health share

Community Health Improvement Plan

October 1, 2014

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Acknowledgements

We would like to acknowledge and extend thanks to the Community Advisory Council, particularly the Community Health Needs Assessment Committee, who with the exceptional leadership of Sonja Ervin, the Committee Chair, and committee members Joseph Lowe, Tab Dansby and Ronda Harrison, has for the last year engaged in a process to identify the population health issues Health Share will address through 2017. Board member Mel Rader has served as an excellent liaison from the committee to our Board of Directors. Elena Weisenthal, Assefash Melles, Omar Carillo, and Rebecca Naga facilitated our use of the Community Readiness Model, which allowed us to hear directly from our diverse communities about what needs we should focus on related to culturally specific traditional health worker services. The people they interviewed provided rich information that will influence our work from here on out, and we thank them for sharing their knowledge and perspectives. As always, we would like to thank our Members, our reason for being!

Executive Summary

Background

The legislation that created Coordinated Care Organizations (CCOs) to provide services to Oregon Health Plan (OHP) beneficiaries in Oregon included provisions requiring that the CCOs' Community Advisory Councils, composed of a majority of Oregon Health Plan members, oversee a Community Health Needs Assessment (CHA) and Community Health Improvement Plan (CHP) every three years.

The purpose of the CHA and CHP is to reduce health disparities, promote health equity, and improve overall population health in the region served by the CCO. This Improvement Plan supports strategies that are intended to benefit the broad Tri-County community with particular focus on issues that disproportionately impact our Members, and is funded through State of Oregon Transformation Funds, which are dedicated to innovative projects aimed at improving integration and coordination of care for Medicaid patients.

Community Health Needs Assessment Findings

Health Share of Oregon's Board of Directors approved two Community Health Needs to be prioritized and addressed through our Community Health Improvement Plan:

- Behavioral Health- Mental Health and Substance Use Disorders; and
- Chronic Disease preventable through physical activity and nutrition

Alignment of the CHP with Health Share activities related to Behavioral health and Chronic Disease: Why Culturally-Specific Traditional Health Workers?

Health Share needed to determine activities to which we would devote one-timeTransformation Funds from OHA to address Chronic Disease and Behavioral Health in our Community Health Improvement Plan. In this process we considered following principles to be essential to our activities:

1. Seek input from communities impacted by disparities about what investments would be most impactful, and matching them to the community's stage of change;
2. Align investments with transformation activities underway at Health Share and through Health Share partners;
3. Measure improvements in health outcomes for members as a result of investments.

The choice of implementing Traditional Health Worker activities through Health Share's CHP supports our work to eliminate health disparities, allows us to facilitate culturally and linguistically appropriate care, and aligns with performance measures that are only achievable through coordination of services and resources throughout our community.

Behavioral Health and Chronic Disease prevention and management are enormously influenced by the social determinants of health: employment, housing, education, environment, opportunities for physical activity and nutrition, and most importantly, social support and empowerment. This is one of the

reasons that the Health Share Community Advisory Council Mental Health and Addictions Committee prioritized Peer Delivered Services when they made recommendations on what should be contained in the CHP.

As Health Share begins to implement more prevention and health promotion activities in addition to addressing the needs of people with multiple chronic conditions and people already engaged in medical care, traditional health workers can provide an important bridge between the environments in which our members live, work, play and learn, and the clinical systems in which they receive health care.

Based on the organizational assessments for Cultural Competence and Health Equity conducted by Health Share's Cultural Competence Workgroup, we know that recruiting and retaining a culturally diverse health care workforce to serve our communities is a goal shared by many of the organizations serving Health Share members. Investing resources in culturally-specific traditional health workers is one step Health Share can take to contribute to diversifying the workforce that serves our members.

Finally, achieving Transformation Plan metrics and CCO Performance Measures pertaining to the elimination of disparities in Chronic Conditions and coordination of care for people with Severe Persistent Mental Illness are contingent upon community-based support for our members.

The Community Readiness Model

In order to learn in which aspects of the Traditional Health Worker model to invest, we conducted key stakeholder interviews following the Community Readiness Model process, which was created by the Tri-Ethnic Center for Prevention Research at Colorado State University and is based on Stages of Change model from the addictions and recovery disciplines. The Community Readiness Model is a multi-dimensional model that integrates a community's culture, resources, and level of readiness into the design of interventions. Readiness is defined by the Tri-Ethnic Center "as the degree to which a community is prepared to take action on an issue."[1]

This model was selected by the committee because of its ability to identify the level of readiness of a community to address issues, which helps to support Health Share's identification of health improvement activities and alignment with impacted communities.

Based on the objectives created based on this input from our communities, we will issue a request for proposals from Community Based Organizations, to provide culturally-specific traditional health worker services, training and outreach to meet objectives specific to the community's level of readiness.

Implementation of the Community Health Improvement Plan will focus on achieving the following objectives:

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[1] Plested, B.A., Edwards, R.W., & Jumper-Thurman, P. (2006). *Community Readiness: A Handbook for Successful Change.* Fort Collins, CO: Tri-Ethnic Center for Prevention Research.

Behavioral Health Objectives

- Increased availability of culturally-specific Peer Support workers to Health Share members who identify as people of color, who speak a preferred language other than English, who identify as LGBTQ, who have a disability or who are young or elderly
- Community Based Organizations train primary care provider teams on peer resources, and referral to Peer Support workers
- Culturally-Specific Community Based Organizations employ Peer Support workers to provide eduation and outreach to communities and individuals about mental health and addictions generally, as well as specific programs and services available to Health Share Members
- Culturally-Specific Community Based Organizations host community discussions about mental health and addictions issues, in order to engage community members in a preventive manner
- Reduce disparities in utilization of Mental Health and Addictions services by members who identify as people of color & who speak a preferred language other than English
- Increase diabetes screening rates for members with Severe Persistent Mental Illness (SPMI)
- Decrease hospitalization rates for members with SPMI
- Increase follow-up after hospitalization for Mental Illness Rates for members with SPMI
- Development of Health Share ability to conduct disparities-sensitive analysis of members diagnosed with SPMI

Chronic Disease Objectives

- Increased availability of culturally-specific Community Health Workers to Health Share members who identify as people of color, who speak a preferred language other than English, who identify as LGBTQ, who have a disability or who are young
- Culturally Specific Community Health workers share information about and lead healthy eating and physical activity groups in their communities
- Community Based Organizations train Community Health Workers on chronic disease outcomes and clinical services related to the CCO's Quality Improvement Plan
- Community Based Organizations train providers on culturally and linguistically appropriate care and Chronic Disease prevention and management in the primary care setting, including how to integrate the use of Community Health Workers into their practice
- Community Based Organizations employ Community Health Workers to conduct culturally-specific health needs assessments with Health Share Members
- Decreased chronic disease outcomes disparities based on Quality Improvement Plan metrics

Community Health Needs Assessment Findings

Health Share of Oregon's Board of Directors approved two Community Health Needs to be prioritized and addressed through our Community Health Improvement Plan:

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- Chronic Disease preventable through physical activity and nutrition

Of people who are eligible for Medicaid in the tri-county area, according to Providence's Center for Outcomes Research and Education's Tri-County Service Profile of 2013:

- 11% have been diagnosed with diabetes

- 28.8% have been diagnosed with high blood pressure

- 21.8% have been diagnosed with high cholesterol

- 43% have been diagnosed with depression or anxiety

Additionally, eight separate community-led self-assessments indicated that Chronic Disease, Mental Health, and Substance Abuse were a priority in the African American, Immigrant and Refugee, Native American/Alaska Native, Asian and Pacific Islander, and Latino/Hispanic communities.

The companion document to this Community Health Improvement Plan, the Community Health Needs Assessment provides detail about the process and data that informed the choices of Chronic Disease and Behavioral Health as Health Share's priorities.

Alignment of the CHP with Health Share Activities related to Behavioral health and Chronic Disease: Culturally-Specific Traditional Health Workers

Health Share needed to determine activities to which we would devote one-time Transformation Funds from OHA to address Chronic Disease and Behavioral Health in our Community Health Improvement Plan. In this process we considered the following principles to be essential to our activities:

1. Seek input from communities impacted by disparities about what investments would be most impactful, and matching them to the community's stage of change;
2. Align investments with transformation activities underway at Health Share and through Health Share partners;
3. Measure improvements in health outcomes for members as a result of investments.

To gather input from communities and target investments to the appropriate level of readiness for change, the committee chose to use a modified version of the Community Readiness Model, which is described in detail in the following section of this plan.

In order to align investments with activities underway at Health Share, and ensure improvements in outcomes are able to be measured, staff proposed the following criteria for inclusion in the CHP:

- Member data related to the investment are able to be disaggregated by Race, Ethnicity and Language, and outcomes are being tracked and analyzed by Health Share
- Community based activities can influence Health Share activities and improve outcomes
- Health Share data and findings can influence the development of Community Based Activities.

Based on these criteria, one of the most promising foundations upon which to build an improvement plan is through the incorporation of Culturally-Specific Traditional Health Workers into Health Share's model of care.

Alignment with Health Share Goals and Activities

The choice of implementing Traditional Health Worker activities through Health Share's CHP supports our work to eliminate health disparities, allows us to facilitate culturally and linguistically appropriate care, and aligns with performance measures that are only achievable through coordination of services and resources throughout our community.

Behavioral Health and Chronic Disease prevention and management are enormously influenced by the social determinants of health: employment, housing, education, environment, opportunities for physical activity and nutrition, and most importantly, social support and empowerment.

As Health Share begins to implement more prevention and health promotion activities in addition to addressing the needs of people with multiple chronic conditions and people already engaged in medical care, traditional health workers can provide an important bridge between the environments in which our members live, work, play, and learn, and the clinical systems in which they receive health care.

Based on the organizational assessments for Cultural Competence and Health Equity conducted by Health Share's Cultural Competence Workgroup, we know that recruiting and retaining a culturally diverse health care workforce to serve our communities is a goal shared by many of the organizations serving Health Share members. Investing resources in culturally-specific traditional health workers is one step Health Share can take to contribute to diversifying the workforce that serves our members.

The choice to focus on Traditional Health Workers also allows us to align and collaborate with the work of our Regional Health Equity Collaborative, the HOPE Coalition (now named Oregon Health Equity Alliance or OHEA), which has chosen to focus on Traditional Health Workers as an aspect of Workforce Diversity and Cultural Competency, one of five priorities in its Five Year Plan. The other HOPE priorities being: Chronic Disease and Other Illness Factors, Access to Health Care, Mental Health /Substance Abuse/Addictions, and Improved Data Collection & Analysis.

> *The HOPE Coalition is a regional partnership of communities of color, health advocates and policy makers working together to create and implement a five- year plan to increase health equity in Clackamas, Marion, Multnomah and Washington Counties. By bringing together*

community voice and experience around the most pressing health equity issues in the region, this partnership is a unique vehicle for driving regional change and making true advances toward health equity.

Grounded in the belief that local communities understand their own needs best, the HOPE Coalition also met with grassroots community leaders and community based organizations to surface their priorities and sustainable solutions for remediating systemic barriers to better health and creating relevant policy change.

