2014 Washington County Community Health Assessment

Including the Healthy Columbia Willamette Collaborative Assessment Reports

December 2014
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Washington County Public Health
I. Executive Summary

Washington County has experienced tremendous population growth over the past two decades resulting in significant demographic changes. To respond to these changing community characteristics and emerging health needs, Washington County Public Health recognizes the need to comprehensively assess the health of the community. The goal of conducting a community health assessment is to identify findings that will enable Washington County Public Health to improve public health practice, ensure relevance and alignment with current health needs, ensure equity of services and inform collaborative work with community partners.

Beginning in 2012, Washington County Public Health and regional partners initiated a community health assessment effort through the Healthy Columbia Willamette Collaborative. The collaborative is comprised of fifteen hospital and health care systems, two coordinated care organizations and four local health departments. The Healthy Columbia Willamette Collaborative assessment process used a modified Mobilizing for Planning and Partnerships approach. This process included extensive community engagement to identify health issues, assets and resources; a health status assessment that included analysis of more than 120 health behavior and health outcome indicators; using prioritization criteria including disparity by race and ethnicity; and input from community stakeholders through an assessment of the local community health system. In addition, the preliminary data was presented in culturally specific community listening sessions in order to validate and build on the findings.
The Healthy Columbia Willamette Collaborative assessment process identified the following as the priority community health issues affecting the four-county region:

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

The Washington County Community Health Assessment document is a comprehensive report that includes both local and regional assessments as well as descriptions of process and findings. It begins with a Washington County health status assessment that includes data on social determinants and health disparities in the county. It also contains the full Healthy Columbia Willamette Collaborative report.

These assessments have been used to develop priority focus areas for the 2014 Washington County Community Health Improvement Plan. The three focus areas are:

- Access to affordable health care
- Chronic disease (related to physical activity and healthy eating)
- Mental health (focus on suicide prevention)

In addition to the three focus areas, Washington County Public Health and community partners are committed to improving health equity and addressing health disparities, prioritizing early intervention and prevention, and strengthening partnerships and collaboration. These are reflected in the Community Health Improvement Plan as foundational goals and are incorporated throughout the work plan.

Numerous community assets and resources were identified through both the Healthy Columbia Willamette community engagement process and the work of Washington County’s Community Health Improvement Plan workgroups. In general, Washington County’s assets and resources are what make it such a thriving community and will be mobilized to support the focus areas within this assessment. These include:

- Pioneering spirit of community members
- Strong and collaborative government leaders
- Resilient and civic minded residents/community members
- Dedicated safety net organizations
- Large, committed and involved faith community and inter-faith collaborations
- Active parks and recreation districts and departments
- Diversity
  - In ethnic populations
  - In land use (urban, suburban and rural)
  - In economy (agriculture, high tech, health care, service industry, retail product development)
- Engaged higher education and K-12 partners
- Active network of early learning advocate and service providers

Washington County Public Health looks forward to building on these existing assets and resources to improve upon the health of the community. This will be accomplished through continued collaboration with community partners to address the identified health priorities detailed in this report. Washington County Public Health is committed to convening partners and serving as the backbone support organization in ongoing assessment, evaluation and monitoring of the community’s health needs.
II. Washington County Demographics

Washington County is one of three counties making up the Portland metropolitan area, located west of Portland, Oregon. The county spans 724 square miles and is the second most populous county in Oregon. Washington County is home to the fifth and sixth largest cities in the state (Hillsboro and Beaverton). Urban portions of the county are known for leadership in the high-tech industry and major employers such as Intel, IBM and Tektronix make it the state’s top county for manufacturing. The world headquarters for both Nike and Columbia Sportswear are located in Washington County.

Washington County includes vast tracts of forestland and nearly 130,000 acres of rural farmland. The county is centered on a fertile plain that continues to produce a wide variety of crops. In 2008, it ranked fifth among all Oregon counties in value of agricultural production, with total cash receipts in 2008 of more than $302 million for all commodities. More than 55% of this total came from greenhouse and nursery products, the county’s largest agricultural commodity, with cash receipts totaling more than $168 million.
Washington County population, demographics and characteristics

Washington County is the second most populous county in Oregon with a very high growth rate. The high birth rate and low death rate contribute to the population growth of the county. Washington County is fortunate to be the second most diverse county in Oregon with increased growth in the Hispanic, African-American and Asian populations. The county is also fortunate to have a robust veteran population with large proportion of Vietnam era and Gulf War veterans.

Population Density

The population density for Washington County is 734 people per square mile (PPS), which is far greater than both Oregon (40 PPS) and the national average (88 PPS). The majority of residents of Washington County live in an urban area (94%) rather than a rural area (6%). Approximately 5% of residents age 18 to 64 live in a rural area compared with 8% of the population age 65 or over living in a rural area.
Population growth
The population of Washington County has experienced steady growth since 1990, increasing approximately 3.4% per year, which is a higher rate of growth compared to both Oregon and the US. The population of Washington County increased nearly 19% between the 2000 and 2010 census, which is also a higher rate of growth compared to Oregon (12%) and the nation (10%). Almost 555,000 people resided in Washington County in 2013.

