10.

Recruitment materials were posted and distributed primarily through agencies and community organizations that serve low-income populations. Over 100 organizations were able to help with recruitment, ranging from individual housing projects to community groups with constituents across the four-county area. Healthy Columbia Willamette Collaborative members also recruited among their own organizations' constituents where appropriate, and asked their colleagues in the community to help recruit participants. In addition, local Spanish-language and Russian-language radio stations promoted the meetings. The listening sessions lasted approximately an hour and a half, and free childcare services were offered on site. Hospital partners provided meals and childcare for each group. Hospitals also provided $25 Fred Meyer gift-cards for the first 25 participants in each group to acknowledge participants' time and contribution to the project.

Group Structure

The Healthy Columbia Willamette Collaborative was interested in hearing specifically from low-income and uninsured residents from across the four-county area, and as mentioned above, efforts were made to reach this population during recruitment.

Listening sessions were opened with a large group introduction before splitting into small discussion groups of 10 or fewer participants. Each small discussion group was facilitated by a different Healthy Columbia Willamette Collaborative member or interpreter. Small groups were facilitated in English, Spanish, Russian, and Somali with the support of interpreters from participating health departments and the Immigrant and Refugee Community Organization (IRCO). In order to encourage attendance, meals were provided, and sessions were scheduled on both weekdays and weekends and at community-accessible locations across the four-county area.

Group discussions revolved around four questions:

- What does a healthy community look like to you?
- Are there other health issues that you think should be on this list? (The list of important health issues identified by the findings of the Community Themes and Strengths, Health Status, and Local Community Health System and Forces of Change Assessments. See Table 1 below.)

- What are the five health issues that you would like to see addressed first? (Participants selected from the issues in Table 1 and any health issues they added to the list.)
- What should be done to fix or address these health issues?

See Appendix 11 for the complete discussion guide and Appendix 12 for the list of health issues used during the discussions in multiple languages.

Table 6. Important health issues identified by the findings of the Community Themes and Strengths, Health Status, and Local Community Health System and Forces of Change Assessments (in alphabetical order)

Access to affordable dental care	Data collection on the health of people from various cultures
Access to affordable health care	Injuries from falling
Access to affordable mental health services	Mental health
Access to services that are relevant/specific to different cultures	Oral Health
Accidental poisoning from chemicals, pesticides, gases, fertilizers, cleaning supplies, etc.	Perinatal health
Cancer	Sexually transmitted infections/diseases
Chronic disease and related health behaviors	Substance abuse

Participants

There were, on average, 14 participants attending each session, though the range in attendance between sessions was between one and 34 participants. Before small group discussions, participants were asked to complete an anonymous survey collecting demographic information. This was done on a voluntary basis and did not affect whether a person could participate or receive a gift card. Almost 96% of participants completed surveys. A copy of the survey in English is in Appendix 13. The survey was available in English, Spanish, Russian, and Somali as well as in large font (in English).

Of participants specifying an income range on their survey, 62% came from households earning less than $20,000 per year. Of those indicating a health insurance status, 63% indicated they were uninsured with an additional 21% indicating they were on the Oregon Health Plan (OHP)[14]. Participants' ages ranged from 17 to 90 years, with an average age of 40 years. Almost three quarters of participants returning the surveys identified as female.

Participants were also asked to identify their race and ethnicity. Regionally, over half (53%) of those providing this information indicated that they were Hispanic, 25% were White, 7% were African, 6% were African American, 2% were Native American, 1% were Asian and 1% were Native Hawaiian/Pacific Islander. Individuals could select selected more than one race/ethnicity; only one participant did so.

[14] Clark County responses for health insurance type were not included in the regional calculation as the equivalent of OHP for Clark County was not on the survey).

The composition of participants involved in the listening sessions is not representative of regional race, ethnicity, or gender demographics. The sample may not be representative of other communities, (e.g., the LGBTQI, disability, and recovery communities). Given that hospitals have impending tax filing deadlines and requirements to focus on low-income and uninsured populations, the Healthy Columbia Willamette Collaborative members agreed for this first cycle, that recruitment for the community listening sessions would focus on people with low income levels and/or no health insurance. The Collaborative members recognized that by using only these criteria, people from other vulnerable communities might not be reached. In order to improve participation by other communities, the Collaborative worked with more than 100 community organizations to help with the recruitment. Examples of the communities these organizations helped recruit, include Native American, LGBTQI, disability, African American, recovery, immigrant/refugee, etc.

When looking at the participation in these community listening sessions and all previous assessment phases, (i.e., Community Strengths and Themes, Health Status, Local Community Health System and Forces of Change Assessments), it becomes clear that the Collaborative included the opinions from a wide array of stakeholders, including many people from culturally-identified communities. Moving forward, community members will be actively engaged to implement and monitor the health of the community. Table 2 presents participants' survey responses by county and region.

Participants lived throughout the four counties; however, not all areas of the four-county region were represented equally due to recruitment challenges such as difficulty connecting with people living in rural areas, or with people speaking languages other than English, Spanish, Somali, or Russian. Figure 2 illustrates the geographic reach of the listening sessions by indicating the percent of surveys responses (to this question) returned from residents living in each zip code in the four-county area. The darker the area on the map, the more participants reported living there.

Following each session, many participants expressed their appreciation for the opportunity to speak about their priorities and needs, and 26% of participants signed up on a contact list so they can be invited to other events, kept informed about how the information collected through the community listening sessions was used, and be informed about upcoming changes in health services and policies. Many participants also expressed that holding these types of groups is an effective way to help reduce social isolation and empower people to become involved in their neighborhoods.

