January 14, 2020

CHA, CHIP, HTWC and you! PHAC presentation

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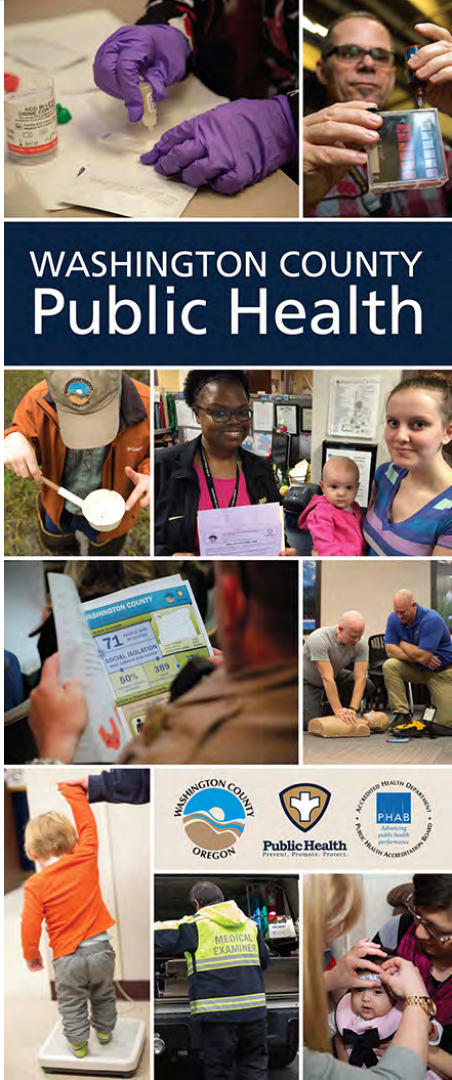
Healthy People, Thriving Communities



Plan for today

Agenda

1. Background
   - Who are we?
   - Why all the acronyms?
2. CHA and CHIP process
3. HCWC data overview
   - HTWC Storyboard
4. What's next?
   - Updated CHIP
   - Discussion questions

PHAC asks

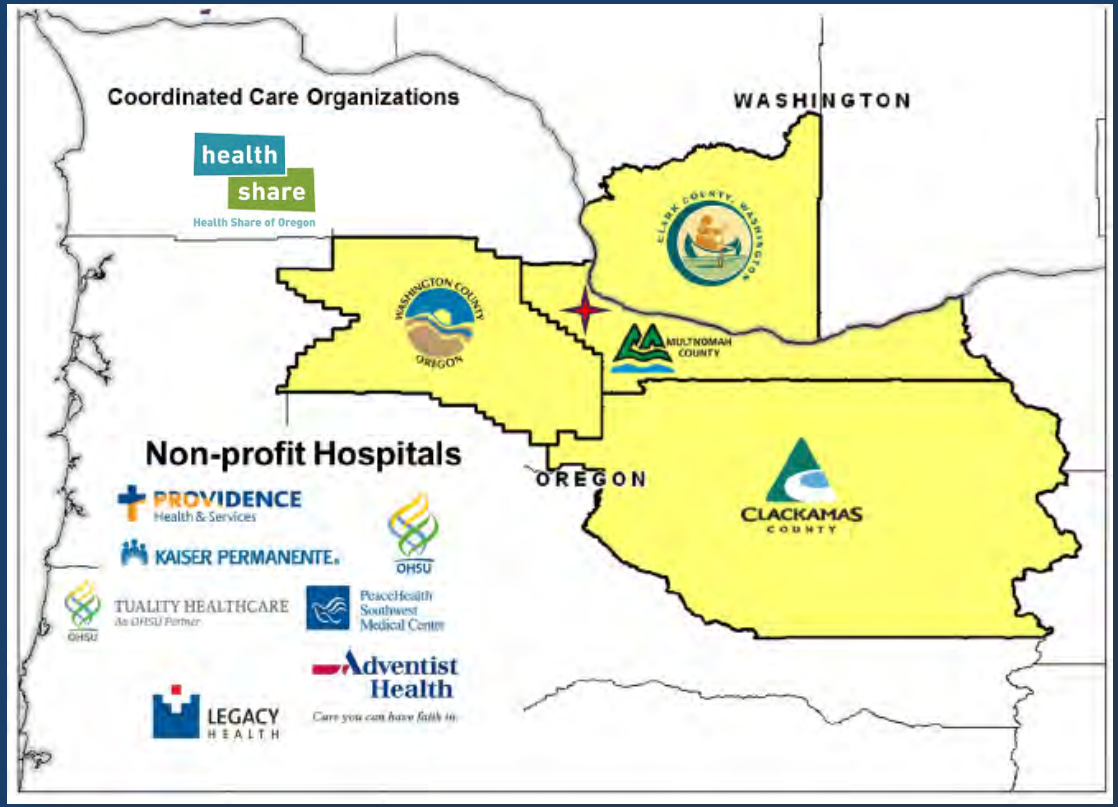
1. Questions or response on CHIP update
2. Input on committee strategies and direction
3. Opportunity for involvement in CHIP committees

