Multnomah County Community Health Assessment

Mobilizing for Action through Planning and Partnerships (MAPP)

To Identify Health-Related Priorities

Summary Report

Prepared for:
The Multnomah County Health Department Leadership Team

Prepared by:
Christine Sorvari, MS
Erin Mowlds, MPH
Health Assessment and Evaluation
Multnomah County Health Department

August 2011

MULTNOMAH COUNTY HEALTH DEPARTMENT

Public Health
Prevent. Promote. Protect.

ACKNOWLEDGMENTS

Multnomah County Community Health Assessment Advisory Group and Stakeholders

Managers, Organizations, and Participants of the Community Assessments and Engagement Projects Included in this Project

Participants of the Multnomah County Focus Groups

Respondents to the Multnomah County Community Health Survey

Participants of the Local Public Health and Forces of Change Assessment Interviews

Innovative Housing, Inc

Human Solutions

Wood Village Baptist Church

Multnomah County Health Department Diversity and Quality Team

Photo Credits (in order of appearance)
public domain
tedeytan/Flickr
Nancy White/Flickr
heac photos/Flickr
public domain
public domain

Multnomah County Community Health Assessment Advisory Group and Stakeholders[1]

Sonali Balajee, Multnomah County Health Department Health Equity Initiative

Liz Baxter, We Can Do Better (formerly The Archimedes Movement)

Rachel Burdon, Public Health Institute

Polo Catalani, Office of Human Relations City of Portland New Portlander Programs

Molly Franks, Multnomah County Health Department HIV/Hep C Prevention Operations

Rujuta Gaonkar, Multnomah County Health Department Community Capacitation Center

Mariotta Gary Smith, Multnomah County Health Department HIV/Hep C Prevention Operations

Jonathan Harker, City of Gresham Comprehensive Plan

Nancy Harvey, Mt Hood Community College Child Development and Family Support Services

Brian Hoop, Office of Neighborhood Involvement Neighborhood Resource Center

Michelle Kunec, Portland Bureau of Planning and Sustainability

Lai-Lani Ovalles, Native American Youth and Family Center Development and Community Engagement

Sandra Meucci, African American Health Coalition

Midge Purcell, Urban League of Portland Advocacy and Civic Engagement

Alejandro Queral, Multnomah County Health Department Communities Putting Prevention to Work

David Rebanal, Northwest Health Foundation

Teresa Rios-Campos, Multnomah County Health Department Community Capacitation Center

Consuelo Saragoza, Multnomah County Health Department Public Health and Community Initiatives

Pei-ru Wang, Immigrant and Refugee Community Organization Community Health

Staff:

Erin Mowlds, Multnomah County Heath Department Health Assessment and Evaluation
Christine Sorvari, Multnomah County Heath Department Health Assessment and Evaluation

[1] Some of the individuals listed above did not participate as advisory group members, but they did provide feedback at different points of the project through individual meetings, e-mail, and phone conversations. These stakeholders are included in this list to acknowledge their contribution.

TABLE OF CONTENTS

I. INTRODUCTION 5
Mobilizing for Action through Planning and Partnerships (MAPP) 5

Multnomah County Modifications to the MAPP Model 5

Figure 1: Multnomah County Community Health Assessment Model 6

The Multnomah County Community Health Assessment Advisory Group and Stakeholders 7

II. THE MAPP ASSESSMENTS 7
Community Themes and Strengths Assessment 7

Table 1: Identified Health Issues: Themes from Preliminary Inventory of Community Assessments and Engagement Projects 8

Additional Community Input Collected 8
Community Health Focus Groups 9
Community Health Survey 11

Focus Group and Community Health Survey Findings Incorporated into the Inventory 13

Table 2: Identified Health Issues. Themes from the Final Inventory of Community Assessments and Engagement Projects 13

Community Health Status Assessment 14

Health Status Assessment Findings

Local Public Health System and Forces of Change Assessments 16
Definition of Public Health System 16

Identification of Stakeholders to Interview 16

Interview Questions 16

Interview Process and Data Analysis 17

Interview Findings 17

III. IDENTIFIED KEY-RELATED HEALTH ISSUES 18
Table 3: Key Health-Related Issues and in which MAPP Assessments they were Identified 19
Table 4: Key Health-Related Issues and Strategy Ideas 20

IV. MULTNOMAH COUNTY COMMUNITY HEALTH ASSESSMENT REPORTS 26

I. INTRODUCTION

This report presents the 11 "key health-related issues" identified by the Multnomah County Community Health Assessment Advisory Group. These key issues were identified through the findings from four assessments conducted between July 2010 and July 2011. This process was based on the National Association of County and City Health Officials' (NACCHO) Mobilizing for Action through Planning and Partnerships (MAPP) model.

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

Mobilizing for Action through Planning and Partnerships (MAPP)

The standard NACCHO MAPP process includes the following four assessments:

(1) The Community Themes and Strengths Assessment identifies the health-related issues that are most important to community members.

(2) The Community Health Status Assessment describes the health of the community through quantitative data on key health indicators (e.g., leading causes of death, rates of first trimester prenatal care).

(3) The Local Public Health System Assessment highlights the strengths and challenges of our current local public health system.

