2017 Washington County

Community Health Improvement Plan

September 2017

Live Well Washington County

Letter from the Division Manager

Dear Community Partner:

It is my pleasure to share with you an update to ***Live Well Washington County***, our community health improvement plan (CHIP). This plan was informed by the most recent regional Community Health Assessment (CHA) conducted by the Healthy Columbia Willamette Collaborative. It also builds upon the progress we've made since our 2014 CHIP.

The CHIP was developed through over 12 months of work across the community to create a shared vision for tackling important health issues. More than 100 diverse organizations shared their thoughts about information in the CHA along with what their organizations' priorities were. Based on these discussions, the CHIP priorities were selected.

The foundational goals for the CHIP are to reduce health disparities, improve health equity and apply a trauma-informed lens to the CHIP work.

Our CHIP priorities are to:

- Improve access to health care, including primary care, behavioral health and oral health services.
- Improve behavioral health outcomes, including mental health, suicide and addictions.
- Prevent chronic disease.

Tackling these priorities is important for Washington County, but improving community health is not just about the work of public health and the products of this CHIP. Improving community health is the outcome of endeavors and activities of partners across many sectors of our community. Research has shown that health and well-being are greatly influenced by many complex factors and that where people live, learn, work and play has a tremendous impact.

To acknowledge the many actions needed to develop and support a healthy community, we are adopting the Robert Wood Johnson Foundation's (RWJF) Framework for a Culture of Health and Well-being as part of our CHIP. The RWJF framework "reflects a vision of health and well-being as the sum of many parts, addressing the interdependence of social, economic, physical, environmental and spiritual factors." Use of this framework will help us as a community talk about and come together around what drives health as well as study and report on broad measures to track our progress. These measures will evolve over time to meet our changing community conditions. Our framework will incorporate local measures important to community partners and those that help us tell our story and track our progress.

Thank you to the many partners focused on supporting and improving individual and community health. These partnerships make a difference in our community.

Tricia Mortell

Tricia Mortell
Washington County Public Health Division Manager

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I. Acknowledgments

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Washington County CHIP Organizations

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Beaverton School District
Boys and Girls Aid
Care Oregon
Cascade Academy
Catholic Charities
Cedar Hills Hospital
Community Action
Domestic Violence Resource Center
Elders in Action
Family Forward Oregon
FamilyCare Health
Health Share of Oregon
Healthy Schools Program
Hillsboro Education Center
Hillsboro Police Department
Hillsboro School District
Home Instead Senior Center
Inukai Family Boys and Girls Club
Jewish Family & Child Services
Kaiser Permanente
Legacy Health
LifeWorks NW
Lines for Life
Lutheran Community Services NW
Meals on Wheels
Metro West Ambulance, Inc.
Morrison Child & Family Services
Neighborhood Health Center
Northwest Regional Education Service District
NW Counseling Associates
Oregon Department of Human Services
Oregon Health and Science University
OSU Extension Service
Pacific University
Project Access NOW
Providence Health & Services
Rose City Geropsychology
Safe Families
Senior Health Insurance Benefits Assistance Program
Sherwood School District
Tigard Police Department
Tigard-Tualatin School District
Tigard Turns the Tide
Tri County 911 Program
Tualatin Hills Parks and Recreation
Tualatin Tomorrow Committee
Tuality Health Alliance
Tuality Healthcare
University of Portland
Veterans Association Medical Center
Virginia Garcia Memorial Health Center
Voices Set Free
Washington County Administrative Office
Washington County Human Services
Washington County Children, Youth and Families
Washington County Cooperative Library System
Washington County Disability, Aging and Veteran Services
Washington County Health and Human Services
Washington County Juvenile Department
Washington County Land Use and Transportation
Washington County Mental Health
Washington County Probation & Parole
Washington County Public Health
Washington County Sheriff's Office
Washington County Solid Waste & Recycling
Westside Transport Alliance

II. Executive Summary

THE MANY
partnerships
focused on improving community conditions to support individual and community health can
make a difference.

The Community Health Improvement Plan (CHIP), **Live Well Washington County**, is a strategic community work plan that defines how Washington County Public Health (WCPH) and community partners will come together to develop a culture of health and to address priority health issues identified by a comprehensive assessment of local Washington County data. Many factors affect the health of individuals and communities. The complexity of these factors makes it essential to work collaboratively with many partners across sectors to address the unique needs of the community. In addition, Washington County's diversity and changing demographics increase the need for cross-sector strategic partnerships to improve health. The CHIP addresses the social and environmental determinants of health by engaging partners from across the community to tap in to expertise, knowledge and resources.

The community health assessment (CHA) is the basis for development of the CHIP. The 2016 CHA was conducted in partnership with regional hospitals, coordinated care organizations and public health partners to improve alignment in our community. The CHA includes population data and robust community engagement to ensure that both are reflected in the prioritization of health issues to inform the CHIP. The process also included a review of the priorities with community stakeholders to gather input on how to address these health priority areas.

Social determinants of health, such as income and employment opportunities, education, environmental conditions, social support networks and access to health care services, are complex and best addressed through a communitywide approach. The leadership of community partners is vital to improving health and is demonstrated through their strategies and programs that work toward achieving this overarching goal. To foster these strong partnerships and to highlight the critical role of community partners to improve health outcomes in Washington County, WCPH has adopted the Robert Wood Johnson Foundation Culture of Health framework as the foundation for the 2017 CHIP.

WCPH evaluated the 2014 CHIP to ensure continuous quality improvement and also to make sure we are building on past successes with this update. Over the past three years, collaborative CHIP committees have been meeting regularly to implement health improvement strategies based on the 2014 CHIP work plan. The committees have achieved successes and made significant progress in developing stronger partnerships across community organizations. The new structure will build on these achievements. Themes from the evaluation process included improving alignment between partners' missions and the CHIP; engaging diverse and non-traditional partners; ensuring accessible and regularly scheduled meetings; providing community partners with technical assistance and capacity-building opportunities; and supporting collaboration among partners.

In an effort to ensure that the CHIP meets the greatest needs in Washington County, WCPH gathered input from a broad range of community stakeholders. Through this process, over 100 diverse Washington County organizations and stakeholders reviewed local data and gave input into the structure and priorities for the Washington County CHIP. This data was used to identify and prioritize focus areas based on gap areas in the community, areas with fewer existing efforts, where there are opportunities to build on existing momentum, and areas that stakeholders have identified as priorities based on input from the populations they serve.

Using this input and the CHA data, the CHIP Steering Committee and WCPH Management Team came together for two half-day facilitated sessions to apply an equity lens to the CHIP. The participants discussed issues related to race, advantage and privilege; practiced implementing the equity tool on case study examples; and applied the tool to identify the foundational goals for the CHIP and three priority areas. These are the areas where the 2017 Washington County CHIP will lead and coordinate efforts in the county. The foundational goals for the CHIP are to reduce health disparities, improve health equity, and apply a trauma-informed lens to the CHIP work.

PRIORITIES

- Improve access to health care, including primary care, behavioral health and oral health services
- Improve behavioral health outcomes, including mental health, suicide and addictions
- Prevent chronic conditions

COMMITTEES

The 2017 CHIP is comprised of the following committees that will implement strategies to address the three priorities:

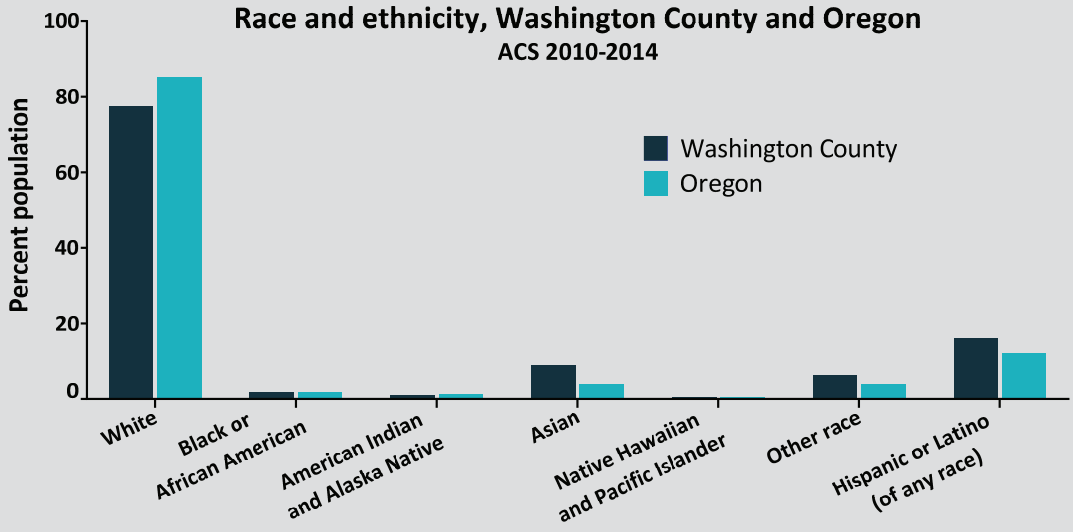
- CHIP Steering Committee
- Access to Care Committee
- Cross Sector Navigation Committee
- Older Adult Behavioral Health Committee
- Healthy Communities Committee (Chronic Conditions and Built Environment)
- Suicide Prevention Council
- Adverse Childhood Experiences (ACEs) Collaborative

The detailed work plan and implementation strategies for each committee are included as an appendix to the 2017 CHIP.