The birth rate in Washington County has traditionally been one of the highest in the state. In 2013, the birth rate was 13 births per 100,000 population, which is significantly higher than the state average of 11.5 births per 100,000 population. Interestingly, Washington County has the lowest death rate in Oregon, with only 5.8 deaths per 100,000 population in 2013. This high birth rate and low death rate contribute to the population growth of the county.

Population by age
Washington County has a relatively young population compared to Oregon with only approximately 10% of the population aged 65 and older versus the state average of 14%.

Population race and ethnicity
Washington County is fortunate to be the second most diverse county in Oregon, with 23% of residents reporting a race other than white. The county has a higher percentage of Asians (9%) compared with Oregon (5%) and persons reporting Hispanic ethnicity (16%) versus the Oregon average (12%). Additionally, looking at the percent change in population in Washington County from 2000 to 2010, there is a larger increase across every racial group compared with the state of Oregon.
Change in the Hispanic/Latino population
Nationally, between 2000 and 2010, there was a 43% increase in the Hispanic population. During this same time period the Hispanic population in Washington County increased by a greater amount (67%) than the state average (64%) and the national average. The map below shows the percent change in the Hispanic population by census tract in Washington County. The darkest green shade on the map represents a census tract increase in the Hispanic population of over 60%. Many tracts throughout the county experienced this increase.
Vulnerable populations

Foreign-born population
Approximately 90,000 Washington County residents are foreign-born, which includes anyone who was not a U.S. citizen or national at birth. Washington County has a much higher percentage of the population that is foreign-born (17%) than the state (10%) and the nation (13%).

Limited English proficiency
The inability to speak English creates barriers to health care access and provider communications and limits health literacy. Compared to Oregon (6%), and the nation (9%), Washington County has a higher percentage of the population age 5 years and older with limited English proficiency (10%).

Language spoken at home
English is the most common language spoken at home in Washington County, followed by Spanish and Chinese, Vietnamese and Korean (see graph to the right). When language spoken at home is evaluated along the lines of nativity/citizenship, there are considerable differences. The foreign-born population in Washington County makes up 17% of the population and 66% of this population speaks a language other than English at home. Of those who speak a language other than English at home, 17% are living below the poverty level, versus 8% of those who speak only English at home (ACS 2008-12).
Population with a disability
As of 2012, there are approximately 54,000 Washington County residents living with a disability. A smaller percentage of Washington County residents report any disability (9%) when compared with Oregon (14%) and the US (12%). This prevalence of disability increases with age, with the oldest residents experiencing a higher prevalence of all types of disability (see graph below). Examining disability along racial and ethnic lines, approximately 6% of African-Americans, 7% of Asians, 11% of whites and 8% of those identifying as Hispanic (of any race) live with a disability in Washington County. The graph below details disability characteristics for Washington County residents by age for the year 2012.

Veterans
There are approximately 34,000 veterans age 18 years and over in Washington County. Approximately 14% of Washington County veterans have a service-connected disability. Six percent of Washington County residents aged 18 to 64 years and 24% of residents aged 65 years and over are veterans. Washington County has a larger percentage of residents under 55 years of age who are veterans (36%) compared with the state of Oregon (29%).

The period of service for veterans in both Washington County and Oregon are shown below. Compared to the state, Washington County has more Gulf War veterans and fewer Vietnam era, Korean War and World War II veterans.
Educational attainment

Higher education is generally associated with more positive health outcomes than lower educational attainment. Approximately 40% of the population has a bachelor’s degree or higher and 14% of the population has a graduate or professional degree. While Washington County has one of the lowest high school dropout rates (1.3% in 2011) and highest high school graduation rates (80%), there are considerable disparities along racial and ethnic groupings. Approximately 4% of non-Hispanic white residents over the age of 25 do not have a high school diploma compared with 41% of Hispanic residents having no high school diploma.

Poverty and unemployment

Approximately 141,000 individuals are living below 200% of the Federal Poverty Level in Washington County. Washington County has a lower percentage of individuals (27%) living in households with an income below 200% of the Federal Poverty Level compared with Oregon (35%) and the national average (34%). However, the burden of poverty does not fall equally among races and ethnicities. American Indians or Alaska Natives make up approximately 27% of families living below poverty level, as do 24% of those reporting Hispanic ethnicity, independent of race. This indicator is relevant because poverty creates barriers to access to health services, healthy food and other necessities (Community Commons). Safety nets, such as free or reduced price lunch for students and SNAP benefits for families are available to aid those families living in poverty. Washington County has a lower percentage of students (39%) eligible for a free or reduced price lunch compared with Oregon (51%) and the US (48%).