Healthy Columbia Willamette Collaborative

2019 Community Health Needs Assessment

Healthy Columbia Willamette Collaborative

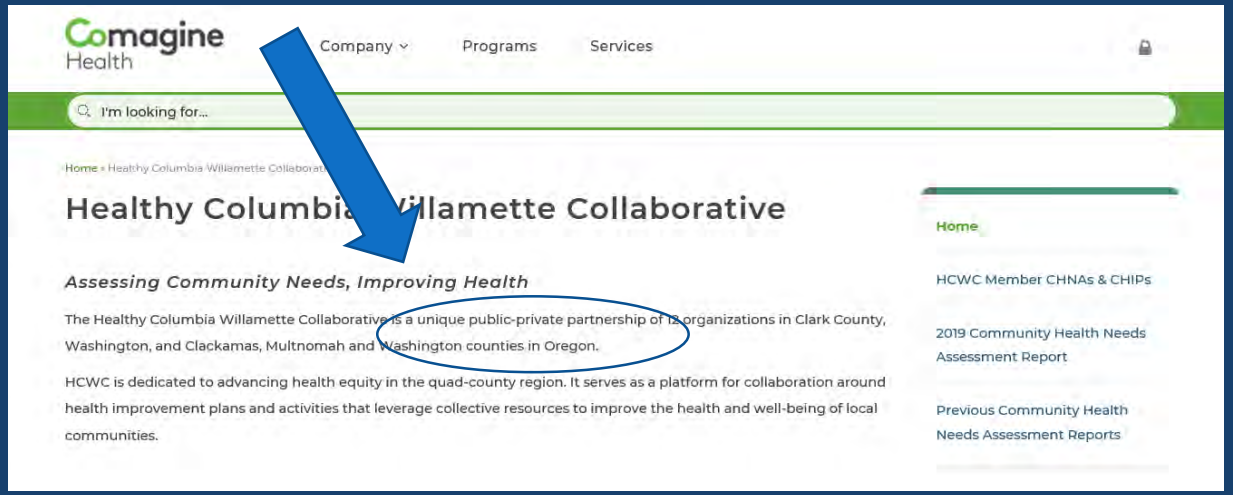
- Four local health departments
- Coordinated care organization
- 15 local hospitals



WHAT IS A CHNA?

- CHNAs inform health improvement plans of participating hospitals, public health authorities, and coordinated care organizations.
- CHNAs are also intended to be shared with the community to inform work across the community

www.HealthyColumbiaWillamette.org



2019 COMMUNITY HEALTH NEEDS ASSESSMENT

This report presents the results of Healthy Columbia Willamette Collaborative's (HCWC) 2016-2019 community health needs assessment of the quad-county region: Clark County, Washington, and Clackamas, Multnomah and Washington counties in Oregon.

The HCWC is a public-private partnership of 12 organizations in Clark County, Washington, and Clackamas, Multnomah and Washington counties in Oregon.

HCWC is dedicated to advancing health equity in the quad-county region. It serves as a platform for collaboration around health improvement plans and activities that leverage collective resources to improve the health and well-being of local communities.

You can download the complete report **here** or click the links below for specific sections.

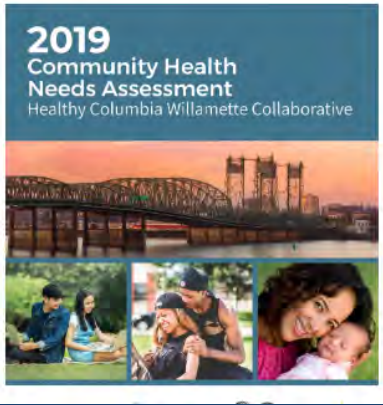
Complete report

About

- **Core issue summaries**
- **Glossary**
- **Project overview and regional demographics**
- **Social determinants of health in the region**
- **References**

Core issues

- **Discrimination & racism**
- **Trauma**
- **Behavioral health**
- **Chronic conditions**
- **Sexually transmitted infections**
- **Access to health care, transportation, and resources**



https://www.clark.wa.gov/public-health/2019-community-health-needs-assessment

HOW IS A CHNA USED?

- Program planning
- CHIP planning/priorities
- Strategic planning
- Grant applications
- Identifying key partnerships and working toward a culture of health and wellbeing
- Identifying priority populations and disparities within the community

Continuous Improvement Goals of CHNA Process

- Better integration of the data
- Map how conditions are connected, and where connections were not found
- Stronger focus on social determinants of health perspective
- Greater understanding and application of health equity lens
- Community stakeholder/member partnership
- Prioritization of health issues for collaboration and targeted strategies
- Improve accessibility/readability of report and data

Health Status and Community Themes and Strengths Assessments

Data sources:

- Public Heath/ Population Data
- Primary Care Data
- Medicaid Data
- Hospital Data
- Listening sessions
- Inventory

Purpose/ Questions

- What does the health status of our community look like?
- What is important to our community?
- How is quality of life perceived in our community
- What assets do we have that can be used to improve community health?

Priority Health Issues:
Identified by bridging all relevant and available data

Community Health System and Forces of Change Assessments

Interviews and meetings with community health stakeholders

Purpose/ Questions

- What are the components, activities, competencies, and capacities of our community health system?
- What is occurring or might occur that affects the health of our community health system?
- What specific threats or opportunities are generated by these occurrences?

