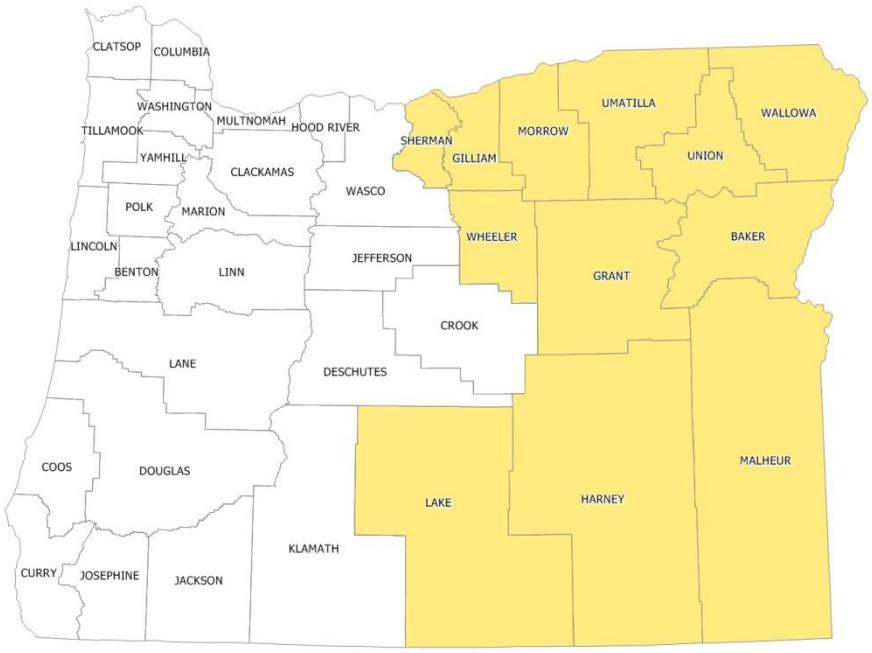
Background, Community Engagement, and Areas of Focus

Background

In 2010, the Affordable Care Act was signed into law with the goal of making health care more effective and efficient. The law strives to achieve the "Triple Aim" of better health, better quality and lower costs The State of Oregon applied for a Medicaid Waiver to implement its own plan to achieve the Triple Aim. This plan includes using Coordinated Care Organizations (CCOs) as the vehicle to deliver better care and lower cost. In addition, Health Exchanges will facilitate the goal of offering more health care coverage to people who currently do not have any.

The Eastern Oregon Coordinated Care Organization (EOCCO) includes the following counties; Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, and Wheeler.



Map provided by Oregon Office of Rural Health

Community Advisory Council's (CACs) were formed in each county to accomplish transformation goals; they organized themselves in a way that allows them to work effectively and strategically. CACs identified the resources and activities communities need to achieve intended results.

Every community is different, but there are similarities in the process by which communities mobilize to affect change. Leadership, Assessment, Planning, Implementation, and Evaluation are critical phases of change.

Local Community Advisory Council Membership

The primary charge of each LCAC is to advocate for preventive care practices, to oversee and collaborate with community partners on a Community Needs Assessment, and to develop, implement and report on a Community Health Improvement Plan.

CAC Members currently serving Umatilla County:

Rod Harwood, Chairperson
Cathy Wamsley, Vice Chair
Sarah Williams, Secretary
Juli Gregory
Colin P. Dumont
Michael L. Gregory
Carolyn R. Mason
Linda Olson
Mark A. Royal
T. Blair Smith, DMD
Chuck Wood

Quantitative Data Collection

EOCCO Community Advisory Councils conducted a Community Health Assessment by collaborating with the Oregon Health Authority Office of Equity and Inclusion to develop meaningful baseline data on health disparities.

Each CAC partnered with local public health authority, local mental health authority and hospital systems to develop a shared Community Health Assessment process. Existing county resources where used from community partners when available.

In reviewing the data sets below it should be noted that the death rates are not age-adjusted and thus populations with a greater elderly population will have higher rates. Also, in small populations' data that is expressed as a rate where the time period under consideration is only one year one or two cases may skew the data/rate inordinately.

