Together in Health

2018-2020 Community Health Needs Assessment

health share

Health Share of Oregon

Health is all around us: at the doctor's office and at home, at the dinner table and the grocery store, among families and friends, at school, at the park, and beyond.

Health Share's 2018-2020 Community Health Needs Assessment (CHNA) considers our region's health with this idea front and center. To understand how to better serve communities throughout the region, including our 320,000 members, we looked beyond claims and demographic data and into the complex interplay between the health system and real life. We also reconsidered how we present information about the region's diverse communities, focusing on elevating community strengths, leading with equity, and being transparent about the limitations of our data.

Our last CHNA, published in 2014, catalyzed innovative and impactful improvements in the quality and type of care available to our members. For example, our work to support traditional health workers—including community health workers and peers—originated in the findings of the 2014 CHNA.

From there, we committed in our 2014 Community Health Improvement Plan (CHP) to better utilize the traditional health worker workforce. We then provided small grants to support the Oregon Community Health Workers Association (ORCHWA) in deploying a cohort of culturally relevant community health workers. This partnership eventually led to Health Share investing $3.3 million in ORCHWA so they could develop an infrastructure that supports community health workers throughout the region.

Our hope is that this CHNA leads to even more innovation and positive impacts throughout our region. We invite our partners within and outside of the health care system to join us in advancing our vision of a healthy community for all. This is truly an opportunity to co-design and coordinate our actions in service to community health.

Sincerely,

Janet L. Meyer
Chief Executive Officer
Health Share of Oregon

Michael Anderson-Nathe
Chief Equity and Engagement Officer
Health Share of Oregon

More Than Numbers

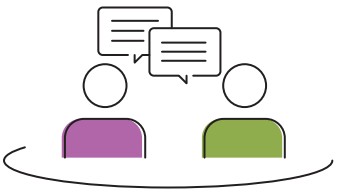
Guiding principles in our 2018-2020 Community Health Needs Assessment

INFORMATION FOR ALL

To expand our reach outside the health care community, we emphasized visual storytelling and an approachable voice throughout this report.

A HOLISTIC APPROACH

Our health is shaped by where we live, how we grow up, and how much support is available to us. These are the social determinants of health, and they factor strongly into how Health Share understands and responds to the health needs of our members.

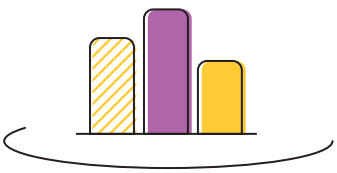


CONNECTION AS FUNDAMENTAL

Research repeatedly demonstrates that social connection strongly influences health. Isolation often surfaces as a key health issue in the communities we serve—indicating that one of the most powerful ways to build health for all is to support social connection.

A STRENGTHS-BASED NARRATIVE

We know that the communities we serve are strong, vibrant, and resilient. Part of our work to advance equity has involved reconsidering how we present data in a way that does no harm. To promote a strengths-based narrative, we chose to present data about communities of color independently from one another rather than in comparison.



GAPS IN OUR KNOWLEDGE

We are committed to being open about what we do not know. Although we analyzed multiple data sources and created new ones, limitations remain in what we know about what our communities need, with particular gaps in information about gender, disability, and other intersecting identities.

What is a Community Health Needs Assessment?

At least every five years, Health Share of Oregon, in partnership with its Community Advisory Council and the Healthy Columbia Willamette Collaborative, undertakes a Community Health Needs Assessment (CHNA). Through an ongoing process of community engagement, a CHNA helps health care organizations plan for future programs and services that best meet the needs of the communities they serve.

SPECIFICALLY, A CHNA HELPS TO:

- Describe the overall health of a community, including community strengths, resources, top illnesses, and chronic conditions
- Identify the health needs of a community and pinpoint key gaps in services, particularly those related to social determinants of health such as housing, education, poverty, and employment
- Highlight areas of potential action and resources needed to remedy the health and health care disparities a community faces

Community Health Needs Assessments play a critical role in pursuing and achieving health equity. By combining the learnings from community engagement and the findings of the CHNA, practitioners and policy makers are better equipped to direct resources and services to people and communities experiencing the greatest disparities in health and health care. This is often captured in a Community Health Improvement Plan (CHP). When done well, CHNAs can help create pathways to health for all families and communities.

Methods

Key data sources

Health Share is a member of the Healthy Columbia Willamette Collaborative (the Collaborative), a regional public-private partnership comprised of 15 hospitals, four health departments, and the region's coordinated care organizations in Oregon's Clackamas, Multnomah, and Washington counties, and in Clark County, Washington.

The findings in Health Share's 2018 CHNA are heavily influenced by the Collaborative's most recent CHNA, conducted in 2016. Detailed methods of this assessment can be found in the Collaborative's final report.

To assess the health needs of the region's many communities, the Collaborative performed a comprehensive study of data, drawing from a variety of sources, including:

- CCO/Medicaid Data (claims data)
- Hospital data
- Population health data
- Online survey results
- Listening sessions
- Local Community Health System and Forces of Change Assessment (assets mapping)
- Community engagement projects

Data limitations

The Collaborative's 2016 CHNA relied on a number of data collection strategies to yield a robust snapshot of the region's health needs. However, gaps in data made it difficult to tell the complete story of the entire community. Below are several data limitations impacting this report's ability to comprehensively illustrate our community's health needs:

Secondary data: The data in this report is predominantly from secondary sources, meaning our report draws on information that was designed and collected for a different purpose. Additionally, because of time lags between when much of the data was collected and when it became available for analysis, the data may reflect past health needs more accurately than present health needs.