The unemployment rate in Washington County (6.0%) is lower than both the Oregon (7.0%) and national average (6.6%). As of July 2014, there are approximately 18,000 residents in Washington County who are unemployed.
Chronic disease

According to the Centers for Disease Control and Prevention (CDC), 75% of US health care dollars go to the treatment of chronic conditions, which are the leading causes of death and disability in the country. In 2009, the Oregon Health Authority released a report detailing the leading fatal behavioral factors that caused these deaths for Oregonians which is shown here. Tobacco is the biggest killer of Oregonians, followed by obesity, poor diet and physical inactivity, and alcohol use. Fortunately, chronic diseases are among the most preventable with modification of health behaviors.

In the most recent community health needs assessment for Washington County, chronic disease emerged as a top health issue due to several factors. Washington County had disconcerting death rates due to heart disease, cerebrovascular disease (CVD)/stroke, prostate cancer and Alzheimer’s disease. Within these disease categories there were significant disparities along the lines of race/ethnicity and sex, a worsening in death rate trend, and a higher death rate in Washington County compared with the Oregon average. In addition to these death rates, Washington County experiences a higher female breast cancer incidence, low adult fruit and vegetable consumption, low levels of adult regular physical activity, and higher levels of low-income preschool obesity. The health behaviors in Washington County that affect chronic disease most strongly are low levels of adult fruit and vegetable consumption and low levels of adult regular physical activity (BRFSS). In addition to these data supporting chronic disease as a serious health issue in the county, 64% of interviewed community stakeholders listed chronic disease as a top health issue of concern.

Chronic disease as a leading cause of death

The two leading causes of death in Washington County in 2012 were cancer and heart disease, comprising 44% of deaths in the county. The two leading causes of death in the U.S. for the most recent year of data available (2011) were heart disease (191 deaths per 100,000 population) and cancer (185 deaths per 100,000 population). Of the leading causes of death, suicide is the only cause of death that is at a higher rate in Washington County than the U.S. average.

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<tbody>
<tr>
<td>Cancer</td>
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<td>167</td>
<td>185</td>
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<tr>
<td>Heart disease</td>
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<td>129</td>
<td>191</td>
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<tr>
<td>Cerebrovascular disease (stroke)</td>
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<td>37</td>
<td>41</td>
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<td>Chronic lower respiratory disease</td>
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<tr>
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<tr>
<td>Parkinson’s disease</td>
<td>9</td>
<td>8</td>
<td>7</td>
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<tr>
<td>Influenza and pneumonia</td>
<td>7</td>
<td>8</td>
<td>17</td>
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Cancer
Cancer is the leading cause of death in Washington County and the second leading cause of death in the U.S.. There are more than 100 types of diagnosable and reportable cancer; in Washington County lung cancer has the highest death rate, followed by prostate cancer (see table to the right). The overall age-adjusted death rate due to cancer has significant disparities along racial, ethnic and sex lines. For 2010-2012 within the Washington County population, non-Hispanic blacks have the highest rate of cancer (218 deaths per 100,000 population), followed by non-Hispanic whites (151 deaths per 100,000 population). The lowest cancer rates are found in the Hispanic population (97 deaths per 100,000 population/year). Men have significantly higher rates of cancer in Washington County (171 deaths per 100,000 population/year) than women (128 deaths per 100,000 population/year). Even with the racial, ethnic and sex disparities, the death rate due to cancer in Washington County is lower than both Oregon and the U.S..

**Cancer mortality, age-adjusted rate per 100,000 population, 2007-2011**

<table>
<thead>
<tr>
<th>Cancer mortality</th>
<th>Age-adjusted death rate per 100K population</th>
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<tr>
<td>Lung, trachea or bronchus cancer</td>
<td>29</td>
</tr>
<tr>
<td>Prostate cancer</td>
<td>25</td>
</tr>
<tr>
<td>Lymph and hematopoietic cancer</td>
<td>15</td>
</tr>
<tr>
<td>Colon, rectum and anus cancer</td>
<td>14</td>
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<tr>
<td>Breast cancer (female)</td>
<td>13</td>
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</table>

Data source: Oregon Public Health Assessment Tool

**2010-2012, Washington County**

**Age-Adjusted Mortality Due to Cancer, by Gender**

- Female: 128 deaths/100,000 population
- Male: 171 deaths/100,000 population
- Overall: 145 deaths/100,000 population

**Age-Adjusted Mortality Due to Cancer, by Race/Ethnicity**

- Asian: 104 deaths/100,000 population
- Black or African American: 218 deaths/100,000 population
- Hispanic, any race: 97 deaths/100,000 population
- White, non-Hispanic: 151 deaths/100,000 population
- Overall: 145 deaths/100,000 population

