Community Conversations:

Creating the Central Oregon Regional Health Assessment and Improvement Plan, 2015

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Acronyms

Acronym	Meaning/ Definition
ACEs	*Adverse Childhood Experiences*
CAC	*Community Advisory Council*
CCO	*Coordinated Care Organization*
COHC	*Central Oregon Health Council*
MAPP	*Mobilizing for Action through Planning and Partnerships*
NACCHO	*National Association of County and City Health Officials*
OHP	*Oregon Health Plan*
OPHI	*Oregon Public Health Institute*
OPS	*Operations Council*
PEP	*Provider Engagement Panel*
RHA	*Regional Health Assessment*
RHIP	*Regional Health Improvement Plan*

Background

To strive for current and quality public health practices, the Central Oregon Operations Council of the Central Oregon Health Council used a community driven strategic planning process, Mobilizing for Action through Planning and Partnership (MAPP), to guide creation of the Regional Health Assessment (RHA) and Regional Health Improvement Plan (RHIP).

MAPP is an interactive process which aims to improve efficiency, effectiveness, and the performance of local public health systems, with the goal of improving community health. The MAPP framework involves organizing, visioning, assessment, developing goals and strategies, and an evaluation action cycle (NACCHO, 2015). This document shows how the MAPP process was used as the Operations Council moved from creation of the Regional Health Assessment, in the assessment stage, to development of the Regional Health Improvement Plan, in the goals and strategies phase.

Overview

From January through August 2015, central Oregon health system partners created the Central Oregon Regional Health Assessment. The assessment includes data and information that describes the health status of Central Oregon residents. From June through August 2015, the same partners completed a series of regional and professional meetings to understand community, partner, and stakeholder perceptions related to health issues and forces of changes that influence Central Oregon. These meetings comprised the Community Themes and Strengths Assessment and Forces of Change Assessment.

Themes from all three assessments were prioritized by the Operations Committee and the Community Advisory Council and approved by the Board. Evidence based goals and strategies were then developed via input from Operations Council members, with external guidance and support. These priorities, goals, and strategies became the outline for the Regional Health Improvement Plan.

A visual overview may be found in Appendix A.

Regional Health Assessment Input and Collaboration

The Central Oregon Regional Health Assessment describes the health of Central Oregon at a point in time. It was created by the Central Oregon Health Council, reviewed by partners, stakeholders, and the community, and revised from January to August, 2015. To create the Regional Health Assessment, input was assessed from a variety of sources, including the Central Oregon Community Advisory Council, Provider Engagement Panel, the Public Health Advisory Board, the Behavioral Health Advisory Board, and during community meetings in Crook, Deschutes, and Jefferson Counties. To address health themes and Central Oregon, data was analyzed and compiled from a range of sources, which may be found in the “Resources” section of the Regional Health Assessment.

Further information on Community Input about the RHA may be found in Appendix C.

Further information on Partner and Stakeholder Input on the RHAmay be found in Appendix D

Community Themes and Strengths and Forces of Change Assessments

Overview

A series of community meetings were hosted throughout Central Oregon (Crook, Deschutes, and Jefferson Counties) as part of the Regional Health Assessment (RHA) and Regional Health Improvement Plan (RHIP). The meetings targeted individuals within the community as a whole, in addition to community partners and stakeholders. The aim of these meetings was to determine Community Themes and Strengths, Forces of Change, and community input on the Draft Regional Health Assessment. Community outreach was organized and completed by the Operations Council of the Central Oregon Health Council.

The Community Themes and Strengths Assessment aims to answer the questions, “What does our community value?” “How is quality of life perceived in our community?” “What assets and resources do we have that can be used to improve community health?” “What are major health concerns in the community?” and “What do you consider barriers to accessing health and health care?” In short, the Themes and Strengths Assessment sheds light on community issues and concerns, assets and resources, and quality of life.

The Forces of Change Assessment aims to determine “What is occurring or might occur that could impact the community or local public health system?” and “What threats or opportunities are generated by these occurrences?” (NACCHO, 2015). This information, along with the Community Themes and Strengths Assessment, guides development of the Central Oregon Regional Health Improvement Plan.

The results from these assessments parallel the quantitative data in the Regional Health Assessment, and demonstrate the need to focus on the social determinants of health, such as socioeconomic status, housing, and transportation. The findings reemphasize the need for prevention and preventive services, and the need for improved coordination and integration of care.

Themes and Strengths

Methods

Methods for qualitative data collection included community meetings and dialogues, focus groups, and surveys. Approximately thirteen meetings were hosted, many of which included several focus groups, and one survey. These were completed during July and August 2015, in all three Central Oregon counties.

This qualitative analysis of narrative data involved reviewers who not only participated in multiple meetings, but also reviewed the notes from all meetings to determine overarching content. The notes for each county were then reviewed separately and foremost concepts determined for each. The same process was followed for Central Oregon as a whole. Once community themes were identified, the data was sorted into categories. Examples of categories include chronic disease which included subtopic like obesity, diabetes, asthma, and cancer. Themes were determined for Crook, Deschutes, and Jefferson Counties, as well as Central Oregon as a whole. The categories were reviewed by peers and checked against the original community notes before finalization.

Results

Predominant Themes and Strengths perceived throughout Central Oregon can be separated into four categories, assets and resources, health and health care concerns and barriers, community values, and quality of life.

Throughout Central Oregon, there were four predominant ***assets and resources*** that were consistently mentioned:

- The ability to utilize the outdoors for recreation, and overall appreciation of the natural environment
- Positive sense of community and community engagement, including a strong non-profit sector and religious community
- New health systems and infrastructure that may results in improved ability to access care; however, there was some disparity between responses as to the true value of the hospitals and the current health infrastructure.

- Increased enrollment in OHP may be a positive; however, the influx of new patients into the health system may result in less access due to an overwhelmed system

In Crook County, the school system was mentioned as a valuable asset. In Deschutes County (predominately in the Bend community meetings) an active lifestyle culture was cited as an asset.

Health and health care concerns and barriers encompassed a wide array of topics. Health and health care concerns and barriers remained similar in all three counties. The following were concerns mentioned throughout Central Oregon:

- Socioeconomic disparity
- Homelessness
- Transportation
- Food Insecurity in rural areas
- Housing
- Adverse Childhood Experiences (ACEs) and a lack of investment in youth
- Livable wages
- Substance abuse and addiction, including prescription opioids, marijuana, heroin, tobacco, and alcohol
- Chronic conditions, specifically obesity, diabetes, and cardiovascular diseases. Of lesser mention were asthma and cancer
- Access to resources and health care, including poor health care infrastructure and provider options in rural areas, poor acceptance of OHP, long wait times for appointments, and a lack of specialty providers and dentists
- Health literacy
- Mental Health, especially the need for inpatient facilitates, and concern for suicide in the middle age and older population
- Poor coordination of care, coupled with a lack of ability to navigate the heath system
- Lack of focus on prevention and preventive care
- Stigma in accessing care, especially in relation to mental health, utilizing ObamaCare, and cultural differences, particularly in the Hispanic community.

In Jefferson County, there was concern about increasing crime. This was not cited as a main concern in the other counties.

Although there were differences both within and between counties when discussing ***community values***, eight main values were mentioned in all three counties.

- Overall value for the natural environment, including clean air and water, and outdoor recreation
- Sense of community
- Independence
- Western culture and traditional values
- Safe communities
- Family
- Health
- Youth and services for youth, including education

Crook county residents indicated that the community values economic development. A value for tourism was emphasized in Deschutes County. In addition, Deschutes and Cook County community members acknowledged the presence of a brewery and beer drinking culture, likely enforced and perpetuated by a high density of microbreweries in the area.

The discussion about ***Quality of Life*** was very similar in all three counties. The answers varied from person to person in each group, with the conclusion that quality of life is dependent on income and location. This again emphasizes the importance of social determinants as an influence on individual and community wellbeing.

