Tuality Healthcare

Community Health Needs Assessment

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Tuality Healthcare

Building a healthier community.

Continue to build a healthier community

For many years, Tuality Healthcare's slogan has been "Building a healthier community." We continue to believe in that slogan as we tackle the challenge of transforming the way hospitals and healthcare organizations deliver health care.

This Community Health Needs Assessment was conducted as a rigorous process with other health care organizations in the four-county Portland metropolitan area as part of the Healthy Columbia Willamette Collaborative. The collaborative includes 14 hospitals, four county health departments and two Coordinated Care Organizations.

About Tuality Healthcare

Tuality is a not-for-profit, community based health care organization based in Washington County. We are proud of our standing as an independent organization governed by community members that aim to provide localized care determined by local community members.

Our organization provided $34 million in community benefit during Fiscal Year 2013 in free and reduced cost medical care, care for underserved patients, community education and investment in community health and community partners.

Thank you to the community

This Community Health Needs Assessment would not have been possible without the assistance of many of our community citizens through focus group participation, stakeholder interviews and advice from content experts. We are grateful for their help.

We strive to provide our community with the best health care possible. We hope to address many of the health care needs and strategies in the years ahead as we continue building a healthier community.

Sincerely,

Manny Berman, FACHE
President & Chief Executive Officer
Tuality Healthcare

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I. Executive Summary

Tuality Healthcare is a community-based, not-for-profit health system with hospitals in Hillsboro and Forest Grove, Oregon. Tuality is a full-service acute care system that offers the full continuum of care, along with health and wellness services. Based in Hillsboro, Tuality's service area is mainly Washington County with some patients from adjacent counties, including the Oregon Coast and Coast Range. Tuality Healthcare participated in the joint venture called the Healthy Columbia Willamette Collaborative (HCWC), which included county health departments in Washington, Multnomah and Clackamas counties in Oregon and Clark County in Washington, as well as hospitals in the Providence, Kaiser, Legacy, Adventist, Peace Health and OHSU systems. The collaborative was established in 2010 to conduct a Community Health Needs Assessment (CHNA) for the four-county Portland metropolitan area.

Providing exceptional care and treating the vulnerable are increasingly important in the changing nature of health care. Our mission and vision for treating the health needs in our region is reflected in our Strategic Business Plan, a 3- to 5-year plan. The healthcare priorities identified by this CHNA are an important part of healthcare transformation and Tuality Healthcare's role in that process.

COMMUNITY HEALTH NEEDS ASSESSMENT

The Healthy Columbia Willamette Collaborative used the Mobilizing for Action through Planning and Partnerships (MAPP) model to conduct the CHNA. The MAPP model is an evidence-based, community-wide strategic planning process for improving community health. The collaborative hired Healthy Communities Institute (HCI) of Berkeley, Calif., to identify and compile data pertinent to improving the community health needs of the Portland metro area. Fourteen hospitals, including the area's major health systems (Tuality, Providence, Legacy, Adventist and PeaceHealth), one academic medical center university (Oregon Health & Science University) and one health system/health insurer (Kaiser), participated in the needs assessment. For more on the collaborative, visit the Healthy Columbia Willamette website at www.healthycolumbia.willamette.org, or view pertinent information in the Appendix of this document.

The information, priorities and identified health needs were drawn from a rich body of quantitative date supplied by the Healthy Communities Institute (HCI) and verified by epidemiologists from the four counties. The collaborative also incorporated large and varied input from key stakeholders such as public officials, community groups and key informants. The collaborative also conducted a series of focus groups and public forums with a wide variety of citizens concerning the health needs of their community. Collectively, these quantitative and qualitative data sources gave the group an outstanding snapshot of the socio-economic and health status of residents of Washington County vs. their counterparts in the Portland metropolitan region and the state of Oregon.

The CHNA process conducted by the Healthy Columbia Willamette Collaborative found the following:

- In general, residents of Washington County are healthier than their counterparts in Multnomah, Clackamas and Clark counties. As an example, data provided by HCI shows that Washington County has the lowest rate of all cancers in the metro area.
- Residents agree that Washington County is healthier than the rest of the metropolitan area. A rate of 89.2 adult residents answered good, very good, or excellent to the question: "How is your general health?"
- Substance abuse isn't nearly as sizeable a problem in Washington County as in the other three counties. The county has the lowest level of binge drinkers, adults who smoke, teens who smoke, death rate due to alcohol consumption and death rate due to drug poisoning in the metro area.
- Washington County does have the second-highest teen pregnancy rate in the metro area.

- Washington County has the highest age-adjusted suicide rate of the three Oregon counties – 15.4 deaths per 100,000 populations.

Where Washington County falls short is in the area of exercise, nutrition and weight. Here's a breakdown:

- Only 24.9 percent of Washington County residents eat five or more servings of fruits and vegetables per day, compared to 30 percent in Clackamas County.
- Only 53.8 percent of Washington County residents engage in regular physical activity compared to 55.1 percent in Multnomah County and 55.6 percent in Clackamas County.
- Washington County has the second highest obesity rate in the metropolitan area with 23.2 percent of residents considered obese according to the Body Mass Index (BMI).
- The same holds true in the overweight category. Washington County has the highest overweight population in the metro area at 36.9 percent of residents, based on the Body Mass Index (BMI).
- Low-income pre-school obesity is also a problem in Washington County, ranking first in the metropolitan area with 15.2 percent of pre-schoolers considered obese based on BMI.

Tuality Healthcare intends to address the four needs identified by the CHNA in a variety of strategic ways:

Access to Affordable Care: Tuality will continue to expand outreach to vulnerable populations via the Tuality Health Alliance and its work with Health Share of Oregon for Oregon Health Plan members. Tuality will also continue to work with a number of community partners to provide basic health services. These include the Southwest Community Health Center – Hillsboro, Project Access Now and Virginia Garcia Medical Center.

Chronic disease: Tuality will continue to support the "Healthy Baby" project, the Public Health Parish Nurse Program and offer educational classes that address chronic conditions. Tuality will work with its HCWC partners on a specific project, focusing on breastfeeding to six months for the most vulnerable populations.

Substance abuse: Tuality and its HCWC partners will promote safe opioid prescribing guidelines, improve monitoring of prescribing practices at institutions, and develop an educational program for safe opioid use.

Mental health: Tuality will increase access to mental health services through the patient-centered primary care home and collaborations with LifeWorks NW, Washington County Department of Health & Human Services and Pacific University.

II. Mission, Vision and Values

Founded by midwife Minnie Jones Coy in 1918, Tuality Healthcare is a not-for-profit health system that offers the full continuum of health and wellness services in communities in Washington County and neighboring counties in Oregon. The organization has over 40 employed physicians, over 200 affiliated community physicians, two hospitals (Hillsboro and Forest Grove), numerous outpatient clinics, a patient and family education center, and comprehensive state-of-the-art Diagnostic Imaging, Surgery, Laboratory and other services. The organization includes specialty clinics like the Tuality Center for Geriatric Psychiatry, as well as partnerships in two dialysis centers and the Tuality/OHSU Cancer Center.

Tuality Healthcare

Building a healthier community.

Mission

With skill and compassion, we are building a healthier community by bringing quality clinical care and unparalleled service to our region in partnership with our patients, physicians and health care professionals.

Vision

To be the health system of choice for our region, our patients, our providers, and our employees by delivering the highest quality care at an exceptional level of service.

Standards for Success

People, Service, Quality, Stewardship

Organizational Values

A Culture of Service to our Community
A Culture of Service to Each Other
A Culture of Service to our Patients

Employee Value Proposition

Tuality is unique because of the relationships we build, And as individuals we are seen and heard.

TUALITY'S COMMITMENT TO COMMUNITY HEALTH NEEDS ASSESSMENT

Tuality Healthcare's Strategic Business Plan supports the Community Health Needs Assessment's focus on population-based healthcare. The Strategic Business Plan adopted by the Tuality Healthcare Board in 2014 has five goals:

- Develop an Exceptional Organizational Culture
- Be the Destination Health Care Employer
- Build a Community Reputation for Unparalleled Value
- Be the Preferred Provider for Area Physicians
- Provide Service Line Excellence

Tuality Healthcare's Mission, Vision, Standards for Success and Organizational Values align well with the five goals of the Strategic Business Plan. With these elements as a roadmap, the employees of Tuality Healthcare are well positioned for achievement in the constantly changing health care environment.

