OPTIONAL Checklist for Community Health Improvement Plan (CHIP) Progress Report

Reporting period July 1, 2014 – June 30, 2015

This checklist is an optional supportive document CCOs can use to guide their compliance to the contract agreements. If this checklist is used, it can serve as the foundation for the progress report due June 30, 2015.

The language is taken from the CCO Contract Exhibit B #4 (pages 28-30). This document relates to "Guidance document for Community Health Improvement Plan (CHIP) update" available on the Transformation Center's Resource page. Select Community Advisory Councils from the dropdown menu: http://www.oregon.gov/oha/Transformation-Center/Pages/Resources-Transformation.aspx.

(a.1.) To the extent practicable, the contractor shall include in the CHA and CHIP a strategy and plan for working with: *Check any partners below that have been included in CHA and CHIP work*
☒ Early Learning Council ☒ Youth Development Council ☒ Local Mental Health Authority ☒ Oral health care providers ☒ Local public health authority ☒ Community based organizations ☒ Hospital systems x School health providers in the service area - the CCO has a relationship with Mid-Columbia Medical Center (MCM), North Central Public Health District (NCPHD) and Hood River County Health Department (HRCHD), all of whom provide school health services. There is also the relationship with One Community Health (OCH) who is the medical sponsor for the newly approved School Based Health Center at Hood River Valley High School (SBHC @ HRV)
Describe actions taken and/or barriers to work: Community Advisory Council (CAC) includes representatives either in a voting capacity or extended inclusion from all of the groups checked above.

(a.2.) To the extent practicable, the contractor shall include in the CHA and CHIP a strategy and plan for coordinating the effective and efficient delivery of health care to children and adolescents in the community: *Check areas of focus for CHIP work*
☒ Base the CHIP on research, including research into adverse childhood experiences ☐ Evaluate the adequacy of the existing school-based health center (SBHC) network to meet the specific pediatric and adolescent health care needs in the community and make recommendations to improve the SBHC system ☒ Improve the integration of all services provided to meet the needs of children, adolescents, and families ☒ Address primary care, behavioral and oral health, promotion of health and prevention, and early intervention in the treatment of children and adolescents
Describe actions taken and/or barriers to work: Pediatric and Adolescent wellness are focus areas for the Clinical Advisory Panel (CAP). The CAP unanimously decided to replace sports physicals in the community with adolescent well-child visits. Articles in the local newspapers have provided educational background on this shift from sports physicals to full adolescent well child visits. The recent addition of the SBHC @ HRV will provide an additional venue for engaging teens in their health. Prenatal/postnatal care has been the focus of a Maternal Child Health committee that works closely with the

CAP and CGHC to develop a model for addressing the needs of at-risk pregnant women, infants and children.

Access to children's mental health is a focus area of the CHIP. Recently, the CMHP has delivered presentations to the CAC, CAP and CGHC describing new services that are being developed and new options for self-referrals to MH specialists that are not part of the CMHP.

(a.3.) To the extent practicable, the contractor shall include in the CHA and CHIP a strategy and plan for: Contractor shall add to its CHIP; *Check any partners below that have been included in CHA and CHIP work*

☒ School Nurses
☒ School Mental Health providers
☒ Individuals representing child and adolescent health services

Describe actions taken and/or barriers to work:

School nurses are employed by either Public Health or MCMC and the school mental health providers are employed by the county mental health agency. The CMHA is also a voting member of the CAC. We developed a single collaborative Community Health Assessment and all of the agencies were actively involved in the assessment, evaluation and selection of CHIP topics.

(b.) Contractor, with its CAC, shall collaborate with OHA Office of Equity and Inclusion to develop meaningful baseline data on health disparities. Resources: OEI Contact – Leann Johnson, Interim OEI Director, leann.r.johnson@state.or.us, 971-673-1287

PacificSource contracted with The Next Door (a local non-profit) to conduct a thorough analysis of health disparities in the Latino population. This information was incorporated into the CHIP systemically by requiring all focus areas to address the needs of members who are Spanish speakers.

The CAC unanimously voted for all communications for members to be in plain language and PacificSource has endorsed that direction through additional work in Transformation Plan 2015-2017.
The community has a local coalition led by a CAC participant – the Mid-Columbia Health Equity Advocates (MCHEA)

The CAHPS survey results were gathered and reviewed by ethnicity and race at both the state and region level by a local data consultant and used to inform the CHIP and policy discussions.

Contractor shall include in the CHA identification and prioritization of health disparities among Contractor's diverse communities, including those defined by the following. Contractor shall include representatives of populations experiencing health disparities in CHA and CHIP prioritization: *Check any that apply*

☒ Race
☒ Ethnicity
☒ Language
☒ Disability
☒ Age
☒ Gender
☒ Sexual orientation
☒ Other factors in the service area: Sexual assault advocates, dual diagnosis individuals and criminal justice involved

Describe engagement and representation of diverse communities:

Seated members on the CAC are representative of the above groups in roughly the same percentage as they are found in the overall population of the region.

(c.) Contractor shall conduct the CHA and CHIP so that they are transparent and public in process and outcomes. Contractor shall assure that the contents and development of the CHIP comply with Section ORS 414.627.

Describe actions to meet this objective:

Community Advisory Council meetings are held monthly alternating between Hood River and The Dalles. All meetings are open to the public and attendance is frequently > 30 participants. The CAC has had to move venues to accommodate the size of the participation.

The Community Health Assessment and resulting Community Health Improvement Process included survey results from: Migrant and Seasonal Farmworkers, Limited English proficiency, Hispanic/Latinos, Disabled Adults, Parents with disabled children, and low income as defined by < 200% FPL. Special effort was made to assure adequate input from minority groups.

