

Providence Health & Services Oregon Region

**2013 Community Health Needs Assessments
2014-2016 Community Health Improvement Plans**



Creating healthier communities, together

It is our privilege, as we are led by our Mission, to ensure that we are caring for the poorest and most vulnerable among us in the communities we serve.

As a member of the Catholic Health Association of the United States, Providence Health & Services of Oregon conducts community health needs assessments every three years. As a result of our 2013 assessment, we're pleased to introduce this health overview, local hospital assessments and local hospital improvement plans.

The 2013 needs assessment process was rigorous, as we worked with several community partners and other health care organizations in our service areas. In the Portland metropolitan area, Providence participated in the Healthy Columbia Willamette Collaborative. This includes all 14 local hospitals, four county health departments and two coordinated care organizations. In the Columbia River Gorge area, we participated in the Columbia Gorge Health Council's regional health assessment, which includes four hospitals and several social service and government health departments, spanning six counties.

About Providence

In Oregon, Providence has eight hospitals, a medical group with 90 clinics serving Oregon and southwest Washington, as well as long-term care facilities. We provided \$237.4 million in community benefit during 2012 for the communities we serve. This includes free and reduced-cost medical care, health services for underserved patients, medical education and research, and local investment in community health, with grants and donations to community partners.

Providence has been active in planning development for local coordinated care organizations. We've also aligned our own goals and strategies to best serve our communities in partnership with other agencies across our service areas. These coordination efforts align with the community health improvement plans you see here: three-year strategic plans that outline our community benefit priorities and will evolve as new partnerships develop.

Our thanks

We are grateful to the many community members who took part in this assessment process across the state, whether through survey response, stakeholder interviews or focus group participation. Additionally, we are grateful for your interest in learning more about the health and needs of these communities.

It is our pleasure to serve you and our community, and we look forward to the opportunities outlined here to continue creating healthier communities, together.

Sincerely,

A handwritten signature in black ink, appearing to read "Dave Underriner".

Dave Underriner
Chief Executive, Oregon Region
Providence Health & Services

A handwritten signature in blue ink, appearing to read "Pamela Mariea-Nason".

Pamela Mariea-Nason, RN
Executive, Community Health Division
Providence Health & Services

Table of Contents

Providence Health and Services Oregon Region: Introduction	1
Community Health Needs Assessment	2
Coordinated Care Organizations and Healthcare Reform	2
Collaborative Approaches	3
Mobilizing for Action through Planning and Partnerships	3
State of Oregon	5
Demographic Profile	5
Key Health Indicators	6
Economic Profile	7
Racial and Ethnic Disparities	8
Children	9
County Health Rankings	10
Community Needs Index	11
Community Health Needs Assessments and Improvement Plans	13
Portland Service Area	
Providence Portland Medical Center	13
Providence St. Vincent Medical Center	22
Providence Milwaukie Hospital/Willamette Falls Medical Center	32
Non-Portland Service Areas	
Providence Hood River Memorial Hospital	47
Providence Medford Medical Center	57
Providence Newberg Medical Center	67
Providence Seaside Hospital	76
Appendix	86
1. List of Key Stakeholders (non-collaborative assessments)	
2. Stakeholder Interview Guide	
3. Focus Group Guide	
4. CORE Community Health Survey	
5. Columbia Gorge Regional Community Health Assessment	
6. Healthy Columbia Willamette Year One Progress Brief	

Providence Health & Services Oregon Region

2013 Community Health Needs Assessments

INTRODUCTION

Providence Health & Services, Oregon Region (Providence) is a Catholic non-profit health system that includes eight hospitals across the state, as well as long-term care facilities, a medical group, and a health insurance plan. It is the largest hospital system in the state and one of its largest employers.

Our Mission: “As a people of Providence, we reveal God’s love for all, especially the poor and vulnerable, through our compassionate service.” In 2012, Providence donated \$237.4 million in care and services, an 88% increase from 2006. Providence calls all employees to serve the needs of the vulnerable, and to provide particular care for those who are poor, reflecting the values of its founders, the Sisters of Providence.

Hospital locations include four within the Portland metropolitan area as well as four others across the state, providing services for over 1.5 million people in 2012:

Portland Service Area (PSA):

- Providence Milwaukie Hospital
- Providence Portland Medical Center
- Providence St. Vincent Medical Center
- Providence Willamette Falls Medical Center

Non-Portland Service Areas:

- Providence Hood River Memorial Hospital (PHRMH, Gorge Service Area)
- Providence Medford Medical Center (PMMC, Southern Oregon Service Area)
- Providence Newberg Medical Center (PNMC, Yamhill Service Area)
- Providence Seaside Hospital (PSH, North Coast Service Area)

Providence Medford and Providence Newberg are both accredited “baby-friendly” hospitals, with the remaining six seeking accreditation by 2015.

COMMUNITY HEALTH NEEDS ASSESSMENT

Providence has conducted Community Health Needs Assessments (CHNAs) every three years for the past 15 as a member of the Catholic Health Association of the United States. In line with the requirements of the Affordable Care Act, this assessment was conducted at the individual hospital level for 2013, which led to hospital-specific Community Health Improvement Plans (CHIPs). These assessments and plans are intended to help shape Community Benefit spending, Community Building activities, and ensure that Providence is being responsive to the needs of the poor and vulnerable in our areas of service.

The primary objectives of the CHNA process are:

- 1) Understand the greatest needs and health care service gaps of various population groups within the communities served by Providence
- 2) Strategically determine which community organizations and non-profits will further the Providence Mission by receiving funds directly from Providence
- 3) Position Providence to best respond the health care needs of community members
- 4) Seek to identify actions that will lead to measurable health improvements
- 5) Align with state and community partner initiatives
- 6) Reflect the best understanding of what impacts community “health”

COORDINATED CARE ORGANIZATIONS AND HEALTHCARE REFORM

As part of the Patient Protection and Affordable Care Act (ACA), Oregon has seen the development of 16 Coordinated Care Organizations (CCOs) and its own health exchange to serve Oregon Health Plan (OHP) clients. CCOs are intended to be patient-centered, team-focused, and hosted in an environment of partnership and collaboration. The overall aim is to integrate physical, mental, and eventually dental health into one “medical care home”.

Eight of these CCOs serve individuals within Providence’s primary service areas across the state, and Providence is directly involved in 6 of them. Relevant CCOs by county and service area are outlined below. Providence’s primary service area counties include Clackamas, Clatsop, Hood River, Jackson, Multnomah, Wasco, Washington, and Yamhill.

CCO	County	Providence Facility
AllCare Health Plan	Curry, Jackson, Josephine, and parts of Douglas	PMMC
Columbia Pacific Coordinated Care Organization	Clatsop, Columbia, Tillamook; parts of Coos and Douglas	PSH
FamilyCare, Inc	Clackamas, Multnomah, Washington; parts of Marion	PSA
Health Share of Oregon	Clackamas, Multnomah, Washington	PSA
Jackson Care Connect	Jackson	PMMC
Pacific Source Community Solutions Coordinated Care Organization Columbia Gorge Region	Hood River, Wasco	PHRMH
PrimaryHealth of Josephine County, LLC	Josephine; parts of Douglas and Jackson	PMMC
Yamhill County Care Organization	Yamhill; parts of Marion, Clackamas, and Polk	PNMC

COLLABORATIVE APPROACHES

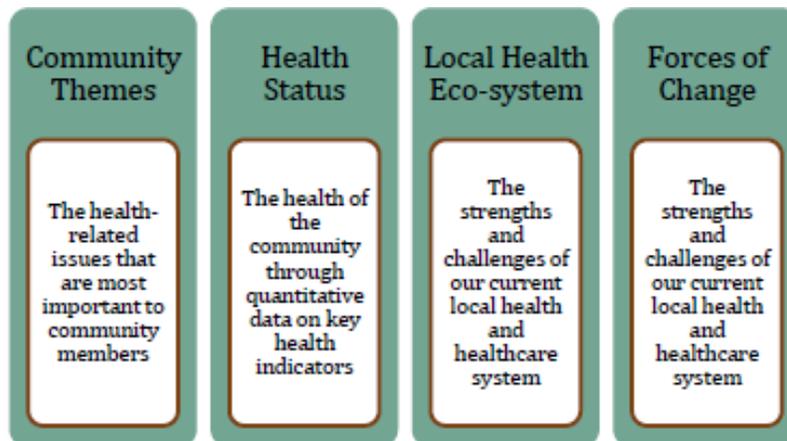
Two service areas participated in collaborative needs assessments and in the development of resulting health improvement plans. In the Portland Service Area, all 4 facilities participated in the Healthy Columbia Willamette Collaborative (HCWC). HCWC is made up of 15 hospitals, four county health departments (Clackamas, Multnomah, and Washington in Oregon as well as Clark County in SW Washington), and two CCOs.

Providence Hood River Memorial Hospital participated as a member of the Columbia Gorge Health Council’s Regional Health Assessment, which included four hospitals, local health departments, social service agencies, Pacific Source CCO, and spanned six counties: Hood River, Wasco, Sherman, and Gilliam in Oregon as well as Klickitat and Skamania in Washington. Both collaborative assessments are available in the appendix and used the same Needs Assessment framework as the other Providence facilities.

MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS

The Mobilizing for Action through Planning and Partnerships (MAPP) process was developed by the National Association of County and City Health Officials to be a “community-driven strategic

planning process for improving community health.”¹ Providence used a modified MAPP framework for its assessments, which was also used for the two collaborative assessments in which Providence participated. The complete framework consists of six components; in the collaborative and individual processes, some of these components were collapsed. The four key Assessments (Phase 3 of MAPP) are Community Themes and Strengths, Local Public Health System, Community Health Status, and Forces of Change.



In each case, the process included secondary research to develop a context for healthcare in the communities, followed by analysis of hospital usage data, a Community Health Survey, and charity care. Each service area also conducted interviews with content experts and other key providers in the area, ranging from city managers and mayors to first responders and school district superintendents, as well as local area social services agencies and business owners. The next step was focus groups with people who were elderly and/or disabled, limited English proficiency, migrant or seasonal farmworkers, and/or low-income (<200% FPL).

The Community Health Survey ran through September and into October, with an average response rate of 34% across the service areas. The survey was only administered to the non-Portland service areas given the exhaustive work being conducted by the Healthy Columbia Willamette Collaborative. The Center for Outcomes Research and Education (CORE) administered the survey and analyzed results. Key findings from the survey are summarized for each service area. More detailed information can be made available upon request.

Each hospital identified a “CHNA Leadership Team”, which consisted of the Service Area Chief Executive and 2-3 administrative and/or mission staff. These teams worked closely with the Regional Support Team (RST) within the Community Health Division throughout the process.

¹National Association of County and City Health Officials.
<http://www.naccho.org/topics/infrastructure/MAPP/index.cfm>. Accessed 30 July 2013.

The Service Area Advisory Councils endorsed the Community Health Needs Assessments and the Community Health Improvement Plans.

The Leadership Teams and members of the hospital boards were invited to participate in the stakeholder interviews in each service area. RST compiled the findings from the various steps of the process, and the Service Area Advisory Councils and Leadership Teams were tasked with identifying which priorities to address in the Community Health Improvement Plans.

STATE OF OREGON

Because Providence has eight hospitals across the state, it was important to look at the statewide healthcare landscape as well as the individual hospital level. The State of Oregon's Oregon Health Authority produced a State Health Improvement Plan in 2010 in partnership with the Oregon Health Policy Board.² Goals from the 2010 plan include achieving health equity and population health by improving social, economic and environmental factors; preventing chronic disease by reducing obesity prevalence, tobacco use, and alcohol abuse; and stimulating innovation and integration among public health, health systems and communities.

Demographic Profile

The state population is approaching 4,000,000 and is seeing growth in populations of all ethnicities and races. As a whole, nearly half of the state (44.9%) lives at or below 250% FPL by 2012 guidelines, though there are concentrated pockets of higher saturation.

Life expectancy is increasing and Oregon as a state is therefore aging, while concurrently becoming more diverse³. Oregon has one of the highest percentages of uninsured persons in the country, and this varies drastically by county. Oregon is a predominantly White state, with slightly over 88% identifying as "White only" in 2012⁴. Only 2% identify as Black or African American (compared with 13.1% nationally), 12.2% as Hispanic or Latino, and 1.8% as American Indian or Alaskan Native.

The Office of Equity and Inclusion notes that Oregon is home to 174,000 migrant and seasonal workers, many of whom have lesser income than non-migrant counterparts and reduced access to social services and healthcare⁵.

² Oregon Health Improvement Plan 2010. <http://www.oregon.gov/OHA/action-plan/hip-report.pdf>.

³ Oregon Health Authority, State Health Profile. September 2012.
<http://public.health.oregon.gov/About/Documents/oregon-state-health-profile.pdf>.

⁴ U.S. Census Bureau QuickFacts. <http://quickfacts.census.gov/qfd/states/41000.html>.

⁵Office of Equity and Inclusion, 2013.

Key Health Indicators

Oregon's overall measures of health have *decreased* since 2011 according to both America's Health Rankings (then ranked at #8) as well as the Gallup-Healthways Well-Being Index. Due to different approaches and methodology, AHR now ranks the State of Oregon as #13 in the country, whereas Gallup-Healthways ranks Oregon at #24^{6,7}. Oregon's strongest measures are in healthy behaviors, low prevalence of low birth-weight babies and teen birth rate. It also has a low infant mortality rate, low prevalence of sedentary lifestyle, a comparatively low rate of preventable hospitalizations, and the highest percentage of social support in the nation and rate of breastfeeding initiation. Some key challenges for the state as a whole include the high rate of uninsured (20% of the population), low per capita public health funding, low immunization rates, and one of the highest suicide rates in the country.

America's Health Rankings Indicator	2010 Value	2010 Ranking	2012 Value	2012 Ranking
Overall (Deviation from the Mean)	0.509	14	0.430	14
Premature Death	6640	19	6741	17
% Uninsured	17%	39	15%	32
Preterm Birth	10.3%	3	9.9%	6
Low Birth Weight	6.1%	2	6.3%	4
Preventable Hospitalizations	46.1	3	42.9	3
Primary Care Physicians (per 100,000 population)	126.5	14	128.1	13
Poor Physical Health Days (out of 30)	3.6	30	4.6	45
Poor Mental Health Days (out of 30)	3.2	15	3.8	25
Diabetes (adult population)	8.2%	22	9.3%	19
Annual Public Health Expenditures (per capita)	\$55.56	38	\$58.59	35
Geographic Disparity	0.101	18	0.111	22
Dental Visit	71.4	24	70.4	23
Income Disparity	0.447	19	0.459	22
Obesity	23.6%	6	26.7%	20

In the past 10 years, the rate of preventable hospitalizations has decreased 20%, from 53.6 discharges per 1,000 Medicare enrollees to just under 43⁸, which is a reflection of increased efficiency in how the population uses various healthcare delivery options to access care. Oregon leads the nation in prevalence of breastfeeding, with a state average 20% higher than the rest of the country 28 days after birth and nearly 40% higher at 8 weeks.

Oregon has one of the highest rates of food insecurity, with 29% of households with children having experienced food insecurity in the past year (compared with the national average of

⁶ America's Health Rankings, 2012. www.americashealthrankings.com. Accessed 1 October 2013.

⁷ Gallup-Healthways Well-Being Index, 2012. www.well-beingindex.com. Accessed 1 October 2013.

⁸ America's Health Rankings.

20.2%). As mentioned above, suicide rates are 36% higher in the state of Oregon than the national average. The Oregon Health Authority found that behavioral patterns relate directly to 40% of premature deaths in the state⁹. Although injury, which includes intentional self-injury leading to death, is ranked third in Cause of Death data, it is the leading contributor to Years of Potential Life Lost (YPLL) in the state. With regard to oral health, Oregon is ranked #48 nationally for access to fluoridated water supplies.

Economic Profile

Oregon is a relatively poor state, with a Gross Domestic Product of \$44,447 per capita in 2012. It is the 26th ranked state in terms of GSP in contribution to the national GDP, contributing approximately 1.16%. The national average of GDP per capita is \$51,144.¹⁰

Recent studies have found that poverty itself may lead to poorer cognitive abilities, and that those with the co-occurring condition of poverty are more likely to suffer from high blood pressure, high cholesterol, or elevated rates of obesity and diabetes.¹¹ Not only are these issues due to high levels of stress, but also through limited access to nutritious food, a higher likelihood to smoke, and poorer living environments.

Oregon has slightly lower than average unemployment rates and lower per capita income compared to national averages. The median household income for 2012 was lower than the national average at \$45,758 (national average of \$51,371) and Oregon had a property rental rate of approximately 34 percent (56% owner-occupied, 9% vacant).¹² Oregon has one of the lowest expenditures on public health per capita in the nation, yet generally achieves median health outcomes.

The Federal Poverty Level (FPL) was assessed as measure of relative poverty. Each year, the United States updates their poverty guidelines to reflect 100% of the Federal Poverty Level based upon the number of persons in a household. Household income can then be assessed as a percentage of the Federal Poverty Level, and is frequently used to determine eligibility for social service programs. The table below outlines the 2013 Poverty Guidelines for the 48 Contiguous States.

⁹ Oregon Health Authority, State Health Profile.

¹⁰ United States Department of Commerce, Bureau of Economic Analysis. https://bea.gov/newsreleases/regional/gdp_state/gsp_newsrelease.htm. Accessed 13 December 2013.

¹¹ Covert, Bryce. "Poverty has same effect on brain as constantly pulling all-nighters." 30 August 2013.

¹² Truven Health Analytics 2012.

Persons in family/household	Poverty guideline
1	\$11,490
2	15,510
3	19,530
4	23,550
5	27,570
6	31,590
7	35,610
8	39,630
For families/households with more than 8 persons, add \$4,020 for each additional person.	

Source: U.S. Department of Health & Human Services, Office of the Assistant Secretary for Planning and Evaluation

Racial and Ethnic Disparities

African-American women are 10% more likely to deliver a low birth-weight baby than other mothers and have a 50% higher infant mortality rate than their White counterparts in the state of Oregon¹³. African-Americans have double the rate of teenage pregnancy (34.1) compared to White mothers, as well as reporting the highest rates of unintended pregnancies.

Hispanic/Latino mothers report the highest teenage pregnancy rates in the state, with 53.7 pregnancies per thousand women aged 15-19¹⁴. In 2010, The Oregon Health Authority partnered with OMEP and other agencies to produce the *State of Equity* report. The committee found ethnic disparities in 20 out of 31 identified Key Performance Measures and noted a startlingly consistent pattern of disparity despite varied methods of collection and data sources¹⁵.

Although the low prevalence of sedentary lifestyle is a strength for the state, there are substantial ethnic disparities in the measure. For example, Hispanics are more likely to report being sedentary (21.3%) than their non-Hispanic white counterparts at 17.3%. African Americans are significantly more likely than Whites to die from heart disease, stroke, diabetes,

¹³ Urban League of Portland, State of Black Oregon, 2009.

¹⁴ Oregon Health Authority, State Health Profile.

¹⁵ Department of Human Services and Oregon Health Authority, State of Equity Report, 2011.

http://www.oregon.gov/oha/OHPR/RSCH/docs/hospital_report/state-of-equity-report.pdf. Accessed 15 August 2013.

and cancer¹⁶. In 2010, cancer was reported as the overall leading cause of death in the state. Of those diagnosed, 55% of invasive cancers were diagnosed in persons over age 65 (an age-group that makes up 14% of the population) and Hispanics were less likely than non-Hispanics to have cancer (352.1 compared to 439.5 per 100,000 population)¹⁷.

America’s Health Rankings note that seniors with less than a high school degree have a lower prevalence of social support and are less likely to rate their own health as “very good or excellent” relative to individuals in the same age cohort who received a college degree. The Office of Equity and Inclusion notes that the 174,000 migrant or seasonal workers in the state experience higher rates of diabetes, hypertension, cardiovascular disease, and cancer than their non-migrant counterparts.

Children

The Annie E. Casey Foundation and their KIDS COUNT Data Project has collected data on children for the past several years, and in Oregon have partnered with Children First for Oregon. They rank Oregon #17 of the 50 states for Child Health (an improvement from #20 in 2012), but only 32 in overall rank (including #41 in Economic Well-Being). Their findings indicate that since 2008, childhood poverty has been consistently increasing at the county level, as has childhood abuse and neglect. The highest rates reported in 2011 were in Wheeler and Gilliam counties. Oregon has a rate that is 5% higher than the national average of children in households who spend more than 30% of their income on housing and a low rate of 3-6 year olds enrolled in preschool. Nearly 70% of Hispanic children lived in households that were under 200% of the Federal Poverty Level in 2011, compared to 40% of non-Hispanic Whites. However, Oregon also has some key strengths: a lower-than-average percentage of low birth weight babies and a consistently lower teenage birth rate¹⁸.

KIDS COUNT	2012	2013
Rankings		
Overall	33	32
Economic Well-Being	41	41
Education	37	37
Health	20	17
Family & Community	22	22

¹⁶ Urban League of Portland, State of Black Oregon, 2009.

¹⁷ Oregon State Cancer Registry, 2010.

¹⁸ Annie E. Casey Foundation, KIDS COUNT 2013. <http://www.aecf.org/MajorInitiatives/KIDSCOUNT.aspx>

The Oregon Department of Human Services published the Child Welfare Data Book in 2012. In it, they recognize that only half of all reports to Child Protective Services were investigated and that over 55% of children who entered foster care had four or more reasons for being removed from their home. These reasons include physical abuse, parent or child drug or alcohol abuse, inadequate housing, child’s disability or behavior, or sexual abuse.¹⁹ Child welfare reports and children in foster care disproportionately represent, and therefore presumably adversely affect, African American and Native American populations—though the percentage of victims from these races have decreased since 2009 and the percentage of Caucasian victims has increased.

COUNTY HEALTH RANKINGS

Each year, the Robert Wood Johnson Foundation and the University of Wisconsin’s Population Health Institute produce County Health Rankings to evaluate overall community health across US counties. Providence used these findings in initial community assessments and evaluations with key stakeholders for its relevant service area counties. Thirty-three of Oregon’s 36 counties were ranked based upon measures for Health Factors and Health Outcomes. The Health Factors ranking is made up of 25 indicators collapsed into 4 measures: Health Behaviors, Clinical Care, Social and Economic Factors, and Physical Environment. The Health Outcomes ranking has only 5 indicators, making up 2 measures: Mortality and Morbidity. While each hospital chapter will include the key findings from the County Health Rankings indicators, below is the completed table for overall rankings. The completed table with values for all indicators for the relevant counties is available upon request.

¹⁹ Oregon Department of Human Services: Children, Adults, and Families Division. “2011 Child Welfare Data Book.” October 2012. <http://www.oregon.gov/dhs/abuse/publications/children/2011-cw-data-book.pdf>. Accessed 30 August 2013.

COUNTY HEALTH RANKINGS	Health Factors	Health Outcomes
Portland Service Area		
Clackamas	4	5
Multnomah	9	15
Washington	3	4
Gorge Service Area		
Hood River	2	3
Wasco	16	11
North Coast Service Area		
Clatsop	15	12
Tillamook	14	25
Southern Oregon Service Area		
Jackson	13	13
Josephine	21	29
Yamhill Service Area		
Yamhill	11	6

COMMUNITY NEEDS INDEX

Truven Health Analytics and Dignity Health produced a ZIP-code level measure of need, the Community Needs Index (CNI). The measure evaluates 11 indicators and compiles them into five categories: income barrier, cultural barrier, education barrier, insurance barrier, and housing barrier. Each ZIP code is assigned a score for these barriers, which are then averaged into a composite overall needs score. The scale runs from 1 to 5, with 1 demonstrating the least need and 5 indicating the greatest.

Income Barrier: Includes the percentage of households below the poverty line with the head of the household age 65 or over, percentage of families with children under 18 below the poverty line; percentage of single-headed families with children under 18 below the poverty line.

Cultural Barrier: Includes score of percentage of population that is minority (including Hispanic ethnicity); percentage of population ages older than 5 that speaks English poorly or not at all (limited English proficiency)

Education Barrier: Percentage of population over 25 without a high school diploma

Insurance Barrier: Percentage of population in the labor force (age 16 and above) without employment; percentage of population without health insurance.

Housing Barrier: Percentage of households renting their homes.

The following scores are composites for each of Providence’s service areas, with more detailed information available in the individual hospital chapters.

Facility	Providence Service Area	Overall 2012 CNI Score	Overall 2013 CNI Score
PHRMH	Gorge	3.3	3.2
PMMC	Southern Oregon	3.3	3.4
PNMC	Yamhill	2.8	3.0
PPMC	Portland (Multnomah County)	3.5	3.7
PSH	North Coast	3.2	3.1
PSVMC	Portland (Washington County)	2.8	2.8
PWFMC/PMH	Portland (Clackamas County)	2.5	2.4

Note: Data and methodology for the Community Need Index (CNI) for use in this publication were supplied by Truven Health Analytics. Dignity Health contributed to the development of the methodology as well. Any analysis, interpretation, or conclusion based on these data is solely that of the authors, and Dignity Health and Truven Health Analytics disclaim responsibility for any such analysis, interpretation or conclusion.

The following chapters will discuss the findings of our assessments at the hospital level, first focusing on the Portland metropolitan area, followed by the non-Portland service areas.

Providence Portland Medical Center

2013 Community Health Needs Assessment

Providence Portland Medical Center (PPMC) is a 483-bed hospital serving Providence’s Portland Service Area. There are 4 Providence hospitals in the Portland Metropolitan area, with PPMC providing care primarily for ZIP codes in Northeast Portland. The hospital’s primary service area includes approximately 193,000 people, covering much of the central Portland Metropolitan Area. PPMC has a diverse service area which includes some of the highest needs communities in the 4-County region.

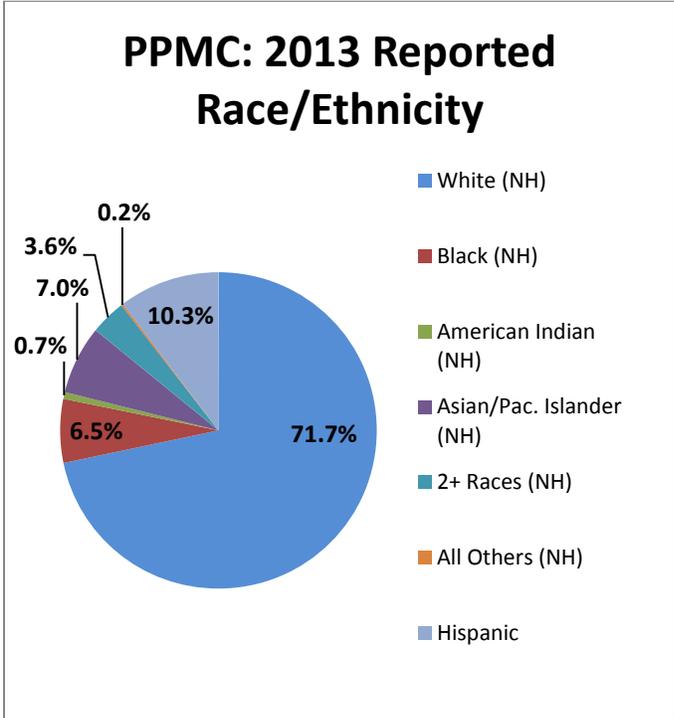
Across the Portland Service Area, Providence participated in the Healthy Columbia Willamette Collaborative (HCW) Needs Assessment. The collaborative consisted of fourteen hospitals, four county health departments, and two CCOs in the Portland Metropolitan Area (FamilyCare and Health Share of Oregon). The data shown here is representative solely of Providence Portland Medical Center, though a more thorough view of the 4-County region, which includes Clackamas, Multnomah, and Washington counties in Oregon as well as Clark County in southwest Washington, is available in the appendix.

Demographic Snapshot

Primary Service Area (all ZIP codes lie within the City of Portland): **97212** (Alameda, Sabin); **97213** (Rose City, Center); **97214** (Buckman, Richmond); **97215** (Mt. Tabor); **97218** (Cully); **97220** (Parkrose, Woodland Park); **97230** (Gateway); and **97232** (Sullivan’s Gulch, Lloyd Center).

Secondary Service Area: 97015, 97019, 97022, 97024, 97030, 97060, 97080, 97086, 97089, 97202, 97203, 97206, 97211, 97216, 97217, 97233, 97236, 97266

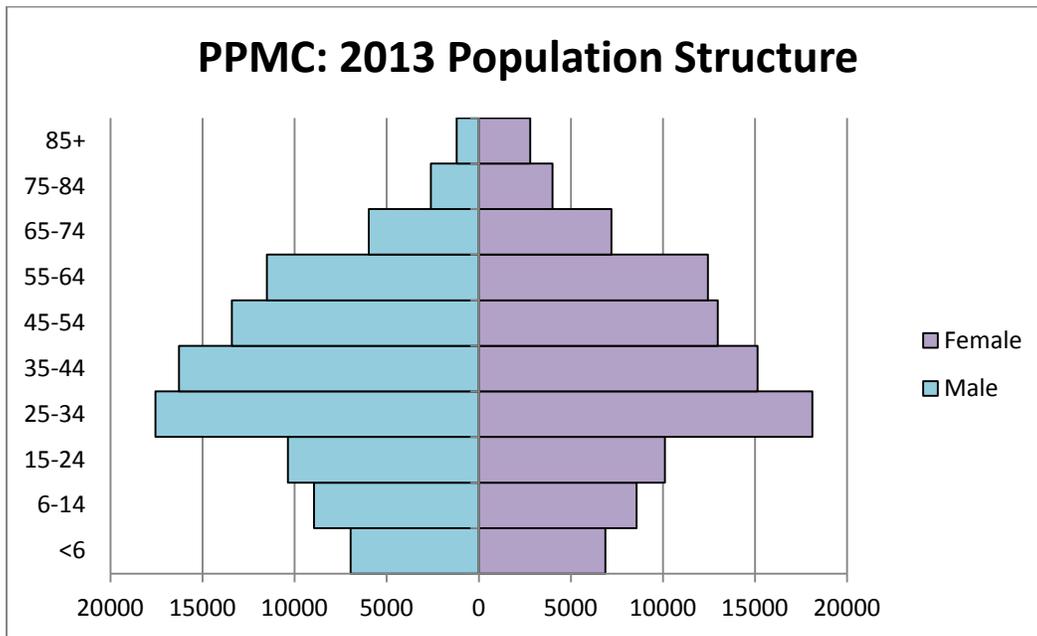
Total Population: 193,032



Northeast Portland is one of the state’s most diverse communities. Over 26% of the primary service area population is identified as a “minority” and an average of 10% of the adult population does not have a high school diploma. Nearly 47% of the population are renting their homes.

The median household income of Multnomah County is **\$45,435**, the lowest of the 4-County area. The Community Needs Index (discussed below) identifies 97218 (Cully), 97220 (Parkrose/Woodland Park), and 97230 (Gateway), as the greatest needs ZIP codes within PPMC’s service area.

Multnomah County has a relatively standard population distribution across gender. The male-female distribution is approximately 50% up until age 65, when females begin representing an increasing proportion of the population. There is a sharp decline in the relative population between ages 15 and 24, presumably because students leave these ZIP codes to attend college. There is also a high concentration of young, working age adults, which gradually decreases as the population ages.



County Health Rankings

The Robert Wood Johnson Foundation evaluates county-level measures of health outcomes and health factors annually in their County Health Rankings. In 2013, Multnomah County was ranked 15th overall for health outcomes and 9th overall for health factors out of Oregon’s 36 counties. This is a stark contrast to neighboring Washington and Hood River Counties, both of which rank in the Top 5 for both indicators.

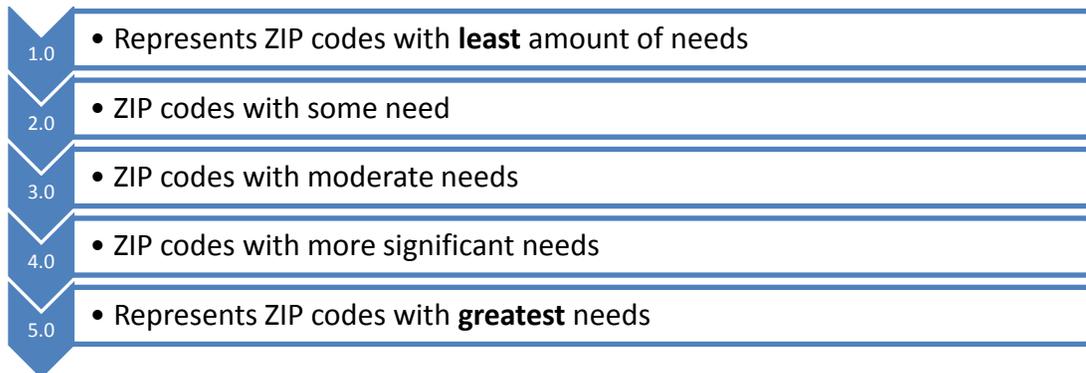
Some identified challenge areas for Multnomah County were a low high school graduation rate, a high rate of sexually transmitted infections, and a violent crime rate more than double the state average. While hovering around the average state values for most indicators, Multnomah County also has some strengths. These include a high number of primary care physicians per population, a low vehicle crash death rate, and a relatively high percentage of adults reporting at least some college education.

Community Needs Index

Truven Health Analytics annually produces a Community Needs Index, which evaluates 11 variables by ZIP code and builds an overall composite needs score for each ZIP. They assess five socioeconomic barriers: income, cultural, education, insurance, and housing. Each ZIP code receives a score, 1 through 5, and equal weight is given to each barrier when assessing the composite or overall score. The lower the score, the lesser the need in the community.

PPMC’s Service Area has an overall CNI of 3.7, indicating relatively high needs overall. The three highest needs ZIP codes all scored high need (4 or greater) for income barriers, cultural barriers were identified in five. Education was a significant barrier in two ZIP codes, insurance in seven. Housing in all eight ZIP codes was ranked a 5.

The Community Needs Index indicates that three ZIP codes are the highest overall need, with Cully, Parkrose and Woodland Park, and Gateway all scoring 4.2 or higher. All three of these ZIP codes have a higher needs score in 2013 than reported in 2012. Approximately 50% of households in poverty are single parents with children across these 3 ZIP codes, they have the highest density minority populations (39-46%), the highest percentage adult population with no high school diploma (15-17%), the highest unemployment and amongst the highest uninsurance rates in the area.



Primary Service Area		
ZIP Code	Neighborhoods	2013 CNI Score
97212	Alameda, Sabin	3.2
97213	Rose City, Center	3.4
97214	Buckman, Richmond	3.0
97215	Mt. Tabor	3.0
97218	Cully	4.6
97220	Parkrose, Woodland Park	4.2
97230	Gateway	4.6
97232	Lloyd Center	3.2

Note: all ZIP codes are within the City of Portland

Hospital Data

Data from PPMC was analyzed to identify trends in hospital usage and common diagnoses. The top discharge diagnoses amongst vulnerable populations (uninsured, Medicaid, or dual eligible) in 2012 were supervision of normal pregnancy, urinary tract infection, and uncomplicated diabetes.

Ambulatory Care Sensitive Conditions (ACSCs) are recognized by the American Healthcare Research and Quality organization as diagnoses for which ED visits or admissions could have been avoided with better access to preventive primary care. The most common ACSCs at Providence Portland for 2012 were severe ear, nose, and throat infections, dental conditions, and cellulitis. Each of these were more frequently reported in identified vulnerable populations than their non-vulnerable counterparts.

Healthy Columbia Willamette Collaborative

HCW hosted the MAPP assessment process across the 4-County area. Please see the included report from HCW for specific findings from the process and identification of the collaboratively prioritized needs: access to coverage and care, behavioral health and substance abuse, and chronic conditions. Providence has also elected to continue addressing oral health needs across the state through partnership with other organizations.

Providence Portland Medical Center

2014-2016 Community Health Improvement Plan

Focus Area	Goal	Focus Population	Indicators/Measure
<p style="text-align: center;">ACCESS TO PREVENTIVE AND PRIMARY CARE‡</p>	<ul style="list-style-type: none"> ▪ More community members will have coverage and access to health services when needed‡ ▪ More community members will be established in a medical home ▪ Community members who face barriers to health insurance coverage will have access to network of free or low-cost services‡ ▪ Community members will receive culturally competent and language-appropriate care 	<ul style="list-style-type: none"> ▪ Low-income and uninsured individuals ▪ Targeted groups: Latino, African American and other racial, ethnic minorities. ▪ Targeted ZIP codes: Multnomah County, with a special emphasis in 97080, 97214, 97215, 97216, 97217, 97230, 97233, 97236, 97266 	<ul style="list-style-type: none"> ▪ Increase # of PCP/1000 population ▪ Increased rate of FQHC-provided services ▪ 2014 – 2016 reduction in the number of uninsured‡ ▪ Increase in the number of residents reporting they have a regular source of care on the CORE survey ▪ Reduction in ED utilization for ambulatory care sensitive conditions ▪ Increased number of PCPCH certifications and utilization ▪ Increased professional and community health education opportunities ▪ Increased number of Spanish language services
<p style="text-align: center;">MENTAL HEALTH AND SUBSTANCE USE‡</p>	<ul style="list-style-type: none"> ▪ Community members in need of mental health services will have improved access‡ ▪ Community members will have improved mental health and decreased rates of substance abuse ‡ ▪ Local providers will implement Persistent Pain program ▪ Community members will experience improved patient-centered communication, continuity of care, and collaboration. 	<ul style="list-style-type: none"> ▪ Low-income and vulnerable individuals residing in the Portland metro area. ▪ Targeted groups: At-Risk Youth; Latino, African American and other racial, ethnic minorities. ▪ Targeted ZIP codes: Multnomah County, with a special emphasis in 97080, 97214, 97215, 97216, 97217, 97230, 97233, 97236, 97266 	<ul style="list-style-type: none"> ▪ Improvement in the 2016 CORE survey regarding self-rated mental health, self-reported incidence of depression and anxiety, and risk assessment scores for mental health and substance abuse ▪ Increase in Spanish language services ▪ Reduced number of opiate prescriptions ▪ Fewer self-rated poor mental health days ▪ Reduction in the number of injuries and deaths from suicide and substance abuse‡ ▪ Increased percentage of providers regularly implementing SBIRT

Focus Area	Goal	Focus Population	Indicators/Measure
<p align="center">CHRONIC CONDITIONS‡</p>	<ul style="list-style-type: none"> ▪ Community members will have increased access to education and support for management or prevention of chronic conditions‡ ▪ Increased capacity of primary care clinics to support patients in optimal management of chronic conditions ▪ Spanish-speakers will have access to culturally competent prevention and management programs ▪ Reduce tobacco use to promote long-term physical and oral health‡ ▪ Increase access to health and wellness services 	<ul style="list-style-type: none"> ▪ Low-income and uninsured individuals ▪ Targeted groups: Latino, African American and other racial, ethnic minorities ▪ Targeted ZIP codes: Multnomah County, with a special emphasis in 97080, 97214, 97215, 97216, 97217, 97230, 97233, 97236, 97266 	<ul style="list-style-type: none"> ▪ Reduced rate of diabetes and coronary artery disease-related ED visits ▪ Increased percentage of individuals with HgA1C levels in normal range ▪ Increase in percentage of individuals reporting regular exercise on 2016 CORE Survey ▪ Increase in % of people self-reporting “about the right weight” on the 2016 CORE survey ▪ Decreased rate of adult and teen tobacco use ▪ Fewer self-rated poor physical health days ▪ Increased rates of exclusive breastfeeding in newborns and at six months ‡
<p align="center">ORAL HEALTH</p>	<ul style="list-style-type: none"> ▪ Community members will have improved access to affordable preventive, primary, and emergency dental care services ▪ Provide community-based outreach and oral health education for the targeted populations. 	<ul style="list-style-type: none"> ▪ Low-income, uninsured individuals ▪ Targeted groups: Latino, African American and other racial, ethnic minorities ▪ Targeted ZIP codes: Multnomah County, with a special emphasis in 97080, 97214, 97215, 97216, 97217, 97230, 97233, 97236, 97266 	<ul style="list-style-type: none"> ▪ Reduced numbers of visits to ER because of dental conditions ▪ DCO enrollment ▪ Increased opportunities for professional and community education related to oral health

Goals & Strategies

Focus Area #1: Access to Preventive and Primary Care ‡

- More community members will have coverage and access to health services when needed‡
- More community members will be established in a medical home
- Community members who face barriers to health insurance coverage will have access to network of free or low-cost services‡
- Community members will receive culturally competent and language-appropriate care

Strategies:

- 1) Provide free education from trained Financial Counselors in at Providence Portland Medical Center (and other Providence facilities) to assist community members in enrollment.
- 2) Support and expand the deployment of Emergency Department guides who help connect patients to a medical home and other needed basic services.
- 3) Maintain stakeholder membership in Project Access NOW to ensure an adequate safety net is viable for the remaining uninsured.
- 4) Partner with Wallace Medical Concern and other community-based health centers to provide access to uninsured seen in the Emergency Departments
- 5) Partner with Project Access NOW to expand Pharmacy Bridge to ensure that free or reduced cost medications are available to a broader number of low income, uninsured and underinsured.
- 6) Participate in Task Force to develop and fund a broad based grant fund to assist low income community members to premium assistance, particularly those with chronic conditions.
- 7) Continue residency program and service to the Medicaid population through primary care physician training.
- 8) Explore partnerships with PMG to provide care for remaining un- and underinsured.
- 9) Continue support of Partnership Project, targeting refugee and immigrant populations living with HIV/AIDS.

