

Multnomah County Community Health Assessment

Using Quantitative Data to Measure the Community's Health

Community Health Status Assessment



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August 2011

BACKGROUND

This report presents findings from an assessment of the health status of Multnomah County residents and is part of the 2011 Multnomah County Community Health Assessment. The MCHA is based on the National Association of County and City Health Officials' (NACCHO) Mobilizing for Action through Planning and Partnerships (MAPP) model.

MAPP is a community planning process developed to identify strategic issues and recommendations to improve public health through the involvement of community members and stakeholders from community based organizations, advocacy organizations and government. The process is facilitated by public health leaders and is intended to increase the efficiency, effectiveness, and, ultimately, the performance of local public health systems.

Mobilizing for Action through Planning and Partnerships (MAPP)

The standard NACCHO MAPP process includes the following four assessments:

- (1) The Community Themes and Strengths Assessment identifies the health-related issues that are most important to community members.
- (2) The Community Health Status Assessment describes the health of the community through quantitative data on key health indicators (e.g., leading causes of death, rates of first trimester prenatal care).
- (3) The Local Public Health System Assessment highlights the strengths and challenges of our current local public health system.
- (4) The Forces of Change Assessment identifies the political, social, and economic issues that could affect the local public health system's ability to address health-related priorities.

Multnomah County Modifications to the MAPP Model

The Multnomah County Assessment was tailored to capitalize on community engagement efforts previously conducted by community-based organizations and local government. These changes meant the Community Themes and Strengths Assessment could build on community input previously collected.

Additionally, the Local Public Health System Assessment and Forces of Change Assessment were combined because the information collected for each was obtained through 43 interviews with more than 50 leaders in public health, local government, community-based services, transportation, education, employment, and planning. All of whom were qualified to speak to the current capacity and future opportunities and uncertainties affecting the local public health system. See Appendix C for information on additional reports from the Multnomah County Community Health Assessment.

HEALTH STATUS

Multnomah County Health Department routinely examines a wide variety of health status indicators, such as maternal child health-related measures, incidence of communicable disease, unintentional injury, and leading causes of death. These indicators are disseminated in the series of reports that comprise the Health of Multnomah County, the Health Assessment Quarterly, and the Report Card on Racial and Ethnic Health Disparities. The health status indicators included in the current report were selected based on a review of these reports. Health status indicators were assessed on five factors: 1) comparison to Oregon and the U.S., 2) trends over time, 3) racial disparities, 4) severity of health issue, and 5) comparison to national benchmarks.¹ The health status indicators selected for inclusion in this report meet at least two of the five conditions listed below:

- The Multnomah County rate is higher than Oregon or the U.S.;
- The trend is worsening;
- There are racial or ethnic disparities;
- The health issue is severe in terms of long-term consequence or premature death; and
- The County does not meet the national benchmark, Healthy People 2020.

Because health is strongly related to social and economic factors, this report also includes an examination of demographic and socio-economic indicators such as race, age, education, income, and employment. This information about county residents provides context for the rest of the report by addressing some of the social determinants of health – or underlying factors that affect well-being.

¹ (95%) confidence intervals around rates were used to compare the County rate to Oregon and the U.S. Significance testing was done to determine trends. Racial and ethnic disparities were determined using either rate ratios or 95% confidence intervals around rates. The severity of a health outcome was determined by Years of Potential Life Lost, a measure of premature mortality or whether a health outcome has long-term consequence.

DEMOGRAPHICS

Multnomah County's population increased nearly 10% between 2000 and 2010. Of the racial and Hispanic origin groups monitored by the Census Bureau, only Native Americans had a decline in total population. The greatest increase in racial and ethnic groups was among Hispanic residents, who make up more than one in ten residents of the County. Over the decade Multnomah County's population became more diverse. In 2010, populations of color made up 28% of the total population compared to 23% of the total population in 2000.

Multnomah County Population by Race/Ethnicity, 2000 and 2010					
Race/Ethnicity	2000	Percent of population	2010	Percent of population	Percent Change 2000-2010
African American	37,429	5.7%	39,919	5.4%	+6.7%
Asian/Pacific Islander	40,795	6.2%	51,378	7.0%	+25.9%
Hispanic	50,230	7.6%	80,138	10.9%	+59.5%
Native American	5,871	0.9%	5,527	0.8%	-5.9%
Two or More Races	17,419	2.6%	26,549	3.6%	+52.4%
White alone non-Hispanic	509,994	77.1%	530,303	72.1%	+3.4%
Total	661,738	100.0%	735,334	100.0%	+9.8%
Source: U.S. Census Bureau					

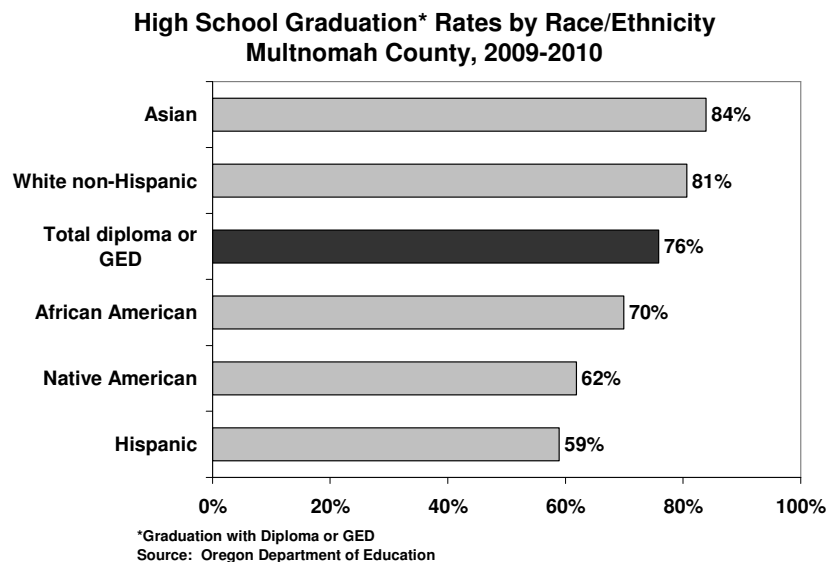
While the populations of 15 to 24 year-olds and adults age 75 and older declined, all other age groups increased in number. The greatest growth was among adults aged 45 to 64 years. The information in the table below presents a comparison of 2000 with 2009 because detailed age group data is not yet available from the 2010 U.S. Census.

Multnomah County Population by Age Group, 2000 and 2009					
Age group	2000	Percent of population	2009	Percent of population	Change 2000-2009
<1 year	8,828	1.3%	10,285	1.4%	+16.5%
1 to 14	114,734	17.3%	120,926	16.6%	+5.4%
15 to 24	92,104	13.9%	85,784	11.8%	-6.9%
25 to 44	223,148	33.7%	252,414	34.7%	+13.1%
45 to 64	149,464	22.6%	183,520	25.2%	+22.8%
65 to 74	34,296	5.2%	37,698	5.2%	+9.9%
75 and older	39,164	5.9%	36,228	5.0%	-7.5%
Total	661,738	100%	726,855	100%	+9.8%
Source: U.S. Census Bureau					

SOCIAL AND ECONOMIC CONDITIONS

Markers of socioeconomic status – education, wealth, and social position – are among the most powerful predictors of an individual’s health. Some of the pathways are direct; for example a person who is earning very little money will likely have difficulty meeting needs for food, shelter, and health care. Other relationships are more complex. An individual’s educational attainment may affect his or her social and professional opportunities, which in turn influence issues ranging from mental health to income over the course of a lifetime. Race and Hispanic origin are associated with many health outcomes. For example, at almost any income level, more African American, Native American, Hispanic, and Asian/Pacific Islander people report poor or fair health than do White non-Hispanics.² This section discusses some of these factors as they relate to the County as a whole and further explores socioeconomic differences between racial and ethnic groups within Multnomah County.

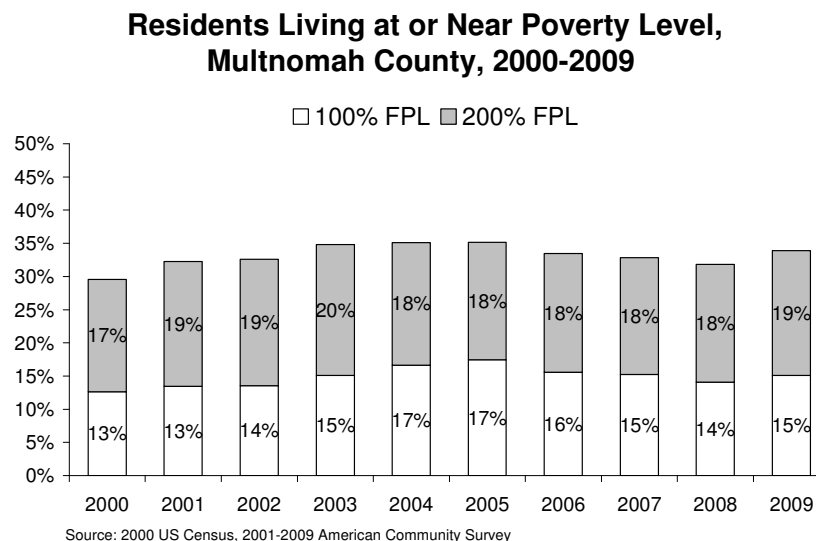
High School Graduation - Educational attainment affects employment opportunities and social connections. For example, high-wage jobs often require specialized training beyond a high school diploma. Overall, 76% of Multnomah County’s high school students complete school, but there are disparities between racial and ethnic groups. High school graduation rates are lowest among Hispanic and Native American students, putting them at a health disadvantage as they enter adulthood.



² http://unnaturalcauses.org/amazing_facts.php
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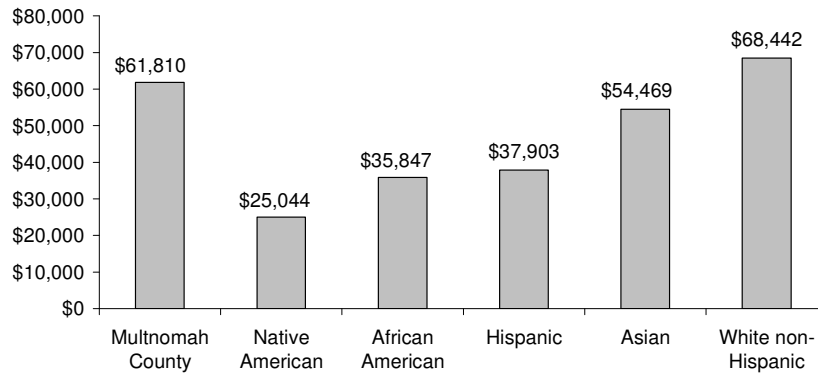
Poverty – The federal poverty threshold identifies an income level below which it is extremely difficult to afford basic needs, such as food, shelter, and transportation. The threshold is based on household size; for a four-person household in 2010, the poverty threshold was \$22,314. Households earning between 101 and 200% of the poverty level are considered “near-poor.” Many of them are “working poor,” holding down jobs but still unable to make ends meet. Pursuing a healthy lifestyle and attending to medical needs can be very challenging at these income levels.