(d.) The CHA and CHIP adopted by the CAC shall describe the full scope of findings, priorities, actions, responsibilities, and results achieved. The CHIP may include, as applicable: *Check all that apply*

- ☒ Findings from the various community health assessments made available by OHA to Contractor
- ☒ Findings on health needs and health disparities from community partners or previous assessments
- ☒ Findings on health indicators, including the leading causes of chronic disease, injury and death in the Service Area
- ☐ Evaluations of and recommendations for improvement of school based health systems in meeting the needs of specific pediatric and adolescent health care needs in the community
- ☒ Focus on primary care, behavioral health and oral health
- ☐ Analysis and development of public and private resources, capacities and metrics based on ongoing CHA activities and population health priorities
- ☐ Description of how the CHA and CHIP support the development, implementation, and evaluation of patient-centered primary care approaches
- ☐ Description of how the objectives of Health Systems Transformation and Contractor's Transformation Plan, described in Exhibit K, are addressed in the CHA and CHIP
- ☒ System design issues and solutions
- ☐ Outcome and Quality Improvement plans and results
- ☒ Integration of service delivery approaches and outcomes
- ☐ Workforce development approaches and outcomes

Describe actions taken and/or barriers to work:
The focus areas outlined in the CHIP were developed to encourage a collective impact approach to improvement in health and healthcare delivery systems. The focus areas are broad in nature and require multiple entities and counties to come together to define an action plan prior to receiving CAC endorsement. This alliance of multiple organizations with a written agreement has increased the success rate in grant awards from organizations outside the region.

In addition, the multi-agency partnership approach has led to a community-wide system integration team to align different case and care management models towards a more unified methodology.

For example, food insecurity is one of the priority areas of the region's CHIP. The CAC facilitated presentations and dialogues that resulted in a survey of food insecurity in the region. CAC members and participants distributed the survey widely through community agencies and forums and other provider and consumer venues. The survey garnered ~2,000 responses and was used to leverage grant proposals and local initiatives to reduce food insecurity, including a "Veggie Rx" initiative which includes primary care screening for food insecurity and providing vouchers if positive.

(e.) The CHIP shall identify the findings of the CHA and the method for prioritizing health disparities for remedy. Contractor shall provide a copy of the CHIP, and annual progress reports to the CHIP, to OHA June 30 of each year.
Deliverable: CHIP progress report due to David Fischer at DMAP by June 30, 2015.

(f.) Adopt a comprehensive local plan for the delivery of local mental health services for children, families, adults and other adults that describes the methods by which the LMHA will provide those services.
Describe actions to meet this objective, if applicable, may reference another CCO related report or document. The Columbia Gorge CHA describes, on pages 14-16, 18-20 and 22, the results of community surveys and forums related to behavioral health strengths and needs. The CHA supplements the attached 2013-2015 LMHA Biennial Implementation Plan to form the comprehensive local plan. Mid-Columbia Center for Living (MCCFL), as the region's LMHA, provides comprehensive outpatient behavioral health services to all populations in this region. These services include, but are not limited to, mental health and substance use disorder services for all populations, developmental disabilities, enhanced care services, and adult crisis respite. MCCFL has clinicians embedded in schools, primary care offices, county jail and juvenile department offices. MCCFL has a strong array of services for the SPMI population including peer to peer services, EASA, ACT, jail diversion, AMHI, supported employment, and housing. MCCFL provides mobile crisis services and is the designee for involuntary placement for psychiatric care. MCCFL is the primary provider for ICTS services and has excellent relationships with both acute care and residential service providers for children. In collaboration with MCCFL and the CCO, Mid-Columbia Outpatient Clinics (MCOC) provide integrated behavioral health and medical services for adults and children who have an MCOC PCP and are interested in receiving behavioral health services at their medical provider's office. There is also a small panel of providers that the community MCCFL can refer to for specialty services not offered at their agency and to provide choice of providers for members.

Columbia Gorge Regional Community Health Assessment

Collaborating for Optimum Health and Optimized Healthcare

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

December 2013

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

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Columbia Gorge Regional Community Health Assessment

Collaborating for Optimum Health and Optimized Healthcare

A spirit of collaboration

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

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

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

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

The Cohort

Columbia Gorge Health Council

Hood River County Health Department

Klickitat Valley Health

Klickitat Valley Health Department

Mid-Columbia Center for Living

Mid-Columbia Medical Center

North Central Public Health District

One Community Health

PacificSource Community Solutions

Providence Hood River Memorial Hospital

Skyline Hospital

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

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

About the Region

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

Figure 1 - Map of Columbia Gorge Region

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

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

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

Table 1 - Total Population

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

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

Demographics

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

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

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

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

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

Table 2 - Ethnicity and Race

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

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

Acknowledgment to the Consumer Community

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

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

Healthcare and Agency Ecosystem

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

Healthcare professionals

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

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

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

Table 3 - Federal designations for under-served groups

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

Source: Health Resources and Services Administration (HRSA)

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

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

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

Acknowledgment to the Healthcare Professional Community

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

Table 4 - List of participating healthcare organizations

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

Social Service and Non-profit Agencies

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

Acknowledgment to the Agency and Faith Communities

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

Table 5 - List of agency and faith community participants

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

How to Read the Results of the Analysis

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

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

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

[2] Source: Data from Truven Market Expert 2013. © Truven Health Analytics.
[3] Source: Data from County Health Rankings from http://www.countyhealthrankings.org/

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

BASIC NEEDS

Income insecurity

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

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

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

Table 6 - Income insecurity

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

Housing insecurity

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

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

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

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

Table 7 - Housing insecurity

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

Food insecurity

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

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

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

Table 8 - Food insecurity

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

Transportation insecurity

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

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

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

Table 9 - Transportation insecurity

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

HEALTHCARE ACCESS

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

Figure 2 - Frequency of comments on healthcare access needs

Health insurance status

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

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

Table 10 - Insurance status

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

Have a Primary Care Provider (PCP)