Traditional Health Worker Strengths

Health Share's Community Health Improvement Plan resources culturally-specific Community Health Workers and Peer Mentors, who, working in conjunction with Patient Centered Primary Care Homes, bring the following assets and skills to our health systems:

Close ties to the community

Cultural competence

Engagement of patients in disease self-management

Continuity of communication between provider and patient

Increased access to preventive care

Improved compliance with prescribed care

Enhanced social support

Addressing the major determinants of health

Peer Support Services Outcomes

Locally, we have organizations that have invested in evaluation of peer support services that have shown early positive results. Since 2009, Health Share's partner organization, Clackamas County Behavioral Health Division, has made significant investments in Peer Support Services to serve the Behavioral Health needs of people in Clackamas County. Evaluation of those investments has shown that Peer Delivered Services have resulted in the following:

3118 people served with 1:1 and drop-in group peer services

87% Engagement Rate (3 appointments in a 6 week period)

80% report improved overall wellness

77% report improved quality of life

73% report an increase in natural supports

48% feel accepted in the community

58% report that would have returned to a higher level of care if not for peer delivered services

Early analysis of cost savings data related to Peer Delivered Services in Clackamas County is extremely positive, with high returns on investment accrued by the Jail and Child Welfare in addition to reduced use of the Emergency Room.

Community Health Workers Outcomes

Oregon has a long and successful history of using Community Health Workers. In a 2010 study of the Salud program at One Community Health in Hood River, Oregon, the 400 case-managed diabetic patients averaged greater than 10 HBa1c at the outset of the program, and reduced this to 7.8 in one year.

Additionally, the program produced stellar maternal child health results for patients, with greater than 90% 1st trimester entry into prenatal care, and ½ the rate of low birth weight babies than the Oregon Community Health Center average. (Volkman & Castanares, 2010)

Other outcomes achieved through the incorporation of Community Health Workers into the model of clinical care are outlined below:

Utilization management:

Presbyterian Hospital in New York State hired CHWs to work with ER triage nurses. The CHWs redirected patients to primary care clinics and increased awareness about the importance of primary care. By the end of the three-year intervention period, the following outcomes had been achieved:

- The rate of broken primary care appointments dropped from 50% to 11%;
- Non-urgent adult ER visits decreased by 42%; and
- The percentage of patients keeping their first primary care appointment stood at 89%.

Increased access to preventive care:
For more than 20 years, Kaiser Permanente Hawaii employed CHWs to increase access to preventive care for their Plan X5 Medicaid clients. These CHWs provided information, advice about using Kaiser services, and referrals for basic services such as food and housing. They also case managed plan members who are at high risk because of pregnancy, diabetes, or asthma. One study of this program revealed the following results:
- Plan x5 members used more preventive services than commercial group members;
- They made more visits to nurse practitioners and fewer visits to specialists than other members; and
- Their use of ambulatory care was similar to that of commercial members. (Knobel, 1992).

Enhanced patient-provider communication:
CHWs can function as "cultural brokers" between the patient and clinic, which can lead to increased understanding and acceptance on the part of both providers and patients (Volkman & Castañares, 2011). They translate complicated information about medical regimens into language which patients can understand (Giblin, 1989), and can elicit more complete information about symptoms and risk factors, leading to more accurate diagnoses and more appropriate care (Castañares, 1992, personal communication).

Improved compliance with prescribed care:
CHWs have been shown to effectively explain diet, exercise and medication regimens in terms which patients can understand, which allows them to improve rates of compliance with care. (Witmer, 1995). For example, CHWs who work with high-risk populations to improve control of hypertension have been shown to increase the number of patients that keep appointments and who comply with prescribed regimens (Rosenthal et al., 2011).

Improved chronic disease management:
Hypertension: A study by researchers at Johns Hopkins University revealed that a five-year intervention by CHWs was associated with a twofold increase in the percentage of controlled hypertensive patients (from 38% to 79%). The treatment group also experienced a 35% decrease in hospitalization and a 65% decrease in mortality from uncontrolled hypertension (Levine et al., 1992). In a more recent literature review of CHW effectiveness in the care of people with hypertension, significant improvements in blood pressure, self-management behaviors, and health care utilization were found (Brownstein et al., 2007).

Diabetes: CHW interventions involving home visits, group sessions, and/or joint provider-CHW visits, compared to control groups with usual care and access to educational materials, showed significant positive outcomes in 6 of 8 studies reviewed, including improvements in HbA1c and improved self-reports of dietary changes (Institute for Clinical & Economic Review, 2013). In Hood River, Oregon, CHWs support over 400 diabetic patients, reducing their average HbA1c from >10 to 7.8 in 1 year (Volkman & Castanares, 2010).

Enhanced social support:
There is overwhelming evidence that social and emotional support can help to protect against a number of health issues (Reblin & Uchino, 2008), including depression and poor perinatal outcomes (Jackson, 2007).The high level of trust that CHWs are able to establish with patients allows them to provide informal one-on-one counseling and to create and facilitate social support groups.

Educating the health care system about community norms and needs:
CHWs educate providers and administrators about the health needs of communities and help increase cultural competency (Rosenthal, 2011; Smedley et al., 2002; Witmer et al., 1995).

Under a contract with the Oregon Health Sciences University (OHSU), from 1993-1995 CHWs from La Familia Sana, Inc. in Hood River facilitated workshops for medical and nursing students. CHWs taught the students about traditional Mexican folk illnesses such as *empacho* and *mal de ojo*. They also helped the students look beyond their class and culture to understand other people's ways of viewing health and illness.

Improved patient and community empowerment:
CHW interventions have been associated with increases in empowerment at the individual, organizational, and community levels (Wiggins, 2012). Empowerment is independently associated with improved self-reported health and decreased depressive symptoms (Wallerstein, 2006).

Addressing the social determinants of health:
As community members with knowledge of health issues and the health care system, CHWs are uniquely situated to mobilize their communities to address the root causes of ill health (Wiggins and Borbón, 1998). Many studies have found evidence that CHWs are able to organize communities to address the social and structural issues that traditional health care providers are often unable to address (Ingram et al., 2013; Eng & Young, 1992). The true "value-added" from the CHW model comes when CHWs are encouraged to use their unique abilities to address the major determinants of health (Wiggins and Borbón, 1998).

Return on investment (ROI):
Many CHW activities save money. When CHWs connect community members to primary care homes or other lower cost medical services, they often prevent the usage of higher cost medical services like the emergency room. When CHWs help patients manage chronic disease and access preventive services, they help achieve long-term savings for both patients and health systems. Return on investment calculations for CHW programs range between $2.28 to $4.80 for every dollar spent on CHWs (Angus et al., 2012). A CHW program in Baltimore has produced an average savings of $2,245 per patient per year and a total savings of $262,080 for 117 patients (Angus et al., 2012).

Table 1 - Behavioral Health Activities At Health Share

○ =alignment with CHP

Performance Improvement Project: Improve Screening rates for Diabetes for People with SPMI

CAC's Mental Health and Addictions Committee recommendations: Support programs to bridge corrections with community mental health and addictions

Mental Health Joint Operating Committee

Culturally Specific Community Health Worker Pilot Project: identify and support people experiencing Depression

CCO Performance measure: SBIRT

Transformation Fund: Future Generations Collaborative- Elders and Natural Helpers reduce substance-exposed pregnancies

CCO Performance measure: Follow Up after hospitalization for Mental Illness

Cultural Competence Workgroup proposed standards for Language Access

Healthy Columbia WIllamette CHP: Opiod Prescribing Standards

Activities Related to Behavioral Health at Health Share

CAC's Mental Health and Addictions Committee recommendations: Expand Culturally Specific Peer Support Services

Communications Public Service Campaign: Reduce Mental Health Stigma

Transformation Fund: Multnomah County FACT Team: supporting people coming out of incarceration

Transformation Plan Metric (Exhibit K): Reduce Hospitalization rates for people with SPMI by 10%

Public Health SIM grant: Community Strategy to distribute Naloxone to reduce opioid overdose

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Table 2 - Chronic Disease Prevention Activities At Health Share

O =alignment with CHP

Transformation Fund Project: Healthy Homes Asthma Program

Healthy Columbia Willamette: Breastfeeding Benefits Standardization

CCO Performance measure: HbA1c Poor Control

Transformation Plan Metric (Exhibit K) Quality Improvement Plan to Reduce Disparities in Chronic Disease

Activities Related to Chronic Disease at Health Share

Culturally Specific Community Health Worker Pilot Project: Support people to make lifestyle changes and find resources to manage and prevent Hypertension and Diabetes

CCO Performance metric: Controlling High Blood Pressure

Performance Improvement Project: Improve Screening rates for Diabetes for People with SPMI

Transformation Fund Project: Bringing Health Home - Public Health Nurses in housing complexes facilitating Chronic DIsease Self-Management

The Community Readiness Model

In order to learn in which aspects of the Traditional Health Worker model to invest, we conducted key stakeholder interviews following the Community Readiness Model process, which was created by the Tri-Ethnic Center for Prevention Research at Colorado State University and is based on Stages of Change model from the addictions and recovery disciplines. The Community Readiness Model is a multi-dimensional model that integrates a community's culture, resources, and level of readiness into the design of interventions. Readiness is defined by the Tri-Ethnic Center "as the degree to which a community is prepared to take action on an issue." [2]

The main components of our Community Readiness process were as follows:

1. Adapting the Community Readiness Model survey instrument to Health Share's specific health priorities: are (1) mental health and addictions and (2) nutrition and physical activity related chronic diseases.
2. Streamlining the Community Readiness model to accommodate our limited timeframe and resources.
3. Identifying, contacting, and arranging to interview community members. We chose to interview people from communities disproportionately impacted by health disparities, and sought to interview consumers and community leaders who identify with the following communities: African American; Latino/Hispanic; Native American/Alaska Native; Asian & Pacific Islander; Immigrants & Refugees; and the Slavic community.
4. Interviewing a total of 40 consumers and community leaders.
5. Transcribing the audio recordings of the interviews.
6. Scoring the interviews to determine the community's stage of readiness according to the Community Readiness Model's anchored rating scales.
7. Analyzing the interviews for common themes and key observations.
8. Reporting the results.

III. Methods

III.A. Adaptation of the Community Readiness Survey Instrument

The Community Readiness Model provides a set of 36 generic questions that are mapped to six dimensions of community readiness. These questions were adapted to Health Share's identified priorities: (1) mental health and addictions and (2) nutrition and physical activity related chronic diseases. Some questions were tailored to be even more specific and elicit responses related to the use of culturally specific peer support services for mental health and addiction and the use of community health workers for work related to chronic diseases. Additionally, for some questions we added specific prompts, follow up questions, and definitions of terms. The questions were adapted by the consultant with feedback provided by Health Share staff members, Community Health Needs Assessment committee members, and the persons hired to conduct the interviews.

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[2] Plested, B.A., Edwards, R.W., & Jumper-Thurman, P. (2006). *Community Readiness: A Handbook for Successful Change.* Fort Collins, CO: Tri-Ethnic Center for Prevention Research.

In order to further streamline the process and elicit the information that would be most useful to the Community Health Improvement Plan process, we excluded all but one question related to Dimension C: Leadership, as we felt the questions would not yield new information. As a result, we still collected information on community leaders (see Appendix E) but did not score Dimension C.

Three interview instruments were created (see Appendices A, B, and C):

- Mental Health and Addictions, with 25 multi-part questions.
- Chronic Disease, with 27 multi-part questions.
- A combined instrument with both sets of questions for community members interviewed about both issues.