2 Age-adjusted death rate due to cancer, OPHAT, 2010-2012.
Heart disease

Heart disease is the second leading cause of death in Washington County. There are significant disparities in the burden of heart disease along racial, ethnic and sex lines. Non-Hispanic whites have the highest heart disease rates with a rate of 118 deaths per 100,000 population per year. The lowest heart disease rates are in Washington County's Hispanic population with a rate of 66 deaths per 100,000 population. The rate of heart disease in men (146 deaths/100,000 population/year) is significantly higher than in women (90 deaths/100,000 population/year) in the county. Even with the racial, ethnic and sex disparities, the death rate due to heart disease in Washington County (109 deaths per 100,000/year) is lower than both the state average (129 deaths per 100,000/year) and the U.S. average (185 deaths per 100,000/year).

The Medicare population in Washington County also has a lower prevalence of heart disease (18%) than Oregon (19%) and the nation (29%). These data suggest that our vulnerable Medicare population has lower heart disease rates than would be expected for those living in Oregon.

High cholesterol is considered a risk factor for heart disease. Approximately 33% of Washington County adults report that they have been told by a doctor, nurse or other health professional that they had high blood cholesterol. The prevalence of high cholesterol is lower than both Oregon (38%) and the U.S. (39%). Washington County’s Medicare population prevalence of high cholesterol also follows a similar trend to the general population with 32% reporting high cholesterol versus Oregon’s Medicare population (34%) and the U.S. Medicare population (45%).

**2010-2012, Washington County**

### Heart disease mortality, age-adjusted rate per 100,000 population, 2007-2011

- **Washington County (120)**
- **Oregon (144)**
- **United States (185)**

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2. Age-adjusted death rate due to heart disease, OPHAT, 2010-2012.
Diabetes
Diabetes is the seventh leading cause of death in Washington County, and there are significant disparities along sex, racial and ethnic lines. Men and African-Americans in Washington County are hospitalized at higher rate due to diabetes than the total population. The age-adjusted death rate for diabetes in Washington County (19 deaths per 100,000 population/year) is lower than the Oregon rate (25 deaths per 100,000 population/year). In 2012, the Medicare population of Washington County had a lower percentage of residents being treated for diabetes (20%) compared with both Oregon (21%) and the U.S. (27%). Modifiable risk factors for Type 2 diabetes include excess body weight and physical inactivity. As discussed in a later section on physical activity, a little more than half (54%) of Washington County residents meet the recommended guidelines for physical activity, and approximately one-third of county residents are overweight and one-quarter are obese.

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1 Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Diabetes Atlas: 2010.
2 Healthy Columbia Willamette, Disparities Dashboard, Washington County (original data from Oregon Association of Hospitals and Health Systems), 2010-2012.
Behavioral factors associated with chronic disease
The protective health behaviors for chronic disease that are lower than optimal in Washington County are levels of adult regular physical activity and adult fruit and vegetable consumption. Unfortunately, none of the health behaviors data are available for analysis by race, ethnicity or sex, thus they are presented for adults at the county-level only.

Physical inactivity
According to the World Health Organization, physical inactivity has been identified as the fourth leading risk factor for global mortality, causing an estimated 3.2 million deaths globally. The Centers for Disease Control and Prevention recommend for important health benefits, adults ages 18-64 should have at least 2 hours and 30 minutes of moderate-intensity aerobic activity per week, in addition to muscle-strengthening activities on two or more days per week. Physical inactivity is generally associated with significant health issues such as obesity and poor cardiovascular health.

In Washington County, approximately 54% of adults met the recommended level of physical activity, and 15% report no leisure time physical activity with little change in the trend from 2004 to 2010. Fortunately, Washington County does have some protective factors for physical inactivity. Approximately 80% of Washington County residents live within one-half mile of a park, which is significantly higher than the Oregon average (54%) and the U.S. average (38%). Another protective factor present in Washington County is the number of recreation and fitness facilities available. There are nearly 12 fitness establishments per 100,000 population in the county, which is higher than the Oregon average of 11, and US average of nine establishments per 100,000 population.

Data Source: Community Commons, via the Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Diabetes Atlas: 2010. Source geography: County.
Access to healthy food

The food environment in which we live has a large impact on our health. According to the Centers for Disease Control and Prevention, food environment includes the physical presence of food that affects a person’s diet, a person’s proximity to food store locations, the distribution of food stores, and a connected system that allows access to food. Measuring community access to healthy food is important because it provides a measure of environmental influences on dietary behaviors. Residents who have better access to supermarkets and other fresh food retailers tend to have healthier diets and lower levels of overweight/obesity.