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

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

Have a usual place for care

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

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

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

Distance from usual place of care

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

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

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

Physical health access

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

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

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

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

Table 11 - Physical health access

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

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

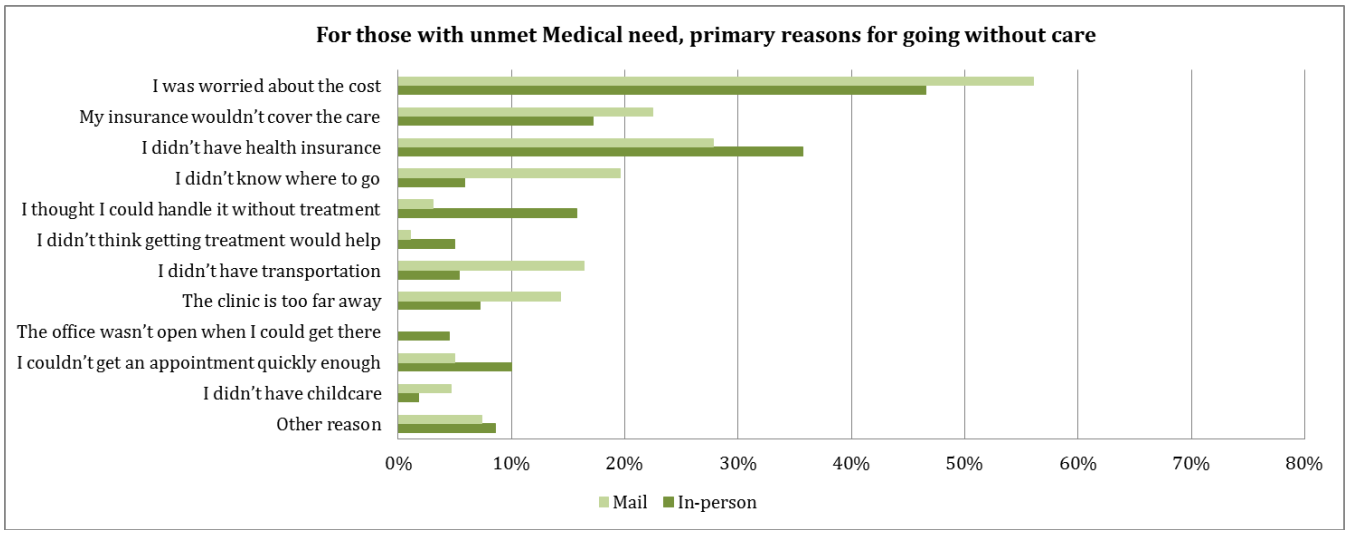


Figure 3 - Reasons for going without Medical care

Dental health access

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

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

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

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

Table 12 - Dental health access

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

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

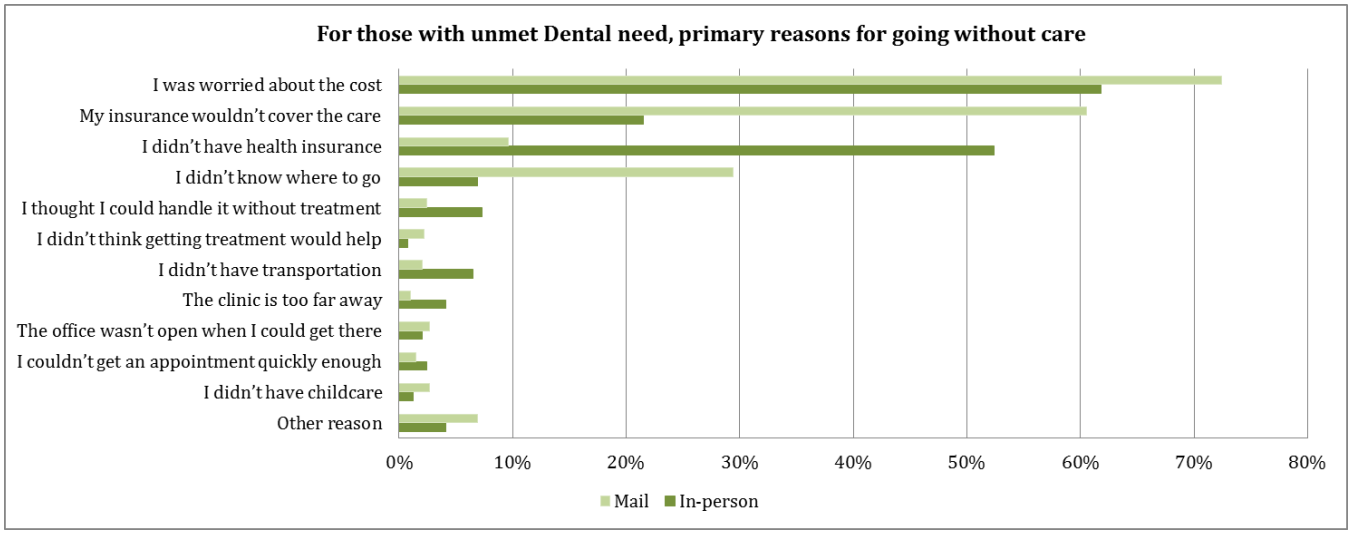


Figure 4 - Reasons for going without Dental care

Mental health access

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

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

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

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

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

Table 13 - Mental health access

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

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

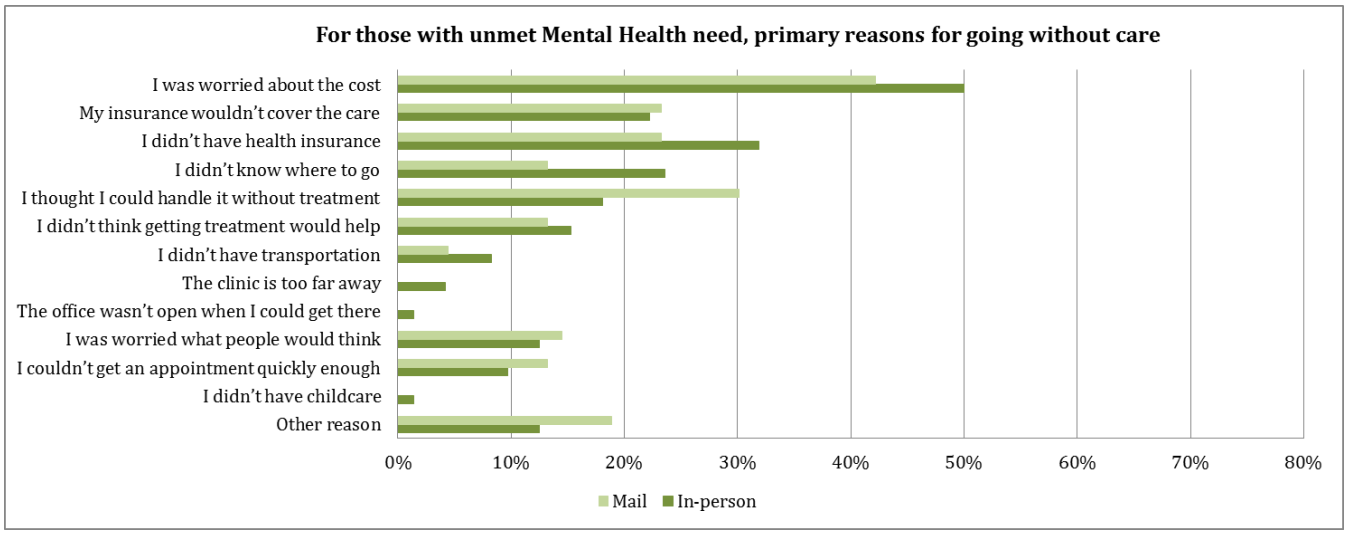


Figure 5 - Reasons for going without Mental Health care

Substance abuse treatment

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

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

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

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

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

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

Table 14 - Substance Abuse treatment access

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

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

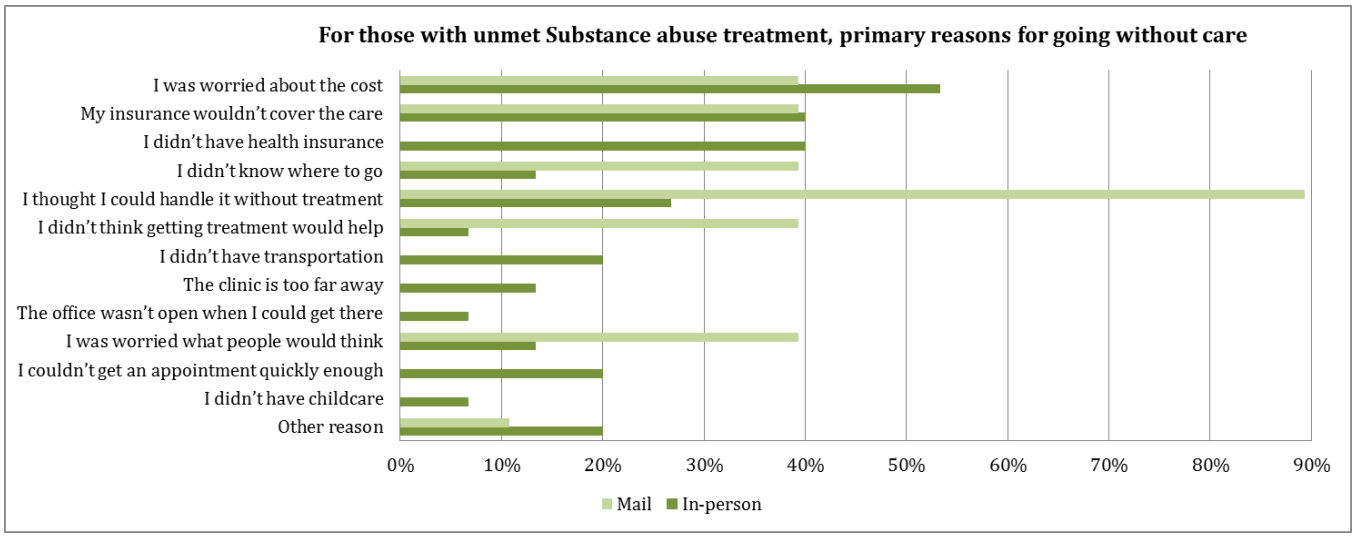


Figure 6 - Reasons for going without substance abuse treatment

Medications

