

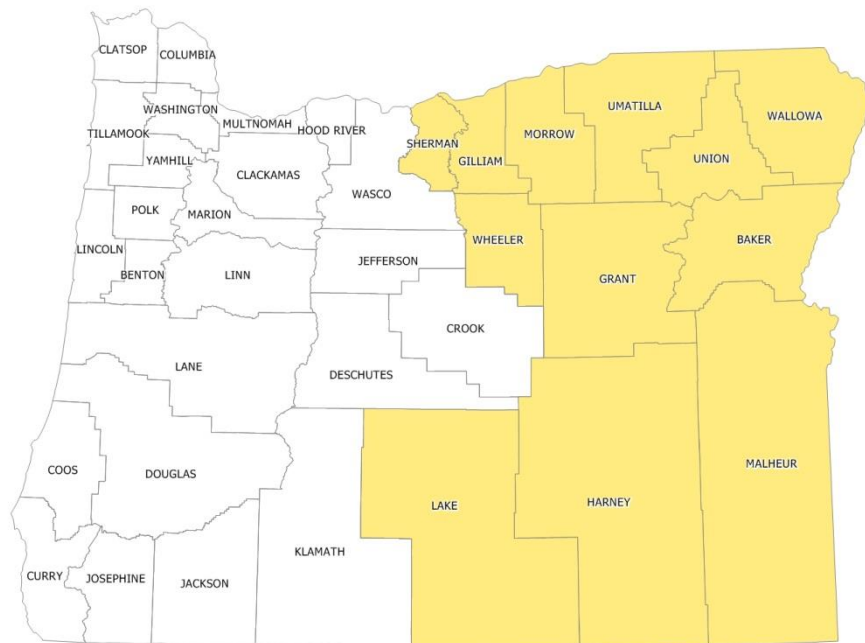
Community Advisory Council Needs Assessment Harney County - 2013

Background, Community Engagement, and Areas of Focus

Background

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

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



Map provided by Oregon Office of Rural Health

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

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

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Local Community Advisory Council Membership

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

CAC Members currently serving Harney County:

Dan Brown, Chairperson	Tim Colahan*
Fred Flippence, Vice Chair	Gail Buermann*
Shauna Hammon, Secretary	Julie Johnson
Pete Runnels, County Commissioner	Angie Lamborn
Angie Temple*	Kathy Rementeria
Stacie Rothwell*	Julie Burri
Donna Schnitker	Jen Yekel*
Kim Mills	William (Bill) Molt
David Glerup*	Chris Siegner
Barbara Rothgeb	Debi Hueckman
Carolyn Bauer	Kirsten Hoagland

*denotes current Mental Health Advisory Board

Quantitative Data Collection

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

Each LCAC partnered with local public health authority, local mental health authority, hospital systems, local public agencies, consumers, and local health service providers to develop a shared Community Health Assessment process. Existing county resources were used from community partners when available.

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

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

* Statewide lists as "Asian / Pacific Islander" and county specific data lists two group = "Asian" and "Pacific Islander."

S - Suppressed Data

Bold = County rate is higher than statewide rate (or lower if a higher rate is more positive)

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

* 2008 rate

S = Suppressed Data

Bold = County rate is higher than statewide rate (or lower if a higher rate is more positive)

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Community Engagement Process

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

Qualitative assessments help the assessment process to determine the distance between what the statistics show as a community need and what the community perceives as a need.

Following are top findings taken from Qualitative Needs Assessments reports that were conducted by Harney County Community Health Improvement Partnership (CHIP) Members in 2009:

The Community-Wide Participation Meeting

The Community-Wide Participation Meeting allows members of the community to freely voice their concerns and satisfaction with the local health care system. The meeting provides an opportunity to express their perceptions about community health issues. Most importantly, it also invites community members to share their hopes for local health care – their vision. This assessment is a modified version of the nominal group technique. The Participation Meeting helps create a vision of what can change to make the community a healthier place.