Partners: Healthy Columbia Willamette partners, Multnomah County Health Department, Central City Concern, Wallace Medical Concern, OHA.

Focus Area #2: Mental Health and Substance Use ‡

- Community members in need of mental health services will have improved access‡
- Community members will have improved mental health and decreased rates of substance abuse ‡
- Local providers will implement Persistent Pain program
- Community members will experience improved patient-centered communication, continuity of care, and collaboration.

Strategies:

- 1) Expand awareness and integrate the use of mental health and substance use resources, education, prevention and wellness/recovery initiatives, for example: Trauma Informed Care, motivational interviewing, patient-centered approaches, risk assessment and intervention (i.e. CASE Methodology and Applied Suicide Intervention Skills Training (ASIST)). Share and promote use of consult, crisis support, and information services.

- 2) Decrease prescription drug abuse and diversion by engaging medical and health care system stakeholders to promote the adoption of a uniform opiate prescribing policies and practices‡
- 3) Implement Persistent Pain program related to chronic pain management and opiate prescription practices across PMG.
- 4) In collaboration with local community partners and school-based health centers, develop and distribute age-specific suicide prevention and educational multimedia materials that target at At-Risk Youth.
- 5) Support Multnomah County Health Department to develop a school-based health center in Centennial School District and programs to focus on prevention, early diagnosis, and treatment of mental health, substance use, and tobacco use amongst at-risk youth (focused in ZIPs 97233, 97236)
- 6) Support Northwest Family Services to develop programs in Centennial and Reynolds School Districts designed to address mental health and drug and alcohol use as well as community and peer education about depression, suicide, and anxiety.
- 7) Implement Screening, Brief Intervention, and Referral to Treatment (SBIRT) screening in line with CCO goals and strategies.
- 8) Explore opportunities for the coordination and centralization of local mental health resources.

Partners: Healthy Columbia Willamette partners, CODA, Oregon Community Foundation, Multnomah County Health Department, Northwest Family Services, other community partners.

Focus Area #3: Chronic Conditions ‡

- Community members will have increased access to education and support for management or prevention of chronic conditions‡
- Increased capacity of primary care clinics to support patients in optimal management and self-management of chronic conditions
- Spanish-speakers will have access to culturally competent prevention and management programs
- Reduce tobacco use to promote long-term physical and oral health‡
- Increase access to health and wellness services

Strategies:

- 1) Continue to support Portland SE area schools to offer summer food programs to ensure children have adequate nutrition and activity during the summer.
- 2) Pursue and successfully achieve “baby friendly” hospital status.
- 3) Continue education and support for the “Living Well with Chronic Disease” workshop series using PMG clinics.
- 4) Partner with the Timbers and Thorns for increased activity programs for low-income youth; work to foster community health and wellness.
- 5) Continue to support Promotores’ chronic disease self-management program “Tomando Control” (“Living Well...” Spanish language workshop) in order to address chronic conditions for Hispanic patients and families.
- 6) Partner local community health centers and volunteer clinics to provide chronic disease management to low-income, underinsured, and uninsured individuals to reduce return visits to ER and repeat hospitalization.

- 7) Support Promotores Program to bring movement and wellness classes to the community.
- 8) Participate in Task Force to develop and fund a broad based grant fund to assist low-income community members to attain premium assistance, particularly those with chronic conditions.

Partners: Parish Health Promotores, Providence Rehabilitation Services, PMG Clinics, Safety Net Clinics, Portland Timbers, Healthy Columbia Willamette partners, Multnomah County Health Department, Oregon Food Bank.

Focus Area #4: Oral Health

- Community members will have improved access to affordable preventive, primary, and emergency dental care services
- Provide community-based outreach and oral health education for the targeted populations

Strategies:

- 1) Provide resource allocation for access to Medical Teams International dental vans once a month at the Emergency Department and SE Residency Clinic.
- 2) Work with community partners to expand facilities and services in school-based health centers in Multnomah County.
- 3) Explore new models of dental care that expand access and lower cost; targeted populations: patients with unmet primary and immediate needs; high risk/high need patients (pregnant women, elderly patients, patients with chronic illnesses). New models may include: mid-level dental provider, advanced practice hygienists, co-location of dental clinics, virtual dental home, FQHC contracting, and others.
- 4) Promote and provide access to preventive services, tooth sealants and tobacco cessation support.
- 5) Support Promotores program's preventative and urgent care dental clinic in partnership with Pacific University.
- 6) Provide tobacco cessation training for Promotores program.
- 7) Continue to support pediatric dentistry program at Providence Child Center.

Partners: Medical Teams International, Parish Health Promotores, Central City Concern, Providence Portland Medical Foundation, Multnomah County Public Health, Pacific University, Providence Child Center.

‡ denotes Healthy Columbia Willamette priority, metric, goal, or strategy.

Providence St Vincent Medical Center

2013 Community Health Needs Assessment

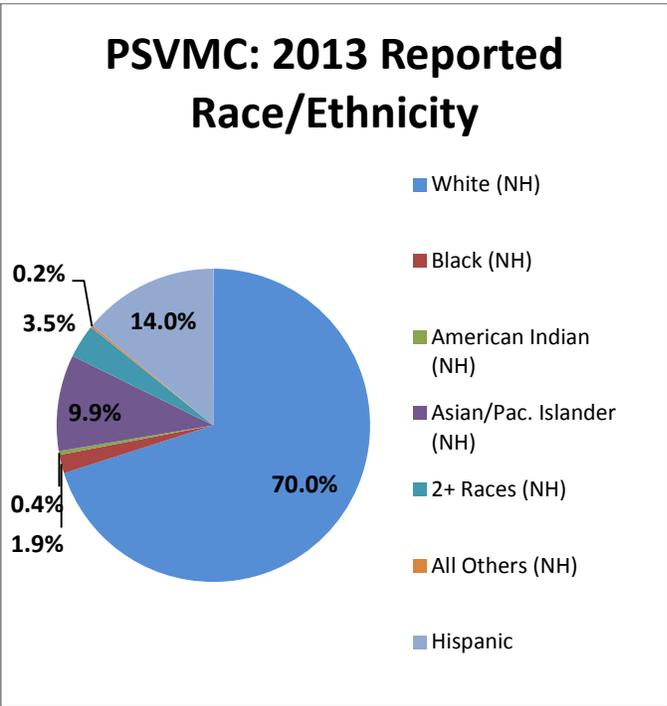
Providence St. Vincent Medical Center (PSVMC) is a 523-bed hospital serving Providence’s Portland Service Area. There are 4 Providence hospitals in the area, with St. Vincent’s providing care primarily for ZIP codes in Washington County. The hospital’s primary service area includes nearly 560,000 people, covering much of the West side of the Portland Metropolitan Area. PSVMC has a diverse service area, representing one of the fastest growing minority populations while also representing some of the wealthiest ZIP codes in the state.

Across the Portland Service Area, Providence participated in the Healthy Columbia Willamette Collaborative (HCW) Needs Assessment. The collaborative consisted of fourteen hospitals, four county health departments, and two CCOs in the Portland Metropolitan Area (FamilyCare and Health Share of Oregon). The data shown here is representative solely of Providence St. Vincent Medical Center, though a more thorough view of the 4-County region, which includes Clackamas, Multnomah, and Washington counties in Oregon as well as Clark County in southwest Washington, is available from the HCW assessment in the appendix.

Demographic Snapshot

Primary Service Area: **97005** (Beaverton); **97006** (Beaverton); **97007** (Beaverton); **97035** (Lake Oswego); **97064** (Vernonia); **97106** (Banks); **97117** (Gales Creek); **97123** (Hillsboro); **97125** (Manning); **97133** (North Plains); **97219** (Portland); **97221** (Portland); **97223** (Portland); **97224** (Portland); **97225** (Portland); **97229** (Portland); and **97239** (Portland)

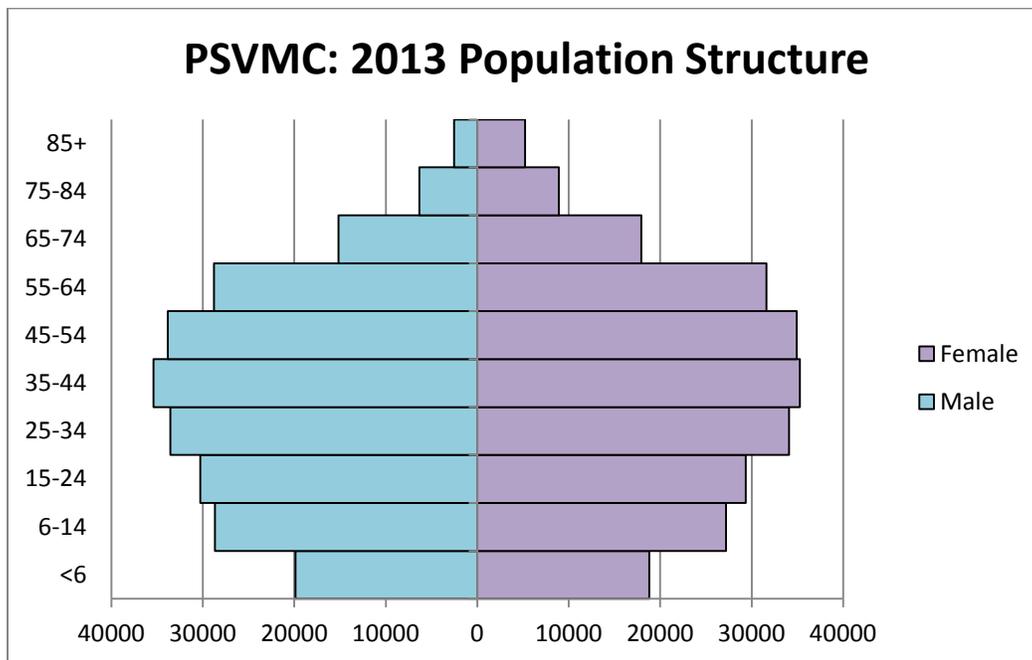
Total Population: 558,084



Since 2010, the PSVMC service area has seen a rapid increase in the percentage of population who identify themselves as Hispanic. Nearly 23% of the service area population is identified as a “minority” and over 10% of residents in 97005 are identified as Limited English Proficiency.

The median household income of Washington County is **\$60,262**, the highest of the 4-County area. The Community Needs Index (discussed below) identifies 97005 and 97006 in Beaverton as well as 97123 in Hillsboro as the greatest needs ZIP codes within PSVMC’s service area.

Washington County has a relatively standard population distribution across gender. The male-female distribution is approximately 50% up until age 65, when females begin representing an increasing proportion of the population. This population structure illustrates a population composed primarily of young and middle-aged working adults.



County Health Rankings

The Robert Wood Johnson Foundation evaluates county-level measures of health outcomes and health factors annually in their County Health Rankings. In 2013, Washington County was ranked 4th overall for health outcomes and 3rd overall for health factors out of Oregon’s 36 counties.

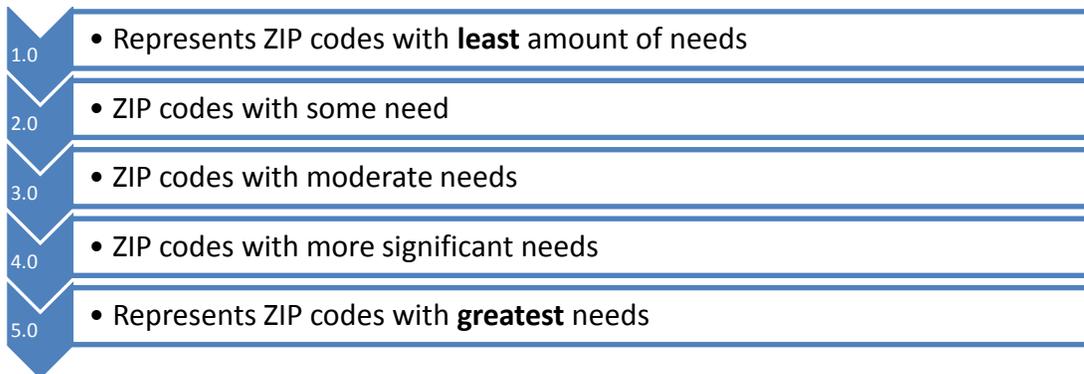
Some identified challenge areas for Washington County were daily fine particulate matter (air quality) and an abundance of fast food restaurants. In most the measures, Washington County excels—fewer than average years of potential life lost (by far the lowest in the 4-County region), fewer self-reported poor mental health days, relatively low rates of adult smoking (13% compared the state average of 17%), and a low vehicle crash death rate. Washington County leads the state in high school graduation rates and has the lowest reported unemployment rate in the 4-County region.

Community Needs Index

Truven Health Analytics annually produces a Community Needs Index, which evaluates 9 variables by ZIP code and builds an overall composite needs score for each ZIP. They assess five socioeconomic barriers: income, cultural, education, insurance, and housing. Each ZIP code receives a score, 1 through 5, and equal weight is given to each barrier when assessing the composite or overall score. The lower the score, the lesser the need in the community.

PSVMC’s Service Area has an overall CNI of 2.8. As noted previously, an “overall” view of the service area can be misleading due to the wide spectrum spanned by its population. The most significant barriers identified were cultural (9 ZIPs identified) and housing (14 ZIP codes), with education and insurance recognized as high-needs in only 1 ZIP code each. Note: no ZIP codes were identified as high needs for the income barrier.

The Community Needs Index indicates that two ZIP codes in Beaverton (97005 and 97006) and one in Hillsboro (97123) are the highest need ZIP codes with overall CNI scores of 3.6 or higher. Each of the three scored 5 for culture and 4 or 5 for housing. 97123 also scored 4 for education.



Primary Service Area		
ZIP Code	City Name	2013 CNI Score
97005	Beaverton	4.0
97006	Beaverton	3.6
97007	Beaverton	2.8
97008	Beaverton	3.2
97035	Lake Oswego	2.4
97064	Vernonia	2.8
97106	Banks	2.0
97117	Gales Creek	2.0
97123	Hillsboro	3.6
97124	Hillsboro	3.0
97125	Manning	1.8
97133	North Plains	2.8
97219	Portland	2.6
97221	Portland	2.4

Hospital Data

Data from PSVMC was analyzed to identify trends in hospital usage and common diagnoses. The top discharge diagnoses for vulnerable populations (uninsured, Medicaid, or dual eligible) in 2011 were hospital birth without cesarean section, supervision of a normal pregnancy, antenatal screening, and non-specific abdominal pain. In non-vulnerable populations, the top diagnoses were screening for malignant neoplasm, chest pain, hospital birth without c-section, and atrial fibrillation.

Ambulatory Care Sensitive Conditions (ACSCs) are recognized by the American Healthcare Research and Quality organization as diagnoses for which ED visits or admissions could have been avoided with better access to preventive primary care. The most common ACSCs at Providence St. Vincent for 2011 were severe ear, nose, and throat infections, dental conditions, and cellulitis. Each of these were disproportionately common in identified vulnerable populations.

Healthy Columbia Willamette Collaborative

HCW hosted the MAPP assessment process for the 4-County area. Please see the included report from HCW for specific findings from the process and identification of the collaboratively prioritized needs: access to coverage and care, behavioral health and substance abuse, and chronic conditions. Providence has also elected to continue addressing oral health needs across the state through partnership with other organizations.

Providence St Vincent Medical Center

2014 -2016 Community Health Improvement Plan

Focus Area	Goal	Focus Population	Indicators/Measure
<p style="text-align: center;">ACCESS TO PREVENTIVE AND PRIMARY CARE‡</p>	<ul style="list-style-type: none"> ▪ More community members will have coverage and access to health services when needed‡ ▪ More community members will be established in a medical home ▪ Community members who face barriers to health insurance coverage will have access to network of free or low-cost services‡ ▪ Community members will receive culturally competent and language-appropriate care 	<ul style="list-style-type: none"> ▪ Low-income and uninsured individuals ▪ Latino, and other racial/ethnic minorities. ▪ Targeted ZIP codes: Washington County, with a special emphasis in 97005, 97006, 97008, 97113, 97123, 97201, 97225, 97229 	<ul style="list-style-type: none"> • 2014 – 2016 reduction in the number of uninsured‡ • Increase in the number of residents reporting they have a regular source of primary care on the CORE survey • Reduction in ED utilization for ambulatory care sensitive conditions amongst focus and general populations • Increased PCPCH membership and utilization
<p style="text-align: center;">MENTAL HEALTH AND SUBSTANCE USE‡</p>	<ul style="list-style-type: none"> • Community members in need of mental health and substance use services will have improved access‡ • Community members will have improved mental health and decreased rates of substance use ‡ • Local providers will implement Persistent Pain program • Community members will receive culturally competent and language-appropriate care • Community members will experience improved patient-centered communication, continuity of care, and collaboration. 	<ul style="list-style-type: none"> ▪ Low-income and vulnerable individuals ▪ Latino, and other racial/ ethnic minorities ▪ Families, children, and at-risk youth. ▪ Targeted ZIP codes: Washington County, with a special emphasis in 97005, 97006, 97008, 97113, 97123, 97201, 97225, 97229 	<ul style="list-style-type: none"> • Improvement in the 2016 CORE survey regarding self-rated mental health, self-reported incidence of depression and anxiety, and risk assessment scores for mental health and substance abuse • Reduced number of opiate prescriptions‡ • Fewer self-rated poor mental health days • Reduction in the number of injuries and deaths from suicide and substance abuse‡ • Increased percentage of providers regularly implementing SBIRT • Increased opportunities for provider education‡

Focus Area	Goal	Focus Population	Indicators/Measure
<p style="text-align: center;">CHRONIC CONDITIONS‡</p>	<ul style="list-style-type: none"> • Community members will have increased access to education and support for management or prevention of chronic conditions‡ • Increased capacity of primary care clinics to support patients in optimal management of chronic conditions • Spanish-speakers will have access to culturally competent prevention and management programs • Reduce tobacco use to promote long-term physical and oral health‡ • Increased access to health and wellness services • Promote and improve access to breastfeeding and milk bank resources‡ 	<ul style="list-style-type: none"> ▪ Low-income and uninsured individuals. ▪ Latino, and other racial/ ethnic minorities ▪ Targeted ZIP codes: Washington County, with a special emphasis in 97005, 97006, 97008, 97113, 97123, 97201, 97225, 97229 	<ul style="list-style-type: none"> • Reduced rate of diabetes and coronary artery disease related ED visits • Increased percentage of individuals with HgA1C levels in normal range • Increase in percentage of individuals reporting regular exercise on 2016 CORE Survey • Increase in % of people self-reporting “about the right weight” on the 2016 CORE survey • Decreased rate of adult and teen tobacco use • Fewer self-rated poor physical health days • Increase in rates of breastfeeding in newborns leaving the hospital and at six months ‡
<p style="text-align: center;">ORAL HEALTH</p>	<ul style="list-style-type: none"> • Community members will have improved access to affordable preventive, primary, and emergency dental care services • Provide community-based outreach and oral health education for the targeted populations. 	<ul style="list-style-type: none"> ▪ Low-income, uninsured individuals ▪ Latino, and other racial/ ethnic minorities ▪ Targeted ZIP codes: Washington County, with a special emphasis in 97005, 97006, 97008, 97113, 97123, 97201, 97225, 97229. 	<ul style="list-style-type: none"> • Reduced numbers of visits to ER because of dental conditions • DCO enrollment • Increased opportunities for professional and community education related to oral health

Goals & Strategies

Focus Area #1: Access to Preventive and Primary Care‡

- More community members will have coverage and access to health services when needed‡
- More community members will be established in a medical home
- Community members who face barriers to health insurance coverage will have access to network of free or low-cost services‡
- Community members will receive culturally competent and language-appropriate care

Strategies:

- 1) Provide free education from trained Financial Counselors at Providence St. Vincent to assist community members in enrollment.
- 2) Expand collaboration with Washington County Community Action to assist enrollment for neediest populations.
- 3) Participate in Task Force to develop and fund a broad based grant fund to assist low income community members to attain “premium scholarships.”
- 4) Support and expand the deployment of Emergency Department guides who help connect patients to a medical home and other needed basic services.
- 5) Maintain stakeholder membership in Project Access NOW to ensure an adequate safety net is viable for the remaining uninsured.
- 6) Partner with Project Access NOW to expand Pharmacy Bridge to ensure that free or reduced cost medications are available to a broader number of low income, uninsured and underinsured.
- 7) Partner with Southwest Community Health Center to provide access to uninsured seen in the Emergency Departments, as well as other community-based health centers.
- 8) Work with local Community Health Centers (CHC) including Washington County, Virginia Garcia and Neighborhood Health Centers to expand the number of primary care providers and sites serving the community.
- 9) Continue to monitor successful outcomes of The Virginia Garcia Memorial Health Center grant and coordinate care for frequent users of the Emergency Department.
- 10) Redesign prenatal clinic to ensure continued access and utilization for all patients.
- 11) Continue Internal Medicine Residency program and service to the Medicaid population through primary care physician training.

Partners: Healthy Columbia Willamette partners, Washington County Health Department, OHA, Virginia Garcia Memorial Health Center, Tualatin Valley Fire and Rescue, Project Access NOW, Neighborhood Health Center, Southwest Community Health Center.

Focus Area #2: Mental Health and Substance Use ‡

- Community members in need of mental health and substance use services will have improved access
- Community members will have improved mental health and decreased rates of substance use ‡
- Local providers will implement Persistent Pain program
- Community members will receive culturally competent and language-appropriate care
- Community members will experience improved patient-centered communication, continuity of care, and collaboration.

Strategies:

- 1) Expand awareness and integrate the use of mental health and substance use resources, education, prevention and wellness/recovery initiatives, for example: Trauma Informed Care, motivational interviewing, patient-centered approaches, risk assessment and intervention (i.e. CASE Methodology and Applied Suicide Intervention Skills Training (ASIST). Share and promote use of consult, crisis support, and information services.
- 2) Decrease opioid and inappropriate prescription drug use and diversion by engaging medical and health care system stakeholders to promote the adoption of uniform opiate prescribing policies and practices. ‡
- 3) Expand use of Persistent Pain Program amongst Providence providers.
- 4) Participate in implementation of Emergency Department Information Exchange (EDIE) program in line with the Oregon Health Leadership Council.
- 5) Enhance connections with ED psychiatric services and outpatient behavioral health services to improve continuum of care.
- 6) Expand education and resources available through grants, as Providence continues to monitor and participate in the evaluation of At-Risk Youth grants.
- 7) Continue to collaborate with Virginia Garcia and Liefworks NW as partners in serving the mental health and social services needs of the community.
- 8) Collaborate with the Promotores program to promote education and wellness information about mental health and substance use to reduce cultural barriers and stigma.
- 9) Implement Screening, Brief Intervention, Referral to Treatment (SBIRT) in line with CCO requirements.
- 10) Enhance cultural competence through improved access to behavioral health services for non-native English speakers.

Partners: Healthy Columbia Willamette partners, Oregon Health Leadership Council, Washington County Health Department, Tri-County Behavioral Health Provider Association members, Mental Health Organizations Collaborative, Oregon Alliance

for Children, PMG, Tualatin Valley Fire and Rescue, Virginia Garcia, Lifeworks NW, other community partners.

Focus Area #3: Chronic Conditions †

- Community members will have increased access to education and support for management or prevention of chronic conditions
- Increased capacity of primary care clinics to support patients in optimal management and self-management of chronic conditions, including chronic pain
- Spanish-speakers will have access to culturally competent prevention and management programs
- Increase access to health and wellness services
- Community members will receive culturally competent and language-appropriate care
- Promote and improve access to breastfeeding and milk bank resources

Strategies:

- 1) Continue to support Washington County and Beaverton area schools to offer summer food programs to ensure children have adequate nutrition and activity during the summer.
- 2) Continue to support Northwest Mother's Milk Bank and partner to establish depot sites within all geographic areas served by Providence.
- 3) Continue to partner with the Postpartum Care Center to promote exclusive breastfeeding.
- 4) Pursue and successfully achieve "baby friendly" hospital status.
- 5) Continue education and support for the "Living Well with Chronic Disease" workshop series using PMG clinics.
- 6) Continue working with Parish Health Promoters in Westside parishes.
- 7) Partner with the Timbers and Providence Rehabilitation for increased activity programs for low-income youth.
- 8) Continue to support Promotores chronic disease management program "Tomando Control" ("Living Well..." Spanish language workshop) leaders in order to address chronic conditions for Hispanic patients and families.
- 9) Partner with local community health centers, volunteer clinics, and Tualatin Valley Fire & Rescue to provide chronic disease management to low-income, uninsured individuals to reduce return visits to ER and repeat hospitalization.
- 10) Support Promotores to offer movement and wellness classes to the community.
- 11) Provide tobacco cessation training for Promotores program.
- 12) Support Tualatin Hills Park & Recreation to develop Access for All Park at Mountain View Middle School

- 13) Partner with and support the Beaverton Community Health Collaborative.
- 14) Expand ElderPlace to accommodate more elderly with compassionate, holistic care.

Partners: Healthy Columbia Willamette partners, Parish Health Promotores, PMG Clinics, Portland Timbers, Tualatin Valley Fire & Rescue, Tualatin Hills Park & Recreation District, Beaverton Community Health Collaborative, Providence Women and Children’s Program, Washington County Health Department.

Focus Area #4: Oral Health

- Community members will have improved access to affordable preventive, primary, and emergency dental care services
- Provide community-based outreach and oral health education for the targeted populations.

Strategies:

- 1) Provide resource allocation for access to Medical Teams International dental vans at least once a month at the Emergency Department.
- 2) Work with community partners to expand facilities and services in school-based health centers in Washington County.
- 3) Explore new models of dental care that expand access and lower cost amongst targeted populations: patients with unmet primary and immediate needs; high risk/high need patients (pregnant women, elderly patients, patients with chronic illnesses). New models may include: mid-level dental provider, advanced practice hygienists, co-location of dental clinics, virtual dental home, FQHC contracting, and others.
- 4) Promote and provide access to preventive services, tooth sealants and tobacco cessation support.
- 5) Support Promotores program’s preventative and urgent care dental clinic in partnership with Pacific University

Partners: Medical Teams International, Parish Health Promotores, Virginia Garcia Memorial Health Center, Neighborhood Health Centers, Providence St Vincent Foundation, Washington County Public Health, Pacific University.

‡ denotes Healthy Columbia Willamette priority, metric, goal, or strategy.

Providence Milwaukie Hospital and Providence Willamette Falls Medical Center

2013 Community Health Needs Assessment

Providence Milwaukie Hospital (PMH) is a 77-bed hospital co-serving Providence's Portland Service Area with the 143-bed Providence Willamette Falls Medical Center (PWFMC). There are 4 Providence hospitals in the Portland metropolitan area, with PMH and PWFMC providing care primarily for ZIP codes in Clackamas County. The hospitals' primary service areas include approximately 240,000 people, covering much of the southeastern Portland Metropolitan Area. PMH/PWFMC has a diverse service area and includes some of the wealthiest cities in Oregon as well as some high needs populations.

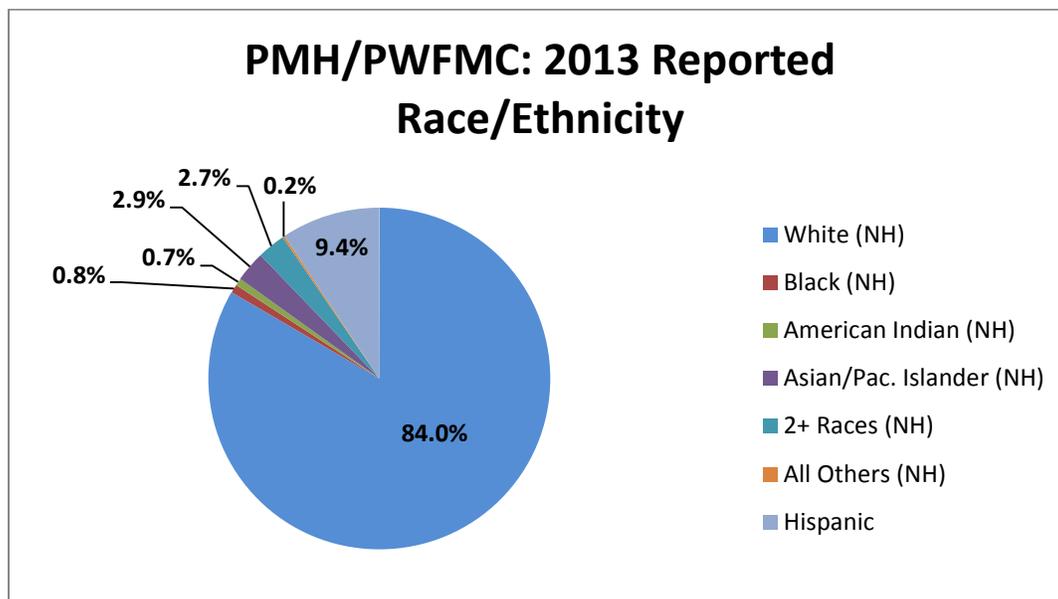
Across the Portland Service Area, Providence participated in the Healthy Columbia Willamette Collaborative (HCW) Needs Assessment. The collaborative consisted of fourteen hospitals, four county health departments, and the two CCOs in the Portland Metropolitan Area (FamilyCare and Health Share of Oregon). The data shown here is representative solely of Providence Milwaukie Hospital and Providence Willamette Falls Medical Center, though a more thorough view of the 4-County region, which includes Clackamas, Multnomah, and Washington counties in Oregon as well as Clark County in southwest Washington, is available in the appendix.

Demographic Snapshot

PMH Primary Service Area: 97015 (Clackamas); 97027 (Gladstone); 97222 (Portland); 97267 (Portland)

PWFMC Primary Service Area: 97004 (Beavercreek); 97013 (Canby); 97015 (Clackamas); 97023 (Estacada); 97027 (Gladstone); 97038 (Molalla); 97042 (Mulino); 97045 (Oregon City); 97068 (West Linn)

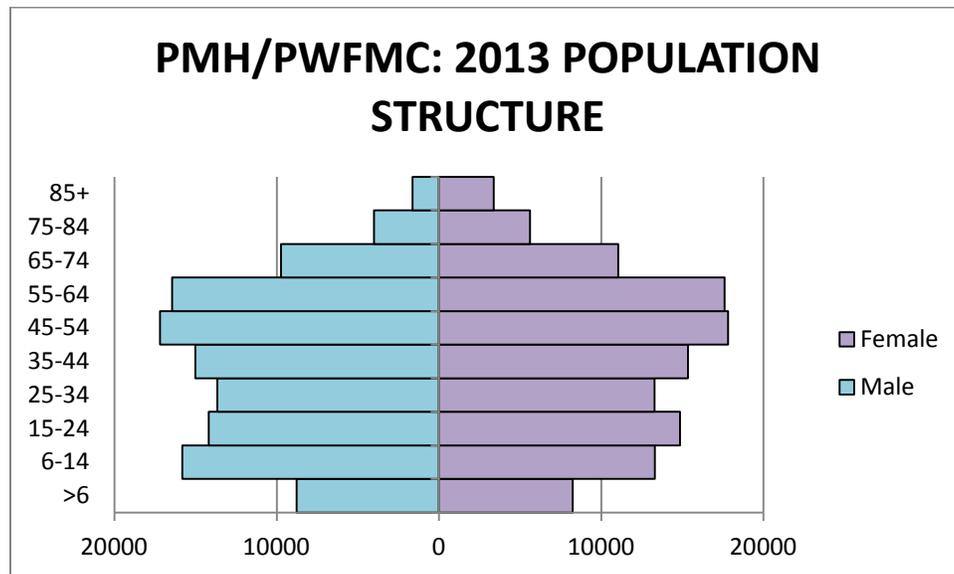
Total Population: 239,736



West Clackamas County contains some of the poorest neighborhoods in the area, as well as some of the wealthiest neighborhoods in the state. 12.5% of households in the service area with children are at or below the Federal Poverty Level, though West Linn has the second highest average adjusted gross income in the state.

The median household income of Clackamas County is **\$58,387**. The Community Needs Index (discussed below) does not highlight any particularly high needs ZIP codes in overall scores, though there are high needs scores in certain categories.

Clackamas County has a relatively standard population distribution across gender. The male-female distribution is approximately 50% up until age 65, when females begin representing an increasing proportion of the population. The county is older than would be expected, with the largest group between the ages of 45 and 54.



County Health Rankings

The Robert Wood Johnson Foundation evaluates county-level measures of health outcomes and health factors annually in their County Health Rankings. In 2013, Clackamas County was ranked 5th overall for health outcomes and 4th overall for health factors out of Oregon’s 36 counties.

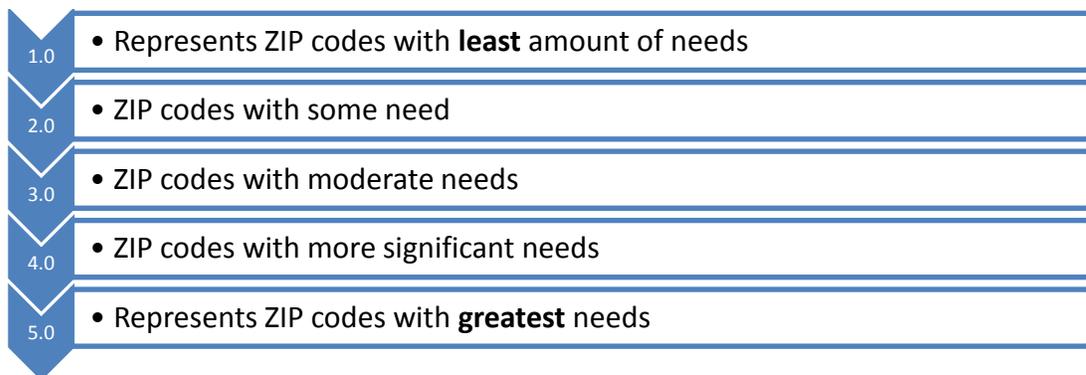
Clackamas County placed highly on most measures, but because these findings are aggregate across the county they do not account for the particularly disparate communities. Clackamas County has nearly 1,000 less years of potential life lost annually than the state average, fewer self-reported poor physical or mental health days, as well as the lowest teen birth rate and the violent crime rate in the 4-county region.

Community Needs Index

Truven Health Analytics annually produces a Community Needs Index, which evaluates 9 variables by ZIP code and builds an overall composite needs score for each ZIP. They assess five socioeconomic barriers: income, cultural, education, insurance, and housing. Each ZIP code receives a score, 1 through 5, and equal weight is given to each barrier when assessing the composite or overall score. The lower the score, the lesser the need in the community.

PMH/PWFMC’s Service Areas have an overall CNI of 2.7. As noted previously, an “overall” view of the service area can be misleading due to the wide spectrum spanned by its population. The three highest needs areas, all of which were scored overall at 3.4, were Estacada, Gladstone, and Molalla.

Canby and Clackamas (97013 and 97015) scored high need (4 or greater) for cultural and housing measures, but low for poverty and education. Estacada was the only ZIP identified as high needs for insurance rank with nearly 15% estimated to be uninsured. Estacada and Molalla scored high needs for education (over 15% of the adult population without a high school diploma), while Gladstone and Molalla scored high need for housing.



Primary Service Areas			
ZIP Code	City	Facility	Overall 2013 CNI
97004	Beavercreek	PWFMC	1.8
97013	Canby	PWFMC	2.8
97015	Clackamas	PMH/PWFMC	3.2
97017	Colton	PWFMC	2.0
97023	Estacada	PWFMC	3.4
97027	Gladstone	PMH/PWFMC	3.4
97038	Molalla	PWFMC	3.4
97042	Mulino	PWFMC	1.6
97045	Oregon City	PWFMC	3.0
97068	West Linn	PWFMC	1.8
97222	Portland	PMH	3.2
97267	Portland	PMH	3.0

Hospital Data

Data from PMH and PWFMC were analyzed to identify trends in hospital usage and common diagnoses. The top discharge diagnoses amongst vulnerable populations (uninsured, Medicaid, or dual eligible) in 2012 for PWFMC were abdominal pain, acute urinary tract infection, and screening mammograms. PMH reported atrial fibrillation, acute bronchitis, and supervision of normal pregnancy as its top diagnoses in 2012.

Ambulatory Care Sensitive Conditions (ACSCs) are recognized by the American Healthcare Research and Quality organization as diagnoses for which ED visits or admissions could have been avoided with better access to preventive primary care. The most common ACSCs at both Providence Milwaukie and Providence Willamette Falls for 2012 were severe ear, nose, and throat infections, dental conditions, and cellulitis. For both PMH and PWFMC, these visits were much more frequent in vulnerable populations.

Healthy Columbia Willamette Collaborative

HCW hosted the MAPP assessment process across the 4-County area. Please see the included report from HCW for specific findings from the process and identification of the collaboratively identified needs: access to coverage and care, behavioral health and substance abuse, and chronic conditions. Providence has also elected to continue addressing oral health needs across the state through partnership with other organizations.

Providence Milwaukie Hospital

2014 -2016 Community Health Improvement Plan

Focus Area	Goal	Focus Population	Indicators/Measure
<p align="center">ACCESS TO PREVENTIVE AND PRIMARY CARE‡</p>	<ul style="list-style-type: none"> ▪ More community members will have coverage and access to health services when needed‡ ▪ More community members will be established in a medical home ▪ Community members who face barriers to health insurance coverage will have access to network of free or low-cost services‡ ▪ Community members will receive culturally competent and language-appropriate care 	<ul style="list-style-type: none"> ▪ Low-income and uninsured individuals ▪ Elderly ▪ Targeted groups: Hispanic and other racial, ethnic minorities ▪ Targeted ZIP codes: Clackamas County with a focus on 97015, 97027, 97202,97206, 97222, 97236, 97266, 97267 	<ul style="list-style-type: none"> ▪ Increase # of PCP/1000 population ▪ Increased rate of primary care provided in Oregon PCPCH Tier 3 certified clinics ▪ 2014 – 2016 reduction in the number of uninsured ‡ ▪ Increase in the number of residents reporting they have a regular source of care on the CORE survey ▪ Reduction in ED utilization for ambulatory care sensitive conditions ▪ Increased professional and community health education opportunities ▪ Increased number of Spanish and Russian language services.
<p align="center">MENTAL HEALTH AND SUBSTANCE USE‡</p>	<ul style="list-style-type: none"> ▪ Community members in need of mental health services will have improved access‡ ▪ Community members will have improved mental health and decreased rates of substance abuse ‡ ▪ Local providers will implement Persistent Pain program ▪ Community members will receive culturally competent and language-appropriate care ▪ Community members will experience improved patient-centered communication, continuity of care, and collaboration 	<ul style="list-style-type: none"> ▪ Low-income and vulnerable individuals ▪ Targeted groups: Children and racial, ethnic minorities. ▪ Elderly ▪ Targeted ZIP codes: Clackamas County with a focus on 97015, 97027, 97202,97206, 97222, 97236, 97266, 97267 	<ul style="list-style-type: none"> ▪ Improvement in the 2016 CORE survey regarding self-rated mental health, self-reported incidence of depression and anxiety, and risk assessment scores for mental health and substance abuse ▪ Increase in Spanish and Russian language services ▪ Reduced number of opiate prescriptions ▪ Fewer self-rated poor mental health days ▪ Reduction in the number of injuries and deaths from suicide and substance abuse‡ ▪ Increased percentage of providers regularly implementing SBIRT

Focus Area	Goal	Focus Population	Indicators/Measure
<p align="center">CHRONIC CONDITIONS‡</p>	<ul style="list-style-type: none"> ▪ Community members will have increased access to education and support for management or prevention of chronic conditions‡ ▪ Increased capacity of primary care clinics to support patients in optimal management and self-management of chronic conditions, including chronic pain ▪ Spanish-speakers will have access to culturally competent prevention and management programs ▪ Reduce tobacco use to promote long-term physical and oral health‡ ▪ Increase access to health and wellness services 	<ul style="list-style-type: none"> ▪ Low-income and uninsured individuals ▪ Targeted groups: Children and racial, ethnic minorities. ▪ Elderly ▪ Targeted ZIP codes: Clackamas County with a focus on 97015, 97027, 97202,97206, 97222, 97236, 97266, 97267 	<ul style="list-style-type: none"> ▪ Reduced rate of diabetes and coronary artery disease-related ED visits ▪ Increased percentage of individuals with HgA1C levels in normal range ▪ Increase in percentage of individuals reporting regular exercise on 2016 CORE Survey ▪ Increase in % of people self-reporting “about the right weight” on the 2016 CORE survey ▪ Decreased rate of adult and teen tobacco use ▪ Fewer self-rated poor physical health days ▪ Increased rates of exclusive breastfeeding in newborns and at six months ‡ ▪ Increased number of individuals utilizing <i>Promotores</i> Program and becoming certified trainers.
<p align="center">ORAL HEALTH</p>	<ul style="list-style-type: none"> ▪ Community members will have improved access to affordable preventive, primary, and emergency dental care services ▪ Provide community-based outreach and oral health education for the targeted populations. 	<ul style="list-style-type: none"> ▪ Low-income, uninsured individuals ▪ Targeted groups: Children and racial, ethnic minorities ▪ Targeted ZIP codes: Clackamas County with a focus on 97015, 97027, 97202,97206, 97222, 97236, 97266, 97267 	<ul style="list-style-type: none"> ▪ Reduced numbers of visits to ER because of dental conditions ▪ DCO enrollment ▪ Increased access to and utilization of PMH dental clinic services ▪ Increased opportunities for professional and community education related to oral health

Goals & Strategies

Focus Area #1: Access to Preventive and Primary Care ‡

- More community members will have coverage and access to health services when needed‡
- More community members will be established in a medical home
- Community members who face barriers to health insurance coverage will have access to network of free or low-cost services‡
- Community members will receive culturally competent and language-appropriate care

Strategies:

- 1) Provide free education from trained Financial Counselors at PMH (and other Providence hospitals) to assist community members in enrollment.
- 2) Establish Mother-Baby Clinic on campus to assist in lactation services, infant checks and growth monitoring, parenting classes, primary care guidance, perinatal mood disorder support, and nutrition counseling and assistance.
- 3) Explore opportunities for geriatric services and programs (PACE, palliative care, hospice, etc)
- 4) Support and expand the deployment of Emergency Department guides who help connect patients to a medical home and other needed basic services.
- 5) Continue Family Medicine Residency program and service to the Medicaid population through primary care physician training.
- 6) Host professional and community health engagement sessions, specifically related to quality, safety, and health disparities.
- 7) Recruit providers and translators to provide language-appropriate medical care, specifically Spanish and Russian.
- 8) Continue training and provider education regarding culturally-competent care.
- 9) Maintain stakeholder membership in Project Access NOW to ensure an adequate safety net is viable for the remaining uninsured.
- 10) Partner with Project Access NOW to expand Pharmacy Bridge to ensure that free or reduced cost medications are available to a broader number of low-income, uninsured and underinsured individuals.
- 11) Maintain relationships and strategically collaborate with Neighborhood Health Center and Clackamas County Health to optimize care coverage for the community.
- 12) Participate in Task Force to develop and fund a broad based grant fund to assist low-income community members to attain “premium scholarships.”
- 13) Explore opportunities for implementing telemedicine services.