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

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

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

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

Table 15 - Medication access

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

HEALTH STATUS

General health and social isolation

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

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

Weight management

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

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

Physical health status

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

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

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

Table 16 - Physical health status

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

Mental health status

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

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

Table 17 - Mental health status

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

Physical and mental health together

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

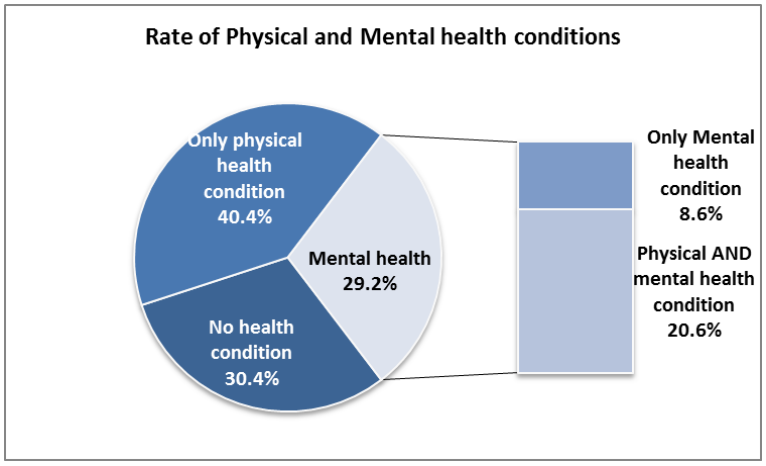


Figure 7 – Overlap of chronic physical and mental health conditions

Alcohol, tobacco and other drugs

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

Tobacco use

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

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

Problem drinking

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

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

Street drug use

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

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

Table 18 - Alcohol, Tobacco and Drug usage

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

Domestic/sexual violence

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

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

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

Table 19 - Domestic violence

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

WE HAVE THE SAME NEEDS – a powerful outcome

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

Limitations

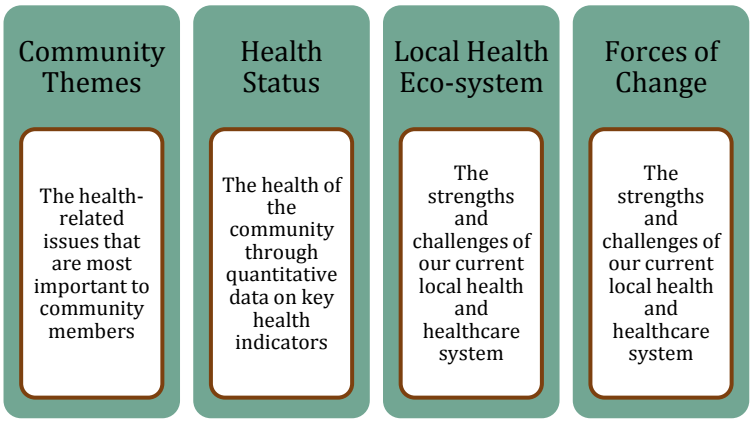
We did a lot right in this first year. Nevertheless, there are always areas for improvement going forward. The three biggest gaps in the theme collection process are: 1) more focus on the Native American population 2) better inclusion of Dental health professionals and 3) better inclusion of schools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

