Providence Newberg Medical Center

2019 Community Health Needs Assessment

To request a printed copy free of charge or provide feedback about this Community Health Needs Assessment, email Joseph Ichter at Joseph.Ichter@providence.org

PROVIDENCE
Newberg
Medical Center

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MESSAGE TO THE COMMUNITY/ ACKNOWLEDGEMENTS

TO OUR COMMUNITY MEMBERS,

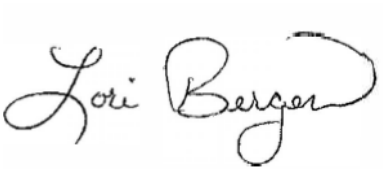
It is with great pleasure that we present the findings of our 2019 Community Health Needs Assessment. The findings within this assessment will be used to inform and create our community health improvement plan, a three-year roadmap to create positive impact in the communities we serve.

Over 160 years ago, the Sisters of Providence came to the Northwest with the goal of addressing the most pressing needs of the time. Today, through their *Hopes and* Aspirations document, the Sisters call us to "be open to the call of those who suffer by addressing emerging needs with wise and discerning responses". Providence is pleased to collaborate with many community based organizations and public sector partners to address the most pressing health and social determinant needs in each of our service areas. We are uniquely positioned to use our role as a primary, acute, and specialty care provider, insurer, and the state's largest employer, to create positive impact on the health of our communities.

We are grateful for the partnership of community organizations, survey respondents, listening session participants, interviewees, and many others in the development of these needs assessments. Addressing these challenges will require long-term commitment, systemic change, and expertise outside of the health system. Our communities have many strengths, and it is our privilege to support programs and organizations actively addressing these needs, as well as generating momentum to think differently about these services within Providence.

Finally, let us thank you for your interest in reviewing this plan and hopefully engaging in our community health improvement efforts. We believe this work is central to our strategic vision of creating healthier communities, together.

Sincerely,



Lori Bergen
Chief Executive
Providence Newberg Medical Center

EXECUTIVE SUMMARY

Understanding and Responding to Community Needs, Together

Improving the health of our communities is a commitment rooted deeply in our heritage and purpose. Our mission calls us to be steadfast in serving all with a special focus on our most poor and vulnerable neighbors. This core belief drives the programs we build, investments we make, and strategies we implement.

Knowing where to focus our resources starts with our Community Health Needs Assessment (CHNA), an opportunity in which we engage the community every three years to help us identify and prioritize the most pressing needs, assets, and opportunities. The 2019 CHNA was approved by the Providence Newberg Medical Center Service Area Advisory Council on November 19, 2019 and made publicly available on December 19, 2019

Our Starting Point: Gathering Community Health Data and Community Input

Through a mixed-methods approach using quantitative and qualitative data, the CHNA process used several sources of information to identify community needs. Across the Yamhill County community, information collected includes public health status indicators related to health behaviors, hospital discharge and utilization data, hospital mortality/morbidity, and emergency department specific primary diagnoses. In addition, 2 separate listening sessions were held involving those in underserved communities along with 10 stakeholder interviews with organizational and community leaders. A mailed Community Health Survey was conducted using an address-based random-sampling of Yamhill County residents, yielding 118 responses. Effort was made to gain input from medically underserved communities who are low-income and represent a diverse sampling of the Yamhill County population. Some key findings:

- Key social determinants of health challenges include housing, transportation, and food insecurity. Approximately 1 in 10 survey respondents reported not having stable housing or experiencing food shortages in the last year.
- Substantial health disparities exist by household income, with those at 200% FPL or below ($51,500 for a family of 4) having higher rates of many chronic health challenges.
- Diabetes, asthma, and hypertension were top reasons uninsured adults seek care in the Emergency Department.
- More than one in five survey respondents live with anxiety, with far fewer behavioral health providers available in Yamhill County compared to the Oregon ratio.
- Access to medical and dental care in rural communities is particularly challenging, with many residents having unmet health care and dental care needs.

Identifying Top Health Priorities, Together

Through a collaborative process engaging a diverse group of community members and stakeholders, hospital leadership, and Oregon Region technical expertise, the following priority areas were agreed upon:

Priority #1: Social determinants of health resulting from poverty and inequity – focus areas in housing, transportation, and food security; includes coordination of supportive services.