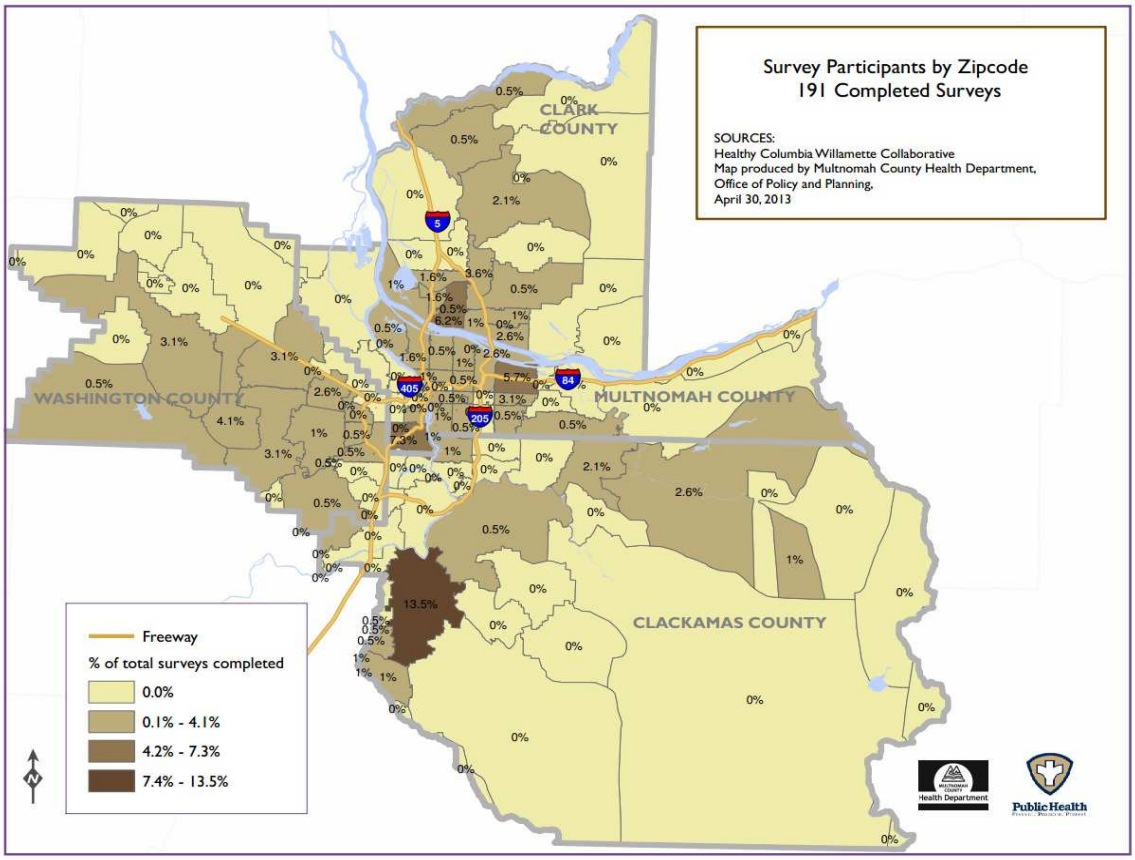
Table 7. Participant Demographics

	Clark	Clackamas	Multnomah	Washington	Region
Age					
Range	17-88 years	20-75 years	18-68 years	17-90 years	17-90 years
Average	44 years	40 years	44 years	45 years	40 years
Language					
English	66%	10%	48%	30%	39%
Russian	11%	0	2%	0	3%
Somali	0	0	9%	20%	7%
Spanish	23%	90%	41%	50%	51%
Race/Ethnicity					
African	0	0	9%	16%	7%
African American	0	0	12%	10%	6%
American Indian/Native American	0	0	5%	2%	2%
Asian	2%	0	0	0	1%
Hispanic	34%	88%	43%	52%	53%
Native Hawaiian/Pacific Islander	0	0	0	2%	1%
White	61%	12%	14%	18%	25%
Other/multiple	0	0	16%	0	5%
Gender					
Female	68%	74%	66%	76%	71%
Male	32%	19%	30%	24%	26%
Income					
Less than $10,000	45%	30%	34%	34%	36%
$10,000 to $19,999	32%	26%	18%	30%	26%
$20,000 to $29,000	9%	19%	23%	16%	17%
$30,000 to $39,000	5%	0	7%	6%	5%
$40,000 to $49,000	5%	2%	0	0	2%
$50,000 or higher	2%	2%	2%	2%	2%
Household Size					
Range	1-8 people	2-8 people	1-9 people	1-9 people	1-9 people
Average	3 people	3 people	4 people	5 people	4 people
Education					
Less than high school	23%	62%	36%	33%	38%
High school diploma/GED	19%	30%	30%	37%	30%
Some college	37%	5%	18%	13%	19%
College graduate or higher	21%	3%	15%	17%	13%
Health Insurance					
No insurance	73%	82%	53%	56%	63%
Oregon Health Plan	--	8%	27%	23%	21%
Medicare[15]	12%	5%	4%	9%	6%
Private insurance through work	14%	5%	15%	12%	11%
Private insurance purchased	0	0	1%	0	<1%
Do you have a health care provider?					
Yes	27%	23%	45%	50%	38%
No	63%	56%	33%	35%	45%
Sometimes	9%	21%	22%	15%	17%
Do you have a dentist?					
Yes	20%	13%	29%	24%	22%
No	74%	80%	64%	67%	71%
Sometimes	6%	7%	7%	9%	7%

Total may not equal 100% due to rounding.

[15] Clark County responses for health care type were not included in regional calculation. The equivalent of OHP for Clark County was not included on the survey.

Figure 4. Survey Participants by Zip Code in the Four-County Region[16]



Findings

The findings represent the opinions and experiences of 202 individuals living in the four counties. As a result of this small number and the use of a convenience sample, findings are presented for the region, not individual counties. There was a lot of agreement across individuals and between small discussion groups on what the important health needs are and what can be done to address them, which supports the possibility that these opinions are likely to be shared by a larger percentage of the population.

The findings are presented in two sections: 1) a description of what a healthy community looks like and 2) the important community health needs, as well as what can be done about them.

Discussing a Healthy Community

When initially asked how they would describe the elements of a healthy community, listening session participants tended to draw from current problems observed in their own communities. They generated a number of ideas about what might constitute a healthy community. The most common themes included people having 1) basic needs met (food, shelter and employment); 2) access to quality health services; 3) a connected and compassionate social system; 4) peer support, resources, and self-determination to practice healthy habits; and 5) access to education and other shared community resources.

[16] 191 of the 196 survey respondents provided a zip code.

In addition, there was strong agreement that a healthy community would have better access to public transportation, more recreation facilities to promote healthy behaviors, and expanded community programming catering to both individuals and families. They wanted to be able to feel safe from gang and street violence, to feel comfortable with the role and effectiveness of law enforcement, and to feel involved in and informed about their community's issues.

> Things have changed since growing up in the 60s. Today, moms have to be watching their kids and have them in view at every moment.

Perhaps most important to their definition of a healthy community, participants frequently stressed the importance of being socially connected to one's community in order to receive support in times of need and stress.

> We need to be moving from an "I" community to an "Us" community.

Important Community Health Issues and Strategies for addressing them

Several specific issues drawn from the Health Issues list (and from additional issues added by participants) recurred in discussions of communities' top health issues. When looking at voting results of all discussion groups, it is clear that there is strong agreement on what health issues are the most important. There are also frequently reoccurring ideas on strategies suggested for addressing these issues. These findings are presented in five sections, beginning with the most-prioritized health issue:

(1) Mental Health and Mental Health Services
(2) Chronic Disease and Related Health Behaviors
(3) Substance Abuse
(4) Access to Affordable Health Care
(5) Oral Health and Access to Oral Health Services

Mental Health and Access to Mental Health Services

Although mental health and access to mental health services were presented as two different health issues on the list, listening session participants most often voted to combine the two into a single issue. Even when this sentiment was not explicitly stated, discussion frequently treated the two together. Mental health stood out as the most voted-for health problem in the community.