III. Demographics and Social Determinants of Health

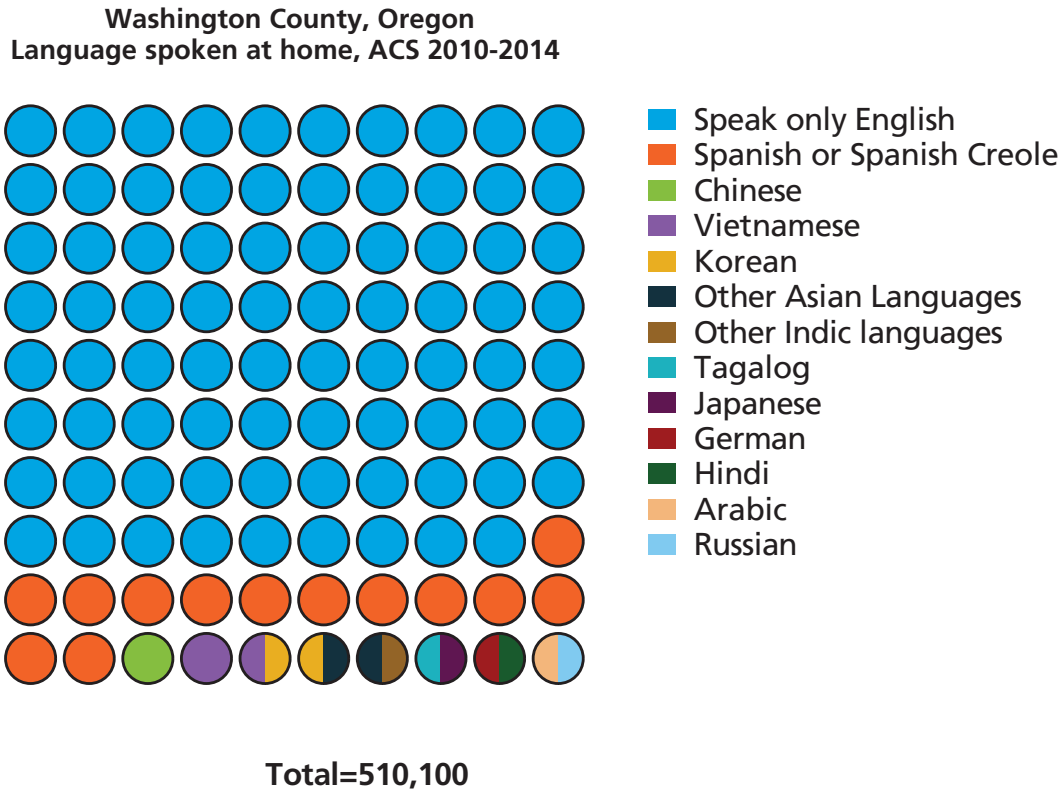
The changing demographics of the county and the impact that complex social issues have on health illustrate the need for cross-sector strategic partnerships to improve health. From 2010-2016, Washington County experienced a population growth of nine percent. As of 2016, 582,779 people lived in the county. Along with this growth came an increase in diversity: The foreign-born population increased 11 percent from 2005-2014, while the Hispanic/Latino population increased 67 percent from 2000 to 2010. The proportion of foreign-born people in Washington County is 17 percent.

Figure 1: Race and ethnicity in Washington County and Oregon



Washington County has a relatively young population, with a median age of 36.5 years. Approximately 64 percent of the population is between 18-64 years of age, and 11 percent are 65 years of age or older. The racial and ethnic population is predominantly white, non-Hispanic/Latino (68%). People identifying as Hispanic/Latino (of any race) are the second-largest population. Almost one quarter (24%) speak a language other than English at home. Following English and Spanish, the top three languages spoken at home in Washington County are Chinese (1%), Vietnamese (1%), and Korean (1%),

Figure 2: Languages spoken at home in Washington County



SOCIAL DETERMINANTS OF HEALTH AND EQUITY

Income and Socioeconomic Status

Socioeconomic status (SES) is a strong predictor of health and well-being. Although Washington County has a median income of $70,447, which is the highest in the Portland Metro region, we also face issues of poverty. Approximately 11 percent of individuals are living in poverty in the county, including 13 percent of children (18 years or younger) and 25 percent of Hispanic/Latino residents. Over 11 percent of households have received SNAP (food assistance) benefits in the past 12 months.

Employment

The ability to secure and maintain a job can have long-lasting effects on the health of people and families. Having a job that pays a living wage can allow a person to live in safer neighborhoods, buy healthier food, and afford health insurance and medical care. Based on 2015 estimates, approximately six percent of Washington County residents ages 20-64 are unemployed.

Education

The percentage of the population (age 25 years and over) with a high school diploma or equivalency in Washington County is over 90 percent, and more than one in three people (43%) have a bachelor's degree or higher. However, when examined by ethnicity, disparities are present in graduation rates. Only 60 percent of our Hispanic/Latino population has a high school diploma, in comparison to 96 percent of the non-Hispanic white population.

Housing

Affordable housing is defined as spending less than 30 percent of a family's income on rent or house payments. When a family spends more than 30 percent of its income on housing, the family can experience financial strain that makes it difficult to afford other basic needs such as food, heating and health care. Washington County and the Portland Metropolitan Region are experiencing rising housing costs and declining vacancy rates, resulting in a shortage of housing affordable for lower-income households. Nearly half (48%) of Washington County renters pay at least 30 percent or more of income on housing and almost one in four (23%) homeowners do. Households that earn 50 percent or less of the median family income have the hardest time finding affordable housing in Washington County.

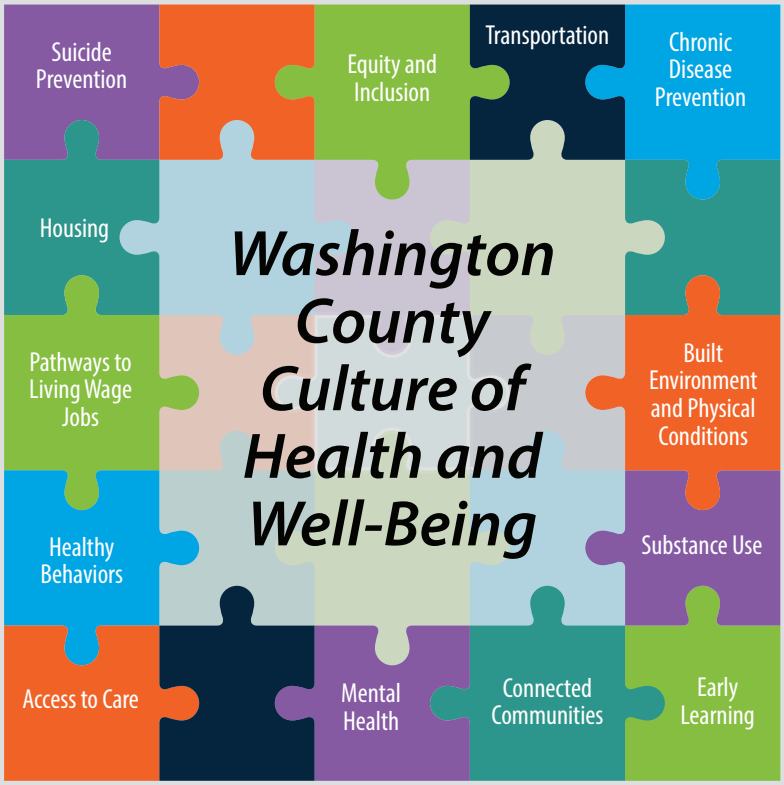
Sources: Portland State University Population Research Center (PSU PRC). Accessed at http://www.pdx.edu/prc/
American Community Survey, 2015 single year estimates

IV. Culture of Health and Well-being

Adapting the Robert Wood Johnson Foundation (RWJF) Culture of Health framework, the CHIP will highlight the leadership and activities of many community partners that are critical to ensuring good health across Washington County.

