



# **Multnomah County Health Department**

## **Public Health Division**

Community Health Assessment

August, 2015





# Table of Contents

<b>Acknowledgements .....</b>	<b>2</b>
<b>Introduction .....</b>	<b>6</b>
<b>Disparities Report Development Process .....</b>	<b>9</b>
<b>African Americans in Multnomah County .....</b>	<b>11</b>
<b>American Indian and Alaska Natives in Multnomah County.....</b>	<b>15</b>
<b>Latinos in Multnomah County.....</b>	<b>19</b>
<b>Asian and Pacific Islanders in Multnomah County.....</b>	<b>22</b>
<b>Disparity Focused Report Recommendations.....</b>	<b>27</b>
<b>Healthy Columbia Willamette Collaborative Assessment.....</b>	<b>33</b>
<b>Community Themes and Strengths Assessment .....</b>	<b>34</b>
<b>Health Status Assessment .....</b>	<b>39</b>
<b>Community Health System and Forces of Change Assessment .....</b>	<b>45</b>
<b>Community Listening Sessions .....</b>	<b>52</b>
<b>Appendices .....</b>	<b>65</b>



## Acknowledgements

### Maternal, Child and Family Health Data Book Multnomah County 2014

**Authors/Collaborators:** Sarah Tran, MPH, MCH Epidemiologist; Ashley Borin, MPH CDC-CSTE, Applied Epidemiology Fellow; Heather Heater, MPH, Health Educator, Early Childhood Services; Jaime Walters, MPH, Epidemiology Research Associate; Amy Gredler, Program Communications Coordinator; Aileen Duldulao, MSW, PhD, MCH Epidemiologist

**Multnomah County Health Department Contributors:** Robert Johnson, MD, Manager, Community Epidemiology Services; Claire Smith, Senior Research Analyst, Health Assessment and Evaluation; Ben Duncan, Manager, Health Equity Initiative; David Brown, MPH, RD, LD, Manager, WIC Program; Marisa McLaughlin, MPH, Quality Improvement Specialist, Community Epidemiology Services; Elizabeth Carroll, Early Childhood Services

### 2014 Report Card on Racial and Ethnic Disparities

**Analysis Team:** Maya Bhat, MPH; Diane McBride; Elizabeth Clapp, MPH; Moriah McSharry McGrath, PhD; Clyde Dent, PhD; Kathy Pickle, MPH; Caislin Firth, MPH; Barbara Pizacani, PhD, MPH; Julie Maher, PhD; Claire Smith

**Advisory Team:** Rachael Banks, Director, Healthy Birth Initiatives (HBI); Benjamin Duncan, Chief Diversity and Equity Officer, Multnomah County; Nafisa Fai, Program Coordinator, Diversity & Quality Improvement, Human Resources & Training; Rujuta Gaonkar, Manager, Health Equity Initiative (HEI); Amy Gredler, Program Communications Coordinator; Tim Holbert, Research Analyst, Program Design and Evaluation Services; Sami Jarrah, MPH, Deputy Director for Integrated Clinical Services; Olivia Quiroz, Senior Policy Specialist, Community Wellness and Prevention Program; Daesha Ramachandran, Research/Evaluation Analyst Senior, Integrated Clinical Services; Consuelo Saragoza, MPA, Senior Advisor of Public Health & Community Initiatives; Kim Toevs, MPH, Manager, Adolescent Health Promotion and STD/HIV/HCV Programs; Amy Zlot, Senior Epidemiologist, Community Health Services

**Other Multnomah County Health Department Contributors:** Sharon Vance Research Assistance, Tara Fechter Research Assistance, Samantha Kaan, MPH Communications/Dissemination, Julie Sullivan-Springhetti Communications/Dissemination, Jaimee Mayfield, MA Communications/Dissemination, Amy Gredler Editing/Production Coordination, Claire Nystrom Editing and Technical Assistance

**Other Contributors:** Tracie Smith-McCarthy Oregon Health Authority, Oral Health Program provided data for the children's untreated tooth decay indicator. Crystal Greene Oregon Department of Education provided data for the high school graduation indicator. Kara Carmosino All Hands Raised provided data for the third grade reading proficiency indicator. Jerry Nemer Apprise Health Insights provided data for the preventable hospitalization indicator.

## Coalition of Communities of Color: An Unsettling Profile

### Authors

Ann Curry-Stevens, MSW, PhD  
 Amanda Cross-Hemmer, MPH  
 Lisa Bates, PhD  
 Coalitions of Communities of Color

### Members and Supporters

Africa House  
 APANO  
 Asian Family Center  
 Center for Intercultural Organizing  
 El Centro Milagro (Miracle Theater)  
 Hacienda Community Development Corporation  
 Immigrant & Refugee Community Organization  
 KairosPDX  
 Latino Network

Native Youth and Family Center (NAYA Family Center)  
 Portland African American Leadership Forum  
 Portland Community Reinvestment Initiatives  
 Portland Indian Leaders Roundtable  
 Portland Youth & Elders Council  
 Self-Enhancement Inc.  
 Slavic Network of Oregon  
 Urban League of Portland  
 Verde  
 VOZ Worker’s Rights Education Project



LatinoNetwork



Please visit our CUIE Park Website

## Healthy Columbia Willamette

### Authors

Maya Bhat, MPH, Multnomah County Health Department  
Meghan Crane, Healthy Columbia Willamette, Multnomah County Health Department  
Tab Dansby, Multnomah County Health Department  
Cally Kamiya, Multnomah County Health Department  
Sunny Lee, MPH, Clackamas County Public Health Division  
Melanie Payne, MPH, Clark County Public Health Department  
Kimberly Repp, PhD, MPH, Washington County Public Health  
Beth Sanders, Healthy Columbia Willamette, Multnomah County Health Department  
Devin Smith, Healthy Columbia Willamette, Multnomah County Health Department  
Christine Sorvari, Healthy Columbia Willamette, Multnomah County Health Department

### Other Contributors

Devarshi Bajpai, Multnomah County Mental Health and Addictions Services Division  
Rachel Burdon, Kaiser Permanente  
Elizabeth Clapp, Multnomah County Health Department  
Katie Clift, Kaiser Permanente  
Tab Dansby, Multnomah County Health Department  
Gerry Ewing, Tuality Healthcare/Tuality Community Hospital  
Jacob Figas, Health Share of Oregon  
Kristin Harding, Providence Health and Services  
Sunny Lee, Clackamas County Public Health Division  
Diane McBride, Multnomah County Health Department  
Devin Smith, Healthy Columbia Willamette, Multnomah County Health Department  
Christine Sorvari, Healthy Columbia Willamette, Multnomah County Health Department

### Contact

Christine Sorvari, MS  
Healthy Columbia Willamette  
c/o Multnomah County Health Department  
503-988-8692  
[christine.e.sorvari@multco.us](mailto:christine.e.sorvari@multco.us)

### Healthy Columbia Willamette Member Organizations

Adventist Medical Center	Legacy Salmon Creek Medical Center
Clackamas County Health Division	Multnomah County Health Department
Clark County Public Health	Oregon Health & Science University
FamilyCare	PeaceHealth Southwest Medical Center
Health Share of Oregon	Providence Milwaukie Hospital
Kaiser Sunnyside Hospital	Providence Portland Medical Center
Kaiser Westside Hospital	Providence St. Vincent Medical Center
Legacy Emanuel Medical Center	Providence Willamette Falls Medical Center
Legacy Good Samaritan Medical Center	Tuality Healthcare
Legacy Meridian Park Medical Center	Washington County Public Health
Legacy Mount Hood Medical Center	





## Section 1: Multnomah County Racial and Ethnic Disparities

### Introduction

Racial and ethnic health disparities have existed for decades and are well documented at the state and national levels.<sup>1,2</sup> Similarly, as in Multnomah County, most disparities have persisted over time. Many factors contribute to these disparities, including racism. Studies have shown that racism negatively impacts health— independent of genetics, behavior, community characteristics and socio-economic factors.<sup>3</sup> Racism in all its forms—at the institutional and the individual levels—is a fundamental cause of racial and ethnic disparities. The focus on racial and ethnic disparities and not other disparities, such as poverty, is because racism gives rise to inequality in income and education levels. Inequalities in poverty are largely due to racism in economic policies and economic structures. As a result, those who have not experienced racism, non-Latino Whites, are used as the group comparison throughout this report.

This report is a review of existing county and regional data reports to understand the current health status of our community. The report does not provide new analysis but instead capitalizes on the rich sources of information our community is fortunate to have. Included in the report are stories of personal experience with racial and ethnic inequality in Multnomah County.

The report is divided into two sections, the first compiles the key findings from reports addressing racial and ethnic disparities. The second section of this report presents the Healthy Columbia Willamette Collaborative community health

assessment which provides a picture of the region's health in Multnomah, Washington, Clackamas and Clark County, Washington.

(<http://www.healthycolumbiawillamette.org/index.php>)

The reports focusing on racial and ethnic disparities include:

- Multnomah County Health Department 2014 Maternal, Child and Family Health Data Book (<https://multco.us/file/34038/download>)
- Multnomah County 2014 Report Card on Racial and Ethnic Disparities (<https://multco.us/file/37530/download>)
- A series of reports from the Coalition of Communities of Color: An Unsettling Profile (<http://www.coalitioncommunitiescolor.org/cccdatarsearch/>)

The goal of this Community Health Assessment is to share the specific areas of disparity experienced by the African American, American Indian/Alaska Native, Asian/Pacific Islander and Latino communities as well as a regional assessment of the health of our community. This assessment will inform a subsequent Community Health Improvement Planning process.

The Multnomah County Equity and Empowerment Lens lays out the foundational assumptions of focusing on race and ethnicity first.

*“In Multnomah County an individual’s positive or negative chances for life success are largely driven by race and ethnicity. Data and reports from the Urban League, the Coalition of Communities of Color, Multnomah County’s Health Department, and other efforts speak clearly. Across major indicators of well-being and across institutions, people of color fare worse than their white counterparts, and across*

<sup>1</sup> Oregon Office of Equity and Inclusion. (2013). State of Equity Report, Phase 2. Portland, Oregon: Oregon Health Authority and Department of Human Services.

<sup>2</sup> Centers for Disease Control and Prevention. (2013). CDC Health Disparities and Inequalities Report—United States, 2013. MMWR, 62(Suppl 3)

<sup>3</sup> Paradies Y. (2006). A systematic review of empirical research on self-reported racism and health. Int J Epidemiol, 35: 888-901

## Section 1: Multnomah County Racial and Ethnic Disparities

*several indicators, these inequities are more grave than those experienced at the national level.”*

*“Although there has been some progress in addressing overt racial discrimination, deeper racial inequities still persist for communities of color, including more subtle racism affecting mental and spiritual safety. Eliminating the root causes of such inequities requires a more thoughtful, complex and direct analysis of all contributing power dynamics and legal, financial, and environmental factors, accompanied by the understanding that racial, class-based and gender based inequities intersect and complicate the analysis. In order to be truly successful, racial equity work must be addressed at the individual, institutional, and systemic levels”<sup>4</sup>*

### Population in Multnomah County

Multnomah County is the most populous county in Oregon, home to 19% of the state’s population. As detailed in the 2014 Report Card on Racial and Ethnic Disparities, the Latino population is the largest non-White community in Multnomah County. Overall, the population of Multnomah County has increased 13% in the last decade. The population increased from 660,486 in 2000 to 748,031 in 2011.<sup>5</sup> The growth in the overall population is explained primarily by an 8% increase in the size of the Latino population. Between 2000 and 2011, the size of the non-Latino White population declined somewhat, while the Black/African American, Asian/Pacific Islander, and American Indian/Alaska Native populations remained approximately the same size. It is important to note that communities of color are often undercounted.<sup>6</sup>

<sup>4</sup> Foundational Assumptions of the Equity and Empowerment Lens Logic Model <https://multco.us/file/31824/download>

<sup>5</sup> Population Research Center, Portland State University. Annual Population Estimates Methodology.

<sup>6</sup> <http://www.coalitioncommunitiescolor.org/ccs-dataresearch/>

### Age

The non-Latino White population is considerably older than the Black/African American, Asian/Pacific Islander, and Latino populations. In 2011, the median age of non-Latino Whites was 38.9 years as compared to the Latino median age of 25.4 years.

Population*	2000	2011
White non-Latino	79.3%	75.4%
African American	6.6%	6.6%
American Indian/Alaska Native	2.0%	2.0%
Asian	6.8%	8.0%
Native Hawaiian/Pacific Islander	7.6%	11.1%
*All Groups single race alone or in combination with other races		

### Language

In Multnomah County, 16.9% of the population five years of age or older speak a language other than English at home. This percent varies by geographic area. The percent of the population that speaks a language other than English at home is greatest in east county (24.5%) and lowest on the west side (5.6%) and central east side of Portland (6.3%).<sup>7</sup>

### Diversity within Racial and Ethnic Categories

Each of the racial/ethnic categories used in this report are comprised of diverse communities. People within each category have different countries of origin, different cultural back grounds, different languages, and different immigration histories. For example, the Asian/Pacific Islander community is particularly diverse in Multnomah County. People from more than fourteen different countries are represented in the Asian category, and more than four countries are represented in the Pacific Islander

<sup>7</sup> U.S. Department of Commerce, 2011

## Section 1: Multnomah County Racial and Ethnic Disparities

category. The Chinese and Vietnamese populations are the largest populations within the Asian/Pacific Islander category; however, no one country of origin represents even a third of the people grouped into the Asian/Pacific Islander grouping.

Asian	Percent of total
Asian Indian	3.6%
Cambodian	1.8%
Chinese, except Taiwanese	25.7%
Filipino	9.1%
Hmong	1.0%
Indonesian	0.5%
Japanese	6.7%
Korean	5.4%
Laotian	4.9%
Pakistani	0.7%
Taiwanese	0.4%
Thai	1.5%
Vietnamese	31.9%
Other Asian	6.8%
Native Hawaiian and Other Pacific Islander	
Native Hawaiian	10.4%
Guamanian or Chamorro	5.3%
Samoan	11.3%
Other Pacific Islander	73.0%

### Multiracial Populations in Multnomah County

In Multnomah County, 3.6% of the non-Latino population selected two or more races in the 2010 Census. The largest groups in the more than one race category were: White and Asian (1.13%), White and Black/African American (.83%), and White and American Indian/Alaska Native (.78%).

Single race selected non-Latino	85.5%
White	72.1%
Black or African American	5.4%
Asian	6.5%
Native Hawaiian/Other Pacific Islander	0.5%
American Indian/Alaska Native	0.8%
Some Other Race	0.2%
More than one race selected non-Latino	3.6%
White; Asian	1.13%
White; Black or African American	0.83%
White; American Indian and Alaska Native	0.78%
Black or African American; American Indian and Alaska Native	0.10%
Asian; Native Hawaiian and Other Pacific Islander	0.10%
White; Native Hawaiian and Other Pacific Islander	0.10%
Black or African American; Asian	0.06%
White; Some Other Race	0.06%
Asian; Some Other Race	0.03%
American Indian and Alaska Native; Asian	0.02%
Black or African American; Native Hawaiian/Other Pacific Islander	0.02%
Black or African American; Some Other Race	0.01%
Native Hawaiian/Other Pacific Islander; Some Other Race	0.01%
American India/Alaska Native; Native Hawaiian/Other Pacific Islander	0.01%
American Indian/Alaska Native; Some Other Race	0.00%
Three or more races	0.34%
Latino	10.9%
White alone	4.4%
Black or African American alone	0.20%
Asian alone	0.06%
Native Hawaiian/Other Pacific Islander alone	0.02%
American Indian/Alaska Native alone	0.31%
Some Other Race alone	4.9%
Two or more races	1.0%

Data source: U.S. Census, 2010

## Section 1: Multnomah County Racial and Ethnic Disparities

### Disparities Report Development Process

#### Maternal, Child and Family Health Data Book Multnomah County 2014

This data book was developed through a collaborative, cross-disciplinary process within the Health Department. The indicators used were selected from data across 51 potential indicators. Each indicator was stratified by seven demographic groupings: maternal race, ethnicity, age, education, Medicaid status at time of birth (Oregon Health Plan - OHP), marital status, and foreign-born status. Collective expertise was used to select data results that were statistically significant and had a story to tell, as well as to identify key findings and themes for each chapter. The data in this data book were organized, analyzed, and interpreted using the Maternal, Child Health Life Course Framework.<sup>8</sup> The framework is an updated and broader way of looking at health, over a life span – not as disconnected stages unrelated to each other, but as an integrated whole. The framework suggests that a complex interplay of biological, behavioral, psychological, social, and environmental factors contribute to health outcomes across the course of a person's entire life.<sup>9</sup>

#### Coalition of Communities of Color: An Unsettling Profile

Six years ago, the Coalition of Communities of Color embarked on a research project in which data could be used to empower communities and eliminate racial and ethnic inequities. The CCC partnered with researchers at Portland State University, as well as

---

<sup>8</sup> Fine A and Kotelchuck M (2010). Rethinking MCH: The Life Course Model as an Organizing Framework. Concept Paper; Prepared for the U.S. Department of Health and Human Services, Health Resources and Services Administration, November 2010. [Online]. <http://mchb.hrsa.gov/lifecourse/rethinkingmchlifecourse.pdf>

<sup>9</sup> Lu, M. C. & Halfon, N. (2003). Racial and ethnic disparities in birth outcomes: A life-course perspective. *Maternal and Child Health J* 7(1):13-30.

local community organizations, to implement a community-based participatory research project into the lived realities of communities of color in Multnomah County. The project produced a series of seven research reports: one that looks at communities of color in aggregate and six community-specific reports in the African, African American, Asian and Pacific Islander, Latino, Native American and Slavic communities.<sup>10</sup>

#### 2014 Report Card on Racial and Ethnic Disparities

This is the fifth release of a racial and ethnic health disparities report for Multnomah County. Previous reports were released in 2004, 2006, 2008, and 2011. The first four reports focused solely on health outcomes—the prevalence of health conditions and common causes of death routinely tracked by public health agencies.

The 2014 report is broader and examines disparities more holistically. The report includes indicators that reflect that a person's health status is shaped by more than genetics and behavior choices. Health status is also shaped by the social, economic, and environmental conditions where people live, work, learn, and play. The context in which people live their lives, the limits of their choices, and the environmental burdens they experience are important to consider when examining health disparities. The lack of healthy options in the physical environment contributes to some of the other health disparities examined in this report such as obesity, diabetes deaths, and being physically active outside of work hours. Recent analyses have shown that communities of color are increasingly being displaced from their historic neighborhoods due to gentrification of close-in Portland neighborhoods. This displacement may prevent

---

<sup>10</sup> <http://www.coalitioncommunitiescolor.org/ccc-dataresearch/>

## Section 1: Multnomah County Racial and Ethnic Disparities

communities of color from benefitting from being in a health-promoting physical environment.

The figure below summarizes a growing body of literature that affirms the strong influence of external factors on an individual's health. The figure shows that environmental factors such as social, economic and political factors, living and working conditions, and public services make a larger contribution to a person's overall health status than individual factors and behaviors. Though the precise contributions of each determinant are not precisely known, some researchers have estimated that these environmental factors account for more than 50% of health status.<sup>11</sup>



Source: Oregon Public Health Institute

<sup>11</sup> Centers for Disease Control and Prevention. (2014). Social Determinants of Health, Definitions. Retrieved from <http://www.cdc.gov/socialdeterminants/definitions.html>

## Section 1: Multnomah County Racial and Ethnic Disparities

### AFRICAN AMERICANS IN MULTNOMAH COUNTY

#### Coalition of Communities of Color: An Unsettling Profile Executive Summary:

The data compiled in this report demonstrate that African-Americans in Multnomah County face pronounced challenges:<sup>12</sup>

- African-American family income is less than half that of White families, and the poverty rate among African-American children is nearly 50% compared to 13% for White children.
- African-Americans are deeply affected by unemployment with local unemployment levels in 2009 nearly double the White unemployment rate.
- Fewer than one-third of African-American households own their homes, compared to about 60% of White households in Multnomah County. African-Americans have experienced housing displacement and the loss of community as the historic Albina District has gentrified.
- African-Americans face substantial disparities for health outcomes like diabetes, stroke, and low birth weight, and in access to health insurance, prenatal care, and mental health care.
- In the child welfare system, African-American children are three times more likely to be placed in foster care than White children. Once in foster care, they are likely to stay in care much longer than White children.
- More than half of African-American youth do not complete high school, compared to just over a third of White students. School administrators are much more likely to discipline Black youth with suspensions and expulsions – at levels more than double those of Whites. This pattern exists despite studies that reveal Black children do not

misbehave more frequently than White students.

- Black youth are 6½ times more likely to be charged with a crime than White youth, and 33% more likely to be held in detention. A White youth found guilty stands a one-in-ten chance of receiving a custodial sentence while a Black youth faces a one-in-four chance.

#### Maternal, Child and Family Health Data Book Findings:

The Maternal, Child and Family Health Data Book analyzed a variety of measures of maternal, child, and family health. Compared to non-Latina White women, Black/African American women had disparities in:<sup>13</sup>

- Unintended pregnancy results in a live birth
- Late or inadequate prenatal care
- Low birth weight births
- Post partum depression
- Not read to daily by a family member

#### Report Card on Racial and Ethnic Disparities Findings

The report card characterized disparities in three categories, a statistically significant disparity of 2 times or greater requires intervention, a disparity between 1.0 and 2 needs improvement and the report identifies where there is no disparity.<sup>14</sup>

Black/African Americans experienced the greatest number of disparities with the highest level of concern relative to other communities of color. Of the 33 indicators examined in the report, Black/African Americans experienced disparities for nine indicators that *require intervention* and 18

<sup>12</sup> Bates, L., Curry-Stevens, A. & Coalition of Communities of Color (2014). *The African-American Community in Multnomah County: An Unsettling Profile*. Portland, OR: Portland State University

<sup>13</sup> Multnomah County Health Department (2014). *Maternal, Child, and Family Health Data Book*. Multnomah County.

<sup>14</sup> Multnomah County Health Department (2014). *Report Card on Racial and Ethnic Disparities*. Multnomah County.



## Section 1: Multnomah County Racial and Ethnic Disparities

indicators that *need improvement*. There were only four indicators where a disparity was not detected. There were no indicators where the group fared significantly better than the non-Latino White comparison group. Black/African Americans experienced a geographic disparity for each of the physical environment indicators.

- Black/African Americans experienced disparities for each of the indicators in the social and economic category. This group was almost four times as likely to have children living in poverty, more than twice as likely to have children not meeting third-grade reading standards, and twice as likely to be unemployed (age 16 and over) compared to non-Latino Whites.
- Black/African Americans also fared poorly for three of the four health behavior categories, with cigarette use and obesity at the *needs improvement* level, and teen birth rates at the *requires intervention* level. Although the birth rates among Black/African American teens have decreased significantly since 1998, the group remains almost two and a half times more likely to give birth than their non-Latino White counterparts.
- Black/African Americans experienced disparities in all four clinical care indicators. Adults without health insurance, first trimester prenatal care, children with untreated tooth decay, and preventable hospitalization rates all were at the *needs improvement* level.
- Black/African Americans fared poorly for four of the six morbidity indicators, particularly for gonorrhea, which *requires intervention*. The incidence of gonorrhea in Black/African Americans was seven times higher than in non-Latino Whites, and had not changed significantly since 2000.
- Black/African Americans fared particularly poorly on 10 of the 11 mortality indicators with three of these indicators at the *requires intervention*

level: infant mortality, diabetes mortality, and homicide rates. Black/African American infant mortality and diabetes mortality rates were more than two and a half times higher, and homicide rates about six times higher, than their non-Latino White counterparts. These rates for Black/African Americans have not changed significantly since 1998.

- Black/African Americans experienced a geographic disparity for both the air quality and retail food environment indicators.

## Section 1: Multnomah County Racial and Ethnic Disparities

### Health Disparities identified for African Americans in Multnomah County Similar disparities identified in more than one report are in **Gray**

Racial and Ethnic Disparities Report Card	MCFH Data Book	An Unsettling Profile Executive Summary
<b>Health Outcomes</b>		
No first trimester prenatal care	Late or inadequate prenatal care	Prenatal care
Low birth weight births	Low birth weight	Low birth weight
Gonorrhea	Small for gestational age	Gonorrhea
Teen birth rate	Preterm birth	Teen birth rate
Diabetes mortality	Unintended pregnancy	Diabetes mortality
Infant mortality	Infant Mortality	
Homicide	Recommended weight gain during pregnancy	Homicide
Adults without health insurance	Poor birth outcome or previous poor birth outcome	Health insurance
Stroke mortality		Stroke
HIV	Postpartum depression/ Depression during pregnancy	Mental health care
Adult obesity	Birth resulting in stay in Neonatal Intensive Care Unit	
Premature mortality		
Coronary heart disease mortality		
Adults current cigarette smoking		
Cancer mortality		
Lung cancer mortality		
Colorectal cancer		
Children grade 1-3 with untreated tooth decay		
Prostate cancer mortality		
Adults hospitalized for ambulatory-care sensitive conditions		
<b>Social, Economic, Physical Environment</b>		
Children under 18 in poverty	Infants put to sleep on their backs	Income/Poverty
Students not meeting third-grade reading level standards	Not read to daily by a family member	Housing cost burden
Ninth-grade cohort that did not graduate high school in 4 yrs with regular diploma	Breastfeeding Initiation	High School Graduation
Population age 16+ unemployed, but seeking work		Unemployment
Adults age 25+ with high school education or less		Over-representation in the justice system
Diesel particulate matter		Discipline in school
Adults reporting fair or poor health		Homeownership
Ratio of less healthy food retail to healthier retail		Children in foster care



## Section 1: Multnomah County Racial and Ethnic Disparities

### Community Story

African American women in Multnomah County are more than twice as likely to deliver a baby with low birth weight, and almost twice as likely to have their babies die in the first year of life, than non-Hispanic White women. The Healthy Birth Initiative Program is changing these alarming statistics.

The program works to improve birth outcomes and the health of mothers and fathers in the African American community. It is a partnership between our health department, program participants, health and social service providers, and the community. The program uses a family-centered approach that engages mothers, fathers, and other caretakers in supporting a child's development. The Healthy Birth Initiative is directed by a client-governed Community Action Network of medical and social service providers and community members.

The program is seeing success. Participants have demonstrated lower rates of infant mortality and low birth weight and higher rates of early prenatal care compared to those not enrolled in the program.

Shaqualia Roach attests that the program has made a big difference in her life. After her

firstborn son died during an asthma attack at age 17 months, the Portland mother found support and education through the program. She attended Healthy Birth Initiative classes about asthma that prepared her to manage the health of her three surviving sons.

"I didn't know anything about asthma, other than about inhalers. But now I know all the triggers," she said. When she was pregnant, program staff helped her reach doctor's appointments. She also attended classes on nutrition, domestic violence—"anything they offered."

*"It is great to be around other African American women my age. The whole group helps me cope," Roach said. "When I get depressed or stressed out, I know all the girls' numbers and can call them."*

This innovative care model brings a high degree of trust and community connection to the health system transformation table. "We are excited about linking the experiences of our clients to the design of new policies and practices in the larger health care system," says Rachael Banks, Program Director for the Healthy Birth Initiative. The Healthy Birth Initiative currently has an agreement with Health Share of

Oregon—an Accountable Care Organization that includes all the major health care systems and three public health departments in the Portland area—to collaborate on improving services. The agreement includes cultural competence training and enrollment data-sharing to reach out to pregnant women earlier and get them into appropriate care.

As we move more deeply into the uncharted terrain of health system transformation, local public health departments can be valuable assets. At Multnomah County Health Department, we have acted as leader, convener, and coordinator on a number of long-standing and emerging public health issues. We do this in partnership with the communities we serve. As one of the moms from the Healthy Birth Initiative Program said, "This program develops leadership skills and supports us to network. This is unique. When I started in this program I was afraid to talk in front of people. Now I'm running for Community Action Network Chair because I think it will help me continue to grow."