Claims data: We recognize that claims data only tells part of the story of a community's health and how people use the health care system. Health and health care happen outside of the exam room, but claims data reflects the health care use and health needs only of those members who have sought and received care.

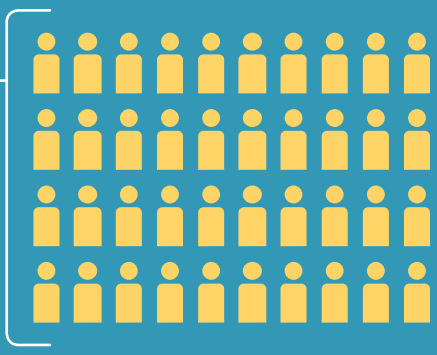
Social identity and lived experience measures: The primary data sources for this report did not include certain measures of social identity or lived experience that we know to be linked to increased health disparities and structural inequities. Nor does the data reflect the significant health disparities and strengths that exist at the intersections of many of these identities. For example, we do not have information on how many people in our community identify as gender fluid/non-binary or LGBTQ*, are unstably housed, are immigrants or refugees, or are living with disabilities.

As stewards of public resources, members of the community, and people dedicated to advancing social justice, we are committed to calling out where and when communities are overlooked. Our aim is to be transparent in these limitations while continuing to acknowledge, challenge, and improve how we collect and use data about communities most impacted by structural inequality. With a more complete picture, we will be better able to change historic and ongoing practices within the health system that continue to make some communities and their needs less visible.

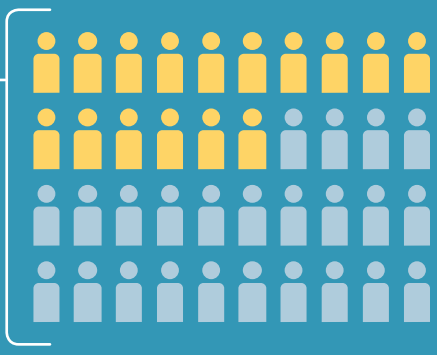
To this end, Health Share conducted a Photovoice project in 2016 to capture the lived experiences of trans and queer communities of color in the tri-county region, acknowledging the scarcity of information about the health and health care needs and experiences of the lesbian, gay, bisexual, transgender, queer, intersex, asexual, and two-spirit (LGBTQIA2) community. This project is an example of Health Share's commitment to making communities most impacted by oppression more visible.

Our Members

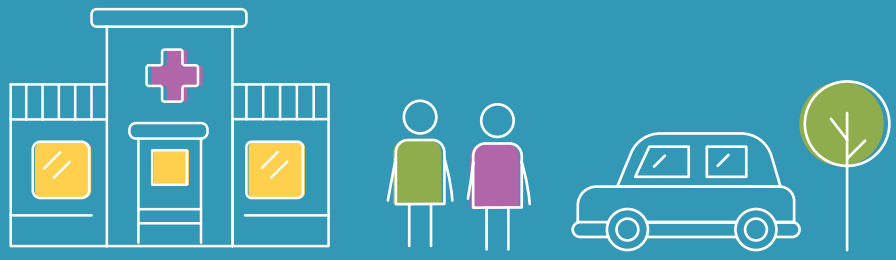
320,348 members

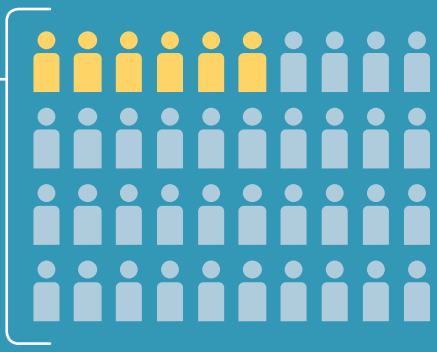


128,241 (40%) under 18

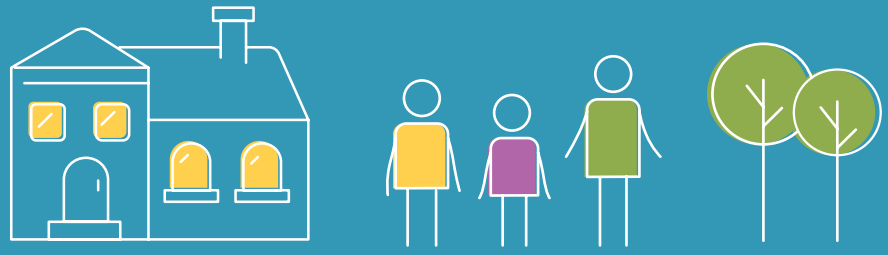


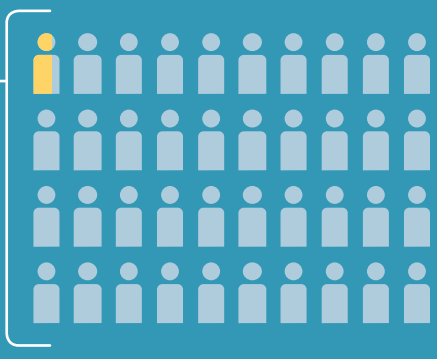
49,097 (15%) have not used services in the last 15 months