Summary

Overall, there were no notable differences in the themes in Crook, Deschutes, and Jefferson counties, however, some issues discussed varied by location, especially in rural vs. urban areas.

Overarching concepts from these meetings include the importance of social determinants on health, the need to focus on prevention and preventive care, and emphasizing the use of our assets and resources to leverage change.

Forces of Change

Methods

In July 2015, The Forces of Change Assessment was conducted by the Operations Council, which includes representation by groups throughout Central Oregon. The information gathered from the Operations Council was reviewed as a whole before predominant themes were selected. Once the main themes were selected, they were reviewed by multiple parties, and collaborative decisions made on the final list of forces, opportunities, and threats.

Results

The forces of change can be consolidated into seven main categories:

- Health care reform has increased access to health care, but there are still gaps
- Integration, collaboration and leadership are critical to improve the health of the community
- Critical issues to address include:
    - Chronic and infectious disease prevention and control
    - Mental health, substance use and abuse, and
    - Continuing to increase access to dental care
- Health system workforce development efforts are needed
- Use of data and increasing accountability will continue to drive our system
- The child health continuum, including mental health, needs to be strengthened
- Socioeconomic status, housing, and the social determinants greatly influence health status

Health care reform and access, integration, collaboration, and leadership, and the child health continuum, present opportunities for greater collaboration and continuity of care, with the goal of improving quality care for clients in Central Oregon.

Dental care changes could result in more community-based focus for dental care, and better integration and coordination of care for clients and the community.

Substance use and abuse, including tobacco, prescription drug abuse, and legalization of marijuana are growing problems in Central Oregon. Acknowledgement of this trend presents opportunities for community education, consideration of prescription drug alternatives,

alternative addiction treatment programs, and an opportunity to partner with new community organizations.

Chronic disease prevention and control reemphasizes the need for prevention, preventive care, and education.

The public health workforce is lacking in some competencies and many organizations and employees end up with a disproportionate workload. This presents opportunities to focus on better collaboration between organizations and development of an understanding of the larger ecosystem.

Opportunities for improved data use and accountability have become a focus in recent years, and present positive opportunities for data driven decisions in Central Oregon.

Socioeconomic status, housing, and social determinants were predominant themes during the Forces of Change discussion, with opportunities for partnerships, collaboration, and focus on prevention and preventive care.

Summary

Similar to the Community Themes and Strengths Assessment, overarching concepts in the Forces of Change Assessment include the importance of social determinants on health and the need to focus on prevention and preventive care.

The Forces of Change Assessment also identified the importance of integration, collaboration and leadership within the health system, and the need to focus on coordination of care for clients and the community.

Further information on Themes and Strengths may be found in Appendix B

Further information on Force of Change may be found in Appendix C

Prioritization, Goal, and Strategy Development

Prioritization Overview

Information from the Regional Health Assessment, the Community Themes and Strengths Assessment, and Forces of Change Assessment were used to develop Central Oregon health priorities, from which were developed the goals and strategies of the Regional Health Improvement Plan. Qualitative and quantitative data was used to guide prioritization, and both quantitative and qualitative methods were used to develop priorities.

In August 2015, the Operations Committee (OPs) of the Central Oregon Health Council completed a prioritization process to identify potential priorities in the areas of diseases and health conditions, health behaviors, and social determinants of health. Committee members used data and information collected from the community and professional meetings to score and rank priorities. Factors considered were the impact (prevalence/incidence, hospitalizations, estimated costs, mortality, years of potential life lost), preventability/controllability (evidence base for action, impact of/ability to influence health behaviors, professional guidelines, peer reviewed literature) and feasibility of addressing the issue (past experience, community willingness, political/legal considerations, community themes, CCO metrics).

On September 3rd, 2015, The Oregon Public Health Institute (OPHI) facilitated the Community Advisory Council (CAC) prioritization using focused conversation and a consensus workshop method. Before the meeting, CAC members reviewed the Regional Health Assessment and selected 8 to 10 health issues they felt were important to address and why they felt them important. OPHI compiled a list of focus areas, translated rationale into criteria, and used the list to lead the CAC into narrowing the list of criteria to five and focus areas from twelve. The list of focus CAC focus areas included health conditions, health behaviors, and health determinants.

On September 10th, 2015, a joint meeting was held with the CAC, OPS, and Board to review preliminary priorities from the CAC and OPS prioritizations and discuss steps moving forward. The priorities were then further refined by the OPs with input from the joint meeting, and five final priorities areas taken to the board for approval in October 2015.

Final priorities that were approved by the Board include;

1. Diabetes
2. Cardiovascular Disease
3. Behavioral Health
    a. Identification and awareness
    b. Substance use and chronic pain
4. Oral Health
5. Reproductive/ Maternal Health
    a. Unintended pregnancy
    b. Pre-term birth
    c. Low birth weight

Ultimately, leveraging both the CAC and OPS input helped lead to decisions and strategies founded in both hard data and community wisdom.

The documents used to OPS prioritization may be found in Appendix E

A Crosswalk of CAC and OPS priorities may be found in in Appendix F

A crosswalk of final priority areas from the joint CAC, OPS and board meeting may be found in Appendix G

Goals and Strategy Development Overview

Once the Board approved the final five priority areas for the Central Oregon Regional Health Improvement plan, the Operations Council (OPs) convened to develop the priorities into actionable objectives. To do this, small groups of professions in the field of each priority area used evidence based research, external input, and their knowledge and experience to craft the goals and strategies for each priority area. The draft goals and strategies were then reviewed by OPs, refined, and formed into the first draft of the Regional Health Improvement Plan. The plan was ultimately adopted by the Board.

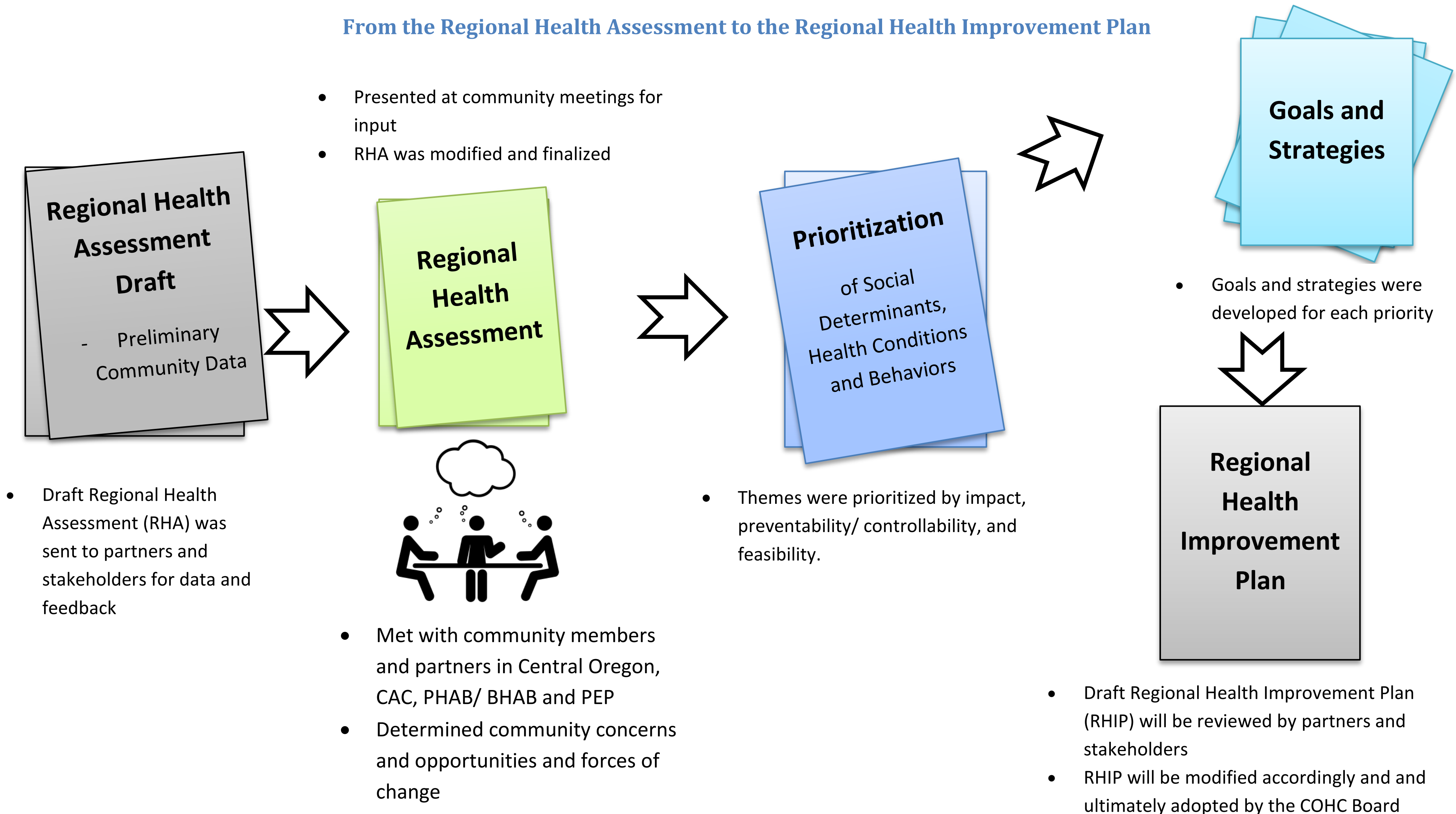
The final priority areas and a structure to develop goals and strategies may be found in Appendix H