Final Product:
Comprehensive Community Health Needs Assessment (CHNA) includes all relevant data and community experience, including prioritization of health issues and community strengths

Social Determinants Focus in the Report

- Education, literacy and language
- Health and health care
- Economic stability
- Neighborhood and built environment

2019 CHNA: DATA SOURCES

- **Population data**
  - health-related behaviors
  - morbidity
  - mortality
- **Medicaid data**
- **Hospital data**
- **Listening sessions with communities** to identify community vision for a health community, needs, and existing strengths
- Town Halls with community leaders
- **Inventory of recent community engagement projects** that assess communities' health needs

Core Issues:

- Key drivers of all core issues:
  - Discrimination and racism
  - Trauma
- Health Outcomes
  - Behavioral Health
  - Chronic Conditions
  - Sexually Transmitted Infections
- Social Factors
  - Access to: Health Care, Transportation and Resources
  - Community Representation
  - Culturally Responsive Care
  - Isolation


Discrimination/ Racism
Key Drivers of all Core Issues
Trauma
Health Outcomes
Social Factors
Behavioral Health
Chronic Conditions
Sexually Transmitted Infections
Access to: Health Care, Transportation, and Resources
Community Representation
Isolation
Culturally Responsive Care

Core Issues

Discrimination and Racism

Discrimination and Racism

- Impact of racism on health and well-being; significant driver of racial and ethnic health disparities.
  - Historical trauma, stress of microaggressions, violence, discrimination, and oppression
- Racism in institutional and health care settings have created a culture of distrust
- Intersectionality between racism and systems (such as political and educational), representation in leadership, and opportunities for employment and advancement

Focus Areas:

- Neighborhoods and Daily Life
- Safety
- Representation
- Data representation and community trust

“There is a lack of acknowledgment that racism is a chronic health issue.”
– Town Hall Participant

Trauma

Trauma

- Stress and trauma as determinants of health
- Adverse Childhood Experiences (ACEs)
  - Trauma and Toxic Stress
  - Systemic, Institutional, Social and Cultural Factors
  - Life course theory
- Historical and Generational Trauma
- Trauma-informed policies, health care, and resources can better help to address these issues and can serve as a protective factors to toxic stress and trauma's impact on health.

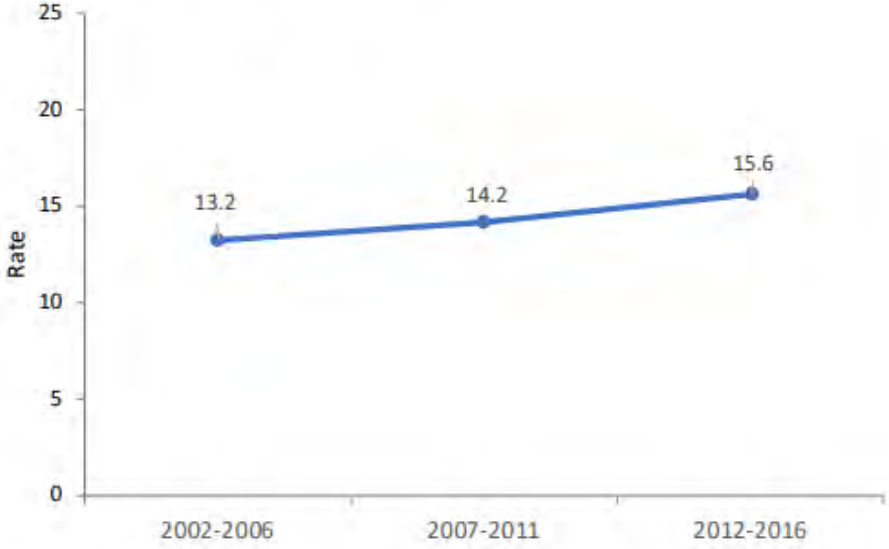
“We need a Starbucks on every corner, but for mental health.”

– Listening Session Participant

Behavioral Health

- Behavioral health includes mental and emotional health and substance use
- Focus areas:
  - Depression in adults and youth
  - Suicide in adults and youth
  - Substance use in teens
  - Access to behavioral health care
    - Culturally and linguistically appropriate behavioral health services

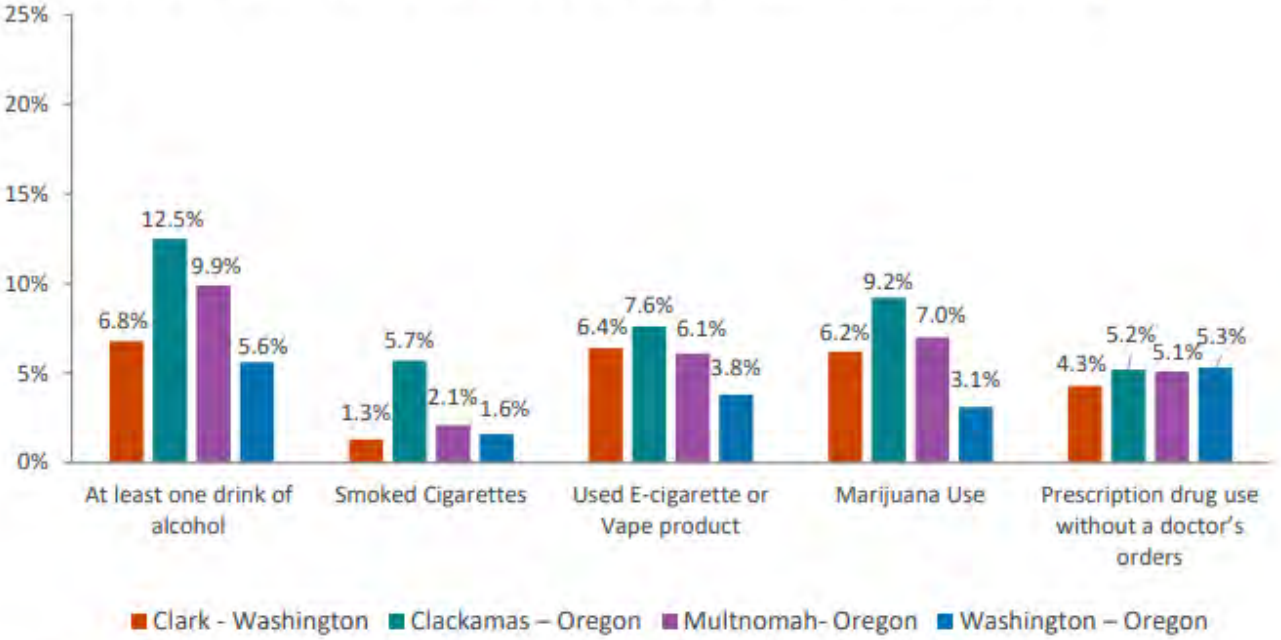
Figure 11. Adult Mortality Rates – Suicide.