Each interview instrument includes introductory and closing scripts. A set of instructions for recording the interviews and tips for conducting the interviews was created and distributed to the interviewers.

III.B. Recruitment of Community Members for Interviews

We chose to interview people from communities disproportionately impacted by health disparities, and began searching for consumers and community leaders who identify with the following communities: African American; Latino/Hispanic; Native American/Alaska Native; Asian & Pacific Islander; Immigrants & Refugees; Slavic community.

Health Share staff reached out to more than 75 community organizations and individuals in order to identify potential stakeholders for these interviews. We focused on reaching out to people who identify as youth, with the disability community, and with the LGBTQ community. We wanted to place special focus on hearing from people within these communities because during the Community Health Needs Assessment process we were unable to find many self-led community assessments of health needs.

Our Community Health Improvement Plan (CHP) is primarily focused on identifying opportunities to integrate Traditional Health Workers into systems of care providing behavioral and physical health services, so we also sought to locate individuals who have received and/or provided traditional health work. These include peer support specialists, health navigators, community health workers, doulas, etc.

Additionally, our Community Advisory Council advised Health Share to seek out and obtain input from Health Share Members to learn about their needs for inclusion and emphasis. From July – September 2014, additional outreach to Health Share members took place, resulting in a total of 40 interviews with community stakeholders. Among those 40 interviews, 31 were Health Share members or came from households with Health Share members.

III.C. The Interviews

Forty community members were interviewed in 38 interview sessions. Two interviews were conducted as joint interviews with two individuals at the same time. Four different interviewers conducted the interviews at community locations. Two of the interviews were conducted in Spanish using interpreters.

The audio of all the interviews were digitally recorded with the participants' consent.

Fourteen persons were interviewed using the mental health and addictions instrument, nine persons were interviewed using the chronic disease instrument, and seventeen persons were interviewed with the combined instrument, for a total of 31 persons asked the mental health and addictions questions and 26 persons asked the chronic disease questions.

III.D. Transcribing, Scoring and Analyzing the Interviews

All recordings were transcribed as accurately as possible.

The transcribed interviews were scored using the Tri-Ethnic Center's anchored rating scales for the five dimensions that we chose (out of six possible dimensions). Each interview was scored individually and then an average was calculated for each dimension using the scores for all the interviews. An overall stage of readiness score was calculated by averaging the stage of readiness for each dimension. Scores were calculated for the mental health and addictions and chronic disease separately.

Table 3 - The Tri-Ethnic Center's Stages of Community of Readiness[3]

Score	Stage of Community Readiness	Description
1	No Awareness	Issue is not generally recognized by the community or leaders as a problem (or it may truly not be an issue).
2	Denial / Resistance	At least some community members recognize that it is a concern, but there is little recognition that it might be occurring locally.
3	Vague Awareness	Most feel that there is a local concern, but there is no immediate motivation to do anything about it.
4	Preplanning	There is clear recognition that something must be done, and there may even be a group addressing it. However, efforts are not focused or detailed.
5	Preparation	Active leaders begin planning in earnest. Community offers modest support of efforts.
6	Initiation	Enough information is available to justify efforts. Activities are underway.
7	Stabilization	Activities are supported by administrators or community decision makers. Staff are trained and experienced.
8	Confirmation / Expansion	Efforts are in place. Community members feel comfortable using services, and they support expansions. Local data are regularly obtained.
9	High Level of Community Ownership	Detailed and sophisticated knowledge exists about prevalence, causes, and consequences. Effective evaluation guides new directions. Model is applied to other issues.

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[3] Plested, B.A., Edwards, R.W., & Jumper-Thurman, P. (2006). *Community Readiness: A Handbook for Successful Change.* Fort Collins, CO: Tri-Ethnic Center for Prevention Research.

The transcribed interviews were also analyzed using standard qualitative methods. The transcript answers were combined into a master document organized by topic. The consultant reviewed the master document to identify patterns, trends, and anomalies within the responses.

Technical Note: The interviews were transcribed as accurately as possible, but it is not always possible to get the exact language used for each response. The interview excerpts used in this report have been stripped of words such as "um," and "you know." Excerpts may be truncated for clarity and focus. At times words were inserted in brackets to facilitate reading and add clarity.

IV. Communities Represented

Below is a summary of the 40 stakeholders that were interviewed. Among these individuals, 30 self-identified as either being a Health Share member or caring for family members with Health Share or OHP benefits:

- African American Community Health Worker from Multnomah County based in NE Portland who runs a Patient Wellness Council and has experience using OHP.
- African American Community Health Worker from Multnomah County employed by a local FQHC who is also a trained doula and provides breastfeeding classes, with a focus on people with substance use and the formerly incarcerated.
- Latina Breastfeeding Peer Counselor from Multnomah County who is in training to become a doula and is a leader of a local breastfeeding coalition.
- Native American woman from Washington County identifying as a youth and challenged by disability who has Health Share benefits.
- Refugee from Somalia who is a recognized leader of immigrant refugee justice issues who lives in Multnomah County and serves the metro region in his leadership role.
- Chuukese Pastor and community health worker from Micronesia who provides culturally-specific services throughout the tri-county region.
- Latino peer support mentor for Latinos in recovery who lives and works in East Multnomah County.
- Caucasian woman who is a supervisor of peer support services program with over 20 years of direct experience serving and living in Clackamas County.
- Slavic community leader of Russian descent who lives in and serves Clackamas County.
- Latina youth from Multnomah County involved with a volunteer community health organization promoting healthy eating in her neighborhood who has Health Share benefits.
- Spanish speaking mother of four from Mexico who is obese with hypertension and identifying as someone with mental health disabilities, uninsured with four children covered by OHP.
- Spanish speaking mother of three from Mexico who identifies as someone with mental health disabilities, also uninsured with three children covered by OHP. These two mothers are trained volunteer community health workers who are currently unemployed.
- Vietnamese community mental health therapist from Clackamas County who specializes in serving Vietnamese refugees and immigrants for over 14 years.
- Bhutanese/Khmer refugee who is a community mental health therapist from Multnomah County who specializes in serving refugees with trauma for over 10 years.
- African American man with HIV identifying with LGBTQ community who provides peer support services and chronic disease self-management services throughout the tri-county region.

- Ugandan immigrant who provides culturally-specific peer navigation and medical case management services to people with chronic conditions from the African and African-American community.
- Burmese case manager providing culturally-specific services supporting newly resettled refugees within the tri-county region.
- Iraqi community activist and refugee advocate from Washington County who is a practicing psychiatrist focused on supporting refugees from Africa and the Middle East.
- African American peer support specialist who oversees a housing program for women in recovery returning to the community following incarceration.
- African American and Native American adult student who has received and provided peer recovery services and who has been incarcerated, identifying as having a mental health disability.
- A Muslim woman who identifies as Malaysian and who grew up in Singapore currently living in Washington County.
- A young woman living in Multnomah County who identifies with the Somali-Bantu community.
- Ethiopian immigrant identifying as part of the Oromo community who lives in Multnomah County.
- Congolese immigrant youth from Multnomah County identifying with mental health disability.
- Sudanese immigrant from Clackams County.
- Somali immigrant identifying with the Beaverton and Portland refugee community who lives in Washington County.
- Congolese immigrant from Washington County.
- African American youth from Multnomah County identifying with homeless/unhoused community, mental health community, LGBTQI community, and African community.
- Caucasian woman with physical disabilities from Multnomah County.
- Somali immigrant from Multnomah County identifying broadly with the African immigrant and refugee community.
- Community health worker and trained peer support specialist with ties to African American and Native American community, LGBTQI, and recovery community from Multnomah County.
- Vietnamese community health worker from Multnomah County.
- Immigrant from Iraq who lives in Clackamas County identifying with the Middle Eastern community and people with physical health disabilities.
- Latina from Washington County identifying with mental health disability who has children covered by Health Share.
- African American woman from North Portland/Multnomah County.
- Caucasian woman with physical disabilities and chronic disease from Clackamas County.
- African American youth with developmental disability identifying with LGBTQI community.

We met our goal of interviewing people representing African American; Latino/Hispanic; Native American/Alaska Native; Asian & Pacific Islander; Immigrants & Refugees; Slavic communities, and 30% of those we interviewed self-identified with the youth, LGBTQ, and/or disability community. Slightly more people from Multnomah County were interviewed than from Clackamas or Washington County.

The people who were interviewed were asked to identify natural leaders within their community who they trust and rely on for access to information about behavioral health and/or chronic disease concerns. In our work to transcribe the interviews we identified:

- 32 specific organizations or programs that are trusted by stakeholders for chronic disease
- 6 community leaders and 4 community plans related to chronic disease prevention efforts
- 60 specific organizations or programs that are trusted by stakeholders for mental health and/or addictions issues
- 22 community leaders and 46 community plans or active programs related to mental health and/or addiction support.

Technical Notes:

- Two of these interviews were conducted with two persons at the same time.
  - One of the joint interviews was scored as one interview because both interviewees were from the same communities and neighborhood and one of the interviewees dominated the conversation. Both interviewees were in agreement for most, if not all, of the questions.
  - For the other joint interview, it was clear in the audio recording which person was speaking, each interviewee answered almost all questions separately, and the interviewees were from different communities. These interviews were scored separately.
- One interviewee did not identify as a person of color but is from a county underrepresented in the interviewee pool, and supervises peer support specialists and peer navigators. This interview represented an outlier in terms of scoring. The scores for this interview were not included in the total scoring and overall stage of readiness. Comments from this interviewee are included in the results section because the content is relevant and represents a unique (for this pool) geographic perspective.
- For one interview that used the combined instrument, there was not enough time to complete the Chronic Disease portion of the interview (the interviewees were also asked the Mental Health & Addictions questions). This interview was not scored, however, comments from these interviewees may be included in the results section.
- Due to a technical error when the interview instruments were adapted, questions representing the last dimension, Resources Related to the Issue, were not asked to every interviewee. Only five of the participants for mental health and addictions answered these questions. The calculation of the scores reflects this. These scores were included in the Overall Stage of Readiness Score.
- Due to technical error, the audio recording for two of the interviews is missing parts of each interview. The interviewers were able to reconstruct the salient answers for the missing audio and this was used to score the interviews.

V. Mental Health and Addictions Results

V.A. Dimensions, Scores, and Stages of Readiness

Interviews were scored and the stage of readiness calculated for each dimension, as well as calculating an overall stage of readiness score as discussed in the Methods section.

Table 4 - Community Readiness Score for Mental Health & Addictions

Dimension	Total Score	Stage of Readiness

	(average for all interviews)	
Community Efforts (programs, activities, policies, etc.)	5.1	Preparation
Community Knowledge of the Efforts	3.5	Vague Awareness / Preplanning
Community Climate	4.8	Preparation
Community Knowledge About the Issue	4.1	Preplanning
Resources Related to the Issue (people, time, money, space, etc.)	4.8	Preparation
Overall Stage of Readiness (averaged across all dimensions)	**4.5**	**Preplanning / Preparation**

According to the Community Readiness Model, the goal of strategies for the communities in the Preplanning stage is to "raise awareness with concrete ideas to combat the condition." The goal of strategies for the communities in the Preparation stage is to "gather existing information with which to plan strategies."[4] These goals can help inform the development of appropriate peer support services to address mental health and addictions issues.