The 2016 CHA identified priority health behaviors that can be affected by policies, systems and environmental factors in the community but can also be modified with a communitywide, collaborative approach, for example: lack of prenatal care, teen marijuana use and binge drinking. The CHA also identified community needs in underserved populations — many of these depict the interconnectedness of health and importance of cross-sector efforts, including: connected communities; pathways to living wage jobs; racism, discrimination and stigma; safe, accessible and affordable housing; and support for people with behavioral health challenges.

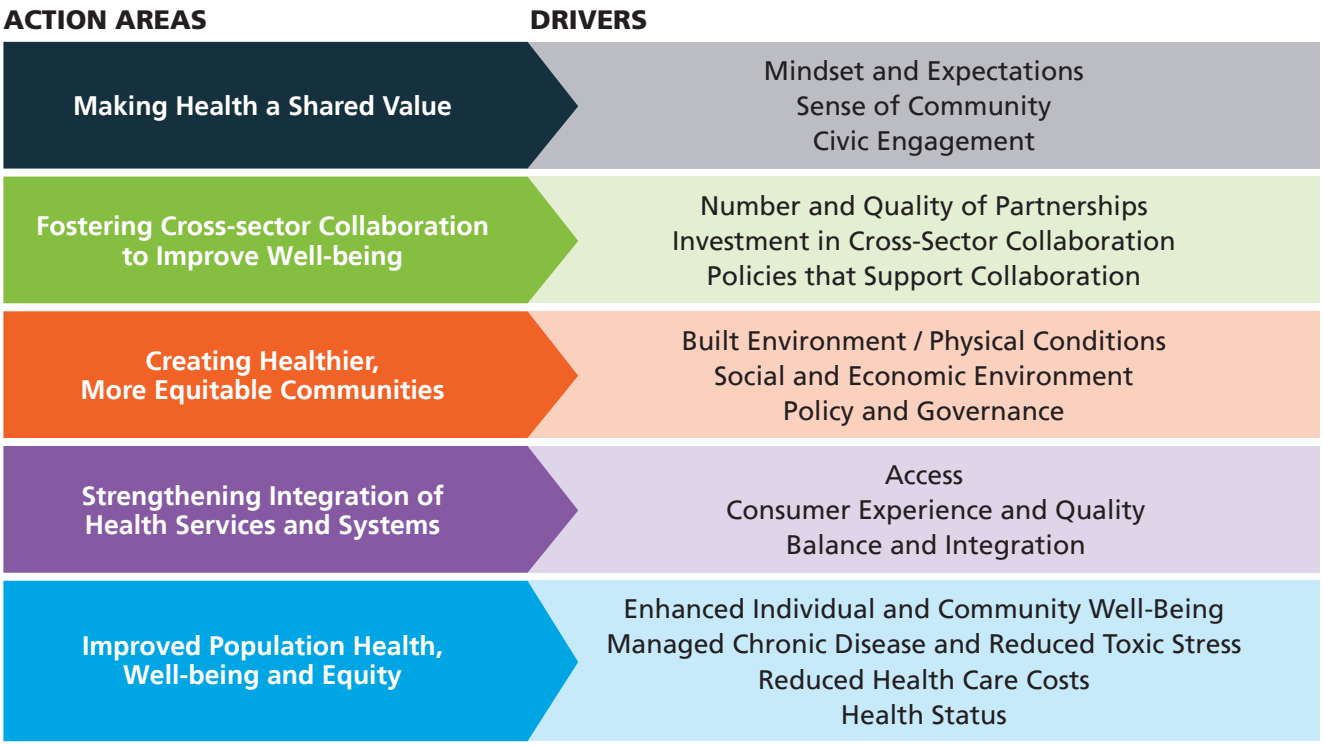
A culture of health reflects a vision of health and well-being as the sum of many parts, addressing the interdependence of social, economic, physical, environmental and spiritual factors. The framework emphasizes collaboration and supports discussion between individuals, organizations in the private and public sectors, and communities representing a range of social, demographic and geographical characteristics. This framework will capture the many actions needed to develop and support a healthy community and address these complex issues to improve health in our community.



COMMUNITY DASHBOARD

Use of the Culture of Health framework assists the community in talking about and coming together around what drives health. WCPH and the Vision Action Network are partnering to create a community-wide dashboard. This dashboard will include a variety of measures that help collectively tell the story of what the community is doing to address important health issues and track progress on common goals. WCPH conducted stakeholder interviews and a survey process to gather input on the most relevant measures across the community to include in the dashboard. The survey was sent to community partners and internal Washington County departments. General themes identified in the survey that will inform the dashboard include access, affordability, housing, education and health care.

RWJF developed the following action areas and drivers that will be used to guide development of the Washington County Culture of Health and Well-being dashboard. The CHIP steering committee is responsible for reviewing these measures, identifying ways to share them with the community, and identifying opportunities for the CHIP to coordinate and facilitate collaboration across sectors.



V. CHIP Priority Areas

The foundational goals of the CHIP are to:

- Reduce health disparities
- Improve health equity
- Use a trauma-informed lens

Through over a year of planning, described in Appendix A, Washington County Public Health and community partners identified foundational goals, priorities and committee objectives for the 2017 Washington County CHIP. These strategic areas are based on community health assessment data, stakeholder input, review of health disparities and gaps in current efforts in the community and application of an equity lens process. These are the areas where the CHIP will lead and coordinate efforts in the county.

THE PRIORITIES FOR THE 2017 CHIP ARE TO:

1. Improve access to health care, including primary care, behavioral health services and oral health services

Measures:

- Increase percent of population with regular provider
- Increase number of providers (primary, mental health, oral health) per population
- Increase adults with insurance

2. Improve behavioral health outcomes, including mental health, suicide and addictions

Measures:

- Decrease suicide count by year and age-adjusted rate
- Reduce drug- and alcohol-induced deaths
- Decrease teen alcohol and drug use
- Decrease depression rates

3. Prevent chronic disease

Measures:

- Decrease percent of population with low healthy food access
- Increase percent of adults with adequate fruit and vegetable consumption
- Increase percent of adults who engage in regular physical activity

Foundational Goals: Equity and Health Disparities

Health disparities are preventable differences in health outcomes experienced by populations who may have greater obstacles based on factors like race/ethnicity, gender, ability and income. Health disparities result from multiple factors including poverty, inadequate access to health care and educational inequities. Washington County Public Health is committed to improving health equity by building on community strengths and addressing disparities to ensure all people have the same opportunity to be healthy.

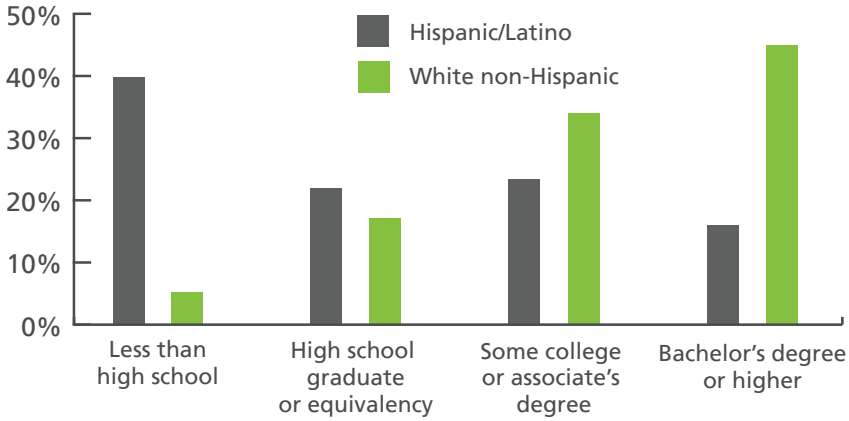
Poverty and Employment

Socioeconomic status is a strong predictor of health and well-being. The ability to secure and maintain a job can have long-lasting effects on the health of individuals and families. Having a job that pays a living wage can allow a person to live in safer neighborhoods, buy healthier food, and afford health insurance and medical care.

Almost **one in four (22%)** Washington County residents earning an income under $25,000 are uninsured.

More than **one quarter (26%)** of our Hispanic/Latino residents earn less than $25,000 year.