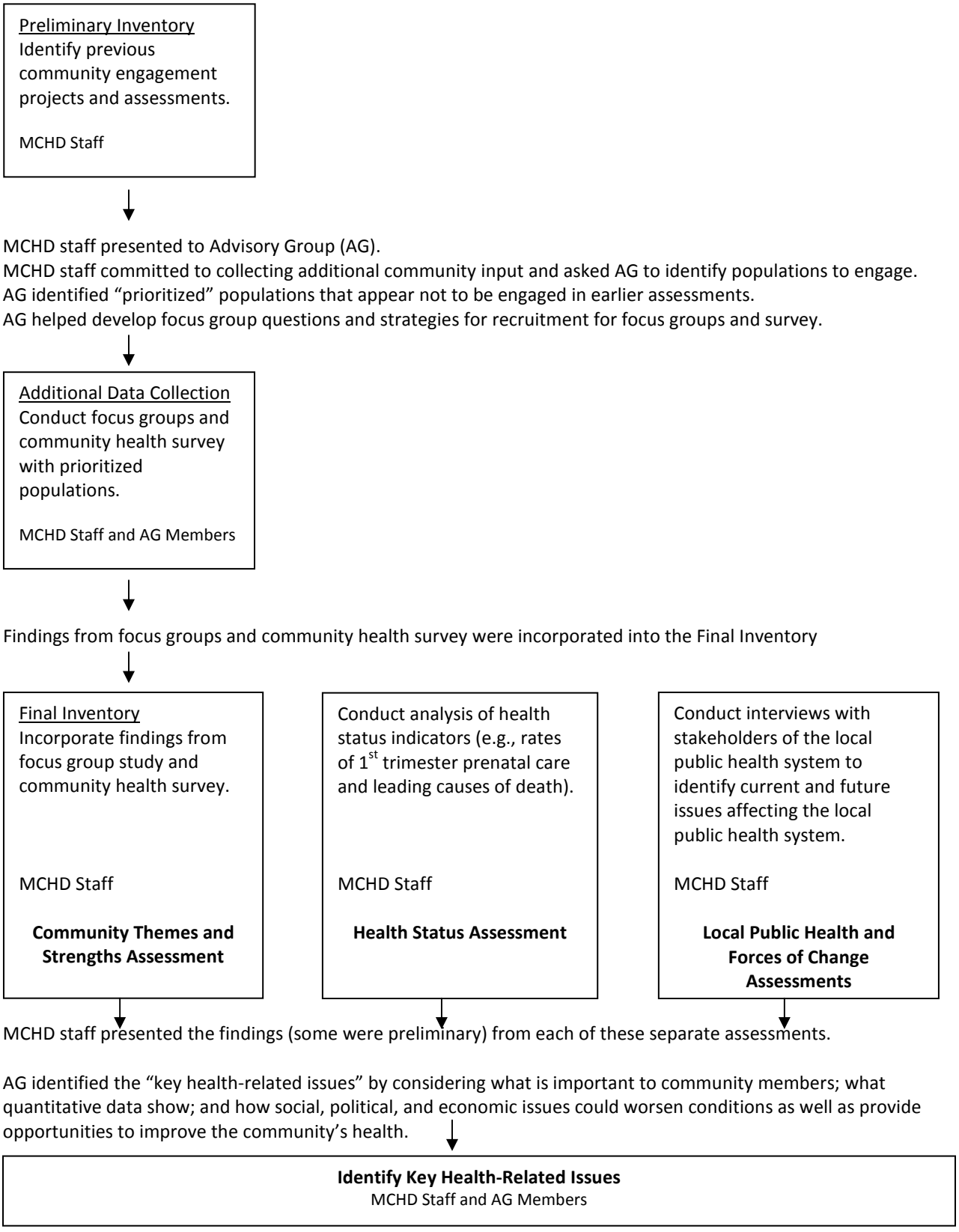
(4) The Forces of Change Assessment identifies the political, social, and economic issues that could affect the local public health system's ability to address health-related priorities.

Multnomah County Modifications to the MAPP Model

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

Additionally, the Local Public Health System Assessment and Forces of Change Assessment were combined because the information collected for each was obtained through 43 interviews with more than 50 leaders in public health, local government, community-based services, transportation, education, employment, and planning. All of whom were qualified to speak to the current capacity and future opportunities and uncertainties affecting the local public health system. The model used in the Multnomah County Community Health Assessment is illustrated in Figure 1.

Figure 1: Multnomah County Community Health Assessment Model



The Multnomah County Community Health Assessment Advisory Group and Stakeholders

The Multnomah County Community Health Assessment Advisory Group and was convened specifically for the community health assessment and was comprised of partners from several programs within the Multnomah County Health Department, city bureaus and community-based organizations. The Advisory Group met five times between October 2010 and June 2011. Special efforts (i.e., phone conversations, e-mail and meetings) were made to solicit feedback from members who were unable to make meetings as well as from partners, who were unable to formally join the Advisory Group, but provided feedback during the process.

The Advisory Group was asked to participate in the development of the MAPP assessments and to use the findings from each of the assessments to identify "key health-related issues." These issues are intended to inform future public health planning and the development of a health improvement plan.

II. THE MAPP ASSESSMENTS

The MAPP assessments use community members' input, population-based quantitative data, and expertise of stakeholders in the public health system to answer the following questions.

(1) What do community members think are the most important health issues?
(2) How healthy is our community?
(3) What does the current local public health system do well and where can it improve?
(4) How will future economic and political issues affect the capacity of the local public health system?

