Healthy Columbia Willamette: Assessing Community Needs, Improving Health

OPHA Annual Meeting
October 15th, 2013
Panelists

- Rachel Burdon, *Kaiser Permanente*
- Priscilla Lewis, *Providence Health & Services*
- Sunny Lee, *Clackamas County Public Health Division*
- Paul Lewis, *Clackamas County Public Health Division*
Healthy Columbia Willamette: Making Collective Impact Work for Healthier Communities

Priscilla Lewis

Providence Health & Services
HCW: Meeting the Conditions for Collective Impact and Community Success

- Collective Impact is more rigorous and specific than collaboration among organizations.
- There are Five Conditions of Collective Impact Success
5 Conditions

- *Common Agenda*: shared vision for change
- *Shared Measurement*: Collecting data and measuring results consistently
- *Mutually Reinforcing Activities*: differentiated while still being coordinated
- *Continuous Communication*: Consistent and open communication
- *Backbone Organization*: serve as the backbone for the entire initiative and coordinate participating organizations and agencies
Condition #1

- **Mutually Reinforcing Activities**: Participant activities must be **differentiated while still being coordinated** through a mutually reinforcing plan of action

- HCW: 20 Public and Private NFP organizations that all have CHNA and CHIP requirements
Condition #2

- **Shared Measurement**: Collecting data and measuring results consistently across all participants ensures efforts remain aligned and participants hold each other accountable.
- So far we have logged 1,600 epidemiologist hours.
- Common measurement has been foundational.
- Still surprises.
Condition #3

- **Common Agenda**: All participants have a shared vision for change including a common understanding of the problem and a joint approach to solving it through agreed upon actions.

- The shared vision has been the most exciting part of this work – evoked “sense of possibility”
Condition #4

- *Continuous Communication*: Consistent and open communication is needed across the many players to build trust, assure mutual objectives, and appreciate common motivation

- Monthly meetings, 3 year MOU’s, stable membership, website, full time project team
Condition #5

- **Backbone Organization**: Creating and managing collective impact requires a separate organization(s) with staff and a specific set of skills to serve as the backbone for the entire initiative and coordinate participating organizations and agencies.

- [www.healthycolumbiawillamette.org](http://www.healthycolumbiawillamette.org)
Regional Community Health Needs Assessment

Sunny Lee, MPH
Epidemiologist
Clackamas County Public Health Division
<table>
<thead>
<tr>
<th><strong>Healthy Columbia Willamette Year 1:</strong> Regional Health Issues Selection</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessments</strong></td>
</tr>
<tr>
<td>Access to Affordable Health Care</td>
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<td>Substance Abuse</td>
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Mobilizing for Action through Planning and Partnerships

- "A community-driven strategic planning process for improving community health"

- Used to identify the most important community health issues
  - Community input, qualitative input, strategic planning, measures to improve community health
Modified MAPP Model

1. Community themes & strengths assessment
2. Health status assessment
3. Local community health system assessment
4. Forces of change assessment

Prioritized community health needs

Leadership group selects community health needs to be addressed

Strategies

Improved health of community

Solicit input from content experts about best practices

Solicit input from target or vulnerable communities about priority needs before finalizing

Hospital, Public Health & Community capacity to address community health needs
Modified MAPP Model

Themes & strengths assessment (qualitative)

Health status assessment

Local community health system assessment

Forces of change assessment

Prioritized community health needs

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Themes & strengths assessment *(qualitative)*

“What is important to our community?”

“How is quality of life perceived in our community?”

Community-Identified Health-Related Themes

“What assets do we have that can be used to improve community health?”
Community Themes and Strengths Assessment: Methodology

- Inventory of previously completed community engagement projects
- Four inclusion criteria (n = 62):
  - Designed to explore health-related needs
  - Completed within last 3 years (since 2009)
  - Had geographic scope within four-county region
  - Engaged individual community members
- Themes ranked by how many reports it was identified in
Community Themes and Strengths Assessment: Results—Identified Health Themes

Social Environment
Equal Economic Opportunities
Access to Affordable Health Care
Education
Access to Healthy Food
Housing
Mental Health & Substance Abuse
Poverty
Early Childhood/Youth
Chronic Disease
Safe Neighborhood
Transportation Options
Modified MAPP Model

Community themes & strengths assessment

Health status assessment (quantitative)

Local community health system assessment

Forces of change assessment

Prioritized community health needs

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Health status assessment (quantitative)

“How healthy are our residents?”

