2016 Community Health Needs Assessment

Executive Summary

Healthy Columbia Willamette Collaborative

The Healthy Columbia Willamette Collaborative (HCWC) is a unique public-private partnership that includes 15 hospitals, four health departments, and two coordinated care organizations (managed Medicaid organizations) in Clackamas, Multnomah, and Washington counties of Oregon, and in Clark County, Washington.

This report documents the community health needs of HCWC's four-county region and each of the counties. The community health needs, referred to in this report as priority health issues, were identified through a comprehensive study of population, hospital, Medicaid, and community data.

2016 Community Health Needs Assessment Data Sources

Health Status Assessment

1) Population data about health-related behaviors, morbidity, and mortality.
2) Medicaid data from local Coordinated Care Organizations (CCOs) about the most frequent conditions for which individuals on Medicaid sought care in the tri-county region in Oregon (Clark County Medicaid data were not available for this report).
3) Hospital data for uninsured people who were seen in the emergency department with a condition that should have been managed in primary or ambulatory care.

Community Themes and Strengths

1) Online survey about quality of life, issues affecting community health, and risky health behaviors.
2) Listening sessions with an array of communities in the four-county region to identify community members' vision for a healthy community, needs in the community, and existing strengths.
3) An inventory of recent community engagement projects in the four-county region that assess communities' health needs.

Key Findings

Regional demographics

Approximately 2.2 million people lived in the four-county region in 2014, having increased 15.5% from 2000 to 2010. Although the racial and ethnic population is predominantly White, non-Hispanic/Latino (74.1%), the demographics of the region continue to diversify. The foreign-born population increased 16.0% from 2005-2014, while the Hispanic/Latino population increased 69.8% in the region from 2000 to 2010.

Social determinants of health and equity

Factors such as income, housing, and education impact communities' health in the region. The number of individuals living in poverty in the region ranged from 9.2–18.8% (depending on the county), while the number of children (18 years or younger) living in poverty ranged from 11.2–24.1%. Nearly one fifth of households in the region received SNAP (food assistance) benefits in the past 12 months. Housing affordability and high rates of homelessness affected communities across the four-county region.

Through listening sessions, an online survey, and an inventory of recent community engagement projects, HCWC identified upstream factors, such as access to food, health care, transportation, and safe, affordable housing, as important needs in our community. Community members specified culturally and linguistically appropriate services and support for people with behavioral health challenges as needed improvements to health care and public health systems. Communities across the four-county region also advocated for policies, systems, and environments that support healthy behaviors and identified racism, discrimination, and stigma as problems that contribute to poor health in the region.

Health behaviors

Population health data from state surveys show that risky health behaviors, such as binge drinking, cigarette smoking, lack of exercise, and not eating enough healthy foods, are prevalent in the region. For teenagers, specifically, the assessment identified alcohol, marijuana, and vaping/e-cigarette use as common behaviors. Access to health care and preventive services were identified as priority health issues—specifically lack of a usual source of care among adults and lack of flu shots and pneumonia vaccines for adults 65 and older.

Diagnosed health conditions for low-income residents

An analysis of Medicaid claims data from CCOs in Oregon showed that for youth, asthma, attention deficit disorder, and post-traumatic stress disorder were the most commonly diagnosed chronic conditions. For adults on Medicaid in the tri-county region, depression, diabetes, and hypertension were the most common diagnoses. People with Medicaid, whose incomes are below 139% of the Federal Poverty Level, represent nearly 20% of the population in the tri-county Oregon region.

Emergency department admissions for uninsured residents

Utilization data from local hospitals were analyzed for people who were uninsured or "self-pay," and were admitted to the Emergency Department for a condition that could have been treated in a primary care setting. The most common conditions for adults within this population were diabetes, hypertension, and kidney/urinary infections. For youth, the top diagnosed conditions were asthma and severe ear, nose, and throat infections.

Morbidity and mortality

Epidemiologists from the four county health departments prioritized 104 health indicators using the following criteria: existence of a disparity by race/ethnicity or sex, comparison with the state, trend over time, severity, and magnitude. Data came from a variety of sources, including vital statistics, disease and injury morbidity data, cancer registries, and adult and student surveys. In addition to the health behaviors described above, the following morbidity and mortality indicators rose to the top as priority health issues.

*Morbidity (Disease)**

- Asthma
- Cancer, 9 types (see population data section of full report for specific types)
- Chlamydia
- Depression
- Hypertension
- High Cholesterol
- Obesity/overweight

*Mortality (Death)**

- Alcohol-induced
- Alzheimer's disease
- Breast cancer
- Diabetes
- Drug-induced
- Heart disease
- Leukemia and lymphoma
- Non-transport accidents (e.g. poisonings, falls)
- Suicide

*Issues are listed in alphabetical order.

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Introduction

History and Structure

Healthy Columbia Willamette Collaborative (HCWC) is a unique public-private partnership that includes 15 hospitals, four health departments, and two coordinated care organizations (managed Medicaid organizations) in the Clackamas, Multnomah, and Washington counties of Oregon, and in Clark County, Washington (see *Appendix C* for full list of organizations and descriptions). HCWC was convened in 2012 to conduct a regional community health needs assessment to inform the health improvement plans of participating organizations.

Purpose and Vision

The purpose of HCWC is to align the efforts of hospitals, public health, CCOs, and the residents of the communities they serve to develop a shared community health needs assessment across the four-county region. HCWC aims to eliminate duplicative efforts, prioritize needs, and enable collaborative efforts to implement and track improvement activities across the four-county region.

This collaborative approach enables an effective and sustainable process; strengthens relationships between communities, CCOs, hospitals and public health; creates meaningful community health needs assessments; and results in a platform for collaboration around regional health improvement plans and activities, leveraging collective resources to improve the health and wellbeing of our communities.

Commitment to Addressing Health Disparities

HCWC member organizations are committed to addressing health disparities and inequities. The 2016 HCWC Community Health Needs Assessment includes data on disparities in our region. The collaborative has also taken strides to make sure diverse community perspectives are included--not only about what the needs are, but how they can be addressed. HCWC recognizes that including people affected by health inequities in the assessment and planning process is a key strategy to ensure health improvement activities will be successful. The HCWC structure has evolved to include an active community engagement workgroup committed to meaningful engagement, equity, and addressing health disparities.

Purpose of this Report

This report documents the community health needs of the Healthy Columbia Willamette Collaborative's four-county region, comprised of Clackamas, Multnomah, and Washington counties in Oregon, and Clark County in Washington. The community health needs, referred to in this report as priority health issues, were identified through a rigorous study of population, hospital, Medicaid, and community data. This is the second community health needs assessment (CHNA) conducted by HCWC. The first was completed in 2013. Reports from the 2013 CHNA are available at www.healthycolumbiawillamette.org.

Hospitals, public health departments, and Coordinated Care Organizations (CCOs) share similar requirements for conducting CHNAs. The federal Affordable Care Act, Section 501(r)(3) requires tax-exempt hospital facilities to conduct a CHNA at minimum once every three years, effective for tax years beginning after March 2012. In conducting a CHNA, hospital facilities are required to integrate input from local health departments

or other similar agencies with current health data. The data are used to inform community health improvement plans and interventions.

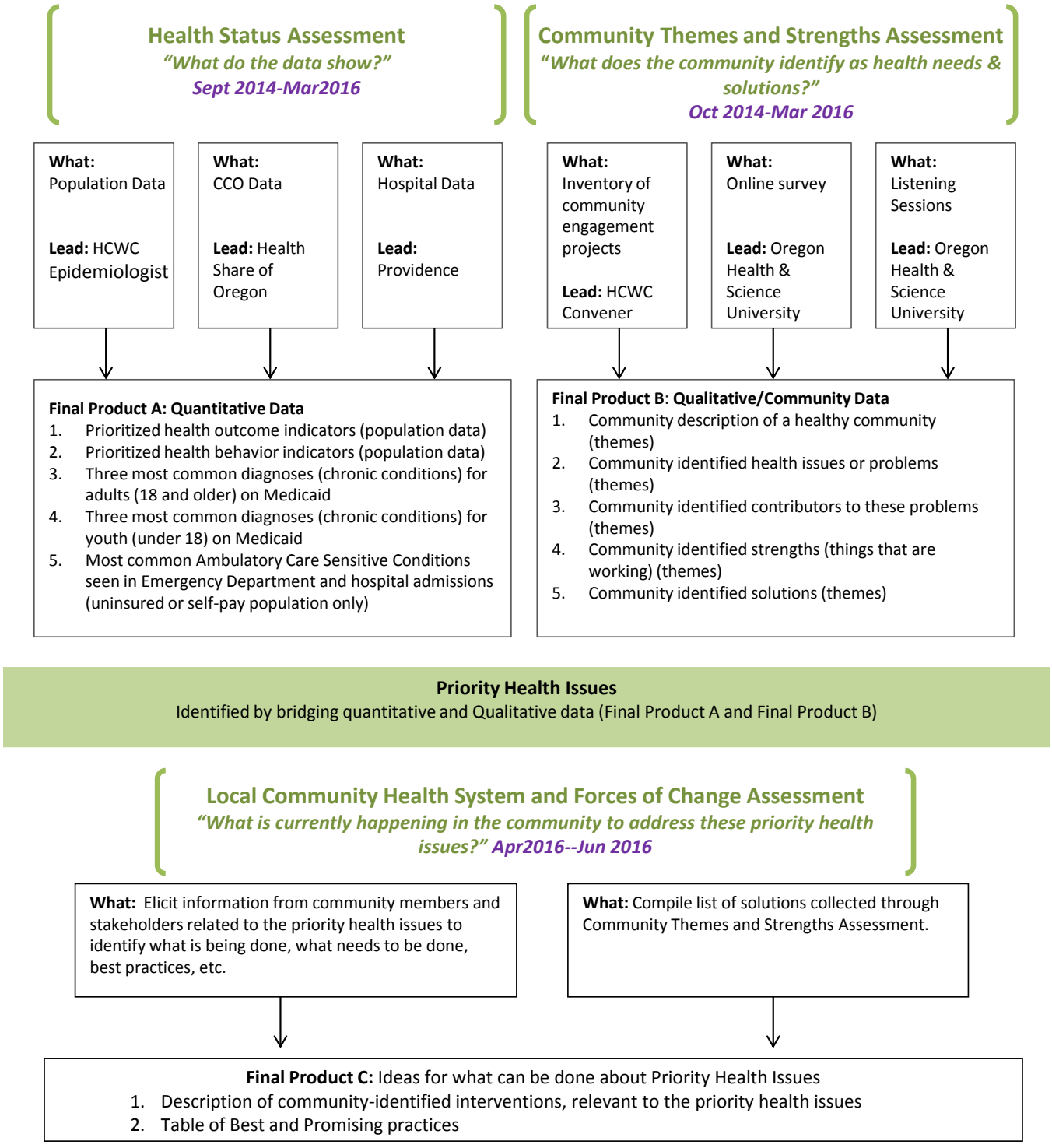
In 2012, Oregon enacted legislation allowing the formation of CCOs. The law requires each CCO to conduct a CHNA every three years and establish a community advisory committee to oversee its CHNA and recommend community health improvement plans to its Board of Directors.

Through the Public Health Accreditation Board, public health departments can achieve accreditation by meeting a set of standards documenting the department's capacity to deliver the core public health functions outlined in the "Ten Essential Public Health Services." [1] As part of the standards, public health departments must complete a community health assessment and a community health improvement plan before applying for accreditation and must complete an updated assessment and improvement plan every five years to maintain accreditation.

2016 Community Health Needs Assessment Model

HCWC used a modified version of the Mobilizing for Action through Planning and Partnerships (MAPP) model to conduct the 2016 CHNA. The MAPP model is an interactive process combining health data and community input to identify and prioritize community health needs.[2] An equity lens was applied to the 2013 assessment model, which led to a number of changes, including the creation of a Community Engagement Workgroup to oversee community outreach and data collection, an explicit effort to seek information from community members on social determinants of health, and a Prioritized Health Issues Group to bridge quantitative and qualitative data without losing community voice.[3] *Figure 1* illustrates the HCWC 2016 assessment model.

Figure 1: HCWC Assessment Model 2014-2016

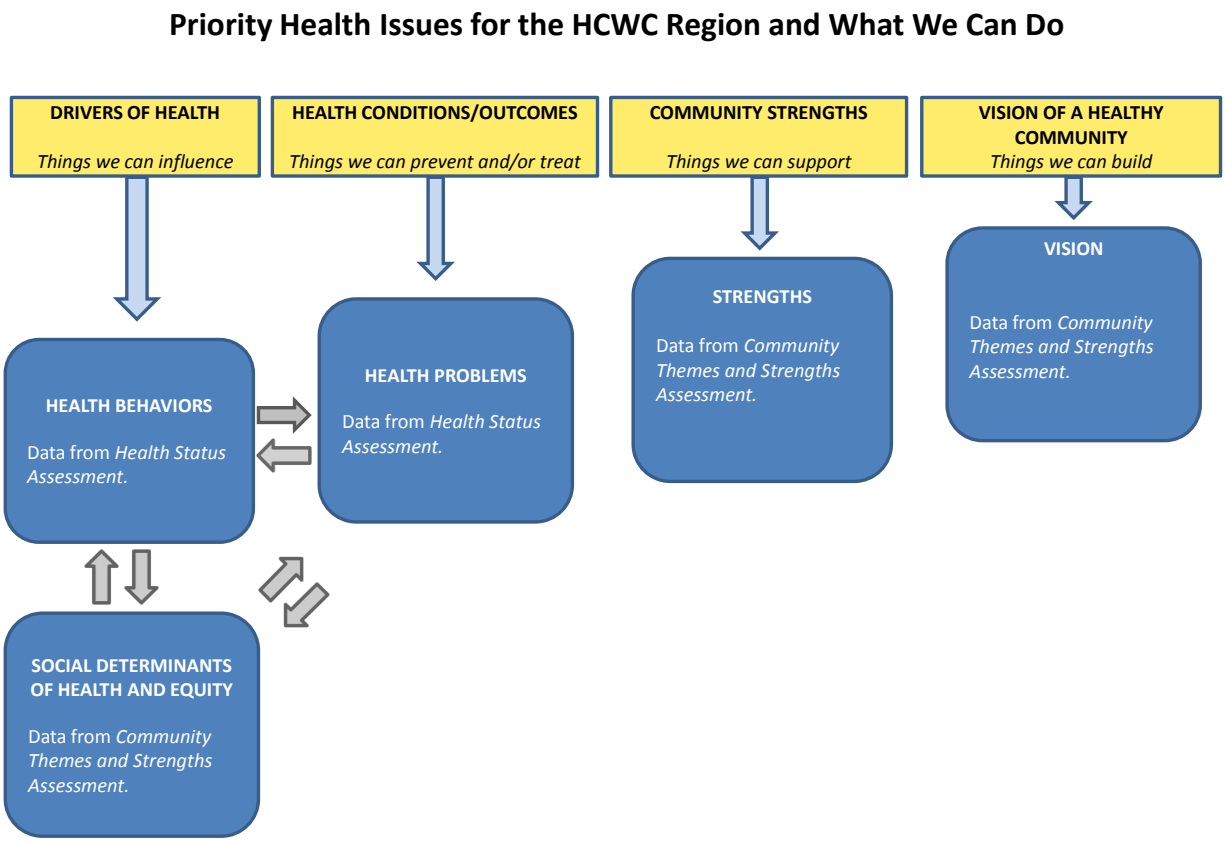


During the *Health Status Assessment* phase, workgroups comprised of HCWC member organization representatives gathered data from epidemiological sources, hospitals, and CCOs. The collection and analysis of hospital and CCO data was an additional modification to the 2013 CHNA. Meanwhile, a Community Engagement Workgroup led the *Community Themes and Strengths Assessment*, which included an online

survey, listening sessions in all four counties, and an inventory of community engagement projects conducted within the last three years. Each data source within these two phases has its own section of the report, which describes the methodology, findings, and limitations.

The quantitative and qualitative data from the 2016 CHNA were blended to create the Priority Health Issues Model, which describes the health needs in our region (page 93). (See A*ppendices H, I, J,* and *K* for county-specific Priority Health Issues Models.) As a modification from the 2013 CHNA, the model includes all data from the assessments, without further prioritizing. This was intentional to leave room for HCWC partners and local communities to identify which priority health issues to address in their improvement planning efforts, as well as to make sure community voice was not overshadowed by other data. The model identifies potential points of intervention for health systems and includes data on community strengths and vision for organizations to build on as they work towards implementing health improvement strategies. *Figure 2* shows a simplified version of the Priority Health Issues Model.

Figure 2: Priority Health Issues Model (simplified version)



Finally, the *Local Community Health System and Forces of Change Assessment* includes input from community members and stakeholders on existing strengths and potential solutions to address these issues, as well as a review of best practices. This section offers ideas for solutions and identifies opportunities for future collaboration between HCWC member organizations and other community partners. The process of gathering this information is not intended to replace individual organizations' community health improvement planning processes.

The Healthy Columbia Willamette Region

Geographic Description

The Healthy Columbia Willamette Region is comprised of three Oregon counties: Clackamas, Multnomah and Washington, and Clark County in Washington State (see *Figure 3).*

Clackamas County, founded in 1843, was named for the Native American Clackamas Tribe living in the area. Oregon City, the county seat, was the first incorporated city west of the Rocky Mountains. From its 55-foot elevation at Oregon City, Clackamas County rises to 11,235 feet at the peak of Mt. Hood. Clackamas County is made up of urban, suburban, and rural communities, along with abundant opportunities for outdoor recreation including skiing, rafting, fishing, and camping. The county includes parts of two national forests: Mount Hood National Forest and Willamette National Forest. Since the county's creation, agriculture, timber, manufacturing, and commerce have been the principal economic activities.

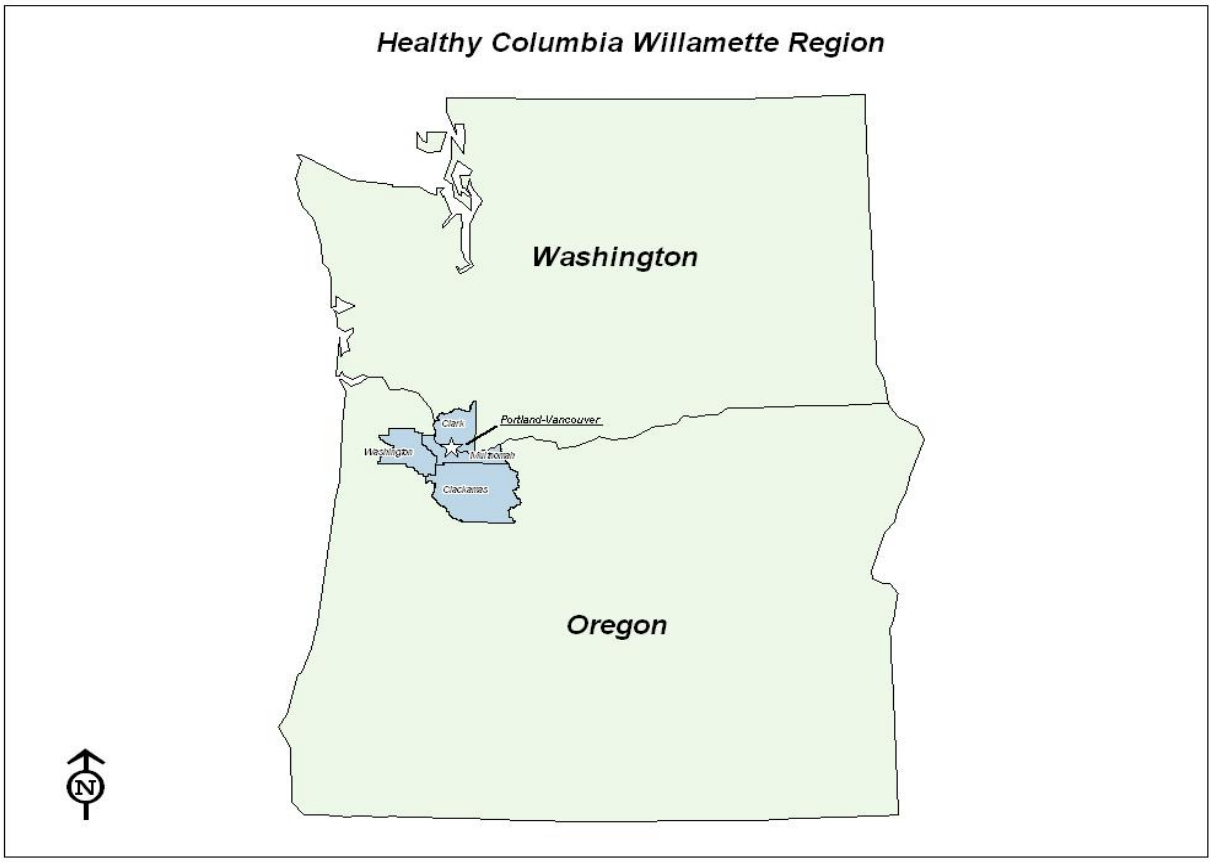
Multnomah County was created by the Territorial Legislature in 1854, five years before Oregon became a state. Although Multnomah is the smallest county geographically, it is the largest in population in Oregon. In 2015, Multnomah County accounted for nearly 20% of Oregon's total population. Multnomah County is geographically diverse, with the city of Portland in the west, and the Columbia River Gorge and Mt. Hood in the east. The City of Portland itself is home to 79% of the county's population, while most of the far eastern portion of the county is covered with timber and is sparsely populated. Multnomah County also includes the City of Gresham, which is home to around 109,000 people.

Washington County was also created in 1843 and is the second largest and fastest growing urban county in Oregon, with approximately 574,000 residents. The population increased 8.4% between 2010-2015, and the development of a large electronics industry during the last two decades has contributed significantly to the economy of the county. The largest cities are Beaverton and Hillsboro, although the county includes many rural and unincorporated communities, as well as smaller cities, such as Forest Grove, Tualiatin, and Cornelius. Washington County is home to the largest Hispanic/Latino population in the HCWC Region, over 16% of the county population.

Clark County is located across the Columbia River in the state of Washington and is one of the fastest growing counties in the state. Currently more than 459,000 people live in Clark County. The largest city is Vancouver, with a population of about 162,000. Other parts of the county are more rural, with cities ranging from 1,000 to 21,000 people. Clark County consistently rates high in terms of livability. Some of the many reasons people choose to live in Clark County are lower housing costs, better funding for school systems, and the lack of a State Income Tax. Residents are still very close to Portland and the metropolitan amenities it offers, and many commute to jobs across the I-5 and I-205 bridges.

Data for the geographic description come from the U.S. Census.[4]

Figure 3: Map of HCWC Region



Regional Demographics

Table 1 summarizes the population demographics for the HCWC four-county region (individual county demographics are summarized in the appendices). Approximately 2.2 million people lived in the four-county region in 2014. Multnomah County was the most populous county with 776,712 people, and Clackamas County was the least populous, with 394,972 people. The region's total population increased 15.5% from 2000 to 2010, with Clark County experiencing the largest increase (23.2%).

The age composition of each of the four counties was similar with the exception of Multnomah County, which had a larger proportion of the population in the 20 to 44 year age group (40.9%) compared with the other three counties. Washington County had the youngest median age (36.3 years) and Clackamas County had the oldest (41.5 years).

The racial and ethnic population of all four counties was predominantly White, non-Hispanic/Latino (74.1% for the region). People identifying as Hispanic/Latino (of any race) were the second-largest population in all counties. The Hispanic/Latino population increased 69.8% in the region from 2000 to 2010, with Multnomah County exhibiting the smallest increase (61.6%) and Clark County having the greatest increase (98.0%).

Other than English and Spanish, the top five languages spoken at home in the region included Russian (1.3%), Vietnamese (1.3%), and Chinese (1.2%). The proportion of the foreign-born population in the region ranged from a low of 8.2% in Clackamas County to 16.5% in Washington County, with a regional average of 12.9%. From 2005-2014, the foreign-born population in the region increased 16.0% (ranging from 11.0% in Washington County to 19.3% in Clackamas and Multnomah counties).

Multnomah County had the lowest median household income in the region (USD $53,660) and the largest proportion of individuals living in poverty (18.8%) and children under 18 years of age living in poverty (24.1%). Clackamas County had the lowest proportion of individuals living in poverty (9.2%) and second lowest proportion of children under 18 years of age living in poverty (11.9%).

All four counties had at least 90% of their populations completing high school (or equivalency). The proportion of the population that earned a bachelor's degree or higher ranged from 26.9% in Clark County to 41.6% in Multnomah County. Other education-related indicators are explored in the *Social Determinants of Health* section of this report.

Comprehensive efforts were made to obtain demographic data for the LGBTQ (lesbian, gay, bisexual, transgender, queer, or questioning) population, but no sufficient data were found at the county level.

Table 1: Regional Demographics

Demographic Indicator	**Region**
Total Population (number of people)	2,185,690
Gender	
Female (%)	50.5
Male (%)	49.5
Age	
Median (years)	range 36.3-41.5
Under 5 years (%)	6.1
5 to 19 years (%)	18.7
20 to 44 years (%)	36.0
45 to 64 years (%)	26.1
65 years and older (%)	13.1
Race/Ethnicity (%)	
White, non-Hispanic/Latino	74.1
Black or African American, non-Hispanic/Latino	2.8
Native American/ Alaska Native, non-Hispanic/Latino	0.5
Asian, non-Hispanic/Latino	6.3
Native Hawaiian and other Pacific Islander, non-Hispanic/Latino	0.5
Hispanic/Latino, any race	11.5
Top 5 languages spoken at home (%)[a]	
English only	81.8
Spanish or Spanish Creole	8.3
Russian	1.3
Vietnamese	1.3

Demographic Indicator	Region
Chinese	1.2
Foreign-born population (%)[b]	12.9
With any disability (%)[c]	12.4
No health insurance (%)[d]	9.2
Unemployment (%)[e]	4.8
Income	
Median household income (USD)	range: 53,660-66,136
Individuals living in poverty (%)[f]	range: 9.2-18.8
Children under 18 years living in poverty (%)[f]	range: 11.2-24.1
Education (%)[g]	
High school graduate or higher	range: 90.2-92.8
Bachelor's degree or higher	range: 26.9-41.6
Total homeless individuals (number of people)[h]	range: 591-3,801
Under 18 years of age	range: 132-1,026
Ages 65 years or older[i]	range: 9-48
Chronically homeless[j]	range: 81-1,033
Veterans	range: 31-422
Change in population (% increase)	
Total population (from 2000-2010)	15.5
Hispanic/Latino origin, any race (from 2000-2010)	69.8
Non-Hispanic/Latino origin (from 2000-2010)	11.1
Foreign-born (from 2005-2014)[b]	16.0

USD: U.S. dollars

Data sources: total population, gender, race/ethnicity, language spoken at home, foreign-born, disability, health insurance, unemployment, income, education, poverty (American Community Survey, 2014 one-year estimates); homeless (Point-in-Time Homeless Count 2015 for Clark, Clackamas, Multnomah, and Washington counties); population change (total population and Hispanic/Latino and non-Hispanic/Latino origin: Community Commons using US Census data from 2000 and 2010; Foreign-born: American Community Survey estimates from 2005 and 2014).

Percentages might not total 100% because of rounding. Percentages for race/ethnicity might not total 100% because data are not shown for some categories, such as two or more races or "other" race.

[a]Language spoken at home is among the population ages 5 years and older.

[b]Foreign-born population includes anyone who was not a US citizen or a US national at birth.

[c]Disability includes hearing, cognitive, vision, ambulatory, independent living, and self-care disabilities.

[d]No health insurance includes people reporting no health coverage or those whose only health coverage was Indian Health Service out of the total civilian non-institutionalized population.

[e]Unemployment is out of the population 16 years of age and older.

[f]Poverty is measured as persons living in households with income below 100% Federal Poverty Level. Poverty in children is out of the total population of children under 18 years of age.

[g]Educational attainment is among the population 25 years of age and older.

[h]Homeless counts include persons within emergency shelter, transitional shelter, safe haven, unstable or doubled-up housing, and unsheltered.

[i]Clackamas, Clark, and Washington counties: ages 65 years or older; Multnomah County: ages 70 years or older.

[j]Chronic homelessness is defined as: "Individuals or families who have been homeless for one year or longer or have had four episodes of homelessness within the last three years and the individual or one family member has a disabling condition." [5, 6]

Social Determinants of Health for the Region

The World Health Organization (WHO) has defined health as "a state of complete physical, mental, and social well-being and not just the absence of sickness or frailty".[7] Our health is influenced by our biology, genetics, and individual behavior.[8] Some external factors are equally important to our health, such as our economic circumstances, where we live, how much education we have, and our access to healthcare.[8] Public health professionals refer to this collection of factors as the *social determinants of health*. In other words, health starts in our homes, schools, and jobs long before illness begins.[9]

This section includes data for the four-county region in the following Healthy People 2020 topic areas that indicate different factors affecting the population's health.[10]

- **Health care**: availability of healthcare providers.
- **Economic stability**: income, poverty, unemployment, food security, and housing costs.
- **Education**: higher education and childhood education.
- **Neighborhood and built environment**: housing, access to healthy food, and commute time to work.

Health care

Medical providers are an important factor in the overall health of a population. Having appropriate, accessible, and high-quality medical care can improve health, prevent disease, and extend lives.[11] The number of people each medical provider serves can have an impact on the quality of care in an area. A 2008 Evidence Review reported that states with a lower patient-to-primary care physician ratio have better health outcomes, including decreased cancer, heart disease, and stroke mortality.[12] In other words, if a physician has fewer patients to care for, the physician potentially has more time to deliver higher quality care to each patient.

Primary care providers and dentists in Clark County and mental health providers in Clackamas County need to serve a greater number of people compared with other counties in the four-county region (*Table 2; Figures 4, 5, 6*). Primary care providers, mental health providers, and dentists in Multnomah County provide care to the fewest number of people per capita.

Table 2: Healthcare Indicators

	County			
Indicator	**Clackamas**	**Clark**	**Multnomah**	**Washington**
Primary care providers (ratio of population to total number of primary care physicians)	1,159:1	1,510:1	725:1	1,110:1
Mental healthcare providers (ratio of population to total number of mental health providers)	476:1	410:1	159:1	415:1
Dentists (ratio of population to total number of dentists)	1,321:1	1,503:1	1,094:1	1,154:1

Source: Robert Wood Johnson Foundation County Health Rankings estimates (primary care providers, 2013; mental health providers, 2015; dentists, 2014)

Figure 4: Primary Care Providers in the Region

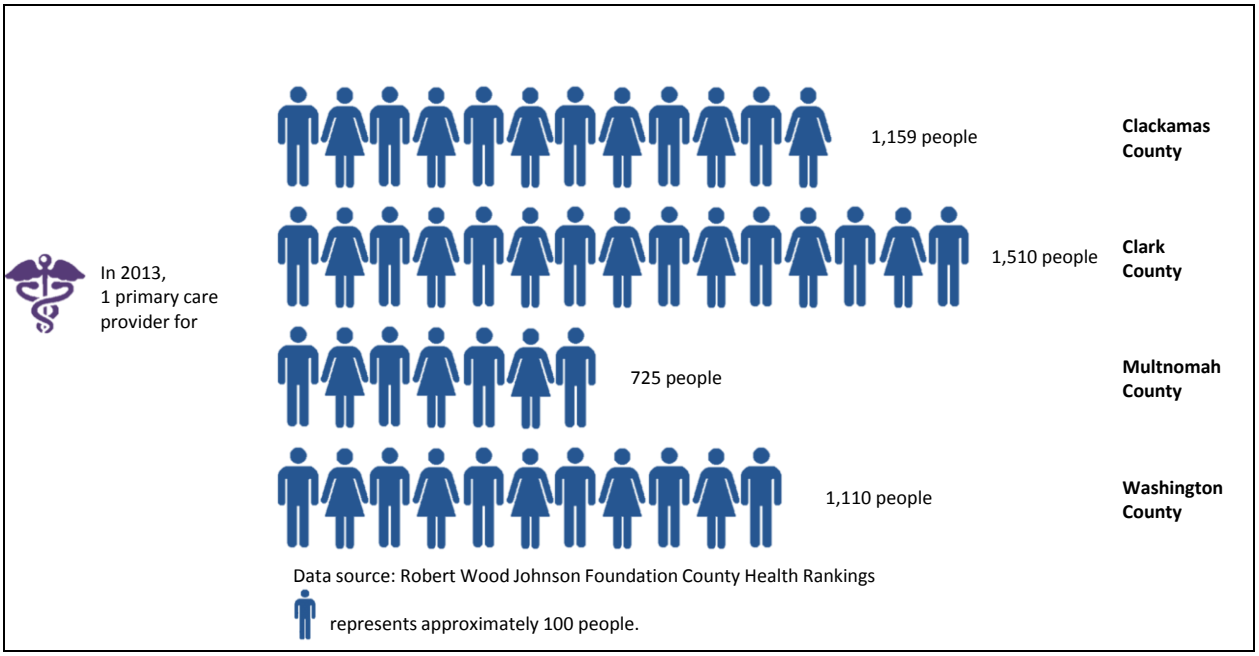


Figure 5: Mental Health Providers in the Region

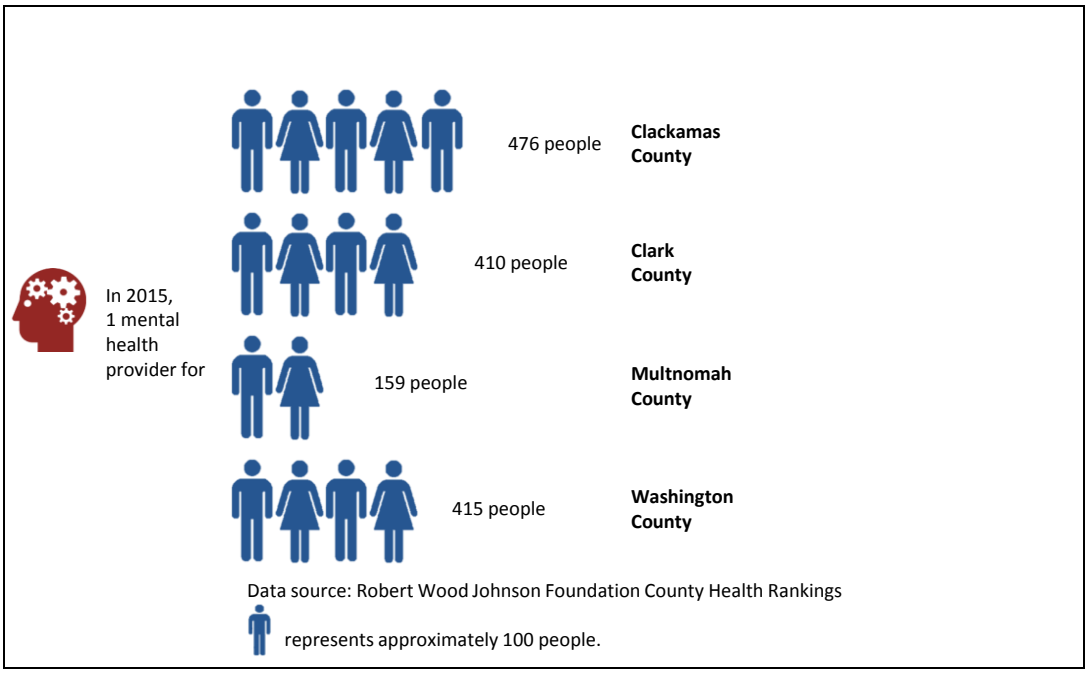
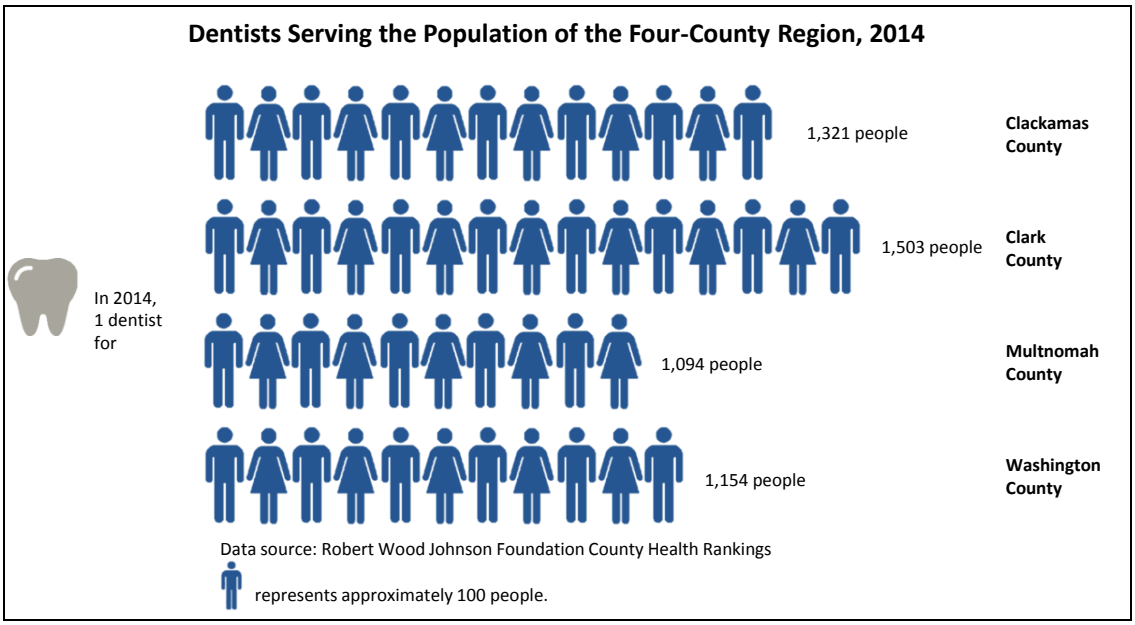


Figure 6: Dentists in the Region



Economic stability

Socioeconomic status (SES) is a strong predictor of health and well-being.[13] *Table 3* shows a wide range of income across the four counties; Washington and Clackamas counties have the highest median income ($66,136 and $65,316, respectively) and Multnomah County has the lowest ($53,660). Multnomah County has the greatest proportion of families (12.8%) and children (24.1%) living in poverty (*Figure 7*). Multnomah County also has the greatest proportion of families (20.2%) receiving Supplemental Nutrition Assistance Program (SNAP) benefits in the past 12 months.

The ability to secure and maintain a job can have long-lasting effects on the health of individuals and families. Having a job that pays a living wage can allow a person to live in safer neighborhoods, buy healthier food, and afford health insurance and medical care.[14] For 2014, the unemployment rate was highest in Multnomah County (5.3%) and lowest in Clackamas County (4.3%) (*Table 3*).

Affordable housing is defined as spending less than 30% of a family's income on rent or house payments.[15] When a family spends more than 30% of its income on housing, the family can experience financial strain so that other basic needs such as food, heating, and healthcare can be shortchanged.[16] The percent of homeowners paying at least 30% of their income toward housing ranged from 28.2% in Clark County to 34.3% in Multnomah County (*Figure 8*). The percent of renters paying at least 30% of their income toward housing ranged from 49.8% in Clark County to 57.1% in Multnomah County (*Table 3, Figure 8).*

Table 3: Economic Stability Indicators

	County			
Indicator	**Clackamas**	**Clark**	**Multnomah**	**Washington**
Median household income (USD)	$65,316	$61,741	$53,660	$66,136
Families living in poverty (%)*	6.8	8.5	12.8	8.7
Children under 18 years of age living in poverty (%)*	11.9	11.2	24.1	17.5
Households receiving SNAP benefits in past 12 months (%)	13.5	15.4	20.2	13.3
Unemployment rate (%)	4.3	4.7	5.3	4.6
Homeowners with a mortgage paying 30% or more of household income on housing (%)	29.2	28.2	34.3	29.8
Renters paying 30% or more of household income on housing (%)	51.8	49.8	57.1	52.4

SNAP: Supplemental Nutritional Assistance Program; USD: U.S. dollars
Sources: 2014 American Community Survey estimates
*The 2014 Federal Poverty Level for a family of four is $24,230.[17]

Figure 7: Poverty in the Region

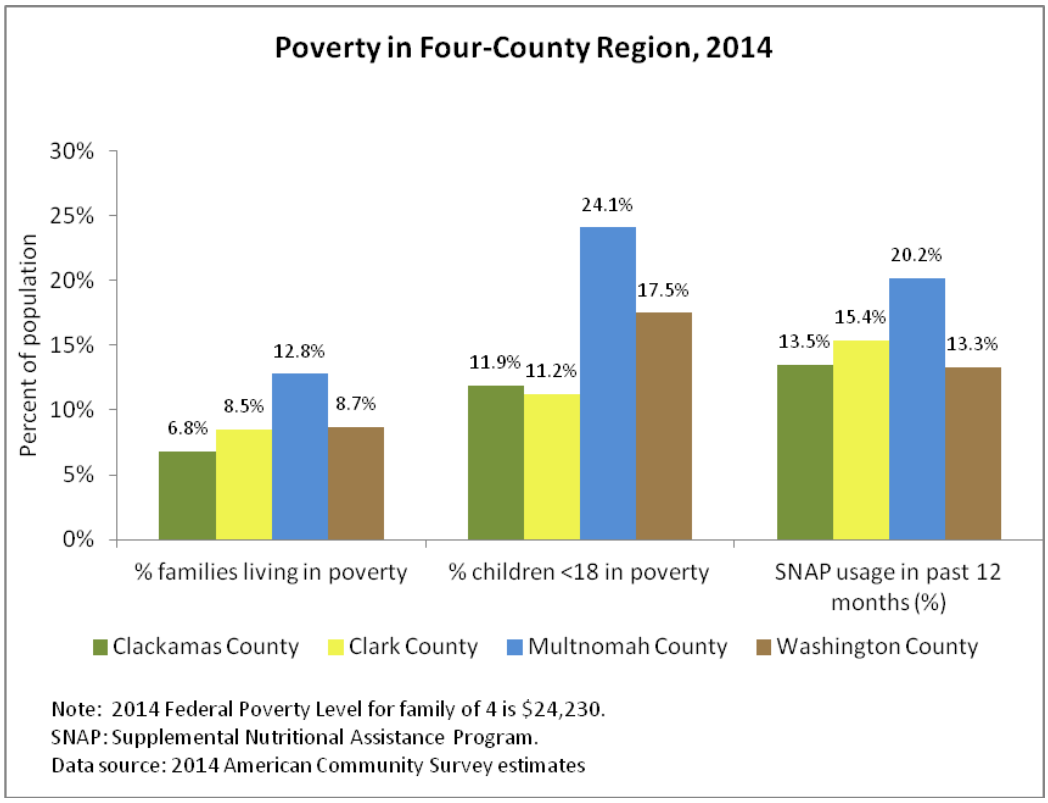
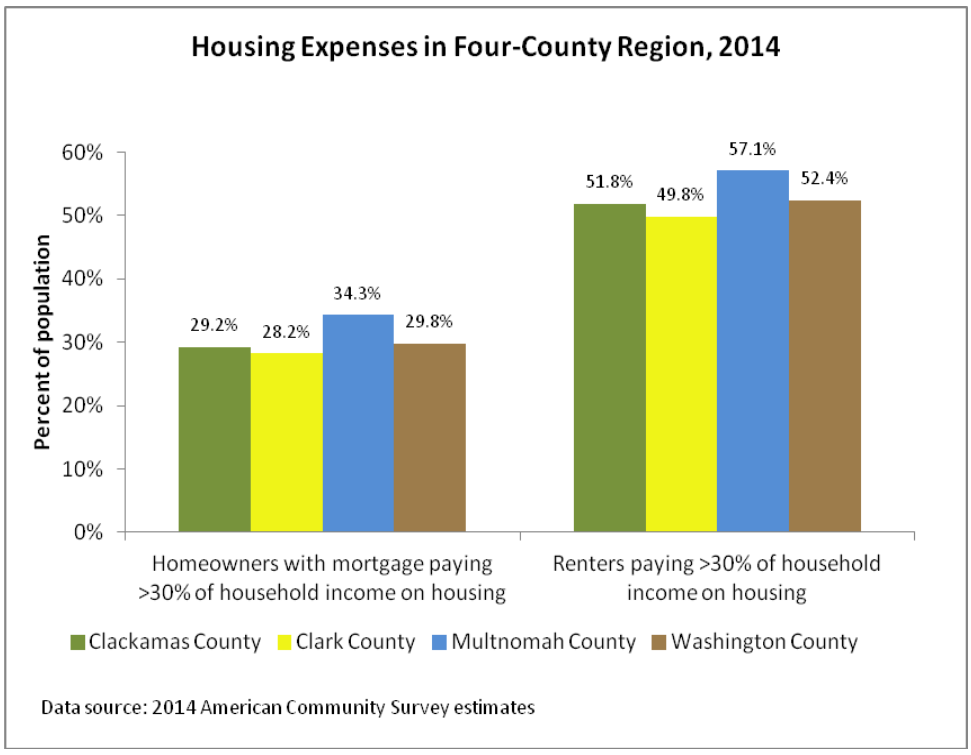


Figure 8: Housing Expenses in the Region



Education

A report in a series exploring the social determinants of health reported strong evidence linking early childhood experiences with a person's health throughout life.[18] Brain, cognitive, and behavioral development in childhood are strongly linked to health outcomes such as cardiovascular disease and stroke, hypertension, diabetes, obesity, depression, and substance use. There is also evidence that children who participate in high-quality early childhood development programs can experience immediate and long-term health benefits. The percentage of children 3 or 4 years old participating in preschool or nursery school programs in the four-county region ranges from a low of 39.1% in Clark County to a high of 49.5% in Multnomah County (*Table 3*).

Educational achievement can predict a child's social and economic future.[19] Research has shown that failure to read proficiently by the end of the third grade can lead to academic difficulties later in school, failure to graduate from high school on time, and a lower chance at economic success later in life.[20] It is less clear how math proficiency affects a child's health and experiences later in life. However, an analysis from a longitudinal study on children from kindergarten through middle school found that early math skills predicted achievement in reading, math, and science and prevented repetition of a grade.[21] Third graders in Washington, Clackamas, and Clark counties performed better than third graders in Multnomah County regarding math and reading proficiency (*Table 4, Figure 10*). Clackamas County had the highest percentage of eighth graders proficient in math (67.2%) and reading (71.1%), with Clark and Multnomah counties having the lowest percentage with proficiency in math (57.6%) and reading (64.1%), respectively.

Educational achievement in adulthood is also highly associated with an individual's potential for a good job, higher income, and better health.[19] Higher educational attainment has been linked with a number of factors, including a longer life, better health outcomes, more positive health-promoting behaviors, and lower infant mortality. Individuals with more education might have greater knowledge of health and, consequently, make more informed decisions regarding issues such as nutrition, exercise, and health and disease management. Individuals with higher education are more likely to be employed and have jobs with healthier working conditions and better benefits. Similarly, individuals with more education have the opportunity for higher paying jobs, allowing them to live in neighborhoods with greater access for physical activity and healthier food. Individuals with higher education are also more likely to have a greater sense of control over their life circumstances (higher self-efficacy), a higher social standing, and more social support, all of which are linked with better health.

Table 4 shows a wide range in the education levels of people living in the four-county region. The percentage of the population with a high school diploma or equivalency ranges from a low of 18.4% in Multnomah County to a high of 25.3% in Clark County. Multnomah County has the highest percentage of people in the four-county region who have at least a four-year degree (41.6%), and Clark County has the lowest (26.9%) (*Figure 8*).

Table 4: Education Indicators

Indicator	County			
	Clackamas	**Clark**	**Multnomah**	**Washington**
Children ages 3-4 years enrolled in public or private preschool or nursery school (%)	44.9	39.1	49.5	45.7
3rd grade students proficient in math (%)	66.1	67.6	57.1	67.9
3rd grade students proficient in reading (%)	71.5	74.9	63.5	71.2
8th grade students proficient in math (%)	67.2	57.6	59.3	65.8
8th grade students proficient in reading (%)	71.1	68.9	64.1	69.9
Highest education attained[a]				
Less than High School graduate (%)	7.2	8.5	8.9	9.7
High School graduate or equivalency (%)	23.1	25.3	18.4	19.8
Some college or associate's degree (%)	36.5	39.3	31.1	30.8
Bachelor's degree or higher (%)	33.2	26.9	41.6	39.7

Sources: 2014 American Community Survey estimate (adult education); 2010-2014 Community Commons using American Community Survey estimates (child enrollment); Annie E. Casey Foundation, Kids Count Data Center (youth math/reading proficiency) (Oregon, 2013-2014; Washington, 2012-2013)

[a]Educational attainment among the population 25 years and older.

Figure 9: Educational Attainment in the Region

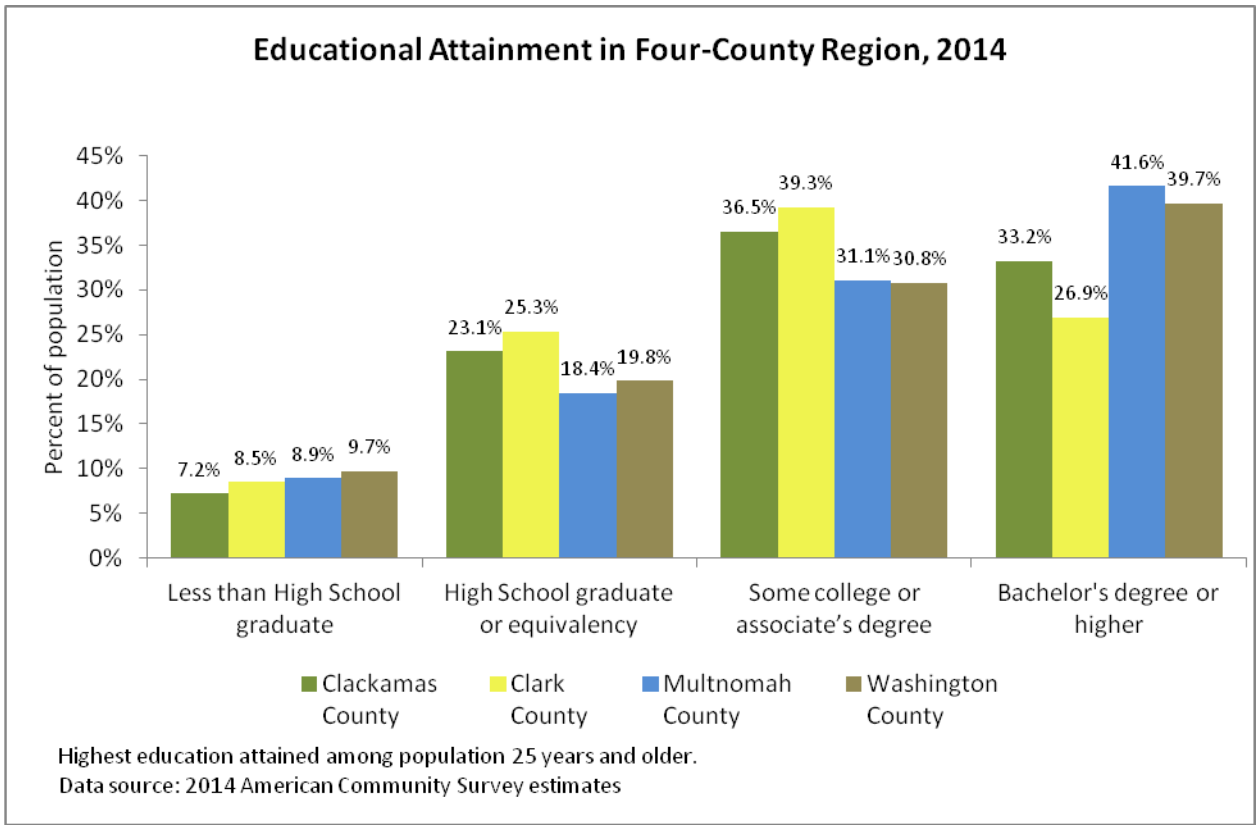
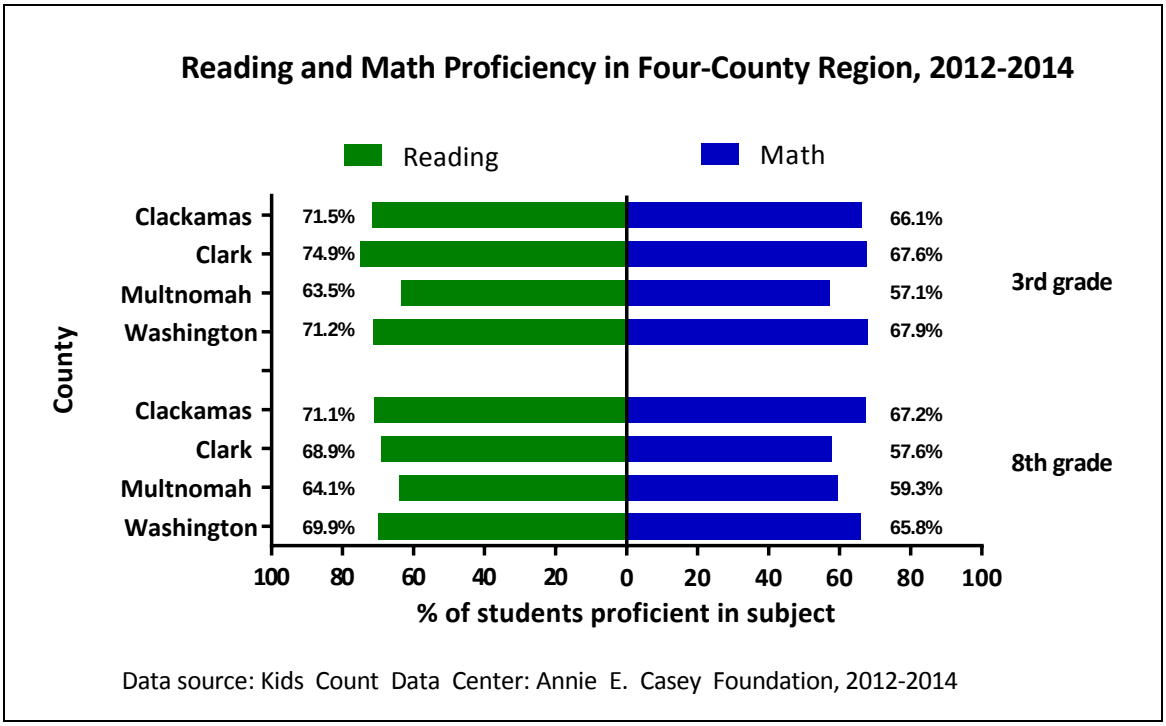


Figure 10: Child and Teen Reading and Math Proficiency in the Region



Neighborhood and built environment

A population's health can be adversely affected by factors that comprise the built environment, such as poor air or water quality, substandard housing conditions, lack of access to nutritious food, few safe places to exercise, ready access to fast food or liquor stores, and dangerous traffic conditions.[22]

Housing serves to provide a place of safety, security, and shelter.[16] However, if housing is of poor quality or with substandard conditions, it can be unhealthy or unsafe. Substandard conditions can include factors such as inadequate plumbing or kitchen facilities or overcrowding. Housing is also a substantial expense; often the largest single monthly expense for families.[23] *Table 5* illustrates the percentage of occupied housing units with one or more of these substandard conditions. Multnomah County had a higher percentage of substandard housing units (42.4%) compared with the other three counties.

A diet of nutritious food is essential for health and is associated with a lower risk of obesity, micronutrient deficiencies, and chronic diseases such as hypertension and diabetes.[24, 25] Limited access to sources of healthy and affordable food can make it harder to maintain a healthy diet. An area where the population has both physical and economic barriers to accessing healthy food is called a food desert.[26, 27] Clark County had the highest percentage (23.2%) of the population living in a low-income census tract and with low access to supermarkets or large grocery stores (*Table 5, Figure 11*).

A long commute to work can have a profound impact on a person's health, including increased levels of stress, increased risk of obesity, less time for physical and social activities, and low back pain.[28] As shown in *Table 5* and *Figure 12*, workers in Clackamas County had the longest commute to work (average of 28.1 minutes), while those in Washington County had the shortest commute (average of 24.7 minutes).

Table 5: Neighborhood and Built Environment Indicators

	County			
Indicator	**Clackamas**	**Clark**	**Multnomah**	**Washington**
Occupied housing units with one or more substandard conditions (% of owner- and renter-occupied housing units)[a]	37.1	36.3	42.4	37.2
Food deserts (% of population in census tracts designated as food desert)[b]	17.0	23.2	13.1	14.7
Travel time to work (average minutes)	28.1	25.3	25.9	24.7

Source: Community Commons using 2010-2014 American Community Survey estimates (substandard housing), Community Commons using 2010 USDA Economic Research Service estimates (food deserts), 2014 American Community Survey estimates (travel time to work)

[a]Substandard conditions are defined as: 1) lacking complete plumbing facilities, 2) lacking complete kitchen facilities, 3) with > 1 occupants per room, 4) selected monthly owner costs as a percentage of household income > 30%, and 5) gross rent as a percentage of household income > 30%.[29]

[b]Food deserts are defined as: a low-income census tract in which a substantial number or share of percentage of residents has low access to a supermarket or large grocery store.[27]

Figure 11: Food Deserts in the Four-County Region

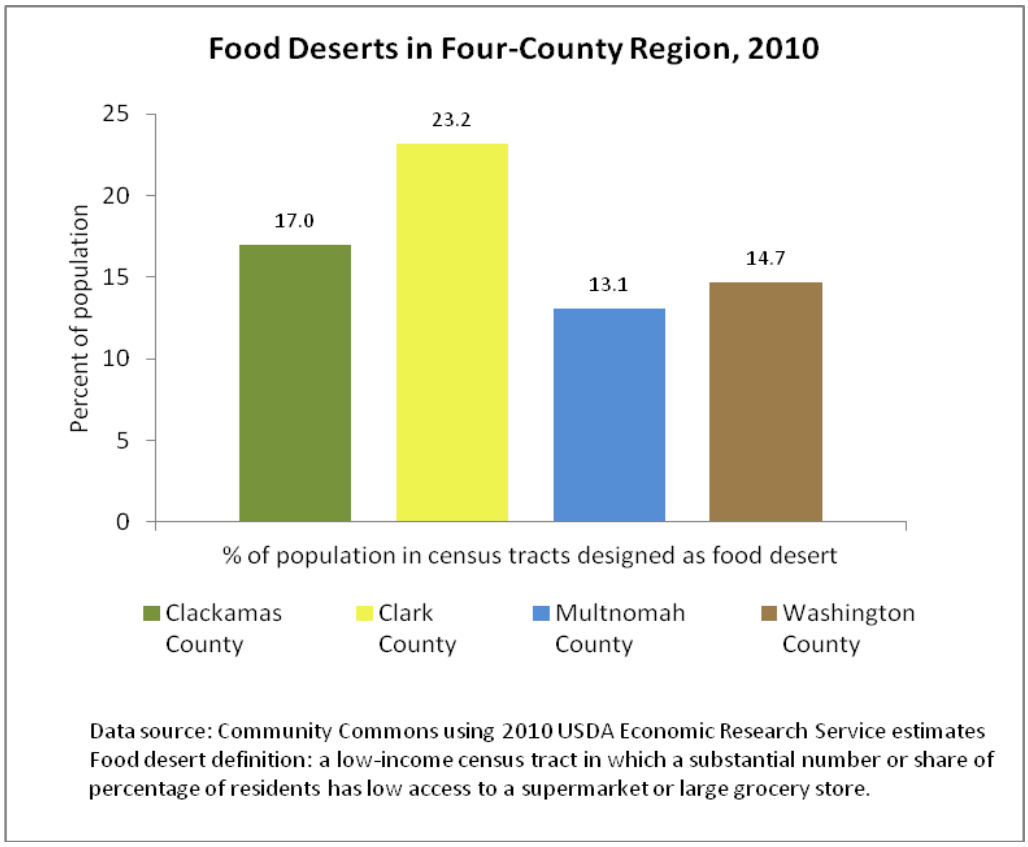
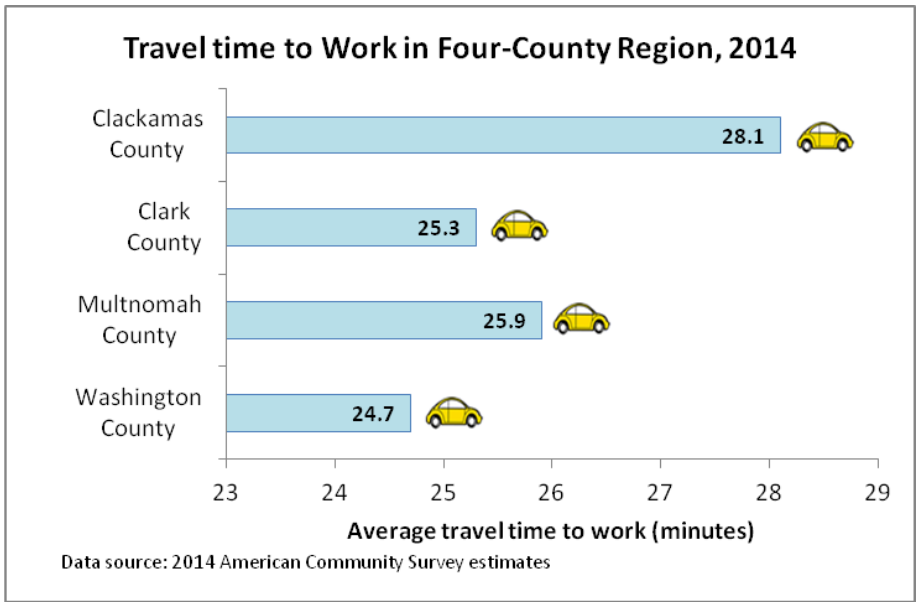


Figure 12: Travel Time to Work in the Region



Health Status Assessment

Introduction

The data in this section came from three assessment components:

1) Population data about health-related behaviors, morbidity, and mortality;
2) Medicaid data from local Coordinated Care Organizations (CCOs) about the most frequent conditions for which individuals on Medicaid sought care in the tri-county region in Oregon (Clark County Medicaid data were not available for this report); and
3) Hospital data for uninsured people who were seen in the emergency department with a condition that should have been managed in primary or ambulatory care.

While the data from these reports are very different, there are several points that standout:

- **Many people suffer from chronic conditions in our region.** Asthma, diabetes, and hypertension were identified as top indicators in all three studies (i.e. population, Medicaid, and hospital data). In the population data, high cholesterol, obesity/overweight, and heart disease were also identified as priority health issues. Health behaviors often seen as related to these conditions, such as lack of physical activity and lack of fruit and vegetable consumption, ranked highly in the population data.
- **Mental health conditions affect many people in our region.** Attention deficit disorder and post-traumatic stress disorder were identified as frequently diagnosed conditions for children on Medicaid. Depression was identified as a priority health issue for adults on Medicaid, as well as for the general population, through population health surveys. Suicide was identified as a priority health issue based on the population data on mortality.
- **Substance use and abuse are common in our region.** Alcohol-induced and drug-induced deaths emerged as top mortality indicators in the population health data. Non-transport accidents, which included accidental overdose deaths, also ranked highly in the population mortality data. Risky health behaviors included high rates of binge drinking; smoking; and alcohol, marijuana, and vaping and e-cigarette use specifically among teens.
- **Cancers of various types are prevalent in our region.** Several types of cancer, including leukemia and lymphoma, non-Hodgkin's lymphoma, breast, colorectal, lung, skin, thyroid, kidney-related, uterine, bladder (among others) ranked as top indicators in the region.

The *Health Status Assessment* presents regional data; county-specific data are included in the appendices of this report. Each data set had different methodologies, findings, and limitations; these are explained in the respective sections below.

A *Glossary of Terms* with definitions can be found in *Appendix A*.

Population Data (Health-Related Behaviors, Morbidity, Mortality)

Introduction

The HCWC Epidemiology Workgroup (the Workgroup) was established to develop and implement a systematic approach to screening and prioritizing quantitative population health data. The Workgroup consisted of epidemiologists from the four county health departments (Clackamas, Clark, Multnomah, and Washington counties) and the Collaborative's epidemiologist. Quantitative health status assessment findings, combined with qualitative data from local communities, provide the HCWC Leadership Group with information necessary to help select health priorities and develop improvement strategies within the communities they serve.

The health behavior, morbidity, and mortality indicators presented in the "Findings" section are the top-ranked indicators for the four-county region based on a systematic analysis and prioritization of available indicators (refer to the "Methods" section below for details). Top-ranked health behavior, morbidity, and mortality indicators for individual counties are located in the appendices. The indicators are listed alphabetically in each table. Socioeconomic and other societal conditions as determinants of population health are presented in the "Social Determinants of Health" section.

Methods

The health status assessment required a systematic examination of population health data to identify health issues faced in the community. The Workgroup's health status assessment focused its analytic efforts on health behavior, morbidity, and mortality outcomes.

The Workgroup compiled a list of health indicators that were analyzed and prioritized systematically, based on a predetermined set of criteria. To be prioritized as a health issue, the data for each health indicator had to be available at the county level for all four counties and for at least four out of six possible criteria (refer to the "Prioritization of Health Indicators" section). Data sources included vital statistics, disease and injury morbidity data, cancer registry data, and adult and student survey data. Health indicators were considered for prioritization if they were 1) identified as important indicators by public health and other local experts, 2) a top-ten leading cause of death in one of the counties, 3) a top-ten cancer incidence in one of the counties, or 4) identified in a gap analysis performed after the 2013 CHNA.

Selection of indicators

Survey data

Adult and teen health indicators were selected from available national and state health surveys. These included the Behavioral Risk Factor Surveillance System (BRFSS), Oregon Healthy Teens Survey (Oregon student survey), and the Washington Healthy Youth Survey (Washington student survey). A total of 25 adult indicators and 15 youth indicators were analyzed and included for prioritization.

Leading causes of death

The top National Center for Health Statistics (NCHS) leading causes of death were determined for each county. The deaths with the ten highest rates were included for prioritization. In addition, the top ten subsets of the leading causes of death were included for prioritization. For example, malignant neoplasm (cancer) is an NCHS leading cause of death and the subsets with the highest death rates might include prostate cancer,

female breast cancer, and pancreatic cancer. The final list of indicators considered for prioritization included all top indicators for each county.

Cancer incidence

The top National Cancer Institute (NCI) cancer incidence indicators were determined for each county. A common list combining all top indicators from the four counties was considered for prioritization. In addition, other cancer incidence indicators were considered if there were available data for a cancer with an associated screening test recommended by national guidelines or if the cancer was in the leading cause of death malignant neoplasm subset.

Indicators of public health significance identified by colleagues

To ensure meaningful representation of health indicators across program areas, the Workgroup solicited input from subject matter experts (SMEs) on the best indicators to represent their area of expertise. SMEs were asked to provide county-level health indicators, including health behavior and health outcomes, to consider for prioritization in the CHNA. Suggested indicators were included if data were available for each county and with a granularity sufficient for inclusion in the prioritization matrix.

Gap analysis

A gap analysis was conducted after the completion of the 2013 CHNA to identify additional health indicators to include in the 2016 CHNA. These health indicators were identified through conversations with HCWC member organizations, community input, and subject matter experts. The analysis identified gaps in the population data including health issues such as obesity, oral health, and breastfeeding.

Prioritization of health indicators

Each of the indicators was assigned points based on the scoring system for the six criteria in *Table 6.* The points were then added up for each indicator for a maximum of six points for the "worst" score possible and zero points for the "best" score possible. If data were not available to evaluate an indicator on at least four of the six criteria, the indicator was excluded from prioritization. Data not available for one or two criteria were imputed using data from the existing criteria. The imputed point value for a missing criterion was the average of the existing point values for that indicator. The highest score meant a health indicator had a disparity by race/ethnicity, a disparity by gender, a worsening trend, a worse rate at the county level compared to the state, a high proportion of the population affected, and a severe health consequence.

Ultimately, 104 health indicators were evaluated by the six criteria and included for prioritization for the region and each of the four counties: 41 health behavior indicators, 39 morbidity indicators, and 24 mortality indicators.

All indicators were scored and ranked in descending order for each county. The average of the county scores was calculated to create a regional score for each indicator; the regional ranking was then created in the same manner as the county rankings. Each category of health indicator (health behavior, morbidity, and mortality) was ranked separately for each county and the overall region. The top indicators for the four-county region are included in the "Findings" section; the top indicators for each county are in the appendices.

Table 6: Prioritization of Health Indicators

Criterion and Definition	Scoring	Determination of Score
Disparity by race/ethnicity Are there disparities by race/ethnicity?	0 = No disparity 1 = Disparity Reference population: White, non-Hispanic	Statistical significance[a]
Disparity by sex Are there disparities by sex?	0 = No disparity 1 = Disparity Reference population: male	Statistical significance[a]
Trend over time What is the pattern of the trend over the last 5 to 10 years?	0 = Improving 0.5 = No change 1 = Worsening	Statistical significance[a]
Relative comparison to the state estimate When comparing the county value to the state value, what is the disease burden?	0 = Better 0.5 = Same 1 = Worse	Statistical significance[a]
Magnitude Is a large percentage of the population affected, relative to the comparison group?	0 = No 1 = Yes	Mortality and cancer incidence: in top 10 list Survey data: prevalence ≥ 10% of at-risk population All other data, including "all cancer" mortality and incidence: rate ≥ 100/100,000/year
Severity What is the severity of the health issue?	<u>Morbidity or Mortality Indicators</u> 0 = Curable and/or with minor sequellae with proper medical treatment 0.5 = Survivable and treatable but associated with permanent health consequences 1 = Immediate death or not treatable <u>Health Behavior Outcomes</u> 0 = No inherent harm with potential for minimum harm 0.5 = Actual harm that is not immediate [or no actual harm] with potential for more than minimal harm that is not immediate 1 = Immediate jeopardy to health or safety	Pre-defined by definitions of each score

[a]Statistical significance is a statistical property of an observation or an estimate that is unlikely to have occurred by chance alone. Statistical significance was determined using a p-value < .05 from a chi-square test or regression analysis or using non-overlapping 95% confidence intervals.

Statistical methods

As data granularity allowed, indicators included in the CHNA were evaluated along the lines of statistically significant disparity by sex, race/ethnicity, trend over time, and comparison to the respective state value. Indicators were also evaluated for magnitude and outcome severity by other pre-defined criteria, though not for statistical significance.

Rates

Rates were calculated using the Oregon Public Health Assessment Tool (OPHAT) and Washington Community Health Assessment Tool (CHAT) or similar methods. Mutually exclusive NCHS sex, race, and ethnicity categories were used when possible. Mortality and cancer incidence rates were age-adjusted to the 2000 US standard population and calculated per 100,000 per population per year. Birth rates were calculated per 100 births per population per year. Indicators with county rates of fewer than five events in the numerator or with a relative standard error over 30% were not considered for assessment. Rates for sex or race/ethnicity with less than these minimum requirements were imputed. Prevalence was calculated for survey data and also age-adjusted to the 2000 US standard population.

Rates with associated p-values from a chi-square test or regression analysis, if available, or 95% confidence intervals were compared for statistical significance across the NCHS race, ethnicity, and sex categories. If p-values were less than .05, the difference between categories was statistically significant and considered a disparity. If p-values were not available, non-overlapping 95% confidence intervals between categories indicated a statistically significant difference and a disparity.

Trends

To determine statistical significance for trends, a chi-square test or regression analysis was performed. A p-value of less than .05 was considered significant. Between 5 and 10 years of data were used to determine trend significance, as data were available. The beta coefficient from simple regression was used to determine the direction of the change in trend. Due to a change in methodology by the CDC (implemented in 2011 for the U.S. and Washington state, in 2010 for Oregon), BRFSS trend data were unavailable at the time of analysis.

Comparison to state value

County level rates were compared to the respective state value for each indicator. If the p-value was less than .05 or there was no overlap in the 95% confidence intervals between county and state values, the difference was considered statistically significant. For Washington State adult and youth survey data, statistical significance was determined by regression analysis and a p-value of less than .05 was considered significant.

Findings

Health behaviors

Behaviors, such as substance use or misuse, lack of regular exercise, and an unhealthy diet, contribute to a person's overall health status and can influence negative health outcomes. Use or misuse of alcohol, marijuana, and cigarettes were identified as top high-risk behaviors in the four-county region (*Table 7*). Teen use of e-cigarettes or vaping products was a top indicator in the region and in Clackamas and Washington counties. Lack of physical activity and fruit and vegetable consumption were high-risk health behaviors in the region and all four counties.

Access to health care and preventive services, such as vaccinations, have the potential to help people live longer and avoid disease and disability, while potentially reducing long-term costs. Not having a usual source of health care for adults was a top indicator in the region and all four counties. Also, underuse of preventive services, such as a flu shot (all adults) and pneumonia vaccination (adults over 65 years), were top indicators in the region.

Some health behavior indicators were top ranked indicators in a specific county or counties, but did not reach the top ranking list for the four-county region. For instance, top indicators for individual counties included prescription drug abuse (Clackamas County), current smoking among pregnant women (Clark County), and inadequate early prenatal care (Washington County). Insufficient dental visits among teens or adults was a top indicator in each of the four counties, but did not make it to the list of top ten indicators in the region.

Table 7: Top Health Behaviors in the Region

Regional Health Behaviors
Alcohol use in teens[a]
Binge drinking in adults and teens[b]
Current cigarette smoking in adults
E-cigarettes/vaping products use in teens[b]
Fruit/vegetable consumption in teens [a] and adults
Marijuana use in teens[b]
Physical activity in teens[a,b]
Received flu shot in adults
Received pneumonia vaccination in adults over 65 years
Usual source of health care in adults

Indicators are listed in alphabetical order, not in order of rank.
[a]8th graders [b]10th (WA) or 11th (OR) graders

Morbidity

Morbidity refers to the unhealthy state of an individual arising from disease, illness, injury, or disability. Top ranked indicators for various types of morbidity are presented in this section, including chronic diseases, infectious diseases, chronic conditions, and mental health.

Chronic diseases, including asthma and various types of cancer, were top ranked indicators in the region (*Table 8*). High blood pressure and high cholesterol were top ranked indicators in the region and in

Multnomah and Clackamas counties. Obesity/overweight was in the top rankings for the region and all four counties.

Chlamydia was the only top-ranked infectious disease indicator in the region and in Clark, Multnomah, and Washington counties. One mental health indicator (depression) was a top indicator in the region and all four counties.

Some morbidity indicators were top ranked indicators in a specific county or counties, but did not reach the top ranking list for the four-county region. For instance, top indicators for individual counties included chronic Hepatitis C (Clark and Multnomah counties), preterm births (Clark County), and diabetes (Clackamas County).

Table 8: Top Morbidity Outcomes in the Region

Regional Morbidity
Asthma in adults
Bladder cancer incidence
Breast cancer incidence among all females
Chlamydia incidence
Colorectal cancer incidence
Depression in adults
High blood pressure in adults
High cholesterol in adults
Kidney/renal pelvis cancer incidence
Lung, trachea, bronchus cancer incidence
Melanoma (skin) cancer incidence
Non-Hodgkin's lymphoma cancer incidence
Obesity/overweight in teens[a] and adults
Thyroid cancer incidence
Uterine cancer incidence among all females

Indicators are listed in alphabetical order, not in order of rank. Unless otherwise specified, the indicators include data for the entire population.
[a] 10^{th} (WA) or 11^{th} (OR) graders

Mortality

Mortality is death due to disease, substance misuse, or injury.

Mortality due to disease, including cancer, diabetes, heart disease, chronic liver disease/cirrhosis, and Alzheimer's disease, were top-ranked causes in the region (*Table 9*). Alcohol- or drug-induced deaths were top-ranked causes of mortality in the region and in all four counties. Deaths due to non-transport accidents (e.g., falls or unintentional poisoning) were top-ranked causes of mortality in the region and in Clackamas, Clark, and Multnomah counties. Suicide mortality was a top-ranked indicator in the region and all four counties.

Some causes of death were top-ranked indicators in a specific county or counties, but did not reach the top-ranking list for the four-county region. For instance, top indicators for individual counties included chronic lower respiratory disease (Clackamas, Multnomah, and Washington counties); essential hypertension and hypertensive renal disease (a form of high blood pressure) (Clackamas County); and lung, trachea, and bronchus cancer (Clark and Multnomah counties).

Table 9: Top Mortality Outcomes in the Region

Regional Mortality
Alcohol-induced[a]
Alzheimer's disease
Breast cancer among all females
Chronic liver disease and cirrhosis
Diabetes
Drug-induced[a]
Heart disease
Lymphoid, hematopoietic, related tissue cancer
Non-transport accidents[b]
Suicide

Indicators are listed in alphabetical order, not in order of rank. Unless otherwise specified, the indicators include data for the entire population.
Deaths are categorized according to the underlying (or primary) cause-of-death on the death certificate. In addition to the underlying cause, death certificates list up to twenty contributing causes of death.
[a]Drug-induced and alcohol-induced death estimates include underlying and contributing causes of death, independent of intent (i.e., natural, homicide, suicide, accidental, or undetermined).
[b]Non-transport accident mortality major category includes deaths due to falls or unintentional poisoning.

Limitations

When using the population data in this CHNA, keep in mind the limitations described below.

Data collection

Each source of data—whether a national/state survey, vital records, or any other source—has its own limitations. For example, health behavior data included in this assessment were based on answers from self-reported national/state surveys and therefore may be affected by recall or response bias. It is important to review known limitations from each data source (see references at the end of this report) before interpreting the data.

Granularity

The data available for this assessment were analyzed at the county level, which allowed application of the prioritization criteria in a consistent manner.

Data availability

The health outcome and behavior indicators analyzed in this CHNA reflected data available to each of the four counties. It was evident that the Collaborative would not be able to assess certain important health areas with this collection of indicators. Thus, these areas with data gaps are not represented by the

quantitative analysis findings. For example, mental health, oral health, youth, LGBTQ (lesbian, gay, bisexual, transgender, queer, or questioning), and some health morbidity data were very limited or not available at all. The Collaborative attempted to fill some of these gaps through the community engagement data (presented in the *Community Themes and Strengths* section of this report) and will continue to investigate the availability of these types of data for inclusion in the next assessment.

Statistical analysis

Results based on certain criteria were suppressed when statistical analysis was unstable due to low counts.

Rate comparison

For purposes of comparison across geographic areas in the appendix tables, age-adjusted rates were used. Age-adjusted rates were calculated using the US 2000 Standard Population. Although age-adjusted rates may not reflect the actual burden of disease or risk factor in a population, they are necessary for comparisons between counties. Rates that are not age-adjusted (e.g., crude rates) should not be compared to age-adjusted rates.