The methodology and findings for all of the MAPP assessments will be discussed briefly in this section. There are separate reports describing each of these assessments in depth. Information about these additional reports is provided at the end of this document.

Community Themes and Strengths Assessment

The purpose of the Community Themes and Strengths Assessment was to learn the most important health-related issues according to people in Multnomah County. To this end, significant effort was put into engaging as many people as possible. The first step was to identify multiple community assessments and engagement projects conducted within recent years,[2] with an emphasis on those conducted within the last five years. In all, findings from 29 community assessments and engagement projects were compiled into the first iteration of an "inventory," (i.e., a compilation of assessment descriptions and their findings).[3]

[2] The majority were conducted within the last five years.

[3] Summary information from *Multnomah County Community Health Assessment: Identifying the Most Important Health Issues through Multiple Community Engagement Processes, Community Themes and Strengths Assessment,* August 2011. Christine Sorvari

These community assessments and engagement projects included large-scale surveys, focus groups, photovoice projects, and stakeholder interviews.

Table one presents the themes from the assessments and engagement projects included in the preliminary inventory. The themes are presented in order by the number of community assessments and engagement projects in which they were identified (i.e., the first theme was identified in the most efforts, etc.).

Table 1: Identified Health Issues: Themes from Preliminary Inventory of Community Assessments and Engagement Projects

• Involvement in public decision making (22) • Economic and employment opportunities for everyone (20) • Community health promotion activities (19) • Healthy built environment (15) • Universal health care (15) • Strong sense of community (15) • Access to behavioral and mental health services (14) • Education opportunities for everyone (14) • Stable housing (13) • Elimination of racism (11) • Public safety (10) • Access to public transportation (10) • Affordable and healthy food (10)	• Environmental health (9) • Preservation of cultural diversity (9) • Commitment to child health and welfare (7) • Equitable health care spending (6) • Access to technology (5) • Access to language classes (5) • Personal responsibility for health (4) • Transparency in research practices (4) • Protection of the natural environment (3) • Presence of art and cultures (2) • Chronic disease prevention (1) • Health education and literacy (1) • Limited government involvement in health care (1)

(#) The number of assessments/engagement projects in which issue was identified

Once the findings from the initial inventory of community assessments and engagement projects were compiled, they were presented to the Advisory Group. The group reviewed the inventory findings to identify populations that did not appear to be adequately involved in these early efforts. As a result of this process, the group recommended that focus groups and a survey be conducted with community members who did not appear to be engaged in these earlier efforts.

Additional Community Input Collected

Specifically, these community members included residents in Mid-County and East County who were aged 20 to 40 years, residents of rural communities, those with low income, members of specific communities of color (Native Americans, African Americans displaced from North and Northeast Portland, Pacific Islanders), immigrants/refugees, renters and those who were homeless. Special efforts were made to engage these community members. Between the survey and focus groups, most of the identified populations were engaged, but some were not included to the desired levels. This limitation was a result of a variety of factors including the difficulty in recruitment and limited resources.

Advisory Group members helped develop the focus group guide and one member conducted two of the 13 focus groups. All the information learned through these groups and the community health survey informed the final version of the inventory.

Community Health Focus Groups

During February and March 2011, 13 focus groups with 72 participants were conducted in Mid-County and East County. The purpose of these discussions was to learn what people feel are the most important issues affecting their health and that of their families and communities. The questions asked were developed by the Health Assessment Advisory Group based on what had and had not been asked in previous assessments. Prior to group discussions participants were asked to provide demographic information on a confidential survey.[4]

Demographic information provided by participants is listed below:

- The vast majority of participants had household incomes of less than $20,000 (79%); were unemployed (65%); and were renting their housing (81%).
- Almost one third of the participants did not have health insurance and another 40% were on the Oregon Health Plan (Medicaid).
- Two-thirds of the participants were female; one-third male.
- Almost 40% of the participants were between the ages of 26-39.

Participants were asked to identify their race and ethnicity. Of those providing this information:

- 46% were White/Caucasian,[5]
- 21% were African,
- 14% were African American,
- 13% were Hispanic/Latino,
- 4% were Native American/American Indian, and
- 3% were Asian Pacific Islander.

All of the participants lived in Mid-County or East County at the time the groups were conducted.

The Multnomah County Health Department partnered with community-based organizations, churches, and public health stakeholders to recruit participants for these groups. Specifically, staff worked with the Immigrant and Refugee Community Organization (IRCO), Multnomah County Rockwood Health Center, Wood Village Baptist Church, and two low-income housing organizations in Mid-County and East County: Human Solutions and Innovative Housing, Inc.

[4] Summary information from *Multnomah County Community Health Assessment: Discussions with People Living in Mid-County and East County, Focus Group Report,* August 2011. Erin Mowlds and Christine Sorvari

[5] Language used NACCHO MAPP Community Strengths and Themes Survey

Eleven of the groups were facilitated by Multnomah County Health Department Staff (Health Assessment and Evaluation and the Community Capacitation Center) and two were conducted by an Advisory Group member from We Can Do Better (formerly the Archimedes Movement). Five of the groups were conducted in languages other than English (i.e., Somali, Spanish, and Amharic) with the support of the IRCO and the Community Capacitation Center.