All rates are per 100,00 population and are age-adjusted to the 2000 U.S. standard population.
Source: Community Health Assessment Tool (CHAT), Oregon Public Health Assessment Tool (OPHAT).

Figure 16. Ratio of Population to Mental Health Providers.

Figure 15. Percent of Teens (8th Grade) who Used Substances in the Last 30 Days.



Source: 2017 Oregon Healthy Teens Survey and 2016 Washington State Healthy Youth Survey.

Chronic Conditions

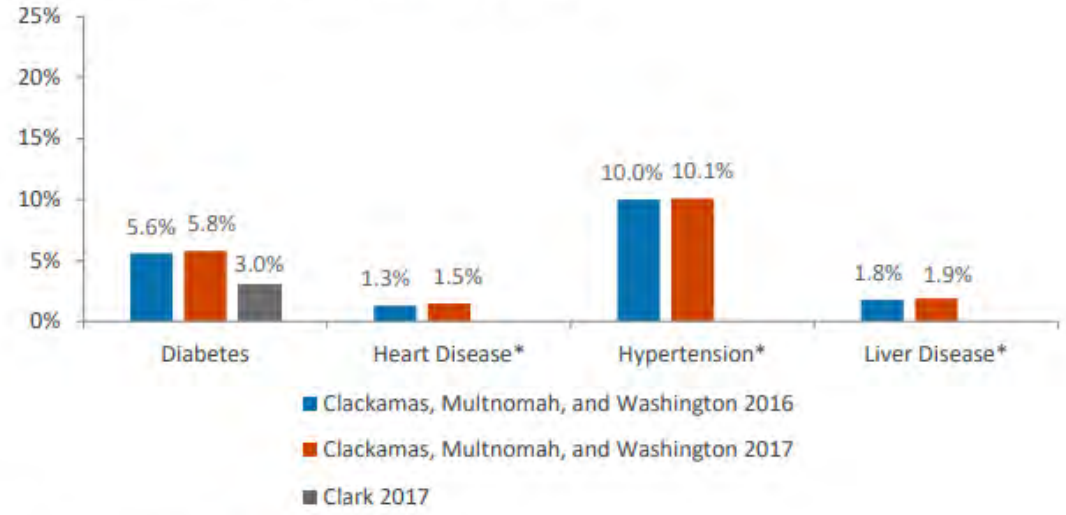
Health Outcome

Chronic Conditions

- Chronic conditions last one year or more and require ongoing medical care and may limit activities of daily living
- Chronic conditions of focus:
  - Heart disease
  - Diabetes
  - Hypertension
  - Liver disease
- Prevalence of condition, disparity by race, mortality rate and emergency department discharge evaluated

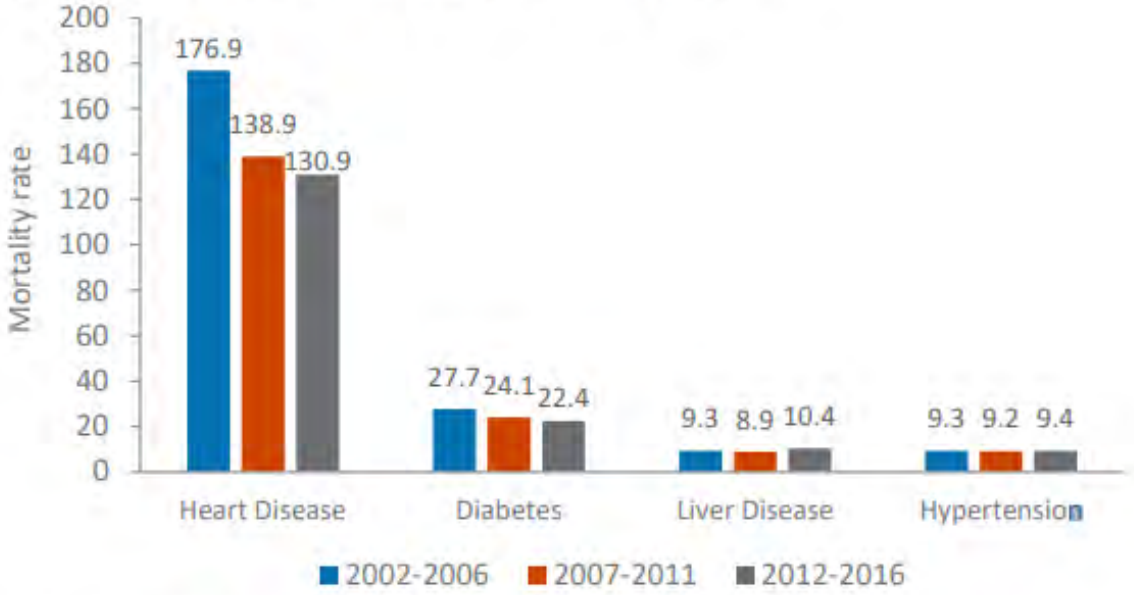
Chronic disease prevalence in Medicaid population

Figure 18. Chronic Disease Prevelence by County.