Like other healthcare organizations, Tuality embraces the Triple Aim developed by the Institute of Healthcare Improvement:

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of health care

TUALITY'S FOCUS ON SERVICE TO OUR COMMUNITY

Tuality Healthcare provided $34 million in benefit to our community in Fiscal Year 2013, including charity care, uncompensated care, community service and volunteering. These community benefit activities include:

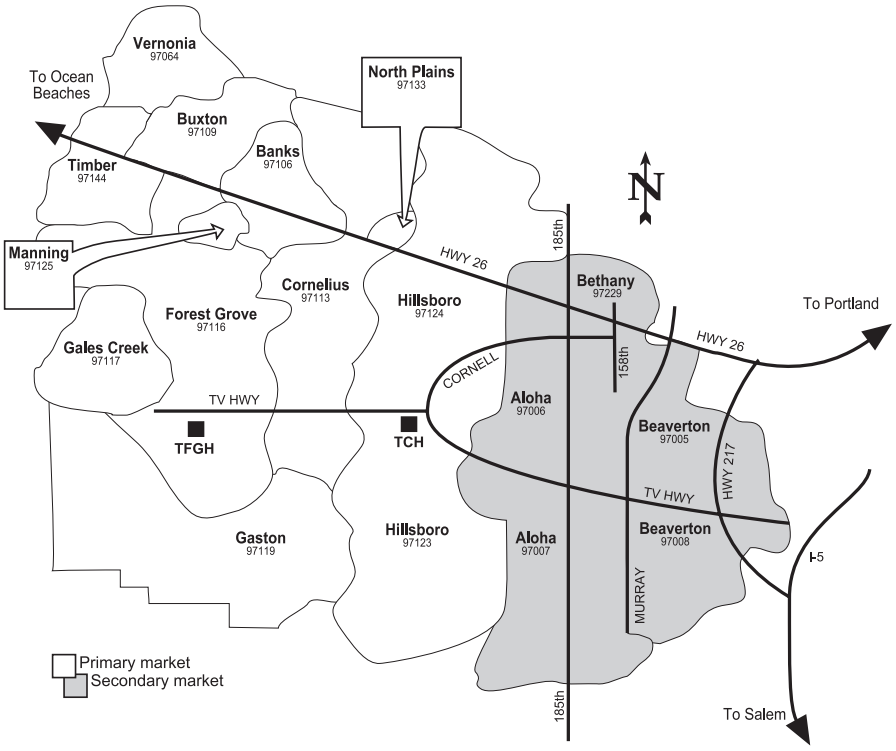
- Providing increased access to healthcare through the Tuality Healthcare Alliance, a physician-hospital community organization.
- Aiding community health improvement through a robust series of educational classes.
- Sponsoring and participating in numerous events and health fairs which promote wellness.
- Financial support for a number of safety-net health clinics run by other non-profits for those living in poverty.

III. Service area and demographics

Tuality Healthcare's service area is primarily Washington County, Oregon, although some patients from neighboring counties do use our services. Washington County lies west of the city of Portland and east of the Oregon Coast range. It is the second most populous county in Oregon, with a July 2013 estimated population of 550,990, according to data supplied by the Portland State University Population Research Center.

Tuality's primary inpatient service area includes the cities of Hillsboro, Forest Grove, Cornelius and North Plains, and the smaller communities of Banks, Gaston, Gales Creek, Manning, Buxton, Vernonia, Timber and Manning. The organization's secondary inpatient service area includes portions of the large suburban Portland cities of Beaverton and Aloha. (See map)

Tuality Healthcare and the Washington County Department of Health and Human Services are both Healthy Columbia Willamette members. The collaborative encompasses three Oregon counties (Washington, Multnomah and Clackamas) and one county in Washington state (Clark). Although Tuality is an HCWC member, the organization's service area is primarily Washington County. One other hospital, Kaiser Permanente Westside Medical Center, serves Washington County. It is also located in Hillsboro.



POPULATION BASE

Washington County, which contains Tuality Healthcare's primary patient service area, is the second most populous county in the 4-county metropolitan Portland area, which also contains Multnomah, Clackamas in Oregon and Clark County in Washington. Hillsboro is the largest city in Washington County with a population of 95,357, according to 2012 data from the United States Census Bureau. It is also the fifth largest city in Oregon. Other larger cities include Beaverton, Forest Grove, Cornelius and North Plains, although most of Beaverton lies in Tuality's secondary patient service area.

Washington County is the fastest-growing county in the four-county metropolitan area. The county population grew by 4.8 percent in the period of 2010 to 2013, surpassing Clark County at 4.3 percent, Multnomah at 4.2 percent and Clackamas at 3.3 percent.

Washington County has the most sizeable Hispanic or Latino population in the metro area at 16.0 percent, significantly higher than the state of Oregon at 12.2 percent. Other county figures for Hispanics are: Multnomah, 11.1 percent, and Clark and Clackamas, 8.1 percent. Washington County has the lowest population in the metro area of persons 65 and older, 10.9 percent, well below the state of Oregon figure of 14.9 percent. Other county figures for the elderly are: Multnomah, 11.2 percent; Clark, 12.6 percent, and Clackamas, 15.0 percent.

Population composition

Total	Population	White	Hispanic	% age 65 or older
Hillsboro	95,357	73.3%	22.6%	7.8%
Beaverton	93,542	73.0%	16.3%	10.4%
Forest Grove	22,419	78.8%	23.1%	12.3%
Cornelius	12,161	64.0%	50.1%	6.3%
Washington Co.	554,996	83.0%	16.0%	10.9%
Clackamas Co.	388,263	90.8%	8.1%	15.0%
Multnomah Co.	766,135	80.9%	11.1%	11.2%
Clark Co.	443,817	87.9%	8.1%	12.6%
Oregon State	3,930,065	77.8%	12.2%	14.9%
Washington State	6,971,406	71.6%	11.7%	13.2%
United States	316,128,839	63.0%	16.9%	13.7%

Source: U.S. Census Bureau, Healthy Communities Institute

Age comparison

City, County, etc	Persons under 5	Persons under 18	Persons 65, over	Female persons
Hillsboro	8.4%	26.8%	7.8%	49.8%
Beaverton	6.8%	22.9%	10.4%	51.4%
Forest Grove	7.0%	26.6%	12.3%	52.0%
Cornelius	8.9%	32.9%	6.3%	48.9%
Washington Co.	6.7%	24.6%	11.4%	50.7%
Clackamas Co.	5.3%	22.5%	15.6%	50.8%
Multnomah Co.	6.0%	19.9%	11.6%	50.6%
Clark Co.	6.4%	22.9%	13.6%	50.0%
Oregon State	5.9%	21.8%	15.5%	50.5%
Washington State	6.4%	22.9%	13.6%	50.0%
United States	6.3%	23.3%	14.1%	50.8%

Note: Persons under 18 includes Persons under 5

EDUCATION AND INCOME

Education and income play an important role in the health of a community. Called the social determinants of health, these are the conditions in which people are born, live, work and age. Studies show that citizens with low income or education tend to have more chronic health programs and have difficulty accessing healthcare.

Washington County ranks third in the metro area with 90.7 percent of residents holding a high school diploma. Clackamas County leads in this category with 92.4 percent of residents holding a high school diploma. The county ranks first in two other important indicators, foreign born with 16.9 percent of residents and percent of homes where a language other than English is spoken at 23.3 percent. Washington County is in the middle of the pack regarding percent of population below the federal poverty level with 10.9 percent. Multnomah County has a sizeable population – 17.9 percent – living below the federal poverty level.

Education and Income

Region	% w/H.S. diploma	Foreign born	% language other than English at home	% below poverty level
Hillsboro	86.7%	20.7%	30.2%	13.0%
Beaverton	91.8%	21.5%	28.0%	13.0%
Forest Grove	82.5%	12.0%	21.3%	19.6%
Cornelius	69.5%	26.0%	48.2%	16.9%
Washington Co.	90.7%	16.9%	23.3%	10.9%
Clackamas Co.	92.4%	8.5%	11.6%	9.7%
Multnomah Co.	89.5%	13.9%	19.6%	17.1%
Clark Co.	91.0%	10.0%	14.0%	12.0%
Oregon State	89.2%	9.8%	14.7%	15.5%
Washington State	90.0%	13.0%	18.2%	12.9%
United States	85.7%	12.9%	20.5%	14.9%

Source: U.S. Census Bureau, Healthy Communities Institute

COMMUNITY NEEDS INDEX SCORE

Dignity Health and Thompson/Reuters have developed a scoring system that rates a population's need for socioeconomic support called the Community Needs Index. This index provides scores on a community's social determinants like percent with high school diplomas, how many citizens have health insurance, how many citizens over age 65 live in poverty, citizens speaking limited English and other determinants. A score of 1 indicates the lowest need; a score of 5 indicates the greatest need.

The figures in the table below show that Washington County has more socioeconomic needs than Clackamas and Clark counties, but less needs than Multnomah County. This data is broken down by zip codes and shows pockets of need. For example, Hillsboro zip code 97123 has a CNI Score of 3.6, while zip code 97124 has a CNI Score of 3.0. These scores are consistent with socioeconomic indicators for the county.

Community Needs Index Score

City, County	CNI Median Score
Hillsboro	3.2
Beaverton	3.2
Forest Grove	4
Cornelius	3.7
Washington County	3.0
Clackamas County	2.7
Multnomah County	3.6
Clark County	2.8

Source: Thompson/Reuters, Dignity Health

IV. Community Health Needs Assessment

OVERVIEW OF PROCESS AND SOURCES

Origination of Project: In 2010, local health care and public health leaders began to discuss the upcoming need for several community health assessments and health improvement plans within our region in response to the Affordable Care Act and Public Health Accreditation.[1] The leaders recognized that conducting a regional community health needs assessment for Clackamas, Multnomah, and Washington counties in Oregon and Clark County in Washington was the most efficient and effective way moving forward. The result is the development of the Healthy Columbia Willamette Collaborative, with assistance from the Oregon Association of Hospitals and Health Systems. The collaborative is a public-private partnership comprised of 14 hospitals, four public health department and two coordinated care organizations (CCOs).