Addressing Isolation and Anxiety as Contributing Factors to Mental Health Issues

In almost all groups, social isolation was a theme related to community mental health issues. Participants expressed significant concern over the detrimental impact of social isolation on mental and emotional health, and especially emphasized it as a cause and contributor to depression in their communities. They noted that isolation derived from many factors, including reliance on technology for communications, lack of employment, lack of cultural integration between different communities, being homeless, and family roles which tended to keep some women in the home or busy with childcare. Many also saw social isolation as a significant barrier to care, in that isolated individuals would feel less comfortable seeking out care themselves and would be less likely to be screened for mental health issues.

Most participants voiced that it was important, in confronting mental health issues, to promote social practices that would work against social isolation. In almost all groups, participants spoke about building a compassionate community that embraces diversity. This included working to eliminate racism, ageism and other forms of discrimination against individuals; as well as raising awareness of the different and special needs of individuals in their community.

> …Develop a sense of community where residents are motivated to care about each other, respect one another, connect with one another, and help out strangers and neighbors.

Many groups felt it was important to remove the stigma associated with mental health issues and treatment in order to help people feel supported by their communities and peers in seeking treatment:

> [Provide] support for people experiencing mental health issues so they can address what's happening and feel supported and secure with themselves.

Additionally, there was strong agreement that increasing opportunities for community involvement would also play a significant role in reducing the incidence of mental health issues. Examples suggested included volunteer programs, community classes and organized activities for individuals and families, more community recreation and arts centers, and sports programs for all ages. Several groups also mentioned the importance of services that could remove the barriers to participate for some people, including childcare, transportation, or providing visits to those who are home-bound.

In addition to isolation, most participants felt that depression in their community was caused by financial stress, the real-life stressors of poverty, homelessness, or adjusting to US systems and society as a member of an immigrant community. Participants generally agreed that, besides the social support discussed above, the way to ease such stress was to continue to work on improving the larger factors that influence a community's health—the economy, housing, and culturally competent services.

Improving Access to Mental Health Services

Many participants felt that there were too few mental health providers to meet community needs. Residents of more rural areas felt this was especially true, and many participants from non-English-speaking communities felt there was sometimes a complete lack of services that would be appropriate for them. Participants from these groups proposed increased training and community placement of mental health service providers, especially those offering therapy and counseling services. Non-English speaking communities hoped to see providers sourced and trained from their own communities.

For example, participants from Somali-speaking communities expressed feeling that Post Traumatic Stress Disorder (PTSD) and other trauma-related mental health issues were some of the most significant of all health issues in their communities. Such issues impacted entire families and communities—not just isolated individuals; and there was a general feeling among Somali participants that this problem was not sufficiently recognized by "western" providers. They expressed that in order to be effective, providers of therapy, counseling and other treatments would need to be much more culturally sensitive and better informed about the patients' backgrounds than they currently are.

Many participants indicated that affordability was an issue. It was frequently expressed that the inconsistency of insurance coverage offered for mental health services was a definite problem. Many participants suggested that in addition to pursuing universal health coverage, it would be important to put regulations in place to extend health coverage to include a full range of mental health treatment services.

Although they agreed that professional mental health services were very important, participants also felt it would be worth investing resources in community groups and support that contribute to good mental health and community-supported recovery. They named churches, peer support groups, and community health educators as examples things they would like to see developed or expanded activities in their communities.

Chronic Disease and Related Health Behaviors
Chronic disease and Related Health Behaviors ran a close second to mental health issues in the voting portion of the discussion. Many participants had stories to share about specific chronic disease issues they had experienced or witnessed in their families and communities. Most often their concerns focused on nutrition and exercise habits, diabetes, and heart disease.

Participants were particularly concerned about the lack of physical activity affecting all generations in their communities, not just adults as the epidemiology data identified. Many participants pointed out that motivation and opportunities for exercise in senior communities was extremely lacking. Participants largely attributed the lack of physical activity to an increasingly sedentary, technology-based society.

Across almost all groups, participants mentioned wanting to increase community programming that promoted physical activity for all ages—and to ensure that the opportunities be affordable. Some suggested that letting people rent or borrow equipment such as bicycles and helmets would help. Examples of programming included senior walking clubs, community gardening initiatives, and increased sports programs for youth. A few participants emphasized that some programming should be tailored to the needs of individuals already facing limiting chronic disease issues such as obesity and heart disease.

Several participants thought that their workplaces could benefit from programs encouraging wellness and physical activity on the job. Participants, whose jobs require sitting or standing in one place for long periods of time, recognized that this was especially detrimental to their health and even to their motivation to exercise outside of work.

Another concern was nutrition. Many participants felt that they could not afford or access the most nutritious food options, and were limited by the prices of produce and the lack of stores offering nutritious options in convenient locations. Participants wanted to see more nutritious options in the locations most convenient to them, such as convenience stores and chain grocery stores—and suggested the support of more farmers markets in their communities. Once again, participants suggested community gardening as an activity that promotes physical activity and provides healthy food to the community inexpensively.

Several participants suggested tactics to encourage low-income community members to choose healthy options where they are already available, such as subsidizing produce and limiting the kinds of food that could be purchased through the Supplemental Nutrition Assistance Program (SNAP). Many participants expressed feeling constantly tempted by “easy” inexpensive, unhealthy food offerings in vending machines and cafeterias and available through the numerous fast food restaurants near their homes. They wanted to see workplaces and schools make efforts to replace unhealthy food options with healthy ones, and wondered if there were a way to develop a “healthy fast food” that could make nutritious meals fairly cheap and easily accessible.

In some cases, working families felt overwhelmed about the cost and time that is required to provide healthy meals consistently to family members, and were unsure how to stop relying on quick and unhealthy food options. Participants from these families felt that they could benefit from community education focused on nutrition and cooking, and from a forum for sharing recipes that balance quick preparation and inexpensive ingredients with good nutrition.

Participants suggested other strategies addressing chronic disease issues that focused on creating educational and motivational opportunities for the community. They felt it was important to make sure the community was informed about the relationship between healthy habits and chronic disease, had skills and strategies for preparing nutritious food, and knew how to access information about chronic disease prevention and early

symptoms. Ideas for implementing this education included a strong motivational media campaign, mailers, cooking classes, health fairs, and a stronger health curriculum in schools.

> Go back to the basics and get it into our curriculum.

Participants generally appreciated existing social services like WIC, but wanted to see this type of program expanded to reach more people not just women and children.

> [We need] NEW programs that educate and motivate people to make healthy choices, like a WIC program for adults.