*Originally published in Northwest Public Health, Summer 2014*

## Section 1: Multnomah County Racial and Ethnic Disparities

### AMERICAN INDIAN/ALASKA NATIVES IN MULTNOMAH COUNTY

#### Coalition of Communities of Color: An Unsettling Profile Executive Summary:

The findings of this report detail an array of disparities, including the following:<sup>15</sup>

- Poverty rates in the Native American community are triple those in White communities. The average poverty rate is 34.0%, while that of Whites is 12.3%. With children and single parents, rates climb steadily. The child poverty rate is 45.2%, which is almost four times higher than the White child poverty rate of 14.0%.
  - Family poverty is particularly intense – with rates more than four times higher than Whites, deepening when single parents lead the family, and also deepening when there are responsibilities for younger children – with a poverty rate of 79.1% for single mothers raising children under 5.
  - Native American poverty rates are deteriorating rapidly, while those of Whites remain largely stagnant at much lower levels. For example, the poverty rate among Native Elders has jumped from 9% to 21% between 2000 and 2009 while the rate of Whites has moved from 6% to 10%.
  - Incomes are typically half that of Whites regardless of living arrangements. For example, married couples raising children try to get by on \$50,540/year while White families live with (on average) \$80,420/year.
  - The unemployment rate, in 2009, was 70% higher than Whites.
  - More than 20% of Native Americans experience hunger on a regular basis (at least monthly).
  - More than ½ of Native American students do not graduate high school (53.4%). In Parkrose and David Douglas, 80% of students do not graduate.
- Centennial has the best graduation rate of Native Americans, at 66.7%.
- Among graduating students, only 54% enter higher education. This level is worse than the best rate of 70% reached in 2001.
  - Access to health insurance deteriorated rapidly from a high of 88% in 2000 to today's level of 76%.
  - While crime rates dropped across all communities, Native American adults were just as likely to be involved in the corrections system; over the last decade, the involvement rate for Whites has dropped significantly.
  - Native Americans are incarcerated at almost double the rate of Whites.
  - Native Americans are the victims of violent crimes at rates 250% higher than Whites.
  - Native youth are charged by the police at levels three times higher than their numbers warrant. Once involved with the system, youth are much more likely to deepen their involvement by being detained and less likely to be diverted away from the justice system and more likely than Whites to enter the chronic re-offender population.
  - Decades of attention to the needs of the Native community finally was responded to by the creation of a set of separate legislative regulations for families (called the Indian Child Welfare Act, or ICWA), while levels of Native children removed from their families and placed into foster care settings reached as high as 35%. Despite this history, today Native Americans face the reality that 22% of their children in Multnomah County are taken from their families. This egregious rate is 20 times higher than that of White children. And this exists despite research that Native parents do not abuse their children more frequently than White parents.

---

<sup>15</sup> Curry-Stevens, A., Cross-Hemmer, A., & Coalition of Communities of Color (2011). *The Native American Community in Multnomah County: An Unsettling Profile*. Portland, OR: Portland State University.

## Section 1: Multnomah County Racial and Ethnic Disparities

### Maternal, Child and Family Health Data Book

#### Findings:

The Maternal, Child and Family Health Data Book analyzed a variety of measures of maternal, child, and family health. Compared to non-Latina White women, American Indian/Alaska Native women had disparities in:<sup>16</sup>

- Unintended pregnancy results in a live birth
- Smoking before pregnancy
- Late or inadequate prenatal care
- Low birth weight births
- Post partum depression
- Not read to daily by a family member

### Report Card on Racial and Ethnic Disparities

#### Findings:

The report card characterized disparities in three categories, a statistically significant disparity of 2 times or greater requires intervention, a disparity between 1.0 and 2 needs improvement and the report identifies where there is no disparity.<sup>17</sup>

The American Indian/Alaska Native group did not fare well overall, with five indicators at the *requires intervention* level and 12 at the *needs improvement* level. The American Indian/Alaska Native group did not fare significantly better than non-Latino Whites for any of the indicators. It is important to note that, for seven other indicators, numbers of cases were too small to provide reliable results, so it is possible that more disparities exist than were detected. Analysts did not calculate geographic disparity ratios for the American Indian/Alaska Native group because there were no census tracts having more than 15% of the population identifying as American Indian/Alaska Native.

- American Indian/Alaska Natives experienced disparities for each of the indicators in the social and economic category. Two of the economic indicators *require intervention*. Specifically, the group was almost three times as likely to have children living in poverty and more than twice as likely to be unemployed (age 16 and over) compared to non-Latino Whites.
- American Indian/Alaska Natives fared particularly poorly for each of the health behavior indicators. Teen births, current cigarette smoking, and adults with no physical activity outside of work all *require intervention*. The teen birth rate among American Indian/Alaska Natives has not changed significantly since 1998; they remained more than twice as likely to experience a teen birth than their non-Latino White counterparts. American Indian/Alaska Natives were about twice as likely to currently smoke cigarettes and to report no physical activity outside of work in the past 30 days.
- One clinical care measure was at the *needs improvement* level for American Indian/Alaska Natives: first trimester prenatal care.
- American Indian/Alaska Natives had six disparities at the *needs improvement* level in the morbidity and mortality categories, including self-reported mental health, overall health, low birth weight, premature death (i.e., years of potential life lost), infant mortality, and stroke mortality. For six indicators in these categories numbers were too small to provide reliable results.

<sup>16</sup> Multnomah County Health Department (2014). *Maternal, Child, and Family Health Data Book*. Multnomah County.

<sup>17</sup> Multnomah County Health Department (2014). *Report Card on Racial and Ethnic Disparities*. Multnomah County.

## Section 1: Multnomah County Racial and Ethnic Disparities

Health Disparities identified for American Indian/Alaska Natives in Multnomah County  
 Similar disparities identified in more than one report are in **Gray**

Racial and Ethnic Disparities Report Card	MCFH Data Book	An Unsettling Profile Executive Summary
<b>Health Outcomes</b>		
No first trimester prenatal care	Late or inadequate prenatal care	Access to health insurance
Low birth weight births	Low birth weight	
Infant mortality	Infant mortality	
Adults current cigarette smoking	Smoking before pregnancy	
Teen birth rate	Unintended pregnancy	
Adult obesity	Recommended weight gain during pregnancy	
Stroke mortality	Postpartum depression or Depression during pregnancy	
Premature mortality	Poor birth outcome or previous poor birth outcome	
Adults reporting fair or poor health	Birth resulting in stay in Neonatal Intensive Care Unit	
	Cesarean delivery among low-risk, first birth women	
<b>Social, Economic, Physical Environment</b>		
Students not meeting third-grade reading level standards	Not read to daily by a family member	
Ninth-grade cohort that did not graduate high school in 4 yrs with regular diploma		High school graduation
Adults age 25+ with high school education or less		Entry and completion of higher education
Population age 16+ unemployed, but seeking work		Unemployment
Children under 18 in poverty		Poverty/Child poverty
Adults reporting mental health not good in 2 of past 4 weeks		Incarceration/ Involvement in corrections system
Adults reporting no physical activity outside work		Youth involvement in justice system
		Hunger
		Victim of violent crime
		Income
		Children in the foster system
		Homeownership

## Section 1: Multnomah County Racial and Ethnic Disparities

### Community Stories from Future Generations Collaborative Community Forums

“When you are a teen mother, you are really scared. You don’t know what to do. You don’t have the support at home. A lot of time, you are looking for support.”

*“I think alcohol is historical trauma. What do we feel when we get drunk? Anger. Because that’s what happens, you get angry and you fight and you beat your old lady up and kick your dog. I can’t drink without getting angry.”*

“Even after conception, stress affects the child. Your emotions affect the child that is conceived. If he is drinking or using drugs, and causing stress, she is going to feel that and the baby is going to be affected by that. If he isn’t doing things because he’s drunk, she has to do everything. It causes stress on her.”

*“Most of my education was in boarding school. It was hard because I didn’t get the nurturing. My dad was alcoholic. My brothers and sisters, they were my heroes and all alcoholics. You get to a certain*

*point and you get addicted. The young people, I think there is a lot of depression and hopelessness. There is an epidemic.”*

“I have couch surfers and a lot of them come from homes where their parents loved them but they didn’t have the skills to deal with their kids. It falls back to whatever your environment is. It really does take a village to deal with wellness.”



Photo: FGC Youth GONA- Intisar Abioto

*“This circle is important. My kids were taken away 40 years ago by the County, and I haven’t seen them since. This is important work and we can’t take it for granted. Our Indian community is important and we need each other.”*

“40 years ago there were many Indian bars in Portland. They were gathering places. Different

tribes had different bars where they hung out. Now things have changed. We have NARA doing drug and alcohol treatment. NARA started the New Years Sobriety Powwow. It’s for everyone. This is the way we celebrate, by being sober.”

*“I hear of unspoken grief. You don’t know why, but it’s there. It gets communicated in ways that we pick up from our grandparents. If something happened in a grandparent’s life, termination, taken away to boarding school... those disconnects... loss of identity, they are not communicated verbally but they are in the patterns that people see. Children pick up and carry it. They don’t know what it is, but it’s a stone in their spirit. We need to help our children turn it into historical pride and how to be resilient and strong and understand that their grief can be released in some way.”*

“One thing that draws the young people is the drum. All the different age groups like listening to the drum and drumming. We let them all do that and have a turn at it.”

<https://www.facebook.com/FutureGenerationsCollaborative>

## Section 1: Multnomah County Racial and Ethnic Disparities

### LATINOS IN MULTNOMAH COUNTY

#### Coalition of Communities of Color: An Unsettling Profile Executive Summary:

Among the findings are the following:<sup>18</sup>

- Individual poverty levels are 77% higher than Whites and family poverty levels are 152% higher.
- Per capita income of \$14,627 is \$18,000/year less than that of Whites, and Latino seniors try to survive on just \$8,676/year.
- The incomes of full-time, year-round Latino workers shows they are only able to earn \$25,306 annually while Whites are paid \$44,701.
- While those earning below average incomes have stagnated among Whites (at 45%), numbers have risen dramatically for Latino households, from 56% in 1989 to 65% today.
- Latinos living in Multnomah County experience an economic “hit” compared with those living elsewhere in the USA, while Whites experience a corresponding “perk.”
- Latino unemployment rate has more than doubled since 2007 while White unemployment has increased by 38%.
- Wealth best reflects economic stature and is calculated by total assets minus total debts. Nationally, Latinos hold only 5½ cents for every dollar held by Whites.
- 43.7% of Latinos have not been able to complete high school, compared with only 6.3% for Whites. Numbers today are stagnant among high school students as only 44.8% graduate on time with a diploma. If Latinos have not yet mastered English, the completion rate drops to 39.0%, with the lowest performance among local school districts in Portland at 33.5%.

- The number of Latino graduates moving into higher education is deteriorating, sliding from 60% in 2001 to 55% in 2005. Once there, less than half will graduate.
- Latino teens give birth at rates six times higher than Whites – and 90% of single mothers raising children under 5 live in poverty.
- Latinos are reported to child welfare officials at levels much higher than incidents warrant and their children are removed from homes into short-term foster care at levels 66% higher than would be expected, based on population size.
- Latino youth face significant disparities among those criminally charged (97% higher rates) and are much more likely to be held in detention: Latinos have rates that are 34% higher than Whites.
- Latino homeownership rates are 31% as compared to 60% of Whites – a growing and worsening gap due to higher rates of recent foreclosures disproportionately affecting minorities in general. The homeownership rate for Latinos nationally is nearly 50%.
- Half of Latinos pay 30% or more of household incomes on rent, making a high number vulnerable to losing these homes

#### Report Card on Racial and Ethnic Disparities Findings

Results for the Latino group were notably mixed. The Latino group experienced six indicators that *require intervention* and nine that *need improvement*. However, there were also eight indicators where Latinos fared significantly better than non-Latino Whites. Latinos experienced a geographic disparity for each of the physical environment indicators.<sup>19</sup>

---

<sup>18</sup> Curry-Stevens, A., Cross-Hemmer, A., & Coalition of Communities of Color (2012). *The Latino Community in Multnomah County: An Unsettling Profile*. Portland, OR: Portland State University.

---

<sup>19</sup> Multnomah County Health Department (2014). *Report Card on Racial and Ethnic Disparities*. Multnomah County.



## Section 1: Multnomah County Racial and Ethnic Disparities

- Latinos experienced disparities for each of the indicators in the social and economic category. Three of the six *require intervention*. Specifically, Latinos are more than twice as likely to have children living in poverty, to have children not meeting third-grade reading standards, and to lack a post-high school education.
- Latinos had three indicators in the health behaviors and clinical care categories that *need improvement*: obesity, first trimester prenatal care, and untreated tooth decay. Teen birth rate and lack of health insurance reached the *requires intervention* level. Although the teen birth rate for Latinas has significantly decreased since 1998, the rate remained three and a half times the rate among non-Latina Whites. In addition, Latino adults were two times more likely to lack health insurance than non-Latino Whites.
- Latinos generally fared relatively well in the morbidity and mortality categories. However, three indicators were at the *needs improvement* level: overall health status, HIV incidence, and diabetes mortality rate. The homicide rate reached the *requires intervention* level, with the rate among Latinos being two times greater than non-Latino Whites.
- Latinos experienced a geographic disparity for both the air quality and retail food environment indicators.

### Health Disparities identified for Latinos in Multnomah County Similar disparities identified in more than one report are in Gray

Racial and Ethnic Disparities Report Card	MCFH Data Book	An Unsettling Profile Executive Summary
<b>Health Outcomes</b>		
Teen birth rate	Previous poor birth outcome	Teen birth rate
No first trimester prenatal care	Late or inadequate prenatal care	
Adult obesity	Small for gestational age	
Diabetes mortality	Depression during pregnancy	
Adults reporting fair or poor health		
HIV		
Homicide		
Children grade 1-3 with untreated tooth decay		
Adults without health insurance		
<b>Social, Economic, Physical Environment</b>		
Students not meeting third-grade reading level standards	Not read to daily by a family member	Engagement in child welfare services
Children under 18 in poverty		Income/poverty
Population age 16+ unemployed, but seeking work		Unemployment
Ninth-grade cohort that did not graduate high school in 4 yrs with regular diploma		High school completion
Adults age 25+ with high school education or less		Entry into higher education
Ratio of less healthy food retail to healthier retail		Proportion of income spent in rent
Diesel particulate matter		Homeownership
		Criminal detention rates

## Section 1: Multnomah County Racial and Ethnic Disparities

### Community Story

Ismael Garcia remembers the day in sixth grade that his mother sat him down at their kitchen table in Northeast Portland to talk about sex. He was going to start a sexuality education program at middle school that day, and his mother Isabel, wanted to talk to him first. The conversation made both of them uncomfortable, but Ismael did have questions and Isabel had some answers.

There are few things that are harder for some people to do than talk about sex and sexuality. Parents often hesitate because they are embarrassed or feel that they don't have enough information. Sometimes it's cultural or religious reasons that keep them from talking openly. And children would often rather be *anywhere* other than talking with their parents, especially about sex.

Garcia, now 25, is helping to make talking about sexuality a little easier for members of the Latino community. He works as a Community Health Specialist for the Multnomah County Health Department and as part of a team that is helping the community talk more openly and positively about the sexual health of adolescents.

"I'm here to open up a dialogue," he says. ". . . With kids, with their parents and with the community."

Garcia works with the *Opciones Y Educacion (OYE)* and *Cuidate* programs to provide information and resources to teens and their parents and to break down barriers

that prevent families from talking openly about sex and sexuality.

OYE is a project of a coalition of community members and organizations that includes the Multnomah County Health Department, Cascade AIDS Project, Teatro Milagro, and Educate Ya. The purpose of the coalition is to promote sexual health in Latino communities by increasing open discussion of sexuality, homophobia, and the traditional roles of men and women. Through OYE, Community Health Workers use dialogue, role playing, theater and more to engage community members in positive conversations about sexuality.

By getting the community comfortable with the topic, OYE hopes to make it easier for teens to feel supported by their families and their community and to make active, informed choices about their own health.

"Sexuality is a normal part of who we are," says Molly Franks, Health Educator with the STD, HIV, Hepatitis C Program and a co-worker of Garcia's. "We want to encourage individuals young or old to understand that and to get comfortable with talking about it."

Vanessa La Torre, from Cascade AIDS Project notes that when program staff talk about sexuality, they aren't just talking about the mechanics of sex and disease prevention. The program covers all aspects of sexuality including personal identity, healthy relationships, sexual interests,

traditional roles of men and women, personal and family values, cultural values and more. "All of these play a role in who we are and how we make choices about what we do and don't do," she says.

Franks notes that the stereotype of the Latino community being conservative and not wanting to talk about these issues doesn't hold up in her experience. "The parents we talk with want their kids to have good information. It's inspiring how eager people are and how engaged they get."

Garcia says his work is like a conversation. "Everybody has information to share and add to the conversation." Garcia says a workshop for single mothers held recently in Gresham is a good example of how receptive the community has been. "The moms wanted information and were looking for suggestions about how to talk to their teens about these issues," he says.

From a booth at a community fair, with leaders in the Latino community or with a group of parents from a school, the OYE program promotes information and conversation that help teens have a healthy sense of themselves and good communication with their parents and their partners. The goal is to have teens actively make choices about their sexuality, their health and their lives.

*Originally featured in El Hispanic News*  
<http://www.elhispanicnews.com/tag/multnomah-county-health-department/>



## Section 1: Multnomah County Racial and Ethnic Disparities

### ASIAN AND PACIFIC ISLANDERS IN MULTNOMAH COUNTY

The Asian and Pacific Islander community in Multnomah County is diverse. The Coalition of Communities of Color *The Asian and Pacific Islander Community in Multnomah County: An Unsettling Profile* identifies priority communities characterized in the following groups:

- Pacific Islander communities: Chuukese, Pohnpeian, Samoan, Tongan,
- Small and new refugee-based communities: Hmong, Karen, Rohingya, Burmese, Bhutanese of Nepali origin
- Older refugee-based communities: Cambodian, Laotian
- Older immigrant communities: Asian Indian, Thai, Korean

The Pacific Islander community has grown considerably in Multnomah County. When reporting data, as is commonly done, by combining Asian and Pacific Islanders, disparities in the Pacific Islander community can be masked. The Coalition of Communities of Color report calls out disparities within distinct Asian Pacific American communities. Multnomah County Health Department supplemented the 2014 Report Card on Racial and Ethnic Disparities with a specific Pacific Islander report.<sup>20</sup>

The Coalition of Communities of Color addresses the issue of the “model minority” – the idea that Asians have reached equality with Whites. In many areas parity has not been reached. This perpetuation of this myth obscures disparities among specific Asian and Pacific Islander communities. The report provides an insightful discussion on the challenges and inadequacy of data available to detail the various Asian communities in Multnomah County.

<sup>20</sup> <https://multco.us/file/41217/download>

#### Coalition of Communities of Color: An Unsettling Profile: Executive Summary

A sampling of disparities is included in the chart to the below.<sup>21</sup> In the chart it can be seen that sometimes the experiences of the Asian community can be three times worse (such as the chances of having graduated high school, or the poverty rate among single parent families).

2009	Multnomah County	
	Whites	Asian
Educational Attainment		
Less than high school	6.3%	20.5%
Bachelor's degree	25.8%	23.8%
Graduate/professional degree	16.1%	12.5%
Occupations		
Management & professions	44.7%	36.4%
Service	14.3%	20.0%
Incomes		
Family median	\$71,296	\$57,807
Full time year-round workers	\$44,262	\$35,967
Married couples raising kids	\$81,636	\$63,931
Female raising kids	\$37,485	\$28,270
Per capita	\$32,740	\$22,035
Poverty rate		
All families raising children	7.3%	13.0%
Married couple families	3.3%	9.9%
Female single parents	22.9%	25.1%
Housing value (median)	\$298,300	\$260,300

Source: American Community Survey, 2009.

<sup>21</sup> Curry-Stevens, A. & Coalition of Communities of Color (2012). *The Asian and Pacific Islander Community in Multnomah County: An Unsettling Profile*. Portland, OR: Portland State University.

## Section 1: Multnomah County Racial and Ethnic Disparities

### Report Card on Racial and Ethnic Disparities

#### Findings

For 11 indicators, Asian/Pacific Islanders, did significantly better than non-Latino Whites. However, one indicator *requires intervention*, and five indicators *need improvement*. Asian/Pacific Islanders experienced a geographic disparity for each of the physical environment indicators.<sup>22</sup>

- Asian/Pacific Islanders experienced a disparity for two indicators in the social and economic category, at the *needs improvement* level—third-grade reading level and post-high school education.
- Asian/Pacific Islanders had three other indicators at the *needs improvement* level: first trimester prenatal care, low birth weight, and homicide rates.
- Adults without health insurance was the one indicator at the *requires intervention* level for Asian/Pacific Islanders. The percentage without health insurance is more than two times higher among non-Latino Asian/Pacific Islanders in Multnomah County than among non-Latino Whites.
- Asian/Pacific Islanders experienced a geographic disparity for both the air quality and the retail food environment indicators.

The Key Findings from the Pacific Islander supplement include:<sup>23</sup>

- Pacific Islander children are more than twice as likely to experience poverty as non-Latino White children (28.6% vs. 13.2%, respectively) in Multnomah County, which is consistent with the national disparity. This disparity is at the *needs improvement* level.

When Asian/Pacific Islander racial groups were combined, the disparity in childhood poverty was less severe.

- Pacific Islander adults are more than twice as likely to have no more than a high school education compared to non-Latino White adults (58.8% vs. 27.0%, respectively). This disparity is at the *requires intervention* level. The magnitude of this disparity is considerably larger than that faced by Pacific Islanders nationally.
- Twenty-six percent of Pacific Islanders aged 16 or older are unemployed, compared to 8% of non-Latino Whites. With a disparity ratio of 3.2, unemployment is one of the largest disparities faced by this community and reaches the *requires intervention* level. Yet when the Asian and the Pacific Islander racial groups were combined to assess unemployment, a disparity did not exist. In Multnomah County, this disparity is double the national Pacific Islander unemployment disparity of 1.6. Furthermore, the percent of unemployment among Pacific Islanders in Multnomah County is more than five times higher than the national benchmark for unemployment (25.9% vs. 5%).
- Disparities exist in reproductive health for Pacific Islanders. The rate of births to teen mothers aged 15–19 years is significantly higher among Pacific Islanders than among non-Latino Whites. This disparity is at the *needs improvement* level. When the Asian and the Pacific Islander racial groups were combined, a disparity in teen births did not exist. The teen birth rate among Pacific Islanders in Multnomah County (33.9 per 1,000 female population) is considerably higher than the national benchmark (22 per 1,000 female population).

<sup>22</sup> Multnomah County Health Department (2014). *Report Card on Racial and Ethnic Disparities*. Multnomah County.

<sup>23</sup> Multnomah County Health Department (2015) *Health Disparities among Pacific Islanders in Multnomah County: A supplement to the 2014 Report Card on Racial and Ethnic Disparities*. Multnomah County.

## Section 1: Multnomah County Racial and Ethnic Disparities

- Disparities exist for both low birth weight babies and for mothers accessing prenatal care during the first trimester of pregnancy. Pacific Islander mothers are less likely to access prenatal care during their first trimester and more likely to have low birth weight babies than non-Latino Whites. The prenatal care disparity reaches the *requires intervention* level, and the disparity in low birth weight babies *needs improvement*. For both indicators, the magnitude of the disparity was considerably less when the Asian and the Pacific Islander groups were combined, emphasizing the need to split out these two groups.
- The proportion of Pacific Islander mothers in Multnomah County not accessing prenatal care in the first trimester (62.7%) is nearly three times higher than the Healthy People

2020 national target of 22.1%. The proportion of low birth weight babies born to the Multnomah County Pacific Islander community (9.3%) is also higher than the national Healthy People 2020 target of 7.8%.

- For both coronary heart disease mortality and Years of Potential Life Lost (YPLL), when the Asian and the Pacific Islander groups were combined, Asians/Pacific Islanders fared significantly better than non-Latino Whites. However, when Pacific Islanders are considered alone, their rates are comparable to that of non-Latino Whites.

The table below presents the disparities for Asians followed by a second table presenting disparities for Pacific Islanders.

### Health Disparities identified for Asians in Multnomah County Similar disparities identified in more than one report are in Gray

Racial and Ethnic Disparities Report Card	MCFH Data Book	An Unsettling Profile Executive Summary
<b>Health Outcomes</b>		
No first trimester prenatal care	Late or inadequate prenatal care	
Low birth weight births	Low birth weight	
Adults without health insurance	Poor birth outcome	
Homicide	Small for gestational age	
	Depression during pregnancy	
<b>Social, Economic, Physical Environment</b>		
Students not meeting third-grade reading level standards	Not read to daily by a family member	Educational Attainment less than high school
Adults ages 25+ with high school education or less		Educational Attainment Bachelor's/ Graduate/ professional degree
Diesel particulate matter		Poverty
Ratio of less healthy food retail to healthier retail		Income
		Housing value

## Section 1: Multnomah County Racial and Ethnic Disparities

Health Disparities identified for Pacific Islanders specifically in Multnomah County  
 Similar disparities identified in more than one report are in **Gray**

Racial and Ethnic Disparities Report Card	MCFH Data Book	An Unsettling Profile Executive Summary
<b>Health Outcomes</b>		
No first trimester prenatal care	Late or inadequate prenatal care	
Low birth weight births	Low birth weight	
Adults without health insurance	Poor birth outcome	
Teen birth rate	Small for gestational age	
Homicide	Depression during pregnancy	
<b>Social, Economic, Physical Environment</b>		
Students not meeting third-grade reading level standards	Not read to daily by a family member	Educational Attainment less than high school
Children under 18 in poverty		Poverty
Adults ages 25+ with high school education or less		Educational Attainment Bachelor's/ Graduate/ professional degree
Population age 16+ unemployed, but seeking work		Income
Diesel particulate matter		Housing value
Ratio of less healthy food retail to healthier retail		

## Section 1: Multnomah County Racial and Ethnic Disparities

### Community Story

Roger Walter loved animals when he was growing up on the tropical Micronesian island of Chuuk, before moving to snow-covered New Jersey and then to the drizzly Northwest. “I loved dogs especially,” he said. “But when I came here I jokingly say, ‘I don’t like dogs anymore. I see how much people spend on health insurance for their pets. If I had all that wealth, to get insurance for my dog, I would do that for one person. Or two.’”

Walter leans on a crumb-covered table at the cafeteria of Multnomah University, where he’s preparing to begin his custodial shift. His lunch cools. Walter has health insurance through his work at the school. His wife qualifies for insurance through her employer, too. Three of their four children were born in the United States, and the kids are covered by Medicaid. But Walter’s eldest is 17 - a young woman now. And his “auntie,” who cared for his wife as a child, is growing old. Both women need to see a doctor. But unlike the rest of their family, because of their birthplace, neither qualifies for health insurance.

Instead they worry. And they wait. Portland is home to one of nation’s largest communities from Palau, Federated States of Micronesia and the Marshall Islands, nations that hold agreements with United States called Compacts of Free Association.

<https://multco.us/multnomah-county/news/family-worries-and-waits>

In exchange for allowing the United States military to occupy their land and water, the Islanders were promised security for health and environmental damages. Their island waters were the site of thousands of nuclear bomb detonations after World War II. The agreement allows COFA citizens to live, work and go to school in the United States. But they’re barred, if hard times hit, from receiving public assistance.



“Our people work. We pay our taxes,” he says. “The government would spend less money to allow us insurance than for the emergency fees. At least we could be advised by a doctor.”

Roger Walter, a Chuuk-American, has health insurance through his work. But he worries because his daughter and his aunt are both uninsured. Walter’s daughter, Thursday, is a senior at Parkrose High School. She wants to be a pediatrician, or maybe a nurse. But she hasn’t had a routine checkup in six years. And despite being 17, she’s never had the annual exam that most women begin with puberty.

“When she gets sick we usually take her to urgent care,” Walter

explains. “She’s a young woman. She’s strong. But there’s always a fear of something going wrong. I feel that almost every day with Auntie.”