HCWC Hospital & Medicaid Data Report

Introduction

As an addition to the 2013 CHNA, HCWC member organizations expressed interest in accessing and analyzing quantitative data from participating hospital systems, Coordinated Care Organizations (CCOs) in Oregon, and Medicaid Managed Care Organizations in Washington. A workgroup comprised of hospital and CCO representatives determined that additional data available from hospitals and CCOs/Medicaid could provide:

- More granular-level data than common indicator data sources
- More recent data
- New or additional information for health issues that may not be included in common indicator data, but is meaningful and of interest
- Greater levels of detail about the health of vulnerable subpopulations of the four-county community, especially people who experience health inequities

The hospital and administrative Medicaid claims data enhanced the Collaborative's ability to answer the research question, "What are the major health issues faced by the community?" The workgroup examined data from two sources: 1) self-pay or uninsured hospital patients and 2) populations who are medically underserved and/or who are very low income (adults with incomes at or below 138% Federal Poverty Level; children from households at or below 305% Federal Poverty Level), who are eligible to receive insurance coverage through Medicaid. By examining patterns of health care utilization among these populations we could better understand needs while focusing on differences between geography, age, gender, race/ethnicity, language preference, and other meaningful differences wherever practical in order to identify avoidable disparities.

This section of the *Health Status Assessment* describes the methods and procedures used by members of the Hospital & Medicaid Data Workgroup (the Workgroup) in order to validate and document the process. The Findings and Limitations sections describe and interpret the data presented in this report, while acknowledging opportunities for improvement. The Workgroup was not able to access data from Washington state Medicaid organizations for the 2016 CHNA, so this report includes Medicaid data from the tri-county region in Oregon only.

Medicaid Data

Determining scope

The Workgroup recognized the need to limit the scope of work and determine primary focus areas within the hospital and CCO/Medicaid data in order to be effective. Following an iterative process that balanced practicality (What data are accessible and simple to analyze?) with meaning (What data are meaningful for identifying priority health needs?), the Workgroup narrowed its focus for Medicaid data to the following parameters:

- **Population:** Adults (19 and older) and youth (0 -18) who are enrolled in the Oregon Health Plan (OHP) and assigned either to FamilyCare or Health Share of Oregon (Health Share), the two CCOs serving the tri-county region of Oregon.

- **Time period:** Utilization between April 1, 2014 – March 31, 2015; Diagnosis between March 31, 2012 – March 31, 2015
- **Data inclusion criteria:** Diagnostic codes derived from administrative Medicaid claims data. Unduplicated count of patients.
- **Chronic conditions and risk factors:** The Workgroup performed analysis of the top three chronic conditions and/or risk factors diagnosed among adults and youth separately that are currently monitored by Health Share and FamilyCare.

Methods

Selection of diagnosis codes

The Workgroup aimed for consistency and precision in the selection of diagnostic codes for the purpose of identifying chronic conditions and risk factors among each Medicaid CCO or plan's population. Referring to ICD-9 codes (a standardized list of codes used for diagnoses) was appropriate given the study's time frame.

The ICD-9 diagnosis codes utilized by the Workgroup were selected through a process that began with understanding how the Oregon Health Authority's Division of Medicaid Assistance Program (DMAP) categorizes diagnosis codes for chronic conditions. Analysts from FamilyCare and Health Share refined these definitions. *Table 10* outlines the ICD-9 diagnostic codes used in this analysis.

Table 10: Medicaid Data ICD-9 Diagnostic Codes

Condition/Risk Factor	**ICD-9 Diagnostic Codes**
Asthma	493.xx
Attention deficit disorder (ADD)	314.xx
Chronic liver disease/ cirrhosis	571.x, 571.4x, 571.5, 571.6, 571.8, 571.9
Depression	296.2x, 296.3x, 298.0
Diabetes	250.xx, 357.2, 362.01, 362.02, 366.41
Hypertension	401.0x, 402.0x, 403.0x, 404.0x, 405.0x
Obesity	278.0x, V85.3x,V85.4, V85.53, V85.54
Post-traumatic stress disorder (PTSD)	309.81 20120217: 995.52, 995.54
Schizophrenia	295.xx, 298.4, 299.1x, 299.9x
Tobacco use	305.1

Individuals enrolled in a Medicaid plan or CCO who were flagged with any of the above conditions must have had two or more different claims with the listed diagnostic code during the time period referenced above. These claims did not need to be limited to primary diagnosis (the main reason the individual was seen). For future assessments, review of the codes will be necessary, as diagnostic codes are updated every October.

Minimum reporting

To ensure confidentiality and data reliability in reporting the top three conditions at the county level, and at any substrata, a minimum of 11 counts in the numerator and 30 counts in the denominator was required.[30, 31] No information was made publicly available about the diagnosis, race/ethnicity, sex, age, or geographic level below the county level.

Demographic data

- **Geography:** Clackamas, Multnomah, and Washington counties in Oregon.
- **Age:** Adults were 19 years and older; youth were counted from birth/0 through 18 years and 364 days.
- **Gender:** Counts of people identified as male or female; additional data to include transgender population is not yet available.
- **Race and Ethnicity:** Categories included White/Caucasian non-Hispanic; Black/African American non-Hispanic; American Indian/Alaska Native non-Hispanic; Asian/Pacific Islander non-Hispanic; Hispanic; and unknown. These categories were constrained by current limitations within Medicaid enrollment data within Oregon's system and will improve over time.
- **Language:** The top spoken languages in addition to English were identified. Among adults, the top spoken languages were English, Spanish, Russian, Vietnamese, and Chinese (including Cantonese and Mandarin). Among youth, the top spoken languages were English, Spanish, Russian, Vietnamese, and Somali. Primary language was also a way the CCO data could describe immigrant/refugee/newcomers among our population.

Data validation

A robust data validation process should include checks for accuracy, validity, and completeness. Although a thorough validation of the Medicaid data used by the CCOs was desirable, resource and time constraints for this effort required a more basic approach. The Providence Center for Outcomes Research & Education (CORE) validated some of the Medicaid administrative claims data that were processed for Health Share of Oregon. FamilyCare's Medicaid administrative claims data was validated against the source data and reviewed for accuracy by internal groups.

Analysis

Adult and youth chronic conditions data from both CCOs were combined for each of the three Oregon counties. Percentages were then calculated for each health indicator, including substrata, and the percentages were age-adjusted to the 2000 U.S. Standard Population. No testing for statistically significant differences across counties or among substrata was performed. The three health indicators for adults and youth were ranked for each county using the overall percentages. The regional ranking for the three health indicators was calculated using the average county rank.

Findings

The two sections below (*Adult chronic conditions* and *Youth chronic conditions*) provide information about FamilyCare's and Health Share's OHP members and the chronic conditions for which they seek care. Full data tables are available in *Appendix D*.

Adult chronic conditions (Medicaid data)

The three most frequently diagnosed chronic conditions among adults with OHP during the reporting period (April 2014-March 2015) were hypertension/high blood pressure, diabetes, and depression. Each condition is explored through the graphs, with limited interpretation below. Low prevalence of a diagnosis may indicate lack of engagement in health care, rather than lower prevalence of the condition. Cultural norms can also play a role in health care engagement and diagnosis, particularly around mental illness.

Adults with hypertension/high blood pressure

Prevalence of diagnosed high blood pressure among CCO members is shown in *Figure 13*, stratified by race/ethnicity, language, and gender. High blood pressure can lead to serious conditions, including heart disease and stroke, or death. Black/African American non-Hispanic adults experienced the highest prevalence of hypertension compared with other races/ethnicities (27.8% in Clackamas County, 30.7% in Multnomah County, and 27.5% in Washington County). For some groups, the prevalence of diagnosed high blood pressure was low, such as among CCO members who speak Vietnamese.

Adults with diabetes

Prevalence of diagnosed diabetes among CCO members is shown in *Figure 14*, stratified by race/ethnicity, language, and gender. The highest prevalence of diabetes was found among Black/African American non-Hispanic adults in Multnomah County (14.7%) and Clackamas County (18.0%), and American Indian/Native American non-Hispanic adults in Washington County (16.1%). In Clackamas County, the prevalence of diagnosed diabetes among Black/African Americans (18%) was nearly twice as high as the prevalence of diagnosed diabetes among White/Caucasian non-Hispanic adults (9.9%).

Adults with depression

Prevalence of diagnosed depression among adult CCO members is shown in *Figure 15*, stratified by race/ethnicity, language, and gender. American Indian/Alaska Native non-Hispanic adults in Multnomah County (15.3%) and Washington County (12.3%) and Black/African American non-Hispanic adults in Clackamas County (13.5%) had the highest prevalence of diagnosed depression. The prevalence of diagnosed depression among Asian/Pacific Islander non-Hispanic adults within each county was low compared with other races/ethnicities. Females in all counties had a higher prevalence of depression (range 10.9%-12.1%) compared with males (range 6.2%-6.5%).

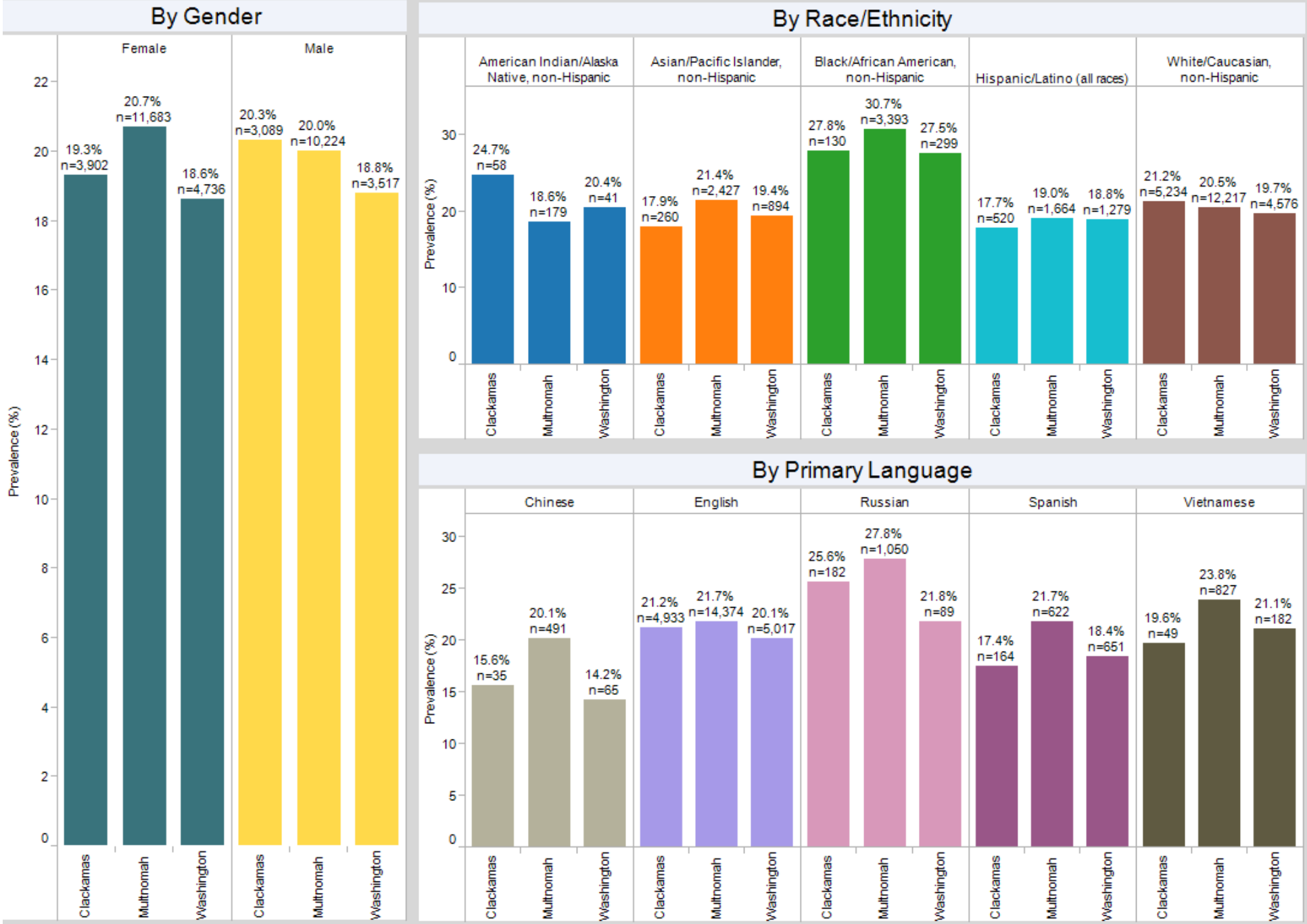
On the following pages:

Figure 13: Adult Hypertension Diagnosis Prevalence among CCO Members

Figure 14: Adult Diabetes Diagnosis Prevalence among CCO Members

Figure 15: Adult Depression Diagnosis Prevalence among CCO Members

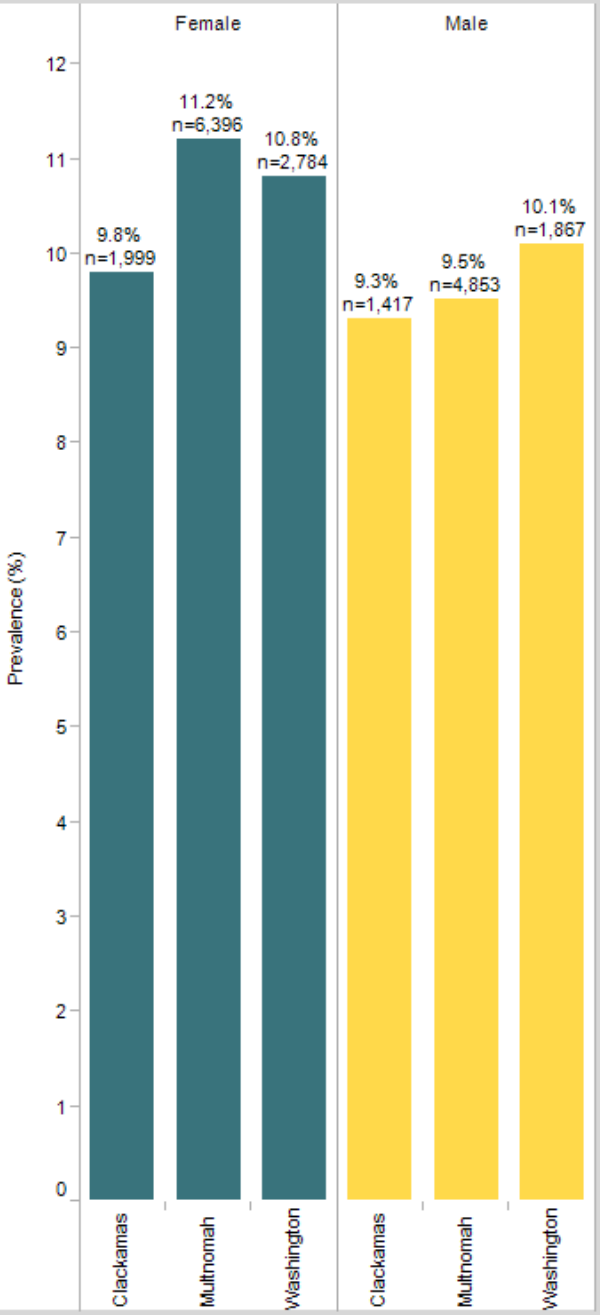
Adult Hypertension Diagnosis Prevalence Among CCO Members



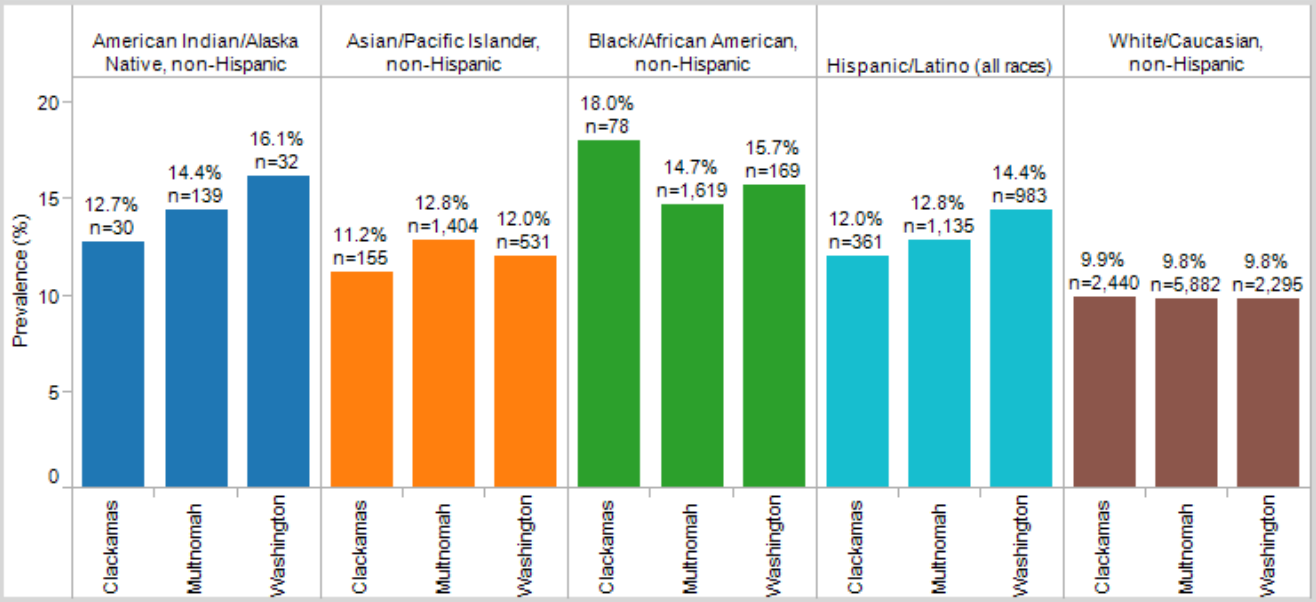
Data reflects members insured by a CCO on 6/15/15 and diagnosed March 2012-March 2015. "n" represents number of members diagnosed with condition. Prevalence is age-adjusted to 2000 US Standard Population. Unknown race/ethnicity or language are excluded from graph. Data suppressed when numerator < 11 or denominator < 30 to ensure patient confidentiality and data reliability.

Adult Diabetes Diagnosis Prevalence Among CCO Members

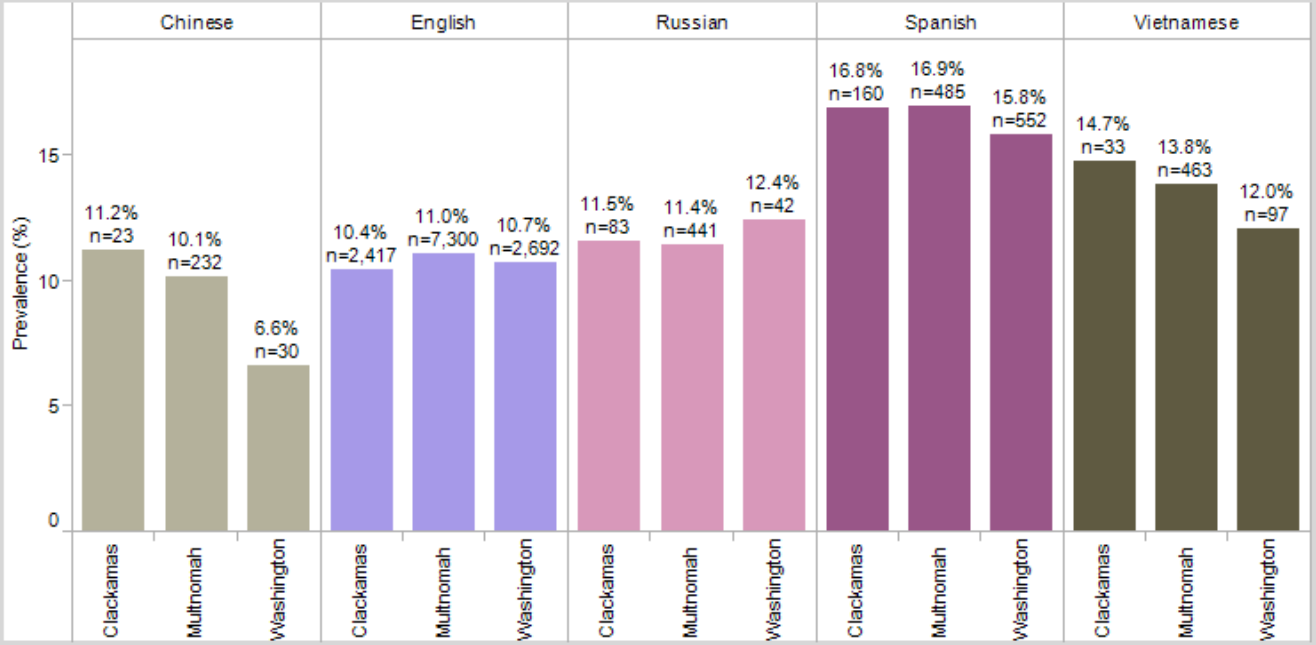
By Gender



By Race/Ethnicity

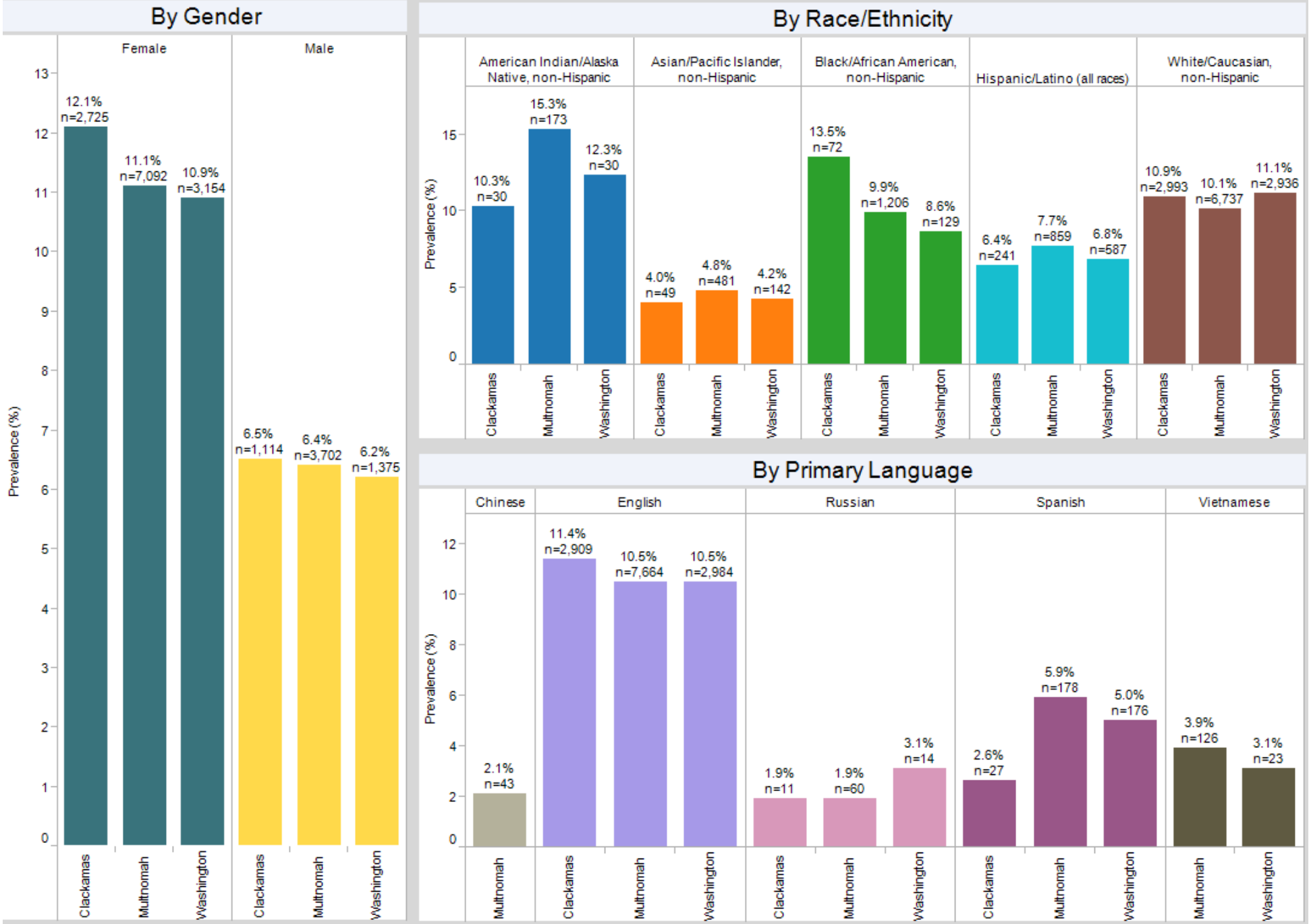


By Primary Language



Data reflects members insured by a CCO on 6/15/15 and diagnosed March 2012-March 2015. "n" represents number of members diagnosed with condition. Prevalence is age-adjusted to 2000 US Standard Population. Unknown race/ethnicity or language are excluded from graph. Data suppressed when numerator < 11 or denominator < 30 to ensure patient confidentiality and data reliability.

Adult Depression Diagnosis Prevalence Among CCO Members



Data reflects members insured by a CCO on 6/15/15 and diagnosed March 2012-March 2015. "n" represents number of members diagnosed with condition. Prevalence is age-adjusted to 2000 US Standard Population. Unknown race/ethnicity or language are excluded from graph. Data suppressed when numerator < 11 or denominator < 30 to ensure patient confidentiality and data reliability.

Youth chronic conditions (Medicaid data)

The top three diagnosed chronic conditions among youth with Medicaid during the reporting period (April 2014-March 2015) were asthma, attention deficit disorder, and/or post-traumatic stress disorder. Each condition is explored through the graphs and limited interpretation below. As stated in the section above, low prevalence of diagnosed conditions for certain populations may indicate lack of access to primary care, rather than lower prevalence of the conditions overall. In other words, it is probably true that there are youth experiencing these conditions that are not being diagnosed.

The Hospital & Medicaid Data Workgroup also analyzed the top three diagnosed conditions among youth stratified by utilization of physical, mental, and oral health services, and by obesity as co-morbidity. These data are included in *Appendix D*.

Youth with asthma

Asthma was the most prevalent chronic condition among youth who received Medicaid coverage through a CCO and sought care. Prevalence of diagnosed asthma among children with Medicaid is shown in *Figure 16*, stratified by race/ethnicity, language, and gender. Nationally, public health data demonstrate that boys have a higher prevalence of asthma than girls; this is also shown in the local CCO data.[32] The prevalence of diagnosed asthma is highest among Black/African American non-Hispanic youth in all three counties. In 2011, 7.8% of all youth 0-17 in Oregon had asthma.[33]

Youth with attention deficit disorder (ADD)

Prevalence of diagnosed attention deficit disorder (ADD) among youth with Medicaid is shown in *Figure 17*, stratified by race/ethnicity, language, and gender. Low prevalence of diagnosed ADD may also indicate a lack of appropriate diagnosis through primary care or mental health services. The prevalence varies significantly by race, ethnicity, and language among children with Medicaid as shown in the graph. Male youth have a higher prevalence of diagnosed ADD than female youth.

Youth with post-traumatic stress disorder (PTSD)

Prevalence of diagnosed post-traumatic stress disorder (PTSD) among youth with Medicaid is shown in *Figure 18*, stratified by race/ethnicity, language, and gender. PTSD is diagnosed after a person experiences symptoms of trauma for at least one month following a traumatic event and is characterized by three main types of symptoms: re-experiencing the trauma through intrusive distressing recollections of the traumatic event(s), flashbacks, and nightmares. Diagnostic criteria for PTSD diagnosis among youth also include other behaviors such as irritability and sleep disturbance. Among CCO members, Native American/Alaska Native non-Hispanic youth have the highest prevalence of diagnosed PTSD compared with other race/ethnicities.

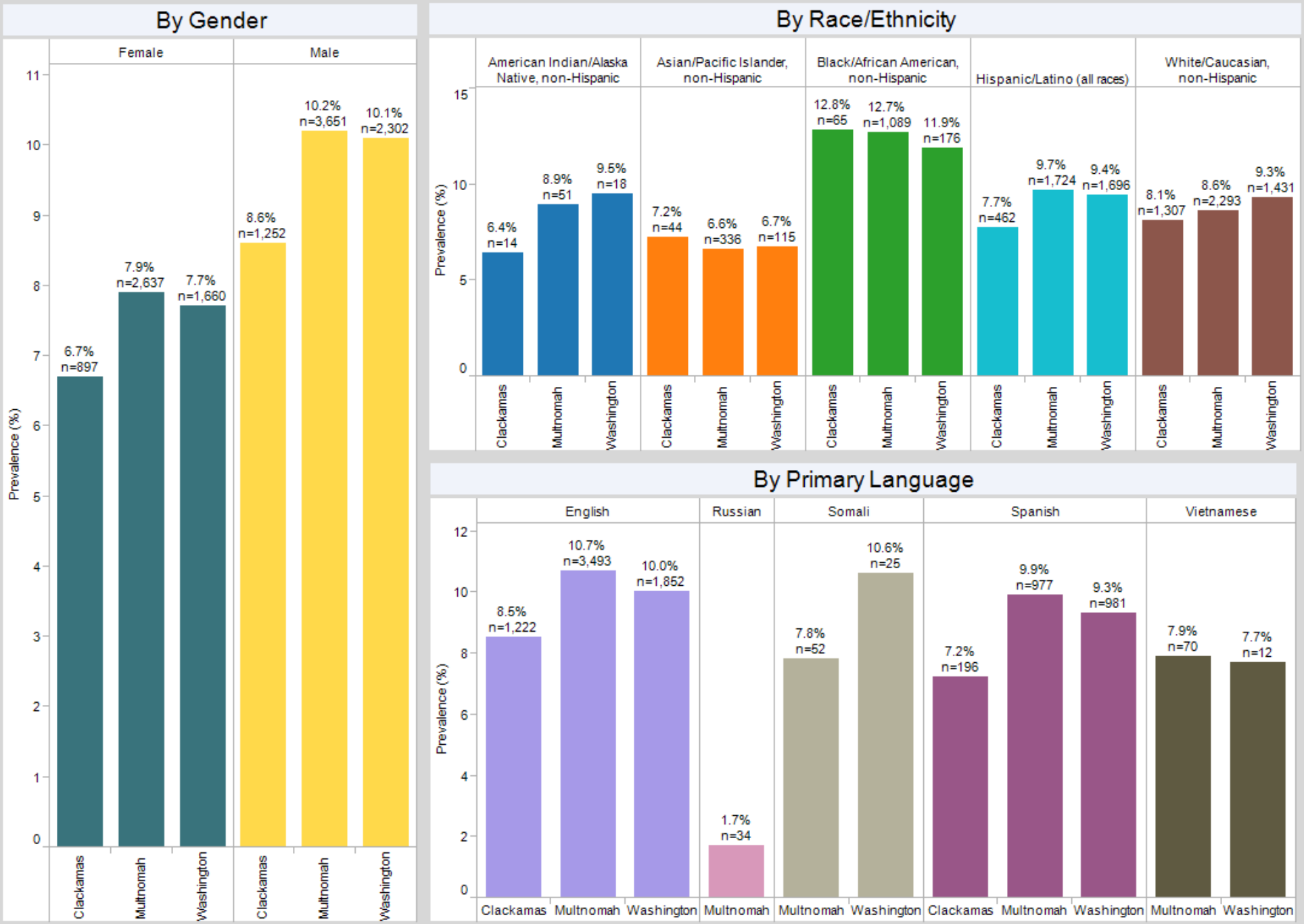
On the following pages:

Figure 16: Youth Asthma Diagnosis Prevalence among CCO Members

Figure 17: Youth Attention Deficit Disorder Diagnosis Prevalence among CCO Members

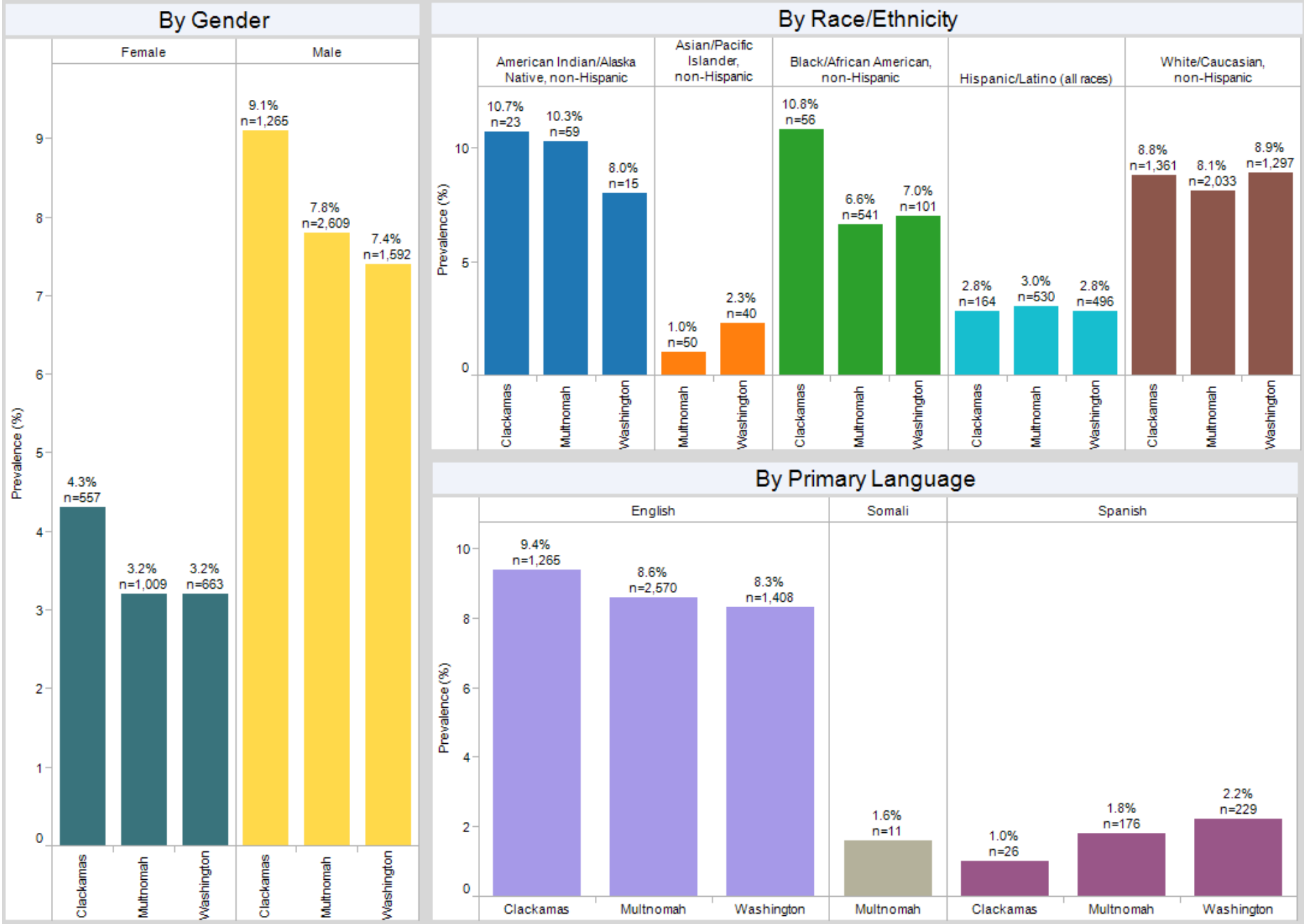
Figure 18: Youth Post-Traumatic Stress Disorder Diagnosis Prevalence among CCO Members

Youth Asthma Diagnosis Prevalence Among CCO Members



Data reflects members insured by a CCO on 6/15/15 and diagnosed March 2012-March 2015. "n" represents number of members diagnosed with condition. Prevalence is age-adjusted to 2000 US Standard Population. Unknown race/ethnicity or language are excluded from graph. Data suppressed when numerator < 11 or denominator < 30 to ensure patient confidentiality and data reliability.

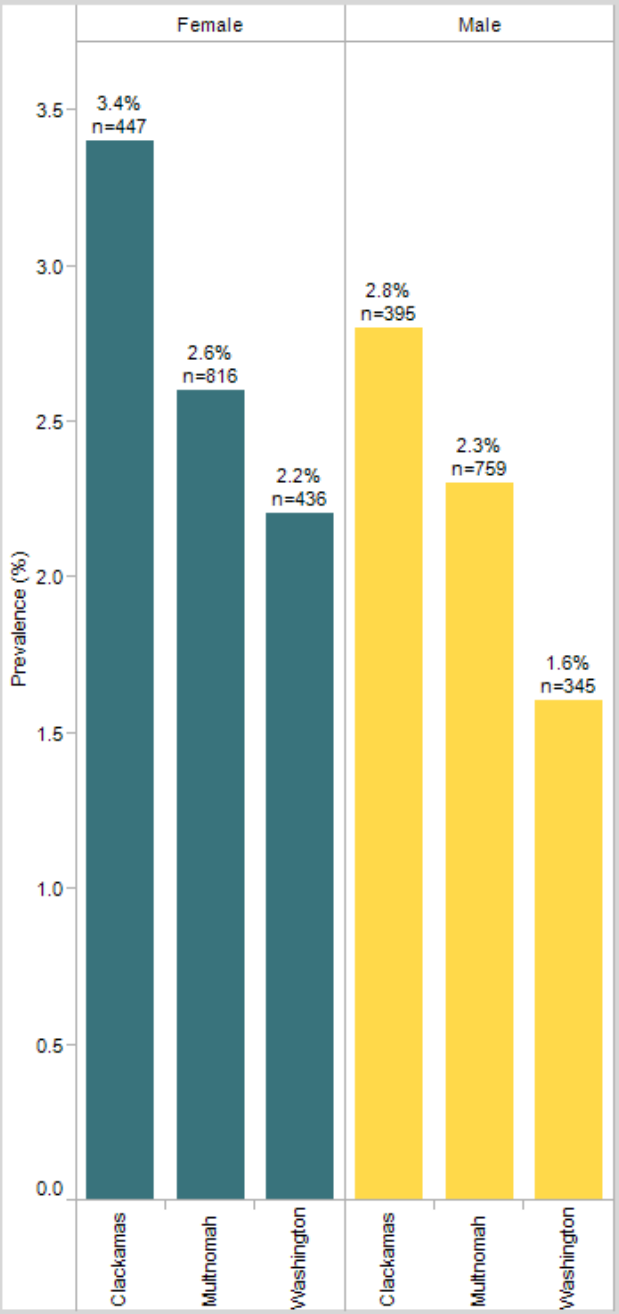
Youth Attention Deficit Disorder Diagnosis Prevalence Among CCO Members



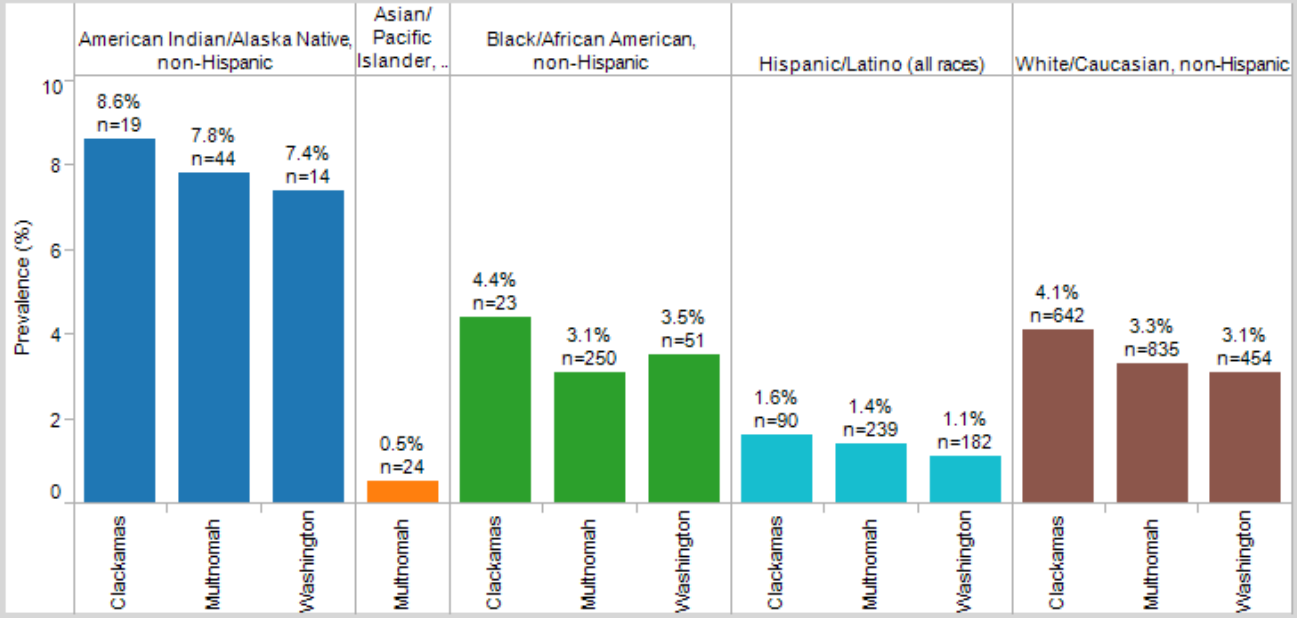
Data reflects members insured by a CCO on 6/15/15 and diagnosed March 2012-March 2015. "n" represents number of members diagnosed with condition. Prevalence is age-adjusted to 2000 US Standard Population. Unknown race/ethnicity or language are excluded from graph. Data suppressed when numerator < 11 or denominator < 30 to ensure patient confidentiality and data reliability.

Youth Post Traumatic Stress Disorder Diagnosis Prevalence Among CCO Members

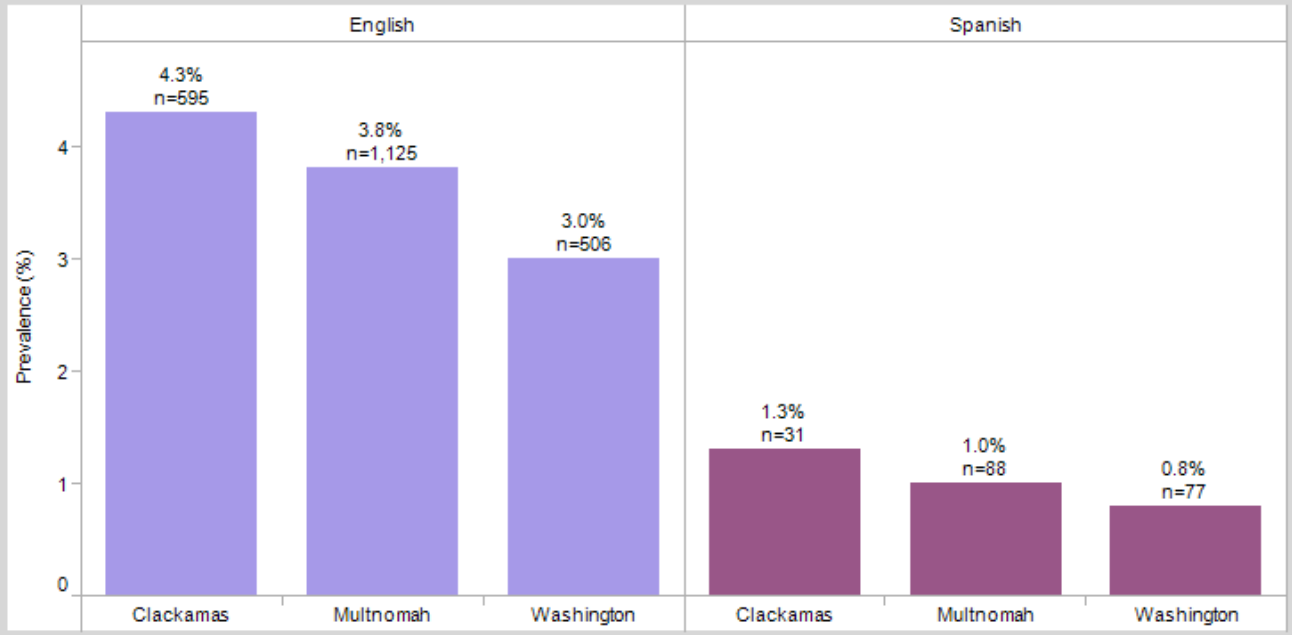
By Gender



By Race/Ethnicity



By Primary Language



Data reflects members insured by a CCO on 6/15/15 and diagnosed March 2012-March 2015. "n" represents number of members diagnosed with condition. Prevalence is age-adjusted to 2000 US Standard Population. Unknown race/ethnicity or language are excluded from graph. Data suppressed when numerator < 11 or denominator < 30 to ensure patient confidentiality and data reliability.

Hospital Utilization Data

Determining scope

In order to complement the Medicaid data and maintain a focus on the most vulnerable people in our community, the participating hospitals agreed to provide supplemental utilization data according to the following parameters:

- **Population**: Adults (18 years and older) and youth (0 through 17 years) with an Emergency Department (ED) admission, who presented with an Ambulatory Care Sensitive Condition (ACSC) or specific mental health diagnosis, and who identified as self-pay or uninsured at the time of service.
- **Time period:** April 1, 2014-March 31, 2015
- **Data inclusion criteria:** Ambulatory Care Sensitive Condition and/or select mental health ICD-9 diagnostic codes included in primary or secondary discharge diagnosis for an ED admission.
- **Data exclusion criteria:** All commercial, public, or otherwise insured individuals; any in-patient, urgent care, or clinic utilization data.
- **Reported information:** A county-level report of the most frequently diagnosed ACSCs during the reporting time period provided by each hospital and aggregated for publication. Only values greater than or equal to 5% of the population after age-adjusting will be reported.

Methods

Selection of diagnosis codes

In order to ensure consistency, a series of ICD-9 codes and a data template were provided to all participating hospital organizations. The ICD-9 codes selected were in line with the diagnostic coding practices during the time period selected. The relevant codes were selected based upon Ambulatory Care Sensitive Conditions, as defined by the Agency for Healthcare Research & Quality (AHRQ). Additionally, hospitals included the same mental illness diagnoses as the CCOs in this report.

Table 11: ICD-9 Codes for HCWC Hospital Data

Ambulatory Care Sensitive Conditions (defined by AHRQ)	
Congenital syphilis	090
Immunization-related and preventable conditions	033, 037, 045, 320.0, 390, 391
Grand mal status and other epileptic convulsions	345
Convulsions "A"	780.3
Convulsions "b"	780.3
Severe ear, nose, and throat infections	382, 462, 463, 465, 472.1
Pulmonary tuberculosis	011
Other tuberculosis	012-018
Chronic obstructive pulmonary disease	491, 492, 494, 496, 466.0
Bacterial pneumonia	481, 482.2, 482.3, 482.9, 483, 485, 486
Asthma	493
Congestive heart failure	428, 402.01, 402.11, 402.91, 518.4
Hypertension	401.0, 401.9, 402.00, 402.10, 402.90

Ambulatory Care Sensitive Conditions (defined by AHRQ)	
Angina	411.1, 411.8, 413
Cellulitis	681, 682, 683, 686
Diabetes "a"	250.1, 250.2, 250.3
Diabetes "b"	250.8, 250.9
Diabetes "c"	250.0
Hypoglycemia	251.2
Gastroenteritis	558.9
Kidney/urinary infections	590, 599.0, 599.9
Dehydration - volume depletion	276.5
Iron deficiency anemia	280.1, 280.8, 280.9
Failure to thrive	783.4
Pelvic inflammatory disease	614
Dental conditions	521, 522, 523, 525, 528
Select Mental Illness Diagnoses (to align with CCO/Medicaid data)	
Attention deficit disorder	314.xx
Post-traumatic stress disorder	309.81; 995.52, 995.54
Depression	296.2x, 296.3x, 298.0
Schizophrenia	295.xx, 298.4, 299.1x, 299.9x

AHRQ: Agency for Healthcare Research and Quality

Minimum reporting

No information will be made publicly available at the diagnosis, sex, age, or geographic level below the county level. To ensure confidentiality and data reliability in reporting the "Top 5" conditions at the County level, and any substrata, a minimum of 11 counts in the numerator and 30 counts in the denominator is required.[30, 31]

Demographic data

- **Geography:** Clackamas, Multnomah, and Washington counties in Oregon and Clark County, Washington. Patient origin ZIP code was used to assign each relevant encounter to a county.
- **Age:** Adults (age 18 and over) and youth (0 to 17 years).
- **Gender:** Counts of people self-identifying as male or female. For reporting and age-adjusting purposes, these counts were aggregated and will be reported as total prevalence rather than stratifying by gender.
- **Race and ethnicity:** Hospital utilization data was not stratified by race/ethnicity. Though improving, many records still indicate "none identified," "refused to respond," or "unknown". To avoid small reporting sizes and misinformed assumptions based upon partial data, these categories were intentionally excluded.

Utilization data

To be included, a patient must have had at least one ACSC or relevant mental illness diagnosed in an Emergency Department setting during the reporting period and their patient record marked as self-pay or uninsured. The patient must have a ZIP code that falls within the four counties of the study. Hospital reports

included both the unduplicated patient count as well as total number of visits for any diagnosis and group as described above.

Analysis

Adult and youth ACSC and mental illness data from the seven hospital systems were combined for each of the four counties. Percentages were then calculated for each health indicator and age-adjusted to the 2000 U.S. Standard Population. No testing for statistically significant differences across counties was performed. The health indicators for adults and youth were ranked for each county using the overall percentages. The regional ranking for the health indicators was calculated using the average county rank.

Data validation

A robust data validation process including checks for accuracy, validity, and completeness was not performed due to time constraints. Instead, random checks and comparisons were performed by data analysts to review for validation.

Findings

All hospital partners across the four-county region contributed data to this report. This participation allowed for results to be age-adjusted and reported at the region as well as county levels. The following tables and discussion relate to the findings from this data. This report only includes diagnoses by region and county that occurred for at least 5% of the population after age-adjusting.

Importantly, these codes were selected for analysis because they are recognized as conditions for which emergency care should not be required with appropriate access to primary care. In other words, all cases reported here *should have been avoidable*.

Four-county region

Regional rank, diagnosis group, and county age-adjusted prevalence (rank within each county) for ACSC/select mental illness diagnostic codes amongst self-pay Emergency Department admissions April 1, 2014-March 31, 2015 are shown in *Table 12* below.

Table 12: Top Diagnoses, Regional Rank, and Age-Adjusted Prevalence for Hospital Admissions Data

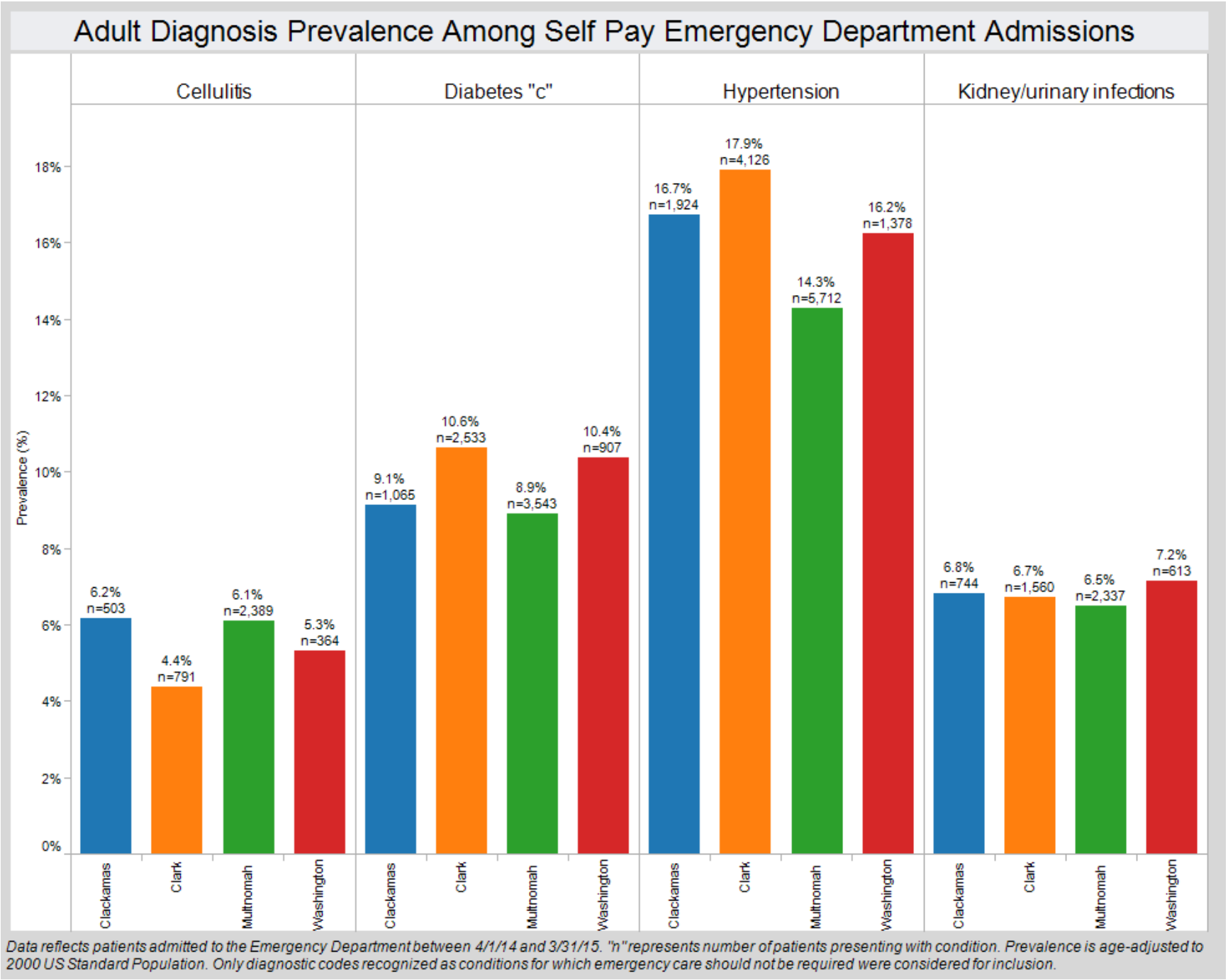
		Proportion (%) among self-pay Emergency Department admissions (rank within county)			
Regional Rank	**ACSC/SPMI Group**	**Clackamas County**	**Multnomah County**	**Washington County**	**Clark County**
Adults					
1	Hypertension	16.7% (1)	14.3% (1)	16.2% (1)	17.9% (1)
2	Diabetes "c" *	9.1% (2)	8.9% (2)	10.4% (2)	10.6% (2)
3	Kidney/urinary infections	6.8% (3)	6.1% (4)	7.2% (3)	6.7% (3)
Youth					
1	Severe ear, nose, and throat infections	38.5% (1)	39.9% (1)	38.3% (1)	39.5% (1)
2	Asthma	12.3% (2)	15.3% (2)	14.6% (2)	13.9% (2)

Prevalence age-adjusted to the 2000 US Standard Population.
*Diabetes “c” defined as Type II (adult-onset) diabetes mellitus, not stated as “uncontrolled”.

Across the four-county region, the most commonly diagnosed health issue for uninsured adults accessing the Emergency Department was hypertension. This was consistently the number one reported condition. Diabetes “c” (adult-onset diabetes not specified as uncontrolled) was consistently the second most commonly diagnosed condition amongst this population (between 8.9% and 10.6%). Finally, kidney/urinary infections were the third most frequently diagnosed condition amongst all the counties, except Multnomah County. Although this information was reported at the population level, individual hospital data showed kidney/urinary infections were far more frequent among women than among men (data not shown). See *Figure 19* for representation of data.

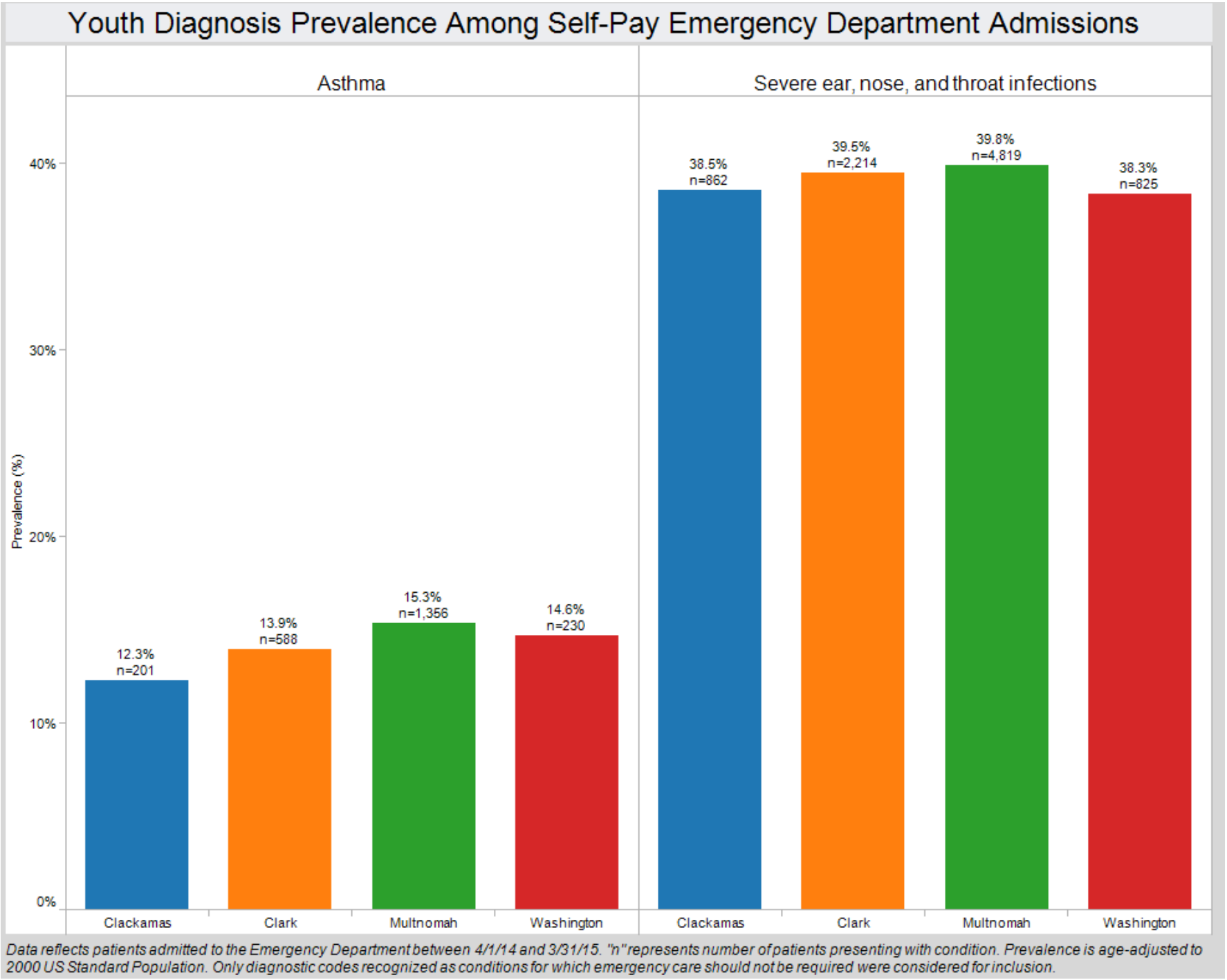
For youth, severe ear, nose, and throat infections made up nearly 40% of the diagnosed codes in each of the four counties amongst the study population. Asthma was consistently ranked second across counties, accounting for between 12.3% and 15.3% of studied visits. See *Figure 20* for representation of data.

Figure 19: Adult Diagnosis Prevalence among Self-Pay Emergency Department Admissions



Data reflects patients admitted to the Emergency Department between 4/1/14 and 3/31/15. "n" represents number of patients presenting with condition. Prevalence is age-adjusted to 2000 US Standard Population. Only diagnostic codes recognized as conditions for which emergency care should not be required were considered for inclusion.

Figure 20: Youth Diagnosis Prevalence among Self-Pay Emergency Department Admissions



Limitations

CCO data limitations

The CCO/Medicaid data did not include information about people living in Clark County with Medicaid, so the analysis only references people with Medicaid who live in Clackamas, Multnomah, or Washington counties in Oregon. Within the tri-county population who were served through a CCO, there were small numbers within the study population, resulting in the need to suppress data in order to protect confidentiality and preserve data stability. The CCO data were not tested for statistical significance.

Hospital data limitations

Across the four counties there were 19,045 children who were identified as uninsured at the time of emergency department admission and eligible for inclusion in this study, and approximately 78,000 adults. The total study population was less than 97,000 individuals out of the total four-county region population of 2,185,690. The results from the hospital data are neither representative of nor generalizable to the population of the four-county region, and instead represent solely the experience of those presenting in an Emergency Department setting and being diagnosed with a specific condition during the specific study window. The hospital data were not tested for statistical significance.

Health Status Assessment Summary

The *Health Status Assessment*, presented above, includes 1) population data from health surveys and vital statistics (health behaviors, morbidity, and mortality), 2) Medicaid data from local CCOs (top three diagnosed conditions for adults and youth), and 3) hospital data on Emergency Department admissions for people who are uninsured or self-pay (select conditions that could have been treated in primary care).

The next section, *Community Themes and Strengths*, presents data gathered through engagement with diverse communities across the four-county region. Findings from the *Health Status Assessment* and *Community Themes and Strengths Assessment* will be combined in the *Priority Health Issues* section of this report (page 93).

Community Themes and Strengths Assessment

Introduction

The Community Themes and Strengths Assessment included three studies: 1) Online survey, 2) Listening sessions, and 3) Inventory of community engagement projects in the four-county region from 2012-2015. This section discusses the methodology, findings, and limitations for each of these studies. In addition, this section discusses how the findings from each tool were blended to identify the priority health needs from the community data.

Equity & Empowerment Lens

In an effort to expand community voice and increase meaningful engagement with marginalized and underrepresented populations for the 2016 community health needs assessment (CHNA), the HCWC Leadership Group created a Community Engagement Workgroup (CEW). The CEW was tasked with designing and implementing a community outreach strategy to ensure the voices of community members in the four-county region were collected and incorporated into the final report. The CEW included staff from HCWC member organizations working with vulnerable populations, as well as community members and stakeholders from community organizations. The goals of the group were to augment community voice in the CHNA, prevent duplicative efforts, respect community member contributions, and build upon existing community engagement work from local organizations and government programs. The group began by applying Multnomah County's Equity & Empowerment Lens to the 2016 assessment model to determine the best ways to reach community members from "priority populations" (defined below). Over the course of 18 months and approximately 30 meetings, the CEW created and promoted an online survey; planned and executed 29 listening sessions; helped analyze data from the listening sessions, survey, and inventory of community engagement projects; and blended data from the three tools to create a list of priority needs in the region.

"This is my first time being involved in a smart group that knows what collaboration looks like…where voices are heard and we know how to compromise. I want to duplicate this structure in other committees I am involved in." -Community member on CEW

Priority Populations

The CEW looked at gaps in data from the 2013 CHNA to determine which communities were missing from previous community engagement efforts. Using an equity lens, with a goal of elevating voices of marginalized and under-represented communities, the CEW identified specific priority populations for community outreach. It was determined that different populations would be best reached through different tools (e.g. the aging population might be better reached through listening sessions than through an online survey), but that there should be overlap between the tools to ensure people could participate in the CHNA in the way that best suited them. Priority populations included: aging community and seniors; communities of color; people experiencing homelessness; immigrants and refugees; limited-English-speaking people and other-language speakers; people identifying as lesbian, gay, bisexual, transgender, queer or questioning (LGBTQ); low-income communities; people living with disabilities; people with mental health issues; people

with addictions or in recovery; rural and unincorporated communities; uninsured people; veterans; and youth.

Summary of Findings

The following table summarizes the data from the three studies (online survey, listening sessions, and inventory of community engagement projects).

Table 13: Summary of Findings from Community Themes and Strengths Assessment

VISION
For all people: Affordable, high-quality, culturally responsive health care Basic needs are met, including food, housing, and transportation Environments and opportunities that support and encourage community involvement and connection Equitable and inclusive society, free from racism, discrimination, and stigma Good schools and equitable access to high quality education Living-wage jobs and pathways to employment Policies, systems, and environments that support good health and high quality of life Safe, accessible, and affordable housing Safe and accessible neighborhoods that are free of crime
STRENGTHS
Culturally specific community-based services Feeling connected to a community Government-supported public assistance and social services Healthy behaviors Low/no-cost programs and services that make health care accessible Opportunities to be involved in the community Pathways to living-wage jobs Resilience
NEEDS
Access to food Access to health care Access to transportation Active elimination of racism, discrimination, and stigma Connected communities Culturally and linguistically appropriate services Pathways to living-wage jobs Policies, systems, and environments that support healthy behaviors Safe, accessible, and affordable housing

Online Survey

Introduction

As a result of the findings from the 2013 CHNA, the Collaborative identified the need to increase data collection on social determinants of health (SDoH). Issues related to housing, poverty, education, and other economic issues were predominant throughout the 2013 listening session findings, but had not been a focus in the 2013 planning and analysis. This lack of information regarding SDoH made it difficult to adequately address these needs in community health improvement efforts. The CEW created an online survey tool to gather specific data related to these issues and to reach more people than possible with listening sessions alone.

Methodology

The CEW decided to use the online survey to ask community members what they think are the most important:

1) Characteristics of a healthy community,
2) Challenges affecting health in their community,
3) Risky behaviors affecting health in their community, and
4) How healthy they think their community is.

The survey was based on a community health survey tool developed by the National Association of County and City Health Officials (NACCHO). Information collected by the survey was combined with listening session results and an inventory of community engagement projects.

Demographics of survey respondents were collected, including ZIP code of residence, age, gender, sexual orientation, Hispanic ethnicity, race, if the respondent spent most of their childhood within or outside of the United States, veteran status, disability status, educational attainment, household income, household size, and type of health insurance coverage. To be more inclusive, the CEW modified the NACCHO survey to include more options for gender, sexual orientation, race, ethnicity, insurance status, and income. For all demographic questions, respondents could choose to write in their own answers or to not respond.

Outreach was done to specifically encourage participation from populations anticipated to be underrepresented through other data collection efforts. These populations included the aging community and older adults, communities of color, LGBTQ individuals, immigrants and refugees, veterans, youth, and persons living with disabilities. The survey was translated into Spanish, Vietnamese, Russian, and Simplified Chinese; and was promoted through social media, emails, flyers, presentations, radio, and direct outreach to organizations serving vulnerable and underserved communities. Paper copies of the survey (in English and Spanish) were distributed to organizations serving homeless and other populations that might be less likely to access the survey online. CEW members and volunteers additionally brought electronic tablets to local health fairs to boost survey participation in counties with lower response rates.

Analysis

The survey results were analyzed to determine the demographics of survey respondents and the frequencies at which responses to the four community health questions were selected. Frequencies were analyzed by each type of demographic information collected so that it could be discerned if/how answers varied by county of residence, age, gender, etc. This analysis of frequencies for specific demographic populations was done for populations with at least 25 survey respondents. This minimum population size was set because fewer than 25 respondents would be a very small sample size from which to gain insight into a population. At the same time, the small sample size enabled highlighting the voices of many different communities who often go unrepresented. Populations whose demographics were collected on the survey but for whom frequencies were not analyzed due to sample sizes of less than 25 respondents include: African, Arab American/Middle Eastern, and persons receiving care through the Indian Health Services system.

Additionally, some demographic categories included in the survey were aggregated to yield a population with a large enough sample size to analyze. Decisions about whether to aggregate certain demographic categories were presented to the CEW for discussion and approval. Decisions were guided by considering which demographic groups are marginalized in dominant society and if some of these groups experience marginalization in similar ways that might reflect similar responses. The following is a list of these decisions:

- "Transgender," "gender non-conforming," and other written-in non-normative gender identities were aggregated. This group is referred to in this report as "non-normative genders."
- Non-heterosexual sexual orientations were aggregated as "minority sexual orientations." These individual sexual orientations included the provided selections "gay or lesbian," "bisexual," "queer," "questioning or unsure," and "another sexual orientation," as well as write-in answers such as, "asexual."
- Many respondents selected multiple racial identities. A "multiracial" category was created by aggregating these respondents. Aggregating and creating a multiracial category for survey analysis recognizes and makes this growing population visible. However, to acknowledge the races, cultures, and communities represented within this group, the demographic section also discusses the representation of individual racial identities within this population.
- Although there were fewer than 25 respondents who identified as African, the CEW chose not to aggregate African and Black/African American respondents. The decision to provide "African" as an option for racial identity was made in order to recognize the different lived experiences of immigrants from Africa and persons who identify with the African American community in the United States. Aggregating these two populations would have been contrary to this decision.
- Respondents who reported speaking a language other than English or Spanish at home were aggregated into one group, "Languages other than English or Spanish". Although representing many countries and cultures, all of these respondents share the experience of speaking a different language at home than the dominant language in the four-county region. They all also represent smaller linguistic communities than Spanish speakers. Spanish was the only language other than English that had at least 25 respondents choose it as their language primarily spoken at home.

Finally, some demographic questions allowed respondents to select multiple answers and/or write in their own answer. Analysis of these responses uncovered some additional populations to consider that were not provided as response options on the survey. Examples include persons covered by both Medicaid and Medicare and persons with an Associate's or technical degree. Some of these populations identified during analysis are included in the demographics discussion, but were too small to analyze the frequencies of their responses to the four community health questions (e.g. the Medicaid/Medicare population was greater than 25, but respondents with an Associate's or technical degree was not).

Findings

Description of survey respondents

Total survey responses

A total of 3,167 respondents submitted a survey. The ZIP codes reported by respondents were used to determine geographic reach throughout the four-county region. The following table presents the results of this ZIP code analysis.

Table 14: Surveys by ZIP code

ZIP code Description	Count of Surveys
Within the four-county region	2,876
ZIP code within other county in Oregon or Washington	65
ZIP code from state other than Oregon or Washington	6
Non-valid ZIP code	18
No ZIP code provided	202
Total	**3,167**

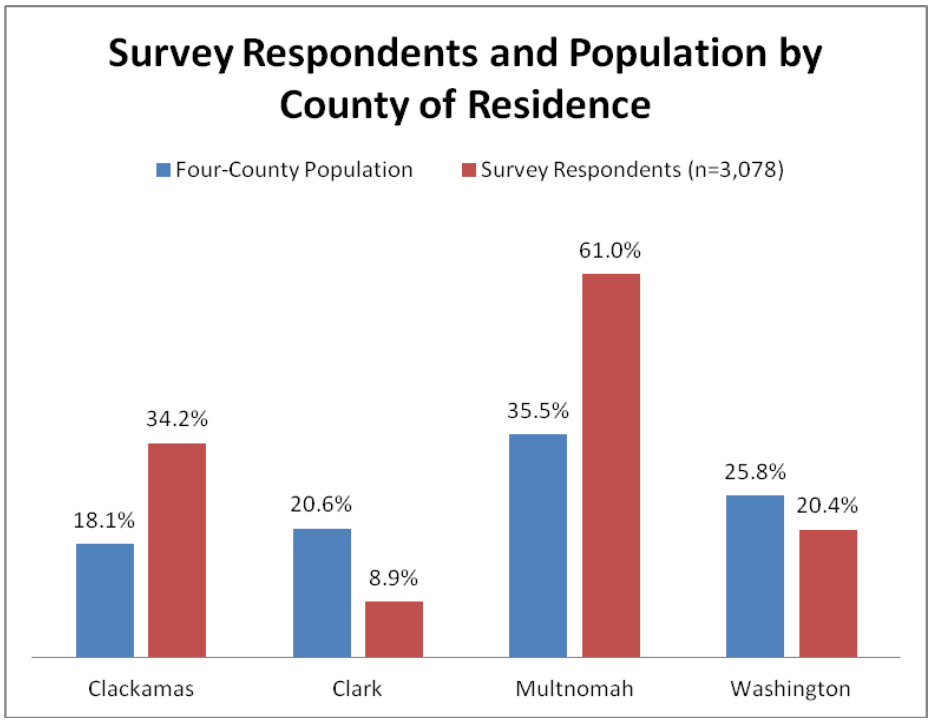
Survey responses residing outside the four-county region and non-valid ZIP codes were discarded for the analysis presented in this report. Blank ZIP codes were included because reporting a ZIP code on the survey was optional, and the CEW did not want to discount the voices of local respondents who chose not to enter a ZIP code. Therefore, the count of surveys included in the four-county regional analysis (N) was **3,078** (2,876 + 202 = 3,078).

Some ZIP codes were split between more than one county. To determine the number of surveys submitted from each of the four counties, all ZIP codes within or overlapping each county's borders were included in that county's count. This methodology means surveys from some ZIP codes are included in more than one county's count. These counts were as follows:

- **1,001** respondents from Clackamas County,
- **259** respondents from Clark County,
- **1,782** respondents from Multnomah County, and
- **595** respondents from Washington County.

The following graph compares the proportion of total surveys from each county to the proportion of the four-county regional population in each county. The percentages of survey respondents per county sum to over 100% since some ZIP codes were counted in more than one county.

Figure 21: Survey Respondents and Population by County of Residence



Population data are from the U.S. Census Bureau 2014 Population Estimates.

Although the CEW sought survey participation proportional to the populations in each county, response rates in Clark and Washington counties were lower than desired. Targeted outreach was conducted in these counties, in an effort to boost response rates. Responses to the four community health questions were also analyzed by each county, to ensure that Multnomah County data did not skew regional results. The analyses of survey data by each county are available in the appendices of this report.

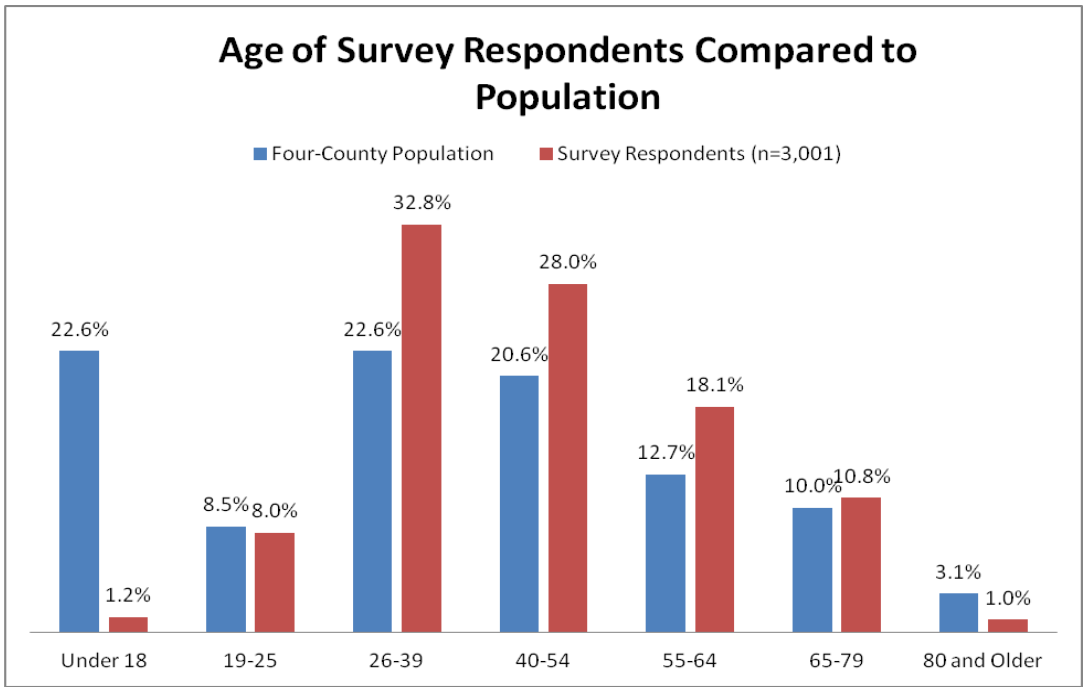
Demographics of total respondents

The survey included several categories of demographics to better allow analysis by specific community groups. The tables below present the demographics of survey respondents, compared to demographics in the four-county population. As all demographic questions were optional, the "n" in the tables represents the number of survey respondents that answered the question. Surveys not including an answer to the respective question were omitted from the total count.

Age

The following graph compares the age of survey respondents to the breakdown of ages for the four-county population.

Figure 22: Age of Survey Respondents Compared to Population



The responses on the survey technically skip age 18. As a result, the next two age groups ("19-25" and "26-39") are one year off from the age groups used by the U.S. Census Bureau ("18-24" and "25-39"). The age groups after these are the same on the survey and in Census data.

Gender

The following table shows the proportion of respondents who selected one of the gender identities listed on the survey.

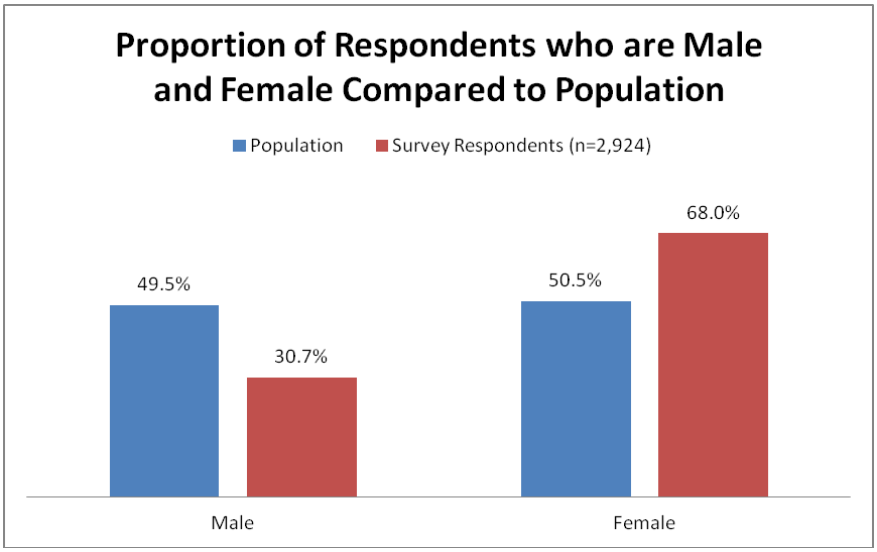
Table 15: Gender of Survey Respondents who Selected One Gender Identity Option

	Male	Female	Transgender	Gender non-conforming	Prefer not to answer
Survey Respondents n = 2,924	29.9%	66.3%	0.5%	0.6%	2.5%

Some respondents selected more than one of the choices to identify their gender. Some of these combinations included "male, female"; "male, gender non-conforming"; "male, transgender"; and "transgender, gender non-conforming." In the analysis of the survey questions, these respondents were aggregated into the "gender non-conforming" category.

The following graph compares survey respondents who selected only male or only female to the proportion of the four-county population estimated to be male and female.