Many participants felt that diabetes was a noticeable problem in their communities due in part to people's inability to recognize and manage symptoms of the disease. Similarly, they felt heart disease went largely unacknowledged and untreated even as it progressed due to unhealthy habits. There was general agreement that, in part, these diseases were going unmanaged as a result of a lack of community education about the diseases and symptoms. It was also stated that in some cases the lack of management was due to a lack of motivation to pursue treatment or lifestyle changes. Participants generally agreed that educating the public about the symptoms, behavioral links, and long-term consequences of these diseases would be the first step toward reducing their burden.

Substance Abuse

Substance abuse issues ranked third in importance to listening session participants. Discussions touched on several issues: smoking, alcohol abuse, misuse of over-the-counter medications, and methamphetamines. Participants were especially concerned about the lack of treatment programs they considered effective, the susceptibility of youth to addictive substances, the lack of clear information and facts about substance abuse issues, and a trend of substance abuse being socially acceptable.

Participants felt that the services currently available for treating substance abuse problems neglect "whole person" care and recovery; that is, they tend to focus too much on the clinical treatment of extreme incidents rather than using therapy, or the treatment of other health issues to support recovery. Prison, they felt, was too-often a substitute for effective treatment in this country. They recognized that residential treatment facilities do exist, but that they are largely targeted to higher-income individuals or are inadequate in capacity to meet the full need in the community. Many participants originally from other countries explained that treatment options in the US seemed significantly less effective than the highly-utilized residential treatment programs for substance abuse in their home countries.

Several groups' ideas involved strategies to create centralized substance abuse treatment services and make them available as part of a comprehensive treatment plan. Some groups wanted to create "case-worker" positions that could help individuals keep track of and coordinate different provider and community support services. Most groups discussing substance abuse mentioned feeling like they had a hard time getting access to unbiased information about the dangers of certain substances, and wanted to see clearly-presented materials developed that they could use as educational tools to protect themselves and their families. Also, as in their approach to mental health issues, participants generally felt that it was important to raise community awareness of existing substance abuse issues and available treatment. Some groups suggested media campaigns that warn, educate, and promote treatment options.

Many participants with children were extremely concerned by the susceptibility of their children to social pressure from peers and drug dealers to try drugs in schools and other settings outside the home. Several

talked about how it seemed to be more and more difficult to talk to kids about these issues before they are approached about drugs. Many of these participants wanted to work with schools to develop a strong anti-drug curriculum targeted towards very young children.

Some participants were worried about themselves or their children becoming the targets of violence related to drug culture. As with their discussion of chronic disease prevention, participants wanted to see an increase in accessible recreation facilities and affordable sports and arts programming available to provide safe and enjoyable spaces. They felt that such spaces and activities—for both youth and adults—are important alternatives to opportunities for substance abuse.

In addition to street drugs, several participants also commented on the widespread abuse of tobacco and alcohol despite ongoing media campaigns they've seen to warn against the use of these products. Many participants repeatedly indicated that smoking and drinking excessively around children in the home is a problem that they witness in their communities on a regular basis. In a few groups, the abuse of over-the-counter drugs was of particular concern. Participants tended to be concerned with an apparent social acceptance of these practices.

Several individuals were frustrated by the role that media plays in marketing certain substances to the general public. A few participants stated that alcohol commercials send mixed messages. Others, especially those originally from other countries where media is differently regulated, found it troubling to constantly see advertisements for over-the-counter and prescription drugs – products, they felt, that didn't need to be advertised and were frequently abused. These participants suggested banning television advertisement for these products.

There were varying suggestions about regulation and policy changes that participants wanted to see established to confront substance abuse issues. On the whole, suggestions were aimed at restricting access to substances and to promotional media. Examples included drug laws with harsher penalties for selling illicit drugs, school policies that punish drug abuse and distribution more severely, more restrictions on medical marijuana, strict rules for medication and alcohol advertisements, and regulations to monitor provider prescriptions and patient need for medications.

Access to Affordable Health Care

As an issue unto itself, access to affordable health care was ranked below mental health, chronic disease and substance abuse issues. However, it is important to remember that many participants tended to incorporate specific access to care issues into their discussion of the health issues listed above, as well as their discussion of other less-prioritized issues.

Most participants felt that their most significant barriers to health care services were financial. Many participants expressed simultaneous concern over both their inability to get sufficient insurance coverage for the services they needed, as well as the often prohibitively expensive cost of insurance premiums. Participants frequently called for the cooperation of health care providers to lower rates for the health services not covered by their insurance, and of insurance companies to offer affordable health coverage. A common suggestion was the widespread adoption of sliding fee scales based on a family's income so that services and coverage could be obtained at a rate that is affordable.

When they could find more affordable services, participants from rural areas often had to travel significant distances and rely on infrequent public transportation to see providers. Many participants, who were struggling to maintain employment—and did not have time off, worried because they could not find affordable care at all outside of regular working hours. Many participants who had to pay for childcare, described the

expense of this due to the travel and wait time necessary to access affordable health care, (e.g., waiting in line at a free clinic).

Several participants suggested extending the operating hours of existing providers and creating childcare options on-site. In addition, there was strong agreement between most groups that more free and low-cost clinics, providers, and urgent-care options be created in their communities. Most participants felt that expanding a workforce to provide these services locally, at low cost, would ultimately be a better long-term goal than improving transportation options to bring patients already-busy urban clinics.

In almost every group someone had a story to share about being unable to receive the care they needed – especially for non-emergency issues. Participants routinely noted that preventative care and screenings were especially out of their reach. Making the trip, missing work or even going into debt were not reasonable options, resulting in delays in care until an emergency medical situation developed. In response to this problem, participants suggested lowering the cost of, and even incentivizing preventative screenings, routine checkups and other care that could help low-income community members avoid waiting until they required costly emergency procedures.

Several participants wanted to loosen eligibility requirements for services like the Medicaid (Oregon Health Plan), SNAP and other programs that help low-income community members to maintain good health and regular access to medical care.
They felt that the current system of public assistance sometimes discouraged recipients to pursue employment out of fear of losing benefits even if it were only a seasonal or temporary increase in income. There was some concern expressed by participants that people living in the US without documentation are not getting the care they should be and having to wait until their situation is an emergency. These participants wanted to see policy changes aimed at granting access to government aid programs and essential health care services for those without basic legal paperwork.

Oral Health and Access to Oral Health Services
Several participants came to listening sessions with worries about oral health issues that were affecting them and their families. In many cases, the pain and distraction resulting from untreated oral health issues had greatly impacted their health, lives, and work.

Almost three quarters of participants responding in the participant survey said they did not have a dentist they could go to, and many participants indicated in discussion that they did not have any kind of coverage for dental services even if they did have health coverage. As with other health issues, participants largely agreed that the cost of dental services was prohibitively high, and that this often resulted in community-members waiting until their oral health problems had become serious issues before seeking treatment. Similar to discussions of strategies for improving access to health care, participants frequently suggested a cooperative agreement between their community's oral health service providers to lower the cost of services. Having providers drop prices specifically for preventative services and/or offer payment plans for costly ones were ideas that came up more than once.