Walter’s family has spent a lot of time in emergency rooms because his aunt, 71-year-old Ywikiko Santiago, has severe untreated asthma. They constantly apply for free samples of the drug that stabilizes her. When they receive a supply they try to ration it out. “There are times when she can’t get medicine,” he says. “When she’s out, we try not to call 911 when she’s wheezing. But when she passes out, then we call.”

The ambulance has been called to the family’s northeast Portland apartment at least five times. “There are times when they resuscitate her after she’s turned purple,” he says. “I said, ‘there must be a reason you keep coming back.’”

The medics give her oxygen and take her to the hospital, where she remains until she’s stable - sometimes one day and sometimes three.

Her medical bills have added up. They owe nearly \$100,000 now but when collection agencies call he just tells them the truth: She’s in her 70s. She doesn’t work. She has Alzheimer’s. And she doesn’t speak English. “I want to say what it’s like living in the house with her,” he says. “My shoulders are down. There’s no hope. There’s a constant worry, knowing there’s nothing I can do other than wait until it gets worse so we can call 911.”

## Section 1: Multnomah County Racial and Ethnic Disparities

### DISPARITY REPORTS RECOMMENDATIONS

**The Coalition of Communities of Color policy recommendations to address the disparities in all communities profiled.**

1. **Expand funding for culturally-specific services.** Designated funds are required, and these funds must be adequate to address needs. Allocation must recognize the size of communities of color, must compensate for the undercounts that exist in population estimates, and must be sufficiently robust to address the complexity of need that are tied to communities of color. Recognizing the complexity and depth of need that exists for communities of color requires that they are provided with a higher funding base in recognition of the urgent need for ameliorative interventions. Culturally-specific services are the most appropriate service delivery method or communities of color. Service providers within culturally-specific services must be involved in establishing funding formulas for such designations.
2. **Implement needs-based funding for communities of color.** This report illuminates the complexity of needs facing communities of color, and highlights that Whites do not face such issues or the disparities that result from them. Accordingly, providing services for these communities is similarly more complex. The Coalition urges funding bodies to begin implementing an equity-based funding allocation that seeks to ameliorate some of the challenges that exist in resourcing these communities.
3. **Emphasize poverty reduction strategies.** Poverty reduction must be an integral element of meeting the needs of communities of color. A dialogue is needed immediately to kick-start economic development efforts that hold the needs of

communities of color high in policy implementation. Improving the quality and quantity of jobs that are available to people of color will reduce poverty. Current economic development initiatives and urban renewal activities do not address equity concerns nor poverty and unemployment among communities of color. Protected initiatives to support access of minority-owned businesses to contracting dollars, along with small business development initiatives must ensure equitable distribution of resources and the public benefits that flow from such investments.

4. **Reduce disparities with firm timelines, policy commitments and resources.** Disparity reduction across systems must occur and must ultimately ensure that one's racial and ethnic identity ceases to determine one's life chances. The Coalition urges the State, County and City governments, including school boards, to establish firm timelines with measurable outcomes to assess disparities each and every year. There must be zero-tolerance for racial and ethnic disparities. Accountability structures must be developed and implemented to ensure progress on disparity reduction. As a first step, plans for disparities reduction must be developed in every institution and be developed in partnership with communities of color. Targeted reductions with measurable outcomes must be a central feature of these plans. Elements of such an initiative would include:
  - Policies to reflect these commitments are needed to ensure accountability exists in legislation.
  - Accountability structures must be developed and implemented to ensure



## Section 1: Multnomah County Racial and Ethnic Disparities

progress on disparity reduction. As a first step, plans for disparities reduction must be developed in every institution and be developed in partnership with communities of color. Targeted reductions with measurable outcomes must be a central feature of these plans.

- Disparities must be understood institutionally, ideologically, behaviorally and historically. Institutional racism must be a major feature of disparity reduction work.
  - Effectively resource these initiatives and place control of these initiatives in the leadership of communities of color who will lead us to real solutions.
  - Accountability and transparency must feature across all institutional efforts.
  - Annual updates must be conducted and the results available to the general public.
5. **Count communities of color.** Immediately, the Coalition demands that funding bodies universally use the most current data available and use the “alone or in combination with other races, with or without Hispanics” as the official measure of the size of our communities. The minor overcounting that this creates is more than offset by the pervasive undercounting that exists when outsiders measure the size of communities. When “community-verified population counts” are available, the Coalition demands that these be used.
6. **Prioritize education and early childhood services.** The Coalition prioritizes education and early childhood services as a significant pathway out of poverty and social exclusion, and urges that disparities in achievement, dropout, post-secondary education and even early education be prioritized. Significant reductions in dropout rates of youth of color, improvements in graduation rates,

increased access to early childhood education (with correlated reductions on disparities that exist by the time children enter kindergarten) and participation in post-secondary education and training programs is essential for the success of youth.

7. **Expand the role for the Coalition of Communities of Color.** The Coalition of Communities of Color seeks an ongoing role in monitoring the outcomes of disparity reduction efforts and seeks appropriate funding to facilitate this task. Disparity reduction efforts will include the following:
- Establishing an external accountability structure that serves an auditing function to keep local and state governments accountable. This leaves the work less vulnerable to changes in leadership.
  - Creating annual reports on the status of inequities on numerous measures, similar to the disparity tally included in this document.
  - Continuing to work with mainstream groups to advise on changes in data collection, research and policy practices to reduce disparities, undercounting and the invisibility of communities of color.
8. **Research practices that make the invisible visible.** Implement research practices across institutions that are transparent, easily accessible and accurate in the representation of communities of color. Draw from the expertise within the Coalition of Communities of Color to conceptualize such practices. This will result in the immediate reversal of invisibility and tokenistic understanding of the issues facing communities of color. Such practices will expand the visibility of communities of color. Better data collection practices on the race and ethnicity for service users needs to exist.

## Section 1: Multnomah County Racial and Ethnic Disparities

Self-identification is essential, with service providers helping affirm a prideful identification of one's race and ethnicity as well as assurances that no harm will come from identifying as a person of color. The Coalition desires people to be able to identify more than one race or ethnicity, by allowing multiple identifiers to be used. The "multiracial" category is not helpful because no information about one's identity is possible. The Coalition of Communities of Color then wants research practices and usage statistics to accurately and routinely reveal variances and disproportionality by race and ethnicity. The Coalition will consult with researchers and administrators as needed on such improvements.

9. **Fund community development.** Significantly expand community development funding for communities of color. Build line items into state, county and city budgets for communities of color to self-organize, network their communities, develop pathways to greater social inclusion, build culturally-specific social capital and provide leadership within and outside their own communities.
10. **Disclose race and ethnicity data for mainstream service providers.** Mainstream service providers and government providers continue to have the largest role in service delivery. Accounting for the outcomes of these services for communities of color is essential. The Coalition expects each level of service provision to increasingly report on both service usage and service outcomes for communities of color. Data collection tools must routinely ask service users to identify their race and ethnicity, and allow for multiple designations to be specified. These data must then be disclosed in an open and transparent manner. The Coalition of Communities of Color expects to be involved

in the design of these data collection tools. Outcomes by race and ethnicity need to be publicly available on an annual basis.

11. **Name racism.** Before us are both the challenge and the opportunity to become engaged with issues of race, racism and Whiteness. Racial experiences are a feature of daily life whether on the harmful end of such experience or on the beneficiary end of the spectrum. The first step is to stop pretending race and racism do not exist. The second is to know that race is always linked to experience. The third is to know that racial identity is strongly linked to experiences of marginalization, discrimination and powerlessness. The Coalition seeks for those in the White community to aim to end a prideful perception that Multnomah County is an enclave of progressivity. Communities of color face tremendous inequities and a significant narrowing of opportunity and advantage. This must become unacceptable for everyone.

### Multnomah County Health Department Maternal, Child and Family Health Data Book Conclusions and Recommendations

A complex interplay of social, environmental and biological factors establishes each individual's foundation for life-long health or ill health. A healthy community depends on creating the strongest foundations possible for all mothers and their children.

While many mothers and children in Multnomah County are healthy and doing well, significant and persistent racial and ethnic disparities are reflected in indicators and outcomes across the preconception, perinatal, postpartum, and early childhood continuum. These disparities are further exacerbated by additional socioeconomic inequities.



## Section 1: Multnomah County Racial and Ethnic Disparities

In general, women of color, women with lower income, and women with less education and their children are experiencing more adverse health issues and health outcomes than their counterparts.

While individual choices do contribute to health outcomes, the environments in which women live, play, work and learn shape available choices and have a profound impact on health. Social determinants of health across the life course — including socioeconomic status; discrimination by race, ethnicity, gender, and/or class; access to health care and other services; as well as other social and environmental stressors — are factors in the results and disparities outlined in this report. If we are to make progress in improving the health and well-being of all mothers and children in Multnomah County, these factors must be acknowledged and addressed.

The recommendations derived from this report are:

- Use a social determinants of health and life course perspective when designing preventive intervention programs aimed at addressing maternal, child, and family health disparities.
- Incorporate an understanding of developmental origins of disease and developmental neuroscience and their impact on health disparities.
- Community-level policy interventions are needed as well as individual-level or clinical interventions.
- Disparities in the quality of medical care, including prenatal care, must be addressed concomitantly with disparities in access to medical care and health insurance.

### Multnomah County Health Department Racial and Ethnic Disparities Recommendations

#### *Social, Economic, and Political Factors*

While addressing social, economic, and political factors may seem a big task for a local public health agency, Multnomah County Health Department has a responsibility for aligning its internal processes to better address upstream factors—such as racism—that lead to racial and ethnic health disparities. Two ways the Health Department is addressing these factors are through:

- Applying the Equity and Empowerment Lens to internal processes
- Committing to equity and empowerment in workforce development

*Applying the Equity and Empowerment Lens* The Equity and Empowerment Lens is a Multnomah County tool for creating more racially and ethnically equitable policies, processes, and programs. The Health Department is committed to increasing use of the Lens to guide key decisions to redress institutional racism and create more equitable conditions in the department. For instance, the tool will be used to inform how the Health Department makes decisions about allocating resources.

*Committing to Equity and Empowerment in Workforce Development* The Health Department offers training for staff, on health inequity, cultural competence, and related subject areas, that calls for self-reflection and shifts in practice toward racial equity. The Department is also improving its practices for recruiting and retaining employees of color in an intentional effort to build a multiracial and multicultural public health workforce.

#### *Living and Working Conditions*

Much of the Health Department's work focuses on improving living and working conditions, to create healthier options where people live, work, play,

## Section 1: Multnomah County Racial and Ethnic Disparities

learn, and worship. The Health Department is committed to increasing the focus on racial equity in this area by:

- Increasing investment in stages of the life course that can have the greatest impact
- Prioritizing Health in All Policies efforts that reduce disparities
- Building the capacity of the Multnomah County Board of Commissioners, as the local Board of Health, to understand and act on health disparities

*Increasing Investment in Stages of the Life Course that can have the Greatest Impact* The life course health model is a way of considering health over the life span. This model tells us that today's experiences and exposures influence tomorrow's health, and that individual health is strongly affected during critical periods, such as early childhood and adolescence. The life course health model also highlights that the broader community environment strongly affects the ability of individuals to be healthy. Shifting Health Department practice to promote life course health means increasing department investment in early childhood and adolescence among families of color and families living in poverty.

*Prioritizing Health in All Policies Efforts that Reduce Disparities* Health in All Policies is an approach to improving the health of all people by incorporating health considerations into decision-making across sectors, like transportation and planning. The Health Department has experience engaging different sectors in considering health in policy decisions, and will increase its commitment in this area by prioritizing Health in All Policies efforts that reduce disparities.

*Building the Capacity of the Multnomah County Board of Commissioners, as the Local Board of Health, to Understand and Act on Health Disparities* The Multnomah County Board of Commissioners can

act as the Board of Health in order to enhance its ability to make policy decisions that impact the public's health. The Health Department is working with the Board of Commissioners to educate and empower them to act to reduce health disparities. The Health Department will work with the Board of Health to create and carry out a joint plan to monitor efforts to reduce disparities.

### **Public Services and Infrastructure**

In order to improve its capacity as a local public health agency to deliver services that reduce disparities, the Health Department commits to:

- Creating a Public Health Advisory Board to inform Health Department decisions
- Supporting culturally-specific approaches to reducing disparities

*Creating a Public Health Advisory Board to Inform Health Department Decisions* A Public Health Advisory Board is a group of partners, clients, and community members who advise the Health Department on key decisions affecting the public's health. The Health Department will create an Advisory Board to help inform work related to disparities reduction, and to hold the Department accountable for making progress.

*Building up Culturally-Specific Approaches to Reduce Disparities* Many times, services are designed for mainstream culture by default and may not be effective for communities of color. Culturally-specific approaches are a promising strategy for reducing disparities. The Health Department has had some success with strengths-based, culturally-specific approaches, and is committed to building on what has worked, as well as exploring new pathways with community partners.

### **Individual Behaviors**

Multnomah County Health Department is increasingly aware of the improvements that can be

## Section 1: Multnomah County Racial and Ethnic Disparities

made related to awareness of trauma and the use of trauma-informed care and approaches. To help people who experience racial and ethnic disparities heal from trauma and better care for themselves and each other, the Health Department commits to:

- Increasing support for and use of trauma-informed approaches

*Increasing Support for and Use of Trauma-Informed Approaches* Generations of untreated trauma from causes such as racism, poverty, and violence persist in individuals, families, and communities. Trauma disrupts healthy development, harms relationships, and contributes to challenges like substance abuse and domestic violence. Trauma-informed approaches involve recognizing and responding to the effects of all types of trauma. The Health Department is working to increase its capacity to use trauma-informed approaches, both in service delivery and in program planning.

### **Community Health Improvement Plan**

A Community Health Improvement Plan is a long-term, community-driven effort to address public health problems. The Health Department commits to:

- Conducting a Community Health Improvement Plan focused on reducing disparities
- Monitoring progress at reducing disparities

The Health Department will work with current and new partners to ensure a community-led, inclusive, strengths-based and empowering process for reducing disparities and improving health equity in Multnomah County. As part of that process, results from this report will be supplemented with information on the communities' experiences and perceptions. This will both provide context for the disparities enumerated in this report, and highlight disparities not identified in this report.

## Section 2: Healthy Columbia Willamette

### SECTION 2 Healthy Columbia Willamette

#### 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.

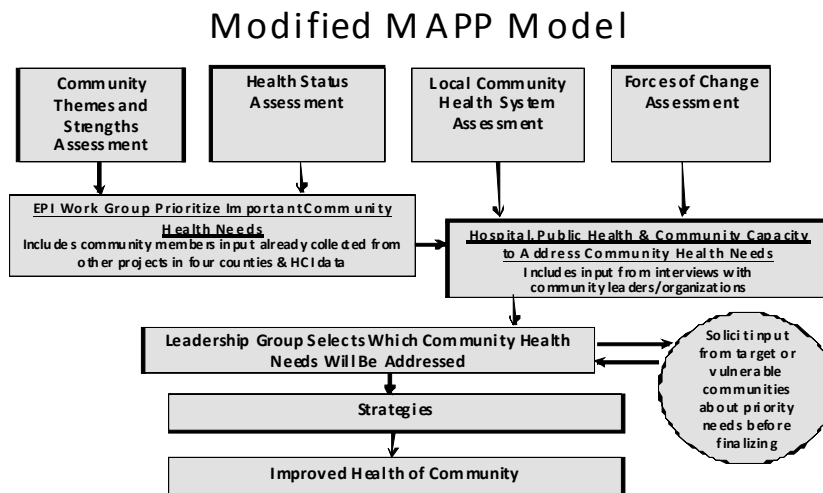
#### Collaborative Origin

In 2010, local health care and public health leaders began to discuss the upcoming need for several community health assessments and health improvement plans within our region in response to the Affordable Care Act and Public Health Accreditation.<sup>24</sup> They recognized that the most efficient and effective approach would be to create a work group responsible for conducting a region-wide community health assessment for Clackamas, Multnomah, Washington counties (Oregon) and Clark County (Washington).

#### Assessment Model

The Healthy Columbia Willamette Collaborative is using a modified version the Mobilizing for Action through Planning and Partnerships (MAPP) assessment model.<sup>25</sup> The MAPP model uses health data and community input to identify the most important community health issues.

Figure 1. Schematic of the Modified MAPP Model



<sup>24</sup> The federal Affordable Care Act, Section 5019(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).

<sup>25</sup> MAPP is a model developed by the National Association of County and City Health Officials (NACCHO)

## Section 2: Healthy Columbia Willamette

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. In all, 202 individuals participated. During these meetings, community members were asked whether they agreed with the issues that were identified through the four assessments. Participants were also asked to add to the list the health issues that they thought were missing. Next, participants voted for what they thought were the most important issues from the expanded list.

## **COMMUNITY THEMES AND STRENGTHS ASSESSMENT**

### **Purpose**

The broad goal of the Community Themes and Strengths Assessment was to identify health-related themes from recent projects engaging community members of Clackamas, Multnomah and Washington counties in Oregon and Clark County in Washington. Conducting the Community Themes and Strengths Assessment served three purposes: 1) to increase the number of community members whose voices could be included; 2) to prevent duplication of efforts and respect the contributions of community members who have already shared their opinions in recent projects; and 3) to utilize the extensive and diverse community engagement work that local community-based organizations, advocacy organizations, and government programs have already done.

Community Themes and Strengths Assessment findings combined with the findings of the other three MAPP assessment components and the community listening sessions provided the Collaborative's Leadership Group with information necessary to select the community

## Section 2: Healthy Columbia Willamette

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 appendices I-IV 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<sup>26</sup> projects, community listening sessions, public assemblies, focus groups, and stakeholder interviews. Not only did their designs vary, the number and included participants were quite different. For example, one project engaged a small group of Somali elders while another was a massive multi-year process engaging thousands of members of the general public. Collectively, these projects’ findings paint a picture of what people living in the four-county area say are the most pressing health issues they and their families face. Although there is not a scientific way to analyze these findings as a whole, it was possible to identify frequently-occurring themes across these projects.

### Findings

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

---

<sup>26</sup> PhotoVoice is a process by which people can identify, represent, and enhance their community by taking photos to record and reflect their community’s strengths and concerns.

## Section 2: Healthy Columbia Willamette

### ***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

### ***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



## Section 2: Healthy Columbia Willamette

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

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

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

The information learned through this compilation of assessment projects showed that when the participants were asked questions about health, community and well-being, they were likely to describe basic needs and social determinants of health<sup>27</sup> rather than specific health conditions. Most of the social determinants prioritized in Table 1

<sup>27</sup>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.

require more than a local response. For instance, “equal economic opportunities/employment” is directly affected by the national economy. This does not mean that the issue isn’t critical, only that it needs to be brought to the attention of those with the reach and authority to have an impact. Local responses could address components of the issue. For example, the Collaborative could choose to support targeted work force development programs that help chronically under-employed populations



## Section 2: Healthy Columbia Willamette

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:

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

## Section 2: Healthy Columbia Willamette

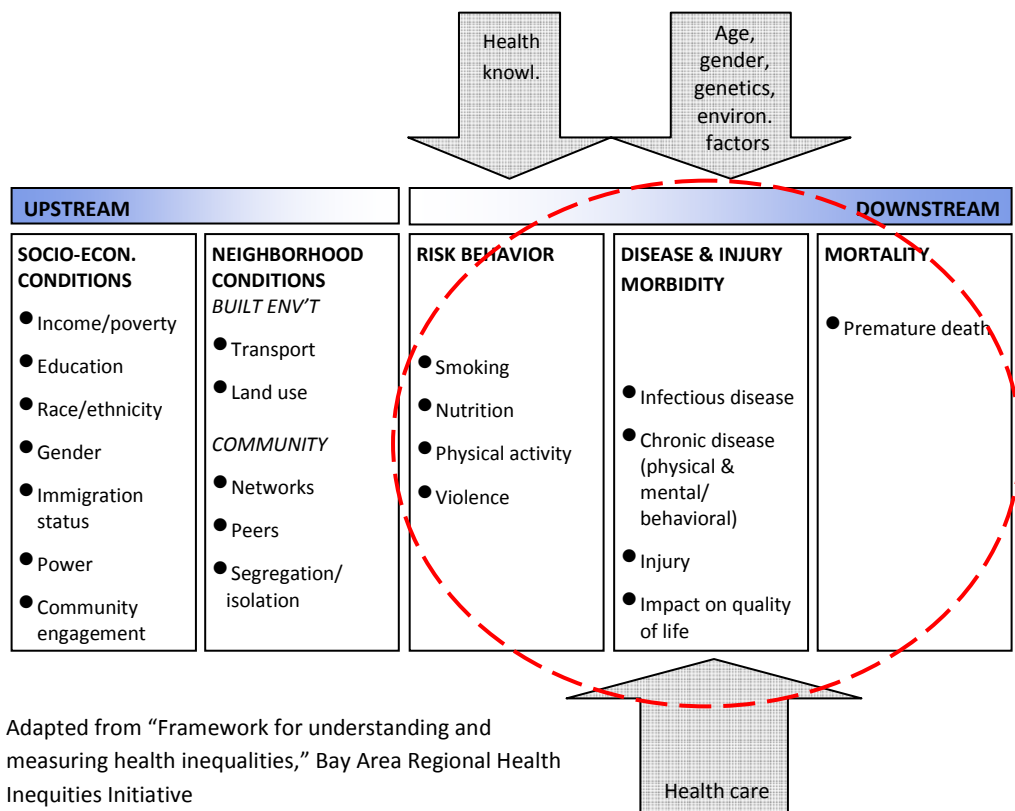
### HEALTH STATUS ASSESSMENT

#### 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.

**Figure 2. Continuum of Health Determinants and Health Outcomes**



#### 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.

## Section 2: Healthy Columbia Willamette

The Workgroup created a list of health indicators that were analyzed and prioritized systematically based on a predetermined set of criteria. Health indicators were placed on the list if they were 1) assigned a “red” or “yellow” status (indicating a health concern) on the Healthy Communities Institute (HCI) web site<sup>28</sup> 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.<sup>29</sup> 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 V. 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.

---

<sup>28</sup> 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](http://www.healthycolumbiawillamette.org).

<sup>29</sup> The Multnomah County Health Department referenced the Pickett Hanlon method of prioritizing public health issues.

## Section 2: Healthy Columbia Willamette

**Table 2. Top Ranked Health Outcomes by County**

<b>Clackamas (OR)</b>	<b>Clark (WA)</b>	<b>Multnomah (OR)</b>	<b>Washington (OR)</b>
<ul style="list-style-type: none"> <li>• Non-transport accident deaths ★</li> <li>• Chlamydia incidence rate ★</li> <li>• Suicide</li> <li>• Breast cancer deaths ★</li> <li>• Adults who are obese ★</li> <li>• Ovarian cancer deaths</li> <li>• Chronic liver disease deaths</li> <li>• Heart disease deaths ★</li> <li>• Drug-related deaths ★</li> <li>• Adults who are overweight</li> <li>• Prostate cancer deaths ★</li> </ul>	<ul style="list-style-type: none"> <li>• Non-transport accident deaths ★</li> <li>• Drug-related deaths ★</li> <li>• Colorectal cancer deaths</li> <li>• Lung cancer deaths</li> <li>• Lymphoid cancer deaths</li> <li>• Diabetes-related deaths ★</li> <li>• Alzheimer's disease deaths ★</li> <li>• Unintentional injury deaths ★</li> <li>• Alcohol-related deaths</li> <li>• Transport accident deaths</li> <li>• Motor vehicle collision deaths</li> </ul>	<ul style="list-style-type: none"> <li>• Non-transport accident deaths ★</li> <li>• Chlamydia incidence rate ★</li> <li>• Diabetes-related deaths ★</li> <li>• Alcohol-related deaths</li> <li>• Drug-related deaths ★</li> <li>• Early syphilis incidence rate</li> <li>• Chronic liver disease deaths</li> <li>• Breast cancer deaths ★</li> <li>• Breast cancer incidence rate</li> <li>• All cancer deaths ★</li> <li>• All cancer incidence rate</li> <li>• Heart disease deaths ★</li> <li>• HIV incidence rate</li> <li>• Suicide ★</li> <li>• Unintentional injury deaths ★</li> <li>• Tobacco-linked deaths</li> </ul>	<ul style="list-style-type: none"> <li>• Suicide ★</li> <li>• Breast cancer incidence rate</li> <li>• Parkinson's disease deaths</li> <li>• All cancer incidence rate</li> <li>• Heart disease deaths ★</li> <li>• Chlamydia incidence rate ★</li> <li>• Unintentional injury deaths ★</li> <li>• Non-transport accident deaths ★</li> <li>• Ovarian cancer deaths</li> <li>• Adults who are obese ★</li> <li>• Chronic liver disease deaths</li> </ul>

**Table 3. Top Ranked Health-Related Behaviors by County**

<b>Clackamas (OR)</b>	<b>Clark (WA)</b>	<b>Multnomah (OR)</b>	<b>Washington (OR)</b>
<ul style="list-style-type: none"> <li>• Adults doing regular physical activity ★</li> <li>• Adults who binge drink: males ★</li> <li>• Adult fruit &amp; vegetable consumption ★</li> <li>• Children with health insurance ★</li> </ul>	<ul style="list-style-type: none"> <li>• Adults with a usual source of health care ★</li> <li>• Adults with health insurance ★</li> <li>• Influenza vaccination rate</li> <li>• Adult fruit &amp; vegetable consumption ★</li> <li>• Teens who smoke</li> <li>• Pap test history</li> <li>• Influenza vaccination rate for adults aged 65+</li> <li>• Mothers receiving early prenatal care ★</li> <li>• Adults doing regular physical activity ★</li> <li>• Adults who smoke ★</li> </ul>	<ul style="list-style-type: none"> <li>• Adults with a usual source of health care ★</li> <li>• Adults with health insurance ★</li> <li>• Mothers receiving early prenatal care ★</li> <li>• Adults who binge drink: female</li> <li>• Adults who binge drink: males ★</li> <li>• Adult fruit &amp; vegetable consumption ★</li> <li>• Adults doing regular physical activity ★</li> <li>• Adults who smoke ★</li> </ul>	<ul style="list-style-type: none"> <li>• Adult fruit &amp; vegetable consumption ★</li> <li>• Adults doing regular physical activity ★</li> <li>• Adults with health insurance ★</li> <li>• Children with health insurance ★</li> </ul>

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

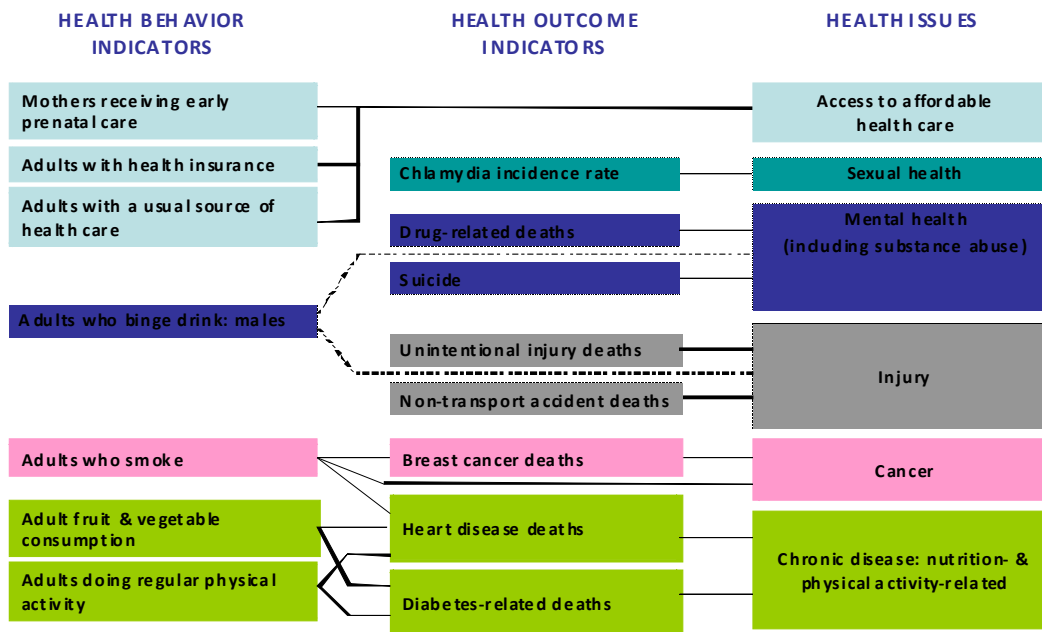
## Section 2: Healthy Columbia Willamette

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

Health Behaviors	Health Outcomes
<ul style="list-style-type: none"> <li>• Adult fruit &amp; vegetable consumption</li> <li>• Adults doing regular physical activity</li> <li>• Adults with health insurance</li> <li>• Adults with a usual source of health care</li> <li>• Adults who binge drink: males</li> <li>• Mothers receiving early prenatal care</li> <li>• Adults who smoke</li> </ul>	<ul style="list-style-type: none"> <li>• Non-transport accident deaths</li> <li>• Suicide</li> <li>• Chlamydia incidence rate</li> <li>• Breast cancer deaths</li> <li>• Heart disease deaths</li> <li>• Unintentional injury deaths</li> <li>• Drug-related deaths</li> <li>• Diabetes-related deaths</li> </ul>
<p><b>The following indicators ranked lower and were not considered for regional action:</b></p>	
<ul style="list-style-type: none"> <li>• Children with health insurance</li> </ul>	<ul style="list-style-type: none"> <li>• Prostate cancer deaths</li> <li>• Alzheimer’s disease deaths</li> <li>• Adults who are obese</li> <li>• All cancer deaths</li> </ul>

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.