Members include (in alphabetical order): Adventist Medical Center, Clackamas County Health Division, Clark County Public Health Department, FamilyCare, Health Share of Oregon,[2] Kaiser Sunnyside Hospital, Legacy Emanuel Medical Center, Legacy Good Samaritan Medical Center, Legacy Meridian Park Medical Center, Legacy Mount Hood Medical Center, Legacy Salmon Creek Medical Center, Multnomah County Health Department, Oregon Health & Science University, PeaceHealth Southwest Washington Medical Center, Providence Milwaukie Hospital, Providence Portland Medical Center, Providence St. Vincent Medical Center, Providence Willamette Falls Medical Center, Tuality Healthcare/Tuality Community Hospital and Washington County Public Health Division.

Convening organization: The Multnomah County Health Department applied for and was given the contract to be the legal entity and neutral convener for the first three-year cycle. Year one started in June 2012.

Vision: Align efforts of hospitals, coordinated care organizations, public health and the residents of the communities they serve to develop an accessible, real-time assessment of community health across the four-county region. This will eliminate duplicative efforts, lead to prioritization of community health needs, enable joint efforts for implementing and tracking improvement activities, and improve the health of the community.

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

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

Key Objectives for Years 1 & 2

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

Assessment Model: The Healthy Columbia Willamette Collaborative is using a modified version of the Mobilizing for Action through Planning and Partnerships (MAPP) assessment model.[4] The MAPP model uses health data and community input to identify the most important community health issues.

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

The Community Themes and Strengths Assessment (Fall 2012): The first assessment involved reviewing 62 community engagement projects that had been conducted in the four-county region since 2009. Findings from the 62 projects were analyzed for themes about how community members described the most important health issues affecting themselves, their families, and the community.

The Health Status Assessment (Fall 2012): The second assessment was conducted by epidemiologists from the four county health departments with representatives from two hospital systems acting in an advisory capacity. This workgroup systematically analyzed quantitative population health-related behavior and outcome data to identify important health issues affecting each of the four counties as well as the four-county region. More than 120 health indicators (mortality, morbidity and health behaviors) were studied. The analysis used the following criteria for prioritization: disparity by race/ethnicity, disparity by gender, a worsening trend, and a worse rate at the county level compared to the state, a high proportion of the population affected, and a severe health consequence. All health issues identified through this assessment were also identified in the first assessment.

The Local Community Health System Assessment & Forces of Change Assessment (Winter 2013): The third and fourth assessments were combined and involved interviewing and surveying 126 stakeholders. This assessment was designed to solicit stakeholder feedback on the health issues resulting from the first two assessments listed above. Stakeholders were asked to add and prioritize health issues they thought should be on the list, as well as describe their organizations' capacity to address these health issues.

[3] The Healthy Columbia Willamette Collaborative website: http://www.healthycolumbiawillamette.org/. Tuality Healthcare website: http://www.tuality.org.

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

Community Listening Sessions (Spring 2013): While not a formal MAPP component, this next phase was added to ensure the findings from the four assessments resonated with the local community. Fourteen community listening sessions were held with uninsured and/or low-income community members living in Clackamas, Clark, Multnomah and Washington counties. In all, 202 individuals participated. During these meetings, community members were asked whether they agreed with the issues that were identified through the four assessments. Participants were also asked to add to include health issues that they thought were missing. Next, participants voted for what they thought were the most important issues from the expanded list. The findings of this assessment resulted in the following:

Findings from First Five Phases: After all of the four assessments and community listening sessions were completed, the findings point to the following "health focus areas" as the most important health issues affecting the four-county community[5] (in alphabetical order):

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

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

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

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

Health Focus Areas Identified after Selection Criteria Applied: Those health focus areas that meet these criteria for the region include (in alphabetical order):

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

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

Focus Area	Goal	Focus Population	Indicators/Measures
More Access to Affordable Care	• More community members will have insurance coverage and access to health services • Community members will have access to a network of free or low cost services • More community members will be established in Medical Homes	• Low income and uninsured • Elderly • Latino and other minority populations; migrant/seasonal farm workers • **Targeted zip codes: 97124, 97123, 97113, 97116, 97005, 97006, 97008**	• Increase number of PCP/1000 population • Increase rate of primary care provided by Tier 3 certified clinics. • Increase community health education opportunities • Reduce ED utilization
Chronic disease	• Members of targeted populations will have increased access to education and support to manage chronic conditions • Spanish speakers will have access to culturally competent care • Reduce tobacco use to promote long-term physical health • Increase access to health and wellness services	• Low income and uninsured • Latino and other minority populations; migrant/seasonal farm workers. • **Targeted zip codes: 97124, 97123, 97113, 97116, 97005, 97006, 97008**	• Increase outreach for community education. • Increase number of Spanish-speaking personnel. • Decrease rate of adult and teen tobacco use

Substance abuse	• Medication management • Patient/family education • Providers will refer to Pain Management physicians • Implement regional Opioid prescription plan	• Low-income and uninsured • Latino and other minority populations • At-risk youth • Targeted zip codes: **97124, 97123, 97113, 97116, 97005, 97006, 97008**	• Reduce number of opioid prescriptions • Increased provider implementation of Screening, Brief Intervention , and Referral to Treatment (SBIRT).
Mental health	• Increase access to mental health services when needed • Integrate behavioral health into patient-centered primary care homes	• Low-income and uninsured • Veterans • At-risk youth • Latino and other minority populations. • Targeted zip codes: **97124, 97123, 97113, 97116, 97005, 97006, 97008**	• Behavioral health providers embedded in medical homes • Increase number of Spanish-speaking employees

Focus Area #1: *Access to Affordable Care*

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

Strategies

1. Continue expanding outreach of Tuality Health Alliance to Oregon Health Plan members.
2. Continue expanding number of primary-care providers accepting Oregon Health Plan members through the Tuality Health Alliance.
3. Continue working with Health Share of Oregon, a Coordinated Care Organization (CCO) serving Washington, Multnomah and Clackamas counties, on providing integrated health care delivery for Oregon Health Plan members in the Tri-County area.
4. Continue working with and funding the Southwest Community Health Center – Hillsboro, a safety-net clinic which provides basic health services for treatment of acute health problems, routine laboratory services for clients and prescription medication (including pharmacy assistance) for clients.
5. Continue working with and supporting Project Access Now, a non-profit which connects low-income, uninsured people to donated care in the Portland metropolitan area.
6. Continue working with and supporting Virginia Garcia Medical Center, a non-profit which provides comprehensive and culturally appropriate primary health care with a special emphasis on migrant and seasonal farmworkers and others with barriers to receiving healthcare.
7. Provide training for employees to become certified medical translators.

Focus Area #2: *Chronic disease*

- Provide increased access to education and support to community members who have chronic conditions.
- Provide best practice health care for those with chronic conditions.
- Provide Spanish speaker with culturally competent prevention and management programs.
- Increase access to health and wellness services.
- Reduce tobacco use to promote long-term physical health.

Strategies

1. Continue participating in "Healthy Baby" project with Oregon Health Leadership Council regarding non-medically necessary early election deliveries.
2. Continue offering educational classes that deal with chronic conditions. An example: Living Well with Chronic Conditions Class, a chronic disease self-management workshop developed by Stanford University.
3. Continue supporting the Public Health Parish Nurse program where a registered nurse receives additional training in lifestyle, faith and wellness counseling and is able to deliver those services to community members with chronic conditions.
4. Work with Healthy Columbia Willamette partners to focus on breastfeeding to six months for the most vulnerable populations most at risk of barriers to breastfeeding.
5. Work with Healthy Columbia Willamette partners to develop a methodology to measure and report on rates of exclusive breastfeeding at discharge.
6. Work with Healthy Columbia Willamette partners to provide community-based lactation support at discharge to continue breastfeeding and breastfeeding education across the continuum of community/clinic based support and promotion.
7. Work with Healthy Columbia Willamette partners to develop a workplace policy supporting breastfeeding/breast milk expression in the workplace to be in compliance with federal and state law.
8. Work with Healthy Columbia Willamette partners to develop a plan to identify and work with regional employers to institute breastfeeding laws which are in compliance with federal and state laws within their places of business.
9. Work with Healthy Columbia Willamette partners to support an optimal breastfeeding support benefit and an agreement on a standard benefit package, which may include breast pumps and lactation specialist consultation.
10. Implement the 10 specific steps to support breastfeeding that are needed to be certified as a "Baby Friendly" hospital.
11. Continue to support free health screenings (blood pressure, glucose, cholesterol) at community events and health fairs.
12. Help ensure patients comply with medical advice and best practices via automated alerts from from health maintenance software.