Figure 23: Proportion of Survey Respondents who are Male and Female Compared to Population



In aggregate, 1.3% of respondents identified as a gender other than male or female. There are very few estimates of the proportion of the general population identifying as transgender, gender non-conforming, or another non-normative gender identity, so it is difficult to compare this percentage of survey respondents with a corresponding proportion of the four-county population. Many estimates combine non-normative gender identities with non-heterosexual sexual orientations. This comparison is included in the Sexual Orientation section, below.

Sexual orientation

The table below presents the sexual orientation choices listed on the survey and the percentage of survey respondents who selected only one of those orientations.

Table 16: Survey Respondents by Listed Sexual Orientation Identities

Orientation	**Percent of Survey Respondents Who Selected Only this Orientation** n=2,723
Gay or lesbian	5.1%
Bisexual	4.6%
Queer	1.9%
Heterosexual (“straight”)	83.1%
Questioning or unsure	0.4%
Another sexual orientation	0.7%

Respondents were given the option to write in a sexual orientation not listed on the survey. Examples of write-in responses include “pansexual” and “asexual.” Additionally, some respondents selected multiple sexual orientations.

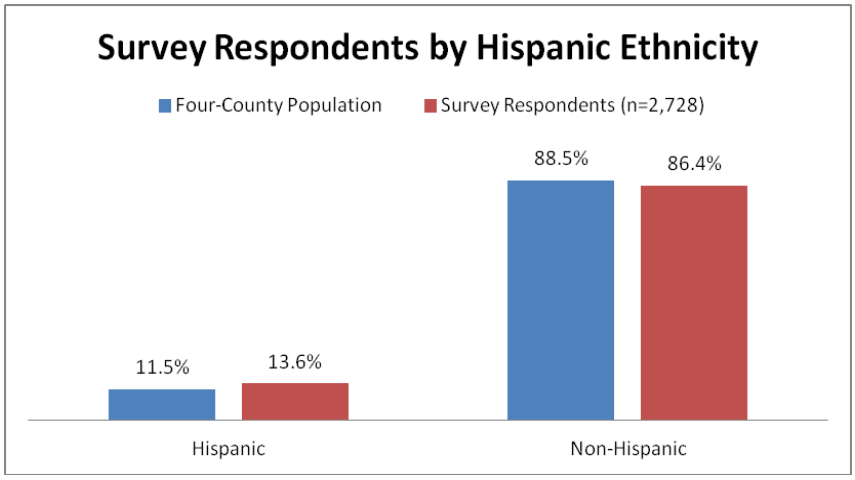
In total, 13.4% responded with a non-heterosexual and, therefore, minority sexual orientation. A 2015 Gallup poll reported that 5.4% of adults in the Portland-Vancouver-Hillsboro metro area (comparable to the four-county region) identify as lesbian, gay, bisexual, or transgender.[34] One possibility for why a higher percentage of survey respondents identified as a sexual minority than is reflected in the Gallup poll is that the survey includes several additional response options. Additionally, outreach to the LGBTQ community, identified as a priority population, may have resulted in oversampling.

The Gallup poll also adds in a gender identity (transgender) to the three sexual minority orientations it counts (lesbian, gay, and bisexual). For a direct comparison to the Gallup poll, 9.7% of survey respondents specifically identified as lesbian, gay, bisexual, or transgender.

Hispanic ethnicity

The following graph compares survey respondents who identified as Hispanic and non-Hispanic, compared to the four-county population.

Figure 24: Survey Respondents by Hispanic Ethnicity



Race

The following is the breakdown of total survey respondents identifying as a single racial identity from the options listed on the survey:

Table 17: Survey Respondents by Listed Single Racial Identity

Single Racial Identity Listed on Survey	**Survey Respondents** n=3,078
African American/Black	5.6%
African	0.3%
Arab American/Middle Eastern	0.2%
Asian American/Asian	2.9%
European American/White/Caucasian	76.7%
Native American/American Indian/Alaska Native	2.9%

In addition to these provided selections, 2.5% of respondents wrote in some other racial identity. Nine percent of survey respondents selected multiple races.

The following table compares the racial/ethnic demographics of the survey respondents to the racial/ethnic composition of the region, and illustrates how the survey groupings align with those used by the U.S. Census Bureau. The demographics of the survey population are different from Census demographics in the following ways: first, the U.S. Census Bureau does not distinguish between African American/Black and African. These two identities from the survey are both considered as "Black/African American" by the U.S. Census Bureau. Second, the survey did not provide a response option corresponding to the U.S. Census Bureau's Native Hawaiian/Other Pacific Islander" category. However, some respondents wrote in similar responses and this proportion is included in the table below.

Table 18: Racial Demographics of Survey Respondents Compared to Population Data

Four-County Population Data		**Survey Respondents**	
American Indian/Alaska Native	1.2%	Native American/American Indian/Alaska Native	2.5%
Asian	6.8%	Asian American/Asian	2.9%
Black/African American	3.2%	African American/Black African	5.6% +0.3% 5.9%
Multiracial	4.0%	Multiracial	9.0%
Native Hawaiian/Other Pacific Islander*	0.6%	Pacific Islander/Polynesian	0.1%
White	84.1%	White	76.7%
No comparable population data	N/A	Arab American/Middle Eastern	0.2%

*Represents written-in responses. Option was not provided on survey.

The following table provides some detail on the specific racial/ethnic identities selected by respondents who selected multiple races. The percentages do not sum to equal 100% because they do not represent discrete groups within multiracial respondents; rather, for example, 37.2% of multiracial respondents listed African American/Black as part of their racial identity. Some multiracial respondents wrote in Latino or Hispanic as part of their racial identity.

Table 19: Representation of Racial/Ethnic Identities among Multiracial Respondents

Racial/Ethnic Identity	**Percent of Multiracial Respondents Who Selected the Racial/Ethnic Identity** n = 234
African American/Black	37.2%
African	8.5%
Arab American/Middle Eastern	9.8%
Asian American/Asian	80.3%
European American/White/Caucasian	79.1%
Native American/American Indian/Alaska Native	56.4%
Latino/Hispanic	5.6%

Grew up domestically or abroad

Respondents were asked where they spent the majority of their time between birth and age 16. The purpose of asking this question was to understand the responses of immigrants and refugees, without asking explicitly about documentation status (as those questions can be stigmatizing and might not solicit accurate information out of fear of deportation). Responses are as follows:

Table 20: Survey Respondents by Where They Spent Their Childhood

Location of Childhood	**Survey Respondents** (n = 2,814)
Inside the United States	96.2%
Outside the United States	3.8%

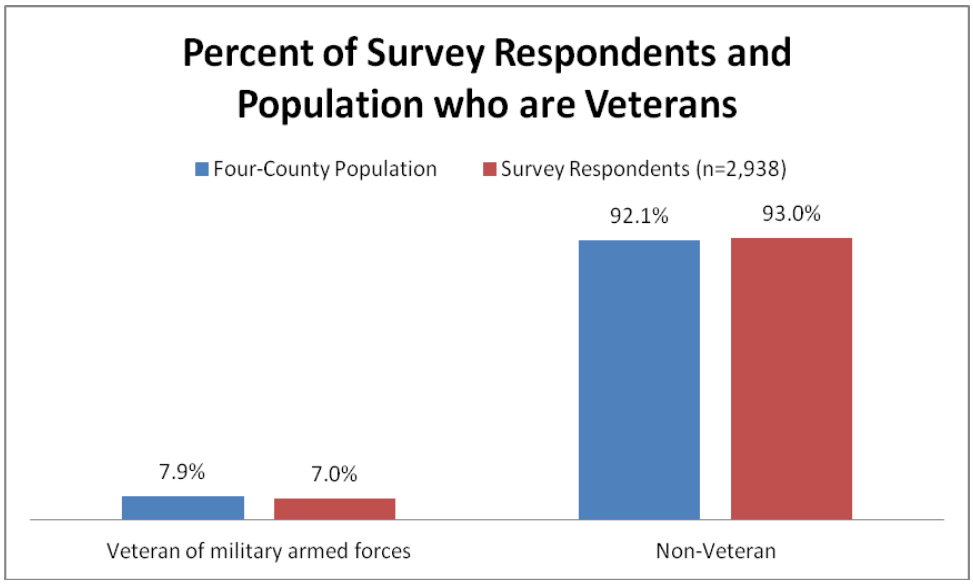
Primary language spoken at home

The most common primary language spoken at home by survey respondents was English (90.3% of respondents). The second most common language was Spanish; 6.9% of survey respondents reported Spanish, Spanish Creole, or a combination of Spanish and English as the language(s) primarily spoken at home. Next were Vietnamese (0.6%), Russian or another Slavic language (0.5%), and Chinese (dialects aggregated) (0.3%). Over 20 different languages were mentioned in the survey responses. Combined, 2.7% primarily spoke a language other than English or Spanish at home. A total of 9.7% said they spoke a language other than English at home. According to census data on the four-county regional population, 18.1% of people ages 5 and older speak a language other than English at home.

Veteran status

The following graph compares the percent of survey respondents who said they were veterans of the military armed forces to the percent of the four-county population that are veterans.

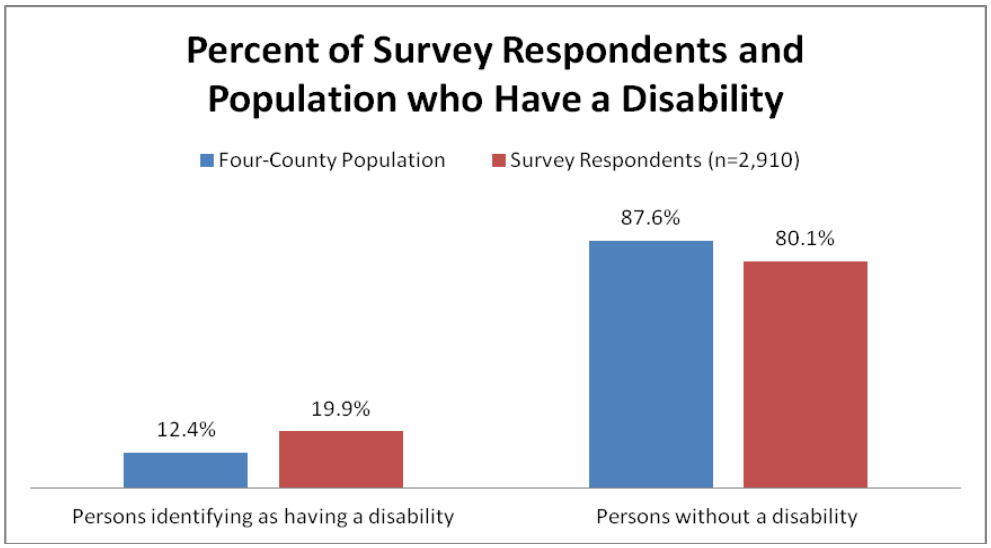
Figure 25: Percent of Survey Respondents and Population who are Veterans



Disability status

The following graph compares the percent of survey respondents who identified as having a disability to the percent of the four-county population estimated by the U.S. Census Bureau as having a disability.

Figure 26: Percent of Survey Respondents and Population who Have a Disability

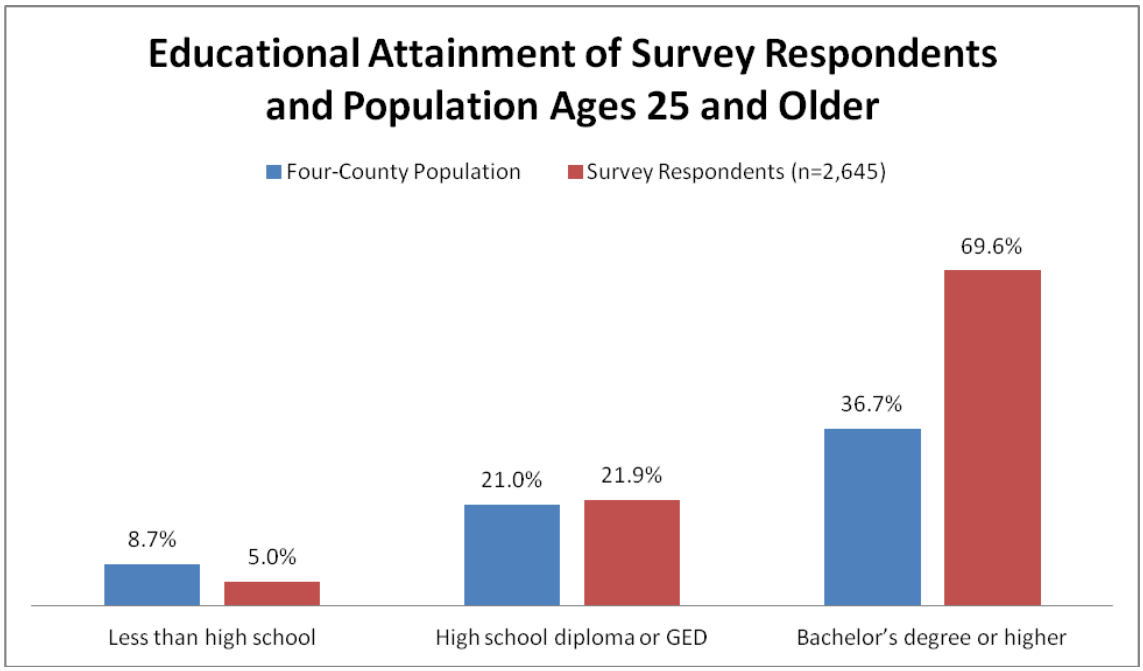


One reason that a larger proportion of survey respondents compared to population as a whole identified as having a disability could be that people living with disabilities were identified by the CEW as a priority population and were intentionally oversampled. In addition, the U.S. Census Bureau data are an estimate of persons with certain defined types of conditions and/or physical limitations, while survey respondents were able to decide what "disability" meant to them, meaning some respondents who identified as having a disability may not fit within the U.S. Census Bureau's definition of disability.

Educational attainment

The graph below presents the educational breakdown of respondents ages 25 and older for survey responses and the four-county region. The survey did not provide "Associate's degree" or "Some college" as options to select, but 3.5% of respondents ages 25 and older wrote in these responses.

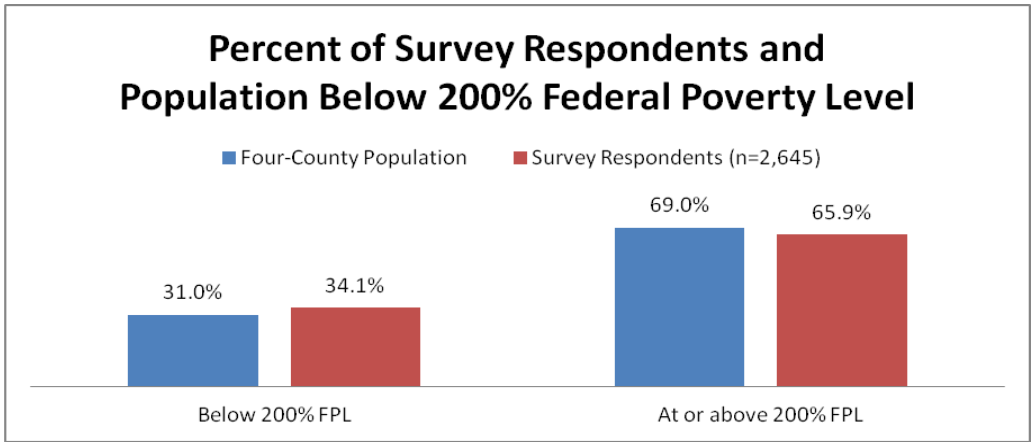
Figure 27: Educational Attainment of Survey Respondents and Population Ages 25 and Older



Ratio of income to federal poverty level

Responses to the survey question asking for total household income and the question asking how many people are supported by this income were used to determine the percent of respondents who live at or below 200% of the Federal Poverty Level (FPL) and the percent who live above 200% FPL. This information is presented in the table below, along with the proportion of the four-county population living at each of these income levels.

Figure 28: Percent of Survey Respondents and Population At/Below 200% FPL and Above 200% FPL



It was not possible to determine ratio of income to FPL for 612 of survey respondents because they did not answer one or both of the relevant questions (household income and number of people supported by income).

Type of health insurance coverage

Respondents were asked how they pay for their health care. The table below presents the distribution of their responses. As with other demographic questions, respondents were able to select more than one response. Analysis of responses prompted the inclusion of two categories in the below table that were not listed as responses on the survey. These coverage categories are "Medicaid/Medicare" and "Other Public Coverage." Individuals who have both Medicaid and Medicare coverage represent a specific population with unique needs. In order to be eligible for both programs, a person must live below a set income level and either be age 65 or older or be younger than 65 with a disability. This population is often referred to as "Dual Eligibles" and tends to have complex health needs.[35] The "Other Public Coverage" category was created to include individuals with various other combinations of public coverage or who wrote in the response "Tricare," which provides health care coverage for active military personnel, military retirees, and their dependents.

Table 21: How Survey Respondents and Population Pay for Their Health Care

	Uninsured	Private Insurance	Medicaid	Medicare	Veterans' Administration	Indian Health Services	Medicaid/ Medicare	Other Public Coverage
Population	9.2%	69.6%	19.8%	14.3%	2.1%	N/A	N/A	N/A
Survey Respondents n = 2,973	4.5%	60.5%	20.8%	10.0%	1.3%	0.8%	1.5%	0.8%

Survey results

The survey asked four questions about community health. Responses were analyzed for all participants, as well as broken down by the demographics discussed in the above section. In this section, the term "subpopulations" refers to the breakdown of survey responses by specific demographics such as race, ethnicity, gender, sexual orientation, and insurance status.

Survey question 1: Quality of life (vision)

The first question on the survey asked about respondents' vision of a healthy community. The question read, *"In the following list, what do you think are the five most important characteristics of a 'Healthy Community'? (Those factors that most improve the quality of life in a community")*. There were 21 characteristics from which to choose. The table below presents the response options ordered by the frequency at which they were selected. Because the question asked respondents to select five characteristics, the five most frequently selected responses are shaded. Frequencies were calculated using the total number of selections as the denominator (presented as "n" in the frequency column).

Table 22: Survey Question 1 Results

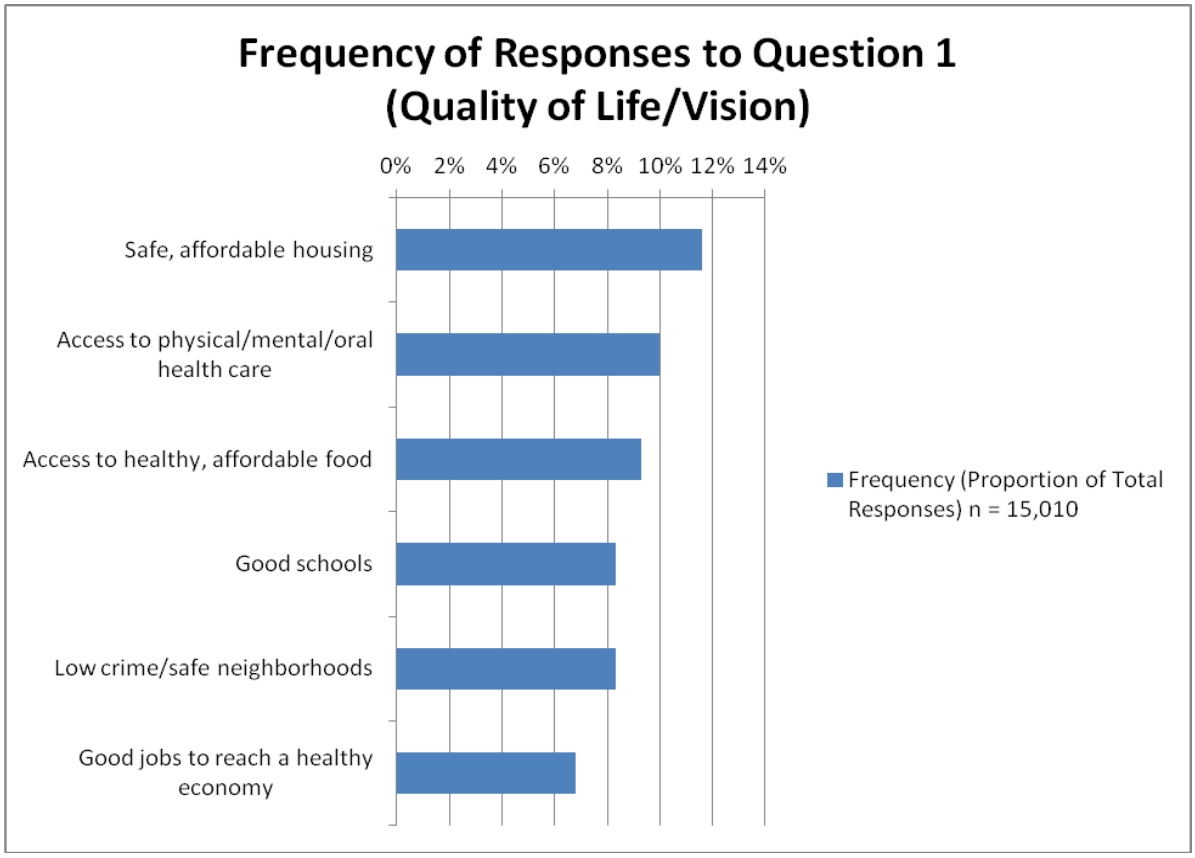
Rank based on Frequency	Response Options	Frequency (Proportion of Total Responses) n = 15,010
1	Safe, affordable housing	11.6%
2	Access to physical, mental, and/or oral health care	10.0%
3	Access to healthy, affordable food	9.3%
4	Good schools	8.3%
5	Low crime/safe neighborhoods	8.3%
6	Good jobs to reach a healthy economy	6.8%
7	Clean environment	5.6%
8	Parks and recreation	4.5%
9	Healthy behaviors and lifestyles	4.4%
10	Welcoming of diverse communities/people	4.3%
11	Safe, nearby transportation	4.0%
12	Supportive and happy family life	4.0%
13	Good place to raise children	3.2%
14	Participating and giving back to the community	2.7%
15	Good job training opportunities	2.6%
16	Religious or spiritual values	2.4%
17	Physical accommodations for people with disabilities	2.0%
18	Low level of child abuse	1.8%
19	Arts and cultural events	1.5%
20	Good daycare and preschools	1.4%
21	Low deaths and disease rates	1.3%

As the table presents, the five most frequently selected responses were 1) Safe, affordable housing; 2) Access to physical, mental, and/or oral health care; 3) Access to healthy, affordable food; 4) Good schools; and 5) Low crime/safe neighborhoods. These responses were the most frequently selected characteristics of a

healthy community for almost all subpopulations based on the demographics presented above (i.e., in general, they were the top five selections across age groups, races, etc.).

Some other characteristics did, however, rise to the surface as important for particular subpopulations. Minority sexual orientations and persons of non-normative genders (two populations the survey particularly sought to be represented among respondents) both ranked "Welcoming of diverse communities/people" within their top five, whereas it ranked tenth for total survey respondents. Additionally, "Good jobs to reach a healthy economy" ranked sixth for 26 different subpopulations. These 26 subpopulations represented a diversity of age groups, races, counties, genders, etc., indicating it is an important issue for many people in the region.

Figure 29: Survey Question 1 Responses



Survey Question 2: Issues Affecting Community Health (Needs)

The second question on the survey asked respondents about the biggest health needs in their community. The question read, *"In the following list, what do you think are the five most important 'issues' that need to be addressed to make your community healthy? (Those topics that have the greatest impact on overall community health)."* The table below presents the response options ordered by the frequency at which they were selected. Again, because the question asked respondents to select five topics, the five most frequently selected responses are shaded in gray. Frequencies were calculated using the total number of selections as the denominator (presented as "n" in the frequency column).

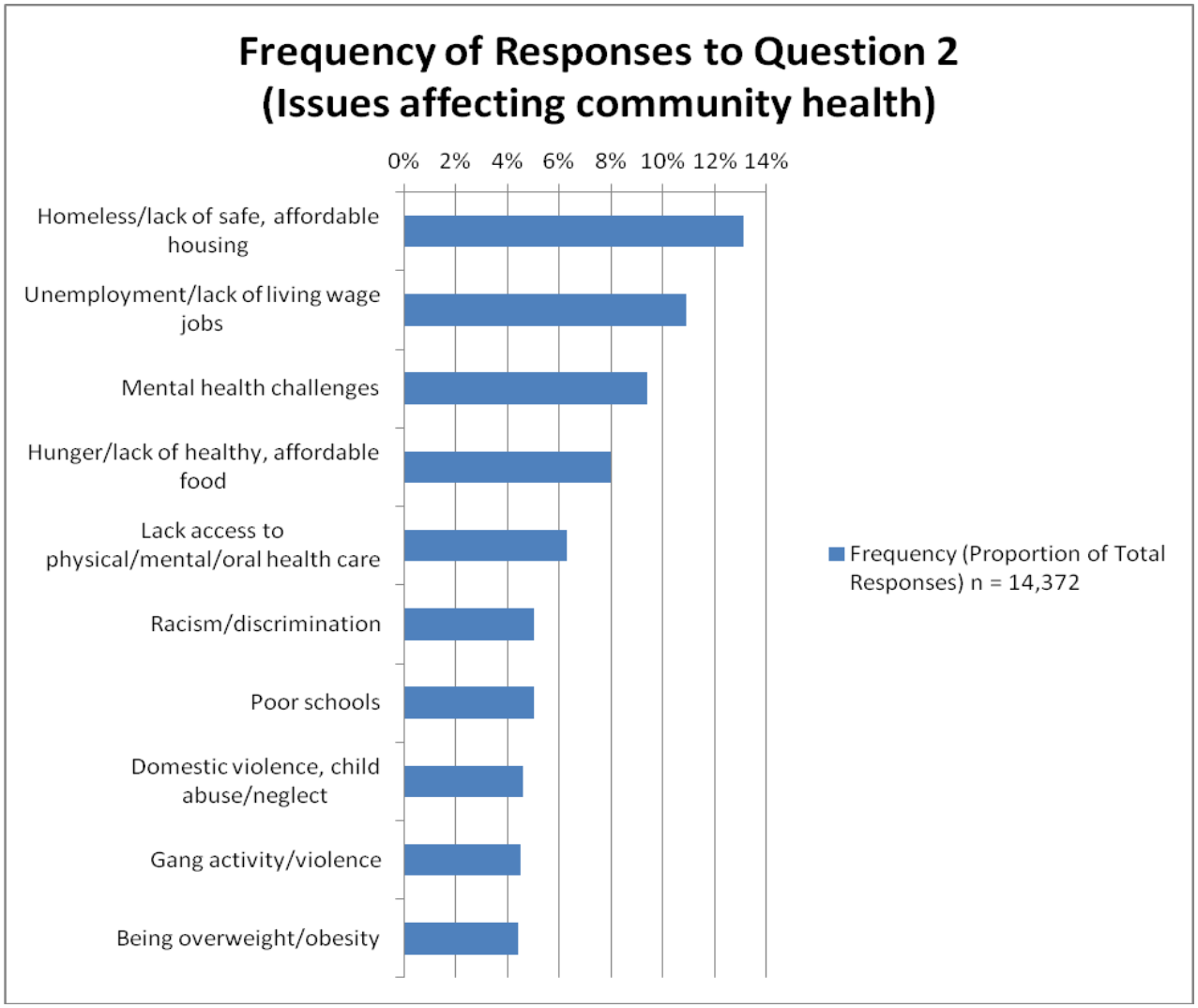
Table 23: Survey Question 2 Results

Rank based on Frequency	Response Options	Frequency (Proportion of Total Responses) n = 14,372
1	Homeless/lack of safe, affordable housing	13.1%
2	Unemployment/lack of living wage jobs	10.9%
3	Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders)	9.4%
4	Hunger/lack of healthy, affordable food	8.0%
5	Lack access to physical, mental, and/or oral health care	6.3%
6	Racism/discrimination	5.0%
7	Poor schools	5.0%
8	Domestic violence, child abuse/neglect	4.6%
9	Gang activity/violence	4.5%
10	Being overweight/obesity	4.4%
11	Unsafe streets (limited crosswalks, bike lanes, lighting, etc.)	3.9%
12	Lack of needed job skills or training	3.5%
13	Lack of community involvement	3.2%
14	Dirty environment	2.6%
15	Lack access to safe, nearby transportation	2.2%
16	Disabilities (physical, mental) and limited mobility	2.1%
17	Bullying/verbal abuse	1.9%
18	Lack of safe and accessible parks/recreation	1.7%
19	Aging problems (e.g. memory loss, hearing/vision loss)	1.5%
20	Lack of good daycare and preschools	1.5%
21	Firearm-related injuries	1.4%
22	Lack of physical accommodations for people with disabilities	1.2%
23	Few arts and cultural events	1.0%
24	Asthma/respiratory/lung disease	0.7%
25	HIV/AIDS	0.5%

As Table 21 shows, the five most frequently selected community needs were 1) Homelessness/lack of safe, affordable housing; 2) Unemployment/lack of living wage jobs; 3) Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders); 4) Hunger/lack of healthy, affordable food; and 5) Lack access to physical, mental, and/or oral health care. As with Question 1, the five most frequently selected responses were largely consistent across different demographic populations.

Despite this general consistency, there were several issues that were also prominent among specific subpopulations. Fourteen subpopulations, representing several age groups, races, insurance coverage types, and more, selected "Racism/discrimination" among their top five responses. "Gang activity/violence" was among the top five issues for respondents under 18 years of age, males, African Americans/Blacks, and respondents covered by Veterans' Administration health insurance. "Poor schools" was among the top five for respondents under 18 years of age, males, Asian Americans/Asians, and Multiracial respondents. "Being overweight/obesity" was among the top five responses for Veterans and ranked sixth for six additional subpopulations.

Figure 30: Survey Question 2 Responses



Survey Question 3: Risky Behaviors

The third question the survey asked was about behaviors that can endanger health. The question read, *"In the following list, what do you think are the three most important 'risky behaviors' in your community? (Those behaviors that have the greatest impact on overall community health)."* The table below presents the response options ordered by the frequency at which they were selected. Because the question asked respondents to select three behaviors, the three most frequently selected responses are shaded in gray. Frequencies were calculated using the total number of selections as the denominator (presented as "n" in the frequency column).

Table 24: Survey Question 3 Results

Rank based on Frequency	**Response Options**	**Frequency (Proportion of Total Responses)** n = 8,792
1	Drug use/abuse	18.6%
2	Alcohol abuse/addiction	16.2%
3	Poor eating habits	10.0%
4	Social isolation/loneliness	9.3%
5	Dropping out of school	9.1%
6	Lack of exercise	8.9%
7	Unsafe driving (e.g. not using seat belts/child safety seats, distracted driving)	7.4%
8	Tobacco use	5.7%
9	Risky sexual behavior/unsafe sex	5.2%
10	Not getting "shots" to prevent disease (immunizations)	4.5%
11	Not using birth control	3.0%
12	Self-harm (e.g. cutting, suicide attempts)	2.2%

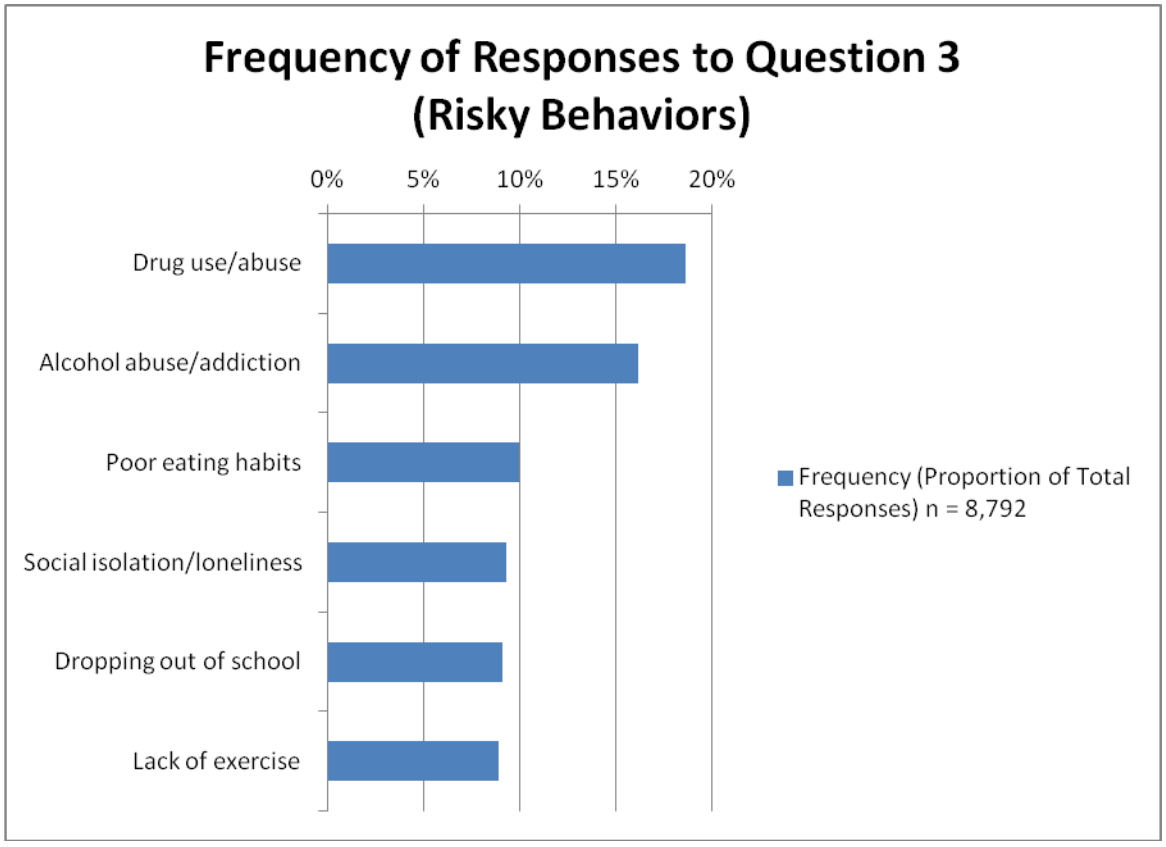
The three most frequently selected responses were 1) Drug use/abuse; 2) Alcohol abuse/addiction; and 3) Poor eating habits. Both "Drug use/abuse" and "Alcohol abuse/addiction" were in the top three responses among all subpopulations analyzed, except for one: respondents under age 18, where "Alcohol abuse/addiction" was ranked fourth. While "Poor eating" was in the top three for the general survey population, it ranked lower for many subpopulations. Meanwhile "Social isolation/loneliness" and "Dropping out of school" ranked higher for several of these subpopulations.

"Social isolation" was among the top three responses for 11 different subpopulations. These subpopulations included the LGBTQ community (both non-normative genders and minority sexual orientations), low income

respondents (both those at or below 200% FPL and those covered by Medicaid), respondents with disabilities (both those identifying as having a disability and those dually eligible for Medicaid and Medicare), as well as other populations (Multnomah County; ages 55-64; multiracial respondents; respondents who speak Spanish, Spanish Creole, or Spanish and English at home; and Medicare).

"Dropping out of school" was among the top three responses for eight subpopulations. These subpopulations included younger respondents (those under age 18 and those ages 19-25), two communities of color (African American/Black and Native American/American Indian/Alaska Native), respondents with less educational attainment (those with less than a high school education and those with a high school diploma or GED), and other populations (ages 65-79 and respondents covered by Veterans' Administration health insurance).

Figure 31: Survey Question 3 Responses



Survey Question 4: Community Health Rating

The fourth survey question asked respondents to rate the health of their community. The question read, "*How healthy would you rate your community as a whole?"* Table 20 presents the distribution of responses. Unlike the previous three questions, respondents were directed to only give one response to this question. Therefore, the proportion of responses per rating was calculated using the number of people indicating that response as the denominator, displayed as "n" in the table.

Table 25: Survey Question 4 Results

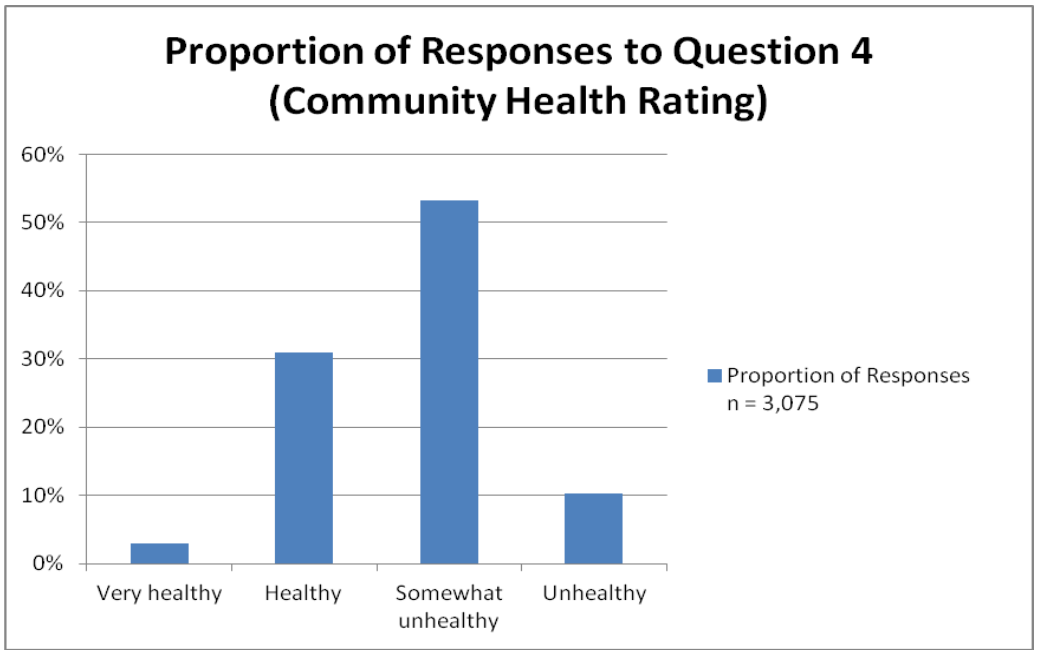
Rating	**Proportion of Responses** n = 3,075
Very healthy	3.0%
Healthy	30.9%
Somewhat unhealthy	53.2%
Unhealthy	10.3%
Very unhealthy	2.6%

The distribution of responses differed for some populations based on their demographics. These differences are summarized below. Populations not mentioned below had response distributions similar to that of all respondents.

Table 26: Populations with Different Community Health Ratings

More "Very Healthy" and/or "Healthy" Ratings	**More "Unhealthy" or "Very Unhealthy" Ratings**
• Clackamas County • Washington County • Under 18 • Ages 55-64 • Ages 65-79 • Ages 80 and older	• Men • Grew up outside the U.S. • African American/Black • Multiracial • Native American/American Indian/Alaska Native • Speak a language other than English or Spanish at home • Have a disability • Less than a high school education • High school diploma or GED • At or below 200% FPL • Medicaid • Veterans' Administration

Figure 32: Survey Question 4 Responses



Limitations

There are limitations associated with collecting data through the online survey. First, findings are based on data collected through a convenience sample. The CEW conducted the majority of outreach for the survey and thus people likely heard about it through colleagues, friends, or organizations they are familiar with. In addition, people could have filled it out more than once.

Next, the online format (with limited hard copies available only in English and Spanish) required participants to have access to computer and internet resources. The online format may not have been the best way to reach people who are not native English speakers. Despite our best efforts to translate the survey and reach out to folks who speak Spanish, Vietnamese, Russian, and Chinese, our response rate from these communities was low. In addition, very few people on our Community Engagement Workgroup speak languages other than English, which meant that our outreach efforts relied on community organizations to encourage people from these communities to take the survey. The in-person outreach efforts made, for example attending community events with the surveys on electronic tablets or paper copies, proved to be effective. A more robust in-person outreach strategy could have further increased the representation from low-response subpopulations.

While we reached more than 3,000 people with the survey, some of the subpopulations were too small to analyze separately. For example, we could not analyze African or Middle Eastern/Arab American as separate subpopulations because the number of responses was less than 25, our minimum for separate analysis.

Finally, upon reflection and analysis, we found several limitations within the survey that may have impacted our findings. The survey failed to list Pacific Islander as an option for race. Although several people wrote it in, we did not have enough responses to analyze this population separately. The health insurance question

may have been confusing for people. Almost everyone with some kind of health insurance selected the option intended to mean private insurance. Many people indicated health insurance coverage and also selected “Pay cash (no insurance).” One reason could have been that people wanted to make it clear they still pay out of pocket, even with their insurance. It is also possible that survey respondents came from households with a mixture of insurance statuses.

Listening Sessions

Introduction

Throughout the development and design of the community engagement efforts for the 2016 CHNA, the CEW recognized that information regarding community strengths and needs could not fully be addressed in the online survey alone. The survey format limits responses to predetermined selections and generally does not afford the opportunity to respond outside of those parameters. In addition, there were populations that had been prioritized based on findings from the 2013 CHNA, who were not fully reached by the survey tool. These populations were prioritized because they experience health disparities or because there is a lack of specific epidemiologic data related to these health issues or disparities. Analysis of initial survey responses also allowed the CEW to identify populations that the online survey did not adequately reach and prioritize those groups for listening session outreach and planning.

In an effort to collect specific community needs and strengths not explicitly outlined in the survey, the CEW decided to conduct small group discussions with a set of open-ended questions. These open-ended question-and-answer sessions allowed community members to express their views and opinions without specific prompts. In a small (10-15 participants) group environment, community members discussed their responses amongst one another, with participants building on each other’s responses. The sessions were intended to augment the prescriptive format of the survey as well as elicit candid responses from the community. Additionally, the use of direct quotes from listening sessions has the potential to represent the voices of the community more accurately and identify unique community needs and solutions.

Methodology

Selection and recruitment

Preliminary survey responses were examined to determine how representative they were of the general population in the four-county region. Based on gaps in the survey responses, priority populations were identified for listening sessions, including: people experiencing homelessness, youth, people experiencing mental health issues and/or addictions, aging populations, rural and unincorporated communities, African Americans, Asians, Pacific Islanders, Native Americans or Alaska Native, Latinos, immigrant and refugees, and veterans.

A total of 29 listening sessions were conducted across the four-county region through existing partnerships with community-based organizations (see *Table 33*). In recognition of the existing and deep community connections HCWC’s partner organizations have with the identified priority populations, the CEW identified local organizations working with the identified priority populations to partner with on the listening sessions. These organizations were offered a stipend to cover the costs of hosting a session in exchange for leveraging

the trust and relationships they have built with communities in order to maximize listening session participation. Organizations independently recruited community members to participate in the listening sessions, through fliers and word-of-mouth. Facilitators with connections and ties to the community were designated from each organization. Each facilitator received guidance and training on group facilitation.

Table 27: Listening Session Populations

			Populations Reached												
Date	Host Organization	# of Participants	Homeless	Youth	Mental Health	Addictions	Aging	Rural	African Amer.	Asian/Pac. Islander	Native Amer./AK Nat.	Latino	Immigrant/Refugee	Veteran	CHW
	Clackamas County														
12/8/2015	Ant Farm	15		X				X							
12/3/2015	NAMI Clackamas	12			X			X							
12/11/2015	Clackamas Service Center	14	X		X	X									
12/29/2015	Hacienda CDC	12						X				X	X		
11/10/2015	Kaiser CHW	15													X
	Clark County														
11/25/2015	Lifeline Connections	12				X									
12/9/2015	Calvary Church	14											X		
12/11/2015	Free Clinic	12										X	X		
12/18/2015	Free Clinic	4	X									X	X		
11/9/2015	Kaiser CHW	14													X
	Multnomah County														
12/14/2015	Central City Concern	9	X		X	X									
11/24/2015	Liberation Street Church	12	X		X	X									
12/2/2015	Outside In	9	X	X	X	X									
12/17/2015	Highland Haven/HARRP	16				X			X						
10/22/2015	Kaiser CHW	10													X
	Washington County														
11/23/2015	Adelante Mujeres	10						X				X	X		
11/23/2015	Adelante Mujeres	12						X				X	X		
12/14/2015	LifeWorks NW Hillsboro	11				X		X							
12/7/2015	LifeWorks NW Beaverton	11				X									
12/17/2015	Kaiser CHW	7													X
	Multi-County														
10/30/2015	Area Councils on Aging	19			X		X	X							
1/7/2016	IRCO Vietnamese*	15								X			X		
1/6/2016	IRCO Tongan*	10								X			X		
1/9/2016	IRCO Somali*	17											X		
1/11/2016	IRCO Russian*	10								X			X		
12/28/2015	Urban League*	12							X						
1/12/2016	NAYA*	21		X							X				
12/7/2015	Latino Network*	19										X	X		
12/19/2015	VA Hospital	10			X		X							X	
	TOTAL PARTICIPANTS	364													
	TOTAL SESSIONS	29													

*Sessions were conducted in partnership with the Oregon Public Health Institute.

Facilitation guide

The facilitation guide was developed by the CEW and included four questions. Designed to be an icebreaker, participants were first asked to draw a picture of their community and then describe it for the group. This icebreaker was suggested by one of the community member participants on the CEW. After each participant had the opportunity to describe their community, four subsequent questions were asked:

1. What makes a healthy community?
2. How can you tell when your community is healthy?
3. What's working? What are the resources that currently help your community to be healthy?
4. What's needed? What more could be done to help your community be healthy?

Training

Training for note-taking and listening session facilitation was conducted prior to the first listening session. CEW members who volunteered to participate were trained by research staff from Providence CORE in note-taking skills. Note-takers were instructed to represent participant comments as accurately as possible, without adding additional interpretation. The workgroup requested that when more than one note-taker was present, both note-takers collect similar information in an effort to ensure all participants' contributions were recorded. A note-taking guide was developed and provided to note-takers as a template for data collection (*Appendix F*).

Data collection

Data was collected in the form of handwritten notes recorded by note-takers and facilitators. The majority of listening sessions had two sets of notes recorded by two note-takers in addition to flip chart notes recorded by facilitators. The workgroup decided not to audio-record sessions due to financial limitations for transcription and due to the concern that some populations might be less comfortable if their comments were audio-recorded. As detailed in the previous section, note-takers were trained in recording quotes, use of paraphrasing, and indication of group consensus or disagreements. At the end of each listening session, note-takers and facilitators spent 20-30 minutes discussing the session dynamics, common themes within the areas of concern, and any bias or prompting present. This "debrief" was documented on a separate note-taking template to capture the overall tone and dominant themes of each session. The sum of listening session notes, flip charts, and debrief notes were used for analysis.

Analysis

Qualitative analysis of listening sessions was completed using both simultaneous and descriptive coding methods conducted with qualitative data analysis software, Atlas.ti. Coding is a method used to highlight and summarize the key themes that emerge across groups of people, while preserving individual voices.

The first step in the analytic process was the merging of session notes. Most, but not all sessions had more than one set of notes, so a process was developed to merge the duplicated notes. Flip chart notes were transcribed and used as the basis for merging. The additional sets of notes were then merged into the flip chart notes to add detail to notations, including quotes and specificity. Debrief notes were transcribed separately from the merged notes and flipcharts. Files were imported into Atlas.ti without a descriptive

name, and instead were assigned a number and crosswalk identifier in an effort to reduce potential coding bias based on listening session group identification.

Two analysts read through the notes and debrief documents and developed a preliminary list of common topics. These broad topics were listed as *codes* within *categories*, and each analyst developed definitions for the codes and categories that they suggested. The analysts compared their lists and reached consensus on a proposed coding dictionary that contained 38 codes. The proposed codes and definitions were brought to the CEW for consideration. Modifications to codes, coding categories, and definitions were made through group recommendations. Three (3) domains (Vision/Indicator, Need/Driver, and Strength), 30 codes, and 15 priority population codes were designated (see *Appendix F*).

To verify that both analysts were using the codes the same way, they independently coded a subset of three listening sessions and then reviewed their work collectively. In cases where there was a discrepancy between analysts, recommendations were made to the CEW for changes in the coding dictionary that would improve consistency with coding. The coding dictionary was updated and coding processes were clarified to reflect these recommendations.

Debrief and Notes documents were divided into even and odd documents; each analyst coded either even or odd numbered documents. Preliminary analysis of Debrief documents was presented to the CEW alongside preliminary analysis of Notes documents. Comparison of the two revealed a lack of notable difference among Notes and Debrief documents. Based on this information, analysis was completed for Notes documents only.

Analysts determined the relative frequency with which each code was applied to the entire dataset. This information told us which codes and subjects were mentioned most frequently, and a secondary analysis was conducted to explore the content of the passages that were coded with these dominant codes. For example, Access to Resources/Care was the most frequently used code, but was frequently coded in tandem with Physical Health/Dental/Vision and Resources/Coordination of Services. To understand this relationship, we developed queries of quotes coded with these three topics, which provided details regarding how physical health related access to resources/care and coordination of services.

Analysts documented thematic patterns related to frequent codes and brought emergent themes before the CEW for discussion. Iterative investigation of thematic patterns was conducted according to recommendations provided by the CEW.

In an effort to elevate the voice of priority populations, analysis was also completed separately for specific priority populations. Sessions that were predominantly Latino, African American, immigrant and refugee (excluding Latino), and Native American/Alaska Native were analyzed separately from the other sessions and compared/contrasted to the overall listening session data. This additional analysis allowed the CEW to identify any notable differences in needs, visions, and strengths within these communities.

Findings

A total of 29 listening sessions were held at 20 organizations, with the voices of 364 community member participants. Demographic information provided by participants during listening sessions is noted in *Appendix F*.

Participants were asked to respond to questions regarding their vision of an ideal healthy community, as well as the strengths and needs that currently exist within their own community. The paragraphs that follow are the most dominant themes expressed in a collective voice throughout the listening sessions.

Vision

Within the Vision domain people expressed what they believed makes up a healthy community. They were asked, "What makes a healthy community" and "How can you tell when your community is healthy?" The most prominent responses were:

- **In a healthy community, people are healthy in mind, body, and spirit.** Participants saw "wholeness" as essential to a vision of a healthy community. They viewed health holistically, encompassing mental, emotional, spiritual, physical, and even financial wellness. Participants suggested a healthy balance in all of these areas was conducive to physical health.

"A [healthy] community is when all of our needs have been met – physically, spiritually, and all of the things we need to be healthy." --Listening session participant

- **In a healthy community, people know one another and feel connected.** Participants described a healthy community as one where "you know your neighbors," where people smile and say hello, where people talk to one another, and where all members feel a sense of belonging. Participants described cookouts, block parties, and other community events. They described a community as sharing a sense of purpose and a sense of cohesion. They envisioned a community where members acknowledged their interdependence and where the community had a role in governance.

"God gave us each other. When we take care of each other, we are more healthy." --Listening session participant

- **In a healthy community, people participate and help others.** According to the listening sessions, participation and collaboration were two key elements to a healthy community. In terms of participation, respondents described a healthy community as one where citizens participate in community activities. Volunteering was seen as an indicator of a healthy community. In terms of collaboration, participants thought it was important to support and help one another. "*Sharing*," said one participant, "*The healthy helping the less healthy. Mutual help. Teamwork*."

"A healthy community cares for the vulnerable." --Listening session participant

- **In a healthy community, everyone feels valued and welcome.** Participants expressed that a healthy community ensures all voices are heard, without judgment or discrimination. A healthy community is diverse and all groups are treated fairly. Inclusiveness and acceptance is important and participants specifically mentioned race, immigration status, gender, and sexual orientation. One participant expressed that in a healthy community "*people feel power to express themselves and the leaders are listening and valuing our input*." The words "*respect*" and "*compassion*" were used often.

- **In a healthy community, everyone is able to meet basic needs.** When participants spoke about basic needs they referenced clothing, food, jobs, and housing. The collective voice was especially concerned about access to affordable housing for everyone. Participants viewed a healthy

community as one where everyone has access to these essential things. One participant summarized this topic saying:

"A healthy community is one where a large percentage of people in the community have access to the material resources they need to be healthy." --Listening session participant

- **In a healthy community, everyone has access to physical and behavioral health care they can afford.** Affordability was expressed by participants as a necessary component of access to physical and behavioral health care. Participants also expressed that in a healthy community people clearly understand how to access these types of care, and have the resources to do so on their own. It was important, especially among African American participants, that people be able to take care of their own physical, mental, and spiritual needs, with access to knowledge pertaining to these services.
- **In a healthy community, people practice healthy behaviors and take care of themselves.** Facilitators heard from participants that in a healthy community people would engage in healthy behaviors and habits, such as eating well, exercising, engaging with nature, and abstaining from substance abuse. Many of these behavior choices were echoed throughout various listening sessions, emphasizing the need for people to take care of themselves by holding themselves accountable to make better choices and lead healthier lives.

Strengths

In this domain, participants described what they believe supports health in their community. Facilitators asked "What's working? What are the resources that currently help your community to be healthy?" The responses are described in detail below.

- **Social services and service organizations support community health.** Organizations providing access to basic needs through specific programs like WIC, clothing donations, food banks, free clinics, detox programs, job training, community gardens, and shelters support healthy families and healthy communities. Some themes emerged throughout the programs and organizations that were described, including being non-profit, open to the public, accessible at free or reduced cost, and providing education or basic resources.

"There are services out there. They just need to get to the right people for the homeless and the economically challenged." --Listening session participant

- **Healthy behaviors and habits support community health.** Similarly mentioned in the vision domain, people attribute much of the health in their community to personal choices and self-care. Proactively engaging in physical activity, connecting to nature, and choosing nutritious foods were considered important elements of personal responsibility for health. Several participants noted that knowledge gained from community cooking courses paired with affordable access to fresh foods was important for choosing healthy meal options. Additionally, safe and accessible recreational activities, gym memberships, walking, and sports for youth were frequently discussed.

"Tai chi, Nia, Zumba – [we enjoy] sharing in things that make us feel good." --Listening session participant

- **Community-based services—especially those provided *by* the community, *for* the community—support community health.** Community health workers (CHWs), peers, and mentors were specifically named as working for the community.

"My English is not perfect, but I'm helping anyways." --Listening session participant

- **A pleasant neighborhood environment supports community health.** Participants suggested neighborhood walkability, safety, community size, and access to parks and nature contributed to community health.

- **Social cohesion supports community health.** The common element through all three domains is a sense of community. In general, people want to know their neighbors and feel connected to their community. One participant said, *"It's not just seeing on Facebook what people are doing, it's face-to-face, personal interactions."* Participants want to be a source of support and also be able to count on their neighbors when they need it most. Participants also find value in sharing information and resources with one another through word-of-mouth.

"We socialize and interact with our neighbors, we learn from each other." --Listening session participant

- **Free or reduced-cost health care services and good, trustworthy providers support community health.** Access to free clinics and dental services were supported by transportation to and from appointments, navigation through the system, and access to health insurance.

Needs

In this domain, participants described issues that need to be addressed in their community. We asked, "What's needed? What more could be done to help your community to be healthy?" Overall, participants felt that in order for a community to be healthy:

- **Community members must be able to meet basic needs.** Participants across populations agreed basic needs—such as food, housing, and transportation—must be met in order to achieve health. Many participants expressed concern that while they themselves might have a home and enough to eat, others in the community are going without. Equity was important; in many listening sessions, at least one person would mention the necessity for *all* members of a community to have their basic needs met in order for the community to be healthy. Housing was especially important to participants, citing displacement and gentrification as particular areas of concern.

"If you can't get up in the morning and take a shower and eat breakfast, how can you do anything else in life?" --Listening session participant

"Anyone who has been homeless knows that it is like being in combat. If you're out there for a long time you get post-traumatic stress disorder." --Listening session participant

- **Community members must respect, empower, and help one another.** Many participants throughout listening sessions articulated the need for unity and a feeling of togetherness. They expressed a desire for more opportunities to interact with one another, work together toward a common goal, build relationships in the community, and volunteer.

- **Discrimination, racism, and disparities must be eradicated.** Participants in each listening session had a unique experience of discrimination or racism, stigmatization of mental illness, racial profiling, systemic and historical racism, historical trauma, and unequal opportunities dependent on immigration status. Every session, regardless of identity, people wanted to be treated with fairness, equity, and respect. Respondents saw the world as an unequal place where some people were treated differently than others based on aspects of their identities. Specifically, participants asked for humane and fair treatment from law enforcement, health care workers, and each other.

"Oregon's racist history has contributed to the lack of a healthy community within the black community." –Listening session participant

"When you're fearful of the response you may get from another person it prevents meaningful interaction." –Listening session participant

- **Community members need access to health care they can afford.** Participants said affordability and lack of insurance were the biggest barriers to accessing health care services. In regard to mental and behavioral health, availability of services was an important issue, more so than affordability or insurance. Access to health care was a specific concern for Latino community members, especially undocumented individuals.

"Members of the Latino population who do not have legal status have to pay for all of their medical services. This is extremely expensive and increases mortality rates because we avoid preventative consultations for years." –Listening session participant

"I brought my son once but they charged me one thousand dollars. He is sick now but I won't bring him in because of the cost." –Listening session participant

- **Community members need access to job training and pathways to employment.** Participants described a world where many things are unaffordable and people are struggling to make ends meet. Participants expressed a need for jobs; better-paying jobs; and job training programs, especially for re-entry into the job market. Employment was more than just an income for some participants; when asked what they needed to be healthy in their community one participant answered, "*Personally? A job. I would feel better about myself if I had somewhere to go every day. Winter is the worst time.*"

"When re-entering the job market, I wish there were more internships. I would like to see more opportunities to go and get the job by doing it for a few months. [I] need a flexible, getting back to work option." –Listening session participant

- **Community members need access to culturally competent, linguistically appropriate care.** Participants expressed that encountering language barriers makes health care and other systems confusing. They need more information, communicated in more languages, and available in public places. Compassionate care by health care providers, guided by cultural relevance was acknowledged as a need throughout listening sessions.

"Providers need to have an open mind, really listen with courtesy and respect." –Listening session participant

- **Community members need access to information about how to get help.** Participants conveyed they have had challenges finding information about resources that may potentially be available to them. As members within listening sessions discussed the need for resources, they started sharing their knowledge of various resources with each other, building each group's knowledge base. Many sessions concluded they need to have resources listed or available in a single, central location, simplifying the process. Many of the comments related to the need for information about resources were related to where to get basic needs (i.e., food, housing, shower, blankets, and clothing) met. Additionally, navigating through heath care and social services systems is challenging, and help with navigation was suggested as a potential solution.

"Newspaper, banners, billboards should be used to advertise social resources, in many different languages." –Listening session participant

"First generation Africans face many barriers…there are programs but we don't know about them. We don't know how to go." –Listening session participant

Limitations

Although the CEW intentionally tried to reach priority populations across the four counties, and was successful in oversampling among communities of color and several other priority populations, the majority of listening session participants were White and English-speaking. Similarly, the majority of listening sessions were held in Multnomah County, although many of the participants for the multi-county sessions lived in Clackamas, Clark, and Washington Counties. This limits the ability to discuss the particular needs of the people living in these counties.

The CEW had the most success connecting with organizations with which we had existing relationships. This was helpful in strengthening HCWC's relationships with these organizations, but presents a selection bias for recruitment. For example, if a CEW participant had stronger relationships with organizations serving veterans, we might have had increased responses from that specific community. In addition, the group's strong relationships with behavioral health organizations meant increased input from those communities.

Listening session participants were recruited by community organizations based on convenience. As is true of all qualitative data, their voices are not meant to represent entire communities, and the listening session data is not generalizable beyond the context in which it was gathered.

Note-takers were transcribing the dialogue in fast paced sessions. There may be limitations in a note-taker's ability to accurately interpret the dialogue without the influence of personal bias or perspective. The CEW conducted listening sessions in the first languages of the participants. Note-takers in languages other than English (who were almost always from the same community as participants) had the choice of taking notes either in the language being spoken or in English, according to their preference. Some note-takers chose to translate into English as they wrote. Notes taken in other languages were translated by an outside agency. Both approaches have advantages and limitations. For example, a translator who was not present for the conversation may have less context for the translation.

Facilitators' emphasis on specific questions or examples may have influenced the direction of the listening session dialogue. Also, listening sessions varied in participation. Some sessions were dominated by a few voices while others were more equally shared by all participants.

The CEW made decisions regarding the analysis of the listening session data. Although CEW participants come from a variety of backgrounds and experiences and work with people from all walks of life, the majority of participants (but not all) are White, able-bodied, heterosexual, and/or gender-conforming. The CEW recognizes that our identities and perspectives affect our analysis of the data.

Inventory of Community Engagement Projects

Introduction

The inventory of community engagement projects, along with the listening sessions and survey, was completed with the goal of exploring issues affecting community health (needs) and the things that are working to address those issues (strengths). An inventory (or qualitative meta-analysis), is a content analysis of other qualitative or community engagement projects that meet a specific set of criteria. In this case, the inventory identified health-related themes collected from existing community engagement projects in Clackamas, Multnomah, and Washington Counties in Oregon and Clark County in Washington. The CEW recognized the existence of an extensive body of work from local community-based organizations, advocacy groups, and government programs that engaged diverse communities in identifying health needs and solutions and that utilizing these resources would reduce duplication of efforts and demonstrate the value and insight gained from these projects.

Inclusion of the inventory in the Community Themes and Strengths Assessment added an additional layer of analysis of the health needs of the priority populations identified by the CEW. All of the community engagement projects included in the inventory focused on one or more of the priority populations. This allowed for a closer look at the health needs of populations often left out of data collection and improvement plans. In combination with the listening sessions and survey, the inventory provided the CEW with the information necessary to explore community-identified health needs, strengths, and vision in the four-county region.

Methodology

A total of 55 community engagement projects were reviewed in the inventory to explore community-identified needs, strengths, and vision.

Inclusion criteria

These assessment projects were chosen based on five criteria:

- Geographic scope within the four-county region of Clackamas, Multnomah, Washington, and Clark counties
- Completed within the last three years (2012-2015)
- Data collected directly from individuals in the community, as opposed to agency or organization leaders
- Focused on the topics of health, mental health, health-related services, or social determinants of health
- Focused on priority populations

Priority populations

Priority populations were identified by the CEW and defined as: aging community and seniors; communities of color; people experiencing homelessness; immigrants and refugees; limited-English-speaking people and other-language speakers; people identifying as lesbian, gay, bisexual, transgender, queer or questioning (LGBTQ); low-income communities; people living with disabilities; people with mental health issues; people with addictions or in recovery; rural and unincorporated communities; uninsured people; veterans; and youth.

Process for identifying projects

Community engagement projects were identified and collected by:

- Internet searches for community assessment projects fitting the inclusion criteria
- Contacting community organizations and individuals for access to projects not readily available on websites
- Including projects from part of the previous Healthy Columbia Willamette Collaborative assessment fitting the criteria for this cycle

Research questions

Based on the 55 community engagement projects collected, a project summary was created for each assessment by categorizing community-identified health information into three research questions:

1) What makes a healthy/thriving community? (Vision)
2) What are the things currently helping your community to be healthy/thriving? (Strengths)
3) What are the health/social determinants of health issues in your community? (Needs)

Analysis

Once the information from the community engagement projects was categorized as vision, strength, or need, a thematic content analysis was performed to identify top themes for each of the three research questions. A preliminary coding dictionary was developed based on emerging themes in the data and was brought to the CEW for feedback. Based on the information in the project summaries, 31 codes were created to capture

health-related themes for each of the three questions. Frequently occurring themes were then pulled for the top codes to illustrate a more in-depth picture of what people saw as health-related visions, needs, and strengths, for their communities.

The community engagement projects included in this inventory used a wide variety of methods, including PhotoVoice projects, community listening sessions, community forums, surveys, focus groups, interviews, listening circles, questionnaires, house meetings, and public hearings. The assessment projects also varied in number of participants, demographics of participants, and duration of projects. The diversity of assessments included in the inventory allowed for a rich insight into community health and wellbeing.

Using the agreed-upon coding dictionary, two analysts coded the same five project summaries to check for coding consistency. Once inter-coder reliability was established, one analyst coded the remaining project summaries. After the top codes emerged within each domain, the analyst did a second review and pulled top themes within those codes to capture a more granular analysis of what community members were saying about vision, strengths, and needs. For example, the code "equity" rose to the top under the Needs domain. Upon further analysis, it became evident that income inequality and the higher rates of poverty experienced by many disenfranchised communities was an important theme within this code.

In addition to pulling top themes for the project summaries as a whole; top codes and themes were pulled from community engagement projects specific to immigrants and refugees, people with disabilities, and Native American/Alaska Native communities. The CEW chose to examine the top themes for these three priority populations as a way to highlight their voices and experiences, which may have been overshadowed in the survey and listening sessions. The project summaries reviewed included several community engagement projects specific to each of the three populations. This specificity allowed for more in-depth content analysis for these populations. Engagement projects that included multiple populations were excluded from this additional thematic analysis.

Findings

Below you will find the list of top codes and themes from the vision, strengths, and needs domains in alphabetical order.

Vision

- **Access to health services, insurance, and the affordability of care all emerged as essential parts of a healthy and thriving community.** The services mentioned most often were mental health, oral health, substance abuse treatment, and chronic disease management.
- **Access to quality education defined as pre-kindergarten, K-12, community college, and universities, emerged as a top theme.** References to schools, universities, and community colleges, as well as issues impacting schools, such as funding, common core (curricula), and equity were also identified as top themes.
- **Economic opportunities, job availability, access to and the ability to pay for basic needs emerged as an important part of a healthy and thriving community.** Food, transportation, and housing were the basic needs mentioned most often among the engagement projects.

- **An equitable society free from racism and discrimination emerged as an important component of participants' vision for a healthy community.** This code included references to disparities, inequities, equity work, discrimination, racism, and/or diversity. Health equity was identified as the top theme under this code.

- **The themes of good overall health, physical activity, and social wellbeing rose to the top as essential components of a vision for a healthy, thriving community.** This code included health status, functional health, disease, disease care, dental care, and vision care.

Strengths

The strengths domain includes the top five codes, as well as the top themes for housing, physical health/ dental/vision, and equity. These three additional codes emerged as top issues for both the Vision and the Needs domains; thus, the CEW wanted to identify what was working within communities to address these issues. As previously stated, the CEW applied a secondary level of analysis to ensure strengths were captured for specific populations: immigrants and refugees, people living with disabilities, and Native American/Alaska Natives. The findings below indicate where the top themes differed from the general analysis for these specific populations.

- **Access to health care services emerged as a community strength**. The health care services mentioned most often were clinics, providers, insurance, and free services. Among projects engaging people living with disabilities, health care services allowing people with disabilities to stay in their homes were identified as a strength.

- **Access to social services and funding of services emerged as strengths.** Community services and programs, public assistance, WIC, and food programs were specifically mentioned.

- **Culturally specific programs and practices and diversity rose to the top as strengths**. For immigrant and refugee communities specifically, cultural diversity and access to culturally specific programs and services were identified, along with resilience, optimism, and wisdom. Among projects engaging people with disabilities, programs and services for people with disabilities and their caregivers were identified as a strength. For projects engaging Native Americans/Alaska Natives, diversity and culture, as well as culturally appropriate information, programs, and activities were identified as strengths. Pride, resilience, and determination also rose to the top as strengths within this community.

- **Equity, particularly community diversity, was recognized as a strength.** Services, programs, and spaces that foster thriving multicultural communities were identified as top themes.

- **Housing programs and services emerged as top themes under the strengths domain.** In particular, housing for people in substance abuse recovery programs, transitional housing programs, and services that provide financial assistance for rent and utilities.

- **The availability of jobs, employment services, and job training emerged as top themes under the strengths domain.** This included education programs, job training, and services that link people to living-wage jobs.

- **Under the physical health/dental/vision code, culturally specific programs and practices and healthy behaviors emerged as top themes under the Strengths domain.** Among projects engaging Native Americans/Alaska Natives, healthy behaviors were identified as strengths.

- **Social support and spirituality emerged as community strengths.** Social support from family, friends, and faith-based communities and community cohesion and support were identified as top themes. This code also came up strongly within projects engaging immigrant and refugee communities and included religious/faith-based community and support, community involvement, and support from family and friends. Social support and inclusion was also identified as a top theme for people living with disabilities. Among projects engaging Native Americans/Alaska Natives, family and community support, community activities, and community-driven ideas were top themes.

Needs

The findings below include the top five codes for the Needs domain. In addition, the CEW chose to explore the top themes for communication and substance abuse, as these were the sixth and seventh most frequently occurring codes and they corresponded to findings from the survey and listening sessions. The codes and top themes within each code are listed below, including themes that emerged for prioritized populations.

- **Access to affordable health services, health centers, and insurance, as well as access to mental health services emerged as top needs in the community.** For immigrant and refugee communities, access to care and insurance, culturally competent services, and lack of understanding of how the health care system works emerged as top themes. For people living with disabilities, access to health care, reliance on unpaid family caregivers, and unmet basic needs rose to the top. For Native American/Alaska Natives, access to health care and insurance, culturally competent care, mental health services, and community services emerged as top themes in the community.

- **Language barriers, especially when communicating with medical professionals, socials services, and community members; access to information about services; and health literacy emerged as top themes under the Needs domain.** Among projects engaging immigrants and refugees, language barriers in healthcare, education, jobs, citizenship, and community and civic engagement emerged as top themes. For Native American/Alaska Native populations, health literacy emerged as a top theme.

- **Income inequality and higher rates of poverty experienced by communities of color, youth, immigrants and refugees, and people with disabilities, as well as health disparities experienced by these populations emerged as top themes under community needs.** In addition, education equity, which included graduation rates by race/ethnicity, neighborhood schools, and funding, also emerged as a top theme under community needs. Among projects engaging immigrants and refugees, racism and discrimination; education equity; and access to voting, decision-making, and civic engagement also rose to the top. For people living with disabilities, discrimination, stigma, and housing segregation were identified. For Native American/Alaska Native populations, racism and discrimination emerged as top themes.

- **Poverty and the ability to pay for basic needs (food, housing, healthcare, transportation, education, and childcare), as well as unemployment and lack of living-wage jobs emerged as top**

themes needing to be addressed in the community. Among immigrants and refugees, poverty, the ability to pay for housing, occupational segregation, and access to living wage jobs emerged as top themes. For people living with disabilities, income and poverty emerged as top themes.

- **Access to mental health services, lack of mental health treatment, and stigma of mental illness emerged as top mental health themes needing to be addressed in the community.** The specific mental health issues of depression, suicide, and trauma also emerged as top needs.
- **Substance abuse and lack of treatment, social acceptance of substance use, and presence of drugs in the community emerged as top themes needing to be addressed in the community.** For Native American/Alaska Native populations, community norms and acceptance of substance abuse and high rates of substance abuse emerged as top themes.
- The code **physical health/dental/vision** did not rise to the top in the general analysis, but came up in priority populations. For people with disabilities, chronic disease and fair/poor health emerged as top themes. For Native American/Alaska Native populations, overweight and obesity, sexually transmitted infections**,** low birth weight, and infant mortality were identified as top themes.
- The code **social support/spirituality** emerged within projects engaging people living with disabilities. For this population, social inclusion and social support emerged as top themes needing to be addressed in the community.

Limitations

It is probable that not all community assessment projects meeting the inclusion criteria were included in the inventory. The 55 assessment projects included in the inventory used a variety of methodologies to gather information on health-related issues impacting community members. Each project summary also had its own sets of questions presented to community members. The unique questions and varying methods could have limited the chance of some topics coming up or solicited information on some issues and not others. In addition, the engagement projects ranged from small groups to thousands of participants. As a result, some findings could have been equally weighted despite the varying number of participants.

Because most of the project summaries included more than one priority population, the CEW was unable to identify most comments based on race/ethnicity. Most assessments also included participants from more than one county. This limited the ability to identify comments based on which county participants lived in. A list of the community engagement projects reviewed, and their geographic scope, is available in *Appendix G*.

Data Blending to Identify Priority Health Issues

The purpose of blending the data from the online survey, listening sessions, and inventory of community engagement projects was to identify the top priority health issues from the community data. The data blending process took place in multiple stages. First, the CEW applied an equity lens to the data analysis for each of the three tools.

- **Online Survey:** In analyzing the survey data to create a list of priority needs, the CEW began by looking at the top answers to the first three questions from all participants (across the region). The

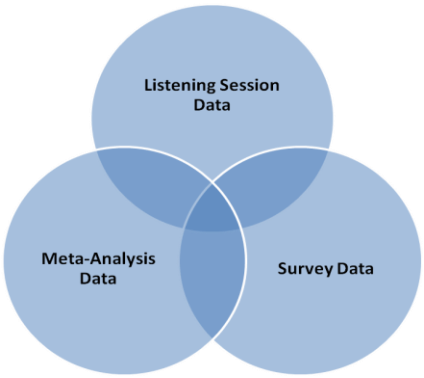
responses were then broken down into the following demographics: county, race, ethnicity, age, gender (including non-normative genders), veteran status, disability status, insurance status, primary language, above/below 200% FPL, sexual orientation, and education level. The CEW looked at whether these groups answered questions 1-3 differently than the region (all participants). Where there were differences, the CEW considered the frequency with which the difference occurred and which population it occurred in, and determined whether to add it to the list of priority needs identified in the survey. For example, "racism/discrimination" did not make it into the top five issues for the region overall (it was sixth); however, it came up in the top five for 15 of the 30 subpopulations. "Racism/discrimination" was a top theme in the listening sessions and inventory of community engagement projects, leading the CEW to add it to the list of priority issues.

- **Listening Sessions:** The CEW worked with Providence Center for Outcomes Research and Education (CORE) to analyze the listening session data. The workgroup collaboratively developed a list of codes, which the CORE team applied to the notes from the sessions. The CEW first looked at which codes came up the most across all listening sessions. The CEW then took a second pass through the data to see whether there were any differences for certain subpopulations: African Americans, Latinos, Native Americans, and Immigrants and Refugees. The CEW chose to do the second level of analysis because it was recognized that while there was oversampling for these groups, the majority of the listening session participants were White, and the CEW wanted to ensure the voices of these smaller populations were not missed.

- **Inventory of Community Engagement Projects:** Similar to the listening sessions, the CEW took a second pass through the inventory data for certain priority populations: immigrants and refugees, people living with disabilities, and Native American/Alaska Natives. The CEW chose these populations based on gaps in the listening session data and because there were studies focused on these populations specifically, so the CEW determined that the analysis would be more accurate. Again, the CEW looked for any codes rising to the top for those populations that may have been overshadowed in the overall analysis. In this case, the second level of analysis confirmed the initial codes were accurately capturing the views of these subpopulations.

After identifying top themes through the online survey, listening sessions, and inventory of community engagement projects, the CEW blended the themes from each tool to identify the Priority Health Issues for the community. Members of the CEW met twice over the course of one month to participate in the blending exercises. During the first meeting, the top themes from each tool were separated into three Venn Diagrams (one each for Vision, Strengths, and Needs).

Figure 33: Venn Diagram of Community Data for Blending



CEW members broke out into small groups to discuss the data, identify overlap between the lists, and develop the final list of priority issues. Issues coming up in all three data sets were prioritized first, followed by issues coming up in two out of three data sets. Several issues were combined, such as "pathways to living-wage jobs," which encompassed job training, education, and living wages. Each small group discussed their list of prioritized issues with the full group and issues were categorized as either a) final list or b) more discussion needed.

Finally, during the second CEW blending exercise, the prioritized issues were brought back to the table, along with decisions made and remaining questions. The group came to agreement on the final list of priority health issues and the wording for each indicator.

Community Engagement Data – Priority Health Issues

The following list represents the blended data from the online survey, listening sessions, and inventory of community engagement projects.

Vision

For all people:

- Affordable, high-quality, culturally responsive health care
- Basic needs are met, including food, housing, and transportation
- Living-wage jobs and pathways to employment
- Policies, systems, and environments that support good health and high quality of life
- Equitable and inclusive society, free from racism, discrimination, and stigma
- Good schools and equitable access to high quality education
- Environments and opportunities that support and encourage community involvement and connection

- Safe and accessible neighborhoods that are free of crime
- Safe, accessible, and affordable housing

Strengths

- Culturally specific, community-based services
- Feeling connected to a community
- Government-supported public assistance and social services
- Healthy behaviors
- Low/no-cost programs and services that make health care accessible
- Opportunities to be involved in the community
- Pathways to living-wage jobs
- Resilience

Needs

- Access to health care
- Access to food
- Access to transportation
- Active elimination of racism, discrimination, and stigma
- Building and sustaining connected communities
- Culturally and linguistically appropriate services
- Pathways to living-wage jobs
- Policies, systems, and environments that support healthy behaviors
- Support for people with behavioral health challenges
- Safe, accessible, and affordable housing

These social determinants of health and equity, identified by diverse communities within the four counties, represent top health priorities for our region. The following section discusses how the priority health issues from the *Community Themes and Strengths Assessment* were blended with the top issues identified through epidemiologic, hospital, and Medicaid data. Potential solutions, strengths, and opportunities identified by community members are described in the final section of this report (*Local Community Health System and Forces of Change Assessment*).

Priority Health Issues Model

Introduction

The Priority Health Issues Group (PHIG) was created to address the challenge of how to combine qualitative and quantitative data from different sources to identify the most pressing health issues in our region. The PHIG was charged with a) ensuring that results from all HCWC assessment steps were used to identify the priority health issues, b) developing a methodology to bridge all of these data, and c) designing a product or format to communicate the priority health issues.

The PHIG was made up of members from each of the data workgroups – epidemiology, hospital and CCO, and community engagement, as well as representation from community members and the HCWC Leadership Group. It also included representation from all four counties and from the three types of health systems that make up HCWC (hospital, CCO, and public health departments).

Methodology

The PHIG met monthly between July 2015 and April 2016. During this time, the group reviewed existing methodologies for mixed-methods approaches and used preliminary data to try out different models. In striving to create an objective process, while not losing community voice, the group created the following decision points:

- We will present the data from all assessments. No data will be left out.
- We will accept the findings as we receive them. Our job is not to decide whether the data make sense or are "right."
- We will not eliminate any data because they are not "feasible or realistic" to address.
- We will not specify which populations experience disparities or higher rates of any issue. Each data group will address disparities, gaps in data, and other limitations in their narrative reports. (*This decision was later revised, as some of the data did not make sense without further clarification of specific populations affected.)*
- We acknowledge that each workgroup has applied a rigorous methodology to collect, analyze, and prioritize the data, and we trust their processes. That is why we are not further prioritizing the data.

Description of the Priority Health Issues Model

Figure VIII-1 illustrates the priority health issues in the four-county region, as identified in the 2016 CHNA (county-specific models can be found in the appendices of this report). The data sources include:

- Population data on health behaviors, morbidity, and mortality
- Medicaid claims data provided by local CCOs
- Hospital admissions data for people who were uninsured or self-pay and were diagnosed with select conditions

- Community data from an online survey, listening sessions in all four counties, and a inventory of community engagement projects from the last 3 years

Each data set has its own specific limitations, which can be found in the *Health Status Assessment* and *Community Themes and Strengths Assessment* sections of this report. The following points characterize the Priority Health Issues model:

- **The Priority Health Issues Model is meant to be a starting place for health improvement planning.** HCWC organizations are expected to engage further with their communities, as well as internally, to identify issues for health improvement planning. In addition, there may be opportunities to work collaboratively with other HCWC members on common areas of interest.