“What does the health status of our community look like?”

Prioritize health status issues
Community Health Status Assessment: Methodology

UPSTREAM SOCIAL FACTORS

SOCIO-ECON. CONDITIONS
- Income/poverty
- Education
- Race/ethnicity
- Gender
- Immigration status
- Power
- Community engagement

NEIGHBORHOOD CONDITIONS
- Built Env’t
  - Transport
  - Land use
- Community
  - Networks
  - Peers
  - Segregation/isolation

DOWNSTREAM HEALTH STATUS

RISK BEHAVIOR
- Smoking
- Nutrition
- Physical Activity
- Violence

DISEASE & INJURY MORBIDITY
- Infectious disease
- Chronic disease (physical & mental/behavioral)
- Injury

MORTALITY
- Death rates
- Premature death
- Disparities

Adapted from “Framework for understanding and measuring health inequalities”, Bay Area Regional Health Inequities Initiative
INDICATORS:
HEALTH OUTCOMES & BEHAVIORS

Health indicators from public data sources

Other indicators identified through consultation with colleagues

Leading causes of death

ANALYSIS CRITERIA
- racial/ethnic disparities
- gender disparities
- comparison to state value
- trend
- magnitude
- severity
Community Health Status Assessment: Methodology cont’d

- All criteria weighted equally
- Possible high score of 6
- Health indicators ranked by score for each county
- Regional health indicator ranking created by averaging individual scores of 4 counties
- Indicators grouped into health issues

<table>
<thead>
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<th>ANALYSIS CRITERIA</th>
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<td>trend</td>
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<tr>
<td>comparison to state value</td>
<td>severity</td>
</tr>
</tbody>
</table>
## Community Health Status Assessment: Results—Top Regional Indicators

<table>
<thead>
<tr>
<th>Rank</th>
<th>Score</th>
<th>Health Outcomes</th>
<th>Rank</th>
<th>Score</th>
<th>Health Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>5.3</td>
<td>Non-transport accident deaths</td>
<td>1</td>
<td>4.0</td>
<td>Adult fruit/vegetable consumption</td>
</tr>
<tr>
<td>2</td>
<td>4.7</td>
<td>Suicide</td>
<td>2</td>
<td>3.7</td>
<td>Adults doing regular physical activity</td>
</tr>
<tr>
<td>2</td>
<td>4.7</td>
<td>Chlamydia incidence rate</td>
<td>3</td>
<td>3.0</td>
<td>Adults with health insurance</td>
</tr>
<tr>
<td>4</td>
<td>4.4</td>
<td>Breast cancer deaths</td>
<td>4</td>
<td>2.4</td>
<td>Adults with usual source of health care</td>
</tr>
<tr>
<td>4</td>
<td>4.4</td>
<td>Heart disease deaths</td>
<td>5</td>
<td>2.1</td>
<td>Adults males who binge drink</td>
</tr>
<tr>
<td>4</td>
<td>4.4</td>
<td>Unintentional injury deaths</td>
<td>6</td>
<td>2.0</td>
<td>Mothers receiving early prenatal care</td>
</tr>
<tr>
<td>7</td>
<td>4.3</td>
<td>Drug-related deaths</td>
<td>7</td>
<td>1.6</td>
<td>Adults who smoke</td>
</tr>
<tr>
<td>8</td>
<td>4.1</td>
<td>Diabetes-related deaths</td>
<td>8</td>
<td>1.4</td>
<td>Children with health insurance</td>
</tr>
<tr>
<td>9</td>
<td>3.9</td>
<td>Prostate cancer deaths</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>3.9</td>
<td>Alzheimer’s disease deaths</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>3.9</td>
<td>Adults who are obese</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>3.9</td>
<td>All cancer deaths</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Solid Line: strong relationship based on scientific studies
Dotted Line: weaker links with less supporting evidence