Partners: Healthy Columbia Willamette partners, Clackamas County Health Department, Neighborhood Health Centers, OAHHS, Project Access NOW.

Focus Area #2: Mental Health and Substance Use ‡

- Community members in need of mental health services will have improved access‡
- Community members will have improved mental health and decreased rates of substance abuse ‡
- Local providers will implement Persistent Pain program
- Community members will receive culturally competent and language-appropriate care

Strategies:

- 1) Expand awareness and integrate the use of mental health and substance use resources, education, prevention and wellness/recovery initiatives, for example: Trauma Informed Care, motivational interviewing, patient-centered approaches, risk assessment and intervention (i.e. CASE Methodology and Applied Suicide Intervention Skills Training (ASIST). Share and promote use of consult, crisis support, and information services.
- 2) Implement Persistent Pain program related to chronic pain management and opiate prescription practices across PMG.
- 3) Decrease prescription drug abuse and diversion by engaging medical and health care system stakeholders to promote the adoption of a uniform opiate prescribing policies and practices. ‡
- 4) Co-located clinical psychologists in Family Medicine residency primary care clinics.
- 5) Recruit providers and translators to provide language-appropriate medical care, specifically Spanish and Russian.
- 6) Explore opportunities to develop Geriatric Behavioral Health Unit for the Portland community.
- 7) Implement regular Screening, Brief Intervention, and Referral to Treatment (SBIRT) screening in line with CCO requirements across PMG.

Partners: Healthy Columbia Willamette partners, PMG, Providence Milwaukie Foundation

Focus Area #3: Chronic Conditions ‡

- Community members will have increased access to education and support for management or prevention of chronic conditions‡
- Increased capacity of primary care clinics to support patients in optimal management and self-management of chronic conditions, including chronic pain
- Spanish-speakers will have access to culturally competent prevention and management programs
- Increase access to health and wellness services

- Community members will receive culturally competent and language-appropriate care

Strategies:

- 1) Establish Mother-Baby Clinic on campus to assist in lactation services, infant checks and growth monitoring, parenting classes, primary care guidance, perinatal mood disorder support, and nutrition counseling and assistance.
- 2) Continue education and support for the “Living Well with Chronic Disease” workshop series using PMG clinics.
- 3) Work with PMG Promotores as “Tomando Control” (“Living Well...” Spanish language workshop) leaders in order to address chronic conditions for Hispanic patients and families.
- 4) Partner local community health centers and volunteer clinics to provide chronic disease management to low-income, uninsured individuals to reduce return visits to ER and repeat hospitalization.
- 5) Implement Persistent Pain program related to chronic pain management and opiate prescription practices across PMG.
- 6) Continue training and provider education regarding culturally-competent care.

Partners: Providence Rehabilitation Services, PMG Clinics, Safety Net Clinics, Healthy Columbia Willamette partners, Clackamas County Health Department

Focus Area #4: Oral Health

- Community members will have improved access to affordable preventive, primary, and emergency dental care services
- Provide community-based outreach and oral health education for the targeted populations.

Strategies:

- 1) Continue support for Joseph Bernard Dental offices to serve patients coming from the ED, primary care clinics, and the community.
- 2) Work with community partners to expand facilities and services in school-based health centers in Clackamas and Multnomah counties.
- 3) Explore new models of dental care that expand access and lower cost amongst targeted populations: patients with unmet primary and immediate needs; high risk/high need patients (pregnant women, elderly patients, patients with chronic illnesses). New models may include: mid-level dental provider, advanced practice hygienists, co-location of dental clinics, virtual dental home, FQHC contracting, and others

- 4) Support the efforts of the Neighborhood Health Center dental hygiene outreach coordinators.
- 5) Expand oral health services to include the use of advanced practice dental hygienists and the provision of preventive services and tooth sealants.
- 6) Explore opportunities to integrate dental residency experience with family medicine residency and expanding dental hygienist clinical rotations.
- 7) Provide opportunities for professional and community education.
- 8) Implement First Tooth program and access to dental care in partnership with Mother-Baby Clinic.

Partners: Neighborhood Health Centers, Providence Milwaukie Foundation, Clackamas County Public Health, Multnomah County Public Health.

‡ denotes Healthy Columbia Willamette priority, metric, goal, or strategy.

Providence Willamette Falls Medical Center

2014 -2016 Community Health Improvement Plan

Focus Area	Goal	Focus Population	Indicators/Measure
<p>ACCESS TO PREVENTIVE AND PRIMARY CARE‡</p>	<ul style="list-style-type: none"> ▪ More community members will have coverage and access to health services when needed‡ ▪ More community members will be established in a medical home ▪ Community members who face barriers to health insurance coverage will have access to network of free or low-cost services‡ ▪ Community members will receive culturally competent and language-appropriate care 	<ul style="list-style-type: none"> ▪ Low-income and uninsured individuals ▪ Targeted groups: Hispanic and other racial, ethnic minorities ▪ Targeted ZIP codes: Clackamas County, 97013, 97015, 97027, 97038, 97045, 97222, 97267 	<ul style="list-style-type: none"> • Increase # of PCP/1000 population • 2014 – 2016 reduction in the number of uninsured‡ • Increase in the number of residents reporting they have a regular source of care on the CORE survey • Reduction in ED utilization for ambulatory care sensitive conditions • Increased number of PCPCH certifications and utilization
<p>MENTAL HEALTH AND SUBSTANCE USE‡</p>	<ul style="list-style-type: none"> • Community members in need of mental health services will have improved access‡ • Community members will have improved mental health and decreased rates of substance use ‡ • Local providers will implement Persistent Pain program • Community members will receive culturally competent and language-appropriate care • Community members will experience improved patient-centered communication, continuity of care, and collaboration 	<ul style="list-style-type: none"> ▪ Low-income, uninsured individuals ▪ Targeted groups: Children and racial, ethnic minorities. ▪ Targeted ZIP codes: Clackamas County with a focus on 97013, 97015, 97027, 97038, 97045, 97222, 97267 	<ul style="list-style-type: none"> • Improvement in the 2016 CORE survey regarding self-rated mental health, self-reported incidence of depression and anxiety, and risk assessment scores for mental health and substance abuse • Increase in Spanish language services • Reduced number of opiate prescriptions ‡ • Fewer self-rated poor mental health days • Reduction in the number of injuries and deaths from suicide and substance abuse‡ • Increased percentage of providers regularly implementing SBIRT

Focus Area	Goal	Focus Population	Indicators/Measure
<p align="center">CHRONIC CONDITIONS‡</p>	<ul style="list-style-type: none"> • Community members will have increased access to education and support for management or prevention of chronic conditions‡ • Increased capacity of primary care clinics to support patients in optimal management of chronic conditions • Spanish-speakers will have access to culturally competent prevention and management programs • Reduce tobacco use to promote long-term physical and oral health‡ • Increase access to health and wellness services 	<ul style="list-style-type: none"> ▪ Low-income and uninsured individuals ▪ Targeted groups: Children and racial, ethnic minorities. ▪ Targeted Zips: Clackamas County with a focus on 97013, 97015, 97027, 97038, 97045, 97222, 97267 	<ul style="list-style-type: none"> • Reduced rate of diabetes and coronary artery disease related ED visits • Increased number of HgA1C levels in appropriate range • Increase in percentage of individuals reporting regular exercise on 2016 CORE Survey • Increase in % of people self-reporting “about the right weight” on the 2016 CORE survey • Decreased rate of adult and teen tobacco use • Fewer self-rated poor physical health days • Increase in rates of breastfeeding in newborns leaving the hospital and at six months ‡
<p align="center">ORAL HEALTH</p>	<ul style="list-style-type: none"> • Community members will have improved access to affordable preventive, primary, and emergency dental care services • Provide community-based outreach and oral health education for the targeted populations. 	<ul style="list-style-type: none"> ▪ Low-income, uninsured individuals ▪ Targeted groups: Children and racial, ethnic minorities. ▪ Targeted Zips: Clackamas County with a focus on 97013, 97015, 97027, 97038, 97045, 97222, 97267 	<ul style="list-style-type: none"> • Reduction in the number of low-income individuals in targeted ZIP codes who report a lack of urgent dental care • Reduced numbers of visits to ER because of dental conditions • DCO enrollment • Increased opportunities for professional and community education related to oral health

Focus Area #1: Access to Preventive and Primary Care

- More community members will have coverage and access to health services when needed
- More community members will be established in a medical home
- Community members who face barriers to health insurance coverage will have access to network of free or low-cost services
- Community members will receive culturally competent and language-appropriate care

Strategies:

- 14) Provide free education from trained Financial Counselors in at Providence Willamette Falls Medical Center to assist community members in enrollment.
- 15) Evaluate Emergency Department Guide program to help connect patients to a medical home and other needed basic services.
- 16) Maintain stakeholder membership in Project Access NOW to ensure an adequate safety net is viable for the remaining uninsured.
- 17) Evaluate relationship with Volunteers In Medicine volunteer clinic.
- 18) Partner with Project Access NOW to expand Pharmacy Bridge to ensure that free or reduced cost medications are available to a broader number of low-income, uninsured and underinsured individuals.
- 19) Participate in Task Force to develop a broad based grant fund to assist low-income community members to attain “premium scholarships.”

Partners: Healthy Columbia Willamette partners, Project Access NOW, Volunteers in Medicine.

Focus Area #2: Mental Health and Substance Use

- Community members in need of mental health services will have improved access
- Community members will have improved mental health and decreased rates of substance abuse
- Local providers will implement Persistent Pain program
- Community members will receive culturally competent and language-appropriate care
- Community members will experience improved patient-centered communication, continuity of care, and collaboration

Strategies:

- 1) Expand awareness and integrate the use of mental health and substance use resources, education, prevention and wellness/recovery initiatives, for example: Trauma Informed Care, motivational interviewing, patient-centered approaches, risk assessment and intervention (i.e. CASE Methodology and Applied Suicide Intervention Skills Training (ASIST). Share and promote use of consult, crisis support, and information services.
- 2) Decrease prescription drug abuse and diversion by engaging medical and health care system stakeholders to promote the adoption of a uniform opiate prescribing policies and practices. ‡
- 3) Implement the Persistent Pain program related to chronic pain management and opiate prescription practices across PMG.
- 4) Continue to support and collaborate with the Children’s Center of Clackamas County in its work with childhood trauma.
- 5) Expand Child and Adolescent Psychiatry Unit (CAPU) programs.
- 6) Continue partnership with Morrison Child & Family Services to provide space on campus for their services.
- 7) Implement Screening, Brief Intervention, Referral to Treatment (SBIRT) screening in line with CCO requirements.
- 8) Increase access to Spanish-language services.

Partners: Healthy Columbia Willamette partners, PMG, Children’s Center of Clackamas County, Morrison Child & Family Services.

Focus Area #3: Chronic Conditions ‡

- Community members will have increased access to education and support for management or prevention of chronic conditions‡
- Increased capacity of primary care clinics to support patients in optimal management and self-management of chronic conditions
- Spanish-speakers will have access to culturally competent prevention and management programs
- Reduce tobacco use to promote long-term physical and oral health‡
- Increase access to health and wellness services

Strategies:

- 1) Support the Canby Center’s Backpack Program to help food insecure families.
- 2) Continue education and support for the “Living Well with Chronic Disease” workshop series using PMG clinics.
- 3) Expand Parish Health Promoters to include Willamette Falls parishes.

- 4) Work with PMG to recruit participants for Promotores “Tomando Control” (“Living Well...” Spanish language workshop) in order to address chronic conditions for Hispanic patients and families.
- 5) Achieve and maintain “Baby Friendly” hospital status.
- 6) Partner local community health centers and volunteer clinics to provide chronic disease management to low-income, under- and uninsured individuals to reduce return visits to ER and repeat hospitalization, specifically amongst target populations.
- 7) Promote and provide access to tobacco cessation outreach and education.
- 8) Participate in Task Force to develop a broad based grant fund to assist low-income community members to attain “premium scholarships,” particularly for those with chronic conditions.

Partners: The Canby Center, Parish Health Promotores, Providence Rehabilitation Services, PMG Clinics, Safety Net Clinics, Healthy Columbia Willamette partners, Oregon Health Authority, Clackamas County Health Department.

Focus Area #4: Oral Health

- Community members will have improved access to affordable preventive, primary, and emergency dental care services
- Provide community-based outreach and oral health education for the targeted populations.

Strategies:

- 1) Provide resource allocation for access to Medical Teams International dental vans once a month at PWFMC.
- 2) Work with community partners to expand facilities and services in school-based health centers in Clackamas County.
- 3) Explore new models of dental care that expand access and lower cost amongst targeted populations: patients with unmet primary and immediate needs; high risk/high need patients (pregnant women, elderly patients, patients with chronic illnesses). New models may include: mid-level dental provider, advanced practice hygienists, co-location of dental clinics, virtual dental home, FQHC contracting, and others.
- 4) Promote and provide access to preventive services and tooth sealants.
- 5) Explore opportunities to provide dental van services in areas such as Canby and Molalla.

Partners: Medical Teams International, Neighborhood Health Centers, Clackamas County Public Health.

‡ denotes Healthy Columbia Willamette priority, metric, goal, or strategy.

Providence Hood River Memorial Hospital

2013 Community Health Needs Assessment

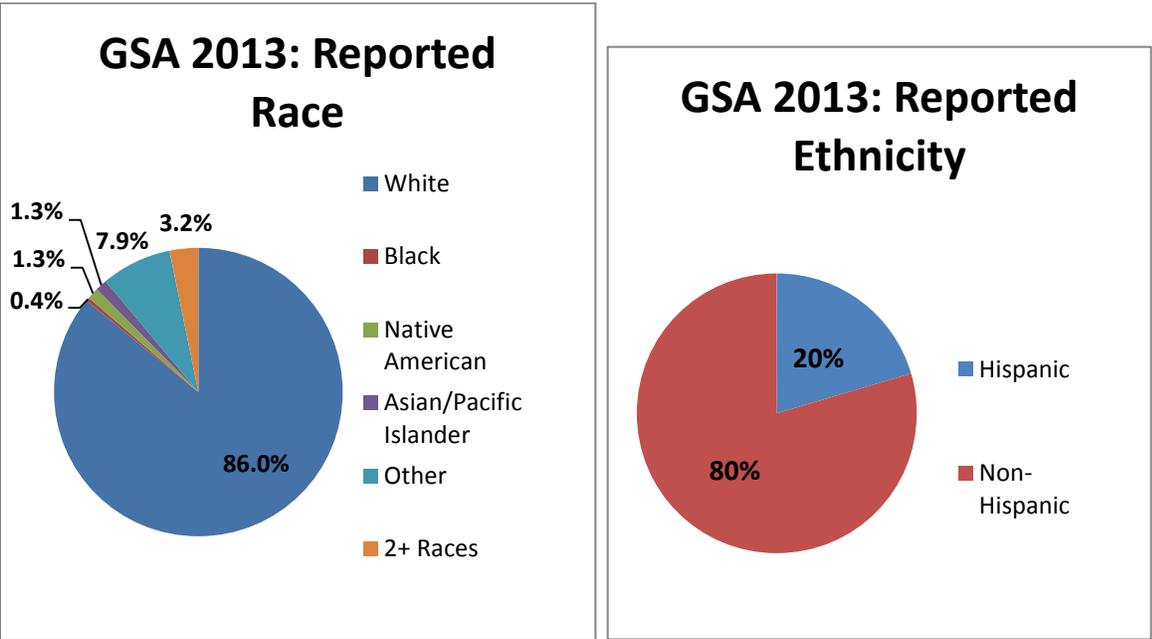
Providence Hood River Memorial Hospital (PHRMH) is a 25-bed Critical Access Hospital with a 15-bed Emergency Department, providing compassionate care within Providence’s Gorge Service Area (GSA). Providence also operates two assisted living facilities in the area, Down Manor and Brookside Manor. The service area includes Hood River and parts of Wasco counties in Oregon, as well as parts of Skamania and Klickitat counties in Washington. The region is notably diverse, with tourism for summer wind-surfing and winter snow sports, as well as a large population of undocumented workers on whom the orchards depend for labor.

PHRMH participated in a collaborative needs assessment as a member of the Columbia Gorge Health Council (CGHC). This effort includes input from six county health departments, four hospitals, the local coordinated care organization, and many social services agencies in the region. While this chapter reflects the specific needs of the Gorge Service Area as defined by Providence, a clearer picture of the region will be provided by reviewing CGHC’s Regional Community Health Assessment¹.

Demographic Snapshot

Primary Service Area: 97014 (Cascade Locks); 97031 (Hood River); 97040 (Mosier); 97041 (Mt. Hood/Parkdale); 97044 (Odell); 97058 (The Dalles); 98605 (Bingen); 98610 (Carson); 98635 (Lyle); 98639 (North Bonneville); 98648 (Stevenson); 98650 (Trout Lake); 98651 (Underwood); 98672 (White Salmon)

Total Service Area Population: 63,944

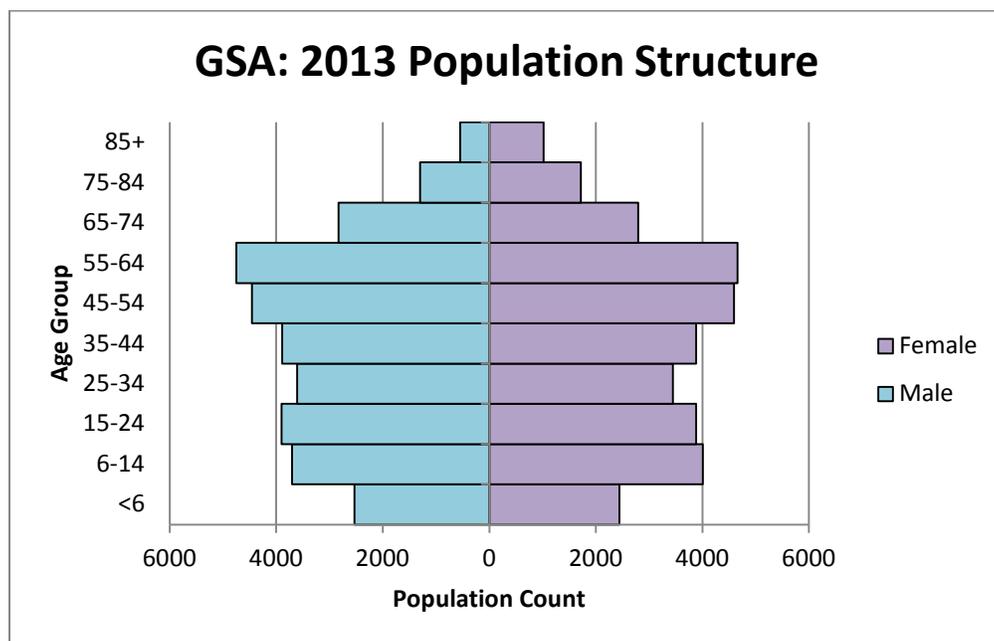


¹ Columbia Gorge Health Council. “Columbia Gorge Regional Community Health Assessment: Collaborating for Optimum Health and Optimized Healthcare.” November 2013.

In 2013, residents of the Gorge Service Area identified themselves primarily as White (86%). This represents a 3% increase in the White-only population than in the 2011 Needs Assessment. A decreased proportion identify as “2+ Races,” which may account for part of this change.

Approximately 20% of the population identifies themselves as Hispanic, a 9% decrease from the last CHNA. This variability in estimates is most likely due to a high number of undocumented workers in the region. The median household income of the service area is **\$45,585** (compared to \$45,758 statewide). The Community Needs Index (discussed below) suggests that The Dalles is the highest need ZIP overall.

The Gorge Service Area has a fairly standard population distribution across gender, but is a relatively aged service area with a greater proportion of people over age 45 than a standard distribution would expect. Compared to the Regional Assessment, the population of PHRMH’s service area is *younger*—particularly when compared to Wasco County. There is also an apparent “indent” of individuals between the ages of 15 and 34, suggesting that young working age adults move elsewhere. The distribution by gender is approximately 50% up until age 65, when females begin representing an increasing proportion of the population.



County Health Rankings

The Robert Wood Johnson Foundation evaluates county-level measures of health outcomes and health factors annually in their County Health Rankings. In 2013, Hood River County was ranked 3rd overall for health outcomes and 2nd overall for health factors out of Oregon’s 36 counties, making it one of the healthiest counties in the state. Neighboring Wasco County was ranked 11th and 16th, respectively.

The key challenges identified in this study for Hood River County are a high percent uninsured (24%) and a low percentage of the adult population with any college education. Wasco’s challenges are more significant, and include a high rate of years of potential life lost due to premature death, high prevalence

of adult obesity, a high teen pregnancy rate, high rate of preventable hospital stays, limited access to healthy foods, and a relatively high percentage of people reporting inadequate social support. Strengths for Hood River County include a low percentage of children in single parent households, low prevalence of low birthweight babies and low rate of poor mental health days, and a low rate of years of potential life lost due to premature death. Both counties have a comparatively low rate of sexually transmitted infections, good access to safe drinking water, and a very low violent crime rate.

Community Needs Index

Truven Health Analytics annually produces a Community Needs Index (CNI), which allows quantification of health needs in communities across the country. It evaluates 9 variables by ZIP code and builds an overall composite needs score for each ZIP. They assess five socioeconomic barriers: income, cultural, education, insurance, and housing. The composite scores run from 1 (least need) to 5 (greatest need).

The Gorge Service Area has a fairly moderate needs score overall, but there are defined pockets of poverty and need. Within the service area, due to small population sizes, not all of the ZIPs have assessed scores. The primary service area has a high percentage limited English proficiency, a high percentage minority population, and a high percent without a high school diploma. GSA also shows a relatively low unemployment rate compared to the state as a whole.

The Community Needs Index indicates three high needs ZIP codes (CNI of 3.6 or higher) within the primary service area, including Bingen, Lyle, and The Dalles. Bingen, Lyle, and Trout Lake in Washington scored 5 for income; Parkdale scored a 5 for cultural; Hood River, Parkdale, and The Dalles all scored 5 for housing barriers.

ZIP Code	City	2013 Overall CNI Score
97014	Cascade Locks	3.2
97031	Hood River	3.4
97040	Mosier	3.0
97041	Mt. Hood/Parkdale	3.4
97044	Odell	1.6
97058	The Dalles	4.0
98605	Bingen	3.6
98610	Carson	3.0
98635	Lyle	3.6
98639	North Bonneville	--
98648	Stevenson	3.2
98650	Trout Lake	3.2
98651	Underwood	2.8
98672	White Salmon	3.2

Hospital Data

Data from PHRMH was analyzed to identify any trends in hospital usage and common diagnoses. The top diagnoses for 2012 were atrial fibrillation (1,918 cases), uncomplicated Type II diabetes (1,298), and hyperlipidemia (890), though the most common reason for visit was follow-up examination (12,341). It is important to note here that because PHRMH is a critical access hospital, these numbers include clinic visits. Looking at Emergency Department utilization, the top diagnoses for 2012 (as identified in the Regional Assessment) were upper respiratory infection, abdominal pain, and viral infection.

Ambulatory Care Sensitive Conditions (ACSCs) are recognized by the American Healthcare Research and Quality organization as diagnoses for which ED visits or admissions could have been avoided with better access to preventive primary care. The top ACSCs in Hood River for 2012 (in descending order) were severe ear, nose, and throat infections, kidney or urinary infection, bacterial pneumonia, and dental conditions. For severe ear, nose, and throat infection and dental conditions, the greatest proportion of services provided were amongst an identified “vulnerable” population (Medicaid, uninsured, or dual eligible).

CORE Survey

The Center for Outcomes Research and Education (CORE), provided analysis of their Community Needs Survey within the Gorge Service Area. They surveyed 995 households within the service area and received 344 responses. A survey was also conducted for the collaborative assessment, whose findings are detailed in the appendix. Some key findings of Providence survey included that 15.5% of respondents struggled with food insecurity in the past year and 14% reported financial strain associated with medical costs. Overall, the survey found a strong link between poverty and poor health outcomes.

Access to transportation differed significantly across insurance status, as did housing stability by both income and race. Income and insurance status had significant effects on social support and isolation (low-income or uninsured were less likely to report having enough social support). Current insurance coverage varied significantly between race/ethnicity, county, and by income. Households in poverty were more likely to report unmet need for services related to medical care, dental care, mental health care, and substance use treatment—all noting the primary barrier of “cost”.

It is also important to note that most respondents (86%) in the Gorge Service Area reported being in “good”, “very good”, or “excellent” physical health and that nearly 84% of respondents have someone they consider their primary care provider.

Stakeholder Interviews

CGHC conducted agency and health care professional sessions in order to capture and rank the primary perceived needs in the Gorge region. Twenty-two organizations were represented in the agency sessions, while 114 surveys were completed by health care professionals. The overall needs identified in these two sessions were adequate income, stable housing, food, transportation, and preventive care. The most challenging domains for each of these needs were availability and cost.

Focus Groups

Two focus groups were conducted to reach out to segments of the community who were recognized populations of concern and those who may not have been represented in the CORE Survey. The focus groups were intended to collect more in-depth feedback from the Hispanic and Spanish-speaking population, the elderly (over 65), and low-income (<200% FPL) regarding both unmet needs as well as current health resources in the area. They were conducted by Providence as part of the CGHC Regional Health Assessment and are also cited there. Further details regarding recruitment, questions, and notes from the sessions can be found in the appendix.

Resources identified by the focus groups were that for the location and its size, the community has good access to specialists and physicians—particularly if one has already established a primary care provider. Other valued resources included payment plans and financial aid for services, as well as access to low-cost or sliding-scale clinics.

Key barriers to accessing care included transportation, cost and availability of primary care, insurance coverage, and dental care. Participants in the senior focus group discussed the importance of coordination of care and interest in improved access to personal medical records. Suggested solutions from both groups included more doctors, more low-cost care or “health fairs,” and better health education.

Key Identified Needs

Throughout the process, the top needs were (in alphabetical order):

- Access to primary care
- Chronic conditions
- Food insecurity
- Health awareness and education
- Oral health
- Stable housing
- Transportation

Providence Hood River Memorial Hospital

2014 -2016 Community Health Improvement Plan DRAFT

Focus Area	Goal	Focus Population	Indicators/Measures
<p>ACCESS TO PREVENTIVE AND PRIMARY CARE</p> <ul style="list-style-type: none"> • Health insurance • Local primary care • Specialty care • Medications • Related supportive services (transportation) • Cultural/language barriers 	<ul style="list-style-type: none"> ▪ More community members will have insurance coverage and access to health services when needed. ▪ Community members who face barriers to health insurance coverage will have access to a reliable network of free or low cost services. ▪ Community members who face transportation barriers to healthcare services will have access to reliable network of free or low cost transportation services. ▪ More community members will be established in a primary care home 	<ul style="list-style-type: none"> • Low-income and uninsured • Elderly • Latino and other racial/ethnic minority populations; migrant/seasonal farm workers • Those facing transportation barriers • Targeted ZIPs: 97031, 97041, 97058, 98605, 98635, 97014, 97044 	<ul style="list-style-type: none"> ▪ Increase # of PCP/1000 population. ▪ Increased rate of primary care provided in Oregon PCPCH Tier 3 certified clinics. ▪ Increased professional and community health education opportunities. ▪ Increase in the number of residents reporting they have a regular source of care on the 2016 CORE survey. ▪ Reduction in ED utilization for ambulatory care sensitive conditions amongst targeted populations.
<p>MENTAL HEALTH AND SUBSTANCE USE</p> <ul style="list-style-type: none"> • Access to services • Outpatient rehabilitation and treatment programs • Medication management • Patient/family education • Community-based recovery programs 	<ul style="list-style-type: none"> ▪ Community members will have improved mental health and decreased substance use ▪ Community members will have access to mental health services when needed ▪ Local providers will implement Persistent Pain program ▪ Behavioral health will be integrated into patient-centered primary care homes (PCPCHs) ▪ Spanish-speakers will have access to culturally competent programs ▪ Community members will experience improved patient-centered communication, continuity of care, and collaboration 	<ul style="list-style-type: none"> • Low-income and uninsured • Latino and other racial/ethnic minority populations; migrant/seasonal farm workers • At-risk youth • Targeted ZIPs: 97031, 97041, 97058, 98605, 98635, 97014, 97044 	<ul style="list-style-type: none"> • Improvement in the 2016 CORE survey regarding self-rated mental health, self-reported incidence of depression and anxiety, and risk assessment scores for mental health and substance abuse • Reduced number of opiate prescriptions • Fewer self-rated poor mental health days • Increased percentage of providers regularly implementing SBIRT • Behavioral health providers embedded in PCPCHs • Increased number of Spanish-speaking providers

Focus Area	Goal	Focus Population	Indicators/Measures
<p style="text-align: center;">CHRONIC CONDITIONS</p> <ul style="list-style-type: none"> • Nutrition • Physical activity • Tobacco cessation • Frail elderly • Health awareness/ education • Access to medication 	<ul style="list-style-type: none"> ▪ Community members of target populations will have increased access to education and support to manage or prevent chronic conditions and improve health ▪ Community members will receive best practice health care for their chronic conditions ▪ Spanish-speakers will have access to culturally competent prevention and management programs ▪ Reduce tobacco use to promote long-term physical and oral health ▪ Increased access to health and wellness services 	<ul style="list-style-type: none"> • Low-income and uninsured • Latino and other racial/ethnic minority populations; migrant/seasonal farm workers • People with 3+ chronic physical and/or mental health conditions • Frail elderly • Food insecure families • Targeted ZIPs: 97031, 97041, 97058, 98605, 98635, 97014, 97044 	<ul style="list-style-type: none"> • Increase in percentage of individuals reporting regular exercise on 2016 CORE Survey • Increased number of HgA1C levels in appropriate range • Increase in % of people self-reporting “about the right weight” on the 2016 CORE survey • Decreased rate of adult and teen tobacco use • Fewer self-rated poor physical health days • Increased outreach for community education • Increased number of Spanish-speaking providers and counselors
<p style="text-align: center;">ORAL HEALTH</p> <ul style="list-style-type: none"> • Preventative care • Primary care • Emergency care 	<ul style="list-style-type: none"> ▪ Community members of target populations will have improved access to affordable preventive, primary and emergency dental care services ▪ Community members in focus populations will have access to outreach and oral health education programs ▪ Participate and encourage ongoing discussion and decision making regarding water fluoridation 	<ul style="list-style-type: none"> • Low-income and uninsured • Latino and other racial/ethnic minority populations; migrant/seasonal farm workers • Targeted ZIPs: 97031, 97041, 97058, 98605, 98635, 97014, 97044 	<ul style="list-style-type: none"> ▪ Reduction in the number of low-income individuals in targeted ZIP codes who report receiving “no care at all” on CORE survey. ▪ Reduced numbers of visits to ER because of dental conditions ▪ DCO enrollment

Goals & Strategies

Focus Area #1: Access to Preventive and Primary Care

- More community members will have insurance coverage and access to health services when needed.
- Community members who face barriers to health insurance coverage will have access to a reliable network of free or low cost services.
- Community members who face transportation barriers to healthcare services will have access to reliable network of free or low cost transportation services.
- More community members will be established in a primary care home.

Strategies:

- 1) Provide free education from trained Financial Counselors at PHRMH to assist community members in enrollment.
- 2) Explore collaboration with Pacific Source Coordinated Care Organization (PSCCO) and the Columbia Gorge Health Council (CGHC) to assist in enrollment for neediest populations and potential joint initiatives.
- 3) Continue partnership with Gorge Access Program (GAP).
- 4) Coordinate care for frequent users of the Emergency Department.
- 5) Explore developing or expanding partnerships with various transportation services, such as Gorge Translink Alliance Members, cab vendors, and Volunteers in Action.
- 6) Expand the number of advanced practice (mid-level) providers serving the community.
- 7) Continue Medication Assistance Program.
- 8) Increase the number of Spanish-speaking providers and translators available to community members for care, particularly through partnership with The Next Door.
- 9) Continue Family Medicine Residency program's rural residency track with Providence Milwaukie Hospital in service to the Medicaid population through primary care physician training.

Partners: PSCCO, CGHC partners, GAP, Gorge Translink, PMG, The Next Door, 211 and other resource directories.

Focus Area #2: Mental Health and Substance Use

- Community members will have improved mental health and decreased substance use.
- Community members will have increased access to mental health services when needed.
- Local providers will implement Persistent Pain program.
- Behavioral health will be integrated into patient-centered primary care homes.
- Spanish-speakers will have access to culturally competent programs.

Strategies:

- 1) Explore opportunities to work with First Responders through EMS services to begin tracking suicide attempts to identify trends.
- 2) Expand awareness and integrate the use of mental health and substance use resources, education, prevention and wellness/recovery initiatives, for example: Trauma Informed Care, motivational interviewing, patient-centered approaches, risk assessment and intervention (i.e. CASE Methodology and Applied Suicide Intervention Skills Training (ASIST)). Share and promote use of consult, crisis support, and information services.
- 3) Decrease prescription drug abuse and diversion by engaging medical and health care system stakeholders to promote the adoption of a uniform opiate prescribing policies and practices; implement Persistent Pain Program across PMG and ED providers.
- 4) Support integration of behavioral health into patient-centered primary care homes.
- 5) Expand education and resource available through grants to partner agencies.
- 6) Implement Screening, Brief Intervention, Referral to Treatment (SBIRT) screening in line with CCO goals and metrics.
- 7) Increase the number of Spanish-speaking providers and translators available to community members for medical care.
- 8) Explore additional opportunities for collaboration with PSCCO and CGHC partners; participate in regional health improvement workgroups.

Partners: PMG, EMS/First Responders, PSCCO, CGHC partners, Hood River County Commission on Children and Families, Central Washington Comprehensive Mental Health, Early Learning Hubs, local courts and probation programs, schools.

Focus Area #3: Chronic Conditions

- Community members of target populations will have increased access to education and support to manage or prevent chronic conditions and improve health.
- Community members will receive best practice health care for their chronic conditions.
- Spanish-speakers will have access to culturally competent prevention and management programs.
- Reduce tobacco use to promote long-term physical and oral health.
- Increased access to health and wellness services.

Strategies:

- 1) Continue support of FISH Food Bank and other food security programs through the schools.
- 2) Pursue and successfully achieve “baby friendly” hospital status.

- 3) Develop relationships with local parish or The Next Door for Promotores “Tomando Control” program (“Living Well...” Spanish language workshop) leaders in order to address chronic conditions for Hispanic patients and families.
- 4) Align with PSCCO goals and metrics, particularly regarding diabetes care.
- 5) Explore opportunities for alignment with CGHC partner activities; participate in regional health improvement workgroups.
- 6) Increase community outreach opportunities for health education and awareness.
- 7) Maintain relationships with Mid-Columbia Council of Governments
- 8) Support and engage Community Health Teams project through Oregon Solutions

Partners: PMG, Providence Women’s & Children Program, PSCCO, CGHC, The Next Door, Hood River County Commission on Children and Families, Health Active Hood River County Coalition, FISH Food Bank, Oregon Solutions.

Focus Area #4: Oral Health

- Community members of target populations will have improved access to affordable preventive, primary and emergency dental care services.
- Community members in focus populations will have access to outreach and oral health education programs.
- Participate and encourage ongoing discussion and decision making regarding water fluoridation.

Strategies:

- 1) Provide resource allocation for access to Medical Teams International dental vans at least once a month in the community.
- 2) Explore new models of dental care that expand access and lower cost amongst targeted populations: patients with unmet primary and immediate needs; high risk/high need patients (pregnant women, elderly patients, patients with chronic illnesses). New models may include: mid-level dental provider, advanced practice hygienists, co-location of dental clinics, virtual dental home, FQHC contracting, and others.
- 3) Explore opportunities to work with community partners to provide oral health outreach and community education.
- 4) Participate in local community discussions regarding water fluoridation.

Partners: Medical Teams International, PSCCO, CGHC partners, local DCOs, Gorge Dental Access Coalition.

*Note: ALL Providence Hood River Memorial Hospital strategies will align with PacificSource CCO’s strategies and the Columbia Gorge Health Council’s initiatives as relevant.

Providence Medford Medical Center

2013 Community Health Needs Assessment

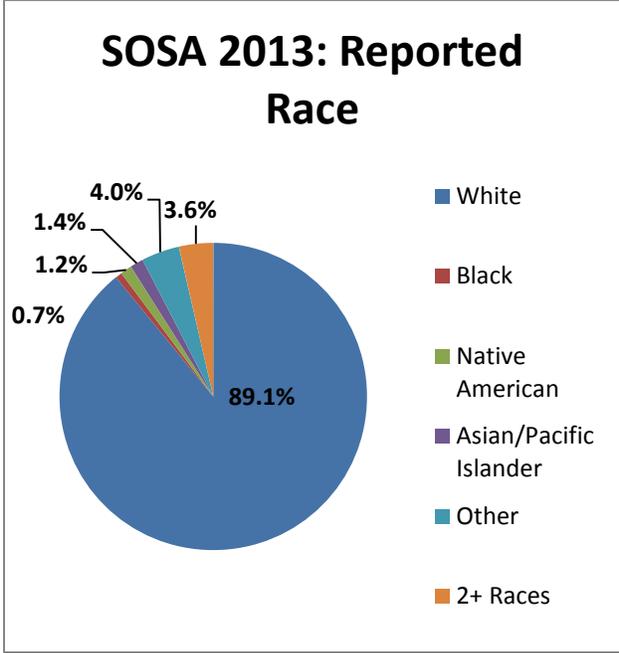
Providence Medford Medical Center (PMMC) is a 168-bed hospital serving Providence’s Southern Oregon Service Area (SOSA), composed of Jackson and Josephine counties. The hospital’s service area includes over 205,000 people in its primary service area, and nearly 300,000 with the inclusion of its secondary service area. The area hosts many migrant and seasonal workers, and has the lowest median household income of any Providence service area in Oregon. AllCare Health Plan, Jackson Care Connect, and PrimaryHealth of Josephine County provide services for Oregon Health Plan members in the area.

Demographic Snapshot

Primary (Jackson County): **97501** (Medford), **97502** (Central Point), **97503** (White City), **97504** (Medford), **97520** (Ashland), **97522** (Butte Falls), **97524** (Eagle Point), **97525** (Gold Hill), **97530** (Jacksonville), **97535** (Phoenix), **97536** (Prospect), **97537** (Rogue River), **97539** (Shady Cove), **97540** (Talent), **97541** (Trail)

Secondary (Josephine County): 97497 (Wolf Creek), 97523 (Cave Junction), 97526 (Grants Pass), 97527 (Grants Pass), 97531 (Kerby), 97532 (Merlin), 97534 (O’Brien), 97538 (Selma), 97543 (Wilderville), 97544 (Williams)

Total Population: 204,738 (290,014 including secondary service area)

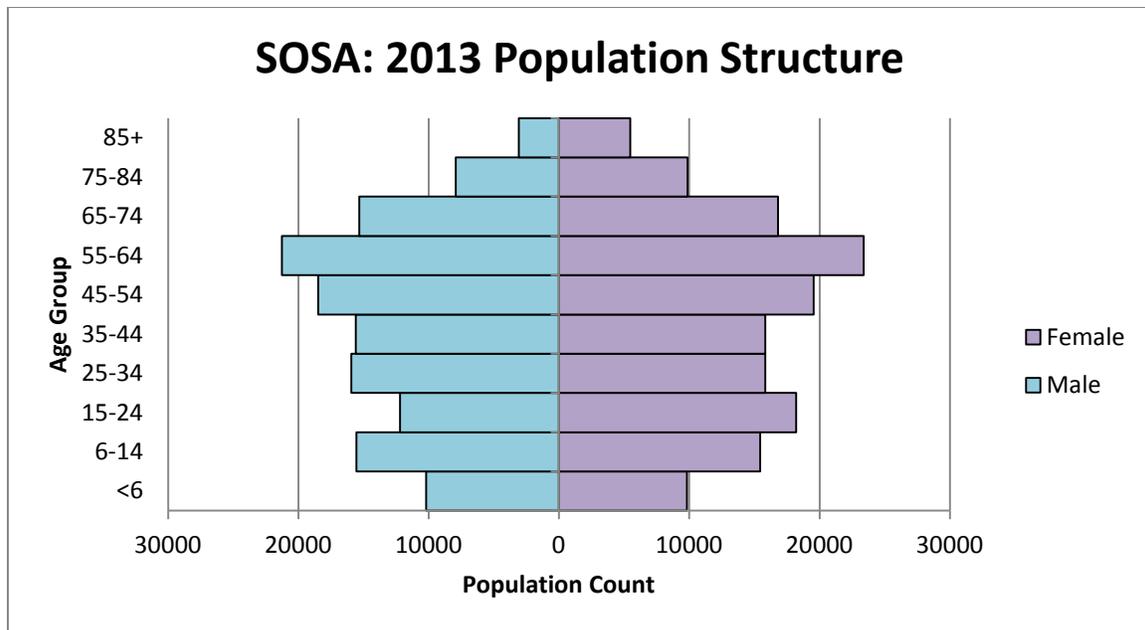


In 2013, residents of the Southern Oregon Service Area identified themselves primarily as White. Since 2011, there has been a decrease of nearly 6% in those identifying as white-only.