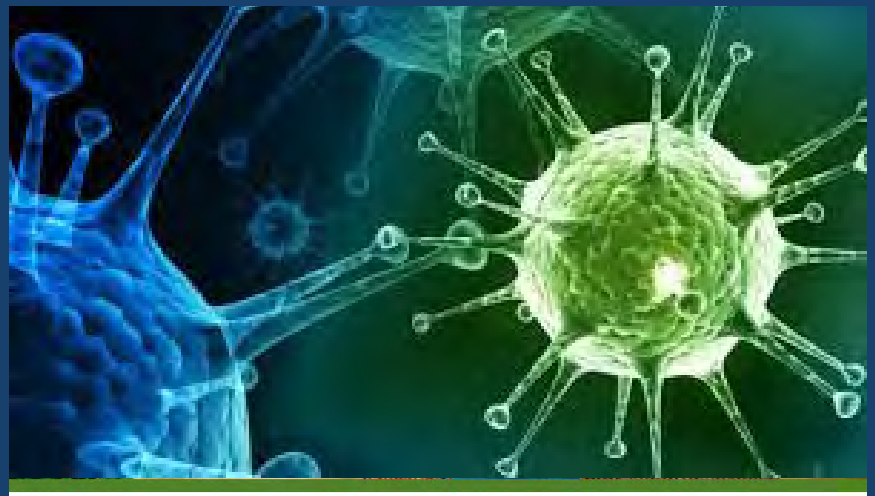


*Data not available for Clark County.
Note: 2016 Oregon N = 299,119; 2017 Oregon N = 280,812. Clark County is based on population estimates.
Source: Health Share of Oregon and Health Washington Dashboard.

Figure 19. Overall Mortality Rates for Quad-County Region.



Note: All rates are per 100,00 population and are age-adjusted to the 2000 U.S. standard population.
Source: Community Health Assessment Tool (CHAT), Oregon Public Health Assessment Tool (OPHAT).



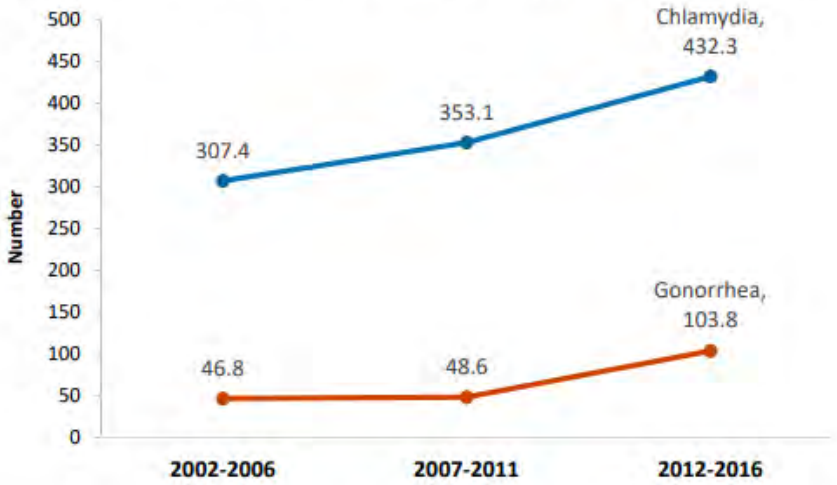
Sexually Transmitted Infections

Health Outcome

Sexually Transmitted Infections (STIs)

- STIs are a focus area as they have been steadily increasing in the quad-county region
- STIs measured:
  - Chlamydia
  - Gonorrhea
  - HIV/AIDS
  - Syphilis

Figure 27. Crude Incidence Rates* of Chlamydia and Gonorrhea in the Region.



*Crude incidence rates reflect the total number of cases diagnosed in a given time frame divided by the total population for that year and are expressed as a rate per 100,000.
Source: Community Health Assessment Tool (CHAT), Oregon Public Health Assessment Tool (OPHAT).

Community Representation

Social Factor

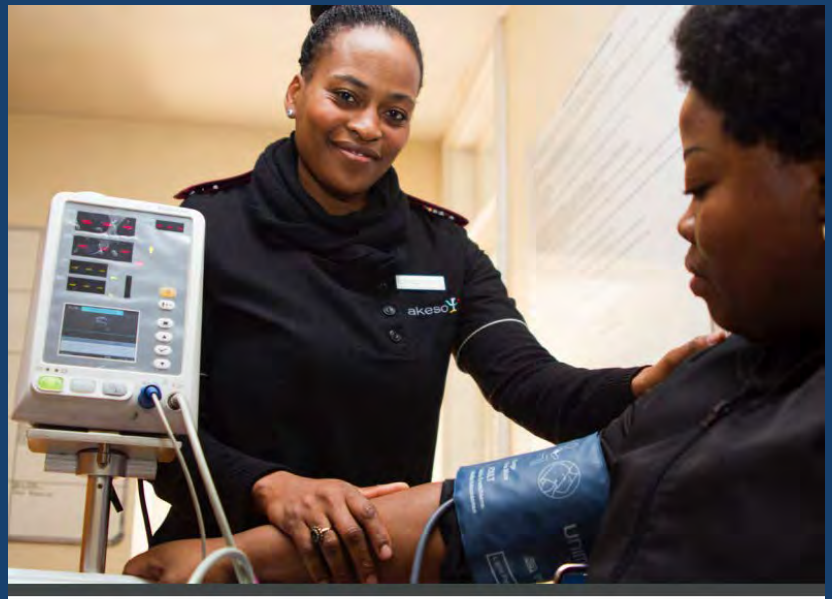
“The demographic makeup of people in leadership positions is a barrier; elected officials and other decision-makers don’t reflect the communities most impacted.”