- **The model includes all the priority health issues identified through the studies and does not further prioritize the issues.** The data were gathered by each workgroup via rigorous and independent methodologies.

- **There is overlap between the issues identified by different data sources.** An asterisk (*) next to an issue indicates that issue was identified through multiple data sources. This does not necessarily mean that issue is more important, but rather that the questions asked and/or data examined were similar enough to identify comparable results. The indicators may not match up exactly. For example, "Access to health care," identified in the community engagement data, includes physical, mental, and oral health care. "Lack of dental visits" and "Lack of a usual source of health care," which were identified as health behaviors in the population data, represent subsets of access to care, and so also have an asterisk.

- **Each county has its own Priority Health Issues Model, in addition to that of the four-county region.** Different issues rose to the top for each county in the population, hospital, and CCO data. In addition, there is no Medicaid (CCO) data available for Clark County at this time. Data were combined across the counties to identify the priority health issues for the region.

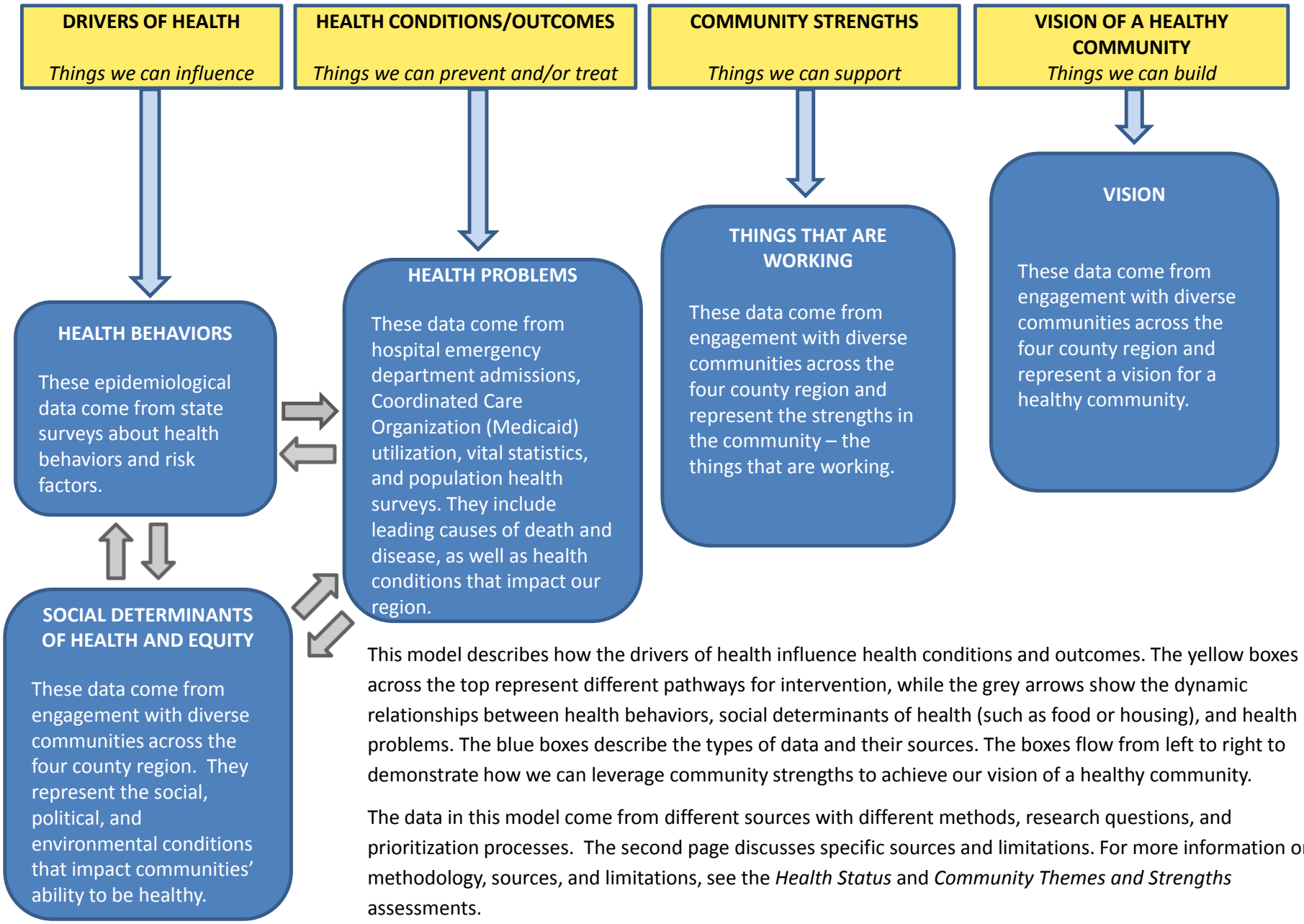
- **The model identifies potential points of intervention for health systems.** The yellow boxes across the top of the model indicate different areas where organizations may choose to direct resources. For example, public health departments may focus on upstream drivers of health, while hospitals might intervene at the level of health conditions or outcomes.

- **The Strengths and Vision are important for a complete narrative of community health.** These are things we can support and build on as we are working toward our vision of a healthy community. Many of the components of the Vision relate to the social determinants, health behaviors, and health outcomes identified in the priority health issues. It is important to consider the connections between these issues to see the complete picture.

- **This information will be used differently by different entities**. This will depend on the type and size of the organization, community connections, and/or existing projects. There is the potential for policy makers, health care providers, and community members to use the information in the Priority Health Issues Model in a variety of ways.

Figure 34: Priority Health Issues Model for the HCWC Region

Priority Health Issues for the HCWC Region and What We Can Do



This model describes how the drivers of health influence health conditions and outcomes. The yellow boxes across the top represent different pathways for intervention, while the grey arrows show the dynamic relationships between health behaviors, social determinants of health (such as food or housing), and health problems. The blue boxes describe the types of data and their sources. The boxes flow from left to right to demonstrate how we can leverage community strengths to achieve our vision of a healthy community.

The data in this model come from different sources with different methods, research questions, and prioritization processes. The second page discusses specific sources and limitations. For more information on methodology, sources, and limitations, see the *Health Status* and *Community Themes and Strengths* assessments.

DRIVERS OF HEALTH

Things we can influence

HEALTH CONDITIONS AND OUTCOMES

Things we can prevent and/or treat

SOCIAL DETERMINANTS OF HEALTH AND EQUITY

- Access to food
- Access to health care*
- Access to transportation
- Connected communities
- Culturally and linguistically appropriate services
- Pathways to living wage jobs
- Policies, systems, and environments that support healthy behaviors
- Racism, discrimination, and stigma
- Safe, accessible, and affordable housing
- Support for people with behavioral health challenges

Community Engagement Data

HEALTH BEHAVIORS

- Alcohol use among teens
- Binge drinking
- Cigarette smoking among adults
- Lack of flu shot for adults 65 and older
- Lack of fruit and vegetable consumption
- Lack of physical activity among teens
- Lack of pneumonia vaccine for adults 65 and older
- Marijuana use among teens
- No usual source of health care among adults*
- Vaping and e-cigarettes use among teens

Population Data

DIAGNOSED HEALTH CONDITIONS FOR LOW-INCOME AND/OR UNINSURED

<u>Children</u>

- Asthma*
- Attention Deficit Disorder
- Post Traumatic Stress Disorder
- Severe ear, nose, and throat infections - (Uninsured ED only)

<u>Adults</u>

- Depression*
- Diabetes*
- Hypertension*
- Kidney/urinary infections- (Uninsured ED only)

Emergency Department (ED) and Medicaid Data

MORBIDITY (DISEASE)

- Asthma*
- Cancer, 9 types♦
- Chlamydia
- Depression*
- Hypertension*
- High cholesterol
- Obesity/overweight

Population Data

MORTALITY (DEATH)

- Alcohol-induced
- Alzheimer's disease
- Breast cancer
- Diabetes*
- Drug-induced
- Heart disease
- Leukemia and Lymphoma
- Liver disease and cirrhosis
- Non-transport accidents (e.g. poisonings, falls)
- Suicide

Population Data

*Indicator identified in more than one of the assessment components (e.g. population, community engagement, emergency department, or Medicaid data)

♦Refer to section III for specific types of cancer

All indicators are in alphabetical order. For full methodology, sources, and limitations, see individual sections of CHNA report.

HCWC Region - 2016

COMMUNITY STRENGTHS

Things we can support

STRENGTHS

Culturally specific, community-based services

Feeling connected to a community

Government supported public assistance and social services

Healthy behaviors

Low/no cost programs and services that make health care accessible

Opportunities to be involved in the community

Pathways to living wage jobs

Resilience

Community Engagement Data

VISION OF A HEALTHY COMMUNITY

Things we can build

VISION

For all people:

Affordable, high-quality, culturally responsive health care

Basic needs are met, including food, housing, and transportation

Environments and opportunities that support and encourage community involvement and connection

Equitable and inclusive society, free from racism, discrimination, and stigma

Good schools and equitable access to high quality education

Living wage jobs and pathways to employment

Policies, systems, and environments that support good health and high quality of life

Safe, accessible, and affordable housing

Safe and accessible neighborhoods free of crime

Community Engagement Data

DATA SOURCES AND LIMITATIONS

SOCIAL DETERMINANTS OF HEALTH AND EQUITY, COMMUNITY STRENGTHS, AND VISION

Data sources:

•29 listening sessions with 364 community members across the four county region
•Online survey (paper version optional) with 3,167 responses
•Meta-analysis of 55 community engagement projects conducted in the four county region between 2012-2015

Limitations:

The data from the survey and listening sessions were collected through small convenience samples. HCWC aimed to engage communities across the four county region and prioritize low-income and communities of color. However, the people that participated in the survey and listening sessions do not represent the full range of diverse experiences in the region.

HOSPITAL DATA

Data sources:

•26 Ambulatory Care and Sensitive Condition (ACSC) codes
•4 Severe and Persistent Mental Illness (SPMI) codes
•15 hospitals in the HCWC region

Limitations:

The data represent a narrow subset of the regional population (4.4%). Out of over 13,000 ICD-9 diagnosis codes, data analysts considered 26 ACSC codes, defined by the Agency for Healthcare Quality and Research, and 4 SPMI codes that aligned with the Medicaid data. In addition, the data only included people who were "self-pay" and who visited the emergency department. This means that the priority health indicators from the hospital data should be viewed as a very small subset, and not generalizable to other populations.

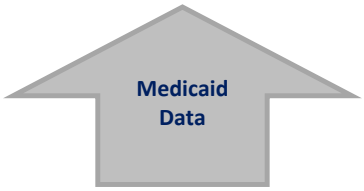
MEDICAID DATA

Data sources:

•2 Coordinated Care Organizations (CCOs) in the Oregon tri-county region
•Health Share of Oregon claims
•FamilyCare claims

Limitations:

The indicators considered are a subset of diagnoses. Data analysts identified three chronic conditions diagnosed separately among adults and children as the priority health issues. Medicaid data for Clark County were not accessible for this CHNA. The regional Priority Health Issues Model includes Medicaid data for the tri-county Oregon region only. The Clark County-specific model does not include any Medicaid data.



HEALTH BEHAVIORS, MORBIDITY, AND MORTALITY

Data sources:

•Behavioral Risk Factor Surveillance System (BRFSS)
•Oregon Healthy Teen Survey
•National Cancer Institute (NCI)
•Washington Healthy Youth Survey
•Vital statistics

Limitations:

HCWC epidemiologists, with input from content experts, developed a list of standard indicators to consider for prioritization. There are many issues that we do not have adequate data for and could not prioritize. For example, the NCI has data on a wide variety of cancers, while the data on oral health are more limited. Similarly, we were able to examine mortality data for heart disease, but not morbidity.

Data from population health surveys rely on self report and are subject to recall and other biases.

For full methodology, sources, and limitations, see individual sections (Health Status Assessment, Community Themes and Strengths).

Local Community Health System and Forces of Change Assessment

Introduction

As the final section of the CHNA report, the *Local Community Health System and Forces of Change Assessment* examines best and promising practices in our community. This section includes:

- A summary of discussions with community members about 1) existing programs and policies that address priority health issues and 2) community members' ideas on how to address priority health issues.
- A table of best practices from the Centers for Disease Control and Prevention, County Health Rankings, and the Community Guide.

Strengths and Opportunities Discussions

Methodology

The Priority Health Issues Model was presented to community members and stakeholders in a series of discussions meant to solicit information on 1) how we can address the identified needs and 2) things that are already working in the community to address the needs. Ten sessions were completed with a total of 118 participants. Discussions were generally conducted during existing organizational meetings, with staff or community advisory councils. One discussion included community members and content experts from the four-county region.

With the exception of two discussions that were predetermined to focus on behavioral health, participants were asked to pick a few (1-3) of the priority health issues, based on their impressions of what were the highest priority needs in their communities. The participants were then asked two questions related to each of their chosen priority health issues: "What are realistic actions that can be taken to address this need?" and "What is currently being done in your community that is working to address this need?" Ideas were captured on flipchart paper and participants were invited to write down additional thoughts and ideas on note cards.

The sessions elicited rich discussions and generated community-driven ideas to address the priority health issues. Participants primarily picked issues from the list of social determinants of health and equity. They felt focusing upstream would address the health behaviors, conditions, and outcomes identified in the research.

The following list shows the topics discussed and the number of groups that chose to discuss these topics:

- Mental health or support for people with behavioral health challenges (five groups)
- Racism, discrimination, and stigma (four groups)
- Pathways to living wage jobs (three groups)
- Safe, accessible, and affordable housing (two groups)
- Access to health care (two groups)
- Policy, systems, and environments that support healthy behaviors (two groups)
- Access to food and fruit and vegetable consumption (two groups)

- Physical activity among teens (one group)
- Access to culturally and linguistically appropriate services (one group)
- Transportation (one group)

Findings

Behavioral health challenges

Participants offered the following ideas to improve support for people with behavioral health challenges.

Mental health services

- **Increase the number and availability of mental health providers, including traditional health workers.** Peer mentors and health care navigators were specifically mentioned as playing a vital role in helping people connect and utilize behavioral health services.

- **Implement integrated care models that allow people to access mental health providers, primary care providers, and specialists in one place**. Integrated care models help reduce the need for multiple appointments and simplify navigation of complex health systems.

- **Support trauma-informed systems and providers.** Trauma-informed care was emphasized as playing a critical role in providing appropriate and sensitive support for people with behavioral health challenges. Health care professionals in primary care need to receive training on behavioral health conditions, such as anxiety and depression, using standardized care models.

- **Increase availability of services that provide immediate response and treatment to behavioral health crises**. People with behavioral health emergencies are often forced to wait days to weeks to see a provider, which can lead to severe health consequences.

- **Increase the diversity of mental and behavioral health providers and implement cross-cultural mental health treatment to support a wide range of people with behavioral health challenges.** Providing cultural competency training for behavioral health providers and increasing the number of bilingual service providers are ways to reduce barriers in receiving behavioral health care.

- **Improve access to insurance coverage for mental health services.** Lack of or insufficient insurance coverage is an ongoing barrier for people with behavioral health challenges. The level of coverage for behavioral health is not consistent across plans. Actions that can be taken to provide support for people with behavioral health challenges include increasing subsidies, implementing a single payer health plan covering all behavioral health care costs, and adopting policy that would allow coverage for undocumented people.

- **Increase access to prenatal care and postpartum mental health screening.** Improved access to these screenings would help prevent and mitigate behavioral health challenges in mothers and children.

Family and peer support

- **Increase services, programs, and education for family members and caregivers of people with behavioral health challenges.** A strong support system would include behavioral health training, peer support, and respite services. It was also mentioned that social work graduate programs need

to teach students how to engage and empower family members in caring for people with behavioral health challenges. Family members and friends are natural supports that need to be tied into treatment and care.

Mental health stigma

- **Support a cultural shift away from shame and stigma through public information campaigns using television, presentations, and billboards.** Mental health stigma is a huge barrier for people in attaining services, reaching out for support, and fully participating in society. Health systems should participate in public campaigns to help to de-stigmatize and change negative perceptions of behavioral health challenges through empathy messaging and health education.

Youth

- **Address behavioral health challenges during formative years as a way to mitigate poor health outcomes later in life.** Strategies include early screening for behavioral health challenges, training for teachers and youth leaders, suicide prevention curriculum in schools, empowering parents as advocates and experts, and partnering with the Juvenile Justice Department. Research on adverse childhood experiences (ACEs) needs to be prioritized in order to better understand and address behavioral health needs.

- **Train people who work with youth about mental health stigma, host mental health discussions in schools, add suicide prevention curriculum in schools, and provide safe spaces for youth to talk about mental health.** Educating and supporting youth can help reduce stigma and eliminate barriers to care.

Workforce development

- **Increase the pay and prestige of workers in the behavioral health field, provide a living wage for traditional health workers, and allow for more flexibility in community partner grants**. Improving the behavioral health workforce will increase access to services and quality of care for people with behavioral health challenges.

- **Adopt supportive employment and fair hiring practices for people with disabilities and behavioral health challenges.** Support for people with behavioral health challenges needs to include fair opportunities for employment. For example, accepting life experience as a qualification and de-stigmatizing disabilities in the workplace.

Justice system

- **Provide trauma-informed care training to probation officers and other justice system employees that work with people with behavioral health challenges**. Trauma-informed skills and care can positively influence the experiences and interaction between the justice system and people with behavioral health challenges. Increase programs that bring a mental health worker along on police calls to properly care for and treat behavioral health emergencies.

Supportive housing

- **Implement a Housing First model into behavioral health treatment and incorporate housing into community health improvement plans as foundational supports for people with behavioral health challenges.** Some options to support people with behavioral health challenges include: housing

specifically for people with mental illness; housing that allows for couples and family members; unrestricted housing (that does not require sobriety); and increased access to Section 8 housing. Increase availability of supportive housing that links people with social workers, case managers, services, and offers life skills training.

Access to food

- **Increase access to food for people with behavioral health challenges.** Increase transportation to food pantries, create more community meals, and increase the number of community kitchens.

Existing supports for people with behavioral health challenges

- Participants listed several programs, services, and elements of the health care system that are currently working to support people with behavioral health challenges: increased access to Medicaid mental health services, support from traditional health workers, integrated care at Providence Neurological Center for Children, and mental health immediate response programs. Additionally, the Multnomah County Healthy Birth Initiative, African American Mental and Behavioral Health Coalition's holistic health approach, Self Enhancement Inc., Project Respond, Clackamas Service Center, Central City Concern's housing and respite programs, and peer support programs are things that are working in the community.

- Education and support groups were also discussed as existing supportive services for people with behavioral health challenges. The National Alliance on Mental Illness's (NAMI's) free education and support groups, crisis intervention training, youth counseling, tutoring, and grief work were discussed. The Department of Human Services' partnership with mental health therapists to train teachers to interact with kids who are drug-affected or have behavioral health issues was also cited as a program that is working.

- The Tigard-Tualatin School District and Washington County Juvenile Department Safe Schools/Healthy Students Initiative identifies at-risk kids and supports them through counseling, navigation of the legal system, and connections to other supportive programs. Education and trainings in classrooms on queer issues also supports youth with behavioral health issues.

Racism, discrimination, and stigma

Participants offered the following ideas to address racism, discrimination, and stigma in our community.

Dismantling discriminatory policies

- **Reform policies to address systematic racism, discrimination, and stigma.** Revise policies that unfairly reduce housing options for communities of color, people with felony convictions, people living with disabilities, people with behavioral health issues, and/or low-income individuals and families. Revise law enforcement policies and practices that target communities of color. Reform policies to prevent gentrification.

Equitable hiring, wages, and employment

- **Increase opportunities for living wage jobs and support institutional level policy change around staffing, recruitment and hiring practices.** Identify and address employment inequities. Include impacted communities and consumers in program development as standard practice.

Equitable and informed health care systems

- **Increase providers' knowledge of trauma-informed care, epigenetics, and culturally and linguistically appropriate services.** Provide fair treatment of patients with behavioral health challenges in hospital settings. Incorporate trauma-informed practices in all aspects of care and throughout the organization (e.g., staff assessments). Increase the availability of traditional health workers (specifically community health workers and peer navigators) to bridge gaps for those who have experienced racism, discrimination, and stigma.

Education

- **Increase education to improve awareness and understanding of racism, discrimination, and stigma.** Support community education through sponsored dialogue sessions for cross-cultural understanding, as well as public workshops on internal oppression, policies that drive and perpetuate racial discrimination, and White power and privilege. Radically revise the K-12 school system to address colonialism and White supremacy.

Dialogue

- **Eliminate the "culture of silence" by actively calling out racism, discrimination, and stigma in private and public settings.** Discussing and "naming" discrimination when it occurs provides opportunities to open up dialogue and plays an important role in holding people and systems accountable. For example, identifying racist comments when they occur in conversations and notifying organizations when they are engaging in discriminatory practices.

Things that are currently being done in the community that address racism, discrimination, and stigma

- Mandatory equity and sensitivity training and education for employees (e.g., the mandatory four-hour cultural competency training for Multnomah County employees and similar trainings for state workers). Employer-sponsored health equity committees were also identified as currently working.

- Fair employment opportunities through active recruitment of people of color, application of an equity lens in hiring practices and decision-making, and internship programs created specifically for students of color.

- Culturally specific organizations and programs that provide communities with opportunities to address racism, discrimination, and stigma (e.g., Future Generations Collaborative's healing workshops and engagement with "elders and natural helpers;" and Central City Concern's culturally-specific peer support programs).

Pathways to living-wage jobs

Participants offered the following ideas to improve pathways to living-wage jobs.

Income equity

- **Implement policies that support and enforce a living wage** Businesses and corporations should redistribute resources and implement equitable pay scales for employees to eliminate large gaps between highest and lowest earners. Paying community health workers a living wage was also suggested during several discussions.

Job training

- **Increase opportunities for job training through free community college and access to skilled trade programs.** Support job training and second-chance programs for people with a criminal record.

Preparing youth for jobs

- **Provide opportunities that prepare youth to enter the workforce to ensure living-wage jobs for future generations.** Mentor programs and school-to-work programs are important pathways to living-wage jobs. Promote programs that help students apply for college scholarships and educate students on how to apply for college scholarships while they are still in high school.

Reducing college debt

- **Reduce college loan interest rates, link people to scholarships and grants, and increase access to job opportunities that offer student loan payment and forgiveness**. Student loan debt is a barrier for people pursuing a college education and skilled trade training. Expand free community college to include older adults.

Opportunities for all populations

- **Increase access to jobs for underserved populations.** Apply an "equity lens" throughout the hiring process from writing job descriptions to recognizing transferable skills. Offer alternatives to online applications to eliminate barriers for people without internet access.

- **Increase culturally and linguistically appropriate training and education services.** Increase outreach to culturally and racially diverse populations about jobs and education.

- **Implement childcare, family leave, and sick leave policies for all workers to promote job security.** The high cost of childcare and losing wages during times of family crisis and illness are significant barriers to earning a living wage. Additionally, access to affordable housing provides the stability people need to maintain employment.

Things that are currently working to provide pathways to living-wage jobs

- Recent policy changes and advocacy work, such as City of Portland employees making no less than $15 an hour, the minimum wage increase to $15 an hour for some Oregonians by 2020, and an increase in employer-sponsored retirement accounts help provide pathways to living-wage jobs.

- Businesses that support second-chance employment and provide living-wage jobs for people with criminal records (e.g., Beaverton Bakery and Dave's Killer Bread).

- High school programs and services that provide pathways to living-wage jobs (e.g., paid manufacturing jobs for high school students, preparatory high schools, Canby high school's job readiness efforts, and Schellengburg school-to-work programs).

- Access to free community college and other educational programs and opportunities (e.g., the Guided Pathways program in Health Sciences at Clackamas Community College, Clackamas Community College's efforts to link students to scholarships, and Todos Juntos grants for leadership and academic enhancement).

Housing

Participants offered the following ideas to address housing as a priority health issue.

Housing and land-use policies

- **Create and enforce housing policies on both the federal and local levels to improve access to safe and affordable housing.** These include policies that mandate a certain number of low-income housing units be equally dispersed throughout the four-county region, requirements for a minimum percentage of affordable units in new developments, and increased availability of Section 8 vouchers. Reviewing and revising the definition of "affordable housing" to fit the income reality of people in the region is an important first step in addressing housing needs.

- **Review how resources are allocated and prioritize funding to house people in need.** Community members need to know how funding decisions are made and where the money is going in order to hold decision-makers accountable. Engaging community members in the decision-making process and should be a top priority, especially among communities that have been historically disenfranchised.

- **Support housing policies that create walkable and accessible communities for all ages and ability levels.** Increase access to and availability of land use for shared, multifamily, and multipurpose housing, and tiny homes.

Programs and services

- **Increase programs and services that promote access to safe and affordable housing and mitigate negative health consequences related to inadequate housing.** Encourage service organizations to adopt a Housing First model, reduce sobriety barriers to housing, and increase the availability of second-chance housing. Increase housing-respite programs providing day-use spaces for the elderly and homeless to go during inclement weather. Health care systems should actively name housing as a health concern and contribute resources to programs that improve access to safe and affordable housing.

Things that are currently working to improve access to safe and affordable housing

- Churches providing food and shelter services, shelters that allow pets and families, and discussion of housing as a priority issue in local elections.

Access to health care

Participants offered the following ideas to improve access to health care.

Insurance coverage and network adequacy

- **Even after the implementation of the Affordable Care Act, health care coverage and cost of care is still an issue in communities.** Some ideas to improve coverage include:

    - Increase Medicaid coverage of doulas and midwives
    - Broaden the definition of "provider" to include traditional health workers
    - Increase Medicaid eligibility to cover more people
    - Eliminate out-of-pocket plans
    - Allow for Medicare buy-in at younger ages
    - Increase access to abortion care and coverage

    - Fund subsidies for medication
    - Enroll eligible people in veterans health benefit plans
    - Support universal health care models
    - Increase taxes for people in higher income brackets and shift funds from non-essential services to pay for health care

- **Provide incentives and supports for health care providers to serve underserved areas and populations.** Hold Coordinated Care Organizations accountable for ensuring that there are enough providers to accommodate the population being served. Increase network adequacy specifically for mental health, abortion services, and gerontology services.

- **Help transport patients to appointments and services and hold health fairs and events in accessible locations**. Lack of transportation is a barrier to receiving care and expanding non-emergent transport through Coordinated Care Organizations (to operate 24 hours a day, seven days a week) would help people get the services they need.

Prevention

- **Participants emphasized the importance of being able to access a wide variety of preventive services.** In addition, they mentioned policies and programs that promote healthy living for all populations as a pathway to improved health outcomes.

Things that are currently working to improve access to health care

- Integrated care clinics that make multiple services available in one stop. Also, Project Access NOW, training for community health workers, the Healthy Birth Initiative's culturally specific family planning tool, and expanded breast cancer screening through Screenwise and the Oregon Health Authority.

- Expanded coverage through the Affordable Care Act, including the additional ways to enroll in health insurance, coverage for individuals from Compact of Free Association (COFA) territories, and momentum towards Basic Health Plan and coverage for undocumented children.

- Patient-Centered Primary Care Home metrics to hold health centers accountable for patient experience and outcomes.

- Multnomah County's use of community engagement to inform its community health improvement plan.

Policies, systems, and environments that support healthy behaviors

Participants offered the following ideas to support healthy behaviors among individuals and communities.

Healthy eating

- **Increase healthy food in schools and reduce access to junk food.** Eliminate junk food fundraisers in schools and other youth activities, enforce healthy school lunch guidelines, and expand free lunch programs. Expand Veggie Rx (prescriptions for food) programs that allow people to get food vouchers for farmers markets and grocery stores.

Physical activity

- **Advocate for policies that support physical activity.** Increase physical activity and education in schools, funding for afterschool activities, joint partnership agreements between schools and outside organizations to share space and equipment, and employee wellness programs that support physical activity at work.

Policies that reduce substance abuse

- **Increase insurance coverage for alternatives to opioids for treatment and management of pain.**

Policies that reduce tobacco use and exposure

- **Enforce smoke-free campuses to reduce exposure to second-hand smoke and support a continued shift toward a smoke-free cultural norm.**

Things that are currently working to support healthy behaviors

- Employee wellness activities, such as Virginia Garcia Memorial Health Center's employee Zumba and yoga classes; Community Action's flex time for wellness activities; Tuality Healthcare's relaxation rooms and access to massage; Intel's use of a computer program that reminds employees to take breaks throughout the day; and OHSU's program that incentivizes healthy behaviors to lower insurance premiums.

- Increasing access to healthy food through elimination of vending machines containing junk food from schools; Oregon Farm-to-School program; SNAP benefit matching programs through New Season's, Whole Foods, and farmers' markets; and the ability to use WIC vouchers at farmers' markets.

- Policies and programs that support physical activity for youth, such as the 2017 Physical Education bill mandating 150 minutes of physical activity a week in elementary schools and 220 minutes of physical activity per week in middle schools, and the Army Junior Reserve Officer Training Corps (JROTC).

- Needle exchange programs to promote harm reduction among IV drug users and Question Persuade Refer (QPR) online suicide-prevention training.

Access to food

Participants offered the following ideas to improve access to food.

Culturally appropriate food

- **Increase access to culturally appropriate food through gardening programs and cooking classes.**

Access to community gardens and garden education

- **Increase access to community and apartment gardens, and support the growing of food-bearing plants native to the region for public consumption.** Explore innovative ways to grow food while using less space, such as vertical and container gardens. Additionally, public and governmental organizations should discontinue the use of pesticides and evaluate food growing practices to be able to feed more people.

- **Support gardening education classes for community members to learn how to grow their own food.** Increase free cooking and gardening classes though libraries and expand WIC programs to include garden education.

Community partnerships

- **Build and strengthen community partnerships and relationships.** Increase opportunities for community dining, community education on bulk shopping, and food shares. In addition to partnering with community members, organizations with existing food programs should work together to increase their capacity to feed more people. Sisters of the Road programs and partnerships with farmers' markets should be expanded.

Access to free food

- **Expand food-box programs and SNAP benefits.** Food boxes should contain fresh and healthy food. Change policies on non-perishable food distribution to allow grocery stores to give away food they are unable to sell.

Access to oral health care

- **Improve access to oral health and dental care as prerequisites to eating healthy food.** Poor oral health makes it challenging to eat fresh fruits and vegetables and healthy sources of protein.

Things that are currently working to improve access to food

- Community gardens effectively increase access to food. The Multnomah County initiative CROPS (Community Reaps Our Produce and Shares), which grows food for donation to charities and non-profit organizations was specifically mentioned.

- Education and cooking classes for families provided through WIC and the Oregon Food Bank help people access food in their communities and learn to prepare healthy meals on a budget.

- Programs providing financial relief to the high cost of food, including farmers' market programs that match SNAP dollars, food pantries, and food Rx (prescription for food) programs.

Physical activity among teens

Participants offered the following ideas to increase physical activity among teens.

Supportive environments

- **Create supportive environments that allow for natural physical activity among teens.** Invest in the safety of parks and neighborhoods. Increase safe routes to school to promote walking and biking. Make natural spaces more welcoming for activity through beautifying parks and planting trees in neighborhoods.

- **Link housing with parks and other amenities that promote activity.** Shift activity norms away from a sedentary lifestyle through infrastructure and transportation systems that promote walking.

- **Support good nutrition.** A healthy diet gives teens the proper nutrition to support physical activity.

Funding for sports and school activity

- **Remove economic barriers to physical activity by increasing funding for physical education, recess, and sports.**

Things that are currently working to increase physical activity among teens

- Programs that increase physical activity through natural play and group activities, including mobile playground through Portland Parks and Recreation, physical activity prescriptions through physicians (Activity Rx), and community health workers connecting people to group physical activities.
- Free breakfast programs and removing soda machines from schools are policies/programs that support good nutrition and give teens the necessary fuel to engage in physical activity.

Culturally and linguistically appropriate services

Participants offered the following ideas to improve culturally and linguistically appropriate services.

Culturally and linguistically representative workforce

- **Health care workers need to be culturally and linguistically representative of the communities they serve, as well as sensitive to cultural practices and beliefs.** Actively recruit culturally and linguistically diverse health care workers and providers, require cultural training for health care workers, and increase availability of translators. Participants also emphasized the inclusion of more diverse consumers on advisory boards

Communication

- **Make all health care communication available in multiple languages and disseminate information about services through cultural leaders and libraries to reach a wider audience.**

Things that are currently working to improve culturally and linguistically appropriate services

- Culturally specific community health workers, multi-cultural provider services, and multicultural commissions were identified as working to improve culturally and linguistically appropriate services.

Transportation

Participants offered the following ideas to address transportation as a priority health issue.

Affordability

- **Reduce public transportation fares and give people with a SNAP card an honored citizen pass.**

Improving access to transportation

- **Increase door-to-door transport (from home to medical appointments) after 5 pm and on weekends and improve access to non-emergency transport for Medicaid populations.**

Table of Best and Promising Practices

The following table lists the priority health issues and whether a best or promising practice exists, related to that issue. Resources reviewed for best practices include: the Centers from Disease Control and Prevention (CDC), Community Prevention Guide, and County Health Rankings.

Table 28: Best and Promising Practices Related to Priority Health Issues

Priority Health Issue	Link to Best Practices
Drivers of Health	
Access to food; Lack of fruit and vegetable consumption; Lack of physical activity among teens	http://www.countyhealthrankings.org/policies?f[0]=field_program_health_factors%3A12058 (diet and exercise) http://thecommunityguide.org/pa/index.html
Access to health care; No usual health care source among adults	http://www.countyhealthrankings.org/policies?search_api_views_fulltext=Access+to+health+care&items_per_page=10&=Go
Access to transportation	http://www.countyhealthrankings.org/policies?search_api_views_fulltext=access+to+transportation&items_per_page=10&=Go
Connected communities	http://www.countyhealthrankings.org/policies?f[0]=field_program_health_factors%3A12062&f[1]=field_program_topics%3A24714
Culturally and linguistically appropriate services	http://www.countyhealthrankings.org/policies?search_api_views_fulltext=culturally+competent+care&items_per_page=10&=Go
Pathways to living-wage jobs	http://www.countyhealthrankings.org/policies?f[0]=field_program_health_factors%3A12063
Policies, systems, and environments that support healthy behaviors	http://www.countyhealthrankings.org/policies?search_api_views_fulltext=healthy%20behaviors&items_per_page=10&f[0]=field_program_evidence_rating%3A1
Racism, discrimination, and stigma	http://www.countyhealthrankings.org/policies?search_api_views_fulltext=racism&items_per_page=10&=Go
Safe, accessible, and affordable housing	http://www.countyhealthrankings.org/policies?search_api_views_fulltext=Housing&items_per_page=10&=Go http://thecommunityguide.org/healthequity/housing/housing.html
Support for people with behavioral health challenges (mental health and substance abuse)	http://thecommunityguide.org/mentalhealth/index.html http://www.countyhealthrankings.org/policies?search_api_views_fulltext=mental+health&items_per_page=10&=Go http://www.countyhealthrankings.org/policies?search_api_views_fulltext=substance+abuse&items_per_page=10&=Go
Alcohol use; Binge drinking; Alcohol-induced death	http://thecommunityguide.org/alcohol/index.html http://www.countyhealthrankings.org/policies?search_api_views_fulltext=Alcohol+abuse&items_per_page=10&=Go https://www.healthypeople.gov/2020/topics-objectives/topic/substance-abuse/ebrs
Cigarette smoking among adults	http://www.countyhealthrankings.org/policies?search_api_views_fulltext=tobacco&items_per_page=10&=Go http://thecommunityguide.org/tobacco/index.html
Lack of flu shot for adults; Lack of pneumonia vaccine for	http://thecommunityguide.org/vaccines/index.html

adults 65 and older	
Marijuana use among teens	https://www.colorado.gov/pacific/sites/default/files/MJ_RMEP_SAMHSA-Marijuana-Strategies-Interventions.pdf
Vaping and e-cigarette use among teens	http://www.countyhealthrankings.org/policies?search_api_views_fulltext=e-cigarettes&items_per_page=10&=Go
Health Conditions and Outcomes	
Asthma	http://www.countyhealthrankings.org/policies?search_api_views_fulltext=asthma&items_per_page=10&=Go
Attention Deficit Disorder	http://www.countyhealthrankings.org/policies?search_api_views_fulltext=attention+deficit+disorder&items_per_page=10&=Go
Post-traumatic stress disorder	http://www.countyhealthrankings.org/policies?search_api_views_fulltext=Post+traumatic+stress+disorder&items_per_page=10&=Go
Severe ear, nose, and throat infections	No best practices for this topic were found among the websites included in the search.
Depression	http://www.countyhealthrankings.org/policies?search_api_views_fulltext=Depression&items_per_page=10&=Go
Diabetes	http://thecommunityguide.org/diabetes/index.html http://www.countyhealthrankings.org/policies?search_api_views_fulltext=diabetes&items_per_page=10&=Go
Kidney/urinary infections	No best practices for this topic were found among the websites included in the search.
Cancer	http://thecommunityguide.org/cancer/screening/client-oriented/index.html http://www.countyhealthrankings.org/policies?search_api_views_fulltext=cancer&items_per_page=10&=Go
Chlamydia	https://www.healthypeople.gov/2020/topics-objectives/topic/sexually-transmitted-diseases/ebrs
Obesity/overweight	http://thecommunityguide.org/obesity/communitysettings.html
Alzheimer's disease	No best practices for this topic were found among the websites included in the search.
Drug-induced deaths	http://www.countyhealthrankings.org/policies?search_api_views_fulltext=drug+overdose&items_per_page=10&=Go
Heart Disease; High cholesterol; Hypertension	http://thecommunityguide.org/cvd/index.html http://www.countyhealthrankings.org/policies?search_api_views_fulltext=hypertension&items_per_page=10&=Go
Leukemia and Lymphoma	No best practices for this topic were found among the websites included in the search.
Liver disease and cirrhosis	No best practices for this topic were found among the websites included in the search.
Non-transport accidents (e.g. poisonings, falls)	http://www.countyhealthrankings.org/policies?search_api_views_fulltext=falls&items_per_page=10&=Go
Suicide	http://www.countyhealthrankings.org/policies?search_api_views_fulltext=suicide&items_per_page=10&=Go

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PeaceHealth
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PROVIDENCE
Health & Services

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Oregon
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Appendix A: Glossary of Terms

Accountable Care Organization (ACO): A healthcare organization characterized by a payment and care delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients. ACOs may be formed in the private commercial plan market and in the traditional Medicare fee-for-service system.

Administrative data: Data created or collected through insurance registration and billing process.

Age-adjusting: A statistical process of using a "standard" population distribution to remove the influence of different age distributions among populations on a health event rate or prevalence, thus allowing a valid comparison of a rate or prevalence of health conditions between different counties for this CHNA. Percentages that are age-adjusted within this report are done according to the 2000 US Standard Population.

Aggregate data: Data extracted from individual health records and combined to form de-identified information about groups of patients, which can be compared and analyzed.

Ambulatory Care Sensitive Conditions (ACSCs): Medical problems that are potentially preventable. Hospitalization for an ACSC is considered to be a measure of access to appropriate primary health care.

Chi-square: A statistic that measures how expectations compare to results.

Claims data: Billing records submitted to Medicaid (CCOs or other Medicaid Managed Care Plans) that are administrative data for the primary purpose of getting paid or reimbursed for services. Secondary uses of claims data include population monitoring and benchmarking.

Clinical data: Data captured during the process of diagnosis and treatment in the clinical setting.

Coded data: Data that are translated into a standard nomenclature of classification so they can be aggregated, analyzed, and compared.

Coordinated Care Organization (CCO): A network of all types of health entities who have agreed to work together to deliver health care and coverage in their local communities for people who are eligible for the Oregon Health Plan (Medicaid).

Data analysis: The process of looking at and summarizing data with the intent to extract useful information and develop conclusions.

Data comparability: The standardization of vocabulary such that the meaning of a single term is the same each time the term is used. Data comparability produces consistency of information derived from those data.

Federal Poverty Level (FPL): Guidelines established by the federal government that determine the minimum amount of gross income a family needs for food, clothing, transportation, shelter, and other necessities as determined by the Department of Health and Human Services. FPL varies according to family size.

Gap analysis: The process of identifying where there is missing information about certain populations or conditions. For example, we have little data about health outcomes in the LGBTQ community; this would be considered a "gap."

Granularity: The level of detail of a data set. For example, county-level data is more "granular" than state-level data.

Health indicator: A characteristic of a population, which researchers use as supporting evidence for describing the health of a population.

P-value: The probability of obtaining a result equal to or more extreme than what is expected. P-values are used to determine if your results are statistically significant (or valid).

Per member per month (PMPM): A common method to express healthcare costs on the basis of a single member in a month.

Prevalence: The proportion of people who have a particular disease or condition at a specified point in time or over a specific period of time.

Qualitative data: Data that describes or characterizes something, but does not measure it in numbers. For example, notes from listening sessions or interviews are qualitative data.

Quantitative data: Data which deals with numbers and can be measured. Measuring the number of people on Medicaid who have diabetes is an example of quantitative data.

Regression analysis: A statistical process to estimate the relationships between different variables. Usually one variable is dependent and another is independent. For example, the level of education of a group of people (independent variable) could correspond to the amount of income they earn (dependent variable).

Socioeconomic status (SES): A measure of a person's work experience, economic, and social position in relation to others, based on income, education, and occupation.

Statistical methods: Mathematical concepts, formulas, models, and techniques used to analyze data.

Trend: A change over time. For example, if more people are being diagnosed with heart disease each year, the trend is increasing.

Unduplicated count: An unduplicated count of a patient or consumer indicates the actual number of individuals enrolled or served, counting a person once in a category. For example, a person with diabetes may receive several health services treating their diabetes in a given time period, but are counted only once in the category identifying them as being diabetic.

Appendix B: Participants in CHNA Development

This report was prepared by HCWC Conveners: Genevieve Ellis, Charina Walker, Christine Sorvari, and Meghan Crane. Special thanks to Claire Nystrom and Diane McBride from Multnomah County Health Department and to Rujuta Gaonkar and Jennifer Moore from the Multnomah County Health Equity Initiative.

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Ant Farm
Calvary Church
Central City Concern
Clackamas County Public Health Advisory Committee
Clackamas Service Center
Coalition of Community Health Clinics
Elders in Action Commission
El Programa Hispano
FamilyCare Community Advisory Council
Free Clinic of SW Washington
Hacienda CDC
Health Share of Oregon Community Advisory Council
Highland Church & Highland Access, Reentry and Recovery Program
Immigrant and Refugee Community Organization
The Intertwine Alliance
Latino Network
Liberation Street Church
Lifeline Connections
LifeWorks Northwest
Multnomah County Health Equity Initiative
Native American Youth Association
National Alliance on Mental Illness (Clackamas)
OHSU Richmond Clinic Health Literacy Committee
Oregon Community Health Worker Association
Oregon Health Equity Alliance
Outside In
Oregon Foundation for Reproductive Health
Oregon Public Health Institute
Project Access NOW
Q Center
Urban League of Portland
Veterans Affairs Hospital
Washington County Mental Health and Addictions Advisory Council
Washington County Public Health Advisory Council

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Appendix C: HCWC Member Organizations

Local Health Departments

Clackamas County Public Health Division: Public Health is a division of the Health, Housing, and Human Services Department and is responsive to the direction of the Board of County Commissioners acting as the Local Board of Health. The Public Health Division provides a range of programs and services focused on prevention, protection, and promotion of the public's health throughout all of Clackamas County. The mission of the Public Health Division is "To promote and assist individuals, families and communities to be healthy, safe & thrive." Source: http://www.clackamas.us/publichealth/

Clark County Public Health: Located in Vancouver, Washington, Clark County Public Health (CCPH) has been serving the community for more than 75 years. CCPH's long term vision is to have active, healthy families and people of all ages, abilities, and cultures living, playing, and working in thriving communities. To achieve this vision, CCPH provides services that prevent and control the spread of diseases; prepares for natural and man-made disasters; ensures safe food, water, and air; promotes wellness and good nutrition; collects and assesses data on the health of the community; reaches out to at-risk and vulnerable populations to improve access to health services; and supports the healthy development of first time moms and their children. Source: https://www.clark.wa.gov/public-health

Multnomah County Public Health: Multnomah County Public Health assures, promotes, and protects the health of the nearly 800,000 people living in the largest county in Oregon. Its programs and initiatives focus on helping individuals, families, and communities gain greater control of the factors that influence their health with an emphasis on equity and reducing disparities. Source: https://multco.us/health

Washington County Public Health Division: Washington County is the second most populous county in Oregon and the most ethnically diverse county in the three-county metropolitan region. Major cities include Beaverton and Hillsboro. The public health division serves a population of 563,000 through a variety of programs and services that protect and promote community health. The mission of the public health department is to "Improve and protect the public's health across the lifespan through prevention, education, partnerships and healthy environments." Source: http://www.co.washington.or.us/HHS/PublicHealth/

Coordinated Care Organizations

FamilyCare Health: FamilyCare's mission is "Creating Healthy Individuals through Innovative Systems." Since 1984, FamilyCare has supported the health of Oregonians through innovative systems that increase access to care, improve quality, and lower healthcare costs. FamilyCare Health serves more than 125,000 residents of Multnomah, Clackamas, Washington, and parts of Marion counties who are eligible for benefits through Medicaid (Oregon Health Plan). FamilyCare also offers Medicare Advantage plans.

Health Share of Oregon: Health Share of Oregon is the state's largest coordinated care organization serving over 240,000 Oregon Health Plan (OHP) members in Clackamas, Multnomah, and Washington counties. Health Share works to coordinate the health care system at the local level to achieve ongoing health system transformation and provide members the care they need in a community-based, culturally appropriate way. Health Share was founded, and continues to be goverened, by eleven health care organizations serving OHP

members: Adventist Health, CareOregon, Central City Concern, Clackamas County, Kaiser Permanente, Legacy Health, Multnomah County, Oregon Health & Science University, Providence Health & Services, Tuality Health Alliance, and Washington County.

Hospitals

Adventist Health Portland: A not-for-profit, faith-based organization that includes Adventist Medical Center (AMC), a 302-bed community hospital. The hospital provides a full range of inpatient, outpatient, emergency, and diagnostic services to communities in and near East Portland. AMC serves more than 900,000 residents. Adventist is a full-service medical center with major emphases in: surgery, cardiology, oncology, neurosurgery, internal medicine, emergency services, mental health, orthopedics, and obstetrics. Source: https://www.adventisthealth.org/nw/pages/default.aspx

Kaiser Permanente Sunnyside and Westside Hospitals: As a values-driven, nonprofit, integrated health care organization, Kaiser Permanente is dedicated to improving the health of its members and the community. Kaiser Sunnyside Hospital has 329 licensed beds, making it the largest in Clackamas County. Westside Hospital, which opened in August 2013 with 126 hospital beds, is planned to expand to 174 beds. Kaiser Permanente improves community health by increasing access to needed care and services to low income communities and by creating conditions for healthy community places by supporting local and regional community-based organizations and government entities. Source: https://share.kaiserpermanente.org/article/northwest-meeting-community-needs/

Legacy Health: Legacy Health is a nonprofit, locally owned organization serving the Portland-Vancouver metropolitan region and surrounding areas. The Legacy system provides an integrated network of health care services, including acute and critical care, inpatient and outpatient treatment, community health education, and a variety of specialty services. Legacy is known for providing care for low-income, under- and uninsured people, and for practices that have made them a leader in sustainable health care. HCWC member hospitals include Legacy Emanuel Medical Center, Legacy Good Samaritan Medical Center, Legacy Meridian Park Medical Center, and Legacy Salmon Creek Medical Center. Source: http://www.legacyhealth.org/our-legacy/about-legacy.aspx

Oregon Health & Science University (OHSU): OHSU is the state's only academic health center. It provides the state's most comprehensive health care, educates the next generation of health and science professionals, and is at the leading edge of biomedical research and innovation. With more than 15,000 employees, OHSU is one of the state's largest employers. OHSU cares for the state's most vulnerable citizens with more than 200 community health programs, reaching out to vulnerable groups in urban areas as well as underserved rural communities throughout the state. OHSU also works to increase the number of primary care practitioners throughout the state and has recently affiliated with Salem Health and Tuality Healthcare to better serve the communities of Western Washington County and the Salem-Keizer region. Source: http://www.ohsu.edu/xd/about/index.cfm

PeaceHealth Southwest Medical Center: PeaceHealth is a Catholic health system, founded by the Sisters of St. Joseph of Peace in 1890. PeaceHealth Southwest Medical Center provides comprehensive specialty care for more than 250,000 patients a year in southwest Washington. PeaceHealth Southwest Medical Center is one of Clark County's largest employers with 2,900 caregivers and 600 active medical staff members. Source: https://www.peacehealth.org/southwest/Pages/default.aspx

Providence Health & Services: Providence Health & Services in Oregon is a not-for-profit Catholic network of hospitals, care centers, health plans, physicians, clinics, home health care, and affiliated services guided by a mission of caring that the Sisters of Providence began in the West nearly 160 years ago. Providence Health & Services provides services that are preventive in nature and that seek to serve the whole person before he or she becomes ill. HCWC member hospitals include Providence Milwaukie Hospital, Providence Portland Medical Center, Providence St. Vincent Medical Center, and Providence Willamette Falls Medical Center. Source: http://www2.providence.org/phs/Pages/default.aspx

Tuality Healthcare: Tuality Healthcare, affiliated with OHSU, is a not-for-profit acute care organization devoted to the healthcare needs of western Washington County. With hospitals in Hillsboro and Forest Grove, as well as numerous outpatient clinics, home health, and medical equipment services, Tuality's reach matches the needs of the communities it serves. As a linchpin of downtown Hillsboro's Health & Education District, Tuality employs close to 1,300 employees. Source: http://www.tuality.org/tuality/

Appendix D: Medicaid Data Tables

The following tables reflect data obtained by the HCWC Hospital and Medicaid Data Workgroup. See the *Health Status Assessment – Hospital and Medicaid Data* section of this report for full methodology, analysis, and limitations. Medicaid data for Clark County, Washington were not available for this report.

Top Diagnosed Conditions and Demographics

Table D-1: Top 3 Diagnosed Conditions for Adult CCO Clients (Health Share of Oregon and FamilyCare Health)

Adult Health Share and FamilyCare CCO Clients, Top 3 Diagnoses† (Age-adjusted %)			
	Clackamas County	**Multnomah County**	**Washington County**
Adults diagnosed with depression	9.6	6.5	8.9
Adults diagnosed with diabetes	9.6	10.4	10.5
Adults diagnosed with hypertension	19.7	20.4	18.8

Note: Data comprises utilization between April 1, 2014 and March 31, 2015 and a diagnosis between March 31, 2012 and March 31, 2015.
All percentages age-adjusted to the 2000 US Standard Population.
Interpretation: The prevalence of diabetes among all adult CCO clients for Clackamas County is 9.6%. The numerator is all Clackamas County adult CCO clients with diabetes; the denominator is all Clackamas County adult CCO clients.
†Administrative Medicaid claims data used as a proxy for medical diagnosis.

Table D-2: Demographics of Adult Health Share and FamilyCare Clients Diagnosed with Diabetes

Demographics of Adult Health Share and FamilyCare CCO Clients Diagnosed with Diabetes† (Age-adjusted %)			
Demographic indicator	**Clackamas County**	**Multnomah County**	**Washington County**
Female	9.8	11.2	10.8
Male	9.3	9.5	10.1
Hispanic/Latino (all races)	12.0	12.8	14.4
Black/African American, non-Hispanic	18.0	14.7	15.7
Asian/Pacific Islander, non-Hispanic	11.2	12.8	12.0
‡White, non-Hispanic	9.9	9.8	9.8
American Indian/Alaska Native, non-Hispanic	12.7	14.4	16.1
Race/ethnicity unknown	6.0	6.3	7.3
Chinese primary language	11.2	10.1	6.6
English primary language	10.4	11.0	10.7
Russian primary language	11.5	11.4	12.4
Spanish primary language	16.8	16.9	15.8
Vietnamese primary language	14.7	13.8	12.0
Primary language unknown	6.4	6.5	7.5

Note: Data comprises utilization between April 1, 2014 and March 31, 2015 and a diagnosis between March 31, 2012 and March 31, 2015.
All percentages age-adjusted to the 2000 US Standard Population.

Interpretation: The prevalence of diabetes among Hispanic/Latino adult CCO clients for Multnomah County is 12.8%. The numerator is Multnomah County Hispanic/Latino adult CCO clients with diabetes; the denominator is all Multnomah County Hispanic/Latino adult CCO clients.
†Administrative Medicaid claims data used as a proxy for medical diagnosis.
‡Also reported as "Caucasian, non-Hispanic".

Table D-3: Demographics of Adult Health Share and FamilyCare Clients Diagnosed with Hypertension

Demographics of Adult Health Share and FamilyCare CCO Clients Diagnosed with Hypertension† (Age-adjusted %)			
Demographic indicator	**Clackamas County**	**Multnomah County**	**Washington County**
Female	19.3	20.7	18.6
Male	20.3	20.0	18.8
Hispanic/Latino (all races)	17.7	19.0	18.8
Black/African American, non-Hispanic	27.8	30.7	27.5
Asian/Pacific Islander, non-Hispanic	17.9	21.4	19.4
‡White, non-Hispanic	21.2	20.5	19.7
American Indian/Alaska Native, non-Hispanic	24.7	18.6	20.4
Race/ethnicity unknown	13.8	12.3	13.3
Chinese primary language	15.6	20.1	14.2
English primary language	21.2	21.7	20.1
Russian primary language	25.6	27.8	21.8
Spanish primary language	17.4	21.7	18.4
Vietnamese primary language	19.6	23.8	21.1
Primary language unknown	15.4	13.8	14.1

Note: Data comprises utilization between April 1, 2014 and March 31, 2015 and a diagnosis between March 31, 2012 and March 31, 2015.
All percentages age-adjusted to the 2000 US Standard Population.
Interpretation: The prevalence of hypertension among Washington County White non-Hispanic adult CCO clients is 19.7%. The numerator is Washington County White non-Hispanic adult CCO clients who have hypertension; the denominator is all Washington County White non-Hispanic adult CCO clients.
†Administrative Medicaid claims data used as a proxy for medical diagnosis.
‡Also reported as "Caucasian, non-Hispanic".

Table D-4: Demographics of Adult Health Share and FamilyCare Clients Diagnosed with Depression

Demographics of Adult Health Share and Family Care CCO Clients Diagnosed with Depression† (Age-adjusted %)			
Demographic indicator	**Clackamas County**	**Multnomah County**	**Washington County**
Female	12.1	11.1	10.9
Male	6.5	6.4	6.2
Hispanic/Latino (all races)	6.4	7.7	6.8
Black/African American, non-Hispanic	13.5	9.9	8.6
Asian/Pacific Islander, non-Hispanic	4.0	4.8	4.2
‡White, non-Hispanic	10.9	10.1	11.1
American Indian/Alaska Native, non-Hispanic	10.3	15.3	12.3

Demographics of Adult Health Share and Family Care CCO Clients Diagnosed with Depression† (Age-adjusted %)			
Race/ethnicity unknown	6.7	6.1	6.6
Chinese primary language	*	2.1	*
English primary language	11.4	10.5	10.5
Russian primary language	1.9	1.9	3.1
Spanish primary language	2.6	5.9	5.0
Vietnamese primary language	*	3.9	3.1
Primary language unknown	7.1	6.4	7.1

Note: Data comprises utilization between April 1, 2014 and March 31, 2015 and a diagnosis between March 31, 2012 and March 31, 2015.
All percentages age-adjusted to the 2000 US Standard Population.
Interpretation: The prevalence of depression among female adult CCO clients for Clackamas County is 12.1%. The numerator is Clackamas County female adult CCO clients with depression, the denominator is all Clackamas County female adult CCO clients.
*To ensure patient confidentiality and data reliability, data is suppressed.
†Administrative Medicaid claims data used as a proxy for medical diagnosis.
‡Also reported as "Caucasian, non-Hispanic".

Table D-5: Top 3 Diagnosed Conditions for Youth CCO Clients (Health Share of Oregon and FamilyCare)

Youth Health Share and FamilyCare CCO Clients, Top 3 Diagnoses† (Age-adjusted %)			
	Clackamas County	**Multnomah County**	**Washington County**
Youth diagnosed with ADD	6.8	5.5	5.3
Youth diagnosed with asthma	7.7	9.0	8.9
Youth diagnosed with PTSD	3.1	2.4	1.9

Note: Data comprises utilization between April 1, 2014 and March 31, 2015 and a diagnosis between March 31, 2012 and March 31, 2015.
All percentages age-adjusted to the 2000 US Standard Population.
ADD: attention deficit disorder; PTSD: post-traumatic stress disorder
Interpretation: The prevalence of ADD among all youth CCO clients for Clackamas County is 6.8%. The numerator is all Clackamas County youth CCO clients with ADD, the denominator is all Clackamas County youth CCO clients.
†Administrative Medicaid claims data used as a proxy for medical diagnosis.

Table D-6: Demographics of Youth Health Share and FamilyCare Clients Diagnosed with ADD

Demographics of Youth Health Share and FamilyCare CCO Clients Diagnosed with ADD † (Age-adjusted %)			
Demographic indicator	**Clackamas County**	**Multnomah County**	**Washington County**
Female	4.3	3.2	3.2
Male	9.1	7.8	7.4
Hispanic/Latino (all races)	2.8	3.0	2.8
Black/African American, non-Hispanic	10.8	6.6	7.0
Asian/Pacific Islander, non-Hispanic	*	1.0	2.3
‡White, non-Hispanic	8.8	8.1	8.9
American Indian/Alaska Native, non-Hispanic	10.7	10.3	8.0

Demographics of Youth Health Share and FamilyCare CCO Clients Diagnosed with ADD † (Age-adjusted %)			
Demographic indicator	**Clackamas County**	**Multnomah County**	**Washington County**
Race/ethnicity unknown	4.8	4.6	4.5
English primary language	9.4	8.6	8.3
Russian primary language	*	*	*
Somali primary language	*	1.6	*
Spanish primary language	1.0	1.8	2.2
Vietnamese primary language	*	*	*
Primary language unknown	5.2	4.1	4.3

Note: Data comprises utilization between April 1, 2014 and March 31, 2015 and a diagnosis between March 31, 2012 and March 31, 2015.
All percentages age-adjusted to the 2000 US Standard Population.
ADD: attention deficit disorder
Interpretation: The prevalence of ADD among Hispanic/Latino youth CCO clients in Multnomah County is 3.0%. The numerator is Multnomah County Hispanic/Latino youth CCO clients with ADD; the denominator is all Multnomah County Hispanic/Latino youth CCO clients.
*To ensure patient confidentiality and data reliability, data is suppressed.
†Administrative Medicaid claims data used as a proxy for medical diagnosis.
‡Also reported as "Caucasian, non-Hispanic".

Table D-7: Demographics of Youth Health Share and FamilyCare Clients Diagnosed with Asthma

Demographics of Youth Health Share and FamilyCare CCO Clients Diagnosed with Asthma† (Age-adjusted %)			
Demographic indicator	**Clackamas County**	**Multnomah County**	**Washington County**
Female	6.7	7.9	7.7
Male	8.6	10.2	10.1
Hispanic/Latino (all races)	7.7	9.7	9.4
Black/African American, non-Hispanic	12.8	12.7	11.9
Asian/Pacific Islander, non-Hispanic	7.2	6.6	6.7
‡White, non-Hispanic	8.1	8.6	9.3
American Indian/Alaska Native, non-Hispanic	6.4	8.9	9.5
Race/ethnicity unknown	5.6	7.6	6.8
English primary language	8.5	10.7	10.0
Russian primary language	*	1.7	*
Somali primary language	*	7.8	10.6
Spanish primary language	7.2	9.9	9.3
Vietnamese primary language	*	7.9	7.7
Primary language unknown	7.1	7.3	7.4

Note: Data comprises utilization between April 1, 2014 and March 31, 2015 and a diagnosis between March 31, 2012 and March 31, 2015.
All percentages age-adjusted to the 2000 US Standard Population.
Interpretation: The prevalence of asthma among Hispanic/Latino youth CCO clients for Washington County is 9.4%. The numerator is Washington County Hispanic/Latino youth CCO clients with asthma; the denominator is all Washington County Hispanic/Latino youth CCO clients.
*To ensure patient confidentiality and data reliability, data is suppressed.

†Administrative Medicaid claims data used as a proxy for medical diagnosis.
‡Also reported as "Caucasian, non-Hispanic".

Table D-8: Demographics of Youth Health Share and FamilyCare Clients Diagnosed with PTSD

Demographics of Youth Health Share and FamilyCare CCO Clients Diagnosed with PTSD† (Age-adjusted %)			
Demographic indicator	**Clackamas County**	**Multnomah County**	**Washington County**
Female	3.4	2.6	2.2
Male	2.8	2.3	1.6
Hispanic/Latino (all races)	1.6	1.4	1.1
Black/African American, non-Hispanic	4.4	3.1	3.5
Asian/Pacific Islander, non-Hispanic	*	0.5	*
‡White, non-Hispanic	4.1	3.3	3.1
American Indian/Alaska Native, non-Hispanic	8.6	7.8	7.4
Race/ethnicity unknown	1.5	2.1	1.1
English primary language	4.3	3.8	3.0
Russian primary language	*	*	*
Somali primary language	*	*	*
Spanish primary language	1.3	1.0	0.8
Vietnamese primary language	*	*	*
Primary language unknown	2.1	1.7	1.4

Note: Data comprises utilization between April 1, 2014 and March 31, 2015 and a diagnosis between March 31, 2012 and March 31, 2015.
All percentages age-adjusted to the 2000 US Standard Population.
PTSD: post-traumatic stress disorder
Interpretation: The prevalence of PTSD among male youth CCO clients for Clackamas County is 2.8%. The numerator is Clackamas County male youth CCO clients with PTSD; the denominator is all Clackamas County male youth CCO clients.
*To ensure patient confidentiality and data reliability, data is suppressed.
†Administrative Medicaid claims data used as a proxy for medical diagnosis.
‡Also reported as "Caucasian, non-Hispanic".

Health Services Utilization

The following tables compare health services usage for youth with and without one of the top three conditions (asthma, ADD, and PTSD). As with the above tables, the population is Health Share of Oregon and FamilyCare CCO clients. Medicaid data for Clark County, Washington were not available for this report.

Table D-9: Health Services Usage for Youth with and without ADD (Health Share and FamilyCare Clients)

Health Services Usage for Youth With and Without ADD† (Health Share and FamilyCare CCO Clients) (Age-adjusted %)		
	Youth with ADD	**Youth without ADD**
Clackamas County		
Primary Care Physician services usage	57.7	46.9
Behavioral Health services usage	39.3	5.3
Dental health services usage	57.2	40.8

Health Services Usage for Youth With and Without ADD† (Health Share and FamilyCare CCO Clients) (Age-adjusted %)		
Usage of no services	1.6	14.6
Emergency department usage (one or more times)	22.2	16.6
Multnomah County		
Primary Care Physician services usage	67.2	54.9
Behavioral Health services usage	42.3	5.2
Dental health services usage	56.7	44.2
Usage of no services	1.6	13.1
Emergency department usage (one or more times)	27.0	19.6
Washington County		
Primary Care Physician services usage	70.3	57.8
Behavioral Health services usage	38.6	4.9
Dental health services usage	59.3	44.1
Usage of no services	1.5	15.4
Emergency department usage (one or more times)	22.7	17.3

Note: Data comprises utilization between April 1, 2014 and March 31, 2015 and a diagnosis between March 31, 2012 and March 31, 2015.
All percentages age-adjusted to the 2000 US Standard Population.
ADD: attention deficit disorder
Interpretation: The prevalence of Behavioral Health services usage by youth with ADD in Clackamas County is 39.3%. The numerator is all Clackamas County youth CCO clients with ADD receiving Behavioral Health services; the denominator is all Clackamas County youth CCO clients with ADD regardless of whether they had Behavioral Health services or any other health services usage. [In comparison, the prevalence of Behavioral Health services usage by youth without ADD in Clackamas County is 5.3%.]
†Administrative Medicaid claims data used as a proxy for medical diagnosis.

Table D-10: Health Services Usage for Youth with and without Asthma (Health Share and FamilyCare Clients)

Health Services Usage for Youth With and Without Asthma† (Health Share and FamilyCare CCO Clients) (Age-adjusted %)		
	Youth with Asthma	**Youth without Asthma**
Clackamas County		
Primary Care Physician services usage	63.9	46.6
Behavioral Health services usage	13.1	7.1
Dental health services usage	54.3	40.3
Usage of no services	1.3	14.8
Emergency department usage (one or more times)	40.0	18.0
Multnomah County		
Primary Care Physician services usage	72.4	54.2
Behavioral Health services usage	12.8	6.7
Dental health services usage	56.5	43.4
Usage of no services	2.1	13.5
Emergency department usage (one or more times)	44.7	20.2
Washington County		
Primary Care Physician services usage	78.2	56.8
Behavioral Health services usage	11.6	6.3
Dental health services usage	57.0	43.4
Usage of no services	2.1	16.0

Emergency department usage (one or more times)	35.9	16.9

Note: Data comprises utilization between April 1, 2014 and March 31, 2015 and a diagnosis between March 31, 2012 and March 31, 2015.
All percentages age-adjusted to the 2000 US Standard Population.
Interpretation: The prevalence of Emergency department usage by youth with asthma in Multnomah County is 44.7%. The numerator is all Multnomah County youth CCO clients with asthma using Emergency department services, the denominator is all Multnomah County youth CCO clients with asthma regardless of whether they had Emergency department or any other health services usage. [In comparison, the prevalence of Emergency department usage by youth without asthma in Multnomah County is 20.2%.]
†Administrative Medicaid claims data used as a proxy for medical diagnosis.

Table D-11: Health Services Usage for Youth with and without PTSD (Health Share and FamilyCare Clients)

Health Services Usage for Youth With and Without PTSD† (Health Share and FamilyCare CCO Clients) (Age-adjusted %)

	Youth with PTSD	Youth without PTSD
Clackamas County		
Primary Care Physician services usage	63.8	47.4
Behavioral Health services usage	50.6	6.1
Dental health services usage	52.8	41.0
Usage of no services	1.9	14.1
Emergency department usage (one or more times)	37.5	19.0
Multnomah County		
Primary Care Physician services usage	61.7	55.6
Behavioral Health services usage	55.1	6.0
Dental health services usage	50.1	44.4
Usage of no services	2.0	12.8
Emergency department usage (one or more times)	42.3	21.7
Washington County		
Primary Care Physician services usage	69.1	58.4
Behavioral Health services usage	50.4	5.8
Dental health services usage	54.9	44.4
Usage of no services	4.1	14.9
Emergency department usage (one or more times)	34.5	18.2

PTSD: post-traumatic stress disorder
Note: Data comprises utilization between April 1, 2014 and March 31, 2015 and a diagnosis between March 31, 2012 and March 31, 2015.
All percentages age-adjusted to the 2000 US Standard Population.
Interpretation: The prevalence of Primary Care Health services usage by youth with PTSD in Washington County is 69.1%. The numerator is all Washington County youth CCO clients with PTSD receiving Primary Care services, the denominator is all Washington County youth CCO clients with PTSD regardless of whether they had Primary Care services or any other health services usage. [In comparison, the prevalence of Primary Care services usage by youth without PTSD in Washington County is 58.4%.]
†Administrative Medicaid claims data used as a proxy for medical diagnosis.

Youth Obesity Analysis

The following tables analyze the top three conditions among youth with Medicaid (asthma, ADD, and PTSD) with the co-morbidity of obesity. Each county (Clackamas, Multnomah, and Washington counties in Oregon) has its own table. Medicaid data for Clark County, Washington were not available for this report.

Table D-12: Clackamas County – Youth Diagnosed With Obesity, With and Without ADD

Clackamas County	Age-adjusted % obese with ADD†	Age-adjusted % obese without ADD†
Overall	18.0	10.7
Females	23.2	10.8
Males	15.9	10.6
Race/ethnicity is unknown	16.6	7.9
Primary language is English	16.5	11.4
Primary language is Russian	*	8.4
Primary language is Somali	*	*
Primary language is Spanish	*	14.7
Primary language is unknown	21.0	9.0
Primary language is Vietnamese	*	*
Hispanic/Latino (all races) youth	23.7	14.0
Black/African American, non-Hispanic youth	*	12.3
American Indian/Alaska Native, non-Hispanic youth	*	12.9
Asian/Pacific Islander, non-Hispanic youth	*	9.9
‡White, non-Hispanic youth	17.3	10.2

All percentages age-adjusted to the 2000 US Standard Population.
ADD: attention deficit disorder
Interpretation: The prevalence of obesity among female youth CCO clients with ADD in Clackamas County is 23.2%. The numerator is Clackamas County obese female youth CCO clients with ADD; the denominator is Clackamas County female youth CCO clients with ADD. [In comparison, the prevalence of obesity among female youth CCO clients without ADD in Clackamas County is 10.8%.]
*To ensure patient confidentiality and data reliability, data is suppressed.
†Administrative Medicaid claims data used as a proxy for medical diagnosis.
‡Also reported as “Caucasian, non-Hispanic”.

Table D-13: Multnomah County – Youth Diagnosed With Obesity, With and Without ADD

Multnomah County	Age-adjusted % obese with ADD†	Age-adjusted % obese without ADD†
Overall	16.8	10.6
Females	20.1	10.9
Males	15.6	10.2
Race/ethnicity is unknown	14.6	8.6
Primary language is English	16.5	10.7
Primary language is Russian	*	3.8

Multnomah County	Age-adjusted % obese with ADD†	Age-adjusted % obese without ADD†
Primary language is Somali	*	4.9
Primary language is Spanish	27.3	17.4
Primary language is unknown	16.2	8.5
Primary language is Vietnamese	*	9.1
Hispanic/Latino (all races) youth	25.2	15.3
Black/African American, non-Hispanic youth	15.2	9.9
American Indian/Alaska Native, non-Hispanic youth	15.9	14.3
Asian/Pacific Islander, non-Hispanic youth	*	8.1
‡White, non-Hispanic youth	15.5	8.7

All percentages age-adjusted to the 2000 US Standard Population.
ADD: attention deficit disorder
Interpretation: The prevalence of obesity among female youth CCO clients with ADD in Multnomah County is 20.1%. The numerator is Multnomah County obese female youth CCO clients with ADD, the denominator is Multnomah County female youth CCO clients with ADD. [In comparison, the prevalence of obesity among female youth CCO clients without ADD in Multnomah County is 10.9%.]
*To ensure patient confidentiality and data reliability, data is suppressed.
†Administrative Medicaid claims data used as a proxy for medical diagnosis.
‡Also reported as "Caucasian, non-Hispanic".

Table D-14: Washington County – Youth Diagnosed With Obesity, With and Without ADD

Washington County	Age-adjusted % obese with ADD†	Age-adjusted % obese without ADD†
Overall	20.4	15.4
Females	24.3	15.4
Males	19.6	15.3
Race/ethnicity is unknown	14.3	10.7
Primary language is English	19.3	14.4
Primary language is Russian	*	*
Primary language is Somali	*	9.3
Primary language is Spanish	32.1	23.7
Primary language is unknown	19.2	10.6
Primary language is Vietnamese	*	*
Hispanic/Latino (all races) youth	31.6	21.2
Black/African American, non-Hispanic youth	18.6	9.1
American Indian/Alaska Native, non-Hispanic youth	*	12.1
Asian/Pacific Islander, non-Hispanic youth	*	8.4
‡White, non-Hispanic youth	18.5	11.9

All percentages age-adjusted to the 2000 US Standard Population.
ADD: attention deficit disorder
Interpretation: The prevalence of obesity among English-speaking youth CCO clients with ADD in Washington County is 19.3%. The numerator is Washington County obese English-speaking youth CCO clients with ADD, the

denominator is Washington County English-speaking youth CCO clients with ADD. [In comparison, the prevalence of obesity among English-speaking youth CCO clients without ADD in Washington County is 14.4%.]
*To ensure patient confidentiality and data reliability, data is suppressed.
†Administrative Medicaid claims data used as a proxy for medical diagnosis.
‡Also reported as "Caucasian, non-Hispanic".

Table D-15: Clackamas County – Youth Diagnosed With Obesity, With and Without Asthma

Clackamas County	Age-adjusted % obese with Asthma†	Age-adjusted % obese without Asthma†
Overall	19.5	10.3
Females	20.1	10.5
Males	19.0	10.1
Race/ethnicity is unknown	19.4	7.4
Primary language is English	19.3	11.1
Primary language is Russian	*	8.4
Primary language is Somali	*	*
Primary language is Spanish	20.0	14.2
Primary language is unknown	19.8	8.4
Primary language is Vietnamese	*	*
Hispanic/Latino (all races) youth	22.3	13.5
Black/African American, non-Hispanic youth	24.0	10.9
American Indian/Alaska Native, non-Hispanic youth	*	13.6
Asian/Pacific Islander, non-Hispanic youth	*	10.4
‡White, non-Hispanic youth	18.7	9.8

All percentages age-adjusted to the 2000 US Standard Population.
Interpretation: The prevalence of obesity among male youth CCO clients with asthma in Clackamas County is 19.0%. The numerator is Clackamas County obese male youth CCO clients with asthma, the denominator is Clackamas County male youth CCO clients with asthma. [In comparison, the prevalence of obesity among male youth CCO clients without asthma in Clackamas County is 10.1%.]
*To ensure patient confidentiality and data reliability, data is suppressed.
†Administrative Medicaid claims data used as a proxy for medical diagnosis.
‡Also reported as "Caucasian, non-Hispanic".

Table D-16: Multnomah County – Youth Diagnosed With Obesity, With and Without Asthma

Multnomah County	Age-adjusted % obese with Asthma†	Age-adjusted % obese without Asthma†
Overall	19.6	9.9
Females	21.2	10.3.
Males	18.4	9.6
Race/ethnicity is unknown	19.8	7.8
Primary language is English	19.5	10.0
Primary language is Russian	*	3.8

Multnomah County	Age-adjusted % obese with Asthma†	Age-adjusted % obese without Asthma†
Primary language is Somali	*	4.8
Primary language is Spanish	24.3	16.8
Primary language is unknown	18.4	8.0
Primary language is Vietnamese	13.6	8.6
Hispanic/Latino (all races) youth	23.3	14.59
Black/African American, non-Hispanic youth	17.2	9.3
American Indian/Alaska Native, non-Hispanic youth	32.2	12.8
Asian/Pacific Islander, non-Hispanic youth	16.0	7.6
‡White, non-Hispanic youth	18.2	8.3

All percentages age-adjusted to the 2000 US Standard Population.
Interpretation: The prevalence of obesity among male youth CCO clients with asthma in Multnomah County is 18.4%. The numerator is Multnomah County obese male youth CCO clients with asthma, the denominator is Multnomah County male youth CCO clients with asthma. [In comparison, the prevalence of obesity among male youth CCO clients without asthma in Multnomah County is 9.6%.]
*To ensure patient confidentiality and data reliability, data is suppressed.
†Administrative Medicaid claims data used as a proxy for medical diagnosis.
‡Also reported as “Caucasian, non-Hispanic”.

Table D-17: Washington County – Youth Diagnosed With Obesity, With and Without Asthma

Washington County	Age-adjusted % obese with Asthma†	Age-adjusted % obese without Asthma†
Overall	27.0	14.5
Females	26.3	14.7
Males	27.6	14.3
Race/ethnicity is unknown	24.7	10.0
Primary language is English	27.3	13.4
Primary language is Russian	*	*
Primary language is Somali	*	8.9
Primary language is Spanish	32.2	23.1
Primary language is unknown	22.5	10.1
Primary language is Vietnamese	*	*
Hispanic/Latino (all races) youth	31.6	20.4
Black/African American, non-Hispanic youth	16.1	9.4
American Indian/Alaska Native, non-Hispanic youth	*	10.3
Asian/Pacific Islander, non-Hispanic youth	19.2	7.4
‡White, non-Hispanic youth	24.8	11.2

All percentages age-adjusted to the 2000 US Standard Population.
Interpretation: The prevalence of obesity among male youth CCO clients with asthma in Washington County is 27.6%. The numerator is Washington County obese male youth CCO clients with asthma; the denominator is Washington County male youth CCO clients with asthma. [In comparison, the prevalence of obesity among male youth CCO clients without asthma in Washington County is 14.3%.]

*To ensure patient confidentiality and data reliability, data is suppressed.
†Administrative Medicaid claims data used as a proxy for medical diagnosis.
‡Also reported as “Caucasian, non-Hispanic”.

Table D-18: Clackamas County – Youth Diagnosed With Obesity, With and Without PTSD

Clackamas County	Age-adjusted % obese with PTSD†	Age-adjusted % obese without PTSD†
Overall	17.9	10.8
Females	19.4	10.8
Males	15.6	10.8
Race/ethnicity is unknown	17.3	8.07
Primary language is English	18.2	11.5
Primary language is Russian	*	8.5
Primary language is Somali	*	*
Primary language is Spanish	*	14.5
Primary language is unknown	17.9	9.1
Primary language is Vietnamese	*	*
Hispanic/Latino (all races) youth	18.9	14.1
Black/African American, non-Hispanic youth	*	12.0
American Indian/Alaska Native, non-Hispanic youth	*	14.1
Asian/Pacific Islander, non-Hispanic youth	*	10.3
‡White, non-Hispanic youth	17.9	10.2

All percentages age-adjusted to the 2000 US Standard Population.
PTSD: post-traumatic stress disorder
Interpretation: The prevalence of obesity among male youth CCO clients with PTSD in Clackamas County is 15.6%. The numerator is Clackamas County obese male youth CCO clients with PTSD, the denominator is Clackamas County male youth CCO clients with PTSD. [In comparison, the prevalence of obesity among male youth CCO clients without PTSD in Clackamas County is 10.8%.]
*To ensure patient confidentiality and data reliability, data is suppressed.
†Administrative Medicaid claims data used as a proxy for medical diagnosis.
‡Also reported as “Caucasian, non-Hispanic”.