More than a third of Multnomah County residents were poor or near-poor in 2009, a small increase over the 2000 statistics. The proportion of residents living in poverty and near-poverty remained relatively constant from 2005 to 2009 at about 35%.



Median Household Income – Median household income in Multnomah County was \$61,810 in 2009 – meaning that half of households earn more and half earn less. However, White non-Hispanic households tend to earn more than the County median while African American, Native American, Asian, and Hispanic households earn less than the County median.

Median Household Income by Race/Ethnicity Multnomah County, 2009

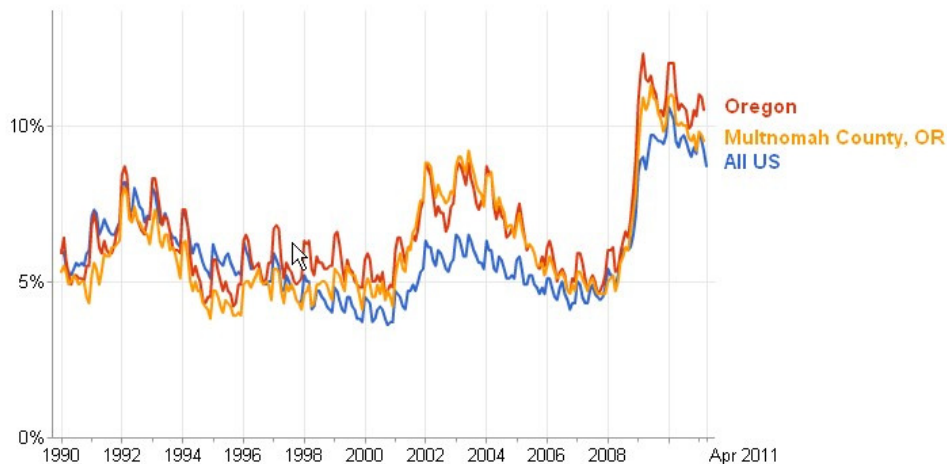


Source: American Community Survey. Single Race Alone.

Unemployment – Unemployment can have a major impact on health. Joblessness or the fear of losing one’s job creates high levels of stress and insecurity which can contribute to poor health. Unemployment can also limit people’s ability to meet many basic needs such as food and health care due to income insecurity. Like the rest of Oregon and the U.S., Multnomah County is currently experiencing high but declining rates of unemployment. After peaking at 11.3% in June 2009, the County’s April 2011 official unemployment rate was 9.5%, compared to 8.7% for the U.S. and 10.5% in Oregon.

Unemployment rate

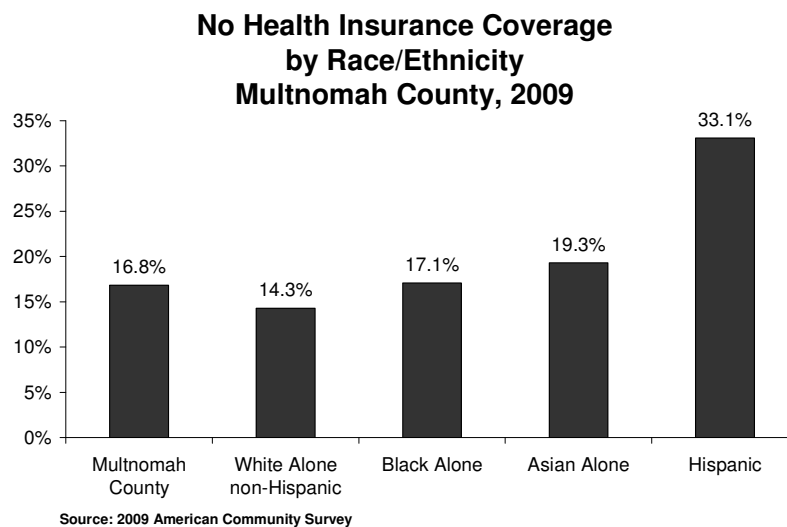
The percent of the labor force that is unemployed, not seasonally adjusted. [More info »](#)



Data source: [U.S. Bureau of Labor Statistics](#) - Last updated May 6, 2011

Lack of health insurance – Given the high cost of health care, health insurance is vital for receiving medical care. People who have no health insurance or who are underinsured tend to go without needed medical care, which may lead to more expensive care in the long run.

Overall, 16.8% of Multnomah County’s population lacks health insurance. Hispanics are least likely to have insurance, significantly outstripping all other groups. White non-Hispanics had the lowest rate of uninsurance, followed by African Americans and Asians. (The number of Native American residents was too small to make a meaningful assessment of insurance coverage.)



HEALTH INDICATORS

Health status indicators are presented in this section. Health indicators were assessed based on trends, racial and ethnic disparities, comparisons to Oregon and the U.S., the severity of the health issue, and a comparison to national benchmarks. See Appendix A for details. The report notes where trends are worsening, racial/ethnic disparities occur, Multnomah County compares unfavorably to Oregon or the U.S., or the County does not meet national benchmarks. An in-depth analysis of racial and ethnic disparities in selected birth outcomes, communicable diseases, and death rates in Multnomah County can be found in a recent Report Card on Racial and Ethnic Health Disparities. Charts from the Report Card are included in Appendix B. The entire report can be found at:

<http://web.multco.us/document/29122/download>

Maternal and Child Health

The table below provides a summary of birth outcomes for Multnomah County and the U.S., displays the national Healthy People 2020 goal, and identifies population groups that experience health disparities relative to White non-Hispanics.

Birth Outcomes in Multnomah County Compared to the U.S. and National Goals, 2009 County Births, 2008 County Infant Death, 2008-09 U.S. Data				
	Multnomah County	U.S.	National Goal	Racial/Ethnic Disparity
Early prenatal care	67.8%	71%	77.9%	All populations of color
Preterm births	8.4%	12%	11.4%	African American Native American
Low birth weight births	7.4%	8.2%	7.8%	African American Asian
Infant Death	4.5 per 1,000	6.7 per 1,000	6.0 per 1,000	African American
Teen Births	18.6 per 1,000 teens 15-17	21.7 per 1,000 teens 15-17	na	African American Native American Hispanic
Source: 2008, 2009 Oregon Health Authority, Center for Health Statistics; 2008, 2009 preliminary National Center for Health Statistics, Healthy People 2020				

Early prenatal care helps to identify and correct health problems and behaviors that may have negative effects on birth outcomes. The percent of women receiving prenatal care in the first trimester is declining in the County. In 2009, 67.8% of Multnomah County women received prenatal care in the first trimester of pregnancy. This is lower than the national rate of 71%, and does not reach the Healthy People 2020 goal of 77.9%. Additionally, rates are lower in Multnomah County populations of color compared to White non-Hispanics. (See Appendix B for chart by race and Hispanic origin.)

Preterm birth is the leading cause of newborn death and has long-term health consequences, such as increased risk of chronic diseases in adulthood. In 2009, 8.4% of Multnomah County births were preterm; this rate is similar to the Oregon rate and lower than the U.S. rate (12%). There has been a slight increase in premature births in the County; however, the County meets the national objective. African Americans and Native Americans have significantly higher rates of premature birth than White non-Hispanics.

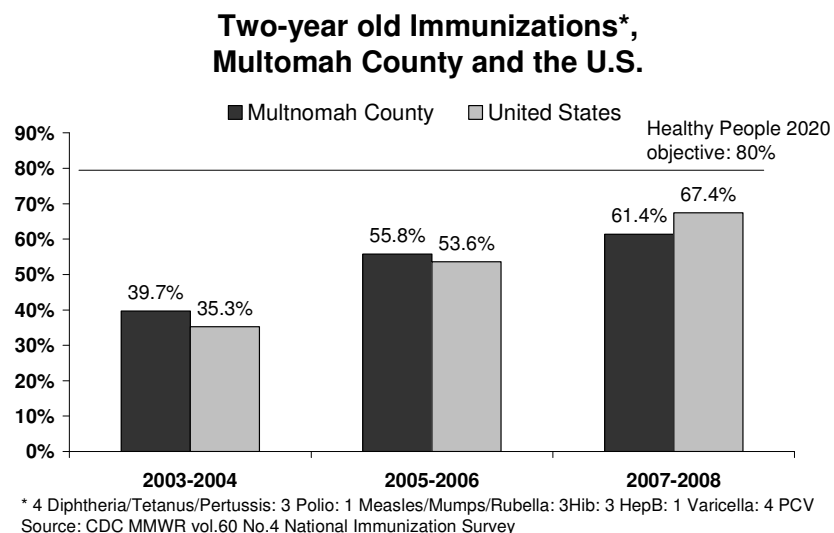
Low birth weight is another birth outcome that creates an increased risk for certain chronic health conditions in adulthood. In 2009, 7.4% of Multnomah County births were low birth weight, meeting the national objective of 7.8%. While the Multnomah County rate has not changed significantly in recent years, African Americans and Asian residents have disproportionately high rates of low birth weight births.

The rate of infant death has decreased since the early 1990s in Multnomah County. In 2008 there were 4.5 infant deaths per 1,000 births, meeting the national objective of 6.0 deaths per 1,000 births. However, the rate was much higher for African American infants.

Teen births present problems for both the young mother and her child. Pregnancy and delivering a child are strongly associated with dropping out of high school, which limits educational and employment opportunities. The rate of 15-17 year-olds delivering babies has decreased in Multnomah County since the late 1990s. Teen births among 15-17 year olds constituted approximately 2% of all births in 2009. Multnomah County's rate of births to 15-17 year-olds is similar to the national statistic. Within the County, African American, Native American, and Hispanic teens have higher birth rates than their White non-Hispanic peers.