The Community Readiness Handbook states, "To move ahead, readiness on all dimensions must be at about the same level – so if you have one or more dimensions with lower scores than the others, focus your efforts on strategies that will increase the community's readiness on that dimension or those dimensions first. Make certain the intensity level of the intervention or strategy is consistent with, or lower than, the stage score for that dimension. To be successful, any effort toward making change within a community must begin with strategies appropriate to its stage of readiness."[5] The lowest scored dimensions for mental health and addictions is community knowledge of efforts and community knowledge of the issue. This is supported in the thematic analysis of the interviews: community education was a repeated theme.

V.B. Themes from Interviews

Mental Health and Addictions: Concern, Knowledge, and Feelings

Most people interviewed said that mental health and addictions issues in their communities were very concerning, and when asked to rate the concern in their communities on a scale of 1-10,[6] most interviewees who gave a number chose a rating of 8 or higher.

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[4] Community Readiness Handbook

[5] Plested, B.A., Edwards, R.W., & Jumper-Thurman, P. (2006). *Community Readiness: A Handbook for Successful Change.* Fort Collins, CO: Tri-Ethnic Center for Prevention Research.

[6] All the scales used in the interview questions use 1 as the lowest level and 10 as the highest (whether it is concern, knowledge, usefulness, etc.).

One interviewee said, *"I think it is a big concern for folks but there's so much stigma surrounding it. So I think if you were to talk to people on an individual basis they might be like, 'Oh, it's not that much of a concern' but in reality it is, when you see it played out…"*

One interviewee said, "*In the African American community I'm kind of split on that because I believe there is some awareness, so I would probably be somewhere around a 6, however, I also feel that a lot of it is denied or kind of ignored and so on that I would probably say like a 3 which is a great concern to me."*

Not all interviewees interpreted this denial as a lack of concern however, *"I think when I'm talking about the black community, African American community, I think that we would probably be a 10. Did you want the reason why? It's been culturally a pattern in our lives as African Americans that we don't talk about our issues and problems so there's a lot of mental health issues around depression that people in our community deal with that's never addressed as well as using drugs and alcohol to offset that."*

For mental health issues in particular, denial, stigma (cultural and/or familial), and lack of education or knowledge, were common themes. Some interviewees felt that communities had more knowledge of addiction issues compared to mental health issues, and that addiction issues were somewhat more acceptable in their communities compared to mental health issues. Multiple interviewees brought up that alcohol and drugs were used to deal with mental health issues that went unaddressed.

One interviewee said, "*I think in the Native American community which is oftentimes as well the impoverished community, mental health and addictions is a very great concern and I think that potentially they aren't privileged to have the knowledge about mental health, so it turns into addictions. I don't know if you talked to people in the community that they would say mental health is a great concern in the Native American community but I think that's mostly because there's so little knowledge shared about it in the community around mental health but that there's definitely a lot of negative coping mechanisms that lead to addictions and people just don't know how to put that into words."*

A common theme was that there was generally knowledge and some support for addictions issues, whereas there was a great need for more education in their communities around mental health.

One interviewee said, *"I feel like we do great with the addiction but I don't see much for mental health. When we say mental health I mean like your everyday diagnosis or you know a diagnosis of a mental health issues like depression. . . I feel that for me, raised in the African American community, the black church community, if you say that you're depressed it's like you're not trusting God enough to help you through whatever struggle you're going through … so I don't think there's really places that offer mental health service for the African American community to be…"*

Another common theme is that persons only become concerned and/or educated about mental health and addictions issues when they or family members are in crisis. One interviewee said,

"We … come from a community that has a lot of fear of stigma so people will keep in denial and only when...facing certain problems, that's when they'll be forced to ask for some kind of service, so mostly they do not understand."

Some interviewees just feel that their communities' needs are not a priority for mainstream institutions, *"I think the overall feeling for a lot of community members that are in need is that they're forgotten, that their needs are mot on the top of the list or prioritized, and that no one really cares. I think that's kind of it, that they're a forgotten invisible population of people that no one really cares about."*

<u>Mental Health and Addictions: Needs / Improvements/ Barriers</u>

The community needs cited and improvement suggested are:

- More education for individuals and the communities, particularly around mental health issues.
- More outreach and information dissemination, about mental health and addiction information generally, as well as specific programs and services available.
- Removal of the stigma around mental health and addictions issues, and encourage more community discussion.
- Culturally specific services.
- Services specifically for the elderly.
- Services specifically for youth.
- Improved access to mental health and addiction services and programs *before* individuals and families are in crisis.
- Use a person-centered approach to deliver services.
- Employ more people from communities being served.

Community education to disseminate information, start conversations, and remove stigma, was commonly suggested as a great place to start. One interviewee said, *"I think educating people about mental health and what that is in the community is a good place to start."*

A Latina-identified Health Share member from Washington County said that *"trying to access mental health services with OHP is really hard…The only way I was actually able to stabilize was landing in a hospital. I couldn't get an appointment when I was going into a mental health crisis."*

Another interviewee explained the connections between stigma and community education, *"I don't think everyone …identifies with mental health and what that looks like and so I feel like if they don't, if they can't identify with it, they don't know how to address it, and so I think education is a big piece that's missing in the community. I think people struggle that a label of mental health means you're crazy for lack of better words and so I think that there's that barrier because people aren't educated … I also think that just from growing up in different cultures, different....just being brought up in a different culture, I think mental health has a different stigma for different people like it was a sign of weakness or it was something you didn't talk about as far as how I grew up..."*

Access to mental health services in languages other than English was another commonly stated need. Cultural differences between generations of immigrants due to assimilation, was also repeated as a

need to be addressed. One interviewee said,*"There is a lot of issue regarding the language… and also regarding access to care access …in my community … there's an elderly population of the age now that they need more even more services. In the same token, the youngsters, the youngest ones who might be understood and understand the language very well but then they absolutely have no idea where they're coming from, that's the issue as well. And sometimes they fall through the cracks cuz there's no services available to them as well."*

Improving access to services before crisis or problems with the law or other institutions was repeated by multiple interviewees: *"You know, it wasn't like an advertisement, it wasn't like, 'oh you need the Oregon Health Plan, you can sign up here' you know it was like 'oh, you're in trouble, these are your options.' You know what I mean? And so it took me being involved in the correctional system or getting DHS involved with my children for me to know that 'okay, I've got some issues and I'm gonna have to do something about it and now I have some options.'"*

"I think that a lot of people often feel that they're not the priority. They feel that some sort of…like you have to set up a goal plan and you have to meet those goals in order to continue receiving services and I feel like a lot of people feel more like a cog in the wheel and they're just going through a set of programs instead of the priority is this person and we're trying to help them reach their goals. It's more of 'well we need funding so we have to have you do this and this and this and this and this' and it starts to feel less and less like it has anything to do with you and more and more about um a business continuing to be a business."

Many barriers to accessing mental health and addictions services were cited throughout the interviews. Many of these barriers are interrelated. These barriers include:

- Not enough services, long waits.
- Not knowing what or where services are available or how to access services.
- No or limited services that are linguistically and culturally specific.
- Problems using interpretation services, especially for mental health services.
- Inability to acknowledge the issue due to lack of knowledge, stigma, and/or other cultural issues, and therefore care is not sought.
- The bureaucracy and administrative hurdles of getting into care and staying in care.
- Lack of medical coverage.
- Undocumented status.
- Being screened out of available services due to serious mental illness or active addictions.
- Racial oppression.
- Homelessness.

When asked how the community gets access to the physical and mental health services that are available, a common response was that no services are available, or there is no knowledge of available services. One interviewee responded, *"The only thing I know is that you have to look for help, but the big question is where?"*

Another interviewee stated, "*Access, I think is sometimes hard for people cuz they just don't know. And*

organizations aren't always the best communicators as well."

"There's not enough culturally specific counselors, and if you taught counselors who will be able to support community members and because again if you have a Somali person or a Latino person and the person who's supposed to be counseling is from the dominant culture and don't understand the historical cultural aspect of that individual it makes very very difficult for people to trust."

"…Mostly it's relying on interpretation services. There is now a good chance that the certification process that will improve because unfortunately there's a lot being missed in the interpretation, but anyway, that's the way to access...For the mental health services it's more difficult you know interpretation cannot help all the time when it comes to issues it's about language."

"Unable to be transparent and say I need help because it's been like we're supposed to be strong people. [In the] African American community you're supposed to be strong people and so you end up carrying things. So instead of saying 'hey this is really breaking down my body cuz I'm carrying this' or 'I'm struggling with ___ '"

"Sometimes it's hard to get health coverage because people are afraid if they have a legal record that they'll be denied coverage or that they will be turned in or something or they, I mean there's people who have a really hard time filling out papers so that can be frustrating or they just don't know what's available...getting access that can be one thing that's the hardest because first you have to introduce the idea, the concept to people and whenever it becomes bureaucratic, whenever it gets stuck somewhere, or whenever there's a problem that arises, it can really turn someone off from the situation because there's a lot of these people who … aren't very used to it ....the system doesn't work for them essentially."

Peer Support: Awareness

Most interviewees had difficulty citing culturally specific peer support services that are available in the community. Some interviewees could not think of any, some only a few places. Many interviewees said there is not enough peer support services, although the need is high.

"Yea I can say that there's zero. We don't have any formal peer support services for the family members. Of course we have our traditional ways of dealing with these issues and mostly it's about denial of course and providing support indirectly ... So when we provide support to each other its not the appropriate scientific or academic services."

When asked to use a scale from 1-10 to how aware are people in your community of peer support services to address mental health and addictions issues, the answered ranged across the scale from 1 up to 8, with the average around 5.

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A sentiment that was repeated is represented in this comment, *"I would say like 5 because how they can know something that hasn't been provided to them, you know what I mean?"* Others thought there were some services, but that the community often isn't made aware of those services and programs, *"Very little awareness, there needs to be a whole lot more messaging toward that."*

Others felt there were some community members who were "in the know," usually those who worked in the field and/or had personal or familial experiences with mental health or addictions issues. *"I think the few wellness specialists out there that are African American are very aware of it so maybe they have been through that themselves so they know how to support people in that."*

Peer Support: Strengths

The strengths of peer support as described by the interviewees were as follows:

- Shared understanding of common culture, community, language, values, and/or history.
- Shared or common experiences; lived experiences.
- Honest, open, non-judgmental support.
- Meeting the person where they are – both physically (e.g. going to court) and in their readiness for treatment or recovery.
- More availability (e.g. non-business hours) than other types of services.
- Ability to help navigate multiple, complex systems that often have emotionally fraught implications (e.g. DHS Child Protective Services)
- Bringing awareness, "starting the conversation."

"Is that the people who are providing the service are people who have walked through exactly what they're trying to help the next person walk through. They're saying 'this is what I've done, this is what worked for me, I've been where you're at, and so if you'd like, I can help you walk through this and this is what we can try' so being able to identify with someone and it's not just feeling like someone who was taught what to say or who did some research and or that has the education behind it but doesn't have the experience, like being able to identify with the person you're working with gives you a level of trust…"

"I think in the Native Community having peer support is massively important to have other Native Americans because there are things that are part of the culture that people who grew up outside of the culture have a really really hard time understanding the concept when it comes to even basic philosophy, finding...Native Americans often find very different value than other communities so I think that it's important...

".. having someone who's not going to judge you, someone who you can identify with, someone who you can see as a result of the choices that they've made that this is what works."