Table D-19: Multnomah County – Youth Diagnosed With Obesity, With and Without PTSD

Multnomah County	Age-adjusted % obese with PTSD†	Age-adjusted % obese without PTSD†
Overall	17.6	10.7
Females	19.1	10.9
Males	16.1	10.4
Race/ethnicity is unknown	12.7	8.6
Primary language is English	17.4	10.8
Primary language is Russian	*	3.9
Primary language is Somali	*	4.8
Primary language is Spanish	21.1	17.5
Primary language is unknown	17.9	8.6

Multnomah County	Age-adjusted % obese with PTSD†	Age-adjusted % obese without PTSD†
Primary language is Vietnamese	*	9.1
Hispanic/Latino (all races) youth	23.9	15.4
Black/African American, non-Hispanic youth	14.7	10.2
American Indian/Alaska Native, non-Hispanic youth	*	14.7
Asian/Pacific Islander, non-Hispanic youth	*	8.1
‡White, non-Hispanic youth	18.4	8.8

All percentages age-adjusted to the 2000 US Standard Population.
PTSD: post-traumatic stress disorder
Interpretation: The prevalence of obesity among male youth CCO clients with PTSD in Multnomah County is 16.1%. The numerator is Multnomah County obese male youth CCO clients with PTSD, the denominator is Multnomah County male youth CCO clients with PTSD. [In comparison, the prevalence of obesity among male youth CCO clients without PTSD in Multnomah County is 10.4%.]
*To ensure patient confidentiality and data reliability, data is suppressed.
†Administrative Medicaid claims data used as a proxy for medical diagnosis.
‡Also reported as "Caucasian, non-Hispanic".

Table D-20: Washington County – Youth Diagnosed With Obesity, With and Without PTSD

Washington County	Age-adjusted % obese with PTSD†	Age-adjusted % obese without PTSD†
Overall	21.1	15.5
Females	19.2	15.4
Males	22.8	15.6
Race/ethnicity is unknown	20.	10.9
Primary language is English	21.7	14.5
Primary language is Russian	*	*
Primary language is Somali	*	9.3
Primary language is Spanish	33.9	23.9
Primary language is unknown	18.2	10.9
Primary language is Vietnamese	*	*
Hispanic/Latino (all races) youth	25.1	21.4
Black/African American, non-Hispanic youth	16.6	9.8
American Indian/Alaska Native, non-Hispanic youth	*	11.4
Asian/Pacific Islander, non-Hispanic youth	*	8.2
‡White, non-Hispanic youth	20.4	12.3

All percentages age-adjusted to the 2000 US Standard Population.
PTSD: post-traumatic stress disorder
Interpretation: The prevalence of obesity among male youth CCO clients with PTSD in Washington County is 22.8%. The numerator is Washington County obese male youth CCO clients with PTSD, the denominator is Washington County male youth CCO clients with PTSD. [In comparison, the prevalence of obesity among male youth CCO clients without PTSD in Washington County is 15.6%.]
*To ensure patient confidentiality and data reliability, data is suppressed.
†Administrative Medicaid claims data used as a proxy for medical diagnosis.
‡Also reported as "Caucasian, non-Hispanic".

Appendix E: Online Survey Tables

Regional Data

The following tables display data for questions 1-3 of the online survey, broken down by age, gender, race, ethnicity, sexual orientation, and other demographics. This breakdown shows how certain populations (e.g. people between the ages of 26-39) responded to the survey questions. For a summary of methodology, analyses, and findings, see the *Community Themes and Strengths Assessment – Online Survey* section of this report.

Question 1: Quality of life (vision)

In the following list, what do you think are the five most important characteristics of a "Healthy Community"? (Those factors that most improve the quality of life in a community.)

Tables E-1 – E-6: Regional responses to question 1 by different age groups

Table E-1: **Age 19-25 (n=241; 1176 selections)**

Safe, affordable housing	12.0%
Access to physical, mental, and/or oral health care	10.5%
Good schools	9.6%
Access to healthy, affordable food	8.1%
Low crime/safe neighborhoods	7.4%
Good jobs to reach a healthy economy	5.1%
Clean environment	5.1%
supportive and happy family life	4.9%
Welcoming of diverse communities/people	4.5%
Healthy behaviors and lifestyles	4.4%
Parks and recreation	4.4%
Good job training opportunities	3.9%
Good place to raise children	3.7%
Safe, nearby transportation	3.6%
Participating and giving back to the community	3.1%
Low level of child abuse	2.2%
Good daycare and preschools	2.1%
Low deaths and disease rates	1.9%
Religious or spiritual values	1.3%
Physical accommodations for people with disabilities	1.1%
Arts and cultural events	1.0%

Table E-2: **Age 26-39 (n=984; 4828 selections)**

Safe, affordable housing	11.7%
Access to healthy, affordable food	10.1%
Access to physical, mental, and/or oral health care	10.1%
Good schools	8.8%
Low crime/safe neighborhoods	7.8%
Good jobs to reach a healthy economy	6.6%
Clean environment	5.2%
Welcoming of diverse communities/people	4.9%
Parks and recreation	4.8%
supportive and happy family life	4.6%
Healthy behaviors and lifestyles	4.0%
Safe, nearby transportation	3.7%
Good place to raise children	3.3%
Participating and giving back to the community	2.7%
Good job training opportunities	2.3%
Low level of child abuse	1.8%
Good daycare and preschools	1.7%
Religious or spiritual values	1.6%
Arts and cultural events	1.4%
Low deaths and disease rates	1.4%
Physical accommodations for people with disabilities	1.3%

Table E-3: **Age 40-54 (n=839; 4095 selections)**

Safe, affordable housing	11.6%
Access to physical, mental, and/or oral health care	10.3%
Access to healthy, affordable food	9.1%
Low crime/safe neighborhoods	8.9%
Good schools	8.4%
Good jobs to reach a healthy economy	7.2%
Clean environment	5.9%
Parks and recreation	4.9%
supportive and happy family life	4.4%
Healthy behaviors and lifestyles	4.2%
Welcoming of diverse communities/people	3.9%
Safe, nearby transportation	3.5%
Good place to raise children	3.2%
Participating and giving back to the community	2.7%
Good job training opportunities	2.6%
Religious or spiritual values	2.6%
Physical accommodations for people with disabilities	1.6%
Low level of child abuse	1.4%
Low deaths and disease rates	1.4%
Arts and cultural events	1.3%
Good daycare and preschools	1.0%

Table E-4: **Age 55-64 (n=544; 2660 selections)**

Safe, affordable housing	11.8%
Access to physical, mental, and/or oral health care	10.0%
Access to healthy, affordable food	9.4%
Low crime/safe neighborhoods	8.6%
Good jobs to reach a healthy economy	7.6%
Good schools	7.2%
Clean environment	5.9%
Healthy behaviors and lifestyles	5.1%
Safe, nearby transportation	4.8%
Parks and recreation	4.1%
Welcoming of diverse communities/people	4.0%
Participating and giving back to the community	3.1%
supportive and happy family life	3.1%
Religious or spiritual values	2.9%
Good place to raise children	2.7%
Physical accommodations for people with disabilities	2.3%
Good job training opportunities	2.2%
Low level of child abuse	1.8%
Arts and cultural events	1.6%
Good daycare and preschools	1.0%
Low deaths and disease rates	0.9%

Table E-5: **Age 65-79 (n=325; 1590 selections)**

Safe, affordable housing	11.4%
Access to physical, mental, and/or oral health care	9.4%
Access to healthy, affordable food	8.6%
Low crime/safe neighborhoods	7.7%
Good schools	7.6%
Good jobs to reach a healthy economy	6.6%
Clean environment	5.8%
Safe, nearby transportation	5.3%
Healthy behaviors and lifestyles	4.8%
Physical accommodations for people with disabilities	4.4%
Welcoming of diverse communities/people	4.3%
Religious or spiritual values	4.0%
Parks and recreation	3.3%
Good place to raise children	2.8%
Participating and giving back to the	2.8%

Table E-6: **Age 80 and older (n=31; 148 selections)**

Low crime/safe neighborhoods	9.5%
Access to physical, mental, and/or oral health care	8.8%
Physical accommodations for people with disabilities	7.4%
Good schools	7.4%
Safe, nearby transportation	7.4%
Safe, affordable housing	7.4%
Good place to raise children	6.8%
Good jobs to reach a healthy economy	6.8%
Access to healthy, affordable food	6.8%
Clean environment	6.1%
Religious or spiritual values	5.4%
Healthy behaviors and lifestyles	4.7%
Good job training opportunities	4.1%
supportive and happy family life	2.7%
Low level of child abuse	2.0%

Table E-5: **Age 65-79 (n=325; 1590 selections)**

community	
Arts and cultural events	2.7%
supportive and happy family life	2.4%
Good job training opportunities	2.0%
Low level of child abuse	1.6%
Good daycare and preschools	1.4%
Low deaths and disease rates	0.9%

Table E-6: **Age 80 and older (n=31; 148 selections)**

Parks and recreation	2.0%
Good daycare and preschools	2.0%
Low deaths and disease rates	1.4%
Arts and cultural events	1.4%
Participating and giving back to the community	0.0%
Welcoming of diverse communities/people	0.0%

Tables E7 – E-9: Regional responses to question 1 by gender

Table E-7: **Female (n=1900; 9750 selections)**

Safe, affordable housing	12.2%
Access to physical, mental, and/or oral health care	10.3%
Access to healthy, affordable food	10.2%
Good schools	8.2%
Low crime/safe neighborhoods	8.1%
Good jobs to reach a healthy economy	6.6%
Clean environment	5.9%
Welcoming of diverse communities/people	4.5%
Healthy behaviors and lifestyles	4.5%
Safe, nearby transportation	4.3%
Parks and recreation	4.3%
supportive and happy family life	3.6%
Good place to raise children	2.9%
Participating and giving back to the community	2.3%
Low level of child abuse	2.1%
Religious or spiritual values	2.1%
Good job training opportunities	1.9%
Physical accommodations for people with disabilities	1.9%
Good daycare and preschools	1.7%
Arts and cultural events	1.4%
Low deaths and disease rates	1.1%

Table E-8: **Male (n=897; 4376 selections)**

Safe, affordable housing	10.2%
Access to physical, mental, and/or oral health care	9.6%
Low crime/safe neighborhoods	8.5%
Good schools	8.5%
Access to healthy, affordable food	7.5%
Good jobs to reach a healthy economy	7.3%
Clean environment	5.3%
Parks and recreation	5.0%
supportive and happy family life	4.9%
Healthy behaviors and lifestyles	4.5%
Good job training opportunities	4.0%
Good place to raise children	3.8%
Participating and giving back to the community	3.8%
Welcoming of diverse communities/people	3.7%
Safe, nearby transportation	3.1%
Religious or spiritual values	3.0%
Arts and cultural events	1.9%
Physical accommodations for people with disabilities	1.8%
Low deaths and disease rates	1.6%
Low level of child abuse	1.2%
Good daycare and preschools	0.9%

Table E-9: **Other than Female or Male Alone (n=38;181 selections)**

Safe, affordable housing	13.8%
Access to physical, mental, and/or oral health care	12.7%
Access to healthy, affordable food	10.5%
Welcoming of diverse communities/people	9.9%
Safe, nearby transportation	8.3%
Physical accommodations for people with disabilities	5.5%
Good schools	5.0%
Good jobs to reach a healthy economy	5.0%

Table E-9: **Other than Female or Male Alone (n=38;181 selections)**

Parks and recreation	4.4%
Clean environment	3.9%
Low crime/safe neighborhoods	3.9%
supportive and happy family life	2.8%
Healthy behaviors and lifestyles	2.8%
Participating and giving back to the community	2.2%
Good job training opportunities	2.2%
Low level of child abuse	2.2%
Low deaths and disease rates	1.7%
Good place to raise children	1.7%
Arts and cultural events	1.1%
Religious or spiritual values	0.6%
Good daycare and preschools	0.0%

Tables E-10 – E-11: Regional responses to question 1 by sexual minority orientation

Table E-11: **Sexual Minority (n=364; 1789 selections)**

Safe, affordable housing	13.4%
Access to physical, mental, and/or oral health care	11.7%
Access to healthy, affordable food	10.3%
Welcoming of diverse communities/people	7.9%
Good schools	6.3%
Good jobs to reach a healthy economy	6.3%
Clean environment	5.9%
Safe, nearby transportation	5.6%
Low crime/safe neighborhoods	5.5%
Parks and recreation	4.1%
Healthy behaviors and lifestyles	3.7%
Good job training opportunities	2.7%
Participating and giving back to the community	2.5%
supportive and happy family life	2.2%
Physical accommodations for people with disabilities	2.1%
Arts and cultural events	2.0%
Good place to raise children	2.0%
Low level of child abuse	2.0%
Low deaths and disease rates	1.7%
Good daycare and preschools	1.4%
Religious or spiritual values	0.7%

Tables E-12 – E-13: Regional responses to question 1 by Hispanic ethnicity

Table E-12: **Hispanic (n=372; 1763 selections)**

Access to physical, mental, and/or oral health care	9.8%
Safe, affordable housing	9.4%
Access to healthy, affordable food	8.9%
Good schools	8.1%
Low crime/safe neighborhoods	7.1%
Good jobs to reach a healthy economy	6.2%

Table E-12: **Hispanic (n=372; 1763 selections)**

Healthy behaviors and lifestyles	5.2%
Clean environment	5.0%
supportive and happy family life	5.0%
Welcoming of diverse communities/people	4.4%
Good job training opportunities	4.1%
Parks and recreation	4.1%
Good place to raise children	4.0%
Safe, nearby transportation	3.2%
Participating and giving back to the community	2.8%
Religious or spiritual values	2.7%
Good daycare and preschools	2.4%
Physical accommodations for people with disabilities	2.0%
Low deaths and disease rates	1.9%
Arts and cultural events	1.8%
Low level of child abuse	1.8%

Tables E-14 – E-18: Regional responses to question 1 by race (only groups with at least 25 respondents were analyzed)

Table E-14: **African American/Black (n=146; 723 selections)**

Safe, affordable housing	12.0%
Access to physical, mental, and/or oral health care	11.2%
Good schools	9.1%
Low crime/safe neighborhoods	7.6%
Access to healthy, affordable food	6.8%
Welcoming of diverse communities/people	6.6%
Good jobs to reach a healthy economy	6.2%
Good job training opportunities	4.8%
Healthy behaviors and lifestyles	4.1%
supportive and happy family life	4.0%
Clean environment	4.0%
Participating and giving back to the community	3.9%
Religious or spiritual values	3.9%
Parks and recreation	3.3%
Safe, nearby transportation	2.4%
Low deaths and disease rates	2.1%
Arts and cultural events	2.1%
Good place to raise children	2.1%
Physical accommodations for people with disabilities	1.5%
Good daycare and preschools	1.2%
Low level of child abuse	1.0%

Table E-15: **Asian American/Asian (n=77; 382 selections)**

Low crime/safe neighborhoods	10.5%
Safe, affordable housing	9.9%
Access to healthy, affordable food	9.2%
Access to physical, mental, and/or oral health care	8.6%
Good schools	8.4%
Good jobs to reach a healthy economy	7.1%
supportive and happy family life	5.0%
Clean environment	5.0%
Welcoming of diverse communities/people	4.7%
Healthy behaviors and lifestyles	4.7%
Safe, nearby transportation	4.7%
Parks and recreation	4.5%
Good place to raise children	3.9%
Participating and giving back to the community	2.6%
Religious or spiritual values	2.6%
Good job training opportunities	2.4%
Low deaths and disease rates	1.8%
Arts and cultural events	1.3%
Physical accommodations for people with disabilities	1.0%
Low level of child abuse	1.0%
Good daycare and preschools	1.0%

Table E-16: **Native American/American Indian/Alaska Native (n=76; 357 selections)**

Access to physical, mental, and/or oral health care	11.5%
Safe, affordable housing	11.5%
Access to healthy, affordable food	7.0%
Low crime/safe neighborhoods	7.0%
Good schools	6.7%
supportive and happy family life	5.3%
Parks and recreation	4.8%
Participating and giving back to the community	4.5%
Good job training opportunities	4.5%
Religious or spiritual values	4.5%
Good place to raise children	3.9%
Welcoming of diverse communities/people	3.9%
Good jobs to reach a healthy economy	3.6%
Healthy behaviors and lifestyles	3.6%
Clean environment	3.4%
Low deaths and disease rates	3.1%
Safe, nearby transportation	3.1%
Physical accommodations for people with disabilities	2.8%
Low level of child abuse	2.2%
Arts and cultural events	1.7%
Good daycare and preschools	1.4%

Table E-17: **European American/White/Caucasian (n=2003; 9868 selections)**

Safe, affordable housing	11.9%
Access to physical, mental, and/or oral health care	10.0%
Access to healthy, affordable food	10.0%
Good schools	8.3%
Low crime/safe neighborhoods	8.2%
Good jobs to reach a healthy economy	7.1%
Clean environment	6.0%
Parks and recreation	4.6%
Healthy behaviors and lifestyles	4.5%
Safe, nearby transportation	4.4%
Welcoming of diverse communities/people	4.3%
supportive and happy family life	3.7%
Good place to raise children	3.2%
Participating and giving back to the community	2.4%
Good job training opportunities	2.0%
Physical accommodations for people with disabilities	1.9%
Low level of child abuse	1.9%
Religious or spiritual values	1.8%
Arts and cultural events	1.5%
Good daycare and preschools	1.3%
Low deaths and disease rates	1.2%

Table E-18: **Multiracial (n=235; 1154 selections)**

Safe, affordable housing	12.6%
Access to physical, mental, and/or oral health care	10.4%
Access to healthy, affordable food	9.3%
Low crime/safe neighborhoods	7.8%
Good schools	7.4%
Good jobs to reach a healthy economy	6.2%
Clean environment	4.6%
Welcoming of diverse communities/people	4.5%
supportive and happy family life	4.3%
Parks and recreation	4.2%
Healthy behaviors and lifestyles	4.0%
Safe, nearby transportation	4.0%
Participating and giving back to the community	3.9%
Good job training opportunities	3.8%
Religious or spiritual values	3.3%
Good place to raise children	2.3%
Physical accommodations for people with disabilities	2.3%
Arts and cultural events	1.6%
Low deaths and disease rates	1.3%

Low level of child abuse	1.3%
Good daycare and preschools	1.0%

Tables E-19 – E-20: Regional responses to question 1 by people that grew up outside of the United States

Table E-20: **Childhood outside of the United States (n=225; 1049 selections)**

Access to physical, mental, and/or oral health care	9.8%
Access to healthy, affordable food	9.2%
Low crime/safe neighborhoods	8.8%
Safe, affordable housing	8.5%
Good jobs to reach a healthy economy	6.6%
Clean environment	6.3%
Healthy behaviors and lifestyles	6.0%
Parks and recreation	4.8%
Good schools	4.7%
Physical accommodations for people with disabilities	4.6%
supportive and happy family life	4.6%
Good job training opportunities	3.6%
Welcoming of diverse communities/people	3.6%
Safe, nearby transportation	3.3%
Religious or spiritual values	3.2%
Good place to raise children	3.1%
Participating and giving back to the community	2.3%
Low level of child abuse	2.0%
Arts and cultural events	1.8%
Good daycare and preschools	1.7%
Low deaths and disease rates	1.4%

Tables E-21 – E-23: Regional responses to question 1 by language

Table E-22: **Spanish or Spanish/English (n=205; 973 selections)**

Access to physical, mental, and/or oral health care	9.2%
Good schools	8.7%
Access to healthy, affordable food	8.2%
Safe, affordable housing	8.0%
Low crime/safe neighborhoods	7.7%
Clean environment	6.2%
Good jobs to reach a healthy economy	5.9%
supportive and happy family life	4.9%
Healthy behaviors and lifestyles	4.8%
Parks and recreation	4.8%
Safe, nearby transportation	4.4%
Good place to raise children	4.1%
Good job training opportunities	3.2%
Welcoming of diverse communities/people	3.2%
Religious or spiritual values	3.2%
Participating and giving back to the community	2.9%
Good daycare and preschools	2.4%
Arts and cultural events	2.3%
Low level of child abuse	2.1%
Physical accommodations for people with disabilities	2.0%

Low deaths and disease rates	1.8%

Table E-23: **Other than English or Spanish, single and combo (n=82; 400 selections)**

Safe, affordable housing	10.0%
Low crime/safe neighborhoods	9.8%
Access to physical, mental, and/or oral health care	9.3%
Access to healthy, affordable food	8.0%
Good schools	7.3%
Good jobs to reach a healthy economy	6.5%
supportive and happy family life	5.5%
Clean environment	5.5%
Welcoming of diverse communities/people	4.5%
Safe, nearby transportation	4.5%
Healthy behaviors and lifestyles	4.0%
Good job training opportunities	3.8%
Religious or spiritual values	3.8%
Parks and recreation	3.8%
Good place to raise children	3.5%
Low deaths and disease rates	3.0%
Participating and giving back to the community	2.8%
Arts and cultural events	1.5%
Physical accommodations for people with disabilities	1.5%
Low level of child abuse	1.0%
Good daycare and preschools	0.8%

Table E-24: Regional responses to question 1 by people with incomes under 200% of the Federal Poverty Level

Table E-24: **200% FPL and below (n=841; 4085 selections)**

Safe, affordable housing	12.3%
Access to physical, mental, and/or oral health care	11.0%
Access to healthy, affordable food	8.6%
Good schools	7.9%
Low crime/safe neighborhoods	7.5%
Good jobs to reach a healthy economy	5.6%
Clean environment	4.7%
supportive and happy family life	4.5%
Safe, nearby transportation	4.2%
Parks and recreation	4.1%
Good job training opportunities	4.0%
Healthy behaviors and lifestyles	3.8%
Participating and giving back to the community	3.6%
Welcoming of diverse communities/people	3.2%
Good place to raise children	2.9%
Physical accommodations for people with disabilities	2.9%
Religious or spiritual values	2.7%
Low level of child abuse	2.1%
Good daycare and preschools	1.6%
Arts and cultural events	1.5%
Low deaths and disease rates	1.3%

Table E-25: Regional responses to question 1 by veterans

Table E-25: **Veteran (n=205; 1006 selections)**

Low crime/safe neighborhoods	10.7%
Safe, affordable housing	10.6%
Access to physical, mental, and/or oral health care	8.7%
Access to healthy, affordable food	8.4%
Good schools	8.3%
Good jobs to reach a healthy economy	6.3%
Clean environment	4.8%
Healthy behaviors and lifestyles	4.5%
Parks and recreation	4.5%
Safe, nearby transportation	4.4%
Participating and giving back to the community	3.7%
Good place to raise children	3.6%
Good job training opportunities	3.5%
Welcoming of diverse communities/people	3.5%
Religious or spiritual values	3.4%
supportive and happy family life	3.3%
Physical accommodations for people with disabilities	2.6%
Arts and cultural events	2.0%
Low deaths and disease rates	1.4%
Low level of child abuse	1.3%
Good daycare and preschools	0.6%

Table E-26: Regional responses to question 1 by people living with disabilities

Table E-26: **Disability reported (n=578; 2819 selections)**

Safe, affordable housing	12.6%
Access to physical, mental, and/or oral health care	11.7%
Access to healthy, affordable food	8.3%
Low crime/safe neighborhoods	7.7%
Good schools	6.4%
Good jobs to reach a healthy economy	5.3%
Safe, nearby transportation	4.8%
Physical accommodations for people with disabilities	4.5%
Clean environment	4.4%
Healthy behaviors and lifestyles	4.3%
Parks and recreation	4.2%
Participating and giving back to the community	3.9%
Good job training opportunities	3.8%
supportive and happy family life	3.7%
Welcoming of diverse communities/people	3.5%
Religious or spiritual values	2.8%
Good place to raise children	2.2%
Low level of child abuse	1.9%
Arts and cultural events	1.8%
Low deaths and disease rates	1.5%
Good daycare and preschools	0.7%

Tables E-27-29: Regional responses to question 1 by education level

Table E-27: **Less than high school (n=133; 626 selections)**

Safe, affordable housing	10.5%
Access to physical, mental, and/or oral health care	10.4%
Good schools	8.3%
Access to healthy, affordable food	7.7%
Low crime/safe neighborhoods	6.9%
supportive and happy family life	6.1%
Good jobs to reach a healthy economy	5.4%
Good job training opportunities	5.1%
Participating and giving back to the community	5.0%
Clean environment	5.0%
Parks and recreation	4.3%
Healthy behaviors and lifestyles	3.8%
Safe, nearby transportation	3.8%
Religious or spiritual values	3.4%
Physical accommodations for people with disabilities	2.9%
Welcoming of diverse communities/people	2.6%
Good place to raise children	2.4%
Low deaths and disease rates	2.1%
Low level of child abuse	1.9%
Arts and cultural events	1.6%
Good daycare and preschools	1.0%

Table E-28: **High School or GED (n=579; 2927 selections)**

Low crime/safe neighborhoods	11.6%
Safe, affordable housing	11.3%
Access to physical, mental, and/or oral health care	10.4%
Access to healthy, affordable food	8.3%
Good schools	7.7%
Good jobs to reach a healthy economy	6.1%
supportive and happy family life	4.9%
Clean environment	4.5%
Healthy behaviors and lifestyles	4.1%
Good job training opportunities	4.0%
Parks and recreation	3.8%
Good place to raise children	3.5%
Participating and giving back to the community	3.3%
Safe, nearby transportation	3.3%
Religious or spiritual values	2.9%
Physical accommodations for people with disabilities	2.7%
Welcoming of diverse communities/people	2.6%
Low level of child abuse	1.8%

Table E-29: **Bachelors or higher (n=1841, 9077 selections)**

Safe, affordable housing	11.7%
Access to healthy, affordable food	9.9%
Access to physical, mental, and/or oral health care	9.7%
Low crime/safe neighborhoods	8.3%
Good schools	8.2%
Good jobs to reach a healthy economy	7.2%
Clean environment	6.0%
Welcoming of diverse communities/people	5.1%
Parks and recreation	4.6%
Healthy behaviors and lifestyles	4.5%
Safe, nearby transportation	4.5%
supportive and happy family life	3.4%
Good place to raise children	3.1%
Participating and giving back to the community	2.4%
Religious or spiritual values	2.2%
Arts and cultural events	1.9%
Physical accommodations for people with disabilities	1.7%
Low level of child abuse	1.6%

Table E-28: **High School or GED (n=579; 2927 selections)**

Low deaths and disease rates	1.3%
Good daycare and preschools	1.1%
Arts and cultural events	0.8%

Table E-29: **Bachelors or higher (n=1841, 9077 selections)**

Good job training opportunities	1.5%
Good daycare and preschools	1.3%
Low deaths and disease rates	1.2%

Tables E-30-35: Regional responses to question 1 type of insurance/insurance status

Table E-30: **Medicaid (n=597; 2913 selections)**

Safe, affordable housing	12.9%
Access to physical, mental, and/or oral health care	11.8%
Access to healthy, affordable food	8.1%
Good schools	7.9%
Low crime/safe neighborhoods	7.7%
Good jobs to reach a healthy economy	5.7%
supportive and happy family life	5.3%
Parks and recreation	4.8%
Good job training opportunities	4.4%
Participating and giving back to the community	4.1%
Clean environment	3.9%
Healthy behaviors and lifestyles	3.5%
Welcoming of diverse communities/people	3.4%
Safe, nearby transportation	3.2%
Good place to raise children	3.0%
Physical accommodations for people with disabilities	2.3%
Religious or spiritual values	2.1%
Low level of child abuse	1.7%
Arts and cultural events	1.5%
Low deaths and disease rates	1.4%
Good daycare and preschools	1.3%

Table E-31: **Medicare (n=287; 1407 selections)**

Safe, affordable housing	10.4%
Access to physical, mental, and/or oral health care	9.9%
Access to healthy, affordable food	8.7%
Good schools	8.0%
Low crime/safe neighborhoods	8.0%
Good jobs to reach a healthy economy	6.8%
Clean environment	5.0%
Healthy behaviors and lifestyles	5.0%
Safe, nearby transportation	4.5%
Welcoming of diverse communities/people	4.1%
Physical accommodations for people with disabilities	4.0%
Religious or spiritual values	4.0%
Good place to raise children	3.3%
Participating and giving back to the community	3.1%
Parks and recreation	3.1%
supportive and happy family life	3.0%
Good job training opportunities	2.6%
Arts and cultural events	2.1%
Good daycare and preschools	1.7%
Low level of child abuse	1.6%
Low deaths and disease rates	1.0%

Table E-32: **Medicaid & Medicare (n=43; 210 selections)**

Safe, affordable housing	15.2%
Access to healthy, affordable food	9.0%
Access to physical, mental, and/or oral health care	8.1%
Low crime/safe neighborhoods	7.6%
Physical accommodations for people with disabilities	6.7%
Clean environment	6.7%
Safe, nearby transportation	6.7%
Healthy behaviors and lifestyles	5.2%
Parks and recreation	4.8%
Arts and cultural events	3.8%
Welcoming of diverse communities/people	3.8%

Table E-33: **Uninsured (n=139; 649 selections)**

Access to physical, mental, and/or oral health care	9.6%
Good schools	9.2%
Safe, affordable housing	8.9%
Low crime/safe neighborhoods	7.1%
Access to healthy, affordable food	6.8%
Good jobs to reach a healthy economy	6.6%
Clean environment	5.7%
Good job training opportunities	5.1%
supportive and happy family life	4.6%
Healthy behaviors and lifestyles	4.5%
Parks and recreation	4.5%

Table E-32: **Medicaid & Medicare (n=43; 210 selections)**

Religious or spiritual values	3.8%
Participating and giving back to the community	3.3%
Good schools	3.3%
Good place to raise children	3.3%
Good job training opportunities	1.9%
Good jobs to reach a healthy economy	1.9%
Low level of child abuse	1.9%
Good daycare and preschools	1.4%
supportive and happy family life	1.0%
Low deaths and disease rates	0.5%

Table E-33: **Uninsured (n=139; 649 selections)**

Good place to raise children	4.2%
Welcoming of diverse communities/people	3.9%
Safe, nearby transportation	3.9%
Participating and giving back to the community	2.9%
Religious or spiritual values	2.8%
Low level of child abuse	2.5%
Low deaths and disease rates	2.2%
Arts and cultural events	1.8%
Physical accommodations for people with disabilities	1.8%
Good daycare and preschools	1.5%

Question 2: Issues affecting community health (needs)

In the following list, what do you think are the five most important "issues" that need to be addressed to make your community healthy? (Those topics that have the greatest impact on overall community health.)

Tables E-36-42: Regional responses to question 2 by different age groups

Table E-36: **Under 18 (n = 37; 175 selections)**

Homelessness/lack of safe, affordable housing	12.0%
Unemployment/lack of living wage jobs	9.7%
Hunger/lack of healthy, affordable food	8.6%
Racism/discrimination	6.9%
Dirty environment	6.3%
Poor schools	6.3%
Gang activity/violence	6.3%
Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders)	6.3%
Domestic violence, child abuse/neglect	5.1%
Unsafe streets (limited crosswalks, bike lanes, lighting, etc.)	5.1%
Being overweight/obesity	4.0%
Bullying/verbal abuse	4.0%
Lack access to physical, mental, and/or oral health care	4.0%
Lack of needed job skills or training	3.4%
Lack of safe and accessible parks/recreation	2.3%
Lack of community involvement	2.3%
Lack of good daycare and preschools	1.7%
Disabilities (physical, mental) and limited mobility	1.7%
Firearm-related injuries	1.7%
HIV/AIDS	0.6%
Aging problems (e.g. memory loss, hearing/vision loss)	0.6%
Asthma/respiratory/lung disease	0.6%
Lack access to safe, nearby transportation	0.6%
Few arts and cultural events	0.0%
Lack of physical accommodations for people with disabilities	0.0%

Table E-37: **Ages 19 - 25 (n = 51; 1141 selections)**

Homelessness/lack of safe, affordable housing	13.1%
Unemployment/lack of living wage jobs	11.1%
Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders)	7.8%
Hunger/lack of healthy, affordable food	6.7%
Racism/discrimination	6.6%
Poor schools	6.1%
Lack access to physical, mental, and/or oral health care	5.6%
Gang activity/violence	4.9%
Domestic violence, child abuse/neglect	4.9%
Being overweight/obesity	3.4%
Bullying/verbal abuse	3.3%
Lack of needed job skills or training	3.2%
Dirty environment	3.1%
Lack of community involvement	2.9%
Unsafe streets (limited crosswalks, bike lanes, lighting, etc.)	2.9%
Disabilities (physical, mental) and limited mobility	2.5%
Lack of safe and accessible parks/recreation	2.2%
Lack of good daycare and preschools	1.8%
Firearm-related injuries	1.7%
Lack access to safe, nearby transportation	1.6%
Few arts and cultural events	1.4%
HIV/AIDS	1.2%
Lack of physical accommodations for people with disabilities	1.0%
Aging problems (e.g. memory loss, hearing/vision loss)	0.5%
Asthma/respiratory/lung disease	0.4%

Table E-38: **Ages 26-39 (n = 984; 4620 selections)**

Homelessness/lack of safe, affordable housing	13.4%
Unemployment/lack of living wage jobs	11.4%
Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders)	9.5%
Hunger/lack of healthy, affordable food	7.8%
Lack access to physical, mental, and/or oral health care	6.8%
Poor schools	5.9%
Racism/discrimination	5.5%
Domestic violence, child abuse/neglect	4.4%
Unsafe streets (limited crosswalks, bike lanes, lighting, etc.)	4.3%
Being overweight/obesity	4.0%
Gang activity/violence	3.9%
Lack of needed job skills or training	3.3%
Lack of community involvement	3.1%
Dirty environment	2.6%
Lack of good daycare and preschools	2.0%
Bullying/verbal abuse	2.0%
Disabilities (physical, mental) and limited mobility	1.9%
Lack of safe and accessible parks/recreation	1.8%
Lack access to safe, nearby transportation	1.6%
Firearm-related injuries	1.0%
Few arts and cultural events	1.0%
Lack of physical accommodations for people with disabilities	1.0%

Table E-38: **Ages 26-39 (n = 984; 4620 selections)**

Aging problems (e.g. memory loss, hearing/vision loss)	0.9%
Asthma/respiratory/lung disease	0.5%
HIV/AIDS	0.5%

Table E-39: **Ages 40-54 (n = 839; 3948 selections)**

Homelessness/lack of safe, affordable housing	13.0%
Unemployment/lack of living wage jobs	10.7%
Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders)	10.1%
Hunger/lack of healthy, affordable food	8.2%
Lack access to physical, mental, and/or oral health care	6.3%
Racism/discrimination	5.3%
Poor schools	5.1%
Gang activity/violence	5.0%
Being overweight/obesity	4.4%
Domestic violence, child abuse/neglect	4.4%
Unsafe streets (limited crosswalks, bike lanes, lighting, etc.)	3.9%
Lack of needed job skills or training	3.3%
Lack of community involvement	2.8%
Dirty environment	2.6%
Lack access to safe, nearby transportation	2.4%
Disabilities (physical, mental) and limited mobility	2.2%
Lack of safe and accessible parks/recreation	1.8%
Bullying/verbal abuse	1.6%
Lack of good daycare and preschools	1.5%
Aging problems (e.g. memory loss, hearing/vision loss)	1.4%
Firearm-related injuries	1.1%
Few arts and cultural events	1.0%
Lack of physical accommodations for people with disabilities	0.8%
Asthma/respiratory/lung disease	0.7%
HIV/AIDS	0.4%

Table E-40: **Ages 55-64 (n = 544; 2544 selections)**

Homelessness/lack of safe, affordable housing	14.2%
Unemployment/lack of living wage jobs	10.3%
Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders)	9.6%
Hunger/lack of healthy, affordable food	8.9%
Lack access to physical, mental, and/or oral health care	6.3%
Being overweight/obesity	5.3%
Domestic violence, child abuse/neglect	4.6%
Gang activity/violence	4.0%
Racism/discrimination	3.7%
Poor schools	3.6%
Unsafe streets (limited crosswalks, bike lanes, lighting, etc.)	3.6%
Lack of needed job skills or training	3.5%
Lack access to safe, nearby transportation	3.4%
Lack of community involvement	3.2%
Aging problems (e.g. memory loss, hearing/vision loss)	2.2%

Table E-40: **Ages 55-64 (n = 544; 2544 selections)**

Firearm-related injuries	2.1%
Dirty environment	2.0%
Disabilities (physical, mental) and limited mobility	2.0%
Bullying/verbal abuse	1.8%
Lack of physical accommodations for people with disabilities	1.3%
Lack of safe and accessible parks/recreation	1.3%
Few arts and cultural events	0.9%
Lack of good daycare and preschools	0.9%
Asthma/respiratory/lung disease	0.8%
HIV/AIDS	0.4%

Table E-41: **Ages 65-79 (n = 325; 1524 selections)**

Homelessness/lack of safe, affordable housing	11.4%
Unemployment/lack of living wage jobs	9.8%
Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders)	8.9%
Hunger/lack of healthy, affordable food	7.9%
Aging problems (e.g. memory loss, hearing/vision loss)	5.4%
Lack access to physical, mental, and/or oral health care	5.2%
Gang activity/violence	5.2%
Domestic violence, child abuse/neglect	4.9%
Being overweight/obesity	4.7%
Unsafe streets (limited crosswalks, bike lanes, lighting, etc.)	4.4%
Lack of community involvement	4.2%
Lack of needed job skills or training	4.2%
Racism/discrimination	3.7%
Poor schools	3.6%
Lack access to safe, nearby transportation	2.5%
Dirty environment	2.4%
Lack of physical accommodations for people with disabilities	2.1%
Bullying/verbal abuse	2.0%
Disabilities (physical, mental) and limited mobility	1.9%
Firearm-related injuries	1.6%
Lack of safe and accessible parks/recreation	1.3%
Few arts and cultural events	1.1%
Lack of good daycare and preschools	0.8%
Asthma/respiratory/lung disease	0.5%
HIV/AIDS	0.4%

Table E-42: **Ages 80 and older (n = 31; 139 selections)**

Homelessness/lack of safe, affordable housing	8.6%
Unemployment/lack of living wage jobs	8.6%
Lack of needed job skills or training	7.9%
Lack access to physical, mental, and/or oral health care	6.5%
Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders)	6.5%
Aging problems (e.g. memory loss, hearing/vision loss)	5.8%
Gang activity/violence	5.8%
Lack access to safe, nearby transportation	5.8%
Lack of physical accommodations for people with disabilities	4.3%
Lack of community involvement	4.3%

Table E-42: **Ages 80 and older (n = 31; 139 selections)**

Hunger/lack of healthy, affordable food	4.3%
Unsafe streets (limited crosswalks, bike lanes, lighting, etc.)	4.3%
Being overweight/obesity	3.6%
Domestic violence, child abuse/neglect	3.6%
Racism/discrimination	2.9%
Lack of safe and accessible parks/recreation	2.9%
Lack of good daycare and preschools	2.9%
Firearm-related injuries	2.9%
Dirty environment	2.2%
Bullying/verbal abuse	2.2%
Poor schools	1.4%
Few arts and cultural events	0.7%
HIV/AIDS	0.7%
Disabilities (physical, mental) and limited mobility	0.7%
Asthma/respiratory/lung disease	0.7%

Tables E-43-45: Regional responses to question 2 by gender

Table E-43: **Female (n = 1992; 9382 selections)**

Homelessness/lack of safe, affordable housing	13.5%
Unemployment/lack of living wage jobs	10.4%
Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders)	10.0%
Hunger/lack of healthy, affordable food	8.5%
Lack access to physical, mental, and/or oral health care	6.6%
Racism/discrimination	4.9%
Poor schools	4.8%
Domestic violence, child abuse/neglect	4.6%
Being overweight/obesity	4.1%
Unsafe streets (limited crosswalks, bike lanes, lighting, etc.)	4.1%
Gang activity/violence	4.0%
Lack of needed job skills or training	3.1%
Lack of community involvement	3.0%
Lack access to safe, nearby transportation	2.5%
Dirty environment	2.3%
Bullying/verbal abuse	2.1%
Lack of good daycare and preschools	1.7%
Lack of safe and accessible parks/recreation	1.7%
Disabilities (physical, mental) and limited mobility	1.6%
Aging problems (e.g. memory loss, hearing/vision loss)	1.6%
Firearm-related injuries	1.5%
Lack of physical accommodations for people with disabilities	1.1%
Few arts and cultural events	1.0%
Asthma/respiratory/lung disease	0.6%
HIV/AIDS	0.4%

Table E-44: **Male (n = 897; 4023)**

Homelessness/lack of safe, affordable housing	12.0%
Unemployment/lack of living wage jobs	11.9%
Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders)	7.9%

Table E-44: **Male (n = 897; 4023)**

Hunger/lack of healthy, affordable food	7.0%
Poor schools	5.4%
Gang activity/violence	5.4%
Lack access to physical, mental, and/or oral health care	5.3%
Being overweight/obesity	5.0%
Racism/discrimination	4.9%
Domestic violence, child abuse/neglect	4.3%
Lack of needed job skills or training	4.3%
Unsafe streets (limited crosswalks, bike lanes, lighting, etc.)	3.8%
Lack of community involvement	3.8%
Dirty environment	3.3%
Disabilities (physical, mental) and limited mobility	2.9%
Lack access to safe, nearby transportation	1.9%
Lack of safe and accessible parks/recreation	1.7%
Bullying/verbal abuse	1.6%
Aging problems (e.g. memory loss, hearing/vision loss)	1.6%
Firearm-related injuries	1.3%
Lack of good daycare and preschools	1.1%
Lack of physical accommodations for people with disabilities	1.1%
Few arts and cultural events	1.0%
HIV/AIDS	0.7%
Asthma/respiratory/lung disease	0.6%

Table E-45: **Non-normative Genders (n = 38; 165 selections)**

Homelessness/lack of safe, affordable housing	17.0%
Unemployment/lack of living wage jobs	13.9%
Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders)	12.1%
Racism/discrimination	8.5%
Lack access to physical, mental, and/or oral health care	7.3%
Domestic violence, child abuse/neglect	5.5%
Gang activity/violence	4.2%
Lack of community involvement	3.6%
Being overweight/obesity	3.0%
Lack of physical accommodations for people with disabilities	2.4%
Poor schools	2.4%
Disabilities (physical, mental) and limited mobility	2.4%
Hunger/lack of healthy, affordable food	2.4%
Lack of needed job skills or training	2.4%
Unsafe streets (limited crosswalks, bike lanes, lighting, etc.)	2.4%
Few arts and cultural events	1.8%
Asthma/respiratory/lung disease	1.8%
Firearm-related injuries	1.8%
Lack access to safe, nearby transportation	1.8%
Aging problems (e.g. memory loss, hearing/vision loss)	1.2%
Bullying/verbal abuse	1.2%
Lack of safe and accessible parks/recreation	0.6%
Dirty environment	0.0%
Lack of good daycare and preschools	0.0%
HIV/AIDS	0.0%

Table E-46: Regional responses to question 2 by minority sexual orientation

Table E-46: **Minority sexual orientation (n = 364; 1744 selections)**

Homelessness/lack of safe, affordable housing	15.4%
Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders)	11.0%
Unemployment/lack of living wage jobs	10.7%
Hunger/lack of healthy, affordable food	8.0%
Racism/discrimination	7.9%
Lack access to physical, mental, and/or oral health care	7.5%
Domestic violence, child abuse/neglect	5.2%
Poor schools	3.9%
Unsafe streets (limited crosswalks, bike lanes, lighting, etc.)	3.7%
Gang activity/violence	3.6%
Being overweight/obesity	3.5%
Lack of needed job skills or training	2.5%
Disabilities (physical, mental) and limited mobility	2.2%
Lack access to safe, nearby transportation	2.2%
Lack of community involvement	1.8%
Dirty environment	1.7%
Firearm-related injuries	1.6%
Bullying/verbal abuse	1.5%
Aging problems (e.g. memory loss, hearing/vision loss)	1.2%
Lack of physical accommodations for people with disabilities	1.0%
Lack of good daycare and preschools	1.0%
Lack of safe and accessible parks/recreation	0.9%
HIV/AIDS	0.9%
Asthma/respiratory/lung disease	0.7%
Few arts and cultural events	0.5%

Table E-47: Regional responses to question 2 by Hispanic ethnicity

Table E-47: **Hispanic ethnicity (n = 372; 1711 selections**

Homelessness/lack of safe, affordable housing	9.6%
Unemployment/lack of living wage jobs	9.5%
Racism/discrimination	7.9%
Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders)	7.2%
Hunger/lack of healthy, affordable food	6.8%
Poor schools	6.5%
Domestic violence, child abuse/neglect	5.6%
Lack access to physical, mental, and/or oral health care	5.2%
Being overweight/obesity	5.1%
Gang activity/violence	4.8%
Lack of needed job skills or training	3.7%
Unsafe streets (limited crosswalks, bike lanes, lighting, etc.)	3.6%
Bullying/verbal abuse	3.3%
Dirty environment	2.9%
Disabilities (physical, mental) and limited mobility	2.4%
Lack of community involvement	2.1%
Firearm-related injuries	1.9%

Table E-47: **Hispanic ethnicity (n = 372; 1711 selections**

Lack of safe and accessible parks/recreation	1.9%
Lack access to safe, nearby transportation	1.9%
Asthma/respiratory/lung disease	1.8%
Lack of good daycare and preschools	1.7%
Few arts and cultural events	1.6%
HIV/AIDS	1.3%
Lack of physical accommodations for people with disabilities	0.9%
Aging problems (e.g. memory loss, hearing/vision loss)	0.9%

Table E-48: Regional responses to question 2 by people who grew up outside of the United States

Table E-48: **Grew up outside U.S. (n = 225; 1064 selections)**

Unemployment/lack of living wage jobs	8.9%
Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders)	8.0%
Homelessness/lack of safe, affordable housing	7.9%
Lack access to physical, mental, and/or oral health care	6.7%
Racism/discrimination	6.1%
Being overweight/obesity	6.0%
Hunger/lack of healthy, affordable food	5.9%
Domestic violence, child abuse/neglect	5.3%
Gang activity/violence	5.2%
Poor schools	5.0%
Firearm-related injuries	4.4%
Unsafe streets (limited crosswalks, bike lanes, lighting, etc.)	4.4%
Dirty environment	3.7%
Lack of community involvement	3.7%
Lack of needed job skills or training	3.6%
Bullying/verbal abuse	2.4%
Disabilities (physical, mental) and limited mobility	2.0%
Few arts and cultural events	1.9%
Lack of safe and accessible parks/recreation	1.9%
Lack of good daycare and preschools	1.7%
Lack access to safe, nearby transportation	1.7%
Lack of physical accommodations for people with disabilities	1.2%
Asthma/respiratory/lung disease	1.0%
HIV/AIDS	0.8%
Aging problems (e.g. memory loss, hearing/vision loss)	0.7%

Tables E-49-53: Regional responses to question 2 by race (only groups with 25 or more respondents were analyzed)

Table E-49: **African American/Black (n = 146; 711 selections)**

Homelessness/lack of safe, affordable housing	12.4%
Unemployment/lack of living wage jobs	12.0%
Racism/discrimination	11.1%
Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders)	8.6%
Gang activity/violence	6.6%
Hunger/lack of healthy, affordable food	6.0%
Poor schools	5.2%

Table E-49: **African American/Black (n = 146; 711 selections)**

Lack access to physical, mental, and/or oral health care	5.1%
Domestic violence, child abuse/neglect	4.2%
Disabilities (physical, mental) and limited mobility	4.1%
Lack of needed job skills or training	3.8%
Being overweight/obesity	2.7%
Unsafe streets (limited crosswalks, bike lanes, lighting, etc.)	2.7%
Lack of community involvement	2.5%
Lack of safe and accessible parks/recreation	2.1%
Dirty environment	1.8%
Firearm-related injuries	1.4%
Few arts and cultural events	1.3%
Bullying/verbal abuse	1.3%
Lack access to safe, nearby transportation	1.3%
Lack of good daycare and preschools	1.1%
Aging problems (e.g. memory loss, hearing/vision loss)	1.0%
Lack of physical accommodations for people with disabilities	0.8%
HIV/AIDS	0.8%
Asthma/respiratory/lung disease	0.1%

Table E-50: **Asian American/Asian (n = 77; 368 selections)**

Homelessness/lack of safe, affordable housing	12.2%
Unemployment/lack of living wage jobs	10.6%
Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders)	8.4%
Poor schools	6.5%
Racism/discrimination	6.3%
Lack access to physical, mental, and/or oral health care	6.3%
Unsafe streets (limited crosswalks, bike lanes, lighting, etc.)	6.3%
Hunger/lack of healthy, affordable food	5.2%
Gang activity/violence	4.9%
Dirty environment	4.3%
Being overweight/obesity	3.5%
Lack of safe and accessible parks/recreation	3.3%
Lack of community involvement	3.3%
Lack of needed job skills or training	3.0%
Domestic violence, child abuse/neglect	2.7%
Lack access to safe, nearby transportation	2.4%
Lack of good daycare and preschools	2.2%
Firearm-related injuries	1.6%
Bullying/verbal abuse	1.4%
Disabilities (physical, mental) and limited mobility	1.4%
Lack of physical accommodations for people with disabilities	1.1%
Aging problems (e.g. memory loss, hearing/vision loss)	1.1%
HIV/AIDS	0.8%
Asthma/respiratory/lung disease	0.8%
Few arts and cultural events	0.5%

Table E-51: **Native American/ American Indian/Alaska Native (n = 76; 362 selections)**

Homelessness/lack of safe, affordable housing	13.3%
Unemployment/lack of living wage jobs	11.3%
Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders)	10.8%
Hunger/lack of healthy, affordable food	8.3%
Racism/discrimination	6.9%
Domestic violence, child abuse/neglect	5.8%
Lack access to physical, mental, and/or oral health care	5.2%
Disabilities (physical, mental) and limited mobility	4.4%
Lack of needed job skills or training	4.4%
Poor schools	3.6%
Gang activity/violence	3.3%
Lack of community involvement	2.8%
Being overweight/obesity	2.2%
Lack of safe and accessible parks/recreation	2.2%
Lack access to safe, nearby transportation	2.2%
Unsafe streets (limited crosswalks, bike lanes, lighting, etc.)	1.9%
Lack of good daycare and preschools	1.7%
HIV/AIDS	1.7%
Dirty environment	1.4%
Aging problems (e.g. memory loss, hearing/vision loss)	1.4%
Bullying/verbal abuse	1.4%
Few arts and cultural events	1.1%
Lack of physical accommodations for people with disabilities	1.1%
Asthma/respiratory/lung disease	1.1%
Firearm-related injuries	0.6%

Table E-52: **Multiracial (n = 153; 1116 selections)**

Homelessness/lack of safe, affordable housing	13.2%
Unemployment/lack of living wage jobs	11.2%
Hunger/lack of healthy, affordable food	8.6%
Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders)	6.9%
Poor schools	5.8%
Gang activity/violence	5.6%
Racism/discrimination	5.6%
Lack access to physical, mental, and/or oral health care	5.2%
Domestic violence, child abuse/neglect	4.8%
Being overweight/obesity	3.8%
Lack of needed job skills or training	3.8%
Dirty environment	3.4%
Lack of community involvement	3.4%
Unsafe streets (limited crosswalks, bike lanes, lighting, etc.)	3.1%
Bullying/verbal abuse	2.4%
Disabilities (physical, mental) and limited mobility	2.4%
Lack access to safe, nearby transportation	1.9%
Lack of safe and accessible parks/recreation	1.6%
Lack of good daycare and preschools	1.5%
Aging problems (e.g. memory loss, hearing/vision loss)	1.3%

Table E-52: **Multiracial (n = 153; 1116 selections)**

Lack of physical accommodations for people with disabilities	1.2%
Firearm-related injuries	1.0%
Few arts and cultural events	0.9%
HIV/AIDS	0.7%
Asthma/respiratory/lung disease	0.6%

Table E-53: **European American/White/Caucasian (n = 2003; 9447 selections)**

Homelessness/lack of safe, affordable housing	13.7%
Unemployment/lack of living wage jobs	11.1%
Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders)	10.0%
Hunger/lack of healthy, affordable food	8.4%
Lack access to physical, mental, and/or oral health care	6.5%
Poor schools	4.8%
Being overweight/obesity	4.6%
Domestic violence, child abuse/neglect	4.6%
Unsafe streets (limited crosswalks, bike lanes, lighting, etc.)	4.2%
Racism/discrimination	4.1%
Gang activity/violence	4.0%
Lack of needed job skills or training	3.3%
Lack of community involvement	3.2%
Dirty environment	2.4%
Lack access to safe, nearby transportation	2.4%
Bullying/verbal abuse	1.8%
Disabilities (physical, mental) and limited mobility	1.7%
Aging problems (e.g. memory loss, hearing/vision loss)	1.7%
Lack of good daycare and preschools	1.5%
Lack of safe and accessible parks/recreation	1.5%
Firearm-related injuries	1.4%
Lack of physical accommodations for people with disabilities	1.1%
Few arts and cultural events	1.0%
Asthma/respiratory/lung disease	0.5%
HIV/AIDS	0.2%

Tables E-54-55: Regional responses to question 2 by language spoken at home

Table E-54: **Spanish, Spanish Creole, or Spanish and English at Home (n = 211; 963 selections)**

Homelessness/lack of safe, affordable housing	8.8%
Racism/discrimination	8.7%
Unemployment/lack of living wage jobs	8.6%
Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders)	6.3%
Hunger/lack of healthy, affordable food	6.0%
Domestic violence, child abuse/neglect	5.9%
Being overweight/obesity	5.8%
Lack access to physical, mental, and/or oral health care	5.3%
Poor schools	5.0%
Gang activity/violence	5.0%
Lack of needed job skills or training	3.7%

Table E-54: **Spanish, Spanish Creole, or Spanish and English at Home (n = 211; 963 selections)**

Unsafe streets (limited crosswalks, bike lanes, lighting, etc.)	3.7%
Bullying/verbal abuse	3.3%
Lack of community involvement	3.1%
Dirty environment	2.9%
Firearm-related injuries	2.9%
Asthma/respiratory/lung disease	2.3%
Disabilities (physical, mental) and limited mobility	2.2%
Lack access to safe, nearby transportation	2.2%
Lack of safe and accessible parks/recreation	2.1%
Few arts and cultural events	1.9%
Lack of good daycare and preschools	1.7%
HIV/AIDS	1.5%
Lack of physical accommodations for people with disabilities	0.9%
Aging problems (e.g. memory loss, hearing/vision loss)	0.1%

Table E-55: **Speak a Language Other than Spanish or English at Home (n = 70; 327 selections)**

Unemployment/lack of living wage jobs	9.2%
Homelessness/lack of safe, affordable housing	8.9%
Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders)	8.6%
Racism/discrimination	6.7%
Lack access to physical, mental, and/or oral health care	6.4%
Hunger/lack of healthy, affordable food	6.4%
Poor schools	5.8%
Unsafe streets (limited crosswalks, bike lanes, lighting, etc.)	5.2%
Gang activity/violence	4.9%
Domestic violence, child abuse/neglect	3.7%
Lack of needed job skills or training	3.7%
Lack of safe and accessible parks/recreation	3.4%
Lack of community involvement	3.4%
Being overweight/obesity	3.1%
Dirty environment	3.1%
Lack of good daycare and preschools	3.1%
Disabilities (physical, mental) and limited mobility	3.1%
Lack access to safe, nearby transportation	3.1%
Bullying/verbal abuse	2.1%
Firearm-related injuries	1.8%
Lack of physical accommodations for people with disabilities	1.5%
HIV/AIDS	1.2%
Aging problems (e.g. memory loss, hearing/vision loss)	0.9%
Few arts and cultural events	0.6%
Asthma/respiratory/lung disease	0.3%

Table E-56: Regional responses to question 2 by people earning less than 200% of the Federal Poverty Level

Table E-56: **200% FPL or Below (n = 841; 3996 selections)**

Homelessness/lack of safe, affordable housing	12.4%
Unemployment/lack of living wage jobs	11.3%
Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating	8.8%

Table E-56: **200% FPL or Below (n = 841; 3996 selections)**

disorders)	
Hunger/lack of healthy, affordable food	7.3%
Lack access to physical, mental, and/or oral health care	5.8%
Racism/discrimination	4.9%
Poor schools	4.9%
Domestic violence, child abuse/neglect	4.9%
Gang activity/violence	4.4%
Lack of needed job skills or training	4.2%
Unsafe streets (limited crosswalks, bike lanes, lighting, etc.)	3.3%
Lack of community involvement	3.2%
Being overweight/obesity	3.2%
Dirty environment	3.0%
Disabilities (physical, mental) and limited mobility	2.9%
Bullying/verbal abuse	2.8%
Lack access to safe, nearby transportation	2.0%
Lack of safe and accessible parks/recreation	1.7%
Aging problems (e.g. memory loss, hearing/vision loss)	1.6%
Lack of physical accommodations for people with disabilities	1.5%
Lack of good daycare and preschools	1.4%
Firearm-related injuries	1.3%
Few arts and cultural events	1.2%
Asthma/respiratory/lung disease	1.2%
HIV/AIDS	1.0%

Table E-57: Regional responses to question 2 by people living with a disability

Table E-57: **Have a disability (n = 578; 2770 selections)**

Homelessness/lack of safe, affordable housing	13.1%
Unemployment/lack of living wage jobs	10.4%
Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders)	10.1%
Hunger/lack of healthy, affordable food	7.6%
Lack access to physical, mental, and/or oral health care	5.6%
Domestic violence, child abuse/neglect	4.6%
Gang activity/violence	4.6%
Racism/discrimination	4.4%
Disabilities (physical, mental) and limited mobility	4.2%
Lack of needed job skills or training	4.1%
Poor schools	3.5%
Lack of community involvement	3.3%
Unsafe streets (limited crosswalks, bike lanes, lighting, etc.)	3.3%
Being overweight/obesity	3.2%
Aging problems (e.g. memory loss, hearing/vision loss)	2.5%
Dirty environment	2.3%
Lack of physical accommodations for people with disabilities	2.3%
Lack access to safe, nearby transportation	2.3%
Bullying/verbal abuse	2.1%
Lack of safe and accessible parks/recreation	1.6%
Asthma/respiratory/lung disease	1.1%

Table E-57: **Have a disability (n = 578; 2770 selections)**

Firearm-related injuries	1.1%
Few arts and cultural events	1.0%
Lack of good daycare and preschools	1.0%
HIV/AIDS	0.6%

Table E-58: Regional responses to question 2 by veterans

Table E-58: **Veteran (n = 205; 953 selections)**

Homelessness/lack of safe, affordable housing	11.4%
Unemployment/lack of living wage jobs	10.3%
Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders)	8.1%
Hunger/lack of healthy, affordable food	7.5%
Being overweight/obesity	6.3%
Gang activity/violence	5.6%
Lack access to physical, mental, and/or oral health care	5.5%
Poor schools	4.7%
Domestic violence, child abuse/neglect	4.7%
Lack of community involvement	4.3%
Unsafe streets (limited crosswalks, bike lanes, lighting, etc.)	4.2%
Lack of needed job skills or training	4.1%
Racism/discrimination	3.9%
Aging problems (e.g. memory loss, hearing/vision loss)	2.7%
Lack access to safe, nearby transportation	2.6%
Dirty environment	2.5%
Disabilities (physical, mental) and limited mobility	2.5%
Bullying/verbal abuse	2.4%
Lack of safe and accessible parks/recreation	1.9%
Firearm-related injuries	1.3%
Lack of physical accommodations for people with disabilities	1.2%
Lack of good daycare and preschools	0.9%
Asthma/respiratory/lung disease	0.7%
Few arts and cultural events	0.6%
HIV/AIDS	0.1%

Tables E-59-61: Regional responses to question 2 by education level

Table E-59: **Less than High School (n = 133; 619 selections)**

Homelessness/lack of safe, affordable housing	11.6%
Unemployment/lack of living wage jobs	9.5%
Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders)	7.9%
Hunger/lack of healthy, affordable food	6.9%
Racism/discrimination	6.1%
Domestic violence, child abuse/neglect	5.7%
Lack of needed job skills or training	5.2%
Lack access to physical, mental, and/or oral health care	5.0%
Poor schools	4.5%
Gang activity/violence	4.5%

Table E-59: **Less than High School (n = 133; 619 selections)**

Disabilities (physical, mental) and limited mobility	3.6%
Being overweight/obesity	2.9%
Lack of community involvement	2.9%
Unsafe streets (limited crosswalks, bike lanes, lighting, etc.)	2.9%
Lack of safe and accessible parks/recreation	2.7%
Asthma/respiratory/lung disease	2.3%
Lack access to safe, nearby transportation	2.3%
Lack of physical accommodations for people with disabilities	2.1%
Bullying/verbal abuse	1.9%
Few arts and cultural events	1.8%
Dirty environment	1.8%
Aging problems (e.g. memory loss, hearing/vision loss)	1.8%
Firearm-related injuries	1.5%
Lack of good daycare and preschools	1.3%
HIV/AIDS	1.3%

Table E-60: **High School Diploma or GED (n = 579; 2717 selections)**

Homelessness/lack of safe, affordable housing	12.4%
Unemployment/lack of living wage jobs	11.7%
Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders)	8.6%
Hunger/lack of healthy, affordable food	8.0%
Lack access to physical, mental, and/or oral health care	5.8%
Gang activity/violence	5.7%
Domestic violence, child abuse/neglect	5.2%
Poor schools	4.7%
Lack of needed job skills or training	4.7%
Racism/discrimination	3.8%
Unsafe streets (limited crosswalks, bike lanes, lighting, etc.)	3.6%
Being overweight/obesity	3.4%
Lack of community involvement	3.4%
Disabilities (physical, mental) and limited mobility	3.0%
Dirty environment	2.5%
Bullying/verbal abuse	2.4%
Aging problems (e.g. memory loss, hearing/vision loss)	1.7%
Lack access to safe, nearby transportation	1.7%
Lack of safe and accessible parks/recreation	1.4%
Lack of physical accommodations for people with disabilities	1.3%
Lack of good daycare and preschools	1.1%
Firearm-related injuries	1.1%
Few arts and cultural events	1.0%
HIV/AIDS	0.8%
Asthma/respiratory/lung disease	0.8%

Table E-61: **Bachelors degree or higher (n = 1841; 8671 selections)**

Homelessness/lack of safe, affordable housing	13.7%
Unemployment/lack of living wage jobs	10.8%
Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders)	10.1%

Table E-61: **Bachelors degree or higher (n = 1841; 8671 selections)**

Hunger/lack of healthy, affordable food	8.2%
Lack access to physical, mental, and/or oral health care	6.7%
Racism/discrimination	5.0%
Being overweight/obesity	4.9%
Poor schools	4.9%
Unsafe streets (limited crosswalks, bike lanes, lighting, etc.)	4.3%
Domestic violence, child abuse/neglect	4.2%
Gang activity/violence	3.9%
Lack of community involvement	3.3%
Lack of needed job skills or training	3.0%
Lack access to safe, nearby transportation	2.6%
Dirty environment	2.4%
Lack of safe and accessible parks/recreation	1.7%
Lack of good daycare and preschools	1.6%
Aging problems (e.g. memory loss, hearing/vision loss)	1.6%
Disabilities (physical, mental) and limited mobility	1.5%
Bullying/verbal abuse	1.5%
Firearm-related injuries	1.4%
Lack of physical accommodations for people with disabilities	1.0%
Few arts and cultural events	0.9%
Asthma/respiratory/lung disease	0.5%
HIV/AIDS	0.2%

Tables E-62-65: Regional responses to question 2 by insurance status/type of insurance

Table E-62: **Medicaid (n = 597; 2784 selections)**

Homelessness/lack of safe, affordable housing	13.9%
Unemployment/lack of living wage jobs	12.5%
Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders)	8.8%
Hunger/lack of healthy, affordable food	6.8%
Lack access to physical, mental, and/or oral health care	5.7%
Racism/discrimination	5.7%
Poor schools	5.3%
Domestic violence, child abuse/neglect	5.1%
Lack of needed job skills or training	5.1%
Gang activity/violence	4.5%
Disabilities (physical, mental) and limited mobility	3.4%
Lack of community involvement	3.2%
Unsafe streets (limited crosswalks, bike lanes, lighting, etc.)	2.8%
Being overweight/obesity	2.6%
Bullying/verbal abuse	2.6%
Lack of safe and accessible parks/recreation	2.0%
Dirty environment	1.7%
Lack of good daycare and preschools	1.4%
Lack access to safe, nearby transportation	1.4%
Lack of physical accommodations for people with disabilities	1.1%
Aging problems (e.g. memory loss, hearing/vision loss)	1.1%

Table E-62: **Medicaid (n = 597; 2784 selections)**

HIV/AIDS	1.0%
Few arts and cultural events	0.8%
Firearm-related injuries	0.8%
Asthma/respiratory/lung disease	0.6%

Table E-63: **Medicare (n = 287; 1385 selections)**

Homelessness/lack of safe, affordable housing	11.6%
Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders)	10.1%
Lack of needed job skills or training	8.7%
Unemployment/lack of living wage jobs	7.1%
Disabilities (physical, mental) and limited mobility	5.2%
Asthma/respiratory/lung disease	5.1%
Being overweight/obesity	4.7%
Bullying/verbal abuse	4.5%
Hunger/lack of healthy, affordable food	4.5%
Lack of community involvement	4.0%
Firearm-related injuries	3.8%
Lack access to safe, nearby transportation	3.8%
Racism/discrimination	3.6%
Aging problems (e.g. memory loss, hearing/vision loss)	3.6%
Other	3.2%
Gang activity/violence	2.2%
HIV/AIDS	2.0%
Dirty environment	1.9%
Lack of safe and accessible parks/recreation	1.9%
Unsafe streets (limited crosswalks, bike lanes, lighting, etc.)	1.9%
Lack access to physical, mental, and/or oral health care	1.7%
Lack of good daycare and preschools	1.6%
Lack of physical accommodations for people with disabilities	1.1%
Few arts and cultural events	0.9%
Poor schools	0.7%
Domestic violence, child abuse/neglect	0.6%

Table E-64: **Medicaid/Medicare (n = 43; 207 selections)**

Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders)	10.1%
Homelessness/lack of safe, affordable housing	9.2%
Hunger/lack of healthy, affordable food	8.2%
Unemployment/lack of living wage jobs	6.3%
Bullying/verbal abuse	5.8%
Lack access to physical, mental, and/or oral health care	5.8%
Disabilities (physical, mental) and limited mobility	5.3%
Unsafe streets (limited crosswalks, bike lanes, lighting, etc.)	5.3%
Domestic violence, child abuse/neglect	4.3%
Racism/discrimination	3.9%
Being overweight/obesity	3.9%
Aging problems (e.g. memory loss, hearing/vision loss)	3.9%
Lack access to safe, nearby transportation	3.9%

Table E-64: **Medicaid/Medicare (n = 43; 207 selections)**

Dirty environment	2.9%
Lack of safe and accessible parks/recreation	2.9%
Lack of physical accommodations for people with disabilities	2.9%
Asthma/respiratory/lung disease	2.9%
Gang activity/violence	2.4%
Lack of needed job skills or training	2.4%
Lack of good daycare and preschools	1.9%
Lack of community involvement	1.9%
Few arts and cultural events	1.4%
Poor schools	1.4%
HIV/AIDS	1.0%
Firearm-related injuries	0.0%

Table E-65: **Uninsured (n = 129; 536 selections)**

Unemployment/lack of living wage jobs	12.3%
Homelessness/lack of safe, affordable housing	11.2%
Hunger/lack of healthy, affordable food	7.3%
Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders)	7.3%
Racism/discrimination	6.5%
Lack access to physical, mental, and/or oral health care	6.5%
Domestic violence, child abuse/neglect	6.5%
Poor schools	6.3%
Gang activity/violence	5.8%
Lack of needed job skills or training	4.5%
Unsafe streets (limited crosswalks, bike lanes, lighting, etc.)	3.7%
Lack access to safe, nearby transportation	3.2%
Lack of community involvement	3.0%
Bullying/verbal abuse	2.6%
Firearm-related injuries	2.4%
Dirty environment	1.7%
Asthma/respiratory/lung disease	1.7%
Being overweight/obesity	1.5%
Few arts and cultural events	1.5%
Lack of safe and accessible parks/recreation	1.3%
Disabilities (physical, mental) and limited mobility	1.3%
Lack of good daycare and preschools	0.9%
Lack of physical accommodations for people with disabilities	0.6%
HIV/AIDS	0.4%
Aging problems (e.g. memory loss, hearing/vision loss)	0.0%

Question 3: Risky behaviors

In the following list, what do you think are the three most important "risky behaviors" in your community? (Those behaviors that have the greatest impact on overall community health."

Tables E-66-72: Regional responses to question 3 by different age groups

Table E-66: **Under 18 (n = 37; 111 selections)**

Drug use/abuse	16.2%
Risky sexual behavior/unsafe sex	12.6%
Dropping out of school	11.7%
Alcohol abuse/addiction	10.8%
Self-harm (e.g. cutting, suicide attempts)	9.0%
Unsafe driving (e.g. not using seat belts/child safety seats, distracted driving)	9.0%
Tobacco use	6.3%
Not using birth control	5.4%
Lack of exercise	5.4%
Poor eating habits	5.4%
Social isolation/loneliness	4.5%
Not getting "shots" to prevent disease (immunizations)	3.6%

Table E-67: **Ages 19-25 (n = 241; 660 selections)**

Drug use/abuse	23.0%
Alcohol abuse/addiction	17.3%
Dropping out of school	11.2%
Social isolation/loneliness	9.7%
Risky sexual behavior/unsafe sex	7.1%
Lack of exercise	7.1%
Unsafe driving (e.g. not using seat belts/child safety seats, distracted driving)	5.6%
Tobacco use	5.5%
Poor eating habits	4.8%
Not using birth control	3.3%
Self-harm (e.g. cutting, suicide attempts)	3.0%
Not getting "shots" to prevent disease (immunizations)	2.3%

Table E-68: **Ages 26-39 (n = 985; 2835 selections)**

Drug use/abuse	18.4%
Alcohol abuse/addiction	15.3%
Poor eating habits	9.9%
Social isolation/loneliness	9.0%
Lack of exercise	8.7%
Dropping out of school	8.4%
Unsafe driving (e.g. not using seat belts/child safety seats, distracted driving)	7.7%
Tobacco use	5.8%
Risky sexual behavior/unsafe sex	5.7%
Not getting "shots" to prevent disease (immunizations)	5.4%
Not using birth control	3.4%
Self-harm (e.g. cutting, suicide attempts)	2.3%

Table E-69: **Ages 40-54 (n = 839; 2416 selections)**

Drug use/abuse	18.5%
Alcohol abuse/addiction	16.5%
Poor eating habits	11.2%
Lack of exercise	9.8%
Social isolation/loneliness	9.1%

Table E-69: **Ages 40-54 (n = 839; 2416 selections)**

Dropping out of school	8.4%
Unsafe driving (e.g. not using seat belts/child safety seats, distracted driving)	6.8%
Tobacco use	5.5%
Risky sexual behavior/unsafe sex	5.1%
Not getting "shots" to prevent disease (immunizations)	3.8%
Not using birth control	2.7%
Self-harm (e.g. cutting, suicide attempts)	2.5%

Table E-70: **Ages 55-64 (n = 543; 1551 selections)**

Drug use/abuse	18.8%
Alcohol abuse/addiction	17.2%
Social isolation/loneliness	10.3%
Poor eating habits	9.7%
Dropping out of school	9.2%
Lack of exercise	8.3%
Unsafe driving (e.g. not using seat belts/child safety seats, distracted driving)	7.7%
Tobacco use	5.4%
Not getting "shots" to prevent disease (immunizations)	4.6%
Risky sexual behavior/unsafe sex	4.3%
Not using birth control	2.9%
Self-harm (e.g. cutting, suicide attempts)	1.6%

Table E-71: **Ages 65-79 (n = 325; 934 selections)**

Drug use/abuse	16.8%
Alcohol abuse/addiction	15.8%
Dropping out of school	11.0%
Lack of exercise	10.3%
Poor eating habits	9.6%
Social isolation/loneliness	9.4%
Unsafe driving (e.g. not using seat belts/child safety seats, distracted driving)	8.2%
Tobacco use	6.1%
Not getting "shots" to prevent disease (immunizations)	5.0%
Risky sexual behavior/unsafe sex	4.0%
Not using birth control	2.6%
Self-harm (e.g. cutting, suicide attempts)	1.1%

Table E-72: **Ages 80 and older (n = 31; 105 selections)**

Risky sexual behavior/unsafe sex	21.9%
Alcohol abuse/addiction	15.2%
Drug use/abuse	14.3%
Tobacco use	11.4%
Social isolation/loneliness	9.5%
Dropping out of school	8.6%
Poor eating habits	6.7%
Not getting "shots" to prevent disease (immunizations)	4.8%
Unsafe driving (e.g. not using seat belts/child safety seats, distracted driving)	3.8%
Lack of exercise	2.9%
Not using birth control	1.0%

Table E-72: **Ages 80 and older (n = 31; 105 selections)**

Self-harm (e.g. cutting, suicide attempts)	0.0%

Tables E-73-75: Regional responses to question 3 by gender

Table E-73: **Female (n = 1992; 5731 selections)**

Drug use/abuse	17.8%
Alcohol abuse/addiction	15.8%
Poor eating habits	10.1%
Social isolation/loneliness	9.6%
Dropping out of school	9.0%
Lack of exercise	8.9%
Unsafe driving (e.g. not using seat belts/child safety seats, distracted driving)	8.0%
Tobacco use	5.7%
Risky sexual behavior/unsafe sex	5.0%
Not getting "shots" to prevent disease (immunizations)	4.8%
Not using birth control	3.2%
Self-harm (e.g. cutting, suicide attempts)	2.3%

Table E-74: **Male (n = 927; 2571 selections)**

Drug use/abuse	20.3%
Alcohol abuse/addiction	16.7%
Poor eating habits	10.2%
Dropping out of school	9.4%
Lack of exercise	9.4%
Social isolation/loneliness	8.6%
Tobacco use	6.0%
Unsafe driving (e.g. not using seat belts/child safety seats, distracted driving)	5.8%
Risky sexual behavior/unsafe sex	5.5%
Not getting "shots" to prevent disease (immunizations)	3.9%
Not using birth control	2.5%
Self-harm (e.g. cutting, suicide attempts)	1.8%

Table E-75: **Non-normative Genders (n = 38; 98 selections)**

Alcohol abuse/addiction	20.4%
Drug use/abuse	16.3%
Social isolation/loneliness	16.3%
Lack of exercise	8.2%
Unsafe driving (e.g. not using seat belts/child safety seats, distracted driving)	7.1%
Self-harm (e.g. cutting, suicide attempts)	6.1%
Dropping out of school	6.1%
Not using birth control	5.1%
Poor eating habits	5.1%
Risky sexual behavior/unsafe sex	4.1%
Not getting "shots" to prevent disease (immunizations)	4.1%
Tobacco use	1.0%

Table E-76: Regional responses to question 3 by minority sexual orientation

Table E-76: **Minority sexual orientation (n = 364; 999 selections)**

Alcohol abuse/addiction	18.1%
Drug use/abuse	17.1%
Social isolation/loneliness	12.6%
Poor eating habits	9.6%
Lack of exercise	8.6%
Dropping out of school	7.6%
Unsafe driving (e.g. not using seat belts/child safety seats, distracted driving)	6.9%
Risky sexual behavior/unsafe sex	6.8%
Not getting "shots" to prevent disease (immunizations)	4.6%
Not using birth control	3.6%
Self-harm (e.g. cutting, suicide attempts)	2.9%
Tobacco use	1.5%

Table E-77: Regional responses to question 3 by Hispanic ethnicity

Table E-77: **Hispanic ethnicity (n = 372; 1046 selections)**

Alcohol abuse/addiction	16.4%
Drug use/abuse	16.2%
Poor eating habits	12.1%
Lack of exercise	10.0%
Dropping out of school	9.3%
Risky sexual behavior/unsafe sex	6.8%
Tobacco use	6.6%
Social isolation/loneliness	6.6%
Unsafe driving (e.g. not using seat belts/child safety seats, distracted driving)	5.3%
Not getting "shots" to prevent disease (immunizations)	4.1%
Not using birth control	3.3%
Self-harm (e.g. cutting, suicide attempts)	3.3%

Table E-78: Regional responses to question 3 by people who grew up outside the United States

Table E-78: **Grew up Outside U.S. (n = 225; 613 selections)**

Alcohol abuse/addiction	15.7%
Drug use/abuse	15.2%
Poor eating habits	12.9%
Lack of exercise	11.4%
Social isolation/loneliness	8.5%
Tobacco use	7.3%
Dropping out of school	7.2%
Unsafe driving (e.g. not using seat belts/child safety seats, distracted driving)	6.7%
Risky sexual behavior/unsafe sex	6.0%
Not getting "shots" to prevent disease (immunizations)	4.7%
Self-harm (e.g. cutting, suicide attempts)	2.4%
Not using birth control	2.0%

Tables E-79-83: Regional responses to question 3 by race (only groups with 25 or more respondents were analyzed)

Table E-79: **African American/Black (n = 146; 410 selections)**

Drug use/abuse	21.7%
Alcohol abuse/addiction	17.8%
Poor eating habits	10.2%
Dropping out of school	10.0%
Risky sexual behavior/unsafe sex	8.0%
Lack of exercise	8.0%
Social isolation/loneliness	6.8%
Unsafe driving (e.g. not using seat belts/child safety seats, distracted driving)	4.6%
Tobacco use	4.1%
Not using birth control	3.2%
Not getting "shots" to prevent disease (immunizations)	2.9%
Self-harm (e.g. cutting, suicide attempts)	2.4%

Table E-80: **Asian American/Asian (n = 77; 217 selections)**

Drug use/abuse	19.4%
Alcohol abuse/addiction	12.4%
Unsafe driving (e.g. not using seat belts/child safety seats, distracted driving)	11.1%
Lack of exercise	10.6%
Poor eating habits	10.1%
Social isolation/loneliness	9.7%
Dropping out of school	7.4%
Tobacco use	6.0%
Risky sexual behavior/unsafe sex	5.5%
Not getting "shots" to prevent disease (immunizations)	3.2%
Not using birth control	2.8%
Self-harm (e.g. cutting, suicide attempts)	1.8%

Table E-81: **Native American/American Indian/Alaska Native (n = 76; 216 selections)**

Drug use/abuse	23.1%
Alcohol abuse/addiction	18.5%
Dropping out of school	10.6%
Lack of exercise	9.7%
Social isolation/loneliness	9.3%
Poor eating habits	6.5%
Tobacco use	6.0%
Risky sexual behavior/unsafe sex	5.6%
Unsafe driving (e.g. not using seat belts/child safety seats, distracted driving)	4.6%
Not getting "shots" to prevent disease (immunizations)	3.2%
Self-harm (e.g. cutting, suicide attempts)	2.3%
Not using birth control	0.5%

Table E-82: **Multiracial (n = 233; 670 selections)**

Drug use/abuse	19.3%
Alcohol abuse/addiction	18.2%
Social isolation/loneliness	10.3%

Table E-82: **Multiracial (n = 233; 670 selections)**

Poor eating habits	8.8%
Dropping out of school	8.5%
Lack of exercise	7.5%
Risky sexual behavior/unsafe sex	7.0%
Unsafe driving (e.g. not using seat belts/child safety seats, distracted driving)	6.4%
Tobacco use	4.3%
Not getting "shots" to prevent disease (immunizations)	3.6%
Not using birth control	3.3%
Self-harm (e.g. cutting, suicide attempts)	2.8%

Table E-83: **European American/White/Caucasian (n = 2003; 5798 selections)**

Drug use/abuse	18.0%
Alcohol abuse/addiction	15.5%
Poor eating habits	10.2%
Social isolation/loneliness	9.8%
Dropping out of school	9.3%
Lack of exercise	9.0%
Unsafe driving (e.g. not using seat belts/child safety seats, distracted driving)	8.0%
Tobacco use	6.0%
Not getting "shots" to prevent disease (immunizations)	4.9%
Risky sexual behavior/unsafe sex	4.4%
Not using birth control	2.9%
Self-harm (e.g. cutting, suicide attempts)	2.1%

Tables E-84-85: Regional responses to question 3 by language spoken at home

Table E-84: **Spanish, Spanish Creole, or Spanish and English (n = 211; 578 selections)**

Alcohol abuse/addiction	17.3%
Drug use/abuse	15.1%
Poor eating habits	11.9%
Lack of exercise	10.9%
Dropping out of school	9.7%
Tobacco use	7.6%
Risky sexual behavior/unsafe sex	6.9%
Unsafe driving (e.g. not using seat belts/child safety seats, distracted driving)	4.8%
Social isolation/loneliness	4.8%
Not getting "shots" to prevent disease (immunizations)	4.5%
Self-harm (e.g. cutting, suicide attempts)	3.8%
Not using birth control	2.6%

Table E-85: **Language Other than Spanish or English (n = 70; 200 selections)**

Drug use/abuse	18.5%
Alcohol abuse/addiction	14.5%
Social isolation/loneliness	11.5%
Tobacco use	9.0%
Lack of exercise	8.5%
Poor eating habits	8.5%
Dropping out of school	6.5%
Risky sexual behavior/unsafe sex	6.0%

Table E-85: **Language Other than Spanish or English (n = 70; 200 selections)**

Unsafe driving (e.g. not using seat belts/child safety seats, distracted driving)	5.5%
Not using birth control	4.5%
Self-harm (e.g. cutting, suicide attempts)	4.0%
Not getting "shots" to prevent disease (immunizations)	3.0%

Tables E-86-88: Regional responses to question 3 by people living at /below 200% of the Federal Poverty Level

Table E-86: **200% FPL or Below (n = 841; 2329 selections)**

Drug use/abuse	19.4%
Alcohol abuse/addiction	18.0%
Social isolation/loneliness	10.4%
Poor eating habits	9.4%
Dropping out of school	8.6%
Lack of exercise	7.1%
Tobacco use	6.5%
Risky sexual behavior/unsafe sex	6.0%
Unsafe driving (e.g. not using seat belts/child safety seats, distracted driving)	5.3%
Not getting "shots" to prevent disease (immunizations)	3.4%
Not using birth control	3.3%
Self-harm (e.g. cutting, suicide attempts)	2.5%

Table E-87: **Veteran (n = 205; 588 selections)**

Drug use/abuse	17.9%
Alcohol abuse/addiction	17.9%
Poor eating habits	10.5%
Lack of exercise	10.0%
Dropping out of school	8.8%
Social isolation/loneliness	8.2%
Unsafe driving (e.g. not using seat belts/child safety seats, distracted driving)	7.3%
Tobacco use	6.3%
Risky sexual behavior/unsafe sex	4.1%
Not getting "shots" to prevent disease (immunizations)	4.1%
Not using birth control	2.9%
Self-harm (e.g. cutting, suicide attempts)	2.0%

Table E-88: **Have a Disability (n = 578; 1636 selections)**

Drug use/abuse	19.7%
Alcohol abuse/addiction	18.8%
Social isolation/loneliness	12.0%
Poor eating habits	8.3%
Dropping out of school	7.2%
Risky sexual behavior/unsafe sex	6.9%
Lack of exercise	6.8%
Unsafe driving (e.g. not using seat belts/child safety seats, distracted driving)	6.4%
Tobacco use	5.3%
Not getting "shots" to prevent disease (immunizations)	3.5%
Not using birth control	2.7%
Self-harm (e.g. cutting, suicide attempts)	2.4%

Tables E-89-91: Regional responses to question 3 by education level

Table E-89: **Less than High School (n = 133; 367 selections)**

Drug use/abuse	18.5%
Alcohol abuse/addiction	17.7%
Dropping out of school	10.6%
Risky sexual behavior/unsafe sex	9.0%
Lack of exercise	8.2%
Social isolation/loneliness	7.9%
Poor eating habits	7.4%
Unsafe driving (e.g. not using seat belts/child safety seats, distracted driving)	6.0%
Tobacco use	5.4%
Not getting "shots" to prevent disease (immunizations)	4.4%
Self-harm (e.g. cutting, suicide attempts)	3.0%
Not using birth control	1.9%

Table E-90: **High School Diploma or GED (n = 579; 1657 selections)**

Drug use/abuse	22.5%
Alcohol abuse/addiction	19.6%
Dropping out of school	9.8%
Social isolation/loneliness	8.4%
Poor eating habits	8.3%
Unsafe driving (e.g. not using seat belts/child safety seats, distracted driving)	6.4%
Risky sexual behavior/unsafe sex	6.2%
Lack of exercise	6.0%
Tobacco use	4.7%
Not using birth control	3.1%
Not getting "shots" to prevent disease (immunizations)	2.8%
Self-harm (e.g. cutting, suicide attempts)	2.2%

Table E-91: **Bachelors degree or higher (n = 1841; 5319 selections)**

Drug use/abuse	17.1%
Alcohol abuse/addiction	14.8%
Poor eating habits	10.9%
Lack of exercise	10.2%
Social isolation/loneliness	9.9%
Dropping out of school	8.8%
Unsafe driving (e.g. not using seat belts/child safety seats, distracted driving)	7.9%
Tobacco use	6.0%
Not getting "shots" to prevent disease (immunizations)	5.3%
Risky sexual behavior/unsafe sex	4.1%
Not using birth control	3.1%
Self-harm (e.g. cutting, suicide attempts)	1.8%

Tables E-92-95: Regional responses to question 3 by type of insurance/insurance status

Table E-92: **Medicaid (n = 597; 1697 selections)**

Drug use/abuse	23.1%
Alcohol abuse/addiction	19.8%
Social isolation/loneliness	9.4%

Table E-92: **Medicaid (n = 597; 1697 selections)**

Dropping out of school	8.4%
Poor eating habits	8.2%
Risky sexual behavior/unsafe sex	8.1%
Lack of exercise	5.5%
Tobacco use	5.1%
Unsafe driving (e.g. not using seat belts/child safety seats, distracted driving)	4.8%
Not using birth control	2.7%
Not getting "shots" to prevent disease (immunizations)	2.5%
Self-harm (e.g. cutting, suicide attempts)	2.4%

Table E-93: **Medicare (n = 287; 832 selections)**

Drug use/abuse	18.3%
Alcohol abuse/addiction	14.9%
Social isolation/loneliness	10.7%
Dropping out of school	10.6%
Poor eating habits	10.0%
Lack of exercise	9.5%
Unsafe driving (e.g. not using seat belts/child safety seats, distracted driving)	8.1%
Tobacco use	5.8%
Not getting "shots" to prevent disease (immunizations)	4.9%
Risky sexual behavior/unsafe sex	4.1%
Not using birth control	1.9%
Self-harm (e.g. cutting, suicide attempts)	1.3%

Table E-94: **Medicaid/Medicare (n = 43; 123 selections)**

Alcohol abuse/addiction	20.3%
Social isolation/loneliness	14.6%
Tobacco use	10.6%
Drug use/abuse	10.6%
Lack of exercise	8.1%
Dropping out of school	7.3%
Unsafe driving (e.g. not using seat belts/child safety seats, distracted driving)	7.3%
Poor eating habits	6.5%
Risky sexual behavior/unsafe sex	5.7%
Not using birth control	4.1%
Not getting "shots" to prevent disease (immunizations)	3.3%
Self-harm (e.g. cutting, suicide attempts)	1.6%

Table E-95: **Uninsured (n = 129; 362 selections)**

Drug use/abuse	19.6%
Alcohol abuse/addiction	18.8%
Poor eating habits	10.5%
Lack of exercise	9.4%
Tobacco use	7.5%
Social isolation/loneliness	7.2%
Dropping out of school	6.6%
Risky sexual behavior/unsafe sex	6.4%
Unsafe driving (e.g. not using seat belts/child safety seats, distracted driving)	5.0%
Not getting "shots" to prevent disease (immunizations)	4.1%
Not using birth control	3.3%
Self-harm (e.g. cutting, suicide attempts)	1.7%

Appendix F: Listening Session Documents

The following documents are from the HCWC listening sessions. A total of 29 listening sessions were conducted across the four-county HCWC region. The methodology, analysis, and findings from the listening sessions can be found in the *Community Themes and Strengths – Listening Sessions* section of this report.