7,399 (5.8% of youth) in foster care

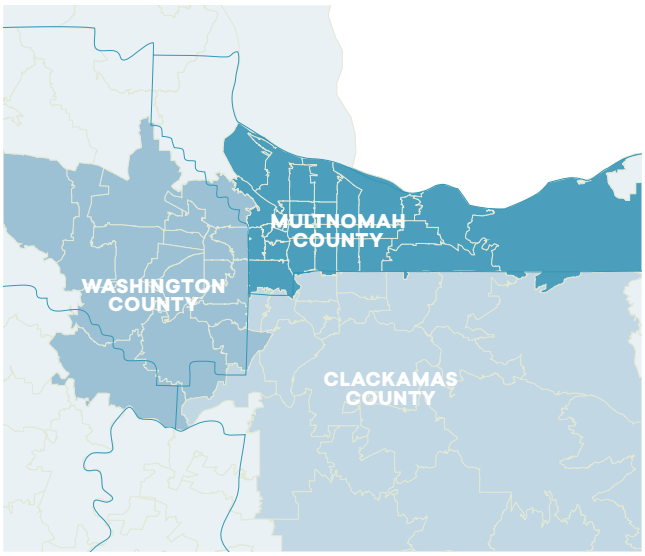




= 8,000 people

Data from Health Share claims as of June 2018

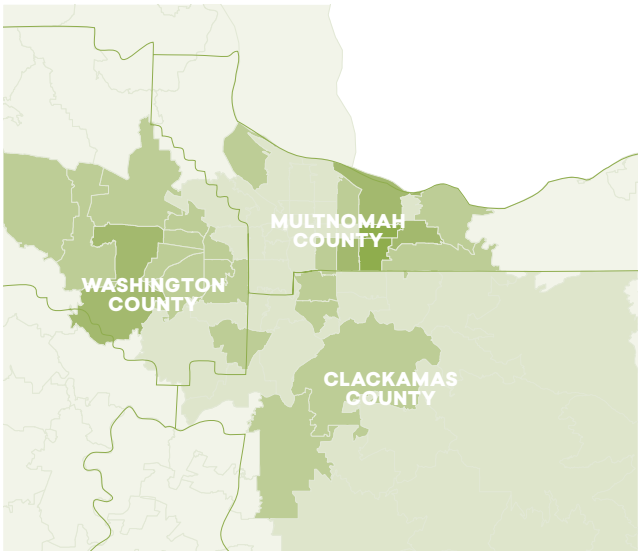
MAP OF CURRENT HEALTH SHARE MEMBERS JUNE 2018



- **Clackamas County**
  62,009 Members | 20% of Health Share members
- **Washington County**
  85,638 Members | 27% of Health Share members
- **Multnomah County**
  170,311 Members | 54% of Health Share members

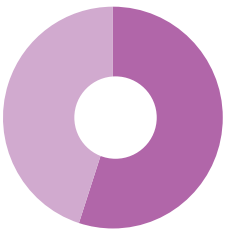
About 1 percent of Health Share members have zip codes outside of the tri-county area due to special circumstances or data entry errors.

TRI-COUNTY MEDICAID ENROLLMENT AGES 0-17 JULY 2018



- **0-2,000** Members
- **2,000-4,000** Members
- **4,000-6,000** Members
- **6,000+** Members

GENDER



- **55%** Female
- **45%** Male

Note: Collected data is limited to binary gender identity and inaccurately reflects members who identify as transgender, two-spirit, and otherwise outside of the gender binary.

LANGUAGE

16% of members speak a language other than English

Our members speak over 68 languages, from Urdu to Croatian

The most frequently spoken languages are English, Spanish, Russian, and Vietnamese

RACE/ETHNICITY

- **41%** Unknown
- **37%** Caucasian
- **9%** Hispanic
- **5%** Black/African American
- **6%** Asian, Pacific Islander or Native Hawaiian
- **1%** Other ethno-racial identities
- **1%** Native Americans and Alaska Natives

Note: Health Share lacks ethno-racial identity data for approximately 40% of our members. Race/ethnicity data comes from OHP applications.
All data from Health Share claims as of June 18, 2018, unless otherwise noted.

HEALTH CARE UTILIZATION IN THE LAST 12 MONTHS

The #1 reason members sought care was for routine, preventive health services

6 in 10 (60%) of members had a primary care visit

4 in 10 (38%) of members had a dental visit

1 in 10 (11%) of members received behavioral health services

Foundations of a Healthy Community

Our health is shaped by where we live, how we grow up, and how much support is available to us. These are the social determinants of health, and they include factors like housing, education, the built environment, employment, social support networks, and access to health care.