Focus Group Findings

Focus group participants defined health and wellness as having comprehensive health care; connections with other people; choosing and having the ability to practice healthy behaviors; and the resources to prevent and manage serious health problems, such as diabetes and asthma.

There was strong agreement that people may be more likely to practice healthy behaviors if they had resources such as money, health care, affordable grocery stores, healthy restaurants (i.e., not only fast food establishments), accessible transportation, and places to socialize and be physically active.

Most participants had difficulty answering, *"Do you think your community is healthy?"* A common response to this question was, *"Some people are and others are not."* In most groups, as the conversation progressed, participants began talking about how they think that for the most part, their communities were not that healthy due to*, "stress from being poor."* People discussed the connections between the reality of being poor and the unhealthy things they observed in their communities. Examples of these problems included drug use, criminal activity, *"directionless youth,"* unhealthy eating, hopelessness about finding work, and depression.

People wanted to be self sufficient and felt that government has the responsibility to provide a safety net for those people who are unable to take care of themselves, whether this inability is due to individual limitations or hard economic times.

Most participants appreciated public safety-net services but felt that government could do a better job advertising the services, broadening the eligibility requirements, and making the application processes easier. There was a fairly strong sentiment that the system does not work when it cuts all help rather than maintaining or prorating support for a short time while people are, *"getting on their feet"* (e.g., starting a job after being unemployed for a long time).

Many people wanted to become more active in public input activities that inform public decision making. Because of daily responsibilities, not knowing how to become involved, and, for some, not having the confidence, getting involved is difficult. Participants appreciated that this project, *"came to us"* and thought that more of their community members would participate if decision makers made the effort to come to their housing developments and other places they frequent regularly, such as churches and social service agencies.

Community Health Survey

The Community Health Survey was conducted during the spring of 2011. The purpose of the survey was to collect opinions and perceptions of health in Multnomah County from specific populations that may have been missed in previous health assessments such as residents of Mid-County and East County. Survey questions elicited opinions on key factors that improve quality of life, the most important health problems, and risky behaviors that have the greatest impact on community health in this county. The survey also asked respondents to rate their health and their community's health on a five point Likert scale. The 15-question survey was adapted from the NACCHO MAPP Community Strengths and Themes Survey. Additionally, demographic information was collected including household income, education level, ethnicity, age, sex and insurance status.[6]

Potential survey respondents were Multnomah County residents 18 years or older who were willing to complete the survey. Surveys were available in English and Spanish. There were 476 completed surveys. The majority of the survey respondents, like the focus group participants, were from Mid-County and East County. The survey reached individuals with higher household incomes than those participating in the focus groups. The survey sample was also older and less racially and ethnically diverse than the focus group participation.

Demographic information provided by respondents is listed below:

- Almost 40% reported household incomes of more than $50,000 and 30% of respondents had household incomes below $20,000.
- Almost 90% of respondents had private or public health insurance.
- Two-thirds of the respondents were female; one-third male.
- Almost 25% of the respondents were between the ages of 26-39 and 25% were over the age 65.

Respondents were asked to identify their race and ethnicity. Of those providing this information:

- 71% were White/Caucasian,[7]
- 12% were African/Black/African American,
- 11% were Hispanic/Latino,
- 3% were Native American/American Indian, and
- 3% were Asian Pacific Islander.

To reach residents of Mid-County and East County, survey staff identified potential organizations, events and other opportunities to administer the surveys. Churches were identified as one potential outlet to reach a large portion of the prioritized populations including: populations between 20 and 40 years old, people with low-income status and communities of color.

[6] Summary information from *Multnomah County Community Health Assessment: A Survey of Multnomah County Residents, Survey Report,* August 2011. Maya Bhat and Emily Francis

[7] Language used NACCHO MAPP Community Strengths and Themes Survey

Church administrators in Mid-County and East County were identified by zip code and then called to ask if they would like to involve their congregants in the survey. Additionally, MCHD staff contacted neighborhood associations in Mid-County and East County and attended their meetings to administer surveys. To reach low-income and elderly residents Health Department staff worked through Loaves and Fishes to distribute surveys.

MCHD staff attended the Early Head Start family picnic and Día de los Libros y Día de los Niños (Day of the Books and Day of the Children) to survey populations between 20 and 40, low-income, renters, communities of color and young Latina mothers. Día de los Libros y Día de los Niños is a bilingual literacy celebration and was identified as an event in Mid-County and East County to survey priority populations.

Survey Findings

Individual and community health

- In general, respondents were most likely to rate their own health as "very healthy" or "healthy" regardless of age, educational attainment, or income. At the same time, most respondents rated the community's health as "somewhat healthy."

Characteristics of a healthy community

- "Low crime and safe neighborhoods" and "good schools" were two of the three most important characteristics of a health community according to most respondents.

- Those who rated the community as "somewhat healthy," "unhealthy" or "very unhealthy" were more likely to pick "good jobs and healthy economy," and "access to health care" as two of their top three factors for a healthy community.

- Those who rated their own health as "somewhat healthy," "unhealthy" or "very unhealthy" were more likely to pick "affordable housing" as one of the three most important factors of a healthy community.

Community health problems and risky behaviors

- In identifying the most important community health problems there was broad agreement across demographic lines that mental health, child abuse, and domestic violence were the three issues with the greatest impact on the community's health. Respondents selected drug abuse and alcohol abuse as two of the top three risky behaviors that have the greatest impact on overall community health.