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



Note: Solid lines represent a strong evidence base for the relationship and dotted lines represent a suggested relationship.

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

## Section 2: Healthy Columbia Willamette

### Quantitative Data Limitations

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

#### **Data collection**

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

#### **Granularity**

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

#### **Data availability**

The initial list of health outcome and behavior indicators reflected data that was available to each of the four counties. Consequently, it was evident that this selection was not able to assess certain important health areas. Thus, these areas with data

gaps are not represented by the quantitative analysis findings. Health behavior data was limited because few counties had these data available. Youth, mental health and oral health data were very limited or not available at all.

#### **Statistical analysis**

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

#### **Rate Comparison**

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

---

### Data Sources

#### Oregon

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

## Section 2: Healthy Columbia Willamette

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

### Washington

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

### Resources

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

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



## Section 2: Healthy Columbia Willamette

### 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 Lesbian, Gay, Bisexual, Transgender, Questioning or Queer, and Intersex (LGBTQI) community, and populations with mental health and/or substance abuse issues. A complete list of interviewed and surveyed stakeholder organizations is in Appendix VI.

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 VII.

Stakeholders were asked about:

- The health of the populations they serve;
- The list of important health issues identified

## Section 2: Healthy Columbia Willamette

through the Community Themes and Strengths and Health Status Assessments (i.e., access to health care, sexual health, mental health & substance abuse, injury, cancer, and chronic disease);

- Health issues that should be added to the list;
- Their opinions on the three most important health issues;
- Their current work to address important health issues;
- The work they would like to be doing in the future to address important health issues;
- Opportunities and threats to their current capacity to do this work; and
- Resources that would help their organization continue or expand their capacity.

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

## Section 2: Healthy Columbia Willamette

*[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 include 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 finding presented in Table 5. 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, in an interviewee selected "mental health & substance abuse" as one of their top three health issues, their response was

## Section 2: Healthy Columbia Willamette

separated in to two votes; one each for mental health and substance abuse. Their other four votes were kept resulting in their having four vote in total. The majority of stakeholders participating in interviews said that the two health issues, “injury” and “sexual health” were not clear. They suggested that these categories needed to be described better by listing the data or indicators that were included. In response to this feedback, both health issues were described. “Injury” was separated into two categories: falls and poisoning/overdose. “Sexual health” was further clarified to include HIV, Syphilis, and Chlamydia, stemming from the epidemiological data. This feedback from the interviews was used to compile the answer choices on the survey:

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

An additional health issue, “perinatal health” emerged from the following write-in survey responses: “women’s health,” “family health,” “reproductive health,” “prenatal health,” “maternal health,” “maternal and child health,” “pre-conception health,” “healthy pregnancy,” “birth outcomes,” and “Fetal Alcohol Spectrum Disorders.”

After a second study of interview notes, answers that corresponded to this “perinatal health” category were classified and were taken into consideration when identifying health issues prioritized by the interview and survey participants

### ***Prioritized Health Issues***

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

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

These five health issues were the priorities all four counties. Stakeholders working in Clark County, Washington also prioritized cancer and oral health. Stakeholders were asked to identify age groups that were at height risk for each of their top health issues. However, stakeholders only differentiated high risk populations among person 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.”

## Section 2: Healthy Columbia Willamette

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

Region	Clackamas (OR)	Clark (WA)	Multnomah (OR)	Washington (OR)
<b>Access to Health care</b> <ul style="list-style-type: none"> <li>72% of interviews</li> <li>67% of surveys</li> </ul>	<b>Access to Health care</b> <ul style="list-style-type: none"> <li>69% of interviews</li> <li>80% of surveys</li> </ul>	<b>Access to Health care</b> <ul style="list-style-type: none"> <li>79% of interviews</li> <li>59% of surveys</li> </ul>	<b>Access to Health care</b> <ul style="list-style-type: none"> <li>73% of interviews</li> <li>74% of surveys</li> </ul>	<b>Access to Health care</b> <ul style="list-style-type: none"> <li>73% of interviews</li> <li>78% of surveys</li> </ul>
<b>Mental Health</b> <ul style="list-style-type: none"> <li>64% of interviews</li> <li>67% of surveys</li> </ul>	<b>Mental Health</b> <ul style="list-style-type: none"> <li>53% of interviews</li> <li>73% of surveys</li> </ul>	<b>Mental Health</b> <ul style="list-style-type: none"> <li>65% of interviews</li> <li>59% of surveys</li> </ul>	<b>Mental Health</b> <ul style="list-style-type: none"> <li>57% of interviews</li> <li>55% of surveys</li> </ul>	<b>Mental Health</b> <ul style="list-style-type: none"> <li>56% of interviews</li> <li>67% of surveys</li> </ul>
<b>Chronic Disease</b> <ul style="list-style-type: none"> <li>65% of interviews</li> <li>35% of surveys</li> </ul>	<b>Chronic Disease</b> <ul style="list-style-type: none"> <li>67% of interviews</li> <li>37% of surveys</li> </ul>	<b>Chronic Disease</b> <ul style="list-style-type: none"> <li>71% of interviews</li> <li>41% of surveys</li> </ul>	<b>Chronic Disease</b> <ul style="list-style-type: none"> <li>69% of interviews</li> <li>37% of surveys</li> </ul>	<b>Chronic Disease</b> <ul style="list-style-type: none"> <li>69% of interviews</li> <li>29% of surveys</li> </ul>
<b>Substance Abuse</b> <ul style="list-style-type: none"> <li>64% of interviews</li> <li>26% of surveys</li> </ul>	<b>Substance Abuse</b> <ul style="list-style-type: none"> <li>53% of interviews</li> <li>17% of surveys</li> </ul>	<b>Substance Abuse</b> <ul style="list-style-type: none"> <li>65% of interviews</li> <li>34% of surveys</li> </ul>	<b>Substance Abuse</b> <ul style="list-style-type: none"> <li>57% of interviews</li> <li>19% of surveys</li> </ul>	<b>Substance Abuse</b> <ul style="list-style-type: none"> <li>56% of interviews</li> <li>19% of surveys</li> </ul>
<b>Culturally Competent Services/Data</b> <ul style="list-style-type: none"> <li>6% of interviews</li> <li>33% of surveys</li> </ul>	<b>Culturally Competent Services/Data</b> <ul style="list-style-type: none"> <li>7% of interviews</li> <li>40% of surveys</li> </ul>	<b>Cancer</b> <ul style="list-style-type: none"> <li>32% of interviews</li> <li>3% of surveys</li> </ul>	<b>Culturally Competent Services/Data</b> <ul style="list-style-type: none"> <li>8% of interviews</li> <li>39% of surveys</li> </ul>	<b>Culturally Competent Services/Data</b> <ul style="list-style-type: none"> <li>7% of interviews</li> <li>41% of surveys</li> </ul>
<b>Oral Health</b> <ul style="list-style-type: none"> <li>10% of interviews</li> <li>12% of surveys</li> </ul>	<b>Cancer</b> <ul style="list-style-type: none"> <li>22% of interviews</li> <li>3% of surveys</li> </ul>	<b>Oral Health</b> <ul style="list-style-type: none"> <li>15% of interviews</li> <li>17% of surveys</li> </ul>	<b>Perinatal Health</b> <ul style="list-style-type: none"> <li>20% of interviews</li> <li>3% of survey</li> </ul>	<b>Cancer</b> <ul style="list-style-type: none"> <li>22% of interviews</li> <li>4% of surveys</li> </ul>
<b>Domestic Violence</b> <ul style="list-style-type: none"> <li>4% of interviews</li> <li>17% of surveys</li> </ul>	<b>Oral Health</b> <ul style="list-style-type: none"> <li>11% of interviews</li> <li>10% of surveys</li> </ul>	<b>Culturally Competent Services/Data</b> <ul style="list-style-type: none"> <li>0 interviews</li> <li>31% of surveys</li> </ul>	<b>Cancer</b> <ul style="list-style-type: none"> <li>18% of interviews</li> <li>3% of surveys</li> </ul>	<b>Domestic Violence</b> <ul style="list-style-type: none"> <li>2% of interviews</li> <li>19% of surveys</li> </ul>
<b>Cancer</b> <ul style="list-style-type: none"> <li>17% of interviews</li> <li>2% of surveys</li> </ul>	<b>Domestic Violence</b> <ul style="list-style-type: none"> <li>2% of interviews</li> <li>17% of surveys</li> </ul>	<b>Domestic Violence</b> <ul style="list-style-type: none"> <li>9% of interviews</li> <li>9% of surveys</li> </ul>	<b>Oral Health</b> <ul style="list-style-type: none"> <li>10% of interviews</li> <li>8% of surveys</li> </ul>	<b>Perinatal Health</b> <ul style="list-style-type: none"> <li>18% of interviews</li> <li>0 surveys</li> </ul>
<b>Perinatal Health</b> <ul style="list-style-type: none"> <li>14% of interviews</li> <li>4% of surveys</li> </ul>	<b>Perinatal Health</b> <ul style="list-style-type: none"> <li>18% of interviews</li> <li>0 surveys</li> </ul>	<b>Sexual Health</b> <ul style="list-style-type: none"> <li>12% of interviews</li> <li>3% of surveys</li> </ul>	<b>Domestic Violence</b> <ul style="list-style-type: none"> <li>2% of interviews</li> <li>13% of surveys</li> </ul>	<b>Oral Health</b> <ul style="list-style-type: none"> <li>11% of interviews</li> <li>7% of surveys</li> </ul>
<b>Sexual Health</b> <ul style="list-style-type: none"> <li>12% of interviews</li> <li>2% of surveys</li> </ul>	<b>Sexual Health</b> <ul style="list-style-type: none"> <li>9% of interviews</li> <li>3% of surveys</li> </ul>	<b>Perinatal Health</b> <ul style="list-style-type: none"> <li>9% of interviews</li> <li>3% of surveys</li> </ul>	<b>Sexual Health</b> <ul style="list-style-type: none"> <li>12% of interviews</li> <li>3% of surveys</li> </ul>	<b>Sexual Health</b> <ul style="list-style-type: none"> <li>9% of interviews</li> <li>4% of survey</li> </ul>

## Section 2: Healthy Columbia Willamette

### **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<sup>30</sup> 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 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

---

<sup>30</sup> Access to health care, mental health, chronic disease, substance abuse, culturally competent services/data, oral health (Clark County), and Cancer (Clark County)

## Section 2: Healthy Columbia Willamette

streams, and by providing services related to social determinants of health (job training, housing, etc).

- Learn from the CCO model to inform the transformation of the mental health system.

### Limitations

An iterative approach was used to identify important health issues from which stakeholders were asked to prioritize (see page 5). As a result, those stakeholders participating in interviews did not have the opportunity to “vote for” or select health issues that were not on the original list or that they did not think of themselves. The stakeholders taking the survey benefited from the

thinking of those interviewed because the additional health issues identified during the interviews were included on the list from which they were asked to select their top three most important. It is unknown how or if interviewees would have “voted” for different health issues if they were provided with the expanded list from the survey.

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

---

### Resources

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

- New Requirements for Charitable 501(c) (3) Hospitals under the Affordable Care. Internal Revenue Service. Available from: [http://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/New-Requirements-for-501\(c\)\(3\)-Hospitals-Under-the-Affordable-Care-Act](http://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/New-Requirements-for-501(c)(3)-Hospitals-Under-the-Affordable-Care-Act)
- IRS Form 990, Schedule H, Part V. Available from: <http://www.irs.gov/pub/irs-pdf/f990sh.pdf>
- Notice and Request for Comments Regarding the Community Health Needs Assessment Requirements for Tax-exempt Hospitals. Available from: <http://www.irs.gov/pub/irs-drop/n-11-52.pdf>
- Oregon Administrative Rule 410-141-3145, Community Health Assessment and Community Health Improvement Plans. Available from: [http://arcweb.sos.state.or.us/pages/rules/oars\\_400/oar\\_410/410\\_141\\_3000-3430.html](http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_410/410_141_3000-3430.html)
- Community Health Assessments and Community Health Improvement Plans, Guidance for Coordinated Care Organizations. Available from: <https://cco.health.oregon.gov/Documents/resources/CHA-guidance.pdf>
- Public Health Accreditation. Public Health Accreditation Board. Available from: <http://www.phaboard.org/>
- Mobilizing for Action through Planning and Partnerships (MAPP). National Association of County and City Health Officials. Available from: <http://www.naccho.org/topics/infrastructure/mapp/>
- CDC Chronic Disease Prevention and Health Promotion, Healthy Aging. Available from: <http://www.cdc.gov/chronicdisease/resources/publications/AAG/aging.htm>
- Healthy Columbia Willamette regional website. Healthy Columbia Willamette Collaborative. Available from: <http://www.healthycolumbiawillamette.org>



## Section 2: Healthy Columbia Willamette

### 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 X.

#### 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.

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

## Section 2: Healthy Columbia Willamette

Forces of Change Assessments. See Table 6 below.)

- 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 XI for the complete discussion guide and Appendix XII for the list of health issues used during the discussions in multiple languages.

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

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

### Participants

There were, on average, 14 participants attending each session, though the range in attendance between sessions was between one and 34 participants. Before small group discussions, participants were asked to complete an anonymous survey collecting demographic information. This was done on a voluntary basis and did not affect whether a person could participate or receive a gift card. Almost 96% of participants completed surveys. A copy of the survey in English is in Appendix XIII. 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).<sup>31</sup> 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

<sup>31</sup> 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).

## Section 2: Healthy Columbia Willamette

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. 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 (to this question) returned from residents living in each zip code in the four-county area. The darker the area on the map, the more participants reported living there. Following each session, many participants expressed their appreciation for the opportunity to speak about their priorities and needs, and 26% of participants signed up on a contact list so they can be invited to other events, kept informed about how the information collected through the community listening sessions was used, and be informed about upcoming changes in health services and policies. Many participants also expressed that holding these types of groups is an effective way to help reduce social isolation and empower people to become involved in their neighborhoods.

## Section 2: Healthy Columbia Willamette

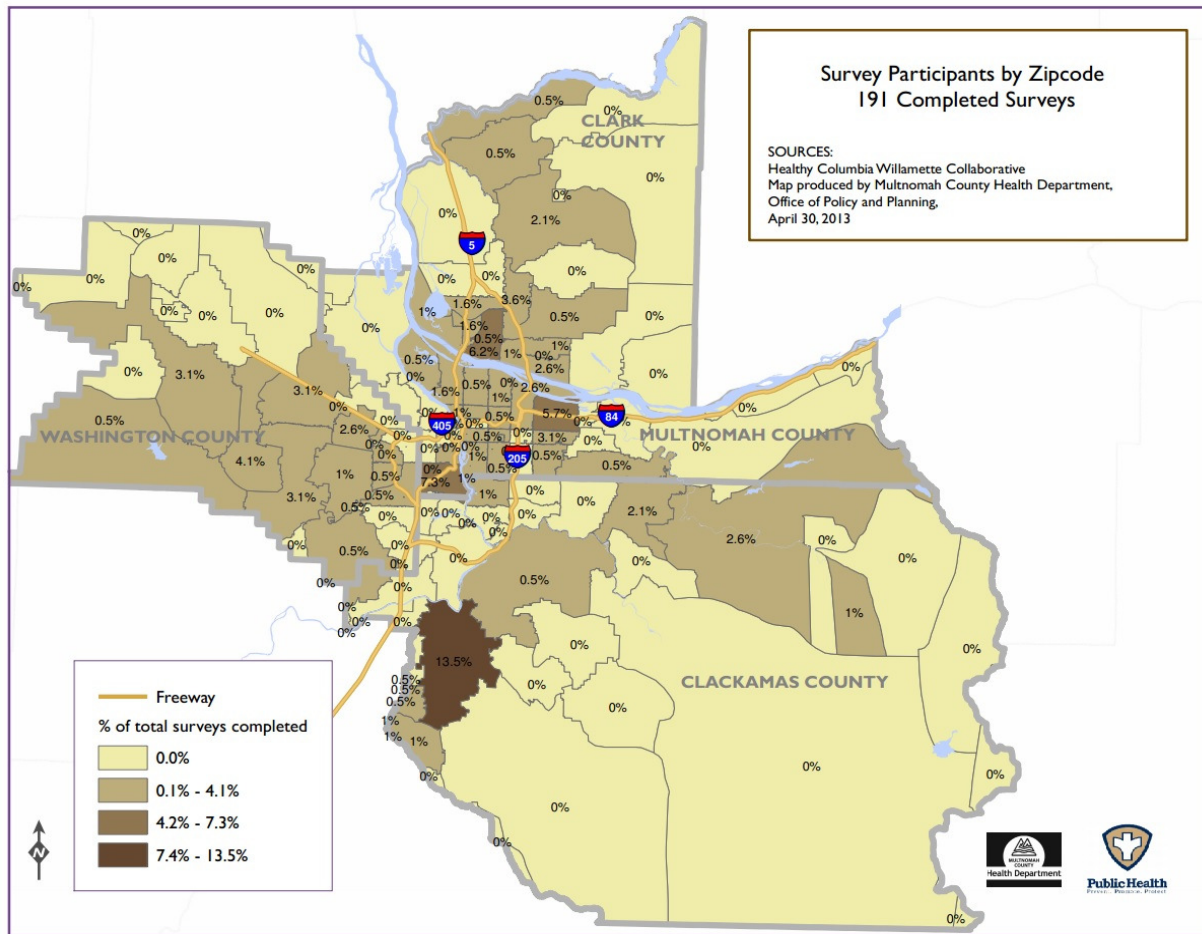
**Table 7. Participant Demographics** – Total may not equal 100% due to rounding.

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

<sup>32</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.

## Section 2: Healthy Columbia Willamette

Figure 4. Survey Participants by Zip Code in the Four-County Region<sup>33</sup>



### 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.

<sup>33</sup>191 of the 196 survey respondents provided a zip code.

## Section 2: Healthy Columbia Willamette

### ***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



## Section 2: Healthy Columbia Willamette

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.



## Section 2: Healthy Columbia Willamette

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

## Section 2: Healthy Columbia Willamette

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.

## Section 2: Healthy Columbia Willamette

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

## Section 2: Healthy Columbia Willamette

drug abuse and distribution more severely, more restrictions on medical marijuana, strict rules for medication and alcohol advertisements, and regulations to monitor provider prescriptions and patient need for medications.

### ***Access to Affordable Health Care***

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

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

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

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

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

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

## Section 2: Healthy Columbia Willamette

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.

## Section 2: Healthy Columbia Willamette

### ***Improve Community Access to Health Data and Information about Health Services***

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

### ***Improve Cultural Competency of the Health Care System***

Improving cultural competency at all levels of the health care system was talked about in most discussions about health issues. Many participants emphasized the need to make sure that any efforts made to improve health care and services in the four-county area would benefit *all* community members. Specifically, this meant producing materials and resources in languages other than English and making them available to cultural

communities that may not frequent the same locations as others. This also meant ensuring quality interpretation services at all levels of health care and training providers to better meet the specific needs of the cultural communities they serve.

### **Limitations**

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

---

## **Resources**

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

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



**APPENDIX I: Community Engagement/Assessment Projects Included in Inventory**

Project Name, Organization, Date	Project Description: Overview, Objectives, Methods, Populations Engaged	Geographic Area
<p><b>ACHIEVE (Action Communities for Health, Innovation and Environmental Change) Community Multnomah County Health Department 2009</b></p>	<p>The overall focus was to increase equitable and culturally relevant policies to promote tobacco-free and smoke-free environments, opportunities for physical activity, and healthy food. The assessment provided an inclusive, empowering political process through group discussions, walking tours, key leader interviews, and organization tours. The project engaged the general population of Multnomah County with specialized efforts in faith based, African-American, low-income communities.</p>	<p>Multnomah (OR)</p>
<p><b>African American Health Coalition CPPW Final Report 2012</b></p>	<p>The coalition conducted interviews and surveys of African-American members involved in the African American Health Coalition exercise program in North and Northeast Portland. Topics included the retail and food environment, community gardens, and park/recreation facility use and barriers.</p>	<p>Multnomah (OR)</p>
<p><b>The Asian and Pacific Islander Community in Multnomah County: An Unsettling Profile Coalition of Communities of Color 2012</b></p>	<p>This report documents the experiences of the Asian and Pacific Islander community in Multnomah County using data from the Census and the American Community Survey and leverages a range of input given by communities of color. The report also includes recommendations and calls for action.</p>	<p>Multnomah (OR)</p>
<p><b>Beaverton Community Vision Action Plan Update City of Beaverton 2012</b></p>	<p>The City of Beaverton surveyed Beaverton residents to share success stories, identify challenges, and let them know how the priorities identified in the Community Vision Action Plan were progressing.</p>	<p>Washington (OR)</p>
<p><b>Cascade AIDS Project Strategic Planning 2009-2014 Data Collection Report 2009</b></p>	<p>To receive insight on what areas of improvement were desired within the service scope of Cascade AIDS Project, staff members facilitated focus groups and conducted a survey with the following populations: women living with HIV, Latino men who have sex with men, African-American men who have sex with men, White men who have sex with men, youth, communities of color leadership (African-American and Latino), Clark County residents, and people living with HIV (mixed population).</p>	<p>Clackamas (OR) Clark (WA) Multnomah (OR) Washington (OR)</p>
<p><b>Causa/Oregon Latino Health Coalition and NW Health Foundation Latino Health Assembly 2010</b></p>	<p>This assembly brought together Latino community members, as well as policy makers, health care advocates, and legislators to discuss expanded access for uninsured Latino children to the Healthy Kids Program and increasing state funding for safety net and community clinics.</p>	<p>Clackamas (OR) Multnomah (OR) Washington (OR)</p>
<p><b>Clackamas County Children's Commission Community Assessment Clackamas County Children's Commission Head Start, Clackamas Education Service District 2012</b></p>	<p>This assessment analyzed service area data to promote program development per Head Start federal requirements. A survey asked questions to Head Start families about their perceptions of their community, social connectedness, health system, and whether they think their family is healthy.</p>	<p>Clackamas (OR)</p>
<p><b>Clackamas County Community Health Improvement Plan Clackamas County Department of Health, Housing, and Human Services 2012</b></p>	<p>This report was intended to both guide local efforts over the next five years to improve overall health of the Clackamas County population, and to meet the requirements of the Public Health Accreditation Board. Community meetings were held in which the general population was invited to identify priorities related to health, education and other topics.</p>	<p>Clackamas (OR)</p>
<p><b>Communities of Color in Multnomah County: An Unsettling Profile Coalition of Communities of Color 2010</b></p>	<p>This report documents the experiences of communities of color in Multnomah County using data from the Census and the American Community Survey and leverages a range of input given by communities of color. The report also includes recommendations and calls for action.</p>	<p>Multnomah (OR)</p>



## Section 2: Healthy Columbia Willamette

Project Name, Organization, Date	Project Description: Overview, Objectives, Methods, Populations Engaged	Geographic Area
<b>Community Health Partnership: SNAP Roundtable</b> <i>Oregon Public Health Institute</i> 2009	The institute conducted roundtable discussions with stakeholders and community members about nutrition and health promotion within the Supplemental Nutrition Assistance Program (SNAP). Participants shared expertise and information, and contributed to ongoing conversations about how best to promote health and good nutrition for low-income Oregonians.	Clackamas (OR) Multnomah (OR) Washington (OR)
<b>Community Value Assessment of North by Northeast Community Health Center</b> 2012	The center conducted surveys, focus groups and phone interviews with the clinic's former and current patient base (residents of N/NE Portland who were low-income, many of whom were African-American) about health concerns and recommendations for the clinic to address health concerns in the future.	Multnomah (OR)
<b>Comprehensive Plan Update</b> <i>Washington County</i> 2010	Organizations, coalitions, networks and community members involved in issues related to children and families participated in interviews addressing successes, challenges, and changes in conditions related to child/family programs.	Washington (OR)
<b>engAGE in Community</b> 2012	Telephone survey of people 60+ in six communities within Clackamas County to assess assets and residents' perceptions of current and future resources required to improve livability or 'age-friendliness.'	Clackamas (OR)
<b>Focus Group Discussions with Housing, Job Training and Employment Professionals</b> <i>Multnomah County Health Department</i> 2009	These focus group discussions about housing and employment issues with African-American community members were used to inform help design of Multnomah County Health Department's Healthy Birth Initiative program.	Multnomah (OR)
<b>Growing Healthier: Planning for a Healthier Clark County</b> <i>Clark County Public Health Advisory Council, Clark County Public Health</i> 2012	This report outlined policy recommendations on ways that Clark County's Comprehensive Growth Management Plan can better address health issues. Outreach efforts with the general population included public meetings, key stakeholder interviews and meetings, presentations to community groups, and online surveys.	Clark (WA)
<b>Healthy Active Communities for Portland's Affordable Housing Families</b> <i>Oregon Public Health Institute</i> 2011	This four-year project aimed to shape policies and neighborhood environments to increase healthy eating and active living for children and families living in Portland's affordable housing communities. This initiative included a PhotoVoice component with residents of multi family housing developments.	Multnomah (OR)
<b>Healthy Communities: Building Capacity Based on Local Tobacco Control Efforts</b> <i>Oregon Health Authority</i> 2011	This report described the process for developing the Healthy Communities: Building Capacity program conducted in Oregon from 2008 through 2011, and the results of the capacity-building phase. It utilized the CHANGE tool, which is a data-collection and planning resource for community members wanting to make their community a healthier place to live, work, play, and learn.	Clackamas (OR) Multnomah (OR) Washington (OR)
<b>Healthy Eating at Farmer's Markets: The Impact of Nutrition Incentive Programs</b> <i>Oregon Public Health Institute</i> 2011	Supplemental Nutrition Assistance Program (SNAP) customers of farmer's markets were surveyed to evaluate the impact of the Nutrition Incentive Programs at selected markets in the Portland area.	Multnomah (OR)
<b>Healthy Eating/Active Living Partnership</b> <i>Portland State University, Multnomah County Health Department</i> 2009	Through community-based participatory research and a PhotoVoice project, Latino community members and children of Portland's Portsmouth neighborhood were engaged to create a healthier built environment and public policies that reduce the disproportionately high rate of obesity in low income and minority communities (particularly among children).	Multnomah (OR)
<b>Hillsboro 2020 Vision and Action Plan</b> <i>Hillsboro City Council</i> 2010	To develop a picture of the community in the year 2020 as seen by citizens from a variety of backgrounds, cultures and interests, the Plan's revision process in 2010 engaged 1,000 people from the general population through multiple venues and outreach opportunities.	Washington (OR)