Approximately 15% of Washington County residents live in food deserts, where residents have low access to a supermarket or large grocery store. These populations are considered vulnerable because food insecurity is a major threat to health. Most racial and ethnic groups in Washington County tend to have better healthy food access than similar groups in the US, but worse than those in Oregon (see graph below).
Healthy food consumption
Fruits and vegetables contribute important and necessary nutrients for development of the human body. Research shows that eating fruit and vegetables lowers the risk of chronic disease and can also be helpful in weight management. Per the CDC, Oregon is one of the top three states in the country for adult vegetable intake per day. However, in Washington County, almost three-quarters (74%) of the residents over 18 years old are not consuming the recommended five servings of fruits and vegetables per day. It is generally accepted in the public health community that increasing access to fresh fruits and vegetables leads to greater consumption of these products by adults and children.

SNAP (Supplemental Nutrition Assistance Program)
SNAP-authorized stores include grocery stores as well as supercenters, specialty food stores and convenience stores. There are disparities in the percent of households receiving SNAP benefits, with more Hispanic/Latino households receiving benefits. The county has fewer SNAP-authorized retailers per 100,000 population than both Oregon and the U.S. average.
Overweight/obesity
Excess weight generally indicates risk for further health issues, especially chronic diseases. Approximately one-third (34%) of Washington County residents are overweight and one-quarter (24%) are obese. The percent of adults who are obese in Washington County has increased from 20% in 2004 to 24% in 2010. The percent of males (25%) and females (23%) who are obese are similar within the county.

Tobacco use
Tobacco use is associated with early death, disability and chronic health issues and is the leading preventable cause of death in the U.S.. As of 2013, 8% of 11th graders and 12% of adults in Washington County report current cigarette smoking. Generally, tobacco use is lower in Washington County than both the state average and the U.S. average.
Suicide

Suicide has a devastating effect on individuals, communities and families. Of the more than 50 health issues evaluated in the quantitative portion of Washington County’s community health needs assessment, death due to suicide was the highest ranked health issue. This health issue was selected as a top priority because there are significant disparities along racial, ethnic and sex lines for suicide rates. Incorporating community input, 81% of interviewed community stakeholders mentioned mental health as a top health issue for the region.

As of 2012, Oregon has one of the highest suicide rates in the country (CDC, MMWR, Nov 14, 2014, 63 (45)). In Oregon, suicide is the leading cause of death for Oregon youth ages 10-24 and for veterans under the age of 45.

Washington County’s suicide rate has been dramatically increasing since 2009, nearly approaching the Oregon average value, which is the ninth highest in the country. From 2003-2010, Washington County has had an average of 65 suicides per year. The 2008-2012 age-adjusted suicide rate is 13.6 deaths per 100,000 population in the county. Firearms, poisoning and suffocation are the most common means of suicide in Washington County.
Age appears to have an influence on suicide rates in Washington County, with adults ages 45 and over having the highest suicide rates. For the most recent year of data (2012), the highest suicide rate by age was 28 deaths per 100,000 population for those ages 45-64 years. The lowest suicide rate was in the 15-24 year olds with a rate of 13 deaths per 100,000 population per year.

With very few exceptions, internationally, nationally, and at the state and local level, males have higher suicide rates than females. In Washington County, the male suicide rate in 2012 was 26 deaths per 100,000 population versus the female suicide rate of nine deaths per 100,000 population.

There are significant disparities in suicide rates. The highest suicide rate by race and ethnicity in the county is non-Hispanic whites with a rate of 21 deaths per 100,000 population in 2012. Evaluating the most at-risk sex, race and ethnicity combination, non-Hispanic white males age 65 and over experienced a suicide rate of 36 deaths per 100,000 population for the years 2008-2012. The rate of suicide in this subgroup is double the rate of the Oregon population average of 18 deaths per 100,000 population per year.
Suicide and veterans
Suicide is a serious health problem for veterans in Oregon. Military veterans make up 8.7% of Oregon’s population (2008-12) yet account for 23% of the suicides. The majority of these suicides occur in veterans age 55 and over.

Veterans comprise 6% of Washington County residents ages 18 to 64 years old and 24% of residents aged 65 years and over. The majority are male (94%), white (93%), Vietnam era (35%) and Gulf War veterans (27%). The veteran suicide rate in Washington County is 42 deaths per 100,000 population in 2012, which is similar to the average Oregon veteran suicide rate. Veterans have the highest subgroup suicide rate found for the county (Shen & Millet, OHA, Suicides among veterans in Oregon, 2014).

Mental health
According to the CDC, mental health is “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stress of life, can work productively and fruitfully, and is able to make a contribution to his or her community.” The limited mental health data available for Washington County show that residents tend to have better overall mental health than expected by the state average. Approximately 69% of Washington County residents reported no poor mental health days in the past 30 days, which is not statistically significantly different than the state average of 66%. Washington County residents reported 2.8 poor mental health days in the past 30 days, which is lower than the Oregon average of 3.3. Approximately 15% of Washington County adults reported inadequate social or emotional support, which is lower than the state average of 16%.