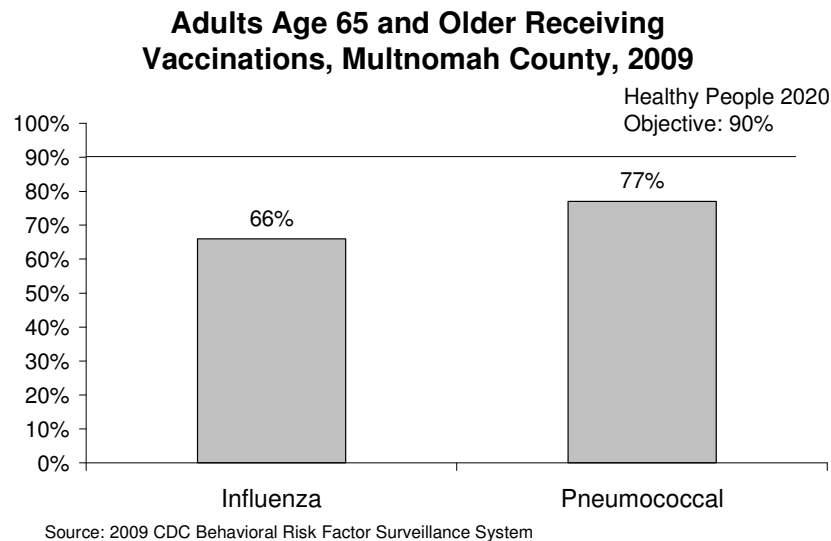
Immunizations

Child Immunizations – Immunizing young children against vaccine-preventable diseases such as measles, mumps, and whooping cough protects children and the overall community by preventing the spread of disease. While Multnomah County does not meet the national goal of 80% of two-year olds fully immunized,³ the rate of immunizations is increasing. Immunization rates in Multnomah County are comparable to national rates.



³ The current recommendations for two-year-olds include: DTaP-diphtheria, tetanus, and pertussis (whooping cough); polio; MMR – measles, mumps and rubella; Hib – hemophilus influenza B; Hepatitis B; Chickenpox; and PCV – pneumococcal conjugate.

Adult Immunizations – Influenza and pneumonia are serious diseases that can lead to hospitalization and even death. Both can be prevented with vaccines. Multnomah County does not meet the national objective for influenza and pneumococcal immunizations among adults age 65 and older. In 2009, 66% of adults age 65 and older received the flu vaccination and 77% received a pneumococcal vaccination. The national objective for both is 90%.

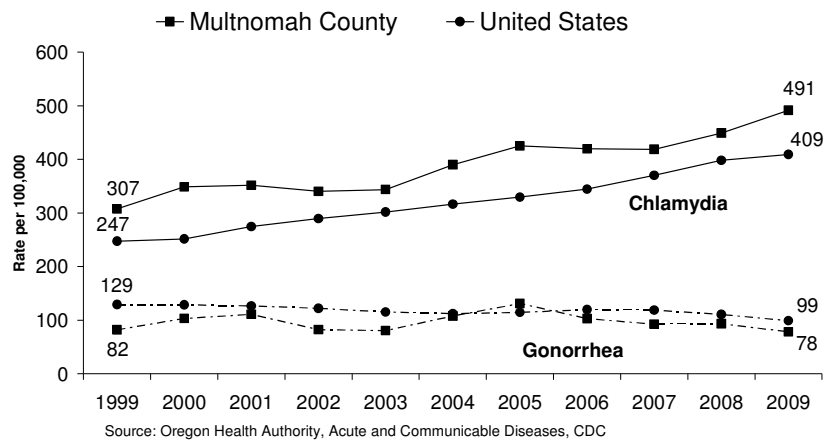


Sexually Transmitted Disease

Chlamydia – Chlamydia is the most frequently reported STD in Multnomah County. Multnomah County rates have been increasing and are higher than rates in Oregon and the U.S. Chlamydia rates are highest among females age 15 to 24. There are elevated rates of chlamydia among African Americans, Native Americans, and Hispanics compared to White non-Hispanics.

Gonorrhea – Rates of gonorrhea have not significantly changed since the late 1990s, and remain consistently higher among African Americans and Hispanics compared to White non-Hispanics. Multnomah County gonorrhea rates are higher than Oregon rates.

Sexually Transmitted Diseases, Multnomah County and the U.S., 1999-2009



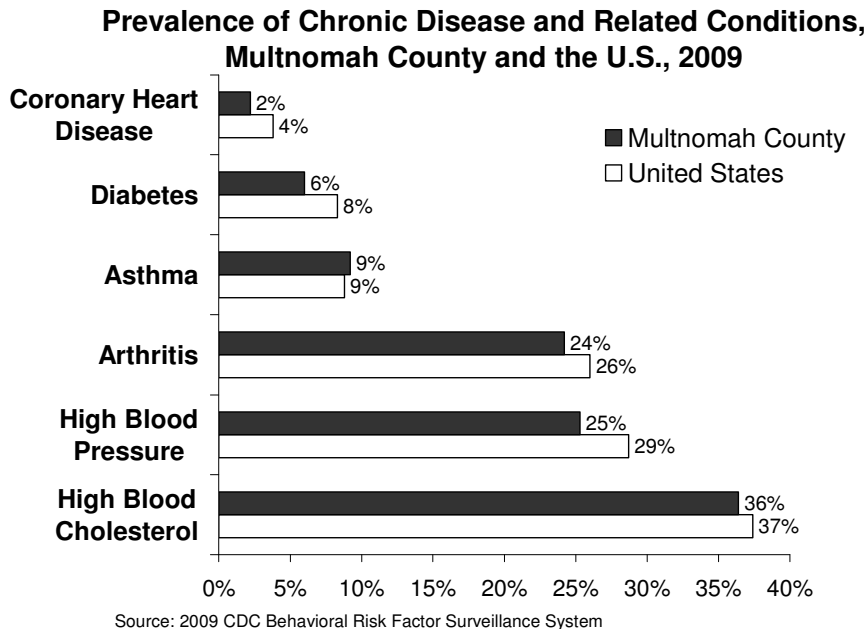
Chronic Disease and Related Conditions

The state Behavioral Risk Factor Surveillance System (BRFSS) is a telephone survey of adults age 18 and older that is conducted annually in Oregon and other states. The BRFSS provides data about the prevalence of a variety of chronic diseases and related conditions. Oregon Healthy Teens is a statewide school-based survey of 8th and 11th graders.

Multnomah County has rates similar to national rates for asthma, arthritis, high blood pressure, and blood cholesterol. Coronary heart disease and diabetes rates are lower in Multnomah County.

Hispanics have a significantly lower prevalence of chronic disease and related conditions than other racial/ethnic groups: rates of high blood pressure and arthritis are the lowest for this group, as compared to African Americans, Whites, and Asians.

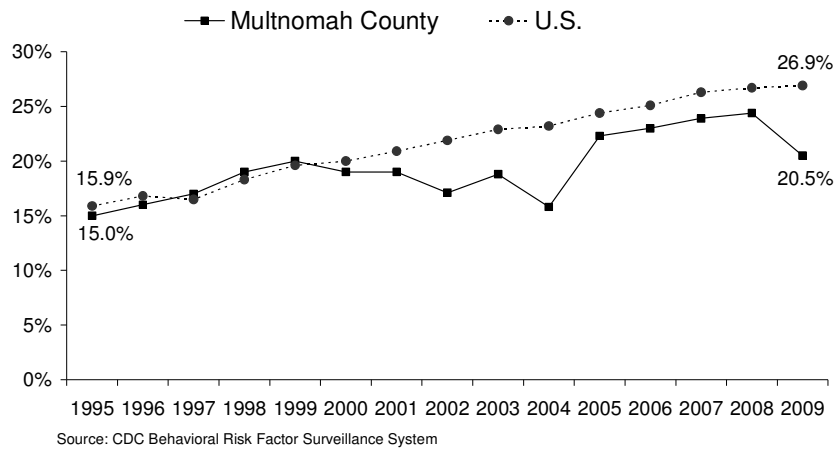
The County meets the national target for high blood pressure prevalence but does not meet the objective for high blood cholesterol. While there are no national objectives for coronary heart disease, asthma, diabetes, or arthritis *prevalence*, there are objectives for *deaths* due to coronary heart disease, asthma, and diabetes-related deaths which are presented in the section on death below.



Obesity – Over the past 20 years the proportion of the population that is overweight or obese has increased nationally and in the County. An adult is considered obese if body mass index is greater than 30. In Multnomah County 21% of adults are obese, with African Americans having the highest prevalence. While the County meets the national objective for reducing obesity (30.6%), it is important to continue the downward trend that began in 2008. Overweight or obesity increases the risk of chronic diseases including diabetes, hypertension, high cholesterol, coronary heart disease, stroke, and certain types of cancer (e.g., breast and colon). In the youth population, 11% of both 8th and 11th graders were obese. BMI for children and teens is age-and sex-specific and is often referred to as BMI-for-age.

$$\text{BMI} = \frac{\text{weight in kilograms}}{(\text{height in meters})^2}$$

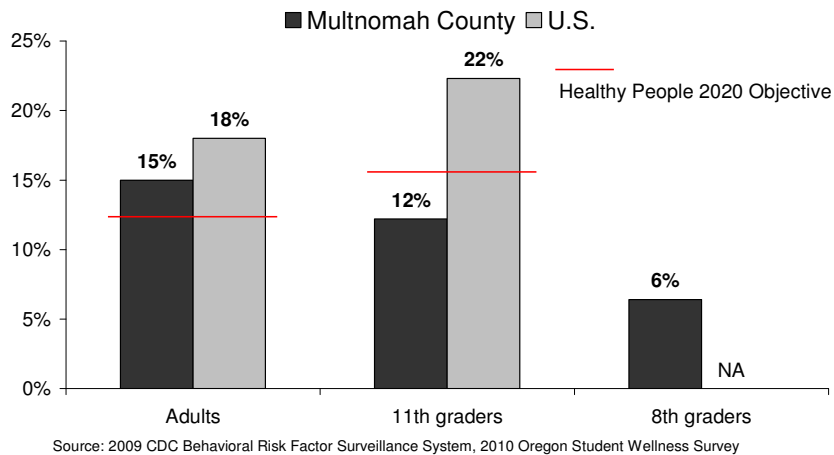
Obese Adults, Multnomah County and the U.S., 1995-2009



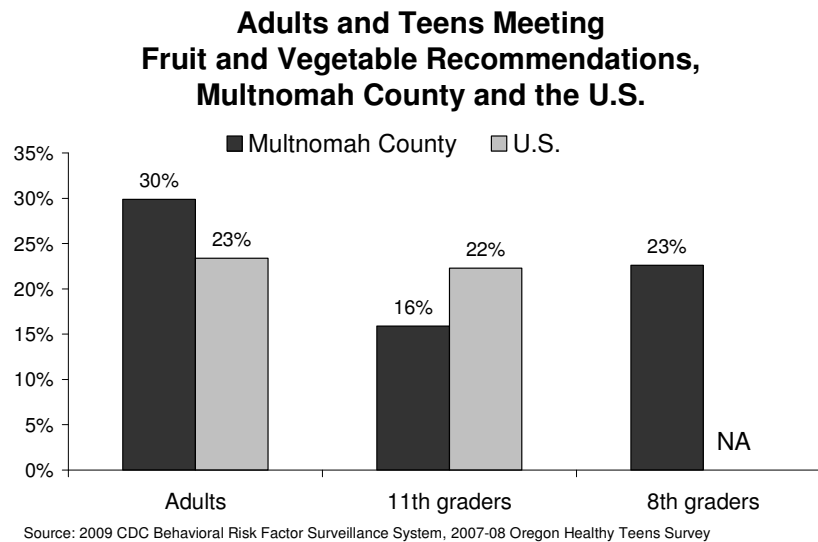
Health Behaviors

Tobacco Use – Tobacco contributes substantially to deaths caused by heart disease, stroke, and chronic lung diseases such as emphysema and bronchitis. Tobacco use was related to 24% of deaths in Multnomah County in 2008. In 2009, the adult smoking rate in Multnomah County was similar to U.S. and Oregon rates, none of which meet the national objective. Native Americans have a greater percent of adults smoking compared to other groups. The target smoking rate for 9th through 12th graders is being met by both Oregon and County 11th graders.