"The strengths is that its the people... because they want to help and they know how to help you know like I seen provider, he keep on a schedule from 8-4 in the office but there it's 24 hours a day and peer support is ready those 24 hours so it's very helpful."

Peer Support: Barriers, Needs, and Improvements

The following were the barriers, needs, and suggested improvements specific to peer support around mental health and addiction issues:

- A need for more peers and peer support programs.
- More culturally and linguistically specific peer support services for specific groups.
- Utilize persons with lived experiences for peer support.
- Ability to work with people in a preventative mode instead of in crisis.
- Training for potential peers.
- Mentor / support peers to become mental health and addiction professionals.
- Centralized services – one stop shopping.
- Trust the community and existing organizations.
- Creating coalitions of organizations and/or peers that are doing culturally specific peer support.
- Raising awareness in communities about existing peer support services and programs.
- Getting people to services if there is cultural stigma or other barriers.
- Funding!

A general feeling was that more peers and peer support programs were needed. *"That we have more of them. I believe that if we had more peers I think that would be helpful. So, finding the funding…"*

"… maybe it might be teens that are homeless that you're looking at that population and teens of color and you know maybe there's abuse or maybe you're looking at incarcerated women or men … because really crazy stuff happens to people when they're incarcerated and there's a lot of mentally ill people there and people that have addictions that guide them there in the first place. So I think even if you looked at the incarcerated population so that when they do return out into the world, that their needs are met and that they have a good support system…"

"…I do feel like it's changing but more needs to happy. Many people in my community [African American, LGBTQI] and that I know and see – more just needs to happen to make that change. Not just going to be overnight."

"… I think the issues for me is that's not enough culturally specific services available for immigrant refugees and people of color so that's a really big issue for me and culturally specific providing means to me means that people… the agencies and individuals who are from the community [are] running those programs, so meaning that the immigrant refugee organization is led and based on the immigrant refugee population and people of color find those programs … we don't have enough services available from those perspectives."

"There's not nearly enough peer-wellness specialists that are really of many different ethnicities or even languages so maybe looking at now we're starting to see bigger populations of Somali folks, Russians, or Vietnamese, just looking at those different populations that really aren't being served well in those aspects."

"I've talked to several individuals that I've work with that identify with that and say it's a struggle for them to sit down with someone who has absolutely no idea, who's never been through DHS involvement,

that's never been incarcerated due to their addiction or mental health and they go, 'Whoa. Wow you're a college graduate but you've never had any of this so how do you understand?' and that's a struggle for them."

One interviewee brought up the desire for more peers to in order to work with people in a preventative mode instead of in crisis, *"We're always dealing with the emergencies, we're not doing enough frontloading so that's why it's really really important to adapt these programs if we were working with people before they got to crisis cuz when they get to crisis, there's nothing, I mean there's just absolutely nothing…Transportation, you know companionship, people who can talk about what the doctor just said in a meaningful way that they hear what the doctor said and they understand it cuz the doctors are doing better with you know speaking culturally where people understand that there's a lot to be done."*

"What could improve the situation is actually in providing training, we do not have training … so at the end of the day it's an issue of funding to provide the training to expand service." "There's so many different populations you can work with to create peer specialist or advocates in those fields that could really become leaders in their communities and you start to empower people in that way to you know to take a path towards healing really but there also does need to be professional mental health consultants that are culturally appropriate for folks. Because people like to see reflections of themselves. And I know that's not stressed enough, I know that we live in Oregon where it's a very white population in some aspects and it its changing but as far as providers go, it still is not nearly where it should be."

"I think that different organizations like Health Share or CCOs or hospital systems don't trust the community members or … nonprofits enough to know that they know their community so I think that they need to tap into the resources that are already there and local nonprofits know what's going to work for their communities. . . let the community speak for itself."

When asked if peer support services are not accessible to certain people in your community, for example, individuals of a certain age group, ethnicity, income level, geographic region, etc, groups with no or limited access include:

- People outside of Portland – lack of culturally appropriate services in other areas of the counties.
    - East Portland / Gresham was specifically discussed
- Undocumented immigrants, who have difficulty accessing services and who may have specific mental health issues.
- Refugees, who may have specific mental health issues.
- People who speak languages other than English.
- Youth.
- Women with children and addiction issues.
- Persons who don't / can't leave the house: women (in some cultures), elderly, disabled

"Geographic region I would probably say would be the biggest thing. It's kinda difficult for me to get out there because there's only two NARA locations and they're both in Portland and they have specific uses

so if I wanna see the doctor, I have to go really really really really far and really really early in the morning."

"In the Latino community it's hard...even if they got insurance, medical, there's no service like right now for a woman to go to a treatment only if she speaks English, if she does not speak English it's outside, you know, left out which is you know, and same thing for men, you know in Oregon...I hear one Latino treatment and I send some guys who were there and it's only one, like they've got 14 beds...we are thousands outside...even if they've got insurance or a health plan, there's no service for the Latino, no bilingual facility or culture of people who can address the problem." "Also with women. If we weren't prosecuting women that were heavy in their addiction, if we were really working with them to coordinate serves to help support them to get through that hard time instead of just removing their children, we wouldn't see women repeatedly having baby after baby to try to replace the ones that they lost because they were removed... women that are in the middle of their addiction really need a place to go to where they can receive comprehensive whole-person care where they can receive holistically so if we could really do a better job of providing services to them."

"We need them for the youths. For the mothers in the house who are not coming out - you know this is our culture [Iraqi refugee] the woman will be in the house and they will not go out, they need outreach to them in the community."

All the interviewees that were asked if there a need to expand these peer support services to address mental health and addictions issues, said yes, there was a need to expand peer support services to address mental health and addictions issues. *"The funding isn't adequate."*

"I think the [peer support] model is amazing, but there's not a lot of funding for it. But it's well needed."

VI. Chronic Disease

VI.A. Dimensions and Scores

Interviews were scored and the stage of readiness for each dimension was calculated, as well as an overall stage of readiness as discussed in the Methods section.

Table 5 - Community Readiness Score for Chronic Disease Impacted by Physical Activity and Nutrition

Dimension	Total Score (average for all interviews)	Stage of Readiness
Community Efforts (programs, activities, policies, etc.)	4.8	Preparation
Community Knowledge of the Efforts	3.8	Preplanning
Community Climate	4.4	Preplanning / Preparation
Community Knowledge About the Issue	4.3	Preplanning

Resources Related to the Issue (people, time, money, space, etc.)	3.9	Preplanning
Overall Stage of Readiness (averaged across all dimensions)	**4.2**	**Preplanning**

According to the Community Readiness Model, the goal of strategies for the communities in the *Preplanning* stage is to "raise awareness with concrete ideas to combat the condition."[7] This goal can help inform the development of appropriate peer support services to address mental health and addictions issues. The lowest scored dimensions for chronic disease that is impacted by physical activity and nutrition are community knowledge of efforts and resources related to the issue. The thematic analysis of the interviews support this. Most interviewees felt community members were aware of the issue but did not know what programs and services are available to address chronic disease or that resources to aid behavior change are lacking in their communities.

VI.B. Themes from Interviews

<u>Chronic Disease: Concern, Knowledge, and Feelings</u>

- Physical Activity

Most people interviewed said that lack of physical activity in their communities was concerning. When asked to rate the concern in their communities on a scale of 1-10, most interviewees who gave a number chose a rating of 7 or higher, although four interviewees rated the concern as a five or lower.

"Culturally, people think of physical activity in the lifestyle here in this context as a luxury; you have a luxury to go and run to do physical activity whereas back home, physical activity is survival. So people do that based on how they're living within culture. To tie it to health, as a need for dealing with our health, it's not really on the radar for our communities as they really don't see it tied directly to health."

"As a doula I work with moms and I worked for seven years in an elementary school where 80% of the population was Latino and noticed that a lot of children spend time watching TV in their houses along with adopting food habits from this country [which] contribute to obesity and not being very active. Some kids play soccer but they don't find a place to practice so they tend to stay home and watch TV, families feel their kids are safer that way, so all those factors contribute."

"So probably the younger generation, because most of us here are first generation immigrants but probably the second generation that are growing up now, they have some awareness of physical activity."

A Health Share member said during her interview that *"I have high blood pressure and I'm just figuring that out and learning about having it even though I've had it for years. I didn't know you could get a heart attack and die, I didn't know that stuff."*

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[7] Plested, B.A., Edwards, R.W., & Jumper-Thurman, P. (2006). *Community Readiness: A Handbook for Successful Change.* Fort Collins, CO: Tri-Ethnic Center for Prevention Research.

- Healthy Eating

When asked how much of a concern is unhealthy eating in this community on a scale of 1-10, interviewees were divided. Half of the respondents said 9 or higher, and half said 2 or 3, with one person saying 5.

"I think it is very concerning, because as I said, we see the negative impact right away in the first generation. We see how that makes us sick, we are more vulnerable, than another member of another community… Coming here and starting eating the diet that is prevalent here, that is making us sick. And also the family is working and that contributes. Get fast food and stop eating the way we ate from our countries. That change happened very fast."

"This varies from family to family. There are some families that are still interested in their traditional meals so they go to African stores and buy African food and cook it which is healthier. And some families tend to pick up on the lifestyle of the new community … or they going for fast foods and eating unhealthy and some of this is related to when they get jobs and they don't have time to cook so they get something which is already made and are not good for them so it's kind of a two way thing."

"If there are [efforts] a lot of us don't know about them."

When asked, "using a scale from 1-10, how knowledgeable are community members about chronic disease can be impacted through physical activity and healthy diet," respondents said 7 or lower.

"I've seen the changes through second generation, children are being physically active, their children might be open to that but I'm not seeing that in necessarily the first generation which can be a burden to a second generation, you know when mom has a chronic disease, the kid has to support the mom."

"I think they may have heard the information but it is not something that is constant or being reinforced all the time. I mean sometimes the terms that people use when giving information people doesn't really understand so maybe language that is more clear and really like, 'so what are you are eating right now' in a week, and being sure they are getting information. Even for me sometimes it is hard to understand like 'protein' and 'carbohydrates' and all those things. So just make it easier. So see what they have, they are already good, and work toward building from there."

Chronic Disease: General Needs / Improvements/ Barriers

The community needs and suggested improvement from interviewees include:

- Addressing social determinants of health and root cases, e.g. racism, poverty, which can then enable behavior change.
- For immigrant communities, address assimilation issues that lead to unhealthy eating and lack of physical activity, as well as cultural differences related to food and exercise.
- Make fresh healthy food more financially and geographically accessible.
- Fast food should be less accessible in impoverished neighborhoods.
- Better nutrition and access to physical activity in schools.
- More information available to the communities in the communities.

- Staff that speak the language instead of relying on interpretation services.

"It's a very high concern but I think I would frame the question instead of focusing on physical activity, I think there's a much broader issue why there is huge disparities between the people of color, even refugees, on chronic diseases such as diabetes and high blood pressure and I think a lot has to do with … access to health food and so there's a broader social issues … racial issues of oppression people face on this issue can confuse that battle. …"

"For Latino communities it is a lot about sharing what we eat. That is huge. So instead of preparing a meal and eating at home, it becomes more about going out, but we go to those places that is not very healthy. You don't see very many families coming together and going for a hike or something like that. More sedentary activities."