Community Advisory Council Health Assessment
Umatilla County - 2013

OHA Required Data Elements for CCOs	Statewide:	Baker	Gilliam	Grant	Harney	Lake	Malheur	Morrow	Sherman	Umatilla	Union	Wallowa	Wheeler
Age PSU 2012													
Total	3,899,801	16,210	1,900	7,450	7,315	7,920	31,395	11,300	1,765	77,120	26,175	7,015	1,425
Ages 0 - 17	861,856	3,252	351	1,362	1,601	1,473	7,927	3,125	348	20,397	5,956	1,356	260
Ages 18 - 64	2,456,875	9,183	1,095	4,147	4,224	4,727	18,533	6,630	1,012	46,434	15,548	3,904	736
Ages 65+	581,070	3,775	454	1,941	1,490	1,720	4,934	1,545	405	10,289	4,671	1,756	429
Race 2007-2011 ACS													
White	87.6%	96%	92.8%	95.2%	92.9%	92.1%	81.1%	88.0%	95.9%	87.4%	94.0%	96.3%	96.7%
African American / Black	1.7%	0.4%	0.3%	0.4%	0.4%	0.6%	1.4%	0.2%	0.2%	0.6%	0.4%	0.2%	0.0%
American Indian	1%	**1.1%**	0.2%	1.0%	**2.9%**	**2.0%**	0.8%	0.7%	0.4%	**2.2%**	0.4%	0.4%	0.4%
Asian *	3.9%	0.4%	0.3%	0.2%	1.0%	0.5%	1.1%	0.9%	0.2%	0.9%	0.8%	0.2%	0.0%
Pacific Islander		0.0%	0.2%	0.0%	0.1%	0.2%	0.2%	0.1%	0.0%	0.1%	0.1%	0.6%	0.0%
Other	1%	0.3%	**4.5%**	0.3%	0.3%	**1.4%**	**10.0%**	**6.1%**	**1.2%**	**4.2%**	0.8%	0.5%	0.9%
2 or More	2.8%	1.9%	1.7%	**2.9%**	2.3%	**3.3%**	**5.4%**	**4.0%**	2.3%	**4.6%**	2.8%	1.9%	2.0%
Ethnicity Hispanic 2007-2011 ACS	11.5%	3.3%	8.3%	2.6%	3.8%	6.4%	**30.9%**	**30.6%**	5.8%	**23.0%**	3.5%	2.2%	1.2%
Language 2007-2011 ACS speak English less than "very well"	6.4%	1.4%	2.3%	0.7%	0.7%	2.0%	**10.1%**	**13.9%**	3.1%	**8.1%**	2.5%	0.7%	0.9%
Gender 2007-2011 ACS (F / Female; M/Male)	49.3% F	50.7% M	54.3% M	49.3% M	51.6% M	52.5% M	54.6% M	50.9% M	50.5% M	52% M	49.1% M	50% M	47.4% M
Lesbian, Gay, and Bi-sexual population	State rate = 4.5% ; EOCCO counties combined = 1.6%												
Family size 2007-2011 ACS	3.02	2.66	2.6	2.63	2.6	2.6	**3.25**	**3.35**	2.78	**3.2**	2.85	2.86	2.55