Adult Smoking Rates, Multnomah County and the U.S., 2009

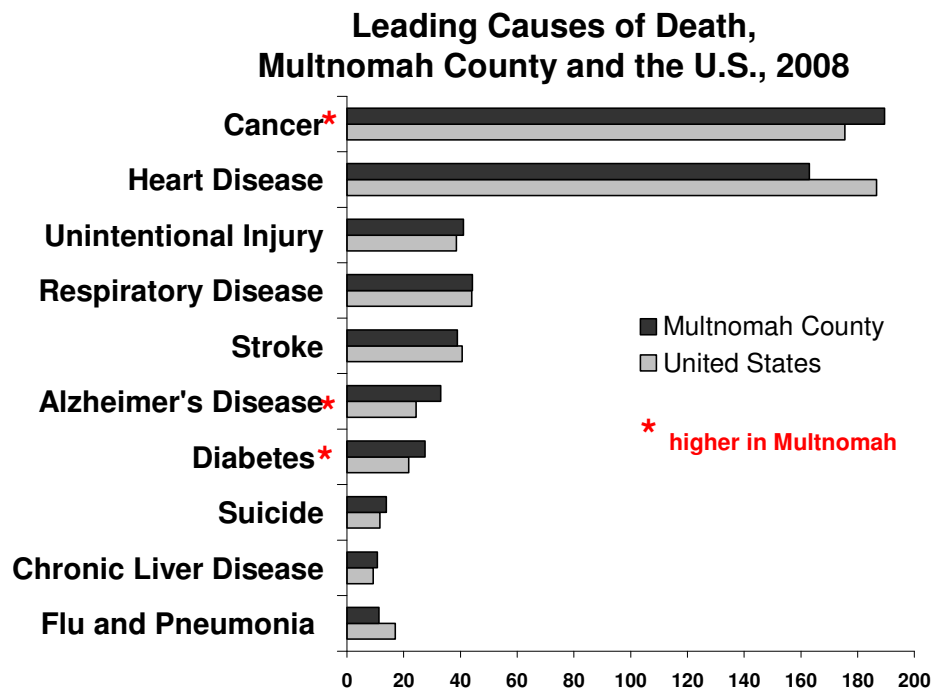


Nutrition – Multnomah County adults exceed U.S. adults in consuming 5 or more servings of fruits and vegetables per day. Among County teens, fewer 11th graders eat the recommended fruit and vegetable servings compared to U.S. 11th graders. The percent of both 8th and 11th graders eating fruit and vegetable serving recommendations declined from the 2005-06 survey to the 2007-08 survey). Not meeting nutritional recommendations among teens can have long-term consequences to health.



Leading Causes of Death

Cancer and heart disease are the two leading causes of death in Multnomah County and the U.S. Cancer death rates in the County, while decreasing, continue to be greater than U.S. rates. Among cancer deaths, lung cancer is the most frequent. Lung cancer death rates have decreased; however, the County does not meet the national objective for lung cancer deaths. Both White non-Hispanics and African Americans have greater lung cancer death rates than Hispanics or Asians. The County does not meet the national objective for prostate cancer deaths and there are disproportionately high rates of prostate cancer deaths among African Americans. Female breast cancer rates are decreasing; however, they do not meet the national objective. Heart disease, flu, and pneumonia deaths rates are lower in Multnomah County than the U.S.



Alzheimer's death rates have increased, and the death rate is greater than the U.S. rate. The death rate due to Alzheimer's disease is higher for White non-Hispanics compared to Hispanics and Asians.

Diabetes deaths are also increasing in the County, and the County rate is greater than the U.S. rate. African Americans have significantly higher rates of diabetes deaths.

Racial and Ethnic Disparity in Death Rates	
Racial Group	Death Disparity
African American	stroke, kidney disease, diabetes, homicide, lung cancer, prostate cancer
White non-Hispanic	Alzheimer's, suicide, respiratory disease, lung cancer
Native American	HIV disease, chronic liver disease
Asian	homicide

The County's unintentional injury death rate is similar to the U.S. However, unintentional injury deaths are increasing and the County does not meet the national objective for injury deaths. Injury deaths are the number-one cause of premature mortality. The death rate due to unintentional injury is greater for White non-Hispanics than other groups. Accidental poisoning deaths are among the types of unintentional injury and are increasing in the County. The County accidental poisoning rate is higher than Oregon and the U.S., and the County does not meet the national objective for reducing accidental poisoning deaths.

Suicide death rates are decreasing in the County and the rate is similar to the U.S. rate. The County does not meet the national objective. The death rate due to suicide is higher among White non-Hispanics.

Respiratory disease rates are highest among White non-Hispanics. Respiratory disease death rates are similar in the County compared to the U.S.

African Americans have significantly higher rates of stroke and kidney disease deaths. Chronic liver disease and HIV disease death rates are highest among Native Americans.

Viral hepatitis and septicemia have seen significant increases in death rates but are not in the top ten causes of death. The County's viral hepatitis rates are higher than U.S. rates, and the septicemia rates are lower.

Homicide is also not among the ten leading causes of death, but there are significant racial disparities in this outcome, with elevated rates among African Americans and Asians.

KEY FINDINGS

The health status indicators in this report are based on clinical measures and meet at least two of the five factors below. The report describes each indicator in relation to these factors.

- The Multnomah County rate is higher than Oregon or the U.S.;
- The trend is worsening;
- There are racial or ethnic disparities;
- The health issue is severe in terms of long-term consequence or premature death; and
- The County does not meet the national benchmark, Healthy People 2020.

The health outcomes included here as findings meet three or more of these factors and should be given consideration as priority health issues for the County.

Maternal and Child Health

- The percent of women receiving first trimester prenatal care is decreasing in the County. The County does not meet the national objective for first trimester prenatal care. Communities of color in Multnomah County continued to have significantly higher proportions of mothers who did not receive prenatal care in the first trimester of pregnancy compared to White non-Hispanics.
- The County meets the national objective for premature births; however, there has been a slight increase in premature births. The percent of premature births is greater among African Americans and Native Americans.

- Although the infant mortality rate has been decreasing for Native Americans and African Americans in the County; they have been persistently higher than those of other racial and ethnic groups as well as the national objective.

Sexually Transmitted Disease

- The rate of chlamydia is increasing in the County and the rate is higher than Oregon and the U.S. In the County, chlamydia rates are greater for African Americans, Native Americans, and Hispanics.
- Gonorrhea rates are greater in the County compared to Oregon. While Gonorrhea rates have not significantly changed in the last 10 years, they remain greater for African Americans and Hispanics.

Health Behaviors

- The County does not meet the national objective for reducing adult smoking. Tobacco use was related to 24% of the County deaths in 2008. Native Americans have a greater percent of adults smoking compared to other groups.
- The percent of 8th and 11th graders meeting nutritional recommendations for fruits and vegetables has decreased in the County. The percent of 11th graders in the County meeting recommendations is lower than U.S. 11th graders. Not meeting nutritional recommendations among teens can have long-term consequences to health.

Chronic Disease and Related Conditions

- Diabetes deaths are increasing in the County. The County rate is higher than the U.S. African Americans have significantly higher rates of diabetes deaths.
- Although cancer mortality rates are decreasing in the County, the rate remains higher than the U.S. The County does not meet the national objective, and White non-Hispanic and African American cancer death rates are greater than other groups.
- Female breast cancer rates have decreased; however, they do not meet the national objective.
- Lung cancer death rates, while decreasing in the County, do not meet the national objective. Rates are greater among White non-Hispanics and African Americans compared to other racial and ethnic groups.
- Adult obesity rates in the County have increased. The percent of African Americans who are obese is greater compared to other racial and ethnic groups. Obesity can have a significant impact on health outcomes.

Other rates of death

- Unintentional injury deaths are increasing and the County does not meet the national objective for injury deaths. Injury deaths are the number-one cause of premature mortality. The death rate due to injury is greater for White non-Hispanics than other groups.

- Accidental poisoning deaths are increasing in the County. The County rate is higher than Oregon and the U.S., and the County does not meet the national objective for reducing accidental poisoning deaths.
- Suicide death rates are decreasing in the County but the County does not meet the national objective. The death rate due to suicide is greater among White non-Hispanics.
- Alzheimer's disease has significantly increased in the County, and the death rate is greater than the U.S. rate. The death rate due to Alzheimer's disease is greater for White non-Hispanics compared to other racial and ethnic groups.