- Town Hall Participant

Community Representation

- Lack of community representation from communities of color
  - Increase civic engagement through education and workshops that are community centered
  - Need for shared power in decision making

"We need more representation of our society in the city government."
– Listening Session Participants



Culturally Responsive Care

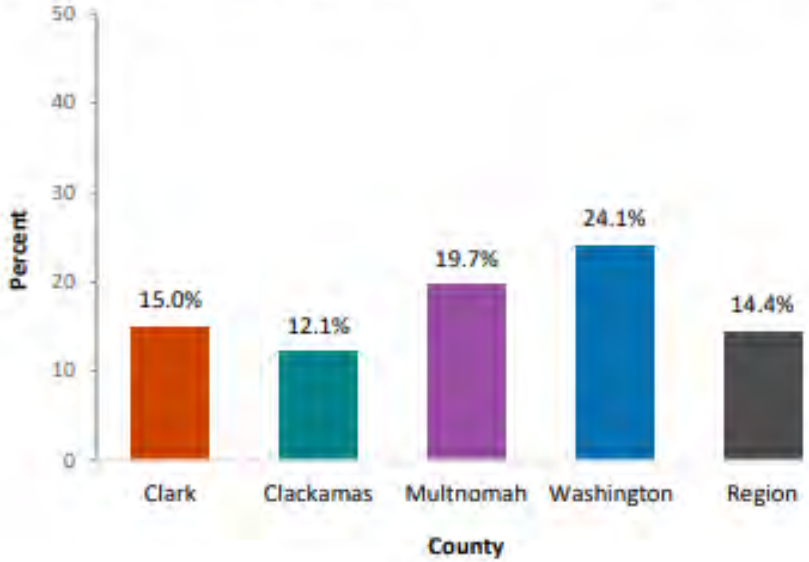
Social Factor

Culturally Responsive Care

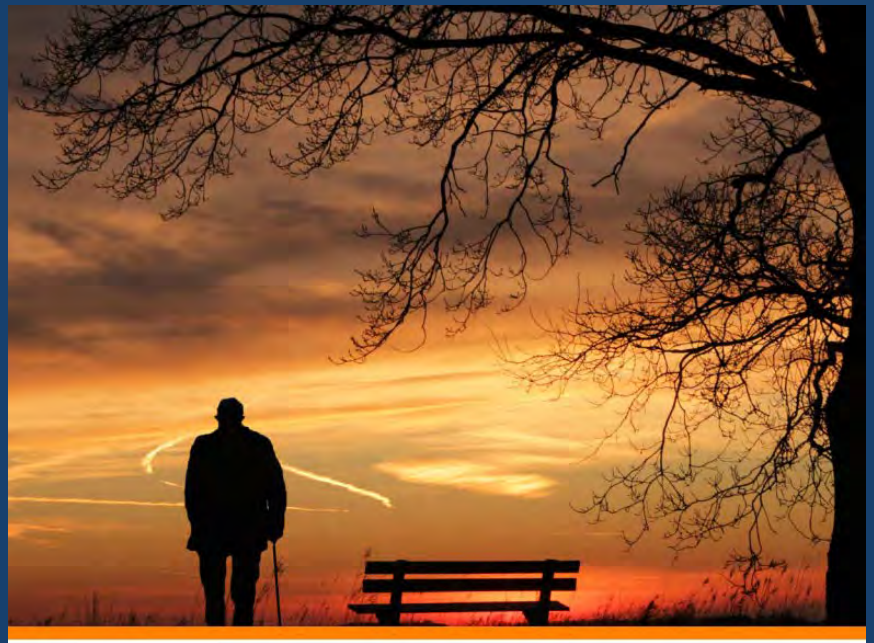
- Need for more providers who share cultural backgrounds as the community
- More community health workers to help navigate the system
- Information and services provided in more languages beyond English and Spanish

"There is a lack of culturally-specific and language-specific programs to improve adjustment and integration into the system."
– Listening Session Participant

Figure 30. Percentage who speak a language other than English at home.



Source: American Community Survey 5-year estimate 2012-2016.



Isolation

Social Factor

Isolation

- Isolation can be geographic, physical or social
- Priority for immigrant populations
- Disconnect between where communities reside and location of services
- Social contacts or network that can include family, friends, and broader environment through social activities
- Has impacts on health outcomes and access to services

Access to Health Care, Transportation, and Resources

Social Factor

“Health care isn’t a right here. There are a lot of situations where the community you live in dictates a lot of the resources you have access to.”