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<tr>
<th>Vulnerable populations Washington County, 2012</th>
<th>Suicide rate per 100,000 population</th>
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<tbody>
<tr>
<td>Veterans (2008-12)</td>
<td>42</td>
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<tr>
<td>Non-Hispanic white males age 65+</td>
<td>36</td>
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<td>Age 45 to 64 years old</td>
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<td>Males</td>
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<td>Non-Hispanic whites</td>
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<td>Oregon average</td>
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</table>
Access to health care

Access to health care is a critical aspect of preventive health medicine. Due to national policy changes, millions of Americans who didn’t have access before will gain access to insurance coverage. However, even if a person has health insurance, it does not mean there is an availability of providers, that the person can afford the care, or that the care is culturally appropriate. Access to health care is on the list of priority health issues in Washington County because the data show lower levels of adults with health insurance, low non-physician primary care provider rate, and a low level of mental health providers. Not only does the data provide support for the importance of this issue, access to health care was also the top health issue reported by community stakeholders, with 88% of those interviews stating access to care needed to be addressed.

Health insurance coverage

In 2013, 81% of Washington County adults had some type of health insurance, which is slightly lower than the county national average of 82%. There are disparities in health insurance coverage, with only 49% of Hispanic/Latino residents reporting having health insurance versus 91% of the Asian population reporting having health insurance coverage. Washington County has a statistically significantly lower percent of the population (3.4%) enrolled in the Oregon Health Plan compared with the state overall (5.1%).

Primary care provider availability

There are eight designated health professional shortage areas in Washington County. The ratio of primary care physicians in Washington County is 1,112:1, which is slightly better than the Oregon average of 1,115:1. Approximately 81% of adult Washington County residents report that they have someone who they consider as their own personal doctor.

<table>
<thead>
<tr>
<th>Primary care physicians, rate per 100,000 population, 2011¹</th>
<th>Percent of adults without any regular doctor, 2011-2012²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Washington County (99)</td>
<td>Washington County (21%)</td>
</tr>
<tr>
<td>Oregon (99)</td>
<td>Oregon (22%)</td>
</tr>
<tr>
<td>United States (86)</td>
<td>United States (22%)</td>
</tr>
</tbody>
</table>


There are health care providers other than physicians who render primary care services. Such providers include nurse practitioners, physician assistants and some other health care providers. The non-physician primary care provider rate in Washington County is lower than desired, with only 46 providers per 100,000 population versus national county average of 47.2 providers per 100,000 population.

Mental health and dental providers

The ratio of mental health providers per population is also of concern. Washington County has a ratio of one mental health provider per 632 population versus the state average of 1:410.

The ratio of dentists in Washington County is 1,220:1 which is much better than the Oregon average of 1,399:1.
References

Demographics
American FactFinder, United States Census Bureau
American Community Survey, United States Census Bureau
Community Commons, Community Health Needs Assessment Report for Washington County
(map and dial indicators throughout report)
Oregon Public Health Assessment Tool (OPHAT), Office of the State Epidemiologist, Public Health Division, Oregon Health Authority
Healthy Columbia Willamette Community Dashboard for Washington County

Vulnerable populations
American FactFinder, United States Census Bureau
American Community Survey, United States Census Bureau
Community Commons, Community Health Needs Assessment Report for Washington County
Healthy Columbia Willamette Community Dashboard for Washington County
Oregon Department of Education

Chronic Disease
CD Summary, July 17, 2012; 61 (15).
Oregon Public Health Assessment Tool
Healthy Columbia Willamette Community Dashboard for Washington County
Community Commons, Community Health Needs Assessment Report for Washington County
US Department of Agriculture Food Atlas

Suicide
Oregon Public Health Assessment Tool (OPHAT)

Access to care
County Health Rankings & Roadmaps, Washington County
Community Commons, Community Health Needs Assessment Report for Washington County
Healthy Columbia Willamette Community Dashboard for Washington County
Health Resources and Services Administration
Oregon Behavioral Risk Factor Surveillance System (BRFSS)
Healthy Columbia Willamette introduction

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. 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 comprised of 14 hospitals and four local public health departments 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. 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)
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.
a. 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 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.