Listening Session Facilitator's Guide

The following guide was used to facilitate each of the listening sessions.

Introduction

Okay, we have a little over an hour to talk. I'd like to start with a creative activity. Here's paper and crayons. I'd like you to start by thinking about your community. People might think of "community" in different ways. Maybe it's family, or maybe it's neighbors, or maybe it's coworkers or friends. For the next 5 minutes, draw a picture that represents **your community**.

Pause; give people ~5 minutes to draw. Facilitator should draw too.

So let's go around in a circle—tell me your name, and tell us something about your drawing I'll start.

Facilitator introduces self, models talking about community.

Then everyone goes in a circle, introducing self and saying a few words about their community.

Thank you. So you all told us your name and told us something about how you see your community. That leads into what we're going to talk about next: the health of your community. This is going to be an informal discussion. We want to hear about your ideas, experiences and opinions. Everyone's comments are important. They might be similar or very different, but they all should be heard. The goal today is to record everyone's opinions.

Context

What we were hoping to talk about today is: ***What makes a healthy community?***

PAUSE, but not long enough for people to pipe up with answers.

That's a difficult question, because it involves two ideas. First, there's ***HEALTH***. What do we mean by health? Do we mean freedom from disease? Having enough to eat? Feeling generally good about life? Being financially healthy?

PAUSE, but not long enough for people to pipe up with answers.

Then there's the idea of ***COMMUNITY***. What do we mean by community? Are we talking about each one of you, individually? Are we talking about your friends and family? Your neighborhood? Your church? Your racial or ethnic group? Your city or town?

We're not going to define these things for you. We're going to keep it open.

Question 1: Vision

Now take a minute to think about your community—that community that is represented in your drawing. How can you tell when your community is healthy?

Instructions: write ideas on the poster.

Question 2: Needs

So we've talked about what a healthy community looks like. Now let's talk about what's not there or what you need more of.

What's needed? What more could be done to help your community be healthy?

Instructions: write ideas on the poster.

Question 3: Strengths

So you've told us what a healthy community looks like and what the needs are in your community. Let's explore this idea a little more. Communities have certain **resources** that can help them be healthy. It might be programs. It might be a park or a community center. It might be a really great teacher at your local school. It might be a local business or a local organization that helps people be healthy.

My question for you is:

What's working? What are the resources that CURRENTLY help your community to be healthy?

Instructions: write ideas on the poster.

Listening Session Demographics

The following table describes the demographics of the listening session participants. The demographic surveys were distributed after the listening session took place and were optional. Of the 364 people who participated in the listening sessions, 298 chose to complete the demographic surveys. Although demographic surveys were made available in participants' native languages (for groups conducted in a language other than English), several of these groups chose not to fill out the surveys. Thus the demographic data for the listening sessions is incomplete and may be skewed towards English speaking groups. In addition, respondents could choose more than one answer for each of the questions (e.g. "High School Diploma" and "Other" for educational status).

Table F-1: Listening Session Demographics

Listening Session Demographics (N = 298)	% Respondents
Age Category (years)	
Under 18	2.7
19 – 25	15.1
26 - 39	24.5
40 - 54	29.5

Listening Session Demographics (N = 298)	% Respondents
55 - 64	14.1
64 - 79	11.4
80 and older	1.3
No Answer	1.0
Gender	
Female	55.7
Male	41.9
Transgender	<1
Gender non-conforming	1.7
Sexual Orientation	
Gay/Lesbian	2.7
Bisexual	5.7
Queer	1.7
Heterosexual	77.9
Questioning/Unsure	<1
Other	3.0
No Answer	10.4
Ethnicity	
Hispanic	25.4
Non-Hispanic	74.2
Race	
African American/Black	13.8
African	2.3
Asian American/Asian	6.4
White/Caucasian	53.4
Native American/Alaska Native	13.4
Other	11.0
No Answer	12.8
Disability Status	
Yes	25.8
No	68.8

Listening Session Demographics (N = 298)	% Respondents
No Answer	5.0
Veteran Status	
Yes	6.7
No	86.6
No Answer	6.4
Education	
Less than high school	13.8
High school diploma/GED	38.2
College degree or higher	35.9
No Answer	73.8
Other	77.1
Income ($)	
0 to 12,000	30.2
12,001 to 23,500	20.1
23,501 to 32,000	12.4
32,001 to 40,000	5.7
40,001 to 48,500	2.7
48,501 to 57,000	2.3
57,001 to 65,000	2.0
65,001 to 73,500	2.0
73,501 to 82,000	2.0
More than 82,000	4.7
No Answer	15.1

Listening Sessions Coding Dictionary

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01 Context

Where are they coming from? How do they identify themselves and their community?

Most descriptions of people's drawings will be coded as context. Could be used in a section of the report that talks about how people defined "community."

---

02 Need/Driver

A health need or something participants need to be healthy.

---

03 Vision/Indicators

Participants were asked to tell us what a healthy community looks like. This code flags their responses. NOTE: Vision and Indicator codes may overlap. VISION is a hypothetical-- it's about the ideal. INDICATOR is about how people measure the healthiness/unhealthiness of their community.

---

04 Strength

Flags anything identified as a strength. Other codes can be combined with this code to identify specific strengths. Includes individual strengths or resources.

Access to Resources/Care

Comments about whether people can get care when/where they need it. Includes references to insurance, coverage, and cost of care, social services. Social services could include food, transportation, recreation, etc.

Behavioral Health

Could include mental health services, psychiatric services, mental health diagnosis or status, stress and strain, and resilience factors.

Communication

Communicating *with* communities, communicating *within* communities. Language, advocacy, media. Could be double coded with cultural competency if related to materials or communication in another language.

Community Events/Community Center

Reference to space or events for community gathering, place for indoor recreation.

Cultural Competency

References to cultural competence, e.g., interpretation, food choices, language appropriateness.

Equity/Inequity/Discrimination

References to disparities, inequity, equity work, discrimination, racism, diversity.

Food

Access to healthy food, grocery stores, fruits and vegetables, diet/nutrition, relationship between food and disease, community gardens, farmers markets.

Formal Education

Reference to formal education -- i.e. schools, universities, community college

---

Good Quote

Flags a good quote for use in the report - not coding all quotes, only quotes which are able to be understood independently without additional context.

Governance/Decision-making

Comments related to who makes decisions in a community or comments about the desire to play a decision-making/participatory role in governance.

Healthy Relationships/Family Health

Emotional health, domestic violence, stress/strain, parenting, childcare, foster care.

Healthy/Unhealthy Behaviors

Individual-level behaviors. Could include gardening, cycling, walking, jogging/running, safe/unsafe sex, smoking, tobacco use, drug use, etc. at the individual level.

Housing

References to affordability, homelessness, evictions, displacement.

Informal Education

Reference to classes to help folks with eating, cooking, lifestyle, parenting, etc.

_____

Jobs/Economy

References to income, poverty, jobs, careers, local businesses/economy, employment, living wage, family finance, affordability.

_____

Neighborhood Condition/Amenities

What does it look/feel like when you step outside your door? What is available? Capture garbage in streets, vandalism, noise, etc. Would also include reference to strip clubs, weed shops, safe streets, pollution, etc.

_____

Other

Anything that does not fit in existing categories, but should be included in a secondary analysis to identify themes.

_____

Parks/Green Space/Natural Resources

Parks, trees, natural spaces. Includes references to environmental health, such as climate change or pollution

_____

Physical Health/Dental/Vision

Health status, functional health, disease, dental care, vision care

_____

Priority Population - Other

Flags specific needs/solutions for priority populations, including ethnic/racial minorities and sexual minorities. Include elders, youth, CoC, imm/refugee.

_____

Priority Population – People with addictions

_____

Priority Population - African American

_____

Priority Population - Aging/Elders

_____

Priority Population - Asian/Pacific Islander

_____

Priority Population - CHW

_____

Priority Population – People experiencing homelessness

_____

Priority Population - Immigrant/Refugee

_____

Priority Population - Latino

_____

Priority Population - LGBTQ

_____

Priority Population – People with mental health issues

_____

Priority Population - Native American/Alaska Native

_____

Priority Population - Rural

_____

Priority Population - Veterans

_____

Priority Population - Youth

_____

Provider Relationship

Can include health care and social services providers. Health literacy, helping patients understand instructions, trust/mistrust of provider or system, provider who comes from your community, feeling listened to.

_____

Resources/Coordination of Services

References to organizing information about supportive resources or helping people connect to resources or educating the community about resources

_____

Safety

References to crime, safe streets, safe sidewalks, lighting, accessibility

_____

Self-Sufficiency/Hope

Captures comments that signify or have to do with optimism, hope, or a positive outlook. Also include comments related to self-empowerment or self-efficacy. Taking responsibility for your own health/condition.

_____

Social Support/Spirituality

Interaction, connection. Could reference family, friends, or community support. Could reference churches or faith-based organizations.

Specific Programs or Organizations

Captures mention of specific programs or organizations.

Substance Use/Treatment

Addictions, counseling, rehab, detox.

Traditional Health Workers (THW)

References to Community Health Workers, Outreach Workers, mentors, peers, navigators, health educators, doulas, etc. NOTE: Dietician/nutritionist, acupuncture, naturopath, Chinese medicine, etc would fall under Physical health/Dental/Vision.

Transition Services

Services that support transitions from crisis, such as homelessness or incarceration. Could also include transition support for veterans.

Transportation

Access to transportation, problems with transportation. Includes bicycle transit if main purpose is transit, not recreation; bus, train, personal vehicle, etc. NOTE: not recreation.

Unity/Togetherness/Cohesion

Captures comments related to community togetherness, common vision, etc. Include trust/mistrust, gentrification, diversity.

Appendix G: Inventory of Community Engagement Projects Documents

The following documents are supplements to the inventory of community engagement projects. The methodology, analysis, and findings from the inventory can be found in the *Community Themes and Strengths – Inventory of Community Engagement Projects* section of this report.

List of Reports Reviewed

The community engagement and community health assessment projects included in the inventory are listed below. The list includes a short description of the project and the geographic scope.

Adolescent Health Tribal Action Plan: A Five-year Strategic Plan for the Tribes of Idaho, Oregon, and Washington 2014-2018 (2014). *Northwest Native Adolescent Health Alliance.*
http://www.npaihb.org/images/epicenter_docs/MSPI/THRIVE/2013/Adolescent%20Health%20Tribal%20Action%20Plan%20-%20Final.pdf

Clackamas (OR)
Multnomah (OR)
Washington (OR)

This project used information from surveys to help promote and improve northwest native adolescent health.

Adventist Medical Center—Portland Community Health Needs Assessment Update (2014). *Adventist Medical Center.*
https://www.adventisthealth.org/nw/Documents/Community%20Benefits/Adventist-Medical-Center-Portland-2014-Community-Health-Plan-Update.pdf

Clackamas (OR)
Multnomah (OR)

This assessment identifies and prioritizes community health needs through the collection and analysis of multiple sources of data. A portion of this data comes from community members that completed an online health and quality of life survey. The results from this survey were used to identify and help develop plans to address community health needs.

The African Immigrant and Refugee Community in Multnomah County: An Unsettling Profile (2013). *Coalition of Communities of Color.*
http://static1.squarespace.com/static/5501f6d4e4b0ee23fb3097ff/t/556d38c1e4b0d8dc09b24d1a/1433221313672/CCC_AfricanReport_FINAL.pdf

Multnomah (OR)

The Coalition of Communities of Color used focus groups to gather information on the lived experiences of African immigrant and refugee communities in Multnomah County. This information was collected to empower communities and eliminate racial and ethnic inequities.

African Refugee and Immigrant Health Needs and Barriers: Report from a Community-Based House Meeting Project (2013). *African Partnership for Health.*
http://www.ncbi.nlm.nih.gov/pubmed/24375177

Multnomah (OR)

This project used community-based participatory research (CBPR) methods to collect and analyze data from nine house meetings with Africans from 14 countries in the Portland area. The data collected from this project was used to inform health

improvement plans among the African community in Portland and define an agenda for future projects.

Aging and Disability Services of Multnomah County Older Americans Act Area Plan 2013-2016 (2013). ***Multnomah County*****.** https://multco.us/file/11126/download — Multnomah (OR)

This project used community dialogues and a community survey to inform the Older Americans Area Plan.

Area Agency on Aging and Disabilities of Clackamas County Older Americans Act Area Plan 2013-2016 (2013). ***Health, Housing & Human Services Clackamas County Social Services.*** http://www.clackamas.us/socialservices/documents/areaplan.pdf — Clackamas (OR)

This area plan utilized input collected from seniors through one-on-one interviews and a telephone survey. This community input is also used to inform the development of new programs and approaches to effectively meet identified needs.

Area Agency on Aging and Disabilities of Southwest Washington 2016-2019 Area Plan (2015). ***Southwest Washington Agency on Aging and Disabilities.*** file:///C:/Users/walkerch/Downloads/2016-2019-AP-Final-10-2-2015%20(1).pdf — Clark (WA)

This area plan outlines strategies to address and identified needs of older adults, adults with disabilities and family caregivers living within the Area Agency on Aging and Disabilities of Southwest Washington service area. Surveys and public hearings were used to gather community members' input on unmet needs.

The Asian and Pacific Islander Community in Multnomah County: An Unsettling Profile (2012). ***Coalition of Communities of Color***. http://static1.squarespace.com/static/5501f6d4e4b0ee23fb3097ff/t/556d3a7ee4b0f81335be44b1/1433221758192/API_UNSETTLING_PROFILE.pdf — Multnomah (OR)

This report documents the experiences of the Asian and Pacific Islander communities in Multnomah County using data from the Census and the American Community Survey. This report leverages input given by communities of color and includes recommendations and calls for action to eliminate racial and ethnic disparities.

Bradley Angle LGBTQ Needs Assessment (2012). ***Bradley Angle.*** http://www.doj.state.or.us/victims/pdf/directors_day_2013_bradley_angle_lgbtq_needs_assessment_summary_of_findings.pdf — Multnomah (OR)

This assessment was informed through an online survey asking LGBTQ-indentified people in Portland, OR about their needs and wants in terms of intimate relationship support services.

Clackamas County Children's Commission Community Assessment (2012). ***Clackamas County Children's Commission Head Start, Clackamas Education Service District.*** http://cccchs.org/docs/community-assessment.pdf — Clackamas (OR)

This assessment analyzed service data to promote program development per Head Start federal requirements. Head Start Families completed a survey about their perceptions of the community, social connectedness, health system, and whether they think their family is healthy.

Clackamas County Community Health Improvement Plan (2012). ***Clackamas County Department of Health, Housing, and Human Services.*** Clackamas (OR)
http://www.clackamas.us/publichealth/documents/clackamas_chip.pdf

This report was intended to both guide local efforts over the next five years to improve overall health of the Clackamas County population, and to meet the requirements of the Public Health Accreditation Board. Community meetings and listening sessions were held to identify priorities related to health, education and other topics.

Community Value Assessment of North by Northeast Community Health Center (2012). ***North by Northeast Community Health Center.*** Multnomah (OR)
http://nxneclinic.org/docs/download/North_by_Northeast_CVA.pdf

The center conducted surveys, focus groups and phone interviews with the clinic's former and current patient base; interviewed community leaders, held a focus group with volunteers, and consulted staff and board members about health concerns and recommendations.

Council for the Homeless Clark County 10-Year Homeless Plan (2012) ***Clark County.*** Clark (WA)
http://www.councilforthehomeless.org/wp-content/uploads/2012/12/Final-CC-10-year-Plan-04.-2012.pdf

The Clark County 10-year homeless plan was informed through community meetings, focus groups, a survey of community members, and a survey of persons who are homeless.

Disability Rights Oregon Behind the Eleventh Door (2015). ***Disability Rights Oregon.*** Clackamas (OR)
https://droregon.org/wp-content/uploads/Behind-the-Eleventh-Door-Electronic-Version.pdf Multnomah (OR)
Washington (OR)

Inmates were interviewed to gather information on treatment and access to mental health services in prison.

Disability Rights Oregon 2014 Community Insights Survey Results (2014). ***Disability Rights Oregon.*** https://droregon.org/wp-content/uploads/DRO-2014-Community-Insights-Survey-Results.pdf Clackamas (OR)
Multnomah (OR)
Washington (OR)

Disability Rights Oregon conducted a broad survey to capture what issues are important to people who care about the rights of people with disabilities.

Disability Rights Oregon Focus Group Results March 11, 2015 (2015). ***Disability Rights Oregon.*** https://droregon.org/wp-content/uploads/DRO-Focus-Group-Results-March-11-2015.pdf Clackamas (OR)
Multnomah (OR)
Washington (OR)

This project explored individual experiences with mental health treatment in hospitals and emergency departments through a 90-minute focus group. The results from this focus group were shared with the team planning a new psychiatric crisis and acute care facility and to inform Disability Rights Oregon's advocacy efforts.

Engaging Oregonians in Identifying Health Equity Policy Priorities: a Modified Policy Delphi Approach (2014). ***Oregon Health Authority Office of Equity and Inclusion.*** Clackamas (OR)
http://www.oregon.gov/oha/oei/reports/Engaging%20Oregonians%20in%20Identifying Multnomah (OR)
Washington (OR)

%20Health%20Equity%20Policy%20Priorities%20-%20a%20Modified%20Policy%20Delphi%20Approach.pdf

Community forums and surveys completed by diverse community members informed this project. Findings were used to help identify health equity policy priorities.

Gresham Opportunity Mapping – Community Engagement Report (2014). ***The City of Gresham and Portland State University.*** Multnomah (OR)
https://greshamoregon.gov/opportunitymapping/

This project created "opportunity maps" that identified barriers to opportunity in the City of Gresham, OR. Community engagement efforts included interviews, listening circles and discussion groups, a questionnaire, technical adviser meetings, community celebration, and a city staff event.

Growing Healthier: Planning for a Healthier Clark County (2012). ***Clark County Public Health Advisory Council, Clark County Public Health.*** Clark (WA)
http://www.clark.wa.gov/public-health/community/growing_healthy/documents/GrowingHealthierReport23Mar2012-1.pdf

This report outlined policy recommendations on ways that Clark County's Comprehensive Growth Management Plan can better address health Issues. Community voice and input was captured through public meetings, key stakeholder interviews and meetings, presentations to community groups, and online surveys.

Healthy Eating and Active Living (HEAL) Amenities on Affordable Multi-Family Housing Developments (2012). ***Oregon Public Health Institute.*** Clackamas (OR)
Multnomah (OR)
http://ophi.org/download/PDF/HKHC_Report.pdf

Community-based PhotoVoice projects were used to help shape policies and neighborhood environments to increase healthy eating and active living for children and families living in Portland's affordable housing communities.

Healthy Oregon Partnership for Equity Coalition Five Year Health Equity Plan (2012). ***The Hope Coalition.*** http://www.apano.org/wp-content/uploads/2012/10/HOPE-COALITION-FIVE-YEAR-PLAN-FINAL_-Sept-26.docx Clackamas (OR)
Multnomah (OR)
Washington (OR)

This plan identified the most pressing health equity needs for Multnomah, Washington, Marion, and Clackamas Counties. Interviews and community forums were utilized to capture missing perspectives from the region.

Health Share Community Health Needs Assessment (2014). ***Health Share*****.** Clackamas (OR)
http://www.healthshareoregon.org/pdfs/Final.CHA_.03.23.2014.pdf Multnomah (OR)
Washington (OR)
Clark (WA)

Community-led self-assessments and community listening sessions were used to identify health needs for this CHNA.

Hear Our Voices: Engage 2013 Survey Report IRCO (2014). ***Immigrant & Refugee Community Organization.*** https://www.portlandoregon.gov/oni/article/486422 Multnomah (OR)

This project used surveys to take a detailed look at the civic engagement behaviors and

attitudes among diverse non-Hispanic immigrant and refugee communities that IRCO's diversity and civic leadership program serves in the Portland area.

Improving Healthy Food Access in Rockwood Using Community Voice and Mapping (2014). ***Coalition for a Livable Future.*** http://clfuture.org/sites/clfuture.org/files/pdfs/improving_health_food_access_in_rockwood_using_community_voice_and_mapping_final.pdf This community-based project examined barriers and solutions to accessing healthy food in the Rockwood neighborhood of Gresham, Oregon. This was informed through focus groups, survey, a community food security assessment tool, and evidence from the Coalition for a Livable Future's Regional Equity Atlas 2.0 .	Multnomah (OR)
Kaiser Foundation Hospital Community Health Needs Assessment – WESTSIDE (2014). ***Kaiser Foundation Hospital.*** http://share.kaiserpermanente.org/wp-content/uploads/2015/01/Westside-CHNA_2013.pdf This CHNA engaged community members through focus groups and surveys to capture a comprehensive picture of community needs for this medical center.	Clackamas (OR) Multnomah (OR) Washington (OR) Clark (WA)
Kaiser Foundation Hospital—Sunnyside: Community Health Needs Assessment (2013). ***Kaiser Foundation Hospital*****.** http://share.kaiserpermanente.org/wp-content/uploads/2013/09/Sunnyside-CHNA_2013.pdf This CHNA engaged community members through focus groups, surveys, community listening sessions, and public assemblies to capture a comprehensive picture of community needs for this medical center.	Clackamas (OR) Multnomah (OR) Washington (OR) Clark (WA)
Knowledge, Attitudes and Perceptions of Northwest American Indian/Alaska Native Community Members and Medical Providers Regarding Childhood Immunizations (2014). ***Portland Area Indian Health Service/Northwest Portland Area Indian Health Board*** http://www.npaihb.org/images/epicenter_docs/narch/2014/1g.pdf Information from community focus groups, interviews, and surveys were used to capture knowledge, attitudes, and perceptions of northwest American Indian/Alaskan native community members and medical providers regarding childhood immunizations.	Multnomah (OR)
Listening to Consumer Perspectives to Inform Addictions and Housing-Related Practice and Research (2014). ***Portland State University, Classical Chinese Medicine/National College of Natural Medicine, Oregon Health and Science University, Central City Concern.*** http://www.centralcityconcern.org/LiteratureRetrieve.aspx?ID=209324 This study engaged community members through interviews and sought to learn about personal experiences with housing, employment, and recovery programs. This information was used to inform addictions and housing-related practice and research.	Multnomah (OR)
The Latino Community in Multnomah County: An Unsettling Profile (2012). ***Coalition of Communities of Color.*** http://static1.squarespace.com/static/5501f6d4e4b0ee23fb3097ff/t/556d3b37e4b0e36a9e0f3968/1433221943127/LATINO_REPORT.pdf	Multnomah (OR)

Community-based participatory research and a community survey were used to inform this report. The information collected from community members was meant to illuminate disparities that might not be seen in census data.

Legacy Salmon Creek Hospital Community Needs Assessment, Community Health Improvement Plan (2015). *Legacy Health*. Retrieved from http://www.legacyhealth.org/our-legacy/legacy-values/in-the-community/community-needs.aspx

Clark (WA)

This CHNA was done to identify and address priority factors influencing the health of the community. Community listening sessions and community engagement activities were used to incorporate community voice into the findings of this report.

Legacy Mount Hood Medical Center Community Health Needs Assessment/Community Health Improvement Plan (2015). *Legacy Health.* http://www.legacyhealth.org/our-legacy/legacy-values/in-the-community/community-needs.aspx

Multnomah (OR)

This CHNA was done to identify and address priority factors influencing the health of the community. Community listening sessions and community engagement activities were used to incorporate community voice into the findings of this report.

Legacy Meridian Park Medical Center Community Health Needs Assessment/Community Health Improvement Plan (2015). *Legacy Health.* http://www.legacyhealth.org/our-legacy/legacy-values/in-the-community/community-needs.aspx

Clackamas (OR)
Washington (OR)

This CHNA was done to identify and address priority factors influencing the health of the community. Community listening sessions and community engagement activities were used to incorporate community voice into the findings of this report.

Legacy Good Samaritan and Medical Center Community Health Needs Assessment/Community Health Improvement Plan (2015) *Legacy Health.* http://www.legacyhealth.org/our-legacy/legacy-values/in-the-community/community-needs.aspx

Multnomah (OR)

This CHNA was done to identify and address priority factors influencing the health of the community. Community listening sessions and community engagement activities were used to incorporate community voice into the findings of this report.

Legacy Emanuel Hospital and Health Center Community Needs Assessment/Community Health Improvement Plan (2015). (2015) *Legacy Health.* http://www.legacyhealth.org/our-legacy/legacy-values/in-the-community/community-needs.aspx

Multnomah (OR)

This CHNA was done to identify and address priority factors influencing the health of the community. Community listening sessions and community engagement activities were used to incorporate community voice into the findings of this report.

The Native American Community in Multnomah County: An Unsettling Profile (2012). *Coalition of Communities of Color.* http://static1.squarespace.com/static/5501f6d4e4b0ee23fb3097ff/t/556d3bfae4b0f81335be4a04/1433222138695/NATIVE_AMERICAN_REPORT.pdf

Multnomah (OR)

This report documents the experiences of the Native American community in Multnomah County using data from the Census and the American Community Survey. It uses community-based participatory research and leverages a range of input given by communities of color. The report also includes recommendations and calls for action.

Native Voices: Project Red Talon, Northwest Portland Area Indian Health Board (2015). *Native Voices.* http://www.npaihb.org/images/epicenter_docs/PRT/VOICES/Native%20VOICES%20Community%20Report.docx

Clackamas (OR)
Multnomah (OR)
Washington (OR)
Clark (OR)

The goal of this project was to adapt a video-based HIV/STI intervention for AI/AN teens and young adults. Focus groups and surveys were used to evaluate its impact among native youth.

Oregon Child Development Coalition Community Assessment (2013). *Oregon Child Development Coalition.* http://www.ocdc.net/wp-content/uploads/2014/08/Community_Assessment-2013-FINAL.pdf

Clackamas (OR)
Multnomah (OR)
Washington (OR)

Information gathered from focus groups, surveys and community meetings was used to inform this community assessment.

Oregon Disability and health Needs Assessment (2013). *Oregon Office on Disability and Health.* http://www.ohsu.edu/xd/research/centers-institutes/institute-on-development-and-disability/public-health-programs/oodh/upload/Needs-Assessment_final_AS_whj.pdf

Clackamas (OR)
Multnomah (OR)
Washington (OR)

Telephone survey, written survey, and a web survey helped to inform this disability and health needs assessment.

Oregon's Healthy Future: A Plan for Empowering Communities (2013). *Oregon Health Authority*. https://public.health.oregon.gov/About/Documents/oregons-healthy-future.pdf

Clackamas (OR)
Multnomah (OR)
Washington (OR)

This project used community listening and feedback sessions to help inform health improvement plans in Oregon.

Oregon Medicare-Medicaid Listening Groups: Final Report Oregon Health Authority (2012). *Oregon Health Authority.* http://www.oregon.gov/oha/OHPB/meetings/2012/2012-0214-oregon-listening.pdf

Multnomah (OR)

Listening groups in five dually-eligible Medicaid-Medicare communities were held to solicit input on Oregon Health Authority's design contract.

Portland's 2035 Comprehensive Plan Update (2015) *City of Portland Bureau of Planning and Sustainability.* https://www.portlandoregon.gov/bps/article/541788

Multnomah (OR)

This plan brought together agency partners, thousands of residents, businesses and nonprofits to create strategic plan for a prosperous, healthy, educated, and equitable Portland. Community members informed this plan through a community engagement project, listening sessions, public hearings, community outreach, and online feedback.

Providence Health 2013 Community Health Needs Assessment, 2014-2016 Community Health Improvement Plans (2013). ***Providence Health & Services***
http://oregon.providence.org/~/media/files/providence%20or%20pdf/about%20us/2013chna.pdf

Clackamas (OR)
Multnomah (OR)
Washington (OR)

A community health survey and focus groups with people who are elderly and/or disabled, limited English proficiency folks, migrant or seasonal farm workers, and low income were used to inform this CHNA.

Profiles of Hunger and Poverty in Oregon: 2012 Oregon Hunger Factors Assessment (2012). ***Oregon Food Bank.***
http://www.oregonfoodbank.org/~/media/files/publications/2012%20profiles%20of%20hunger%20and%20poverty%20in%20oregonpdf.pdf

Clackamas (OR)
Multnomah (OR)
Washington (OR)

This report draws attention to the underlying problems that cause hundreds of thousands of Oregonians to seek help from their local food pantries. Findings from this report were based on the Hunger Factors Assessment Survey completed by emergency food box clients.

Providence Portland Medical Center—Community Health Needs Assessment (2013). ***Providence Health & Services.***
http://oregon.providence.org/~/media/files/providence%20or%20pdf/about%20us/chna%20finalfull_appendix.pdf

Multnomah (OR)

In order to capture a comprehensive picture of community needs, Providence conducted community stakeholder interviews, focus groups, and surveys to inform their CHNA.

Providence St. Vincent Medical Center—Community Health Needs Assessment (2013) ***Providence Health & Services.***
http://oregon.providence.org/~/media/files/providence%20or%20pdf/about%20us/chna%20finalfull_appendix.pdf

Clackamas (OR)
Multnomah (OR)
Washington (OR)

In order to capture a comprehensive picture of community needs, Providence conducted community stakeholder interviews, focus groups, and surveys to inform their CHNA.

Roadmap to Health Communities: A Community Health Assessment (2012). ***Clackamas County Department of Health and Human Services.***
http://www.clackamas.us/publichealth/documents/roadmap_update2012.pdf

Clackamas (OR)

This project gathered information on needs and priorities for building a healthy community from diverse citizens through online grassroots dialogue, survey, and community meetings.

Running on Empty: Services and Citizens Stretched to the Limit (2012). ***Washington County Anti-Poverty Workgroup*****.**
http://commons.pacificu.edu/cgi/viewcontent.cgi?article=1051&context=casfac

Washington (OR)

This assessment explored the impact of the economic recession through focus groups and interviews. The results were compared to an earlier needs assessment.

The Slavic Community in Multnomah County: An Unsettling Profile (2014). Coalition of Communities of Color. http://static1.squarespace.com/static/5501f6d4e4b0ee23fb3097ff/t/556d3c6be4b0728bb8d51045/1433222251042/Slavic-Report-FINAL-COMPLETE.pdf

Multnomah (OR)

This report details the lived experiences of the Slavic community in Multnomah County. Interviews were used to capture disparities that might not be seen in the census data.

State of Black Oregon (2015). ***Urban League of Portland.*** http://ulpdx.org/wp-content/uploads/2015/05/State-Of-Black-Oregon-2015.pdf

Clackamas (OR)
Multnomah (OR)
Washington (OR)

This project tells the story of many Black communities in Oregon to convey the continued urgency for social justice required for thriving communities. This report puts forward a strategy for community members and policy makers to take political action. The use of survey, interviews, and focus groups incorporated community voice into the findings of this report.

Trauma-Informed Research and Planning: Understanding Government and Urban Native Community Partnerships to Addressing Substance-Exposed Pregnancies in Portland, Or. ***Amanda Mercier, Portland State University.*** http://pdxscholar.library.pdx.edu/cgi/viewcontent.cgi?article=2804&context=open_access_etds

Multnomah (OR)

This project solicited community information on substance affected pregnancies in Multnomah county through a community forum.

Using CBPR to Promote Healthy Pregnancies and Births Among the Native American Community in an Urban-Based Setting (2014). ***Multnomah County and Native American Youth and Family Center.*** http://www.npaihb.org/images/epicenter_docs/narch/2014/2f.pdf

Multnomah (OR)

Community forums facilitated by elders and natural helpers informed this report.

Washington County Department of Health and Human Services Disability, Aging and Veteran Services Strategic Plan 2015-2017 (2015). ***Washington County Department of Health and Human Services.*** Link unavailable.

Washington (OR)

This strategic plan was informed through online surveys and focus groups.

Coding Dictionary for Inventory of Community Engagement Projects

Code	Description
Jobs/Economy/Income	References to jobs, economy, careers, local businesses, poverty, affordability of goods, and low income.
Housing	References to affordability, availability, homelessness, evictions, displacement, and housing policies.
Food	Access to healthy food, grocery stores, references to diet/nutrition, relationship between food and disease, food security, community gardens and farmers markets.
Transportation	Access to transportation and problems with transportation. Includes bicycle transit if main purpose is transit and not recreation. Bus, train, personal vehicle, etc.
Neighborhood Condition/Amenities	Appearance of neighborhood and the built environment (what looks/feels like and how it is navigated) and what is available. Garbage in streets, vandalism, gang presence, and noise can be captured in this code. This code also includes reference to strip clubs, weed shops, safe streets, pollution, as well as positive amenities; community gardens, public art, etc.
Recreation/Physical Activity	Captures different kinds of recreational activities that participants enjoy for mental and physical health benefits.
Parks/Green Spaces/ Natural Resources	Includes references to parks, natural spaces, environmental health, climate change, and pollution.
Social Support/Spirituality	Interaction, connection and support from family, friends or community. Mention of churches or faith-based organizations, spirituality, social norms and volunteering in the community.
Healthy Relationships/Family Emotional Health	Emotional health, domestic violence, abuse, neglect, stress/strain, parenting, childcare, and foster care. This code also includes references to in-home healthcare by family members or friends.
Community Events/Community Center	References to space or events for community gathering and indoor recreation.
Formal Education	References to formal education – i.e. schools, universities, community colleges. Also include issues that impact schools (funding, common core,

	equity).
Informal Education	References to continuing education classes in the community; cooking, lifestyle, parenting etc.
Access to Care	Comments about whether people can get care when/where they need it. Includes references to insurance coverage and cost of care.
Physical health/Dental/Vision	Health status, functional health, disease, disease care, dental care and vision care.
Mental Health	Includes references to mental health services, psychiatric services, mental health diagnosis or status, stress and strain. This code also captures community and individual resilience, grit, and determination.
Substance Use/Treatment	Addictions, counseling, rehabilitation, and detoxification.
Provider Relationships	Includes mention of relationship with health care and social service providers. Health literacy, culturally competent services and care, helping patients understand instructions, trust/mistrust of provider or system, provider who comes from your community, and feeling listened to are also included in this code.
Equity/Inequity/Discrimination	References to disparity, inequity, equity work, discrimination/racism, diversity.
Governance/Decision Making	Comments related to who makes decisions in a community or comments about the desire to play a decision making/participatory role in governance. Also include comments related to policy.
Unity/Together/Cohesion	Captures comments related to community togetherness and common vision. Include trust/mistrust, gentrification, and diversity.
Self-Sufficiency/Hope	Captures comments that signify or have to do with optimism, hope, or a positive outlook. Also includes comments related to self-empowerment or self-efficacy, motivation, happiness, and personal freedom.
Communication	Includes communicating with communities, communication within communities, language, advocacy, and media.
Resources/Coordination of Services	References to organizing information about supportive resources, helping people connect to resources, and educating the community about resources.
Traditional Health Workers/Resource Navigators	References to community health workers, outreach workers, mentors, peers, navigators, health educators, doulas, etc. NOTE: Dietician/nutritionist, acupuncture, naturopath, Chinese medicine, etc would fall under physical health/dental/vision.

Safety	References to crime, safe streets, safe sidewalks, lighting, and accessibility. Also include comments on police brutality and gang violence.
Access to Social Services/Funding of Services	Access and use of social services, i.e. food stamps, cash assistance, domestic violence services, Section 8, and transition services. Also include comments about funding and service navigation.
Diversity and Culture/Culturally Specific Services and Practices	References related to accessing culturally specific events, food, services, and practices. Comments about community diversity and inclusion.
Early childhood Programs and Services	Comments on early childhood programs and services; Head Start, child care, WIC, etc.
Coordination of Community/Social/Health Services	Coordination and efficiency between social services and health services.
Youth Development and School Based Programs	Programs to facilitate youth development. Comments that include references to sports programs, Sun Schools, school gardening, school band, and enrichment activities. Also include funding of youth programs.

Appendix H: Clackamas County, Oregon Data

Executive Summary

The Healthy Columbia Willamette Collaborative (HCWC) is a unique public-private partnership that includes 15 hospitals, four health departments, and two coordinated care organizations (managed Medicaid organizations) in Clackamas, Multnomah, and Washington counties of Oregon, and in Clark County, Washington.

This report documents the community health needs of HCWC's four-county region and each of the counties. The community health needs were identified through a comprehensive study of population, hospital, Medicaid, and community data. This appendix includes data specific to **Clackamas County, Oregon**.

2016 Community Health Needs Assessment Data Sources

Health Status Assessment

4) Population data about health-related behaviors, morbidity, and mortality.

5) Medicaid data from local Coordinated Care Organizations (CCOs) about the most frequent conditions for which individuals on Medicaid sought care in the tri-county region in Oregon (Clark County Medicaid data were not available for this report).

6) Hospital data for uninsured people who were seen in the emergency department with a condition that could have been managed in primary or ambulatory care.

Community Themes and Strengths

4) Online survey about quality of life, issues affecting community health, and risky health behaviors.

5) Listening sessions with diverse communities in the four-county region to identify community members' vision for a healthy community, needs in the community, and existing strengths.

6) An inventory of recent community engagement projects in the four-county region that assess communities' health needs.

Key Findings for Clackamas County, Oregon

Demographics

Approximately 395,000 people lived in Clackamas County in 2014, having increased 11.1% from 2000 to 2010. Although the racial and ethnic population is predominantly white, non-Hispanic/Latino, the demographics of the county continue to diversify. The foreign-born population in Clackamas County increased 19.3% from 2005 to 2014, while the Hispanic/Latino population increased 74% from 2000 to 2010.

Social determinants of health and equity

Factors such as income, housing, and education impact communities' health in Clackamas County. Approximately 9% of individuals were living in poverty in Clackamas County in 2014, including 11.9% of children 18 years or younger. Over 13% of households received SNAP (food assistance) benefits in the past 12 months. Clackamas County residents have been affected by increased housing costs and high rates of homelessness, particularly among youth. Nearly 93% percent of adults have at least a high school diploma (the highest rate in the region) and 33.2% have at least a four year college degree.

Through listening sessions, an online survey, and an inventory of recent community engagement projects, HCWC identified upstream factors, such as access to food, health care, transportation, and safe, affordable housing, as important needs in Clackamas County and the region. Community members specified culturally and linguistically appropriate services, and support for people with behavioral health challenges, as needed improvements to health care and public health systems. Communities advocated for policies, systems, and environments that support healthy behaviors and identified racism, discrimination, and stigma as problems that contribute to poor health in the region.

Health behaviors

Population health data from state surveys show that risky health behaviors, such as binge drinking, cigarette smoking, lack of exercise, and not eating enough healthy foods, are prevalent in Clackamas County. For teenagers specifically, the assessment identified alcohol, marijuana, prescription drug, and vaping/e-cigarette use as common behaviors. Access to health care was identified as a priority health issue for adults in Clackamas County, including access to preventive services (such as flu shots or vaccines), lack of dental visits, and not having a usual source of health care, such as a primary care provider.

Diagnosed health conditions for low-income residents

An analysis of Medicaid claims data from local CCOs in Oregon showed that for youth, asthma, attention deficit disorder, and post-traumatic stress disorder were the most commonly diagnosed chronic conditions. For adults on Medicaid in Oregon, depression, diabetes, and hypertension were the most common diagnoses. People with Medicaid, whose incomes are below 139% of the Federal Poverty Level, represent 17.6% of the population in the Clackamas County.

Emergency department admissions for uninsured residents

Utilization data from local hospitals were analyzed for Clackamas residents who were uninsured or self-pay and were admitted to the Emergency Department for a condition that could have been treated in primary care. The most common conditions for adults were diabetes, hypertension, kidney/urinary infections, and skin infections. For youth, the top conditions were asthma and severe ear, nose, and throat infections.

Morbidity and mortality

Epidemiologists from the four county health departments prioritized 104 health indicators using the following criteria: disparity by race/ethnicity or sex, comparison with the state, trend over time, severity, and magnitude. Data came from a variety of sources, including vital statistics, disease and injury morbidity data, cancer registries, and adult and student surveys. In addition to the health behaviors described above, the following morbidity and mortality indicators rose to the top as priority health issues in Clackamas County.

*Morbidity (Disease)**

- Asthma
- Cancer, 5 types (see population data section of full report for specific types)
- Depression
- Diabetes
- Hypertension
- High Cholesterol
- Obesity/overweight

*Mortality (Death)**

- Alcohol-induced
- Breast cancer
- Chronic lower respiratory disease
- Drug-induced
- Hypertension (primary and kidney disease related)
- Leukemia and lymphoma
- Liver disease and cirrhosis
- Non-transport accidents (e.g. poisonings, falls)
- Pancreatic cancer
- Prostate cancer
- Suicide

*Issues are listed in alphabetical order.

Clackamas County Demographics

Table H-1 summarizes the population demographics for Clackamas County.

Table H-1: Population demographics for Clackamas County

Demographic Indicator	Clackamas County Estimate	Oregon Estimate
Total Population (number of people)	394,972	3,970,239
Gender		
Female (%)	50.6	50.5
Male (%)	49.4	49.5
Age		
Median (years)	41.5	39.3
Under 5 years (%)	5.3	5.7
5 to 19 years (%)	19.3	18.4
20 to 44 years (%)	30.3	33.5
45 to 64 years (%)	28.8	26.4
65 years and older (%)	16.2	16.0
Race/Ethnicity (%)		
White, non-Hispanic/Latino	82.9	76.9
Black or African American, non-Hispanic/Latino	1.0	1.7
Native American/ Alaska Native, non-Hispanic/Latino	0.6	0.9
Asian, non-Hispanic/Latino	4.0	4.0
Native Hawaiian and other Pacific Islander, non-Hispanic/Latino	0.3	0.3
Hispanic/Latino, any race	8.4	12.5
Top 5 languages spoken at home (%)[a]		
English only	88.1	84.5
Spanish or Spanish Creole	5.6	9.3
Russian	1.0	0.6
Chinese	0.9	0.7
Vietnamese	0.5	0.7
Foreign-born population (%)[b]	8.2	9.9
With any disability (%)[c]	12.1	15.2
No health insurance (%)[d]	8.5	9.7
Unemployment (%)[e]	4.3	4.8
Income		
Median household income (USD)	65,316	51,075
Individuals living in poverty (%)[f]	9.2	16.6
Children under 18 years living in poverty (%)[f]	11.9	21.6
Education (%)[g]		

Demographic Indicator	Clackamas County Estimate	Oregon Estimate
High school graduate or higher	92.8	89.7
Bachelor's degree or higher	33.2	30.8
Total homeless individuals (number of people)[h]	2,196	n/a
Under 18 years of age	1,026	n/a
Ages 65 years or older	48	n/a
Chronically homeless[i]	205	n/a
Veterans	74	n/a
Change in population (% increase)		
Total population (from 2000-2010)	11.1	12.0
Hispanic/Latino origin, any race (from 2000-2010)	74.0	63.5
Non-Hispanic/Latino origin (from 2000-2010)	7.8	7.5
Foreign-born (from 2005-2014)[b]	19.3	14.2

n/a: data not available; USD: U.S. dollars

Data sources: total population, gender, race/ethnicity, language spoken at home, foreign-born, disability, health insurance, unemployment, income, education, poverty (American Community Survey, 2014 one-year estimates); homeless (Point-in-Time Homeless Count 2015); population change (Hispanic/Latino and non-Hispanic/Latino origin: Community Commons using US Census data from 2000 and 2010; Foreign-born: American Community Survey estimates from 2005 and 2014).

Percentages might not total 100% because of rounding. Percentages for race/ethnicity might not total 100% because data are not shown for some categories, such as two or more races or "other" race.

[a]Language spoken at home is among the population ages 5 years and older.

[b]Foreign-born population includes anyone who was not a US citizen or a US national at birth.

[c]Disability includes hearing, cognitive, vision, ambulatory, independent living, and self-care disabilities.

[d]No health insurance includes people reporting no health coverage or those whose only health coverage was Indian Health Service out of the total civilian noninstitutionalized population.

[e]Unemployment is out of the population 16 years of age and older.

[f]Poverty is measured as persons living in households with income below 100% Federal Poverty Level. Poverty in children is out of the total population of children under 18 years of age.

[g]Educational attainment is among the population 25 years of age and older.

[h]Homeless counts include persons within emergency shelter, transitional shelter, safe haven, unstable or doubled-up housing, and unsheltered.

[i]Chronic homelessness is defined as: "Individuals or families who have been homeless for one year or longer or have had four episodes of homelessness within the last three years and the individual or one family member has a disabling condition." (U.S. Department of Housing and Urban Development, *Defining Chronic Homelessness*. 2007; National Alliance to End Homelessness, 2015)

Population Data (Health Behaviors, Morbidity, Mortality)

The tables below present the findings from the *Health Status Assessment – Population Data* section. Refer to this section of the report for a description of methodology, regional findings, and limitations.

Tables H-2, *H-3*, and *H-4* summarize the top ranked health behaviors, morbidity, and mortality resulting from a systematic analysis and prioritization of available indicators. The top indicators in these three tables reflect the following: a disparity by race/ethnicity, a disparity by gender, a worsening trend, a worse rate at the county level compared to the state, a high proportion of the population affect, and a severe health consequence. Indicators are listed in alphabetical order in each table. Unless otherwise specified, the indicators include data for the entire population.

Table H-2: Top health behaviors in Clackamas County

Clackamas County Health Behaviors
Alcohol use in teens[a]
Binge drinking in teens[a,b] and adults
Current cigarette smoking in adults
Dental visits in teens[a] and adults
E-cigarettes/vaping products use in teens[b]
Fruit/vegetable consumption in teens[a] and adults
Marijuana use in teens[b]
Physical activity in teens[a,b] and adults
Prescription drug abuse in teens[a]
Received flu shot in adults
Received pneumonia vaccination in adults over 65 years
Usual source of health care in adults

[a] 8th graders
[b] 11th graders

Table H-3: Top health conditions (morbidity) in Clackamas County

Clackamas County Morbidity
Asthma in teens[b]
Bladder cancer incidence
Breast cancer incidence in all females
Depression in adults
Diabetes in adults
High blood pressure in adults
High cholesterol in adults
Kidney/renal pelvis cancer incidence
Non-Hodgkin lymphoma cancer incidence
Obesity/overweight in adults and teens[a]
Thyroid cancer incidence

[a] 8th graders

[b] 11th graders

Table H-4: Top health outcomes (mortality) in Clackamas County

Clackamas County Mortality
Alcohol-induced
Breast cancer among all females
Chronic liver disease and cirrhosis
Chronic lower respiratory disease
Drug-induced
Essential hypertension and hypertensive renal disease
Lymphoid, hematopoietic, related tissue cancer
Non-transport accidents
Pancreatic cancer
Prostate cancer
Suicide

Deaths are categorized according to the underlying (or primary) cause-of-death on the death certificate. In addition to the underlying cause, death certificates list up to twenty contributing causes of death. Drug-induced and alcohol-induced death estimates include underlying and contributing causes of death, independent of intent (natural, homicide, suicide, accidental, or undetermined).
Non-transport accident mortality major category includes deaths due to falls and unintentional poisoning.

Table H-5 summarizes all health behaviors, morbidity, and mortality indicators that were included in the analysis and prioritization described in the methodology section.

Table H-5. Population estimates for all health behavior, morbidity, and mortality indicators for Clackamas County and Oregon

Health Indicator	Clackamas County Estimate	County Data Year(s)	Oregon Estimate	Oregon Data Year(s)	Population
Asthma					
Current asthma (%) ★	9.0	2010-2013	11.2	2013	adults
Ever been diagnosed with asthma (%)	21.6	2013, 2015	21.9	2015	8th graders
Ever been diagnosed with asthma (%)	22.1	2013, 2015	24.4	2015	11th graders
Cancer & Cancer Screening					
All cancer mortality (per 100,000)	149.6	2013	163.3	2013	total
All cancer incidence (per 100,000)	447.3	2008-2012	447.6	2008-2012	total
Bladder cancer incidence (per 100,000) ★	19.3	2008-2012	21.9	2008-2012	total
Breast cancer mortality (per 100,000) ★	20.1	2013	19.9	2013	all females
Breast cancer incidence (per 100,000) ★	141.3	2008-2012	128.4	2008-2012	all females
Colorectal cancer mortality (per 100,000)	10.5	2013	14.4	2013	total
Colorectal cancer incidence (per 100,000) ★	36.2	2008-2012	38.3	2008-2012	total
Received colorectal cancer screening (%)	67.9	2010-2012	63.2	2012	adults 50 years or older
Kidney/renal pelvis cancer incidence (per 100,000) ★	13.7	2008-2012	14.8	2008-2012	total
Leukemia cancer incidence (per 100,000)	11.9	2008-2012	11.7	2008-2012	total
Lung, trachea, bronchus cancer mortality (per 100,000)	40.5	2013	42.0	2013	total
Lung, trachea, bronchus cancer incidence (per 100,000) ★	55.5	2008-2012	61.0	2008-2012	total
Lymphoid, hematopoietic, related tissue cancer mortality (per 100,000) ★	15.8	2013	17.5	2013	total
Non-Hodgkin lymphoma cancer incidence (per 100,000) ★	19.3	2008-2012	18.7	2008-2012	total
Melanoma (skin) cancer incidence (per 100,000) ★	31.8	2008-2012	26.6	2008-2012	total
Ovarian cancer mortality (per 100,000)	7.4	2013	8.4	2013	all females
Ovarian cancer incidence (per 100,000)	12.3	2008-2012	12.6	2008-2012	all females

Health Indicator	Clackamas County Estimate	County Data Year(s)	Oregon Estimate	Oregon Data Year(s)	Population
Pancreatic cancer mortality (per 100,000)	10.6	2013	9.6	2013	total
Pancreatic cancer incidence (per 100,000)	11.7	2008-2012	11.8	2008-2012	total
Prostate cancer mortality (per 100,000)	15.4	2013	19.4	2013	all males
Prostate cancer incidence (per 100,000)	120.4	2008-2012	122.8	2008-2012	all males
Thyroid cancer incidence (per 100,000) ★	13.3	2008-2012	12.4	2008-2012	total
Uterine cancer incidence (per 100,000) ★	28.0	2008-2012	26.7	2008-2012	all females
Diabetes					
Diabetes mortality (per 100,000) ★	23.6	2013	23.5	2013	total
Diabetes (%)	8.7	2010-2013	8.7	2013	adults
Exercise, Nutrition, & Weight					
Fruit/vegetable consumption: 5 or more times/day (%) ★	24.7	2010, 2011, 2013	22.1	2013	adults
Fruit/vegetable consumption: 5 or more times/day (%) ★	21.6	2013, 2015	23.4	2015	8th graders
Fruit/vegetable consumption: 5 or more times/day (%)	19.5	2013, 2015	19.5	2015	11th graders
Obesity (BMI ≥ 30) (%)	25.6	2010-2013	25.9	2013	adults
Obesity (BMI ≥ 30) (%)	9.4	2013, 2015	11.4	2015	8th graders
Obesity (BMI ≥ 30) (%) ★	11.0	2013, 2015	13.2	2015	11th graders
Overweight (BMI 25.0 - 29.9) (%) ★	34.2	2010-2013	32.6	2013	adults
Overweight (BMI 25.0 - 29.9) (%)	14.7	2013, 2015	15.4	2015	8th graders
Overweight (BMI 25.0 - 29.9) (%)	12.7	2013, 2015	15.4	2015	11th graders
Overweight or obese (BMI ≥ 25.0) (%) ★	59.9	2010-2013	58.6	2013	adults
No physical activity outside of work within past month (%)	17.6	2010-2013	17.5	2013	adults
Participated in 150 minutes or more of aerobic physical activity per week (%)	63.8	2010-2013	65.0	2013	adults
Met guidelines for aerobic and muscle strengthening exercises (%)[a]	23.8	2011, 2013	26.5	2013	adults
Participated in muscle strengthening exercises more than twice per week (%)	31.3	2011, 2013	33.8	2013	adults
Physically active for total of 60+ minutes in past 7 days on all 7 days (%) ★	28.4	2013, 2015	30.7	2015	8th graders
Physically active for total of 60+ minutes in past 7 days on all 7 days (%) ★	23.7	2013, 2015	23.7	2015	11th graders

Health Indicator	Clackamas County Estimate	County Data Year(s)	Oregon Estimate	Oregon Data Year(s)	Population
Muscle strengthening/toning exercises in past 7 days for minimum of 3 days (%) ★	59.2	2013, 2015	61.8	2015	8th graders
Muscle strengthening/toning exercises in past 7 days for minimum of 3 days (%) ★	49.6	2013, 2015	51.6	2015	11th graders
Family Planning					
Teen pregnancy rate (per 1,000)	8.0	2013	14.0	2013	females ages 15-17
Healthcare Access & Coverage					
Usual source of health care or one or more personal doctors (%) ★	78.4	2010-2013	74.4	2013	adults
With health insurance (%)	84.5	2010-2012	80.3	2013	adults
Could not afford to see doctor at any time in past year because of cost (%)	16.5	2010-2013	18.1	2013	adults
Heart Disease & Stroke					
Heart disease mortality (per 100,000) ★	126.3	2013	134.5	2013	total
Cerebrovascular diseases mortality (per 100,000)	33.3	2013	37.2	2013	total
High blood pressure (%) ★	26.3	2010, 2011, 2013	28.7	2013	adults
High cholesterol (%) ★	33.8	2010, 2011, 2013	30.6	2013	adults
Essential hypertension and hypertensive renal disease mortality (per 100,000)	9.9	2013	10.7	2013	total
Major cardiovascular diseases mortality (per 100,000)	175.6	2013	189.7	2013	total
Immunizations & Infectious Diseases					
Influenza/pneumonia mortality (per 100,000)	9.2	2013	10.5	2013	total
Pneumonia mortality (per 100,000)	7.5	2013	9.0	2013	total
Received flu shot in past year (%)	58.5	2010-2013	55.5	2013	adults 65 years or older
Received flu shot in past year (%) ★	35.8	2010-2013	33.8	2013	adults
Ever received pneumonia vaccination (%) ★	74.0	2010-2013	75.5	2013	adults 65 years or older
Chronic Hepatitis C incidence (per 100,000)	105.6	2014	126.4	2014	total
Chlamydia incidence (per 100,000) ★	300.7	2014	410.4	2014	total
Gonorrhea incidence (per 100,000)	30.4	2014	60.9	2014	total
Early syphilis incidence (per 100,000)	3.9	2014	11.1	2014	total
HIV/AIDS, HIV and AIDS incident cases (per 100,000)	2.0	2014	6.2	2014	total

Health Indicator	Clackamas County Estimate	County Data Year(s)	Oregon Estimate	Oregon Data Year(s)	Population
Injury					
Accidents (unintentional injuries) mortality (per 100,000)	35.2	2013	39.6	2013	total
Non-transport accidents mortality (per 100,000)[b] ★	28.3	2013	29.8	2013	total
Maternal, Fetal & Infant Health					
Low birth weight, <2500 grams or 5.5 pounds (%)	6.1	2013	6.3	2013	all live births
Early prenatal care, Kotelchuck index of adequate prenatal care (%)	72.3	2013	72.2	2013	all live births
Mothers smoking during pregnancy (%)	6.3	2013	10.2	2013	all live births
Preterm births, < 36 weeks (%)	7.0	2013	7.6	2013	all live births
Mental & Emotional Health					
Suicide mortality (per 100,000) ★	13.4	2013	16.8	2013	total
Any suicide attempt in past 12 months (%)	7.6	2013, 2015	8.2	2015	8th graders
Any suicide attempt in past 12 months (%)	4.6	2013, 2015	6.2	2015	11th graders
Depression (%) ★	23.7	2011-2013	25.9	2013	adults
Poor emotional/mental health for 14 or more days in a month (%)	11.8	2010-2013	13.0	2013	adults
Poor emotional/mental health (%)	5.0	2013, 2015	5.8	2015	8th graders
Poor emotional/mental health (%)	5.5	2013, 2015	6.5	2015	11th graders
Miscellaneous					
Nephritis, nephrotic syndrome, and nephrosis mortality (per 100,000)	5.9	2013	6.8	2013	total
Chronic liver disease and cirrhosis mortality (per 100,000) ★	11.7	2013	11.7	2013	total
Older Adults & Aging					
Alzheimer's disease mortality (per 100,000) ★	29.4	2013	27.2	2013	total
Oral Health					
Had dental visit in past year (%)	70.1	2010, 2012, 2013	67.8	2013	adults
Had any permanent teeth missing due to decay/gum disease (%)	33.7	2010, 2012, 2013	37.9	2013	Adults
Had last visit to dentist within past 12 months (%)	84.7	2013, 2015	82.2	2015	8th graders
Had last visit to dentist within past 12 months (%)	82.3	2013, 2015	79.9	2015	11th graders

Health Indicator	Clackamas County Estimate	County Data Year(s)	Oregon Estimate	Oregon Data Year(s)	Population
Respiratory Diseases					
Chronic lower respiratory disease mortality (per 100,000)	39.1	2013	42.9	2013	total
Substance Abuse					
Drug-induced mortality (per 100,000) ★	13.3	2013	13.0	2013	total
Alcohol-induced mortality (per 100,000) ★	11.5	2013	15.4	2013	total
Binge drinking (%)[c] ★	16.5	2010-2013	18.2	2013	adults
Heavy drinking (%)[d]	6.7	2010-2013	8.7	2013	adults
Any alcohol use (%)[e] ★	12.3	2013, 2015	11.9	2015	8th graders
Any alcohol use (%)[e]	30.3	2013, 2015	29.1	2015	11th graders
Any binge drinking (%)[c]	4.8	2013, 2015	5.3	2015	8th graders
Any binge drinking (%)[c] ★	17.7	2013, 2015	16.5	2015	11th graders
Current cigarette smoker (%) ★	18.1	2010-2013	16.9	2013	adults
Current cigarette smoker (%)	3.8	2013, 2015	3.9	2015	8th graders
Current cigarette smoker (%)	8.9	2013, 2015	8.3	2015	11th graders
Any use of marijuana in past month (%)	7.7	2013, 2015	8.8	2015	8th graders
Any use of marijuana in past month (%) ★	21.5	2013, 2015	19.1	2015	11th graders
Any use of e-cigarettes/vaping products in past month (%)[f]	6.4	2013, 2015	9.3	2015	8th graders
Any use of e-cigarettes/vaping products in past month (%)[f] ★	13.2	2013, 2015	17.1	2015	11th graders
Any prescription drug abuse in past 30 days (%)	3.8	2013, 2015	4.1	2015	8th graders
Any prescription drug abuse in past 30 days (%)	6.0	2013, 2015	6.5	2015	11th graders

★ Indicates top ranking regional indicator (note that multiple physical activity and obese/overweight indicators are presented as one indicator in the top ranking regional tables).

All data are age-adjusted to the 2000 US standard population. Death rates and cancer incidence rates are per 100,000; other incidence rates are per 100,000 of the population at risk. Adult and teen health behavior data are a percent of the population at risk. Teen health behavior data are a percent of student enrollment per grade.

BMI: body mass index

[a]Guidelines for aerobic and muscle strengthening exercise: at least 150 minutes of moderate intensity (or 75 minutes of vigorous-intensity) aerobic physical activity per week and moderate or high intensity muscle strengthening activity 2 or more days per week.

[b]Non-transport accident mortality major category includes deaths due to falls or unintentional poisoning.

[c]Binge drinking for adults: 4 or more drinks on one occasion (females) or 5 or more drinks on one occasion (males). Binge drinking for teens: 5 or more drinks of alcohol in a row during past 30 days.
[d]Heavy drinking for adults: 1 or more drinks per day (females) or 2 or more drinks per day (males).
[e]Alcohol use in teens: at least one drink of alcohol during past 30 days.
[f]E-cigarettes/vaping products include electronic nicotine delivery product, such as an e-cigarette, e-cigar, or e-hookah.

Table H-6 summarizes the leading cancer incidence in Clackamas County. Note that this incidence data was used in the analysis and prioritization of the morbidity indicators in the tables above.

Table H-6. Leading cancer incidence in Clackamas County

Type of Cancer	Clackamas County Incidence Rate
All cancer sites	447.3
Breast (female)	141.3
Prostate (male)	120.4
Lung & bronchus	55.5
Colon & rectum	36.2
Melanoma of the skin	31.8
Uterus (female)	28.0
Bladder	19.3
Non-Hodgkin lymphoma	19.3
Kidney & renal pelvis	13.7
Thyroid	13.3

Source: National Cancer Institute (NCI) State Cancer Profiles, 2008-2012.
All rates are per 100,000 population and are age-adjusted to the 2000 US standard population.

Table H-7 summarizes the mortality rates for the leading types of cancer in Clackamas County. Note that this mortality data was used in the analysis and prioritization of the mortality indicators in the tables above.

Table H-7. Leading causes of death in Clackamas County

Clackamas County Top Leading Causes of Death, 2013	Mortality Rate
Major cardiovascular diseases	175.63
Diseases of heart	126.34
Cerebrovascular diseases	33.27
Essential hypertension and hypertensive renal disease	9.94
Malignant neoplasms	149.59
Malignant neoplasms of trachea, bronchus and lung	40.48
Malignant neoplasm of breast in females	20.06
Malignant neoplasms of lymphoid, hematopoietic and related tissue	15.82
Malignant neoplasm of prostate in males	15.40
Malignant neoplasm of pancreas	10.62
Malignant neoplasms of colon, rectum and anus	10.47
Chronic lower respiratory diseases	39.06
Accidents (unintentional injuries)	35.19
Non-transport accidents[a]	28.34
Alzheimer's disease	29.45
Diabetes mellitus	23.64
Intentional self-harm (suicide)	13.41

Clackamas County Top Leading Causes of Death, 2013	Mortality Rate
Drug-induced[b]	13.31
Chronic liver disease and cirrhosis	11.74
Alcohol-induced[b]	11.45

Data source: National Center for Health Statistics (NCHS) 113 Leading Cause of Death list from the Oregon Public Health Assessment Tool (OPHAT).
All rates are per 100,000 population and are age-adjusted to the 2000 US Standard Population.
Malignant neoplasm: a new abnormal growth of tissue, also referred to as a tumor or cancer.
[a]Non-transport accident mortality major category includes deaths due to falls and unintentional poisoning.
[b]The drug- and alcohol-induced death categories are included within the other NCHS 113 Leading Cause of Death categories and, therefore, are not mutually exclusive categories.

Hospital (Emergency Department) Data

The tables below present the findings from the *Health Status Assessment – Hospital Data* section. Refer to this section of the report for a description of methodology, regional findings, and limitations.

Table H-8: List of diagnoses and age-adjusted percentages for uninsured and self-pay admissions to hospital emergency departments in Clackamas County (adults only)

Clackamas County: Adults	
Ambulatory Care Sensitive Conditions (ACSC) and Select Mental Illness Diagnoses	**Age-Adjusted %**
Hypertension	16.7%
Diabetes "c"	9.1%
Kidney/urinary infections	6.8%
Cellulitis (skin infections)	6.2%

Only diagnoses greater than 5% are shown.

Table H-9: List of diagnoses and age-adjusted percentages for uninsured and self-pay admissions to hospital emergency departments in Clackamas County (youth only)

Clackamas County: Youth	
Ambulatory Care Sensitive Conditions (ACSC) and Select Mental Illness Diagnoses	**Age-Adjusted %**
Severe ear, nose, and throat infections	38.5%
Asthma	12.3%

Only diagnoses greater than 5% are shown.

Online Survey Data

The tables below present the findings from the *Community Themes and Strengths Assessment – Online Survey* section. Refer to this section of the report for a description of methodology, regional findings, and limitations.

A total of 1,001 surveys were submitted that reported a zip code within or overlapping Clackamas County borders. These 1,001 surveys represented 34.2% of all surveys from the four-county region. In comparison, Clackamas County makes up 18.1% of the four-county population.

The demographics of Clackamas County survey respondents are presented, below, in tables that compare them to the respective demographics of the Clackamas County population (when available). Percentages were calculated using the number of surveys that reported a meaningful answer to the respective question as the total or denominator; this number is presented as "n" for each demographic indicator. Surveys that did not include an answer to the respective question were omitted from the total count.

Table H-10: Demographics of survey respondents from Clackamas County

Demographic Indicator	**Population of survey respondents who live in Clackamas County (n=1,001)**	**Clackamas County Population**
Age	n=975	
Under 18	.9%	22.3%
19-25	5.1%	8.1%
26-39	29.5%	17.8%
40-54	25.7%	20.8%
55-64	19.3%	14.7%
65-79	17.0%	12.6%
80 and older	2.4%	3.6%
Gender	n=949	
Female	73.0%	50.6%
Male	26.3%	49.4%
Other than male or female alone	0.6%	N/A
Sexual Orientation	n=884	
Sexual Minority	8.4%	N/A
Heterosexual	91.6%	N/A
Hispanic Ethnicity	n=936	
Hispanic	11.4%	8.4%
Non-Hispanic	88.6%	91.6%
Race	n=866	
African American/Black	1.5%	1.0%
African	0.3%	
Arab American/Middle Eastern	0.5%	N/A
Asian American/Asian	2.5%	4.2%
European American/White/Caucasian	82.0%	90.2%
Native American/American Indian/Alaska Native	2.3%	1.1%
Native Hawaiian or Pacific Islander	N/A	.3%

Demographic Indicator	Population of survey respondents who live in Clackamas County (n=1,001)	Clackamas County Population
Multiracial	7.9%	3.2%
Other	3.0%	N/A
Location of Childhood	n=951	
Inside U.S.	92.7%	N/A
Outside U.S.	7.3%	N/A
Language	n=967	
English	90.7%	88.1%
Spanish or Spanish/English	7.2%	5.6%
Other than Spanish or English	2.1%	6.3%
Veteran Status	n=882	
Veteran	1.2%	9.6%
Not a veteran	98.8%	90.4%
Disability Status	n=953	
Has a disability	17.5%	12.1%
Does not have disability	82.5%	87.9%
Education Level	n=891	
Less than high school	4.4%	7.2%
High school/GED	21.5%	23.1%
Bachelors degree or higher	70.5%	33.2%
Federal Poverty Level	n=792	
200% or below	31.7%	25.9%
Above 200%	68.3%	74.1%
Type of Health Insurance	n=947	
Uninsured	3.7%	8.5%
Medicaid	15.0%	15.6%
Medicare	14.8%	16.9%
Medicaid/Medicare	2.7%	N/A
Indian Health Services	0.3%	N/A
VA	1.3%	2.1%
Other public	0.6%	N/A
Private insurance	61.6%	74%

Survey question 1: Quality of life (vision)

The first question on the survey asked about respondents' vision of a healthy community. The question read, *"In the following list, what do you think are the five most important characteristics of a 'Healthy Community'? (Those factors that most improve the quality of life in a community")*. There were 21 characteristics from which to choose. The table below presents the response options ordered by the frequency at which they were selected. Because the question asked respondents to select five characteristics, the five most frequently selected responses are shaded in gray. Frequencies were calculated using the total number of selections as the denominator (presented as "n" in the frequency column).

Table H-11: Survey question 1 results for Clackamas County respondents

Rank based on Frequency	Response Options	Frequency (Proportion of Total Responses) n = 4,830
1	Safe, affordable housing	10.8%
2	Low crime/safe neighborhoods	9.6%
3	Access to healthy, affordable food	9.0%
4	Access to physical, mental, and/or oral health care	8.9%
5	Good schools	8.7%
6	Good jobs to reach a healthy economy	6.6%
7	Clean environment	6.5%
8	Healthy behaviors and lifestyles	4.9%
9	Supportive and happy family life	4.3%
10	Parks and recreation	4.3%
11	Good place to raise children	4.1%
12	Safe, nearby transportation	4.1%
13	Welcoming of diverse communities/people	3.2%
14	Religious or spiritual values	3.0%
15	Participating and giving back to the community	2.7%
16	Low level of child abuse	2.1%
17	Good job training opportunities	2.0%
18	Arts and cultural events	1.6%
19	Good daycare and preschools	1.5%
20	Physical accommodations for people with disabilities	1.2%
21	Low deaths and disease rates	1.0%

The five responses most frequently selected by Clackamas County respondents were 1) Safe, affordable housing; 2) Low crime/safe neighborhoods; 3) Access to healthy, affordable food; 4) Access to physical, mental, and/or oral health care; and 5) Good schools. These were the same top five choices for total four-county respondents, although in a different order.

Survey question 2: Issues affecting community health (needs)

The second question on the survey asked respondents about the biggest health needs in their community. The question read, *"In the following list, what do you think are the five most important 'issues' that need to be addressed to make your community healthy? (Those topics that have the greatest impact on overall community health)."* The table below presents the response options ordered by the frequency at which they were selected. Again, because the question asked respondents to select five topics, the five most frequently selected responses are shaded in gray. Frequencies were calculated using the total number of selections as the denominator (presented as "n" in the frequency column).

Table H-12: Survey question 2 results for Clackamas County respondents

Rank based on Frequency	**Response Options**	**Frequency (Proportion of Total Responses)** n = 4,632
1	Homeless/lack of safe, affordable housing	11.9%
2	Unemployment/lack of living wage jobs	10.5%
3	Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders)	9.1%
4	Hunger/lack of healthy, affordable food	7.6%
5	Lack of access to physical, mental, and/or oral health care	5.6%
6	Being overweight/obesity	5.1%
7	Domestic violence, child abuse/neglect	4.6%
8	Poor schools	4.4%
9	Unsafe streets (limited crosswalks, bike lanes, lighting, etc.)	4.4%
10	Racism/discrimination	4.2%
11	Gang activity/violence	4.0%
12	Lack of needed job skills or training	3.9%
13	Lack of community involvement	3.5%
14	Dirty environment	2.7%
15	Lack of access to safe, nearby transportation	2.6%
16	Bullying/verbal abuse	2.6%
17	Aging problems (e.g. memory loss, hearing/vision loss)	2.4%
18	Disabilities (physical, mental) and limited mobility	2.0%
19	Lack of safe and accessible parks/recreation	1.9%

20	Lack of physical accommodations for people with disabilities	1.7%
21	Lack of good daycare and preschools	1.7%
22	Firearm-related injuries	1.5%
23	Few arts and cultural events	1.2%
24	Asthma/respiratory/lung disease	0.6%
25	HIV/AIDS	0.4%

As *Table H-12* shows, the five most frequently selected community needs were 1) Homelessness/lack of safe, affordable housing; 2) Unemployment/lack of living wage jobs; 3) Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders); 4) Hunger/lack of healthy, affordable food; and 5) Lack access to physical, mental, and/or oral health care. These were the same five most frequently selected community needs, and in the same order, as those of total four-county respondents.