Many participants also wanted to approach the problem of affordability by expanding dental insurance coverage for their communities. This included both expanding the number of people eligible for dental coverage, and expanding the number of important dental health services covered under such policies.

In several groups participants wanted to make dental insurance standard as part of any health insurance package, including those offered through the government, those offered by employers, and those purchased independently. It was also suggested that routine checkups for children and all significant services for adults,

including dentures should all be covered under any dental insurance plan. The idea behind this was to create a standard of dental coverage that all parties could understand and expect.

Several participants also expressed a specific need in rural communities for more affordable oral health service providers in order to eliminate the need for repeated travel to urban centers to access these services. In one group participants expressed interest in the idea of funding mobile clinics to meet the on-going dental health needs of agricultural workers and other more-remote community members.

Over-Arching Strategies for Approaching Health Issues in the Community
In almost all of the groups, discussion included similar, over-arching strategies for improving community health.

Increase Health Education
Notably, in almost every discussion group participants mentioned a general desire to increase health education that focused on each community's major health issues. Examples of what could be done included, increasing the number of community health educators, working with schools to develop strong health curriculums supported by activity and nutrition programs, launching media campaigns targeting specific health issues, and engaging the community regularly through events such as nutrition classes, talks, and health fairs in accessible locations.

Improve Community Access to Health Data and Information about Health Services
Similarly, many participants called for easily accessible health information. They especially mentioned creating community information centers where all residents could go to access health data and research, as well as information about available health services—including eligibility requirements and instructions on how to apply. In some groups it was suggested that having staff who could provide reference services would be very helpful in such a setting in order to help people navigate the vast amount of information.

Improve Cultural Competency of the Health Care System
Improving cultural competency at all levels of the health care system was talked about in most discussions about health issues. Many participants emphasized the need to make sure that any efforts made to improve health care and services in the four-county area would benefit *all* community members. Specifically, this meant producing materials and resources in languages other than English and making them available to cultural communities that may not frequent the same locations as others. This also meant ensuring quality interpretation services at all levels of health care and training providers to better meet the specific needs of the cultural communities they serve.

Limitations
The information and ideas generated during these listening sessions came from participants recruited as part of a convenience sample. The sample does not represent the whole geographical scope of the four-county area. The opinions and ideas collected from 202 individuals through these listening sessions cannot be generalized to the overall population. The goal was to provide an opportunity for community members to express their needs and perspectives in order to help inform Healthy Columbia Willamette Collaborative members as they begin to develop plans to better serve the communities in which participants live. There was much agreement between the top health issues prioritized by participants of the listening groups, the findings from previously conducted community engagement/assessment projects, and the epidemiological data.

Resources

The following resources are referenced above and may be useful for background information:

- New Requirements for Charitable 501(c)(3) Hospitals under the Affordable Care. Internal Revenue Service. Available from: http://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/New-Requirements-for-501(c)(3)-Hospitals-Under-the-Affordable-Care-Act
- Public Health Accreditation. Public Health Accreditation Board. Available from: http://www.phaboard.org/
- Mobilizing for Action through Planning and Partnerships (MAPP). National Association of County and City Health Officials. Available from: http://www.naccho.org/topics/infrastructure/mapp/
- Healthy Columbia Willamette regional website. Healthy Columbia Willamette Collaborative. Available from: http://www.healthycolumbiawillamette.org.

YEAR ONE PROGRESS BRIEF

Key Objectives for Years One and Two

The objectives for the first year focused on assessing the community health needs; the second year's objectives will focus on actions to address those needs:

- To prioritize community health needs identified through the community health needs assessment.
- To make available online data dashboards displaying community health statistics to inform and engage the broader community in understanding the health status of the entire community[17].
- To develop regional, shared, and aligned hospital/county level strategies that will begin to address prioritized community health needs.
- To identify regional, hospital, and county level indicators to monitor health outcomes and implemented strategies.

Five phases of this assessment model were completed between August 2012 and April 2013:

The Community Themes and Strengths Assessment (Fall 2012)

This first assessment involved reviewing 62 community engagement projects that had been conducted in the four-county region since 2009. Qualitative responses from community members participating in 62 projects were analyzed for themes about health issues they identified as the most significant to the community, their families, and themselves.

The Health Status Assessment (Fall 2012)

The second assessment was conducted by epidemiologists from the four county health departments with representatives from two hospital systems acting in an advisory capacity. This workgroup systematically 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 analysis used the following criteria for prioritization: disparity by race/ethnicity, disparity by gender, a worsening trend, a worse rate at the county level compared to the state, a high proportion of the population affected, and severity of the health impact.

The Local Community Health System Assessment & Forces of Change Assessment (Winter 2013)

The third and fourth assessments were combined, and involved interviewing and surveying 126 stakeholders. This assessment was designed to solicit stakeholder feedback on the health issues resulting from the first two assessments listed above. Stakeholders were asked to add and prioritize health issues they thought should be on the list, as well as describe their organizations' capacity to address these health issues.

Community Listening Sessions (Spring 2013)

The next phase is not a formal MAPP component, but was added to ensure the findings from the four assessments resonated with the local community. Fourteen community listening sessions were held with uninsured and/or low-income community members living in Clackamas, Clark, Multnomah and Washington counties. More than 100 organizations and local businesses helped recruit for these discussions so that members of a variety of culturally-identified communities and geographic communities would be reached. In all, 202 individuals participated. During these meetings, community members were asked whether they agreed with the issues that were identified through the four assessments. Participants were also asked to add to the list the health issues that they thought were missing. Next, participants voted for what they thought were the most important issues from the expanded list.

[17] The Healthy Columbia Willamette Collaborative's website: http://www.healthycolumbiawillamette.org/

Findings from First Five Phases

After all of the four assessments and community listening sessions were completed, the findings from all of this work point to the following health issues or "health focus areas" as the most important ones affecting the four-county community[18] (in alphabetical order):

- Access to affordable health care
- Cancer
- Chronic disease (related to physical activity and healthy eating)
- Culturally-competent services and data collection
- Injury (falls and accidental poisoning/overdose)
- Mental health
- Oral health
- Sexual health (Chlamydia)
- Substance abuse

Healthy Columbia Willamette Selection Process

Recognizing that nine health focus areas would be too many to address in a way that could show improvement in health indicators over a relatively short period the Collaborative developed selection criteria to further prioritize health issues from the list above. The health focus area will meet the following requirements:

- Is identified by at least two of the three community engagement activities (i.e., Community Themes & Strengths Assessment, Local Community Health System & Forces of Change Assessment and/or the community listening sessions);
- Is identified as a health issue (with indicators) through the Health Status Assessment OR as an issue for which data are not currently available;
- Is one of the top five most expensive in the metropolitan statistical areas in western U.S. OR as an issue for which health care expenditure data are not currently available; and
- Has been shown to improve as a result of at least one type of intervention (evidence-based practices).