HEALTH BEHAVIOR INDICATORS:
- Mothers receiving early prenatal care
- Adults with health insurance
- Adults with a usual source of health care
- Adults who binge drink: males
- Adults who smoke
- Adult fruit & vegetable consumption
- Adults doing regular physical activity

HEALTH OUTCOME INDICATORS:
- Chlamydia incidence rate
- Drug-related deaths
- Suicide
- Unintentional injury deaths
- Non-transport accident deaths
- Breast cancer deaths
- Heart disease deaths
- Diabetes-related deaths

HEALTH ISSUES:
- Access to affordable health care
- Sexual health
- Mental health (including substance abuse)
- Injury
- Cancer
- Chronic disease: nutrition- & physical activity-related

Mental health (including substance abuse) is connected to Suicide, Unintentional injury deaths, and Non-transport accident deaths.
Modified MAPP Model

Community themes & strengths assessment

Health status assessment

Local community health system assessment

Forces of change assessment

Prioritized community health needs

Hospital, Public Health & Community capacity to address community health needs

Leadership group selects community health needs to be addressed

Strategies

Improved health of community

Solicit input from content experts about best practices

Solicit input from target or vulnerable communities about priority needs before finalizing
Modified MAPP Model

Local community health system assessment

Forces of change assessment

“What are the components, activities, competencies, and capacities of our local public health system?”

“What is occurring or might occur that affects the health of our community or the local public health system?”

Assess local community health system’s client needs & capacity to address health needs
Local Community Health System & Forces of Change Assessment: Methodology

- Stakeholder list (N=126) was developed from CHNA requirements of HCW members

- Interview (n=69) and survey (n=57) questions:
  - Health of population served
  - Name health issues not identified by previous assessments
  - Rank top three health issues
    - Current and future work related to the issue
    - Factors that may help and hinder their organization’s ability to address the issue
    - Organizational capacity to address the issue

- Prioritized issues: 30% of respondents
## Local Community Health System & Forces of Change Assessment: Results—Health Issues

<table>
<thead>
<tr>
<th>LCHS-Identified Health Issue</th>
<th>Interview (n=69)</th>
<th>Survey (n=57)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Health Care</td>
<td>50 (72%)</td>
<td>38 (67%)</td>
</tr>
<tr>
<td>Mental Health</td>
<td>44 (64%)</td>
<td>38 (67%)</td>
</tr>
<tr>
<td>Chronic Disease</td>
<td>45 (65%)</td>
<td>20 (35%)</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>44 (64%)</td>
<td>15 (26%)</td>
</tr>
<tr>
<td>Culturally Competent Services/Data</td>
<td>4 (6%)</td>
<td>19 (33%)</td>
</tr>
</tbody>
</table>
# Local Community Health System & Forces of Change Assessment: Results—Capacity

<table>
<thead>
<tr>
<th>Frequent Activities</th>
<th>Needed Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Collaborate with others to identify strategies to address health issues</td>
<td>• Partnerships with other organizations</td>
</tr>
<tr>
<td>• Provide services to individuals</td>
<td>• Increased availability of services</td>
</tr>
<tr>
<td>• Help clients navigate the health care/social service system</td>
<td>• Health care reform</td>
</tr>
<tr>
<td>• Work to coordinate care</td>
<td>• Expanded access to Medicaid or other insurance</td>
</tr>
<tr>
<td>• Policy advocacy for the community</td>
<td>• Advocacy, new legislation, and political support</td>
</tr>
<tr>
<td></td>
<td>• Funding</td>
</tr>
<tr>
<td></td>
<td>• Raise public awareness and interest in the issue</td>
</tr>
</tbody>
</table>
Modified MAPP Model

1. Community themes & strengths assessment
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4. Forces of change assessment

Prioritized community health needs

Hospital, Public Health & Community capacity to address community health needs

Leadership group selects community health needs to be addressed

Strategies

Improved health of community

Listening Sessions

Solicit input from content experts about best practices
Modified MAPP Model

Verify identified health issues with vulnerable communities

“What does a healthy community look like to you?”