Disability status (N/A more recent than 2000 Census)	28.8%	27.0%	28.7%	21.6%	20.6%	26.7%	21.0%	23.2%	28.7%	21.0%	26.9%	21.2%	N/A
Employment 2012 OR Employment Dept unemployed	8.7%	**10%**	7.4%	**13.4%**	**12.6%**	**12.8%**	**9.8%**	8.2%	8.4%	8.4%	**9.2%**	**10.2%**	7.6%
Households Homeless	N/A	4	8	N/A	3	31	31	5	N/A	107	20	0	1
Renters	36.9%	30.80%	**37.0%**	29.2%	34.8%	33.9%	34.3%	28.2%	33.5%	35.6%	34.8%	25.1%	26.1%
Overall health Good, Very Good, or Excellent BRFSS 2006-2009	86.9%	**85.5%**	**77.7%**	87.0%	**83.6%**	91.4%	**83.8%**	**85.7%**	**77.7%**	**82.7%**	87.0%	88.8%	**79.2%**
Tobacco use Smoking BRFSS 2006-2009	17.1%	**20.0%**	**22.8%**	**24.4%**	14.3%	**19.9%**	**22.0%**	**23.0%**	**22.8%**	**24.2%**	14.0%	13.0%	S
Tobacco use Smokeless BRFSS 2006-2009 by males	6.3%	**18.3%**	**8.4%**	**30.3%**	**28.7%**	S	**23.5%**	**19.6%**	**8.4%**	**13.3%**	**20.9%**	**19.0%**	S
Obesity BRFSS 2006-2009	24.5%	22.3%	**31%**	**27.9%**	22.8%	19%	**33%**	**36.0%**	**31%**	**36.0%**	23%	19.5%	S
Heart disease 2007-2011 Death Rate per 100,000	163.1	**272.8**	**237.8**	**231.8**	**230.9**	**176.8**	**237.3**	118.0	**251.7**	161.3	**177.2**	**235.6**	**345.8**
Stroke 2007-2011 Death Rate per 100,000	47.9	**63.5**	**54.1**	**62**	**62.5**	**80.8**	**62**	39.3	22.9	**50.4**	**62.6**	**62.5**	**55.3**
Intentional injuries	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Unintentional injuries 2007-2011 Death Rate per 100,000	41.9	**78.5**	21.6	**56.6**	**84.2**	**68.2**	**44.8**	**42.9**	**68.6**	**44.7**	**45.8**	**59.6**	**69.2**
Suicide 2007-2011 Death Rate per 100,000	16.2	**31.1**	**43.2**	**24.3**	**21.7**	**30.3**	14.1	10.7	11.4	**17.7**	**19.1**	**17**	**41.5**
Prescription drug abuse (no county specific data)													
Mental health conditions Good BRFSS 2006-2009	66.4	72.1%	66.8%	66.9%	75.9%	79.0%	81.3%	74.8%	66.8%	71.6%	**63.9%**	77.9%	95.7%