Education Status by Ethnicity



Education

Education is a major predictor of health outcomes at an individual, community and social level. Disparities in education and health are closely linked. The less education people have, the higher their levels of risky behaviors (for example smoking, low levels of physical exercise) which can lead to negative health outcomes.

Hispanic/Latino youth and foreign-born youth have disproportionally low high school graduation rates in Washington County.

Two in five (40%) Hispanic/Latino students do not graduate high school compared to **one in twenty-five (4%)** non-Hispanic white students.

> A healthy community cares for the vulnerable. –Listening session participant

Priority #1: Access to Health Care

Access to primary care, behavioral health (mental health and addiction services) and oral health are priorities based on an assessment of Washington County data. Barriers to access include issues related to availability of services in different languages, access to transportation, access to health insurance coverage, and workforce capacity of the health care systems in Washington County.

Uninsured in Washington County (in 2015)

7% of all residents

4% of children

25% of people with less than a high school graduation

19% of Hispanic/Latino residents

Disparities in access to care can result in disproportionate burden of health care costs and negative outcomes that could have been prevented with access to insurance and primary care.

Dentists Serving Washington County Residents (in 2015)

1 dentist for 1,126 residents

The ratio for Oregon is 1 provider per 1,300 people.

Primary Care Providers Serving Washington County Residents (in 2014)

1 primary care provider for 1,081 residents

The ratio for Oregon is 1 provider per 1,070 people.

Medical providers are an important factor in the overall health of a population. Having appropriate, accessible, and high-quality medical care can improve health, prevent disease and extend lives.

24% of Washington County residents speak a language other than English at home.

Ability to navigate the health care system is a barrier to accessing care that comes up in Washington County community surveys. Complexity of the health care system and limited services in languages other than English contribute to access issues for many populations.

The number of people each medical provider serves can have an impact on the quality of care in an area. A 2008 Evidence Review reported that states with a lower patient-to-primary care physician ratio have better health outcomes, including decreased cancer, heart disease and stroke mortality.

> (There is a) lack of clarity with health care systems, the people making decisions are not representative of the people accessing the services, we have to jump through hoops for services –Listening session participant

Priority #2: Behavioral Health (Mental Health & Addictions)

Behavioral health issues, including mental health and substance use, emerged as priority health issues in the community health assessment. This included alcohol- and drug-induced death, substance use, depression, suicide and access to mental health services.

Suicide

9th leading cause of death in 2015

3 male deaths for each **female** death

There is one suicide every **5 days**

8% of 8th graders and **6%** 11th graders had a suicide attempt in the past 12 months

Access to Mental Health Services

1 mental health provider for 415 people in Washington County

The ratio for Oregon is one provider per 250 people. This represents a severe shortage of mental health providers in the county.

Depression

22% of Washington County adults report ever being told they had depression

9% of Washington County adults on Medicaid have a current diagnosis of depression

Alcohol Use

20% of adults report binge drinking

24% of driving deaths involved alcohol

Drug-induced Death

Drug-induced death was the 11th leading cause of death in 2015.

Substance Use

Behaviors such as substance use or misuse contribute to a person's overall health status and are associated with poorer health outcomes, especially in youth.

18% of 11th graders report using marijuana in the past 30 days, as do **7% of 8th graders**. Marijuana use at a young age is associated with brain damage, poorer health outcomes and increased substance use into adulthood.

28% of 11th graders report alcohol use and 14% report binge drinking. Alcohol consumption while the brain is still developing can cause long-term brain damage.

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

Priority #3: Chronic Conditions

Mortality due to chronic diseases and contributing factors have been identified as priority health issues in assessments of Washington County data, including heart disease, chronic lower respiratory diseases, fruit and vegetable consumption and physical activity. Community conditions that contribute to these health outcomes were also prioritized, including access to healthy food, access to affordable and safe housing, and community design to support physical activity.

Built Environment

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

A food desert is a low-income area where the population has both physical and economic barriers to accessing healthy food.

One in five (20%) of the census tracts in Washington County are food deserts.

Lack of access to affordable housing contributes to poor living conditions that can lead to chronic disease.

48% of renters live in unaffordable housing and 23% of homeowners spend more than **30% of income** on housing

Health Behaviors

Fruit and vegetable consumption and physical activity were among the top 10 health behavior priorities identified through the Community Health Assessment.

Fewer than **1 in 4** adults and youth reported eating 5 or more servings of fruit and vegetables a day.

Fewer than **1 in 3** youth are physically active.

Chronic disease and health outcomes

Asthma and obesity were among the top ten chronic conditions experienced by Washington County residents. There are evidence-based policy and place-based solutions that can improve these conditions.

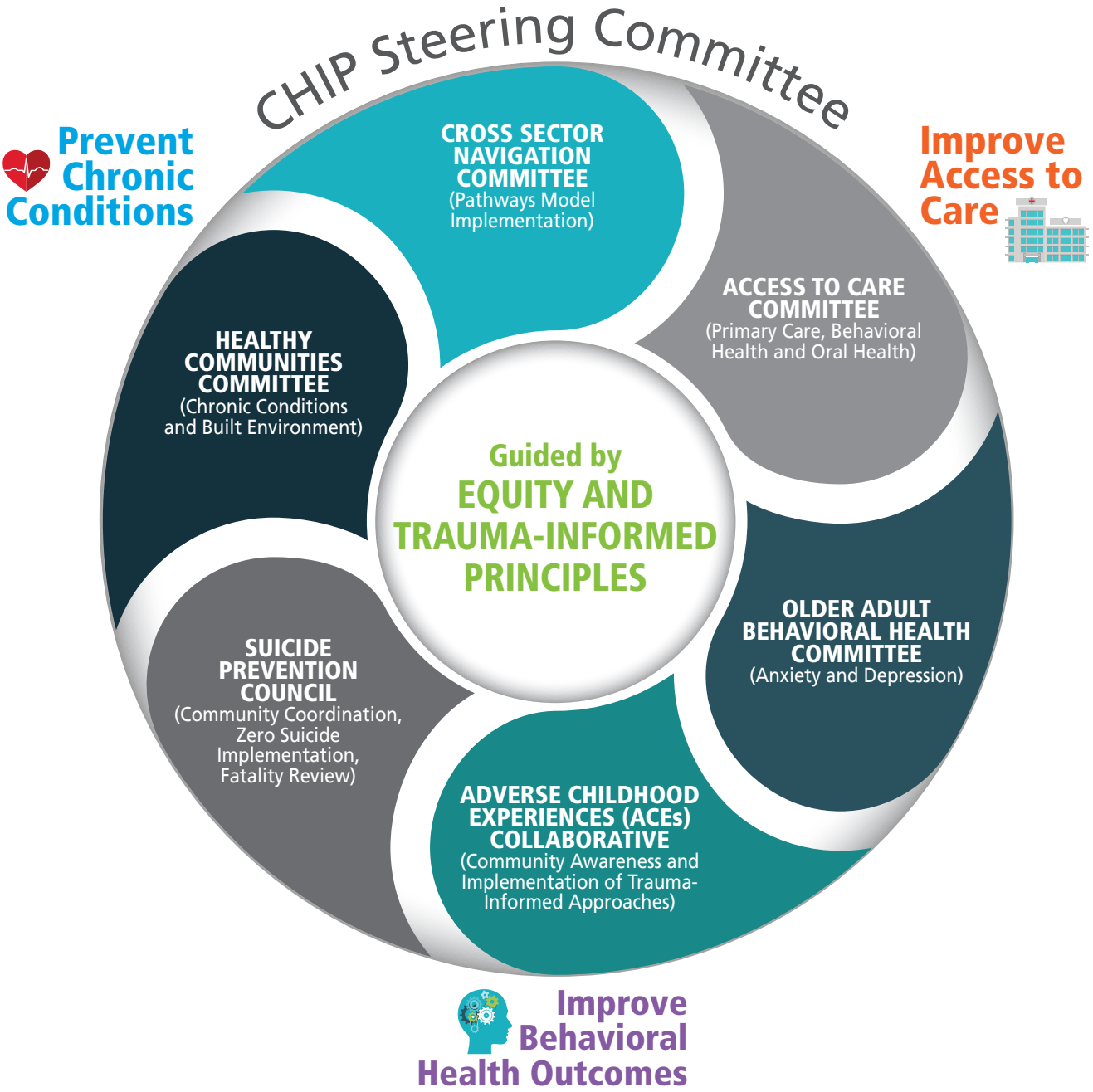
More than **½** of adults are obese or overweight.

More than **1 in 5** youth have ever had asthma and **1 in 10** current adults have asthma.