## Section 2: Healthy Columbia Willamette

Project Name, Organization, Date	Project Description: Overview, Objectives, Methods, Populations Engaged	Geographic Area
<b>HOPE (Healthy Oregon Partnership for Equity) Coalition Five Year Health Equity Plan 2012</b>	This plan identified the most pressing health equity needs for Multnomah, Washington, Marion, & Clackamas Counties, drew from interviews and community forums and built upon years of community advocacy efforts in the region.	Clackamas (OR) Multnomah (OR) Washington (OR)
<b>Immigrant and Refugee Community Organization Shaping Our Future: Community Needs Assessment Conference 2010</b>	This all-day conference allowed immigrant and refugee community members to prioritize their needs, engage in facilitated group discussions, and interface with policymakers.	Clackamas (OR) Multnomah (OR) Washington (OR)
<b>Improving Access to Affordable Health Care: An Outreach Audit of North Clackamas County Residents Living Below 200% of Poverty Clackamas County Department of Health, Housing, and Human Services 2011</b>	A bilingual survey was sent to North Clackamas County residents to gather information about the health activities and social needs of this community. Findings informed service decisions and outreach efforts to residents who live below 200 percent of the federal poverty level.	Clackamas (OR)
<b>The Latino Community in Multnomah County: An Unsettling Profile Coalition of Communities of Color 2012</b>	This report was prepared to ensure that the experiences of communities of color are widely available. The information collected from community members was meant to determine and illustrate disparities that might not be seen in census data.	Multnomah (OR)
<b>Legacy Health Community Needs Assessment 2011</b>	This assessment included over 100 interviews with various stakeholders within the four-county Portland metropolitan area which covers Legacy Health's greater service area. The purpose of the assessment was to determine the elements within the health factors that have the greatest impact on our communities and to compare them with Legacy's strategic priorities, available expertise and available resources.	Clackamas (OR) Clark (WA) Multnomah (OR) Washington (OR)
<b>Legacy Salmon Creek Hospital Community Needs Assessment and Implementation Strategies Plan Legacy Health 2012</b>	This assessment included interviews with various stakeholders within the primary service area (five mile radius) of Legacy Salmon Creek Hospital in Clark County. The purpose of the assessment was to determine the elements within the health factors that have the greatest impact on our communities and to compare them with Legacy's strategic priorities, available expertise and available resources.	Clark (WA)
<b>Lessons from the Field: Portland, Oregon: Kelly GROW: Integrating Healthy Eating and Active Learning (HEAL) at Kelly Elementary Oregon Public Health Institute 2010</b>	Through engaging with 3rd-5th graders in Kelly Elementary School's SUN afterschool program by having them create "Personal Meaning Maps", this exercise helped determine the impact of the Kelly GROW project.	Multnomah (OR)
<b>Multnomah County Community Health Assessment Multnomah County Health Department 2011</b>	This assessment included interviews, surveys and focus groups with various populations to learn the most important health-related issues according to people in Multnomah County.	Multnomah (OR)
<b>Multnomah County Health Equity Initiative: Unnatural Causes Multnomah County Health Department 2009</b>	Through a hosted "report back" session as well as surveys with community members and county employees, this process helped provide insight into the levels of concern regarding a list of selected health-related issues.	Multnomah (OR)
<b>The Native American Community in Multnomah County: An Unsettling Profile Coalition of Communities of Color 2012</b>	This report documents the experiences of the Native American community in Multnomah County using data from the Census and the American Community Survey and leverages a range of input given by communities of color. The report also includes recommendations and calls for action.	Multnomah (OR)

## Section 2: Healthy Columbia Willamette

Project Name, Organization, Date	Project Description: Overview, Objectives, Methods, Populations Engaged	Geographic Area
<b>Oregon Food Bank Nutrition Education Program Long-Term Follow-up Survey 2010</b>	Through surveys and interviews with Operation Frontline course participants, this process identified measurable lifestyle changes among nutrition education class participants, gathered feedback about the class, and created a baseline for future long-term surveys of the program and its Oregon Food Bank participants. Of Operation Frontline participants, the majority were 50+ in age, while others were disabled adults in low-income housing, parents of pre-school and school-aged children, single adults and families.	Clackamas (OR) Clark (WA) Multnomah (OR) Washington (OR)
<b>Oregon Health Improvement Plan Oregon Health Policy Board, Oregon Health Authority 2010</b>	A series of forums and public input surveys with community members across Oregon resulted in recommendations to improve the lifelong health of Oregonians, prevent chronic disease, and stimulate innovation and collaboration within our communities.	Clackamas (OR) Multnomah (OR) Washington (OR)
<b>Oregon Latino Agenda for Action Summit 2010</b>	This event focused on finding consensus on the issues facing Latinos in Oregon, on ways to address those issues, and finally on which issue should be our first priority. Group discussion topics among varying community members and stakeholders included health, economics, and education	Clackamas (OR) Multnomah (OR) Washington (OR)
<b>Oregon Medicare-Medicaid Listening Groups: Final Report Oregon Health Authority 2011</b>	Listening groups comprised of individuals eligible for dual enrollment for Medicare-Medicaid were convened across Oregon. These events informed Oregon Health Authority's Design Contract proposal for individuals who would be directly impacted.	Clackamas (OR) Multnomah (OR) Washington (OR)
<b>Overview of Hispanics in an Aging Population: A supplement to the enAGE in Community initiative 2011</b>	This project interviewed Latino Baby Boomers as well as younger Latino community members in order to understand and gauge the age-friendliness of Clackamas County.	Clackamas (OR)
<b>Partnering for Student Success-The Cradle to Career Framework: Report To The Community 2010</b>	The Cradle to Career strategic framework was developed through data collection and group conversations with a variety of stakeholders, including Multnomah County residents and community members from organizations committed to student academic/social growth. The framework was a set of educational and student support goals and a plan to coordinate community efforts to achieve them.	Multnomah (OR)
<b>The Path to Economic Prosperity: Equity and the Education Imperative Greater Portland Pulse 2011</b>	The report was developed so that elected officials, community leaders, and the public can have access to up-to-date, consistent, measurable data in order to engage in informed regional and community decisions. The process involved people across the region, from Hillsboro to Gresham and Wilsonville to Vancouver.	Clackamas (OR) Clark (WA) Multnomah (OR) Washington (OR)
<b>Patient Centered Primary Care Home Implementation Task Force Report Oregon Health Authority, NW Health Foundation 2011</b>	This report dealt with workgroups developed as a result of feedback from targeted interviews/surveys conducted by Oregon Health Authority and NW Health Foundation in 2010 and 2011. This report provides recommendations that would support the goal to have 75% of Oregonians accessing care in a Patient-Centered Primary Care Home by 2015.	Clackamas (OR) Multnomah (OR) Washington (OR)
<b>Perceived and Actual Diabetes Risk in the Chinese and Hispanic/Latino Communities in Portland, Oregon Portland State University 2011</b>	This was a community-based participatory research study surveying Chinese and Hispanic/Latino immigrants in Portland about diabetes risk and awareness. The report assessed the association between perceived and actual risk and identified factors associated with disease risk.	Multnomah (OR)

## Section 2: Healthy Columbia Willamette

Project Name, Organization, Date	Project Description: Overview, Objectives, Methods, Populations Engaged	Geographic Area
<b>Portland Mercado: Community Economic Development to Revitalize, Uplift, and Empower Adelante Planning, Hacienda Community Development Corporation, Portland State University 2011</b>	Over 200 Portland-area Latinos were interviewed with open-ended questions about entrepreneurial attitudes and assets, consumer habits and shopping perceptions, and interest in a new Mercado in the Portland area.	Multnomah (OR)
<b>Portland Plan City of Portland Bureau of Planning and Sustainability 2012</b>	This multi-faceted community engagement project was intended to inform and develop a 25-year strategic plan for Portland. It included processes in goal-setting, discussing obstacles, and generating ideas about what the community really wants for the future. Multiple listening sessions and subcommittees were formed to process all information gathered.	Multnomah (OR)
<b>Project Access Now 2008-2010 Program Evaluation 2010</b>	In order to effectively improve the health of the community, Project Access Now implemented a program evaluation in the midst of their strategic planning efforts that engaged the Project's clients via surveys.	Clark (WA) Multnomah (OR) Washington (OR)
<b>Providence Milwaukie Hospital and Providence Willamette Falls Medical Center-Community Health Needs Assessment 2012</b>	In order to capture a comprehensive picture of community needs for these hospitals, Providence utilized a supplemental survey conducted with 2,500 individuals who participated in the Oregon Health Study and who live in these facilities' service areas.	Clackamas (OR)
<b>Providence Portland Medical Center- Community Health Needs Assessment 2012</b>	In order to capture a comprehensive picture of community needs for this Medical Center, Providence conducted community stakeholder interviews, focus groups, and surveys for people living in its primary and secondary service areas.	Multnomah (OR)
<b>Providence St. Vincent Medical Center- Community Health Needs Assessment 2012</b>	In order to capture a comprehensive picture of community needs for this Medical Center, Providence conducted community stakeholder interviews, focus groups, and surveys for people living in its primary and secondary service areas.	Clackamas (OR) Multnomah (OR) Washington (OR)
<b>Public Health Improvement Partnership Agenda for Change Action Plan: Initial Priorities and First Steps for Advancing Washington's Public Health System Washington Health Authority 2012</b>	This process surveyed multiple stakeholders (including community members) with the purpose of informing and driving the course of change for public health in Washington for the next three-to-five years.	Clark (WA)
<b>Regional Equity Atlas Project Action Agenda Coalition for a Livable Future 2007-2009</b>	The Action Agenda was a blueprint for action that responded to the research and direction from the community. It established policy priorities that aimed to address systemic causes of inequities in access to essential community resources and to opportunities for prosperity and good health. The Agenda was created between 2005 and 2007, and was unveiled in a series of forums that gathered feedback from community members from 2007 to 2009.	Clackamas (OR) Clark (WA) Multnomah (OR) Washington (OR)
<b>Roadmap to Health Communities: A Community Health Assessment Clackamas County Department of Health and Human Services 2012</b>	This process gathered community information from as many diverse citizens as possible (via grassroots dialogue and surveys) on needs and priorities for building a healthy community while using limited resources wisely.	Clackamas (OR)

## Section 2: Healthy Columbia Willamette

Project Name, Organization, Date	Project Description: Overview, Objectives, Methods, Populations Engaged	Geographic Area
<b>Running on Empty: Services and Citizens Stretched to the Limit</b> <i>Washington County Anti-Poverty Workgroup</i> 2012	The purpose of this process was to explore via focus groups and interviews how residents had been faring during the recession, and to compare findings to an earlier needs assessment.	Washington (OR)
<b>Share Our Strength's No Kid Hungry Lead Partner Report</b> <i>Oregon Food Bank</i> 2011	In order to evaluate the impact of the Cooking Matters course, adult, teen and child participants were surveyed. Cooking Matters empowers families at risk of hunger with the skills, knowledge and confidence to make healthy and affordable meals.	Clackamas (OR) Clark (WA) Multnomah (OR) Washington (OR)
<b>Speak Out Survey 2009</b> <i>Multnomah County Health Department</i> 2010	This survey gathered descriptive data about the health and well-being of LGBTQI individuals in the Portland metropolitan area. It was conducted to inform efforts to promote health equity across sexual orientation and gender identity.	Multnomah (OR)
<b>State of Black Oregon</b> <i>Urban League of Portland</i> 2009	This report on the African-American community used case studies, developed policy recommendations and drew from community knowledge. It examined seven key social and economic indicators, racial disparities, and institutional barriers to prosperity and well-being for this community.	Clackamas (OR) Multnomah (OR) Washington (OR)
<b>State of Cultural Competency Community Forum-Results</b> <i>Asian Pacific American Network of Oregon</i> 2012	In this forum, 70 community members representing Asian and Pacific Islander communities split into small groups to identify policy recommendations through which to advance cultural competency and health equity.	Clackamas (OR) Multnomah (OR) Washington (OR)
<b>Together for Children: A Comprehensive Plan for Children and Families</b> <i>Washington County Commission on Children and Families</i> 2010	This Plan documents the work of more than 250 individuals and organizations who gathered in small and large groups over the past year to develop a plan around Washington County's needs including those of a large Latino population.	Washington (OR)
<b>Tri-County Supported Housing and Supportive Services Needs Assessment</b> <i>Central City Concern on behalf of CareOregon</i> 2012	This assessment interviewed low-income and homeless individuals with the goal of supporting the current health care transformation efforts in the tri-county region by identifying the services needed to decrease hospital utilization by determining best practice interventions.	Clackamas (OR) Multnomah (OR) Washington (OR)
<b>United Way White House Community Conversations—Clackamas, Clark, Washington counties, East Portland, and Camp Odyssey members (Five separate reports)</b> 2012	United Way of the Columbia Willamette (UWCW) held conversations in the four-county area with members—including high school students, nontraditional community groups, the general population, residents of East Portland, and Spanish-speaking low-income apartment complex residents—so that UWCW could gain a stronger sense of the community's aspirations/concerns and so that UWCW could deepen relationships with members of nontraditional community groups.	Clackamas (OR) Clark (WA) Multnomah (OR) Washington (OR)
<b>Washington County Community Assessment</b> <i>Oregon Child Development Coalition</i> 2009	This assessment was conducted for Oregon Child Development Coalition's Migrant Seasonal Head Start Program and leveraged input from parents with perceived needs and Latino migrants.	Washington (OR)
<b>Washington County Issues of Poverty</b> <i>Community Action</i> 2011	Through conducting interviews and a convening a focus group, this process addressed the causes and conditions of poverty in Washington County. Participants included Washington County residents, 40 of whom were low-income and seven of whom were Spanish-speaking.	Washington (OR)

**APPENDIX II: Populations Identified in Community Engagement/Assessment Projects for Region<sup>34</sup>**

**Members of medically underserved populations, low income populations, minority populations and populations with chronic disease needs:**

- African-American population
- Asian and Pacific Islander population
- Black Oregonians<sup>35</sup>
- Chinese immigrant population
- Communities of color
- HIV-positive population
- Homeless population
- Immigrant and Refugee communities
- Latino and immigrant population
- Latino community members
- Latino migrant population
- Latino population/Spanish speaking
- LGBTQI population
- Low-income older adults (ages 50+)
- Low-income population
- Low-income renters in North and Northeast Portland
- Native American population
- Oregon Food Bank recipients (low-income adults, teens, children)
- Oregon Food and Nutrition Assistance Program participants
- Seniors (ages 60-93)
- Somali and Ethiopian elders
- Spanish speaking population
- Uninsured population

**People who represent communities served by the following hospital facilities:**

- Residents of Legacy Emanuel Hospital service area
- Residents of Legacy Good Samaritan Hospital service area
- Residents of Legacy Meridian Park Hospital service area
- Residents of Legacy Mt. Hood Hospital service area
- Residents of Legacy Salmon Creek Hospital service area
- Residents of Providence Milwaukie Hospital service area
- Residents of Providence Portland Hospital service area
- Residents of Providence St. Vincent Hospital service area
- Residents of Providence Willamette Falls Hospital service area

**Other populations:**

- 3<sup>rd</sup> and 5<sup>th</sup> graders in SUN afterschool program
- General population<sup>36</sup>
- High school students
- Residents of East Portland

<sup>34</sup> Populations identified in community engagement/assessment projects are arranged by IRS 990 requirements.

<sup>35</sup>As identified in *State of Black Oregon*

<sup>36</sup> General population is defined as adult and/or youth community members who do not represent any specific population

**APPENDIX III: Populations Identified in Community Assessment Projects by County**

<p><b>Clackamas (OR)</b></p>	<p><b>Members of medically underserved populations, low income populations, minority populations and populations with chronic disease needs:</b></p> <ul style="list-style-type: none"> <li>• Asian and Pacific Islander population</li> <li>• Black Oregonians</li> <li>• HIV-positive population</li> <li>• Homeless population</li> <li>• Immigrant and refugee communities</li> <li>• Latino population/Spanish speaking</li> <li>• LGBTQI population</li> <li>• Low-income older adults (ages 50+)</li> <li>• Low-income population</li> <li>• Oregon Food Bank recipients (low-income adults, teens, children)</li> <li>• Oregon Food and Nutrition Assistance program participants</li> <li>• Seniors (ages 60-93)</li> </ul> <p><b>People who represent communities served by the following hospital facilities<sup>3</sup>:</b></p> <ul style="list-style-type: none"> <li>• Residents of Legacy Meridian Park Hospital service area</li> <li>• Residents of Providence Milwaukie Hospital service area</li> <li>• Residents of Providence Willamette Falls Hospital service area</li> </ul> <p><b>Other populations:</b></p> <ul style="list-style-type: none"> <li>• General population</li> <li>• High school students</li> </ul>
<p><b>Clark (WA)</b></p>	<p><b>Members of medically underserved populations, low income populations, minority populations and populations with chronic disease needs:</b></p> <ul style="list-style-type: none"> <li>• HIV-Positive population</li> <li>• LGBTQI population</li> <li>• Low-income older adults (ages 50+)</li> <li>• Oregon Food Bank recipients (low-income adults, teens, children)</li> <li>• Uninsured population</li> </ul> <p><b>People who represent communities served by the following hospital facilities:</b></p> <ul style="list-style-type: none"> <li>• Residents of Legacy Salmon Creek Hospital Service Area</li> </ul> <p><b>Other populations:</b></p> <ul style="list-style-type: none"> <li>• High school students</li> <li>• General population</li> </ul>
<p><b>Multnomah (OR)</b></p>	<p><b>Members of medically underserved populations, low income populations, minority populations and populations with chronic disease needs:</b></p> <ul style="list-style-type: none"> <li>• African-American population</li> <li>• Asian &amp; Pacific Islander population</li> <li>• Black Oregonians<sup>4</sup></li> <li>• Chinese immigrant population</li> <li>• Communities of color</li> <li>• HIV-positive population</li> <li>• Homeless population</li> <li>• Immigrant and refugee communities</li> </ul>



**Section 2: Healthy Columbia Willamette**

<p><b>Multnomah (OR)</b>  (continued)</p>	<ul style="list-style-type: none"> <li>• Latino immigrant population</li> <li>• Latino population/Spanish speaking</li> <li>• LGBTQI population</li> <li>• Low-income older adults (ages 50+)</li> <li>• Low-income population</li> <li>• Low-income renters in North and Northeast Portland</li> <li>• Low-income uninsured residents of East, North and Northeast Portland</li> <li>• Native American population</li> <li>• Oregon Food Bank recipients (low-income adults, teens, children)</li> <li>• Oregon Food and Nutrition Assistance program participants</li> <li>• Seniors (ages 60-93)</li> <li>• Somali and Ethiopian elders</li> </ul> <p><b>People who represent communities served by the following hospital facilities:</b></p> <ul style="list-style-type: none"> <li>• Residents of Legacy Emanuel Hospital service area</li> <li>• Residents of Legacy Good Samaritan Hospital service area</li> <li>• Residents of Legacy Mt. Hood Hospital service area</li> <li>• Residents of Providence Portland Hospital service area</li> <li>• Residents of Providence St. Vincent Hospital service area</li> </ul> <p><b>Other populations:</b></p> <ul style="list-style-type: none"> <li>• 3<sup>rd</sup> and 5<sup>th</sup> graders in SUN afternoon program</li> <li>• General population</li> <li>• High school students</li> <li>• Residents of East Portland</li> </ul>
<p><b>Washington (OR)</b></p>	<p><b>Members of medically underserved populations, low income populations, minority populations and populations with chronic disease needs:</b></p> <ul style="list-style-type: none"> <li>• Asian and Pacific Islander population</li> <li>• Black Oregonians</li> <li>• HIV-positive population</li> <li>• Immigrant and refugee communities</li> <li>• Latino community members</li> <li>• Latino migrant population</li> <li>• LGBTQI population</li> <li>• Low-income older adults (ages 50+)</li> <li>• Low-income population</li> <li>• Oregon Food Bank recipients (low-income adults, teens, children)</li> <li>• Oregon Food and Nutrition Assistance program participants</li> <li>• Seniors (ages 60-93)</li> <li>• Spanish speaking population</li> </ul> <p><b>People who represent communities served by the following hospital facilities:</b></p> <ul style="list-style-type: none"> <li>• Residents of Legacy Meridian Park Hospital service area</li> <li>• Residents of Providence St. Vincent Hospital service area</li> </ul> <p><b>Other populations:</b></p> <ul style="list-style-type: none"> <li>• General population</li> <li>• High school students</li> </ul>

**APPENDIX IV: Top Health-Related Themes with Corresponding Community Engagement/ Assessment Projects for Region**

Theme	Corresponding Community Engagement/Assessment Projects
<p><b>Social environment:</b> Sense of community; social support for the community, families, and parents; equity; social inclusion; racism; opportunities/venues to socialize; spirituality</p>	<ul style="list-style-type: none"> <li>• ACHIEVE (Action Communities for Health, Innovation and Environmental Change) Community, Multnomah County Health Department</li> <li>• The Asian and Pacific Islander Community in Multnomah County: An Unsettling Profile, Coalition of Communities of Color</li> <li>• Beaverton Community Vision Action Plan Update, City of Beaverton</li> <li>• Cascade AIDS Project Strategic Planning 2009-2014 Data Collection Report</li> <li>• Clackamas County Community Health Improvement Plan, Clackamas County Department of Health, Housing, and Human Services</li> <li>• Communities of Color in Multnomah County: An Unsettling Profile, Coalition of Communities of Color</li> <li>• Comprehensive Plan Update, Washington County</li> <li>• engAGE in community</li> <li>• Focus Group Discussions with Housing, Job Training and Employment Professionals, Multnomah County Health Department</li> <li>• Growing Healthier: Planning for a Healthier Clark County, Health Advisory Council, Clark County Public Health</li> <li>• Healthy Eating/Active Living, Multnomah County Health Department</li> <li>• HOPE (Healthy Oregon Partnership for Equity Coalition) Five Year Health Equity Plan</li> <li>• Hillsboro 2020 Vision and Action Plan, Hillsboro City Council</li> <li>• Immigrant and Refugee Community Organization Shaping Our Future: Community Needs Assessment Conference</li> <li>• The Latino Community in Multnomah County: An Unsettling Profile, Coalition of Communities of Color</li> <li>• Legacy Health 2011 Community Needs Assessment</li> <li>• Legacy Salmon Creek Hospital Community Needs Assessment</li> <li>• Multnomah County Community Health Assessment 2011, Multnomah County Health Department</li> <li>• Multnomah County Health Equity Initiative: Unnatural Causes, Multnomah County Health Department</li> <li>• The Native American Community in Multnomah County: An Unsettling Profile, Coalition of Communities of Color</li> <li>• Oregon Health Improvement Plan, Oregon Health Authority</li> <li>• Oregon Latino Agenda for Action Summit-2010</li> <li>• Overview of Hispanics in an Aging Population: A supplement to the engAGE in Community initiative</li> <li>• The Path to Economic Prosperity: Equity and the Education Imperative, Greater Portland Pulse</li> <li>• Portland Plan, City of Portland Bureau of Planning and Sustainability</li> <li>• Regional Equity Atlas Project Action Plan, Coalition for a Livable Future</li> <li>• Roadmap to Healthy Communities: A Community Health Assessment, Clackamas County Health Department</li> <li>• Running on Empty: Services and Citizens Stretched to the Limit, Washington County Anti-Poverty Workgroup</li> <li>• Speak Out Survey 2009, Multnomah County Health Department</li> <li>• State of Black Oregon, Urban League of Portland</li> <li>• State of Cultural Competency Community Forum-Results, Asian Pacific American Network of Oregon</li> <li>• Together for Children: A Comprehensive Plan for Children and Families, Washington County Commission on Children and Families</li> <li>• Tri-County Supported Housing and Supportive Services Needs Assessment, Central City Concern on behalf of CareOregon</li> <li>• United Way White House Community Conversation-Camp Odyssey</li> <li>• United Way White House Community Conversation-Clackamas County</li> <li>• United Way White House Community Conversation-Clark County</li> <li>• United Way White House Community Conversation-East Portland Community Center</li> <li>• United Way White House Community Conversations-Washington County</li> <li>• Washington County Community Assessment, Oregon Child Development Coalition</li> </ul>

## Section 2: Healthy Columbia Willamette

<p><b>Equal economic opportunities:</b> Jobs; prosperous households; economic self-sufficiency; equal access to living wage jobs; workforce development; economic recovery.</p>	<ul style="list-style-type: none"> <li>• The Asian and Pacific Islander Community in Multnomah County: An Unsettling Profile, Coalitions of Communities of Color, Coalitions of Communities of Color</li> <li>• Beaverton Community Vision Action Plan Update 2012, City of Beaverton</li> <li>• Communities of Color in Multnomah County: An Unsettling Profile, Coalitions of Communities of Color</li> <li>• Healthy Eating/Active Living, Multnomah County Health Department</li> <li>• Comprehensive Plan Update, Washington County</li> <li>• engAGE in community</li> <li>• Focus Group Discussions with Housing, Job Training and Employment Professionals, Multnomah County Health Department</li> <li>• Hillsboro 2020 Vision and Action Plan, Hillsboro City Council</li> <li>• HOPE (Healthy Oregon Partnership for Equity Coalition) Five Year Health Equity Plan</li> <li>• Immigrant and Refugee Community Organization Shaping Our Future: Community Needs Assessment Conference</li> <li>• Legacy Health 2011 Community Needs Assessment</li> <li>• Legacy Salmon Creek Hospital Community Needs Assessment</li> <li>• Multnomah County Community Health Assessment 2011</li> <li>• Multnomah County Health Equity Initiative: Unnatural Causes, Multnomah County Health Department</li> <li>• Oregon Latino Agenda for Action Summit-2010</li> <li>• Overview of Hispanics in an Aging Population: A supplement to the engAGE in Community initiative</li> <li>• Partnering for Student Success-The Cradle to Career Framework: 2010 Report To The Community</li> <li>• Portland Mercado: Community Economic Development to Revitalize, Uplift, and Empower</li> <li>• Portland Plan, City of Portland Bureau of Planning and Sustainability</li> <li>• Public Health Improvement Partnership Agenda for Change Action Plan: Initial Priorities and First Steps for Advancing Washington's Public Health System, Washington Department of Health</li> <li>• Regional Equity Atlas Project Action Plan, Coalition for a Livable Future</li> <li>• Roadmap to Healthy Communities: A Community Health Assessment, Clackamas County Health Department</li> <li>• Running on Empty: Services and Citizens Stretched to the Limit, Washington County Anti-Poverty Workgroup</li> <li>• State of Black Oregon, Urban League of Portland</li> <li>• State of Cultural Competency Community Forum-Results, Asian Pacific American Network of Oregon</li> <li>• The Native American Community in Multnomah County: An Unsettling Profile, Coalition of Communities of Color</li> <li>• The Path to Economic Prosperity: Equity and the Education Imperative, Greater Portland Pulse</li> <li>• Tri-County Supported Housing and Supportive Services Needs Assessment, Central City Concern on Behalf of CareOregon</li> <li>• United Way White House Community Conversation-Camp Odyssey</li> <li>• United Way White House Community Conversation-Clackamas County</li> <li>• United Way White House Community Conversation-Clark County</li> <li>• United Way White House Community Conversation-East Portland Community Center</li> <li>• United Way White House Community Conversations-Washington County</li> <li>• Washington County Community Assessment, Oregon Child Development Coalition</li> <li>• Washington County Issues of Poverty, Community Action</li> </ul>
<p><b>Access to Affordable Health Care:</b> Access for low income, uninsured, underinsured; access to primary care, medications; emergency room utilization; health care</p>	<ul style="list-style-type: none"> <li>• Beaverton Community Vision Action Plan Update 2012, City of Beaverton</li> <li>• Cascade AIDS Project Strategic Planning 2009-2014 Data Collection Report</li> <li>• Causa/Latino Health Coalition and NW Health Foundation Latino Health Assembly</li> <li>• Community Value Assessment of North by Northeast Community Health Center</li> <li>• Comprehensive Plan Update, Washington County</li> <li>• engAGE in Community</li> <li>• Hillsboro 2020 Vision and Action Plan, Hillsboro City Council</li> <li>• HOPE (Healthy Oregon Partnership for Equity) Coalition Five Year Health Equity Plan</li> <li>• Improving Access to Affordable Health Care: An Outreach Audit of North Clackamas County Residents Living Below %200 of Poverty, Clackamas County Department of Health, Housing, and Human Services</li> <li>• Legacy Health 2011 Community Needs Assessment</li> <li>• Legacy Salmon Creek Hospital Community Needs Assessment</li> </ul>