Priority #2: Chronic health conditions – focus on prevention of obesity, diabetes, hypertension, and depression.

Priority #3: Community mental health/well-being and substance use disorders - focus on prevention (particularly for youth), culturally responsive care and health education, social isolation, and community building.

Priority #4: Access to health services – Focus on services navigation and coordination, culturally responsive care and oral health.

PNMC will develop a 3-year Community Health Improvement Plan (CHIP) to respond to these prioritized needs in collaboration with community partners in early 2020 considering resources, community capacity, and core competencies. The 2020-2022 CHIP will be approved and made publicly available no later than May 15, 2020.

INTRODUCTION

MISSION, VISION, AND VALUES

Our Mission: *As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.*

Our Vision: *Health for a Better World.*

Our Values: *Compassion – Dignity – Justice – Excellence – Integrity*

WHO WE ARE

Providence Newberg Medical Center (PNMC) serves the city of Newberg, Oregon and greater Yamhill County. The original hospital was established in the 1994 acquisition of Newberg Community Hospital and replaced in 2006 with a new 40-bed acute care facility. Across a 56 acre campus, it includes a hospital, medical office building, and healing and wellness garden. PNMC employs more than 540 care providers and a physician staff of more than 250. Major programs and services offered to the community include general medical, surgical, diagnostic imaging, obstetrics and gynecology, pediatrics, a sleep center, and emergency department.

OUR COMMITMENT TO COMMUNITY

Organizational Commitment

PNMC dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of the economically poor and vulnerable. During 2018, PNMC provided $22,689,045 in community benefit[1,2] in response to unmet needs and to improve the health and well-being of those we serve in Yamhill County. PNMC is a part of the Providence Health & Services – Oregon, which includes the following hospital facilities: Providence Portland Medical Center, Providence Medford Medical Center, Providence St. Vincent Medical Center, Providence Milwaukie Hospital, Providence Willamette Falls Medical Center, Providence Hood River Memorial Hospital, and Providence Seaside Hospital.

PNMC further demonstrates organizational commitment to the Community Health Needs Assessment (CHNA) through the allocation of staff time, financial resources, participation, and collaboration to address community identified needs. The Providence's Oregon Region Community Health Investment lead, Joseph Ichter, DrPH, is responsible for ensuring the

[1] A community benefit is an initiative, program or activity that provides treatment or promotes health and healing as a response to identified community needs and meets at least one of the following community benefit objectives: a. Improves access to health services; b. Enhances public health; c. Advances increased general knowledge; and/or d. Relieves government burden to improve health. Note: Community benefit includes both services to the economically poor and broader community.

[2] To be reported as a community benefit initiative or program, community need must be demonstrated. Community need can be demonstrated through the following: 1) community health needs assessment developed by the ministry or in partnership with other community organizations; 2) documentation that demonstrates community need and/or a request from a public agency or community group was the basis for initiating or continuing the activity or program; 3) or the involvement of unrelated, collaborative tax-exempt or government organizations as partners in the community benefit initiative or program.

compliance Federal 501r requirements as well as providing the opportunity for community leaders and hospital leadership, physicians and others to work together in planning and implementing the resulting Community Health Improvement Plan (CHIP).

OUR COMMUNITY

Description of Community Served

Providence Newberg Medical Center (PNMC) primarily serves residents of Yamhill County. Cities include Sherwood, Newberg, Dundee, Dayton, and Lafayette, with some patients traveling from McMinnville. Given the geography of the area, all of Yamhill County is considered the primary service area for PNMC. This geography includes a population of approximately 107,000 people as of 2019, an increase of 4% from 2016. The secondary service area includes bordering zip codes of nearby Washington County.

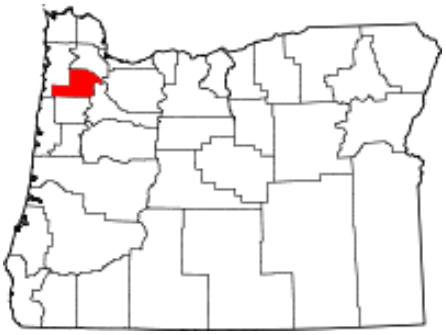
Hospital Total Service Area

The community served by PNMC is defined based not only on the patients who have visited the hospital campus, but also all those living in Yamhill County. PNMC's service area includes the following cities and zip codes:

Table 1. Cities and ZIP codes in PNMC's service area

Cities/ Communities	ZIP Codes
Amity	97101
Carlton	97111
Dayton	97214
Dundee	97115
Lafayette	97127
McMinnville	97128
Newberg	97132
Sheridan	97148
Willamina	97378
Yamhill	97396

Figure 1. PNMC's Total Service Area (Yamhill County)



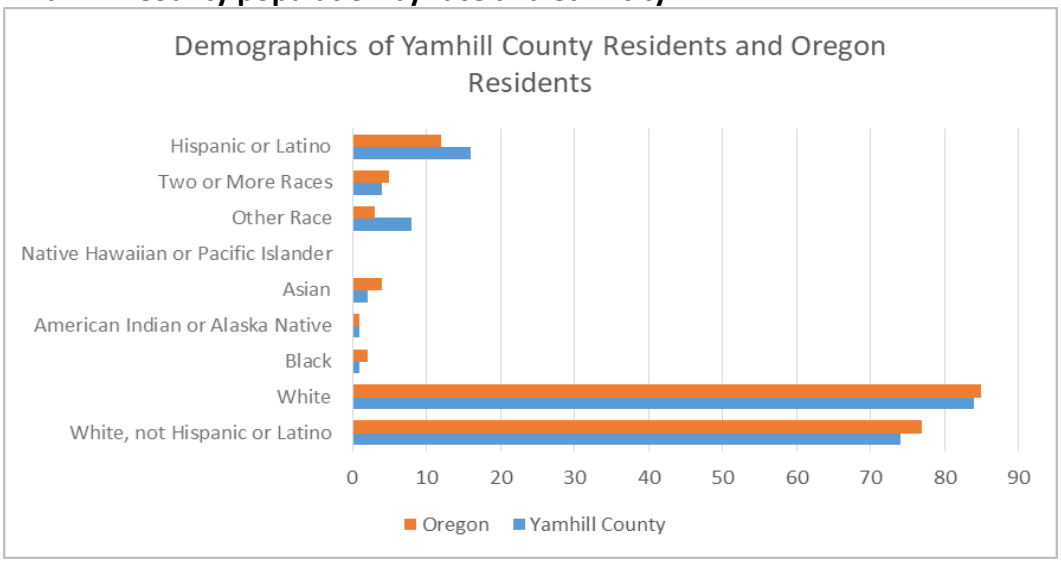
Community Demographics

Yamhill County is home to approximately 106,906 people, 23% of whom live in rural areas. The County is served by a second hospital, the for-profit, 60-bed Willamette Valley Medical Center.

The county is slightly more racially and ethnically diverse than the state as a whole, representing a greater proportion of individuals identifying as Hispanic or Latino (16.3%) than the state average (12.3%).

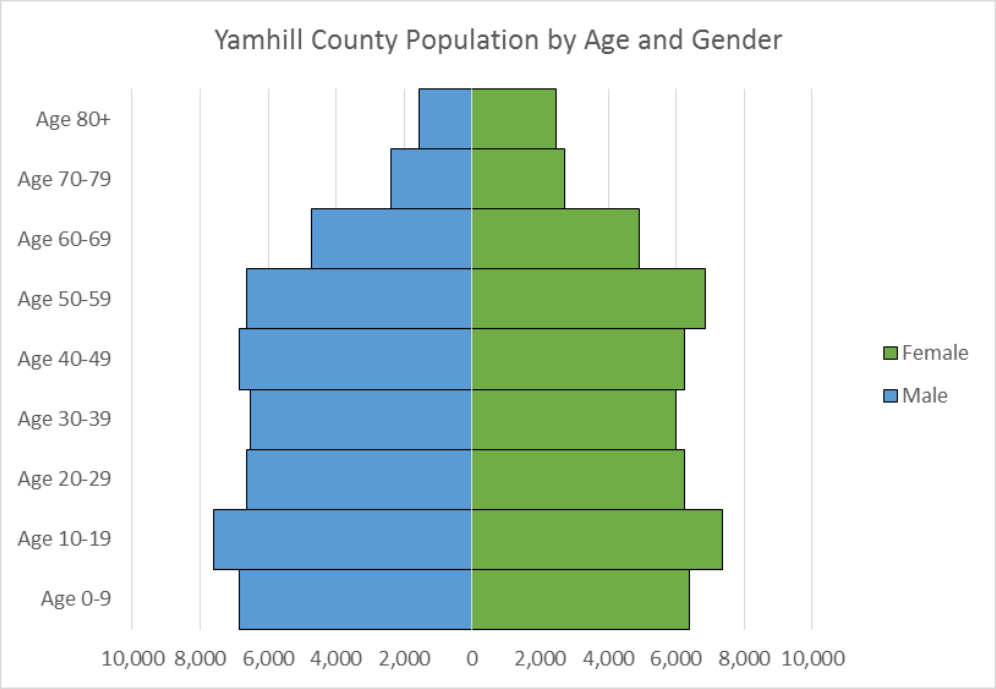
Figure 2 shows the Census-designated race and ethnicity for residents in Yamhill County compared to Oregon overall. The largest portion of the population identifies as white and non-Hispanic.