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

VI. CHIP Structure & Committees

The CHIP is comprised of a steering committee and six community committees responsible for implementing strategies to address the three priorities. The committees have aligned organizational goals and developed collaborative approaches to address these common priorities. The CHIP is developed using evidence-based best practices and a collective impact approach to identify mutually reinforcing collaborative activities. Each committee has developed a detailed work plan included in Appendix E.



Washington County Public Health has adopted the Robert Wood Johnson Foundation Culture of Health and Well-being framework to guide the CHIP and drive the important partnerships needed to develop and support a healthy community in Washington County.

THE SIX COMMITTEES AND STEERING COMMITTEE ARE DESCRIBED BELOW:

CHIP STEERING COMMITTEE

The CHIP Steering Committee includes a representative from each of the committees, along with other partners focused on implementing equity and trauma-informed care objectives across the CHIP committees. The steering committee is responsible for tracking and coordinating Culture of Health strategies, including a community dashboard with metrics selected by partners to help tell the story of community health in Washington County. The steering committee will use the evaluation of the 2014 CHIP, described in Appendix B to inform improvements in this new cycle.

Steering Committee Objectives:

- Integrate and coordinate sharing and partnerships across CHIP committees
- Implement trauma-informed care and equity approaches across CHIP committees
- Implement and track Culture of Health and Well-being goals across CHIP committees

ACCESS TO CARE COMMITTEE

The Access to Care Committee includes partners from hospitals, health care systems, federally qualified health care centers, safety net clinics, behavioral health service providers, oral health organizations, public health and behavioral health leadership, emergency medical services, and culturally-specific community-based organizations. The objectives are focused on improving access to and integration of primary care, behavioral health and oral health for residents of Washington County.

Access to Care Objectives:

- Improve access to and utilization of primary care, mental and behavioral health services and oral health services

CROSS-SECTOR NAVIGATION COMMITTEE

The Cross-Sector Navigation Committee was formed to implement the evidence-based Pathways community coordination model in Washington County. The national Pathways approach involves referring eligible participants and their families to a community health worker (CHW). The CHW works directly with the family to assess social determinants of health and provide navigation and closed loop referrals to needed resources. The navigation includes selecting a number of specific defined pathways that, when bundled together, achieve the selected outcome. This committee is focused on increasing CHW workforce in Washington County and coordinating services and resources.

Cross-Sector Navigation Objectives:

- Support coordination between direct service providers and community-based organizations to improve access to care for specific priority populations (physical, behavioral, oral health)
- Increase capacity for community health worker (CHW) workforce in Washington County

OLDER ADULT BEHAVIORAL HEALTH COMMITTEE

The Older Adult Behavioral Health Committee is focused on identifying and implementing innovative strategies to treat and prevent depression and anxiety in older adults in Washington County. Washington County Disability, Aging and Veteran Services, in partnership with Washington County Behavioral Health, is providing support and resources to community partners to implement strategies. The committee is focused on identifying, implementing and evaluating those efforts.

Older Adult Behavioral Health Objectives:

- Prevent and treat anxiety and depression in older adults by cultivating and strengthening a community that supports the aging process.

HEALTHY COMMUNITIES COMMITTEE

The Healthy Communities Committee is comprised of organizations focused on improving access to healthy food and opportunities for physical activity, reducing tobacco use, improving programs for people living with chronic disease, and addressing built environment and place-based issues that impact chronic disease. The committee's objectives are focused on supporting health in all policies and increasing access to and awareness of affordable, healthy food, physical activity and chronic disease self-management opportunities.

Healthy Communities Objectives:

- Increase access to and awareness of affordable and healthy food, physical activity and chronic disease self-management opportunities through educational programs and resources.
- Identify opportunities to incorporate health into community design processes and policies to support (1) access to healthy and affordable food, (2) opportunities for physical activity and (3) access to tobacco-free environments.
- Develop and maintain infrastructure to support implementation of committee objectives.

SUICIDE PREVENTION COUNCIL

The Suicide Prevention Council objectives and strategies are based on the 2012 National Strategy for Suicide Prevention, with the goal of preventing suicide in Washington County. The vision of the council is "Zero is possible" in alignment with the national Zero Suicide approach. The Council is comprised of behavioral health service providers, community-based organizations, law enforcement, medical examiners, emergency medical services, private practice mental health providers, public health and faith leaders. The objectives are focused on integrating and coordinating suicide prevention activities across multiple sectors, reducing access to lethal means, promoting suicide prevention as a core component of health care services, and evaluating the impact and effectiveness of suicide prevention interventions. A subcommittee reviews suicide fatalities to inform local prevention efforts.

Suicide Prevention Objectives:

- Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illness in the entertainment industry, and the safety of online content related to suicide.
- Integrate and coordinate suicide prevention activities across multiple sectors and settings.
- Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.
- Develop, implement and monitor effective programs that promote wellness and prevent suicide and related behaviors.
- Promote suicide prevention as a core component of health care services.
- Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.

ADVERSE CHILDHOOD EXPERIENCES (ACES) COLLABORATIVE

The Adverse Childhood Experiences (ACEs) Collaborative includes both an internal committee and an external community committee. The internal committee is focused on implementing trauma-informed strategies across Washington County Health and Human Services. The community committee is made up of early childhood experts, education partners, health care partners, community-based organizations and mental health organizations. The group focuses on sharing lessons learned, increasing awareness of trauma-informed strategies, providing technical assistance to assist organizations in implementing trauma-informed practices, and identifying ways to implement a trauma-informed lens across the other CHIP committees.

ACEs Objectives:

- Coordinate information sharing and sharing lessons learned across organizations.
- Provide technical assistance for implementing trauma-informed care practices.
- Implementation of trauma-informed lens across CHIP committees in partnership with Steering Committee.

See Appendix E for detailed work plans with strategies and activities, time-framed targets, responsible partners, alignment with national and state priorities and needed policy changes.

IMPROVING
community
health
is the outcome of
endeavors and activities of
partners
across many sectors
of our community.

IMPLEMENTATION AND TRACKING

The detailed CHIP work plans are attached in Appendix E. The work plans are living documents that include specific activities and tasks for each participant. Progress and updates to activities will be tracked quarterly using the work plan tracking spreadsheet. Overall implementation of the CHIP will be tracked by the CHIP Steering Committee. The committee will review the work plans and measures of success to track progress across the CHIP objectives.

Each year, the committees will review the work plan to identify any changes, including any changes to the CHIP objectives or strategies.

Annual progress reports will be developed by each committee to highlight successes, progress on objectives, and identify any opportunities for quality improvement for the coming year.





VII. Appendices

Appendix A

CHIP PLANNING PROCESS

WCPH used an adapted version of the MAPP (Mobilizing for Action through Planning and Partnerships) model in both the community health assessment process and in CHIP planning. The process included community input, quantitative data, stakeholder input about the current public health system and upcoming changes that may impact the current environment.

The Community Health Assessment (CHA) is the basis for development of the CHIP. The CHA includes population data and robust community engagement to ensure that both are reflected in the final prioritization of health issues. The process also included a review of the priorities with community stakeholders to gather input on the approach to address these health priority areas.

To ensure the CHIP focuses on areas that are strategic for the Washington County community (e.g., gap areas in the community, areas with fewer existing efforts, areas where there are opportunities to build on existing momentum, and areas that stakeholders have identified as priorities based on input from the populations they serve), WCPH reviewed the CHA data and gathered input from a broad range of community stakeholders.

Washington County hosted a CHA release event with over 80 community partners. At the event, WCPH epidemiologists presented the CHA data, and there were facilitated table discussions and surveys to gather input on the focus of the CHIP. After the event, WCPH staff presented the CHA at numerous community meetings and gathered input on the direction of the CHIP. WCPH also conducted stakeholder interviews and a survey process. See Appendix C for full list of participants.

After gathering this input, the WCPH management team and the CHIP steering committee participated in a facilitated process to apply the WCPH equity lens to the CHIP and to develop the CHIP priority areas. Each of these processes is described in detail below.

2016 Community Health Assessment

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

HCWC's vision is to: 1) align the efforts of hospitals, public health, CCOs and residents of the communities they serve to develop a shared, real-time assessment of community health across the four-county region; 2) eliminate duplicative efforts; 3) prioritize community health needs; 4) enable collaborative efforts to implement and track improvement activities across the four-county region; and 5) leverage collective resources to improve community health.

In the 2016 Community Health Assessment, health needs were identified through a comprehensive study of population, hospital, Medicaid and community data. The CHA identifies and describes the health status of the community, factors that contribute to health challenges, and existing assets and resources that can be mobilized to improve the health status of the community. The assessment is intended to provide the foundation for improving the health of the community.