- Mental health and related issues topped the list of community health problems and risky behaviors identified by survey respondents. Stress and other mental health issues are known to be associated with child abuse, domestic violence, and substance abuse. These survey results may indicate the community's support for stronger mental health and substance abuse prevention efforts on a community-wide basis.

Focus Group and Community Health Survey Findings Incorporated into the Inventory

The input collected through these additional data-collection efforts confirmed 17 of the 26 themes that were presented in the preliminary inventory. The first 10 themes remained the same after adding the findings from these additional studies; however "access to behavioral and mental health services" and "education opportunities for all" moved up within the top 10.

The themes that were supported by both the focus groups and the survey include, "access to behavioral and mental health services"; "education opportunities for all"; "public safety"; "commitment to child health and welfare"; and "chronic disease prevention." Preventing chronic diseases had been previously identified as a priority by only one earlier community engagement effort, but was identified in both of the additional studies. The prevention and management of chronic and serious diseases was considered one of the main dimensions of "health and wellness" in the focus group discussions.

Three new themes were added to the inventory as a result of the focus group and survey findings. These issues include, "increased accessibility of resources," "governmental accountability and responsibility," and "domestic/intimate partner violence." The final themes are presented in Table 2.

Table 2: Identified Health Issues. Themes from the Final Inventory of Community Assessments and Engagement Projects[8]

• **Involvement in public decision making (23)***	• Preservation of cultural diversity (9)
• **Economic and employment opportunities for everyone (22)***	• **Commitment to child health and welfare (9)***
• **Community health promotion activities (20)***	• Equitable health care spending (6)
• **Healthy built environment (16)***	• Access to technology (5)
• **Universal health care (16)***	• Access to language classes (5)
• **Access to behavioral and mental health services (16)***	• **Personal responsibility for health (5)***
• **Strong sense of community (16)***	• Transparency in research practices (4)
• **Education opportunities for everyone (16)***	• Protection of the natural environment (3)
• **Stable housing (14)***	• **Chronic disease prevention (3)***
• **Elimination of racism (12)***	• Presence of art and cultures (2)
• **Public safety (12)***	• Health education and literacy (1)
• **Access to public transportation (11)***	• Limited government involvement in health care (1)
• **Affordable and healthy food (11)***	• **Increased accessibility of resources (1)***
• **Environmental health (10)***	• **Government accountability and responsibility (1)***
	• **Domestic/Intimate partner violence (1)***

(#) The number of assessments/engagement projects in which issue was identified

***Finding supported (or identified) by focus groups and/or community health survey**

[8] As a result of the focus group and community health survey, the final inventory includes the findings of 31 assessments and community engagement projects; the preliminary included 29.

Community Health Status Assessment

Multnomah County Health Department routinely examines a wide variety of health status indicators, such as maternal child health-related measures, incidence of communicable disease, unintentional injury, and leading causes of death. These indicators are disseminated in the series of reports that comprise the Health of Multnomah County, the Health Assessment Quarterly, and the Report Card on Racial and Ethnic Health Disparities. The health status indicators included were selected based on a review of these reports.[9]

Health status indicators were assessed on five factors: 1) comparison to Oregon and the U.S., 2) trends over time, 3) racial disparities, 4) severity of health issue, and 5) comparison to national benchmarks. [10] The health status indicators selected for inclusion in this report meet at least two of the five conditions listed below:

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

Health Status Assessment Findings

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

Maternal and child health

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

[9] Summary information from *Multnomah County Community Health Assessment: Using Quantitative Data to Measure the Community's Health, Community Health Status Assessment,* August 2011. Claire Smith

[10] (95%) confidence intervals around rates were used to compare the County rate to Oregon and the U.S. Significance testing was done to determine trends. Racial and ethnic disparities were determined using either rate ratios or 95% confidence intervals around rates. The severity of a health outcome was determined by Years of Potential Life Lost, a measure of premature mortality or whether a health outcome has long-term consequence.

Sexually transmitted disease

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

Health behaviors

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

Chronic disease and related conditions

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

Other rates of death

- Unintentional injury deaths are increasing and the County does not meet the national objective for injury deaths. Injury deaths are the number-one cause of premature mortality. The death rate due to injury is greater for White non-Hispanics than other groups.
- Accidental poisoning deaths are increasing in the County. The County rate is higher than Oregon and the U.S., and the County does not meet the national objective for reducing accidental poisoning deaths.
- Suicide death rates are decreasing in the County but the County does not meet the national objective. The death rate due to suicide is greater among White non-Hispanics.

- Alzheimer's disease has significantly increased in the County, and the death rate is greater than the U.S. rate. The death rate due to Alzheimer's disease is greater for White non-Hispanics compared to other racial and ethnic groups.

Local Public Health System and Forces of Change Assessments

The Local Public Health System Assessment and The Forces of Change Assessment are critical parts of a Community Health Assessment. The goals of both are complimentary; the Local Public Health Assessment identifies current strengths and weaknesses within the local public health system. The goal of the Forces of Change Assessment is to look at what social, political, or economic issues could affect the capacity for the public health system. This second goal is an especially pertinent component of this assessment because of the current economic climate and changes with health care reform.[11]

Definition of Public Health System

For the purposes of this assessment, the "public health system" was defined as all departments, organizations and agencies who work on the traditional/core public health services or the "social determinants of health" including public, private, and nonprofit organizations. This broad definition allowed the use of a wide lens to examine capacity and all the different elements that are needed to create a healthy, thriving community.