An increasing percentage (10%) of individuals now identify themselves as Hispanic, with the still overwhelming majority, 90%, identifying as non-Hispanic.

The median household income of the service area is **\$38,850**, the lowest of our Oregon service areas. The Community Needs Index (discussed below) identifies Medford, Phoenix, Shady Cove, and Talent as the highest needs areas within the primary service area.

The Southern Oregon Service Area has a relatively standard population distribution across gender. The male-female distribution is approximately 50% up until age 65, when females begin representing an increasing proportion of the population. There are, however, a disproportionate number of individuals aged 55-64 with a lower proportion of those aged 25-44 than one would expect.



County Health Rankings

The Robert Wood Johnson Foundation evaluates county-level measures of health outcomes and health factors annually in their County Health Rankings. In 2013, Jackson County was ranked 13th overall for both health outcomes and health factors out of Oregon’s 36 counties. Josephine was ranked 29th and 21st, respectively.

Some identified challenge areas for Jackson County were unemployment and a relatively high percentage of children in single-parent households. Both Jackson and Josephine counties have a low rate of sexually transmitted infections compared the state average, both have very safe drinking water and relatively low rates of violent crime. Specific challenge areas for Josephine County include high rate of years of potential life lost due to premature death (8,311, the highest of any service area county), a high percentage of those in poor or fair health, high percentage of adult smoking, a high rate of adult smoking, and one of the highest vehicle crash death rates in the state.

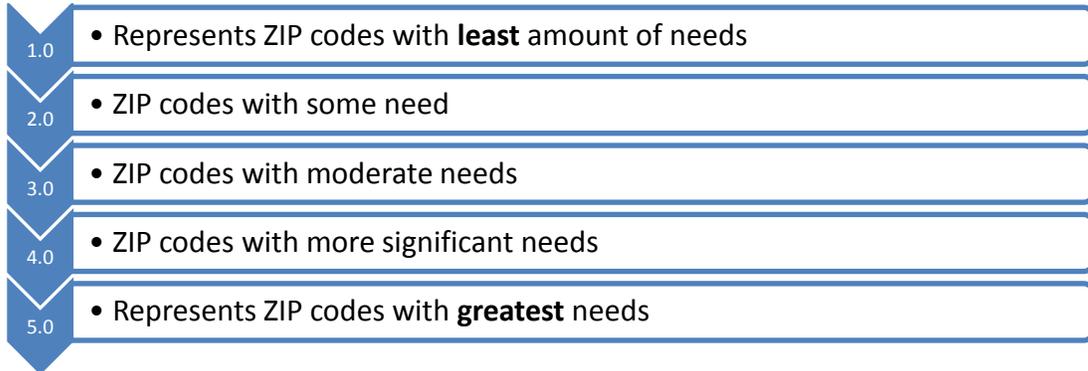
Community Needs Index

Truven Health Analytics annually produces a Community Needs Index, which evaluates 9 variables by ZIP code and builds an overall composite needs score for each ZIP. They assess five socioeconomic barriers: income, cultural, education, insurance, and housing.

The Southern Oregon Service Area has an overall CNI of 3.5. The primary service area has a relatively low percentage of limited-English proficiency, though a high rate of uninsured. All of SOSA’s ZIP codes have **increased** their level of need compared to 2012 CNI scores.

The Community Needs Index indicates that Medford, Phoenix, Shady Cove, and Talent are the highest need ZIP codes (Overall CNI scores of 3.8 or higher). Medford, Phoenix and Shady Cove were ranked in

the highest-need category for insurance coverage and Medford, Phoenix, and Talent were each scored 5 for housing.



Primary Service Area		
ZIP Code	City Name	2013 CNI Score
97501	Medford	4.2
97502	Central Point	3.2
97503	White City	3.4
97504	Medford	3.4
97520	Ashland	3.4
97522	Butte Falls	2.8
97524	Eagle Point	3.0
97525	Gold Hill	3.4
97530	Jacksonville	3.0
97535	Phoenix	4.2
97536	Prospect	3.0
97537	Rogue River	3.4
97539	Shady Cove	3.8
97540	Talent	3.8
97541	Trail	3.2

Hospital Data

Data from PMMC was analyzed to identify trends in hospital usage and common diagnoses. The top three diagnoses amongst vulnerable populations (uninsured, Medicaid, or dual eligible) in 2012 were urinary tract infection, benign hypertension, and uncomplicated Type II diabetes.

Ambulatory Care Sensitive Conditions (ACSCs) are recognized by the American Healthcare Research and Quality organization as diagnoses for which ED visits or admissions could have been avoided with better

access to preventive primary care. The most common ACSCs in Medford for 2012 were severe ear, nose, and throat infections, dental conditions, and kidney/urinary infections.

CORE Survey

The Center for Outcomes Research and Education (CORE) conducted a mail survey and analysis to provide a better picture of health needs and access across the Oregon region. Over 780 households received the survey, and CORE received 229 responses. Some key findings from the Southern Oregon Service Area include that nearly one-third of respondents live at or below the Federal Poverty Level, and over 15% report financial strain associated with medical costs. Non-white respondents were more likely to report being unemployed, having transportation difficulties, and to report low social support. Nearly 22% of respondents screened positive for possible problem drinking (significantly more Whites), and over 9% of respondents noted use of street drugs. 88.5% of respondents were able to identify a usual place of care, and nearly 80% self-assessed their health as being “good”, “very good,” or “excellent”. Over 11% reported being in poor or fair mental health.

Stakeholder Interviews

Twenty-three individuals and agencies were interviewed as part of the MAPP process across the Southern Oregon Service Area. They represented a broad range of perspectives, including first responders and social service agencies, as well as school districts and city mayors. Full details of those interviewed can be found in the appendix.

The primary needs identified in this step of the process were access to primary care, behavioral health and substance abuse, suicide prevention, oral health, and basic needs including housing, transportation, and poverty alleviation.

Focus Groups

Three focus groups took place in Medford to gather more detailed information regarding resources and barriers amongst identified populations of concern: low-income, Spanish-speaking, and elderly (>65). The focus group guide can be found in the appendix.

The most significant finding in the low-income focus group was limited awareness of how to access insurance under the Affordable Care Act. Additional needs identified included behavioral health services (particularly related to addiction services), oral health, skin and hygiene issues, and pulmonary health issues. The Latino focus group identified access to primary care, access to pediatric care, and oral health as their three top priorities within the community. Specific access issues included legal standing, cost, and language barriers, while attitude and perceptions of providers often made for a negative experience when seeking health care. The Senior group was much smaller and many were low-income. The top needs they identified included mental health services for depression and Alzheimer’s, oral health, primary care and access to preventive medicine, transportation, and access to healthy food.

Key Identified Needs

Throughout the process, the key needs that emerged (in alphabetical order) were:

- Access to primary care
- Behavioral health and substance abuse
- Chronic conditions
- Food insecurity
- Health awareness and education
- Oral health
- Suicide prevention

Providence Medford Medical Center

2014 -2016 Community Health Improvement Plan

Focus Area	Goal	Focus Population	Indicators/Measure
<p style="text-align: center;">ACCESS TO PREVENTIVE AND PRIMARY CARE</p> <ul style="list-style-type: none"> • Health insurance • Local primary care • Specialty care • Medications • Related supportive services (transportation) • Cultural/language barriers 	<ul style="list-style-type: none"> • More community members will have coverage and access to health services when needed • More community members will be established in a medical home • Community members who face barriers to health insurance coverage will have access to network of free or low-cost services 	<ul style="list-style-type: none"> • Low-income and uninsured; homeless population • Elderly • Latino and other racial/ethnic minority populations • Targeted ZIPs: 97501, 97535, 97539, 97540 	<ul style="list-style-type: none"> • Increase # of PCP/1000 population • Increase in the number of residents reporting they have a regular source of care on the CORE survey • Reduction in ED utilization for ambulatory care sensitive conditions amongst focus and general populations • Continued use of Medication Assistance Program • Decreased days until available appointment in PMG clinics
<p style="text-align: center;">MENTAL HEALTH AND SUBSTANCE USE</p> <ul style="list-style-type: none"> • Access to services • Hospitalization • Medical detox • Rehab • Medication management • Patient/family education • Community-based outpatient treatment 	<ul style="list-style-type: none"> • Community members in need of mental health services will have improved access • Community members will have improved mental health and decreased rates of substance use. • Local providers will implement Persistent Pain protocol • Community members will experience improved patient-centered communication, continuity of care, and collaboration. 	<ul style="list-style-type: none"> • Low-income and uninsured; homeless population • Latino and other racial/ethnic minority populations • At-risk youth • Targeted ZIPs: 97501, 97535, 97539, 97540 	<ul style="list-style-type: none"> • Improvement in the 2016 CORE survey regarding self-rated mental health, self-reported incidence of depression and anxiety, and risk assessment scores for mental health and substance abuse • Reduced number of opiate prescriptions • Fewer self-rated poor mental health days • Increased percentage of providers regularly implementing SBIRT

Focus Area	Goal	Focus Population	Indicators/Measure
<p style="text-align: center;">CHRONIC CONDITIONS</p> <ul style="list-style-type: none"> • Nutrition • Physical activity • Tobacco cessation • Frail elderly • Health awareness/ education 	<ul style="list-style-type: none"> • Community members will have increased access to education and support for management or prevention of chronic conditions • Increased capacity of primary care clinics to support patients in optimal management and self-management of chronic conditions • Spanish-speakers will have access to culturally competent prevention and management programs • Reduce tobacco use to promote long-term physical and oral health 	<ul style="list-style-type: none"> • Low-income and uninsured; homeless population • Latino and other racial/ethnic minority populations • Low-income and food insecure families • Frail elderly • Targeted ZIPs: 97501, 97535, 97539, 97540 	<ul style="list-style-type: none"> • Reduced rate of Diabetes and Coronary Artery Disease-related ED visits • Increased number of HgA1C levels in appropriate range • Increase in percentage of individuals reporting regular exercise on 2016 CORE Survey • Increase in % of people self-reporting “about the right weight” on the 2016 CORE survey • Decreased rate of adult and teen tobacco use • Fewer self-rated poor physical health days
<p style="text-align: center;">ORAL HEALTH</p> <ul style="list-style-type: none"> • Preventative care • Emergency care • Restorative care 	<ul style="list-style-type: none"> • Community members will have improved access to affordable preventive, primary, and emergency dental care services ▪ Provide community-based outreach and oral health education for the targeted populations. 	<ul style="list-style-type: none"> • Low-income and uninsured; homeless population • Latino and other racial/ethnic minority populations • Targeted ZIPs: 97501, 97535, 97539, 97540 	<ul style="list-style-type: none"> • Reduced numbers of visits to ER because of dental conditions • DCO enrollment

Focus Area #1: Access to Coverage and Care

- More community members will have coverage and access to health services when needed
- More community members will be established in a medical home
- Community members who face barriers to health insurance coverage will have access to network of free or low-cost services

Strategies:

- 1) Continue to provide free education from trained Financial Counselors and ED Guides at Providence Medford Medical Center to assist community members in enrollment.
- 2) Continue ED Guide program to connect patients to primary care and dental homes.
- 3) Coordinate care for frequent users of the Emergency Department.
- 4) Partner with local Community Health Center and La Clinica to provide access to uninsured or newly insured seen in the Emergency Departments.
- 5) Work with PMG to expand the number of primary care providers serving the community
- 6) Explore collaboration with local CCOs (AllCare, Jackson Care Connect, and PrimaryHealth) to assist enrollment for neediest populations and potential joint initiatives.
- 7) Continue Medication Assistance Program in partnership with Providence's regional Clinical Pharmacy team

Partners: PMG, local Community Health Centers, AllCare Health Plan, Jackson Care Connect, PrimaryHealth of Josephine County, La Clinica

Focus Area #2: Mental Health and Substance Use

- Community members in need of mental health services will have improved access
- Community members will have improved mental health and decreased rates of substance use.
- Local providers will implement opiate prescription policies (i.e. Persistent Pain program)

Strategies:

- 1) Partner with OnTrack, Inc and LifeART to support LifeTrack program for reduction in gang-related violence and suicide through peer mentorship services.

- 2) Expand the use of mental health and chemical dependency resources, education, prevention and wellness/recovery programs, for example: tele-psychiatry and the Providence Behavioral Health Triage Line.
- 3) Decrease prescription drug abuse and diversion by engaging medical and health care system stakeholders to promote the adoption of uniform opiate prescribing policies and practices.
- 4) Implement Persistent Pain program to provide provider and community education classes.
- 5) In collaboration with local community providers and partners, develop and distribute age specific suicide prevention and multi-media educational materials that target families, children and At-Risk Youth.
- 6) Implement SBIRT (Screening, Brief Intervention, Referral to Treatment) in line with CCO requirements.
- 7) Align with local CCO's strategies and goals as possible.
- 8) Implement Emergency Department Information Exchange (EDIE) program in Jackson County.

Partners: PMG, OnTrack, LifeART, Jackson Care Connect, AllCare Health Plan, and PrimaryHealth of Josephine County, Jackson County Public Health, Opioid Providers Group of Southern Oregon

Focus Area #3: Chronic Conditions

- Community members will have increased access to education and support for management or prevention of chronic conditions
- Increased capacity of primary care clinics to support patients in optimal management and self-management of chronic conditions
- Spanish-speakers will have access to culturally competent prevention and management programs
- Reduce tobacco use to promote long-term physical and oral health

Strategies:

- 1) Pursue and successfully achieve "baby friendly" hospital status.
- 2) Partner with local federally-qualified health centers and volunteer clinics to provide chronic disease management to low-income, uninsured individuals to reduce return visits to ER and repeat hospitalization; utilization of ED Guide program.
- 3) Explore opportunities to work with community partners to provide tobacco cessation outreach and education in the community.
- 4) Align with local CCOs goals and strategies as possible.

Partners: Promotores Program, PMG, La Clinica, Community Health Center, Jackson Care Connect, AllCare Health Plan, and PrimaryHealth of Josephine County

Focus Area #4: Oral Health

- Improve access to affordable preventive, primary and urgent dental care for low-income children, youth, adults and seniors.
- Provide community-based outreach and oral health education for the targeted populations.

Strategies:

- 1) Direct patients with dental pain to Medical Teams International dental vans in the community and La Clinica.
- 2) Explore funding opportunities and partnerships with St. Vincent de Paul to continue Medical Teams International van program.
- 3) Explore opportunities to work with community partners to provide oral health outreach and education in the community.
- 4) Provide support to the La Clinica Healthy Smiles program.
- 5) Align with local DCO and CCO goals and strategies as possible.

Partners: Medical Teams International, La Clinica, Jackson Care Connect, AllCare Health Plan, PrimaryHealth of Josephine County, local DCOs.

Providence Newberg Medical Center

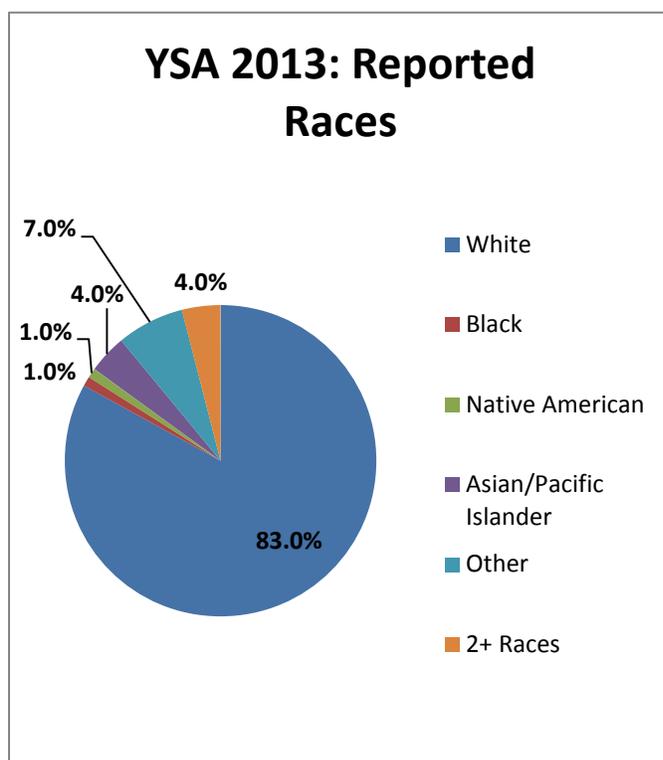
2013 Community Health Needs Assessment

Providence Newberg Medical Center (PNMC) is located in Newberg, Oregon, which lies south and west of Portland. PNMC is a designated Type B hospital with 40 beds and many specialists on-site. The medical center serves Providence's Yamhill Service Area, which includes ZIP Codes in Yamhill, Marion, and Washington counties. The surrounding area is perhaps best known for its vineyards and wine tourism. While there are many affluent retirees, there are also many disparate populations within the service area: migrant and seasonal workers, an aging population, and pockets of low-income individuals and families. Yamhill County Care Organization is the local Coordinated Care Organization.

Demographic Snapshot

ZIPs: **97115** (Dundee), **97132** (Newberg), **97137** (St. Paul), **97140** (Sherwood), **97148** (Yamhill)
Secondary: 97062 (Tualatin), 97070 (Wilsonville), 97101 (Amity), 97111 (Carlton), 97114 (Dayton), 97127 (Lafayette), 97128 (McMinnville), 97224 (Tigard)

Total Population: 63,363 (Primary Service Area); 195,155 including Secondary

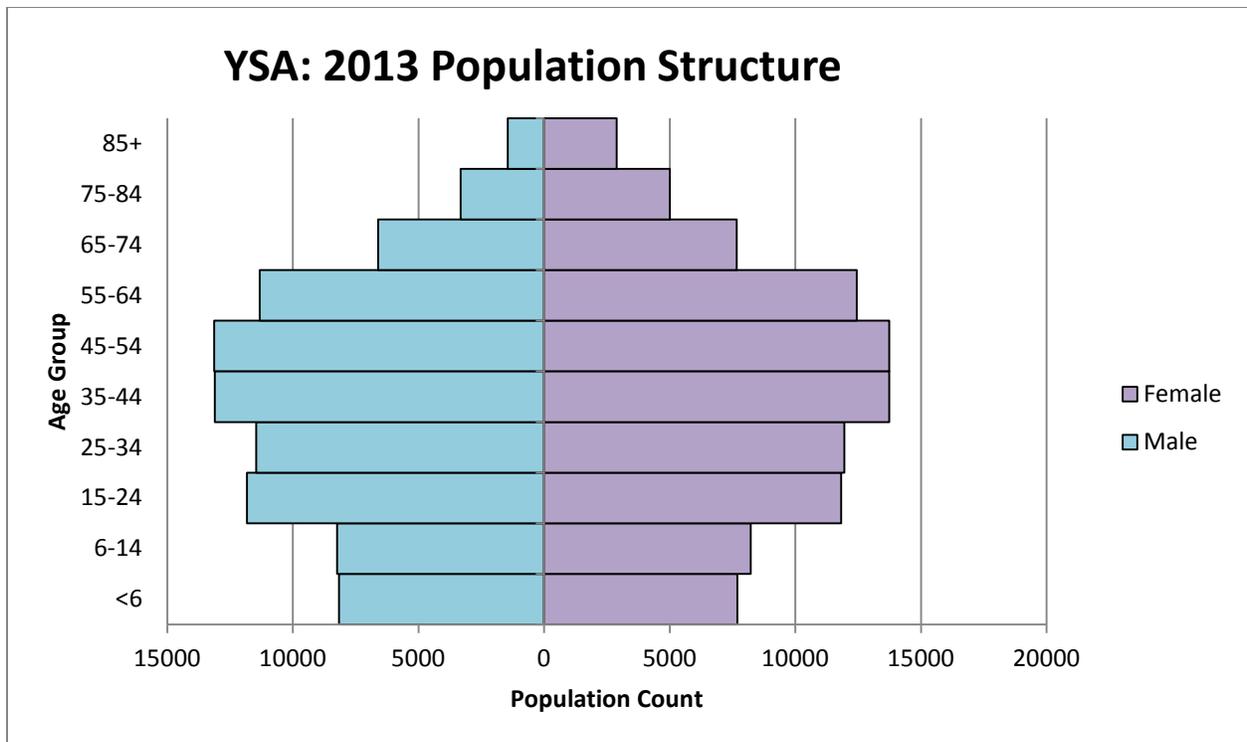


In 2013, residents of the Yamhill Service Area identified themselves primarily as White. Since 2012, there has been a slight increase in the percentage of individuals identifying as "2+ Races" and a matching decline in those identifying as White-only.

An increasing percentage (14%) of individuals now identify themselves as Hispanic, with the still overwhelming majority, 86%, describe themselves as non-Hispanic.

The median household income of the service area is **\$55,747**, with Dundee having the 3rd highest median household income in the state. However, the Community Needs Index (discussed below) suggests that Dayton and Lafayette, in the secondary service area, are amongst the poorest ZIP codes in the state.

The Yamhill Service Area has a fairly standard population distribution across age and gender. The distribution by gender is approximately 50% up until age 65, when females begin representing an increasing proportion of the population. This is a normal distribution as it is noted that with aging populations, women tend to live longer. There are fewer children under the age of 14 than would normally be expected in a community with so many working-age individuals.



County Health Rankings

The Robert Wood Johnson Foundation evaluates county-level measures of health outcomes and health factors annually in their County Health Rankings. In 2013, Yamhill County was ranked 6th overall for health outcomes in the state of Oregon and 11th overall for health factors out of Oregon’s 36 counties, making it amongst Oregon’s healthiest communities.

Some identified challenge areas were: air quality, drinking water safety, a low rate of dentists per population, and relatively limited access to recreation. However, Yamhill County also had many strengths compared to state averages, including low years of potential life lost due to premature death, as well as low rates of sexually transmitted infections, preventable hospital stays, and violent crime.

Community Needs Index

Truven Health Analytics annually produces a Community Needs Index (CNI), which allows quantification of health needs in communities across the country. It evaluates 9 variables by ZIP code and builds an overall composite needs score for each ZIP, ranked from 1 (lowest need) to 5 (greatest need). They assess five socioeconomic barriers: income, cultural, education, insurance, and housing.

The Yamhill Service Area has the lowest CNI of all Providence service areas, but there are pockets of poverty or need that can be masked by looking at the overall scores. The primary service area has a relatively low percentage of children in poverty and a comparatively low unemployment rate compared to those observed across the state. However, nearly all of these ZIP codes have **increased** their level of need compared to 2012 CNI scores.

The Community Needs Index indicates that Dayton, Lafayette, and McMinnville are the areas of greatest need with YSA ZIP codes (Overall CNI scores of 3.8 or higher). Lafayette scored a 5 in income, all three scored 4 for culture and education, and McMinnville scored 4 for insurance coverage and 5 for housing, indicating that a large proportion of homes were rented.

Primary Service Area			Secondary Service Area		
ZIP Code	City Name	2013 CNI Score	ZIP Code	City Name	2013 CNI Score
97115	Dundee	2.0	97062	Tualatin	3.0
97132	Newberg	3.0	97070	Wilsonville	3.2
97137	St. Paul	3.4	97101	Amity	3.4
97140	Sherwood	1.8	97111	Carlton	2.8
97148	Yamhill	2.2	97114	Dayton	3.8
			97127	Lafayette	3.8
			97128	McMinnville	4.0
			97224	Tigard	2.8

Hospital Data

Data from PNMC was analyzed to identify any trends in hospital usage and common diagnoses. The top three diagnoses amongst vulnerable populations (uninsured, Medicaid, or dual eligible) for 2012 were atrial fibrillation, urinary tract infections, and diabetes (uncomplicated).

Ambulatory Care Sensitive Conditions (ACSCs) are recognized by the American Healthcare Research and Quality organization as diagnoses for which ED visits or admissions could have been avoided with better access to preventive primary care. The top ACSCs presented in Newberg in 2012 were severe ear, nose, and throat infections, kidney or urinary infections, and dental conditions. For each of these three, the greatest proportion of cases were amongst an identified “vulnerable population”.

The two ZIP codes utilizing the most services are 97132 and 97140, Newberg and Sherwood respectively.

CORE Survey

The Center for Outcomes Research and Education (CORE) provided analysis of their Community Needs Survey within the Yamhill Service Area. Their survey was mailed to 779 households in the service area, with 242 responses submitted. The study found that 23% of respondents live at or below the federal poverty level, and nearly 15% struggled with food insecurity in the past 12 months. Just over 15% of respondents screened positive for a potential drinking problem, and that over 87% identified a usual source of care. Over 80% of respondents determined their health to be “good,” “very good,” or “excellent”.

Correlations in the study note the interrelated themes of poverty, stress, low social support, and poor health outcomes—both physical and mental.

Stakeholder Interviews

Twelve individuals and organizations were interviewed as part of the MAPP Process across the Yamhill Service Area. They represented a wide range of interests across the community, from mayors and city managers, to first responders and executives of major business (a full list of those interviewed can be found in the appendix).

The primary needs identified in the process were access to primary care, behavioral health, and geriatric care, as well as health awareness and education.

Focus Groups

Two focus groups took place in Yamhill Service Area, one with young mothers and the other with a group of seniors and persons living with a disability. Caregivers also attended this conversation in order to share their insights and perceptions of key challenges. Key findings from the mother’s group included the need for better lactation services and young parent education, as well as the need for increased resource advertising.

The senior and disabled group emphasized the importance of health as being a community effort, particularly having the “ability to serve and care for others” while maintaining a purpose in life and interacting with others—especially family. Some key health needs were that of fall prevention, respite care, an interest in extending the hours of the food bank, and a lack of Alzheimer’s and adult daycare services in the area. However, this group focused much more on the resources that were available in the community, noting the programs available through the Senior Center, Faith in Action, transportation assistance, emergency and first responders, amongst many others.

Key Identified Needs

Throughout the process, the key identified needs (in alphabetical order) were:

- Access to primary care
- Behavioral/mental health
- Chronic conditions
- Food insecurity
- Frail elderly
- Health awareness and education
- Oral health

Providence Newberg Medical Center

2014 -2016 Community Health Improvement Plan

Focus Area	Goal	Target Population	Indicators/Measure
<p style="text-align: center;">ACCESS TO PREVENTIVE AND PRIMARY CARE</p> <ul style="list-style-type: none"> • Health insurance • Local primary care • Specialty care • Medications • Related supportive services (transportation) • Cultural/language barriers 	<ul style="list-style-type: none"> • More community members will have coverage and access to health services when needed • More community members will be established in a medical home • Community members who face barriers to health insurance coverage will have access to network of free or low-cost services • Community members will be aware of appropriate alternatives for non-emergent ED care 	<ul style="list-style-type: none"> • Low-income and uninsured • Elderly • Latino and other racial/ethnic minority populations • Targeted ZIPs: 97114, 97127, 97128, 97132, 97137 	<ul style="list-style-type: none"> • Increase # of PCP/1000 population • Increase in the number of residents reporting they have a regular source of care on the CORE survey • Reduction in ED utilization for ambulatory care sensitive conditions amongst focus and general populations • Increased availability of Medication Assistance Program
<p style="text-align: center;">MENTAL HEALTH AND SUBSTANCE USE</p> <ul style="list-style-type: none"> • Access to services • Hospitalization • Medical detox • Rehab • Medication management • Patient/family education • Community-based outpatient treatment 	<ul style="list-style-type: none"> • Community members in need of mental health services will have improved access • Community members will have improved mental health and decreased rates of substance use. • Local providers will instate Persistent Pain protocol • Behavioral health will be integrated into patient-centered primary care homes (PCPCHs) • Community members will experience improved patient-centered communication, continuity of care, and collaboration 	<ul style="list-style-type: none"> • Low-income and uninsured; homeless population • At-Risk youth • Latino and other racial/ethnic minority populations • Targeted ZIPs: 97114, 97127, 97128, 97132, 97137 	<ul style="list-style-type: none"> • Improvement in the 2016 CORE survey regarding self-rated mental health, self-reported incidence of depression and anxiety, and risk assessment scores for mental health and substance abuse • Reduced number of opiate prescriptions • Fewer self-rated poor mental health days • Increased percentage of providers regularly implementing SBIRT • Utilization of telepsych services at ED • Behavioral health providers embedded in PCPCHs

Focus Area	Goal	Target Population	Indicators/Measure
<p style="text-align: center;">CHRONIC CONDITIONS</p> <ul style="list-style-type: none"> • Nutrition • Physical activity • Frail elderly • Health awareness/ education • Food Insecurity 	<ul style="list-style-type: none"> • Community members will have increased access to education and support for management or prevention of chronic conditions • Increased capacity of primary care clinics to support patients in optimal management and self-management of chronic conditions • Spanish-speakers will have access to culturally competent prevention and management programs • Educate patients regarding tobacco use and prevention to promote long-term physical and oral health • Food-insecure community members, particularly children, will have access to a network of support services 	<ul style="list-style-type: none"> • Low-income and uninsured • Latino and other racial/ethnic minority populations • Frail elderly • Children • Food-insecure families • Targeted ZIPs: 97114, 97127, 97128, 97132, 97137 	<ul style="list-style-type: none"> • Increase in percentage of individuals reporting regular exercise on 2016 CORE Survey • Increased number of HgA1C levels in appropriate range • Increase in % of people self-reporting “about the right weight” on the 2016 CORE survey • Decreased rate of adult and teen tobacco use • Fewer self-rated poor physical health days • Implementation of food insecurity reduction program • Implementation of <i>Promotores</i> Program in Yamhill County • Increased outreach for community education
<p style="text-align: center;">ORAL HEALTH</p> <ul style="list-style-type: none"> • Preventative care • Emergency care • Restorative care 	<ul style="list-style-type: none"> • Community members will have improved access to affordable preventive, primary, and emergency dental care services ▪ Provide community-based outreach and oral health education for the targeted populations. 	<ul style="list-style-type: none"> • Low-income and uninsured • Latino and other racial/ethnic minority populations • Targeted ZIPs: 97114, 97127, 97128, 97132, 97137 	<ul style="list-style-type: none"> • Increased number of dental visits to Virginia Garcia Newberg • Reduced numbers of visits to ER because of dental conditions • DCO enrollment • Increased utilization of available dental chairs

Goals & Strategies

Focus Area #1: Access to Preventive and Primary Care

- More community members will have coverage and access to health services when needed
- More community members will be established in a medical home
- Community members who face barriers to health insurance coverage will have access to network of free or low-cost services
- Community members will be aware of appropriate alternatives for non-emergent ED care

Strategies:

- 1) Provide free education from trained Financial Counselors at Providence Newberg Medical Center to assist community members in enrollment.
- 2) Explore collaboration with Yamhill County Care Organization to assist in enrollment for neediest populations and potential joint initiatives.
- 3) Expand the number of Advanced Practice Providers serving the community.
- 4) Coordinate care for frequent users of the emergency department.
- 5) Continue Medication Assistance Program.
- 6) Increase the number of Spanish-speaking providers and translators available to community members for medical care.
- 7) Provide support for Virginia Garcia's Newberg clinic.
- 8) Increase access for Medicaid patients in PMG patient-centered primary care homes.

Partners: Providence Medical Group, ED Guide Program, Yamhill County Care Organization, Virginia Garcia

Focus Area #2: Mental Health and Substance Use

- Community members in need of mental health services will have improved access
- Community members will have improved mental health and decreased rates of substance use.
- Local providers will institute opiate prescription policies (i.e. Persistent Pain program)
- Behavioral health will be integrated into patient-centered primary care homes (PCPCHs)
- Community members will experience improved patient-centered communication, continuity of care, and collaboration

Strategies:

- 1) Expand the use of behavioral health resources, education, prevention and wellness/recovery programs, for example: tele-psychiatry and the Providence Behavioral Health Triage Line.
- 2) Decrease prescription drug abuse and diversion by engaging medical and health care system stakeholders to promote the adoption of a uniform opiate prescribing policies and practices; implement Persistent Pain Program.
- 3) Implement Screening, Brief Intervention, Referral to Treatment (SBIRT) screening in line with Yamhill County Care Organization goals and metrics.
- 4) Increase the number of Spanish-speaking providers and translators available to community members for medical care.
- 5) Partner with Yamhill County Care Organization and Yamhill County Public Health on relevant behavioral health strategies.

Partners: Providence Medical Group, Providence Health Plan, Yamhill County Care Organization, Yamhill County Public Health

Focus Area #3: Chronic Conditions

- Community members will have increased access to education and support for management or prevention of chronic conditions
- Increased capacity of primary care clinics to support patients in optimal management and self-management of chronic conditions
- Spanish-speakers will have access to culturally competent prevention and management programs
- Educate patients regarding tobacco use and prevention to promote long-term physical and oral health
- Food-insecure community members, particularly children, will have access to a network of support services

Strategies:

- 1) Support local food programs for low-income and food-insecure children.
- 2) Expand Parish Health Promoters to include Newberg parishes.
- 3) Develop relationships with local parish for Promotores “Tomando Control” program (“Living Well...” Spanish language workshop) leaders in order to address chronic conditions for Hispanic patients and families.
- 4) Partner Virginia Garcia Memorial Health Center to provide chronic disease management to low-income, uninsured individuals to reduce return visits to ER and repeat hospitalization.

- 5) Align with Yamhill County Care Organization's goals and metrics, particularly regarding diabetes care.
- 6) Increase community outreach opportunities for health education and awareness, particularly through the Service Area Advisory Council's Community Relations Committee.

Partners: Parish Health Promotores, Providence Medical Group, Virginia Garcia Memorial Health Center, Yamhill County Care Organization

Focus Area #4: Oral Health

- Improve access to affordable preventive, primary and urgent dental care for low-income children, youth, adults and seniors.
- Provide community-based outreach and oral health education for the targeted populations.

Strategies:

- 1) Provide resource allocation for access to Medical Teams International dental vans at the Love, INC location at least once every other month.
- 2) Work with Pacific University and Chemeketa Community College dental programs to provide free and low-cost services; explore use of existing dental chairs at the Church of Christ.
- 3) Explore new models of dental care that expand access and lower cost amongst targeted populations: patients with unmet primary and immediate needs; high risk/high need patients (pregnant women, elderly patients, patients with chronic illnesses). New models may include: mid-level dental provider, advanced practice hygienists, co-location of dental clinics, virtual dental home, federally-qualified health center contracting, and others.
- 4) Promote and provide access to preventive services, tooth sealants and tobacco cessation support.
- 5) Explore opportunities to include patient recruitment and education through *Promotores* program outreach.
- 6) Support new Virginia Garcia dental program in Newberg.
- 7) Align with Yamhill County Care Organization goals and strategies.
- 8) Monitor enrollment in Dental Care Organizations.

Partners: Medical Teams International, Virginia Garcia Memorial Health Center, Love INC, Pacific University, Chemeketa Community College, Yamhill County Care Organization, local Dental Care Organizations.

Providence Seaside Hospital

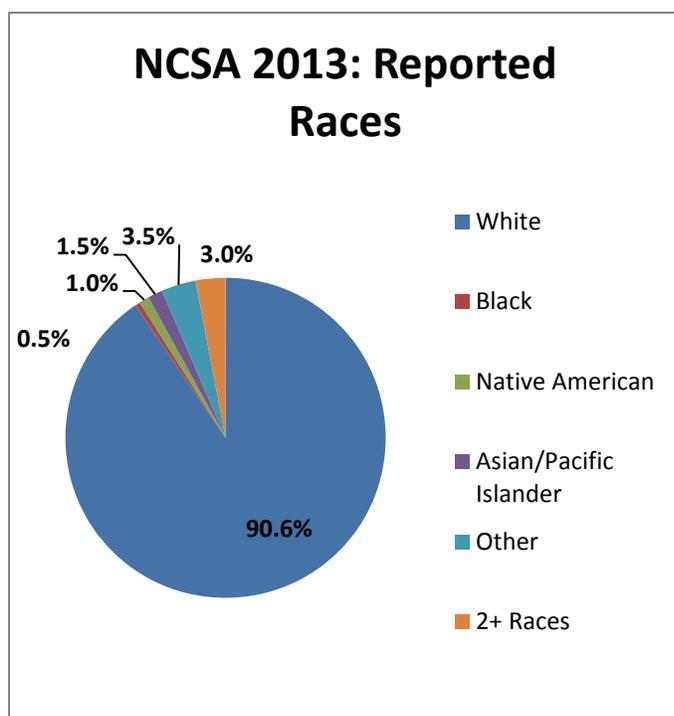
2014 -2016 Community Health Improvement Plan

Providence Seaside Hospital (PSH), a 25-bed Critical Access Hospital with a 22-bed extended care unit, is located in Seaside, Oregon, Providence’s North Coast Service Area. The fulltime population is nearly 40,000, including ZIP codes in Clatsop and northern Tillamook counties. The economy is largely seasonal and based upon tourism during the summer months, including the “Hood to Coast” relay. The population of the City of Seaside swells from approximately 5,600 to nearly 60,000 during those months. There are many homes that are secondary or vacation residences, and there is also a significant indigent population. Columbia Pacific Coordinated Care Organization provides care for Oregon Health Plan members in the area.

Demographic Snapshot

Primary Service Area: **97102** (Arch Cape); **97103** (Astoria); **97110** (Cannon Beach); **97121** (Hammond); **97130** (Manzanita); **97131** (Nehalem); **97138** (Seaside); **97145** (Tolovana Park); **97146** (Warrenton); **97147** (Wheeler)

Total Service Area Population: 39,892

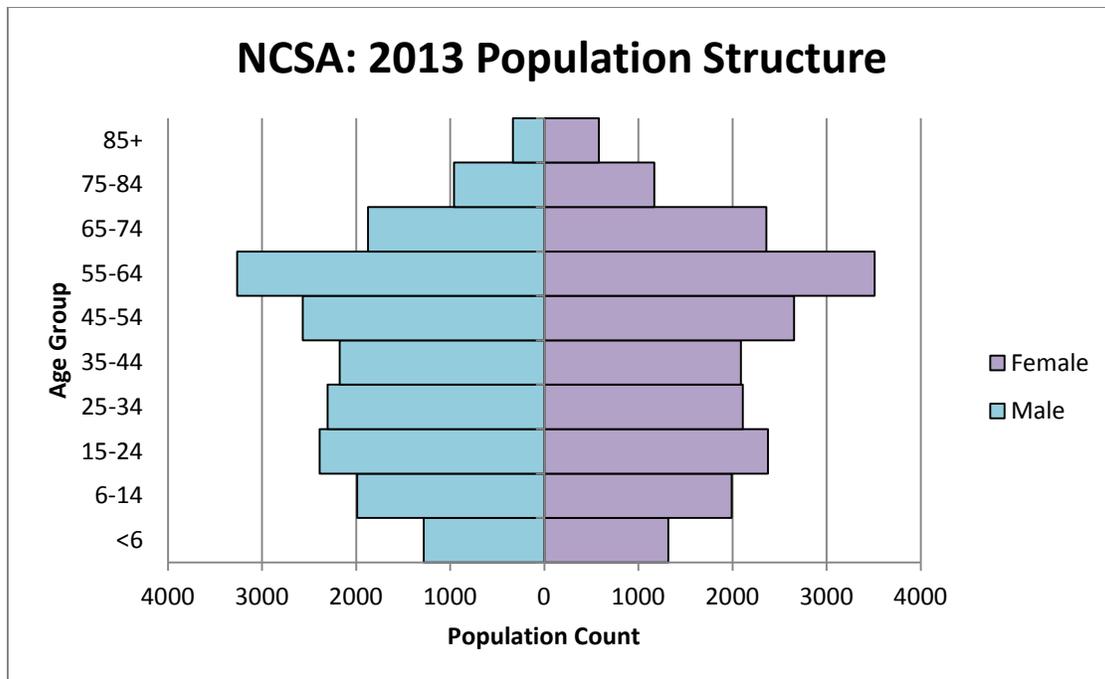


The population in the North Coast Service Area is primarily as White (91%), though 5% less than identified themselves as White in the 2011 Needs Assessment. An increased proportion identify as “2+ Races,” which may account for part of this change.

Approximately 8% of the population identifies as Hispanic, a 2% increase since 2011, though the vast majority (92%) still identify themselves as non-Hispanic.

The median household income of the service area is **\$41,591**. There are no “high needs” ZIP codes (>3.8) identified in the Community Needs Index, though there was not enough data available to evaluate overall needs in Tolovana Park or Wheeler.