HCWC used a modified version of the Mobilizing for Action through Planning and Partnerships (MAPP) model to conduct the 2016 CHA. The MAPP model uses health data and community input to identify and prioritize community health needs. An equity lens, which is a tool used to improve planning and decision-making leading to more equitable outcomes, was applied in order to make improvements to the original 2013 assessment model and to better meet the needs of the community. The lessons learned from the first assessment led to the creation of a Community Engagement Workgroup to conduct community outreach and data collection, and a Prioritized Health Issues Group to bridge quantitative and qualitative data without losing community voice.

2016 Community Health Needs Assessment Data Sources

Health Status Assessment:

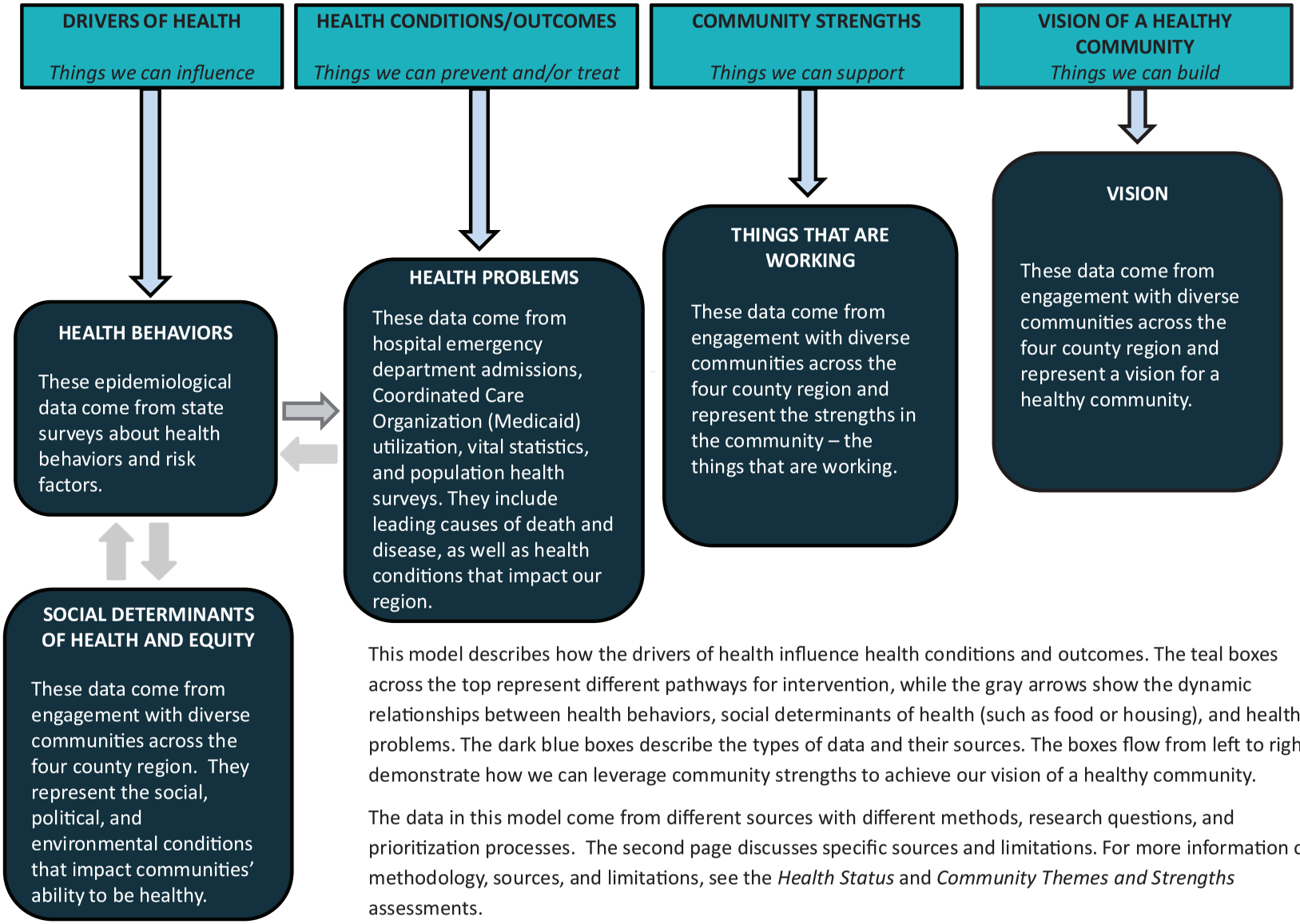
1) Population data about health-related behaviors, morbidity and mortality
2) Medicaid data from local Coordinated Care Organizations (CCOs) about the most frequent conditions for which individuals on Medicaid sought care
3) Hospital data for uninsured people who were seen in the emergency department with a condition that should have been managed in primary or ambulatory care

Community Themes and Strengths:

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

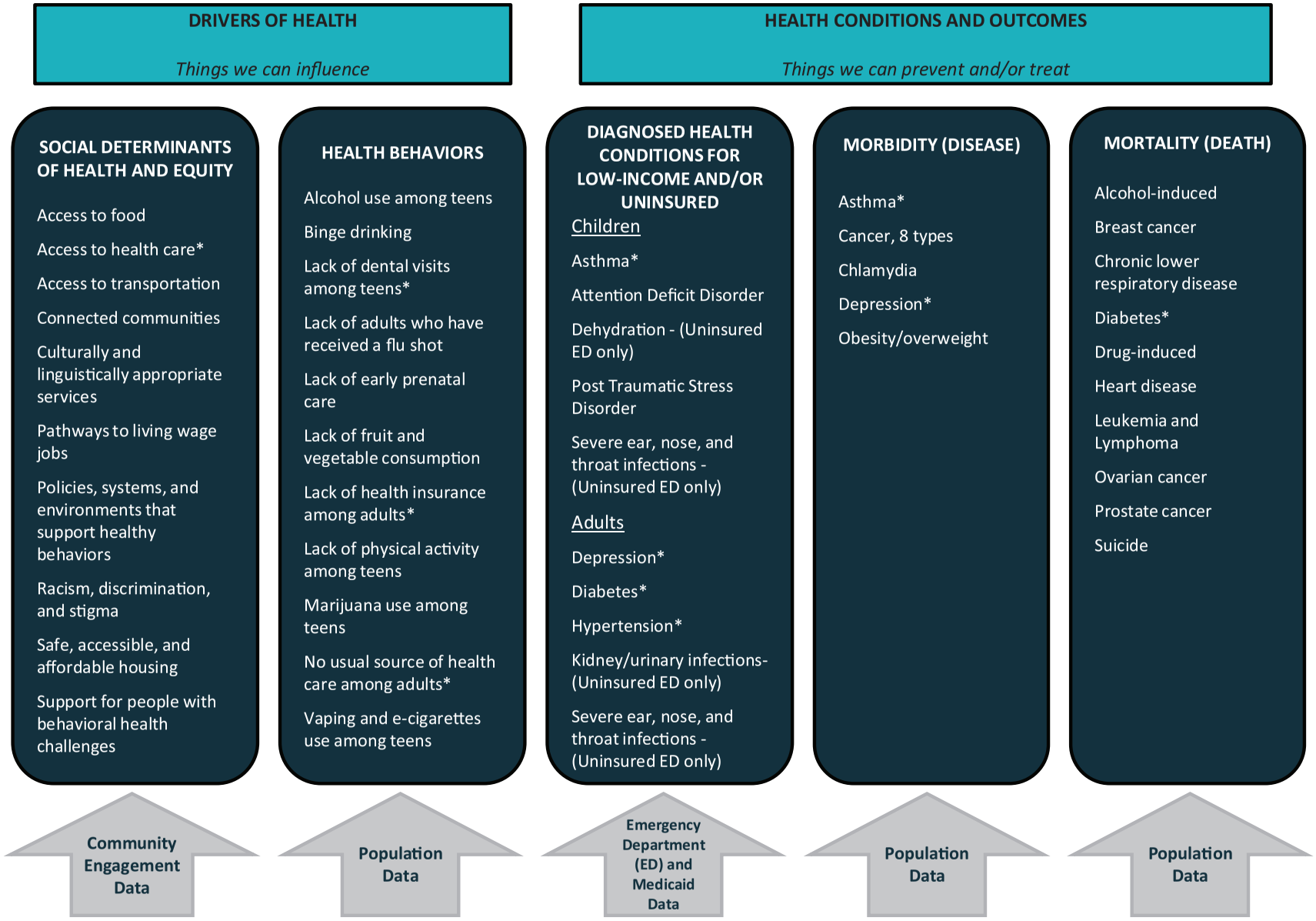
The graphic on the next page depicts the priority issues that resulted from this process.