## Section 2: Healthy Columbia Willamette

	<ul style="list-style-type: none"> <li>• Multnomah County Health Equity Initiative: Unnatural Causes, Multnomah County Health Department</li> <li>• Oregon Health Improvement Plan, Oregon Health Authority</li> <li>• Oregon Medicare-Medicaid Listening Groups: Final Report, Oregon Health Authority</li> <li>• Overview of Hispanics in an Aging Population: A supplement to the engAGE in Community initiative</li> <li>• The Path to Economic Prosperity: Equity and the Education Imperative, Greater Portland Pulse</li> <li>• Project Access Now 2008-2010 Program Evaluation</li> <li>• Providence Milwaukie Hospital and Providence Willamette Falls Medical Center-Community Health Needs Assessment</li> <li>• Providence Portland Medical Center-Community Health Needs Assessment</li> <li>• Providence St. Vincent Medical Center-Community Health Needs Assessment</li> <li>• Public Health Improvement Partnership Agenda for Change Action Plan: Initial Priorities and First Steps for Advancing Washington's Public Health System, Washington Department of Health</li> <li>• The Native American Community in Multnomah County: An Unsettling Profile, Coalition of Communities of Color</li> <li>• Regional Equity Atlas Project Action Plan, Coalition for a Livable Future</li> <li>• Roadmap to Healthy Communities: A Community Health Assessment, Clackamas County Health Department</li> <li>• Running on Empty: Services and Citizens Stretched to the Limit, Washington County Anti-Poverty Workgroup</li> <li>• Speak Out Survey 2009, Multnomah County Health Department</li> <li>• State of Black Oregon, Urban League of Portland</li> <li>• State of Cultural Competency Community Forum-Results, Asian Pacific American Network of Oregon</li> <li>• Together for Children: A Comprehensive Plan for Children and Families, Washington County Commission on Children and Families</li> <li>• Tri-County Supported Housing and Supportive Services Needs Assessment, Central City Concern on Behalf of CareOregon</li> <li>• United Way White House Community Conversation-East Portland Community Center</li> <li>• Washington County Issues of Poverty, Community Action</li> </ul>
<p><b>Education:</b> culturally-relevant curriculum; student empowerment; education quality; opportunity to go to college; long term funding/ investment in education</p>	<ul style="list-style-type: none"> <li>• The Asian and Pacific Islander Community in Multnomah County: An Unsettling Profile, Coalitions of Communities of Color</li> <li>• Beaverton Community Vision Action Plan Update 2012, City of Beaverton</li> <li>• Clackamas County Community Health Improvement Plan, Clackamas County Department of Health and Human Services</li> <li>• Comprehensive Plan Update, Washington County</li> <li>• Focus Group Discussions with Housing, Job Training and Employment Professionals, Multnomah County Health Department</li> <li>• Healthy Communities: Building Capacity Based on Local Tobacco Control Efforts, Oregon Health Authority</li> <li>• Healthy Eating/Active Living, Multnomah County Health Department</li> <li>• Hillsboro 2020 Vision and Action Plan, Hillsboro City Council</li> <li>• Immigrant and Refugee Community Organization Shaping Our Future: Community Needs Assessment Conference</li> <li>• The Latino Community in Multnomah County: An Unsettling Profile, Coalition of Communities of Color</li> <li>• Legacy Health 2011 Community Needs Assessment</li> <li>• Legacy Salmon Creek Hospital Community Needs Assessment</li> <li>• Lessons from the Field: Portland, Oregon: Kelly GROW: Integrating Healthy Eating and Active Learning (HEAL) at Kelly Elementary, Oregon Public Health Institute</li> <li>• Multnomah County Community Health Assessment 2011</li> <li>• Multnomah County Health Equity Initiative: Unnatural Causes, Multnomah County Health Department</li> <li>• The Native American Community in Multnomah County: An Unsettling Profile, Coalition of Communities of Color</li> <li>• Oregon Health Improvement Plan, Oregon Health Authority</li> <li>• Oregon Latino Agenda for Action Summit-2010</li> <li>• Partnering for Student Success-The Cradle to Career Framework: 2010 Report To The Community</li> <li>• The Path to Economic Prosperity: Equity and the Education Imperative, Greater Portland Pulse</li> </ul>

## Section 2: Healthy Columbia Willamette

<p><b>Education:</b> (continued)</p>	<ul style="list-style-type: none"> <li>• Portland Plan, City of Portland Bureau of Planning and Sustainability</li> <li>• Regional Equity Atlas Project Action Plan, Coalition for a Livable Future</li> <li>• Roadmap to Healthy Communities: A Community Health Assessment, Clackamas County Health Department</li> <li>• Running on Empty: Services and Citizens Stretched to the Limit, Washington County Anti-Poverty Workgroup</li> <li>• State of Black Oregon, Urban League of Portland</li> <li>• United Way White House Community Conversation-Camp Odyssey</li> <li>• United Way White House Community Conversation-Clackamas County</li> <li>• United Way White House Community Conversation-Clark County</li> <li>• United Way White House Community Conversation-East Portland Community Center</li> <li>• United Way White House Community Conversations-Washington County</li> <li>• Washington County Community Assessment, Oregon Child Development Coalition</li> </ul>
<p><b>Access to healthy food:</b> Hunger; EBT-SNAP benefits; nutrition; fruit and vegetable consumption; community gardens; farmers markets; healthy food retail; farm-to-school</p>	<ul style="list-style-type: none"> <li>• ACHIEVE (Action Communities for Health, Innovation and Environmental Change) Community, Multnomah County Health Department</li> <li>• African American Health Coalition CPPW Final Report</li> <li>• Clackamas County Community Health Improvement Plan, Clackamas County Department of Health, Housing, and Human Services</li> <li>• Community Health Partnership: SNAP Roundtable, Oregon Public Health Institute</li> <li>• Community Value Assessment of North by Northeast Community Health Center</li> <li>• engAGE in community</li> <li>• Growing Healthier: Planning for a Healthier Clark County</li> <li>• Healthy Active Communities for Portland's Affordable Housing Families, Oregon Public Health Institute</li> <li>• Healthy Communities: Building Capacity Based on Local Tobacco Control Efforts</li> <li>• Healthy Eating/Active Living, Multnomah County Health Department</li> <li>• Healthy Eating at Farmers Markets: The Impact of Nutrition Incentive Programs, Oregon Public Health Institute</li> <li>• HOPE (Healthy Oregon Partnership for Equity) Coalition Five Year Health Equity Plan</li> <li>• Legacy Salmon Creek Hospital Community Needs Assessment</li> <li>• Lessons from the Field: Portland, Oregon: Kelly GROW: Integrating Healthy Eating and Active Learning (HEAL) at Kelly Elementary, Oregon Public Health Institute</li> <li>• Multnomah County Community Health Assessment</li> <li>• Multnomah County Health Equity Initiative: Unnatural Causes, Multnomah County Health Department</li> <li>• The Native American Community in Multnomah County: An Unsettling Profile, Coalition of Communities of Color</li> <li>• Oregon Food Bank Nutrition Education Program 2010 Long-Term Follow-up Survey</li> <li>• Portland Plan, City of Portland Bureau of Planning and Sustainability</li> <li>• Providence Milwaukie Hospital and Providence Willamette Falls Medical Center-Community Health Needs Assessment</li> <li>• Providence St. Vincent Medical Center- Community Health Needs Assessment</li> <li>• Public Health Improvement Partnership Agenda for Change Action Plan: Initial Priorities and First Steps for Advancing Washington's Public Health System, Washington Department of Health</li> <li>• Regional Equity Atlas Project Action Plan, Coalition for a Livable Future</li> <li>• Roadmap to Healthy Communities: A Community Health Assessment, Clackamas County Health Department</li> <li>• Running on Empty: Services and Citizens Stretched to the Limit, Washington County Anti-Poverty Workgroup</li> <li>• Share Our Strength's No Kid Hungry Lead Partner Report, Oregon Food Bank</li> <li>• Speak Out Survey 2009, Multnomah County Health Department</li> <li>• State of Cultural Competency Community Forum-Results, Asian Pacific American Network of Oregon</li> <li>• United Way White House Community Conversation-Clackamas County</li> <li>• Washington County Community Assessment, Oregon Child Development Coalition</li> <li>•</li> </ul>

## Section 2: Healthy Columbia Willamette

<p><b>Housing:</b> Affordability; availability; stability; evictions; tenant education; homelessness; healthy housing; housing integrated with social services/ transportation</p>	<ul style="list-style-type: none"> <li>• The Asian and Pacific Islander Community in Multnomah County: An Unsettling Profile, Coalitions of Communities of Color</li> <li>• Beaverton Community Vision Action Plan Update 2012, City of Beaverton</li> <li>• Cascade AIDS Project Strategic Planning 2009-2014 Data Collection Report</li> <li>• Legacy Salmon Creek Hospital Community Needs Assessment</li> <li>• Community Value Assessment of North by Northeast Community Health Center</li> <li>• engAGE in community</li> <li>• Focus Group Discussions with Housing, Job Training and Employment Professionals, Multnomah County Health Department</li> <li>• Growing Healthier: Planning for a Healthier Clark County, Health Advisory Council, Clark County Public Health</li> <li>• Healthy Active Communities for Portland's Affordable Housing Families, Oregon Public Health Institute</li> <li>• Healthy Communities: Building Capacity Based on Local Tobacco Control Efforts</li> <li>• Healthy Eating/Active Living, Multnomah County Health Department</li> <li>• HOPE (Healthy Oregon Partnership for Equity) Five Year Health Equity Plan</li> <li>• Hillsboro 2020 Vision and Action Plan, Hillsboro City Council</li> <li>• Immigrant and Refugee Community Organization Shaping Our Future: Community Needs Assessment Conference</li> <li>• Legacy Health 2011 Community Needs Assessment</li> <li>• Multnomah County Community Health Assessment 2011</li> <li>• Multnomah County Health Equity Initiative: Unnatural Causes, Multnomah County Health Department</li> <li>• Portland Plan, City of Portland Bureau of Planning and Sustainability</li> <li>• Providence Milwaukie Hospital and Providence Willamette Falls Medical Center-Community Health Needs Assessment</li> <li>• Providence St. Vincent Medical Center- Community Health Needs Assessment</li> <li>• Public Health Improvement Partnership Agenda for Change Action Plan: Initial Priorities and First Steps for Advancing Washington's Public Health System, Washington Department of Health</li> <li>• Regional Equity Atlas Project Action Plan, Coalition for a Livable Future</li> <li>• Roadmap to Healthy Communities: A Community Health Assessment, Clackamas County Health Department</li> <li>• Running on Empty: Services and Citizens Stretched to the Limit, Washington County Anti-Poverty Workgroup</li> <li>• State of Black Oregon, Urban League of Portland</li> <li>• State of Cultural Competency Community Forum-Results, Asian Pacific American Network of Oregon</li> <li>• Tri-County Supported Housing and Supportive Services Needs Assessment, Central City Concern on behalf of CareOregon</li> <li>• United Way White House Community Conversation-Camp Odyssey</li> <li>• United Way White House Community Conversation-Clackamas County</li> <li>• Washington County Issues of Poverty, Community Action</li> </ul>
<p><b>Mental health &amp; substance abuse treatment:</b> Depression; suicide; drug/alcohol abuse; access for culturally-specific groups and LGBTQI community; counseling; inpatient treatment; prevention.</p>	<ul style="list-style-type: none"> <li>• Community Value Assessment of North by Northeast Community Health Center</li> <li>• Focus Group Discussions with Housing, Job Training and Employment Professionals, Multnomah County Health Department</li> <li>• HOPE (Healthy Oregon Partnership for Equity) Five Year Health Equity Plan</li> <li>• Improving Access to Affordable Health Care: An Outreach Audit of North Clackamas County Residents Living Below% 200 of Poverty, Clackamas County Department of Health, Housing, and Human Services</li> <li>• The Latino Community in Multnomah County: An Unsettling Profile, Coalition of Communities of Color</li> <li>• Legacy Salmon Creek Hospital Community Needs Assessment</li> <li>• Multnomah County Community Health Assessment 2011</li> <li>• Oregon Health Improvement Plan, Oregon Health Authority</li> <li>• Patient Centered Primary Care Home Implementation Task Force Report, Oregon Health Authority, NW Health Foundation</li> <li>• Project Access Now 2008-2010 Program Evaluation</li> <li>• Providence Milwaukie Hospital and Providence Willamette Falls Medical Center-Community Health Needs Assessment</li> </ul>



## Section 2: Healthy Columbia Willamette

<p><b>Mental health &amp; substance abuse treatment:</b> (continued)</p>	<ul style="list-style-type: none"> <li>• Providence Portland Medical Center-Community Health Needs Assessment</li> <li>• Public Health Improvement Partnership Agenda for Change Action Plan: Initial Priorities and First Steps for Advancing Washington's Public Health System, Washington Department of Health</li> <li>• Regional Equity Atlas Project Action Plan, Coalition for a Livable Future</li> <li>• Running on Empty: Services and Citizens Stretched to the Limit, Washington County Anti-Poverty Workgroup</li> <li>• Speak Out Survey 2009, Multnomah County Health Department</li> <li>• State of Cultural Competency Community Forum-Results, Asian Pacific American Network of Oregon</li> <li>• Together for Children: A Comprehensive Plan for Children and Families, Washington County Commission on Children and Families</li> <li>• Tri-County Supported Housing and Supportive Services Needs Assessment, Central City Concern on behalf of CareOregon</li> <li>• United Way White House Community Conversation-Camp Odyssey</li> <li>• United Way White House Community Conversation-Clackamas County</li> <li>• United Way White House Community Conversation-East Portland Community Center</li> <li>• Washington County Community Assessment, Oregon Child Development Coalition</li> <li>• Washington County Issues of Poverty, Community Action</li> </ul>
<p><b>Poverty:</b> Basic needs; cost of living; financial status; daily struggles to make ends meet</p>	<ul style="list-style-type: none"> <li>• The Asian and Pacific Islander Community in Multnomah County: An Unsettling Profile, Coalitions of Communities of Color</li> <li>• Comprehensive Plan Update, Washington County</li> <li>• Communities of Color in Multnomah County: An Unsettling Profile, Coalition of Communities of Color</li> <li>• Community Value Assessment of North by Northeast Community Health Center</li> <li>• Focus Group Discussions with Housing, Job Training and Employment Professionals, Multnomah County Health Department</li> <li>• Growing Healthier: Planning for a Healthier Clark County, Health Advisory Council, Clark County Public Health</li> <li>• Healthy Eating/Active Living, Multnomah County Health Department</li> <li>• The Latino Community in Multnomah County: An Unsettling Profile, Coalition of Communities of Color</li> <li>• Legacy Salmon Creek Hospital Community Needs Assessment</li> <li>• Multnomah County Health Equity Initiative: Unnatural Causes, Multnomah County Health Department</li> <li>• The Native American Community in Multnomah County: An Unsettling Profile, Coalition of Communities of Color</li> <li>• Oregon Food Bank Nutrition Education Program 2010 Long-Term Follow-up Survey</li> <li>• Oregon Health Improvement Plan, Oregon Health Authority</li> <li>• Project Access Now 2008-2010 Program Evaluation</li> <li>• Providence Milwaukie Hospital and Providence Willamette Falls Medical Center-Community Health Needs Assessment</li> <li>• Providence St. Vincent Medical Center- Community Health Needs Assessment</li> <li>• Regional Equity Atlas Project Action Plan, Coalition for a Livable Future</li> <li>• Running on Empty: Services and Citizens Stretched to the Limit, Washington County Anti-Poverty Workgroup</li> <li>• State of Black Oregon, Urban League of Portland</li> <li>• United Way White House Community Conversation-Clackamas County</li> <li>• United Way White House Community Conversation-East Portland Community Center</li> <li>• Washington County Issues of Poverty, Community Action</li> </ul>



## Section 2: Healthy Columbia Willamette

<p><b>Early childhood/ Youth:</b> Child welfare; youth development &amp; empowerment; opportunities for youth; parental support of student education experience</p>	<ul style="list-style-type: none"> <li>• Causa/Latino Health Coalition and NW Health Foundation Latino Health Assembly</li> <li>• Clackamas County Community Health Improvement Plan, Clackamas County Department of Health, Housing, and Human Services</li> <li>• Communities of Color in Multnomah County: An Unsettling Profile</li> <li>• Comprehensive Plan Update, Washington County</li> <li>• Hillsboro 2020 Vision and Action Plan, Hillsboro City Council</li> <li>• The Latino Community in Multnomah County: An Unsettling Profile, Coalition of Communities of Color</li> <li>• Legacy Salmon Creek Hospital Community Needs Assessment</li> <li>• Multnomah County Community Health Assessment 2011</li> <li>• Multnomah County Health Equity Initiative: Unnatural Causes, Multnomah County Health Department</li> <li>• Oregon Latino Agenda for Action Summit-2010</li> <li>• The Native American Community in Multnomah County: An Unsettling Profile, Coalition of Communities of Color</li> <li>• Partnering for Student Success-The Cradle to Career Framework: 2010 Report To The Community</li> <li>• The Path to Economic Prosperity: Equity and the Education Imperative, Greater Portland Pulse</li> <li>• Portland Plan, City of Portland Bureau of Planning and Sustainability</li> <li>• Running on Empty: Services and Citizens Stretched to the Limit, Washington County Anti-Poverty Workgroup</li> <li>• State of Black Oregon, Urban League of Portland</li> <li>• Together for Children: A Comprehensive Plan for Children and Families, Washington County Commission on Children and Families</li> <li>• United Way White House Community Conversation-Camp Odyssey</li> <li>• United Way White House Community Conversation-Clackamas County</li> <li>• United Way White House Community Conversation-Clark County</li> <li>• United Way White House Community Conversation-East Portland Community Center</li> <li>• Washington County Community Assessment, Oregon Child Development Coalition</li> </ul>
<p><b>Chronic disease:</b> obesity; smoking; chronic disease support, management &amp; prevention</p>	<ul style="list-style-type: none"> <li>• African American Health Coalition CPPW Final Report</li> <li>• Community Value Assessment of North by Northeast Community Health Center</li> <li>• Focus Group Discussions with Housing, Job Training and Employment Professionals, Multnomah County Health Department</li> <li>• Healthy Communities: Building Capacity Based on Local Tobacco Control Efforts, Oregon Health Authority</li> <li>• HOPE (Healthy Oregon Partnership for Equity) Coalition Five Year Health Equity Plan</li> <li>• Legacy Health 2011 Community Needs Assessment</li> <li>• Legacy Salmon Creek Community Needs Assessment</li> <li>• Oregon Health Improvement Plan, Oregon Health Authority</li> <li>• The Path to Economic Prosperity: Equity and the Education Imperative, Greater Portland Pulse</li> <li>• Perceived and actual diabetes risk in the Chinese and Hispanic/Latino Communities in Portland, OR, Portland State University</li> <li>• Portland Plan, City of Portland Bureau of Planning and Sustainability</li> <li>• Project Access Now 2008-2010 Program Evaluation</li> <li>• Providence Milwaukie Hospital and Providence Willamette Falls Medical Center-Community Health Needs Assessment</li> <li>• Providence Portland Medical Center-Community Health Needs Assessment</li> <li>• Providence St. Vincent Medical Center-Community Health Needs Assessment</li> <li>• Public Health Improvement Partnership Agenda for Change Action Plan: Initial Priorities and First Steps for Advancing Washington's Public Health System, Washington Department of Health</li> <li>• Speak Out Survey 2009, Multnomah County Health Department</li> <li>• State of Black Oregon, Urban League of Portland</li> <li>• State of Cultural Competency Community Forum-Results, Asian Pacific American Network of Oregon</li> <li>• Tri-County Supported Housing and Supportive Services Needs Assessment, Central City Concern on behalf of CareOregon</li> <li>• Washington County Community Assessment, Oregon Child Development Coalition</li> </ul>

## Section 2: Healthy Columbia Willamette

<p><b>Safe neighborhood:</b> Public safety; crime; violence; police relations; traffic/pedestrian safety</p>	<ul style="list-style-type: none"> <li>• Beaverton Community Vision Action Plan Update 2012, City of Beaverton</li> <li>• engAGE in community</li> <li>• Comprehensive Plan Update, Washington County</li> <li>• Growing Healthier: Planning for a Healthier Clark County, Health Advisory Council, Clark County Public Health</li> <li>• Healthy Active Communities for Portland's Affordable Housing Families, Oregon Public Health Institute</li> <li>• Hillsboro 2020 Vision and Action Plan, Hillsboro City Council</li> <li>• Immigrant and Refugee Community Organization Shaping Our Future: Community Needs Assessment Conference</li> <li>• Healthy Eating/Active Living, Multnomah County Health Department</li> <li>• Multnomah County Community Health Assessment 2011</li> <li>• The Path to Economic Prosperity: Equity and the Education Imperative, Greater Portland Pulse</li> <li>• Portland Plan, City of Portland Bureau of Planning and Sustainability</li> <li>• Providence Milwaukie Hospital and Providence Willamette Falls Medical Center-Community Health Needs Assessment</li> <li>• Regional Equity Atlas Project Action Plan, Coalition for a Livable Future</li> <li>• Roadmap to Healthy Communities: A Community Health Assessment, Clackamas County Health Department</li> <li>• State of Black Oregon, Urban League of Portland</li> <li>• United Way White House Community Conversation-Camp Odyssey</li> <li>• United Way White House Community Conversation-Clackamas County</li> <li>• United Way White House Community Conversation-Clark County</li> <li>• United Way White House Community Conversation-East Portland Community Center</li> <li>• United Way White House Community Conversations-Washington County</li> <li>• Washington County Issues of Poverty, Community Action</li> </ul>
<p><b>Transportation options:</b> Equitable access to public transportation; bicycling and pedestrian issues; transportation infrastructure investments</p>	<ul style="list-style-type: none"> <li>• Beaverton Community Vision Action Plan Update 2012, City of Beaverton</li> <li>• Community Value Assessment of North by Northeast Community Health Center</li> <li>• engAGE in community</li> <li>• Growing Healthier: Planning for a Healthier Clark County, Health Advisory Council, Clark County Public Health</li> <li>• Healthy Active Communities for Portland's Affordable Housing Families, Oregon Public Health Institute</li> <li>• Healthy Eating/Active Living, Multnomah County Health Department</li> <li>• Hillsboro 2020 Vision and Action Plan, Hillsboro City Council</li> <li>• Immigrant and Refugee Community Organization Shaping Our Future: Community Needs Assessment Conference</li> <li>• Lessons from the Field: Portland, Oregon: Kelly GROW: Integrating Healthy Eating and Active Learning (HEAL) at Kelly Elementary, Oregon Public Health Institute</li> <li>• Multnomah County Community Health Assessment 2011</li> <li>• Multnomah County Health Equity Initiative: Unnatural Causes, Multnomah County Health Department</li> <li>• Overview of Hispanics in an Aging Population: A supplement to the engAGE in Community initiative</li> <li>• Portland Plan, City of Portland Bureau of Planning and Sustainability</li> <li>• Project Access Now 2008-2010 Program Evaluation</li> <li>• Providence Milwaukie Hospital and Providence Willamette Falls Medical Center-Community Health Needs Assessment</li> <li>• Providence St. Vincent Medical Center- Community Health Needs Assessment</li> <li>• Regional Equity Atlas Project Action Plan, Coalition for a Livable Future</li> <li>• Roadmap to Healthy Communities: A Community Health Assessment, Clackamas County Health Department</li> <li>• Running on Empty: Services and Citizens Stretched to the Limit, Washington County Anti-Poverty Workgroup</li> <li>• United Way White House Community Conversation-Clackamas County</li> <li>• Washington County Issues of Poverty, Community Action</li> </ul>

## Section 2: Healthy Columbia Willamette

### APPENDIX V:

Table 1. Overall Population Rates for Top Ranked Health-Related Behavior and Health Outcome Indicators, Clark County and Washington State

	Washington State	Clark County	Year
<b>ACCESS TO HEALTH SERVICES</b>			
★ Adults with a usual source of health care (%)	78.5%	77.3%	2010
★ Adults with health insurance (%)	85.0%	85.2%	2010
Children with health insurance (%)	93.6%	93.5%	2010
<b>CANCER</b>			
All cancer incidence (per 100,000)	534.3	451.8	2009
★ All cancer deaths (per 100,000)	170.0	181.4	2010
★ Breast cancer incidence (per 100,000 females)	179.9	164.8	2009
★ Breast cancer deaths (per 100,000 females)	21.2	24.1	2010
Colorectal cancer deaths (per 100,000)	14.1	13.3	2010
Lung cancer deaths (per 100,000)	46.8	50.4	2010
★ Prostate cancer deaths (per 100,000)	23.2	29.3	2010
Ovarian cancer deaths (per 100,000)	8.4	5.2	2010
Lymphoid hematopoietic cancer deaths (per 100,000)	17.0	18.3	2010
Pap test history (%)	80.7%	80.9%	2010
<b>DIABETES</b>			
★ Diabetes-related deaths (per 100,000)	75.2	83.0	2010
<b>EXERCISE, NUTRITION &amp; WEIGHT</b>			
★ Adult fruit and vegetable consumption (%)	26.0%	21.7%	2009
★ Adults engaging in regular physical activity (%)	53.6%	55.2%	2009
★ Adults who are obese (%)	25.8%	27.7%	2010
Adults who are overweight (%)	35.5%	34.1%	2010
<b>HEART DISEASE &amp; STROKE</b>			
★ Heart disease deaths (per 100,000)	150.5	144.9	2010
<b>IMMUNIZATIONS &amp; INFECTIOUS DISEASES</b>			
Adults aged 65+ years with influenza vaccination (%)	69.8%	69.1%	2010

## Section 2: Healthy Columbia Willamette

	Washington State	Clark County	Year
Influenza and pneumonia deaths (per 100,000)	8.3	10.2	2010
★ Chlamydia incidence (per 100,000)	318.3	316.7	2010
Early syphilis incidence (per 100,000)	3.9	1.4	2010
HIV/AIDS incidence <sup>†</sup> (per 100,000)	8.3	7.5	2010
<b>MATERNAL, FETAL &amp; INFANT HEALTH</b>			
★ Mothers who received early prenatal care (%)	80.1%	76.2%	2010
<b>MENTAL HEALTH &amp; MENTAL DISORDERS</b>			
★ Suicide deaths (per 100,000)	13.8	17.7	2010
Teen self-reported emotional and mental health (%)	29.8%	29.2%	2010
<b>OTHER ADULTS &amp; AGING</b>			
★ Alzheimer's disease deaths (per 100,000)	43.6	42.7	2010
Parkinson's disease deaths (per 100,000)	7.8	9.3	2010
<b>PREVENTION &amp; SAFETY</b>			
★ Unintentional injury deaths (per 100,000)	37.3	41.5	2010
★ Nontransport accidents deaths (per 100,000)	28.4	32.7	2010
<b>SUBSTANCE ABUSE</b>			
Adults who binge drink: females (%)	11.7%	7.6%	2010
★ Adults who binge drink: males (%)	19.7%	20.1%	2010
Alcohol-related deaths <sup>‡</sup> (per 100,000)	11.2	8.1	2010
Chronic liver disease and cirrhosis deaths (per 100,000)	10.4	5.9	2010
★ Adults who smoke (%)	14.9%	17.1%	2010
Teens who smoke (%)	12.7%	13.7%	2010
Tobacco-related deaths (per 100,000)	not avail	not avail	--
★ Drug-related deaths <sup>‡</sup> (per 100,000)	13.7	12.6	2010
<b>TRANSPORTATION SAFETY</b>			
Motor vehicle collision deaths (per 100,000)	7.8	8.2	2010
Transport accident deaths (per 100,000)	8.9	8.8	2010

## Section 2: Healthy Columbia Willamette

Notes: ★ indicates top ranking regional indicators. Death rates and cancer incidence rates are per 100,000 age-adjusted to US 2000 Standard Population. Other incidence rates are per 100,000 of the population at risk. Adult behavior data are a percent of the population at risk (and are not age-adjusted). Youth behavior data are a percent of student enrollment per grade (note Washington State uses 10<sup>th</sup> grade data). For comparisons, age-adjusted rates should be used.