Works Cited

National Association of County and City Health Officials (NACCHO). (2015). *MAPP Framework.* Retrieved from naccho.org: http://www.naccho.org/topics/infrastructure/mapp/framework/

Appendices

Appendix A



Appendix B

Community Themes and Strengths Notes

Central Oregon Themes

What assets and resources do we have that can be used to improve community health?	What are the major health concerns in the community?	What do you consider barriers to health?	What do you consider barriers to accessing health care?	What does our community value?	How is quality of life perceived in our community?
Outdoors - More in Deschutes than others	Substance abuse & addiction - Prescription opioid use - Marijuana - Heroin - Tobacco	Stratified community - Bend very different than other towns	Access to care - Lack of convenient access in rural areas (especially sick day visits/urgent care) - OHP acceptance - Wait time - Lack of providers, physicians, specialty care	Sense of Community	Quality of Life is extremely dependent on income and location
Engaged community	Socioeconomic disparities	Transportation	Transportation	Family	
Increase in OHP enrollment	Housing	There is not a well-advertised/ centralized system to help people access health resources	Stigma in accessing care - Within the Hispanic population - Generally in accessing Mental health services or using	Outdoor recreation & nature	

			ObamaCare (ACA)		
Strong non-profit presence	Chronic conditions	Prevention and preventive care not a focus	Lack of coordinated care	Independence	
Health system - New facilities and infrastructure	Suicide in middle age and older population	Health literacy	Health literacy	Tourism (in some areas)	
	Transportation	Family erosion		Safe communities	
	Food insecurity/ access to resources	Lack of livable wages		Clean air and water	
		SES disparity		Rural/ western tradition and lifestyle	
		Housing		Health	
				Youth and youth services	

Crook County Main Themes

What assets and resources do we have that can be used to improve community health?	What helps you receive care?	What do you consider barriers to health & Health Care?	What does our community value?	How is quality of life perceived in our community?
Outdoor space for recreation - Parks, trails, nature, etc.	Employment with insurance/ higher pay	Homelessness	Affordable housing	Low SES community with limited economy and high unemployment
Great & active Health department in the community (PH & MH)	Health Insurance/ Enrollment assister	Lack of access - No providers - lack of experienced providers - Don't accept OHP - Wait time - No sick day	Ease and affordability of access - Needed resources and services available within the community - Not having to drive to other city	Outdoor opportunities & active lifestyle improve quality of life

		visits/urgent apt - Wait time to appointment	- Health Department - Stores	
Strong sense of community and community involvement	Information on care options and resources	Transportation!	Sense of Community, community pride, and community involvement	Room to improve
Several gyms in Prineville	Local Providers	Joblessness	Family, friends, and health	*Wide range in responses from Poor to Good*
New hospital	Local resources - Food banks, churches, homeless shelters, etc.	Affordability/ Poverty	Public safety	
Non-profit presence strong			Independence/ freedom	
Great school system			Economic development and opportunities	
			Quality healthcare	
			Health education	
			Livable wages	
			"Western" Culture & Traditional Values	

Deschutes County Main Themes

What assets and resources do we have that can be used to improve community health?	**What are the major health concerns in the community?**	**What do you consider barriers to health?**	**What do you consider barriers to accessing health care?**	**What does our community value?**	**How is quality of life perceived in our community?**
Positive sense of community	Fragile economy - focus on tourism - not diversified	Lack of transportation	Lack of transportation	Recreation and outdoor activities	Quality of Life is extremely dependent on Income and ability

					to afford living here
Access to the outdoors and recreation opportunities	Substance abuse - Prescription opioid use - Marijuana - Heroin - Tobacco	Lack of focus on prevention and preventive care and the "big picture"	Rules and regulation barriers	Tourism	Disparities by community area - higher in some than others
Many medical and health focused organizations and groups	Mental health access lacking - especially for youth - in patient and psychiatric care	Lack of education on available resources - There is not a well-advertised centralized system to help people access the health resources	Providers not accepting OHP - also less access for lower end insurance: Moda	Healthy athletic people	Generally high perception of Quality of Life - why so many people are moving here
Community philanthropy and engagement	Obesity	Health literacy	Lack of coordinated care	Culture of drinking - Breweries - Distilleries - Alcohol	
Active lifestyle is a culture	Suicide -In elderly -also in youth	Family erosion	Stigma in using Obamacare	Community and community focused activities	
Well trained health professionals	Lack of focus on prevention	Lack of livable wage jobs	SES Disparity - Hugh gap between rich and poor in region	Family	
	Homelessness		Lack of local health facilities for more rural areas	Independence	
			Stigma in accessing care - Hispanic	Youth and youth services	

			population - Mental health services		

Jefferson County Main Themes

What assets and resources do we have that can be used to improve community health?	What are the major health concerns in the community?	What do you consider barriers to health and health care?	What do you consider barriers to accessing health care?	How is quality of life perceived in our community?
Improved access via service delivery changes - Same day/ next day services	Socioeconomic Status - Affordable housing - Drought hurts farmers	Few training opportunities	OHP expansion overwhelming system	Disparity by demographic and socioeconomic status
OHP enrollment	"White collar flight"	Recruitment and retention of providers	Cost of care	
Legalization of marijuana could increase local revenues	Culture of poverty and poor economy	Transportation	Need more mental health and SUD treatment	
Involved community	Substance abuse - Marijuana - Prescription Opiates	Language/ Interpreters		
	Crime increasing	Education		
	Mental health services	Lack of access - Enrollment - Lack of providers - Urgent care - Lack dental providers - Mental health - Local resources and health care - OHP reimbursement - Wait time		
	Lack of family support	Cost		
	Jefferson County	Ability to navigate OHP		

	issues are overlooked by CCO and State programs	and health system		

Provider Engagement Panel Themes

What assets and resources do we have that can be used to improve community health?	What are the major health concerns in the community?	What do you consider barriers to health?	What do you consider barriers to accessing health care?	What does our community value?	How is quality of life perceived in our community?
Outdoor recreation and nature	Chronic pain management	Poor nutrition	OHP/ Medicaid acceptance	Money	Dependent of SES
Coordination and collaboration improving	Mental health - Especially pediatric	Poverty	Transportation	Recreational activities	People want to move here
School based health centers can be leveraged	Addition and drug use -Tobacco - Opioid	Poor health literacy	Providers in rural areas	Athleticism and fitness	
University presence	Transportation	Homelessness	Primary care access limited	Our youth	
Healthcare infrastructure	Food insecurity	Primary Care Physicians lacking		Tourism?	
	Lack of adequate foster care	Housing		Education	
	SES disparity	Transportation		Alcohol acceptance	
	ACEs	SES disparity		Safe communities	
	Access to resources and care	Culture			
	Dental				