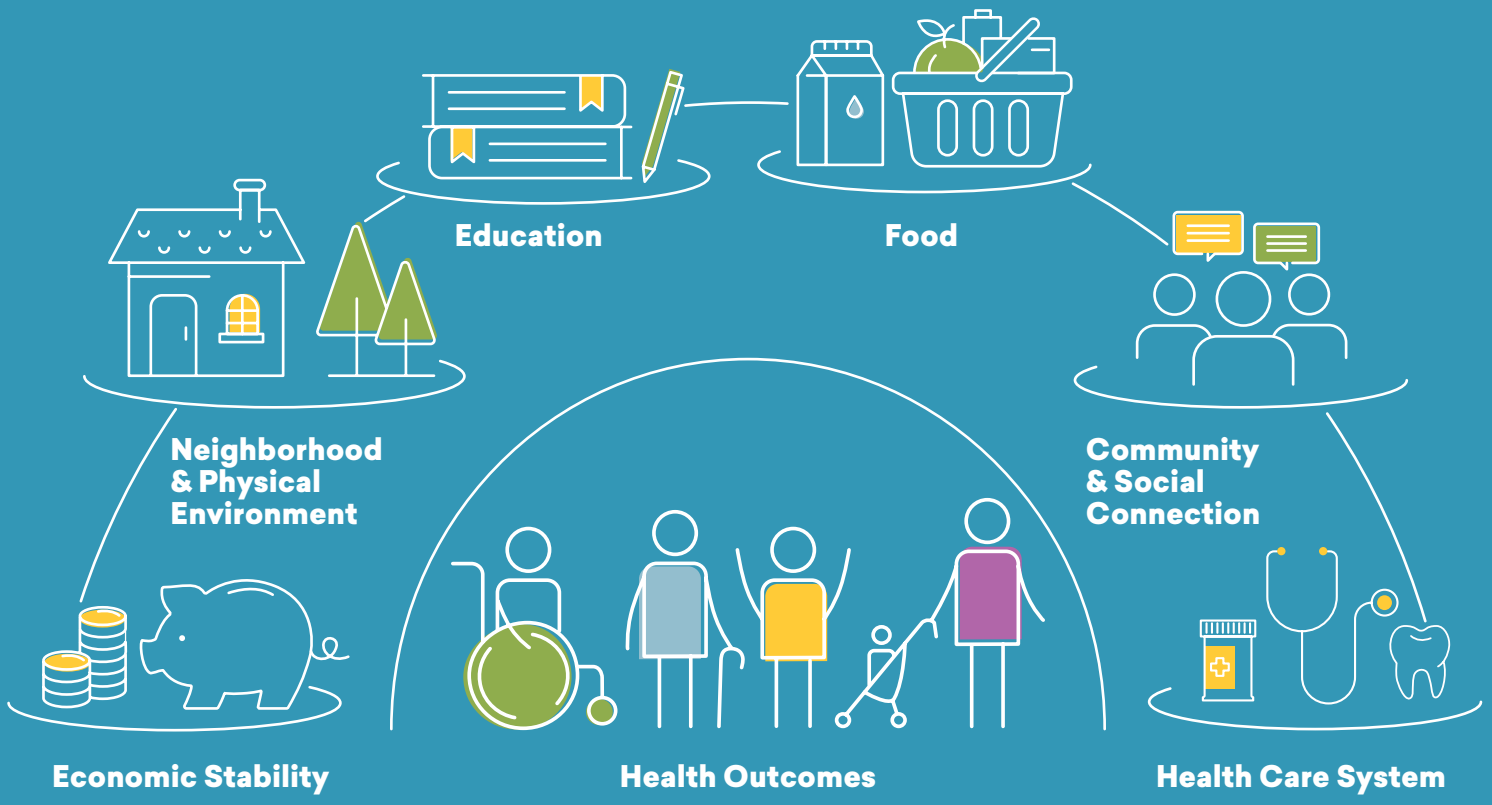
In 2016, the Healthy Columbia Willamette Collaborative engaged community members across Clackamas, Clark, Multnomah, and Washington counties in a survey and a series of listening sessions to identify the most important characteristics of a healthy community. Community members reported that the following have the greatest impact on community health.

Connection as a determinant of health

> "The work of creating health is the work of creating connection."
>
> **– DIDI PERSHOUSE**

Research repeatedly demonstrates that social connection strongly influences health. Feeling connected to a community was one of the strengths identified in the community engagement data in this CHNA. The Full Frame Initiative defines social connection as "the degree to which a person has and perceives a sufficient number and diversity of relationships that: allow them to give and receive information, emotional support, and material aid; create a sense of belonging and value; and foster growth.[1]" Investing in social connectedness – between individuals and within communities – can be a powerfully protective force in nurturing health for all.

SOCIAL DETERMINANTS OF HEALTH



People who feel socially connected to the people in their life are at a lower risk of premature death[1]

Social connections—both in clinical and community settings—help people learn about the resources available to them.[1]

Strong social cohesion is linked to increased neighborhood safety for people living in low-income public housing.[1]

Social cohesion is correlated to higher rates of physical activity and lower risk for obesity among children, regardless of where they live.[1]

Access to safe, affordable, and supportive housing

Housing is a key social determinant of health that often underlies individual and community health disparities. Safe, affordable, and supportive housing is correlated to improved access to health care and reduced exposure to injury, communicable disease, and violence. Poor-quality or substandard housing can be unhealthy or unsafe and is associated with chronic health issues such as asthma.[2] Access to safe, affordable housing impacts some communities, including people of color, those living with disabilities, and the LGBTQIA2 community, more than others.

OCCUPIED HOUSING UNITS WITH ONE OR MORE SUBSIDIZED CONDITIONS

(% of owner-renter occupied housing units)

Clackamas	Clark	Multnomah	Washington
 37%	 36%	 42%	 37%

Access to inclusive & accessible physical, behavioral, and oral health care

Culturally responsive, accessible, and high-quality medical care can help people live longer, healthier lives. Access to medical care integrates many factors, many of which are difficult to measure at the system level. One factor that impacts access is the ratio of providers to community members in an area. A 2008 Evidence Review reported that states with a lower ratio of patients to primary care physicians have better health outcomes, including decreased cancer, heart disease, and stroke mortality. Low-income communities, communities of color, people living with disabilities, and the LGBTQIA2 and immigrant and refugee communities often experience additional barriers to access in health care services that further amplify regional variations in access to care.

PRIMARY CARE IN 2013[3]

1 primary care provider for:

1159 people in Clackamas

725 people in Multnomah

1110 people in Washington

BEHAVIORAL HEALTH IN 2015[4]

1 behavioral health provider for:

476 people in Clackamas

159 people in Multnomah

415 people in Washington

DENTAL CARE IN 2015[5]

1 dentist for:

1321 people in Clackamas

1094 people in Multnomah

1154 people in Washington

Access to healthy, affordable, and culturally relevant food

The ability to access fresh, affordable, and culturally relevant foods is a cornerstone of individual and community health, especially for low-income communities, people living with disabilities, and communities of color. People in these communities are disproportionately impacted by the effects of food deserts, limited access to culturally relevant food options, and chronic health conditions such as diabetes and hypertension.