Identification of Stakeholders to Interview

The Community Health Assessment Advisory Group, along with Health Department staff developed a list of key stakeholders to interview for the Local Public Health and Forces of Change Assessments. Stakeholders were selected based on their experience, expertise, and ability to represent the different components and levels of work within the public health system. State and local health departments, other government entities, and community-based organizations were included in the list. The variety of stakeholders provided a wide array of perspectives at both the big-picture and the on-the-ground levels. Given the large role the local health department plays in the public health system, multiple individuals from the Health Department were included as key stakeholders.

Interview Questions

Questions were developed to illicit discussion on services, overall strengths, challenges and recommendations for the public health system. The final interview guide included four questions.

(1) What do you see as your role in the local public health system or in contributing to the health of the community?

[11] Summary information from *Multnomah County Community Health Assessment: Interviews with Local Public Health System Stakeholders about Future Opportunities and Challenges, Local Public Health Care System & Forces of Change Assessments,* August 2011. Erin Mowlds and Nicole Hermanns

(2) How would you describe (summarize) your department or agency's role in the local public health system?
(3) What opportunities, assets, and strengths do you see that affect or could potentially impact public health or your work? (Upcoming changes like collaborations, funding, technology, legislation, etc.)
(4) What challenges do you see that may affect public health or your work? (Upcoming changes like collaborations, funding, technology, legislation, etc.)

Interview Process and Data Analysis

Project staff conducted 43 interviews involving more than 50 stakeholders between July 2010 and August 2011. Interviews were conducted one-on-one, or with groups of stakeholders who worked for the same organization. Notes were taken by the project staff during all interviews and then analyzed in aggregate at the conclusion of the interviews for recurring themes and key points.

Interview Findings

One of the major roles of public health is to be "at the table" to show how health matters and how health is connected to other issues. Being at the table is also critically important during health care reform to shape the role of public health and secure funding for public health services.

Collaboration is an essential part of the development and delivery of effective public health services. We need more deliberate partnerships and collaborative efforts that support our strategic vision. Clear roles for partners that are based on experience and expertise must be identified for all collaborative relationships.

Prevention must be considered on multiple levels, and public health work must be balanced between upstream and downstream approaches.

Equity must be incorporated into all public health work. In order to do this, leadership must dedicate resources to educate staff and the public about equity and health, and dedicate funds for the implementation of equity tools. Equity work needs to be driven by community needs that have been identified through community health assessments, and it must include culturally specific services and practices.

There are current gaps in access to relevant data. Critical gaps include culturally competent data collection, data at the local levels, and the ability to access data across technology/data systems.

III. IDENTIFIED KEY-RELATED HEALTH ISSUES

To identify the 11 "key health-related issues," the Advisory Group used the findings from each of the MAPP assessments: 1) The Community Themes and Strengths Assessment, 2) Community Health Status Assessment, and 3) Local Public Health System and Forces of Change Assessments.

The group decided to select most of the key health issues from the Community Themes and Strengths Assessment with the belief that addressing these larger, community-identified issues would improve the problems identified through the Health Status Assessment. For example, rates of obesity, diabetes, and heart disease could be reduced by making healthy food accessible, implementing community health promotion activities, improving access to health care, and promoting physical activity. The group recommended that the health data presented through the Health Status Assessment be used to track progress on specific health conditions that would be expected to improve as a result of addressing these larger issues.

The preliminary findings from the Local Public Health System and Forces of Change Assessments were used to guide the development of strategy ideas for each of the 11 key health issues One example of how these findings influenced the strategy ideas is to collaborate with partners working in education to improve high school retention rates for students of color as a way to influence life-long health.

Table 3 lists the "key health-related issues" and indicates from which of the MAPP assessments each of the issues was identified. Table 4 includes the strategy ideas developed for each health-related issue.

As might be expected, not all issues were directly identified in all of the MAPP assessments. Findings from the Community Themes and Strengths Assessment focused on the social determinants of health and included some specific health conditions. Information from the Health Status Assessment included population-based rates for health conditions such as diabetes deaths, and social determinants of health like education and income. Information gathered from the Local Public Health System and Forces of Change Assessments focused on gaps in the system and ideas for ensuring that all essential public health services are provided. Rarely did condition-specific information (e.g., asthma) come up during this later assessment.

Many of the health-related issues and associated strategies presented in the following tables are currently being implemented by the health department and partners; others would be new and would require additional partnerships. Advisory Group members emphasized that effective strategies addressing the identified health issues would require collaboration between multiple partners and that the health department could not be expected to (or should) take the lead on all of the issues. An example of one of the key health issues for which the health department could serve as a convener but not the lead is "poverty, economic support and opportunities."