Community Advisory Council Themes

What assets and resources do we have that can be used to improve community health?	What are the major health concerns in the community?	What do you consider barriers to health?	What do you consider barriers to accessing health care?	What does our community value?
Emphasis and value on nature (in Bend, OR)	Alcohol abuse & beer culture	High school graduation rates	Transportation	Value of community
Unified hospital and healthcare system	Addictions and drug use - Heroin - Prescriptions	Transportation	No urgent care options in some areas (ex: madras)	
4 year University and COCC	Youth education and reading	Chronic Condition - Asthma - Obesity	Need for interpreters	
	SES disparity	Housing	Providers unaware of poverty culture	
	Casino (Jefferson Co)	Rural community access to resources		

Appendix C

Force of Change Notes

*Not listed in order of importance

Forces of Change	Opportunities	Threats
Health Care Reform and Access	**Healthcare reform** • Increase in access; offers opportunities for prevention to become more integrated. • Flexibility to change the way care is delivered through one global budget/ability to do APM. • Opportunity to look at where care is being delivered – team based care; does post-hospital appointment require full physician visit? Can a nurse take that? • Homeless people proud that they have a doctor • More people insured • Time has allowed us to understand what the change happening actually is and what the impact is; we know understand this will take a long time to see many of the results desired. • Long time frame to implement and realize success. • Greater understanding can overwhelm. The community may begin to perceive that things are moving really fast **Access to Care** • Reproductive health: From what has been seen in the community, reproductive health care should stay with public health because it works better and increases access. • A QIM on long-lasting reversible contraceptives will be in place for 2016.	**Healthcare reform** • We have created an illusion of access. • Finite funding; high need for services for high risk – have to bend cost curve and prevent new generations of poverty. **Access to Care** • Access issues to try to get people in. Waiting 3 months just to establish care. • We have been moving to CCOs for reproductive health, and the transition seems to be decreasing access to care, especially for youth. • Affordability of birth control is not ideal, and also limits access. • Access to child psychiatry region wide is lacking • Poor access to transportation services (regionally and across state) • Lacking access to bilingual services in some areas • Lack of specialty care, particularly mental health/behavioral health services and substance abuse treatment
Integration, Collaboration and Leadership	• Concept of integration is great. • Integration of efforts is important also • Central Oregon Counties have been, and will continue, to try to work as a more integrated	• Is integration only embedding? • A lot of talking about integration but have we dived as deep and wide as we can. • Lots of holding on to the old ways;

	whole • Improvement to care coordination and integration • The CCO Transformation Plan includes Elements of Transformation & integration (e.g. Integration PCPCH, HIE, etc.). This is a useful guide. • Define better what care coordination looks like… • St. Charles internally focused right now: good thing; needs to happen • COHC: Can we build health council to effectively address social determinants? • Focus on Health in All Policies (RWJ initiative)	everyone defining it their own way • St. Charles internally focused: Less involvement in governance/system collaboration, etc. • Disintegrated or disjointed leadership; who has authority; who defines who gets to be involved. Too much turf and politics. • A structure to set priorities, develop plans and move forward with an agenda is lacking. Can this be the COHC? • While integration is good for care, it may lead to consolidation of healthcare systems and monopolies
Dental Care	• Seeing patients that dental providers wouldn't normally see. Gaining a better understanding of the oral health status of the community. • Changing to more community-based model • Integrated and coordinated care • Innovative care delivery models in non-traditional settings • New treatments/therapies (e.g., silver diamine fluoride) <u>Legislation:</u> • Dental pilot project (SB 606) extended until January 2, 2025 • Oral disease prevention (HB 2024)	• Research project RWJ with University of WA. Placing expanded practice dental hygienists at other locations in the community setting…just rolling out. May or may not be working. Could derail current efforts that are promising. Could be positive as well… • Prevalence of tooth decay high
Substance Use and Abuse	**<u>Tobacco</u>** • Passing of Clean Air Act: decreased second hand smoke exposure • Opportunity to partner with other organizations and pass anti-tobacco policies (eg. e-cig) • Preventable, take a public health focus to health care, opportunity for COHC to lead policy change, RWJ's Culture of Health. • Create policy pertaining to e-cig • Increased educational opportunities • PH/primary care collaboration on cessation	**<u>Tobacco</u>** • Hard to counter addictions (tobacco, substance abuse, etc.) • Tobacco use among pregnant women is too high across the region • e-cigs use is too high and attractive to youth • False/unproven idea that alternative nicotine delivery systems (ex. e-cigs) are safe, harm reduction mechanisms or even aids to quitting **<u>Prescription Drug Abuse</u>**

	Prescription Drug • Opening of Bend Treatment Center • Maybe increasing awareness (still not nearly what it needs to be) • Provide education about prescribing at lower rates; • Beef up already existing prescription drug disposal systems • Provide alternative treatments • Beef up already existing needle exchange programs • Harm reduction needed **Marijuana Legalization** • Could create dollars into the community. • Opportunity to educate to make it as safe as possible. • Monitor impact on health	• Very high in Central Oregon • Leads to rise in I.V drug use, Hep C, and maybe HIV • Not very robust or complete system to prevent currently. **Marijuana Legalization** • Kids will do it. • Unanticipated health consequences. • Location of marijuana dispensaries. • Cultural and social normalization of use.
Chronic and Infectious Disease Prevention and Control	• Opportunity to integrate prevention into health care • Diabetes, cardiovascular disease, cancer, hypertension, obesity and overweight are on the rise and offer opportunities for public health and primary care to collaborate. • Focus on preventable mortality (influenza and pneumonia are still leading causes of death in vulnerable populations – infants, elderly and those with chronic conditions) • Immunization task force • 50% of hypertension is uncontrolled; this can be mainly addressed with medication • Education about prevention interventions that show results. • Some prevention efforts are aimed at long-term changes and are harder to measure • Change the focus to talk about prevention measures that do work and stop talking about how hard and slow it is to make a difference.	• Payment system needs reform to focus on prevention • Inattention to prevention; training issue – re-orient the health care system. • Focus on short term health improvement goals – these do exist • Rise in chronic disease and obesity over time • Prevalence of depression high among those with chronic disease • High vaccine exemption rates • Low influenza immunization rates
Workforce	• Can identify people who are doing really great things and do more of it	• Lots of people retiring; (OB); may not have a strong enough structure of people who

	• Work with education systems; need a community 'shared-sense' of core competencies • Develop understanding of larger ecosystem • Have a transformation plan element on this to add momentum. • Increase opportunity to share information and get more folks involved	understand systems, larger ecosystem, etc. • Same people at same meetings= lack of information dissemination and causes burnout • Lack of adequate public health provider workforce/ lack of specialty care
Data Use and Accountability	• Opportunity to build our analytic capability. • Use data for quality improvement in more focused short-term projects (clinical quality improvement projects could be established and show results quickly for certain measures such as control of hypertension). Build on these successes. • CCO metrics have helped inform services and clinical care. Should continue to focus efforts on improving practice. • Use all of the OHA metrics for quality improvement projects, not just the QIMs. There are lots of opportunities for improvement.	• We try to go too big. • The warehouse or data dumpster approach won't produce much. • Don't have enough sophistication as to how we use data. We need people to help us ask the right questions…answers exist and we don't need a data warehouse to find them. • Don't have enough statisticians and epidemiologists to maintain up-to-date stats on everything we want.
Child Health Continuum	• We need to partner with schools and strengthen relationships that will help prevent ACEs • Should continue to partner with child welfare. • SBHC have expanded in the community. Need to determine how to better partner and use this to increase holistic care (providing PCP, dental, behavioral health, etc.) • Increase birth control use in target population (in and before high school)	• Adverse Childhood Experiences (ACEs) high. We need to focus on more preventive and primary care • Access to childcare is not sufficient • Education and graduation rates low. Starting to get better, but definitely not sufficient yet. • Pregnancy rates before graduation trend too high – low use of birth control • Poor inpatient residential services for kids with mental health concerns • Transition of care for kids with mental health needs is also poor • Access to child psychiatry region wide is lacking • Increasing child homelessness • Decrease in therapeutic foster care opportunities • Risky sexual behavior