PERCENT OF CENSUS TRACTS DESIGNATED AS FOOD DESERTS

Clackamas

17%

Multnomah

13%

Washington

15%

Access to high-quality, identity-affirming trauma-informed education

Education is a strong predictor of health outcomes. Much of our formative years are spent in the school environment. A healthy, safe, identify-affirming academic environment promotes social cohesion, healthy self-concept, and increased mental well-being. Additionally, these environments increase health-promoting behaviors, self-advocacy, and life expectancy while also reducing stress.[6] High-quality educational experiences are not equally accessible to all communities in the tri-county region – income, ethno-racial identity, primary language, and disability status are all associated with disparities in access to education.

EDUCATION INDICATORS[7,8,9]

Children ages 3-4 years enrolled in public or private preschool or nursery school (%)

Clackamas

45%

Multnomah

50%

Washington

46%

3rd grade students proficient in reading (%)

Clackamas

72%

Multnomah

64%

Washington

71%

Safe neighborhoods

Where we live is deeply linked to how well we live. Housing quality, access to services, and proximity to playgrounds, schools, libraries, and parks are all associated with individual and community health. Some communities are disproportionately impacted by poor air and water quality, proximity to hazardous waste, and a lack of basic infrastructure such as sidewalks and paved roads.

Top Chronic Conditions & Illnesses*

The following data is drawn from medical claims. It gives a snapshot of the top reasons people have received care and the top chronic conditions or illnesses diagnosed and monitored by Health Share and FamilyCare between 2012 and 2015.

This data only reflects those who sought care for health issues. Low prevalence of a diagnosis may indicate lack of engagement in health care, rather than lower prevalence of the condition. In this section, we examine these top conditions by ethno-racial identity to focus attention on how health differs within communities of color, who are often most impacted by health disparities. Because comparing communities of color with each other can lead to harmful comparisons, we have reported each of these health conditions for each ethno-racial community on its own.

We recognize that by adopting an ethno-racial approach, we are prioritizing a racial equity analysis to these top chronic conditions and illnesses. We are doing so with the hopes of the following:

1. Shining a light on the structural and systematic racism and discrimination experienced by communities of color, and the connection between racism, discrimination, and health
2. Providing data for community-based organizations to use in program design and funding to respond to these disparities
3. Modeling an approach to health equity work that decenters white/Caucasian experiences by not comparing communities of color to white communities

Making the Invisible, Visible

Health Share recognizes that life is lived at the intersections of multiple identities and is committed to improving how we capture and use data that reflects this. See page 4 for more information on how we are working to make community needs more visible.

* **Population:** Adults (19 and older) and youth (0-18) who are enrolled in the Oregon Health Plan (OHP) and assigned either to FamilyCare or Health Share of Oregon, the two CCOs serving the tri-county region until January 2018. **Time period:** Utilization between April 1, 2014, and March 31, 2015. Diagnosis between March 31, 2012, and March 31, 2015. **Data inclusion criteria:** Diagnostic codes derived from administrative Medicaid claims data. Unduplicated count of patients.

Top Health Conditions

Because tri-county and even state-level data is difficult to find for several of the top chronic conditions, the following prevalence estimates are pulled from national data sources as a comparison point for our claims data.

Adults

HYPERTENSION/HIGH BLOOD PRESSURE

National average[11]

32% ~1 in 3 adults

DIABETES

National prevalence[12]

9%

DEPRESSION

National prevalence[13]

8%

Youth

ASTHMA

National prevalence[14]

8%

ADD/ADHD

National prevalence[15]