* Statewide lists as "Asian / Pacific Islander" and county specific data lists two group = "Asian" and "Pacific Islander."
S – Suppressed Data
Bold = County rate is higher than statewide rate (or lower if a higher rate is more positive)

Community Advisory Council Health Assessment
Umatilla County - 2013

EOCCO Specific Data:	Statewide	Baker	Gilliam	Grant	Harney	Lake	Malheur	Morrow	Sherman	Umatilla	Union	Wallowa	Wheeler
% of population without high school diploma 2007-2011 ACS	11.1%	**11.6%**	**13.2%**	11.0%	**11.2%**	**12.8%**	**20.4%**	**22.9%**	9.6%	**18.2%**	11.0%	7.3%	**12.6%**
% single parents 2007-2011 ACS	30.4%	**31.5%**	**34.5%**	**33.3%**	**30.9%**	29.8%	**31.6%**	**33.2%**	26.0%	**32.4%**	**31.2%**	**35.1%**	**48.9%**
% elderly poverty (Age data only 18 or less)													
% of population in poverty 2011 Small Area Income and Poverty	17.3%	**20%**	11.8%	17.2%	**18.6%**	**20.6%**	**24.5%**	16.1%	15.0%	**17.7%**	15.8%	16%	**20.1%**
Binge Drinking (BRFSS data)													
Male	18.7%	11.1%	17.0%	S	S	13.6%	S	S	17.0%	17.5%	S	**28.5%**	S
Female	10.8%	9.6%	4.3%	**26.6%**	S	S	10.2%	**18.6%**	4.3%	6.6%	5.6%	**43.1%**	S
Heavy Drinking (BRFSS data)													
Male	5.4%	S	S	S	S	S	S	S	S	S	S	S	S
Female	6.1%	5.9%	S	**10.5%**	S	S	S	S	S	2.6%	4.8%	**17.8%**	S
Physical activity levels (BRFSS data) Met CDC recommendations	55.8%	**42.3%**	57%	57%	**54%**	60%	57%	**52%**	57%	60%	**50%**	**44%**	S
DUI Rates Arrests 2009 Criminal Justice Commission per 100,000	506	389 **	**1,014**	**896.8**	**1007**	**750.6**	474	488.2	**669.6**	**578.6**	473	212.9	345.5
% of population without personal transportation 2007-2011 ACS	7.7%	5.8%	5.3%	6.4%	6.6%	4%	6.4%	6.1%	2.2%	6.1%	7.4%	5.1%	1.5%
% of population without access to phone 2007-2010 ACS	2.9%	**4.2%**	1.9%	2.3%	**3.8%**	**4.4%**	2.7%	**3.0%**	1.3%	**3.0%**	**3.1%**	2.1%	1.0%
EOCCO Specific Data which relates to youth and potentially the Early Learning Councils													
% of population under age 18 PSU 2012	22.3%	20.1%	18.5%	18.3%	21.9%	18.6%	25.2%	27.7%	19.7%	26.4%	22.8%	19.3%	18.3%
% of births to mothers younger than 18 2010 OHA	2.2%	1.8%	**4.8%**	n/a	**3.4%**	1.4%	**4.4%**	1.8%	n/a	**3.6%**	**2.5%**	1.6%	n/a
low birth weight infants 2010 OHA per 1000 births	63	**67.1**	n/a	50.8	**90.9**	**114.3**	56.6	49.1	n/a	**63.2**	**85.4**	16.4	**133.3**
% of mothers receiving inadequate prenatal care 2010 OHA	5.5%	5.5%	4.8%	**8.5%**	**6.0%**	**7.2%**	**12.8%**	**13.5%**	**6.2%**	**9.7%**	**9.6%**	3.4%	n/a
% premature births (Not recorded by OHA)													
% of women experiencing abuse before or during pregnancy													
Infant mortality rate (HIPPA issue?) 2009 OHA per 1000 births	4.8	**32.7**	n/a	n/a	n/a	n/a	n/a	n/a	n/a	4.0	**12.7**	n/a	n/a
Maternal Depression/Prenatal Depression Rates													
Child Maltreatment Rates Abuse DHS 2011 per 1000 under 18	13.4	**24.1**	**60**	11.4	12.3	**25.4**	**19.4**	**16.5**	n/a	9.3	**22.5**	**14.9**	**53.1**
% of schools meeting physical education standards (as measure of child access to physical activity)													
# or % of children on school lunch program (potential measure of food insecurity) 2011-2012 School Year	51.7%	42.8%	32.6%	**58.4%**	**59.7%**	50.4%	**69.8%**	**71.4%**	**52.4%**	**62.9%**	**53.3%**	37.5%	48.5%
% of children attending preschool prior to entering kindergarten													
% of children screened with a developmental tool (by 36 months of age)													
% of children current with immunizations by age 3	66.6%	72.3%	68.7%	**62.3%**	**53.4%**	**53.8%**	**61.8%**	68.1%	68.7%	**58.0%**	**63.7%**	**57.9%**	S

* 2008 rate
S = Suppressed Data
Bold = County rate is higher than statewide rate (or lower if a higher rate is more positive)

Community Engagement Process

Community Advisory Councils used qualitative assessments to explore values, perceptions, and the "why" behind the "what" of community members. These assessments do not strive for a statistical sampling. Rather they reach for the reason behind the numbers generated from the quantitative assessments such as surveys, vital statistics and behavioral risk factor studies.

Qualitative assessments help the assessment process to determine the distance between what the statistics show as a community need and what the community perceives as a need. St. Anthony Hospital worked as a member of the Umatilla County Community Health Partnership to assess the needs of Umatilla County residents.

Two surveys were conducted, one in the winter of 2011 which assessed the overall adult population of the county. For better representation of the Hispanic population, a second survey was conducted in the winter of 2012.