The North Coast Service Area has a fairly standard population distribution across gender, but is our oldest service area with a greater proportion of people over age 55 (35%) than a “normal” age structure. The distribution by gender is approximately 50% up until age 65, when females begin representing an increasing proportion of the population.



County Health Rankings

The Robert Wood Johnson Foundation evaluates county-level measures of health outcomes and health factors annually in their County Health Rankings. In 2013, Clatsop County was ranked 12th overall for health outcomes and 15th overall for health factors out of Oregon’s 36 counties, placing it in the healthiest half of the State’s counties.

Some challenge areas identified in the study were rate of preventable hospital stays, percentage of children in poverty, percentage of children in single-parent households, and air quality. Strengths included a low teen birth rate, low violent crime rate, and fairly limited access to fast food restaurants.

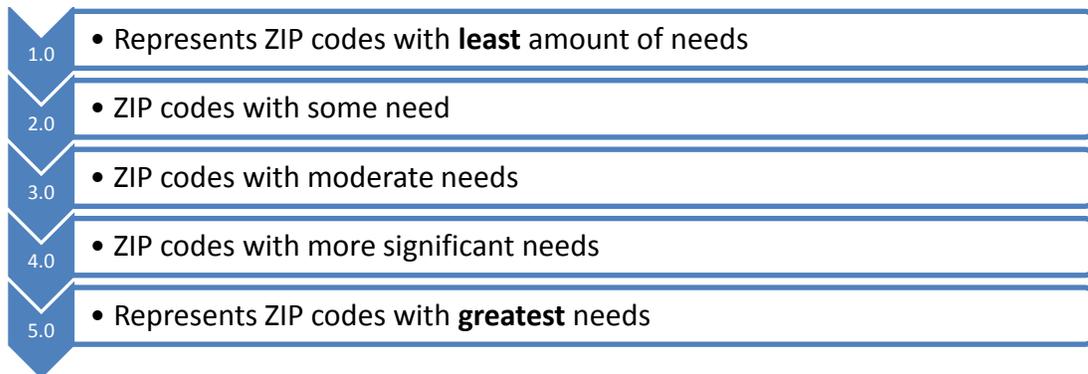
Community Needs Index

Truven Health Analytics annually produces a Community Needs Index (CNI), which allows quantification of health needs in communities across the country. It evaluates 9 variables by ZIP code and builds an overall composite needs score for each ZIP. They assess five socioeconomic barriers: income, cultural, education, insurance, and housing.

North Coast Service Area has a moderate CNI score overall, but there are defined pockets of poverty and need. Within the service area, due to small population sizes, not all of the ZIPs have assessed scores. The primary service area has a relatively low limited English proficiency and minority population, a high percentage who complete high school, and a relatively low unemployment rate.

The Community Needs Index indicates that there are no specific high needs ZIPs overall, but that Manzanita and Tolovana Park scored 5 (high need) for income, and Astoria, Hammond, Seaside and

Tolovana Park each scored 5 for housing due to the high percentages of people renting their homes. Manzanita has many vacation or secondary homes, so the population residing there full-time is different from those who own homes there.



Primary Service Area		
ZIP Code	City Name	2013 CNI Score
97102	Arch Cape	2.4
97103	Astoria	3.4
97110	Cannon Beach	--
97121	Hammond	3.0
97130	Manzanita	3.2
97131	Nehalem	3.2
97138	Seaside	3.4
97145	Tolovana Park	3.4
97146	Warrenton	2.4
97147	Wheeler	--

Hospital Data

Data from PSH was analyzed to identify any trends in hospital usage and common diagnoses amongst vulnerable populations (Medicaid, uninsured, or dual eligible). The top diagnosis in 2012 was atrial fibrillation (nearly 3,000 cases), with uncomplicated diabetes and urinary tract infections following with roughly 500 cases.

Ambulatory Care Sensitive Conditions (ACSCs) are recognized by the American Healthcare Research and Quality organization as diagnoses for which ED visits or admissions could have been avoided with better access to preventive primary care. The top ACSCs in Seaside for 2012 (in descending order) were severe ear, nose, and throat infections, kidney or urinary infection, chronic obstructive pulmonary disorder, and dental conditions. For each of these, the greatest proportion of services provided were amongst an identified “vulnerable” population.

CORE Survey

The Center for Outcomes Research and Education (CORE), provided analysis of their Community Needs Survey within the North Coast Service Area. Of the 779 households mailed a survey, CORE received 242 responses. Nearly 31% of respondents were at or below the federal poverty level, with 17% reporting food insecurity. Transportation was a barrier for nearly 13% of respondents and over 11% self-identified as current smokers. Nearly 57% of respondents consider themselves overweight and 15% were uninsured. However, 85% of respondents noted that they did have someone they considered a primary care provider. Over 80% of respondents considered their health “good”, “very good”, or “excellent” and 8% classified themselves as being in poor or fair mental health.

Nearly 40% of the respondents identified themselves as retired and just under 50% as employed. Food insecurity differed significantly by income level and insurance status, as did medical cost strain. Current smoking and alcohol abuse were more likely in respondents from Tillamook County than from Clatsop and the most common reason for not accessing medical, dental, or mental health care had to do with concerns about cost. For mental health services, many respondents (nearly 30%), reported that either they “thought they were okay without it” or that they didn’t know where to go for services.

Stakeholder Interviews

Twenty-two stakeholders were interviewed within the North Coast Service Area, representing a broad range of interests and expertise. A full list of those interviewed is available in the appendix. Representatives from mental and behavioral health, social services, senior care facilities, first responders, and city administrators were invited to share their opinions of key health needs in the community. The primary identified needs were access to primary care, behavioral health care (including substance abuse), oral health, and care for frail elderly.

Focus Groups

Three focus groups were conducted to reach out to people from recognized populations of concern and those who may not have been represented in the CORE Survey. All focus groups were held locally and participants were recruited by local volunteers. The focus groups were intended to collect more in-depth feedback from the Hispanic and Spanish-speaking population, the elderly (over 65), and low-income (<200% FPL) regarding both unmet needs as well as current health resources in the area.

Identified resources included the dental van, financial aid services, an on-site cardiologist, available transportation services, recognition of the Seaside ER as being “phenomenal” and very efficient, as well as good access to a primary care provider if one already has an established relationship.

Key feedback from the Hispanic group included the needs for better access to care—specifically more doctors, insurance coverage, dental care, and in-person translation services. The Senior group also recognized the need for more doctors, better information about available resources, mental and behavioral health services, and an “Ask-a-Nurse” program or something similar. The low-income population mentioned the need for more doctors and access to primary care, better education or vocational training, and dental care.

Identified Needs

Throughout the process, the top—and repeatedly identified—needs were (in alphabetical order):

- Access to primary care
- Food insecurity
- Frail elderly
- Mental health and substance abuse
- Oral Health
- Stable housing
- Vision care

Providence Seaside Hospital

2014 -2016 Community Health Improvement Plan

Focus Area	Goal	Focus Population	Indicators/Measure
<p style="text-align: center;">ACCESS TO PREVENTIVE AND PRIMARY CARE</p> <ul style="list-style-type: none"> ▪ Health insurance ▪ Local primary care ▪ Specialty care ▪ Medications ▪ Related supportive services (transportation) ▪ Cultural/language barriers 	<ul style="list-style-type: none"> ▪ More community members will have coverage and access to health services when needed ▪ More community members will be established in a medical home ▪ Community members who face barriers to health insurance coverage will have access to network of free or low-cost services 	<ul style="list-style-type: none"> • Low-income and uninsured; homeless population • Elderly • Latino and other racial/ethnic minority populations • Targeted ZIPs: 97130, 97145, 97138, 97103 	<ul style="list-style-type: none"> • Increase in the number of residents reporting they have a regular source of care on the CORE survey • Increased rate of primary care provided in Oregon PCPCH Tier 3 certified clinics • Reduction in ED utilization for ambulatory care sensitive conditions amongst focused populations • Increase in Spanish-speaking providers
<p style="text-align: center;">MENTAL HEALTH AND SUBSTANCE USE</p> <ul style="list-style-type: none"> • Access to services • Hospitalization • Medical detox • Rehab • Medication management • Patient/family education • Community-based outpatient treatment 	<ul style="list-style-type: none"> • Community members will have improved access to local methadone treatment • Community members in need of mental health services will have improved access • Community members will have improved mental health and decreased rates of substance use. • Local providers will implement Persistent Pain program • Community members will experience improved patient-centered communication, continuity of care, and collaboration 	<ul style="list-style-type: none"> • Low-income and uninsured; homeless population • Those seeking methadone treatment or other medical detox • Latino and other racial/ethnic minority populations • At-risk youth • Targeted ZIPs: 97130, 97145, 97138, 97103 	<ul style="list-style-type: none"> • Improvement in the 2016 CORE survey regarding self-rated mental health, self-reported incidence of depression and anxiety, and risk assessment scores for mental health and substance abuse • Increase in Spanish language services • Reduced number of opiate prescriptions • Fewer self-rated poor mental health days • Increased percentage of providers regularly implementing SBIRT

Focus Area	Goal	Focus Population	Indicators/Measure
<p style="text-align: center;">CHRONIC CONDITIONS</p> <ul style="list-style-type: none"> • Nutrition • Physical activity • Tobacco cessation • Frail elderly • Health awareness/ education 	<ul style="list-style-type: none"> • Community members will have increased access to education and support for management or prevention of chronic conditions • Increased capacity of primary care clinics to support patients in optimal management of chronic conditions • Spanish-speakers will have access to culturally competent prevention and management programs • Reduce tobacco use to promote long-term physical and oral health 	<ul style="list-style-type: none"> • Low-income and uninsured; homeless population • Latino and other racial/ethnic minority populations • Frail elderly • Food insecure families • Targeted ZIPs: 97130, 97145, 97138, 97103 	<ul style="list-style-type: none"> • Reduced rate of diabetes and coronary artery disease-related ED visits • Increased percentage of population with HgA1C levels in normal range • Increase in percentage of individuals reporting regular exercise on 2016 CORE Survey • Increase in % of people self-reporting “about the right weight” on the 2016 CORE survey • Decreased rate of adult and teen tobacco use • Fewer self-rated poor physical health days • Increased number of individuals utilizing <i>Promotores</i> Program and becoming certified trainers.
<p style="text-align: center;">ORAL HEALTH</p> <ul style="list-style-type: none"> • Preventative care • Emergency care • Restorative care 	<ul style="list-style-type: none"> • Community members will have improved access to affordable preventive, primary, and emergency dental care services ▪ Provide community-based outreach and oral health education for the targeted populations. 	<ul style="list-style-type: none"> • Low-income and uninsured; homeless population • Latino and other racial/ethnic minority populations • Targeted ZIPs: 97130, 97145, 97138, 97103 	<ul style="list-style-type: none"> • Reduction in the number of low-income individuals in targeted ZIP codes who report a lack of urgent dental care • Reduced numbers of visits to ER because of dental conditions • Increased opportunities for professional and community education related to oral health • DCO enrollment

Goals & Strategies

Focus Area #1: Access to Preventive and Primary Care

- More community members will have coverage and access to health services when needed
- More community members will be established in a medical home
- Community members who face barriers to health insurance coverage will have access to network of free or low-cost services

Strategies:

- 1) Provide free education from trained Financial Counselors at Providence Seaside Hospital to assist community members in enrollment.
- 2) Coordinate care for frequent users of the Emergency Department.
- 3) Partner with Coastal Family Health to provide access to uninsured seen in the Emergency Departments.
- 4) Work with PMG to expand the number of primary care providers serving the community
- 5) Explore collaboration with Columbia Pacific CCO to assist with enrollment for neediest populations.
- 6) Increase the number of Spanish-speaking providers and translators available to community members for medical care.
- 7) Participate in Partners for Seniors transportation program.
- 8) Explore PACE model to increase access for frail elders.
- 9) Continue Mission/Spiritual Care work in arranging access to charity care.

Partners: PMG, Columbia Pacific CCO, Coastal Family Health, Partners for Seniors

Focus Area #2: Mental Health and Substance Use

- Community members will have improved access to local methadone treatment
- Community members in need of mental health services will have improved access
- Community members will have improved mental health and decreased rates of substance use.
- Local providers will implement Persistent Pain program
- Community members will experience improved patient-centered communication, continuity of care, and collaboration

Strategies:

- 1) Conduct Gap Analysis in partnership with CCO, Clatsop Behavioral Health, and change facilitators from other community agencies regarding mental health and substance abuse services, using a Level of Care Utilization System in order to determine gaps within the continuum of care for mental health and substance use services.

- 2) Develop partnership for integrated network of case managers between Clatsop County Jail, Clatsop Behavioral Health, and PSH.
- 3) Expand awareness and integrate the use of mental health and substance use resources, education, prevention and wellness/recovery initiatives, for example: Trauma Informed Care, motivational interviewing, patient-centered approaches, risk assessment and intervention (i.e. CASE Methodology and Applied Suicide Intervention Skills Training (ASIST). Share and promote use of consult, crisis support, and information services.
- 4) Decrease prescription drug abuse and diversion by engaging medical and health care system stakeholders to promote the adoption of a uniform opiate prescribing policies and practices; implement Persistent Pain program.
- 5) Expand education and resources available through grants, as Providence continues to monitor and participate in the evaluation of At-Risk Youth grants.
- 6) Develop partnerships or programs with partners to determine a local solution for providing methadone services, or mobile methadone services in Seaside
- 7) Partner with community stakeholders to provide education and information about the Principles of Recovery and culturally competent trauma-informed care.
- 8) Increase the number of Spanish-speaking providers available in the community.
- 9) Implement Screening, Brief Intervention, and Referral to Treatment (SBIRT) screening in line with CPCCO requirements.
- 10) Support Helping Hands Re-Entry programs to meet needs related to drug and alcohol dependency and mental health.

Partners: PMG, Oregon Community Foundation, CCJ, CBH, Columbia Memorial Hospital, Columbia Pacific CCO, Helping Hands

Focus Area #3: Chronic Conditions

- Community members will have increase access to education and support for management or prevention of chronic conditions
- Increased capacity of primary care clinics to support patients in optimal management and self-management of chronic conditions
- Spanish-speakers will have access to culturally competent prevention and management programs
- Reduce tobacco use to promote long-term health

Strategies:

- 1) Participate in area-wide initiatives to promote healthy eating and active living.
- 2) Explore PACE as a means of addressing the needs of frail elderly.
- 3) Pursue and successfully achieve “baby friendly” hospital status.
- 4) Introduce education and develop support for the “Living Well with Chronic Disease” workshop series using PMG clinics.
- 5) Expand Parish Health Promoters to include the Seaside parish.

- 6) Provide experienced Promotores as “Tomando Control” (“Living Well...” Spanish language workshop) leaders in order to address chronic conditions for Hispanic patients and families.
- 7) Partner with local community health centers and volunteer clinics to provide chronic disease management to low-income, underinsured, and uninsured individuals to reduce return visits to ER and repeat hospitalization.
- 8) Align with Columbia Pacific CCO goals and metrics, particularly as relevant to diabetes care.
- 9) Expand palliative care offerings, particularly related to congestive heart failure and chronic obstructive pulmonary disease.
- 10) Provided dedicated case management between PMG home health, and palliative care.
- 11) Promote and provide access to tobacco cessation support.
- 12) Support Sunday Supper program at Our Lady of Victory Catholic Church.
- 13) Support Clatsop Community Action’s housing activities.

Partners: Promotores Program, PMG, Coastal Family Health, Providence Women’s and Children Program, Columbia Pacific CCO, Providence Home Health, ElderPlace, Our Lady of Victory, Clatsop Community Action

Focus Area #4: Oral Health

- Improve access to affordable preventive, primary and urgent dental care for low-income children, youth, adults and seniors.
- Provide community-based outreach and oral health education for the targeted populations.

Strategies:

- 1) Provide resource allocation for access to Medical Teams International dental vans 20 times annually at various community locations.
- 2) Explore new models of dental care that expand access and lower cost amongst targeted populations: patients with unmet primary and immediate needs; high risk/high need patients (pregnant women, elderly patients, patients with chronic illnesses). New models may include: mid-level dental provider, advanced practice hygienists, co-location of dental clinics, virtual dental home, FQHC contracting, and others.
- 3) Explore opportunities to work with community partners to provide oral health outreach and education in the community.
- 4) Promote and provide access to preventive services and tooth sealants
- 5) Align with Columbia Pacific CCO goals and metrics as possible.

Partners: Medical Teams International, Columbia Pacific CCO

APPENDIX 1. LIST OF KEY STAKEHOLDERS

(non-Collaborative Assessments)

Providence Medford Medical Center:

Phil Long, Superintendent, Medford School District 549c
Teresa Sayre, Superintendent, Phoenix-Talent School District
Michelle Wilson, Development Director, Children's Advocacy Ctr. of Jackson Co.
Tom Cole, Executive Director, Kids Unlimited
Traci Fossen, Clinical Director, Kids Health Connection
Tim George, Chief of Police, Medford
Hank Williams, Mayor, Central Point
Gordon Sletmoe, Acting Chief, Medford Fire Department
Rita Sullivan, Executive Director, On-Track
Jackie Schad, Executive Director, ACCESS
DeeAnn Everson, Executive Director, United Way
Tiffanie Lambert, Director Special Services, Eagle Point School District
Dan Peterson, Chief, Jackson County Fire Department
Ida Saito, Chief Operating Officer, LaClinica
John Stromberg, Mayor, Ashland
Ed Smith-Burns, Deputy Director, Addictions Recovery Center
Mark Orndoff, Director, Jackson County Health & Human Services
Jackson Baures, Division Manager Jackson County Public Health
Stacy Brubaker, Division Manager, Jackson County Mental Health
Peg Crowley, Executive Director Community Health Center
Brenda Johnson, Executive Director, LaClinica
Monty Holloway, Administrative Captain, Jackson County Sheriff's Office
Susan Fisher, Jackson County Commission on Children and Families

Providence Newberg Medical Center:

Scott Parrish, CEO, A-Dec
Ted Crawford, Mayor, City of Dundee
Bob Andrews, Mayor, City of Newberg
Paula Terp, Mayor, City of Yamhill
Robin Baker, President, George Fox University
Kathy Watson, Manager, Faith in Action
Polly Siler, Manager, Love In the Name of Christ (Love, INC)
Kym Leblanc-Esparza, Superintendent, and Claudia Stewart, Newberg Public Schools
Les Hallman, Fire Chief and Frank Douglas, EMS Division Chief, Newberg Fire Department
Fr. Don Gutmann, St. Peter Catholic Church
Silas Halloran-Steiner, Director of Health and Human Services, Yamhill County HHS

Providence Seaside Hospital:

Don Larson, Mayor of Seaside
Mark Winstanley, Seaside City Manager
George Sabol, ED Clatsop Community Action
Jim Coffee, CEO Coastal Health Center
Sumeur Watkins, ED Clatsop Behavioral Health
Jorge Gutierrez, Program Manager Lower Columbia Hispanic Council
Brian Mahoney, Director Clatsop County Public Health
Nicole Williams, CEO Clatsop Care Center Health District
Mandy Brenchly, Administrator Clatsop Care Center
Jay Flint, ED Sunset Empire Transportation District
Gina Kyter, School Nurse Seaside School District
Steve Phillips, Board Member, Seaside School District
Carol Gallagher, ED Neawanna by the Sea Retirement Community
Denise Hayes, Community Relations Director, Neawanna by the Sea
Paul Tesi, Jail Commander Clatsop County Sheriff
Fr. Nick Nilema, Our Lady of Victory Church
Melissa Johnstone, NW Senior and Disability Services
Debra Birkby, Clatsop County Commissioner
Ayle Rhea, Executive Director, Suzanne Elise
Dominique Greco, Physician, PMG
Doug Wood, Union Health District
Mark Terranova, Restoration House

APPENDIX 2. STAKEHOLDER INTERVIEW GUIDE

Key Community Stakeholder Interview	Providence Representatives
Date and Time Of Interview	<i>(please list all attendees)</i>
Location	
Key Community Stakeholder Names/Titles <i>(please list all attendees)</i>	
Organization Name	
Address	
Phone(s)/Email	
How would you describe your race and ethnicity?	
How would you describe your organization's role within the community?	
How would you describe the geographic area your organization serves?	
Please identify and discuss specific unmet health needs in your community for the persons you serve:	
Can you prioritize these issues? What are your top concerns?	
Please identify and discuss specific gaps in community services for the persons you serve that contribute to the unmet health needs cited above. We have a particular concern for those that are low income, vulnerable or are experiencing health inequities.	
What existing community health initiatives or programs in your community are helpful in addressing the health needs of the persons you serve, especially with identifying health needs earlier? Can you rank them in terms of effectiveness?	
What other things do you think we should hear about?	
Other comments:	

APPENDIX 3. FOCUS GROUP GUIDE.

Focus Group Guide—CHNA 2013

	Questions	Prompts (only if needed)
Warm Up	<p>We're here to talk about your health needs today. Those needs could be for medical care, dental care, mental health services, emergency care, preventive care, or any other type of service that adds to your health and well-being.</p> <p>As we get started, tell me a bit about what it means for you and your family to be "healthy".</p>	<ul style="list-style-type: none"> • How do you feel and act when you're healthy? • What can you do when you're healthy that you cannot when you're not? • What is it in particular that keeps you healthy?
Needs	Now tell me the top two or three health needs for you and your family.	<ul style="list-style-type: none"> • Why do you seek out a doctor or other provider or counselor?
Health Resources	How are your health needs being met now?	<ul style="list-style-type: none"> • What was the health need? • How did you address it?
Gaps in Service	Do you have health needs that are not being met? Please give me an example of a time that you or your family could not receive the health services you needed. What happened?	<ul style="list-style-type: none"> • What need(s) were not taken care of? What happened as a result of that lack of treatment? • Have you ever been unsure about whether you were "sick enough" to see a doctor? Please explain.
What Works	Now I'd like to hear some examples of what has worked for you. Tell me about a time when you or your family needed healthcare and received the help you needed in the past year or so.	<ul style="list-style-type: none"> • Preventive care (flu shot, vaccinations) • Screening (Pap, TB) • Acute/emergency care • Long term care • Dental/vision • Mental health services • Chronic care or management
Solutions	<p>If you were put in charge of health services for your entire community, what three things would you do immediately to improve the health services for everyone in the community?</p> <p>Why?</p> <p>Which agencies should provide these services?</p>	<ul style="list-style-type: none"> • Care delivery, care structure, costs, alternative therapies, translation, exercise or nutrition classes, diabetes and heart health groups
Wrap Up	Is there anything we have not talked about today that you think providers in the Columbia Gorge should know about you or your family's health needs?	

COMMUNITY HEALTH SURVEY

COMMUNITY HEALTH SURVEY

INSTRUCTIONS: For each question, please fill in the box that best represents your answer. Your results are *completely private*, and you can skip any question you do not want to answer. When you are finished, please place the survey in the private, postage-paid envelope we have provided and drop it in the mail. If you have questions about this survey, please read the included letter, call us at 1-877-215-0686, or email us at: core@providence.org.

YOUR HEALTH CARE

These questions help us understand your health care over the last twelve months.

1. Do you currently have any kind of health insurance?
 Yes
 No → **If No, Go to Question 3**
2. What kind of health insurance do you have?
Mark all that apply.
 Medicaid/Oregon Health Plan (OHP)
 Medicare
 Private coverage through an employer or family member's employer
 A private plan I pay for myself
 Other (tell us): _____
 I don't have any insurance now
 I don't know
3. For how many of the **last 12 months** did you have some kind of health insurance?
 Not insured during the last 12 months
 1-3 months
 4-6 months
 7-9 months
 10-11 months
 Insured for ALL of the last 12 months
4. Do you receive care through the Indian Health Service (IHS)?
 Yes
 No
5. Is there a place you **usually** go to receive medical care?
 Yes
 No → **If No, Go to Question 8**

6. Where do you **usually** go to receive medical care?
Mark only one.
 A private doctor's office or clinic
 A public health clinic or community health center
 A tribal health clinic
 A hospital-based clinic
 A hospital emergency room
 An urgent care clinic
 Somewhere else (tell us): _____
 I don't have a usual place
7. How far do you have to travel to get to the place where you **usually** get medical care?
 0-5 miles
 6-10 miles
 11-20 miles
 21-50 miles
 More than 50 miles
8. Do you have **one person** you think of as your personal doctor or health care provider?
 Yes
 No
9. Was there a time in the **last 12 months** when you needed medical care?
 Yes
 No → **If No, Go to Question 12**
10. If you needed medical care in the **last 12 months** did you get **all** the care you needed?
 I got **all** the care I needed
 I got **some but not all** needed care
 I got **no care at all**
 I don't know

11. The **most recent time** you went **without** needed medical care, what were the main reasons?
Mark all that apply.
- I haven't had to skip any needed care
 - I was worried about the cost
 - I didn't have health insurance
 - My insurance wouldn't cover the care
 - I didn't know where to go
 - I didn't have transportation
 - The clinic is too far away
 - I didn't have childcare
 - The office wasn't open when I could get there
 - I couldn't get an appointment quickly enough
 - I thought I could handle it without treatment
 - I didn't think getting treatment would help
 - Other: _____
12. Was there a time in the last **12 months** when you needed **dental** care?
- Yes
 - No ➔ **If No, Go to Question 15**
13. If you needed dental care in the **last 12 months** did you get **all** the care you needed?
- I got **all** the care I needed
 - I got **some but not all** needed care
 - I got **no care at all**
 - I don't know
14. The **most recent time** you went **without** needed dental care, what were the main reasons?
Mark all that apply.
- I haven't had to skip any needed care
 - I was worried about the cost
 - I didn't have dental insurance
 - My insurance wouldn't cover the care
 - I didn't know where to go
 - I didn't have transportation
 - The office is too far away
 - I didn't have childcare
 - The office wasn't open when I could get there
 - I couldn't get an appointment quickly enough
 - I thought I could handle it without treatment
 - I didn't think getting treatment would help
 - Other: _____

15. In the **last 12 months** have you needed treatment or counseling for a **mental health condition or personal problem**?
- Yes
 - No ➔ **If No, Go to Question 18**
16. In the **last 12 months**, when you needed treatment or counseling for a mental health condition or personal problem, did you get **all** the care you needed?
- I got **all** the care I needed
 - I got **some but not all** needed care
 - I got **no care at all**
 - I don't know
17. The **most recent time** you went **without** needed mental health care, what were the main reasons?
Mark all that apply.
- I haven't had to skip any needed care
 - I was worried about the cost
 - I didn't have insurance
 - My insurance wouldn't cover the care
 - I didn't know where to go
 - I didn't have transportation
 - The clinic is too far away
 - I didn't have childcare
 - The office wasn't open when I could get there
 - I couldn't get an appointment quickly enough
 - I thought I could handle it without treatment
 - I didn't think getting treatment would help
 - I was worried about what people would think
 - Other: _____
18. In the **last 12 months** have you needed treatment or counseling for your use of alcohol or any drug, not counting cigarettes?
- Yes
 - No ➔ **If No, Go to Question 21**
19. In the **last 12 months**, when you needed treatment or counseling for your use of alcohol or drugs, did you get **all** the care you needed?
- I got **all** the care I needed
 - I got **some but not all** needed care
 - I got **no care at all**
 - I don't know

20. The **most recent time** you went **without** needed drug or alcohol abuse treatment, what were the main reasons? **Mark all that apply.**
- I haven't had to skip any needed care
 - I was worried about the cost
 - I didn't have insurance
 - My insurance wouldn't cover the care
 - I didn't know where to go
 - I didn't have transportation
 - The clinic is too far away
 - I didn't have childcare
 - The office wasn't open when I could get there
 - I couldn't get an appointment quickly enough
 - I thought I could handle it without treatment
 - I didn't think getting treatment would help
 - I was worried about what people would think
 - Other: _____
21. Was there a time in the **last 12 months** when you needed **prescription medication**?
- Yes
 - No → **If No, Go to Question 24**
22. Were the prescriptions you needed for physical health problems, mental health or personal problems, or both?
- Physical health problems
 - Mental health or personal problems
 - Both physical AND mental health problems
23. If you needed prescription medication in the **last 12 months**, did you get **all** the medications you needed?
- I got **all** the medication I needed
 - I got **some but not all** medications
 - I got **no medications at all**
 - I don't know
24. Do you have any children (under 19 years of age) living in your household?
- Yes
 - No → **If No, Go to Question 31**
25. In the **last 12 months**, has any child of yours needed medical care?
- Yes
 - No → **If No, Go to Question 27**

26. In the **last 12 months**, when your child needed medical care, did they get **all** the care they needed?
- They got **all** the care they needed
 - They got **some but not all** needed care
 - They got **no care at all**
 - I don't know
27. In the **last 12 months**, has any child of yours had an emotional, developmental or behavioral problem for which they needed treatment or counseling?
- Yes
 - No → **If No, Go to Question 29**
28. In the **last 12 months**, when your child needed treatment or counseling, did they get all the care they needed?
- They got **all** the care they needed
 - They got **some but not all** needed care
 - They got **no care at all**
 - I don't know
29. In the **last 12 months**, have any children of yours needed dental care?
- Yes
 - No → **If No, Go to Question 31**
30. In the last 12 months, when your child or children needed dental care, did they get all the care they needed?
- They got **all** the care they needed
 - They got **some but not all** needed care
 - They got **no care at all**
 - I don't know

YOUR HEALTH & LIFESTYLE

These questions give us a picture of your overall health.

31. In general, how would you rate your **physical health**?
- Excellent
 - Very Good
 - Good
 - Fair
 - Poor

32. **Compared to last year**, would you say your **physical health** is now better, worse, or about the same?

- Better
- Worse
- About the same

33. In general, how would you rate your **mental health**, including your mood and ability to think?

- Excellent
- Very Good
- Good
- Fair
- Poor

34. **Compared to last year**, would you say your **mental health** is now better, worse, or about the same?

- Better
- Worse
- About the same

35. Have you **ever** been told by a doctor or other health professional that you have any of the following?

	Yes	No
Diabetes or sugar diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Post-traumatic stress disorder (PTSD)	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Another ongoing health condition	<input type="checkbox"/>	<input type="checkbox"/>

↳ Tell us: _____

36. During the **past 2 weeks**, about how often have you been bothered by the following problems:

	Not at all	Several days	Over half the days	Nearly every day
Little interest or pleasure in doing things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling down, depressed, or hopeless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling nervous, anxious, or on edge?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not being able to stop or control worrying?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

37. In the **last 12 months**, has anyone ever forced you to do something sexual that you didn't want to do?

- Yes
- No

38. In the **last 12 months**, has someone you live with ever hurt or threatened to hurt you or your children?

- Yes
- No
- Doesn't apply

39. Do you consider yourself **now** to be overweight, underweight, or about the right weight?

- About the right weight
- Underweight
- Overweight
 - ↳ Are you actively trying to lose weight now?
 - Yes
 - No

40. Have you smoked at least 100 cigarettes in your **entire life**?

- Yes
- No → If No, Go to Question 43

41. Do you **now** smoke cigarettes every day, some days, or not at all?

- Every day
- Some days
- Not at all → If No, Go to Question 43

42. Are you **currently** trying to reduce smoking or quit smoking altogether?

- Yes, trying to reduce smoking
- Yes, trying to quit altogether
- No

43. Do you **currently** use chewing tobacco, snuff, or snus every day, some days, or not at all?

- Every day
- Some days
- Not at all

44. How often did you have a drink containing alcohol in the **past year**?

- Never → If No, Skip to Question 47
- Monthly or less
- 2-4 times a month
- 2-3 times a week
- 4 or more times a week

45. On the days when you did drink alcohol, how many drinks did you usually have **per day**? A 'drink' is one beer, one glass of wine, or one shot of liquor.

- 1 to 2
- 3 to 4
- 5 to 6
- 7 to 9
- 10 or more

46. How often did you have **six or more** drinks on one occasion in the **past year**?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

47. In the **last 12 months**, have you used any of the following? *Check all that apply. Remember, your answers are completely private.*

- Marijuana or hashish
- Prescription pain medication that was not prescribed to you
- Any other street drug
- I did not use any of these in the last 12 months

YOUR HOUSEHOLD FINANCES

These questions help us understand finances for you and your family.

48. In the **last 12 months**, how often have you been worried that your food would run out before you got money to buy more?

- Never
- Sometimes
- Often

49. In general, how often do you have a difficult time accessing transportation when you need it?

- Never
- Sometimes
- Often

50. In the **last 12 months**, did you or other members of your household have to move because you could not afford to pay rent, mortgage, or utility bills?

- Yes
- No

51. In the **last 12 months**, have you had to borrow money, skip paying other bills, or pay other bills late in order to pay health care bills?

- Yes
- No

52. In the **last 12 months**, has a doctor, clinic, or medical service refused to treat you because you owed money to them for past treatment?

- Yes
- No
- I don't know

ABOUT YOU & YOUR FAMILY

These questions help us understand more about you and your family.

53. Are you male or female?

- Male
- Female

54. What year were you born?

19_____

55. Would you describe yourself as being of Hispanic or Latino origin or descent?

- Yes, Hispanic or Latino
- No, not Hispanic or Latino

56. How would you describe your race? *Mark all that apply.*

- White
- Black or African-American
- American Indian
- Asian
- Native Hawaiian or Pacific Islander
- Other: _____

57. What language do you speak best?
- English
 - Spanish
 - Vietnamese
 - Russian
 - Other: _____

58. What is the highest level of education you have completed? *Mark only one.*
- Less than high school
 - High school diploma or GED
 - Vocational training or 2-year degree
 - A 4-year college degree
 - An advanced or graduate degree

59. Are you currently employed or self-employed?
- Yes, employed by someone else
 - Yes, self-employed
 - Not currently employed
 - Retired

60. About how many hours per week, on average, do you work at your current job(s)?
- I don't currently work
 - Less than 20 hours per week
 - 20-39 hours per week
 - 40 or more hours per week

61. What is your gross household income (before taxes and deductions are taken out) for last year (2012)? *Your best estimate is fine.*
- | | |
|---|--|
| <input type="checkbox"/> \$0 | <input type="checkbox"/> \$50,001-\$55,000 |
| <input type="checkbox"/> \$1 to \$5,000 | <input type="checkbox"/> \$55,001 to \$60,000 |
| <input type="checkbox"/> \$5,001 to \$10,000 | <input type="checkbox"/> \$60,001 to \$65,000 |
| <input type="checkbox"/> \$10,001 to \$15,000 | <input type="checkbox"/> \$65,001 to \$70,000 |
| <input type="checkbox"/> \$15,001 to \$20,000 | <input type="checkbox"/> \$70,001 to \$75,000 |
| <input type="checkbox"/> \$20,001 to \$25,000 | <input type="checkbox"/> \$75,001 to \$80,000 |
| <input type="checkbox"/> \$25,001 to \$30,000 | <input type="checkbox"/> \$80,001 to \$85,000 |
| <input type="checkbox"/> \$30,001 to \$35,000 | <input type="checkbox"/> \$85,001 to \$90,000 |
| <input type="checkbox"/> \$35,001 to \$40,000 | <input type="checkbox"/> \$90,001 to \$95,000 |
| <input type="checkbox"/> \$40,001 to \$45,000 | <input type="checkbox"/> \$95,001 to \$100,000 |
| <input type="checkbox"/> \$45,001 to \$50,000 | <input type="checkbox"/> \$100,001 or more |

62. How many family members, **including yourself**, are living in your home? *Include both adults and children.* (For example, if you live alone, you should write "1".)
- ↳ *Size of household:* _____
- ↳ *How many of them are under 19?:* _____

63. What is your **current** living arrangement? *Mark all that apply.*
- Live alone
 - Live with spouse or partner
 - Live with parents
 - Live with other relatives (including children)
 - Live with friends or roommates
 - Other: _____

64. Do you **currently** have anyone living in your home who doesn't **normally live there**, but doesn't have anywhere else to live right now?
- No _____
 - Yes
 - ↳ *How many people?* _____
 - ↳ *How many of them are under 19?:* _____

65. How often do you think you would have someone available to do each of the following?
- | | None of
the time | Some of
the time | Most of
the time | All of
the time |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| Love you and make you feel wanted? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Give you good advice about a crisis? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Get together with for relaxation? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Confide in or talk to about your problems? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Help you if you were confined to a bed?... .. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

STOP HERE

Thank you very much for taking time to complete this survey. Please place the survey in the postage-paid envelope and mail it. Contact us at -877-215-0686 or core@providence.org with any questions.

Columbia Gorge Regional Community Health Assessment

Collaborating for Optimum Health and Optimized
Healthcare

A summary of the needs and opportunities for improved health for the residents of the Columbia Gorge region including Hood River, Wasco, Sherman, Gilliam counties in Oregon and Skamania and Klickitat counties in Washington

December 2013

The following people were instrumental in creating this document: Barb Seatter, M.S. Catherine Whalen, Coco Yackley, Ellen Larsen, RN, Erin Quinn, MSN, FNP, Julie Reynolds, PhD, Maija Yasui, Mark Thomas, Chaplain, Megan McAninch, MSc, Teri Thalhofer, RN, BSN

The Cohort.....	1	Mental health status.....	18
About the Region	2	Physical and mental health together.....	19
Demographics	2	Alcohol, tobacco and other drugs.....	19
Acknowledgment to the Consumer		Tobacco use	19
Community	4	Problem drinking	19
Healthcare and Agency Ecosystem	4	Street drug use	20
Healthcare professionals.....	4	Domestic/sexual violence.....	20
Acknowledgment to the Healthcare		WE HAVE THE SAME NEEDS – a powerful	
Professional Community.....	5	outcome.....	21
Social Service and Non-profit Agencies.....	6	Limitations.....	21
Acknowledgment to the Agency and Faith		METHODS and PROCESS.....	21
Communities.....	6	The MAPP process	21
How to Read the Results of the Analysis.....	7	Gathering Community Themes.....	21
BASIC NEEDS.....	8	Community Advisory Council.....	22
Income insecurity	8	Behavioral Health Community Forum.....	22
Housing insecurity	8	Consumer Surveys by Mail	22
Food insecurity.....	9	Consumer Surveys In-person	23
Transportation insecurity.....	9	Focus groups	24
HEALTHCARE ACCESS	10	Gathering Health Status.....	25
Health insurance status.....	10	Gathering Local Health Eco-system Status.....	25
Have a Primary Care Provider (PCP).....	11	Provider and agency input	25
Have a usual place for care	11	MAPPING the Information Gathered	27
Distance from usual place of care	11	Gathering Forces of Change	27
Physical health access.....	12	Appendix.....	29
Dental health access	13	List of Figures and Tables.....	29
Mental health access.....	14	Community Health Survey.....	30
Substance abuse treatment	15	MOU from the Cohort	37
Medications.....	16	Data from Truven Market Expert 2013. ©	
HEALTH STATUS	17	Truven Health Analytics.....	42
General health and social isolation	17	Rank Order of Emergency Room Usage	
Weight management	17	Frequency by Diagnosis.....	45
Physical health status	17	Community Needs Index (CNI).....	46

Columbia Gorge Regional Community Health Assessment

Collaborating for Optimum Health and Optimized Healthcare

A spirit of collaboration

The organizations listed in the sidebar have come together to create our first integrated Columbia Gorge Regional Community Health Assessment. Together, we have been able to combine social and economic conditions with key healthcare information to build a prioritized set of needs for the region and identify unique needs in specific locations or populations.

Historically, needs assessments were conducted separately for various populations and areas in the Columbia Gorge Region. Local organizations independently collected and analyzed data and implemented health improvement activities. As a result, efforts to prioritize needs and to collaborate on health improvement have been inconsistent and less impactful. This year, we pursued a different path using the newly formed Columbia Gorge Health Council with its Consumer Advisory Council as the organizer.

With this new cross-organizational, cross-county forum, we chose to embark on a collaborative effort to serve the needs of multiple organizations. Our Principles of Collaboration outline our mutual intentions:

- A collaborative community health assessment (“CHA”) can be better; more accurate and actionable as community providers agree on the needs within our region and communities and will support our ability to address those needs together.
- A collaborative CHA will maximize collective resources available for improving population health.
- A collaborative CHA must be truly collaborative, requiring financial commitments from all participants who would use it to satisfy a regulatory requirement.

While Community Health Assessments are often anchored in the healthcare ecosystem, we elected to be inclusive of the social service agencies and non-profits that serve the vulnerable populations in our area.

This document represents our collaborative work and, more importantly, our harmonized voice on the highest needs for our region overall.

The Cohort

Columbia Gorge Health Council

Hood River County Health Department

Klickitat Valley Health

Klickitat Valley Health Department

Mid-Columbia Center for Living

Mid-Columbia Medical Center

North Central Public Health District

One Community Health

PacificSource Community Solutions

Providence Hood River Memorial Hospital

Skyline Hospital

About the Region

The Columbia Gorge region lies on both sides of the Columbia River, in north central Oregon and south central Washington. It includes Hood River, Wasco, Sherman, and Gilliam counties in Oregon, and Skamania and Klickitat counties in Washington State. These six counties have a combined area of 8,560 square miles and a combined population of less than 84,000; only six cities in the region have a population greater than 1,000: The Dalles (13,620), Hood River¹ (7,167), Goldendale (3,407), White Salmon (2,224), Stevenson (1,465), and Cascade Locks (1,144). The region is primarily rural with some residents living more than an hour from healthcare.



Figure 1 - Map of Columbia Gorge Region

The four bridges that cross the Columbia River along the 60 miles of the region’s borders help connect the communities in the two states, as do interstate and state highways. There is no public transportation network that serves the region overall, but local public bus transportation options exist.