Socioeconomic Status, (SES), Housing, Social Determinants	**SES** • Can partner with programs already focusing on this **Housing** • Interest from the health care system • Money is there, we need leadership to bring the right partners together. Unclear who should/will lead **Other** • Address root causes and social determinants of health such as SES • Efforts to address health literacy • Continue to address mental health issues	**SES** • High poverty rates in some areas/ large SES disparity • Need living wage jobs • Low literacy • Low health literacy • Lack of transportation for this demographic • Increasing food cost **Housing** • Housing sounds simple but it is so complex; employment; how to people qualify for rental; big, messy complex. • Some people are okay with those people 'going away' • Prineville and Madras have poor housing quality • Bend low availability • Housing costs; 1% vacancy rate • Increasing rent

Appendix D

RHA comments

Do you have any comments on the RHA? What stood out to you?

PEP

- Dental providers don't take Medicaid, so there is limited access. But, there is not a shortage
- Mental Health needs to include access issues
- Suicide is high for ALL populations
- Flesh out addiction theme
- Need to increase mental health prescribers for Medicare and Medicaid
- There is poor/ inequitable distribution of resources
- Rural health status in Jefferson
- Childhood vaccination rates based on deeply held principles
- Graduation rate + not getting pregnant (correlation)
- Mental Health and Suicide rate (correlation)

CAC

- Binge Drinking
- Teen Pregnancy- Jefferson County
- Lack of adolescent psychiatric care
- Income disparities
- ACE scores
- Immunization rates
- Rates of smoking during pregnancy (tobacco)
- Low prenatal care rates in Jefferson Co
- Frail elderly population- time bomb
- Dementia qualifies a person for Oregon LTC COCOA supports
- How did these themes come about?
- Why is mortality focused (higher) on Native Americans
- There may be county specific things/ hot pockets
- Like the RHA layout

Crook County

Mental Health Advisory Board

- Focus too broad - more target questions for specific aspects of community health

- Do assessment more often – every 3 years
- Glad it's happening
- I think it's a very worthy cause - kudos you who are conducting this. I believe it will be worth the time and effort
- Address opiate prescriptions issue and pain management care in our county
- Not enough emphasis on substance abuse & mental health
- Our needs are very different from other counties in the region
- Crook Co. has a large population of givers and a large population of Takers. The giving population is growing tired. Generational poverty continues to grow.

Crook County Rotary Club

- Glad we look and question the needs, but must do something to make those changes
- Need to coordinate resources to maximize funds
- Regional is great but good to hear you are working on the needs of each community

Crook County Fair

- Good
- None
- None
- Great work through the health dept.
- Great idea to get input from everyone
- County fathers won't let anything improve for people
- Good luck
- Nothing ever happens or changes here
- We need to share more big businesses coming in to bring employment and more money
- I think it won't work
- I guess if we got together and shared more things to help people out it would be ok
- We don't want to get with anyone else, they look down on us

Crook County Survey

- I think it is a grand idea.
- If everyone in Crook County did the survey it would get a better view of things
- What is that?
- One should be done specific to Crook County.
- TO MUCH CANCER

- I'm fairly certain that the stats will speak louder than a survey.
- Haven't seen it.

Deschutes County

Public Health Advisory Board and Behavioral Health Advisory Board

- There is no shortage of dental providers- access is based on socioeconomic status
- Mention self-management programs as an underutilized chronic disease prevention effort
- Some confusion on early childhood screenings
- Separate out by age. Central Oregon has changing demographic; tend to have more people over the age of 65.

Bend community Meetings (2)

- More emphasis on prevention
- Behavioral health
- More on ACEs/ importance of ACEs
- Drug abuse & alcohol abuse
- Long-term cost of chronic disease + how prevention impacts this
- YPLL in Jefferson? Explain why
- Warm springs -> engage and connect more
- Need to integrate the WHOLE community
- Hitting nail on the head
- Data supports what we are feeling
- Lots of misconception from non-white community pertaining to accessing care- fear of getting caught for something else
- Can be overwhelming from a client/ provider perspective; there is a lot to work on
- ACEs go into so many areas. It is important as a community to work on this.
- Lack of health education for young people is missing --> should be part of the solution
- Low income pilot group to review RHA would be great
- Maternal and infant health: need resources on how to be parents
- Alcohol and opiate: highlight in D.C; stratify across SES
- Safe and affordable housing is a huge issue. Need community planning
- Rate of other STIs besides chlamydia also on rise (syphilis, etc.)
- Problem with condom access/ distribution
- Binge drinking is missing from themes
- Cultural norms around drinking and substance abuse

- Lacking info on senior population/ Medicare population
- Access to mental health care
- Education under child/ adolescent health
- Teen pregnancy? Jefferson extremely high
- Indian health services not represented in conversation
- Domestic violence not addressed in assessment -> lacking data?
- Children in foster care
- Helmets and seatbelts
- Surprise that D.C substance rates higher that crook & Jefferson
- More on alcohol
- Public pool use- favorable marijuana use
- ACEs trauma surprised at the number who believe # are higher in D.C.
- Surprised by chlamydia rates
- What is standard for being under covered
- Surprised at suicide #. What is the attempt rate?
- Need to address trauma as a diverse health issue
- Motor accidents and relation to alcohol
- Rx opioid death data confirmed previous information

La Pine Community Meeting

- There are more questions to ask- (focused on RHIP development)
- What do we do with folks with mental health needs?
- Sexual education and education on drugs/ marijuana needed
- Assume ACEs are high in La Pine
- Kids taking care of younger siblings
- Lack of ability to afford Childcare
- Nothing surprising in the RHA overview
- No surprises
- Need education and focus on marijuana
- We need to make an impact on education, transportation, and the health system
- Community pride is powerful
- Need to improve branding in La Pine
- High alcohol use
- STIs
- High mortality rates for chronic issues
- High suicide rated in mid-life
- Cancer
- Double suicide mortality in Native Americans!

- Lack of physical activity
- Poor lifestyle choices
- Low immunization rates
- Tooth decay surprising: child health issues may not be a parent priority
- Drowning of children- not supervised?
- Lack of care in first trimester: Lack of education?

Redmond Community Meeting

- Need to find a way to engage youth; give responsibility, keep busy. This could help decrease use of drugs and alcohol
- We should invest resources in our Youth. It's an investment for the future
- Beer culture could be dangerous- for youth
- Need to focus on prevention
- Need to find a way to engage the retired population and the people who want to volunteer in ways to help improve health.
- Meds are an easy solution for hypertension – need to bring people around this
- Death rate for co-occurring is high (45 years!)
- No perceived risk of marijuana
- Traffic fatalities high
- Deschutes County vaccination rates low

Feedback on Regional Health Assessment Findings

All feedback was reviewed by OPS council members, and additions, modifications, or alterations made based on community and partner feedback.

Example of email sent to receive feedback (one amongst many saying with similar request)

From: Jane Smilie
Sent: Monday, July 20, 2015 5:14 PM
To: _HS Managers
Subject: For Your Review: Updated RHA
Importance: High

All,

Attached is the most recent DRAFT version of the Central Oregon Regional Health Assessment (RHA). Please review it and send your final feedback as indicated below.

If you feel there are key partners and constituencies who would like a chance to review it, please feel free to distribute it with an invitation to do so. (Key community partners involved in CCO/COHC work have already received it.) You may also want to distribute it to your staff.