Appendix A: Health Indicator Assessment Table

(CI=confidence interval, YPLL=years of potential live lost)

Health Issue	Rate (CI) (Year)	Racial or ethnic disparity	Trend analysis	Compare to Healthy People	Compare to OR (CI), US	Severe consequences (premature mortality , long term consequences)
Maternal and Child Health-Related Outcomes						
Fertility rates	58.9 per 1,000 (57.8-60.1) (2009)	Hispanic	slight increase	no objective	lower than OR 62.5 (62.0-63.1) and US 66.7 (prelim 09)	not severe
First trimester Prenatal care	67.8% (66.2-69.5) (2009)	all non-white populations compared to White non-Hispanic	decreasing	HP2020 77.9%	lower than OR 71.2% (70.5-72.0) and US 70.8% (07)	long-term consequence
Inadequate Prenatal Care (late or no Prenatal Care)	6.0% (5.5-6.5) (2009)	all non-white populations	no change	HP2020 77.6% early and adequate prenatal care	higher than OR 5.0% (4.8-5.3); lower than US 7% (prelim 09)	long-term consequence
Preterm births	8.4% (7.8-9.0) (2009)	African American, Native American higher than White non-Hispanic	slight increase	HP2020 11.4%	similar to OR 7.8% (7.6-8.1); lower than US 12.2% (prelim 09)	long-term consequence
Low birth weight babies	7.4% (6.8-7.9) (2009)	African American, Asian higher than White non-Hispanic	no change	HP2020 7.8%	higher than OR 6.3% (6.1-6.5); lower than US 8.2% (prelim 09)	long-term consequence
Teen births (age 15-17)	18.6 per 1,000 live births (16.2-21.3) (2009)	African American, Native American, Hispanic	decreasing	no objective	similar to OR 16.1 (15.2-17.1); lower than US 21.7 (08)	long-term consequence

Infant Mortality	4.5 per 1,000 live births (3.3-6.0) (2008)	African American higher than White non-Hispanic	Although decreasing, the rates for African American and Native American have been persistently higher than White non-Hispanic	HP2020 6.0 African American does not meet	similar to OR 5.1 (4.5-5.8); lower than US 6.7 (6.61-6.76) (06)	long-term consequence
Immunizations						
Two-year old immunization rates 4:3:1:3:3:1:4	61.4% (52.8-70.0) (07-08)	no data	improving 39.7% (+-8.1) (03-04), 55.8% (+-8.5) (05-06)	HP2020 80%	OR-NA; similar to US 67.4% (66.5-68.3) (07-08)	long-term consequence
Influenza immunization adults 65+	66.4% (59.1-73.6) (2009)	too few by race	no change	HP2020 90%	similar to OR 64.6% (62.0-67.3) and US 70.1% (09)	long-term consequence
Pneumococcal immunization adults 65+	76.6% (69.9-83.2) (2009)	too few by race	no change	HP2020 90%	similar to OR 69.5% (66.9-72.1); higher than US 68.5% (09)	long-term consequence
Sexually Transmitted Disease						
Chlamydia	491.3 per 100,000 (475.2-507.4) (2009)	African American, Native American, Hispanic	increasing	no objective	higher than OR 300.5 (295.0-306.0) and US 409 (2009)	long-term consequence

Gonorrhea	78.3 per 100,000 (71.9-84.7) (2009)	African American, Hispanic, higher than White non-Hispanic	no significant change since '96	HP 2020 females age 15 to 44 257, males 198	higher than OR 29.1 (27.4-30.8); lower than US 99.1 (2009)	long-term consequence
Chronic Disease and Related Conditions						
Coronary heart disease prevalence	2.2% (1.2-3.1) (2009)	no disparity	no change	no objective	similar to OR 3.7% (3.0-4.4); lower than US 3.8% (09)	long-term consequence
Diabetes prevalence	6.0% (4.2-7.7) (2009)	African American	no change	no objective	similar to OR 8.3% (7.2-9.3) lower than US 8.3% (09)	long-term consequence
Current Asthma prevalence	9.2% (6.2-12.1) (2009)	African American higher than Hispanic	no change	no objective	similar to OR 11.1% (9.7-12.5) and US 8.8% (09)	long-term consequence
Arthritis prevalence	24.2% (20.2-28.1) (2009)	White, Native American, African American higher than Hispanic	no change	no objective	similar to OR 27.2% (25.5-28.9) and US 26.0% (09)	long-term consequence
High Blood Pressure prevalence	25.3% (21.3-29.2) (2009)	African American, White, Asian higher than Hispanic	no change	HP2020 26.9%	similar OR 27.2% (25.5-28.8) and US 28.7% (09)	long-term consequence
High Cholesterol prevalence	36.4% (31.5-41.3) (2009)	no disparity	no change	HP2020 15.5%	similar OR 35.3% (33.3-37.2) and US 37.5% (09)	long-term consequence
Obesity prevalence	20.5% (16.3-24.6) (2009)	African American higher than White non-Hispanic	increasing	HP2020 30.6% obese	similar to OR 23.6% (21.8-25.4); lower than US 26.9% (09)	long-term consequence

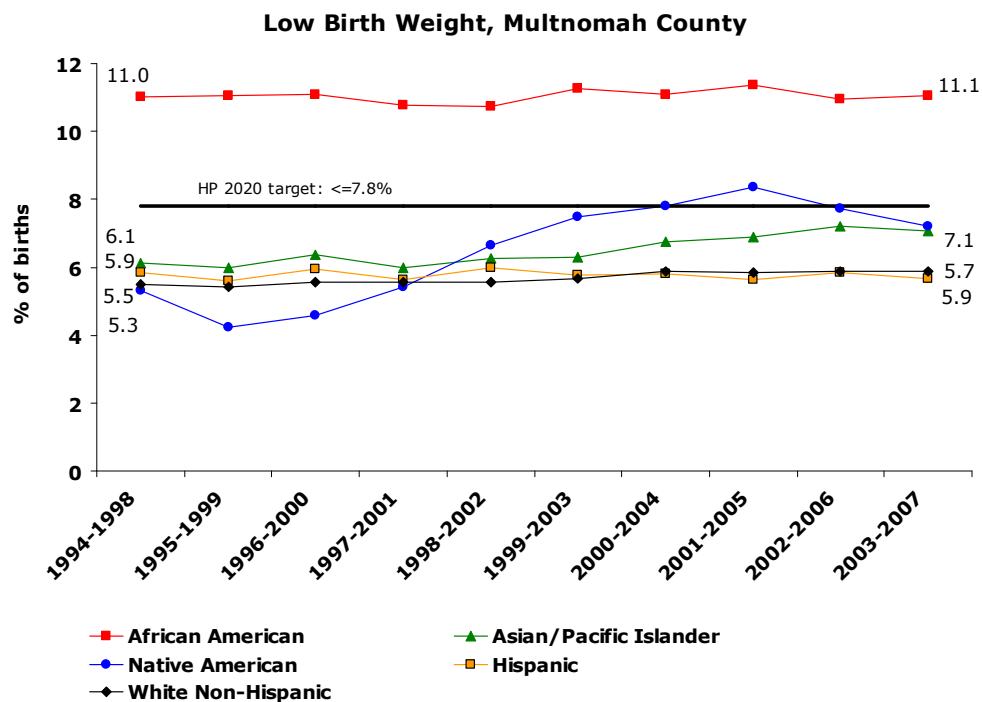
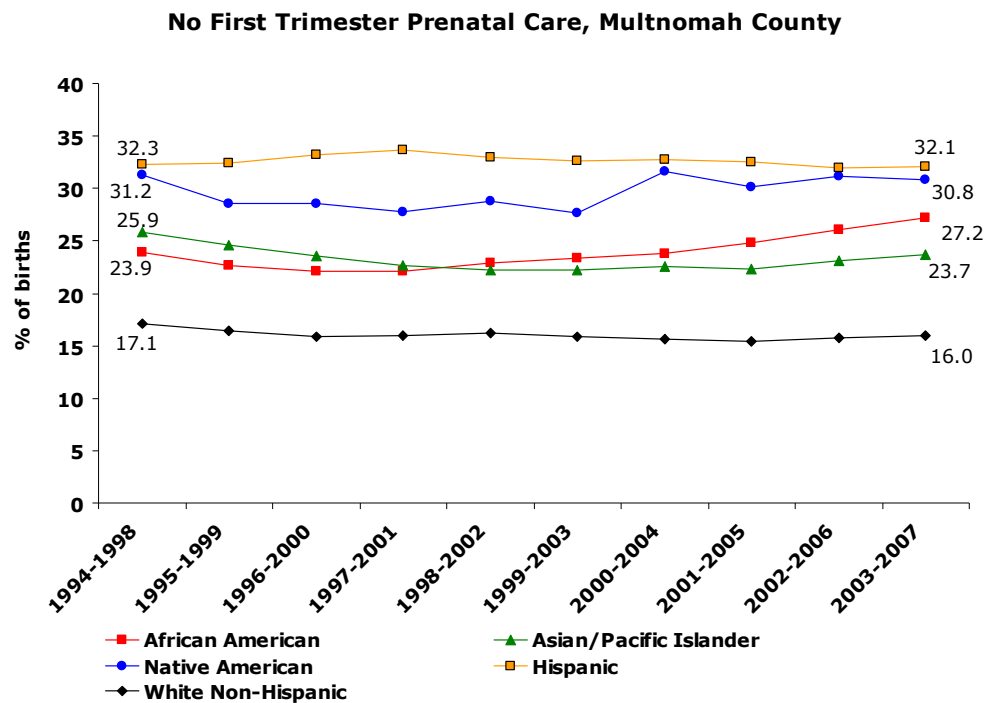
Health Behaviors						
Current Adult Smokers	15.0% (10.8-19.1) (2009)	Native American higher than White	no change	HP2020 12%	similar OR 17.9% (16.0-19.7) and US 17.9% (09)	long-term consequence
Teen Smokers	grade 6 2.4%, grade 8 6.4% grade 11 12.2% (2010)	no data	grade 8 9.1%, grade 11 16.2% (05-06)	HP2020 grade 9-12 16%	OR grade 6 2.7%, grade 8 8.2% grade 11 14.3% (2010); US grade 11 22.3% (19.6-25.2) (09)	long-term consequence
Adult Nutrition (5+ fruits/veg per day)	29.9% (25.0-34.8) (2009)	no disparity	no change	no objective	similar to OR 26.3% (24.5-28.2); higher than US 23.4% (09)	long-term consequence
Teen Nutrition (5+ fruits/veg per day)	grade 8 22.6% grade 11 15.9% (07-08)	no data	grade 8 25.4%, grade 11 18.6% (05-06)	no objective	OR – NA; lower than US grade 11 77.7% (75.4-79.8) (09)	long-term consequence
Leading Causes of Death						
Cancer mortality	190 per 100,000 (178.9-200.6) (2008)	White non-Hispanic and African American higher than Hispanic and Asian	decreasing	HP2020 160.6	similar to OR 177.8 (173.7-181.9); higher than US 175.5 (08)	562.4 YPLL