"I think it is very concerning, because as I said, we see the negative impact right away in the first generation. We see how that makes us sick, we are more vulnerable, than another member of another community… Coming here and starting eating the diet that is prevalent here, that is making us sick."
Barriers to healthy diet and exercise include:

- Cultural reasons.
- Financial reasons; poverty.
- Habits.
- Limited opportunities.
- Lack of linguistically and culturally appropriate services, programs, opportunities.
- No knowledge of current efforts – lack of information dissemination, e.g. Oregon Trail program with farmer's markets.
- For immigrants, different habits, environments, circumstances, opportunities compared to home country.
- Chronic disease has been normalized or thought of as inevitable in families and/or communities.
- Not a priority – basic needs or sending money to family in home country are a priority.
- Lack of time. Days are filled working enough to pay the bills.

"There's almost zero opportunities in our communities. The only one thing that I can think of is when a certain organization, usually churches, organize some kind of sports event so the youth would come together and play basketball or volleyball for a period of time but that's about it. There's no real organized activity." "I think the barrier is it would be great if more people had employees who spoke our language. Language is a big one, especially for older adults. … Language is a big deal and in terms of just understanding culture, you know since this is all for a larger purpose...there's still a lot of stigma I think with people who come from Russia and live here in the United States...I think larger community doesn't necessarily understand the background and I know that it's not easy for seniors to interact with other seniors, seniors who are Russian or Ukrainian for example, they tend to interact only with people from their own country."

"They may not have diabetes. An older person might say 'I have that sugar.' 'My mom had it, my auntie had it, my dad had it,' so it's also in a sense its like it's okay to have it cuz it's a norm in our family. Then here you are saying it's not normal. My grandma may have lived to 75, my mom may live till 70, so I'm thinking living to 70 is gonna be a great age because of what I know. But if I'm living a healthy life, I've got until 95. I short change myself 15 years because of lifestyles and not having the basics of information."

"What's not working is … just being able to access food, afford foods that they need to eat and just the difficulty of behavior changes and lack of education."

"A lot of people think it's an inevitable thing for us. It's come to the point where people just accept the reality that as you grow older, you will get diabetes, you will get high blood pressure and that's not something that's preventable. It's something that our community has accepted as part of life which is very sad."

"I think they know a lot but I think there's a lot of myths that they know about it too. Like having high blood pressure is hereditary so it's accepted. So that's another hard thing to see in your community that people are dying so young but it's almost like it's accepted cuz they have high blood pressure, oh they died of a heart attack. But the preventable piece they don't talk about. So it's almost accepted that we are the way we are around chronic disease."

"If you're asking me if there's enough culturally specific information or education programs addressing those issues, I don't think so, I don't think there's enough."

Community Health Workers: Awareness

"I think this [Community Health Workers] just started. I mean, excuse me, with a specific name it just started. We have been community health workers for years, years, helping each other out. Like I said the older generation helping, used to do births, having a doula, I mean it's been called doula but it was 'so and so's' mom would come over hand help that person deliver her baby. So it's been a lot of community type health work within the community that goes on there…so the community health workers, we've have them in the community, they've been here for years but now we have a name that's called a community health worker so now it's almost a sense of validation of what we've done."

"Yea, the community health workers at Urban League are working on that, they've done… they've graduated two classes and they are working in the community… I think they are based out of Urban League and so they're doing a lot of canvassing the communities, working in the community centers, working with churches, anywhere they can get in to talk to people about chronic diseases. Again trying to just work on the inequity of the health disparities that we find in our communities that's their mission, that's their goal."

Many of the community members we interviewed didn't know about any community health workers. Among our consumer interviews, "*I don't know"* and "*I wouldn't know about that,"* were common

answers when asked about efforts to help people in the community or about community health workers specifically.

"Not that I know of in Clackamas County...Maybe in Multnomah County...Our community is about 150,000 people between Washington, Multnomah, Marion, those three counties primarily...I can't speak to the larger community but I can tell you as far as I know we don't have anybody who speaks Russian in Clackamas County that does health promotions."

"I don't really know about Latino. I know about African American but I don't know about Latino."

Community Health Workers: Strengths

When asked to describe the community's attitude about using culturally specific community health workers to address chronic disease preventable through physical activity and nutrition, using a scale of 1–10, all respondents said 8 or higher, and half said 10.

"You can never get enough of culturally specific community health workers or health information."

"Grassroots, you know it's very natural, it's the community does it but the lack of resources make it impossible to do it on a larger scale."

"It's bringing more awareness of how people eat especially when we're thinking about diabetes cuz it's just so prevalent. People are getting diabetes diagnosis younger and younger in our community and so it's really raising the awareness and people seem to be very conscious, there's a lot of conversations about it."

I like Stanford [the Stanford School of Medicine Chronic Disease Self-Management Program] because Stanford talks about you have an action plan and you start small. You think big and you start small ... I think it's an excellent way of getting that conversation started, I notice we're using materials from them in the community of faith ... I like Stanford and I'm trained in it and I wanna take Stanford into the community because I see that people are open to talking about chronic disease in that way and so I see that the people are open to it and so I'm happy..." "I work in the field of HIV and I've found that they're more receptive when I talk about chronic disease versus HIV. And in chronic disease, we can name HIV and talk about how it is a manageable disease and that takes some of the sting out of the stigma, it takes some of the stigma out of HIV and ... normalizes it. And I think the more that we do that, the more success we'll have in the community in addressing HIV and how we see people who are HIV in the black community..."

Interviewees from a variety of communities spoke of church efforts.

"I know that for our church … we've done some things to kind of ask the people to make better food choices for the sake of our children and because you know we, I, personally see it as also very important for our spiritual health to be physically healthy. So I know of that effort. Also our church has made it part of their, kind of our ethic, how we do community gatherings. Right now we are moving away from the traditional way we do foods which is bringing as much food as you can you know and right now we're

trying to limit it…"

"I think if the larger community was more willing to support culturally appropriate services, I think anything's possible."

"I think it will be really useful but I think it needs to come from an institution that people trust."

Community Health Workers: Barriers, Needs, and Improvements

- Lack of resources / funding.
- Not enough culturally and linguistically specific community health workers.
- Not enough outreach, notice of activities is not widespread or timely or in languages other than English.
- Differences within communities, religious or ethnic.
- Provide culturally specific education, e.g. cooking classes that feature recipes the community already cooks.

"Back to resources, we can only do so much with what we have."

"Show us how to cook them... Like if there were some cooking piece component where someone could really come Tuesday and Thursday … over at [a clinic in North Portland] and do a cooking demonstration on something around southern cooking, how to make it taste good and be really great for a diabetic person. It's culture specific. If there were something like that, that would be great."

"Oh yes! …if you're saying that what we're eating is causing these things -- high blood pressure, diabetes -- these chronic issues, then we need them financially to be more accessible to be able to purchase them."

"I think part of it is we can't wait for people to come to us; we need to go and see if they need our help. When I came for example here to Clackamas County, I remember people saying 'oh wow, that's so cool you speak Russian, we don't really have a lot of Russian clients' and I said that's interesting because we have at least 30,000 [Russian] people in Clackamas County. And part of it was as I started to go out and meet with people...just the other day I was at a meeting with Slavic families and literally next day we had three referrals at the agency.. and these referrals .. this one child has not had medical insurance so we got her with medical insurance … another child who go get social security for disability, we got her mom to complete the SSI form … and all of it was because somebody who spoke their language and happened to be at their meeting. I was that person."

"The biggest challenge is the language. People don't feel comfortable to walk into a place where you can't communicate."

Objectives: Behavioral Health

Goal: Identify and eliminate health care disparities in Physical and Mental Health outcomes for people diagnosed with Severe Persistent Mental Illness, people who identify as People of Color, and people who speak a preferred language other than English

Strategy : Work with Culturally Specific community based organizations and behavioral health providers and community based organizations, to support the use and availability of Culturally-Specific Peer Support Services for Health Share Members, with outcomes tracked by Race, Ethnicity and Language, and attention to young people, people with disabilities and people identifying as LGBTQ.

Table 6 - Behavioral Health Driver Diagram

Culturally-Specific Peer Mentors Reduce Disparities in Outcomes for Members with SPMI and Increase use of Behavioral Health Services

Aim	Primary Drivers	Secondary Drivers	Specific Changes to Test

Aim

Eliminate racial, ethnic and language-based disparities in use of services to address Mental Health and Substance Use Disorders and improve health outcomes for people diagnosed with Severe Persistent Mental Illness.
among culturally-specific communities by:
o   Supporting and expanding availability of Culturally-Specific Peer Mentors
o   Collaborating more effectively with peer support services organizations and culturally-specific organizations
o   Increasing understanding of health disparities among Health Share's members

Disparities-sensitive Outcome Measures
Improve quality: Increase diabetes screening rates for Members with SPMI from baseline (x%) to (x%)

Improve experience:
Increase Follow-Up after Hospitalization for Mental Illness Rates for members with SPMI from baseline (x%) to (x%)

Increase rate of Addictions services use by members who identify as people of color & who speak a preferred language other than English from (x%) to (X%)

Increase rate of mental health services use by members who identify as people of color & who speak a preferred language other than English from (x%) to (x%)

Decrease costs: Decrease hospitalization rates for members with Severe Persistent Mental Illness from baseline (x%) to (x%)

Primary Drivers

Culturally-specific Peer Mentors

Process Measure
# of Culturally-specific Peer Mentors available for referral to members

Collaboration with Community Based Organizations

Process Measure
# of Community based organizations and culturally-specific organizations in contract with Health Share to provide Peer Services

Health & healthcare disparities data analysis

Process Measure:
Member Data on point-in-time cohort of members diagnosed with SPMI is analysable by Race, Ethnicity and Language

Data on use of Mental Health and Substance Use Disorders services are analysed for disparities by race, ethnicity and language

Secondary Drivers

Improve partnerships between Primary Care and Behavioral Health practices and Peer Mentors

Enhance focus on Culturally-Specific Peer Mentors, LEP members, LGBTQI, youth, and people with disabilities

Improve collaboration between culturally-specific CBOs, Peer Services CBOs and Health Share provider practices

Support culturally and linguistically appropriate care teams through education

Enhance Peer Mentors' knowledge of health system transformation outcomes measures

Disparity analysis plan utilizing best practices

Focus on Behavioral Health services use and improved outcomes for people with SPMI

Use disparities data to enhance SPMI quality improvement initiative on screening for diabetes

Specific Changes to Test

Culturally-specific Peer Mentors support members to make lifestyle changes and find resources to improve their health

Behavioral Health and Primary Care practice teams identify and provide referrals connecting members to Peer Mentors

CBOs provide training on Health Transformation outcomes measures to Peer Mentors

CBOs provide training to primary care and behavioral health practices about culturally-specific Peer Mentors and integrating peer workforce into care teams

Develop and refine a set of standard agreed upon measureable disparities-sensitive outcomes

Optimize analysis of behavioral health outcomes and member utilization data

Implement a Quality Improvement Plan to address healthcare disparities for members diagnosed with SPMI

Objectives:

Alignment with Health Share Activity	Baseline (2014)	July 2015 Objective	2016 Objective	2017 Objective
Recommendation of CAC Mental Health and Addictions Committee: Expand Peer Support Services	# of Culturally-Specific Peer Support workers available for referral to Health Share members who identify as people of color, who speak a preferred language other than English, who identify as LGBTQ, who have a disability or who are young or ederly	4	To be developed in 2015, based on the findings of the Culturally-specific community led self assessments conducted by CBOs in 2014	TBD in 2016
	Referrals by Health Share providers to peers for members who identify as people of color, LGBTQ, who speak a preferred language other than English, who have a disability or who are young or elderly	Target # of referrals TBD, based on the peers services proposed- could be high or low "touch" depending on the complexity of the population served	To be developed in 2015, based on the findings of the Culturally-specific community led self assessments conducted by CBOs in 2014	TBD in 2016
	# of Culturally-Specific CBO-Sponsored Community Dialogues focused on decreasing stigma of Mental Health and Addictions, and increasing community knowledge of services available to Health Share Members	10	To be developed in 2015, based on the findings of the Culturally-specific community led self assessments conducted by CBOs in 2014	

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Community Based Organizations employ Peers to conduct culturally-specific health needs assessments with Health Share Members	# of culturally-specific community- led self assessments conducted by June 30, 2015	4	To be developed in 2015	To be developed in 2016
Recommendation of CAC Mental Health and Addictions Committee: Increase the use of Mental Health and Addictions Services	Service Utilization Rate of members who identify as people of color& or who speak a preferred language other than English	Increase use of mental health and addictions services to match rate of general population	TBD in 2015	TBD in 2016
Health Share Transformation Fund Project: Future Generations Collaborative	Increase ability to share learnings about trauma informed process, and spread practices developed by FGC to other groups	# Organizations involved in collaborative: 8 # orgs financially supported through collaborative: 4 #elders and natural helpers trained & working in community: 18	TBD in 2015	TBD in 2016
CCO Performance Improvement Project	PIP: Diabetes screening rates for members with SPMI (who identify as people of color or with a language preference other than English)	Meet or exceed benchmarkrate for for HbA1C completed and LDL-c screenings completed for Health Share members	TBD in 2015	TBD in 2016
Health Share Transformation Plan Metric	Hospitalization Rates for members with SPMI who identify as people of color or with a language preference other than English	Reduce rates by 10% for overall SPMI population, eliminate disparities based on R/E/L	TBD in 2015	TBD in 2016
CCO Performance Measure	Follow-Up after hospitalization for Mental Illness Rates for members with SPMI who identify as people of color or with a language preference other than English	Benchmark=68%	TBD in 2015	TBD in 2016

Objectives: Nutrition and Physical Activity-related Chronic Disease

Goal: Identify and eliminate disparities in Nutrition and Physical Activity related Chronic Disease outcomes for Health Share Members who identify as People of Color, speak a preferred language other than English, identify as LGBTQ, or have disabilities

Strategy : Work with Culturally-Specific community based organizations and the Oregon Community Health Worker Association, to support and expand the use and availability of Culturally-Specific Community Health Workers available for referral to Health Share Members
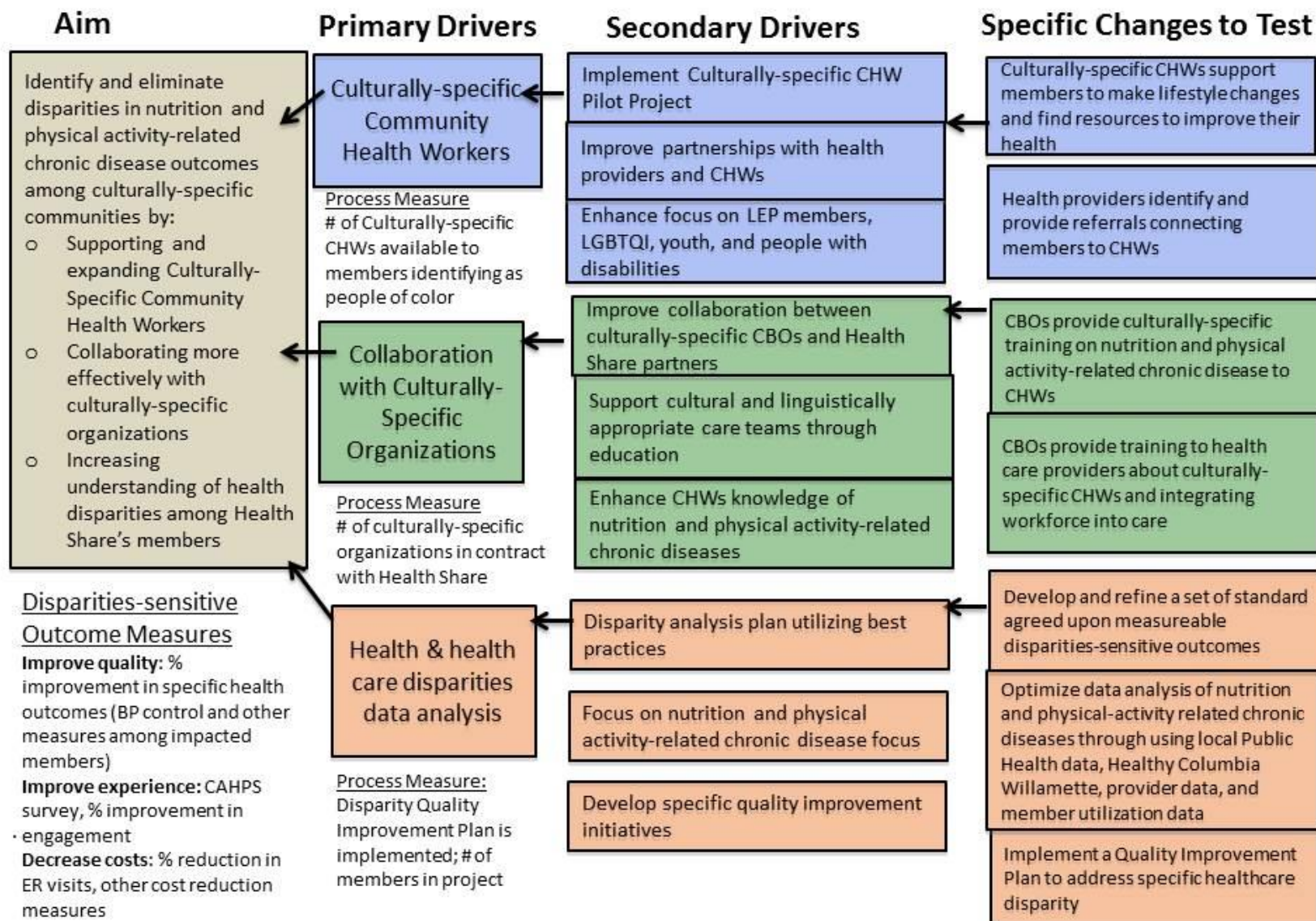
Strategy : Improve Health Share's ability to conduct health and healthcare disparities data analysis

Objectives:	Baseline (July 2014)	July 2015 Objective	2016 Objective	2017 Objective
Culturally Specific Community Health Workers support members to improve conditions in their families and neighborhoods, make lifestyle changes and find resources to manage and prevent chronic conditions	# of Culturally-Specific Community Health Workers available to Health Share members who identify as people of color, who speak a preferred language other than English, who identify as LGBTQ, who have a disability or who are young	4 FTE	To be developed in 2015, based on the findings of the Culturally-specific community led self assessments conducted by CBOs in 2014	To be developed in 2016
Culturally-Specific Community-Based Organizations provide trainings to Community Health Workers on nutrition and physical activity related chronic disease and clinical services related to Health Share's Quality Improvement Plan	# Contracts in place with Community Based Organizations to train Community Health Workers	1	To be developed in 2015, based on the findings of the Culturally-specific community led self assessments conducted by CBOs in 2014	To be developed in 2016

Culturally Specific Community Health workers share information about and lead healthy eating and physical activity groups in their communities	# of members who set personal goals around healthy eating and physical activities, as captured by Community Health Workers in pre and post assessment forms	TBD, based on the community members that the CHWs propose to engage with (could be high or low "touch" members, a range could be between 20 and 50 people per CHW per month)	To be developed in 2015, based on the findings of the Culturally-specific community led self assessments conducted by CBOs in 2014	To be developed in 2016
Community Based Organizations employ Community Health Workers to conduct culturally-specific health needs assessments with Health Share Members	# of culturally-specific community-led self assessments conducted by June 30, 2015	4		To be developed in 2016
Culturally-Specific Community-Based Organizations provide trainings to Primary Care Providers about culturally-specific traditional health workers and integrating the workforce into care teams	# Contracts in place with Community Based Organizations to train Providers	1	To be developed in 2015, based on the findings of the Culturally-specific community led self assessments conducted by CBOs in 2014	To be developed in 2016
Disparities Sensitive data analysis plan is created to improve Health Share's ability to identify and eliminate health and health care disparities among our members	# of disparities-sensitive measures identified that Health Share can utilize to identify, track, and reduce healthcare disparities.	Improvement to measures or positive change in utilization of disparities-sensitive measures	To be developed in 2015	To be developed in 2016
CCO Quality Improvement Plan: Reduce an avoidable disparity in a chronic condition impacting a specific member population defined by Race, Ethnicity or Language by 10%	Submit plan to OHA prior to July 1; plan objectives to be finalized by Quality Mgmt Council in June 2014.	Specific improvement using a disparities-sensitive measure, TBD July 2014	To be developed in 2015	To be developed in 2016

Table 7 - Chronic Disease Driver Diagram

Culturally-specific Community Health Workers Reduce Chronic Disease Disparities

Aim	Primary Drivers	Secondary Drivers	Specific Changes to Test
Identify and eliminate disparities in nutrition and physical activity-related chronic disease outcomes among culturally-specific communities by: ○ Supporting and expanding Culturally-Specific Community Health Workers ○ Collaborating more effectively with culturally-specific organizations ○ Increasing understanding of health disparities among Health Share's members	**Culturally-specific Community Health Workers** Process Measure # of Culturally-specific CHWs available to members identifying as people of color	Implement Culturally-specific CHW Pilot Project Improve partnerships with health providers and CHWs Enhance focus on LEP members, LGBTQI, youth, and people with disabilities	Culturally-specific CHWs support members to make lifestyle changes and find resources to improve their health Health providers identify and provide referrals connecting members to CHWs
	Collaboration with Culturally-Specific Organizations Process Measure # of culturally-specific organizations in contract with Health Share	Improve collaboration between culturally-specific CBOs and Health Share partners Support cultural and linguistically appropriate care teams through education Enhance CHWs knowledge of nutrition and physical activity-related chronic diseases	CBOs provide culturally-specific training on nutrition and physical activity-related chronic disease to CHWs CBOs provide training to health care providers about culturally-specific CHWs and integrating workforce into care
Disparities-sensitive Outcome Measures **Improve quality:** % improvement in specific health outcomes (BP control and other measures among impacted members) **Improve experience:** CAHPS survey, % improvement in · engagement **Decrease costs:** % reduction in ER visits, other cost reduction measures	**Health & health care disparities data analysis** Process Measure: Disparity Quality Improvement Plan is implemented; # of members in project	Disparity analysis plan utilizing best practices Focus on nutrition and physical activity-related chronic disease focus Develop specific quality improvement initiatives	Develop and refine a set of standard agreed upon measureable disparities-sensitive outcomes Optimize data analysis of nutrition and physical-activity related chronic diseases through using local Public Health data, Healthy Columbia Willamette, provider data, and member utilization data Implement a Quality Improvement Plan to address specific healthcare disparity

Identifying Disparities: Top Chronic Conditions Identified By Member Race and Ethnicity

The tables below contain information that supports our ability to observe differences in rates of diagnosis of chonic conditions among our members by race and ethnicity. Most of these conditions are related to the two areas of focus for the CHP.