Please send comments, suggestions, and feedback to info@cohealthcouncil.org by **July 27, 2015**. People can use the attached feedback sheet to organize their thoughts and send them to us.

The RHA document is intended to examine and describe the health status of Central Oregonians, and highlight key health issues in the region. Data and information outlined in the RHA will be used to inform development of the Central Oregon Regional Health Improvement Plan (RHIP). The RHIP will be developed this summer/early fall with input from community members and community health system partners, and will set priorities to improve the health status of Central Oregonians, including enhancing health services, programs, policies, and resources.

We appreciate your participation in this process. Thank you.

Jane Smilie, Lindsey Hopper, Maggie O'Connor, Nikole Zogg, Jeff Davis, Tom Machala, Muriel DeLaVergne-Brown, Kate Wells

Community Partners who provided input include;

Rick Trelevan, Best Care, Executive Director

Leslie Neugebauer, Pacific Source, Central Oregon CCO Director

Nikki Zogg, Advantage Dental, Central Oregon Regional Manager, Community Liaison

Dave Huntley, Oregon Health Science University Epidemiology and Biostatistics

Chris Ogren

And many others

Groups and Partners who provided feedback on Regional Health Improvement Plan

Public Health Advisory Board, Deschutes County Health Services

Behavioral Health Advisory Board, Deschutes County Health Services

Provider Engagement Panel

Community Advisory Council

Sean Ferrell (CAC Member)

Jeff White's (CAC Member)

Operations Council Members

Appendix E

Prioritization Matrix Scoring Guide – Diseases and Health Conditions

From the information collected in the assessment and the prioritization reference guide, please rate each condition by impact, preventability/controllability, and feasibility. Use the scoring guide (below) for reference.

<table>
<tr><th colspan="7">Prioritization Matrix Scoring Guide</th></tr>
<tr><th></th><th colspan="2">Impact</th><th colspan="2">Preventability/Controllability</th><th colspan="2">Feasibility</th></tr>
<tr><td>What to Reference</td><td colspan="2">Based on <u>factors 1-6 in</u> the reference guide, how does this disease or condition impact the population?
Factors 1-6:
• Percent of population with problem
• Hospitalizations
• Estimated Costs
• Mortality
• YPLL</td><td colspan="2">Does evidence exist that this disease or condition can be prevented or controlled?
• Impact of/ability to influence health behaviors
• U.S. Preventive Task Force Recommendations
• Community Guide to Preventive Services
• Clinical Guidelines
• Prevention opportunities
• National Guidelines from CDC, SAMSHA, etc.</td><td colspan="2">If a prevention strategy exists, is it feasible for the Central Oregon health system partners to apply?
• Past experience
• Community willingness to use intervention/ change
• Political/ legal considerations
• CCO Metric or Healthy People 2020 Objective (Factor 7 in reference guide)
• Community theme (Factor 8 in reference guide)</td></tr>
<tr><td rowspan="4">How to Score</td><td>3</td><td>High Impact</td><td>3</td><td>Very Preventable/ Controllable</td><td>3</td><td>Very Feasible</td></tr>
<tr><td>2</td><td>Some Impact</td><td>2</td><td>Preventable/ Controllable</td><td>2</td><td>Feasible</td></tr>
<tr><td>1</td><td>Little Impact</td><td>1</td><td>Moderately Preventable/ Controllable</td><td>1</td><td>Moderately Feasible</td></tr>
<tr><td>0</td><td>No Impact</td><td>0</td><td>Not Preventable/ Controllable</td><td>0</td><td>Not Feasible</td></tr>
</table>

SCORE DISEASES/CONDITIONS WITH FOLLOWING MATRIX

Modified Hanlon Method: Prioritization scoring				
Condition	**Impact = A** **Based on factors 1-6 in the reference guide, how does this disease or condition impact the population?** Factors 1-6: • Percent of population with problem • Hospitalizations • Estimated Costs • Mortality • YPLL	**Preventability/ Controllability = B** **Does evidence exist that this disease or condition can be prevented or controlled?** • Impact of/ability to influence health behaviors • U.S. Preventive Task Force Recommendations • Community Guide to Preventive Services • Clinical Guidelines • Prevention opportunities • National Guidelines from CDC, SAMSHA, etc.	**Feasibility = C** **If a prevention strategy exists, is it feasible for the Central Oregon health system partners to apply?** • Past experience • Community willingness to use intervention/ change • Political/ legal considerations • CCO Metric or Healthy People 2020 Objective (Factor 7 in reference guide) • Community theme (Factor 8 in reference guide)	**Priority Score = A + B + C**

Scored topics for Diseases and Health Conditions included:

Asthma	Diarrheal disease	Low birth weight and preterm birth	Suicide	Vaccine preventable diseases childhood (ex: pertussis)
Cancer	Healthcare Associated Infections	Poor mental health	Unintended pregnancy	Vaccine preventable disease adults (ex: influenza)
Cardiovascular disease	Hepatitis C (past or present)	Poor oral health	Unintentional injuries adults	
Diabetes	Lead poisoning	STIs	Unintentional injuries children	

Prioritization Matrix Scoring Guide – Social Determinants

From the information collected in the assessment and the prioritization reference guide, please rate each condition by impact and feasibility. Use the scoring guide (below) for reference.

	Impact		Feasibility	
What to Reference	**Based on factors 1-3 in the reference guide for social determinants, how does this impact the population?** Factors 1-3: • Percent of population affected • Estimated Costs • Mortality		**Is it feasible for the Central Oregon health system partners to address this social determinant?** • Past experience • Community willingness • Political/ legal considerations • Community theme (Factor 4 in reference guide) • CCO Measures (Factor 5 in the reference guide)	
How to Score	**3**	High Impact	**3**	Very Feasible
	2	Some Impact	**2**	Feasible
	1	Little Impact	**1**	Moderately Feasible
	0	No Impact	**0**	Not Feasible

SCORE CONDITIONS WITH FOLLOWING MATRIX

C = Priority Score, A = Impact, B = Feasibility

Condition	Impact = A	Feasibility = B	Score = A + B
	Based on factors 1-3 in the reference guide for social determinants, how does this impact the population? **Factors 1-3:** • Percent of population affected • Estimated Costs • Mortality	**Is it feasible for the Central Oregon health system partners to address this social determinant?** • Past experience • Community willingness • Political/ legal considerations • Community theme (Factor 4 in reference guide) • CCO Measures (Factor 5 in reference guide)	

Scored topics for Social Determinants included:

Lack of access to transportation	Poverty	High school graduation	Uninsured
Poor air quality	Homelessness	Early Childhood Ed and Development	Primary care home
Availability of quality housing	Employment	Adverse Childhood Experiences	
Crime and violence	Food insecurity		

Reference Guide for Prioritization-Diseases and Health Conditions

Disease or Condition	1. Percent of Population with Health Problem (Incidence/ Prevalence)	2. Number of Hospitalizations per year	3.Estimated Costs related to Condition	4.Mortality (# of Deaths)	5.YPLL (Years of Potential Life Lost)	6. Health Behaviors Contributing to the Disease or Condition	7. CCO or Healthy People 2020 Measures	8. Community Theme (Y or N)
Asthma	8%-24%	94 (2013)	$3,300 /person with asthma/yr major cause of missed school days	3/yr	13 (2013 CO)	Smoking, overweight/obesity, lack of breastfeeding, poor mental health	CCO: • Medical assistance with smoking cessation • Adult asthma admission rate	Y
Cancer	10-12% ever had cancer		Average $3,039/pt/yr (primary secondary claims-CO PacificSource-no RX)	391	2,644 (2013 CO)	Smoking, tobacco use, overweight/obesity, overuse of alcohol, tanning, physical inactivity, poor diet, lack of breastfeeding, poor mental health, ACEs, lack of vaccine,	CCO: • Colorectal Cancer Screening • Medical assistance with smoking cessation • Cervical cancer screening	Y