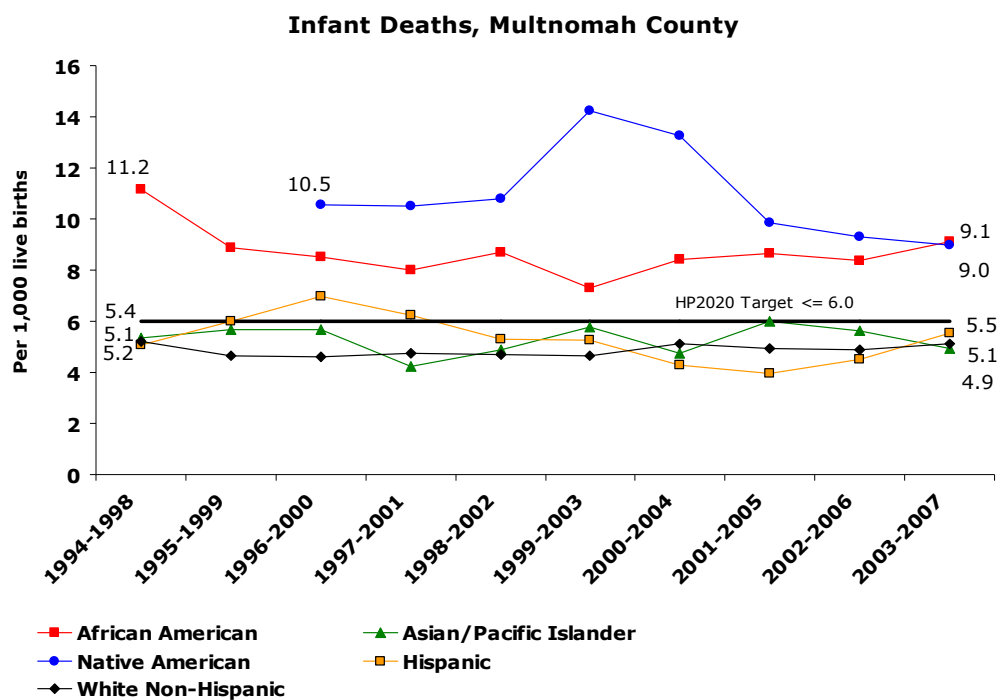
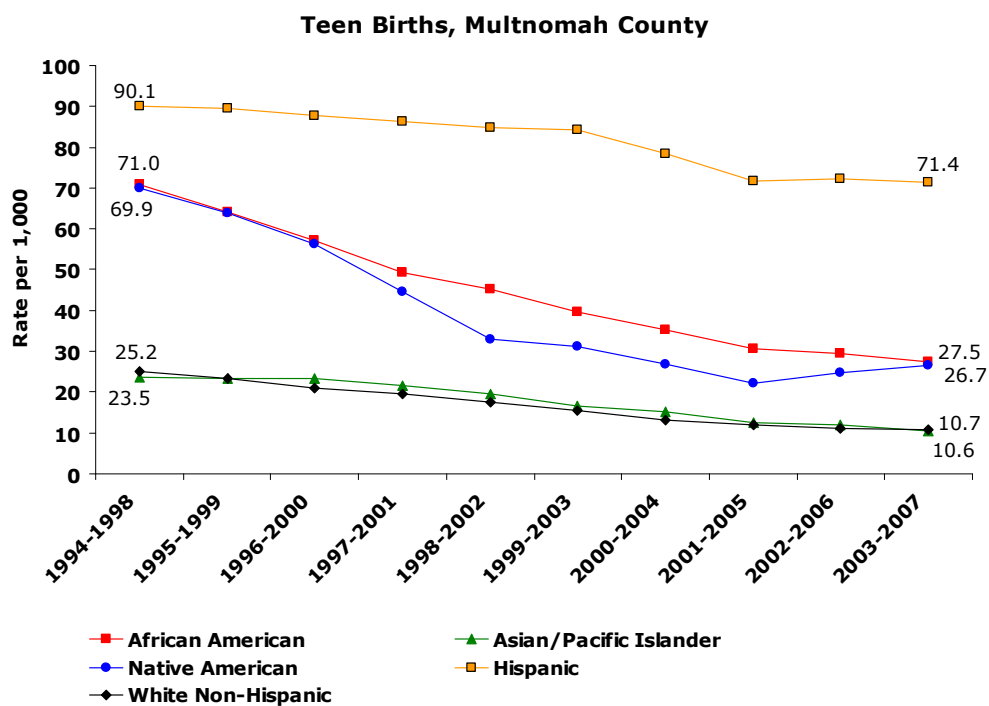
Lung cancer mortality	52.2 per 100,000 (46.6-58.3) (2008)	White non-Hispanic and African American higher than Hispanic and Asian	decreasing - highest death rates of all cancers	HP2020 45.5	similar to OR 49.8 (47.7-52.0) and US 49.6 (08)	103.5 YPLL
Female breast cancer mortality	22.7 per 100,000 (18.2-28.1) (2008)	White non-Hispanic higher than Asian	decreasing - highest incidence rates	HP2020 20.6	similar to OR 22.3 (20.4-24.3) and US 22.9 (07)	137.4 YPLL
Prostate cancer mortality	30.5 per 100,000 (23.8-38.4) (2008)	African American higher than White non-Hispanic	decreasing - highest incidence rates	HP2020 21.2	similar to OR 25.4 (23.0-27.9); higher than US 23.5 (07)	11.2 YPLL
Coronary Heart disease mortality	104.2 per 100,000 (96.5-112.4) (2008)	no disparity	decreasing	HP2020 100.8	similar to OR 96.7 (93.8-99.8); lower than US 135.5 (07)	257.1 YPLL
Unintentional injury mortality	41.0 per 100,000 (34.6-46.1) (2008)	White non-Hispanic higher than Hispanic and Asian	increasing	HP2020 36.0	similar to OR 42.2 (40.2-44.3) and US 38.6 (08)	779.9 YPLL
Respiratory disease mortality	44.3 per 100,000 (39.2-49.9) adults 45+ 109.7 (97.2-123.4) (2008)	White non-Hispanic higher than African American, Hispanic, and Asian	decreasing	HP2020 98.5 COPD adults 45+	similar to OR 46.7 (44.7-48.9) and US 44.0 (08)	106.8 YPLL

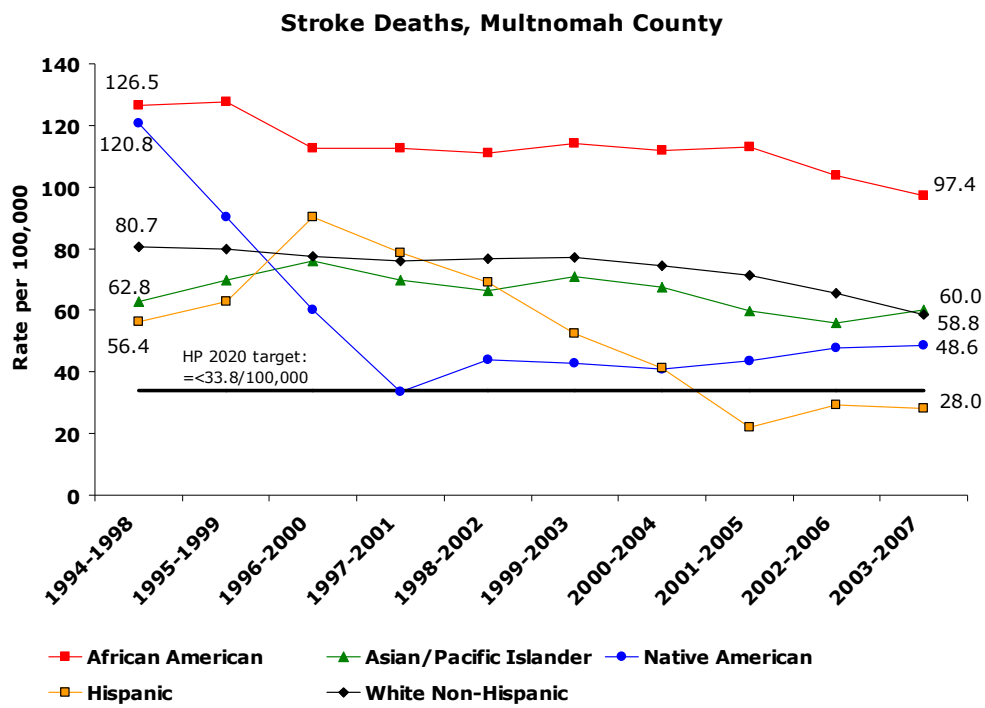
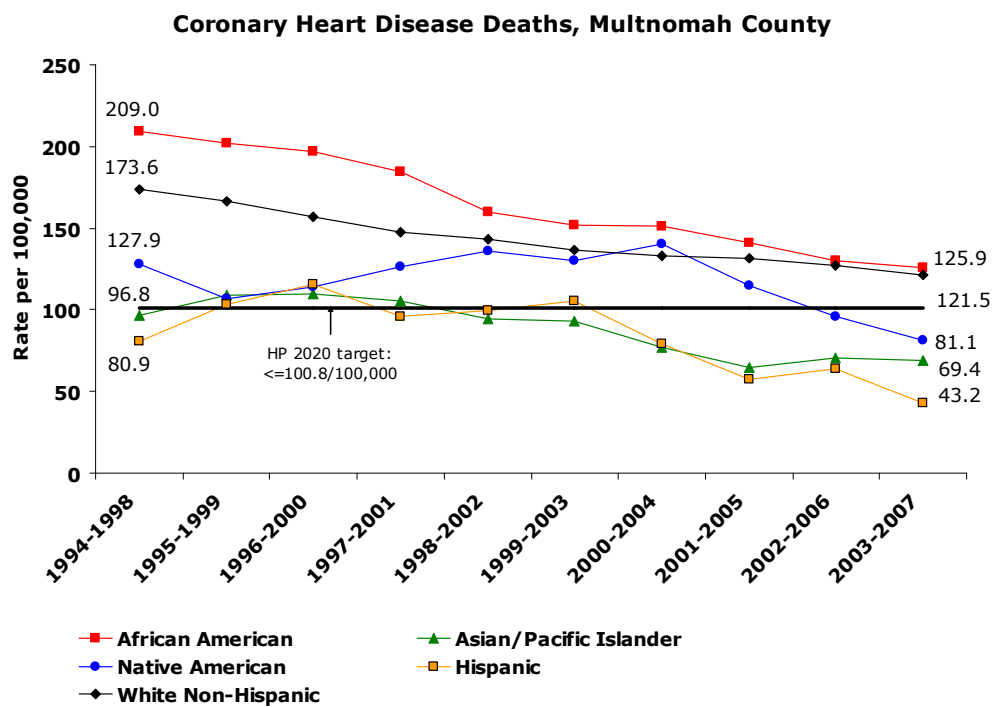
Stroke mortality	38.9 per 100,000 (34.2-44.1) (2008)	African American higher than White non-Hispanic	decreasing	HP2020 33.8	similar to OR 44.7 (42.7-46.7) and US 40.6 (08)	68.3 YPLL
Alzheimer's disease mortality	33.0 per 100,000 (28.8-37.8) (2008)	White non-Hispanic higher than Hispanic and Asian	increasing	no objective	similar to OR 30.0 (28.4-31.7); higher than US 24.4 (08)	1.9 YPLL
Diabetes mortality	27.5 per 100,000 (23.6-31.9) (2008)	African American higher than White non-Hispanic	increasing	no objective	similar to OR 24.2 (22.8-25.8); higher than US 21.8 (08)	76.8 YPLL
Suicide mortality	13.9 per 100,000 (11.3-17.0) (2008)	White non-Hispanics higher than African American and Asian	decreasing	HP2020 10.2	similar to OR 14.7 (13.5-16.0) and US 11.6 (08)	317.8 YPLL
Chronic liver disease mortality	10.7 per 100,000 (8.4-13.5) (2008)	Native American higher than White non-Hispanic and Asian	decreasing	no objective	similar to OR 10.9 (9.9-12.0) and US 9.2 (08)	136.0 YPLL
Other Causes of Death						
Accidental poisoning deaths	16.3 per 100,000 (13.6-19.6) (2008)	White non-Hispanic higher than Hispanic	increased in the last 8 years	HP2020 11.1 unintentional and undetermined poisoning	higher than OR 10.8 (9.8-11.9) and US 9.9 (08)	437.5 YPLL