Table 8 - Health Share of Oregon – Top 20 Chronic Conditions Diagnoses Among Non-ACA Expansion Member Population (all ages, as of April 2014)

Health Share of Oregon - Chronic Conditions Top 20 Report		
Condition	**Count of Diagnosed Members**	**Percent of Members**
Hypertension	21953	13.7%
Obesity	19286	12.0%
Asthma	17861	11.1%
Diabetes	11548	7.2%
Tobacco Use	11337	7.1%
Depression	9753	6.1%
Attention Deficit Disorder (ADD)	6880	4.3%
Post-Traumatic Stress Disorder (PTSD)	5631	3.5%
Schizophrenia (Schizo)	4276	2.7%
Chronic Ischemic Heart Disease (CIHD)	3408	2.1%
Chronic Kidney Disease (ESRD)	2999	1.9%
Chronic Liver Disease/Cirrhosis (Liver)	2964	1.8%
Chronic Obstructive Pulmonary Disease (COPD)	2602	1.6%
Hepatitis C (HepC)	2297	1.4%
Chronic Bronchitis	2200	1.4%
Chemical Dependency	1906	1.2%
Chronic Coronary Heart Disease (CHF)	1005	0.6%
Hemophilia	623	0.4%
Hiv/Aids	459	0.3%
Cystic Fibrosis	18	0.0%
	Total=160,492	

Below, Tables 9 and 10 outline the same chronic conditions with our members as identified by race and ethnicity. Table 9 portrays the count of members diagnosed with a chronic condition, which can help to show differences in diagnosis that can be attributed to a health disparity. For example, 14.7% of African American members are diagnosed with asthma, while 11.9% of Caucasians are diagnosed with asthma. Note: chronic conditions diagnoses among our Hispanic members appears very low. Part of this is attributed to 80% of our Hispanic members being under 18; many of these chronic diseases emerge in adulthood.

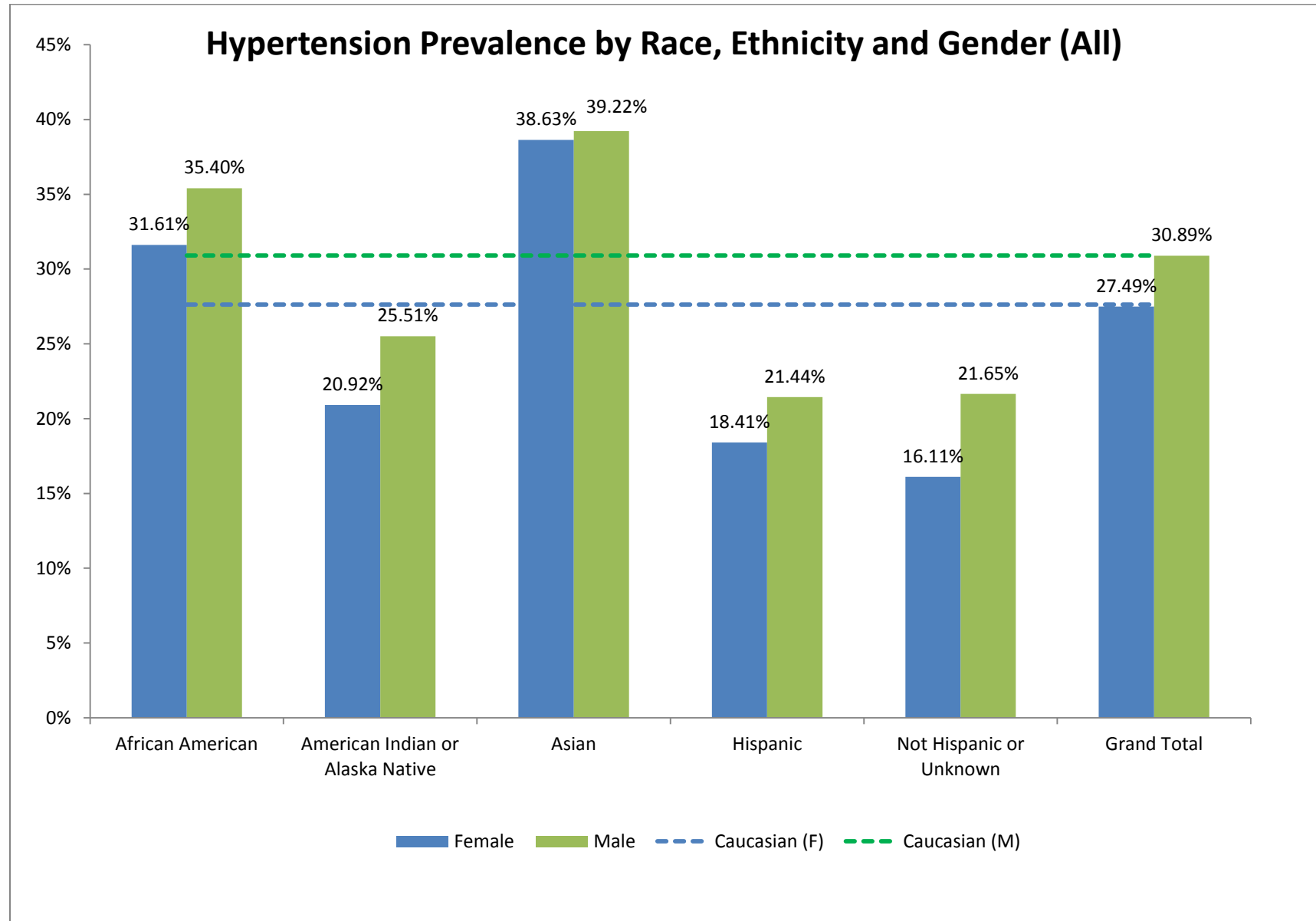## Table 9 - Count of Members Diagnosed by Race and Ethnicity

Count of Members Diagnosed	African American (N= 15,143)	AI/AN (N=1,326)	Asian (N=11,217)	Caucasian (N= 75,883)	Hispanic (N=37,738)	Health Share (N = 152,050)
Hypertension	2417	153	2450	12049	1412	19086
Obesity	1997	185	493	9325	5724	18844
Asthma	2225	184	781	9003	3769	17166
Diabetes	1176	105	1304	5967	967	9873
Tobacco Use	1524	164	213	8319	491	11297
Depression	1015	131	490	6254	864	9234
Attention Deficit Disorder (ADD)	625	97	74	4337	907	6582
Post-Traumatic Stress Disorder (PTSD)	670	112	266	3609	416	5400
Schizophrenia (Schizo)	507	55	231	2728	155	3766
Chronic Ischemic Heart Disease (CIHD)	291	27	298	1976	188	2870
Chronic Kidney Disease (ESRD)	322	26	345	1467	162	2410
Chronic Liver Disease/Cirrhosis (Liver)	196	33	229	1935	343	2840
Chronic Obstructive Pulmonary Disease (COPD)	270	36	112	2046	77	2590
Hepatitis C (HepC)	297	30	85	1746	75	2290
Chronic Bronchitis	214	29	79	1549	73	1995
Chemical Dependency	165	51	15	1439	87	1815
Chronic Coronary Heart Disease (CHF)	149	10	75	697	46	1001
Hemophilia	83	8	41	359	66	578
Hiv/Aids	83	5	15	310	20	452
Cystic Fibrosis	1	0	0	14	1	18

Table 10 - Per-Member Per-Year Cost by Diagnosis and Race/Ethnicity

Per-Member Per-Year Cost by Diagnosis	African American (N= 15,143)	AI/AN (N=1,326)	Asian (N= 11,217)	Caucasian (N= 75,883)	Hispanic (N=37,738)	Health Share (N = 152,050)
Hypertension	$12,516	$17,631	$4,697	$11,311	$8,804	$10,491
Obesity	$7,938	$8,914	$4,311	$8,551	$2,103	$6,182
Asthma	$7,916	$12,959	$6,881	$9,299	$3,178	$7,412
Diabetes	$15,640	$20,341	$5,265	$13,743	$8,318	$12,362
Tobacco Use	$11,183	$14,804	$6,637	$10,230	$7,173	$10,078
Depression	$11,397	$14,689	$6,595	$10,978	$7,897	$10,392
Attention Deficit Disorder (ADD)	$4,565	$8,834	$4,729	$6,113	$3,384	$5,480
Post-Traumatic Stress Disorder (PTSD)	$9,925	$15,603	$6,035	$11,559	$7,970	$10,703
Schizophrenia (Schizo)	$11,132	$14,411	$6,524	$10,583	$10,872	$10,476
Chronic Ischemic Heart Disease (CIHD)	$24,883	$25,950	$7,624	$15,771	$12,804	$15,752
Chronic Kidney Disease (ESRD)	$33,178	$34,810	$9,560	$20,518	$25,917	$21,417
Chronic Liver Disease/Cirrhosis (Liver)	$19,095	$36,097	$11,550	$18,144	$11,293	$16,946
Chronic Obstructive Pulmonary Disease (COPD)	$27,587	$24,296	$11,023	$18,066	$13,682	$18,891
Hepatitis C (HepC)	$21,845	$38,444	$10,215	$15,988	$16,611	$16,763
Chronic Bronchitis	$28,309	$19,513	$7,877	$18,848	$14,941	$19,799
Chemical Dependency	$24,187	$31,860	$21,923	$16,879	$12,795	$17,828
Chronic Coronary Heart Disease (CHF)	$44,442	$57,776	$35,732	$25,069	$17,694	$28,876
Hemophilia	$78,571	$25,762	$82,531	$41,634	$33,732	$49,600
Hiv/Aids	$35,236	$32,779	$28,538	$32,829	$28,636	$32,753

Amounts highlighted in red in Table 10 denote the highest costs for that diagnosis by race/ethnicity of Health Share members. It is helpful to analyze cost data by race and ethnicity because it provides another layer of understanding about how much of a burden chronic diseases are for our members who people of color. Nationally, African Americans and Native Americans tend to have the highest burden of chronic disease. We can see through Health Share cost data that there are high costs associated with providing care to some of our members, with a clear pattern of higher costs in some conditions.High costs can be associated with diseases that are costly to treat and are often the result of complex social and medical needs.These diseases tend to result in higher mortality; for example, End Stage Renal Disease is incurable and can result from diabetes, hypertention, and obesity. These data help us better understand how significant health disparities impact African Americans and Native Americans in particular.

Table 11 - Top Conditions Identified by Race, Ethnicity, and Gender

Hypertension Prevalence by Race, Ethnicity and Gender (All)

Race/Ethnicity	Female	Male
African American	31.61%	35.40%
American Indian or Alaska Native	20.92%	25.51%
Asian	38.63%	39.22%
Hispanic	18.41%	21.44%
Not Hispanic or Unknown	16.11%	21.65%
Grand Total	27.49%	30.89%

Legend: Female, Male, Caucasian (F), Caucasian (M)

Diabetes Prevalence by Race, Ethnicity and Gender (All)

	Female	Male
African American	16.16%	16.10%
American Indian or Alaska Native	15.70%	13.75%
Asian	20.68%	20.50%
Hispanic	14.17%	14.19%
Not Hispanic or Unknown	9.15%	11.70%
Grand Total	14.87%	14.74%

Legend: Female, Male, Caucasian (F), Caucasian (M)