Focus Area #3: *Substance abuse*

- Medication management
- Patient/family education
- Providers will refer to Pain Management specialists
- Implement regional Opioid prescription plan

Strategies

1. Promote implementation of safe opioid prescribing guidelines across all Healthy Columbia Willamette partner organizations. Engage medical and health care system stakeholders to develop and implement safe opioid prescribing policies. Policies should help providers to prescribe safely and include a process for situations in which guidelines are inadequate.
2. Improve monitoring of prescribing practices at institutions and the regional levels. Use prescribing monitoring systems to ensure that opioids are used safely at the practitioner, practice, organization, and regional levels.
3. Develop a plan for provider, patient, and public education covering the safe use of opioids. HCWC partners will provide education to providers and patients about safe opioid use. Additionally, HCWC members will collaborate to develop a proposal for public education about safe use of prescription opioids.
4. Explore Options to expand capacity for non-pharmaceutical treatment of pain. Develop plans to increase capacity and payment methods for complimentary therapies for chronic pain, (e.g., therapeutic pools, yoga, physical therapy, acupuncture, occupational therapy, etc.).
5. Expand medically assisted treatment for opioid addiction. Develop plans to increase capacity and payment methods for medically assisted treatment for opioid addiction.
6. Implement use of Emergency Department Information Exchange (EDIE) to monitor patients who are frequent visitors to Emergency Departments.
7. Continue to support Lung Cancer Screening program for chronic smokers that provides a low dose CT scan, consultation with a pulmonologist and smoking cessation training.

Focus Area #4: *Mental Health*

- Increase access to mental health services
- Integrate behavioral health into patient-centered primary care homes

Strategies

1. Invite the Veterans Administration Hospital in Portland to join the Healthy Columbia Willamette Collaborative to address the issue of veteran's mental health and suicide.
2. Increase access to mental health services through integrating behavioral health in patient-centered primary care home.
3. Explore collaborating with LifeWorks NW and Washington County Department of Health and Human Services to increase access to mental health services.
4. Explore collaborating with Pacific University Psychology Clinic to increase access to mental health services.
5. Continue working with Pacific University and other stakeholders to site a Veterans Administration Clinic in Hillsboro.
6. Improve transition from Emergency Department/inpatient to better follow-up discharge planning.
7. Provide psychiatric consultation support to Emergency Department/Inpatient

Healthy Columbia Willamette Partner Organizations

Organization	Type of Organization
Adventist Medical Center	Hospital in Portland
Clark County Health Department	County Health Department
Clackamas County Health Department	County Health Department
Healthy Communities Institute	Health care information organization
Kaiser Permanente	Hospitals in Sunnyside, Hillsboro; health insurer
Legacy Emanuel Medical Center	Hospital in Portland
Legacy Good Samaritan Medical Center	Hospital in Portland
Legacy Meridian Park Medical Center	Hospital in Tualatin
Legacy Mount Hood Medical Center	Hospital in Gresham
Legacy Salmon Creek Medical Center	Hospital in Vancouver, Wash.
Multnomah County Health Department	County Health Department
Oregon Health & Science University	Hospital, academic medical center in Portland
PeaceHealth SW Washington Medical Center	Hospital in Vancouver, Wash.
Providence Milwaukie	Hospital in Milwaukie
Providence Portland	Hospital in Portland
Providence St. Vincent	Hospital in Portland
Providence Willamette Falls	Hospital in Oregon City
Tuality Healthcare	Hospital in Hillsboro
Washington County Health Department	County Health Department

V. APPENDIX

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A: Frequently Asked Questions: Healthy Columbia Willamette

1. What is a Community Health Needs Assessment?

A community health needs assessment (CHNA) is an analysis of community health needs and assets. It is performed by examining population health data and seeking community input.

The federal Affordable Care Act, Section 501(r)(3) requires tax-exempt hospital facilities to conduct a Community Health Needs Assessment (CHNA) at minimum once every three years, effective for tax years beginning after March 2012. Through the Public Health Accreditation Board, public health departments now may achieve accreditation by meeting a set of standards. As part of the standards, they must complete a Community Health Assessment (CHA) and a Community Health Improvement Plan (CHIP). Coordinated Care Organizations (CCO) serving the three counties in Oregon are required to meet Oregon Administrative Rules and Oregon Health Authority guidelines pertaining to the development of a CHA and a CHIP.

2. What is the Healthy Columbia Willamette Collaborative?

The Collaborative is a large public-private partnership among 15 hospitals, four health departments and two Coordinated Care Organizations in Clackamas, Multnomah and Washington Counties of Oregon and Clark County, Washington.

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

3. How did the project originate?

In 2010, local health care and public health leaders began to discuss the upcoming need for several community health assessments and health improvement plans within our region in response to the Affordable Care Act and Public Health Accreditation. They recognized that the most efficient and effective approach would be to create a work group responsible for conducting a region-wide community health assessment. With start-up assistance from the Oregon Association of Hospitals and Health Systems, the Healthy Columbia Willamette leadership group was developed.

In June 2013, FamilyCare and Health Share of Oregon, the Coordinated Care Organizations serving the three counties in Oregon, joined the Collaborative in response to Oregon Administrative Rules and Oregon Health Authority guidelines pertaining to community health assessment and health improvement plans.

4. What is the vision of the Healthy Columbia Willamette Collaborative?

Align efforts of hospitals and public health and the residents of the communities they serve

- Develop an accessible, real-time assessment of community health across the four-county region
- Eliminate duplication
- Enable joint efforts for implementing and tracking improvement activities
- Improve the health of the community

5. What is the assessment model being used by the Collaborative?

The Collaborative is using a modified version of the Mobilizing for Action through Planning and Partnerships (MAPP) assessment model. The MAPP model uses health data and community input to identify the most important community health issues. This assessment will be an on-going, real-time assessment with formal community-wide findings every three years. The modified MAPP model used by the Collaborative includes four major assessments. These assessments were completed between August 2012 and April 2013:

The Community Themes and Strengths Assessment (Fall 2012)

This first assessment involved reviewing 62 community engagement projects that had been conducted in the four-county region since 2009.

The Health Status Assessment (Fall 2012)

The second assessment was conducted by epidemiologists from the four county health departments with representatives from two hospital systems acting in an advisory capacity.

The Local Community Health System Assessment & Forces of Change Assessment (Winter 2013)).The third and fourth assessments were combined, and involved interviewing and surveying 126 stakeholders.

Community Listening Sessions (Spring 2013)

The next phase is not a formal MAPP component, but was added to ensure the findings from the four assessments resonated with the local community. Fourteen community listening sessions were held with uninsured and/or low-income community members living in Clackamas, Clark, Multnomah and Washington counties.

6. How are the findings from the assessment being used by the Collaborative?

Based on the above described assessment results, nine health focus areas were identified. Below is a chart displaying these health focus areas.

Summary of Top Health Issues

	Assessments			
	Community Themes & Strengths	Health Status	LCHS Forces of Change	Listening Sessions
Was the issue identified by community members or population data?				
Access to Affordable Health Care	**Yes**	**Yes**	**Yes**	**Yes**
Cancer	**Yes**	**Yes**	**No**	**No**
Chronic Disease: Nutrition, Physical Activity	**Yes**	**Yes**	**Yes**	**Yes**
Culturally Competent Data/Services	**No**	**No Data**	**Yes**	**No**
Injury	**No**	**Yes**	**No**	**No**
Mental Health	**Yes**	**Yes**	**Yes**	**Yes**
Oral Health	**No**	**No Data**	**No**	**Yes**
Sexual Health	**No**	**Yes**	**No**	**No**
Substance Abuse	**Yes**	**Yes**	**Yes**	**Yes**

Recognizing that nine health focus areas would be too many to address in a way that could show improvement in health indicators over a relatively short period the Collaborative developed selection criteria to further prioritize health issues from the list above. The selection criteria are described in the summary assessment report. The top health needs identified in the region that the Collaborative will work on are:

- Access to Affordable Health Care
- Behavioral Health
- Chronic Disease

After meeting with content experts from these areas to provide information regarding best practices and recommendations for strategies that the Collaborative could consider moving forward with, the Collaborative created five Health Improvement Teams to develop and implement collective strategies for. These Health Improvement Teams are:

- Access to Affordable Health
- Mental Health
- Opioid Prescription Misuse
- Breast Milk/Feeding Promotion

7. Who can I contact if I would like more information about the Collaborative?

Please contact christine.e.sorvari@multco.us or meghan.crane@multco.us for more information.