“What are the five health issues that you would like to see addressed first?”
Community Listening Sessions: Methodology

- Targeted no/low-income and/or uninsured population
- Distributed recruitment flyers to organizations and community-accessible locations
- At least three sessions per county
- Hospital partners provided food, childcare, and gift card incentives
- Language services on-site: Spanish, Somali, Russian
- Voluntary exit surveys given to participants
### Community Listening Sessions: Methodology (cont’d)

- **Small group questions**
  - What does a healthy community look like to you?
  - Are there other health issues that you think should be on this list?

<table>
<thead>
<tr>
<th>Health Issue</th>
<th>Issue Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to affordable dental care</td>
<td>Perinatal health</td>
</tr>
<tr>
<td>Access to affordable health care</td>
<td>Injuries from falling</td>
</tr>
<tr>
<td>Access to affordable mental health services</td>
<td>Mental health</td>
</tr>
<tr>
<td>Access to services that are relevant/specific to different cultures</td>
<td>Oral health</td>
</tr>
<tr>
<td>Accidental poisoning from chemicals, pesticides, gasses, fertilizers, etc.</td>
<td>Data collection on the health of people from various cultures</td>
</tr>
<tr>
<td>Cancer</td>
<td>Sexually transmitted infections/diseases</td>
</tr>
<tr>
<td>Chronic disease and related health behaviors</td>
<td>Substance abuse</td>
</tr>
</tbody>
</table>

- What are the five health issues that you would like to see addressed first? (vote)
- What should be done to fix or address these health issues?
Community Listening Sessions: Results—Participant Demographics

- 14 sessions conducted
- 202 total participants (mean: 14, range: 1-34)
- Composition of participants not represented equally in region
  - 53% Hispanic, 25% White, 7% African, 6% African American, 2% Native American, 1% Asian, 1% Native Hawaiian/Pacific Islander
- 62% from households earning less than $20,000
## Community Listening Sessions: Results—Health Issues

<table>
<thead>
<tr>
<th>Top Five Issues</th>
<th>Community-Supported Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Mental Health</td>
<td>Promote <em>social practices</em> that work against social isolation, stigma, and anxiety</td>
</tr>
<tr>
<td>2. Chronic Disease (nutrition, physical activity related)</td>
<td>Build <em>affordable community</em> programs promoting physical activity for all ages and nutritious options in convenience &amp; grocery stores; farmers markets, <em>community</em> gardens; limit SNAP options; disease risk factors &amp; symptom <em>education</em></td>
</tr>
<tr>
<td>3. Substance Abuse</td>
<td>Create centralized treatment services as part of comprehensive treatment plan; raise <em>community</em> awareness of issues &amp; treatment; work with elementary schools to develop strong anti-drug <em>curriculum; policies</em> restricting access</td>
</tr>
<tr>
<td>4. Access to Affordable (and convenient) Health Care</td>
<td><em>Lower rates</em> for health services not covered by insurance; more <em>affordable</em> health insurance coverage; <em>sliding fee scale</em>; extend hours of operation; <em>lower cost of/incentivize preventive</em> screenings, routine checkups so low-income persons avoid waiting until require <em>costly</em> emergency procedures</td>
</tr>
<tr>
<td>5. Oral Health and Access to Oral Health Services</td>
<td><em>Drop provider prices</em> specifically for <em>preventive</em> services and/or offer <em>payment plans</em> for costly ones; <em>expand</em> insurance coverage—eligibility and geography</td>
</tr>
<tr>
<td>Top Five Issues</td>
<td>Affordability</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td><strong>1. Mental Health</strong></td>
<td></td>
</tr>
<tr>
<td><strong>2. Chronic Disease (nutrition, physical activity related)</strong></td>
<td>Grocery stores</td>
</tr>
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<td><strong>3. Substance Abuse</strong></td>
<td></td>
</tr>
<tr>
<td><strong>4. Access to Affordable (and convenient) Health Care</strong></td>
<td>• Lower rates for insurance</td>
</tr>
<tr>
<td><strong>5. Oral Health and Access to Oral Health Services</strong></td>
<td>• Drop provider prices</td>
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</table>
## Putting the Pieces Together: Regional Health Issues Selection