Table 3: Key Health-Related Issues and in which MAPP Assessments they were Identified

Key Health-Related Issues Identified by Advisory Group (In alphabetic order)	Community Themes and Strengths Assessment	Community Health Status Assessment	Local Public Health System Assessment and Forces of Change Assessment
Access to affordable and healthy food	X		
Community health promotion activities	X		X
Education	X	X	X
Elimination of institutional racism and health disparities	X	X	X
Infant mortality		X	
Involvement in public decision making	X		X
Poverty, economic support and opportunities	X	X	
Promote healthy sexuality across the lifespan		X	
Promote physical activity	X		
Strong sense of community	X		
Universal health care	X		

Table 4: Key Health-Related Issues and Strategy Ideas

Key Health-Related Issues Identified by Advisory Group (In alphabetic order)	**Strategy Ideas**[12]
Access to affordable and healthy food: Access to affordable, culturally appropriate, nutritious food; access to education about nutrition	Promote the "backyard garden" in addition to community gardens. For some, community gardens may be seen as "gated communities" with limited access. Work with resettlement agencies to teach new immigrants and refugees about the pitfalls of unhealthy food in this country. For example, fast food and soda. They are cheap but unhealthy. Help them find ways to continue to eat the types of food they ate in their old country and healthy options here that they may not be familiar with (e.g., connect with specific stores, farmers markets, gardening programs, etc). Work with immigrant and refugee children to counter any negative pressure they receive from other children about their traditional food to prevent their wanting to eat only "Americanized food." Develop a deliberate plan for this education for new comers. Explore ways to do this for people already here too. Provide education about opportunities (e.g., zoning codes and urban agriculture). Work to provide opportunities for people to "take control of their access." Work on neighborhood retail initiatives. Hold conversations about price differentials as a way to make healthier food more affordable. Continue to focus on the healthy built environment and how this work can promote food accessibility. Change what is being served to children at school. Look at WIC foods. They are very dairy-focused. This is not good for all people. Lobby for revisions to the federal farm bill (up for vote in 2012) so unhealthy foods are not subsidized.

[12] Specific terms or issues named by Advisory Groups are identified by quotation marks in order to illustrate the thinking of the group as they identified key issues.

Community health promotion activities: Commitment to culturally-appropriate disease prevention, wellness programs, health education and health promotion activities including access to opportunities for physical activity; services provided in appropriate languages	Strengthen the Community Health Worker (CHW) role. Viewing it as a "paraprofessional" position makes it vulnerable to becoming a lower-paying and lower-status position. This can disproportionally affect people of color and other disadvantaged populations. Invest more resources to help people learn how to navigate systems. The County could help develop more leaders within communities (e.g., CHWs). Direct resources toward activities and facilities that support culturally relevant physical activity (e.g., soccer fields, joint agreements with parks and recreation facilities). Develop mental health services that are culturally and financially accessible.
Education: Access to culturally competent, relevant, quality education and skill-building opportunities, especially related to employment attainment; commitment to healthy learning environments; address unequal education /achievement disparities; navigating education system; assistance in navigating system/ planning for college and job training; good schools	Collect community input on education issues. "Why do we have these 'drop outs'?" Galvanize community to find solutions. CHWs have a role. Look at institutional racism (e.g., disproportionate discipline, fewer staff of color, and lower expectations for students of color). "What are the expectations for certain student groups?" Understand why students are dropping out. Address reasons when possible. For example, help students who need to support their families, are pregnant, or not learning and being left behind. Also, support students whose families may be dealing with mental illness, immigration issues, abuse, etc.). Understand that youth are losing respect for authority figures including teachers, police, and legal system. Work as a community to counter this trend. Teach students about the long-term consequences of dropping out compared to the short-term benefits. Target education approaches for different populations.

Elimination of institutional racism and health disparities: Commitment to issues related to racism and discrimination including cultural competence, achievement disparities, criminal justice disparities, mistreatment at the hands of authority (especially police), exclusion from opportunities, direct violence, stress, and lack of respect; commitment to equity; eliminate police intimidation and harassment	Use tools like the equity and empowerment lens. Continue working with CHWs. Track health status and outcomes for disparities and trends. Have conversations with community members, organizations, and governmental agencies about what is meant by institutional racism and how we got here. Capture people's stories to illustrate where they run into barriers due to institutional racism. For example, Trimet was well intentioned and they developed bus lines to reach communities; however, the buses are all heading downtown not north and south (on east side of river). Also, they are not running frequently and long enough for people working swing shifts. Work with partners to Identify and address immigration, police, and corrections system issues. All of these issues can affect individual and community health by increasing stress, disintegrating families, and preventing people from being self sufficient. The County and Cities could work to educate the community at large about disparities in health and opportunities to address these disparities. The increase in awareness and understanding may get public backing for investing in equity efforts.
Infant mortality: Prevention of infant deaths with an emphasis on African American and Native American populations	Focus on populations with disparities, specifically Native American and African Americans. These populations have had persistently higher rates of infant deaths than other racial/ethnic communities. Address factors contributing to poor perinatal health including income, stress, and opportunities for self sufficiency.