B: Washington County Census data

	Washington County	Oregon
Population, 2013 estimate	554,996	3,930,065
Population, 2012 estimate	547,543	3,899,801
Population, 2010 (April 1) estimates base	529,712	3,831,073
Population, percent change - April 1, 2010 to July 1, 2013	4.8%	2.6%
Population, percent change - April 1, 2010 to July 1, 2012	3.4%	1.8%
Population, 2010	529,710	3,831,074
Persons under 5 years, percent, 2012	6.9%	6.0%
Persons under 18 years, percent, 2012	25.0%	22.1%
Persons 65 years and over, percent, 2012	10.9%	14.9%
Female persons, percent, 2012	50.7%	50.5%
White alone, percent, 2012 (a)	83.0%	88.3%
Black or African American alone, percent, 2012 (a)	2.1%	2.0%
American Indian and Alaska Native alone, percent, 2012 (a)	1.2%	1.8%
Asian alone, percent, 2012 (a)	9.3%	4.0%
Native Hawaiian and Other Pacific Islander alone, percent, 2012 (a)	0.5%	0.4%
Two or More Races, percent, 2012	3.9%	3.5%
Hispanic or Latino, percent, 2012 (b)	16.0%	12.2%
White alone, not Hispanic or Latino, percent, 2012	68.9%	77.8%
Living in same house 1 year & over, percent, 2008-2012	82.9%	82.1%
Foreign born persons, percent, 2008-2012	16.9%	9.8%
Language other than English spoken at home, pct age 5+	23.3%	14.7%
High school graduate or higher, percent of persons age 25+	90.7%	89.2%
Bachelor's degree or higher, percent of persons age 25+	39.5%	29.2%
Veterans, 2008-2012	34,054	333,395
Mean travel time to work (minutes), workers age 16+	24.2	22.4
Housing units, 2013	215,773	1,684,035
Homeownership rate, 2008-2012	61.7%	62.5%
Housing units in multi-unit structures, percent, 2008-2012	30.4%	23.2%
Median value of owner-occupied housing units, 2008-2012	$290,900	$246,100
Households, 2008-2012	200,160	1,512,718
Persons per household, 2008-2012	2.63	2.48
Per capita money income in past 12 months (2012 dollars)	$31,476	$26,702
Median household income, 2008-2012	$64,375	$50,036
Persons below poverty level, percent, 2008-2012	10.9%	15.5%

C: Health Columbia Willamette Dashboard Data

This is an example of data available on the Health Columbia Willamette and Tuality Healthcare webpages.

Red < 74.0
Green > = 77.9
In-between = **Y**ellow
Unit: percent

Adults with a usual Source of Health Care

Value:	89.6 percent
Measurement Period:	2006 2009
Location:	County: Washington Located in State: Oregon
Comparison:	Oregon Counties
Categories:	Health Access to Allied Services

What is this Indicator?

This indicator shows the percentage of adults that report having one or more persons they think of as their personal doctor or health care provider.

Why this is important:

People who lack a regular source of health care may not receive the proper medical services when they need them. This can lead to missed diagnoses, untreated conditions, and adverse health outcomes. People without a regular source of health care are less likely to get routine checkups and screenings. When they become ill, they generally delay seeking treatment until the condition is more advanced and therefore more difficult and costly to treat. Young children and elderly adults are most likely to have a usual source of care, whereas adults aged 18 to 64 years are the least likely. Maintaining regular contact with a health care provider is especially difficult for low-income people, who are less likely to have health insurance. This often results in emergency room visits, which raises overall costs and lessens the continuity of care.

The Healthy People 2020 national health target is to increase the proportion of people with a usual primary care provider to 83.9%.

Technical Note: The distribution is based on data from 34 Oregon counties and county groups.
The value is age-adjusted to the 2000 U.S. Standard Population.
Source: Oregon Behavioral Risk Factor Surveillance System
URL of Source: http://public.health.oregon.gov/BirthDeathCertificates/Su...
URL of Data: http://public.health.oregon.gov/BirthDeathCertificates/Su...
Maintained By: Healthy Communities Institute

D: Community Themes and Strengths Assessment

Purpose

The broad goal of the Community Themes and Strengths Assessment was to identify health-related themes from recent projects engaging community members of Clackamas, Multnomah and Washington counties in Oregon and Clark County in Washington.

Conducting the Community Themes and Strengths Assessment served three purposes: 1) to increase the number of community members whose voices could be included; 2) to prevent duplication of efforts and respect the contributions of community members who have already shared their opinions in recent projects; and 3) to utilize the extensive and diverse community engagement work that local community-based organizations, advocacy organizations, and government programs have already done.

Community Themes and Strengths Assessment findings combined with the findings of the other three MAPP assessment components and the community listening sessions provided the Collaborative Leadership Group with information necessary to select the community health needs and improvement strategies within the four-county region.

Methodology

The Community Themes and Strengths Assessment, the first of four major components of MAPP, was an analysis of findings from recently conducted health-related community assessment projects conducted in Clackamas, Multnomah, and Washington counties in Oregon and Clark County in Washington State.

Between September and December 2012, the Collaborative identified community assessment projects conducted within the four-county region. Four criteria were used for inclusion in the "inventory" of assessment projects that would be used to identify community-identified themes. The assessment project needed to: 1) be designed to explore health-related needs, 2) have been completed within the last three years (since 2009), 3) have a geographic scope within the four-county region, and 4) engage individual community members in some capacity, as opposed to only agency-level stakeholders.

Community assessment projects were identified by: 1) contacting individual community leaders, community-based organizations, public agencies and Healthy Columbia Willamette Collaborative leadership members to solicit their recommendations for projects to include in the inventory; 2) conducting numerous Internet searches, which consisted of using a Google search engine and by examining hundreds of organizational websites across the four-county region and; 3) including recent community assessment projects that had already been identified through the Multnomah County Health Department's 2011 Community Health Assessment. In all, 62 community assessment projects' findings were included in the "inventory" of assessments.

Findings

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

Social environment

- Issues identified as important: sense of community, social support for the community, families, and parents, equity, social inclusion, opportunities/venues to socialize, spirituality
- Issue identified as problems: racism

Equal economic opportunities

- Issues identified as important: jobs, prosperous households, economic self-sufficiency, equal access to living-wage jobs, workforce development, economic recovery
- Issue identified as problems: unemployment

Access to affordable health care

- Issues identified as important: access for low income, uninsured, underinsured, access to primary care, medications, health care coordination

Issue identified as problems: emergency room utilization

Education

- Issues identified as important: culturally relevant curriculum, student empowerment, education quality, opportunity to go to college, long term funding/investment in education
- Issues identified as problems: low graduation rates, college too expensive

Access to healthy food

- Issues identified as important: Electronic Benefit Transfer-Supplemental Nutrition Assistance Program (EBTSNAP) benefits, nutrition, fruit and vegetable consumption, community gardens, farmers' markets, healthy food retail, farm-to-school
- Issue identified as problems: hunger

Housing

- Issues identified as important: affordability, availability, stability, tenant education, healthy housing, housing integrated with social services/transportation
- Issues identified as problems: evictions, homelessness
- Mental health & substance abuse treatment
- Issues identified as important: access for culturally-specific groups and LGBTQI community, counseling, quality and availability of inpatient treatment, prevention
- Issues identified as problems: depression, suicide, drug/alcohol abuse

Poverty

- Issues identified as important: basic needs, family financial status
- Issues identified as problems: cost of living, daily struggles to make ends meet
- Early childhood/youth
- Issues identified as important: child welfare, youth development and empowerment, opportunities for youth, parental support of student education experience
- Issues identified as problems: lack of support for youth of all ages, child protection services

Chronic disease

- Issues identified as important: chronic disease support, management and prevention
- Issues identified as problems: obesity, smoking
- Safe neighborhood
- Issues identified as important: public safety, traffic/pedestrian safety

- Issues identified as problems: crime, violence, police relations

Transportation options

- Issues identified as important: equitable access to public transportation, transportation infrastructure investments
- Issues identified as problems: bus is too expensive, limited routes for shift workers

E: Local Community Health System and Forces of Change Assessment

Purpose

The purpose of the Local Community Health System and Forces of Change Assessment was to learn the most important health issues facing the clients of stakeholder organizations across Clackamas, Multnomah, and Washington counties in Oregon and Clark County in Washington, as well as the organizations' capacity to address those needs. The assessment was designed to also collect input about the current opportunities and threats to the "local community health system" (LCHS).

The LCHS is the network of organizations that contributes to the health of a community. LCHS stakeholders include public health authorities, community based organizations, hospitals, health care providers, and advocacy groups. A LCHS can also include stakeholders working to address social determinants of health—housing, education, employment, and other factors—and could expand to include less obvious contributors to the community's health. Examples include media companies that can participate in health promotion efforts and grocery stores that influence what types of food are available.

Findings from the Local Community Health System and Forces of Change Assessment were used in conjunction with the results from the Community Themes & Strengths Assessment, Health Status Assessment, and Community Listening Sessions to guide the Healthy Columbia Willamette Collaborative's selection process of community health issues it will work to address.

Methodology

Between January and March 2013, 126 stakeholder organizations were interviewed (n=69) and surveyed

(n=57). The stakeholders play primary roles of the LCHS in Clackamas, Multnomah, and Washington Counties in Oregon and Clark County, Washington.

For the scope of this first cycle of the Healthy Columbia Willamette community needs assessment, the list of stakeholders engaged was driven by the Community Health Needs Assessment (CHNA) requirements for nonprofit hospitals and Coordinated Care Organizations set forth by the Internal Revenue Service and the Oregon Health Authority respectively.