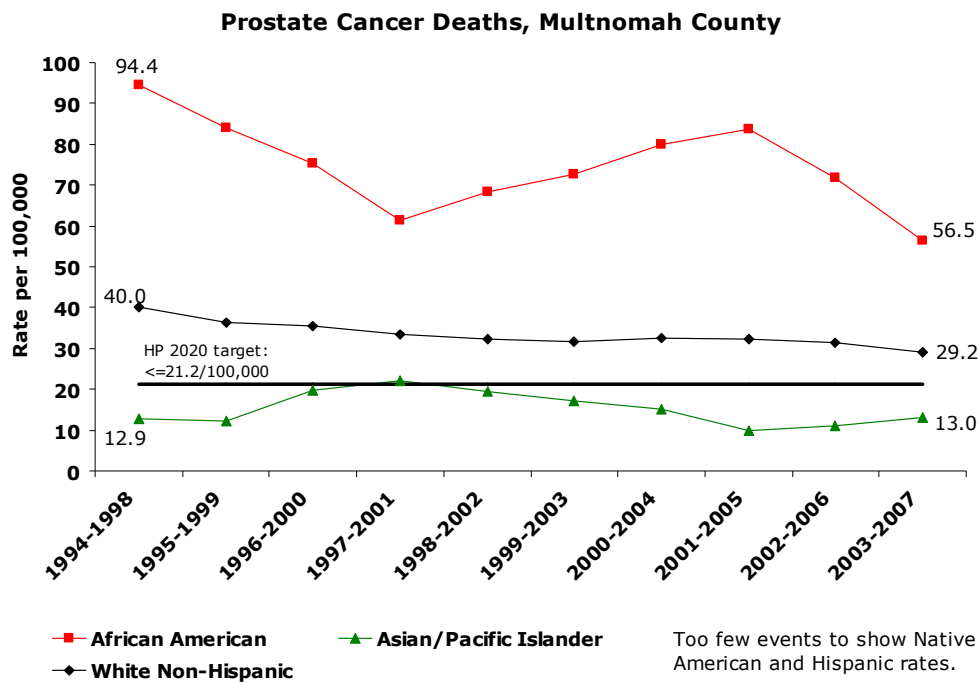
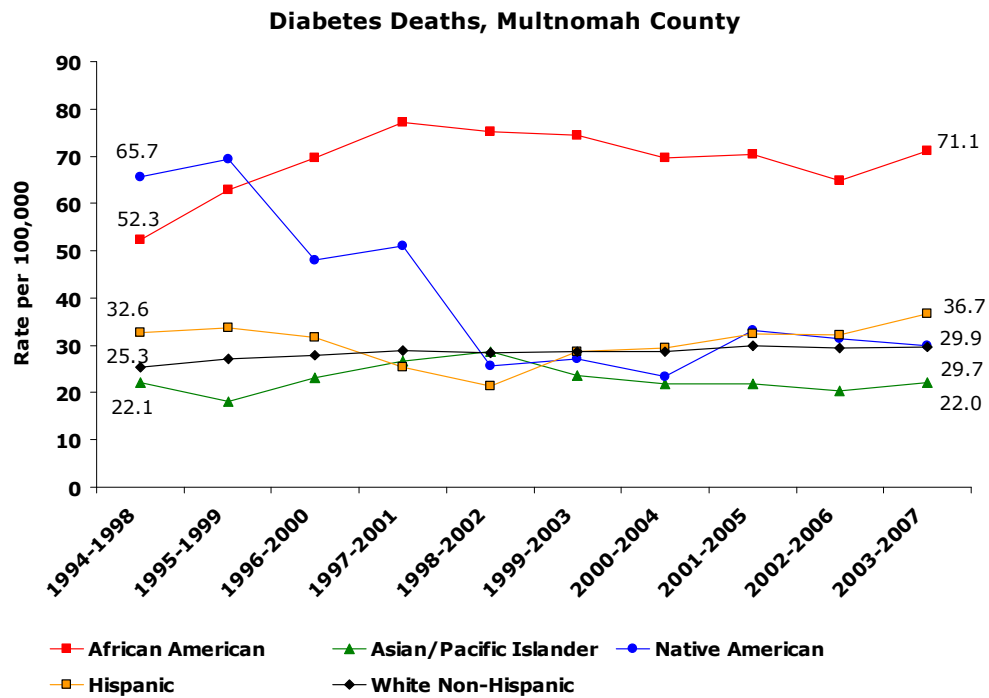
Falls mortality	11.6 per 100,000 (9.2-14.6) (2008); age 65+ 92.0 (71.4-116.8)	no disparity	increasing	HP2020 7.0 all ages; age 65 and older 53.3	similar to OR 10.5 (9.6-11.6); higher than US 7.3 (08), 48.4 65+ (07)	23.3 YPLL
HIV disease mortality	2.2 per 100,000 (1.3-3.7) (2008)	Native American higher than White non-Hispanic	decreasing	HP2020 3.3	similar to OR 1.0 (0.7-1.4) and US 3.3 (08)	41.0 YPLL
Homicide	3.9 per 100,000 (2.6-5.7) (2008)	African American, Asian higher than White non-Hispanic	decreasing	HP2020 5.5	similar to OR 2.6 (2.1-3.2); lower than US 5.9 (08)	133.5 YPLL
Kidney disease mortality	10.4 per 100,000 (8.0-13.2) (2008)	African American higher than White non-Hispanic	increasing	no objective	similar to OR 9.4 (8.5-10.4); lower than US 14.8 (08)	25.6 YPLL
Septicemia mortality	4.7 per 100,000 (3.2-6.8) (2008)	no disparity	increasing	no objective	similar to OR 5.3 (4.6-6.0); lower than US 11.1 (08)	18.9 YPLL
Viral hepatitis mortality	5.8 per 100,000 (4.2-7.8) (2008)	no disparity	increasing	no objective	similar to OR 3.4 (3.2-4.3); higher than US 2.3 (07)	55.5 YPLL

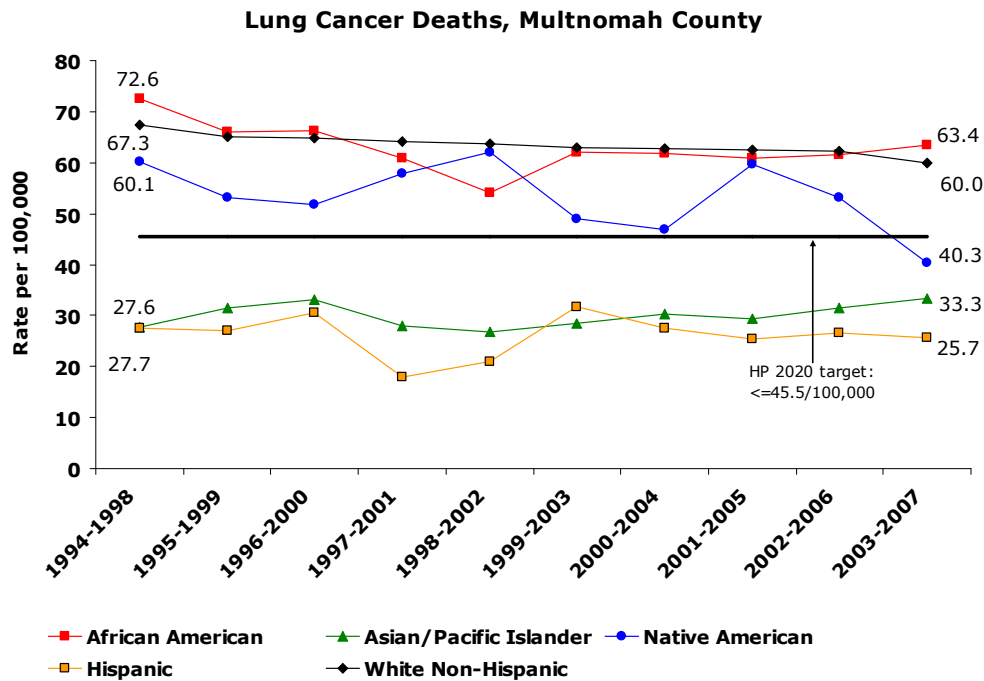
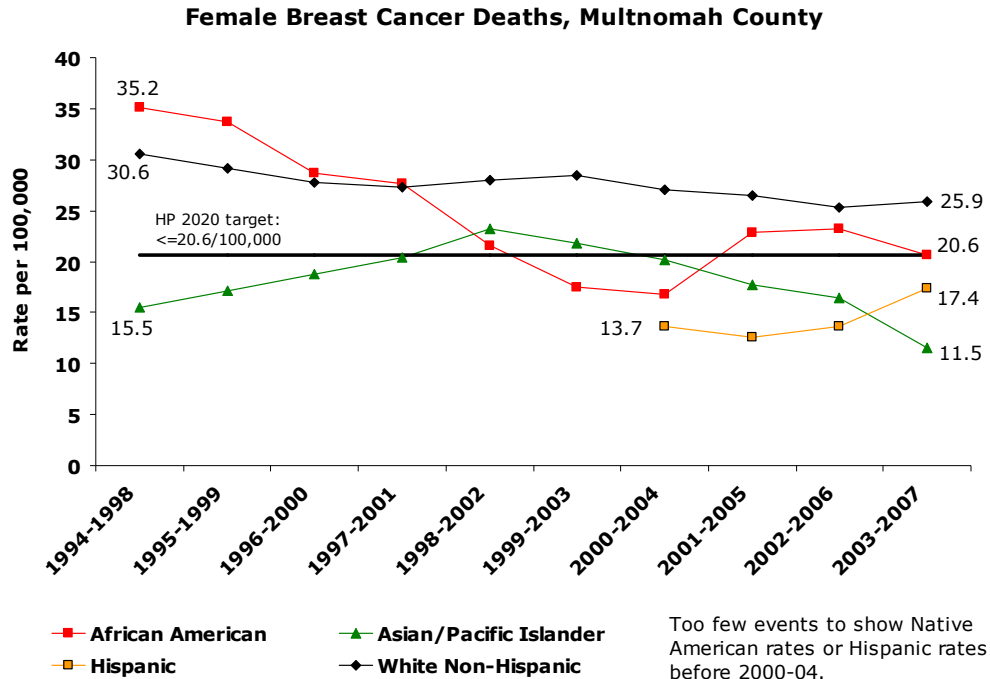
Appendix B: Racial and Ethnic Disparity Charts from the Multnomah County Health Department Report Card on Racial and Ethnic Health Disparities, April 2011