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3PhotoVoice 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.
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 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*

<table>
<thead>
<tr>
<th>Region 62 Assessment Projects</th>
<th>Clackamas (OR) 29 Assessment Projects</th>
<th>Clark (WA) 12 Assessment Projects</th>
<th>Multnomah (OR) 42 Assessment Projects</th>
<th>Washington (OR) 28 Assessment Projects</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Social environment</td>
<td>- Access to affordable health care</td>
<td>- Social environment</td>
<td>- Social environment</td>
<td>- Social environment</td>
</tr>
<tr>
<td>- Equal economic opportunities</td>
<td></td>
<td>- Access to affordable health care</td>
<td>- Equal economic opportunities</td>
<td>- Access to affordable health care</td>
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<tr>
<td>- Access to affordable health care</td>
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<td>- Housing</td>
<td>- Equal economic opportunities</td>
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<tr>
<td>- Education</td>
<td></td>
<td>- Housing</td>
<td>- Housing</td>
<td></td>
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<tr>
<td>- Access to healthy food</td>
<td></td>
<td>- Education</td>
<td>- Education</td>
<td></td>
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<tr>
<td>- Housing</td>
<td></td>
<td>- Access to healthy food</td>
<td>- Access to affordable health care</td>
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<tr>
<td>- Mental health and substance abuse</td>
<td></td>
<td>- Chronic disease</td>
<td>- Mental health &amp; substance abuse</td>
<td></td>
</tr>
<tr>
<td>- Poverty</td>
<td></td>
<td>- Mental health &amp; substance abuse</td>
<td>- Chronic disease</td>
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</tr>
<tr>
<td>- Early childhood/youth</td>
<td></td>
<td>- Safe neighborhood</td>
<td>- Chronic disease</td>
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<td>- Chronic disease</td>
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<td>- Safe neighborhood</td>
<td>- Safe neighborhood</td>
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<tr>
<td>- Safe neighborhood</td>
<td></td>
<td>- Poverty</td>
<td>- Early childhood/youth</td>
<td></td>
</tr>
<tr>
<td>- Transportation options</td>
<td></td>
<td>- Poverty</td>
<td>- Access to healthy food</td>
<td></td>
</tr>
</tbody>
</table>

*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 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 workforce 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 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:


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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.
b. 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](image)

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) website\(^5\) 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 2 and Table 3). 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 4). 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

<table>
<thead>
<tr>
<th>Clackamas (OR)</th>
<th>Clark (WA)</th>
<th>Multnomah (OR)</th>
<th>Washington (OR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-transport accident deaths</td>
<td>Non-transport accident deaths</td>
<td>Non-transport accident deaths</td>
<td>Non-transport accident deaths</td>
</tr>
<tr>
<td>Chlamydia incidence rate</td>
<td>Drug-related deaths</td>
<td>Chlamydia incidence rate</td>
<td>Breast cancer incidence rate</td>
</tr>
<tr>
<td>Suicide</td>
<td>Colorectal cancer deaths</td>
<td>Diabetes-related deaths</td>
<td>Parkinson’s disease deaths</td>
</tr>
<tr>
<td>Breast cancer deaths</td>
<td>Lung cancer deaths</td>
<td>Alcohol-related deaths</td>
<td>All cancer incidence rate</td>
</tr>
<tr>
<td>Adults who are obese</td>
<td>Lymphoid cancer deaths</td>
<td>Drug-related deaths</td>
<td>Heart disease deaths</td>
</tr>
<tr>
<td>Ovarian cancer deaths</td>
<td>Diabetes-related deaths</td>
<td>Early syphilis incidence rate</td>
<td>Chlamydia incidence rate</td>
</tr>
<tr>
<td>Chronic liver disease deaths</td>
<td>Alzheimer’s disease deaths</td>
<td>Chronic liver disease deaths</td>
<td>Unintentional injury deaths</td>
</tr>
<tr>
<td>Heart disease deaths</td>
<td>Unintentional injury deaths</td>
<td>Breast cancer deaths</td>
<td>Non-transport accident deaths</td>
</tr>
<tr>
<td>Drug-related deaths</td>
<td>Alcohol-related deaths</td>
<td>Breast cancer incidence rate</td>
<td>Ovarian cancer deaths</td>
</tr>
<tr>
<td>Adults who are overweight</td>
<td>Transport accident deaths</td>
<td>All cancer deaths</td>
<td>Adults who are obese</td>
</tr>
<tr>
<td>Prostate cancer deaths</td>
<td>Motor vehicle collision deaths</td>
<td>Heart disease deaths</td>
<td>Chronic liver disease deaths</td>
</tr>
</tbody>
</table>

![Health outcomes and health-related behavior indicators that were top-ranked for the region (see Table 3).](image-url)
The strongest consideration for regional action was given to the highest scoring health behavior and health outcome indicators listed in Table 4 (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 4.

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

*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
• VistaPHw: Software for Public Health Assessment in Oregon.

Washington
• 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:
• 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/
c. Local community health system 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 LGBTQI7 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.

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.

7 Lesbian, Gay, Bisexual, Transgender, Questioning or Queer, and Intersex
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___________


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

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

Stakeholders described the type of work they would like to 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.