Disease or Condition	1. Percent of Population with Health Problem (Incidence/ Prevalence)	2. Number of Hospitalizations	3.Estimated Costs related to Condition	4.Mortality (# of Deaths)	5.YPLL (Years of Potential Life Lost)	6. Health Behaviors Contributing to the Disease or Condition	7. CCO or Healthy People 2020 Measures	8. Community Theme (Y or N)
						participation in screenings		
Cardiovascular disease	~2.0-2.5%	1351 (heart disease), 362 (stroke)	~$1,500 /pt/yr (pacificsource CCO-CO)	189	1,222 (heart disease), 118 (stroke) (2013 CO)	Smoking, overweight/obesity, physical inactivity, overuse of alcohol, poor diet, poor mental health, ACEs	CCO: • Controlling high blood pressure • Medical assistance with smoking cessation • Congestive heart failure admission rate	Y
Diabetes	4.5-8.4%	235 (primary)	$930/pt/yr (pacificsource CCO-CO)	64	467 (2013 CO)	Overweight/obesity, poor diet, physical inactivity, poor mental health, smoking	CCO: • HbA1c Poor Control • Medical assistance with smoking cessation • LDL-C Screening • Hemoglobin A1c testing • Diabetes, short term complication admission rate	Y
Diarrheal disease	Average: 56/yr Campy. 3/yr crypto. 13/yr STEC 31/yr Giardia. 19/yr salmo.	4% of salmonella hospitalized ~15% of campy. hospitalized	$2,300/campy case (medical) $3,600/salmonella $900/crypto[5]			Poor food handling, poor water quality, lack of sanitation	HP2020: • Reduce infections caused by key pathogens that are transmitted through food	N

	4/yr shigell.							
Healthcare Associated Infections	6 CLABSI 2 CBCG 6 COLO 2 HPRO 6 KRPO 7 LAM 60 HO-CDI		$20,000-25,000 per HAI[3]				HP2020: • Reduce CLABSI, reduce MRSA	N
Hepatitis C (past or present)	~250 (2013)		$1,850-$6,000 depending on stage/pt/yr	18	281 (2013 CO)	Injection drug use (illegal/ prescription drugs), exposure to items contaminated with blood, unprotected sex	• Increase % population aware of Hepatitis C infection	N
Disease or Condition	**1. Percent of Population with Health Problem** (Incidence/ Prevalence)	**2. Number of Hospitalizations**	**3.Estimated Costs related to Condition**	**4.Mortality** (# of Deaths)	**5.YPLL** (Years of Potential Life Lost)	**6. Health Behaviors Contributing to the Disease or Condition**	**7. CCO or Healthy People 2020 Measures**	**8. Community Theme (Y or N)**
Lead poisoning	2.5% >=5ug/dL (US-NHANES, children)		$43 billion in the US[6]			Poor housing	HP2020: • Reduce blood lead levels in children	N
Low birth weight and pre-term births	8.1% LBW 10.1% pre-term		LBW: $260,000/yr in CO[8] Pre-term: $1.5 million in CO/yr[7]	23% Very LBW die in first year, 5% LBW die in first year of life[10] 35% of all		Smoking, use of alcohol, use of illegal/prescription drugs, lack of prenatal care, poor diet	CCO measures: • Timeliness of prenatal care • Elective delivery before 39 weeks • Medical assistance with tobacco use cessation HP 2020:	Y

				infant deaths are pre-term[7]			• Reduce low birth weight (LBW) and very low birth weight (VLBW)	
Poor mental health	21-25% depression ~5% SMI	21% of non-maternal hospitalizations involved MD	Costs due to lost wages, increased medical costs,		Co occurring SMI and substance abuse had average age of death of 45 (20 years YPLL before age 65 years)	ACEs, use of illegal drugs	CCO measures: • Alcohol or substance misuse • Depression screening and follow-up plan • Follow-up hospitalization for mental illness • Mental, physical, and dental health assessments within 60 days for children in DCHS custody • Follow-up care for children prescribed ADHD meds	Y

Disease or Condition	1. Percent of Population with Health Problem (Incidence/ Prevalence)	2. Number of Hospitalizations	3.Estimated Costs related to Condition	4.Mortality (# of Deaths)	5.YPLL (Years of Potential Life Lost)	6. Health Behaviors Contributing to the Disease or Condition	7. CCO or Healthy People 2020 Measures	8. Community Theme (Y or N)
Poor oral health	72%-78% of 8th graders ever had a cavity		$2000-$6000 (lifetime cost to treat one decayed molar) --major cause of missed school days			Smoking, tobacco use, poor diet	CCO: • Dental sealants on permanent molars for children • Mental, physical, and dental health assessments within 60 days for children in DCHS custody	Y

							HP2020: • Reduce the proportion of children and adolescents who have dental caries experience in their primary or permanent teeth • Reduce the proportion of adults with untreated dental decay	
STIs	721 cases Chlamydia 4 cases early syphilis 79 cases gonorrhea 6 cases HIV		Cost per case[4] of: Chlamydia: $244 (F) $20 (M) Gonorrhea: $266 (F) $53 (M) Syphilis: $444			Unprotected sex, overuse of alcohol, injection drug use, lack of vaccine	CCO: • Chlamydia screening in women ages 16-24	N
Suicide	Average of 38/yr in CO			38/yr	965 (2013)	Poor mental health	CCO: • Follow-up hospitalization for mental illness • HP2020: Reduce suicide rate	Y

Disease or Condition	1. Percent of Population with Health Problem (Incidence/ Prevalence)	2. Number of Hospitalizations	3.Estimated Costs related to Condition	4.Mortality (# of Deaths)	5.YPLL (Years of Potential Life Lost)	6. Health Behaviors Contributing to the Disease or Condition	7. CCO or Healthy People 2020 Measures	8. Community Theme (Y or N)
Unintended pregnancy	41.7%		$2.6 million in CO/yr [9]			Unprotected sex, improper	CCO: • Effective contraceptive	N

Updated: 11/30/15

						use of contraception	use among women at risk of unintentional pregnancy	
Unintentional injuries adults		~78/yr: MVC ~485/yr: falls	$422 million in OR (2005) productivity and medical $35,000/hospitalization for fall	~78 deaths/yr: MVC; 3.6 deaths/100,000: RX opioid 11.4 deaths/100,000: Falls 7.8 deaths/100,000		Lack of personal protective equipment (seatbelt, helmet), recreational/misuse prescription drugs, overuse of alcohol	CCO: • Alcohol or Substance misuse HP 2020 goals: • Reduce the number of deaths due to MVC • Prevent increase in number of deaths due to falls	N
Unintentional injuries children	<5 deaths/yr	43 (2013) only ages 0-14yrs		<5 (CO-2013)		Lack of personal protective equipment (PFD, helmet, car seat)	HP 2020: • Increase age-appropriate vehicle restraint system use in children	N
Vaccine preventable diseases childhood (ex: pertussis)	69 cases (2014-CO)	3% of adults are hospitalized =~2 in CO	$2,200/case (2008 $ based on NE experience)			Exemptions, lack of vaccine acceptance	CCO: • Childhood immunization status • Immunizations for adolescents	Y
Vaccine preventable disease adults (ex: influenza)	5%-20% of population depending on the year			25 (CO-2013)	98 (CO-2013)	Lack of vaccine provision	HP 2020: • Increase the percentage of children and adults who are vaccinated annually against seasonal influenza	N

1. http://www.cdc.gov/obesity/data/adult.html
2. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb137.pdf
3. http://www.cdc.gov/HAI/pdfs/hai/Scott_CostPaper.pdf
4. https://www.guttmacher.org/pubs/journals/3601104.html
5. http://www.ers.usda.gov/data-products/cost-estimates-of-foodborne-illnesses.aspx#48498
6. http://www.who.int/ceh/publications/leadguidance.pdf
7. http://www.cdc.gov/reproductivehealth/maternalinfanthealth/pretermbirth.htm
8. http://www.ncbi.nlm.nih.gov/pubmed/17606536
9. http://www.guttmacher.org/media/nr/2011/05/19/
10. http://mchb.hrsa.gov/chusa13/perinatal-health-status-indicators/p/low-birth-weight.html