METHODS and PROCESS

The MAPP process

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

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



Gathering Community Themes

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

Community Advisory Council

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

Behavioral Health Community Forum

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

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

Consumer Surveys by Mail

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

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

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

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

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

Consumer Surveys In-person

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

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

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

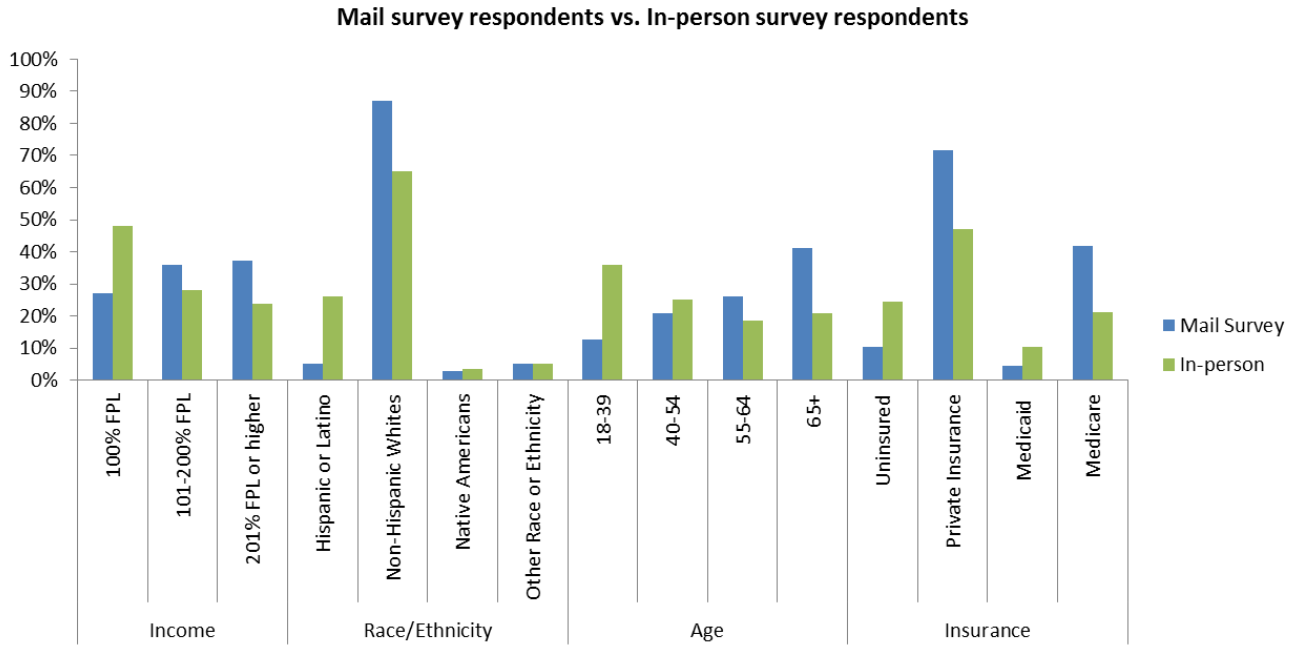


Figure 8 - Comparison of Mail and In-person survey responses by demographic groups

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

Focus groups

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

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

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

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

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

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

Gathering Health Status

We used Health Status information from three primary sources:

1. Providence Health and Services facilitated access to Truven Health Analytics demographic data, general population data as well as Community Need Index[4] information
2. County health departments furnished County Health Rankings demographic and Health Status information
3. Self-reported health and chronic conditions through the Consumer Survey – both mail and In-person

Gathering Local Health Eco-system Status

Provider and agency input

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

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

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

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

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

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

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

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

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

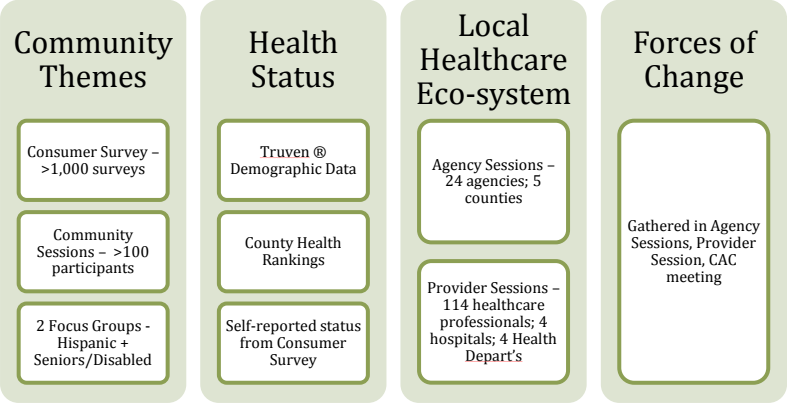
- Adequate income and stable housing were #1 or #2
- Food and transportation were #3 or #4
- Prevention ranked #5
- Availability and cost were the two predominant attributes

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

MAPPing the Information Gathered

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

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



Gathering Forces of Change

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

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

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

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COMMUNITY HEALTH SURVEY

COMMUNITY HEALTH SURVEY

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

YOUR HEALTH CARE

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

1. Do you currently have any kind of health insurance?
   - ❑ Yes
   - ❑ No ➡ **If No, Go to Question 3**

2. What kind of health insurance do you have?
   Mark all that apply.
   - ❑ Medicaid/Oregon Health Plan (OHP)
   - ❑ Medicare
   - ❑ Private coverage through an employer or family member's employer
   - ❑ A private plan I pay for myself
   - ❑ Other (tell us):_____
   - ❑ I don't have any insurance now
   - ❑ I don't know