Survey question 3: Risky behaviors

The third question the survey asked was about behaviors that can endanger health. The question read, *"In the following list, what do you think are the three most important 'risky behaviors' in your community? (Those behaviors that have the greatest impact on overall community health)."* The table below presents the response options ordered by the frequency at which they were selected. Because the question asked respondents to select three behaviors, the three most frequently selected responses are shaded in gray. Frequencies were calculated using the total number of selections as the denominator (presented as "n" in the frequency column).

Table H-13: Survey question 3 results for Clackamas County respondents

Rank based on Frequency	**Response Options**	**Frequency (Proportion of Total Responses)** n = 2,883
1	Drug use/abuse	17.5%
2	Alcohol abuse/addiction	15.9%
3	Poor eating habits	10.5%
4	Lack of exercise	9.2%
5	Social isolation/loneliness	8.8%
6	Dropping out of school	8.7%
7	Unsafe driving (e.g. not using seat belts/child safety seats, distracted driving)	8.0%
8	Tobacco use	6.6%

9	Risky sexual behavior/unsafe sex	5.0%
10	Not getting "shots" to prevent disease (immunizations)	4.8%
11	Not using birth control	2.6%
12	Self-harm (e.g. cutting, suicide attempts)	2.4%

The three most frequently selected responses were 1) Drug use/abuse; 2) Alcohol abuse/addiction; and 3) Poor eating habits. These were the same most frequently selected responses as for total regional respondents.

Survey question 4

The fourth survey question asked respondents to rate the health of their community. The question read, "*How healthy would you rate your community as a whole?" Table H-14* presents the distribution of responses. Unlike the previous three questions, respondents were directed to only give one response to this question. Therefore, the proportion of responses per rating was calculated using the number of people indicating that response as the denominator, displayed as "n" in the table.

Table H-14: Survey question 4 results for Clackamas County respondents

Rating	**Proportion of Responses from Clackamas County Respondents** n = 1,001	**Proportion of Responses from Entire Survey Population** n = 3,075
Very healthy	4.2%	3.0%
Healthy	37.3%	30.9%
Somewhat unhealthy	50.0%	53.2%
Unhealthy	7.5%	10.3%
Very unhealthy	1.0%	2.6%

This distribution has slightly more "Very healthy" and "Healthy" ratings, and correspondingly fewer "Unhealthy" and "Very unhealthy" ratings, than that of total regional respondents.

Clackamas County Priority Health Issues Model

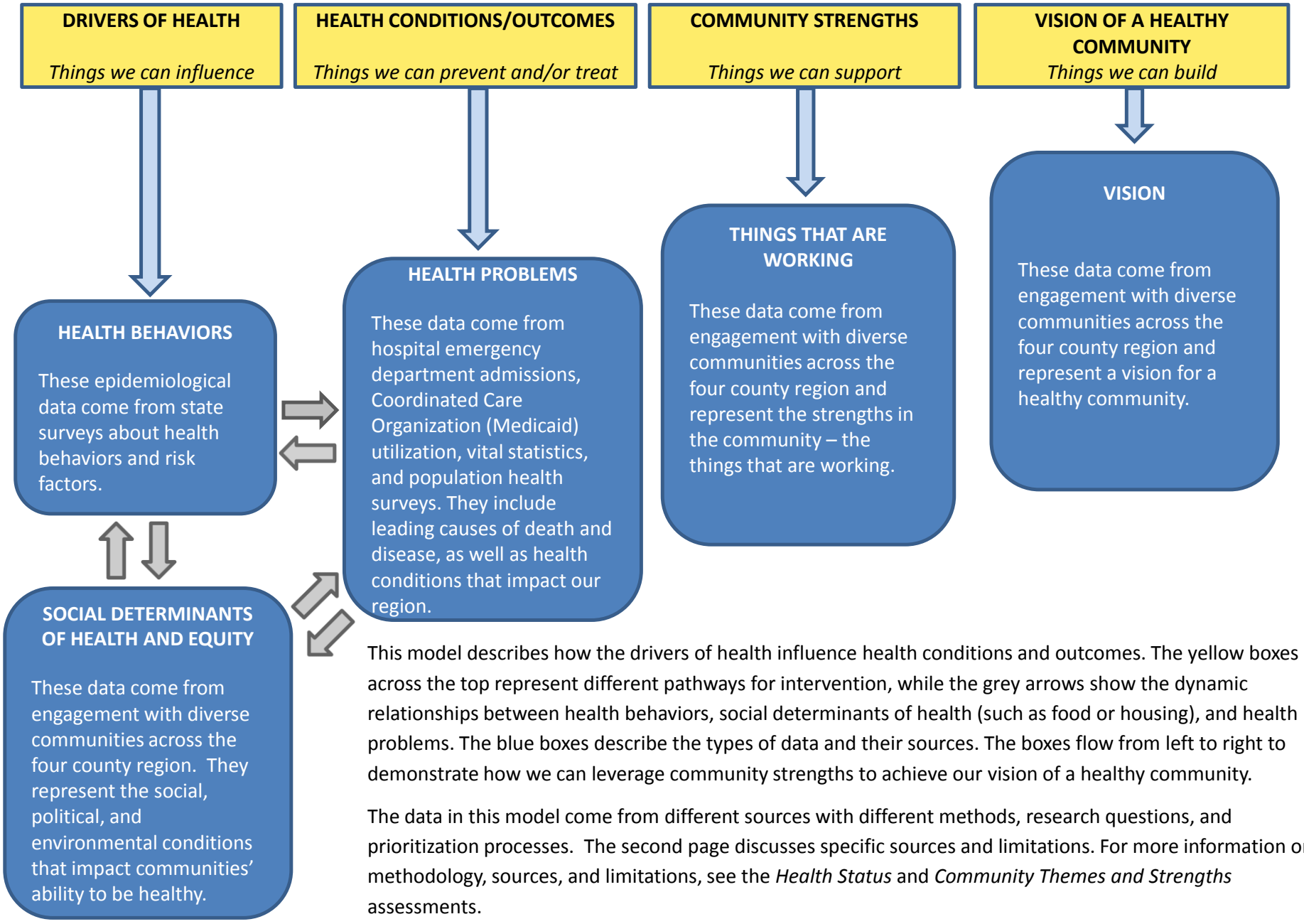
Figure H-1 illustrates the priority health issues in Clackamas County, as identified in the 2016 CHNA. The data sources include:

- Population data on health behaviors, morbidity, and mortality
- Medicaid claims data provided by local CCOs
- Hospital admissions data for people who were uninsured or self-pay and were diagnosed with select conditions
- Community data from an online survey, listening sessions in all four counties, and a qualitative meta-analysis of community engagement projects from the last 3 years

Each data set has its own specific limitations, which can be found in the *Health Status Assessment* and *Community Themes and Strengths Assessment* sections of this report.

Figure H-1: Priority Health Issues Model for Clackamas County

Priority Health Issues for Clackamas County and What We Can Do



This model describes how the drivers of health influence health conditions and outcomes. The yellow boxes across the top represent different pathways for intervention, while the grey arrows show the dynamic relationships between health behaviors, social determinants of health (such as food or housing), and health problems. The blue boxes describe the types of data and their sources. The boxes flow from left to right to demonstrate how we can leverage community strengths to achieve our vision of a healthy community.

The data in this model come from different sources with different methods, research questions, and prioritization processes. The second page discusses specific sources and limitations. For more information on methodology, sources, and limitations, see the *Health Status* and *Community Themes and Strengths* assessments.

DRIVERS OF HEALTH

Things we can influence

HEALTH CONDITIONS AND OUTCOMES

Things we can prevent and/or treat

SOCIAL DETERMINANTS OF HEALTH AND EQUITY

- Access to food
- Access to health care*
- Access to transportation
- Connected communities
- Culturally and linguistically appropriate services
- Pathways to living wage jobs
- Policies, systems, and environments that support healthy behaviors
- Racism, discrimination, and stigma
- Safe, accessible, and affordable housing
- Support for people with behavioral health challenges

Community Engagement Data

HEALTH BEHAVIORS

- Alcohol use among teens
- Binge drinking
- Cigarette smoking among adults
- Lack of dental visits*
- Lack of adults who have received flu shot
- Lack of fruit and vegetable consumption
- Lack of physical activity
- Lack of adults 65 and older who have received pneumonia vaccine
- Marijuana use among teens
- No usual source of health care among adults*
- Prescription drug abuse among teens
- Vaping and e-cigarettes use among teens

Population Data

DIAGNOSED HEALTH CONDITIONS FOR LOW-INCOME AND/OR UNINSURED

<u>Children</u>

- Asthma*
- Attention Deficit Disorder
- Post Traumatic Stress Disorder
- Severe ear, nose, and throat infections - (Uninsured ED only)

<u>Adults</u>

- Depression*
- Diabetes*
- Hypertension*
- Kidney/urinary infections - (Uninsured ED only)
- Skin infections - (Uninsured ED only)

Emergency Department (ED) and Medicaid Data

MORBIDITY (DISEASE)

- Asthma*
- Cancer, 5 types♦
- Depression*
- Diabetes*
- Hypertension*
- High cholesterol
- Obesity/overweight

Population Data

MORTALITY (DEATH)

- Alcohol-induced
- Breast cancer
- Chronic lower respiratory disease
- Drug-induced
- Hypertension (primary and kidney disease-related)*
- Leukemia and Lymphoma
- Liver disease and cirrhosis
- Non-transport accidents (e.g. poisonings, falls)
- Pancreatic cancer
- Prostate cancer
- Suicide

Population Data

***Indicator identified in more than one of the assessment components (e.g. population, community engagement, emergency department, or Medicaid data)

♦Refer to section III for specific types of cancer

All indicators are in alphabetical order. For full methodology, sources, and limitations, see individual sections of CHNA report.

COMMUNITY STRENGTHS

Things we can support

STRENGTHS

Culturally specific, community-based services

Feeling connected to a community

Government supported public assistance and social services

Healthy behaviors

Low/no cost programs and services that make health care accessible

Opportunities to be involved in the community

Pathways to living wage jobs

Resilience

Community Engagement Data

VISION OF A HEALTHY COMMUNITY

Things we can build

VISION

For all people:

Affordable, high-quality, culturally responsive health care

Basic needs are met, including food, housing, and transportation

Environments and opportunities that support and encourage community involvement and connection

Equitable and inclusive society, free from racism, discrimination, and stigma

Good schools and equitable access to high quality education

Living wage jobs and pathways to employment

Policies, systems, and environments that support good health and high quality of life

Safe, accessible, and affordable housing

Safe and accessible neighborhoods free of crime

Community Engagement Data

DATA SOURCES AND LIMITATIONS

SOCIAL DETERMINANTS OF HEALTH AND EQUITY, COMMUNITY STRENGTHS, AND VISION

Data sources:

•29 listening sessions with 364 community members across the four county region
•Online survey (paper version optional) with 3,167 responses
•Meta-analysis of 55 community engagement projects conducted in the four county region between 2012-2015

Limitations:

The data from the survey and listening sessions were collected through small convenience samples. HCWC aimed to engage communities across the four county region and prioritize low-income and communities of color. However, the people that participated in the survey and listening sessions do not represent the full range of diverse experiences in the region.

HOSPITAL DATA

Data sources:

•26 Ambulatory Care and Sensitive Condition (ACSC) codes
•4 Severe and Persistent Mental Illness (SPMI) codes
•15 hospitals in the HCWC region

Limitations:

The data represent a narrow subset of the regional population (97,045 people). Out of over 13,000 ICD-9 diagnosis codes, data analysts considered 26 ACSC codes, defined by the Agency for Healthcare Quality and Research, and 4 SPMI codes that aligned with the Medicaid data. Also, the data only include people who are "self-pay" and who visited the emergency department and received a diagnosis with one of the codes considered above. This means that the priority health indicators from the hospital data, should be viewed as a very small subset, and not generalizable to any population.

MEDICAID DATA

Data sources:

•Health Share of Oregon claims
•FamilyCare claims

Limitations:

The indicators considered are a subset of diagnoses. Data analysts considered the top three chronic conditions diagnosed among adults and children to identify the priority health issues. Medicaid data for Clark County were not accessible for this CHNA. The regional Priority Health Issues model includes Medicaid data for the tri-county Oregon region. The Clark County-specific model does not include any Medicaid data.

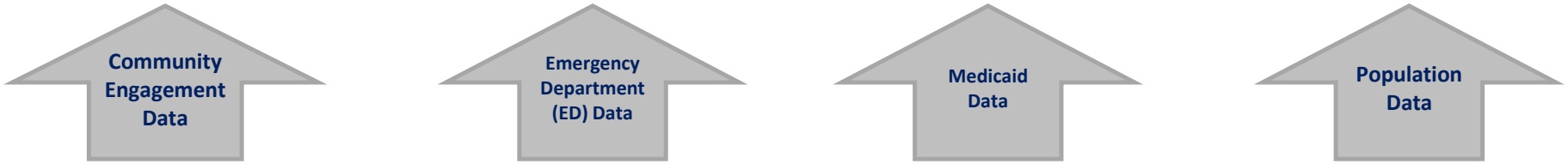
HEALTH BEHAVIORS, MORBIDITY, AND MORTALITY

Data sources:

•Behavioral Risk Factor and Surveillance Survey (BRFSS)
•Oregon Healthy Teen Survey
•National Cancer Institute (NCI)
•Washington Healthy Youth Survey
•Vital statistics

Limitations:

HCWC epidemiologists, with input from content experts, chose which indicators to consider for prioritization. Therefore, the issues that rose to the top are a subset of data that were considered. There are many issues that we do not have adequate data for and could not prioritize. For example, the National Cancer Institute has data on a wide variety of cancers, while the data on oral health are more limited. Similarly, we were able to examine mortality data for *heart disease*, but not morbidity. Much of the morbidity data came from population health surveys, which rely on self report and are subject to recall and other biases.



For full methodology, sources, and limitations, see individual sections (Health Status Assessment, Community Themes and Strengths).

Appendix I: Clark County, Washington Data

Executive summary

The Healthy Columbia Willamette Collaborative (HCWC) is a unique public-private partnership that includes 15 hospitals, four health departments, and two coordinated care organizations (managed Medicaid organizations) in Clackamas, Multnomah, and Washington counties of Oregon, and in Clark County, Washington.

This report documents the community health needs of HCWC's four-county region and each of the counties. The community health needs were identified through a comprehensive study of population, hospital, Medicaid, and community data. This appendix includes data specific to **Clark County, Washington**.

2016 Community Health Needs Assessment Data Sources

Health Status Assessment

7) Population data about health-related behaviors, morbidity, and mortality.

8) Medicaid data from local Coordinated Care Organizations (CCOs) about the most frequent conditions for which individuals on Medicaid sought care in the tri-county region in Oregon (Clark County Medicaid data were not available for this report).

9) Hospital data for uninsured people who were seen in the emergency department with a condition that could have been managed in primary or ambulatory care.

Community Themes and Strengths

7) Online survey about quality of life, issues affecting community health, and risky health behaviors.

8) Listening sessions with diverse communities in the four-county region to identify community members' vision for a healthy community, needs in the community, and existing strengths.

9) An inventory of recent community engagement projects in the four-county region that assess communities' health needs.

Key Findings for Clark County, Washington

Demographics

Approximately 451,000 people lived in Clark County in 2014, having increased 23.2% from 2000 to 2010. Although the racial and ethnic population is predominantly white, non-Hispanic/Latino, the demographics of the county continue to diversify. The foreign-born population in Clark County increased 16.4% from 2005 to 2014, while the Hispanic/Latino population increased 98% from 2000 to 2010.

Social determinants of health and equity

Factors such as income, housing, and education impact communities' health in Clark County. Approximately 9% of individuals were living in poverty in Clark County in 2014, including 11.2% of children 18 years or younger. Over 15% of households received SNAP benefits in the past 12 months. Clark County residents have been affected by increased housing costs, although rates of homelessness are lower than other counties in the region. Nearly 92% percent of adults have at least a high school diploma and 26.9% have at least a four year college degree.

Through listening sessions, an online survey, and an inventory of recent community engagement projects, HCWC identified upstream factors, such as access to food, health care, transportation, and safe, affordable housing, as important needs in Clark County and the region. Community members specified culturally and linguistically appropriate services and support for people with behavioral health challenges as needed improvements to health care and public health systems. Diverse communities advocated for policies, systems, and environments that support healthy behaviors and identified racism, discrimination, and stigma as problems that contribute to poor health in the region.

Health behaviors

Population health data from state surveys and vital statistics show that risky health behaviors, such as binge drinking, cigarette smoking among teens and pregnant women, not eating enough healthy foods, and lack of exercise, are common in Clark County. For teenagers specifically, the assessment identified cigarette smoking, alcohol, and marijuana use as prevalent behaviors. Access to health care and preventive services were identified as priority health issues for Clark County, specifically lack of dental visits for teens, lack of flu shots for adults, lack of pneumonia vaccines for adults 65 and older, and no usual source of health care among adults.

Diagnosed health conditions for low-income residents

Clark County Medicaid data were not available for this report.

Emergency department admissions for uninsured residents

Utilization data from local hospitals were analyzed for Clark County residents who were uninsured or self-pay and were admitted to the Emergency Department for a condition that could have been treated in primary care. The most common conditions for adults were diabetes, hypertension, and kidney/urinary infections. For youth within this population, the top diagnosed conditions were asthma, dehydration, and severe ear, nose, and throat infections.

Morbidity and mortality

Epidemiologists from the four county health departments prioritized 104 health indicators using the following criteria: disparity by race/ethnicity or sex, comparison with the state, trend over time, severity, and magnitude. Data came from a variety of sources, including vital statistics, disease and injury morbidity data, cancer registries, and adult and student surveys. In addition to the health behaviors described above, the following morbidity and mortality indicators rose to the top as priority health issues in Clark County.

*Morbidity (Disease)**

- Asthma
- Cancer, 9 types (see population data section of full report for specific types)
- Chlamydia
- Depression
- Hypertension
- High Cholesterol
- Obesity/overweight

*Mortality (Death)**

- Alcohol-induced
- Alzheimer's disease
- Breast cancer
- Diabetes
- Drug-induced
- Heart disease
- Leukemia and lymphoma
- Non-transport accidents (e.g. poisonings, falls)
- Suicide

*Issues are listed in alphabetical order.

Clark County Demographics

Table I-1 summarizes the population demographics for Clark County.

Table I-1: Population demographics for Clark County

Demographic Indicator	Clark County Estimate	Washington Estimate
Total Population (number of people)	451,008	7,061,530
Gender		
Female (%)	50.3	50.0
Male (%)	49.7	50.0
Age		
Median (years)	37.5	37.5
Under 5 years (%)	6.4	6.3
5 to 19 years (%)	21.2	18.9
20 to 44 years (%)	32.3	34.5
45 to 64 years (%)	26.3	26.3
65 years and older (%)	13.8	14.1
Race/Ethnicity (%)		
White, non-Hispanic/Latino	79.5	70.3
Black or African American, non-Hispanic/Latino	1.6	3.4
Native American/ Alaska Native, non-Hispanic/Latino	0.5	1.1
Asian, non-Hispanic/Latino	3.9	7.8
Native Hawaiian and other Pacific Islander, non-Hispanic/Latino	0.8	0.6
Hispanic/Latino, any race	8.7	12.2
Top 5 languages spoken at home (%)[a]		
English only	85.8	81.2
Spanish or Spanish Creole	5.2	8.4
Russian	2.5	0.9
Vietnamese	0.9	0.9
Other Slavic languages[b]	0.8	0.4
Foreign-born population (%)[c]	10.4	13.4
With any disability (%)[d]	12.4	13.0
No health insurance (%)[e]	8.8	9.2
Unemployment (%)[f]	4.7	4.1
Income		
Median household income (USD)	61,741	61,366
Individuals living in poverty (%)[g]	9.3	13.2
Children under 18 years living in poverty (%)[g]	11.2	17.5
Education (%)[h]		

Demographic Indicator	Clark County Estimate	Washington Estimate
High school graduate or higher	91.6	90.4
Bachelor's degree or higher	26.9	33.1
Total homeless individuals (number of people)[i]	662	19,418
Under 18 years of age	200	n/a
Ages 65 or older	9	n/a
Chronically homeless[j]	81	2,250
Veterans	31	1,293
Change in population (% increase)		
Total population (from 2000-2010)	23.2	14.1
Hispanic/Latino origin, any race (from 2000-2010)	98.0	71.2
Non-Hispanic/Latino origin (from 2000-2010)	19.5	9.5
Foreign-born (from 2005-2014)[c]	16.4	25.9

n/a: data not available; USD: U.S. dollars

Data sources: total population, gender, race/ethnicity, language spoken at home, foreign-born, disability, health insurance, unemployment, income, education, poverty (American Community Survey, 2014 one-year estimates); homeless (Point-in-Time Homeless Count 2015, WA Department of Commerce Annual Point in Time Count 2015); population change (Hispanic/Latino and non-Hispanic/Latino origin: Community Commons using US Census data from 2000 and 2010; Foreign-born (American Community Survey estimates from 2005 and 2014).

Percentages might not total 100% because of rounding. Percentages for race/ethnicity might not total 100% because data are not shown for some categories, such as two or more races or "other" race.

[a]Language spoken at home is among the population ages 5 years and older.

[b]Other Slavic languages include Czech, Slovak, and Ukrainian.

[c]Foreign-born population includes anyone who was not a US citizen or a US national at birth.

[d]Disability includes hearing, cognitive, vision, ambulatory, independent living, and self-care disabilities.

[e]No health insurance includes people reporting no health coverage or those whose only health coverage was Indian Health Service out of the total civilian noninstitutionalized population.

[f]Unemployment is out of the population 16 years of age and older.

[g]Poverty is measured as persons living in households with income below 100% Federal Poverty Level. Poverty in children is out of the total population of children under 18 years of age.

[h]Educational attainment is among the population 25 years of age and older.

[i]Homeless counts include persons within emergency shelter, transitional shelter, safe haven, unstable or doubled-up housing, and unsheltered.

[j]Chronic homelessness is defined as: "Individuals or families who have been homeless for one year or longer or have had four episodes of homelessness within the last three years and the individual or one family member has a disabling condition." (U.S. Department of Housing and Urban Development, *Defining Chronic Homelessness*. 2007; National Alliance to End Homelessness, 2015)

Population Data (Health Behaviors, Morbidity, Mortality)

The tables below present the findings from the *Health Status Assessment – Population Data* section. Refer to this section of the report for a description of methodology, regional findings, and limitations.

Tables I-2, I-3, and *I-4* summarize the top ranked health behaviors, morbidity, and mortality resulting from a systematic analysis and prioritization of available indicators. The top indicators in these three tables reflect the following: a disparity by race/ethnicity, a disparity by gender, a worsening trend, a worse rate at the county level compared to the state, a high proportion of the population affect, and a severe health consequence. Indicators are listed in alphabetical order in each table. Unless otherwise specified, the indicators include data for the entire population.

Table I-2: Top health behaviors in Clark County

Clark County Health Behaviors
Alcohol use in teens[b]
Binge drinking in teens[b] and adults
Current cigarette smoking in teens[b] and pregnant women
Dental visits in teens[b]
Fruit/vegetable consumption in teens[a]
Marijuana use in teens[b]
Physical activity in teens[a,b] and adults
Received flu shot in adults
Received pneumonia vaccination in adults over 65 years
Usual source of health care and could not afford to see a doctor due to cost in adults

[a] 8th graders
[b] 10th graders

Table I-3: Top health conditions (morbidity) in Clark County

Clark County Morbidity
Asthma in adults
Bladder cancer incidence
Chlamydia incidence
Chronic Hepatitis C incidence
Depression in teens[a,b] and adults
Kidney/renal pelvis cancer incidence
Lung, trachea, bronchus cancer incidence
Melanoma (skin) cancer incidence
Obesity/overweight in teens[b] and adults
Preterm births among live births
Thyroid cancer incidence

Mental health indicator includes poor emotional/mental health (teens) and depression (adults).
[a] 8th graders
[b] 10th graders

Table I-4: Top health outcomes (mortality) in Clark County

Clark County Mortality
Alcohol-induced
Alzheimer's disease
Breast cancer among all females
Chronic liver disease and cirrhosis
Diabetes
Drug-induced
Heart disease
Lung, trachea, bronchus cancer
Lymphoid, hematopoietic, related tissue cancer
Non-transport accidents
Suicide

Deaths are categorized according to the underlying (or primary) cause-of-death on the death certificate. In addition to the underlying cause, death certificates list up to twenty contributing causes of death. Drug-induced and alcohol-induced death estimates include underlying and contributing causes of death, independent of intent (natural, homicide, suicide, accidental, or undetermined).
Non-transport accident mortality major category includes deaths due to falls and unintentional poisoning.

Table I-5 summarizes all health behaviors, morbidity, and mortality indicators that were included in the analysis and prioritization described in the methodology section.

Table I-5. Population estimates for all health behavior, morbidity, and mortality indicators for Clark County and Washington

Health Indicator	Clark County Estimate	County Data Year(s)	Washington Estimate	Washington Data Year(s)	Population
Asthma					
Current asthma (%) ★	11.0	2014	9.2	2014	adults
Ever been diagnosed with asthma (%)	18.1	2014	18.4	2014	8th graders
Ever been diagnosed with asthma (%)	21.5	2014	21.5	2014	10th graders
Cancer & Cancer Screening					
All cancer mortality (per 100,000)	173.3	2014	157.1	2014	total
All cancer incidence (per 100,000)	427.4	2008-2012	467.5	2008-2012	total
Bladder cancer incidence (per 100,000) ★	21.3	2008-2012	22.0	2008-2012	total
Breast cancer mortality (per 100,000) ★	20.3	2014	20.5	2014	all females
Breast cancer incidence (per 100,000) ★	127.0	2008-2012	135.0	2008-2012	all females
Colorectal cancer mortality (per 100,000)	12.0	2014	12.0	2014	total
Colorectal cancer incidence (per 100,000) ★	37.0	2008-2012	38.7	2008-2012	total
Received colorectal cancer screening (%)	72.0	2011-2014	70.8	2014	adults 50 years or older
Kidney/renal pelvis cancer incidence (per 100,000) ★	14.0	2008-2012	15.8	2008-2012	total
Leukemia cancer incidence (per 100,000)	10.3	2008-2012	14.5	2008-2012	total
Lung, trachea, bronchus cancer mortality (per 100,000)	45.5	2014	39.1	2014	total
Lung, trachea, bronchus cancer incidence (per 100,000) ★	60.6	2008-2012	61.6	2008-2012	total
Lymphoid, hematopoietic, related tissue cancer mortality (per 100,000) ★	19.3	2014	16.1	2014	total
Non-Hodgkin lymphoma cancer incidence (per 100,000) ★	18.9	2008-2012	21.1	2008-2012	total
Melanoma (skin) cancer incidence (per 100,000) ★	25.8	2008-2012	25.6	2008-2012	total
Ovarian cancer mortality (per 100,000)	8.4	2014	7.8	2014	all females
Ovarian cancer incidence (per 100,000)	11.2	2008-2012	13.1	2008-2012	all females
Pancreatic cancer mortality (per 100,000)	10.7	2014	11.2	2014	total
Pancreatic cancer incidence (per 100,000)	12.1	2008-2012	12.5	2008-2012	total

Health Indicator	Clark County Estimate	County Data Year(s)	Washington Estimate	Washington Data Year(s)	Population
Prostate cancer mortality (per 100,000)	16.5	2014	19.8	2014	all males
Prostate cancer incidence (per 100,000)	97.9	2008-2012	133.9	2008-2012	all males
Thyroid cancer incidence (per 100,000) ★	13.8	2008-2012	13.4	2008-2012	total
Uterine cancer incidence (per 100,000) ★	27.6	2008-2012	25.8	2008-2012	all females
Diabetes					
Diabetes mortality (per 100,000) ★	22.7	2014	21.4	2014	total
Diabetes (%)	9.3	2014	8.3	2014	adults
Exercise, Nutrition, & Weight					
Fruit/vegetable consumption: 5 or more times/day (%) ★	19.4	2013	16.7	2013	adults
Fruit/vegetable consumption: 5 or more times/day (%) ★	23.2	2014	24.5	2014	8th graders
Fruit/vegetable consumption: 5 or more times/day (%)	19.9	2014	21.5	2014	10th graders
Obesity (BMI ≥ 30) (%)	26.9	2014	27.0	2014	adults
Obesity (BMI ≥ 30) (%)	9.6	2014	9.3	2014	8th graders
Obesity (BMI ≥ 30) (%) ★	10.7	2014	11.2	2014	10th graders
Overweight (BMI 25.0 - 29.9) (%) ★	43.2	2014	36.0	2014	adults
Overweight (BMI 25.0 - 29.9) (%)	13.3	2014	13.6	2014	8th graders
Overweight (BMI 25.0 - 29.9) (%)	13.2	2014	13.8	2014	10th graders
Overweight or obese (BMI ≥ 25.0) (%) ★	70.1	2014	62.9	2014	adults
No physical activity outside of work within past month (%)	82.1	2014	82.1	2014	adults
Participated in 150 minutes or more of aerobic physical activity per week (%)	58.4	2013	55.9	2013	adults
Met guidelines for aerobic and muscle strengthening exercises (%)[a]	24.5	2013	22.0	2013	adults
Participated in muscle strengthening exercises more than twice per week (%)	33.0	2013	31.9	2013	adults
Physically active for total of 60+ minutes in past 7 days on all 7 days (%) ★	30.8	2014	31.0	2014	8th graders
Physically active for total of 60+ minutes in past 7 days on all 7 days (%) ★	25.4	2014	23.5	2014	10th graders
Muscle strengthening/toning exercises in past 7 days for minimum of 3 days (%) ★	54.8	2014	55.8	2014	8th graders
Muscle strengthening/toning exercises in past 7 days for minimum of 3 days (%) ★	53.8	2014	52.0	2014	10th graders
Family Planning					

Health Indicator	Clark County Estimate	County Data Year(s)	Washington Estimate	Washington Data Year(s)	Population
Teen pregnancy rate (per 1,000)	11.6	2014	13.3	2014	females ages 15-17
Healthcare Access & Coverage					
Usual source of health care or one or more personal doctors (%) ★	76.9	2014	73.4	2014	adults
With health insurance (%)	93.5	2014	88.7	2014	adults
Could not afford to see doctor at any time in past year because of cost (%)	11.1	2014	12.6	2014	adults
Heart Disease & Stroke					
Heart disease mortality (per 100,000) ★	139.9	2014	138.3	2014	total
Cerebrovascular diseases mortality (per 100,000)	30.5	2014	34.7	2014	total
High blood pressure (%) ★	28.3	2013	29.0	2013	adults
High cholesterol (%) ★	29.2	2013	31.8	2013	adults
Essential hypertension and hypertensive renal disease mortality (per 100,000)	7.2	2014	7.5	2014	total
Major cardiovascular diseases mortality (per 100,000)	182.3	2014	187.9	2014	total
Immunizations & Infectious Diseases					
Influenza/pneumonia mortality (per 100,000)	7.3	2014	9.5	2014	total
Pneumonia mortality (per 100,000)	6.4	2014	8.3	2014	total
Received flu shot in past year (%)	55.5	2014	59.2	2014	adults 65 years or older
Received flu shot in past year (%) ★	39.8	2014	40.4	2014	adults
Ever received pneumonia vaccination (%) ★	75.2	2014	73.4	2014	adults 65 years or older
Chronic Hepatitis C incidence (per 100,000)	128.3	2014	86.1	2014	total
Chlamydia incidence (per 100,000) ★	373.0	2014	390.4	2014	total
Gonorrhea incidence (per 100,000)	51.2	2014	91.4	2014	total
Early syphilis incidence (per 100,000)	6.5	2014	7.7	2014	total
HIV/AIDS, HIV and AIDS incident cases (per 100,000)	5.0	2014	6.5	2014	total
Injury					
Accidents (unintentional injuries) mortality (per 100,000)	50.2	2014	40.5	2014	total
Non-transport accidents mortality (per 100,000)[b] ★	37.5	2014	31.7	2014	total
Maternal, Fetal & Infant Health					

Health Indicator	Clark County Estimate	County Data Year(s)	Washington Estimate	Washington Data Year(s)	Population
Low birth weight, <2500 grams or 5.5 pounds (%)	6.3	2014	6.4	2014	all live births
Early prenatal care, Kotelchuck index of adequate prenatal care (%)	72.0	2014	71.2	2014	all live births
Mothers smoking during pregnancy (%)	15.0	2014	9.6	2014	all live births
Preterm births, < 36 weeks (%)	10.7	2014	9.5	2014	all live births
Mental & Emotional Health					
Suicide mortality (per 100,000) ★	16.7	2014	15.4	2014	total
Any suicide attempt in past 12 months (%)	8.5	2014	8.9	2014	8th graders
Any suicide attempt in past 12 months (%)	10.0	2014	10.2	2014	10th graders
Depression (%) ★	21.7	2014	21.5	2014	adults
Poor emotional/mental health for 14 or more days in a month (%)	14.9	2014	11.0	2014	adults
Poor emotional/mental health (%)	28.9	2014	27.2	2014	8th graders
Poor emotional/mental health (%)	34.0	2014	34.9	2014	10th graders
Miscellaneous					
Nephritis, nephrotic syndrome, and nephrosis mortality (per 100,000)	7.3	2014	6.2	2014	total
Chronic liver disease and cirrhosis mortality (per 100,000) ★	12.4	2014	11.2	2014	total
Older Adults & Aging					
Alzheimer's disease mortality (per 100,000) ★	46.2	2014	44.1	2014	total
Oral Health					
Had dental visit in past year (%)	69.1	2014	66.6	2014	adults
Had any permanent teeth missing due to decay/gum disease (%)	40.1	2014	37.7	2014	adults
Had last visit to dentist within past 12 months (%)	76.7	2014	76.9	2014	8th graders
Had last visit to dentist within past 12 months (%)	76.1	2014	79.1	2014	10th graders
Respiratory Diseases					
Chronic lower respiratory disease mortality (per 100,000)	41.7	2014	38.3	2014	total
Substance Abuse					
Drug-induced mortality (per 100,000) ★	13.7	2014	14.6	2014	total
Alcohol-induced mortality (per 100,000) ★	14.4	2014	12.9	2014	total

Health Indicator	Clark County Estimate	County Data Year(s)	Washington Estimate	Washington Data Year(s)	Population
Binge drinking (%)[c] ★	16.1	2014	17.7	2014	adults
Heavy drinking (%)[d]	6.2	2014	6.7	2014	adults
Any alcohol use(%)[e] ★	9.2	2014	8.1	2014	8th graders
Any alcohol use (%)[e]	20.5	2014	20.6	2014	10th graders
Any binge drinking (%)[c]	5.2	2014	4.5	2014	8th graders
Any binge drinking (%)[c] ★	11.6	2014	10.6	2014	10th graders
Current cigarette smoker (%) ★	17.4	2014	15.6	2014	adults
Current cigarette smoker (%)	4.4	2014	4.0	2014	8th graders
Current cigarette smoker (%)	10.2	2014	7.9	2014	10th graders
Any use of marijuana in past month (%)	8.2	2014	7.3	2014	8th graders
Any use of marijuana in past month (%) ★	19.1	2014	18.1	2014	10th graders
Any use of e-cigarettes/vaping products in past month (%)[f]	10.4	2014	8.5	2014	8th graders
Any use of e-cigarettes/vaping products in past month (%)[f] ★	20.9	2014	18.0	2014	10th graders
Any prescription drug abuse in past 30 days (%)	4.4	2014	4.2	2014	8th graders
Any prescription drug abuse in past 30 days (%)	6.3	2014	7.6	2014	10th graders

★ Indicates top ranking regional indicator (note that multiple physical activity and obese/overweight indicators are presented as one indicator in the top ranking regional tables).

All data are age-adjusted to the 2000 US standard population. Death rates and cancer incidence rates are per 100,000; other incidence rates are per 100,000 of the population at risk. Adult and teen health behavior data are a percent of the population at risk. Teen health behavior data are a percent of student enrollment per grade.

BMI: body mass index

[a]Guidelines for aerobic and muscle strengthening exercise: at least 150 minutes of moderate intensity (or 75 minutes of vigorous-intensity) aerobic physical activity per week and moderate or high intensity muscle strengthening activity 2 or more days per week.

[b]Non-transport accident mortality major category includes deaths due to falls and unintentional poisoning.

[c]Binge drinking for adults: 4 or more drinks on one occasion (females) or 5 or more drinks on one occasion (males). Binge drinking for teens: 5 or more drinks of alcohol in a row during past 30 days.

[d]Heavy drinking for adults: 1 or more drinks per day (females) or 2 or more drinks per day (males).

[e]Alcohol use in teens: at least one drink of alcohol during past 30 days.

[f]E-cigarettes/vaping products include electronic nicotine delivery product, such as an e-cigarette, e-cigar, or e-hookah.

Table I-6 summarizes the leading cancer incidence in Clark County. Note that this incidence data was used in the analysis and prioritization of the morbidity indicators in the tables above.

Table I-6. Leading cancer incidence in Clark County

Type of Cancer	Clark County Incidence Rate
All cancer sites	427.4
Breast (female)	127.0
Prostate (male)	97.9
Lung & bronchus	60.6
Colon & rectum	37.0
Uterus (female)	27.6
Melanoma of the skin	25.8
Bladder	21.3
Non-Hodgkin lymphoma	18.9
Kidney & renal pelvis	14.0
Thyroid	13.8

Source: National Cancer Institute (NCI) State Cancer Profiles, 2008-2012.
All rates are per 100,000 population and are age-adjusted to the 2000 US standard population.

Table I-7 summarizes the mortality rates for the leading types of cancer in Clark County. Note that this mortality data was used in the analysis and prioritization of the mortality indicators in the tables above.

Table I-7. Leading causes of death in Clark County

Clark County Top Leading Causes of Death, 2013	Mortality Rate
Major cardiovascular diseases	186.29
Diseases of heart	137.05
Cerebrovascular diseases	33.02
Essential (primary) hypertension and hypertensive renal disease	9.67
Malignant neoplasms	171.44
Malignant neoplasms of trachea, bronchus and lung	44.33
Malignant neoplasm of breast in females	29.31
Malignant neoplasm of prostate in males	20.62
Malignant neoplasms of lymphoid, hematopoietic and related tissue	17.77
Malignant neoplasms of colon, rectum and anus	10.90
Malignant neoplasm of pancreas	10.29
Alzheimer's disease	44.26
Chronic lower respiratory diseases	37.27
Accidents	36.74
Non-transport accidents[a]	31.31
Diabetes mellitus	24.73
Drug-related[b]	14.29

Clark County Top Leading Causes of Death, 2013	Mortality Rate
Intentional self-harm (suicide)	14.02
Alcohol-related[b]	12.46
Chronic liver disease and cirrhosis	9.11

Data source: National Center for Health Statistics (NCHS) 113 Leading Cause of Death list from the Washington Community Health Assessment Tool (CHAT), Washington State Department of Health.
All rates are per 100,000 population and are age-adjusted to the 2000 US Standard Population.
Malignant neoplasm: a new abnormal growth of tissue, also referred to as a tumor or cancer.
[a]Non-transport accident mortality major category includes deaths due to falls and unintentional poisoning.
[b]Washington state's NCHS 113 Leading Cause of Death list does *not* include the drug- or alcohol-induced death categories; these categories were added to be comparable with Oregon's NCHS 113 list that *does* include the two categories.

Hospital (Emergency Department) Data

The tables below present the findings from the *Health Status Assessment – Hospital Data* section. Refer to this section of the report for a description of methodology, regional findings, and limitations.

Table I-8: List of diagnoses and age-adjusted percentages for uninsured and self-pay admissions to hospital emergency departments in Clark County (adults only)

Clark County: Adults	
Ambulatory Care Sensitive Conditions (ACSC) and Select Mental Illness Diagnoses	**Age-Adjusted %**
Hypertension	17.9%
Diabetes "c"	10.6%
Kidney/urinary infections	6.7%

Only diagnoses greater than 5% are shown.

Table I-9: List of diagnoses and age-adjusted percentages for uninsured and self-pay admissions to hospital emergency departments in Clark County (youth only)

Clark County: Youth	
Ambulatory Care Sensitive Conditions (ACSC) and Select Mental Illness Diagnoses	**Age-Adjusted %**
Severe ear, nose, and throat infections	39.5%
Asthma	13.9%
Dehydration - volume depletion	5.2%

Only diagnoses greater than 5% are shown.

Online Survey Data

The tables below present the findings from the *Community Themes and Strengths Assessment – Online Survey* section. Refer to this section of the report for a description of methodology, regional findings, and limitations.

A total of 259 surveys were submitted that reported a zip code within or overlapping Clark County borders. These 259 surveys represented 8.9% of all surveys from the four-county region. In comparison, Clark County makes up 20.6% of the four-county population.

The demographics of Clark County survey respondents are presented, below, in tables that compare them to the respective demographics of the Clark County population (when available). Percentages were calculated using the number of surveys that reported a meaningful answer to the respective question as the total or denominator; this number is presented as "n" for each demographic indicator. Surveys that did not include an answer to the respective question were omitted from the total count.

Table I-10: Demographics of survey respondents from Clark County

Demographic Indicator	**Population of survey respondents who live in Clark County (n=259)**	**Clark County Population**
Age	n=258	
Under 18	1.9%	25.5%
19-25	7.8%	8.8%
26-39	23.3%	19.2%
40-54	30.6%	20.6%
55-64	28.3%	12.8%
65-79	8.1%	10.8%
80 and older	0.0%	3.0%
Gender	n=253	
Female	77.1%	50.3%
Male	22.5%	49.7%
Other than male or female alone	0.4%	N/A
Sexual Orientation	n=239	
Sexual Minority	8.8%	N/A
Heterosexual	91.2%	N/A
Hispanic Ethnicity	n=252	
Hispanic	13.5%	8.7%
Non-Hispanic	86.5%	91.3%
Race	n=229	
African American/Black	2.2%	2.2%
African	0.0%	
Arab American/Middle Eastern	0.0%	N/A
Asian American/Asian	.4%	4.6%
European American/White/Caucasian	84.3%	87.3%
Native American/American Indian/Alaska Native	1.3%	1.1%
Native Hawaiian or Pacific Islander	N/A	0.8%

Demographic Indicator	Population of survey respondents who live in Clark County (n=259)	Clark County Population
Multiracial	7.4%	4.0%
Other	4.4%	N/A
Location of Childhood	n=252	
Inside U.S.	89.7%	N/A
Outside U.S.	10.3%	N/A
Language	n=255	
English	89.0%	85.8%
Spanish or Spanish/English	8.6%	5.2%
Other than Spanish or English	2.4%	9.0%
Veteran Status	n=255	
Veteran	7.8%	9.8%
Not a veteran	92.2%	90.2%
Disability Status	n=250	
Has a disability	10.0%	12.4%
Does not have disability	90.0%	87.6%
Education Level	n=227	
Less than high school	2.6%	8.5%
High school/GED	9.3%	25.3%
Bachelors degree or higher	85.9%	26.9%
Federal Poverty Level	n=222	
200% or below	20.7%	27.7%
Above 200%	79.3%	72.3%
Type of Health Insurance	n=248	
Uninsured	7.7%	8.8%
Medicaid	3.2%	21%
Medicare	6.5%	15.1%
Medicaid/Medicare	3.2%	N/A
Indian Health Services	0.0%	N/A
VA	2.0%	2.7%
Other public	1.6%	N/A
Private insurance	79.0%	69.2%

Survey question 1: Quality of life (vision)

The first question on the survey asked about respondents' vision of a healthy community. The question read, *"In the following list, what do you think are the five most important characteristics of a 'Healthy Community'? (Those factors that most improve the quality of life in a community")*. There were 21 characteristics from which to choose. The table below presents the response options ordered by the frequency at which they were selected. Because the question asked respondents to select five characteristics, the five most frequently selected responses are shaded in gray. Frequencies were calculated using the total number of selections as the denominator (presented as "n" in the frequency column).

Table I-11: Survey question 1 results for Clark County respondents

Rank based on Frequency	Response Options	Frequency (Proportion of Total Responses) n = 1,378
1	Safe, affordable housing	10.5%
2	Access to physical, mental, and/or oral health care	8.1%
3	Low crime/safe neighborhoods	8.1%
4	Good daycare and preschools	7.9%
5	Good schools	7.7%
6	Access to healthy, affordable food	7.6%
7	Clean environment	6.4%
8	Good jobs to reach a healthy economy	6.2%
9	Healthy behaviors and lifestyles	4.6%
10	Welcoming of diverse communities/people	4.4%
11	Parks and recreation	4.2%
12	Supportive and happy family life	3.6%
13	Safe, nearby transportation	3.6%
14	Good place to raise children	3.4%
15	Participating and giving back to the community	3.2%
16	Religious or spiritual values	2.5%
17	Low level of child abuse	2.1%
18	Good job training opportunities	1.9%
19	Physical accommodations for people with disabilities	1.5%
20	Arts and cultural events	1.3%
21	Low deaths and disease rates	1.2%

The six responses most frequently selected by Clark County respondents were 1) Safe, affordable housing; 2) Access to physical, mental, and/or oral health care; 3) Low crime/safe neighborhoods; 4) Good daycare and preschools; 5) Good schools; and 6) Access to healthy, affordable food. Responses 1-4 and 6 were the top five choices for total four-county respondents, although in a different order. Clark County was the only

population within the regional survey respondents to have "Good daycare and preschools" within the most frequently selected responses.

Survey question 2: Issues affecting community health (needs)

The second question on the survey asked respondents about the biggest health needs in their community. The question read, *"In the following list, what do you think are the five most important 'issues' that need to be addressed to make your community healthy? (Those topics that have the greatest impact on overall community health)."* The table below presents the response options ordered by the frequency at which they were selected. Again, because the question asked respondents to select five topics, the five most frequently selected responses are shaded in gray. Frequencies were calculated using the total number of selections as the denominator (presented as "n" in the frequency column).

Table I-12: Survey question 2 results for Clark County respondents

Rank based on Frequency	**Response Options**	**Frequency (Proportion of Total Responses)** n = 1,220
1	Homeless/lack of safe, affordable housing	13.9%
2	Unemployment/lack of living wage jobs	10.3%
3	Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders)	10.2%
4	Lack access to physical, mental, and/or oral health care	7.5%
5	Hunger/lack of healthy, affordable food	7.3%
6	Being overweight/obesity	5.0%
7	Domestic violence, child abuse/neglect	4.8%
8	Lack access to safe, nearby transportation	4.2%
9	Gang activity/violence	3.9%
10	Lack of needed job skills or training	3.9%
11	Racism/discrimination	3.8%
12	Unsafe streets (limited crosswalks, bike lanes, lighting, etc.)	3.8%
13	Lack of community involvement	3.4%
14	Dirty environment	2.9%
15	Poor schools	2.9%
16	Bullying/verbal abuse	2.9%
17	Lack of safe and accessible parks/recreation	1.6%

18	Lack of good daycare and preschools	1.3%
19	Aging problems (e.g. memory loss, hearing/vision loss)	1.3%
20	Few arts and cultural events	1.2%
21	Lack of physical accommodations for people with disabilities	1.1%
22	Disabilities (physical, mental) and limited mobility	1.1%
23	Firearm-related injuries	1.1%
24	Asthma/respiratory/lung disease	0.6%
25	HIV/AIDS	0.1%

As *Table I-12* shows, the five most frequently selected responses were 1) Homeless/lack of safe, affordable housing; 2) Unemployment/lack of living wage jobs; 3) Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders); 4) Lack access to physical, mental, and/or oral health care; and 5) Hunger/lack of healthy, affordable food. These were the same five most frequently selected community needs as the total four-county respondents.

Survey question 3: Risky behaviors

The third question the survey asked was about behaviors that can endanger health. The question read, *"In the following list, what do you think are the three most important 'risky behaviors' in your community? (Those behaviors that have the greatest impact on overall community health)."* The table below presents the response options ordered by the frequency at which they were selected. Because the question asked respondents to select three behaviors, the three most frequently selected responses are shaded in gray. Frequencies were calculated using the total number of selections as the denominator (presented as "n" in the frequency column).

Table I-13: Survey question 3 results for Clark County respondents

Rank based on Frequency	**Response Options**	**Frequency (Proportion of Total Responses)** n = 750
1	Drug use/abuse	19.6%
2	Alcohol abuse/addiction	14.1%
3	Lack of exercise	9.2%
4	Dropping out of school	9.1%
5	Social isolation/loneliness	9.1%
6	Poor eating habits	9.1%

7	Unsafe driving (e.g. not using seat belts/child safety seats, distracted driving)	8.0%
8	Risky sexual behavior	5.1%
9	Not getting "shots" to prevent disease (immunizations)	4.9%
10	Tobacco use	4.4%
11	Not using birth control	4.3%
12	Self-harm (e.g. cutting, suicide attempts)	3.2%

The three most frequently selected responses were 1) Drug use/abuse; 2) Alcohol abuse/addiction; and 3) Lack of exercise. "Drug use/abuse" and "Alcohol abuse/addiction" were also the top two responses for total regional respondents, while the third most frequently selected response for the region was "Poor eating habits."

Survey question 4

The fourth survey question asked respondents to rate the health of their community. The question read, "*How healthy would you rate your community as a whole?" Table I-14* presents the distribution of responses. Unlike the previous three questions, respondents were directed to only give one response to this question. Therefore, the proportion of responses per rating was calculated using the number of people indicating that response as the denominator, displayed as "n" in the table.

Table I-14: Survey question 4 results for Clark County respondents

Rating	**Proportion of Responses from Clark County Respondents** n = 259	**Proportion of Responses from Entire Survey Population** n = 3,075
Very healthy	0.4%	3.0%
Healthy	31.7%	30.9%
Somewhat unhealthy	60.2%	53.2%
Unhealthy	6.9%	10.3%
Very unhealthy	0.8%	2.6%

This distribution has a higher percentage of "Somewhat unhealthy" ratings, with fewer "Very healthy," "Healthy," "Unhealthy," and "Very unhealthy" ratings, compared to that of total regional respondents.

Clark County Priority Health Issues Model

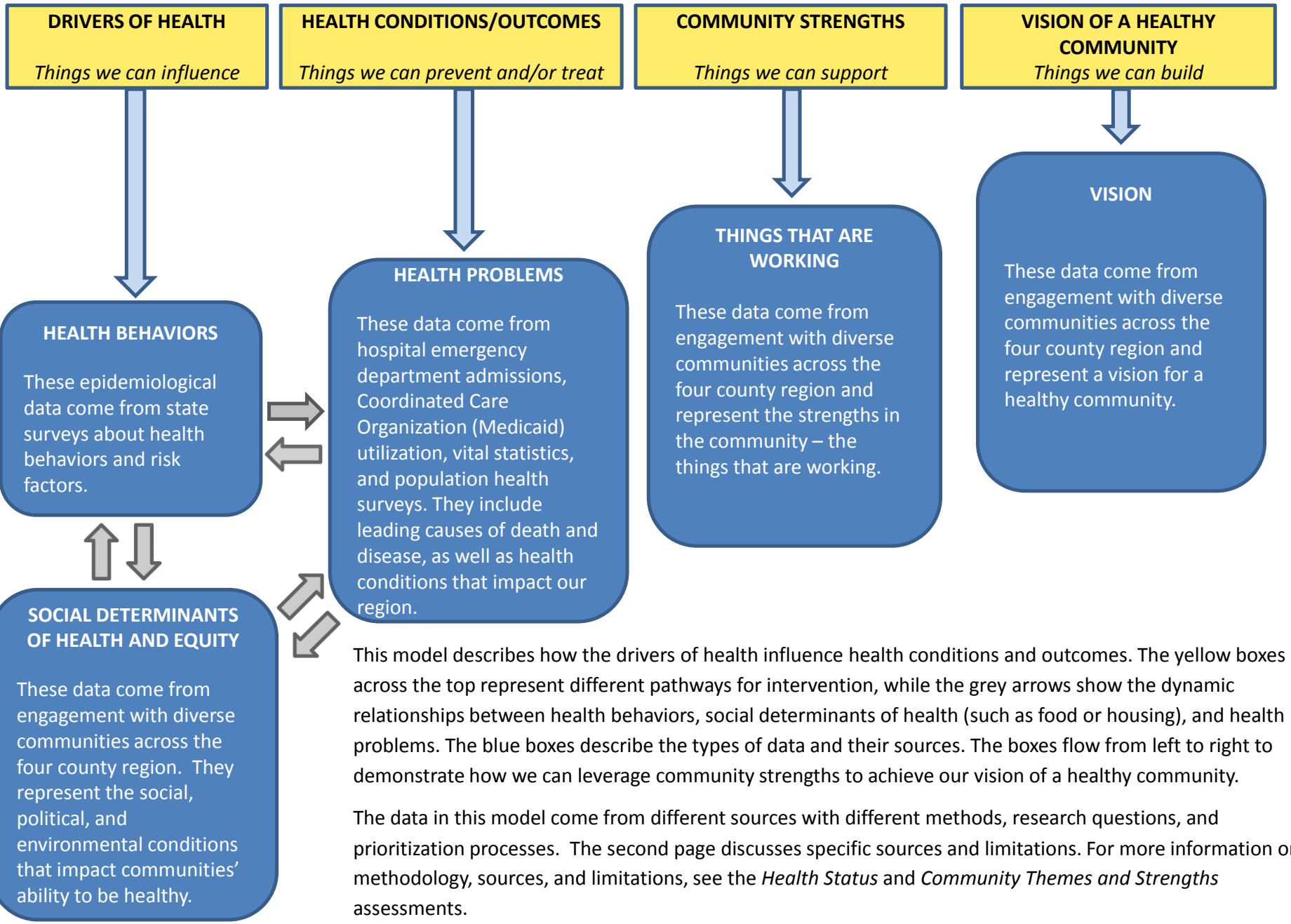
Figure I-1 illustrates the priority health issues in Clark County, as identified in the 2016 CHNA. The data sources include:

- Population data on health behaviors, morbidity, and mortality
- Hospital admissions data for people who were uninsured or self-pay and were diagnosed with select conditions
- Community data from an online survey, listening sessions in all four counties, and a qualitative meta-analysis of community engagement projects from the last 3 years

Each data set has its own specific limitations, which can be found in the *Health Status Assessment* and *Community Themes and Strengths Assessment* sections of this report. The Clark County Priority Health Issues Model does not include Medicaid data.

Figure I-1: Priority Health Issues Model for Clark County

Priority Health Issues for Clark County and What We Can Do



This model describes how the drivers of health influence health conditions and outcomes. The yellow boxes across the top represent different pathways for intervention, while the grey arrows show the dynamic relationships between health behaviors, social determinants of health (such as food or housing), and health problems. The blue boxes describe the types of data and their sources. The boxes flow from left to right to demonstrate how we can leverage community strengths to achieve our vision of a healthy community.

The data in this model come from different sources with different methods, research questions, and prioritization processes. The second page discusses specific sources and limitations. For more information on methodology, sources, and limitations, see the *Health Status* and *Community Themes and Strengths* assessments.

DRIVERS OF HEALTH

Things we can influence

HEALTH CONDITIONS AND OUTCOMES

Things we can prevent and/or treat

SOCIAL DETERMINANTS OF HEALTH AND EQUITY

- Access to food
- Access to health care*
- Access to transportation
- Connected communities
- Culturally and linguistically appropriate services
- Pathways to living wage jobs
- Policies, systems, and environments that support healthy behaviors
- Racism, discrimination, and stigma
- Safe, accessible, and affordable housing
- Support for people with behavioral health challenges

Community Engagement Data

HEALTH BEHAVIORS

- Alcohol use among teens
- Binge drinking
- Cigarette smoking among teens and pregnant women
- Lack of adults 65 and older who have received a pneumonia vaccine
- Lack of adults who have received a flu shot
- Lack of dental visits for teens*
- Lack of fruit and vegetable consumption
- Lack of physical activity
- Marijuana use among teens
- No usual source of health care among adults*

Population Data

DIAGNOSED HEALTH CONDITIONS FOR UNINSURED IN THE EMERGENCY DEPARTMENT

<u>Children</u>

- Asthma*
- Dehydration
- Severe ear, nose, and throat infections

<u>Adults</u>

- Diabetes*
- Hypertension*
- Kidney/urinary infections

Emergency Department (ED) Data

MORBIDITY (DISEASE)

- Asthma*
- Cancer, 4 types♦
- Chlamydia
- Chronic Hepatitis C
- Depression
- Obesity/overweight
- Preterm births

Population Data

MORTALITY (DEATH)

- Alcohol-induced
- Alzheimer's disease
- Breast cancer
- Diabetes*
- Drug-induced
- Heart disease
- Leukemia and Lymphoma
- Liver disease and cirrhosis
- Lung-related cancer
- Non-transport accidents (e.g. poisonings, falls)
- Suicide

Population Data

*Indicator identified in more than one of the assessment components (e.g. population, community engagement, emergency department, or Medicaid data)

♦Refer to section III for specific types of cancer

All indicators are in alphabetical order. For full methodology, sources, and limitations, see individual sections of CHNA report.

COMMUNITY STRENGTHS

Things we can support

STRENGTHS

Culturally specific, community-based services

Feeling connected to a community

Government supported public assistance and social services

Healthy behaviors

Low/no cost programs and services that make health care accessible

Opportunities to be involved in the community

Pathways to living wage jobs

Resilience

Community Engagement Data

VISION OF A HEALTHY COMMUNITY

Things we can build

VISION

For all people:

Affordable, high-quality, culturally responsive health care

Basic needs are met, including food, housing, and transportation

Environments and opportunities that support and encourage community involvement and connection

Equitable and inclusive society, free from racism, discrimination, and stigma

Good schools and equitable access to high quality education

Living wage jobs and pathways to employment

Policies, systems, and environments that support good health and high quality of life

Safe, accessible, and affordable housing

Safe and accessible neighborhoods free of crime

Community Engagement Data

DATA SOURCES AND LIMITATIONS

SOCIAL DETERMINANTS OF HEALTH AND EQUITY, COMMUNITY STRENGTHS, AND VISION

Data sources:

•29 listening sessions with 364 community members across the four county region
•Online survey (paper version optional) with 3,167 responses
•Meta-analysis of 55 community engagement projects conducted in the four county region between 2012-2015

Limitations:

The data from the survey and listening sessions were collected through small convenience samples. HCWC aimed to engage communities across the four county region and prioritize low-income and communities of color. However, the people that participated in the survey and listening sessions do not represent the full range of diverse experiences in the region.

HOSPITAL DATA

Data sources:

•26 Ambulatory Care and Sensitive Condition (ACSC) codes
•4 Severe and Persistent Mental Illness (SPMI) codes
•15 hospitals in the HCWC region

Limitations:

The data represent a narrow subset of the regional population (4.4%). Out of over 13,000 ICD-9 diagnosis codes, data analysts considered 26 ACSC codes, defined by the Agency for Healthcare Quality and Research, and 4 SPMI codes that aligned with the Medicaid data. In addition, the data only included people who were "self-pay" and who visited the emergency department. This means that the priority health indicators from the hospital data should be viewed as a very small subset, and not generalizable to other populations.

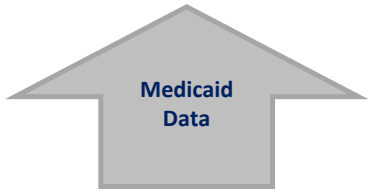
MEDICAID DATA

Data sources:

•2 Coordinated Care Organizations (CCOs) in the Oregon tri-county region
•Health Share of Oregon claims
•FamilyCare claims

Limitations:

The indicators considered are a subset of diagnoses. Data analysts identified three chronic conditions diagnosed separately among adults and children as the priority health issues. Medicaid data for Clark County were not accessible for this CHNA. The regional Priority Health Issues Model includes Medicaid data for the tri-county Oregon region only. The Clark County-specific model does not include any Medicaid data.



HEALTH BEHAVIORS, MORBIDITY, AND MORTALITY

Data sources:

•Behavioral Risk Factor Surveillance System (BRFSS)
•Oregon Healthy Teen Survey
•National Cancer Institute (NCI)
•Washington Healthy Youth Survey
•Vital statistics

Limitations:

HCWC epidemiologists, with input from content experts, developed a list of standard indicators to consider for prioritization. There are many issues that we do not have adequate data for and could not prioritize. For example, the NCI has data on a wide variety of cancers, while the data on oral health are more limited. Similarly, we were able to examine mortality data for heart disease, but not morbidity.

Data from population health surveys rely on self report and are subject to recall and other biases.

For full methodology, sources, and limitations, see individual sections (Health Status Assessment, Community Themes and Strengths).

Appendix J: Multnomah County, Oregon Data

Executive Summary

The Healthy Columbia Willamette Collaborative (HCWC) is a unique public-private partnership that includes 15 hospitals, four health departments, and two coordinated care organizations (managed Medicaid organizations) in Clackamas, Multnomah, and Washington counties of Oregon, and in Clark County, Washington.

This report documents the community health needs of HCWC's four-county region and each of the counties. The community health needs were identified through a comprehensive study of population, hospital, Medicaid, and community data. This appendix includes data specific to **Multnomah County, Oregon**.

2016 Community Health Needs Assessment Data Sources

Health Status Assessment

10) Population data about health-related behaviors, morbidity, and mortality.

11) Medicaid data from local Coordinated Care Organizations (CCOs) about the most frequent conditions for which individuals on Medicaid sought care in the tri-county region in Oregon (Clark County Medicaid data were not available for this report).

12) Hospital data for uninsured people who were seen in the emergency department with a condition that could have been managed in primary or ambulatory care.

Community Themes and Strengths

10) Online survey about quality of life, issues affecting community health, and risky health behaviors.

11) Listening sessions with diverse communities in the four-county region to identify community members' vision for a healthy community, needs in the community, and existing strengths.

12) An inventory of recent community engagement projects in the four-county region that assess communities' health needs.

Key Findings for Multnomah County, Oregon

Demographics

Approximately 777,000 people lived in Multnomah County in 2014, having increased 11.3% from 2000 to 2010. Although the racial and ethnic population is predominantly white, non-Hispanic/Latino, the demographics of the county continue to diversify. The foreign-born population in Multnomah County increased 19.3% from 2005-2014, while the Hispanic/Latino population increased 61.6% from 2000 to 2010.

Social determinants of health and equity

Factors such as income, housing, and education impact communities' health in Multnomah County. Approximately 19% of individuals were living in poverty in Multnomah County in 2014 (the highest rate in the region), including 24.4% of children 18 years or younger. Over 20% of households received SNAP (food assistance) benefits in the past 12 months. Multnomah County residents have been affected by increased housing costs and growing rates of homelessness, which are highest in the four-county region. Ninety one percent of residents have at least a high school diploma and 41.6% have at least a four year college degree.

Through listening sessions, an online survey, and an inventory of recent community engagement projects, HCWC identified upstream factors, such as access to food, health care, transportation, and safe, affordable housing, as important needs in Multnomah County and the region. Community members specified culturally and linguistically appropriate services, and support for people with behavioral health challenges, as needed improvements to health care and public health systems. Communities also advocated for policies, systems, and environments that support healthy behaviors and identified racism, discrimination, and stigma as problems that contribute to poor health in the region.

Health behaviors

Population health data from state surveys show that risky health behaviors, such as binge drinking, cigarette smoking, and not eating enough healthy foods are prevalent in Multnomah County. For teenagers specifically, the assessment identified lack of exercise, alcohol use, and marijuana use as common behaviors. Access to health care was identified as a priority health issue for adults, specifically lack of dental care, lack of access to preventive services (e.g. flu shots or pneumonia vaccines), and lack of a usual source of health care.

Diagnosed health conditions for low-income residents

An analysis of Medicaid claims data from local CCOs in Oregon showed that for youth, asthma, attention deficit disorder, and post-traumatic stress disorder were the most commonly diagnosed chronic conditions. For adults on Medicaid in Oregon, depression, diabetes, and hypertension were the most common diagnoses. People with Medicaid, whose incomes are below 139% of the Federal Poverty Level, make up 26% of the population in Multnomah County, the highest percentage in the region.

Emergency department admissions for uninsured residents

Utilization data from local hospitals were analyzed for people who were uninsured or self-pay and were admitted to the Emergency Department for a condition that could have been treated in primary care. The most common conditions for adults were diabetes, hypertension, skin infections, and kidney/urinary infections. For youth, the top conditions were asthma and severe ear, nose, and throat infections.

Morbidity and mortality

Epidemiologists from the four county health departments prioritized 104 health indicators using the following criteria: disparity by race/ethnicity or sex, comparison with the state, trend over time, severity, and magnitude. Data came from a variety of sources, including vital statistics, disease and injury morbidity data, cancer registries, and adult and student surveys. In addition to the health behaviors described above, the following morbidity and mortality indicators rose to the top as priority health issues in Multnomah County.

*Morbidity (Disease)**

- Cancer, 3 types (see population data section of full report for specific types)
- Chlamydia
- Chronic Hepatitis C
- Depression
- Gonorrhea
- Hypertension
- High Cholesterol
- Obesity/overweight

*Mortality (Death)**

- Alcohol-induced
- Alzheimer's disease
- Breast cancer
- Chronic lower respiratory disease
- Colorectal cancer
- Diabetes
- Drug-induced
- Heart disease
- Lung-related cancer
- Non-transport accidents (e.g. poisonings, falls)
- Suicide

*Issues are listed in alphabetical order.

Multnomah County Demographics

Table J-1 summarizes the population demographics for Multnomah County.

Table J-1: Population demographics for Multnomah County

Demographic Indicator	Multnomah County Estimate	Oregon Estimate
Total Population (number of people)	776,712	3,970,239
Gender		
Female (%)	50.5	50.5
Male (%)	49.5	49.5
Age		
Median (years)	36.8	39.3
Under 5 years (%)	5.9	5.7
5 to 19 years (%)	16.0	18.4
20 to 44 years (%)	40.9	33.5
45 to 64 years (%)	25.2	26.4
65 years and older (%)	11.9	16.0
Race/Ethnicity (%)		
White, non-Hispanic/Latino	71.0	76.9
Black or African American, non-Hispanic/Latino	5.0	1.7
Native American/ Alaska Native, non-Hispanic/Latino	0.6	0.9
Asian, non-Hispanic/Latino	6.7	4.0
Native Hawaiian and other Pacific Islander, non-Hispanic/Latino	0.6	0.3
Hispanic/Latino, any race	11.2	12.5
Top 5 languages spoken at home (%)[a]		
English only	80.0	84.5
Spanish or Spanish Creole	8.3	9.3
Vietnamese	2.0	0.7
Chinese	1.5	0.7
Russian	1.4	0.6
Foreign-born population (%)[b]	14.2	9.9
With any disability (%)[c]	14.2	15.2
No health insurance (%)[d]	9.4	9.7
Unemployment (%)[e]	5.3	4.8
Income		
Median household income (USD)	53,660	51,075
Individuals living in poverty (%)[f]	18.8	16.6
Children under 18 years living in poverty (%)[f]	24.1	21.6
Education (%)[g]		

Demographic Indicator	Multnomah County Estimate	Oregon Estimate
High school graduate or higher	91.1	89.7
Bachelor's degree or higher	41.6	30.8
Total homeless individuals (number of people)[h]	3,801	n/a
Under 18 years of age	374	n/a
Ages 70 years or older	30	n/a
Chronically homeless[i]	1,033	n/a
Veterans	422	n/a
Change in population (% increase)		
Total population (from 2000-2010)	11.3	12.0
Hispanic/Latino origin, any race (from 2000-2010)	61.6	63.5
Non-Hispanic/Latino origin (from 2000-2010)	7.3	7.5
Foreign-born (from 2005-2014)[b]	19.3	14.2

n/a: data not available; USD: U.S. dollars

Data sources: total population, gender, race/ethnicity, language spoken at home, foreign-born, disability, health insurance, unemployment, income, education, poverty (American Community Survey, 2014 one-year estimates); homeless (Point-in-Time Homeless Count 2015); population change (Hispanic/Latino and non-Hispanic/Latino origin: Community Commons using US Census data from 2000 and 2010; Foreign-born: American Community Survey estimates from 2005 and 2014).

Percentages might not total 100% because of rounding. Percentages for race/ethnicity might not total 100% because data are not shown for some categories, such as two or more races or "other" race.

[a]Language spoken at home is among the population ages 5 years and older.

[b]Foreign-born population includes anyone who was not a US citizen or a US national at birth.

[c]Disability includes hearing, cognitive, vision, ambulatory, independent living, and self-care disabilities.

[d]No health insurance includes people reporting no health coverage or those whose only health coverage was Indian Health Service out of the total civilian noninstitutionalized population.

[e]Unemployment is out of the population 16 years of age and older.

[f]Poverty is measured as persons living in households with income below 100% Federal Poverty Level. Poverty in children is out of the total population of children under 18 years of age.

[g]Educational attainment is among the population 25 years of age and older.

[h]Homeless counts include persons within emergency shelter, transitional shelter, safe haven, unstable or doubled-up housing, and unsheltered.

[i]Chronic homelessness is defined as: "Individuals or families who have been homeless for one year or longer or have had four episodes of homelessness within the last three years and the individual or one family member has a disabling condition." (U.S. Department of Housing and Urban Development, *Defining Chronic Homelessness*. 2007; National Alliance to End Homelessness, 2015)

Population Data (Health Behaviors, Morbidity, Mortality)

The tables below present the findings from the *Health Status Assessment – Population Data* section. Refer to this section of the report for a description of methodology, regional findings, and limitations.

Tables J-2, J-3, and *J-4* summarize the top ranked health behaviors, morbidity, and mortality resulting from a systematic analysis and prioritization of available indicators. The top indicators in these three tables reflect the following: a disparity by race/ethnicity, a disparity by gender, a worsening trend, a worse rate at the county level compared to the state, a high proportion of the population affect, and a severe health consequence. Indicators are listed in alphabetical order in each table. Unless otherwise specified, the indicators include data for the entire population.

Table J-2: Top health behaviors in Multnomah County

Multnomah County Health Behaviors
Alcohol use in teens[a]
Binge drinking in teens[a,b] and adults
Current cigarette smoking in teens[a] and adults
Dental visit in adults
Fruit/vegetable consumption in teens[a] and adults
Marijuana use in teens[b]
Physical activity in teens[a,b]
Received flu shot in adults
Received pneumonia vaccination in adults over 65 years
Usual source of health care and could not afford to see a doctor due to cost in adults

[a] 8th graders
[b] 11th graders

Table J-3: Top health conditions (morbidity) in Multnomah County

Multnomah County Morbidity
Breast cancer incidence among all females
Chlamydia incidence
Chronic Hepatitis C incidence
Depression in adults
Gonorrhea incidence
High blood pressure in adults
High cholesterol in adults
Lung, trachea, bronchus cancer incidence
Obesity/overweight in teens[a,b] and adults
Ovarian cancer incidence among all females

[a] 8th graders
[b] 11th graders

Table J-4: Top health outcomes (mortality) in Multnomah County

Multnomah County Mortality
Alcohol-induced
Alzheimer's disease
Breast cancer among all females
Chronic lower respiratory disease
Colorectal cancer
Diabetes
Drug-induced
Heart disease
Lung, trachea, bronchus cancer
Non-transport accidents
Suicide

Deaths are categorized according to the underlying (or primary) cause-of-death on the death certificate. In addition to the underlying cause, death certificates list up to twenty contributing causes of death. Drug-induced and alcohol-induced death estimates include underlying and contributing causes of death, independent of intent (natural, homicide, suicide, accidental, or undetermined).
Non-transport accident mortality major category includes deaths due to falls and unintentional poisoning.

Table J-5 summarizes all health behaviors, morbidity, and mortality indicators that were included in the analysis and prioritization described in the methodology section.

Table J-5. Population estimates for all health behavior, morbidity, and mortality indicators for Multnomah County and Oregon

Health Indicator	Multnomah County Estimate	County Data Year(s)	Oregon Estimate	Oregon Data Year(s)	Population
Asthma					
Current asthma (%) ★	9.8	2010-2013	11.2	2013	adults
Ever been diagnosed with asthma (%)	20.5	2013, 2015	21.9	2015	8th graders
Ever been diagnosed with asthma (%)	22.6	2013, 2015	24.4	2015	11th graders
Cancer & Cancer Screening					
All cancer mortality (per 100,000)	170.5	2013	163.3	2013	total
All cancer incidence (per 100,000)	459.5	2008-2012	447.6	2008-2012	total
Bladder cancer incidence (per 100,000) ★	20.4	2008-2012	21.9	2008-2012	total
Breast cancer mortality (per 100,000) ★	18.5	2013	19.9	2013	all females
Breast cancer incidence (per 100,000) ★	137.8	2008-2012	128.4	2008-2012	all females
Colorectal cancer mortality (per 100,000)	15.0	2013	14.4	2013	total
Colorectal cancer incidence (per 100,000) ★	40.7	2008-2012	38.3	2008-2012	total
Received colorectal cancer screening (%)	65.9	2010-2012	63.2	2012	adults 50 years or older
Kidney/renal pelvis cancer incidence (per 100,000) ★	13.7	2008-2012	14.8	2008-2012	total
Leukemia cancer incidence (per 100,000)	11.2	2008-2012	11.7	2008-2012	total
Lung, trachea, bronchus cancer mortality (per 100,000)	41.6	2013	42.0	2013	total
Lung, trachea, bronchus cancer incidence (per 100,000) ★	65.3	2008-2012	61.0	2008-2012	total
Lymphoid, hematopoietic, related tissue cancer mortality (per 100,000) ★	16.7	2013	17.5	2013	total
Non-Hodgkin lymphoma cancer incidence (per 100,000) ★	18.5	2008-2012	18.7	2008-2012	total
Melanoma (skin) cancer incidence (per 100,000) ★	28.4	2008-2012	26.6	2008-2012	total
Ovarian cancer mortality (per 100,000)	8.5	2013	8.4	2013	all females
Ovarian cancer incidence (per 100,000)	13.2	2008-2012	12.6	2008-2012	all females
Pancreatic cancer mortality (per 100,000)	8.3	2013	9.6	2013	total
Pancreatic cancer incidence (per 100,000)	12.7	2008-2012	11.8	2008-2012	total

Health Indicator	Multnomah County Estimate	County Data Year(s)	Oregon Estimate	Oregon Data Year(s)	Population
Prostate cancer mortality (per 100,000)	26.4	2013	19.4	2013	all males
Prostate cancer incidence (per 100,000)	113.3	2008-2012	122.8	2008-2012	all males
Thyroid cancer incidence (per 100,000) ★	11.1	2008-2012	12.4	2008-2012	total
Uterine cancer incidence (per 100,000) ★	24.7	2008-2012	26.7	2008-2012	all females
Diabetes					
Diabetes mortality (per 100,000) ★	25.5	2013	23.5	2013	total
Diabetes (%)	8.0	2010-2013	8.7	2013	adults
Exercise, Nutrition, & Weight					
Fruit/vegetable consumption: 5 or more times/day (%) ★	22.1	2010, 2011, 2013	22.1	2013	adults
Fruit/vegetable consumption: 5 or more times/day (%) ★	26.6	2013, 2015	23.4	2015	8th graders
Fruit/vegetable consumption: 5 or more times/day (%)	20.5	2013, 2015	19.5	2015	11th graders
Obesity (BMI ≥ 30) (%)	21.1	2010-2013	25.9	2013	adults
Obesity (BMI ≥ 30) (%)	11.1	2013, 2015	11.4	2015	8th graders
Obesity (BMI ≥ 30) (%) ★	12.7	2013, 2015	13.2	2015	11th graders
Overweight (BMI 25.0 - 29.9) (%) ★	32.9	2010-2013	32.6	2013	adults
Overweight (BMI 25.0 - 29.9) (%)	13.4	2013, 2015	15.4	2015	8th graders
Overweight (BMI 25.0 - 29.9) (%)	13.4	2013, 2015	15.4	2015	11th graders
Overweight or obese (BMI ≥ 25.0) (%) ★	54.0	2010-2013	58.6	2013	adults
No physical activity outside of work within past month (%)	15.2	2010-2013	17.5	2013	adults
Participated in 150 minutes or more of aerobic physical activity per week (%)	65.9	2010-2013	65.0	2013	adults
Met guidelines for aerobic and muscle strengthening exercises (%)[a]	30.6	2011, 2013	26.5	2013	adults
Participated in muscle strengthening exercises more than twice per week (%)	38.5	2011, 2013	33.8	2013	adults
Physically active for total of 60+ minutes in past 7 days on all 7 days (%) ★	28.1	2013, 2015	30.7	2015	8th graders
Physically active for total of 60+ minutes in past 7 days on all 7 days (%) ★	20.4	2013, 2015	23.7	2015	11th graders
Muscle strengthening/toning exercises in past 7 days for minimum of 3 days (%) ★	60.6	2013, 2015	61.8	2015	8th graders
Muscle strengthening/toning exercises in past 7 days for minimum of 3 days (%) ★	53.7	2013, 2015	51.6	2015	11th graders
Family Planning					

Health Indicator	Multnomah County Estimate	County Data Year(s)	Oregon Estimate	Oregon Data Year(s)	Population
Teen pregnancy rate (per 1,000)	16.3	2013	14.0	2013	females ages 15-17
Healthcare Access & Coverage					
Usual source of health care or one or more personal doctors (%) ★	74.5	2010-2013	74.4	2013	adults
With health insurance (%)	83.0	2010-2012	80.3	2013	adults
Could not afford to see doctor at any time in past year because of cost (%)	16.7	2010-2013	18.1	2013	adults
Heart Disease & Stroke					
Heart disease mortality (per 100,000) ★	136.9	2013	134.5	2013	total
Cerebrovascular diseases mortality (per 100,000)	38.7	2013	37.2	2013	total
High blood pressure (%) ★	28.0	2010, 2011, 2013	28.7	2013	adults
High cholesterol (%) ★	31.2	2010, 2011, 2013	30.6	2013	adults
Essential hypertension and hypertensive renal disease mortality (per 100,000)	9.7	2013	10.7	2013	total
Major cardiovascular diseases mortality (per 100,000)	192.4	2013	189.7	2013	total
Immunizations & Infectious Diseases					
Influenza/pneumonia mortality (per 100,000)	11.2	2013	10.5	2013	total
Pneumonia mortality (per 100,000)	8.9	2013	9.0	2013	total
Received flu shot in past year (%)	60.9	2010-2013	55.5	2013	adults 65 years or older
Received flu shot in past year (%) ★	37.6	2010-2013	33.8	2013	adults
Ever received pneumonia vaccination (%) ★	77.6	2010-2013	75.5	2013	adults 65 years or older
Chronic Hepatitis C incidence (per 100,000)	150.0	2014	126.4	2014	total
Chlamydia incidence (per 100,000) ★	555.4	2014	410.4	2014	total
Gonorrhea incidence (per 100,000)	112.8	2014	60.9	2014	total
Early syphilis incidence (per 100,000)	26.5	2014	11.1	2014	total
HIV/AIDS, HIV and AIDS incident cases (per 100,000)	14.4	2014	6.2	2014	total
Injury					
Accidents (unintentional injuries) mortality (per 100,000)	42.8	2013	39.6	2013	total
Non-transport accidents mortality (per 100,000)[b] ★	34.0	2013	29.8	2013	total
Maternal, Fetal & Infant Health					

Health Indicator	Multnomah County Estimate	County Data Year(s)	Oregon Estimate	Oregon Data Year(s)	Population
Low birth weight, <2500 grams or 5.5 pounds (%)	6.4	2013	6.3	2013	all live births
Early prenatal care, Kotelchuck index of adequate prenatal care (%)	71.2	2013	72.2	2013	all live births
Mothers smoking during pregnancy (%)	6.3	2013	10.2	2013	all live births
Preterm births, < 36 weeks (%)	7.2	2013	7.6	2013	all live births
Mental & Emotional Health					
Suicide mortality (per 100,000) ★	16.2	2013	16.8	2013	total
Any suicide attempt in past 12 months (%)	7.6	2013, 2015	8.2	2015	8th graders
Any suicide attempt in past 12 months (%)	5.2	2013, 2015	6.2	2015	11th graders
Depression (%) ★	24.9	2011-2013	25.9	2013	adults
Poor emotional/mental health for 14 or more days in a month (%)	12.4	2010-2013	13.0	2013	adults
Poor emotional/mental health (%)	4.2	2013, 2015	5.8	2015	8th graders
Poor emotional/mental health (%)	6.1	2013, 2015	6.5	2015	11th graders
Miscellaneous					
Nephritis, nephrotic syndrome, and nephrosis mortality (per 100,000)	8.7	2013	6.8	2013	total
Chronic liver disease and cirrhosis mortality (per 100,000) ★	9.4	2013	11.7	2013	total
Older Adults & Aging					
Alzheimer's disease mortality (per 100,000) ★	29.5	2013	27.2	2013	total
Oral Health					
Had dental visit in past year (%)	69.1	2010, 2012, 2013	67.8	2013	adults
Had any permanent teeth missing due to decay/gum disease (%)	36.6	2010, 2012, 2013	37.9	2013	Adults
Had last visit to dentist within past 12 months (%)	81.9	2013, 2015	82.2	2015	8th graders
Had last visit to dentist within past 12 months (%)	77.1	2013, 2015	79.9	2015	11th graders
Respiratory Diseases					
Chronic lower respiratory disease mortality (per 100,000)	42.7	2013	42.9	2013	total
Substance Abuse					
Drug-induced mortality (per 100,000) ★	18.3	2013	13.0	2013	total
Alcohol-induced mortality (per 100,000) ★	15.6	2013	15.4	2013	total

Health Indicator	Multnomah County Estimate	County Data Year(s)	Oregon Estimate	Oregon Data Year(s)	Population
Binge drinking (%)[c] ★	20.2	2010-2013	18.2	2013	adults
Heavy drinking (%)[d]	9.6	2010-2013	8.7	2013	adults
Any alcohol use(%)[e] ★	10.8	2013, 2015	11.9	2015	8th graders
Any alcohol use (%)[e]	29.2	2013, 2015	29.1	2015	11th graders
Any binge drinking (%)[c]	4.4	2013, 2015	5.3	2015	8th graders
Any binge drinking (%)[c] ★	16.2	2013, 2015	16.5	2015	11th graders
Current cigarette smoker (%) ★	18.5	2010-2013	16.9	2013	adults
Current cigarette smoker (%)	2.9	2013, 2015	3.9	2015	8th graders
Current cigarette smoker (%)	7.1	2013, 2015	8.3	2015	11th graders
Any use of marijuana in past month (%)	9.7	2013, 2015	8.8	2015	8th graders
Any use of marijuana in past month (%) ★	23.7	2013, 2015	19.1	2015	11th graders
Any use of e-cigarettes/vaping products in past month (%)[f]	4.5	2013, 2015	9.3	2015	8th graders
Any use of e-cigarettes/vaping products in past month (%)[f] ★	9.9	2013, 2015	17.1	2015	11th graders
Any prescription drug abuse in past 30 days (%)	2.5	2013, 2015	4.1	2015	8th graders
Any prescription drug abuse in past 30 days (%)	5.4	2013, 2015	6.5	2015	11th graders

★ Indicates top ranking regional indicator (note that multiple physical activity and obese/overweight indicators are presented as one indicator in the top ranking regional tables).