9%

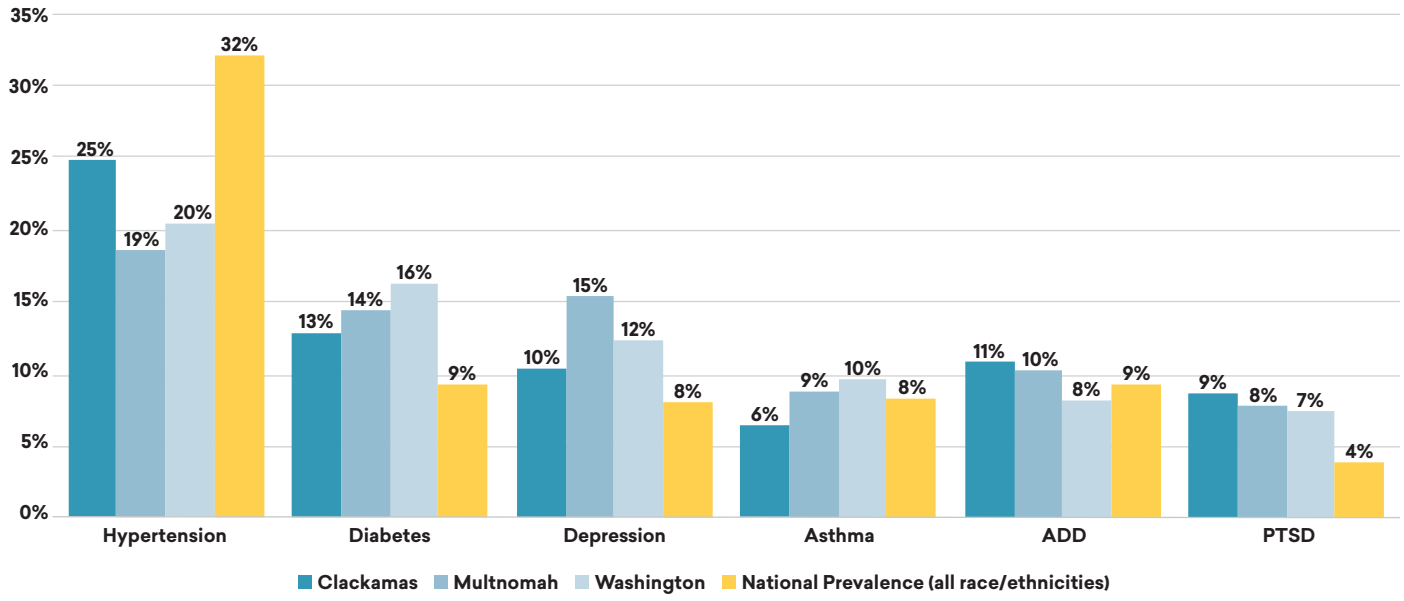
PTSD

National prevalence[16]

4%

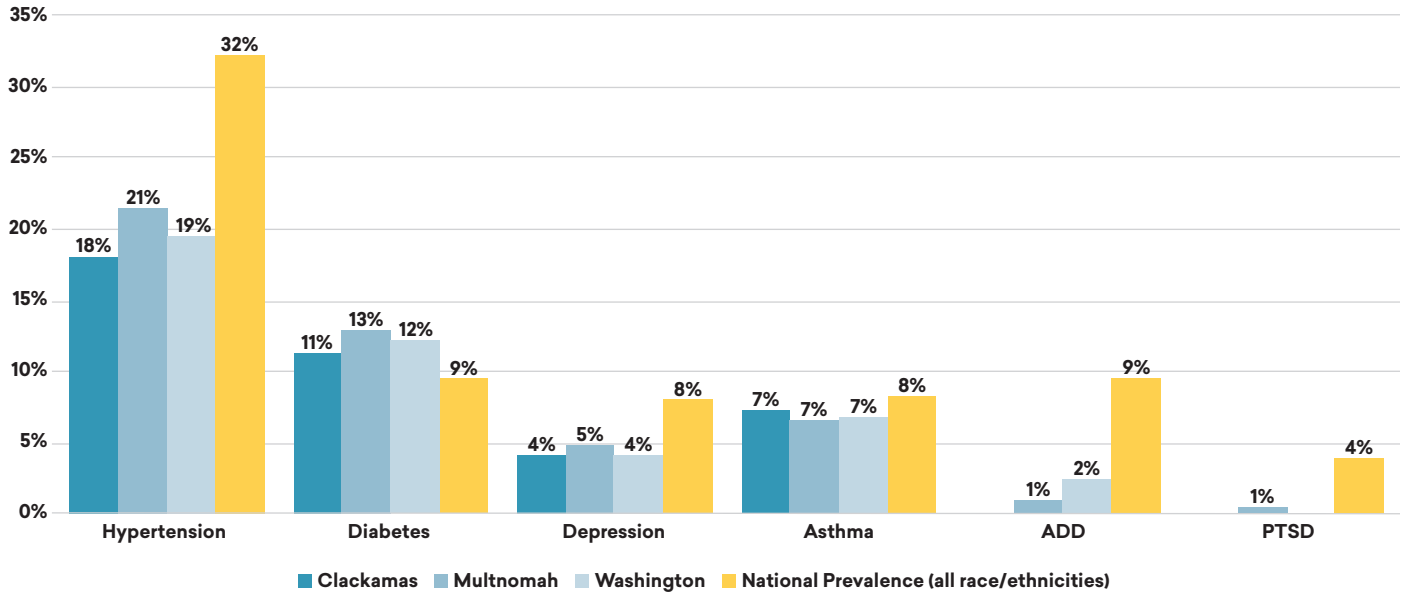
Top Health Conditions for Native Americans and Alaska Natives

For Native American and Alaska Native members, the leading health issue for adults in all three counties was hypertension. For youth, ADD was the top condition in Clackamas and Multnomah counties, and asthma was the top condition in Washington County.



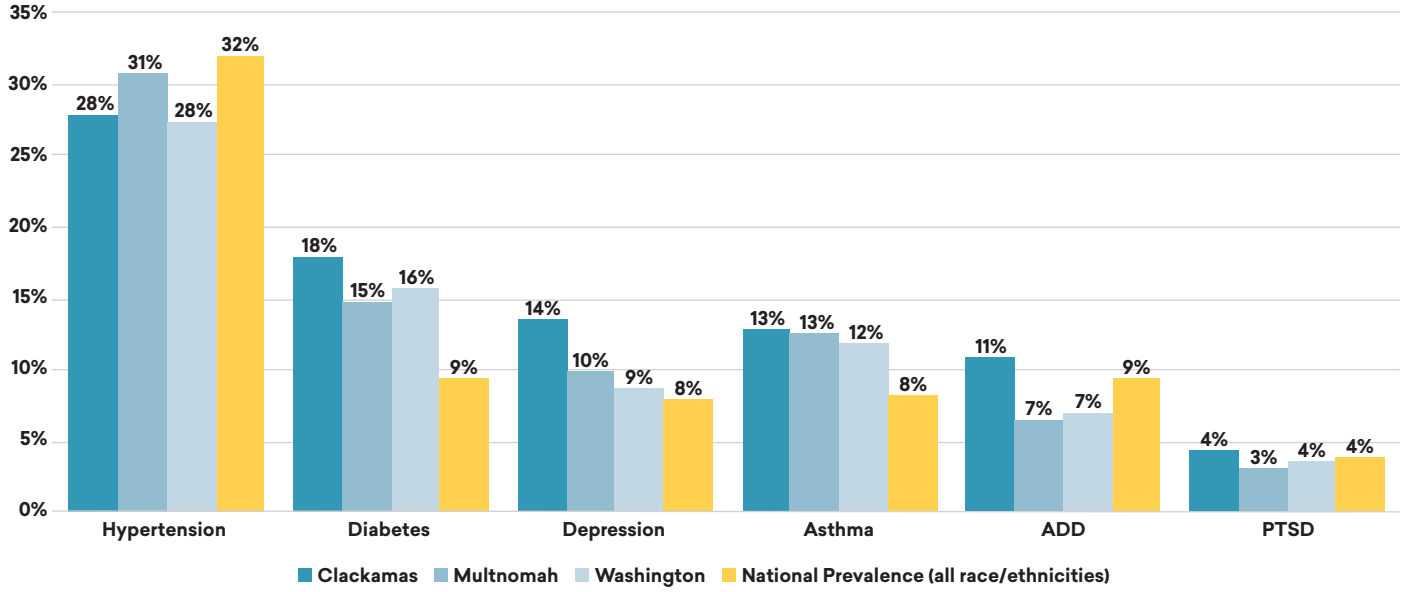
Top Health Conditions for Asians and Pacific Islanders