3. For how many of the **last 12 months** did you have some kind of health insurance?
   - ❑ Not insured during the last 12 months
   - ❑ 1-3 months
   - ❑ 4-6 months
   - ❑ 7-9 months
   - ❑ 10-11 months
   - ❑ Insured for ALL of the last 12 months

4. Do you receive care through the Indian Health Service (IHS)?
   - ❑ Yes
   - ❑ No

5. Is there a place you **usually** go to receive medical care?
   - ❑ Yes
   - ❑ No ➡ **If No, Go to Question 8**

6. Where do you **usually** go to receive medical care?
   Mark only one.
   - ❑ A private doctor's office or clinic
   - ❑ A public health clinic or community health center
   - ❑ A tribal health clinic
   - ❑ A hospital-based clinic
   - ❑ A hospital emergency room
   - ❑ An urgent care clinic
   - ❑ Someplace else (tell us): _____
   - ❑ I don't have a usual place

7. How far do you have to travel to get to the place where you **usually** get medical care?
   - ❑ 0-5 miles
   - ❑ 6-10 miles
   - ❑ 11-20 miles
   - ❑ 21-50 miles
   - ❑ More than 50 miles

8. Do you have **one person** you think of as your personal doctor or health care provider?
   - ❑ Yes
   - ❑ No

9. Was there a time in the **last 12 months** when you needed medical care?
   - ❑ Yes
   - ❑ No ➡ **If No, Go to Question 12**

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

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

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

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

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

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

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

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

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

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

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

21. Was there a time in the **last 12 months** when you needed **prescription medication**?
- ❑ Yes
- ❑ No ➡ **If No, Go to Question 24**

22. Were the prescriptions you needed for physical health problems, mental health or personal problems, or both?
- ❑ Physical health problems
- ❑ Mental health or personal problems
- ❑ Both physical AND mental health problems

23. If you needed prescription medication in the **last 12 months**, did you get **all** the medications you needed?
- ❑ I got **all** the medication I needed
- ❑ I got **some but not all** medications
- ❑ I got **no medications at all**
- ❑ I don't know

24. Do you have any children (under 19 years of age) living in your household?
- ❑ Yes
- ❑ No ➡ **If No, Go to Question 31**

25. In the **last 12 months**, has any child of yours needed medical care?
- ❑ Yes
- ❑ No ➡ **If No, Go to Question 27**

26. In the **last 12 months**, when your child needed medical care, did they get **all** the care they needed?
- ❑ They got **all** the care they needed
- ❑ They got **some but not all** needed care
- ❑ They got **no care at all**
- ❑ I don't know

27. In the **last 12 months**, has any child of yours had an emotional, developmental or behavioral problem for which they needed treatment or counseling?
- ❑ Yes
- ❑ No ➡ **If No, Go to Question 29**

28. In the **last 12 months**, when your child needed treatment or counseling, did they get all the care they needed?
- ❑ They got **all** the care they needed
- ❑ They got **some but not all** needed care
- ❑ They got **no care at all**
- ❑ I don't know

29. In the **last 12 months**, have any children of yours needed dental care?
- ❑ Yes
- ❑ No ➡ **If No, Go to Question 31**

30. In the last 12 months, when your child or children needed dental care, did they get all the care they needed?
- ❑ They got **all** the care they needed
- ❑ They got **some but not all** needed care
- ❑ They got **no care at all**
- ❑ I don't know

YOUR HEALTH & LIFESTYLE

These questions give us a picture of your overall health.

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

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

33. In general, how would you rate your **mental health**, including your mood and ability to think?
- ❑ Excellent
- ❑ Very Good
- ❑ Good
- ❑ Fair
- ❑ Poor

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

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

	Yes	No
Diabetes or sugar diabetes	❑	❑
Asthma	❑	❑
High blood pressure	❑	❑
High cholesterol	❑	❑
Depression	❑	❑
Post-traumatic stress disorder (PTSD)	❑	❑
Anxiety	❑	❑
Another ongoing health condition	❑	❑

➳ *Tell us:* _____

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

	Not at at all	Several days	Over half the days	Nearly every day
Little interest or pleasure in doing things?	❑	❑	❑	❑
Feeling down, depressed, or hopeless?	❑	❑	❑	❑
Feeling nervous, anxious, or on edge?	❑	❑	❑	❑
Not being able to stop or control worrying?	❑	❑	❑	❑

37. In the **last 12 months**, has anyone ever forced you to do something sexual that you didn't want to do?
- ❑ Yes
- ❑ No

38. In the **last 12 months**, has someone you live with ever hurt or threatened to hurt you or your children?
- ❑ Yes
- ❑ No
- ❑ Doesn't apply

39. Do you consider yourself **now** to be overweight, underweight, or about the right weight?
- ❑ About the right weight
- ❑ Underweight
- ❑ Overweight
  - ➳ Are you actively trying to lose weight now?
    - ❑ Yes
    - ❑ No

40. Have you smoked at least 100 cigarettes in your **entire life**?
- ❑ Yes
- ❑ No ➡ **If No, Go to Question 43**

41. Do you **now** smoke cigarettes every day, some days, or not at all?
- ❑ Every day
- ❑ Some days
- ❑ Not at all ➡ **If No, Go to Question 43**

42. Are you **currently** trying to reduce smoking or quit smoking altogether?
- ❑ Yes, trying to reduce smoking
- ❑ Yes, trying to quit altogether
- ❑ No

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

44. How often did you have a drink containing alcohol in the **past year**?
- ❑ Never ➡ **If No, Skip to Question 47**
- ❑ Monthly or less
- ❑ 2-4 times a month
- ❑ 2-3 times a week
- ❑ 4 or more times a week

45. On the days when you did drink alcohol, how many drinks did you usually have **per day**? *A 'drink' is one beer, one glass of wine, or one shot of liquor.*
- ❑ 1 to 2
- ❑ 3 to 4
- ❑ 5 to 6
- ❑ 7 to 9
- ❑ 10 or more

46. How often did you have **six or more** drinks on one occasion in the **past year**?
- ❑ Never
- ❑ Less than monthly
- ❑ Monthly
- ❑ Weekly
- ❑ Daily or almost daily