<table>
<thead>
<tr>
<th></th>
<th>Community Themes &amp; Strengths</th>
<th>Health Status</th>
<th>LCHS &amp; Forces of Change</th>
<th>Listening Sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access to Affordable Health Care</strong></td>
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<td><strong>Cancer</strong></td>
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<td><strong>Chronic Disease: Nutrition, Physical Activity</strong></td>
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<td>Yes</td>
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<td><strong>Oral Health</strong></td>
<td>No</td>
<td>No Data</td>
<td>No</td>
<td>Yes</td>
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Modified MAPP Model

- Community themes & strengths assessment
- Health status assessment
- Local community health system assessment
- Forces of change assessment

Prioritized community health needs

领导小组选择需要解决的社区健康需求

策略

改善社区健康状况
Strategies for Improving Community Health Together

Paul Lewis, MD, MPH
Health Officer
Clackamas County Public Health Division
How Should HCW Focus?

- Was Topic Identified in Community Engagement?
- Identified by Health Assessment?
- Expensive?
- Are there Evidence-based interventions?
## Healthy Columbia Willamette Year 1: Regional Health Issues Selection

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<tr>
<td><strong>Was the issue identified by community members or population data?</strong></td>
<td></td>
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<td></td>
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<td>Yes</td>
<td>Yes</td>
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<td>Yes</td>
</tr>
</tbody>
</table>
HCW Focus Areas for Year 2

Mental Health + Substance Abuse

Prevention of Chronic Disease through Healthy Eating and Active Living

Access to Affordable Health Care
Articulating Goals for Focus Areas

- Meaningful
- Measurable
- Address one or more disparity
Criteria for Collective Strategies

- Measurable outcomes
- Evidence-based
- Feasible in 3-5 years
- Supported by HCW members
Our Vision
Reduce suffering and deaths from mental illness

Our 2014-17 Goal
Identify preventable risk factor patterns in suicides/attempts

Our Proposed Strategies
Suicide-attempt/fatality reviews & Develop and implement relevant prevention interventions
Substance Abuse

Our Vision
Reduce frequency and severity of substance abuse

Our 2014-17 Goal
Reduce the number of opiate overdose deaths

Our Proposed Strategies
Promote adoption of uniform opiate prescribing guidelines
Access to Care

Our Vision
All people will have access to affordable health care

Our 2014-17 Goal
Support widespread enrollment in insurance expansion programs

Our Proposed Strategies
Identify populations that are lagging in enrollment and support focused outreach
Chronic Disease-Food and Exercise

Our Vision
work in progress

Our 2014-17 Goal
work in progress

Our Proposed Strategies
work in progress
Challenges and Opportunities

- Many perspectives
  - Hospitals
  - Insurers
  - Counties
  - CCOs
- Many experts
- Much room to improve

- Vision vs SMART Objectives
- Competing priorities and deadlines
- Funding and Sustainability
## Local Community Health System & Forces of Change Assessment: Results