Priority Health Issues for Washington County and What We Can Do



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

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



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

◆ Refer to section III for specific types of cancer

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

Washington County - 2016

COMMUNITY STRENGTHS

Things we can support

STRENGTHS

Culturally specific, community-based services

Feeling connected to a community

Government supported public assistance and social services

Healthy behaviors

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

Opportunities to be involved in the community

Pathways to living wage jobs

Resilience

Community Engagement Data

VISION OF A HEALTHY COMMUNITY

Things we can build

VISION

For all people:

Affordable, high-quality, culturally responsive health care

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

Environments and opportunities that support and encourage community involvement and connection

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

Good schools and equitable access to high quality education

Living wage jobs and pathways to employment

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

Safe, accessible, and affordable housing

Safe and accessible neighborhoods free of crime

Community Engagement Data

DATA SOURCES AND LIMITATIONS

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

Data sources:

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

Limitations:

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

HOSPITAL DATA

Data sources:

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

Limitations:

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

MEDICAID DATA

Data sources:

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

Limitations:

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

HEALTH BEHAVIORS, MORBIDITY, AND MORTALITY

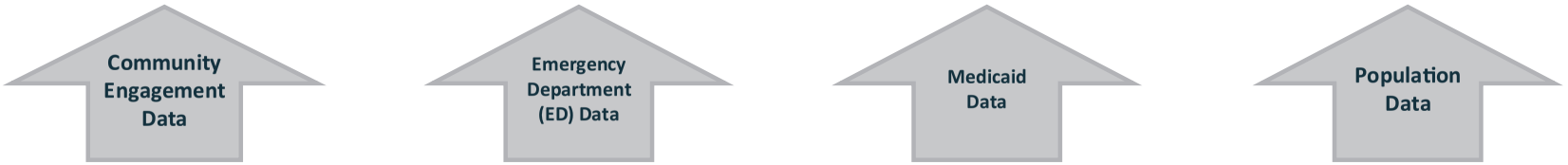
Data sources:

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

Limitations:

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

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



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

Input from Washington County Community Partners and Stakeholders

WCPH released the 2016 CHA in October at a community event. WCPH epidemiologists presented the data to over 80 community partners. The participant list is attached in Appendix C. The partners then engaged in facilitated discussions about the data and gave input on the CHIP priority areas. The discussions included the following questions:

- Which health issues are most serious from their perspective?
- What stood out from the data?
- Who should lead this work?
- Are there specific areas where WCPH should take a leadership role?

> The gap between the number of affordable housing units and the people on wait lists is the most alarming data to us. As a Temporary Emergency Shelter within the Severe Weather Shelter System we have very limited capacity and resources. Seeing the access to housing increase is necessary.
> –Community Partner

> Social and economic factors of public health seem to be the most challenging for our organization to address, but it is very much needed as it is a critical component of overall public health.
> –Community Partner

Notes from these discussions were used in the next steps of the CHIP planning process. Participants were also provided a survey with questions about the seriousness of different health issues based on input from the populations they serve and their organizational capacity and engagement on different priorities.

Following the event, WCPH staff presented the report to community partners throughout the county and gathered feedback on the CHIP priority areas. Following presentations, a link to the same survey used during the CHA release event was sent to community partners. The combined survey findings and discussion themes helped Washington County identify areas to lead and coordinate community health efforts and areas to support or be a resource to community partners. Partners ranked each of the categories with a 1, 2 or 3, with 3 being assigned the highest priority. The averages are listed below.

N=66	How **serious** is this issue for the community you serve?	What is your organization's **ability to impact** this issue?	How much of a **priority** is this issue for your organization?	Is your organization **currently engaged** in work to address this issue?
Sense of Community	2.45	2.12	2.30	2.10
Built Environment/ Physical Conditions	2.66	1.78	2.31	2.07
Social and Economic Environment	2.63	1.82	2.36	2.04
Access to Care	2.70	2.10	2.55	2.14
Mental/Behavioral Health	2.71	2.22	2.56	2.29
Consumer Experience and Quality	2.56	2.34	2.48	2.31
Substance Abuse	2.32	1.73	1.87	1.72

WCPH analyzed the survey results to find the gap between how serious an issue was ranked and overall organizational capacity to address that issue. Organizational capacity included the score for ability to impact, prioritization and current engagement. The highest gap scores in the following table indicate areas that are considered serious for the community, but there is overall lower capacity for community partners to lead that work. These are the areas that potentially make sense for WCPH to lead through the CHIP process.

Focus Area	Gap Scores
Access to care	0.43
Mental and behavioral health	0.35
Substance abuse	0.55
Social and economic development	0.56
Sense of community	0.28
Built environment and physical conditions	0.61
Consumer experience and quality	0.18

Culture of Health Stakeholder Interviews and Survey

The RWJF Culture of Health framework acknowledges the many actions across a community that are needed to develop and support health. It emphasizes the collaboration and supports discussion between individuals, organizations in the private and public sectors, and communities representing a range of social, demographic and geographical characteristics. The dashboard will be one of the ways to facilitate this collaboration.

To gather input on this framework and the proposed community dashboard concept, and to gauge community partner interest, WCPH leadership conducted interviews with community stakeholders.

1. What do you see as your organizational role related to improving community health (types of issues you are leading vs. supporting)? What efforts are you leading?
2. Do you have measures/metrics related to this work? If so, what are they/ what types of things are you tracking?
3. In what ways could Washington County Health and Human Services and Washington County Public Health support your efforts?
4. Are you interested in partnering to build this shared metrics system/ linking metrics across our organizations/ Culture of Health scorecard?

The following are the themes that emerged from the interviews and community discussions about the CHA:

Overall themes:

- Implement collaborative, cross-sector approaches
- Use a collective impact approach
- Focus on strong authentic partnerships
- Include both a focus on youth and aging
- Incorporate local experiences, creative indicators and intersectional data
- Support training and workforce development for partners
- Focus on community health worker (CHW) role across CHIP committees

Public Health Roles

- Lead data collection, analysis, accessibility and availability
- Remove barriers to support partners' efforts
- Lead discussions on equity and social determinants of health
- Leadership role in ACEs, access to care, mental and behavioral health including addictions issues, social and economic development, safe and affordable housing, and suicide prevention

Access to Health Care

- Focus on access to primary care, mental health and oral health

Adverse Childhood Experiences (ACEs) and Trauma-Informed Care

- Focus on ACEs, mitigating trauma, trauma stewardship
- Focus on care coordination, collaboration, measurement and tracking
- Include a focus on ACEs screening in health care settings, resilience training, domestic violence

Built Environment and Chronic Disease

- Focus on policy
- Lead conversation about health impacts for other sectors and settings

Community Health Workers and Peers

- Incorporate role of community health workers and peers into committee strategies
- In mental health strategies, include peers and people with lived experience

Diversity and Equity Approaches

- Focus on health disparities for Hispanic/ Latino populations
- Incorporate trauma into equity approach (consider issues related to trauma and culture)
- Consider language and interpretation
- Involve bicultural/ bilingual staff
- Focus on health literacy
- Improve multicultural and multilingual materials and services

Housing

- Focus on cost of living
- Focus on affordable housing, especially for aging population, those with mental illness and domestic violence victims
- Improve data availability or analysis on homelessness

Mental and Behavioral Health

- Focus on insurance and access issues
- Include focus on suicide prevention, substance use and addictions issues, youth substance use
- Consider county and CCOs partnership opportunities

Social Determinants of Health (Including Education and Employment)

- Focus on education disparities; partner with schools on education disparity issues
- Focus on pathways to living wage jobs and workforce development

Equity Planning Process

WCPH has adopted an equity policy and equity lens tool. To ensure this tool was fully utilized in developing the updated CHIP, the CHIP Steering Committee and WCPH Management Team came together for two half-day facilitated sessions to discuss race, advantage and privilege; to practice implementing the equity tool on case study examples; and to apply the tool to a review of community health assessment data and community partner input to identify the CHIP priority areas. The facilitator, Maria Lisa Johnson, is a well-known and respected equity trainer and facilitator in the community.

On the first day, the group discussed common terminology, the history of racism in the United States and Oregon, and how these historical systems and structures remain today. The group discussed ways that the CHIP can help address these structures. The process was focused on equity using a racial analysis. The reasoning is that WCPH recognizes that racial inequity is one of the most entrenched inequities in our society. On the second day, the group applied these tools and discussion to the CHA data and identified CHIP priority areas based on this lens.