-listening session participant

Access to: Health Care, Transportation and Resources

Health Care access needs

- Language barriers
- Geographic isolation
- System navigation
- Lack of culturally responsive care
- Insurance coverage and cost

Transportation access needs

- Cost
- Travel time
- Mobility access
- Public transportation infrastructure outside of transportation hub areas

Resource access needs

- Financial counseling
- Access to mental health services and screening
- Emergency, temporary and transitional shelter or alternative housing
- School-based interventions and family focused community programs for economic stability

Transportation

72.3%
Of most residents in the quad-county region commute to work by driving

11.1%
Multnomah County residents have the highest percentage of commuters using public transportation

The mean commute times for counties in the region are similar, with a mean time of **26.2 minutes** for the region.

Access to reliable transportation is crucial to economic stability and staying connected to community and resources, but this access is very dependent on:

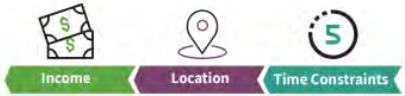


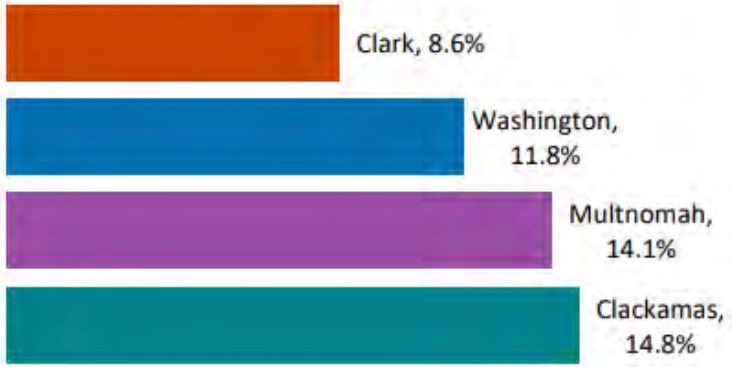
Figure 28. Commuting to Work by County.

Commuting to Work	Clark	Clackamas	Multnomah	Washington	Region*
Car, Truck, or Van – drove alone	78.9%	76.8%	60.3%	73.2%	72.3%
Car, Truck, or Van – carpooled	9.0%	9.3%	9.5%	10.4%	9.6%
Public Transportation	2.3%	2.9%	11.1%	6.5%	5.7%
Walked	1.9%	2.0%	5.4%	2.5%	2.9%
Other Means	1.5%	1.6%	6.7%	1.9%	2.9%
Mean Travel Time to Work (Minutes)	26	28	26.1	24.8	26.2

*Regional percentages calculated by unweighted averages.
Source: American Community Survey 5-year estimate 2012-2016.

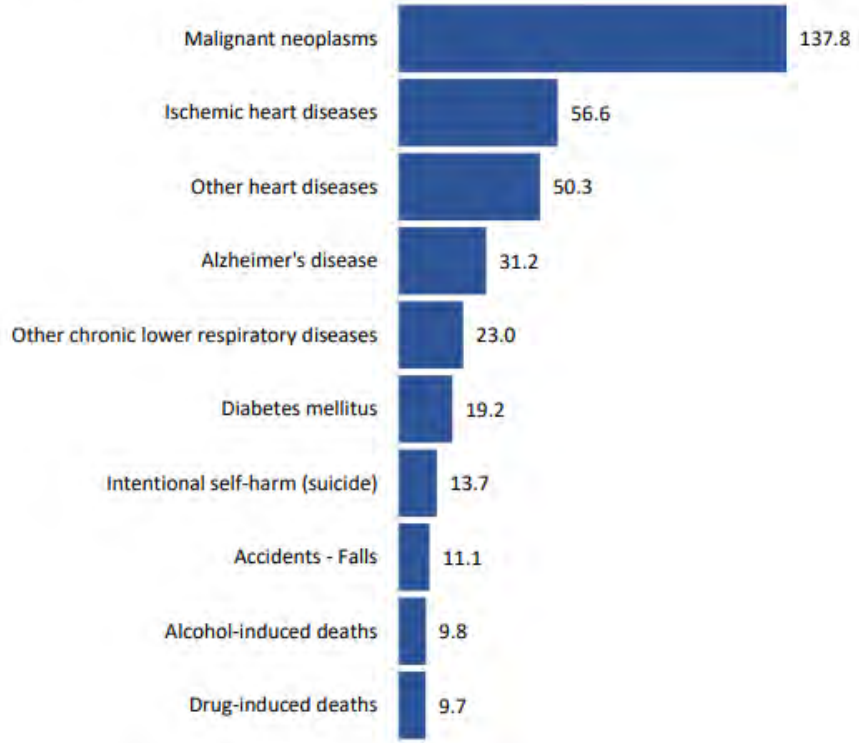
"Transportation is a huge barrier to health and to connecting to resources."
-listening session participant

Figure 29. Percent of Food Insecure Youth (8th Grade).



Sources: 2017 Oregon Healthy Teens Survey and 2016 Washington Healthy Youth Survey.

Figure 1. Washington County Mortality Rates 2012–2016.



Note: All rates are per 100,00 population and are age-adjusted to the 2000 US standard population.
Source: Oregon Public Health Assessment Tool (OPHAT).

Table G.4-2. Top 10 Communicable Diseases in Washington County.