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Access to health care, mental health, chronic disease, substance abuse, culturally competent services/data, oral health (Clark County), and Cancer (Clark County)
Limitations
An iterative approach was used to identify important health issues from which stakeholders were asked to prioritize (see page 38). 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:

- 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
d. 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 6 on the following page.)
- What are the five health issues that you would like to see addressed first? (Participants selected from the issues in Table 6 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)

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

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). 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.

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.

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 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 7 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 4 illustrates the geographic reach of the listening sessions by indicating the percent of surveys responses 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

<table>
<thead>
<tr>
<th></th>
<th>Clark</th>
<th>Clackamas</th>
<th>Multnomah</th>
<th>Washington</th>
<th>Region</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>17-88 years</td>
<td>20-75 years</td>
<td>18-68 years</td>
<td>17-90 years</td>
<td>17-90 years</td>
</tr>
<tr>
<td>Average</td>
<td>44 years</td>
<td>40 years</td>
<td>44 years</td>
<td>45 years</td>
<td>40 years</td>
</tr>
<tr>
<td><strong>Language</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>English</td>
<td>66%</td>
<td>10%</td>
<td>48%</td>
<td>30%</td>
<td>39%</td>
</tr>
<tr>
<td>Russian</td>
<td>11%</td>
<td>0</td>
<td>2%</td>
<td>0</td>
<td>3%</td>
</tr>
<tr>
<td>Somali</td>
<td>0</td>
<td>0</td>
<td>9%</td>
<td>20%</td>
<td>7%</td>
</tr>
<tr>
<td>Spanish</td>
<td>23%</td>
<td>90%</td>
<td>41%</td>
<td>50%</td>
<td>51%</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African</td>
<td>0</td>
<td>0</td>
<td>9%</td>
<td>16%</td>
<td>7%</td>
</tr>
<tr>
<td>African American</td>
<td>0</td>
<td>0</td>
<td>12%</td>
<td>10%</td>
<td>6%</td>
</tr>
<tr>
<td>American Indian/Native American</td>
<td>0</td>
<td>0</td>
<td>5%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Asian</td>
<td>2%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>34%</td>
<td>88%</td>
<td>43%</td>
<td>52%</td>
<td>53%</td>
</tr>
<tr>
<td>Native Hawaiian/Pacific Islander</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>White</td>
<td>61%</td>
<td>12%</td>
<td>14%</td>
<td>18%</td>
<td>25%</td>
</tr>
<tr>
<td>Other/multiple</td>
<td>0</td>
<td>0</td>
<td>16%</td>
<td>0</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>68%</td>
<td>74%</td>
<td>66%</td>
<td>76%</td>
<td>71%</td>
</tr>
<tr>
<td>Male</td>
<td>32%</td>
<td>19%</td>
<td>30%</td>
<td>24%</td>
<td>26%</td>
</tr>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than $10,000</td>
<td>45%</td>
<td>30%</td>
<td>34%</td>
<td>34%</td>
<td>36%</td>
</tr>
<tr>
<td>$10,000 to $19,999</td>
<td>32%</td>
<td>26%</td>
<td>18%</td>
<td>30%</td>
<td>26%</td>
</tr>
<tr>
<td>$20,000 to $29,000</td>
<td>9%</td>
<td>19%</td>
<td>23%</td>
<td>16%</td>
<td>17%</td>
</tr>
<tr>
<td>$30,000 to $39,000</td>
<td>5%</td>
<td>0</td>
<td>7%</td>
<td>6%</td>
<td>5%</td>
</tr>
<tr>
<td>$40,000 to $49,000</td>
<td>5%</td>
<td>2%</td>
<td>0</td>
<td>0</td>
<td>2%</td>
</tr>
<tr>
<td>$50,000 or higher</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Household Size</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>1-8 people</td>
<td>2-8 people</td>
<td>1-9 people</td>
<td>1-9 people</td>
<td>1-9 people</td>
</tr>
<tr>
<td>Average</td>
<td>3 people</td>
<td>3 people</td>
<td>4 people</td>
<td>5 people</td>
<td>4 people</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
<td>23%</td>
<td>62%</td>
<td>36%</td>
<td>33%</td>
<td>38%</td>
</tr>
<tr>
<td>High school diploma/GED</td>
<td>19%</td>
<td>30%</td>
<td>30%</td>
<td>37%</td>
<td>30%</td>
</tr>
<tr>
<td>Some college</td>
<td>37%</td>
<td>5%</td>
<td>18%</td>
<td>13%</td>
<td>19%</td>
</tr>
<tr>
<td>College graduate or higher</td>
<td>21%</td>
<td>3%</td>
<td>15%</td>
<td>17%</td>
<td>13%</td>
</tr>
<tr>
<td><strong>Health Insurance</strong></td>
<td></td>
<td></td>
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<td><strong>Do you have a dentist?</strong></td>
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<sup>10</sup> 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.
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.

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 U.S. 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:


• 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/