Health Focus Areas Identified after Selection Criteria Applied

Those health issues/health focus areas that meet the selection criteria for the region include (in alphabetical order):

- Access to affordable health care
- Chronic disease (related to physical activity and healthy eating)
- Mental health
- Substance abuse

The Healthy Columbia Willamette Collaborative is committed to addressing health disparities and working with communities who are experiencing them. All phases of community engagement completed to date have built on the information learned from vulnerable communities and through epidemiological study specifically looking for health indicators with racial/ethnic and/or gender health disparities.

[18] Findings for individual counties: Clackamas and Multnomah counties same as region; Washington County same as region plus Parkinson disease; Clark County Washington same as region plus immunization and aging-related issues.

The focus area entitled, "culturally competent services and data collection" did not meet the selection criteria. It was selected only during one instead of at least two of the three community-input activities. The focus area, "culturally competent services and data collection" is not parallel with "mental health" or "chronic disease." It is not a health problem but a strategy toward a solution. The Collaborative will emphasize culturally competent services for the health issues/focus areas it works to address. Also, efforts to increase capacity for collecting and analyzing data will place attention to the data gaps that currently exist for vulnerable communities.

Next Steps

During the summer of 2013, the Collaborative will work with content experts in the four health focus areas to identify the types of support that will help address the health needs within these focus areas. For instance, if mental health is one of the selected focus areas, and the rate of suicide is the associated "indicator" that had been prioritized in this focus area (as identified during the epidemiological study), then we will be asking content expert to help identify what can be done in the community to prevent suicide. See Table 1 for the specific indicators associated with each health focus area/health issue.

We recognize that there are most likely additional indicators in these focus areas that would demonstrate problems; however there may not have been population-based data to investigate them.

Table 1. Health Focus Areas and Related Indicators[19]

Access to affordable health care	Chronic disease (related to physical activity and healthy eating)	Mental health	Substance abuse
Adults with an usual source of health care	Adults doing regular physical activity	Suicide	Adult binge drinking (males)
Adults with health insurance	Adult fruit/vegetable consumption		Adult smoking
Mothers receiving early prenatal care	Diabetes-related deaths		Drug-related deaths
	Heart disease deaths		

During the August Healthy Columbia Willamette's monthly meeting, content experts will be asked to discuss questions like those listed below:

- Do these issues resonate with you as a priority? Is it what you are observing in your work?
- Are there additional priority indicators that we missed?
- Who is most affected by these issues (culturally-identified and geographic communities)?
- Can you suggest evidence-based interventions to address these issues?
- What strategies are being implemented and planned to address these issues?
- What type of support could the Healthy Columbia Willamette Collaborative provide to help those (not your specific agency/organization specifically)?

Starting this summer, information will be published in an on-going manner on the Healthy Columbia Willamette Webpage: http://www.healthycolumbiawillamette.org/. On this website, we encourage you to post feedback, recommendations, and questions. We also encourage phone calls. Please contact our Convener, Christine Sorvari at 503-988-3663 ext. 29054.

[19] Identified after analyzing 120+ indicators for a disparity by race/ethnicity, disparity by gender, a worsening trend, a worse rate at the county level compared to the state, a high proportion of the population affected, and a severe health consequence

The following reports will be published on the website soon.

- Community Themes and Strengths Assessment: Important Health Issues Identified by Community Members
- Health Status Assessment: Quantitative Data Analysis Methods and Findings
- Local Community Health System and Forces of Change Assessment: Stakeholders' Priority Health Issues and Capacity to Address Them
- Community Listening Sessions: Important Health Issues and Ideas for Solutions
- Healthy Columbia Willamette: Assessing Community Needs and Improving Health in Clackamas, Multnomah, and Washington Counties in Oregon and Clark County, Washington

Stakeholder Engagement To-Date

The community-engagement projects used in the Community Themes and Strengths Assessment, stakeholders interviewed and surveyed as part of the Local Community Health and Forces of Change Assessments, and community listening sessions are listed in Tables 2, 3, and 4 respectively.

Table 2. The Community Themes and Strengths Assessment: Community Engagement Projects Used