† HIV incidence rate includes unduplicated counts of newly diagnosed cases regardless of diagnostic status (HIV or AIDS). ‡ Alcohol-related deaths and Drug-related deaths in Oregon include additional death categories that are not included in the Washington State indicators.

**Table 2. Overall Population Rates for Top Ranked Health-Related Behavior and Health Outcome Indicators, Clackamas, Multnomah, and Washington Counties, and Oregon**

	Oregon	Clackamas County	Multnomah County	Washington County	Year
<b>ACCESS TO HEALTH SERVICES</b>					
★ Adults with a usual source of health care (%)	79.1%	81.5%	77.1%	80.6%	2006-09
★ Adults with health insurance (%)	83.6%	86.8%	85.0%	87.2%	2006-09
Children with health insurance (%)	91.2%	92.0%	92.5%	94.3%	2010
<b>CANCER</b>					
All cancer incidence (per 100,000)	464.6	457.1	477.3	435.1	2005-09
★ All cancer deaths (per 100,000)	172.8	163.3	182.4	149.6	2010
★ Breast cancer incidence (per 100,000 females)	130.7	134.8	140.5	138.1	2005-09
★ Breast cancer deaths (per 100,000 females)	23.0	24.9	23.7	25.9	2010
Colorectal cancer deaths (per 100,000)	14.8	14.7	16.9	15.5	2010
Lung cancer deaths (per 100,000)	46.9	46.0	51.9	35.2	2010
★ Prostate cancer deaths (per 100,000)	21.8	21.7	24.3	18.1	2010
Ovarian cancer deaths (per 100,000)	9.2	9.3	9.3	7.5	2010
Lymphoid hematopoietic cancer deaths (per 100,000)	17.3	16.2	17.0	16.9	2010
Pap test history (%)	85.8%	88.3%	86.6%	91.5%	2006-09
<b>DIABETES</b>					
★ Diabetes-related deaths (per 100,000)	82.3	75.6	79.5	62.1	2010
<b>EXERCISE, NUTRITION &amp; WEIGHT</b>					
★ Adult fruit and vegetable consumption (%)	27.0%	24.7%	30.0%	24.9%	2006-09
★ Adults engaging in regular physical activity (%)	55.8%	55.6%	55.1%	53.8%	2006-09

## Section 2: Healthy Columbia Willamette

	Oregon	Clackamas County	Multnomah County	Washington County	Year
★ Adults who are obese (%)	24.5%	23.6%	21.8%	23.2%	2006-09
Adults who are overweight (%)	36.1%	35.7%	33.8%	36.9%	2006-09
<b>HEART DISEASE &amp; STROKE</b>					
★ Heart disease deaths (per 100,000)	134.2	126.8	135.0	124.4	2010
<b>IMMUNIZATIONS &amp; INFECTIOUS DISEASES</b>					
Adults aged 65+ years with influenza vaccination* (%)	69.2%	70.0%	72.0%	70.9%	2006-09
Influenza and pneumonia deaths (per 100,000)	9.2	6.7	9.4	7.6	2010
★ Chlamydia incidence (per 100,000)	334.6	287.4	438.3	320.2	2010
Early syphilis incidence (per 100,000)	2.9	3.7	8.1	4.4	2010
HIV/AIDS incidence <sup>†</sup> (per 100,000)	6.4	7.6	14.1	6.1	2010
<b>MATERNAL, FETAL &amp; INFANT HEALTH</b>					
★ Mothers who received early prenatal care (%)	73.1%	73.2%	70.1%	79.1%	2010
<b>MENTAL HEALTH &amp; MENTAL DISORDERS</b>					
★ Suicide deaths (per 100,000)	17.1	15.8	14.1	13.8	2010
Teen self-reported emotional and mental health (%)	14.4%	17.5%	13.8%	13.8%	2010
<b>OTHER ADULTS &amp; AGING</b>					
★ Alzheimer's disease deaths (per 100,000)	28.2	31.9	29.1	23.7	2010
Parkinson's disease deaths (per 100,000)	8.3	9.2	10.4	9.0	2010
<b>PREVENTION &amp; SAFETY</b>					
★ Unintentional injury deaths (per 100,000)	37.5	35.4	38.0	27.2	2010
★ Nontransport accidents deaths (per 100,000)	28.5	27.1	36.9	21.5	2010
<b>SUBSTANCE ABUSE</b>					
Adults who binge drink: females (%)	10.8%	9.3%	14.0%	9.0%	2006-09
★ Adults who binge drink: males (%)	18.7%	18.9%	21.8%	15.3%	2006-09
Alcohol-related deaths <sup>‡</sup> (per 100,000)	12.9	8.7	13.7	6.7	2010
Chronic liver disease and cirrhosis deaths (per 100,000)	11.2	7.1	11.3	6.4	2010
★ Adults who smoke (%)	17.1%	15.4%	15.3%	12.9%	2006-09

## Section 2: Healthy Columbia Willamette

	Oregon	Clackamas County	Multnomah County	Washington County	Year
Teens who smoke (%)	14.3%	15.6%	8.2%	11.4%	2010
Tobacco-related deaths (per 100,000)	160.1	143.8	165.3	113.3	2010
★Drug-related deaths <sup>‡</sup> (per 100,000)	14.5	13.3	18.1	8.0	2010
<b>TRANSPORTATION SAFETY</b>					
Motor vehicle collision deaths (per 100,000)	8.1	7.6	6.3	4.9	2010
Transport accident deaths (per 100,000)	8.9	8.4	6.9	5.7	2010

Notes: ★ indicates top ranking regional indicators. Death rates, sexually transmitted disease, and cancer incidence rates are per 100,000 age-adjusted to US 2000 Standard Population. Adult behavior data are a percent of the population at risk and are age-adjusted to the US 2000 Standard Population unless otherwise noted. Youth behavior data are a percent of student enrollment per grade (note Oregon uses 11<sup>th</sup> grade data). For comparisons, age-adjusted rates should be used.

\* Not age-adjusted. <sup>†</sup>HIV incidence rate includes unduplicated counts of newly diagnosed cases regardless of diagnostic status (HIV or AIDS). <sup>‡</sup>Alcohol-related deaths and Drug-related deaths in Oregon include additional death categories that are not included in the Washington State indicator.



## Section 2: Healthy Columbia Willamette

### APPENDIX VI: Stakeholder Organizations that Participated in the Local Community Health System & Forces of Change Assessment

Organization Name	County(s)	Participation Format
Adelante Mujeres	Washington (OR)	Interview
Adventist Medical Center	Clackamas (OR), Clark (WA), Multnomah (OR), Washington (OR)	Survey
Affordable Community Environments	Clark (WA)	Survey
African American Health Coalition	Clackamas (OR), Clark (WA), Multnomah (OR), Washington (OR)	Survey
African Partnership for Health	Clackamas (OR), Multnomah (OR), Washington (OR)	Interview
Albertina Kerr Centers	Clackamas (OR), Multnomah (OR), Washington (OR)	Survey
American Cancer Society, Cancer Action Network, Oregon State	Clackamas (OR), Clark (WA), Multnomah (OR), Washington (OR)	Interview
American Cancer Society, Cancer Action Network, Washington State	Clackamas (OR), Clark (WA), Multnomah (OR), Washington (OR)	Interview
American Diabetes Association of Oregon & SW Washington	Clackamas (OR), Clark (WA), Multnomah (OR), Washington (OR)	Interview
American Lung Association of the Mountain Pacific	Clackamas (OR), Clark (WA), Multnomah (OR), Washington (OR)	Interview
American Medical Response	Clackamas (OR), Clark (WA), Multnomah (OR), Washington (OR)	Survey
Area Agency on Aging and Disabilities of Southwest Washington	Clark (WA)	Interview
Asian Health and Service Center	Clackamas (OR), Clark (WA), Multnomah (OR), Washington (OR)	Interview
Asian Pacific American Network of Oregon	Clackamas (OR), Clark (WA), Multnomah (OR), Washington (OR)	Interview
Basic Rights Oregon	Clackamas (OR), Clark (WA), Multnomah (OR), Washington (OR)	Interview
CareOregon	Clackamas (OR), Multnomah (OR), Washington (OR)	Interview
Cascade AIDS Project	Clackamas (OR), Clark (WA), Multnomah (OR), Washington (OR)	Survey
Catholic Charities of Oregon	Clackamas (OR), Multnomah (OR), Washington (OR)	Interview
Catholic Charities of Oregon, El Programa Hispano	Clackamas (OR), Multnomah (OR)	Survey
Catholic Community Services of Southwest Washington	Clackamas (OR), Clark (WA), Multnomah (OR), Washington (OR)	Survey
Causa	Clackamas (OR), Multnomah (OR), Washington (OR)	Survey
Centro Cultural	Clackamas (OR), Multnomah (OR), Washington (OR)	Interview
Children's Home Society of Washington	Clark (WA)	Interview
Children's Center	Clark (WA)	Survey
Children's Community Clinic	Multnomah (OR)	Survey
Children's Health Alliance	Clackamas (OR), Clark (WA), Multnomah (OR), Washington (OR)	Survey
City of Portland Office of Equity & Human Rights, New Portlander Programs	Multnomah (OR)	Interview

## Section 2: Healthy Columbia Willamette

City of Portland, Office of Neighborhood Involvement, Community and Neighborhood Involvement Center	Multnomah (OR)	Interview
City of Portland, Office of Neighborhood Involvement, Diversity and Civic Leadership Program	Multnomah (OR)	Interview
City of Wilsonville, Community Center	Clackamas (OR)	Survey
Clackamas County Area Agency on Aging	Clackamas (OR)	Interview
Clackamas County Department of Health, Housing and Human Services	Clackamas (OR)	Interview
Clackamas County Department of Health, Housing and Human Services, Public Health Division	Clackamas (OR)	Interview
Clackamas County Health Centers	Clackamas (OR)	Survey
Clackamas Service Center	Clackamas (OR), Multnomah (OR)	Survey
Clark College, Corporate and Continuing Education	Clackamas (OR), Clark (WA), Multnomah (OR), Washington (OR)	Interview
Clark County Community Services	Clark (WA)	Interview
Clark County Public Health	Clark (WA)	Survey
Coalition of Community Health Clinics	Clackamas (OR), Clark (WA), Multnomah (OR), Washington (OR)	Interview
Columbia River Mental Health Services	Clark (WA)	Interview
Community Action	Washington (OR)	Survey
Confederated Tribes of Siletz Indians, Portland Office	Clackamas (OR), Multnomah (OR), Washington (OR)	Interview
Council for the Homeless	Clark (WA)	Survey
Cowlitz Family Health Center	Clark (WA)	Interview
Cowlitz Indian Tribe	Clark (WA)	Survey
Disability Rights Oregon	Clackamas (OR), Multnomah (OR), Washington (OR)	Interview
Educational Service District 112	Clark (WA)	Survey
Emmanuel Community Services	Clackamas (OR), Clark (WA), Multnomah (OR), Washington (OR)	Interview
Familias En Acción	Clackamas (OR), Clark (WA), Multnomah (OR), Washington (OR)	Survey
FamilyCare Health Plans	Clackamas (OR), Multnomah (OR), Washington (OR)	Interview
Filipino-American Association of Clark County and Vicinity	Clark (WA)	Interview
Free Clinic of Southwest Washington	Clark (WA)	Survey
Future Generations Collaborative	Multnomah (OR)	Survey
Health Share of Oregon	Clackamas (OR), Multnomah (OR), Washington (OR)	Interview
Health Share of Oregon	Clackamas (OR), Multnomah (OR), Washington (OR)	Interview
Healthy Oregon Partnership for Equity Coalition	Clackamas (OR), Multnomah (OR), Washington (OR)	Interview
Human Solutions, Inc.	Multnomah (OR)	Survey
Immigrant and Refugee Community Organization, Asian Family Center	Clackamas (OR), Clark (WA), Multnomah (OR), Washington (OR)	Interview
Immigrant and Refugee Community Organization, Healthy Kids Program	Clackamas (OR), Multnomah (OR)	Survey
Impact NW	Clackamas (OR), Clark (WA), Multnomah (OR), Washington (OR)	Survey

## Section 2: Healthy Columbia Willamette

Inclusion, Inc.	Clackamas (OR), Multnomah (OR)	Survey
Independence Northwest	Clackamas (OR), Multnomah (OR), Washington (OR)	Survey
Independent Living Resources	Clackamas (OR), Multnomah (OR), Washington (OR)	Survey
Iraqi Society of Oregon	Clackamas (OR), Multnomah (OR), Washington (OR)	Interview
Janus Youth Programs	Multnomah (OR), Washington (OR)	Survey
Kaiser Permanente	Clackamas (OR), Multnomah (OR), Washington (OR)	Interview
Latino Learning Community	Multnomah (OR)	Interview
Latino Network	Clackamas (OR), Multnomah (OR), Washington (OR)	Interview
League of United Latin American Citizens, Southwest Washington Council #47013	Clark (WA)	Interview
Legacy Health	Clackamas (OR), Clark (WA), Multnomah (OR), Washington (OR)	Survey
Legacy Weight and Diabetes Institute	Clackamas (OR), Clark (WA), Multnomah (OR), Washington (OR)	Survey
Los Niños Cuentan	Clackamas (OR), Multnomah (OR), Washington (OR)	Survey
Luke-Dorf, Inc.	Clackamas (OR), Washington (OR)	Survey
Mentor Oregon Brokerage, Metro	Clackamas (OR), Multnomah (OR), Washington (OR)	Survey
Metropolitan Family Service	Clackamas (OR), Clark (WA), Multnomah (OR)	Survey
Multnomah County Aging and Disability Services	Multnomah (OR)	Interview
Multnomah County Health Department	Multnomah (OR)	Interview
Multnomah County Health Department, Health Equity Initiative	Multnomah (OR)	Interview
Multnomah County Mental Health and Addiction Services	Multnomah (OR)	Survey
Multnomah County Mental Health and Addiction Services	Multnomah (OR)	Interview
National Alliance on Mental Illness-Clackamas County	Clackamas (OR)	Survey
National Alliance on Mental Illness-Clark County	Clark (WA)	Survey
National College of Natural Medicine, Community Clinics	Multnomah (OR), Washington (OR)	Survey
National Indian Child Welfare Association	Clackamas (OR), Clark (WA), Multnomah (OR), Washington (OR)	Survey
Native American Youth and Family Center	Clackamas (OR), Clark (WA), Multnomah (OR), Washington (OR)	Interview
New Heights Physical Therapy Plus	Clark (WA), Multnomah (OR)	Survey
North by Northeast Community Health Center	Multnomah (OR)	Survey
NorthWest Tribal Epidemiology Center	Clackamas (OR), Clark (WA), Multnomah (OR), Washington (OR)	Interview
NW Health Foundation	Clackamas (OR), Clark (WA), Multnomah (OR), Washington (OR)	Interview
NW Indian Veterans Association, Portland and Vancouver Chapter	Clackamas (OR), Clark (WA), Multnomah (OR), Washington (OR)	Interview
Oregon College of Oriental Medicine	Multnomah (OR)	Survey
Oregon Department of Human Services	Clackamas (OR)	Survey
Oregon Health and Science University, Oregon Office on Disability and Health	Clackamas (OR), Multnomah (OR), Washington (OR)	Interview

## Section 2: Healthy Columbia Willamette

Oregon Health and Sciences University	Clackamas (OR), Clark (WA), Multnomah (OR), Washington (OR)	Interview
Oregon Health Authority, Office of Equity and Inclusion	Clackamas (OR), Multnomah (OR), Washington (OR)	Interview
Oregon Health Authority, Public Health Division	Clackamas (OR), Multnomah (OR), Washington (OR)	Interview
Oregon Health Equity Alliance	Clackamas (OR), Multnomah (OR), Washington (OR)	Interview
Oregon Latino Agenda for Action	Clackamas (OR), Multnomah (OR), Washington (OR)	Interview
Oregon Public Health Institute	Clackamas (OR), Multnomah (OR), Washington (OR)	Interview
Organizing People, Activating Leaders	Clackamas (OR), Multnomah (OR), Washington (OR)	Interview
PeaceHealth Southwest Medical Center	Clark (WA)	Interview
Project Access NOW	Clackamas (OR), Clark (WA), Multnomah (OR), Washington (OR)	Interview
Providence Health & Services	Clackamas (OR), Clark (WA), Multnomah (OR), Washington (OR)	Interview
Q Center	Clackamas (OR), Clark (WA), Multnomah (OR), Washington (OR)	Survey
Regional Health Alliance	Clark (WA)	Focus Group
Sea Mar Community Health Centers	Clark (WA), Multnomah (OR)	Interview
Second Step Housing	Clark (WA)	Survey
Self Enhancement, Inc.	Multnomah (OR)	Survey
Sí Se Puede Oregon	Washington (OR)	Survey
Southwest Washington Behavioral Health, Regional Support Network	Clark (WA)	Survey
Susan G. Komen for the Cure, Oregon and Southwest Washington	Clackamas (OR), Clark (WA), Multnomah (OR), Washington (OR)	Interview
Tuality Healthcare	Washington (OR)	Interview
Tuality Healthcare, iSalud! Services	Clackamas (OR), Multnomah (OR), Washington (OR)	Interview
United Way of the Columbia-Willamette	Clackamas (OR), Clark (WA), Multnomah (OR), Washington (OR)	Interview
Upstream Public Health	Clackamas (OR), Multnomah (OR), Washington (OR)	Interview
Urban League of Portland	Multnomah (OR)	Interview
Vietnamese Community of Clark County	Clark (WA)	Interview
Virginia Garcia Memorial Health Center	Washington (OR)	Interview
Washington County Health & Human Services	Washington (OR)	Interview
Washington County Health and Human Services, Healthy Start of Washington County	Washington (OR)	Survey
Washington State Department of Health	Clark (WA)	Survey
YMCA of Columbia-Willamette, Clark County Family YMCA	Clark (WA)	Survey

## Section 2: Healthy Columbia Willamette

### APPENDIX VII: Interview Tool

**The purpose of this interview is to ask about your opinions on important health issues in our community and about the capacity to address them. This information will be used by hospitals and health departments during the Healthy Columbia Willamette process (formally called Four County Community Health Needs Assessment), along with data and additional community feedback to identify which health issues to address.**

**Your responses along with feedback from 100+ organizations will help us find themes of what stakeholders have said about the local community health system's capacity to address important health issues.**

1. What geographic area and population does your organization serve? (Select all that apply.)

- Clackamas county
- Clark county
- Multnomah county
- Washington county
- Medically underserved, uninsured, underinsured populations
- Low income populations
- Tribal populations
- Communities of color
- Populations with a chronic disease (e.g. heart disease, diabetes, cancer)
- Populations with mental health and/or substance abuse needs
- Aging population
- Disability community
- LGBTQI populations
- Children/youth
- General population
- Other

2. How healthy is the population/community you serve compared to the larger population?

The next few questions are about identifying the most important health issues in the community. I am going to share with you a list of six health issues that were identified in earlier steps of this project and ask you to respond to them. These issues were identified by analyzing quantitative data and considering racial/ ethnic/ gender disparities, magnitude of the population affected, severity, 5-10 year trend and comparison to state-level data. The issues identified are:

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

3. 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? Note: issues such as housing, education, economy, built environment (social determinants of health) will be incorporated into the stage when strategies are being developed. We are looking for health outcomes and behavior at this time.

4. From all of the issues I shared with you, and the issue(s) you brought up, what are the top three most important issues to your organization and the community it serves? You do not need to rank them, just select the three top ones.

## Section 2: Healthy Columbia Willamette

**Now I am going to ask you a series of questions for each of the three health issues you have said are the most important.**

5. For Issue 1: \_\_\_\_\_
- Is your organization currently working on this issue? If so, what type of work are you doing? If not, why?
  - Would your organization like to work on this issue in the future? If so, what type of work would you like to be doing?
  - Is there a particular age group you see affected by this issue?
  - In the next few years, what are some things that may help your organization address this issue?
  - In the next two to three years, what are some things that may hinder your organization's ability address this issue?
  - How would you rate your organization's capacity to address this issue in the next two to three years? Why is this? (Select only one.)
    - currently don't have capacity
    - capacity will be eliminated
    - capacity will be reduced
    - capacity will be about the same
    - capacity will be increased
    - I don't know/not applicable
6. For Issue 2: \_\_\_\_\_
- Is your organization currently working on this issue? If so, what type of work are you doing? If not, why?
  - Would your organization like to work on this issue in the future? If so, what type of work would you like to be doing?
  - Is there a particular age group you see affected by this issue?
  - In the next few years, what are some things that may help your organization address this issue?
  - In the next two to three years, what are some things that may hinder your organization's ability to address this issue?
  - How would you rate your organization's capacity to address this issue in the next two to three years? Why is this? (Select only one.)
    - currently don't have capacity
    - capacity will be eliminated
    - capacity will be reduced
    - capacity will be about the same
    - capacity will be increased
    - I don't know/not applicable
7. For Issue 3: \_\_\_\_\_
- Is your organization currently working on this issue? If so, what type of work are you doing? If not, why?
  - Would your organization like to work on this issue in the future? If so, what type of work would you like to be doing?
  - Is there a particular age group you see affected by this issue?
  - In the next few years, what are some things that may help your organization to address this issue?
  - In the next two to three years, what are some things that may hinder your organization's ability to address this issue?
  - How would you rate your organization's capacity to address this issue in the next two to three years? Why is this? (Select only one.)
    - currently don't have capacity
    - capacity will be eliminated
    - capacity will be reduced
    - capacity will be about the same
    - capacity will be increased
    - I don't know/not applicable
8. Could you suggest other organizations/groups in our community who would be important to interview/survey?
9. Do you have any questions or something to add that can help make this project a success?

**Thank you for your time today and for sharing your thoughts and feedback.**

## Section 2: Healthy Columbia Willamette

### APPENDIX VIII: Online Survey Tool

#### PURPOSE OF SURVEY

To learn about the community health issues that stakeholders think are the most important and ideas on how to address them. This is part of the project's second phase of community engagement. Responses from this survey will be analyzed along with 100+ other interviews/surveys to help find themes of what stakeholders have said about the local community health system's capacity to address important health issues. Your name and findings from this survey will be reported in aggregate. Survey findings will not be presented in any way that would connect the information to individual people or organizations.

#### BACKGROUND

Healthy Columbia Willamette is a collaborative project among 14 local hospitals and four health departments to assess community health across Clackamas, Multnomah and Washington Counties in Oregon and Clark County in Washington. Under the requirements from the Patients Rights and Affordable Care Act, Oregon and Washington State laws and public health accreditation prerequisites, hospitals, coordinated care organizations and local health departments are required to conduct Community Health Needs Assessments every three to five years. In an effort to develop the most meaningful community health needs assessments and plans to improve community health, avoid duplication, and leverage resources, these partners within the four counties have come together to develop a comprehensive assessment for the region.

#### COMMUNITY ENGAGEMENT PROCESS

The Healthy Columbia Willamette Leadership Group is soliciting input from communities across the four counties in three distinct phases:

- 1) Sixty two, recently conducted projects during which community members gave input about health issues in the four-county region were studied. Findings from these projects were compiled to understand what community members think are the most important community health issues. (August 2012 and January 2013.)
- 2) Representatives of organizations in the local community health system (public health experts, government/tribal agencies, community based organizations that work with low income populations, communities of color, veterans, populations with chronic disease needs and medically underserved, LGBTQI, aging, disability communities) are being interviewed/surveyed to understand health issues of the populations they serve and their ideas around the community health system's capacity to address the issues (between now-end of January 2013). This survey is part of this step.
- 3) After completing the first two phases, the Leadership Group will use the community input to select a smaller list of proposed health issues that reflects both community input and data. Then community members across the four counties will be asked whether they "got it right." Specifically, community members participating in these community listening sessions will be asked which of the health issues on the list are the most important, which issues should be on the list but are not, and what types of things can be done to address these important health issues.

**The next section asks you to share** information about your organization, your role and your contact information.

1. What is your organization's name?
2. What is your name?
3. What is your job title or role?
4. What is your phone number?
5. What is your email?

The next few questions ask about your organization's geographic scope, population(s) served, and the general health status of the community.

6. Which of the following counties do you operate in? Check all that apply.

Clackamas County, Oregon

Clark County, Washington

Multnomah County, Oregon

Washington County, Oregon

Other: \_\_\_\_\_

7. In general, how would you rate people's health and quality of life in the counties you work in? Select one of the responses below.

Very healthy

Somewhat healthy

Somewhat unhealthy

Very unhealthy



## Section 2: Healthy Columbia Willamette

**The next set of questions asks about the population(s) your organization serves.**

**8.** Does your organization target programs, services, or interventions specifically for communities of color? Note: you will be able to answer this question for multiple populations.

Yes  No

**If you answered 'Yes' to Question #8, Proceed to Questions 8a-e. If you answered 'No', Skip to Question #9.**

**8a.** Does your organization target programs, services, or interventions specifically for the African American community? Select one answer below.

Yes  No

**8b.** Does your organization target programs, services, or interventions specifically for the American Indian/Alaska Native community? Select one answer below.

Yes  No

**8c.** Does your organization target programs, services, or interventions specifically for Asian and Pacific Islander communities? Select one answer below.

Yes  No

**8d.** Does your organization target programs, services, or interventions specifically for the Hispanic/Latino community? Select one answer below.

Yes  No

**8e.** If your organization specifically targets programs, services, or interventions for another community of color, please list your answer below.

**9.** Does your organization target programs, services, or interventions specifically for immigrants and refugees? Select one answer below.

Yes  No

**10.** Does your organization target programs, services, or interventions specifically for populations that speak limited English? Select one answer below.

Yes  No

**If you answered 'Yes' to Question #10, Proceed to Question 10a. If you answered 'No', Skip to Question #11.**

**10a.** Please identify the languages that your organization specifically targets programs, services, or interventions. Check all that apply or add other language(s).

Arabic

Chinese/Cantonese

Somali

Spanish

Russian

Vietnamese

Other: \_\_\_\_\_

**11.** Does your organization target programs, services, or interventions specifically for children and/or youth? Select one answer below.

Yes  No

**If you answered 'Yes' to Question #11, Proceed to Question 11a. If you answered 'No', Skip to Question #12.**

**11a.** Among which of the following age groups does your organization specifically target children/youth related programs, services, or interventions? Check all that apply.

0-4

5-9

10-14

15-18

19-24

Other: \_\_\_\_\_

## Section 2: Healthy Columbia Willamette

**12.** Does your organization target programs, services, or interventions specifically for aging populations? Select one answer below.

Yes  No

**13.** Does your organization target programs, services, or interventions specifically for communities that rely on public transportation? Select one answer below.

Yes  No

**14.** Does your organization target programs, services, or interventions specifically for populations with chronic disease needs (e.g. heart disease, diabetes, cancer)? Select one answer below.

Yes  No

**15.** Does your organization target programs, services, or interventions specifically for the disability community? Select one answer below.

Yes  No

**16.** Does your organization target programs, services, or interventions specifically for the LGBTQI community? Select one answer below.