Five separate community events were held in April of 2012 and May of 2012 to give the public an opportunity to review the assessment primary and secondary data that had been collected through the assessment process. Participants at these community events were asked to give feedback to the following questions:

- What surprised you
- What would you like to see covered in the report next time
- What will you/your organization do with this data
- Are there programs in other communities that Umatilla should be looking into
- If the Umatilla County Community Health Partnership can choose 2-3 priorities to work on over the next three years, what should they be

Community feedback and data from the assessment reports were used later in helping to prioritize health needs in Umatilla County. The entire Executive Summary Report can be viewed at: www.sahpendleton.org

Umatilla County Community Health Assessment Summary
Community Partners

Beginning in 2011, the Umatilla County Community Health Partnership (UCCHP) met to initiate the first collaborative countywide health assessment. In the years leading up to this assessment, numerous agencies had been routinely completing varying degrees of assessments to assist in identifying the needs of county residents. The catalyst for this new, collaborative countywide assessment project occurred during a community coalition meeting to discuss the development of a free medical clinic. The coalition group rapidly recognized—and ultimately recommended—that a comprehensive community health assessment was needed in order to proceed with the project. The assessment of Umatilla County was conducted with significant input from individuals and agencies throughout the community. Partners who were consistently involved (attended the majority of the meetings include: St. Anthony Hospital, Umatilla County Public Health, Community Action Program of Central East Oregon (CAPECO), Good Shepherd Health Care System, Clearview Mediation Disability Resource Center, Mirasol Family Health Center, Oregon Childhood Development Coalition (OCDC), Umatilla-Morrow Head Start Inc., Lifeways, Yellowhawk Tribal Health Center, Eastern Oregon Center for Independent Living (EOCIL) and the Department of Human Services – District 12.

After receiving the results of the 2011 assessment, it was apparent a significant group of the county's population was underrepresented in the survey. Nearly one-quarter of the county's population is identified as Hispanic and partners felt it was essential to have an accurate representation of this population as they moved forward in utilizing the data obtained through the health assessment to create a Community Health Improvement Plan (CHIP). Partners listed above as well as the Migrant Health Promotion conducted a second health assessment focusing on the Hispanic population.

Data Sources

Primary Data Sources:

- 2011 Umatilla County Community Health Assessment
  - Self-administered survey of adults using structured questionnaire
    - Survey questions based on CDC national survey and Behavioral Risk Factor Surveillance System (BRFSS)
- 2012 Umatilla County Community Hispanic Health Assessment
  - Self-administered survey of adults using structured questionnaire
    - Survey questions based on CDC national survey and Behavioral Risk Factor Surveillance System (BRFSS)
- 2012 & 2013 Key Informant Meetings/Community Input Meetings
  - Hermiston, Milton-Freewater, Pendleton

Secondary Data Sources:

- ❖ Obesity , Tobacco Use Chronic Illness (Diabetes/Asthma)

- CDC 2010
- CDC, *Physical Activity for Everyone*
- BRFSS 2010
- Healthy People 2020
- Vital Statistics, County Data Book *2005-2009*
- *OHA, Vital Statistics County Data Book*
- *OHA, Tobacco Prevention and Education Program, 2011 Facts Sheet*
- American Diabetes Assoc., *Diabetes Basics, Your Risk: Who is at Greater Risk for Type 2 Diabetes, Symptoms*
- Mortality and Healthy People 2020
- CDC- National Center for Environmental Health, 2011
  National Center for Biotechnology Information, U.S. National Library of Medicine, Asthma, 5-1-11

- ❖ The Umatilla Community Health County Assessment drew upon over 40 secondary sources. This summary only lists those related to the Primary Needs identified.

Health Priorities

The Partnership formed a strategic planning group after the presentation of the results of the general adult survey of the county CHA in the spring of 2012. This group reviewed feedback from the community events and the results of the survey of the adults of the households throughout Umatilla County. Utilizing data from the survey and feedback from community meetings, each member then listed their top five priorities using the "Identifying Key Issues and Concerns Worksheet." Participates made their choices based the following criteria: percentage of population most at risk, age group most at risk and gender most at risk.