The results of the participation meeting tell us three things; **1) what residents like about the current local health care delivery system. 2) what the community does not like about the current local health care delivery system 3) what the community thinks can be done to make their community healthier.**

In July of 2009, Harney County CHIP held a Community-Wide Participation Meeting. The top issues determined by participants from that meeting are:

- 1. Recruiting Quality Health Providers**
- 2. More Focus on Healthcare Prevention Classes, Healthy Living, Personal Responsibility**
- 3. Cancer Treatment and/or Mobile Dialysis**
- 4. Need for Nursing Home**

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Key Informant Interviews

Key Informant interviews are not meant to be a statistical sampling of communities. This process gathers qualitative information – opinions, attitudes and beliefs. The concern is not with specific numbers. Hence, instead of stating “Seven key informants of the 65 interviewed perceived...” We use terms like “*many*,” “*some*,” “*majority*,” “*most*,” etc. The key is being consistent in their use. The Key Informant Interviews follow a pre-determined question guide and information presented from the Key Informant report follows this guide’s format.

In spring/summer of 2009, 77 Key Informant Assessment Interviews were conducted by CHIP members representing Burns, Hines, Crane, Drewsey, Frenchglen, and Fields.

The following are key questions and findings taken from the Key Informant report, reflecting attitudes, opinions and beliefs of participants. The findings ARE NOT intended as a statement of fact and to consider them as such would be erroneous.

- 1. What do you think/perceive as the most important health care resource problem facing Harney County residents?**
 - Affordability – *Many*
 - Chemotherapy and Oncology Services – *Many*
 - More Services/Less Travel – *Several*
 - Dialysis – *Some*
 - Retaining and Recruiting Providers – *Some*
 - Rural Health/Outreach and Access Issues - *Some*

- 2. What do you think/perceive as the most important health problem (health status) facing the Harney County area?**
 - Obesity – *Many*
 - Substance Abuse – *Many*
 - Diabetes – *Some*
 - Cancer – *Some*

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Harney Community Survey

The Harney County community survey was conducted by the Harney County Health Department in September of 2013.

Community members selected, in order of priority, the most important health concerns of their community as follows:

- Alcohol and Drug Use
- Obesity
- Ability to pay/access to insurance
- Domestic Violence/Child Abuse/Neglect

Community members selected, in order of priority, which health concerns you/your family is facing as:

- None
- Ability to pay/access to insurance
- Obesity
- Diabetes

Overall, responses were similar from findings in the nine Eastern Oregon counties which used a household mail out survey.

EOCCO County Surveys

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

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

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2013 Harney County Community Advisory Council Needs Assessment Report

Partners:

We began pulling the group together in early spring 2013. We looked at all available agencies to make sure we were covering the widest possible range of ages. Also, through agencies already giving care to patients in order to reach out to OHP utilizers. Our group formed in conjunction with our Mental Health Advisory Board and our first official meeting minutes came in May 2013.

Our partners in the group come from many areas with representation from:

Harney District Hospital Board Member and Employees
Burns Dental Group
Harney County Senior and Community Services
Public Health
SSI
Department of Human Services
Burns Paiute Tribe
Early Childhood Center
Harney School District

Data Sources

Our data sources came from Oregon Epidemiological Report on Alcohol, Drugs and Mental Health, County Health Rankings, Oregon Student Wellness Survey, County Health rankings via OHA, and local surveys done through Harney District Hospital, Burns Paiute Tribe, Symmetry Care, Early Childhood Center Data, and our Public Health Dept. Survey.

Priority Needs

Our priority needs were identified as follows:

- #1 – Obesity/Overweight**
- #2 – Mental Health**
- #3 – Chronic Disease Management**
- #4 – Social Determinants of Health**

Our priority needs were established by reviewing triangulated data and using the Forced Choice Matrix. We were quite surprised at how the top needs came out from the 10 identified health issues listed. We are now in the process of breaking up the top four priority issues into two groups.