All data are age-adjusted to the 2000 US standard population. Death rates and cancer incidence rates are per 100,000; other incidence rates are per 100,000 of the population at risk. Adult and teen health behavior data are a percent of the population at risk. Teen health behavior data are a percent of student enrollment per grade.

BMI: body mass index

[a]Guidelines for aerobic and muscle strengthening exercise: at least 150 minutes of moderate intensity (or 75 minutes of vigorous-intensity) aerobic physical activity per week and moderate or high intensity muscle strengthening activity 2 or more days per week.

[b]Non-transport accident mortality major category includes deaths due to falls and unintentional poisoning.

[c]Binge drinking for adults: 4 or more drinks on one occasion (females) or 5 or more drinks on one occasion (males). Binge drinking for teens: 5 or more drinks of alcohol in a row during past 30 days.

[d]Heavy drinking for adults: 1 or more drinks per day (females) or 2 or more drinks per day (males).

[e]Alcohol use in teens: at least one drink of alcohol during past 30 days.

[f]E-cigarettes/vaping products include electronic nicotine delivery product, such as an e-cigarette, e-cigar, or e-hookah.

Table J-6 summarizes the leading cancer incidence in Multnomah County. Note that this incidence data was used in the analysis and prioritization of the morbidity indicators in the tables above.

Table J-6. Leading cancer incidence in Multnomah County

Type of Cancer	Multnomah County Incidence Rate
All cancer sites	459.5
Breast (female)	137.8
Prostate (male)	113.3
Lung & bronchus	65.3
Colon & rectum	40.7
Melanoma of the skin	28.4
Uterus (female)	24.7
Bladder	20.4
Non-Hodgkin lymphoma	18.5
Kidney & renal pelvis	13.7
Ovary (female)	13.2

Source: National Cancer Institute (NCI) State Cancer Profiles, 2008-2012.
All rates are per 100,000 population and are age-adjusted to the 2000 US standard population.

Table J-7 summarizes the mortality rates for the leading types of cancer in Multnomah County. Note that this mortality data was used in the analysis and prioritization of the mortality indicators in the tables above.

Table J-7. Leading causes of death in Multnomah County

Multnomah County Top Leading Causes of Death, 2013	Mortality Rate
Major cardiovascular diseases	192.38
Heart disease	136.95
Cerebrovascular diseases	38.70
Essential hypertension and hypertensive renal disease	9.67
Malignant neoplasms	170.52
Malignant neoplasms of trachea, bronchus and lung	41.61
Malignant neoplasms of prostate in males	26.36
Malignant neoplasms of breast in females	18.49
Malignant neoplasms of lymphoid, hematopoietic and related tissue	16.68
Malignant neoplasms of colon, rectum and anus	15.05
Accidents (unintentional injuries)	42.80
Non-transport accidents[a]	34.02
Chronic lower respiratory diseases	42.71
Alzheimer's disease	29.55
Diabetes mellitus	25.55
Drug-induced[b]	18.26
Intentional self-harm (suicide)	16.24

Multnomah County Top Leading Causes of Death, 2013	Mortality Rate
Alcohol-induced[b]	15.60
Influenza and pneumonia	11.18
Pneumonia	8.89

Data source: National Center for Health Statistics (NCHS) 113 Leading Cause of Death list from the Oregon Public Health Assessment Tool (OPHAT).
All rates are per 100,000 population and are age-adjusted to the 2000 US Standard Population.
Malignant neoplasm: a new abnormal growth of tissue, also referred to as a tumor or cancer.
[a]Non-transport accident mortality major category includes deaths due to falls and unintentional poisoning.
[b]The drug- and alcohol-induced death categories are included within the other NCHS 113 Leading Cause of Death categories and, therefore, are not mutually exclusive categories.

Hospital (Emergency Department) Data

The tables below present the findings from the *Health Status Assessment – Hospital Data* section. Refer to this section of the report for a description of methodology, regional findings, and limitations.

Table J-8: List of diagnoses and age-adjusted percentages for uninsured and self-pay admissions to hospital emergency departments in Multnomah County (adults only)

Multnomah County: Adults	
Ambulatory Care Sensitive Conditions (ACSC) and Select Mental Illness Diagnoses	**Age-Adjusted %**
Hypertension	14.3%
Diabetes "c"	8.9%
Cellulitis	6.5%
Kidney/urinary infections	6.1%

Only diagnoses greater than 5% are shown.

Table J-9: List of diagnoses and age-adjusted percentages for uninsured and self-pay admissions to hospital emergency departments in Multnomah County (youth only)

Multnomah County: Youth	
Ambulatory Care Sensitive Conditions (ACSC) and Select Mental Illness Diagnoses	**Age-Adjusted %**
Severe ear, nose, and throat infections	39.9%
Asthma	15.3%

Only diagnoses greater than 5% are shown.

Online Survey Data

The tables below present the findings from the *Community Themes and Strengths Assessment – Online Survey* section. Refer to this section of the report for a description of methodology, regional findings, and limitations.

A total of 1,782 surveys were submitted that reported a zip code within or overlapping Multnomah County borders. These 1,782 surveys represented 61% of all surveys from the four-county region. In comparison, Multnomah County makes up 35.5% of the four-county population.

The demographics of Multnomah County survey respondents are presented, below, in tables that compare them to the respective demographics of the Multnomah County population (when available). Percentages were calculated using the number of surveys that reported a meaningful answer to the respective question as the total or denominator; this number is presented as "n" for each demographic indicator. Surveys that did not include an answer to the respective question were omitted from the total count.

Table J-10: Demographics of survey respondents from Multnomah County

Demographic Indicator	**Population of survey respondents who live in Multnomah County (n=1,782)**	**Multnomah County Population**
Age	n=1,753	
Under 18	.9%	19.8%
19-25	7.9%	8.6%
26-39	36.2%	27.0%
40-54	29.4%	20.5%
55-64	16.0%	12.3%
65-79	8.8%	9.0%
80 and older	.7%	3.0%
Gender	n=1,709	
Female	66.2%	50.5%
Male	31.9%	49.5%
Other than male or female alone	1.9%	N/A
Sexual Orientation	n=1,626	
Sexual Minority	17.0%	N/A
Heterosexual	83.0%	N/A
Hispanic Ethnicity	n=1,556	
Hispanic	9.6%	11.2%
Non-Hispanic	90.4%	88.8%
Race	n=1,583	
African American/Black	7.6%	5.7%
African	0.3%	
Arab American/Middle Eastern	0.1%	N/A
Asian American/Asian	3.3%	7.2%
European American/White/Caucasian	74.0%	80.5%
Native American/American Indian/Alaska Native	3.0%	1.5%
Native Hawaiian or Pacific Islander	N/A	.6%

Demographic Indicator	Population of survey respondents who live in Multnomah County (n=1,782)	Multnomah County Population
Multiracial	9.7%	4.4%
Other	2.1%	N/A
Location of Childhood	n=1,730	
Inside U.S.	94.9%	N/A
Outside U.S.	5.1%	N/A
Language	n=1,745	
English	94.3%	80.0%
Spanish or Spanish/English	3.0%	8.3%
Other than Spanish or English	2.8%	11.7%
Veteran Status	n=1,721	
Veteran	6.5%	6.2%
Not a veteran	98.8%	93.8%
Disability Status	n=1,699	
Has a disability	22.6%	14.2%
Does not have disability	77.4%	85.8%
Education Level	n=1,573	
Less than high school	3.6%	8.9%
High school/GED	22.0%	18.4%
Bachelors degree or higher	70.6%	41.6%
Federal Poverty Level	n=1,573	
200% or below	35.0%	37.1%
Above 200%	65.0%	62.9%
Type of Health Insurance	n=1,703	
Uninsured	3.0%	9.4%
Medicaid	25.0%	23.3%
Medicare	8.5%	13.5%
Medicaid/Medicare	1.4%	N/A
Indian Health Services	0.9%	N/A
VA	1.1%	1.9%
Other public	0.5%	N/A
Private insurance	59.7%	66.5%

Survey question 1: Quality of life (vision)

The first question on the survey asked about respondents' vision of a healthy community. The question read, *"In the following list, what do you think are the five most important characteristics of a 'Healthy Community'? (Those factors that most improve the quality of life in a community")*. There were 21 characteristics from which to choose. The table below presents the response options ordered by the frequency at which they were selected. Because the question asked respondents to select five characteristics, the five most frequently selected responses are shaded in gray. Frequencies were calculated using the total number of selections as the denominator (presented as "n" in the frequency column).

Table J-11: Survey question 1 results for Multnomah County respondents

Rank based on Frequency	Response Options	Frequency (Proportion of Total Responses) n = 8,675
1	Safe, affordable housing	12.3%
2	Access to physical, mental, and/or oral health care	10.6%
3	Access to healthy, affordable food	9.8%
4	Low crime/safe neighborhoods	8.0%
5	Good schools	7.9%
6	Good jobs to reach a healthy economy	6.7%
7	Clean environment	5.1%
8	Welcoming of diverse communities/people	4.8%
9	Safe, nearby transportation	4.6%
10	Parks and recreation	4.5%
11	Healthy behaviors and lifestyles	4.0%
12	Supportive and happy family life	3.9%
13	Participating and giving back to the community	2.8%
14	Good job training opportunities	2.8%
15	Good place to raise children	2.7%
16	Physical accommodations for people with disabilities	1.9%
17	Religious or spiritual values	1.9%
18	Arts and cultural events	1.6%
19	Low level of child abuse	1.5%
20	Low deaths and disease rates	1.3%
21	Good daycare and preschools	1.3%

The five responses most frequently selected by Multnomah County respondents were 1) Safe, affordable housing; 2) Access to physical, mental, and/or oral health care; 3) Access to healthy, affordable food; 4) Low crime/safe neighborhoods; and 5) Good schools. These were the same top five choices for total regional respondents, although in a different order.

Survey question 2: Issues affecting community health (needs)

The second question on the survey asked respondents about the biggest health needs in their community. The question read, *"In the following list, what do you think are the five most important 'issues' that need to be addressed to make your community healthy? (Those topics that have the greatest impact on overall community health)."* The table below presents the response options ordered by the frequency at which they were selected. Again, because the question asked respondents to select five topics, the five most frequently selected responses are shaded in gray. Frequencies were calculated using the total number of selections as the denominator (presented as "n" in the frequency column).

Table J-12: Survey question 2 results for Multnomah County respondents

Rank based on Frequency	**Response Options**	**Frequency (Proportion of Total Responses)** n = 8,357
1	Homeless/lack of safe, affordable housing	14.1%
2	Unemployment/lack of living wage jobs	11.5%
3	Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders)	9.7%
4	Hunger/lack of healthy, affordable food	7.9%
5	Lack access to physical, mental, and/or oral health care	6.2%
6	Racism/discrimination	5.6%
7	Poor schools	5.3%
8	Gang activity/violence	4.6%
9	Domestic violence, child abuse/neglect	4.4%
10	Unsafe streets (limited crosswalks, bike lanes, lighting, etc.)	3.9%
11	Being overweight/obesity	3.8%
12	Lack of needed job skills or training	3.3%
13	Lack of community involvement	3.0%
14	Dirty environment	2.5%
15	Disabilities (physical, mental) and limited mobility	2.2%
16	Lack access to safe, nearby transportation	2.1%
17	Lack safe and accessible parks/recreation	1.6%
18	Bullying/verbal abuse	1.6%
19	Lack of good daycare and preschools	1.5%

20	Firearm-related injuries	1.3%
21	Aging problems (e.g. memory loss, hearing/vision loss)	1.2%
22	Lack of physical accommodations for people with disabilities	1.2%
23	Few arts and cultural events	0.7%
24	Asthma/respiratory/lung disease	0.5%
25	HIV/AIDS	0.4%

As *Table J-12* shows, the five most frequently selected community needs were 1) Homelessness/lack of safe, affordable housing; 2) Unemployment/lack of living wage jobs; 3) Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders); 4) Hunger/lack of healthy, affordable food; and 5) Lack access to physical, mental, and/or oral health care. These were the same five most frequently selected community needs, and in the same order, as those of total four-county respondents.

Survey question 3: Risky behaviors

The third question the survey asked was about behaviors that can endanger health. The question read, *"In the following list, what do you think are the three most important 'risky behaviors' in your community? (Those behaviors that have the greatest impact on overall community health)."* The table below presents the response options ordered by the frequency at which they were selected. Because the question asked respondents to select three behaviors, the three most frequently selected responses are shaded in gray. Frequencies were calculated using the total number of selections as the denominator (presented as "n" in the frequency column).

Table J-13: Survey question 3 results for Multnomah County respondents

Rank based on Frequency	**Response Options**	**Frequency (Proportion of Total Responses)** n = 5,091
1	Drug use/abuse	19.3%
2	Alcohol abuse/addiction	16.6%
3	Social isolation/loneliness	10.6%
4	Poor eating habits	9.9%
5	Dropping out of school	8.6%
6	Lack of exercise	8.4%
7	Unsafe driving (e.g. not using seat belts/child safety seats, distracted driving)	7.1%

8	Tobacco use	5.6%
9	Risky sexual behavior/unsafe sex	5.0%
10	Not getting “shots” to prevent disease (immunizations)	4.0%
11	Not using birth control	3.0%
12	Self-harm (e.g. cutting, suicide attempts)	1.9%

The three most frequently selected responses were 1) Drug use/abuse; 2) Alcohol abuse/addiction; and 3) Social isolation/loneliness. “Drug use/abuse” and “Alcohol abuse/addiction” were both in the top three choices of total regional respondents. “Social isolation” was not in the top three responses for the regional population; however, it was a top selection for several subpopulations within the regional responses.

Survey question 4

The fourth survey question asked respondents to rate the health of their community. The question read, “*How healthy would you rate your community as a whole?” Table J-14* presents the distribution of responses. Unlike the previous three questions, respondents were directed to only give one response to this question. Therefore, the proportion of responses per rating was calculated using the number of people indicating that response as the denominator, displayed as “n” in the table.

Table J-14: Survey question 4 results for Multnomah County respondents

Rating	**Proportion of Responses from Multnomah County Respondents** n = 1,782	**Proportion of Responses from Entire Survey Population** n = 3,075
Very healthy	2.9%	3.0%
Healthy	30.2%	30.9%
Somewhat unhealthy	51.7%	53.2%
Unhealthy	11.8%	10.3%
Very unhealthy	3.4%	2.6%

This distribution of community health ratings has fewer “Very healthy” and “Healthy” ratings and more “Unhealthy” and “Very unhealthy” ratings than that of total regional respondents.

Multnomah County Priority Health Issues Model

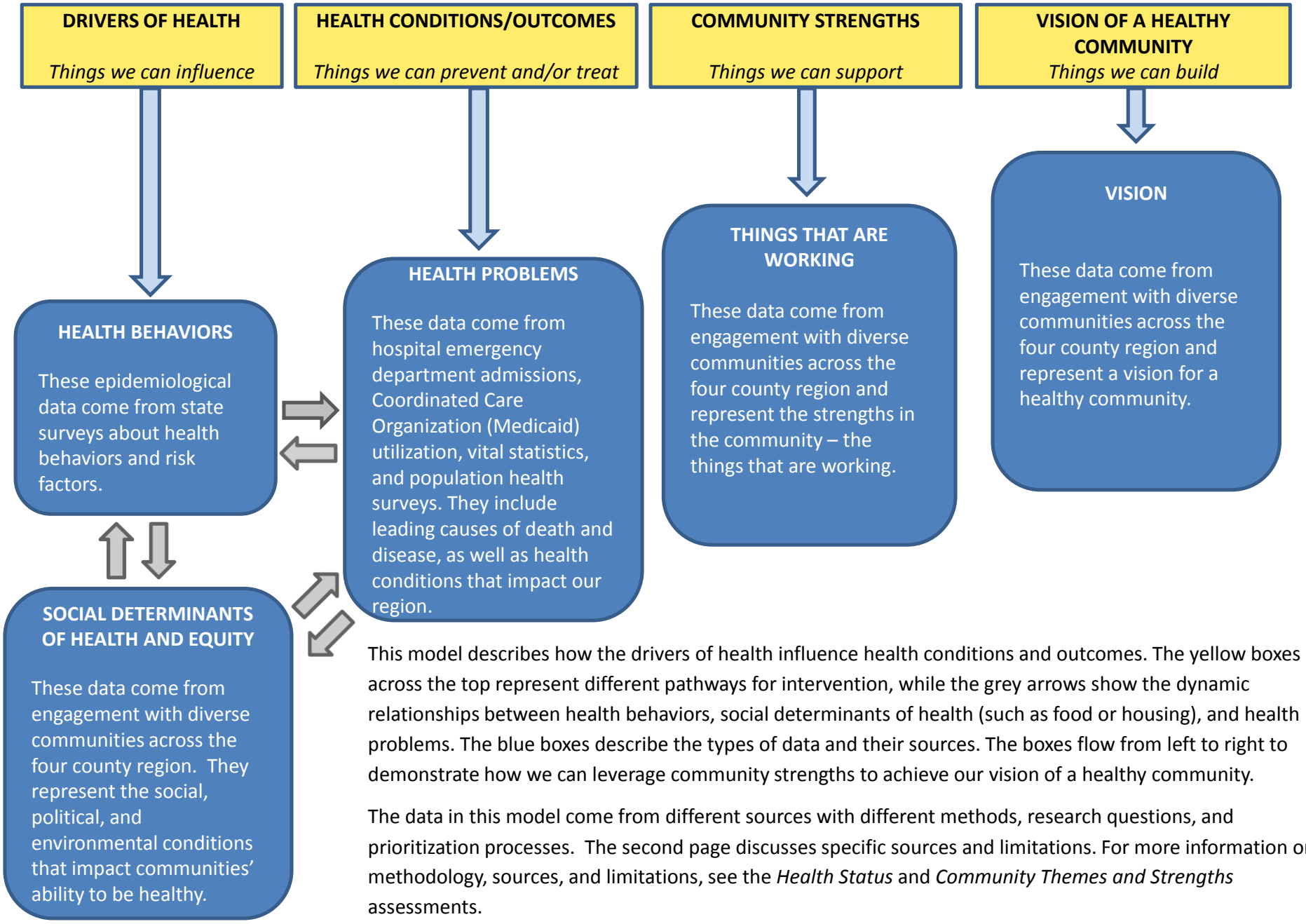
Figure J-1 illustrates the priority health issues in Multnomah County, as identified in the 2016 CHNA. The data sources include:

- Population data on health behaviors, morbidity, and mortality
- Medicaid claims data provided by local CCOs
- Hospital admissions data for people who were uninsured or self-pay and were diagnosed with select conditions
- Community data from an online survey, listening sessions in all four counties, and a qualitative meta-analysis of community engagement projects from the last 3 years

Each data set has its own specific limitations, which can be found in the *Health Status Assessment* and *Community Themes and Strengths Assessment* sections of this report.

Figure J-1: Priority Health Issues Model for Multnomah County

Priority Health Issues for Multnomah County and What We Can Do



This model describes how the drivers of health influence health conditions and outcomes. The yellow boxes across the top represent different pathways for intervention, while the grey arrows show the dynamic relationships between health behaviors, social determinants of health (such as food or housing), and health problems. The blue boxes describe the types of data and their sources. The boxes flow from left to right to demonstrate how we can leverage community strengths to achieve our vision of a healthy community.

The data in this model come from different sources with different methods, research questions, and prioritization processes. The second page discusses specific sources and limitations. For more information on methodology, sources, and limitations, see the *Health Status* and *Community Themes and Strengths* assessments.

DRIVERS OF HEALTH

Things we can influence

HEALTH CONDITIONS AND OUTCOMES

Things we can prevent and/or treat

SOCIAL DETERMINANTS OF HEALTH AND EQUITY

- Access to food
- Access to health care*
- Access to transportation
- Connected communities
- Culturally and linguistically appropriate services
- Pathways to living wage jobs
- Policies, systems, and environments that support healthy behaviors
- Racism, discrimination, and stigma
- Safe, accessible, and affordable housing
- Support for people with behavioral health challenges

Community Engagement Data

HEALTH BEHAVIORS

- Alcohol use among teens
- Binge drinking
- Cigarette smoking
- Lack of dental visits for adults*
- Lack of adults who have received a flu shot
- Lack of fruit and vegetable consumption
- Lack of physical activity among teens
- Lack of adults 65 and older who have received a pneumonia vaccine
- Marijuana use among teens
- No usual source of health care among adults*

Population Data

DIAGNOSED HEALTH CONDITIONS FOR LOW-INCOME AND/OR UNINSURED

<u>Children</u>

- Asthma*
- Attention Deficit Disorder
- Post Traumatic Stress Disorder
- Severe ear, nose, and throat infections - (Uninsured ED only)

<u>Adults</u>

- Depression*
- Diabetes*
- Hypertension*
- Kidney/urinary infections- (Uninsured ED only)
- Skin infections - (Uninsured ED only)

Emergency Department (ED) and Medicaid Data

MORBIDITY (DISEASE)

- Cancer, 3 types♦
- Chlamydia
- Chronic Hepatitis C
- Depression*
- Gonorrhea
- Hypertension*
- High cholesterol
- Obesity/overweight

Population Data

MORTALITY (DEATH)

- Alcohol-induced
- Alzheimer's disease
- Breast cancer
- Chronic lower respiratory disease
- Colorectal cancer
- Diabetes*
- Drug-induced
- Heart disease
- Lung-related cancer
- Non-transport accidents (e.g. poisonings, falls)
- Suicide

Population Data

*Indicator identified in more than one of the assessment components (e.g. population, community engagement, emergency department, or Medicaid data)

♦Refer to population data report for specific types of cancer

All indicators are in alphabetical order. For full methodology, sources, and limitations, see individual sections of CHNA report.

Multnomah County - 2016

COMMUNITY STRENGTHS

Things we can support

STRENGTHS

Culturally specific, community-based services

Feeling connected to a community

Government supported public assistance and social services

Healthy behaviors

Low/no cost programs and services that make health care accessible

Opportunities to be involved in the community

Pathways to living wage jobs

Resilience

Community Engagement Data

VISION OF A HEALTHY COMMUNITY

Things we can build

VISION

For all people:

Affordable, high-quality, culturally responsive health care

Basic needs are met, including food, housing, and transportation

Environments and opportunities that support and encourage community involvement and connection

Equitable and inclusive society, free from racism, discrimination, and stigma

Good schools and equitable access to high quality education

Living wage jobs and pathways to employment

Policies, systems, and environments that support good health and high quality of life

Safe, accessible, and affordable housing

Safe and accessible neighborhoods free of crime

Community Engagement Data

DATA SOURCES AND LIMITATIONS

SOCIAL DETERMINANTS OF HEALTH AND EQUITY, COMMUNITY STRENGTHS, AND VISION

Data sources:

•29 listening sessions with 364 community members across the four county region
•Online survey (paper version optional) with 3,167 responses
•Meta-analysis of 55 community engagement projects conducted in the four county region between 2012-2015

Limitations:

The data from the survey and listening sessions were collected through small convenience samples. HCWC aimed to engage communities across the four county region and prioritize low-income and communities of color. However, the people that participated in the survey and listening sessions do not represent the full range of diverse experiences in the region.

HOSPITAL DATA

Data sources:

•26 Ambulatory Care and Sensitive Condition (ACSC) codes
•4 Severe and Persistent Mental Illness (SPMI) codes
•15 hospitals in the HCWC region

Limitations:

The data represent a narrow subset of the regional population (4.4%). Out of over 13,000 ICD-9 diagnosis codes, data analysts considered 26 ACSC codes, defined by the Agency for Healthcare Quality and Research, and 4 SPMI codes that aligned with the Medicaid data. In addition, the data only included people who were "self-pay" and who visited the emergency department. This means that the priority health indicators from the hospital data should be viewed as a very small subset, and not generalizable to other populations.

MEDICAID DATA

Data sources:

•2 Coordinated Care Organizations (CCOs) in the Oregon tri-county region
•Health Share of Oregon claims
•FamilyCare claims

Limitations:

The indicators considered are a subset of diagnoses. Data analysts identified three chronic conditions diagnosed separately among adults and children as the priority health issues. Medicaid data for Clark County were not accessible for this CHNA. The regional Priority Health Issues Model includes Medicaid data for the tri-county Oregon region only. The Clark County-specific model does not include any Medicaid data.

HEALTH BEHAVIORS, MORBIDITY, AND MORTALITY

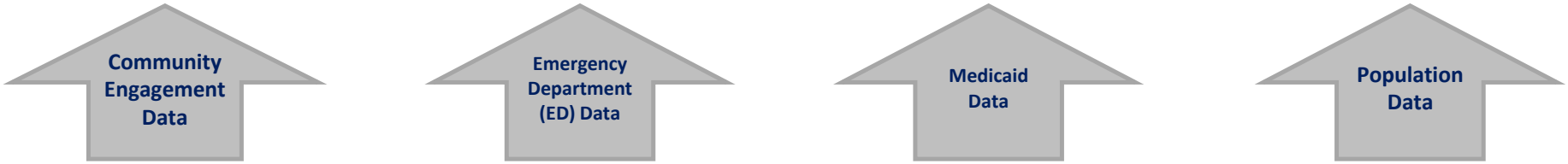
Data sources:

•Behavioral Risk Factor Surveillance System (BRFSS)
•Oregon Healthy Teen Survey
•National Cancer Institute (NCI)
•Washington Healthy Youth Survey
•Vital statistics

Limitations:

HCWC epidemiologists, with input from content experts, developed a list of standard indicators to consider for prioritization. There are many issues that we do not have adequate data for and could not prioritize. For example, the NCI has data on a wide variety of cancers, while the data on oral health are more limited. Similarly, we were able to examine mortality data for heart disease, but not morbidity.

Data from population health surveys rely on self report and are subject to recall and other biases.



For full methodology, sources, and limitations, see individual sections (Health Status Assessment, Community Themes and Strengths).

Appendix E: Washington County, Oregon Data

Executive Summary

The Healthy Columbia Willamette Collaborative (HCWC) is a unique public-private partnership that includes 15 hospitals, four health departments, and two coordinated care organizations (managed Medicaid organizations) in Clackamas, Multnomah, and Washington counties of Oregon, and in Clark County, Washington.

This report documents the community health needs of HCWC's four-county region and each of the counties. The community health needs were identified through a comprehensive study of population, hospital, Medicaid, and community data. This appendix includes data specific to **Washington County, Oregon**.

2016 Community Health Needs Assessment Data Sources

Health Status Assessment

13) Population data about health-related behaviors, morbidity, and mortality.

14) Medicaid data from local Coordinated Care Organizations (CCOs) about the most frequent conditions for which individuals on Medicaid sought care in the tri-county region in Oregon (Clark County Medicaid data were not available for this report).

15) Hospital data for uninsured people who were seen in the emergency department with a condition that could have been managed in primary or ambulatory care.

Community Themes and Strengths

13) Online survey about quality of life, issues affecting community health, and risky health behaviors.

14) Listening sessions with diverse communities in the four-county region to identify community members' vision for a healthy community, needs in the community, and existing strengths.

15) An inventory of recent community engagement projects in the four-county region that assess communities' health needs.

Key Findings for Washington County, Oregon

Demographics

Approximately 563,000 people lived in Washington County in 2014, having increased 18.9% from 2000 to 2010. Although the racial and ethnic population is predominantly white, non-Hispanic/Latino, the demographics of the county continue to diversify. The foreign-born population in Washington County increased 11% from 2005-2014, while the Hispanic/Latino population increased 67.4% from 2000 to 2010.

Social determinants of health and equity

Factors such as income, housing, and education impact communities' health in Washington County. Approximately 13% of individuals were living in poverty in Washington County in 2014, including 17.5% of children (18 years or younger). Over 13% of households received SNAP (food assistance) benefits in the past 12 months. Washington County residents have been affected by increased housing costs, although rates of homelessness are lower than other counties in the region. Ninety percent of adult residents have at least a high school diploma and nearly 40% have at least a four year college degree.

Through listening sessions, an online survey, and an inventory of recent community engagement projects, HCWC identified upstream factors, such as access to food, health care, transportation, and safe, affordable housing, as important needs in Washington County and the region. Community members specified culturally and linguistically appropriate services, and support for people with behavioral health challenges, as needed improvements to health care and public health systems. Communities also advocated for policies, systems, and environments that support healthy behaviors and identified racism, discrimination, and stigma as problems that contribute to poor health in the region.

Health behaviors

Population health data from state surveys show that risky health behaviors, such as binge drinking, lack of exercise among teens, and not eating enough healthy foods, are prevalent in Washington County. For teenagers, the assessment identified alcohol, marijuana, and vaping/e-cigarette use as common behaviors. Access to health care and preventive services were identified as priority health issues for Washington County, including lack of health insurance for adults, lack of dental visits among teens, and lack of early prenatal care.

Diagnosed health conditions for low-income residents

An analysis of Medicaid claims data from local CCOs in Oregon showed that for youth, asthma, attention deficit disorder, and post-traumatic stress disorder were the most commonly diagnosed chronic conditions. For adults on Medicaid in Oregon, depression, diabetes, and hypertension were the most common diagnoses. People with Medicaid, whose incomes are below 139% of the Federal Poverty Level, represent 17.9% of the population in Washington County.

Emergency department admissions for uninsured residents

Utilization data from local hospitals were analyzed for Washington County residents who were uninsured or self-pay and were admitted to the Emergency Department for a condition that could have been treated in primary care. The most common conditions for adults were diabetes, hypertension, kidney/urinary infections, and severe ear, nose, and throat infections. For youth within this population, the top diagnosed conditions were asthma, severe ear, nose, and throat infections, and dehydration.

Morbidity and mortality

Epidemiologists from the four county health departments prioritized 104 health indicators using the following criteria: disparity by race/ethnicity or sex, comparison with the state, trend over time, severity, and magnitude. Data came from a variety of sources, including vital statistics, disease and injury morbidity data, cancer registries, and adult and student surveys. In addition to the health behaviors described above, the following morbidity and mortality indicators rose to the top as priority health issues in Washington County.

*Morbidity (Disease)**

- Asthma
- Cancer, 8 types (see population data section of full report for specific types)
- Chlamydia
- Depression
- Obesity/overweight

*Mortality (Death)**

- Alcohol-induced
- Breast cancer
- Chronic lower respiratory disease
- Diabetes
- Drug-induced
- Heart disease
- Leukemia and lymphoma
- Ovarian cancer
- Prostate cancer
- Suicide

*Issues are listed in alphabetical order.

Washington County Demographics

Table K-1 summarizes the population demographics for Washington County.

Table K-1: Population demographics for Washington County

Demographic Indicator	Washington County Estimate	Oregon Estimate
Total Population (number of people)	562,998	3,970,239
Gender		
Female (%)	50.8	50.5
Male (%)	49.2	49.5
Age		
Median (years)	36.3	39.3
Under 5 years (%)	6.6	5.7
5 to 19 years (%)	19.9	18.4
20 to 44 years (%)	36.3	33.5
45 to 64 years (%)	25.2	26.4
65 years and older (%)	11.9	16.0
Race/Ethnicity (%)		
White, non-Hispanic/Latino	67.7	76.9
Black or African American, non-Hispanic/Latino	1.8	1.7
Native American/ Alaska Native, non-Hispanic/Latino	0.4	0.9
Asian, non-Hispanic/Latino	9.4	4.0
Native Hawaiian and other Pacific Islander, non-Hispanic/Latino	0.3	0.3
Hispanic/Latino, any race	16.3	12.5
Top 5 languages spoken at home (%)[a]		
English only	76.6	84.5
Spanish or Spanish Creole	12.5	9.3
Chinese	1.3	0.7
Vietnamese	1.2	0.7
Korean	1.0	0.3
Foreign-born population (%)[b]	16.5	9.9
With any disability (%)[c]	10.3	15.2
No health insurance (%)[d]	10.0	9.7
Unemployment (%)[e]	4.6	4.8
Income		
Median household income (USD)	66,136	51,075
Individuals living in poverty (%)[f]	12.8	16.6
Children under 18 years living in poverty (%)[f]	17.5	21.6
Education (%)[g]		

Demographic Indicator	Washington County Estimate	Oregon Estimate
High school graduate or higher	90.2	89.7
Bachelor's degree or higher	39.7	30.8
Total homeless individuals (number of people)[h]	591	n/a
Under 18 years of age	132	n/a
Ages 65 or older	n/a	n/a
Chronically homeless[i]	120	n/a
Veterans	77	n/a
Change in population (% increase)		
Total population (from 2000-2010)	18.9	12.0
Hispanic/Latino origin, any race (from 2000-2010)	67.4	63.5
Non-Hispanic/Latino origin (from 2000-2010)	12.9	7.5
Foreign-born (from 2005-2014)[b]	11.0	14.2

n/a: data not available; USD: U.S. dollars

Data sources: total population, gender, race/ethnicity, language spoken at home, foreign-born, disability, health insurance, unemployment, income, education, poverty (American Community Survey, 2014 one-year estimates); homeless (Point-in-Time Homeless Count 2015); population change (Hispanic/Latino and non-Hispanic/Latino origin: Community Commons using US Census data from 2000 and 2010; Foreign-born: American Community Survey estimates from 2005 and 2014).

Percentages might not total 100% because of rounding. Percentages for race/ethnicity might not total 100% because data are not shown for some categories, such as two or more races or "other" race.

[a]Language spoken at home is among the population ages 5 years and older.

[b]Foreign-born population includes anyone who was not a US citizen or a US national at birth.

[c]Disability includes hearing, cognitive, vision, ambulatory, independent living, and self-care disabilities.

[d]No health insurance includes people reporting no health coverage or those whose only health coverage was Indian Health Service out of the total civilian noninstitutionalized population.

[e]Unemployment is out of the population 16 years of age and older.

[f]Poverty is measured as persons living in households with income below 100% Federal Poverty Level. Poverty in children is out of the total population of children under 18 years of age.

[g]Educational attainment is among the population 25 years of age and older.

[h]Homeless counts include persons within emergency shelter, transitional shelter, safe haven, unstable or doubled-up housing, and unsheltered.

[i]Chronic homelessness is defined as: "Individuals or families who have been homeless for one year or longer or have had four episodes of homelessness within the last three years and the individual or one family member has a disabling condition." (U.S. Department of Housing and Urban Development, *Defining Chronic Homelessness*. 2007; National Alliance to End Homelessness, 2015)

Population Data (Health Behaviors, Morbidity, Mortality)

The tables below present the findings from the *Health Status Assessment – Population Data* section. Refer to this section of the report for a description of methodology, regional findings, and limitations.

Tables K-2, *K-3*, and *K-4* summarize the top ranked health behaviors, morbidity, and mortality resulting from a systematic analysis and prioritization of available indicators. The top indicators in these three tables reflect the following: a disparity by race/ethnicity, a disparity by gender, a worsening trend, a worse rate at the county level compared to the state, a high proportion of the population affect, and a severe health consequence. Indicators are listed in alphabetical order in each table. Unless otherwise specified, the indicators include data for the entire population.

Table K-2: Top health behaviors in Washington County

Washington County Health Behaviors
Alcohol use in teens[a]
Binge drinking in teens[b] and adults
Dental visit in teens[a]
Early prenatal care among mothers delivering a live birth
E-cigarettes/vaping products use in teens[b]
Fruit/vegetable consumption in teens [a] and adults
Marijuana use in teens[b]
Physical activity in teens[a,b]
Received flu shot in adults
Usual source of health care and health insurance in adults

[a] 8th graders
[b] 11th graders

Table K-3: Top health conditions (morbidity) in Washington County

Washington County Morbidity
Asthma in teens[a] and adults
Bladder cancer incidence
Breast cancer incidence among all females
Chlamydia incidence
Depression in adults
Kidney/renal pelvis cancer incidence
Leukemia cancer incidence
Non-Hodgkin lymphoma cancer incidence
Obesity/overweight in teens[b] and adults
Prostate cancer incidence among all males
Thyroid cancer incidence
Uterine cancer incidence among all females

[a] 8th graders
[b] 11th graders

Table K-4: Top health outcomes (mortality) in Washington County

Washington County Mortality
Alcohol-induced
Breast cancer among all females
Chronic lower respiratory disease
Diabetes
Drug-induced
Heart disease
Lymphoid, hematopoietic, related tissue cancer
Ovarian cancer among all females
Prostate cancer among all males
Suicide

Deaths are categorized according to the underlying (or primary) cause-of-death on the death certificate.
In addition to the underlying cause, death certificates list up to twenty contributing causes of death.
Drug-induced and alcohol-induced death estimates include underlying and contributing causes of death, independent of intent (natural, homicide, suicide, accidental, or undetermined).
Non-transport accident mortality major category includes deaths due to falls and unintentional poisoning.

Table K-5 summarizes all health behaviors, morbidity, and mortality indicators that were included in the analysis and prioritization described in the methodology section.

Table K-5. Population estimates for all health behavior, morbidity, and mortality indicators for Washington County and Oregon

Health Indicator	Washington County Estimate	County Data Year(s)	Oregon Estimate	Oregon Data Year(s)	Population
Asthma					
Current asthma (%) ★	10.0	2010-2013	11.2	2013	adults
Ever been diagnosed with asthma (%)	22.8	2013, 2015	21.9	2015	8th graders
Ever been diagnosed with asthma (%)	24.0	2013, 2015	24.4	2015	11th graders
Cancer & Cancer Screening					
All cancer mortality (per 100,000)	144.5	2013	163.3	2013	total
All cancer incidence (per 100,000)	429.2	2008-2012	447.6	2008-2012	total
Bladder cancer incidence (per 100,000) ★	19.9	2008-2012	21.9	2008-2012	total
Breast cancer mortality (per 100,000) ★	20.1	2013	19.9	2013	all females
Breast cancer incidence (per 100,000) ★	134.0	2008-2012	128.4	2008-2012	all females
Colorectal cancer mortality (per 100,000)	11.3	2013	14.4	2013	total
Colorectal cancer incidence (per 100,000) ★	35.2	2008-2012	38.3	2008-2012	total
Received colorectal cancer screening (%)	67.6	2010-2012	63.2	2012	adults 50 years or older
Kidney/renal pelvis cancer incidence (per 100,000) ★	14.9	2008-2012	14.8	2008-2012	total
Leukemia cancer incidence (per 100,000)	11.5	2008-2012	11.7	2008-2012	total
Lung, trachea, bronchus cancer mortality (per 100,000)	34.1	2013	42.0	2013	total
Lung, trachea, bronchus cancer incidence (per 100,000) ★	49.7	2008-2012	61.0	2008-2012	total
Lymphoid, hematopoietic, related tissue cancer mortality (per 100,000) ★	18.0	2013	17.5	2013	total
Non-Hodgkin lymphoma cancer incidence (per 100,000) ★	19.2	2008-2012	18.7	2008-2012	total
Melanoma (skin) cancer incidence (per 100,000) ★	27.7	2008-2012	26.6	2008-2012	total
Ovarian cancer mortality (per 100,000)	9.2	2013	8.4	2013	all females
Ovarian cancer incidence (per 100,000)	12.5	2008-2012	12.6	2008-2012	all females
Pancreatic cancer mortality (per 100,000)	7.5	2013	9.6	2013	total

Health Indicator	Washington County Estimate	County Data Year(s)	Oregon Estimate	Oregon Data Year(s)	Population
Pancreatic cancer incidence (per 100,000)	11.0	2008-2012	11.8	2008-2012	total
Prostate cancer mortality (per 100,000)	16.7	2013	19.4	2013	all males
Prostate cancer incidence (per 100,000)	114.4	2008-2012	122.8	2008-2012	all males
Thyroid cancer incidence (per 100,000) ★	13.6	2008-2012	12.4	2008-2012	total
Uterine cancer incidence (per 100,000) ★	28.8	2008-2012	26.7	2008-2012	all females
Diabetes					
Diabetes mortality (per 100,000) ★	20.0	2013	23.5	2013	total
Diabetes (%)	8.5	2010-2013	8.7	2013	adults
Exercise, Nutrition, & Weight					
Fruit/vegetable consumption: 5 or more times/day (%) ★	22.7	2010, 2011, 2013	22.1	2013	adults
Fruit/vegetable consumption: 5 or more times/day (%) ★	22.4	2013, 2015	23.4	2015	8th graders
Fruit/vegetable consumption: 5 or more times/day (%)	20.1	2013, 2015	19.5	2015	11th graders
Obesity (BMI ≥ 30) (%)	22.9	2010-2013	25.9	2013	adults
Obesity (BMI ≥ 30) (%)	9.2	2013, 2015	11.4	2015	8th graders
Obesity (BMI ≥ 30) (%) ★	10.8	2013, 2015	13.2	2015	11th graders
Overweight (BMI 25.0 - 29.9) (%) ★	34.7	2010-2013	32.6	2013	adults
Overweight (BMI 25.0 - 29.9) (%)	13.5	2013, 2015	15.4	2015	8th graders
Overweight (BMI 25.0 - 29.9) (%)	14.3	2013, 2015	15.4	2015	11th graders
Overweight or obese (BMI ≥ 25.0) (%) ★	57.6	2010-2013	58.6	2013	adults
No physical activity outside of work within past month (%)	17.0	2010-2013	17.5	2013	adults
Participated in 150 minutes or more of aerobic physical activity per week (%)	62.5	2010-2013	65.0	2013	adults
Met guidelines for aerobic and muscle strengthening exercises (%)[a]	26.1	2011, 2013	26.5	2013	adults
Participated in muscle strengthening exercises more than twice per week (%)	35.0	2011, 2013	33.8	2013	adults
Physically active for total of 60+ minutes in past 7 days on all 7 days (%) ★	29.9	2013, 2015	30.7	2015	8th graders
Physically active for total of 60+ minutes in past 7 days on all 7 days (%) ★	21.6	2013, 2015	23.7	2015	11th graders
Muscle strengthening/toning exercises in past 7 days for minimum of 3 days (%) ★	63.8	2013, 2015	61.8	2015	8th graders

Health Indicator	Washington County Estimate	County Data Year(s)	Oregon Estimate	Oregon Data Year(s)	Population
Muscle strengthening/toning exercises in past 7 days for minimum of 3 days (%) ★	53.4	2013, 2015	51.6	2015	11th graders
Family Planning					
Teen pregnancy rate (per 1,000)	10.4	2013	14.0	2013	females ages 15-17
Healthcare Access & Coverage					
Usual source of health care or one or more personal doctors (%) ★	78.1	2010-2013	74.4	2013	adults
With health insurance (%)	83.7	2010-2012	80.3	2013	adults
Could not afford to see doctor at any time in past year because of cost (%)	14.6	2010-2013	18.1	2013	adults
Heart Disease & Stroke					
Heart disease mortality (per 100,000) ★	115.1	2013	134.5	2013	total
Cerebrovascular diseases mortality (per 100,000)	33.7	2013	37.2	2013	total
High blood pressure (%) ★	27.5	2010, 2011, 2013	28.7	2013	adults
High cholesterol (%) ★	30.9	2010, 2011, 2013	30.6	2013	adults
Essential hypertension and hypertensive renal disease mortality (per 100,000)	7.9	2013	10.7	2013	total
Major cardiovascular diseases mortality (per 100,000)	162.3	2013	189.7	2013	total
Immunizations & Infectious Diseases					
Influenza/pneumonia mortality (per 100,000)	9.5	2013	10.5	2013	total
Pneumonia mortality (per 100,000)	8.5	2013	9.0	2013	total
Received flu shot in past year (%)	60.5	2010-2013	55.5	2013	adults 65 years or older
Received flu shot in past year (%) ★	34.9	2010-2013	33.8	2013	adults
Ever received pneumonia vaccination (%) ★	81.5	2010-2013	75.5	2013	adults 65 years or older
Chronic Hepatitis C incidence (per 100,000)	90.5	2014	126.4	2014	total
Chlamydia incidence (per 100,000) ★	364.9	2014	410.4	2014	total
Gonorrhea incidence (per 100,000)	34.7	2014	60.9	2014	total
Early syphilis incidence (per 100,000)	9.6	2014	11.1	2014	total
HIV/AIDS, HIV and AIDS incident cases (per 100,000)	5.4	2014	6.2	2014	total

Health Indicator	Washington County Estimate	County Data Year(s)	Oregon Estimate	Oregon Data Year(s)	Population
Injury					
Accidents (unintentional injuries) mortality (per 100,000)	28.2	2013	39.6	2013	total
Non-transport accidents mortality (per 100,000)[b] ★	23.5	2013	29.8	2013	total
Maternal, Fetal & Infant Health					
Low birth weight, <2500 grams or 5.5 pounds (%)	5.8	2013	6.3	2013	all live births
Early prenatal care, Kotelchuck index of adequate prenatal care (%)	66.0	2013	72.2	2013	all live births
Mothers smoking during pregnancy (%)	4.3	2013	10.2	2013	all live births
Preterm births, < 36 weeks (%)	7.0	2013	7.6	2013	all live births
Mental & Emotional Health					
Suicide mortality (per 100,000) ★	12.5	2013	16.8	2013	total
Any suicide attempt in past 12 months (%)	7.2	2013, 2015	8.2	2015	8th graders
Any suicide attempt in past 12 months (%)	5.9	2013, 2015	6.2	2015	11th graders
Depression (%) ★	22.2	2011-2013	25.9	2013	adults
Poor emotional/mental health for 14 or more days in a month (%)	9.9	2010-2013	13.0	2013	adults
Poor emotional/mental health (%)	4.6	2013, 2015	5.8	2015	8th graders
Poor emotional/mental health (%)	5.3	2013, 2015	6.5	2015	11th graders
Miscellaneous					
Nephritis, nephrotic syndrome, and nephrosis mortality (per 100,000)	4.8	2013	6.8	2013	total
Chronic liver disease and cirrhosis mortality (per 100,000) ★	8.4	2013	11.7	2013	total
Older Adults & Aging					
Alzheimer's disease mortality (per 100,000) ★	27.7	2013	27.2	2013	total
Oral Health					
Had dental visit in past year (%)	71.4	2010, 2012, 2013	67.8	2013	adults
Had any permanent teeth missing due to decay/gum disease (%)	33.6	2010, 2012, 2013	37.9	2013	Adults
Had last visit to dentist within past 12 months (%)	85.8	2013, 2015	82.2	2015	8th graders
Had last visit to dentist within past 12 months (%)	82.6	2013, 2015	79.9	2015	11th graders
Respiratory Diseases					

Health Indicator	Washington County Estimate	County Data Year(s)	Oregon Estimate	Oregon Data Year(s)	Population
Chronic lower respiratory disease mortality (per 100,000)	24.6	2013	42.9	2013	total
Substance Abuse					
Drug-induced mortality (per 100,000) ★	9.5	2013	13.0	2013	total
Alcohol-induced mortality (per 100,000) ★	9.2	2013	15.4	2013	total
Binge drinking (%)[c] ★	14.9	2010-2013	18.2	2013	adults
Heavy drinking (%)[d]	7.3	2010-2013	8.7	2013	adults
Any alcohol use(%)[e] ★	10.5	2013, 2015	11.9	2015	8th graders
Any alcohol use (%)[e]	27.5	2013, 2015	29.1	2015	11th graders
Any binge drinking (%)[c]	3.9	2013, 2015	5.3	2015	8th graders
Any binge drinking (%)[c] ★	14.2	2013, 2015	16.5	2015	11th graders
Current cigarette smoker (%) ★	13.9	2010-2013	16.9	2013	adults
Current cigarette smoker (%)	2.9	2013, 2015	3.9	2015	8th graders
Current cigarette smoker (%)	7.1	2013, 2015	8.3	2015	11th graders
Any use of marijuana in past month (%)	6.7	2013, 2015	8.8	2015	8th graders
Any use of marijuana in past month (%) ★	18.1	2013, 2015	19.1	2015	11th graders
Any use of e-cigarettes/vaping products in past month (%)[f]	4.9	2013, 2015	9.3	2015	8th graders
Any use of e-cigarettes/vaping products in past month (%)[f] ★	10.4	2013, 2015	17.1	2015	11th graders
Any prescription drug abuse in past 30 days (%)	3.1	2013, 2015	4.1	2015	8th graders
Any prescription drug abuse in past 30 days (%)	6.3	2013, 2015	6.5	2015	11th graders

★ Indicates top ranking regional indicator (note that multiple physical activity and obese/overweight indicators are presented as one indicator in the top ranking regional tables).

All data are age-adjusted to the 2000 US standard population. Death rates and cancer incidence rates are per 100,000; other incidence rates are per 100,000 of the population at risk. Adult and teen health behavior data are a percent of the population at risk. Teen health behavior data are a percent of student enrollment per grade.

BMI: body mass index

[a]Guidelines for aerobic and muscle strengthening exercise: at least 150 minutes of moderate intensity (or 75 minutes of vigorous-intensity) aerobic physical activity per week and moderate or high intensity muscle strengthening activity 2 or more days per week.

[b]Non-transport accident mortality major category includes deaths due to falls and unintentional poisoning.

[c]Binge drinking for adults: 4 or more drinks on one occasion (females) or 5 or more drinks on one occasion (males). Binge drinking for teens: 5 or more drinks of alcohol in a row during past 30 days.

[d]Heavy drinking for adults: 1 or more drinks per day (females) or 2 or more drinks per day (males).
[e]Alcohol use in teens: at least one drink of alcohol during past 30 days.
[f]E-cigarettes/vaping products include electronic nicotine delivery product, such as an e-cigarette, e-cigar, or e-hookah.

Table K-6 summarizes the leading cancer incidence in Washington County. Note that this incidence data was used in the analysis and prioritization of the morbidity indicators in the tables above.

Table K-6. Leading cancer incidence in Washington County

Type of Cancer	Washington County Incidence Rate
All cancer sites	429.2
Breast (female)	134.0
Prostate (male)	114.4
Lung & bronchus	49.7
Colon & rectum	35.2
Uterus (female)	28.8
Melanoma of the skin	27.7
Bladder	19.9
Non-Hodgkin lymphoma	19.2
Kidney & renal pelvis	14.9
Thyroid	13.6

Source: National Cancer Institute (NCI) State Cancer Profiles, 2008-2012.
All rates are per 100,000 population and are age-adjusted to the 2000 US standard population.

Table K-7 summarizes the mortality rates for the leading types of cancer in Washington County. Note that this mortality data was used in the analysis and prioritization of the mortality indicators in the tables above.

Table K-7. Leading causes of death in Washington County

Washington County Top Leading Causes of Death, 2013	Mortality Rate
Major cardiovascular diseases	162.34
Diseases of the heart	115.13
Cerebrovascular disease	33.71
Malignant neoplasm	144.50
Malignant neoplasms of trachea, bronchus and lung	34.07
Malignant neoplasm of breast in females	20.10
Malignant neoplasms of lymphoid, hematopoietic and related tissue	18.00
Malignant neoplasm of the prostate in males	16.65
Malignant neoplasms of colon, rectum and anus	11.27
Malignant neoplasm of ovary in females	9.19
Accidents (unintentional injury)	28.16
Non-transport accidents[a]	23.49
Alzheimer's disease	27.67
Chronic lower respiratory diseases	24.59
Diabetes mellitus	20.04
Suicide	12.45
Influenza and pneumonia	9.49

Washington County Top Leading Causes of Death, 2013	Mortality Rate
Pneumonia	8.55
Drug-induced[b]	9.49
Alcohol-induced[b]	9.20

Data source: National Center for Health Statistics (NCHS) 113 Leading Cause of Death list from the Oregon Public Health Assessment Tool (OPHAT).
All rates are per 100,000 population and are age-adjusted to the 2000 US Standard Population.
Malignant neoplasm: a new abnormal growth of tissue, also referred to as a tumor or cancer.
[a]Non-transport accident mortality major category includes deaths due to falls and unintentional poisoning.
[b]The drug- and alcohol-induced death categories are included within the other NCHS 113 Leading Cause of Death categories and, therefore, are not mutually exclusive categories.

Hospital (Emergency Department) Data

The tables below present the findings from the *Health Status Assessment – Hospital Data* section. Refer to this section of the report for a description of methodology, regional findings, and limitations.

Table K-8: List of diagnoses and age-adjusted percentages for uninsured and self-pay admissions to hospital emergency departments in Washington County (adults only)

Washington County: Adults	
Ambulatory Care Sensitive Conditions (ACSC) and Select Mental Illness Diagnoses	**Age-Adjusted %**
Hypertension	16.2%
Diabetes "c"	10.4%
Kidney/urinary infections	7.2%
Severe ear, nose, and throat infections	5.3%

Only diagnoses greater than 5% are shown.

Table K-9: List of diagnoses and age-adjusted percentages for uninsured and self-pay admissions to hospital emergency departments in Washington County (youth only)

Washington County: Youth	
Ambulatory Care Sensitive Conditions (ACSC) and Select Mental Illness Diagnoses	**Age-Adjusted %**
Severe ear, nose, and throat infections	38.3%
Asthma	14.6%
Dehydration - volume depletion	5.7%

Only diagnoses greater than 5% are shown.

Online Survey Data

The tables below present the findings from the *Community Themes and Strengths Assessment – Online Survey* section. Refer to this section of the report for a description of methodology, regional findings, and limitations.

A total of 595 surveys were submitted that reported a zip code within or overlapping Washington County borders. These 595 surveys represented 20.4% of all surveys from the four-county region. In comparison, Washington County makes up 25.8% of the four-county population.

The demographics of Washington County survey respondents are presented in the table below, which compares them to the respective demographics of the Washington County population (when available). Percentages were calculated using the number of surveys that reported a meaningful answer to the respective question as the total or denominator; this number is presented as "n" for each demographic indicator. Surveys that did not include an answer to the respective question were omitted from the total count.

Table K-10: Demographics of survey respondents from Washington County

Demographic Indicator	**Population of survey respondents who live in Washington County (n=595)**	**Washington County Population**
Age	n=579	
Under 18	2.1%	24.4%
19-25	9.8%	8.3%
26-39	31.1%	23.0%
40-54	28.7%	20.8%
55-64	18.1%	11.8%
65-79	10.0%	8.9%
80 and older	0.2%	3.1%
Gender	n=562	
Female	74.4%	50.8%
Male	25.4%	49.2%
Other than male or female alone	0.2%	N/A
Sexual Orientation	n=533	
Sexual Minority	10.1%	N/A
Heterosexual	89.9%	N/A
Hispanic Ethnicity	n=548	
Hispanic	17.9%	16.3%
Non-Hispanic	82.1%	83.7%
Race	n=493	
African American/Black	1.0%	2.2%
African	0.2%	
Arab American/Middle Eastern	0.2%	N/A
Asian American/Asian	4.3%	9.9%
European American/White/Caucasian	83.8%	82.2%

Demographic Indicator	Population of survey respondents who live in Washington County (n=595)	Washington County Population
Native American/American Indian/Alaska Native	1.8%	1.1%
Native Hawaiian or Pacific Islander	N/A	0.5%
Multiracial	6.5%	4.0%
Other	2.2%	N/A
Location of Childhood	n=570	
Inside U.S.	88.8%	N/A
Outside U.S.	11.2%	N/A
Language	n=577	
English	87.9%	84.5%
Spanish or Spanish/English	9.9%	9.3%
Other than Spanish or English	2.3%	6.2%
Veteran Status	n=577	
Veteran	6.2%	7.8%
Not a veteran	93.8%	92.2%
Disability Status	n=571	
Has a disability	9.1%	10.3%
Does not have disability	90.9%	89.7%
Education Level	n=501	
Less than high school	3.0%	9.7%
High school/GED	13.0%	19.8%
Bachelors degree or higher	81.4%	39.7%
Federal Poverty Level	n=486	
200% or below	22.4	28.7%
Above 200%	77.6	71.3%
Type of Health Insurance	n=562	
Uninsured	5.7%	10%
Medicaid	10.9%	16.8%
Medicare	8.5%	12.9%
Medicaid/Medicare	0.2%	N/A
Indian Health Services	0.4%	N/A
VA	1.2%	1.9%
Other public	0.7%	N/A
Private insurance	72.4%	71.0%

Survey question 1: Quality of life (vision)

The first question on the survey asked about respondents' vision of a healthy community. The question read, *"In the following list, what do you think are the five most important characteristics of a 'Healthy Community'? (Those factors that most improve the quality of life in a community")*. There were 21 characteristics from which to choose. The table below presents the response options ordered by the frequency at which they were selected. Because the question asked respondents to select five characteristics, the five most frequently

selected responses are shaded in gray. Frequencies were calculated using the total number of selections as the denominator (presented as "n" in the frequency column).

Table K-11: Survey question 1 results for Washington County respondents

Rank based on Frequency	**Response Options**	**Frequency (Proportion of Total Responses)** n = 2,924
1	Safe, affordable housing	10.6%
2	Access to physical, mental, and/or oral health care	9.6%
3	Access to healthy, affordable food	9.3%
4	Good schools	8.5%
5	Low crime/safe neighborhoods	8.5%
6	Good jobs to reach a healthy economy	7.5%
7	Clean environment	6.8%
8	Healthy behaviors and lifestyles	5.0%
9	Parks and recreation	5.0%
10	Supportive and happy family life	4.0%
11	Safe, nearby transportation	3.9%
12	Welcoming of diverse communities/people	3.7%
13	Good place to raise children	3.3%
14	Participating and giving back to the community	2.5%
15	Religious or spiritual values	2.3%
16	Good daycare and preschools	2.1%
17	Good job training opportunities	1.8%
18	Low level of child abuse	1.8%
19	Arts and cultural events	1.5%
20	Low deaths and disease rates	1.4%
21	Physical accommodations for people with disabilities	1.1%

The five responses most frequently selected by Washington County respondents were 1) Safe, affordable housing; 2) Access to physical, mental, and/or oral health care; 3) Access to healthy, affordable food; 4) Good schools; and 5) Low crime/safe neighborhoods. These were the same top five selections, in the same order, for total regional respondents.

Survey question 2: Issues affecting community health (needs)

The second question on the survey asked respondents about the biggest health needs in their community. The question read, *"In the following list, what do you think are the five most important 'issues' that need to be addressed to make your community healthy? (Those topics that have the greatest impact on overall community health)."* The table below presents the response options ordered by the frequency at which they were selected. Again, because the question asked respondents to select five topics, the five most frequently selected responses are shaded in gray. Frequencies were calculated using the total number of selections as the denominator (presented as "n" in the frequency column).

Table K-12: Survey question 2 results for Washington County respondents

Rank based on Frequency	Response Options	Frequency (Proportion of Total Responses) n=2753 selections
1	Homeless/lack of safe, affordable housing	12.1%
2	Unemployment/lack of living wage jobs	9.9%
3	Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders)	9.4%
4	Hunger/lack of healthy, affordable food	8.7%
5	Lack access to physical, mental, and/or oral health care	6.6%
6	Being overweight/obesity	5.6%
7	Poor schools	5.3%
8	Racism/discrimination	5.0%
9	Domestic violence, child abuse/neglect	4.8%
10	Unsafe streets (limited crosswalks, bike lanes, lighting, etc.)	4.4%
11	Gang activity/violence	4.1%
12	Lack of needed job skills or training	3.1%
13	Lack of community involvement	3.1%
14	Dirty environment	2.9%
15	Lack access to safe, nearby transportation	2.4%
16	Bullying/verbal abuse	2.1%
17	Lack of good daycare and preschools	1.9%
18	Disabilities (physical, mental) and limited mobility	1.6%
19	Lack of safe and accessible parks/recreation	1.5%

Rank based on Frequency	Response Options	Frequency (Proportion of Total Responses) n=2753 selections
20	Firearm-related injuries	1.5%
21	Aging problems (e.g. memory loss, hearing/vision loss)	1.3%
22	Few arts and cultural events	1.1%
23	Lack of physical accommodations for people with disabilities	0.8%
24	Asthma/respiratory/lung disease	0.4%
25	HIV/AIDS	0.4%

As *Table K-12* shows, the five most frequently selected community needs were 1) Homelessness/lack of safe, affordable housing; 2) Unemployment/lack of living wage jobs; 3) Mental health challenges (e.g. depression, lack of purpose or hope, anxiety, bi-polar, PTSD, eating disorders); 4) Hunger/lack of healthy, affordable food; and 5) Lack access to physical, mental, and/or oral health care. These were the same five most frequently selected community needs, and in the same order, as those of total four-county respondents.

Survey question 3: Risky behaviors

The third question the survey asked was about behaviors that can endanger health. The question read, *"In the following list, what do you think are the three most important 'risky behaviors' in your community? (Those behaviors that have the greatest impact on overall community health)."* The table below presents the response options ordered by the frequency at which they were selected. Because the question asked respondents to select three behaviors, the three most frequently selected responses are shaded in gray. Frequencies were calculated using the total number of selections as the denominator (presented as "n" in the frequency column).

Table K-13: Survey question 3 results for Washington County respondents

Rank based on Frequency	Response Options	Frequency (Proportion of Total Responses) n = 1,741
1	Drug use/abuse	17.0%
2	Alcohol abuse/addiction	14.3%
3	Poor eating habits	10.9%
4	Lack of exercise	10.5%
5	Dropping out of school	10.4%
6	Unsafe driving (e.g. not using seat belts/child safety seats, distracted driving)	8.4%

Rank based on Frequency	Response Options	Frequency (Proportion of Total Responses) n = 1,741
7	Social isolation/loneliness	7.8%
8	Tobacco use	6.1%
9	Not getting "shots" to prevent disease (immunizations)	5.3%
10	Risky sexual behavior/unsafe sex	4.8%
11	Not using birth control	3.0%
12	Self-harm (e.g. cutting, suicide attempts)	1.6%

The three most frequently selected responses were 1) Drug use/abuse; 2) Alcohol abuse/addiction; and 3) Poor eating habits. These were the same most frequently selected responses as for total regional respondents.

Survey question 4

The fourth survey question asked respondents to rate the health of their community. The question read, "*How healthy would you rate your community as a whole?" Table K-14* presents the distribution of responses. Unlike the previous three questions, respondents were directed to only give one response to this question. Therefore, the proportion of responses per rating was calculated using the number of people indicating that response as the denominator, displayed as "n" in the table.

Table K-14: Survey question 4 results for Washington County respondents

Rating	Proportion of Responses from Washington County Respondents n = 594	Proportion of Responses from Entire Survey Population n = 3,075
Very healthy	3.7%	3.0%
Healthy	38.6%	30.9%
Somewhat unhealthy	50.2%	53.2%
Unhealthy	6.4%	10.3%
Very unhealthy	1.2%	2.6%

This distribution of community health ratings has a higher percentage of "Healthy" ratings and a lower percentage of "Unhealthy" and "Very unhealthy" ratings compared to that of total regional responses.

Washington County Priority Health Issues Model

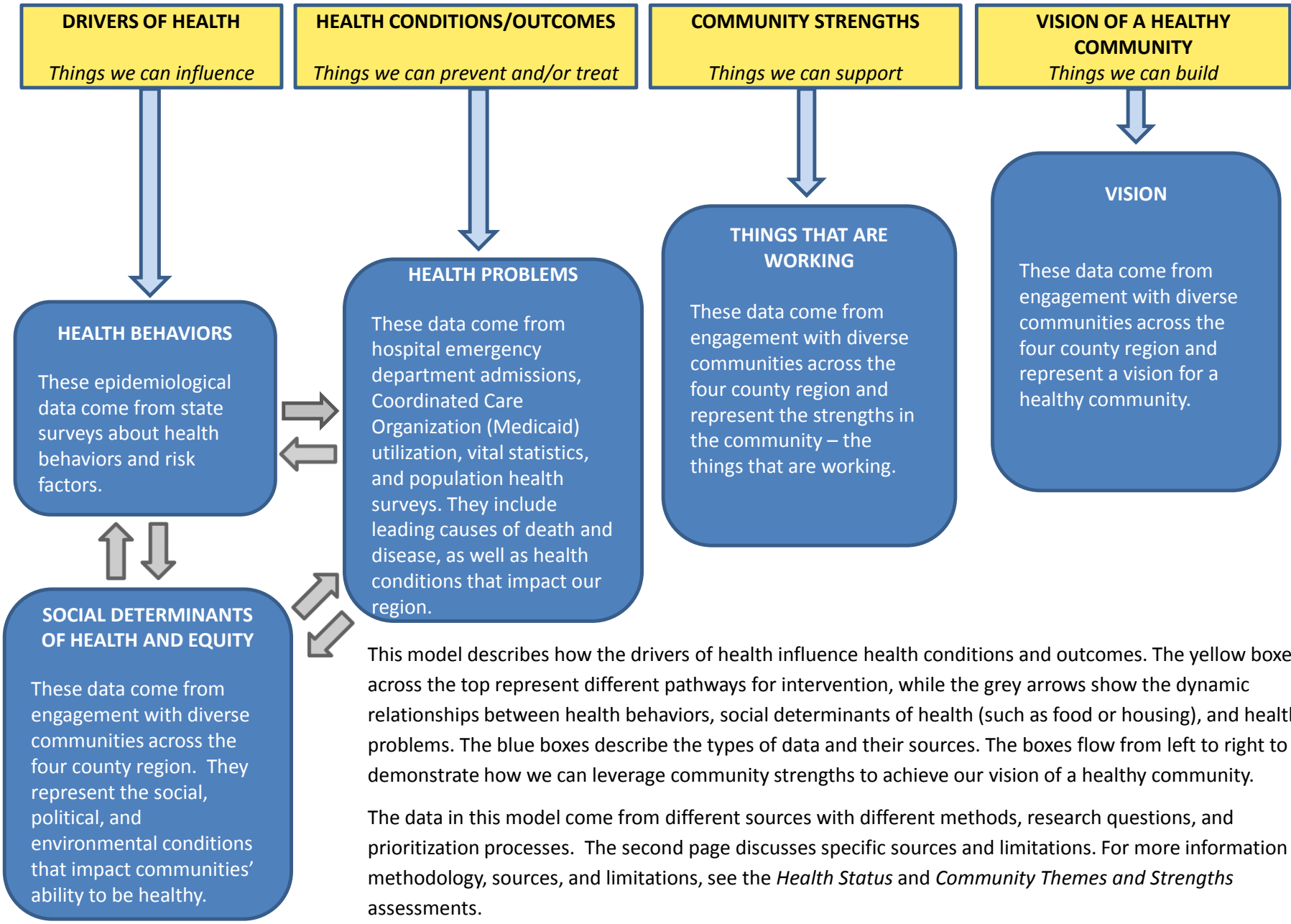
Figure K-1 illustrates the priority health issues in Washington County, as identified in the 2016 CHNA. The data sources include:

- Population data on health behaviors, morbidity, and mortality
- Medicaid claims data provided by local CCOs
- Hospital admissions data for people who were uninsured or self-pay and were diagnosed with select conditions
- Community data from an online survey, listening sessions in all four counties, and a qualitative meta-analysis of community engagement projects from the last 3 years

Each data set has its own specific limitations, which can be found in the *Health Status Assessment* and *Community Themes and Strengths Assessment* sections of this report.

Figure K-1: Priority Health Issues Model for Washington County

Priority Health Issues for Washington County and What We Can Do



This model describes how the drivers of health influence health conditions and outcomes. The yellow boxes across the top represent different pathways for intervention, while the grey arrows show the dynamic relationships between health behaviors, social determinants of health (such as food or housing), and health problems. The blue boxes describe the types of data and their sources. The boxes flow from left to right to demonstrate how we can leverage community strengths to achieve our vision of a healthy community.

The data in this model come from different sources with different methods, research questions, and prioritization processes. The second page discusses specific sources and limitations. For more information on methodology, sources, and limitations, see the *Health Status* and *Community Themes and Strengths* assessments.

DRIVERS OF HEALTH

Things we can influence

HEALTH CONDITIONS AND OUTCOMES

Things we can prevent and/or treat

SOCIAL DETERMINANTS OF HEALTH AND EQUITY

- Access to food
- Access to health care*
- Access to transportation
- Connected communities
- Culturally and linguistically appropriate services
- Pathways to living wage jobs
- Policies, systems, and environments that support healthy behaviors
- Racism, discrimination, and stigma
- Safe, accessible, and affordable housing
- Support for people with behavioral health challenges

Community Engagement Data

HEALTH BEHAVIORS

- Alcohol use among teens
- Binge drinking
- Lack of dental visits among teens*
- Lack of adults who have received a flu shot
- Lack of early prenatal care
- Lack of fruit and vegetable consumption
- Lack of health insurance among adults*
- Lack of physical activity among teens
- Marijuana use among teens
- No usual source of health care among adults*
- Vaping and e-cigarettes use among teens

Population Data

DIAGNOSED HEALTH CONDITIONS FOR LOW-INCOME AND/OR UNINSURED

<u>Children</u>

- Asthma*
- Attention Deficit Disorder
- Dehydration - (Uninsured ED only)
- Post Traumatic Stress Disorder
- Severe ear, nose, and throat infections - (Uninsured ED only)

<u>Adults</u>

- Depression*
- Diabetes*
- Hypertension*
- Kidney/urinary infections- (Uninsured ED only)
- Severe ear, nose, and throat infections - (Uninsured ED only)

Emergency Department (ED) and Medicaid Data

MORBIDITY (DISEASE)

- Asthma*
- Cancer, 8 types♦
- Chlamydia
- Depression*
- Obesity/overweight

Population Data

MORTALITY (DEATH)

- Alcohol-induced
- Breast cancer
- Chronic lower respiratory disease
- Diabetes*
- Drug-induced
- Heart disease
- Leukemia and Lymphoma
- Ovarian cancer
- Prostate cancer
- Suicide

Population Data

*Indicator identified in more than one of the assessment components (e.g. population, community engagement, emergency department, or Medicaid data)

♦Refer to section III for specific types of cancer

All indicators are in alphabetical order. For full methodology, sources, and limitations, see individual sections of CHNA report.

COMMUNITY STRENGTHS

Things we can support

STRENGTHS

Culturally specific, community-based services

Feeling connected to a community

Government supported public assistance and social services

Healthy behaviors

Low/no cost programs and services that make health care accessible

Opportunities to be involved in the community

Pathways to living wage jobs

Resilience

Community Engagement Data

VISION OF A HEALTHY COMMUNITY

Things we can build

VISION

For all people:

Affordable, high-quality, culturally responsive health care

Basic needs are met, including food, housing, and transportation

Environments and opportunities that support and encourage community involvement and connection

Equitable and inclusive society, free from racism, discrimination, and stigma

Good schools and equitable access to high quality education

Living wage jobs and pathways to employment

Policies, systems, and environments that support good health and high quality of life

Safe, accessible, and affordable housing

Safe and accessible neighborhoods free of crime

Community Engagement Data

DATA SOURCES AND LIMITATIONS

SOCIAL DETERMINANTS OF HEALTH AND EQUITY, COMMUNITY STRENGTHS, AND VISION

Data sources:

•29 listening sessions with 364 community members across the four county region
•Online survey (paper version optional) with 3,167 responses
•Meta-analysis of 55 community engagement projects conducted in the four county region between 2012-2015

Limitations:

The data from the survey and listening sessions were collected through small convenience samples. HCWC aimed to engage communities across the four county region and prioritize low-income and communities of color. However, the people that participated in the survey and listening sessions do not represent the full range of diverse experiences in the region.

HOSPITAL DATA

Data sources:

•26 Ambulatory Care and Sensitive Condition (ACSC) codes
•4 Severe and Persistent Mental Illness (SPMI) codes
•15 hospitals in the HCWC region

Limitations:

The data represent a narrow subset of the regional population (4.4%). Out of over 13,000 ICD-9 diagnosis codes, data analysts considered 26 ACSC codes, defined by the Agency for Healthcare Quality and Research, and 4 SPMI codes that aligned with the Medicaid data. In addition, the data only included people who were "self-pay" and who visited the emergency department. This means that the priority health indicators from the hospital data should be viewed as a very small subset, and not generalizable to other populations.

MEDICAID DATA

Data sources:

•2 Coordinated Care Organizations (CCOs) in the Oregon tri-county region
•Health Share of Oregon claims
•FamilyCare claims

Limitations:

The indicators considered are a subset of diagnoses. Data analysts identified three chronic conditions diagnosed separately among adults and children as the priority health issues. Medicaid data for Clark County were not accessible for this CHNA. The regional Priority Health Issues Model includes Medicaid data for the tri-county Oregon region only. The Clark County-specific model does not include any Medicaid data.

HEALTH BEHAVIORS, MORBIDITY, AND MORTALITY

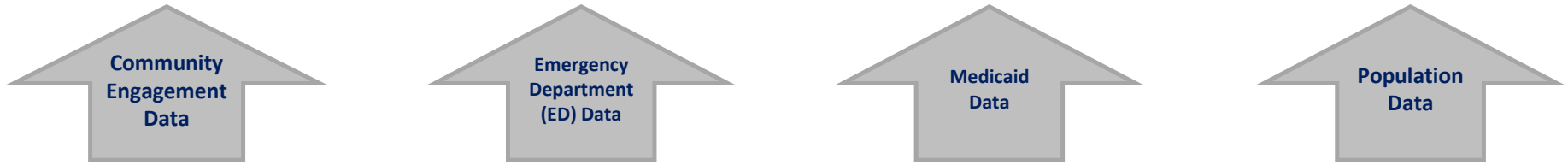
Data sources:

•Behavioral Risk Factor Surveillance System (BRFSS)
•Oregon Healthy Teen Survey
•National Cancer Institute (NCI)
•Washington Healthy Youth Survey
•Vital statistics

Limitations:

HCWC epidemiologists, with input from content experts, developed a list of standard indicators to consider for prioritization. There are many issues that we do not have adequate data for and could not prioritize. For example, the NCI has data on a wide variety of cancers, while the data on oral health are more limited. Similarly, we were able to examine mortality data for heart disease, but not morbidity.

Data from population health surveys rely on self report and are subject to recall and other biases.



For full methodology, sources, and limitations, see individual sections (Health Status Assessment, Community Themes and Strengths).