Agriculture, tourism, forestry and healthcare services are the predominant industries with a very small but growing high tech industry contributing to the economic health of the Columbia Gorge region. Agriculture, tourism and forestry all have seasonal employment with the agricultural sector relying heavily on the presence of a migrant or seasonal farmworker population. The cost and availability of housing, especially in Hood River County, is influenced by seasonal recreational activity.

The current total population of the area is expected to increase over the next five years from 84,482 to 87,932, an increase of 3,450 residents (4%). This increase will not happen equally across the counties, with changes ranging from an increase for Gilliam County (6.8%), to a decrease for Sherman County (-2.6%). See Table 1 - Total Population below for a more detailed description of the population of the area.

Table 1 - Total Population

	Service Area Counties						Oregon
	Hood River	Klickitat	Skamania	Wasco	Gilliam	Sherman	
TOTAL POPULATION							
Current Population (Yr.)	22,888	21,142	11,345	25,426	1,961	1,720	3,918,925
5 Yr. Proj. Population (Yr.)	23,814	22,531	11,880	25,937	2,095	1,675	4,070,407
5 Year Growth (#)	926	1,389	535	511	134	(45)	151,482
5 Year Growth (%)	4.0%	6.6%	4.7%	2.0%	6.8%	-2.6%	3.9%

Source: Data from Truven Market Expert 2013. © Truven Health Analytics.

Demographics

The Columbia Gorge region has an increasingly older population, as do most rural counties. The Latino/Hispanic population in Hood River and Wasco counties is increasing rapidly. Native Americans and

¹ Hood River County also has a city named Hood River. The notation Hood River[^] will mean the city. All other references to Hood River are intended to be inclusive of the entire county.

Pacific Islanders are the other main racial groups resident in the region; African Americans are present in very small numbers (Table 2 on page 3).

Our region and Hood River in particular, has a high number of Latino/Hispanic residents. Within this population are a significant number of undocumented people, who face many additional challenges to meeting basic needs and to access healthcare. Themes related to legal status were strongly present in the Spanish focus group, specifically transportation barriers related to drivers' licenses and ineligibility for health insurance.

The size of the undocumented population is difficult to establish because disclosure of undocumented status could result in discrimination or deportation. Undocumented members of our community are therefore cautious about disclosing this status, even to each other, making the prevalence extremely difficult to measure. There are no formal studies or surveys regarded as accurate. Local agencies with trusted expertise in the Latino/Hispanic population estimate that conservatively, 30-45% of local Latino/Hispanic community members are undocumented and therefore categorically ineligible for many programs and benefits that support health. This ineligibility applies to the current expansion of Medicaid and government-subsidized health insurance plans under the Affordable Care Act. We anticipate that this population will continue to be largely uninsured. Based on these estimates and regional demographics, Hood River's uninsured population could remain above 15% even after robust expansion of health insurance programs.

Table 2 - Ethnicity and Race

		Service Area Counties						Oregon
		Hood River	Klickitat	Skamania	Wasco	Gilliam	Sherman	
POPULATION - ETHNICITY (All Races)								
Hispanic	Current Population (#)	6,971	2,396	590	4,110	106	100	495,693
	Current Pop. (% of Total)	30%	11%	5%	16%	5%	6%	13%
	5 Year Growth (#)	550	342	52	569	29	(6)	70,013
Non-Hispanic	Current Population (#)	15,917	18,746	10,755	21,316	1,855	1,620	3,423,232
	Current Pop. (% of Total)	70%	89%	95%	84%	95%	94%	87%
	5 Year Growth (#)	376	1,047	483	(58)	105	(39)	81,469
POPULATION - RACE (Hisp & Non Ethn)								
White	Current Population (#)	18,907	18,534	10,509	21,688	1,857	1,604	3,245,172
	Current Pop. (% of Total)	83%	88%	93%	85%	95%	93%	83%
	5 Year Growth (#)	628	1,224	478	154	112	(42)	79,408
Black	Current Population (#)	102	55	49	112	3	4	72,668
	Current Pop. (% of Total)	0.4%	0.3%	0.4%	0.4%	0.2%	0.2%	1.9%
	5 Year Growth (#)	-	9	7	12	-	1	5,587
Native American	Current Population (#)	174	437	157	1,166	21	26	54,627
	Current Pop. (% of Total)	1%	2%	1%	5%	1%	2%	1%
	5 Year Growth (#)	(15)	(70)	(27)	95	3	(1)	2,184
Asian Pac. Isl.	Current Population (#)	355	141	119	342	20	4	166,036
	Current Pop. (% of Total)	2%	1%	1%	1%	1%	0%	4%
	5 Year Growth (#)	2	(10)	20	(1)	6	1	16,609
Other Race	Current Population (#)	2,579	1,263	153	1,437	31	50	225,125
	Current Pop. (% of Total)	11%	6%	1%	6%	2%	3%	6%
	5 Year Growth (#)	202	176	14	197	9	-	31,601
2+ Race	Current Population (#)	771	712	358	681	29	32	155,297
	Current Pop. (% of Total)	3%	3%	3%	3%	1%	2%	4%
	5 Year Growth (#)	109	60	43	54	4	(4)	16,093

Source: Data from Truven Market Expert 2013. © Truven Health Analytics.

Acknowledgment to the Consumer Community

For this first collaborative health assessment, it was vital to have a clear and undeniable voice of the consumers of health and healthcare services in the region. We used a 65-question survey that was delivered by postal mail and through specific in-person settings. The survey was available in English and Spanish. In addition, two focus groups were held – one for seniors and disabled; one for low-income Latinos/Hispanics. A large community forum was hosted for emphasis on mental and behavioral health needs. Across the community, we had over 1,000 detailed surveys completed, more than 100 attendees at the community forum and 31 individuals in the focus groups. We appreciate the time people took to participate and, more importantly, to share their perspectives and experiences.

Gathering community feedback is both art and science. We would like to acknowledge the individuals and organizations who gathered this valuable input. The following agencies and individuals fielded hundreds of mail and in-person surveys and hosted, translated, transcribed and analyzed focus groups and recruited participants: The Center for Outcomes Research and Education (CORE); Marvin Pohl at Mid-Columbia Council of Governments and the Area Agency on Aging; Lorena Sprager, Joel Palayo and the Community Health Workers at the Next Door, Nuestra Comunidad Sana; Megan McAninch from the Community Health Division, Interpreter Services and the Administrative Assistant pool at Providence; Mid-Columbia Medical Center; Mid Valley Elementary School; the Hood River Adult Center; Columbia Area Transit bus drivers; Meals on Wheels delivery staff; and Hood River, Klickitat and North Central Public Health departments.

Healthcare and Agency Ecosystem

Due to the relatively small size of the regional population, many healthcare professionals, social service agencies and non-profits in the Columbia Gorge Region serve patients and clients across county and state boundaries. This regional approach to a community health needs assessment provides a forum for multiple organizations to leverage our collective work for the benefit of the entire community.

Healthcare professionals

Four hospitals serve the Columbia Gorge region: Providence Hood River Memorial Hospital (Hood River[^]), Mid-Columbia Medical Center (The Dalles), Skyline Hospital (White Salmon) and Klickitat Valley Hospital (Goldendale). All but Mid-Columbia Medical Center are designated Critical Access Hospitals.

Primary care is available in all six counties. Gilliam and Sherman county residents can receive care locally from mid-level providers. A mixture of mid-level providers and physicians serves the other four counties. In addition, the region has a Federally Qualified Health Center (FQHC), One Community Health, with offices in Hood River[^] and The Dalles.

There are several federally designated underserved areas and populations in the region (Table 3 on page 5) including those for migrant or seasonal farmworkers, Native Americans and income status.

Table 3 - Federal designations for under-served groups

	Hood River	Wasco	Klickitat	Skamania	Sherman	Gilliam
Medically Underserved Area (MUA)					✓	✓
Medically Underserved Population (MUP)	Migrant/farmworker	Migrant/farmworker	Native American			
Health Professional Shortage Area (HPSA)	Migrant/farmworker	Migrant/farmworker	Migrant/farmworker Low-income	Low-income	✓	✓
Mental Health Underserved Area	✓	✓			✓	✓
Dental Health Underserved Area (DUA)	Migrant/farmworker Low-income	Migrant/farmworker Low-income			✓	✓

Source: Health Resources and Services Administration (HRSA)

County mental health services for Medicaid and uninsured residents with mental health, addictions or developmental disabilities are provided by three organizations determined by county: Mid-Columbia Center for Living (MCCFL) serves residents of Hood River, Wasco, and Sherman counties, Community Counseling Solutions serves residents of Gilliam County and Central Washington Comprehensive Mental Health serves residents of Klickitat and Skamania counties. Mental health services in Hood River, Wasco and Klickitat Counties are provided by numerous professionals, including those in private practice and those employed by Providence Gorge Counseling and Mid-Columbia Outpatient Clinics.

Four public health departments provide population-based services and maintain an overview of regional health status: Hood River Public Health Department serves Hood River County; North Central Public Health District covers Wasco, Sherman, and Gilliam counties; Skamania County Health Department and Klickitat County Health Department serve their respective counties in Washington.

Dental care is available in all counties except Sherman and Gilliam, which are designated by the Health Resources and Services Administration (HRSA) as Dental Health Underserved Areas.

Acknowledgment to the Healthcare Professional Community

As a second set of inputs into this Community Health Assessment, we sought out the perspectives of the Healthcare Professionals in the region. We had over 140 professionals provide feedback and insights into the health and healthcare needs of the community using a relative rank approach. We would like to acknowledge the organizations that supported their employees in participating in this important activity:

Table 4 - List of participating healthcare organizations

Cascade Orthopedics	Northern Oregon Regional Corrections (NORCOR)
Columbia Gorge Family Medicine	Northshore Medical Group
Columbia River Women’s Center	Northwest Pediatrics
Deschutes Rim Clinic	One Community Health
Hood River County Health Department	OHSU
Klickitat Valley Hospital	Providence Hood River Medical Clinics & Hospital
Mid-Columbia Center for Living	Skyline Hospital
Mid-Columbia Medical Center Clinics and Hospital	Summit Family Medicine
North Central Public Health District	

Social Service and Non-profit Agencies

Social service and non-profit agencies assist the most vulnerable populations in the Columbia Gorge Region. Whether they are government or independent non-profit organizations, they help those who are disadvantaged by social or economic conditions. The relatively small size of the region's population means agencies must work across long distances, and even state boundaries, to serve their clients. Agencies in the Columbia Gorge Region represent a broad cross-section of services that meet the basic needs and some healthcare needs of the population.

Acknowledgment to the Agency and Faith Communities

The agency and faith communities bring a critical eye to the social and economic conditions of our most vulnerable residents. We sought out their perspectives and insights into the health and healthcare needs of the community as a separate perspective from Healthcare professionals and consumers. We would like to acknowledge the organizations that supported their employees or volunteers in participating in this important activity:

Table 5 - List of agency and faith community participants

Area Agency on Aging	Mid-Columbia Community Action Council
Cascade Locks Bible Fellowship	Mid-Columbia Council of Gov'ts
DHS Aging and People with Disabilities	Mid-Columbia Fire and Rescue
FISH Food Bank	Mid-Columbia Medical Center – Community Outreach
HAVEN	Providence Foundation
Hood River Church of Nazarene	Sherman County Court
Hood River Commission on Children and Families	The Next Door, Nuestra Comunidad Sana
Hood River Fire and EMS	Warming Shelter
Klickitat County Health Department	Wasco County Youth Services
Meals on Wheels – The Dalles	YOUTHTHINK
Mid-Columbia Children's Council	

How to Read the Results of the Analysis

The following pages include the results of the consumer surveys, consumer focus groups, agency experts, healthcare professionals and accredited data sources such as Truven and County Health Rankings. In the next several pages, you will see a table like the one below.

Survey Source	Region		by County View			Vulnerable Populations						
	All 6 counties		Hood River	Wasco	Klickitat	MSFW	LEP	Disabled	<200% FPL	>65		
	In-person	Mail				In-person	In-person	In-person	In-person	Mail	In-person	Mail
<i>Income Insecurity</i>	N= 691	457	126	191	109	121	155	56	420	248	135	183
<i>Any Financial Insecurity</i>	38%	24%	17%	29%	0%	55%	52%	45%	48%	35%	20%	15%
Focus Group Theme	●		●	Q1 2014	Q1 2014	●	●	○	●		○	
Agency Rank	2nd of 8		2nd	2nd	1st							
Health Care Professionals Rank	1st of 8		1st	1st	4th							
Unemployment*			6.0%	5.6%	7.0%							

- The topic heading and the key data points.
 - The first row(s) in italics are responses to specific consumer survey questions (e.g. *Any financial insecurity* refers to responses to Questions 48-52 in the survey.). The full survey is included in the Appendix for reference.
 - Focus Group Theme.** If a Focus Group highlighted the topic as a barrier to accessing healthcare services, then ● is shown. If the topic was not mentioned as a barrier to accessing healthcare services in the focus groups, then ○ is shown. The absence of an identified focus group theme should not be regarded as an absence of need in general. Focus groups were held in Hood River. Focus group sessions are planned for early 2014 in Wasco and Klickitat.
 - Agency Rank** and **Healthcare Professional Rank** are the relative ranking results from Agency and Healthcare Professionals.
 - Relevant County, Truven or similar accredited data sources deemed highly important for context. It will be noted with a *2 or **3 to indicate data source. Region-wide County Health Ranking data does not exist therefore those portions of the table will be grey.
- Survey Source** indicates 'In-person' for those surveys conducted at specific settings. 'Mail' indicates those results from the postal mail approach. N= represents the number of completed surveys and are called survey respondents throughout this document.
- The **Region** column represents all six counties together.
- By County View** shows results for Hood River, Wasco and Klickitat counties. These counties have the highest amount of information across all categories and groups. Sherman, Gilliam and Skamania counties had smaller amounts of information making it unreliable to call out those counties separately.
- Vulnerable populations** were specific groups of interest including Migrant or Seasonal Farmworker (MSFW), Limited English Proficiency (LEP), Disabled, Households with incomes less than 200% Federal Poverty Level (<200% FPL) and respondents ages 65 and older (>65). For 2013, the 100% Federal poverty guideline is an annual income of \$23,550 for a family of four; a single-person household is \$11,490 or less. The 200% Federal poverty level is \$44,100 for a family of four; \$22,980 for a single-person.

² Source: Data from Truven Market Expert 2013. © Truven Health Analytics.

³ Source: Data from County Health Rankings from <http://www.countyhealthrankings.org/>

We designed our research to understand the needs of the vulnerable populations listed above. These groups did report higher needs in many areas. However, we also learned of significant needs identified by Native Americans in our region based on 37 survey responses either in-person or by mail. The degree of need in this population is worthy of further study and some of the narrative in this document will highlight the largest areas of need.

BASIC NEEDS

Income insecurity

Mail survey. 23.5% of participants reported experiencing some kind of financial hardship over the past year. The most common form of hardship was food insecurity. The burden of healthcare bills was a challenge for 14.4% of participants.

In-person survey. More than one in three (37.9%) participants reported experiencing some kind of financial hardship over the past year. As might be expected, financial hardship was more common among those with lower incomes. Latino/Hispanics and Native Americans were more likely to report financial hardship than non-Hispanic whites. Those under 54 were more likely to report financial hardship than those 55 and over. The burden of healthcare bills was a challenge for 20.5% of participants.

Focus Groups. The Spanish-speaking focus group recognized income insecurity as a substantial barrier overall. Since the focus group format did not include specific questions on income, this feedback should be strongly regarded as a need.

Table 6 - Income insecurity

Survey Source	Region		by County View			Vulnerable Populations						
	All 6 counties		Hood River	Wasco	Klickitat	MSFW	LEP	Disabled	<200% FPL	>65		
	In-person	Mail	Mail	Mail	Mail	In-person	In-person	In-person	In-person	Mail	In-person	Mail
Income Insecurity	N= 691	457	126	191	109	121	155	56	420	248	135	183
<i>Any Financial Insecurity</i>	38%	24%	17%	29%	29%	55%	52%	45%	48%	35%	20%	15%
Focus Group Theme	●		●	Q1 2014	Q1 2014	●	●	○	●	○		
Agency Rank	2nd of 8		2nd	2nd	1st							
Healthcare Professionals Rank	1st of 8		1st	1st	4th							
Unemployment**			6.0%	5.6%	7.0%							

Housing insecurity

Mail survey. Housing insecurity was not common among this population, likely because a mail survey would exclude those without published addresses. There were no statistically significant differences in rates of financial hardship by race/ethnicity. Women were significantly more likely to report experiencing financial hardship over the past 12 months than men were. In addition, financial difficulties appeared to lessen among individuals 55 and over.

In-person survey. The In-person survey was not tied to a residential address; 7.0% of respondents reported housing insecurity.

Focus Groups. Housing insecurity did not emerge as a theme from either focus group. The absence of housing as a theme means people did not specify housing as a primary barrier to accessing healthcare services. It should not be regarded as an absence of need for housing supports in general.

Housing insecurity is based on responses to Question 50 – *Did you or family members have to move in the last 12 months due to inability to pay rent, mortgage or utilities?* While few in numbers, a response of Yes indicates a very disruptive circumstance to individuals and families.

Table 7 - Housing insecurity

Survey Source	Region		by County View			Vulnerable Populations						
	All 6 counties		Hood River	Wasco	Klickitat	MSFW	LEP	Disabled	<200% FPL		>65	
	In-person	Mail	Mail	Mail	Mail	In-person	In-person	In-person	In-person	Mail	In-person	Mail
Housing Insecurity N=	691	457	126	191	109	121	155	56	420	248	135	183
<i>Could not afford; had to move</i>	7%	1.6%	1.9%	2.0%	0%	4%	8%	5%	9%	3%	2%	2%
Focus Group Theme	○		○	Q1 2014	Q1 2014	○	○	○	○		○	
Agency Rank	1st of 8		1st	1st	1st							
Healthcare Professionals Rank	2nd of 8		2nd	3rd	4th							
Owner Occupied*			55.0%	56.0%	60.0%							
High Housing Costs**			35.0%	33.0%	34.0%							

Food insecurity

Mail survey. Nearly one-third of those living below 100% of the federal poverty line reported experiencing food insecurity. 17.2% of mail respondents reported that they had been worried that food would run out before they had money to buy more. Those who identified as Hispanic or Latino were significantly more likely to experience food insecurity; 36% report that they experienced it in the past year. In addition, food insecurity lessens with age; those above 55 years of age reported much less food insecurity.

In-person survey. The most common form of hardship was food insecurity: 31.8% of in-person respondents reported that they had been worried that food would run out before they had money to buy more. Latino/Hispanics and Native Americans are more likely to experience food insecurity than non-Hispanic whites. Nearly half of Latino/Hispanics (47.4%) and nearly two-thirds (65.2%) of Native Americans report experiencing food insecurity.

Focus Groups. Food insecurity did not emerge as a theme from either focus group, but this should not negate the importance identified in the survey. The absence of food as a theme means people did not specify food as a primary barrier to accessing healthcare services.

Table 8 - Food insecurity

Survey Source	Region		by County View			Vulnerable Populations						
	All 6 counties		Hood River	Wasco	Klickitat	MSFW	LEP	Disabled	<200% FPL		>65	
	In-person	Mail	Mail	Mail	Mail	In-person	In-person	In-person	In-person	Mail	In-person	Mail
Food Insecurity N=	691	457	126	191	109	121	155	56	420	248	135	183
<i>Worried that food would run out</i>	32%	17%	10%	20%	25%	53%	49%	36%	41%	27%	17%	10%
Focus Group Theme	○		○	Q1 2014	Q1 2014	○	○	○	○		○	
Agency Rank	4th of 8		4th	4th	3rd							
Healthcare Professionals Rank	3rd of 8		3rd	2nd	2nd							
Limited Acces to Healthy Foods**			1.0%	15.0%	9.0%							

Transportation insecurity

Mail survey. The vast majority of mail survey respondents (91.4%) report that they never have trouble accessing transportation. However, the 8.6% who do have trouble accessing transportation may be some of the most vulnerable in the community. Food insecurity was also high among those who report transportation barriers (70%). We also found significantly higher rates of current anxiety and depression among those who report transportation hardship. Those who were not experiencing transportation barriers were significantly less likely to list the emergency department as their usual source of care.

In-person survey. The vast majority of mail survey respondents (91.4%) reported that they never have trouble accessing transportation. Among In-person survey respondents, that number is only 80%. 62.5% of Native Americans report transportation barriers. 27.6% of migrant or seasonal farmworkers report transportation barriers, and 49.6% of the unemployed report transportation barriers. Since transportation can be an important factor in pursuing a job, this suggests that many people may be feeling “stuck” where they are.

Focus Groups. All vulnerable populations recruited for the focus groups noted lack of transportation, though were also clear to note that it has improved over the past several years. A major concern amongst the MSFW and LEP group were access to driver's licenses or driver's cards. Since the focus group format did not include specific questions on transportation but rather barriers to accessing healthcare services, this feedback should be strongly regarded as a need.

Table 9 - Transportation insecurity

Survey Source	Region		by County View			Vulnerable Populations						
	All 6 counties		Hood River	Wasco	Klickitat	MSFW	LEP	Disabled	<200% FPL	>65		
	In-person	Mail	Mail	Mail	Mail	In-person	In-person	In-person	In-person	Mail	In-person	Mail
Transportation	N= 691	457	126	191	109	121	155	56	420	248	135	183
<i>Very difficult accessing when needed</i>	20%	9%	5%	11%	14%	28%	27%	29%	24%	13%	16%	9%
Focus Group Theme	●		●	Q1 2014	Q1 2014	●	●	●	●			●
Agency Rank x of 8	3rd of 8		3rd	3rd	2nd							
Healthcare Professionals Rank	5th of 8		5th	5th	5th							

HEALTHCARE ACCESS

Having health insurance, having a place you usually go for care and having a regular provider are generally associated with improved health outcomes. We wanted to know where residents in the Columbia Gorge area go for care, how far they have to travel to get there, whether they have a usual primary care provider and their insurance status.



Figure 2 - Frequency of comments on healthcare access needs

Health insurance status

Mail survey. 89.8% of mail survey respondents report having some form of health insurance, including Medicare. Few (4%) respondents report receiving Medicaid benefits. The majority (87%) of respondents were insured for all of the past 12 months; 5% were insured for some but not all of the past 12 months.

In-person survey. Compared to the mail survey rate, respondents in the In-person survey were much less likely to have health insurance. Employer-sponsored coverage is the most common form of insurance for this group. 13.6% of respondents receive Medicaid benefits. After those covered by private insurance, the next largest group (24.5%) is the uninsured. The majority (67.6%) of respondents were insured for all of the past 12 months; this is a much smaller proportion than the mail survey. 14.2% were insured for some but not all of the past 12 months. This response was our best indication of “churning” rates: the rate of those who move on and off insurance coverage.

Table 10 - Insurance status

Survey Source	Region		by County View			Vulnerable Populations							
	All 6 counties		Hood River	Wasco	Klickitat	MSFW	LEP	Disabled	200% FPL		>65		
	In-person	Mail	Mail	Mail	Mail	In-person	In-person	In-person	In-person	Mail	In-person	Mail	
Insurance Status	N=	691	457	126	191	109	121	155	56	420	248	135	183
<i>Without any health insurance</i>		18%	8%	8%	15%	7%	51%	55%	11%	30%	16%	2%	4%
<i>Had insurance for only part of year</i>		14%	5%	3%	6%	5%	22%	28%	7%	16%	4%	6%	2%
Focus Group Theme		●	●	Q1 2014	Q1 2014	●	●	○	●			●	
Uninsured Adults**				29%	29%	23%							
Uninsured Children**				13%	13%	9%							

Have a Primary Care Provider (PCP)

Mail survey. Respondents were asked to indicate whether they had *one person* that they usually thought of as their personal doctor or primary care provider (PCP). 83.3% of respondents said that they did have a PCP. There were no significant differences in access to a PCP by race or ethnicity.

In-person survey. Respondents were asked to indicate whether they had *one person* that they usually thought of as their personal doctor or primary care provider (PCP). 73.4% of respondents said that they did have a PCP. Non-Hispanic whites, those who were 65 and older, and women were significantly more likely to have a PCP. Younger adults, Latino/Hispanics, migrant or seasonal farmworkers, and men were less likely to have a PCP.

Have a usual place for care

Mail survey. Having a place you usually go for care and having a regular provider are generally associated with improved health outcomes. 93% of all respondents indicated that they had a usual source of care. 70.2% of those with a usual source of care said that they usually go to a private doctor’s office or clinic. Those with incomes below 100% of Federal Poverty Level (< 100% FPL) were significantly less likely than others to list a private clinic as their usual source of care and significantly more likely than others to list a public health clinic or community clinic. Medicaid beneficiaries were significantly more likely than others to use a public health clinic, and so were Latino/Hispanics.

In-person survey. 82.5% of all respondents indicated that they had a usual source of care. This is a lower rate than that among mail respondents. 93.7% of those with a usual source of care said that they usually go to a private doctor’s office or clinic. Demographically, the In-person survey respondents look more like the mail survey respondents who frequent public health or community health clinics — but only 2.8% of In-person survey respondents said that such a clinic was their usual source of care.

Focus Groups. Four of the five vulnerable populations noted challenges with access to care, the outlier being those living with disabilities, which were underrepresented in the groups and usually already had an established relationship with the primary care provider.

Distance from usual place of care

Mail survey. More than half of respondents (54%) reported that they lived more than five miles of their usual place of care. For Latino/Hispanics, it was more common to live between 6 and 10 miles from their usual source of care.

In-person survey. 60% of participants reported that they lived more than five miles from their usual place of care. For Latino/Hispanics, it was more common to live between 6 and 10 miles from their

usual source of care. More than 50% of Native Americans reported that they live more than 20 miles from their usual source of care.

Physical health access

Mail survey. Notably, most adults who needed medical care got all the care they needed. Only 1% of respondents needed care but got none. When asked about reasons for unmet medical care needs, cost was the biggest factor. The uninsured were far more likely (86%) than the stably insured (50%) to cite cost as a factor. Medicaid beneficiaries were much less likely (21%) to worry about cost; they were also less likely to be concerned that their insurance wouldn't cover needed care. For Medicaid beneficiaries, the most common reasons for going without needed care were not knowing where to go (33%) and not being able to get an appointment quickly enough (26%). There were no significant differences in common reasons by race/ethnicity. 23.4% of respondents have children living in their household, and 84.1% of those with children said that at least one of their children had needed medical care in the past year. Of those whose children needed care, 86.7% got all the medical care they needed.

In-person survey. Most adults who needed medical care got all the care they needed. But the proportion of those who needed medical care and did not get it was much larger among the In-person survey population. When asked about reasons for unmet medical care needs, cost was the biggest factor. Even some of the respondents with insurance found that they couldn't afford all the care they needed. 18.5% indicated that they thought they could handle their medical need without treatment. Nearly 40% of respondents have children living in their household, and approximately 77% of those with children said that at least one of their children had needed medical care in the past year. The overwhelming majority (89%) of children who needed care received all the medical care they needed.

Focus Groups. Child physical health access emerged as a barrier from the Spanish-speaking focus group, again citing access to care, insurance coverage, and cost as the primary barriers.

Note: Adult/Child N = number of adults and children respectively who needed Physical Healthcare within the last 12 months

Table 11 - Physical health access

	Region		by County View			Vulnerable Populations							
	All 6 counties		Hood River	Wasco	Klickitat	MSFW	LEP	Disabled	<200% FPL	>65			
Survey Source	In-person	Mail	Mail	Mail	Mail	In-person	In-person	In-person	In-person	Mail	In-person	Mail	
Physical Health	Adult/Child N=	491/200	361/89	130/39	131/42	73/16	74/48	90/71	49/6	309/161	199/64	106/90	141
Adult received no care when needed		5%	1.5%	1.4%	0.3%	2.5%	9%	8%	0%	6%	1%	0%	0%
Child received no care when needed		0.5%	0.4%	0.0%	0.0%	3.4%	0%	1%	0%	0.6%	0%	11%	8%
Focus Group Theme		●	●	Q1 2014	Q1 2014	●	●	○		●		●	
Agency Rank		1st of 4	1st of 4	1st of 4	1st of 4								
Healthcare Professionals Rank		1st of 4	1st of 4	1st of 4	1st of 4								

Note: Respondents could select multiple reasons for going without care.

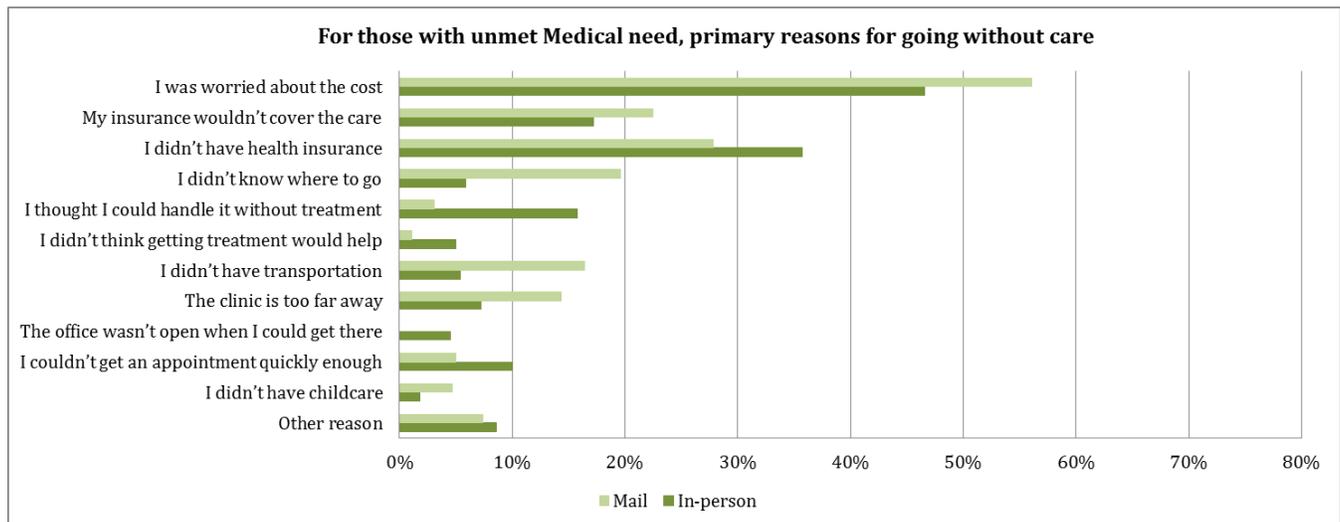


Figure 3 - Reasons for going without Medical care

Dental health access

Mail survey. Dental care was the most common form of unmet need. One in five adults reported that they had unmet dental care needs within the past year. 80% of those with children said that at least one of their children had needed dental care in the past year. Of those whose children needed care, 78.6% got all the dental care they needed. More children went without needed dental care than without any other healthcare treatment.

In-person survey. Dental care was the most common form of unmet need. More than one in five (27.5%) adults reported that they had unmet dental care needs within the past year. Three out of four respondents with children (74.4%) reported at least one of their children needed dental care in the past year; most children that needed dental care received all of the dental care they needed (82.9%).

Focus Groups. All groups identified the need for better access to dental care, noting specifically the barriers of cost, appointment availability, and insurance coverage.

Note: Adult/Child N = number of adults and children respectively who needed Dental Healthcare within the last 12 months

Table 12 - Dental health access

Survey Source	Region		by County View			Vulnerable Populations								
	All 6 counties		Hood River	Wasco	Klickitat	MSFW	LEP	Disabled	<200% FPL	>65				
	In-person	Mail	Mail	Mail	Mail	In-person	In-person	In-person	In-person	Mail	In-person	Mail		
Dental Health	Adult/Child N=		455/194	343/85	118/33	135/32	67/15	65/52	81/83	36/4	280/155	176/59	89/2	123/5
Adult received no care when needed	22%	13%	6%	13%	25%	22%	14%	27%	30%	19%	11%	14%		
Child received no care when needed	3%	6%	0%	14%	5%	0%	2%	0%	3%	9%	0%	9%		
Focus Group Theme	●		●	Q1 2014	Q1 2014	●	●	●	●	●	●	●		
Agency Rank	3rd		3rd	3rd	2nd									
Healthcare Professionals Rank	3rd		3rd	3rd	2nd									
ED Utilization Rank x of Top 20	5th		7th	2nd	7th									

Note: Respondents could select multiple reasons for going without care.

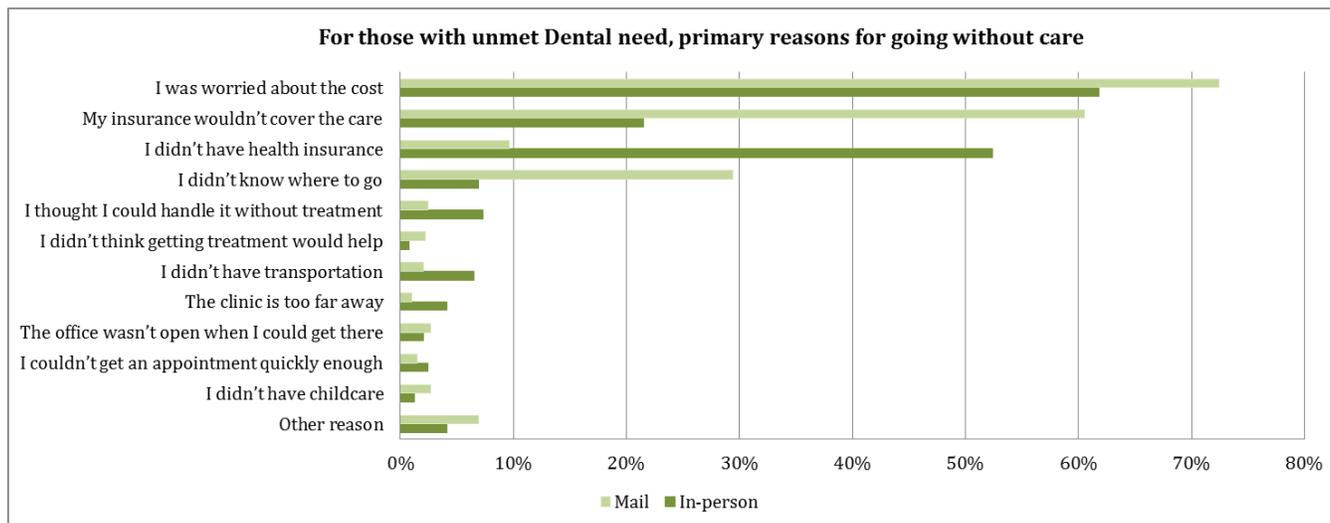


Figure 4 - Reasons for going without Dental care

Mental health access

Mail survey. Behavioral healthcare was a less common need (13.4% of all mail respondents), but 50% of Adults who needed behavioral healthcare did not get all the care they needed. 17% of those with children said that at least one of their children had needed treatment or counseling for an emotional, developmental or behavioral problem. Of those, only 43.6% said that their child received all the care that he or she needed. Although the numbers of parents whose children require behavioral health treatment may be smaller, behavioral healthcare for children may be a significant unmet need in the Columbia Gorge area.

In-person survey. Behavioral healthcare was a less common need, but 50% of Adults who needed behavioral healthcare did not get all the care they needed; primary reason being cost. Approximately 12.7% of those with children said that at least one of their children had needed treatment or counseling for an emotional, developmental or behavioral problem in the past 12 months. Of those, 54.5% said that their child received all the care that he or she needed.

Focus Groups. The senior and disabled group strongly noted the need for better mental healthcare, particularly counseling or therapy services for depression. The key barrier that emerged was access and having too few mental health professionals in the area.

Mental Health Community forum. Results of the Behavioral Health Community Needs assessment included improving access for hard-to-reach populations based on both geography as well as special needs such as veterans, migrant or seasonal workers and Native Americans. Suggestions also included to improve access by meeting with people where they are such as in schools, primary care offices, jails, churches, shelters and on the street. Participants also requested improved collaboration between multiple agencies that serve people with mental illness and addictions issues. Other identified needs included specialized training and services for children 0-7 years old, services for family members of people with addictions issues, and intensive recovery support for people with serious addictions and mental health issues, such as housing, employment and peer delivered support. Finally, recommendations included increasing psychiatry availability, as wait times to see psychiatrists in the region were longer than other services.

Note: Adult/Child N = number of adults and children respectively who needed Mental Healthcare within the last 12 months. Due to the small numbers of adults and children seeking mental health services, the table includes only the Region view.

Table 13 - Mental health access

Mental Health	Survey Source Adult/Child N=	Region	
		All 6 counties	
		In-person	Mail
Adult received no care when needed	123/33	24%	24%
Child received no care when needed	61 / 18	12%	13%
Focus Group Theme		●	
Agency Rank		2nd	
Healthcare Professionals Rank		2nd	

Note: Respondents could select multiple reasons for going without care.

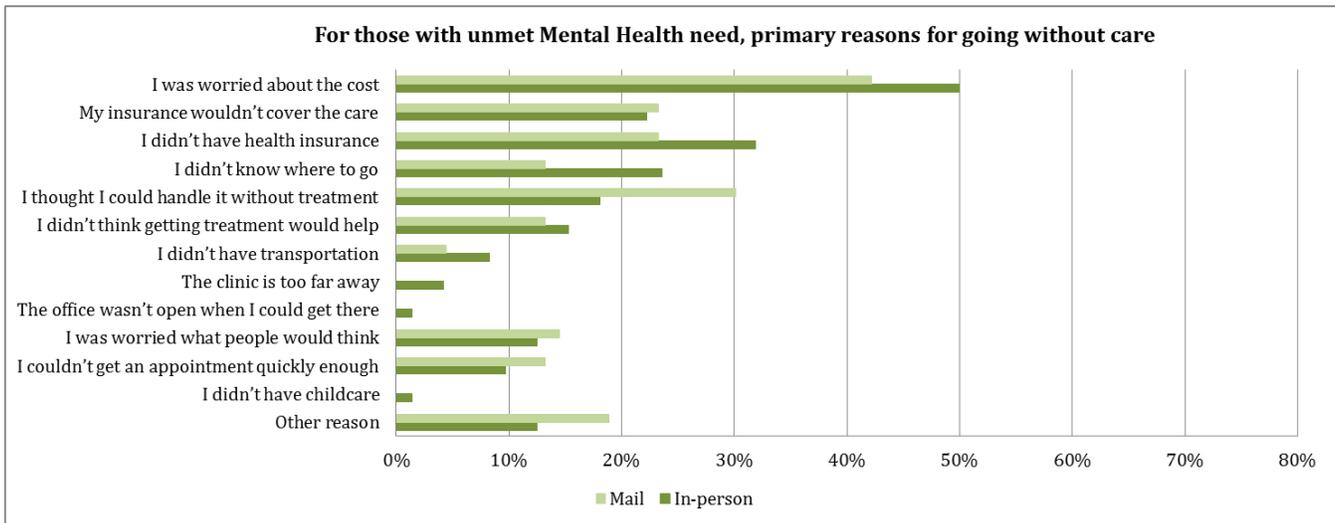


Figure 5 - Reasons for going without Mental Health care

Substance abuse treatment

Mail survey. Substance abuse treatment and counseling was not a common need, but 50% of those who needed it did not get all the care they needed.

In-person survey. Substance abuse treatment or counseling was not a common need (3.7% of all in-person respondents), but 50% of those who needed it did not get all the care they needed.

Focus Groups. Substance abuse treatment was not recognized as an unmet need in either of the focus groups.

Mental Health Community forum. Results of the Behavioral Health Community Needs assessment included improving access for hard-to-reach populations based on both geography as well as special needs, such as veterans, migrant or seasonal workers and Native Americans. Also suggestions to improve access by meeting with people where they are such as in schools, primary care offices, jails, churches, shelters and on the street. Participants also requested improved collaboration between multiple agencies that serve people with mental illness and addictions issues. Other identified needs included specialized training and services for children 0-7 years old, services for family members of people with addictions issues, and intensive recovery support for people with serious addictions and mental health issues, such as housing,

employment and peer delivered support. Finally, recommendations included increasing psychiatry availability, as wait times to see psychiatrists in the region were longer than other services.

Note: Adult N = number of adults who needed Substance abuse Treatment within the last 12 months. There was no separate question for Substance abuse treatment for children. Due to the small numbers of adults seeking substance abuse treatment, the chart includes only the Region view.

Table 14 - Substance Abuse treatment access

Substance Abuse Treatment	Survey Source Adult N=	Region	
		In-person	Mail
	25	6	
<i>Adult received no care when needed</i>		22%	50%
Focus Group Theme		○	
Agency Rank		2nd	
Healthcare Professionals Rank		2nd	
ED Utilization Rank x of Top 20		20th	

Note: Respondents could select multiple reasons for going without care.