For Asian and Pacific Islander members, hypertension was the top health condition among adults, and asthma was the most prevalent condition among youth across all three counties.



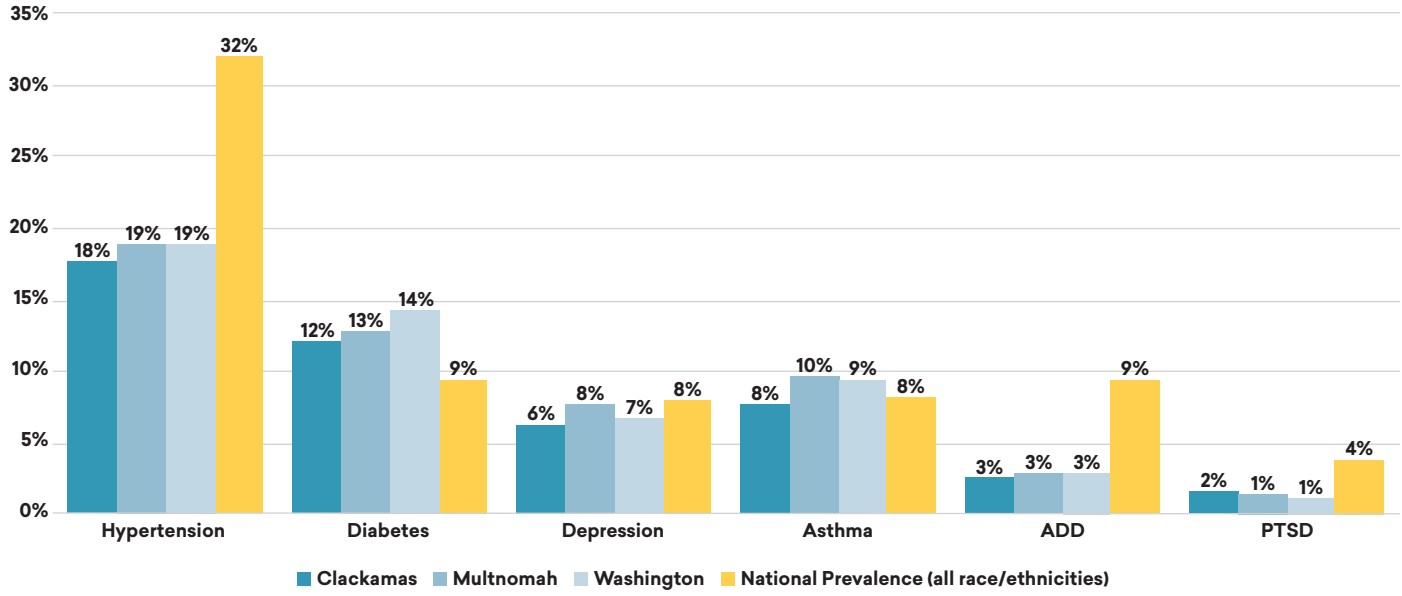
Top Health Conditions for Black/African Americans

For black/African-American members, hypertension was the top health condition among adults and asthma was the most prevalent condition among youth across all three counties.