ACHIEVE (Action Communities for Health, Innovation and Environmental Change) Community , *Multnomah County Health Department* 2009
African American Health Coalition CPPW , Final Report 2012
The Asian and Pacific Islander Community in Multnomah County: An Unsettling Profile , *Coalition of Communities of Color* 2012
Beaverton Community Vision Action Plan Update, *City of Beaverton* 2012
Cascade AIDS Project Strategic Planning, 2009-2014 Data Collection Report 2009
Causa/Oregon Latino Health Coalition and NW Health Foundation Latino Health, Assembly 2010
Clackamas County Children's Commission Community Assessment, *Clackamas County Children's Commission Head Start, Clackamas Education Service District* 2012
Clackamas County Community Health Improvement Plan, *Clackamas County Department of Health, Housing, and Human Services* 2012
Communities of Color in Multnomah County: An Unsettling Profile, *Coalition of Communities of Color* 2010
Community Health Partnership: SNAP Roundtable, *Oregon Public Health Institute* 2009
Community Value Assessment of North by Northeast, Community Health Center 2012
Comprehensive Plan Update, *Washington County* 2010
engAGE in Community 2012
Focus Group Discussions with Housing, Job Training and Employment Professionals , *Multnomah County Health Department* 2009
Growing Healthier: Planning for a Healthier Clark County, *Clark County Public Health Advisory Council, Clark County Public Health* 2012
Healthy Active Communities for Portland's Affordable Housing Families, *Oregon Public Health Institute* 2011
Healthy Communities: Building Capacity Based on Local Tobacco Control Efforts, *Oregon Health Authority* 2011
Healthy Eating at Farmer's Markets: The Impact of Nutrition Incentive Programs, *Oregon Public Health Institute* 2011
Healthy Eating/Active Living Partnership, *Portland State University, Multnomah County Health Department* 2009
Hillsboro 2020 Vision and Action Plan, *Hillsboro City Council* 2010
HOPE (Healthy Oregon Partnership for Equity) Coalition Five Year Health Equity Plan 2012
Immigrant and Refugee Community Organization Shaping Our Future: Community Needs Assessment Conference 2010
Improving Access to Affordable Health Care: An Outreach Audit of North Clackamas County Residents Living Below 200% of Poverty, *Clackamas County Department of Health, Housing, and Human Services* 2011
The Latino Community in Multnomah County: An Unsettling Profile, *Coalition of Communities of Color*2012
Legacy Health Community Needs Assessment 2011
Legacy Salmon Creek Hospital Community Needs Assessment and Implementation Strategies Plan, *Legacy Health* 2012
Lessons from the Field: Portland, Oregon: Kelly GROW: Integrating Healthy Eating & Active Learning at Kelly Elementary, *Oregon Public Health Institute* 2010
Multnomah County Community Health Assessment, *Multnomah County Health Department* 2011
Multnomah County Health Equity Initiative: Unnatural Causes, *Multnomah County Health Department* 2009
The Native American Community in Multnomah County: An Unsettling Profile, *Coalition of Communities of Color* 2012
Oregon Food Bank Nutrition Education Program, Long-Term Follow-up Survey 2010
Oregon Health Improvement Plan, *Oregon Health Policy Board, Oregon Health Authority* 2010
Oregon Latino Agenda for Action Summit 2010
Oregon Medicare-Medicaid Listening Groups: Final Report, *Oregon Health Authority* 2011
Overview of Hispanics in an Aging Population: A supplement to the engAGE in Community initiative 2011
Partnering for Student Success-The Cradle to Career Framework: Report To The Community 2010
The Path to Economic Prosperity: Equity and the Education Imperative, *Greater Portland Pulse* 2011
Patient Centered Primary Care Home Implementation Task Force Report, *Oregon Health Authority, NW Health Foundation* 2011
Perceived and Actual Diabetes Risk in the Chinese and Hispanic/Latino Communities in Portland, Oregon, *Portland State University* 2011
Portland Mercado: Community Economic Development to Revitalize, Uplift, and Empower, *Adelante Planning, Hacienda Community Development Corporation, Portland State University* 2011
Portland Plan, *City of Portland Bureau of Planning and Sustainability* 2012
Project Access Now 2008-2010 Program Evaluation 2010
Providence Milwaukie Hospital and Providence Willamette Falls Medical Center-Community Health Needs Assessment 2012
Providence Portland Medical Center- Community Health Needs Assessment 2012
Providence St. Vincent Medical Center- Community Health Needs Assessment 2012
Public Health Improvement Partnership Agenda for Change Action Plan: Initial Priorities and First Steps for Advancing Washington's Public Health System, *Washington Health Authority* 2012
Regional Equity Atlas Project Action Agenda, *Coalition for a Livable Future* 2007-2009
Roadmap to Health Communities: A Community Health Assessment, *Clackamas County Department of Health and Human Services* 2012
Running on Empty: Services and Citizens Stretched to the Limit, *Washington County Anti-Poverty Workgroup* 2012
Share Our Strength's No Kid Hungry Lead Partner Report, *Oregon Food Bank* 2011
Speak Out Survey 2009, *Multnomah County Health Department* 2010
State of Black Oregon, *Urban League of Portland* 2009
State of Cultural Competency Community Forum-Results, *Asian Pacific American Network of Oregon*2012
Together for Children: A Comprehensive Plan for Children and Families, *Washington County Commission on Children and Families* 2010
Tri-County Supported Housing and Supportive Services Needs Assessment, *Central City Concern on behalf of CareOregon* 2012
United Way White House Community Conversations—Clackamas, Clark, Washington counties, East Portland, and Camp Odyssey members 2012
Washington County Community Assessment, *Oregon Child Development Coalition* 2009
Washington County Issues of Poverty, *Community Action* 2011

Table 3. Local Community Health Status and Forces of Change Assessment: Interviewees /Survey Respondents

Adelante Mujeres	Independence Northwest
Adventist Medical Center	Independent Living Resources
Affordable Community Environments	Iraqi Society of Oregon
African American Health Coalition	Janus Youth Programs
African Partnership for Health	Kaiser Permanente
Albertina Kerr Centers	Latino Learning Community
American Cancer Society, Cancer Action Network, Oregon State	Latino Network
American Cancer Society, Cancer Action Network, Washington State	League of United Latin American Citizens, Southwest Washington Council #47013
American Diabetes Association of Oregon & SW Washington	Legacy Health
American Lung Association of the Mountain Pacific	Legacy Weight and Diabetes Institute
American Medical Response	Los Niños Cuentan
Area Agency on Aging and Disabilities of Southwest Washington	Luke-Dorf, Inc.
Asian Health and Service Center	Mentor Oregon Brokerage, Metro
Asian Pacific American Network of Oregon	Metropolitan Family Service
Basic Rights Oregon	Multnomah County Aging and Disability Services
CareOregon	Multnomah County Health Department
Cascade AIDS Project	Multnomah County Health Department, Health Equity Initiative
Catholic Charities of Oregon	Multnomah County Mental Health and Addiction Services
Catholic Charities of Oregon, El Programa Hispano	Multnomah County Mental Health and Addiction Services
Catholic Community Services of Southwest Washington	National Alliance on Mental Illness-Clackamas County
Causa	National Alliance on Mental Illness-Clark County
Centro Cultural	National College of Natural Medicine, Community Clinics
Children's Home Society of Washington	National Indian Child Welfare Association
Children's Center	Native American Youth and Family Center
Children's Community Clinic	New Heights Physical Therapy Plus
Children's Health Alliance	North by Northeast Community Health Center
City of Portland Office of Equity & Human Rights, New Portlander Programs	NorthWest Tribal Epidemiology Center
City of Portland, Office of Neighborhood Involvement, Community and Neighborhood Involvement Center	NW Health Foundation
City of Portland, Office of Neighborhood Involvement, Diversity and Civic Leadership Program	NW Indian Veterans Association, Portland and Vancouver Chapter
City of Wilsonville, Community Center	Oregon College of Oriental Medicine
Clackamas County Area Agency on Aging	Oregon Department of Human Services
Clackamas County Department of Health, Housing and Human Services	Oregon Health and Science University, Oregon Office on Disability and Health
Clackamas County Department of Health, Housing and Human Services, Public Health Division	Oregon Health and Sciences University
Clackamas County Health Centers	Oregon Health Authority, Office of Equity and Inclusion
Clackamas Service Center	Oregon Health Authority, Public Health Division
Clark College, Corporate and Continuing Education	Oregon Health Equity Alliance
Clark County Community Services	Oregon Latino Agenda for Action
Clark County Public Health	Oregon Public Health Institute
Coalition of Community Health Clinics	Organizing People, Activating Leaders
Columbia River Mental Health Services	PeaceHealth Southwest Medical Center
Community Action	Project Access NOW
Confederated Tribes of Siletz Indians, Portland Office	Providence Health & Services
Council for the Homeless	Q Center
Cowlitz Family Health Center	Regional Health Alliance
Cowlitz Indian Tribe	Sea Mar Community Health Centers
Disability Rights Oregon	Second Step Housing
Educational Service District 112	Self Enhancement, Inc.
Emmanuel Community Services	Sí Se Puede Oregon
Familias En Acción	Southwest Washington Behavioral Health, Regional Support Network
FamilyCare Health Plans	Susan G. Komen for the Cure, Oregon and Southwest Washington
Filipino-American Association of Clark County and Vicinity	Tuality Healthcare
Free Clinic of Southwest Washington	Tuality Healthcare, ¡Salud! Services
Future Generations Collaborative	United Way of the Colombia-Willamette
Health Share of Oregon	Upstream Public Health
Health Share of Oregon	Urban League of Portland
Healthy Oregon Partnership for Equity Coalition	Vietnamese Community of Clark County
Human Solutions, Inc.	Virginia Garcia Memorial Health Center
Immigrant and Refugee Community Organization, Asian Family Center	Washington County Health & Human Services
Immigrant and Refugee Community Organization, Healthy Kids Program	Washington County Health and Human Services, Healthy Start of Washington County
Impact NW	Washington State Department of Health
Inclusion, Inc.	YMCA of Columbia-Willamette, Clark County Family YMCA