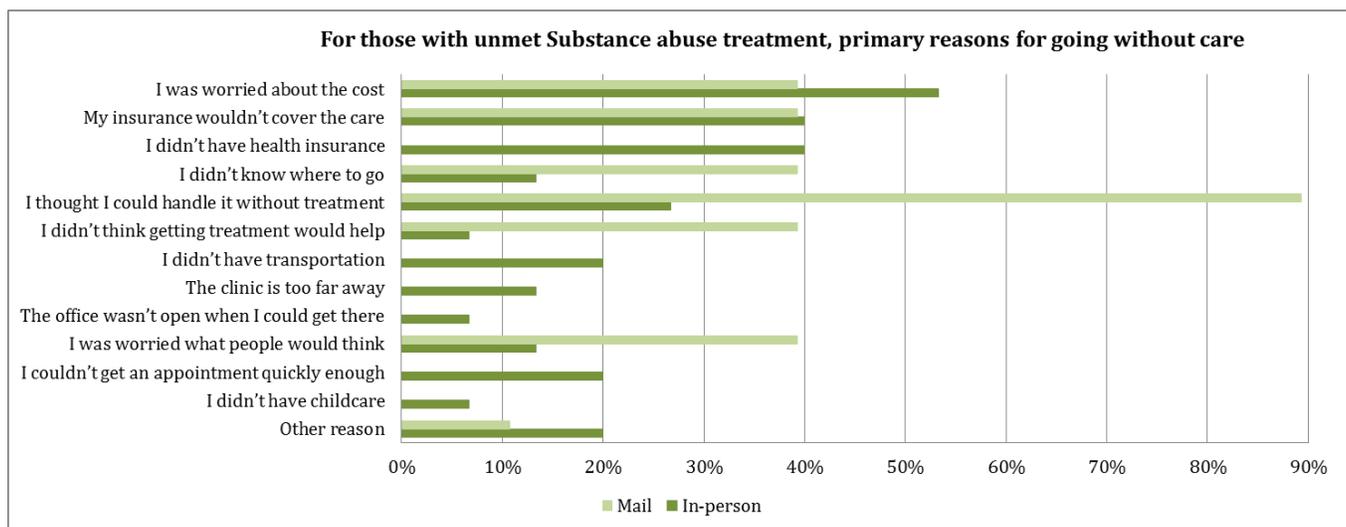


Figure 6 - Reasons for going without substance abuse treatment

Medications

Mail survey. A large majority (81.6%) of respondents need some form of prescription medication. 83% of those need medications for physical health problems; 3.1% needed them for mental health or personal problems; and 13.8% need medications for both physical and mental health problems.

In-person survey. A majority (70.3%) of respondents need some form of prescription medication. 79.3% of those need medications for physical health problems; 5.6% needed them for mental health or personal problems; and 15.1% need medications for both physical and mental health problems.

Focus Groups. The Hispanic focus group identified access to medication as a challenge, particularly due to cost. It emerged at a slight level in the senior and disabled group, specifically related to transportation barriers.

Note: Adult N = number of adults who needed Medications within the last 12 months. There was no separate question about Medications needed for children.

Table 15 - Medication access

Survey Source	Region		by County View			Vulnerable Populations						
	All 6 counties		Hood River	Wasco	Klickitat	MSFW	LEP	Disabled	<200% FPL		>65	
	In-person	Mail	Mail	Mail	Mail	In-person	In-person	In-person	In-person	Mail	In-person	Mail
Adult N=	473	376	123	147	78	55	60	53	287	227	126	162
Did not receive all meds needed	4%	1.0%	0.0%	1.3%	1.9%	6%	7%	8%	5%	2%	0%	0%
Focus Group Theme	●		●	Q1 2014	Q1 2014	●	●	○	●		○	

HEALTH STATUS

General health and social isolation

Mail survey. The majority of the Columbia Gorge mail survey respondents reported having good or excellent physical health (83.6%). Approximately one out of four respondents who were at or below 100% of the Federal Poverty Level (25.5%) or had only a high school diploma or less (26%) reported having fair or poor physical health. About one out of five unemployed respondents also reported fair or poor physical health. The proportion of mail survey respondents reporting fair or poor physical health was greater (16.4%) than those reporting fair or poor mental health (9.8%). Social isolation is an issue affecting more people: nearly one in five Columbia Gorge area residents may be socially isolated; 18.8% of respondents indicated that they would not have access to social support most of the time.

In-person survey. The majority of respondents (78.7%) in the In-person survey also reported having good or excellent physical health; 21.3% reported having fair or poor health. However, the proportion reporting fair or poor physical health is greater for Latinos, community members who earn at or below 100% of the Federal Poverty Level, have only a high school diploma or less, and are unemployed. The proportion of In-person survey respondents reporting fair or poor mental health is less (13.8%) than those reporting fair or poor physical health (21.3%). However, rates of fair or poor mental health are above 25% for Native Americans, migrant or seasonal farmworkers, the unemployed, and those experiencing transportation hardships. Social isolation is more prevalent: nearly one in four (23.8%) respondents scored as socially isolated. Social isolation has been linked to poor mental and physical health outcomes.

Weight management

Mail survey. The most common risk factor in the Columbia Gorge area is the prevalence of overweight or obesity; over half of respondents reported that they were overweight. Native Americans were significantly more likely to report that they were overweight.

In-person survey. The most common risk factor among respondents is being overweight or obese; over half of respondents reported that they were overweight.

Physical health status

Mail survey. Although most respondents rated their health as good, 61.3% of participants reported having been diagnosed with a chronic physical health condition (diabetes, asthma, high blood pressure, or high cholesterol). The most common chronic condition reported was high blood pressure.

In-person survey. Chronic disease was still prevalent among In-person survey respondents, although slightly less so than it was among mail survey respondents. 53.8% of participants reported having

been diagnosed with a chronic physical health condition. The most common chronic condition reported was high blood pressure.

Table 16 - Physical health status

Survey Source	Region		by County View			Vulnerable Populations						
	All 6 counties		Hood River	Wasco	Klickitat	MSFW	LEP	Disabled	<200% FPL		>65	
	In-person	Mail	Mail	Mail	Mail	In-person	In-person	In-person	In-person	Mail	In-person	Mail
Physical Health Status N=	691	457	126	191	109	121	155	56	420	248	135	183
<i>Consider themselves to be overweight</i>	53%	56%	52%	55%	59%	42%	41%	59%	54%	57%	48%	55%
<i>Rate physical health Fair or Poor</i>	21%	16%	12%	14%	29%	35%	34%	34%	29%	20%	15%	21%
<i>Report any chronic disease diagnosis</i>	54%	61%	55%	63%	67%	35%	31%	39%	52%	60%	82%	77%
Adult obesity**			23%	33%	27%							
Physical inactivity**			17%	20%	23%							

Mental health status

Mail survey. 29.2% reported that they had been diagnosed with a specific mental illness (depression, PTSD, or anxiety). 8.9% of respondents screened positive for depression, and 11.6% screened positive for anxiety. Rates of anxiety and depression were highest among the very poor (below 100% of the Federal Poverty Level), those with less education, and those who were experiencing unemployment. Those who had indicated that they were experiencing financial strain had high rates of anxiety (28.5%); current smokers and current street drug users also had high rates of anxiety.

In-person survey. 21.4% report that they have been diagnosed with a mental illness. 10.1% of respondents screened positive for depression, and 11.8% screened positive for anxiety. Rates of anxiety and depression were highest among the very poor, the unemployed, and those who had experienced transportation hardship or social isolation. While there were no statistically significant differences by race for depression rates, Native Americans had higher rates of anxiety. Latinos had lower rates of depression and anxiety, which correlates with a lower incidence of mental illness diagnoses and better self-reported mental health among Latinos.

Table 17 - Mental health status

Survey Source	Region		by County View			Vulnerable Populations						
	All 6 counties		Hood River	Wasco	Klickitat	MSFW	LEP	Disabled	<200% FPL		>65	
	In-person	Mail	Mail	Mail	Mail	In-person	In-person	In-person	In-person	Mail	In-person	Mail
Mental Health Status N=	691	457	126	191	109	121	155	56	420	248	135	183
<i>Rate Mental Health Fair or Poor</i>	14%	10%	6%	11%	12%	25%	23%	20%	17%	11%	9%	10%
<i>Screen positive for Depression</i>	10%	9%	9%	9%	11%	9%	8%	20%	12%	10%	7%	11%
<i>Screen positive for Anxiety</i>	12%	12%	10%	13%	11%	8%	6%	15%	12%	15%	4%	12%
<i>Report any mental health diagnosis</i>	33%	29%	19%	45%	22%	22%	19%	41%	36%	32%	28%	30%
Suicide rate per 100,000**			13.3	7.9	24.4							

Physical and mental health together

Mental health conditions have a strong connection with physical health conditions and mortality. 29.2% of mail survey respondents reported that they had been diagnosed with a specific mental illness. 61.3% of participants reported having been diagnosed with a chronic physical health condition (diabetes, asthma, high blood pressure, or high cholesterol). 20.6% overall reported having both a mental health and chronic physical health condition.

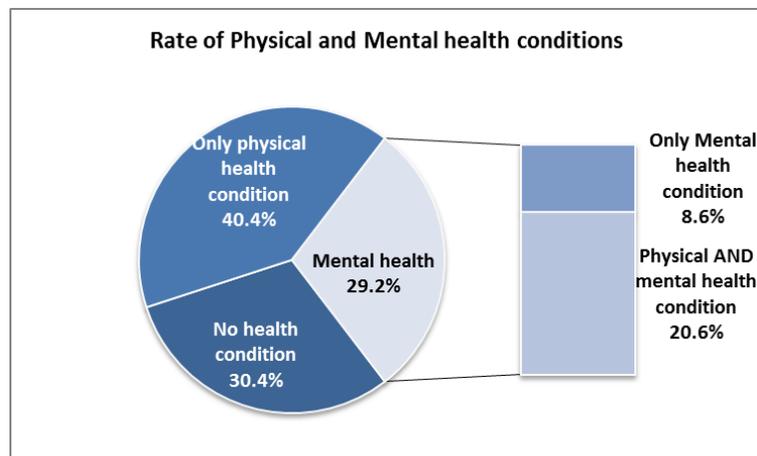


Figure 7 – Overlap of chronic physical and mental health conditions

Alcohol, tobacco and other drugs

A topic ranked highly by Agencies and Healthcare professionals was Prevention of Risky Behaviors. Both expert groups felt strongly that Prevention and Health Promotion were similar in importance to Nutritious Food and Transportation.

Tobacco use

Mail survey. Smoking rates were lower among survey respondents than they are in the general population; 11.1% of respondents are current smokers, and 82.6% of those are currently trying to reduce or quit smoking. 3.9% report using chewing tobacco. Smoking was significantly more common among the very poor; the smoking rate for those at 100% Federal Poverty Level or lower is 20.6%. Latinos were significantly less likely to smoke; only 1.7% report currently smoking cigarettes. Smoking was also significantly higher among those ages 55-64.

In-person survey. The smoking rate was slightly higher (13.6%) than it was among mail survey respondents (11.1%). 3.4% report using chew tobacco.

Problem drinking

Mail survey. Problem drinking is less prevalent in the Columbia Gorge area than it is in the general population; 16.1% of respondents screened positive for a potential drinking problem (either binge drinking or heavy drinking). Problem drinking was more common with younger adults; respondents age 18-39 were significantly more likely to score as having a potential drinking problem.

In-person survey. Problem drinking is much more prevalent among In-person survey respondents; 28% of respondents indicated a potential drinking problem (either binge drinking or heavy drinking). This high rate may be driven by the relative youth of the In-person survey population.

Street drug use

Mail survey. 10.8% of respondents indicated that they were currently using a street drug; this result was driven largely by marijuana use. Drug use was significantly more common among the very poor. There is no statistically significant difference between Hispanic or Latino, whites or Native Americans in their use of all forms of street drugs.

In-person survey. 9.8% of respondents indicated that they were currently using a street drug; this result was driven largely by marijuana use (only 2% reported using pain medications that were not prescribed to them, and 1.3% of the population reported using any street drug besides marijuana or pain pills).

Table 18 - Alcohol, Tobacco and Drug usage

Alcohol, Tobacco and Other Drugs	Survey Source	Region		by County View			Vulnerable Populations						
		All 6 counties		Hood River	Wasco	Klickitat	MSFW	LEP	Disabled	<200% FPL		>65	
		In-person	Mail	Mail	Mail	Mail	In-person	In-person	In-person	In-person	Mail	In-person	Mail
	N=	691	457	126	191	109	121	155	56	420	248	135	183
Smoking Rate		14%	11%	6%	16%	11%	10%	5%	16%	15%	14%	6%	14%
Smokeless tobacco		3%	4%	1%	4%	5%	1%	3%	0%	3%	3%	0%	4%
Potential problem drinking AUDIT-C		28%	16%	21%	11%	12%	26%	27%	22%	27%	16%	14%	11%
Marijuana or hashish use		9%	10%	13%	7%	14%	4%	2%	13%	11%	12%	2%	6%
Street drug use		1.3%	0.6%	1%	1%	0.4%	0%	0.6%	2%	2%	0.6%	0%	0%

Domestic/sexual violence

Mail survey. Less than one percent of respondents reported ever experiencing sexual abuse or domestic violence. Domestic violence was very uncommon among all groups, and while Latinos and women were more likely to report sexual abuse, these results were also not statistically significant.

In-person survey. Less than one percent of respondents reported ever experiencing sexual abuse or domestic violence.

Prevalence of domestic violence and sexual abuse may be underreported. Social stigma leads to low rates of self-report in these domains. In addition, domestic violence was measured using the question, "Has anyone you lived with ever hurt or threatened to hurt you or your children," and many respondents selected "I don't know" instead of "no." This response pattern suggests that domestic violence may be a more complex issue than can be captured with one question.

Table 19 - Domestic violence

Domestic Violence	Survey Source	Region		by County View			Vulnerable Populations						
		All 6 counties		Hood River	Wasco	Klickitat	MSFW	LEP	Disabled	<200% FPL		>65	
		In-person	Mail	Mail	Mail	Mail	In-person	In-person	In-person	In-person	Mail	In-person	Mail
	N=	691	457	126	191	109	121	155	56	420	248	135	183
Unsure of domestic violence		18%	23%	21%	23%	21%	10%	9%	27%	16%	24%	30%	29%

WE HAVE THE SAME NEEDS – a powerful outcome

With six counties, four hospitals, 2 states and a multitude of clinics, agencies, and public and mental health departments, we assumed we were going to uncover significantly differing needs and differing priorities. Those concerns were unfounded. We learned that we share many of the same top concerns in Basic Needs and the same top concerns in Healthcare Access. Some communities may have the order slightly different but the top concerns remain the same throughout the region. This outcome motivates us to continue collaborating on implementation plans as well as future assessments.

Limitations

We did a lot right in this first year. Nevertheless, there are always areas for improvement going forward. The three biggest gaps in the theme collection process are: 1) more focus on the Native American population 2) better inclusion of Dental health professionals and 3) better inclusion of schools and school-based clinics. None of these groups were excluded and we have some information from each, but a more explicit inclusion would yield a more comprehensive view.

METHODS and PROCESS

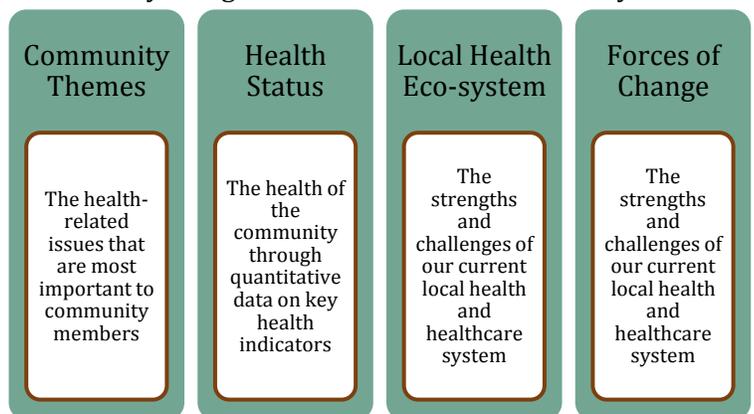
The MAPP process

We decided to use Mobilizing for Action through Planning and Partnerships (MAPP) as the organizing model for our work. MAPP is an interactive, community-driven strategic planning process for improving community health by prioritizing health issues and identifying resources to address them. Its comprehensive perspective included input from local community members, social service agencies, and healthcare professionals. The MAPP assessment model seeks information in four key areas: 1) Community Themes and Strengths, 2) Health Status, 3) Local Health Ecosystem, and 4) Forces of Change that make sure no important area is neglected. With this groundwork in place, we began to prepare the Community Health Assessment.

We wanted to get input from the community (consumers, healthcare professionals, and agencies) to understand their perspectives on the health of the community. We gathered information from many sources: community forums, a Community Advisory Council, a behavioral health forum, agency worksheets and forums, provider surveys and forum, a consumer survey, an In-person survey, focus groups, and demographic data from several sources.

Gathering Community Themes

We used five different approaches to gather consumer inputs and community themes regarding Health and Healthcare concerns.



Community Advisory Council

A Community Advisory Council (CAC) was formed in October 2012, to ensure the Community Health Assessment had input from broad segment of both consumers and providers of healthcare. CAC members were recruited from public venues and by word-of-mouth. More than 50% of the voting members needed to be active consumers or directly involved with individuals who are on Oregon Health Plan (OHP).

Behavioral Health Community Forum

A behavioral health community forum was held in Wasco and Hood River counties on May 13, 2013, and in Sherman County on May 21, 2013. Over 100 people participated in the Wasco/Hood River event; 25 people participated in the Sherman County event. The goals of both events were to find out what local mental health and addictions treatment programs should continue, start, or stop. We also wanted to review the strengths and needs of the system to develop recommendations for improvements. Forum participants assessed our coordination of care, and reviewed access to services with regard to health equity.

Feedback from the forum noted strengths of the mental health system that included existing mental health promotion, mental illness prevention, and substance abuse prevention programs. Current treatment protocols had both strengths and weaknesses. Problem gambling prevention and suicide prevention were seen as areas needing improvement. Service coordination with other agencies was another area needing improvement, as was behavioral health equity in service delivery, trauma-informed service delivery, stigma reduction, peer-delivered services, and crisis and respite services.

Consumer Surveys by Mail

We wanted to know consumers were able to access all aspects of care they needed (e.g., physical health, counseling services, dental health, prescriptions, mental health). We wanted to understand the barriers to accessing care (e.g., appointment times, hours, transportation, costs, daycare). We also wanted to learn about the depth and breadth of consumers' current health and health habits. Finally, we wanted to know how the answers to these questions were related to population demographics (age, county of residence, ethnicity, etc.).

The Center for Outcomes Research and Education (CORE) had been contracted to administer a consumer survey in the Providence service areas, including the Gorge. We were able to expand the reach and depth of the CORE survey through our regional collaboration. The Community Advisory Council, and the majority of participating agencies in this Community Health Assessment provided input to develop the survey. This approach accomplished three things:

- Reduce survey fatigue for consumers – one survey would collect data for multiple uses
- Provide trustworthy results for the Columbia Gorge region – CORE's standardized questions have been tested for reliability and validity so results can be compared to others.
- Allow access to expertise and project management – CORE's survey research unit could provide survey development, printing, mailing, follow-up, and analysis.

The final consumer survey had 65 questions in multiple-choice format. CORE selected a simple random sample of 1,321 households in the Columbia Gorge region to receive a mail survey. We oversampled consumers in Wasco and Hood River counties, and low-income households in the region. A final tally of 457 mail surveys (an adjusted response rate of 35%) were collected from community members. (The Community Health Survey is in the Appendix on page 30.)

Compared to the known demographics of the region, the majority of mail survey respondents were ages 55 and older, and non-Hispanic white. More respondents were male (55.7%) than female (44.3%). Nearly two-thirds of respondents (63%) had household incomes at or below 200% of the Federal Poverty Level, and approximately 60% of respondents had completed a two-year degree or more. Although most respondents were employed, 41.8% were retired.

Consumer Surveys In-person

Some populations may be hard to reach with a mail survey, including groups for whom English is a second language, for instance, or those who are experiencing housing insecurity. In order to ensure that the voices of these hard-to-reach populations were considered, the Cohort listed on page 3 fielded surveys by hand. Volunteers and staff went to places where hard-to-reach populations might be found, and asked people in person to complete the survey. 1,000 surveys were printed for this purpose; 691 In-person surveys were completed yielding close to a 70% return rate

The In-person survey filled many gaps left by the mail survey and is a useful complement. It included a higher percentage of women, younger people, and low-income individuals with less education. More of these respondents are employed and fewer are retired than in the mail survey sample. Our goal of reaching more Hispanics and those whose primary language is not English was highly successful. 26.2% identify as Hispanic or Latino, as compared to 1.5% of mail survey respondents. 23.1% say that English is not their primary language, as compared to 1.9% of mail survey respondents. 23.9% of In-person survey respondents were seasonal workers, and while we did not collect this information from mail survey respondents, seasonal workers may be less likely to be reached by a mail survey.

The survey analysts noted that the In-person survey responses may be especially useful because they demographically resemble the population eligible for Medicaid under the 2014 expansion. It includes a higher percentage of women. More of these respondents are employed and fewer are retired than in the mail survey sample. See Figure 8 for comparison details.

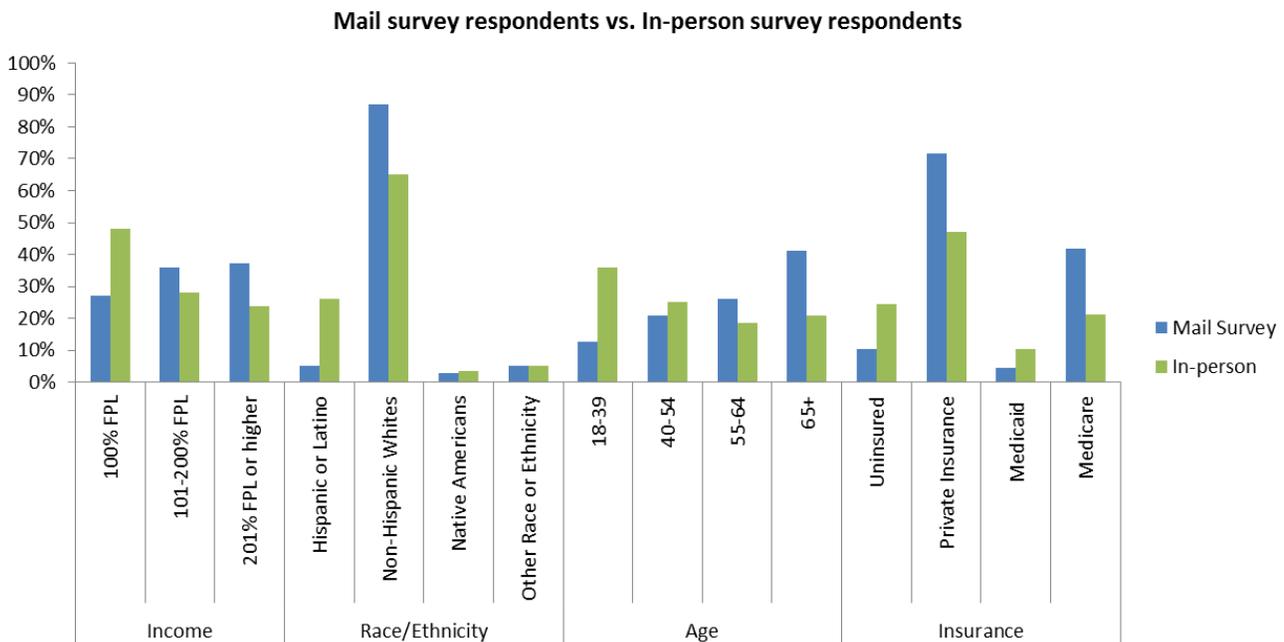


Figure 8 - Comparison of Mail and In-person survey responses by demographic groups

The In-person survey reached a different population from the mail survey, and therefore their results should be treated separately. Since a convenience sample was used, differences in responses from different subpopulations should be considered significant only within this sample and are not necessarily generalizable.

Focus groups

Two focus groups were held to get a deeper understanding of the concerns of specific populations identified as vulnerable because of concerns related to the social and economic conditions that impact health: migrant or seasonal farm workers (MSFW), people with limited English proficiency (LEP), people living with disabilities, people with a low-income, defined as less than twice the Federal Poverty Level (<200% FPL), and seniors, defined as over 65 years (>65). We wanted to understand more about the barriers these populations might face in accessing healthcare and in having positive health outcomes within the healthcare system.

The focus group participants were invited from the general public as members of two broad groups: Spanish-speaking and Seniors. In both groups, our recruitment approach aimed to include representatives of the above-named vulnerable populations. In practice, the Spanish focus group included very high numbers of migrant or seasonal farmworkers, people with limited English proficiency and people with low-income. One participant was disabled. The Seniors focus group was comprised predominantly of those over 65, but did include participants who were also low-income and/or disabled.

Senior/disability. A focus group of 14 seniors (defined as “over the age of 65”) and disabled was held on October 24, 2013 in Hood River, for a discussion about unmet health needs and health resources within the community. The group ranged in age from 66 to 93 years old with 9 women and 5 men. There was one participant under the age of 60 who was wheel chair bound and arrived with a caregiver. The participants were all Caucasian, with the exception of one Japanese elder.

In the Senior focus group, “health” was most often recognized as being an individual, independent pursuit of health-related activities and behaviors. Seniors mentioned “role-reversal,” and becoming dependent upon one’s children for transportation and care. Some of the major unmet health needs discussed were loss of independence, the depression that often accompanies it, dental care, respite for caregivers, and a lack of transportation or activity options.

Hispanic/low-income. The Hispanic focus group of 17 persons was conducted in Spanish during October in Odell, Oregon. We invited low-income Spanish-speaking families to join us for a discussion about unmet health needs and health resources within the community. “Health” was recognized as being very much a family-focused value, which lies in the community more so than the individual. Health was also strongly associated with “being happy.” The greatest expressed need was that of insurance, access to affordable healthcare, and dental care. Transportation, specifically driver’s licenses, also emerged as a significant barrier—all participants recognized that it was a barrier for either themselves or someone they knew.

Many noted that they only access care in an emergency, largely due to concerns regarding cost. Additionally, as many participants identified as Farm Workers, the use of pesticides and subsequent prevalence of asthma in children was a concern. Many participants expressed concern that the doctors at health resources within the community, particularly low-cost clinics and those with payment plans, were less qualified than the doctors at the hospital. Other solutions included the use of community health workers to provide education about nutrition and hygiene and to support those living with chronic conditions.

Gathering Health Status

We used Health Status information from three primary sources:

1. Providence Health and Services facilitated access to Truven Health Analytics demographic data, general population data as well as Community Need Index⁴ information
2. County health departments furnished County Health Rankings demographic and Health Status information
3. Self-reported health and chronic conditions through the Consumer Survey – both mail and In-person

Gathering Local Health Eco-system Status

Provider and agency input

As a community, we were concerned not only with people’s unmet healthcare needs, but also their unmet basic needs (like food and housing), which take into account the importance of the social and economic conditions that impact health. Many health and healthcare organizations had conducted independent health assessments in previous years. Using the numerous previous assessments combined with insights from the Community Advisory Council, two grids were constructed that intersected unmet needs with their attributes.

Although agencies generally deliver the services on the Basic needs grid and Healthcare professionals deliver the services on the Healthcare needs grid, both groups were asked to prioritize the Top 5 on each grid, giving a complementary view into each other’s discipline as well as their own. The combination of a category (e.g., Food) with an attribute (e.g., Cost) forced the participants to be specific about their top concern, but allow us to look at attributes taken together (e.g. ‘Cost is the highest concern across all categories’). The list of participating agencies is in Table 5 - List of agency and faith community participants on page 6.

<i>Basic Needs Grid</i>	Safe	Convenient	Available	Language	Cost
Nutritious Food					
Stable Housing					
Transportation					
Living Wage					
Education					
Family Support Services					
Exercise/Sports					
Prevention of risky Health Behaviors (tobacco, unsafe sex, alcohol, drugs)					

⁴ Data and methodology for the Community Need Index (CNI) for use in this publication were supplied by Truven Health Analytics. Dignity Health contributed to the development of the methodology as well. Any analysis, interpretation, or conclusion based on these data is solely that of the authors, and Dignity Health and Truven Health Analytics disclaim responsibility for any such analysis, interpretation or conclusion.

<i>Healthcare Needs</i>	Physical Health	Behavioral Health	Dental Health	Emergency Services
Location				
Hours				
Appointment Access				
Urgent Care Access				
Language				
Cost to Client				
Services Not Covered				

These two grids, Basic Needs and Healthcare Needs, provided the framework for the Agency Sessions and Provider Survey.

Agency rankings and sessions. Agency representatives ranked what they believed to be their clientele’s top 5 unmet basic needs, and the top 5 unmet healthcare needs, using the grids above, and provided written comments about access to healthcare and the barriers to care. Nineteen agencies provided input and the responses were collated for use in two agency sessions, held June 16 in The Dalles, and June 18 in Hood River. Twenty-two organization representatives participated in the two sessions. The moderator for the sessions presented the collated rankings and facilitated a process to collectively refine the rankings and gather further insights about these needs. Participants were asked to place five sticky notes numbered 1-5 on a poster showing the areas of greatest unmet basic needs, and another five numbered sticky notes on a different poster to indicate the areas of greatest unmet healthcare needs of their clients. Two additional organizations provided their information after the facilitated sessions.

Healthcare Professionals session and survey. An online survey to gather the same information was distributed to healthcare professionals across all six counties in July, asking them to rank unmet basic and healthcare needs, in the same format as the agency sessions. 114 surveys were completed by Healthcare Professionals representing many disciplines, including physicians, dentists, nurses, physician assistants, physical therapists, dieticians, pharmacologists, specialty MDs, pharmacists, primary care, OB-GYN, and nurse practitioners. In October, five physicians responded to an invitation to review the rankings submitted by agency and healthcare professionals, and discuss the top-ranked basic and healthcare needs of patients in the region. The conversation was facilitated and their input was documented.

The overall agreement among social service agencies and Healthcare professionals on the “Top 5” unmet needs on the Basic Needs and Healthcare Needs was a surprise – we assumed that healthcare professionals and agencies would have very different perceptions of unmet needs, but their priorities were quite similar. There were small differences in the rankings, but:

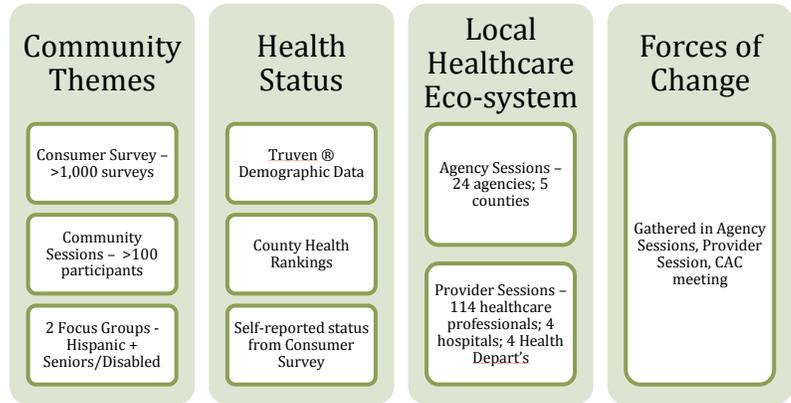
- Adequate income and stable housing were #1 or #2
- Food and transportation were #3 or #4
- Prevention ranked #5
- Availability and cost were the two predominant attributes

Healthcare professionals, but not agencies, were asked where the majority of their patients lived. Those who said that most of their patients were from Hood River prioritized stable housing higher, while those who said most of their patients were from Wasco County prioritized nutritious food higher. The list of participating healthcare organizations appears in Table 4 - List of participating healthcare organizations on page 5.

MAPPING the Information Gathered

Across the various methods and process, the collective information gathered for this health assessment was quite extensive.

The diagram to the right summarizes the data gathered across the main categories' of the MAPP model.



Gathering Forces of Change

Throughout the process, there have been a few opportunities to collect a list of Forces of Change. The current list includes:

- Healthcare Eco-system changes
 - New certified medical interpreter standards
 - Potential for regionalized public health via legislation
 - ICD-10 and DSM-5; affects what's diagnosable and what's covered
 - Aging PCP workforce and aging population
 - Bottleneck at federal level for funding primary care education and residency programs—this results in shortages
 - Use of physician extenders is helping mitigate the shortages
 - Is there a way to use physician skills in flexible ways that meets needs of an aging workforce (e.g., less intense time or skill commitment, overseeing hospice programs, etc.)
 - Increasing attention to palliative care needs; there's a huge opportunity to help families navigate late-life healthcare issues
 - We're trying to orient more toward community-based and in-home services versus hospital and office-based care
 - May be a need to change practices so that docs go to homes
 - No way to pay for home visits right now
 - Maybe we need team-based care with an NP and a doc, other staff, who see a group of patients
 - How do we make new practice models financially viable and rewarding to docs (in terms of pace, etc.)?
- Insurance coverage changes
 - Does Hood River County decision to move to PacificSource have impact or potential opportunity?
 - Inclusion of OEBB/PEBB (Public Employees Benefit Board) into CCO
 - Insurance changes affecting contractual agreements between payers and providers and shifting provider networks
 - Inclusion of dental into CCO

- Affordable Care Act implementation in January 2014: unknown impact on medical, behavioral, and dental health healthcare; great concern for the capacity of the current system and practitioners available.
- Medicaid expansion
- Will the sum of all the healthcare changes result in significant contract shifts such as Providence and HealthNet.
- Insurance Exchange—will trend of shifting costs to employees change. What will happen to those who end up not purchasing and paying higher taxes? Will it be cheaper and better coverage purchasing on your own?
- Global budget could affect services
- General Health and Population changes
 - Aging population; nuclear families not as common—will we have enough residential care; assisted living; skilled nursing facilities?
 - Increasing birth rate
 - Legalization of marijuana
- Immigration reform
 - Driver licenses for undocumented—unless new legislation goes into effect
 - Immigration law and access to Medicaid or other benefits
 - Immigration reform – depending on how it evolves, many of our current residents could qualify for services.
- ‘Built’ Environment changes
 - Early Learning Hubs
 - Only 1% of EMS responses are for fires; 99% are other emergency response services
 - Coal trains through the Gorge
 - Land use planning
 - Federal ownership of land; loss of timber payments – how will elimination of these revenues affect county services?
- Environmental Factors
 - Need winter walking facilities or low-impact exercise facilities for patients
 - 25 people showing up every Monday for Zumba class, especially Latinos

Appendix

List of Figures and Tables

Figure 1 - Map of Columbia Gorge Region.....	2
Table 1 - Total Population.....	2
Table 2 - Ethnicity and Race.....	3
Table 3 - Federal designations for under-served groups.....	5
Table 4 - List of participating healthcare organizations	5
Table 5 - List of agency and faith community participants.....	6
Table 6 - Income insecurity.....	8
Table 7 - Housing insecurity.....	9
Table 8 - Food insecurity.....	9
Table 9 - Transportation insecurity.....	10
Figure 2 - Frequency of comments on healthcare access needs.....	10
Table 10 - Insurance status	11
Table 11 - Physical health access.....	12
Figure 3 - Reasons for going without Medical care.....	13
Table 12 - Dental health access	13
Figure 4 - Reasons for going without Dental care.....	14
Table 13 - Mental health access.....	15
Figure 5 - Reasons for going without Mental Health care.....	15
Table 14 - Substance Abuse treatment access.....	16
Figure 6 - Reasons for going without substance abuse treatment.....	16
Table 15 - Medication access.....	17
Table 16 - Physical health status.....	18
Table 17 - Mental health status	18
Figure 7 - Overlap of chronic physical and mental health conditions	19
Table 18 - Alcohol, Tobacco and Drug usage	20
Table 19 - Domestic violence.....	20
Figure 8 - Comparison of Mail and In-person survey responses by demographic groups.....	23

**COMMUNITY
HEALTH
SURVEY**

COMMUNITY HEALTH SURVEY

INSTRUCTIONS: For each question, please fill in the box that best represents your answer. Your results are *completely private*, and you can skip any question you do not want to answer. When you are finished, please place the survey in the private, postage-paid envelope we have provided and drop it in the mail. If you have questions about this survey, please read the included letter, call us at 1-877-215-0686, or email us at: core@providence.org.

YOUR HEALTH CARE

These questions help us understand your health care over the last twelve months.

1. Do you currently have any kind of health insurance?
 Yes
 No → If No, Go to Question 3
2. What kind of health insurance do you have?
Mark all that apply.
 Medicaid/Oregon Health Plan (OHP)
 Medicare
 Private coverage through an employer or family member's employer
 A private plan I pay for myself
 Other (tell us): _____
 I don't have any insurance now
 I don't know
3. For how many of the **last 12 months** did you have some kind of health insurance?
 Not insured during the last 12 months
 1-3 months
 4-6 months
 7-9 months
 10-11 months
 Insured for ALL of the last 12 months
4. Do you receive care through the Indian Health Service (IHS)?
 Yes
 No
5. Is there a place you **usually** go to receive medical care?
 Yes
 No → If No, Go to Question 8
6. Where do you **usually** go to receive medical care?
Mark only one.
 A private doctor's office or clinic
 A public health clinic or community health center
 A tribal health clinic
 A hospital-based clinic
 A hospital emergency room
 An urgent care clinic
 Someplace else (tell us): _____
 I don't have a usual place
7. How far do you have to travel to get to the place where you **usually** get medical care?
 0-5 miles
 6-10 miles
 11-20 miles
 21-50 miles
 More than 50 miles
8. Do you have **one person** you think of as your personal doctor or health care provider?
 Yes
 No
9. Was there a time in the **last 12 months** when you needed medical care?
 Yes
 No → If No, Go to Question 12
10. If you needed medical care in the **last 12 months** did you get **all** the care you needed?
 I got **all** the care I needed
 I got **some but not all** needed care
 I got **no care at all**
 I don't know

11. The **most recent time** you went **without** needed medical care, what were the main reasons?
Mark all that apply.
- I haven't had to skip any needed care
 - I was worried about the cost
 - I didn't have health insurance
 - My insurance wouldn't cover the care
 - I didn't know where to go
 - I didn't have transportation
 - The clinic is too far away
 - I didn't have childcare
 - The office wasn't open when I could get there
 - I couldn't get an appointment quickly enough
 - I thought I could handle it without treatment
 - I didn't think getting treatment would help
 - Other: _____

12. Was there a time in the last **12 months** when you needed **dental** care?
- Yes
 - No → If No, Go to Question 15

13. If you needed dental care in the **last 12 months** did you get **all** the care you needed?
- I got **all** the care I needed
 - I got **some but not all** needed care
 - I got **no care at all**
 - I don't know

14. The **most recent time** you went **without** needed dental care, what were the main reasons?
Mark all that apply.
- I haven't had to skip any needed care
 - I was worried about the cost
 - I didn't have dental insurance
 - My insurance wouldn't cover the care
 - I didn't know where to go
 - I didn't have transportation
 - The office is too far away
 - I didn't have childcare
 - The office wasn't open when I could get there
 - I couldn't get an appointment quickly enough
 - I thought I could handle it without treatment
 - I didn't think getting treatment would help
 - Other: _____

15. In the **last 12 months** have you needed treatment or counseling for a **mental health condition or personal problem**?
- Yes
 - No → If No, Go to Question 18

16. In the **last 12 months**, when you needed treatment or counseling for a mental health condition or personal problem, did you get **all** the care you needed?
- I got **all** the care I needed
 - I got **some but not all** needed care
 - I got **no care at all**
 - I don't know

17. The **most recent time** you went **without** needed mental health care, what were the main reasons?
Mark all that apply.
- I haven't had to skip any needed care
 - I was worried about the cost
 - I didn't have insurance
 - My insurance wouldn't cover the care
 - I didn't know where to go
 - I didn't have transportation
 - The clinic is too far away
 - I didn't have childcare
 - The office wasn't open when I could get there
 - I couldn't get an appointment quickly enough
 - I thought I could handle it without treatment
 - I didn't think getting treatment would help
 - I was worried about what people would think
 - Other: _____

18. In the **last 12 months** have you needed treatment or counseling for your use of alcohol or any drug, not counting cigarettes?
- Yes
 - No → If No, Go to Question 21

19. In the **last 12 months**, when you needed treatment or counseling for your use of alcohol or drugs, did you get **all** the care you needed?
- I got **all** the care I needed
 - I got **some but not all** needed care
 - I got **no care at all**
 - I don't know

20. The **most recent time** you went **without** needed drug or alcohol abuse treatment, what were the main reasons? **Mark all that apply.**
- I haven't had to skip any needed care
 - I was worried about the cost
 - I didn't have insurance
 - My insurance wouldn't cover the care
 - I didn't know where to go
 - I didn't have transportation
 - The clinic is too far away
 - I didn't have childcare
 - The office wasn't open when I could get there
 - I couldn't get an appointment quickly enough
 - I thought I could handle it without treatment
 - I didn't think getting treatment would help
 - I was worried about what people would think
 - Other: _____
21. Was there a time in the **last 12 months** when you needed **prescription medication**?
- Yes
 - No ⇒ If No, Go to Question 24
22. Were the prescriptions you needed for physical health problems, mental health or personal problems, or both?
- Physical health problems
 - Mental health or personal problems
 - Both physical AND mental health problems
23. If you needed prescription medication in the **last 12 months**, did you get **all** the medications you needed?
- I got **all** the medication I needed
 - I got **some but not all** medications
 - I got **no medications at all**
 - I don't know
24. Do you have any children (under 19 years of age) living in your household?
- Yes
 - No ⇒ If No, Go to Question 31
25. In the **last 12 months**, has any child of yours needed medical care?
- Yes
 - No ⇒ If No, Go to Question 27

26. In the **last 12 months**, when your child needed medical care, did they get **all** the care they needed?
- They got **all** the care they needed
 - They got **some but not all** needed care
 - They got **no care at all**
 - I don't know
27. In the **last 12 months**, has any child of yours had an emotional, developmental or behavioral problem for which they needed treatment or counseling?
- Yes
 - No ⇒ If No, Go to Question 29
28. In the **last 12 months**, when your child needed treatment or counseling, did they get all the care they needed?
- They got **all** the care they needed
 - They got **some but not all** needed care
 - They got **no care at all**
 - I don't know
29. In the **last 12 months**, have any children of yours needed dental care?
- Yes
 - No ⇒ If No, Go to Question 31
30. In the last 12 months, when your child or children needed dental care, did they get all the care they needed?
- They got **all** the care they needed
 - They got **some but not all** needed care
 - They got **no care at all**
 - I don't know

YOUR HEALTH & LIFESTYLE

These questions give us a picture of your overall health.