<table>
<thead>
<tr>
<th>IRS/OHA Requirement</th>
<th>Interviews</th>
<th>Surveys</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medically underserved, underinsured, uninsured, low income, minority populations, populations with chronic disease needs &amp; other special populations</td>
<td>53%</td>
<td>56%</td>
</tr>
<tr>
<td>Federal, tribal, regional, State, or local health or other agencies</td>
<td>29%</td>
<td>17%</td>
</tr>
<tr>
<td>Area Agencies on Aging (AAAs), mental health, substance abuse, disability, aging and LGBTQI communities</td>
<td>14%</td>
<td>28%</td>
</tr>
<tr>
<td>People with special knowledge of or expertise in public health</td>
<td>4%</td>
<td>0</td>
</tr>
<tr>
<td>Population Served</td>
<td>Interviews</td>
<td>Surveys</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------</td>
<td>------------</td>
<td>---------</td>
</tr>
<tr>
<td>Medically underserved, uninsured, underinsured populations</td>
<td>56%</td>
<td>72%</td>
</tr>
<tr>
<td>Communities of color</td>
<td>74%</td>
<td>41%</td>
</tr>
<tr>
<td>Children/youth</td>
<td>43%</td>
<td>70%</td>
</tr>
<tr>
<td>Populations with mental health and/or substance abuse needs</td>
<td>45%</td>
<td>59%</td>
</tr>
<tr>
<td>Disability community</td>
<td>43%</td>
<td>47%</td>
</tr>
<tr>
<td>Populations with a chronic disease need</td>
<td>42%</td>
<td>47%</td>
</tr>
<tr>
<td>Aging community</td>
<td>46%</td>
<td>33%</td>
</tr>
<tr>
<td>Low income populations</td>
<td>61%</td>
<td>7%</td>
</tr>
<tr>
<td>LGBTQI community</td>
<td>35%</td>
<td>18%</td>
</tr>
<tr>
<td>People who are dependent on public transportation</td>
<td>1%</td>
<td>53%</td>
</tr>
<tr>
<td>Immigrants and/or refugees</td>
<td>14%</td>
<td>19%</td>
</tr>
</tbody>
</table>
Modified MAPP Model

- Community themes & strengths assessment
- Health status assessment
- Local community health system assessment
- Forces of change assessment

Prioritized community health needs

Hospital, Public Health & Community capacity to address community health needs

Leadership group selects community health needs to be addressed

Strategies

Improved health of community

Solicit input from target or vulnerable communities about priority needs before finalizing
# Listening Sessions: Preliminary Regional Issues

<table>
<thead>
<tr>
<th>Regional Community Health Issue</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>More than three quarter of individual participants</td>
</tr>
<tr>
<td>Chronic Disease (nutrition, physical activity related)</td>
<td>About two-thirds of individual participants</td>
</tr>
<tr>
<td>Oral Health (including dental care)</td>
<td>A little less than half of individual participants</td>
</tr>
<tr>
<td>Access to Affordable (and Convenient) Health Care</td>
<td>A little less than half of individual participants</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>About one quarter of individual participants</td>
</tr>
<tr>
<td>Interpersonal Violence (domestic violence, child abuse, sexual harassment, bullying)</td>
<td>A little more than 10% of participants</td>
</tr>
</tbody>
</table>
Modified MAPP Model

Community themes & strengths assessment

Health status assessment

Local community health system assessment

Forces of change assessment

Prioritized community health needs

Hospital, Public Health & Community capacity to address community health needs

Leadership group selects community health needs to be addressed

Strategies

Improved health of community

Solicit input from content experts about best practices

Solicit input from target or vulnerable communities about priority needs before finalizing
Modified MAPP Model

1. Community themes & strengths assessment
2. Health status assessment
3. Local community health system assessment
4. Forces of change assessment

Prioritized community health needs

Hospital, Public Health & Community capacity to address community health needs

Leadership group selects community health needs to be addressed

Strategies

Improved health of community

Solicit input from target or vulnerable communities about priority needs before finalizing
Community Themes and Strengths Assessment: Strengths & Limitations

Limitations
- Targeted populations
- Varied methodologies
- Selection bias
- Not representative

Strengths
- Overall scope of community engagement efforts
- Prevents duplication efforts
- Respect previous contribution of community members
Community Health Status Assessment: Limitations & Strengths

Limitations

- Differing data collection methodologies
- Self-reported surveys
- Data gaps
- Granularity
- Low counts

Strengths

- Prioritization scheme based on established methodology
- Systematic analysis across county and region
- Similar health issues prioritized across region
Local Community Health System & Forces of Change Assessment: Limitations & Strengths

Limitations

● Convenience sample
● Organizational focus affects population representation

Strengths

● Iterative process: validation of health priorities
● Addressed capacity around priorities from those who serve community members
Community Listening Sessions: Limitations & Strengths

Limitations
- Group bias
- Convenience sample
  - Number of sessions
  - Locations

Strengths
- Validation of health priorities
- Account for needs of vulnerable populations