Table 4. Schedule of Healthy Columbia Willamette Community Listening Sessions

	Date	Location	Time	Languages Available	Number of Participants
Clark County	**March 19th (Tues)**	**Jim Parsley Community Center** Vancouver, WA 98661	5:30pm–7pm	English, Spanish, Russian	**15**
	March 20th (Wed)	**Maple Grove Middle School** Battle Ground, WA 98604	5:30pm-7pm	English, Spanish, Russian	**11**
	April 11th (Thurs)	**Jim Parsley Community Center** Vancouver, WA 98661	6pm-7:30pm	English, Spanish, Russian	**16**
Washington County					
	April 1st (Mon)	**Tuality Education Center** Hillsboro, OR 97123	5:30pm–7pm	English, Spanish	**2**
	April 8th (Mon)	**Centro Cultural** Cornelius, OR 97133	5:30pm–7pm	English, Spanish	**21**
	April 13th (Sat)	**Beaverton City Library** Beaverton, OR 97005	1pm-2:30pm	English, Spanish, Somali	**28**
	April 17th (Wed)	**Forest Grove Senior and Community Center** Forest Grove, OR 97116	1pm-2:30pm	English	**5**
Multnomah County					
	April 14th (Sun)	**Human Solutions** Gresham, OR 97203	3pm–4:30pm	English, Spanish,Russian	**12**
	April 16th (Tues)	**Markham Elementary** Portland, OR 97219	1:30pm–3pm	English, Spanish	**13**
	April 18th (Thurs)	**Catholic Charities** Portland, OR 97202	5:30pm–7pm	English, Spanish, Somali	**18**
	April 20th (Sat)	**Matt Dishman Community Center** Portland, OR 97212	11:30am–1pm	English, Spanish, Somali	**12**
Clackamas County					
	April 23rd (Tues)	**Milwuakie High School** Milwaukie, OR 97222	6pm–7:30pm	English, Spanish	**1**
	April 24th (Wed)	**Sandy High School** Sandy, OR 97055	6pm–7:30pm	English, Spanish	**14**
	April 25th (Thurs)	**Canby High School** Canby, OR 97013	6pm–7:30pm	English, Spanish	**34**

N = 202 Clackamas County n= 49, Clark County n= 42, Multnomah County n= 55, Washington County n= 56

YEAR TWO PROGRESS BRIEF

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 community health needs. Community input was collected during three distinct phases of the assessment:

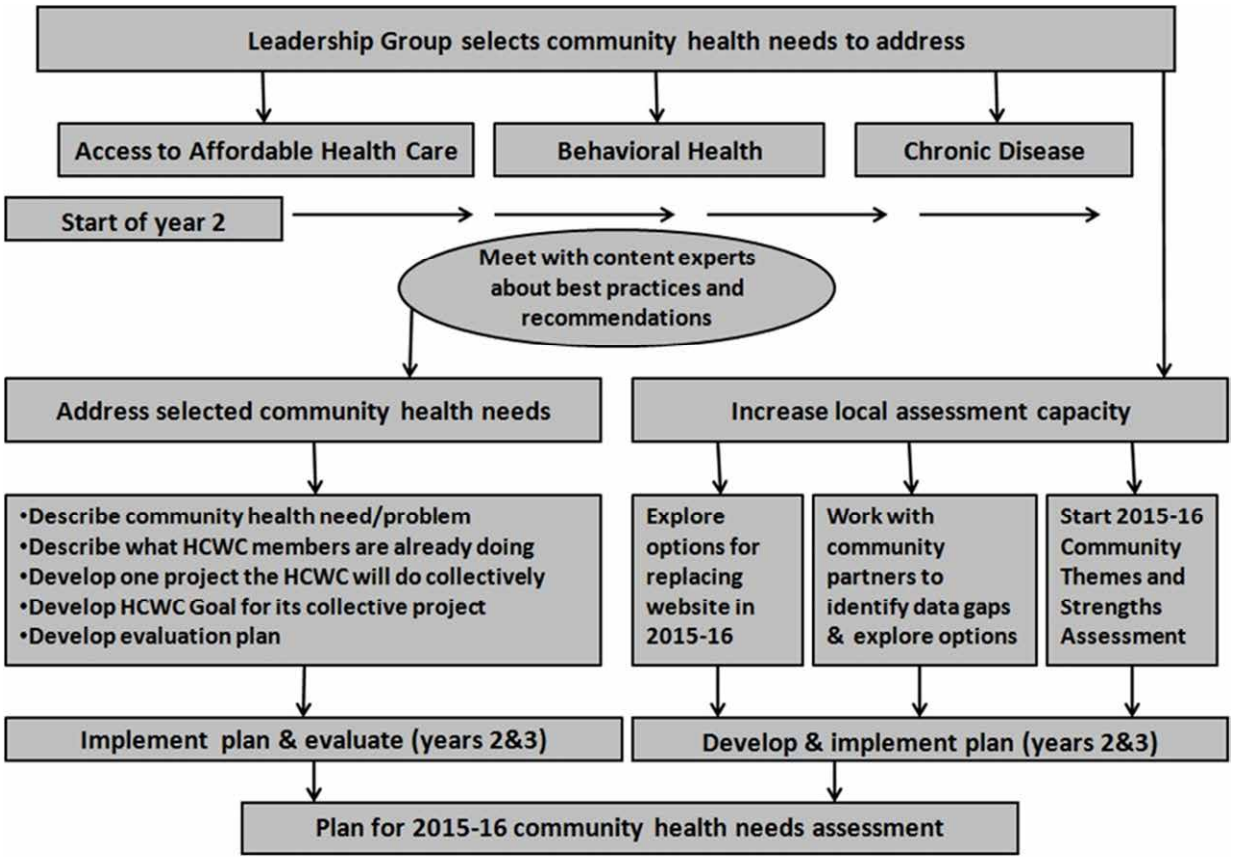
- ***Community Themes and Strengths Assessment (Fall 2012)***: Findings from 62 projects, conducted in the four-county region since 2009, were analyzed for themes about how community members described the most important health issues affecting themselves, their families, and the community.
- ***The Health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