The Internal Revenue Service and the Oregon Health Authority identify the following stakeholder groups that should be engaged during the CHNA process: 1) people with special knowledge of, or expertise in public health; 2) federal, tribal, regional, state, local, or other departments/agencies; and 3) community members and/or agencies that represent or serve medically underserved/underinsured/uninsured populations, low income populations, communities of color, populations with chronic disease issues, aging populations, the disability community, the LGBTQ community, and populations with mental health and/or substance abuse issues.

Interview questions were informed by Healthy Columbia Willamette members' experiences—hospitals conducting CHNAs and local health departments completing community health assessments. Members also reviewed resources available from the National Association of County and City Health Officials

(NACCHO) MAPP Clearinghouse.

Stakeholders were asked about:

- The health of the populations they serve;
- The list of important health issues identified through the Community Themes and Strengths and Health Status Assessments (i.e., access to health care, sexual health, mental health & substance abuse, injury, cancer, and chronic disease);
- Health issues that should be added to the list;
- Their opinions on the three most important health issues;
- Their current work to address important health issues;
- The work they would like to be doing in the future to address important health issues;
- Opportunities and threats to their current capacity to do this work; and
- Resources that would help their organization continue or expand their capacity.

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

Findings

Stakeholder organizations that participated in interviews and surveys described the important health issues facing community members and what is currently being done to improve the health of the community. Stakeholders participating in interviews and surveys indicated that they served primarily:

- Medically underserved, uninsured, and underinsured populations;
- Communities of color;
- Children and youth;
- The disability community; and/or
- Populations with mental health and/or substance abuse issues.

Of those organizations reporting that they work with communities of color, American Indians/Alaska Natives and Hispanics/Latinos were the most common populations they mentioned. Of those who work with populations that speak limited English, Spanish and Russian were the most commonly spoken languages.

The Community's Health

During the interviews participants were asked, "How healthy is the population/community you serve compared to the larger population?" More than half of the interviewees did not think the community they served was as healthy as the larger population.

- There are still too many health disparities, not enough breastfeeding, too many people who are overweight, too many people who smoke, and not enough focus on prevention.
- It's clear that our population of folks is struggling much more than the general population. They have a higher level of health challenges that come with poverty, struggling with basic health care. Often homeless populations are in those situations because they have health issues. It creates a vicious cycle that spirals downwards.

- There are a lot of barriers to good health because of a lack of cultural competency in provider settings. Many [people] experience discrimination and consequently put off care, making them less healthy in the long run.
- There is an "immigrant paradox" where new immigrants are healthier and the longer they are in the US, the less healthy they become.
- [It] depends. Children? Yes. Adults? No—[due to] lack of specialists, lack of mental health care, lack of programs to educate about wellness, and often adults have chronic conditions.
- We know that Native American, African American, Latino, Asian Pacific Islander, and low-income communities fare worse than Non-Hispanic Whites with chronic conditions and have increased illnesses across the board. We've spent time enumerating the health inequities; a lot of it is understood.

An Iterative Process to Identify Health Issues

During interviews, stakeholders were asked to review the list of health issues that were identified through the first two assessments of the Healthy Columbia Willamette Collaborative's CHNA. The first assessment, The Community Strengths and Themes Assessment, looked at recently conducted local community engagement projects; the second assessment, The Health Status Assessment looked at the epidemiological data to describe the current health status of the community. *(Community Themes and Strengths Assessment: Important Health Issues Identified by Community Members. July 2013 and Health Status Assessment: Quantitative Data Analysis Methods and Findings. July 2013)*

These two assessments had complementary findings with both the qualitative data and the quantitative data describing similar health issues in the community. The only community health issue that was not identified during both assessments was "injury." Injury was identified through the Health Status Assessment and included deaths due to falls and accidental poisoning deaths—including drug overdoses. The list of health issues discussed during the stakeholder interviews (in alphabetical order) included:

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

Stakeholders were asked, *"After looking over this list, is there any health issue, specifically a health outcome or behavior--that you are surprised to not see? If so, what is it and why do you think it's important?"*

As a result, the most common health issues stakeholders added to the list included domestic violence and oral health. Although not mentioned as frequently as domestic violence or oral health, the need to develop culturally competent services and collect culturally competent data was discussed by several stakeholders. These issues were added to the survey for two reasons: 1) addressing racial/ethnic health disparities is a top priority for all Healthy Columbia Willamette Collaborative members, and 2) the lack of data available for the Health Status Assessment made it challenging to assess indicators stratified by race/ethnicity.

During the interviews, mental health and substance abuse were grouped together as one health issue. Many stakeholders suggested that mental health and substance abuse be separated into two issues for the "voting" process because both are important problems that are distinct from one another and have unique interventions. Because "mental health & substance abuse" was one issue during the interviews, it was not possible to determine, in all cases, whether there was more importance placed on mental health or substance abuse. For the analysis, if an interviewee selected "mental health & substance abuse" as one of their top three

health issues, their response was separated into two votes; one each for mental health and substance abuse. Their other four votes were kept resulting in their having four votes in total.

The majority of stakeholders participating in interviews said that the two health issues, "injury" and "sexual health" were not clear. They suggested that these categories needed to be described better by listing the data or indicators that were included. In response to this feedback, both health issues were described. "Injury" was separated into two categories: falls and poisoning/overdose. "Sexual health" was further clarified to include HIV, Syphilis, and Chlamydia, stemming from the epidemiological data. This feedback from the interviews was used to compile the answer choices on the survey:

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

An additional health issue, "perinatal health," emerged from the following write-in survey responses: "women's health," "family health," "reproductive health," "prenatal health," "maternal health," "maternal and child health," "pre-conception health," "healthy pregnancy," "birth outcomes," and "Fetal Alcohol Spectrum Disorders." After a second study of interview notes, answers that corresponded to this "perinatal health" category were classified and were taken into consideration when identifying health issues prioritized by the interview and survey participants.

Prioritized Health Issues

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

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

These five health issues were the priorities all four counties. Stakeholders working in Clark County, Washington also prioritized cancer and oral health. Stakeholders were asked to identify age groups that were at high risk for each of their top health issues. However, stakeholders only differentiated high risk populations among persons aged 45-64 years and 65+ years for chronic disease and cancer. This finding is consistent with national trends as the Centers for Disease Control and Prevention cites that "about 80% of older adults have one chronic condition, and 50% have at least two."

F: Community Listening Session

Purpose

The purpose of these discussions was to learn what low-income and uninsured residents of the four-county region feel are the most important issues affecting their health, their families' health, and the community's health. In addition, the groups were held to solicit ideas about how to address these health needs.

Methodology

During March and April of 2013, 14 community listening sessions were conducted in Clackamas, Multnomah, and Washington Counties in Oregon and Clark County, Washington. In total, 202 individuals participated, sharing their opinions with one another about important community health issues and how the community's health can be improved.

Recruitment

In advance of the listening sessions, recruitment flyers were developed by hospital members of the Collaborative and translated into Spanish, Russian, and Somali by health department members. They were distributed to organizations, community networks, and community-accessible locations to be posted or handed out. Flyers specified that low-income/no income and/or uninsured adults were the intended participants, and advertised locations and times for sessions, as well as the provided food, childcare, and $25 gift card incentives.

Recruitment materials were posted and distributed primarily through agencies and community organizations that serve low-income populations. Over 100 organizations were able to help with recruitment, ranging from individual housing projects to community groups with constituents across the four-county area. Healthy Columbia Willamette Collaborative members also recruited among their own organizations' constituents where appropriate, and asked their colleagues in the community to help recruit participants. In addition, local Spanish-language and Russian-language radio stations promoted the meetings. The listening sessions lasted approximately an hour and a half, and free childcare services were offered on site. Hospital partners provided meals and childcare for each group. Hospitals also provided $25 Fred Meyer gift-cards for the first 25 participants in each group to acknowledge participants' time and contribution to the project.

Group Structure

The Healthy Columbia Willamette Collaborative was interested in hearing specifically from low-income and uninsured residents from across the four-county area, and as mentioned above, efforts were made to reach this population during recruitment.

Listening sessions were opened with a large group introduction before splitting into small discussion groups of 10 or fewer participants. Each small discussion group was facilitated by a different Healthy Columbia Willamette Collaborative member or interpreter. Small groups were facilitated in English, Spanish, Russian, and Somali with the support of interpreters from participating health departments and the Immigrant and Refugee Community Organization (IRCO). In order to encourage attendance, meals were provided, and sessions were scheduled on both weekdays and weekends and at community-accessible locations across the four-county area.

Group discussions revolved around four questions:

- What does a healthy community look like to you?
- Are there other health issues that you think should be on this list? (The list of important health issues identified by the findings of the Community Themes and Strengths, Health Status, and Local Community Health System and Forces of Change Assessments.

- What are the five health issues that you would like to see addressed first?
- What should be done to fix or address these health issues?

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

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

Participants

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

The survey was available in English, Spanish, Russian, and Somali as well as in large font (in English). Of participants specifying an income range on their survey, 62 percent came from households earning less than $20,000 per year. Of those indicating a health insurance status, 63 percent indicated they were uninsured with an additional 21 percent indicating they were on the Oregon Health Plan (OHP). Participants' ages ranged from 17 to 90 years, with an average age of 40 years. Almost three quarters of participants returning the surveys identified as female.