Reference Guide for Prioritization-Social Determinants

Social Determinant	1. Percent of Population Affected	2. Estimated Costs	3. Mortality	4. Community Theme (Y or N)	5. CCO Measures
Availability of quality housing	Wait list for housing vouchers of 1000s in CO Vacancy rate=1%			Y	
Crime and violence	21% OHP reported that neighborhood was "not at all" or "slightly" safe 2,367 calls to sexual and domestic violence helpline in CO in 2014	$8.3 billion (Intimate partner violence in US[8]		Y	
EDUCATION					
High school graduation	23.1% (don't graduate in 5 yr-CO)	$240,000 per non HS grad in economic costs[5]		N	
Early Childhood Ed and Development	41% of preschool eligible children in Oregon attend preschool[10]	Every public dollar spent on high-quality preschool returns $7 through a reduced		N	CCO: • Developmental screening in first 36 month of life • Well-child visit in the first 15

	45.5% had at least 6 well child visits with a HCP by age 15 mo	need for spending on other services[11]			months of life
SOCIAL AND COMMUNITY CONTEXT					
Social Cohesion - Adverse childhood experiences	~20% high ACEs score (OR adults)	Lifetime cost for each victim of child maltreatment who survived was $210,012[12]		Y	
Social Determinant	**1. Percent of Population Affected**	**2. Estimated Costs**	**3. Mortality**	**4. Community Theme (Y or N)**	**5. CCO Measures**
HEALTH AND HEALTH CARE					
Uninsured-healthcare	<1-4.6%	Uninsured are typically billed for any care they receive, often paying higher charges than the insured[13]	45,000 excess deaths in US[6]	Y	CCO: • CAHPS composite access to care • Provider access questions from the physician workforce study
Primary care home	92.6% OHP are enrolled in a PCPCH (2014)			N	CCO: • Adolescent well-care visits • Mental, physical, and dental assessments for children in DCHS custody • Patient centered primary care home enrollment • Child and adolescent access to primary care practitioners • Well-child visit in the first 15 months of life • Provider access questions from the physician workforce study

1. **http://www.ncbi.nlm.nih.gov/pubmed/21680937**
2. **http://federalsafetynet.com/poverty-and-spending-over-the-years.html**
3. **http://www.endhomelessness.org/pages/cost_of_homelessness**
4. **http://www.nokidhungry.org/problem/economic-impact**
5. **https://nces.ed.gov/pubs2012/2012006.pdf**
6. **http://news.harvard.edu/gazette/story/2009/09/new-study-finds-45000-deaths-annually-linked-to-lack-of-health-coverage/**
7. **http://newsoffice.mit.edu/2013/study-air-pollution-causes-200000-early-deaths-each-year-in-the-us-0829**
8. **http://www.cdc.gov/violenceprevention/intimatepartnerviolence/consequences.html**
9. **http://datacenter.kidscount.org/data/tables/5938-head-start-enrollment-by-age-group#detailed/2/39/false/36,868,867,133,38/1830,558,559,1831,122/12570**
10. **http://www.oregonlive.com/education/index.ssf/2015/01/oregon_ranks_no_46_for_early_c.html**
11. **http://www.ed.gov/early-learning**
12. http://www.cdc.gov/media/releases/2012/p0201_child_abuse.html
13. **http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/**

Appendix F

Crosswalk of CAC and OPS Priorities

Priority Diseases and Health Conditions	
Operations Council	***Community Advisory Council***
Diabetes	Chronic disease
Low birth weight and preterm birth	Childhood health and education
Poor oral health	Dental care/oral health
Unintended pregnancy	Childhood health and education
Cardiovascular disease	Chronic disease
Vaccine preventable diseases in children	Childhood health and education
Poor mental health	Mental health
	Asthma
Priority Health Behaviors and Systems Issues	
Operations Council	***Community Advisory Council***
Overweight/obesity/physical inactivity	Obesity/overweight
Smoking and tobacco use	
Substance use/abuse and addictions	Substance abuse
Barriers to seeking, accessing and receiving health care	Access to care
Lack of care coordination	Access to care
Priority Social Determinants	
Operations Council	***Community Advisory Council***
Early childhood education and development	Childhood health and education
Lack of access to transportation	Discussed as an aspect of access to care
Adverse childhood experiences	Adverse childhood experiences
High school graduation	Childhood health and education
Availability of quality housing	Availability and affordability of quality housing
	Homelessness
	Food insecurity

Appendix G

Crosswalk to Focused RHIP Priorities

RHIP Priority Causes/Drivers*	RHIP Priority Diseases and Health Conditions/Outcomes								
	CHRONIC DISEASE				CHILDHOOD HEALTH			ORAL HEALTH	BEHAVIORAL HEALTH
	Diabetes	**CVD**	**Asthma**	**Chronic Pain**	**Low-Birth Weight and Pre-Term Birth**	**Unintended Pregnancy**	**Vaccine Preventable Disease**	**Oral Health**	**Behavioral Health**
Health Behaviors	O/O SU Tobacco	O/O SU Tobacco	O/O Tobacco	SU O/O	Tobacco SU	SU	N/A	SU O/O Tobacco	SU O/O Tobacco
Social/Env. Determinants	Housing FI TD	Housing FI TD	Housing	TD	ECD HSG Housing	ECD HSG	N/A	ACEs (see below)	Housing FI
Drivers specific to children's health outcomes by condition	Childhood O/O	Childhood O/O	Housing O/O	N/A	N/A	N/A	Barriers to care	Barriers to care	ACEs (see below)
ACEs & Systems Issues (Barriers to Care, Transportation, Lack of Care Coordination) **These are foundational drivers, must address at a systems level for optimal impact**									

KEY *** Priority Drivers = What is causing or making outcomes worse, factors to impact to improve health outcomes**

Substance Use (SU) = use, abuse and addiction
Overweight/Obesity (O/O) = physical inactivity and/or poor nutrition
Tobacco = Smoking or other forms
Transportation Disadvantage (TD)
Early Childhood Development (ECD)
Food Insecurity/Access to Food (FI)

Lack of Care Coordination (LCC)
Barriers to care = Seeking, accessing and/or receiving care
(e.g. immunization rates in children impacted by parents not seeking care)
Adverse Childhood Experiences (ACEs) =multiple factors
High School Graduation (HSG)
Housing = safe, clean affordable/accessible

Appendix H

Final Priorities and Structure for Development of Goals and Strategies

Regional Health Improvement Plan: Implementation Strategies for Prioritized Health Concerns

	Diabetes	Cardiovascular Disease	Behavioral Health Identification & Awareness	Behavioral Health Substance Abuse & Chronic Pain	Oral Health	Reproductive/Maternal Health (Unintended Pregnancy, Pre-Term Birth, & Low Birth Weight)
Intervention (Hotspot)	**Goal**: **Measurement**: **Strategies**:	**Goal**: **Measurement**: **Strategies**:	**Goal**: **Measurement**: **Strategies**:	**Goal**: **Measurement**: **Strategies**:	**Goal**: **Measurement**: **Strategies**:	**Goal**: **Measurement**: **Strategies**:
Prevention (Upstream)	**Goal**: **Measurement**: **Strategies**:	**Goal**: **Measurement**: **Strategies**:	**Goal**: **Measurement**: **Strategies**:	**Goal**: **Measurement**: **Strategies**:	**Goal**: **Measurement**: **Strategies**:	**Goal**: **Measurement**: **Strategies**:
Health behaviors (drivers) that affect this priority						
Social determinants that affect this priority						
How does the priority affect Childhood Health (0-18 years)?						