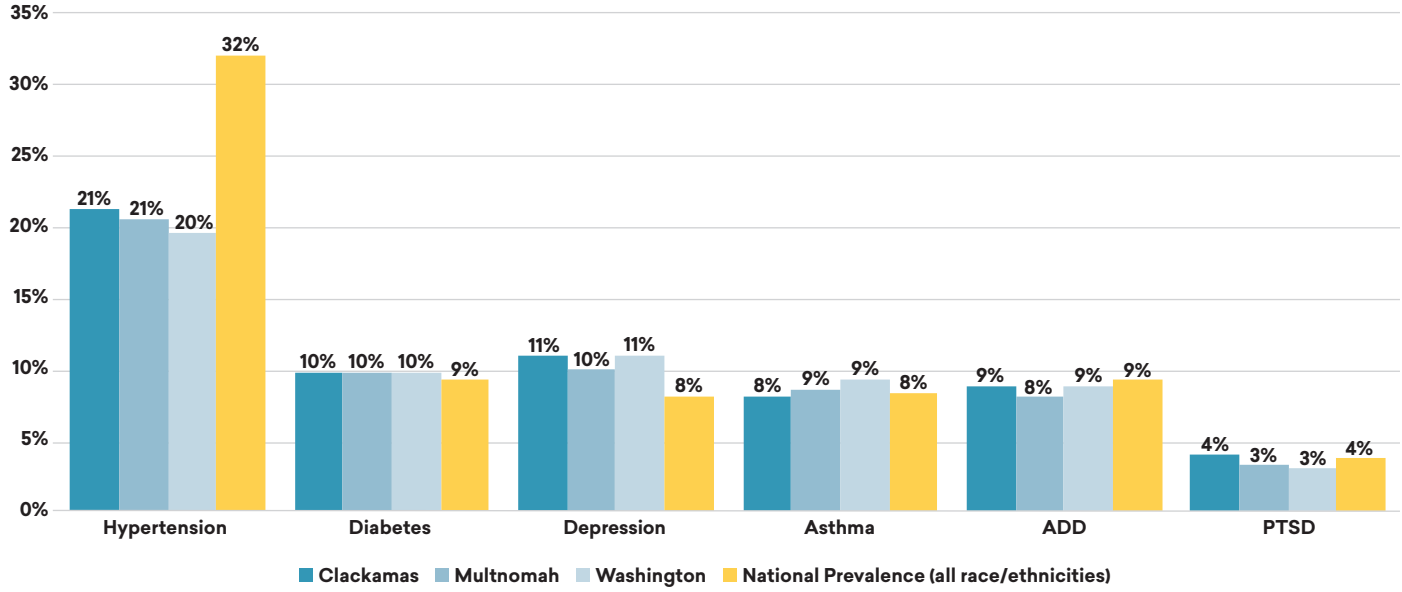
Top Health Conditions for Latinos

For Latino members, hypertension was the top health condition among adults and asthma was the most prevalent condition among youth across all three counties.



Top Health Conditions for White/Caucasians

For white/Caucasian members, hypertension was the top health condition among adults. For youth, asthma was the most prevalent condition in Multnomah and Washington counties and ADD was most prevalent in Clackamas County.



What's Next?

Health Share's Community Health Improvement Plan

This CHNA serves the purpose of describing the overall health of our community. It is based on both quantitative data (public health, Medicaid, and hospital data) and qualitative feedback (listing sessions, community surveys, etc.). Combined, this data captures the top chronic illnesses and conditions experienced by our communities as well as community input on what makes a healthy community.

Using the information in this CHNA, the Community Advisory Council will develop a Community Health Improvement Plan (CHP) to serve as a roadmap for how Health Share can meet the identified needs of the community. The Council will partner with Health Share staff to engage the community and our members to determine how Health Share prioritizes and responds to the identified health needs from the CHNA. Some of the questions that will guide this process include:

- What are the best strategies for response to the identified needs and strengths in the CHNA?
- Are there communities that are not represented and, if so, what can we do to capture that information in the community health improvement plan?
- Of the priorities listed here, which ones are communities interested in addressing?
- How can we continue to make the health needs of communities most impacted by structural inequality more visible?
- Where is the work already being done to address these priorities, and how can Health Share leverage or support those efforts?

Health Share is committed to engaging our communities throughout the development of our CHP. Indeed, we recognize that it is only through true partnership and engagement that real change will come.

About Health Share

Health Share is Oregon's largest coordinated care organization, providing health care for more than 300,000 residents.

OUR VISION
A healthy community for all

OUR MISSION
We partner with communities to achieve ongoing transformation, health equity, and the best possible health for each individual.

OUR VALUES
At Health Share, we believe:

- member voice and experience are at the center of what we do
- health equity is achievable and requires deliberate action on our part
- in honoring our commitments
- using continuous improvement is vital to our efforts
- in operating transparently and using data to guide our work
- in working in partnership to maximize our resources

OUR FOUNDERS
Health Share was founded and continues to be governed by 11 health and social services organizations serving OHP members:

- Adventist Health
- CareOregon
- Central City Concern
- Clackamas County
- Kaiser Permenente
- Legacy Health
- Multnomah County
- Oregon Health & Science University
- Providence Health & Services
- Tuality Healthcare
- Washington County

Health Share works closely with community, state, and local governments, health advocacy groups, communities of color, and social service agencies to help address social determinants of health in a person-centered, culturally relevant way.

Health Share, along with all of our partners, works within our community to improve the ways that members, providers, and health care delivery systems interact with one another and to connect our members with the services they need to be healthy.

Our health as individuals and as a region depends not just on the medical system, but also on the resources available to each of us in our communities. We are committed to making the health delivery system responsive to the needs of those we serve, and we are committed to strengthening partnerships with others outside the health care system to reach a mutual goal of ensuring the healthiest and most productive life possible for everyone.

Acknowledgements

HEALTH SHARE COMMUNITY ADVISORY COUNCIL

LAKEESHA DUMAS
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Multnomah County

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NATASHA SMITH
EPS Project Specialist, Multnomah County Public Health Department

2016 HEALTHY COLUMBIA WILLAMETTE COLLABORATIVE MEMBER ORGANIZATIONS

Adventist Health Portland*
Clackamas County Public Health Division*
Clark County Public Health
FamilyCare Health
Kaiser Permanente Sunnyside and Westside Hospitals*
Legacy Health*
Multnomah County Public Health*
Oregon Health & Science University (OHSU)*
PeaceHealth Southwest Medical Center
Providence Health & Services*
Tuality Healthcare*
Washington County Public Health Division*

2016 HEALTHY COLUMBIA WILLAMETTE COLLABORATIVE COMMUNITY PARTNERS

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

*Original founding partners of Health Share of Oregon

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