Participants were also asked to identify their race and ethnicity. Regionally, over half (53 percent) of those providing this information indicated that they were Hispanic, 25 percent were White, 7 percent were African, 6 percent were African American, 2 percent were Native American, 1 percent were Asian and 1 percent were Native Hawaiian/Pacific Islander. Individuals could select selected more than one race/ethnicity; only one participant did so.

The composition of participants involved in the listening sessions is not representative of regional race, ethnicity, or gender demographics. The sample may not be representative of other communities, (e.g., the LGBTQI, disability, and recovery communities). Given that hospitals have impending tax filing deadlines and requirements to focus on low-income and uninsured populations, the Healthy Columbia Willamette Collaborative members agreed for this first cycle, that recruitment for the community listening sessions

would focus on people with low income levels and/or no health insurance. The Collaborative members recognized that by using only these criteria, people from other vulnerable communities might not be reached. In order to improve participation by other communities, the Collaborative worked with more than 100 community organizations to help with the recruitment. Examples of the communities these organizations helped recruit, include Native American, LGBTQI, disability, African American, recovery, immigrant/refugee, etc.

When looking at the participation in these community listening sessions and all previous assessment phases, (i.e., Community Strengths and Themes, Health Status, Local Community Health System and Forces of Change Assessments), it becomes clear that the Collaborative included the opinions from a wide array of stakeholders, including many people from culturally-identified communities. Moving forward, community members will be actively engaged to implement and monitor the health of the community.

Participants lived throughout the four counties; however, not all areas of the four-county region were represented equally due to recruitment challenges such as difficulty connecting with people living in rural areas, or with people speaking languages other than English, Spanish, Somali, or Russian.

Following each session, many participants expressed their appreciation for the opportunity to speak about their priorities and needs, and 26 percent of participants signed up on a contact list so they can be invited to other events, kept informed about how the information collected through the community listening sessions was used, and be informed about upcoming changes in health services and policies. Many participants also expressed that holding these types of groups is an effective way to help reduce social isolation and empower people to become involved in their neighborhoods.

Findings

The findings represent the opinions and experiences of 202 individuals living in the four counties. As a result of this small number and the use of a convenience sample, findings are presented for the region, not individual counties. There was a lot of agreement across individuals and between small discussion groups on what the important health needs are and what can be done to address them, which supports the possibility that these opinions are likely to be shared by a larger percentage of the population. The findings are presented in two sections: 1) a description of what a healthy community looks like and 2) the important community health needs, as well as what can be done about them.

Discussing a Healthy Community

When initially asked how they would describe the elements of a healthy community, listening session participants tended to draw from current problems observed in their own communities. They generated a number of ideas about what might constitute a healthy community. The most common themes included people having 1) basic needs met (food, shelter and employment); 2) access to quality health services; 3) a connected and compassionate social system; 4) peer support, resources, and self-determination to practice healthy habits; and 5) access to education and other shared community resources.

In addition, there was strong agreement that a healthy community would have better access to public transportation, more recreation facilities to promote healthy behaviors, and expanded community programming catering to both individuals and families. They wanted to be able to feel safe from gang and street violence, to feel comfortable with the role and effectiveness of law enforcement, and to feel involved in and informed about their community's issues. Things have changed since growing up in the 60s. Today, moms have to be watching their kids and have them in view at every moment. Perhaps most important to their definition of a healthy community, participants frequently stressed the importance of being socially connected to one's community in order to receive support in times of need and stress. We need to be moving from an "I" community to an "Us" community.

Important Community Health Issues and Strategies for addressing them

Several specific issues drawn from the Health Issues list (and from additional issues added by participants) recurred in discussions of communities' top health issues. When looking at voting results of all discussion groups, it is clear that there is strong agreement on what health issues are the most important. There are also frequently reoccurring ideas on strategies suggested for addressing these issues. These findings are presented in five sections, beginning with the most-prioritized health issue:

(1) Mental Health and Mental Health Services

(2) Chronic Disease and Related Health Behaviors

(3) Substance Abuse

(4) Access to Affordable Health Care

(5) Oral Health and Access to Oral Health Services

Mental Health and Access to Mental Health Services

Although mental health and access to mental health services were presented as two different health issues on the list, listening session participants most often voted to combine the two into a single issue. Even when this sentiment was not explicitly stated, discussion frequently treated the two together. Mental health stood out as the most voted-for health problem in the community.

Addressing Isolation and Anxiety as Contributing Factors to Mental Health Issues

In almost all groups, social isolation was a theme related to community mental health issues. Participants expressed significant concern over the detrimental impact of social isolation on mental and emotional health, and especially emphasized it as a cause and contributor to depression in their communities. They noted that isolation derived from many factors, including reliance on technology for communications, lack of employment, lack of cultural integration between different communities, being homeless, and family roles which tended to keep some women in the home or busy with childcare. Many also saw social isolation as a significant barrier to care, in that isolated individuals would feel less comfortable seeking out care themselves and would be less likely to be screened for mental health issues.

Most participants voiced that it was important, in confronting mental health issues, to promote social practices that would work against social isolation. In almost all groups, participants spoke about building a compassionate community that embraces diversity. This included working to eliminate racism, ageism and other forms of discrimination against individuals; as well as raising awareness of the different and special needs of individuals in their community.

> *…Develop a sense of community where residents are motivated to care about each other, respect one another, connect with one another, and help out strangers and neighbors.*

Many groups felt it was important to remove the stigma associated with mental health issues and treatment in order to help people feel supported by their communities and peers in seeking treatment:

> *[Provide] support for people experiencing mental health issues so they can address what's happening and feel supported and secure with themselves.*

Additionally, there was strong agreement that increasing opportunities for community involvement would also play a significant role in reducing the incidence of mental health issues. Examples suggested included volunteer programs, community classes and organized activities for individuals and families, more community recreation and arts centers, and sports programs for all ages. Several groups also mentioned the importance of services that could remove the barriers to participate for some people, including

childcare, transportation, or providing visits to those who are home-bound. In addition to isolation, most participants felt that depression in their community was caused by financial stress, the real-life stressors of poverty, homelessness, or adjusting to US systems and society as a member of an immigrant community. Participants generally agreed that, besides the social support discussed above, the way to ease such stress was to continue to work on improving the larger factors that influence a community's health—the economy, housing, and culturally competent services.

Improving Access to Mental Health Services

Many participants felt that there were too few mental health providers to meet community needs. Residents of more rural areas felt this was especially true, and many participants from non-English-speaking communities felt there was sometimes a complete lack of services that would be appropriate for them. Participants from these groups proposed increased training and community placement of mental health service providers, especially those offering therapy and counseling services. Non-English speaking communities hoped to see providers sourced and trained from their own communities.

For example, participants from Somali-speaking communities expressed feeling that Post Traumatic Stress Disorder (PTSD) and other trauma-related mental health issues were some of the most significant of all health issues in their communities. Such issues impacted entire families and communities—not just isolated individuals; and there was a general feeling among Somali participants that this problem was not sufficiently recognized by "western" providers. They expressed that in order to be effective, providers of therapy, counseling and other treatments would need to be much more culturally sensitive and better informed about the patients' backgrounds than they currently are. Many participants indicated that affordability was an issue. It was frequently expressed that the inconsistency of insurance coverage offered for mental health services was a definite problem. Many participants suggested that in addition to pursuing universal health coverage, it would be important to put regulations in place to extend health coverage to include a full range of mental health treatment services.

Although they agreed that professional mental health services were very important, participants also felt it would be worth investing resources in community groups and support that contribute to good mental health and community-supported recovery. They named churches, peer support groups, and community health educators as examples things they would like to see developed or expanded activities in their communities

Chronic Disease and Related Health Behaviors

Chronic disease and Related Health Behaviors ran a close second to mental health issues in the voting portion of the discussion. Many participants had stories to share about specific chronic disease issues they had experienced or witnessed in their families and communities. Most often their concerns focused on nutrition and exercise habits, diabetes, and heart disease.

Participants were particularly concerned about the lack of physical activity affecting all generations in their communities, not just adults as the epidemiology data identified. Many participants pointed out that motivation and opportunities for exercise in senior communities was extremely lacking. Participants largely attributed the lack of physical activity to an increasingly sedentary, technology-based society.

Across almost all groups, participants mentioned wanting to increase community programming that promoted physical activity for all ages—and to ensure that the opportunities be affordable. Some suggested that letting people rent or borrow equipment such as bicycles and helmets would help. Examples of programming included senior walking clubs, community gardening initiatives, and increased sports programs for youth. A few participants emphasized that some programming should be tailored to the needs of individuals already facing limiting chronic disease issues such as obesity and heart disease.

Several participants thought that their workplaces could benefit from programs encouraging wellness and physical activity on the job. Participants, whose jobs require sitting or standing in one place for long periods of time, recognized that this was especially detrimental to their health and even to their motivation to exercise outside of work.