The objectives for the facilitated process were to:

- Develop a collective analysis of where we are as leaders with regard to diversity, equity and inclusion.
- Examine beliefs about race, advantage and justice and how these issues impact our communities and our organizations.
- Understand how the history of race in the United States has shaped our perceptions and our practices.
- Begin to recognize examples of personal, institutional and structural racism in our community and in the media and how these examples impact our communities and organizations.
- Explore strategies to further equity and inclusion.
- Identify and practice tools and language to apply this lens to the CHIP and WCPH programmatic work.
- Use community health assessment data, community partner input and equity lens tools to identify CHIP priority areas and overall structure for CHIP work.
- Identify lead and support roles for WCPH in the CHIP.

During the facilitated process, the group used the WCPH equity lens tool to prioritize important health issues in our community. There were health issue profiles of each priority area. The profiles included CHA data, themes from community listening sessions and community partner survey data. The group reviewed the profiles and discussed questions about which health issue community residents would say is the biggest problem; which issues receive the most and least focus, local action or funding; and which issues do the participants in their current roles think are the biggest problem. The participants then discussed the difference opinions that are informed by proximity to the issues, perceptions, who we hear, who has access and who does not. The group then used this conversation, along with the CHA data and partner input, to identify priority CHIP focus areas. The group also identified critical lead and support roles for WCPH through review of disparity data and community inequities. The groups discussed and proposed priorities based on data to advance health equity.

Through prioritization and use of an equity lens tool the group prioritized the following:

1. Access to care — including behavioral health services
2. Built environment and physical conditions — including policy, systems and environments
3. Mental health and behavioral health — including trauma-informed care

Appendix B

2014 CHIP: ACHIEVEMENTS AND EVALUATION FROM THE LAST CYCLE

Over the past three years, collaborative CHIP committees have been meeting regularly to implement health improvement strategies based on the 2014 CHIP work plan. The committees have achieved successes and made significant progress in developing stronger partnerships across community organizations. The following is an overview of the progress and achievements from the past three years and a description of the evaluation process that informed the 2017 CHIP.

2014-2017 Access to Integrated Care Achievements:

The Access to Integrated Care Committee is committed to improving access to quality, affordable, culturally responsive health care across Washington County. The committee is comprised of key partners from across the health care system and has achieved the following:

- Provided regular opportunity for information sharing and networking
- Developed access to care and oral health assessment reports
- Coordinated funding proposal for safety net providers (focus on uninsured)
- Collaborated on successful grant proposal for Safety Net Capacity Grant to provide services to uninsured children
- Developed and implemented pediatric oral health toolkit
- Developed older adult behavioral health workgroup and facilitated community summit
- Initiated Pathways model process

2014-2017 Chronic Disease Prevention Achievements:

The Chronic Disease Prevention Committee focuses on community-based chronic disease prevention strategies. The committee has a network of stakeholders including community-based nonprofits, government and health care organizations. Achievements include the following:

- Increased collaboration and resources for partners
- Submitted collaborative funding proposal
- Increased knowledge of policy among partner organizations
- Developed new partnerships with health care (Veggie Rx, Rx Play, educational classes)

2014-2017 Suicide Prevention Council Achievements:

The Suicide Prevention Council addresses and coordinates countywide suicide prevention efforts. The council has a network of engaged stakeholders including mental health providers, first responders, educators, the faith community, community based organizations, hospitals, government organizations, survivors of suicide loss, law enforcement and other concerned citizens. Achievements include the following:

- Awarded Garrett Lee Smith suicide prevention grant
- Hired full-time suicide prevention coordinator
- Developed regional partnerships to implement GetTrainedToHelp.com to provide free suicide prevention trainings in the community
- Partnered with LifeWorks Northwest to implement Zero Suicide initiative
- Implemented Suicide Fatality Review committee
- Hosted national suicide prevention speakers and experts to discuss topics like lethal means restriction, the nature and causes of suicidal behavior

Evaluation of 2014 CHIP

Washington County Public Health evaluated the 2014 CHIP to identify ways to integrate partnership, collaboration and community feedback into the Community Health Improvement Plan (CHIP) vision and mission. Surveys, community listening sessions and interviews were conducted with community and partner organizations between July 2015 and June 2017. Key themes that emerged from the evaluation fell into three categories: content, structure and roles. Content themes include CHIP and organizational priorities, focal areas, and the gap in community services to community needs. Structure themes include findings related to logistics, convening style, facilitation and use of tools in the CHIP process. Role themes include initial community partner perspectives regarding opportunities for leadership and community support from Washington County.

Content Themes:

- Continue to improve alignment of the CHIP strategic plan with partner organizations' missions and activities.
- Continue to encourage non-traditional and diverse community partners to participate and collaborate.
- Ensure that there are multiple opportunities for involvement through broad strategic goals and structured activities.

Structure Themes:

- In-person quarterly meetings are beneficial for schedule constraints, networking and relationship building.
- Ensure easy and accessible methods for community partners to share information and update each other in a timely manner.
- CHIP committee facilitation is collaborative and accessible for diverse partner needs.

Role Themes:

- Support community organizations with technical assistance and capacity building.
- Support and facilitate collaboration, partnership and networking.
- Lead broad community awareness of and diverse participation in CHIP.
- Lead the Community Health Assessment data process, reporting and distribution.

Washington County Public Health used the evaluation findings, in conjunction with the 2016 Community Health Assessment, to inform strategic planning and equity planning to inform the updated CHIP. This process was designed to ensure quality improvement, a continued collaborative approach and continued alignment with community needs and priorities. Washington County will continue working toward an effective balance of a long-term strategic vision with structured objectives that will provide opportunities for varying levels of community involvement and participation.

Appendix C

In addition to the CHIP partners listed in the introduction, the following partners provided input in the priorities and objectives for the 2017 CHIP:

211info
Adelante Mujeres
Beaverton Child Welfare
Bienestar
CareOregon
Cascadia Behavioral Healthcare
Centro Cultural
Coalition of Communities of Color
CODA Recovery Center
Community Action Organization
Community Housing Fund
DHS: Aging & People with Disabilities
Doernbecher Westside Pediatrics
Domestic Violence Resource Center
Early Learning Washington County
FamilyCare Health Plans
Forest Grove School District
Hillsboro Chamber of Commerce
Hillsboro Early Childhood Center
Hillsboro School District
Inukai Family Boys & Girls Club and Youth Advisory Council
Jewish Family & Child Service
Legacy Health
LifeWorks NW
Luke Dorf
Lutheran Community Services NW
Mental Health Provider Association
Morrison Child and Family
National Alliance on Mental Illness of Washington County and Multnomah County
Neighborhood Health Center
Northwest Regional Education District
Nurse-Family Partnership Advisory Board
NW Counseling Associates
Oregon Community Health Workers Association
Oregon Health and Science University
Oregon Project Independence
Oregon Public Health Division
Oregon State University Extension Service
Pacific University
Portland Veterans Administration Health Care System
Project Access NOW
Providence Health & Services
Regional Prevention Promotion Partnership
Saint Child
Sequoia Mental Health Services Inc.
Sherwood School District
Southwest Community Health Center
Tri-County 911 Service Coordination Program
Tuality Healthcare
Virginia Garcia Memorial Health Center
Vision Action Network
Voices Set Free
Washington County Consolidated Communications Agency
Washington County Cooperative Library Services
Washington County Disability, Aging and Veteran Services
Washington County Children, Youth and Families Division
Washington County Housing Services
Washington County Human Services
Washington County Public Health
Washington County Sheriff's Office
Western Psychology

Appendix D

SOURCES

Introduction
Robert Wood Johnson Foundation, Culture of Health, Measuring What Matters, 2015

Demographics
Portland State University Population Research Center (PSU PRC). Accessed at http://www.pdx.edu/prc/

American Community Survey, 2015 single year estimates

Equity and Health Disparities
American Community Survey, 2015

Access to Health Care
American Community Survey, 2015

County Health Rankings, 2014 and 2015

Behavioral Health
Vital Statistics, 2015

County Health Rankings, 2014 and 2015

Behavioral Risk Factor Surveillance System, 2010-2013

Oregon Healthy Teens, 2013-2015

Chronic Conditions
American Community Survey, 2015

Behavioral Risk Factor Surveillance System, 2010-2013

US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas: 2010-2015

Appendix E

Detailed work plans for each committee will be developed in fall 2017.