A master list of the key concerns was compiled. Members were then asked to rank the issues on the master list using the "Ranking of Key Concerns" worksheet. Each key issue was given a score from 1 to 10 in three areas (magnitude of issue, consequence of issue and most feasible to correct). The averages of the scores were as follows: Obesity: 28.4, Tobacco: 26.8, Diabetes/Asthma-Chronic Disease: 26.4, Addiction: 26.25, Mental Health: 24.2, and Access to Care: 23.4. It is recognized that each of these areas are important. However, in order to make the greatest impact, the group decided to set the top three (Obesity, Tobacco, and Chronic Disease) as priorities and the primary focus for strategic planning.

It became apparent mental health, particularly in the pediatric population, was of great concern, as the group continued working to further define a CHIP for CCO purposes. Armed with data from the Adverse Childhood Experiences (ACEs) study, and additional data from EOCCO staff, Umatilla County voted in November of 2013 to move Children's mental health forward as a priority issue.

Priority Needs

Based on the data gathered by the Health Assessments and the strategic planning group, the top three health needs in Umatilla County are to decrease obesity, decrease tobacco usage and decrease chronic disease rates. UCCHP and the community coalitions intend to use strategies to address each of this issues which are evidence based or categorized as identified promising practices.

Decrease Obesity

- 67% of Umatilla county residents as overweight or obese based on BMI.
- Over three-fourths (76%) of Hispanic adults were classified as overweight or obese.
- 32% of adults were classified as obese compared to the state and national average of 28%.
- Only 56% of adults met the CDC recommendations for physical activity
- 7% of adults ate 5 or more servings of fruits and veggies each day.
- Decreasing BMI leads to many improved health outcomes including lower risk of heart attack or stroke.

Decrease Tobacco Use

- 18% of the population identified as current smokers while the state average was 15%.
- 2,629 Umatilla County residents suffer from a serious illness caused by tobacco use
- $25 million is spent on medical care for tobacco related illnesses in Umatilla County.
- Tobaccos use is the most preventable cause of disease and early death (American Cancer Society, 2011). Estimates indicate 1 in 5 deaths in the U.S. are tobacco related.

Decrease Chronic Disease (Diabetes/Asthma)

- 13% of Umatilla County adults had been diagnosed with diabetes (state average is 8%)
- Of those diagnosed with diabetes, 86% were obese or overweight.
- Leading cause of kidney failure, non-traumatic lower-limb amputations, and new cases of blindness among adults as well as a major cause of heart disease and stroke.
- One-fifth (20%) of the population has an asthma diagnosis (state average is 16%).
- One important factor which may trigger an asthma attack is second hand smoke.

Improve Children's Mental Health & Resiliency

- 26.4% of Umatilla County residents are younger than 18 years of age
- 62.9% of children are on the school lunch program
- 32.4% of the population are single parents
- Over 18% of residents do not have a high school diploma

Umatilla County hopes to have identifiable change when the next health assessment is conducted in 2016. They are doing this by focusing on these four health priorities through use of evidence based practices. Already the results of the health assessments are being used to implement strategies to improve the health of the county as well as decrease medical expenses. There is much work to do, but the assessment process has provided Umatilla County with useful data to formulate goals to move forward together in achieving the triple aim.

EOCCO Findings

The Umatilla County community responses had some similarities from findings in the nine Eastern Oregon counties which used a household mail out survey.

In total, 3,098 community members participated in those surveys. The goal was to identify community members' perceptions of the most pressing community health issues. In summary, the primary concerns in *each* of the respective counties are obesity and alcohol and other substance use / abuse. Domestic violence and child abuse were also noted among half of the counties as either primary or secondary community health concerns. Respondents also reported problems related to access to health care in rural Oregon.

There is a particular nuance within the behavioral health data that warrants further investigation. While 20 percent to 40 percent of respondents reported being bothered by little interest in doing things and by feeling down or depressed, less than 12 percent reported needing treatment for mental health issues (or substance use). This difference indicates that respondents were more likely to experience feeling emotionally "down" or depressed but less likely to seek help for these feelings; or to believe their distress needed attention. These data seem even more significant when compared to other health needs. For example, over 80 percent of all respondents received needed medical care and between 43 percent and 94 percent received the dental care they needed.