Another concern was nutrition. Many participants felt that they could not afford or access the most nutritious food options, and were limited by the prices of produce and the lack of stores offering nutritious options in convenient locations. Participants wanted to see more nutritious options in the locations most convenient to them, such as convenience stores and chain grocery stores—and suggested the support of more farmers markets in their communities. Once again, participants suggested community gardening as an activity that promotes physical activity and provides healthy food to the community inexpensively.

Several participants suggested tactics to encourage low-income community members to choose healthy options where they are already available, such as subsidizing produce and limiting the kinds of food that could be purchased through the Supplemental Nutrition Assistance Program (SNAP).

Many participants expressed feeling constantly tempted by "easy" inexpensive, unhealthy food offerings in vending machines and cafeterias and available through the numerous fast food restaurants near their homes. They wanted to see workplaces and schools make efforts to replace unhealthy food options with healthy ones, and wondered if there was a way to develop a "healthy fast food" that could make nutritious meals fairly cheap and easily accessible.

In some cases, working families felt overwhelmed about the cost and time that is required to provide healthy meals consistently to family members, and were unsure how to stop relying on quick and unhealthy food options. Participants from these families felt that they could benefit from community education focused on nutrition and cooking, and from a forum for sharing recipes that balance quick preparation and inexpensive ingredients with good nutrition.

Participants suggested other strategies addressing chronic disease issues that focused on creating educational and motivational opportunities for the community. They felt it was important to make sure the community was informed about the relationship between healthy habits and chronic disease, had skills and strategies for preparing nutritious food, and knew how to access information about chronic disease prevention and early symptoms. Ideas for implementing this education included a strong motivational media campaign, mailers, cooking classes, health fairs, and a stronger health curriculum in schools.

> *Go back to the basics and get it into our curriculum.*

Participants generally appreciated existing social services like WIC, but wanted to see this type of program expanded to reach more people not just women and children.

> *[We need] NEW programs that educate and motivate people to make healthy choices, like a WIC program for adults.*

Many participants felt that diabetes was a noticeable problem in their communities due in part to people's inability to recognize and manage symptoms of the disease. Similarly, they felt heart disease went largely unacknowledged and untreated even as it progressed due to unhealthy habits. There was general agreement that, in part, these diseases were going unmanaged as a result of a lack of community education about the diseases and symptoms. It was also stated that in some cases the lack of management was due to a lack of motivation to pursue treatment or lifestyle changes. Participants generally agreed that educating the public about the symptoms, behavioral links, and long-term consequences of these diseases would be the first step toward reducing their burden.

Substance Abuse

Substance abuse issues ranked third in importance to listening session participants. Discussions touched on several issues: smoking, alcohol abuse, misuse of over-the-counter medications, and methamphetamines. Participants were especially concerned about the lack of treatment programs they considered effective, the susceptibility of youth to addictive substances, the lack of clear information and facts about substance abuse issues, and a trend of substance abuse being socially acceptable.

Participants felt that the services currently available for treating substance abuse problems neglect "whole person" care and recovery; that is, they tend to focus too much on the clinical treatment of extreme incidents rather than using therapy, or the treatment of other health issues to support recovery. Prison, they felt, was too often a substitute for effective treatment in this country. They recognized that residential treatment facilities do exist, but that they are largely targeted to higher-income individuals or are inadequate in capacity to meet the full need in the community. Many participants originally from other countries explained that treatment options in the U.S. seemed significantly less effective than the highly-utilized residential treatment programs for substance abuse in their home countries.

Several groups' ideas involved strategies to create centralized substance abuse treatment services and make them available as part of a comprehensive treatment plan. Some groups wanted to create "case-worker" positions that could help individuals keep track of and coordinate different provider and community support services. Most groups discussing substance abuse mentioned feeling like they had a hard time getting access to unbiased information about the dangers of certain substances, and wanted to see clearly-presented materials developed that they could use as educational tools to protect themselves and their families. Also, as in their approach to mental health issues, participants generally felt that it was important to raise community awareness of existing substance abuse issues and available treatment. Some groups suggested media campaigns that warn, educate, and promote treatment options.

Many participants with children were extremely concerned by the susceptibility of their children to social pressure from peers and drug dealers to try drugs in schools and other settings outside the home. Several talked about how it seemed to be more and more difficult to talk to kids about these issues before they are approached about drugs. Many of these participants wanted to work with schools to develop a strong anti-drug curriculum targeted towards very young children.

Some participants were worried about themselves or their children becoming the targets of violence related to drug culture. As with their discussion of chronic disease prevention, participants wanted to see an increase in accessible recreation facilities and affordable sports and arts programming available to provide safe and enjoyable spaces. They felt that such spaces and activities—for both youth and adults—are important alternatives to opportunities for substance abuse.

In addition to street drugs, several participants also commented on the widespread abuse of tobacco and alcohol despite ongoing media campaigns they've seen to warn against the use of these products. Many participants repeatedly indicated that smoking and drinking excessively around children in the home is a problem that they witness in their communities on a regular basis. In a few groups, the abuse of over-the-counter drugs was of particular concern. Participants tended to be concerned with an apparent social acceptance of these practices.

Several individuals were frustrated by the role that media plays in marketing certain substances to the general public. A few participants stated that alcohol commercials send mixed messages. Others, especially those originally from other countries where media is differently regulated, found it troubling to constantly see advertisements for over-the-counter and prescription drugs – products, they felt, that didn't need to be advertised and were frequently abused. These participants suggested banning television advertisement for these products.

There were varying suggestions about regulation and policy changes that participants wanted to see established to confront substance abuse issues. On the whole, suggestions were aimed at restricting access to substances and to promotional media. Examples included drug laws with harsher penalties for selling illicit drugs, school policies that punish drug abuse and distribution more severely, more restrictions on medical marijuana, strict rules for medication and alcohol advertisements, and regulations to monitor provider prescriptions and patient need for medications.

Access to Affordable Health Care

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

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

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

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

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

Several participants wanted to loosen eligibility requirements for services like the Medicaid (Oregon Health Plan), SNAP and other programs that help low-income community members to maintain good health and regular access to medical care.

They felt that the current system of public assistance sometimes discouraged recipients to pursue employment out of fear of losing benefits even if it were only a seasonal or temporary increase in income. There was some concern expressed by participants that people living in the US without documentation are not getting the care they should be and having to wait until their situation is an emergency. These participants wanted to see policy changes aimed at granting access to government aid programs and essential health care services for those without basic legal paperwork.

Oral Health and Access to Oral Health Services

Several participants came to listening sessions with worries about oral health issues that were affecting them and their families. In many cases, the pain and distraction resulting from untreated oral health issues had greatly impacted their health, lives, and work.

Almost three quarters of participants responding in the participant survey said they did not have a dentist they could go to, and many participants indicated in discussion that they did not have any kind of coverage for dental services even if they did have health coverage. As with other health issues, participants largely agreed that the cost of dental services was prohibitively high, and that this often resulted in community-members waiting until their oral health problems had become serious issues before seeking treatment. Similar to discussions of strategies for improving access to health care, participants frequently suggested a cooperative agreement between their community's oral health service providers to lower the cost of services. Having providers drop prices specifically for preventative services and/or offer payment plans for costly ones were ideas that came up more than once.

Many participants also wanted to approach the problem of affordability by expanding dental insurance coverage for their communities. This included both expanding the number of people eligible for dental coverage, and expanding the number of important dental health services covered under such policies. In several groups participants wanted to make dental insurance standard as part of any health insurance package, including those offered through the government, those offered by employers, and those purchased independently.

It was also suggested that routine checkups for children and all significant services for adults, including dentures should all be covered under any dental insurance plan. The idea behind this was to create a standard of dental coverage that all parties could understand and expect

Several participants also expressed a specific need in rural communities for more affordable oral health service providers in order to eliminate the need for repeated travel to urban centers to access these services. In one group participants expressed interest in the idea of funding mobile clinics to meet the on-going dental health needs of agricultural workers and other more-remote community members.

Over-Arching Strategies for Approaching Health Issues in the Community

In almost all of the groups, discussion included similar, over-arching strategies for improving community health.

Increase Health Education

Notably, in almost every discussion group participants mentioned a general desire to increase health education that focused on each community's major health issues. Examples of what could be done included, increasing the number of community health educators, working with schools to develop strong health curriculums supported by activity and nutrition programs, launching media campaigns targeting specific health issues, and engaging the community regularly through events such as nutrition classes, talks, and health fairs in accessible locations.

Improve Community Access to Health Data and Information about Health Services

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

Improve Cultural Competency of the Health Care System

Improving cultural competency at all levels of the health care system was talked about in most discussions about health issues. Many participants emphasized the need to make sure that any efforts made to improve health care and services in the four-county area would benefit all community members. Specifically, this meant producing materials and resources in languages other than English and making them available to cultural communities that may not frequent the same locations as others. This also meant ensuring quality interpretation services at all levels of health care and training providers to better meet the specific needs of the cultural communities they serve.

Limitations

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

Resources

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

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

Tuality Healthcare

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