47. In the **last 12 months**, have you used any of the following? *Check all that apply. Remember, your answers are completely private.*
- ❑ Marijuana or hashish
- ❑ Prescription pain medication that was not prescribed to you
- ❑ Any other street drug
- ❑ I did not use any of these in the last 12 months

YOUR HOUSEHOLD FINANCES

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

48. In the **last 12 months**, how often have you been worried that your food would run out before you got money to buy more?
- ❑ Never
- ❑ Sometimes
- ❑ Often

49. In general, how often do you have a difficult time accessing transportation when you need it?
- ❑ Never
- ❑ Sometimes
- ❑ Often

50. In the **last 12 months**, did you or other members of your household have to move because you could not afford to pay rent, mortgage, or utility bills?
- ❑ Yes
- ❑ No

51. In the **last 12 months**, have you had to borrow money, skip paying other bills, or pay other bills late in order to pay health care bills?
- ❑ Yes
- ❑ No

52. In the **last 12 months**, has a doctor, clinic, or medical service refused to treat you because you owed money to them for past treatment?
- ❑ Yes
- ❑ No
- ❑ I don't know

ABOUT YOU & YOUR FAMILY

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

53. Are you male or female?
- ❑ Male
- ❑ Female

54. What year were you born?

19_____

55. Would you describe yourself as being of Hispanic or Latino origin or descent?
- ❑ Yes, Hispanic or Latino
- ❑ No, not Hispanic or Latino

56. How would you describe your race? *Mark all that apply.*
- ❑ White
- ❑ Black or African-American
- ❑ American Indian
- ❑ Asian
- ❑ Native Hawaiian or Pacific Islander
- ❑ Other: _____

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

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

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

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

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

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

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

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

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

	None of the time	Some of the time	Most of the time	All of the time
Love you and make you feel wanted?	❑	❑	❑	❑
Give you good advice about a crisis?	❑	❑	❑	❑
Get together with for relaxation?	❑	❑	❑	❑
Confide in or talk to about your problems?	❑	❑	❑	❑
Help you if you were confined to a bed?...	❑	❑	❑	❑

STOP HERE

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

MOU from the Cohort

Six-County Collaborative Community Health Needs Assessment
Memorandum of Understanding

October 31, 2013

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

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

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

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

Shared Understandings

- The participating organizations declare their shared intent to collaborate in a CHA, as is evidenced in the meeting minutes of the CGHC's Community Advisory Council and numerous collaborative CHA activities in advance of finalizing this document. A copy of this MOU will be included in the appendix of the collaborative CHA.

- This MOU's term begins October 31, 2013 and continues through February 28, 2014.

- The CGHC's Community Advisory Council will serve as the convener of participating organizations and community stakeholders in this process.

- Each of the participating organizations agrees to contribute cash and/or in-in kind resources to develop this collaborative and realize the CHA.

- Subject to applicable law and each organization's applicable policies, the participating organizations have agreed to share, both publically and with each other, the findings of population demographic and health data; agency, service, provider, and community sessions; focus groups; community forums; interviews; and consumer surveys. Any facility-specific utilization data will be shared by further agreement of the individual parties and in the most consistent format possible.

- While efforts will be made to accommodate as many needs as possible, each of the participating organizations is responsible for amending the collaborative CHA to satisfy the specific requirements of any regulatory bodies to whom they are accountable.

- Each of the participating organizations recognizes that this is the first instance of an ongoing collaborative effort, that future iterations of a collaborative CHA will evolve, and that there is a shared intention to be inclusive of additional participating organizations.

The Six-County Collaborative Community Health Assessment (CHA)

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

Component	*Agreement*
	Each hospital will distribute, via e mail, an electronic worksheet/survey to clinical employees and a majority of their medical staff, concentrating on primary care providers. The survey will be well-publicized and open for a minimum of seven days. As requested and organized by hospital leadership, and with a minimum of 7 days advance notice, CGHC will facilitate in-person sessions to present worksheet/survey findings and clarify feedback on health priorities.; CGHC Community Advisory Council will summarize the results and make them available to all participating organizations.
Consumer Survey	**By October 22th, 2013:** The Center for Outcomes Research and Education (CORE) will develop a community health survey with input from CGHC Community Advisory Council and other local stakeholders and content experts. Providence will contract with CORE to deploy, track, collect and tabulate 900 surveys by mail. Mid Columbia Medical Center and One Community Health will contribute monies to CGHC, who will contract with CORE to expand the survey and analysis of data by an additional 500 mailed surveys and an additional 500 locally-administered surveys in targeted locations or populations as determined by CGHC's Community Advisory Council. Costs to Mid Columbia Medical Center for these expanded surveys is not to exceed $6,500. Costs to One Community Health for these additional surveys is not to exceed $4,500. Klickitat Valley Health and Skyline Hospital will contribute monies to CGHC to expand the survey and analysis of data by an additional 400 locally-administered surveys in Klickitat County. Costs to Klickitat Valley Health for these expanded surveys is not to exceed $ 2,000. Costs to Skyline hospital for these expanded surveys is not to exceed $2,000. Final costs for expanded surveys will be based on billing from CORE in addition to CGHC direct expenses plus an admin fee and be allocated as 40% MCMC, 30% OCH, and 15% each for KVH and Skyline. CGHC will invoice participating agencies for these expenses. Participating organizations are responsible for distributing and facilitating completion of locally administered surveys within their service areas, in both English and Spanish at agency sites or in strategic locations to reach targeted groups. These groups will include the following populations of interest: • Seniors (65+) • Migrant and seasonal farm workers • Limited English Proficiency • Low Income (<200% FPL) • Disabled Hood River County Health Department will provide data entry for locally-administered surveys fielded in Oregon. Locally-administered surveys from Washington will be organized for distribution, collected and entered electronically, or returned to CORE, via Providence Hood River Memorial Hospital, by Klickitat County Health Department. **By November 4th, 2013:** CORE will make findings and analysis of all surveys available to CGHC, who will share them with all participating organizations.