Rank	Communicable Disease	2007-2009	2009-2011	2014-2016
1	Chlamydia	229.2	282.0	383.6
2	Hepatitis C (chronic)	99.6	74.3	87.0
3	Gonorrhea	20.5	20.5	57.7
4	Campylobacteriosis	19.0	21.3	20.2
5	Hepatitis B (chronic)	17.9	14.5	18.6
6	Syphilis (Early)	0.9	3.2	14.1
7	Salmonellosis (non-typhoidal)	11.9	11.4	11.1
8	Pertussis (whooping cough)	3.6	4.4	10.1
9	Giardiasis	8.3	8.8	7.0
10	HIV/AIDS	6.9	5.6	5.9

Note: All rates are per 100,00 population and are age-adjusted to the 2000 US standard population.
Source: Oregon Public Health Assessment Tool (OPHAT).

CONSIDERATIONS

Population-level public health data have limitations

- Does not cover every possible dimension of health
- Publicly available only at county level
- Must be big enough sample to be analyzed
- Data reporting lag time

Why community engagement is important

- Can identify issues in the community before they are reflected in the population data
- Community voice is directly reflected in assessment
- Opportunity to use equity lens to better understand strengths & concerns of unique groups

Community Health Assessments and Improvement Plans in the Region

Go to:

http://www.q-corp.org/hcwc-member-links-community-health-assessments-and-improvement-plans

to find the HCWC member organizations' CHIP/CHA links

Healthier Together Washington County

www.HealthierTogetherWashingtonCounty.com

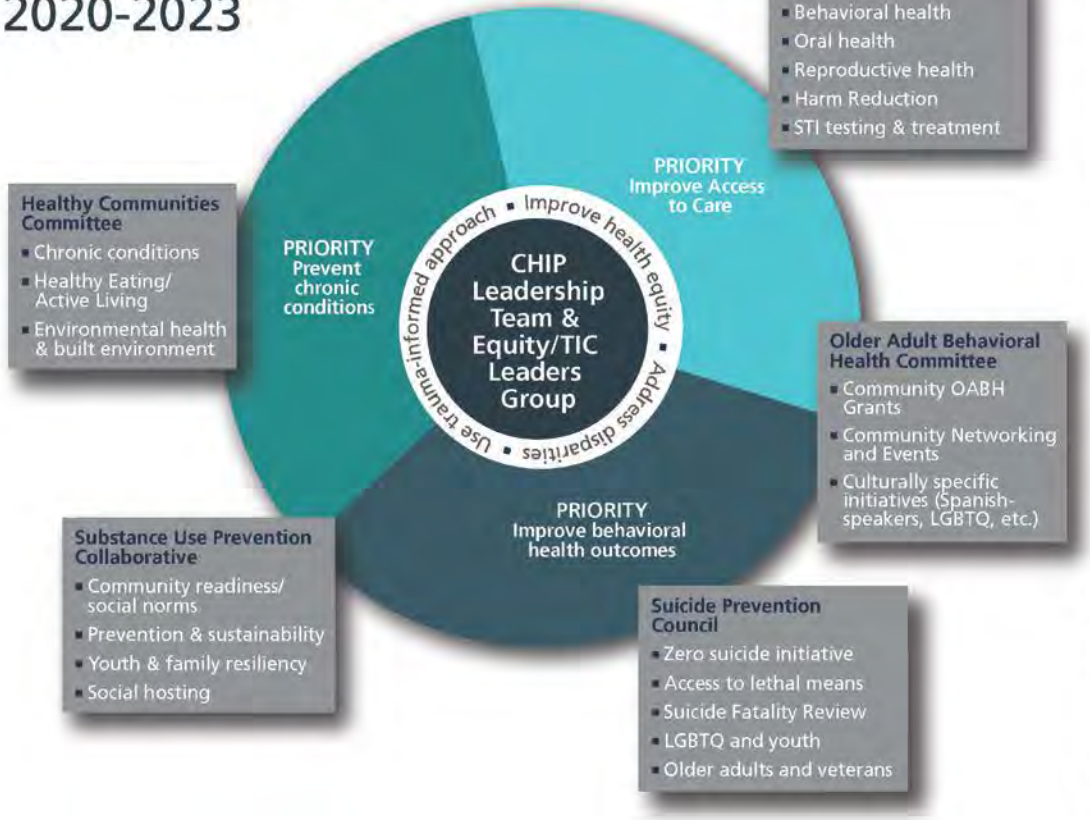
CHIP Planning Process

- HCWC Stakeholder Input Process (including input from PHAC)
- Data review with CHIP committees and CHIP LT
- CHIP Leadership Team and Committee Chairs:
  - CHIP visioning process
  - CHIP alignment planning
  - CHIP structure

Key Updates for 2020 CHIP

- Youth Substance Use Prevention Collaborative (SUP) CHIP Committee
- Harm Reduction Coalition as subcommittee to Access to Care
- TIC central to CHIP structure
- Reproductive Health Coalition of Washington County STI strategies
- Addressing structural racism in committee strategies
- New Suicide Prevention Council subcommittees
- Healthy Communities relaunch

Washington County Community Health Improvement Plan 2020-2023



Vision

By collaborating to leverage community strengths and resources and honoring lived expertise, we support the community to improve our own health.

Values:

- **Collaboration**
- **Access**
- **Equity**
- **Community Voice**
- **Prevention**
- **Safety**
- **Strength-based**
- **Connection**

The Culture of Health and Wellbeing Framework guides the CHIP and drives the important partnerships needed to develop and support a healthy community in Washington County. The CHIP is aligned with a network of other plans and partnerships to ensure collaboration and connection.

Discussion Questions

- What was surprising?
- What questions do you have?
- Thoughts on new CHIP structure?
- Input or questions for the committees as they develop their workplans?

Thank you!