Involvement in public decision making: Commitment to social and civic engagement; responsiveness and accountability to community input and priorities; access to the legislative process; self-advocacy; knowing your voice counts; voting	Invest in leadership development (CHW and others). County (and other jurisdictions) can be more intentional in how they get public input. *"A good way to do this is to follow the community engagement principles the City of Portland has adopted."* [13] These principles focus on partnership, early involvement, building relationships and community capacity, inclusiveness and equity, good quality process design and implementation (appropriate involvement for scope), transparency, and government accountability. (Note: The Health Department was credited as being a leader in community engagement activities.)
Poverty, economic support and opportunities: Commitment to economic prosperity, sustainability and innovation and to workforce development; equity in access to living wage, employment opportunities and economic recovery; commitment to poverty reduction; access to financial education; hiring of more bilingual/ bicultural staff; pay incentives for linguistic and cultural skills; providing basic needs for survival; assistance with utility bills; ability to become self sufficient	Advocate against unfair employment practices. For example, *"If someone doesn't have a driver's license they can be paid less than someone doing the exact same job who does have a license."* Legitimize different work and economic opportunities. For example, food made and sold from home versus food carts. Work to open doors and address barriers to help people grow their business into *"legitimate businesses"* so they can become self sufficient. This type of work could possibly be a way to increase the number of food carts offering healthy foods. Encourage business creation opportunities for disenfranchised populations. Work on employment discrimination issues. Deepen understanding of why so many disenfranchised youth (especially youth of color) leave school. How can schools better support youth of color? For some families, students leave so that they can contribute to their families' incomes. Work to help students finish high school while respecting their role in the family. Advocate and collaborate for stable, affordable housing. People need to have a home in order to successfully work and support their family.

[13] From City of Portland Public Involvement Principles, Adopted by the City of Portland, Oregon on August 4, 2010

Promote healthy sexuality across the lifespan: The use of policies, supportive environments, responsive health services, community empowerment, and comprehensive education to enable all people to enjoy sexual health. A holistic vision of sexuality encompasses relationships, sexual orientation and gender identity, sexual and reproductive health, and sexual pleasure and safety.	Promote dialogue about sexuality, gender roles, and sexual orientation in all communities. CHWs play an important role, as well as elders, parents, schools, media, medical providers, peers, etc. Promote healthy relationships. *"We need to figure out what healthy sexuality is for people. It is different in different communities."* For example, there are different expectations and acceptance of teens becoming parents. There must be respectful, two-way discussions about these types of issues. There also needs to be appropriate services. Work to eliminate stigma so that people will use preventive practices and seek treatment for sexually transmitted infections.
Promote physical activity: Commitment to improving personal health behaviors and encouraging people to exercise; personal responsibility for their own health; focus on multigenerational habits and norms. Commitment to an accessible and sustainable built environment including sidewalks, streets, neighborhoods, community gardens, bike routes, walking routes, bike parking, landscape character, parks, recreation areas, community and meeting spaces; provision of social services, and city centers; creation of "20-minute neighborhoods"; clean neighborhoods	Continue to focus on the healthy built environment and how this work can promote physical activity. Work with parks, gyms, and youth sports to make them affordable. Work with education policy to restore physical education and recess. Work with communities to learn what types of activities, resources, and spaces they would like to use for activities. Promote existing places and develop new ones. Many people in a lot of different communities play team sports (adults and youth). They need places to go that are close by, safe, and affordable (e.g., soccer fields, basketball courts, etc.).

Strong sense of community: Commitment to community distinctiveness and diversity. Commitment to community empowerment; social connectivity, social cohesion, and access to social networks; community activities	This discussion was about the role of government in cultural identity, integrity, and pride. County (and other jurisdictions) can partner to provide services that create an environment that insulates families from elements that disintegrate (e.g., mental illness, stress, poor education system, unemployment, and child protection system's lack of support for different cultural practices/beliefs). Systems and services can be developed and strengthened to encourage family structure. Utilize CHWs and community-based organizations as cultural translators.
Universal health care: Access to affordable, culturally appropriate and sustainable health care/ medical care; navigating health and medical care system; coverage for undocumented people; including dental/ oral health; unrestricted (by gender, age or status with or without kids); access to preventive care Access to mental health services; access to behavioral health care including drug and alcohol counseling; mental health and drug addiction as chronic diseases.	Work to ensure culturally appropriate medical homes for people. Use CHWs to help make these connections. Strengthen the health care workforce, especially encouraging a culturally competent workforce. Develop school programs to reach students early. Take an active role in the development of the health care workforce through schools and internship opportunities. Provide support to help students remain in health care programs and complete college and graduate programs.

IV. MULTNOMAH COUNTY COMMUNITY HEALTH ASSESSMENT REPORTS

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

Multnomah County Community Health Assessment Mobilizing for Action through Planning and Partnerships (MAPP) to Identify Health-Related Priorities
Summary Report, August 2011
Christine Sorvari, MS and Erin Mowlds, MPH

Multnomah County Community Health Assessment: Identifying the Most Important Health Issues through Multiple Community Engagement Processes
Community Themes and Strengths Assessment, August 2011
Christine Sorvari, MS

Multnomah County Community Health Assessment: Discussions with People Living In Mid-County and East County
Focus Group Report, August 2011
Erin Mowlds, MPH and Christine Sorvari, MS

Multnomah County Community Health Assessment: A Survey of Multnomah County Residents
Survey Report, August 2011
Maya Bhat, MPH and Emily Francis, MPH

Multnomah County Community Health Assessment: Using Quantitative Data to Measure the Community's Health
Community Health Status Assessment, August 2011
Claire Smith, MURP

Multnomah County Community Health Assessment: Interviews with Local Public Health System Stakeholders about Future Opportunities and Challenges
Local Public Health Care System & Forces of Change Assessments, August 2011
Erin Mowlds, MPH and Nicole Hermanns, MA

Photo Credits (in order of appearance): public domain, tedeytan/Flickr, Nancy White/Flickr, heac photos/Flickr, public domain, public domain