Component	*Agreement*
Focus Groups	**By October 31, 2013:** Providence will coordinate and fund two focus groups. Participants for each focus group will be solicited from the general public. • **Aging/Disabled/<200% FLP:** in English • **Migrant and Seasonal Farm Workers/People with limited English proficiency/<200% FPL:** in Spanish. **By November 4th, 2013:** Providence will provide experts in thematic analysis to summarize the findings of these sessions and make them available to the Community Advisory Council.
Summarizing the data and writing the draft assessment	**By October 31, 2013:** Community Advisory Council will appoint an analysis team of qualified experts to review findings from the above activities and provide recommendations on final CHA activities for any populations that may be underrepresented. The group will demonstrate impartiality to their agencies of employment and aspire for consensus in their identification of prioritized needs. The participants of this analysis team, with the exception of the lead writer, will each be contributed in-kind by participating organizations. The Community Advisory Council will identify and contract with a qualified writer to lead the analysis team and summarize the findings and prioritized needs in an agreed-upon format that fully satisfies the requirements of the CCO and other participating organizations to the fullest extent possible. A Table of Contents for the final deliverable is attached to this document. Each hospital will provide an amount not to exceed $1,500 for the services of this writer. CGHC will invoice each hospital for this expense. **By November 15, 2013:** The draft CHA will be completed and made available to all participating organizations. **By November 29, 2013:** All participating organizations will review the CHA and if acceptable, validate and endorse the same. Participating organizations will make any specific requests for changes with the exception of requesting further primary research before the final draft.
Finalizing and publishing the CHNA	**By December 20, 2013:** Community Advisory Council will collect feedback, validation and endorsement of CHA. The contracted writer will integrate appropriate requested changes. Participating Organizations will achieve any additional necessary endorsements. The writer will prepare a final document for publication. The document, along with the data and summaries described above, will be released to partners for publication and published on the CGHC website.
Next Steps	**By January 31, 2014:** Klickitat Valley Health, Skyline Hospital, Providence Hood River Memorial Hospital and Mid Columbia Medical Center, in partnerships with the health departments in their respective counties will each coordinate, host and fund community forums in a consistent, agreed-upon format. The forums should include health care and social service agency stakeholders, as well as public at large/consumers. The goal of these forums is:

Participating Organizations (in alphabetical order):

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

Six -County Region of Study:

Oregon Counties: Gilliam, Hood River, Sherman, Wasco
Washington Counties: Klickitat, Skamania

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

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

Signature Blocks on Following Pages

Data from Truven Market Expert 2013. © Truven Health Analytics

Columbia Gorge Region
2013 Community Health Needs Assesment Data

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

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

DATA INFO

Workbook: Federal Poverty Level Calculator

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

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

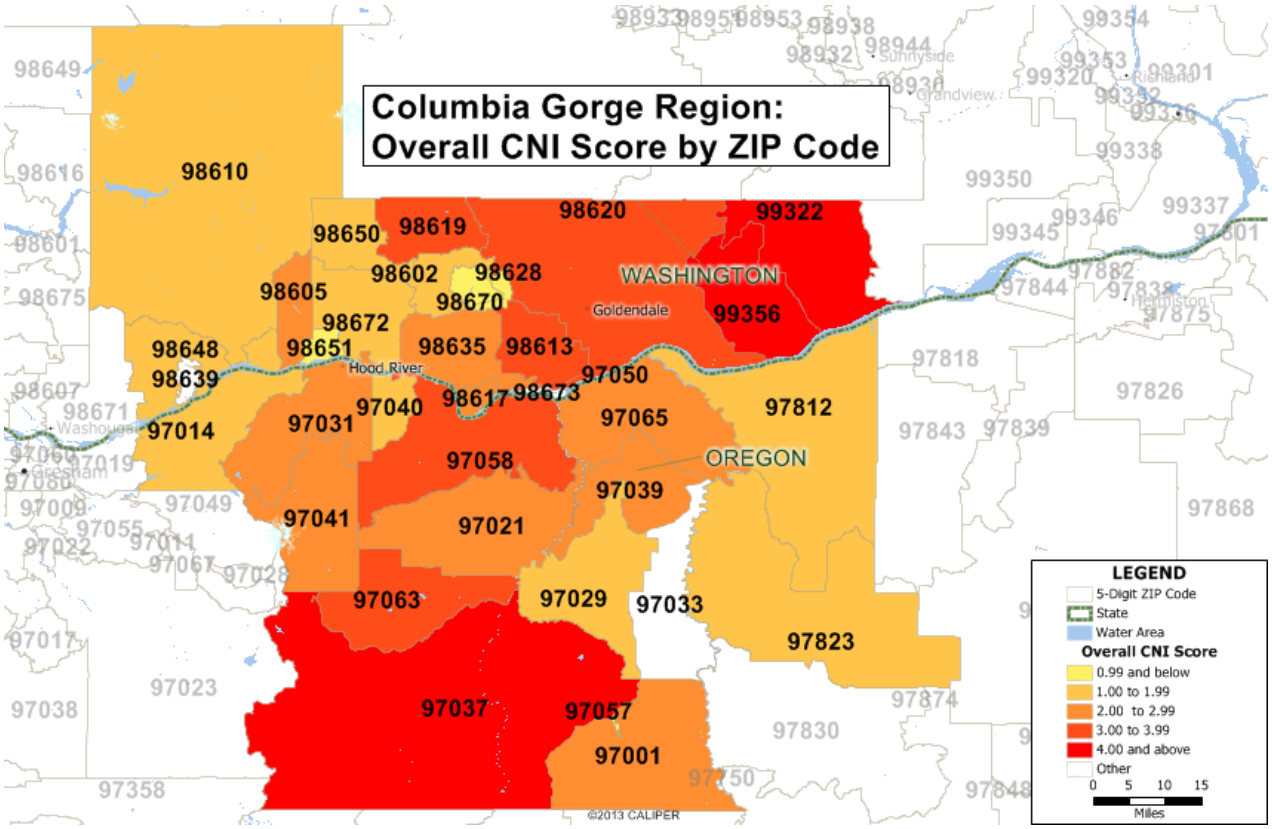
Rank Order of Emergency Room Usage Frequency by Diagnosis

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

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

Community Needs Index (CNI)

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

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

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