Yes  No

**17.** Does your organization target programs, services, or interventions specifically for medically underserved, uninsured, underinsured and/or Medicaid populations? Select one answer below.

Yes  No

**18.** Does your organization target programs, services, or interventions specifically for populations with mental health and/or substance abuse needs? Select one answer below.

Yes  No

**19.** Does your organization target programs, services, or interventions specifically for veterans? Select one answer below.

Yes  No

**20.** If your organization targets programs, services, or interventions for other specific population(s), write your response below.

**The next question is about identifying the most important health issues in the community.**

Below is a preliminary list of health issues that were identified earlier in this process by analyzing quantitative data and collecting community input. The issues identified are:

- 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

**21.** Is there any important health issue—specifically a health outcome or behavior—that is missing from this list? Note: issues such as housing, economy, built environment (social determinants of health) will be incorporated into the state when strategies are being developed. We are looking for health outcomes and behaviors at this time.

**The next questions are about prioritizing three health issues, starting with your first selection.**

**22.** Of the above issues and any that you previously identified, what is your first top health issue? Choose one option below. Note: you will be able to select two other issues later in the survey. The issues do not need to be ranked in order of priority.

- Access to Health care
- Cancer
- Chronic Disease
- Culturally Competent Services/Data
- Domestic Violence
- Falls

## Section 2: Healthy Columbia Willamette

Mental Health  
Oral Health  
Poisoning/Overdose  
Sexual Health (HIV, Syphilis, Chlamydia)  
Substance Abuse  
Other: \_\_\_\_\_

**23.** How is your organization currently working on this issue? Choose up to three options below.

Not currently working on this issue  
Collaborate with others to identify strategies to address health issues  
Manage contracts with other organizations to provide services  
Work to increase workforce capacity to provide culturally-appropriate services  
Convene conferences/trainings  
Policy advocacy for the community  
Provide financial support to community partners  
Implement the Affordable Care Act  
Redesign service delivery to build capacity  
Work to coordinate care  
Research/data collection  
Provide health education to populations  
Provide education to medical providers  
Provide health education to individuals  
Help clients navigate the health care/social service system  
Provide health care services to individuals  
Provide in-home services to individuals  
Provide advocacy or legal assistance to individuals  
Other: \_\_\_\_\_

**24.** Do you see a role for your organization to be addressing this issue in the future? Choose one option below.

Yes  No

**If you answered 'Yes' to Question #24, Proceed to Questions 24a-f. If you answered 'No', Skip to Question #25.**

**24a.** How would your organization like to be working on this issue in the future? Choose up to three options below.

Collaborate with others to identify strategies to address health issues  
Manage contracts with other organizations to provide services  
Work to increase workforce capacity to provide culturally-appropriate services  
Convene conferences/trainings  
Policy advocacy for the community  
Provide financial support to community partners  
Implement the Affordable Care Act  
Redesign service delivery to build capacity  
Work to coordinate care  
Research/data collection  
Provide health education to populations  
Provide education to medical providers  
Provide health education to individuals  
Help clients navigate the health care/social service system  
Provide health care services to individuals  
Provide in-home services to individuals  
Provide advocacy or legal assistance to individuals  
Other: \_\_\_\_\_

**24b.** Is there a particular age group you see affected by this issue? Check all that apply.

0-4  
5-9  
10-14  
15-18  
19-24  
Other: \_\_\_\_\_

## Section 2: Healthy Columbia Willamette

**24c.** In the next two to three years, what are some things that may help your organization address this issue? Choose up to three options below.

- Leadership in our organization
- Leadership in the community
- Funding
- Expanded access to Medicaid and other health insurance
- Increased public awareness and interest in the issue
- Advocacy, new legislation, and political support
- Partnerships with other organizations
- Health care reform
- Increased availability of services
- The public's understanding/acceptance of groups, who have been marginalized, (e.g., transgendered people, disability community, communities of color, homeless people)
- Community organizing /engagement
- Focus on prevention
- Other: \_\_\_\_\_

**24d.** In the next two to three years, what are some things that may hinder your organization's ability to address this issue? Choose up to three options below.

- Lack of leadership in our organization
- Lack of leadership in our community
- Lack of funding
- Developing new services based on funding sources rather than need
- CCOs could cause a reduction in funding for community organizations
- The public's understanding/acceptance of marginalized groups (e.g., transgendered people, disability community, communities of color, homeless, mentally ill, substance abusers)
- The public's lack of interest about this health issue
- The public's lack of knowledge of this health issue
- Affordability of services
- Lack of services for this health issue
- Competition between organizations
- Lack of trust between organizations
- Stigma associated with this health issue
- Racism
- Stigma/Attitudes about the LGBTI community
- Other: \_\_\_\_\_

**24e.** Does your organization intend to work on this issue over the next few years? Select one answer below.

- Yes, but we have very limited capacity to do so
- Yes, but we have only moderate capacity to do so
- Yes, and we have sufficient capacity to do so
- No, but we would if we could get resources to do it
- No
- I don't know at this time

**24f.** Would your organization be willing to collaborate with others to address this issue? Select one answer below.

- Yes
- Maybe
- No
- I don't know at this time

**25.** Of the above issues and any that you previously identified, what is your second top health issue? Choose one option below.  
Note: you will be able to select one other issue later in the survey. The issues do not need to be ranked in order of priority.

- Access to Health care
- Cancer
- Chronic Disease
- Culturally Competent Services/Data
- Domestic Violence
- Falls

## Section 2: Healthy Columbia Willamette

Mental Health  
Oral Health  
Poisoning/Overdose  
Sexual Health (HIV, Syphilis, Chlamydia)  
Substance Abuse  
Other: \_\_\_\_\_

**26.** How is your organization currently working on this issue? Choose up to three options below.

Not currently working on this issue  
Collaborate with others to identify strategies to address health issues  
Manage contracts with other organizations to provide services  
Work to increase workforce capacity to provide culturally-appropriate services  
Convene conferences/trainings  
Policy advocacy for the community  
Provide financial support to community partners  
Implement the Affordable Care Act  
Redesign service delivery to build capacity  
Work to coordinate care  
Research/data collection  
Provide health education to populations  
Provide education to medical providers  
Provide health education to individuals  
Help clients navigate the health care/social service system  
Provide health care services to individuals  
Provide in-home services to individuals  
Provide advocacy or legal assistance to individuals  
Other: \_\_\_\_\_

**27.** Do you see a role for your organization to be addressing this issue in the future? Choose one option below.

Yes  No

**If you answered 'Yes' to Question #27, Proceed to Questions 27a-f. If you answered 'No', Skip to Question #28.**

**27a.** How would your organization like to be working on this issue in the future? Choose up to three options below.

Collaborate with others to identify strategies to address health issues  
Manage contracts with other organizations to provide services  
Work to increase workforce capacity to provide culturally-appropriate services  
Convene conferences/trainings  
Policy advocacy for the community  
Provide financial support to community partners  
Implement the Affordable Care Act  
Redesign service delivery to build capacity  
Work to coordinate care  
Research/data collection  
Provide health education to populations  
Provide education to medical providers  
Provide health education to individuals  
Help clients navigate the health care/social service system  
Provide health care services to individuals  
Provide in-home services to individuals  
Provide advocacy or legal assistance to individuals  
Other: \_\_\_\_\_

**27b.** Is there a particular age group you see affected by this issue? Check all that apply.

0-4  
5-9  
10-14  
15-18  
19-24  
Other: \_\_\_\_\_

## Section 2: Healthy Columbia Willamette

**27c.** In the next two to three years, what are some things that may help your organization address this issue? Choose up to three options below.

- Leadership in our organization
- Leadership in the community
- Funding
- Expanded access to Medicaid and other health insurance
- Increased public awareness and interest in the issue
- Advocacy, new legislation, and political support
- Partnerships with other organizations
- Health care reform
- Increased availability of services
- The public's understanding/acceptance of groups, who have been marginalized, (e.g., transgendered people, disability community, communities of color, homeless people)
- Community organizing /engagement
- Focus on prevention
- Other: \_\_\_\_\_

**27d.** In the next two to three years, what are some things that may hinder your organization's ability to address this issue? Choose up to three options below.

- Lack of leadership in our organization
- Lack of leadership in our community
- Lack of funding
- Developing new services based on funding sources rather than need
- CCOs could cause a reduction in funding for community organizations
- The public's understanding/acceptance of marginalized groups (e.g., transgendered people, disability community, communities of color, homeless, mentally ill, substance abusers)
- The public's lack of interest about this health issue
- The public's lack of knowledge of this health issue
- Affordability of services
- Lack of services for this health issue
- Competition between organizations
- Lack of trust between organizations
- Stigma associated with this health issue
- Racism
- Stigma/Attitudes about the LGBTI community
- Other: \_\_\_\_\_

**27e.** Does your organization intend to work on this issue over the next few years? Select one answer below.

- Yes, but we have very limited capacity to do so
- Yes, but we have only moderate capacity to do so
- Yes, and we have sufficient capacity to do so
- No, but we would if we could get resources to do it
- No
- I don't know at this time

**27f.** Would your organization be willing to collaborate with others to address this issue? Select one answer below.

- Yes
- Maybe
- No
- I don't know at this time

**28.** Of the above issues and any that you previously identified, what is your third top health issue? Choose one option below.

- Access to Health care
- Cancer
- Chronic Disease
- Culturally Competent Services/Data
- Domestic Violence
- Falls
- Mental Health

## Section 2: Healthy Columbia Willamette

Oral Health  
Poisoning/Overdose  
Sexual Health (HIV, Syphilis, Chlamydia)  
Substance Abuse  
Other: \_\_\_\_\_

**29.** How is your organization currently working on this issue? Choose up to three options below.

Not currently working on this issue  
Collaborate with others to identify strategies to address health issues  
Manage contracts with other organizations to provide services  
Work to increase workforce capacity to provide culturally-appropriate services  
Convene conferences/trainings  
Policy advocacy for the community  
Provide financial support to community partners  
Implement the Affordable Care Act  
Redesign service delivery to build capacity  
Work to coordinate care  
Research/data collection  
Provide health education to populations  
Provide education to medical providers  
Provide health education to individuals  
Help clients navigate the health care/social service system  
Provide health care services to individuals  
Provide in-home services to individuals  
Provide advocacy or legal assistance to individuals  
Other: \_\_\_\_\_

**30.** Do you see a role for your organization to be addressing this issue in the future? Choose one option below.

Yes  No

**If you answered 'Yes' to Question #23, Proceed to Questions 30a-f. If you answered 'No', Skip to the end of the survey.**

**30a.** How would your organization like to be working on this issue in the future? Choose up to three options below.

Collaborate with others to identify strategies to address health issues  
Manage contracts with other organizations to provide services  
Work to increase workforce capacity to provide culturally-appropriate services  
Convene conferences/trainings  
Policy advocacy for the community  
Provide financial support to community partners  
Implement the Affordable Care Act  
Redesign service delivery to build capacity  
Work to coordinate care  
Research/data collection  
Provide health education to populations  
Provide education to medical providers  
Provide health education to individuals  
Help clients navigate the health care/social service system  
Provide health care services to individuals  
Provide in-home services to individuals  
Provide advocacy or legal assistance to individuals  
Other: \_\_\_\_\_

**30b.** Is there a particular age group you see affected by this issue? Check all that apply.

0-4  
5-9  
10-14  
15-18  
19-24  
Other: \_\_\_\_\_



## Section 2: Healthy Columbia Willamette

**30c.** In the next two to three years, what are some things that may help your organization address this issue? Choose up to three options below.

- Leadership in our organization
- Leadership in the community
- Funding
- Expanded access to Medicaid and other health insurance
- Increased public awareness and interest in the issue
- Advocacy, new legislation, and political support
- Partnerships with other organizations
- Health care reform
- Increased availability of services
- The public's understanding/acceptance of groups, who have been marginalized, (e.g., transgendered people, disability community, communities of color, homeless people)
- Community organizing /engagement
- Focus on prevention
- Other: \_\_\_\_\_

**30d.** In the next two to three years, what are some things that may hinder your organization's ability to address this issue? Choose up to three options below.

- Lack of leadership in our organization
- Lack of leadership in our community
- Lack of funding
- Developing new services based on funding sources rather than need
- CCOs could cause a reduction in funding for community organizations
- The public's understanding/acceptance of marginalized groups (e.g., transgendered people, disability community, communities of color, homeless, mentally ill, substance abusers)
- The public's lack of interest about this health issue
- The public's lack of knowledge of this health issue
- Affordability of services
- Lack of services for this health issue
- Competition between organizations
- Lack of trust between organizations
- Stigma associated with this health issue
- Racism
- Stigma/Attitudes about the LGBTI community
- Other: \_\_\_\_\_

**30e.** Does your organization intend to work on this issue over the next few years? Select one answer below.

- Yes, but we have very limited capacity to do so
- Yes, but we have only moderate capacity to do so
- Yes, and we have sufficient capacity to do so
- No, but we would if we could get resources to do it
- No
- I don't know at this time

**30f.** Would your organization be willing to collaborate with others to address this issue? Select one answer below.

- Yes
- Maybe
- No
- I don't know at this time

**Thank you for your time today and for sharing your thoughts and feedback.**

## Section 2: Healthy Columbia Willamette

### Appendix IX: Populations Served by Stakeholder Organizations

Population	Percentage of Participating Stakeholder Serving Population
Aging community	• 33% of surveys 46% of interviews
Children/youth	• 70% of surveys 43% of interviews
Populations with a chronic disease need	• 47% of surveys 42% of interviews
Communities of color (all)	• 42% of surveys 74% of interviews
Communities of color: African Americans	18% of surveys completed by stakeholders that target programs, services, or interventions specifically for communities of color. Interview asked about "communities of color," not specific communities.
Communities of color: American Indians/Alaska Natives	12% of surveys completed by stakeholders that target programs, services, or interventions specifically for communities of color. Interview asked about "communities of color," not specific communities.
Communities of color: Asian and Pacific Islanders	9% of surveys completed by stakeholders that target programs, services, or interventions specifically for communities of color. Interview asked about "communities of color," not specific communities.
Communities of color: Hispanics/Latinos	32% of surveys completed by stakeholders that target programs, services, or interventions specifically for communities of color. Interview asked about "communities of color," not specific communities.
People who are dependent on public transportation	• 53% of surveys 1% of interviews
Disability community	• 47% of surveys 43% of interviews
Immigrants and/or refugees	• 19% of surveys 14% of interviews
LGBTQI community	• 18% of surveys 35% of interviews
Low income populations	• 7% of surveys 61% of interviews
Medically underserved, uninsured, underinsured populations	• 72% of surveys 56% of interviews
Populations with mental health and/or substance abuse needs	• 59% of surveys 45% of interviews
Populations that speak Limited English	• 32% of surveys 3% of interviews
Populations that speak Arabic	6% of surveys completed by stakeholders targeting programs, services, or interventions specifically for populations that speak limited English
Populations that speak Chinese/Cantonese	28% of surveys completed by stakeholders targeting programs, services, or interventions specifically for populations that speak limited English
Populations that speak Russian	39% of surveys completed by stakeholders targeting programs, services, or interventions specifically for populations that speak limited English
Populations that speak Somali	22% of surveys completed by stakeholders targeting programs, services, or interventions specifically for populations that speak limited English
Populations that speak Spanish	89% of surveys completed by stakeholders targeting programs, services, or interventions specifically for populations that speak limited English
Populations that speak Vietnamese	22% of surveys completed by stakeholders targeting programs, services, or interventions specifically for populations that speak limited English
Populations that speak Other Languages	11% of surveys completed by stakeholders targeting programs, services, or interventions specifically for populations that speak limited English
Veterans	• 15% of surveys 1% of interviews

N=126 (69 interviews, 57 surveys)

## Section 2: Healthy Columbia Willamette

### APPENDIX X: Schedule of Healthy Columbia Willamette Community Listening Sessions

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

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

## Section 2: Healthy Columbia Willamette

### APPENDIX XI: Discussion Guide

#### Healthy Columbia Willamette Collaborative Community Listening Session Guide

**Large Group Introduction:** *(Instruction: Convener team or Leadership group member will present this to larger group and Interpreters will translate this information to non-English speakers. This is just a guide. Information should be covered but doesn't need to be read as written.)*

#### Welcome

Welcome everyone. Thank you so much for coming out tonight/today to participate in this important project. My name is \_\_\_\_\_ and I work at \_\_\_\_\_. I want to give you a quick overview of why we are here, but first I want to take care of some housekeeping things.

#### Housekeeping

- First, if you have questions about childcare, please ask \_\_\_\_\_
- If you haven't already, please help yourself to refreshments.
- The bathrooms are located \_\_\_\_\_
- Please make sure that you have signed in. The 25 adults who arrived and signed in first will receive Fred Meyer gift cards at the end of the meeting.
- We will be done by 7:00 sharp.

#### Project Overview

Today, we want to hear from you all about what are the most important health issues in the community. There are no right or wrong answers. We are here to hear your opinions and ideas. The information we hear from you today is going to be combined with information collected in 13 other groups just like this one.

We are hosting these meetings as part of the Healthy Columbia Willamette Collaborative. It is a collaborative of 14 hospitals and 4 health departments in Clark County Washington, and Clackamas, Multnomah and Washington Counties in Oregon.

The goal of this project is to identify the most important needs of the community and find ways that we can all work together to work on them. In June we will have a final list of priority health issues and will start planning what we all can do about these issues.

We have a handout describing the Healthy Columbia Willamette Collaborative, as well as a sheet that you can sign if you would like us to send you information about the process as we move forward. They are both on the table. I would like the group to break into smaller groups so that all of us have more of an opportunity to speak. In these small groups, you will have a facilitator who has some questions to ask you. But before we do this, does anyone have any questions?

*Instructions: Ask people to break into groups of about 10 people. Each group will need at least one facilitator. If there are two available, have one take notes on poster sheets and the other ask the questions.*

#### **Small Group Discussion Questions:**

Okay, we have a little over an hour to talk about health and what health issues are the most important in our community. This is going to be an informal discussion. We want to hear about your ideas, experiences and opinions. There are no wrong answers. I am also going to request that we let everyone have a chance to speak. The goal today is to have everyone's opinions recorded rather than come to an agreement. If we all end up agreeing however, that is just fine too.

## Section 2: Healthy Columbia Willamette

Okay, let's start with a general question.

**What does a healthy community look like to you? For this question, please define community however you like. It could be only people, or it can include things like the job market, housing, conditions of your neighborhood, etc.**

*Instructions: Please document the answers on a poster sheet.*

Now I would like to talk about this list of health issues. (*Refer to poster or handout.*) These health issues have been identified as the most important issues affecting our community through a series of activities similar to this one and through data. Let's go over this list and make sure we have the same understanding of each issue. Then we are going to identify health issues that we think need to be added to the list. After that, we will each pick the five issues that each of us consider to be the most important. Remember there are no right or wrong answers.

*Instructions: Go over the list as a group so that people understand what each issue is.*

**Are there other health issues that you think should be on this list?**

*Instructions: Write the new issues on a separate handout or poster sheet—assign a letter to each new issue so it fits in the existing list.*

**Alright, now we get to each pick the five issues that are the most important ones. The five issues that you would like to see addressed first. This is going to be a challenge because all of these issues are important.**

*Instructions: Read out each health issue (those you started with and any additional ones that were added). As you read through the list, ask participants to vote for their top five (only five). Having people vote with a show of hands is the best option; however, if you feel that group members may not feel comfortable to share their vote publicly, ask them to write down their votes. Make sure to record the votes on a poster sheet.*

**Okay, it looks like # issues have been voted for. Let's now brainstorm ideas on what we think should be done to fix or address the issue. Let's start with the issue with the most votes and work through all of the ones that at least one person voted for.**

*Instructions: On a poster sheet, write the issue down (or just its letter) and write down the ideas that participants come up with to address/fix the issue. Do this for each issue that received a vote, but start with the issue receiving the most votes in case you run out of time.*

**APPENDIX XII: List of Health Issues**

**Health Issues (English)**

**A) Mental health**

- depression
- trauma
- stress
- mood disorders
- anxiety
- suicide

**B) Substance Abuse**

- prescription drug abuse
- illegal/street drug use
- alcohol abuse
- Adult smoking

**C) Chronic Disease and related health behaviors**

- adults not eating enough fruits and vegetables
- adults not being physically active
- obesity or being overweight
- heart disease
- diabetes

**D) Sexually transmitted infections/diseases** (Chlamydia, Syphilis, HIV, Herpes, etc)

**E) Accidental poisoning** from chemicals, pesticides, gases, fertilizers, cleaning supplies, etc

**F) Injuries from falling**

**G) Cancer**

**H) Oral Health** (gum disease, tooth decay, etc)

**I) Perinatal health**

**J) Access to affordable mental health services**

**K) Access to affordable dental care**

**L) Access to affordable health care**

**M) Access to services that are relevant/specific to different cultures** (such as African American, Latino, Native American, Asian, Slavic, refugee/immigrant, LGBT, disability communities, etc)

**N) Data collection on the health of people from various cultures** (such as African American, Latino, Native American, Asian, Slavic, refugee/immigrant, LGBT, disability communities, etc)

## Section 2: Healthy Columbia Willamette

### (Health Issues List, Spanish) Problemas de la Salud

#### A) Salud Mental

- depresión
- trauma
- estrés
- trastornos del estado de ánimo
- angustia
- suicidio

#### B) Abuso de Sustancias

- Abuso del medicamento recetado
- Uso de drogas ilegales/de calle
- Abuso del alcohol
- Fumar adulto

#### C) Enfermedad crónica y conductas relacionadas con la salud

- adultos que no comen bastantes frutas y verduras
- adultos no siendo físicamente activos
- obesidad o ser demasiado pesado
- enfermedad cardíaca
- diabetes

#### D) Infecciones/enfermedades transmitidas sexualmente (Chlamydia, Sifilis, VIH, Herpes, etc)

#### E) Envenenamiento accidental de productos químicos, pesticidas, gases, fertilizantes, productos de limpieza, etc.

#### F) Heridas de caída

#### G) Cáncer

#### H) Salud oral (enfermedad periodontal, caries, etc)

#### I) Salud perinatal

#### J) Acceso a servicios de salud mental económicos

#### K) Acceso a cuidado dental económico

#### L) Acceso a asistencia médica económica

#### M) El acceso a servicios que son relevantes /específicos para culturas diferentes (como el afroamericano, Latino, americano indígena, asiáticos, eslavos, refugiado/inmigrante, LGBT, comunidades de invalidez, etc)

#### N) Recogida de datos en la salud de la gente de varias culturas (como el afroamericano, Latino, americano indígena, asiáticos, eslavos, refugiado/inmigrante, LGBT, comunidades de invalidez, etc)



## Section 2: Healthy Columbia Willamette

### (Health Issues List, Russian) Вопросы Здравоохранения

#### **A) Психическое здоровье**

- депрессия
- травма
- стресс
- расстройство настроения
- страх
- самоубийство

#### **B) Злоупотребление различными веществами**

- злоупотребление лекарственными препаратами
- употребление наркотиков
- злоупотребление алкоголем
- курение (для взрослых)

#### **C) Хронические болезни и ответственность за собственное здоровье**

- Взрослые, не употребляющие достаточного количества фруктов и овощей
- взрослые, ведущие малоподвижный образ жизни
- ожирение или избыточный вес
- болезни сердца
- диабет

#### **D) Заболевания, передающиеся половым путём (Хламидия, Сифилис, ВИЧ, Герпес и др.)**

#### **E) Случайное отравление химикатами, пестицидами, газом, удобрением, материалами для уборки и др.**

#### **F) Повреждения от того, что вы упали**

#### **G) Рак**

#### **H) Гигиена полости рта: заболевание десен, кариес зубов и др.**

#### **I) перинатального здоровья**

#### **J) Доступное лечение психического здоровья**

#### **K) Доступное стоматологическое обслуживание**

#### **L) Доступная медицина**

#### **M) Доступ к получению обслуживания, которое особенно важно или относительно для разных культур, т.к. афроамериканцев, латиноамериканцев, коренных американцев, азиат, славян, беженцев/иммигрантов, лезбиянок, геев, бисексуалов и трансгендерных людей, лиц с ограниченными возможностями и др.)**

#### **N) Сбор информации о здоровье людей с разных культур (таких как афроамериканцев, латиноамериканцев, коренных американцев, азиат, славян, беженцев/иммигрантов, лезбиянок, геев, бисексуалов и трансгендерных людей, лиц с ограниченными возможностями и др.)**

## Section 2: Healthy Columbia Willamette

### (Health Issues List, Somali) Cudurada Caafimaadka

#### A) Cudurada Meskaxda

- Murugo
- Walaac/dhibaadooyin kugu dhacay oo xasuus xunleh
- Walwal/Walbahaar
- Isbadbadalka Dareenka
- kurbo
- isidilid

#### B) Isticmaalka Xaddhaafa daroogada

- Isticmaalka Xaddhaafa Daawada Laguu qoray
- Daawa aan laguu qorin/ama jidadka kazoo gadatay
- Isticmaalka Alkolada
- Qofka weyn sigaarka cabaaya

#### C) Cudurada Hoose iyo dhaqamada caafimaad

- dadka waaweyn oo aanan cuneyn qudaarta
- dadka waaweyn oo aanan aalmiiteyneynin
- cayilaka ama cayilka xeddhaafka ah
- cudurka wadnaha
- cudurka sokorowka

#### D) Cudurala isu taga ee infakshanka leh, ee leyska qaado (Chlamydia, Syphilis, HIV, Herpes, etc)

#### E) Sunta la cuno ama lasiiyo qofkale ayadoon loola jeedin, sida kimikadoo kale, suntan xayawaanka disha, sunta wax lagu dhaqdo, gaaska iyo wax yaaba badan.

#### F) Jabista laga qaada marka ladhoco

#### G) Cuduka Kaankaraha

#### H) Caafimaadka afka gudhiisa (Cudurka Ciridka, Ilka jajibka, iyo waxyaaba badan)

#### I) Caafimaadka Perinatal

#### J) Helista caadimaad raqiiska ah oo cudurka meskaxda

#### K) Helista caafimaad raqiiska ah ee dhaqaaleenta ilkaha

#### L) Helista caafimaad raqiiska ah

#### M) Helista brogaramya u gaar ah/loogu talagalay dadweynaha heysta dhaqanyada kala duwan (sidiiba African American, Latino, Native American, Asian, Slavic, refugee/immigrant, LGBT, disability communities, etc)

#### N) Gurbiska xisaabta caafimaadka ee dadka kakala imaaday dhaqanyo kala duwan (sidiiba African American, Latino, Native American, Asian, Slavic, refugee/immigrant, LGBT, disability communities, etc)

## Section 2: Healthy Columbia Willamette

### Appendix XIII: Healthy Columbia Willamette Collaborative Community Listening Session: Participant Survey

This information will be used to describe who participated in the discussions. This is an anonymous survey, so please do not put your name on it.

1) **What is your gender?**

- Female
- Male
- Other

2) **What is your age?** \_\_\_\_\_ years

3) **How would you describe your race/ethnicity? Please mark all that apply:**

- African American/Black
- American Indian/Native American
- Asian
- Hispanic
- Native Hawaiian/Pacific Islander
- White
- Other (please specify): \_\_\_\_\_

4) **What is your household's yearly income?**

- Less than \$10,000
- \$10,000 to \$19,999
- \$20,000 to \$29,000
- \$30,000 to \$39,000
- \$40,000 to \$49,000
- \$50,000 or higher

5) **How many people live in your home?**

1    2    3    4    5    6    7    8    9 or more

6) **What is your zip code?** \_\_\_\_\_

7) **Do you have a health care provider you can see?**

- Yes
- No
- Sometimes

8) **Do you have a dentist you can see?**

- Yes
- No
- Sometimes

9) **How much school have you had?**

- Less than high school
- High school diploma/GED
- Some college
- College graduate or higher

10) **What kind of health insurance do you have?**

- No insurance
- Oregon Health Plan
- Medicare
- Private insurance through work
- Private insurance that you pay for