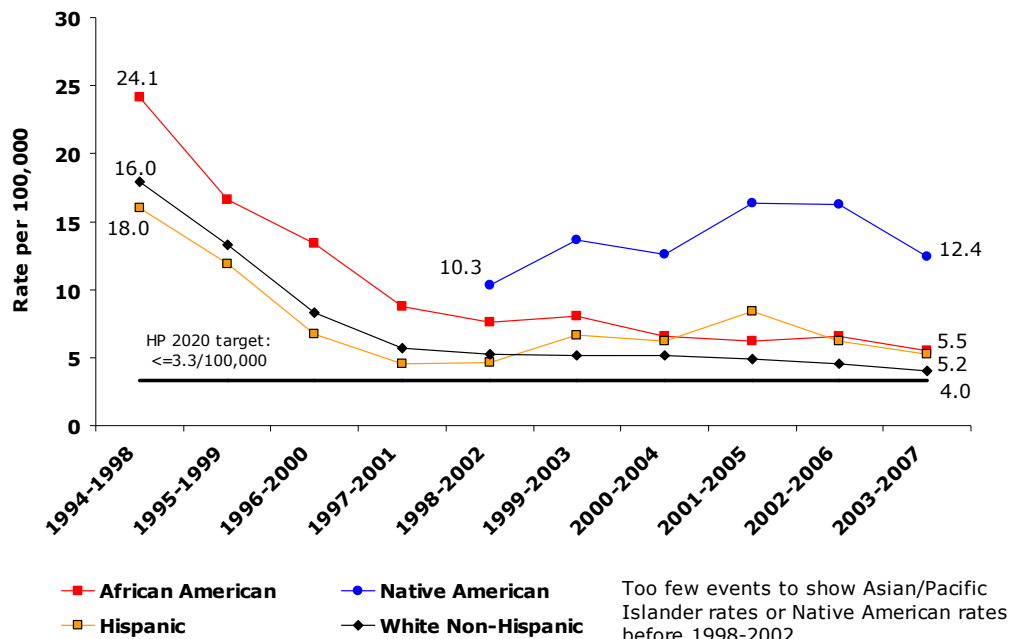




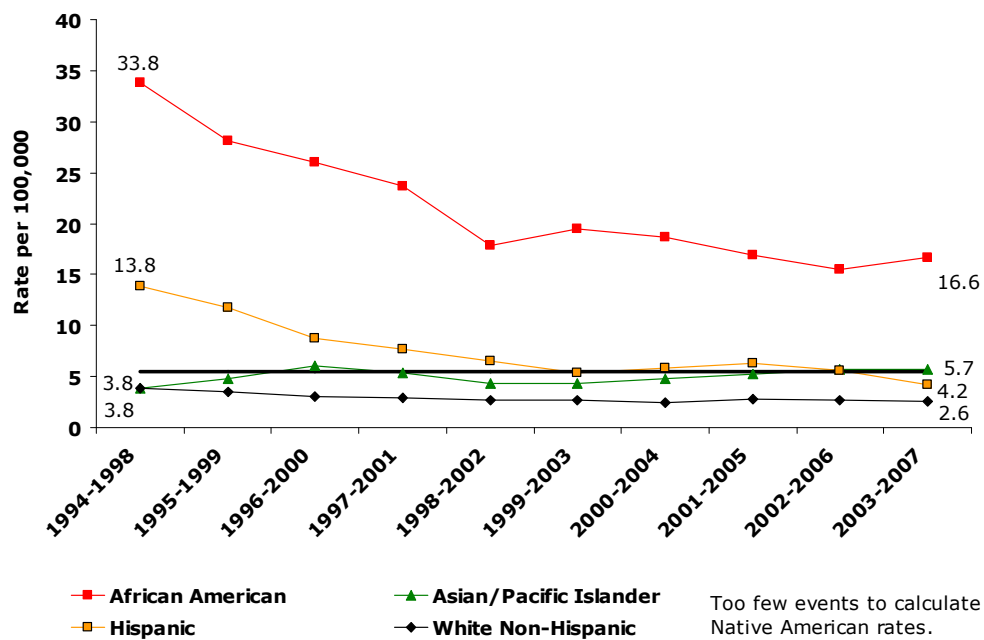


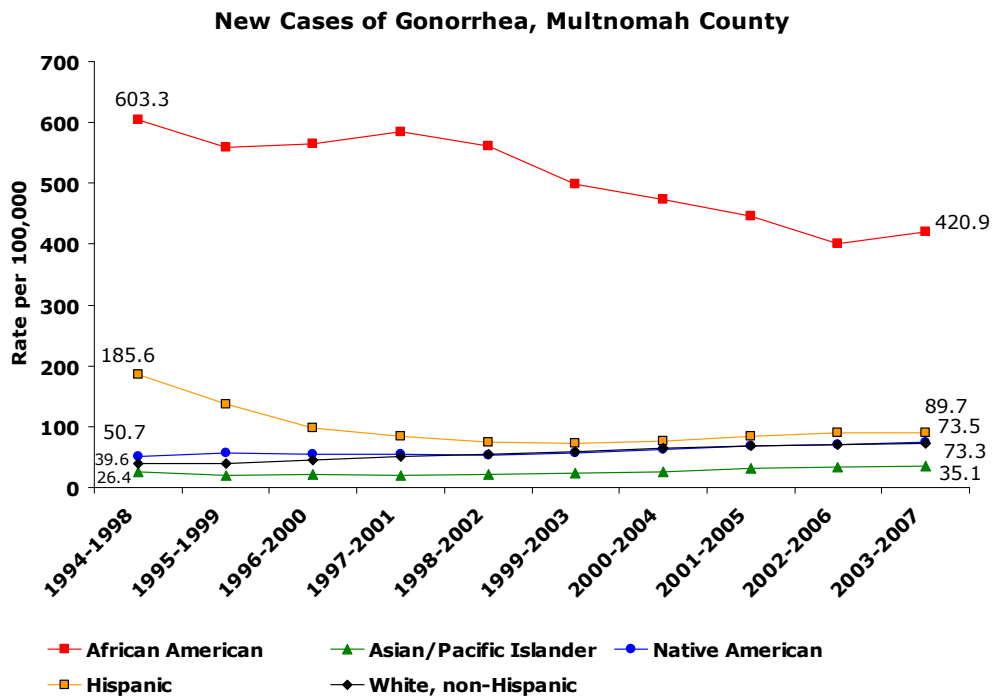
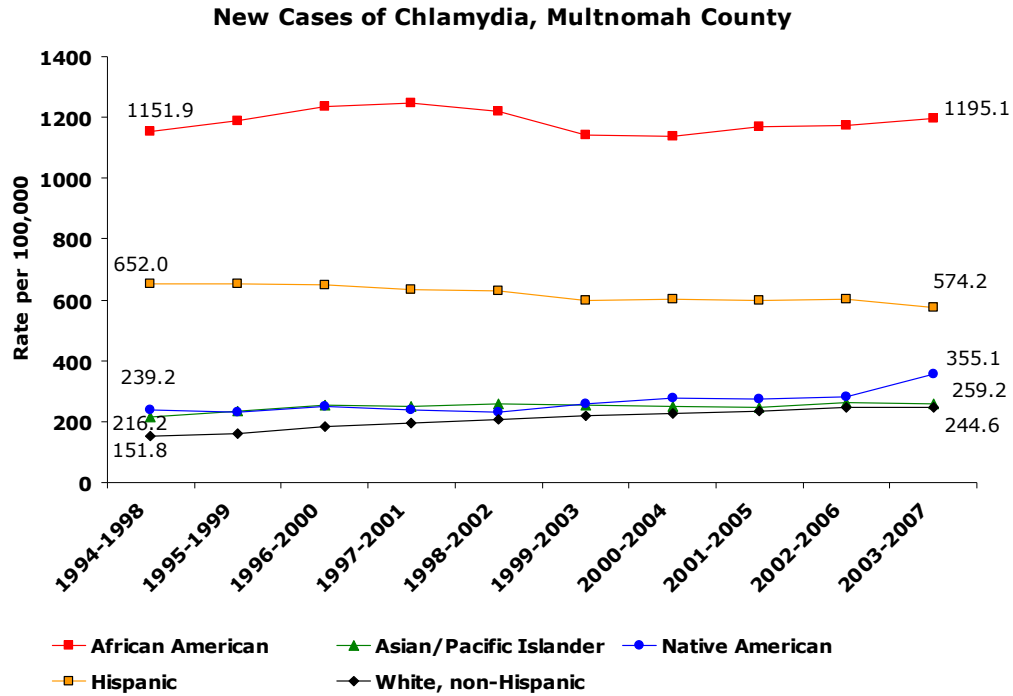


HIV Deaths, Multnomah County



Homicide Deaths, Multnomah County





Appendix C: Multnomah County Community Health Assessment Reports

The following six reports, written by the Health Assessment and Evaluation and Grants Development Teams, describe the methodology and findings of the multiple components of the Multnomah County Community Health Assessment.



Multnomah County Community Health Assessment Mobilizing for Action through Planning and Partnerships (MAPP) to Identify Health-Related Priorities

Summary Report, August 2011

Christine Sorvari, MS and Erin Mowlds, MPH



Multnomah County Community Health Assessment: Identifying the Most Important Health Issues through Multiple Community Engagement Processes

Community Themes and Strengths Assessment, August 2011

Christine Sorvari, MS



Multnomah County Community Health Assessment: Discussions with People Living In Mid-County and East County

Focus Group Report, August 2011

Erin Mowlds, MPH and Christine Sorvari, MS



Multnomah County Community Health Assessment: A Survey of Multnomah County Residents

Survey Report, August 2011

Maya Bhat, MPH and Emily Francis, MPH



Multnomah County Community Health Assessment: Using Quantitative Data to Measure the Community's Health

Community Health Status Assessment, August 2011

Claire Smith, MURP



Multnomah County Community Health Assessment: Interviews with Local Public Health System Stakeholders about Future Opportunities and Challenges

Local Public Health Care System & Forces of Change Assessments, August 2011

Erin Mowlds, MPH and Nicole Hermanns, MA

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