31. In general, how would you rate your **physical health**?
- Excellent
 - Very Good
 - Good
 - Fair
 - Poor

32. **Compared to last year**, would you say your **physical health** is now better, worse, or about the same?

- Better
- Worse
- About the same

33. In general, how would you rate your **mental health**, including your mood and ability to think?

- Excellent
- Very Good
- Good
- Fair
- Poor

34. **Compared to last year**, would you say your **mental health** is now better, worse, or about the same?

- Better
- Worse
- About the same

35. Have you **ever** been told by a doctor or other health professional that you have any of the following?

	Yes	No
Diabetes or sugar diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Post-traumatic stress disorder (PTSD) ..	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Another ongoing health condition ...	<input type="checkbox"/>	<input type="checkbox"/>

↳ Tell us: _____

36. During the **past 2 weeks**, about how often have you been bothered by the following problems:

	Not at all	Several days	Over half the days	Nearly every day
Little interest or pleasure in doing things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling down, depressed, or hopeless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling nervous, anxious, or on edge?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not being able to stop or control worrying?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

37. In the **last 12 months**, has anyone ever forced you to do something sexual that you didn't want to do?

- Yes
- No

38. In the **last 12 months**, has someone you live with ever hurt or threatened to hurt you or your children?

- Yes
- No
- Doesn't apply

39. Do you consider yourself **now** to be overweight, underweight, or about the right weight?

- About the right weight
- Underweight
- Overweight
 - ↳ Are you actively trying to lose weight now?
 - Yes
 - No

40. Have you smoked at least 100 cigarettes in your **entire life**?

- Yes
- No ⇒ If No, Go to Question 43

41. Do you **now** smoke cigarettes every day, some days, or not at all?

- Every day
- Some days
- Not at all ⇒ If No, Go to Question 43

42. Are you **currently** trying to reduce smoking or quit smoking altogether?

- Yes, trying to reduce smoking
- Yes, trying to quit altogether
- No

43. Do you **currently** use chewing tobacco, snuff, or snus every day, some days, or not at all?

- Every day
- Some days
- Not at all

44. How often did you have a drink containing alcohol in the **past year**?

- Never ⇒ If No, Skip to Question 47
- Monthly or less
- 2-4 times a month
- 2-3 times a week
- 4 or more times a week

45. On the days when you did drink alcohol, how many drinks did you usually have per day? A 'drink' is one beer, one glass of wine, or one shot of liquor.

- 1 to 2
- 3 to 4
- 5 to 6
- 7 to 9
- 10 or more

46. How often did you have six or more drinks on one occasion in the past year?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

47. In the last 12 months, have you used any of the following? *Check all that apply. Remember, your answers are completely private.*

- Marijuana or hashish
- Prescription pain medication that was not prescribed to you
- Any other street drug
- I did not use any of these in the last 12 months

YOUR HOUSEHOLD FINANCES

These questions help us understand finances for you and your family.

48. In the last 12 months, how often have you been worried that your food would run out before you got money to buy more?

- Never
- Sometimes
- Often

49. In general, how often do you have a difficult time accessing transportation when you need it?

- Never
- Sometimes
- Often

50. In the last 12 months, did you or other members of your household have to move because you could not afford to pay rent, mortgage, or utility bills?

- Yes
- No

51. In the last 12 months, have you had to borrow money, skip paying other bills, or pay other bills late in order to pay health care bills?

- Yes
- No

52. In the last 12 months, has a doctor, clinic, or medical service refused to treat you because you owed money to them for past treatment?

- Yes
- No
- I don't know

ABOUT YOU & YOUR FAMILY

These questions help us understand more about you and your family.

53. Are you male or female?

- Male
- Female

54. What year were you born?

19_____

55. Would you describe yourself as being of Hispanic or Latino origin or descent?

- Yes, Hispanic or Latino
- No, not Hispanic or Latino

56. How would you describe your race? *Mark all that apply.*

- White
- Black or African-American
- American Indian
- Asian
- Native Hawaiian or Pacific Islander
- Other: _____

57. What language do you speak best?

- English
- Spanish
- Vietnamese
- Russian
- Other: _____

58. What is the highest level of education you have completed? *Mark only one.*

- Less than high school
- High school diploma or GED
- Vocational training or 2-year degree
- A 4-year college degree
- An advanced or graduate degree

59. Are you currently employed or self-employed?

- Yes, employed by someone else
- Yes, self-employed
- Not currently employed
- Retired

60. About how many hours per week, on average, do you work at your current job(s)?

- I don't currently work
- Less than 20 hours per week
- 20-39 hours per week
- 40 or more hours per week

61. What is your gross household income (before taxes and deductions are taken out) for last year (2012)? *Your best estimate is fine.*

- | | |
|---|--|
| <input type="checkbox"/> \$0 | <input type="checkbox"/> \$50,001-\$55,000 |
| <input type="checkbox"/> \$1 to \$5,000 | <input type="checkbox"/> \$55,001 to \$60,000 |
| <input type="checkbox"/> \$5,001 to \$10,000 | <input type="checkbox"/> \$60,001 to \$65,000 |
| <input type="checkbox"/> \$10,001 to \$15,000 | <input type="checkbox"/> \$65,001 to \$70,000 |
| <input type="checkbox"/> \$15,001 to \$20,000 | <input type="checkbox"/> \$70,001 to \$75,000 |
| <input type="checkbox"/> \$20,001 to \$25,000 | <input type="checkbox"/> \$75,001 to \$80,000 |
| <input type="checkbox"/> \$25,001 to \$30,000 | <input type="checkbox"/> \$80,001 to \$85,000 |
| <input type="checkbox"/> \$30,001 to \$35,000 | <input type="checkbox"/> \$85,001 to \$90,000 |
| <input type="checkbox"/> \$35,001 to \$40,000 | <input type="checkbox"/> \$90,001 to \$95,000 |
| <input type="checkbox"/> \$40,001 to \$45,000 | <input type="checkbox"/> \$95,001 to \$100,000 |
| <input type="checkbox"/> \$45,001 to \$50,000 | <input type="checkbox"/> \$100,001 or more |

62. How many family members, including yourself, are living in your home? *Include both adults and children.* (For example, if you live alone, you should write "1".)

↳ *Size of household:* _____

↳ *How many of them are under 19?:* _____

63. What is your current living arrangement? *Mark all that apply.*

- Live alone
- Live with spouse or partner
- Live with parents
- Live with other relatives (including children)
- Live with friends or roommates
- Other: _____

64. Do you currently have anyone living in your home who doesn't normally live there, but doesn't have anywhere else to live right now?

No _____

Yes
↳ *How many people?* _____

↳ *How many of them are under 19?:* _____

65. How often do you think you would have someone available to do each of the following?

	None of the time	Some of the time	Most of the time	All of the time
--	------------------	------------------	------------------	-----------------

Love you and make you feel wanted?

Give you good advice about a crisis?

Get together with for relaxation?

Confide in or talk to about your problems?

Help you if you were confined to a bed?.....

STOP HERE

Thank you very much for taking time to complete this survey. Please place the survey in the postage-paid envelope and mail it. Contact us at -877-215-0686 or core@providence.org with any questions.

MOU from the Cohort

Six-County Collaborative Community Health Needs Assessment Memorandum of Understanding

October 31, 2013

Overview

This Memorandum of Understanding describes project timing, roles, and responsibilities between participating organizations in the six-county region comprised of Hood River, Wasco, Sherman and Gilliam Counties in Oregon as well as Klickitat and Skamania Counties of Washington to develop a single health needs assessment across hospital, community health center, behavioral health, public health and coordinated care organization stakeholders. A complete list of participating organizations is attached.

Background

Over the past three years, multiple needs assessments were conducted separately for various populations and geographies within this region. Staff from the representative organizations independently collected and analyzed data and implemented health improvement activities. There has been limited common framework or process to organize data in a way that is simultaneously accessible to all stakeholders in the region, and therefore missed opportunities to provide valuable and strategic services within our community. Efforts to prioritize needs and to collaborate on health improvement and track outcomes have been inconsistent, resulting in less impactful outcomes.

Principles of Collaboration

The Community Advisory Council of the Columbia Gorge Health Council ("CGHC") has endorsed the following principles of collaboration:

- A collaborative community health assessment ("CHA") can be better; more accurate and actionable as community providers agree on the needs within our region and communities and will support our ability to address those needs together.
- A collaborative CHA will maximize collective resources available for improving population health.
- A collaborative CHA must be truly collaborative, requiring commitments of cash or in-kind resources from all participants who would use it to satisfy a regulatory requirement.

Shared Understandings

- The participating organizations declare their shared intent to collaborate in a CHA, as is evidenced in the meeting minutes of the CGHC's Community Advisory Council and numerous collaborative CHA activities in advance of finalizing this document. A copy of this MOU will be included in the appendix of the collaborative CHA.
- This MOU's term begins October 31, 2013 and continues through February 28, 2014.
- The CGHC's Community Advisory Council will serve as the convener of participating organizations and community stakeholders in this process.
- Each of the participating organizations agrees to contribute cash and/or in-kind resources to develop this collaborative and realize the CHA.

- Subject to applicable law and each organization’s applicable policies, the participating organizations have agreed to share, both publically and with each other, the findings of population demographic and health data; agency, service, provider, and community sessions; focus groups; community forums; interviews; and consumer surveys. Any facility-specific utilization data will be shared by further agreement of the individual parties and in the most consistent format possible.
- While efforts will be made to accommodate as many needs as possible, each of the participating organizations is responsible for amending the collaborative CHA to satisfy the specific requirements of any regulatory bodies to whom they are accountable.
- Each of the participating organizations recognizes that this is the first instance of an ongoing collaborative effort, that future iterations of a collaborative CHA will evolve, and that there is a shared intention to be inclusive of additional participating organizations.

The Six-County Collaborative Community Health Assessment (CHA)

Component	Agreement
Population data for assessment	<p>By October 31st, 2013:</p> <p>Providence will provide basic demographic data for the six county area. When published, this data must appear in a format that cites the source according to Providence/Truven requirements.</p> <p>CGHC will contract with an analyst to gather any additional demographic data in an agreed upon format, as needed.</p> <p>Other participating organizations will validate congruency with any data sources they are required to use.</p> <p>Public health departments will make available raw data from health assessments they may have published after January 1, 2012.</p>
Health care utilization data for assessment	<p>By November 4th, 2013:</p> <p>Each hospital will each provide data on hospital utilization in a consistent format. The dates of utilization will be from January 1, 2012 through December 31, 2012.</p> <p>A template will be provided for utilization data, which each hospital will aspire to populate for the zip codes that define their service area. At a minimum, each hospital will include the top 20 diagnoses in the Emergency Department for uninsured, Medicaid and dual-eligible patients.</p> <p>PacificSource Community Solutions will provide relevant data on Oregon Health Plan utilization for members in Hood River and Wasco counties.</p>
Agency Sessions	<p>By October 31st, 2013:</p> <p>CGHC’s Community Advisory Council will collect feedback from key social service stakeholders in the region around health needs through a “forced ranking” worksheet. Respondents will be asked to rank their choices on the basis of prior needs assessments and current experience, supported by data, whenever possible.</p> <p>Klickitat County Health Department will distribute, via email, an electronic link to a survey for Klickitat County social service agency stakeholders to contribute feedback in the same “forced ranking” format.</p> <p>As requested and organized by county health departments, and with a minimum of 7 days advance notice, CGHC Community Advisory Council will facilitate in-person sessions with social service stakeholders to present worksheet/survey findings and clarify feedback on health priorities; CGHC Community Advisory Council will summarize the results of these sessions, and make them available to the participating organizations.</p>
Provider Sessions	<p>By October 31st, 2013:</p>

Component	Agreement
	<p>Each hospital will distribute, via e mail, an electronic worksheet/survey to clinical employees and a majority of their medical staff, concentrating on primary care providers. The survey will be well-publicized and open for a minimum of seven days.</p> <p>As requested and organized by hospital leadership, and with a minimum of 7 days advance notice, CGHC will facilitate in-person sessions to present worksheet/survey findings and clarify feedback on health priorities.; CGHC Community Advisory Council will summarize the results and make them available to all participating organizations.</p>
Consumer Survey	<p>By October 22th, 2013:</p> <p>The Center for Outcomes Research and Education (CORE) will develop a community health survey with input from CGHC Community Advisory Council and other local stakeholders and content experts.</p> <p>Providence will contract with CORE to deploy, track, collect and tabulate 900 surveys by mail.</p> <p>Mid Columbia Medical Center and One Community Health will contribute monies to CGHC, who will contract with CORE to expand the survey and analysis of data by an additional 500 mailed surveys and an additional 500 locally-administered surveys in targeted locations or populations as determined by CGHC's Community Advisory Council. Costs to Mid Columbia Medical Center for these expanded surveys is not to exceed \$6,500. Costs to One Community Health for these additional surveys is not to exceed \$4,500.</p> <p>Klickitat Valley Health and Skyline Hospital will contribute monies to CGHC to expand the survey and analysis of data by an additional 400 locally-administered surveys in Klickitat County. Costs to Klickitat Valley Health for these expanded surveys is not to exceed \$ 2,000. Costs to Skyline hospital for these expanded surveys is not to exceed \$2,000.</p> <p>Final costs for expanded surveys will be based on billing from CORE in addition to CGHC direct expenses plus an admin fee and be allocated as 40% MCMC, 30% OCH, and 15% each for KVH and Skyline. CGHC will invoice participating agencies for these expenses.</p> <p>Participating organizations are responsible for distributing and facilitating completion of locally administered surveys within their service areas, in both English and Spanish at agency sites or in strategic locations to reach targeted groups. These groups will include the following populations of interest:</p> <ul style="list-style-type: none"> • Seniors (65+) • Migrant and seasonal farm workers • Limited English Proficiency • Low Income (<200% FPL) • Disabled <p>Hood River County Health Department will provide data entry for locally-administered surveys fielded in Oregon.</p> <p>Locally-administered surveys from Washington will be organized for distribution, collected and entered electronically, or returned to CORE, via Providence Hood River Memorial Hospital, by Klickitat County Health Department.</p> <p>By November 4th, 2013:</p> <p>CORE will make findings and analysis of all surveys available to CGHC, who will share them with all participating organizations.</p>

Component	Agreement
Focus Groups	<p>By October 31, 2013:</p> <p>Providence will coordinate and fund two focus groups. Participants for each focus group will be solicited from the general public.</p> <ul style="list-style-type: none"> • Aging/Disabled/<200% FLP: in English • Migrant and Seasonal Farm Workers/People with limited English proficiency/<200% FPL: in Spanish. <p>By November 4th, 2013:</p> <p>Providence will provide experts in thematic analysis to summarize the findings of these sessions and make them available to the Community Advisory Council.</p>
Summarizing the data and writing the draft assessment	<p>By October 31, 2013:</p> <p>Community Advisory Council will appoint an analysis team of qualified experts to review findings from the above activities and provide recommendations on final CHA activities for any populations that may be underrepresented. The group will demonstrate impartiality to their agencies of employment and aspire for consensus in their identification of prioritized needs. The participants of this analysis team, with the exception of the lead writer, will each be contributed in-kind by participating organizations.</p> <p>The Community Advisory Council will identify and contract with a qualified writer to lead the analysis team and summarize the findings and prioritized needs in an agreed-upon format that fully satisfies the requirements of the COD and other participating organizations to the fullest extent possible. A Table of Contents for the final deliverable is attached to this document.</p> <p>Each hospital will provide an amount not to exceed \$1,500 for the services of this writer. CGHC will invoice each hospital for this expense.</p> <p>By November 15, 2013:</p> <p>The draft CHA will be completed and made available to all participating organizations.</p> <p>By November 29, 2013:</p> <p>All participating organizations will review the CHA and if acceptable, validate and endorse the same. Participating organizations will make any specific requests for changes with the exception of requesting further primary research before the final draft.</p>
Finalizing and publishing the CHNA	<p>By December 20, 2013:</p> <p>Community Advisory Council will collect feedback, validation and endorsement of CHA.</p> <p>The contracted writer will integrate appropriate requested changes.</p> <p>Participating Organizations will achieve any additional necessary endorsements.</p> <p>The writer will prepare a final document for publication.</p> <p>The document, along with the data and summaries described above, will be released to partners for publication and published on the CGHC website.</p>
Next Steps	<p>By January 31, 2014:</p> <p>Klickitat Valley Health, Skyline Hospital, Providence Hood River Memorial Hospital and Mid Columbia Medical Center, in partnerships with the health departments in their respective counties will each coordinate, host and fund community forums in a consistent, agreed-upon format. The forums should include health care and social service agency stakeholders, as well as public at large/consumers. The goal of these forums is:</p>

Participating Organizations (in alphabetical order):

- Columbia Gorge Health Council
- Hood River County Health Department
- Klickitat Valley Health
- Klickitat Valley Health Department
- Mid Columbia Medical Center
- Mid-Columbia Center for Living
- North Central Public Health District
- One Community Health
- Pacific Source Community Solutions
- Providence Hood River Memorial Hospital
- Skyline Hospital

Six -County Region of Study:

Oregon Counties: Gilliam, Hood River, Sherman, Wasco

Washington Counties: Klickitat, Skamania

Common Assessment Process: The participating organizations have selected a modified Mobilizing for Action through Planning and Partnerships (MAPP) process as a common assessment framework. Developed by NAACHO, the MAPP framework consists of 6 phases: Organizing, Visioning, Assessments, Strategic Issues, Formulate Goals and Strategies, and Action Cycle.

Participant Commitment: Representative organizations will commit to participate in this project throughout the term of this Agreement. Each participant organization will contribute a designated organizational representative to work with the convening organization to implement and sustain the project. A reevaluation will occur at the end of term to determine ongoing needs.

Signature Blocks on Following Pages

Data from Truven Market Expert 2013. © Truven Health Analytics

Columbia Gorge Region								
2013 Community Health Needs Assessment Data								
		Region Counties					Oregon	
		Hood River	Klickitat	Skamania	Wasco	Gilliam	Sherman	
TOTAL POPULATION								
	Current Population (Yr.)	22,888	21,142	11,345	25,426	1,961	1,720	3,918,925
	5 Yr. Proj. Population (Yr.)	23,814	22,531	11,880	25,937	2,095	1,675	4,070,407
	5 Year Growth (#)	926	1,389	535	511	134	(45)	151,482
	5 Year Growth (%)	4.0%	6.6%	4.7%	2.0%	6.8%	-2.6%	3.9%
POPULATION - RACE (Hisp & Non Ethn)								
White	Current Population (#)	18,907	18,534	10,509	21,688	1,857	1,604	3,245,172
	Current Pop. (% of Total)	83%	88%	93%	85%	95%	93%	83%
	5 Year Growth (#)	628	1,224	478	154	112	(42)	79,408
Black	Current Population (#)	102	55	49	112	3	4	72,668
	Current Pop. (% of Total)	0.4%	0.3%	0.4%	0.4%	0.2%	0.2%	1.9%
	5 Year Growth (#)	-	9	7	12	-	1	5,587
Native American	Current Population (#)	174	437	157	1,166	21	26	54,627
	Current Pop. (% of Total)	1%	2%	1%	5%	1%	2%	1%
	5 Year Growth (#)	(15)	(70)	(27)	95	3	(1)	2,184
Asian Pac. Isl.	Current Population (#)	355	141	119	342	20	4	166,036
	Current Pop. (% of Total)	2%	1%	1%	1%	1%	0%	4%
	5 Year Growth (#)	2	(10)	20	(1)	6	1	16,609
Other Race	Current Population (#)	2,579	1,263	153	1,437	31	50	225,125
	Current Pop. (% of Total)	11%	6%	1%	6%	2%	3%	6%
	5 Year Growth (#)	202	176	14	197	9	-	31,601
2+ Race	Current Population (#)	771	712	358	681	29	32	155,297
	Current Pop. (% of Total)	3%	3%	3%	3%	1%	2%	4%
	5 Year Growth (#)	109	60	43	54	4	(4)	16,093
POPULATION - ETHNICITY (All Races)								
Hispanic	Current Population (#)	6,971	2,396	590	4,110	106	100	495,693
	Current Pop. (% of Total)	30%	11%	5%	16%	5%	6%	13%
	5 Year Growth (#)	550	342	52	569	29	(6)	70,013
Non-Hispanic	Current Population (#)	15,917	18,746	10,755	21,316	1,855	1,620	3,423,232
	Current Pop. (% of Total)	70%	89%	95%	84%	95%	94%	87%
	5 Year Growth (#)	376	1,047	483	(58)	105	(39)	81,469
POPULATION - AGE GROUPS								
<3	Current Population (#)	904	691	349	998	58	57	146,492
	Current Pop. (% of Total)	4%	3%	3%	4%	3%	3%	4%
	5 Year Growth (#)	62	84	30	74	10	3	8,823
<18	Current Population (#)	5,819	4,580	2,452	5,885	365	340	880,274
	Current Pop. (% of Total)	25%	22%	22%	23%	19%	20%	22%
	5 Year Growth (#)	36	197	18	189	26	(3)	29,973
18-44	Current Population (#)	7,661	5,820	3,273	7,745	466	448	1,392,513
	Current Pop. (% of Total)	33%	28%	29%	30%	24%	26%	36%
	5 Year Growth (#)	176	383	128	197	33	(5)	12,730
45-64	Current Population (#)	6,384	6,690	3,809	7,035	671	536	1,058,606
	Current Pop. (% of Total)	28%	32%	34%	28%	34%	31%	27%
	5 Year Growth (#)	148	(14)	(37)	(512)	(9)	(68)	(944)
65+	Current Population (#)	3,024	4,052	1,811	4,761	459	396	587,532
	Current Pop. (% of Total)	13%	19%	16%	19%	23%	23%	15%
	5 Year Growth (#)	566	823	426	637	84	31	109,723

		Region Counties						Oregon
		Hood River	Klickitat	Skamania	Wasco	Gilliam	Sherman	
POPULATION - GENDER								
MALE	Current Population (#)	11,441	10,661	5,685	12,609	1,009	871	1,939,112
	Current Pop. (% of Total)	50%	50%	50%	50%	51%	51%	49%
FEMALE	Current Population (#)	11,447	10,481	5,660	12,817	952	849	1,979,813
	Current Pop. (% of Total)	50%	50%	50%	50%	49%	49%	51%
	Total <3 Pop - Female (%)	453 (50%)	344 (50%)	173 (50%)	496 (50%)	32 (55%)	32 (56%)	49%
	Total <18 Pop - Female (%)	2850 (49%)	2218 (48%)	1218 (50%)	2896 (49%)	162 (44%)	165 (49%)	49%
	Total 18-44 Pop - Female (%)	3736 (49%)	2848 (49%)	1633 (50%)	3783 (49%)	205 (44%)	216 (48%)	49%
	Total 45-64 Pop - Female (%)	3171 (50%)	3365 (50%)	1874 (49%)	3574 (50%)	328 (49%)	264 (49%)	51%
	Total 65-79 Pop - Female (%)	1099 (52%)	1563 (49%)	729 (51%)	1720 (51%)	170 (35%)	150 (52%)	53%
Total 80+ Pop - Female (%)	591 (65%)	487 (58%)	206 (56%)	871 (62%)	87 (64%)	54 (51%)	62%	
INCOME (2013)								
Total Households		8,413	8,747	4,697	10,147	919	767	1,559,406
Median Household Income		\$ 51,459	\$ 36,472	\$ 48,633	\$ 40,995	\$ 44,583	\$ 40,859	\$ 45,758
Average Household Income		\$ 66,745	\$ 52,052	\$ 58,026	\$ 53,831	\$ 54,059	\$ 52,679	\$ 61,043
HOUSING (2013)								
Housing Units		9,542	10,286	5,852	11,618	1,228	906	1,719,675
% Occupied by Owners		55%	60%	59%	56%	49%	57%	56%
% Occupied by Renters		33%	25%	21%	31%	26%	28%	34%
% Vacant		12%	15%	20%	13%	25%	15%	9%
Avg. Residence (Yrs.)		14.0	15.0	17.0	15.0	15.0	17.0	12.3
Median Home Value		\$ 242,762	\$ 167,679	\$ 225,276	\$ 169,679	\$ 85,300	\$ 110,601	\$ 210,684
LANGUAGE								
% Speak English Only at Home		73%	91%	96%	85%	90%	95%	86%
% Speak Spanish at Home		26%	8%	3%	12%	9%	4%	9%
% Speak Asian or Pac. Isl. Lang.		1%	0%	0%	1%	0%	1%	3%
% Speak Other Lang. at Home		0%	1%	1%	2%	1%	0%	3%
SOCIOECONOMIC - OTHERS								
% Uninsured (SAME = county #)		24.0%	19.0%	16.0%	24.0%	20.0%	20.0%	15.4%
% Unemployed (Adj '13; Non-Adj)		6.0	7.0	8.8	5.6	7.4	7.3	8.1
≤100% FPL (% of county pop)*		2,480 (11%)	4,006 (19%)	1,538 (18%)	4,480 (18%)	243 (12%)	302 (18%)	18%
≤200% FPL (% of county pop)*		7,607 (33%)	9,781 (47%)	3,113 (36%)	10,629 (42%)	684 (35%)	686 (40%)	39%
% without HS diploma		3.6%	5.8%	5.3%	7.1%	6.7%	5.7%	4.8%

DATA INFO

Workbook: Federal Poverty Level Calculator

Author: Analytics & Research in support of Strategic & Business Planning | SMS | PHSOR

<i>Data Source</i>	<i>Of Note</i>	<i>Comment</i>
Truven Market Expert	Data covers	2012 & 2013. (Based on 2010 census and proprietary analysis, with projections by year at 5-year intervals.)
	Description	General consumer profiles and demographics with breakdown by county. Some IP and OP forecasts. Data sourced from Truven Health Analytics' Market Expert product.
	Exclusion	Inpatient volume forecasts are not included. (Can be developed by request by using actual hospital data as a baseline.)
	Inclusion	CNI Note1: Data and methodology for the Community Need Index (CNI) for use in this publication were supplied by Truven Health Analytics. Dignity Health contributed to the development of the methodology as well.
		CNI Note2: Any analysis, interpretation, or conclusion based on these data is solely that of the authors, and Dignity Health and Truven Health Analytics disclaim responsibility for any such analysis, interpretation or conclusion.
		Demographic data: Some are available by # people (example: population per county). Others are available only by # of households (example: # households per city).
		Inpatient and outpatient market estimates are population-based using Truven's data and research methodologies. These volumes may not match actual COMPdata volumes, but the growth rate can be used to estimate future direction.
	Last update	In July 2013, the 2013 data was incorporated (along with a refresh of projection estimates).
Next update	In Q1 or Q2 of 2014, the 2014 data will be incorporated.	
Updated	Yearly	

Rank Order of Emergency Room Usage Frequency by Diagnosis

Below is the rank order listing of the most frequent diagnoses for Medicaid (OHP), uninsured and dual eligible (Medicaid and Medicare) patients for 2013. If the same number appears twice in a row, it means the total count was the same for those rows. For example, under Skyline Rank Order, there are two rows that are 7th – Chest Pain and Fever, unspecified. Both rows had an equal amount of patient encounters in the emergency room for those two diagnoses.

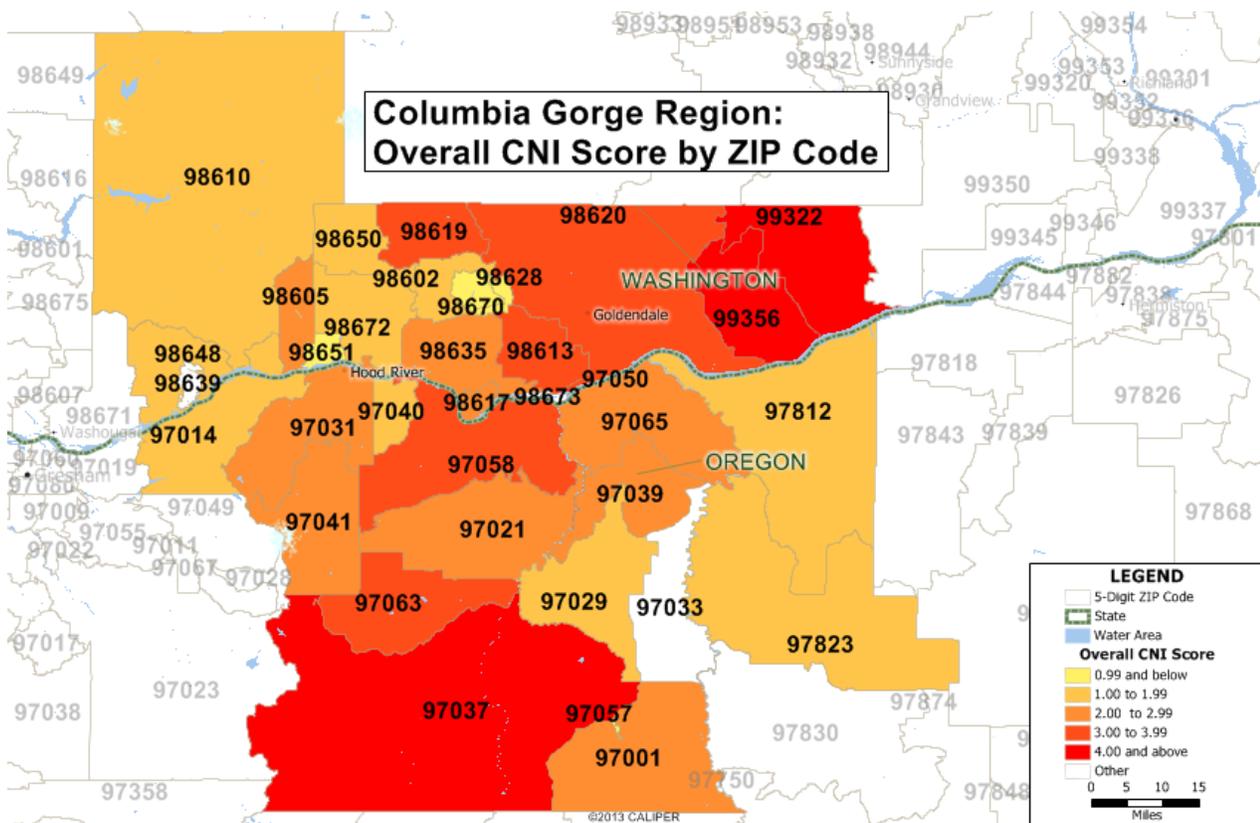
Row Labels	Regional Rank Order	PHRMH Rank Order	MCMC Rank Order	KVH Rank Order	Skyline Rank Order
Upper Respiratory Infection	1	1	1	1	1
Abdominal Pain (all locations & unspecified)	2	2	4	2	2
Vomiting and/or Nausea	3	11	7	5	3
Chest Pain	4	13	3	3	7
Tooth/Supporting Structure	5	7	2	7	
Fever, unspecified	6	9	10	4	7
Lower Back Pain and/or Sprain	7	4	5	10	
Headache	8	8	9	6	8
Rashes	9		12	9	4
Urinary Tract Infection	10	5		12	6
Wound, Fingers or hand	11	10	11	15	
Head and/or face injury/wound (except eyes)	12	12		11	8
Viral Infection	13	3			
Shortness of breath	14	10		8	
Patient left without being seen	15		6		
Sprain of ankle	16		14	14	
Pregnancy related	17	6			
Change Surgical dressing	18		8		
Dehydration	19				5
Alcohol Abuse	20		11		
Diarrhea	21	10			
Administrative Encounter	22		13		
Pain in limb	23			13	

Community Needs Index (CNI)

In 2005 Dignity Health, in partnership with Truven Health, pioneered the nation's first standardized Community Need Index (CNI). The CNI identifies the severity of health disparity for every zip code in the United States and demonstrates the link between community need, access to care, and preventable hospitalizations.

To determine the severity of barriers to healthcare access in a given community, the CNI gathers data about that community's socio-economy. For example, what percentage of the population is elderly and living in poverty; what percentage of the population is uninsured; what percentage of the population is unemployed, etc. This data is used to assign a score to each barrier condition (with 1 representing less community need and 5 representing more community need). The scores are then aggregated and averaged for a final CNI score (each barrier receives equal weight in the average). A score of 1.0 indicates a zip code with the lowest socio-economic barriers, while a score of 5.0 represents a zip code with the most socio-economic barriers.

Data and methodology for the Community Need Index (CNI) for use in this publication were supplied by Truven Health Analytics. Dignity Health contributed to the development of the methodology as well. Any analysis, interpretation, or conclusion based on these data is solely that of the authors, and Dignity Health and Truven Health Analytics disclaim responsibility for any such analysis, interpretation or conclusion.





Year One Progress Brief July 2013

Origination of Project

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 Accreditation¹. 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).

Members

With start-up assistance from the Oregon Association of Hospitals and Health Systems, the Healthy Columbia Willamette Collaborative was developed. It is a large public-private collaborative comprised of fourteen hospitals, four local public health departments and two coordinated care organizations in the four-county region. Members include: Adventist Medical Center, Clackamas County Health Division, Clark County Public Health Department, FamilyCare², Health Share of Oregon, Kaiser Sunnyside Hospital, Legacy Emanuel Medical Center, Legacy Good Samaritan Medical Center, Legacy Meridian Park Medical Center, Legacy Mount Hood Medical Center, Legacy Salmon Creek Medical Center, Multnomah County Health Department, Oregon Health & Science University, PeaceHealth Southwest Medical Center, Providence Milwaukie Hospital, Providence Portland Medical Center, Providence St. Vincent Medical Center, Providence Willamette Falls Medical Center, Tuality Healthcare/Tuality Community Hospital and Washington County Public Health Division. Multnomah County Health Department applied for and was given the contract to be the legal entity and neutral convener for the first three-year cycle. Year one started in June 2012.

Vision

Align efforts of 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. It will eliminate duplicative efforts; lead to prioritization of community health needs, enable joint efforts for implementing and tracking improvement activities, and improve the health of the community.

¹ The federal Affordable Care Act, Section 501(r)(3) requires tax exempt hospital facilities to conduct a Community Health Needs Assessment (CHNA) at minimum once every three years, effective for tax years beginning after March 2012. Through the Public Health Accreditation Board, public health departments now have the opportunity to achieve accreditation by meeting a set of standards. As part of the standards, they must complete a Community Health Assessment (CHA) and a Community Health Improvement Plan (CHIP).

² FamilyCare and Health Share of Oregon joined the Collaborative June 2013. Coordinated Care Organizations are required by OAR 410-141-3145 to conduct a CHNA every three years.

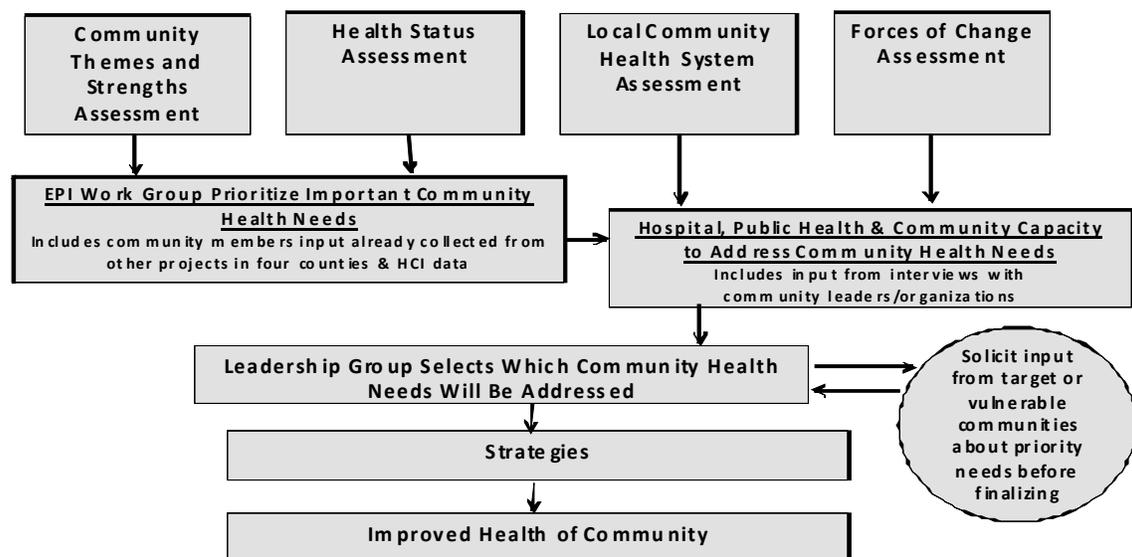
Key Objectives for Years 1 & 2

- To prioritize community health needs identified through the community health needs assessment.
- To develop regional, shared, and aligned hospital/county level strategies that will begin to address prioritized community health needs.
- To identify regional, hospital, and county level indicators to monitor health outcomes and implemented strategies.
- To make available online data dashboards displaying community health statistics to inform and engage the broader community in understanding the health status of the entire community.³

Assessment Model

The Healthy Columbia Willamette Collaborative is using a modified version the Mobilizing for Action through Planning and Partnerships (MAPP) assessment model⁴. The MAPP model uses health data and community input to identify the most important community health issues.

Modified MAPP Model



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

The Community Themes and Strengths Assessment (Fall 2012)

This first assessment involved reviewing 62 community engagement projects that had been conducted in the four-county region since 2009. Findings from the 62 projects were analyzed for themes about how community members described the most important health issues affecting themselves, their families, and the community.

³ The Healthy Columbia Willamette Collaborative's website: <http://www.healthycolumbiawillamette.org/>

⁴ MAPP is a model developed by the National Association of County and City Health Officials (NACCHO)

Christine Sorvari: Christine.e.sorvari@multco.us, 503.988.8692

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 four-county region. More than 120 health indicators (mortality, morbidity and health behaviors) were studied.

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 a severe health consequence. All health issues identified through this assessment were also identified in the first assessment.

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. The findings of this assessment resulted in the following

Findings from First Five Phases

After all of the four assessments and community listening sessions were completed, the findings from all combined point to the following "health focus areas" as the most important health issues affecting the four-county community⁵ (in alphabetical order):

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

⁵ These focus areas are also what was found for Clackamas and Multnomah County. Clark County Washington had two additional areas: Immunization and aging-related issues. Washington County had one additional area: Parkinson Disease.

Healthy Columbia Willamette Selection Process

Recognizing that nine focus areas would be too many to address in a way that could affect the improvement of indicators over a few-year time period. The Collaborative developed selection criteria to further prioritize health issues from the list above. The health focus area will be/have

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

Health Focus Areas Identified after Selection Criteria Applied

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

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

The Healthy Columbia Willamette Collaborative is committed to addressing disparities for all health areas, and even though the focus area of “culturally-competent services and data collection” did not meet their selection criteria, it was agreed that for each of the selected areas there will be specific strategies directed toward culturally competent services and data collection.

Next Steps

Before finalizing which health focus areas to address, the Healthy Columbia Willamette Collaborative plans to take the next steps:

Meet with content experts for the four health focus areas (July-August 2013)

During the August Healthy Columbia Willamette’s monthly meeting, content experts will be invited to discuss the following topics.

- Do these indicators (Table 1) represent what you are seeing?
- What are the additional problematic related-behaviors and outcomes are you seeing in this focus area?
- Who is most affected by these indicators? Culturally-identified and geographic populations (this will also be informed by the data)?
- What are the evidence-based interventions to address these indicators?
- How can the Health Columbia Willamette help to support these evidence based practices?

The specific indicators for each of these four focus areas are listed below. They were identified through the epidemiological study. It is recognized that there are most likely additional indicators in these focus areas that would demonstrate problems; however there may not have been population-based data to investigate them.

Table 1. Health Focus Areas and Related Indicators⁶

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

Table 1. Health Focus Areas and Related Indicators⁷

Year One Reports (July-August 2013)

The following reports will be on the Healthy Columbia Willamette Webpage: <http://www.healthycolumbiawillamette.org/>

- Community Themes and Strengths Assessment: Important Health Issues Identified by Community Members. July 2013
- Health Status Assessment: Quantitative Data Analysis Methods and Findings. July 2013
- Local Community Health System and Forces of Change Assessment: Stakeholders’ Priority Health Issues and Capacity to Address Them. July 2013
- Community Listening Sessions: Important Health Issues and Ideas for Solutions. July 2013
- Healthy Columbia Willamette: Assessing Community Needs and Improving Health in Clackamas, Multnomah, and Washington Counties in Oregon and Clark County, Washington. July 2013

Stakeholders and Assessment Projects Consulted to Date

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

⁶ Identified after analyzing 120+ indicators for a disparity by race/ethnicity, disparity by gender, a worsening trend, a worse rate at the county level compared to the state, a high proportion of the population affected, and a severe health consequence

⁷ Identified after analyzing 120+ indicators for a disparity by race/ethnicity, disparity by gender, a worsening trend, a worse rate at the county level compared to the state, a high proportion of the population affected, and a severe health consequence

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

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

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

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

Healthy Columbia Willamette Collaborative