Figure 2. Yamhill County population by race and ethnicity



Yamhill County average residents age (38.2 years) is in line with that of the state as a whole (39.2 years). The following chart shows the age and gender distribution of the current population of Yamhill County.

Figure 3. Yamhill County population by age and gender



Income and Employment

The 2017 estimate for Yamhill County median household income is $58,392, slightly higher than the median household income for both Oregon and the United States. The unemployment rate most recently (June 2019) was 3.6%, lower than Oregon's at 4.1%, and on par with the United States during that same period. Over the last year, the majority of job growth was in construction, leisure/hospitality, and other service industry jobs, which are typically lower paying and often without health care benefits. Despite a low unemployment rate, 13.2% of Yamhill County Residents live in poverty, approximately 2% higher than state or federal poverty rates.

Health Care and Coverage

Approximately 8.2% of Yamhill County residents under 65 were uninsured per 2018 estimates, which is on par with Oregon overall and lower than the national 10%. Recent rises in the uninsured rate nationally may be indicative of new trends, reversing 5 years of steady declines. As Yamhill County has significant numbers of migrant and seasonal farmworkers, these estimates could vary greatly depending on populations surveyed and the depth of outreach. The Community Health Survey conducted specifically for this CHNA (including 118 participants), showed that 2.3% of respondents reported having no insurance, showing that wide variations may exist. Additionally, the survey demonstrated that those with lower incomes and on Medicaid were often more likely to go without needed care.

OVERVIEW OF COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) FRAMEWORK AND PROCESS

The Community Health Needs Assessment (CHNA) process is based upon the understanding that health and wellness happen across our communities, not only in medical facilities. In gathering information on the communities served by PNMC, we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, and health behaviors. Additionally, we invited key stakeholders and community members to provide additional context to the quantitative data through qualitative data in the form of stakeholder interviews and listening sessions. As often as possible, equity is at the forefront of our conversations and presentation of the data, which often has biases based on collection methodology.

In addition, we recognize that there are often geographic areas where the conditions for supporting health are substantially worse than nearby areas. Whenever possible and reliable, data is reported at the ZIP code or census block group level. These smaller geographic areas allow us to better understand the neighborhood level needs of our communities and better address disparities within and across communities.

We reviewed data from the American Community Survey, the Yamhill Community Care Organization (YCCO), and other local public health authorities. PNMC, Yamhill County Public Health, and YCCO all participated in the development of the 2019 YCCO CHNA. The input of the Yamhill County Public Health was extrapolated from that collaboration for use in the PNMC CHNA. In addition, we include hospital utilization data to identify disparities in utilization by income and insurance, geography, and race/ethnicity when reliably collected.

Data Limitations and Information Gaps

While care was taken to select and gather data that would tell the story of the hospital's service area, it is important to recognize that limitations and gaps in information occur, though effort was taken to minimize limitations. Data limitations are inherent in most community-based qualitative designs including participant selection bias, the use of independent facilitators, and variable note taking practices, among other factors. The YCCO data on members' race and ethnicity are very limited; more than 4 in 10 individuals were categorized as "unknown race."

For the Community Health Survey, data collected via population mail surveys also have notable limitations. They only include responses from people with known mailing addresses who can respond to written surveys, and thus may underrepresent those who are unstably housed, facing language or literacy barriers, or other vulnerable or underserved populations. Households from diverse racial-ethnic backgrounds or where the primary language is not English are also less likely to respond to mail surveys, although Spanish language surveys were offered. Because of these limitations, the CHNA uses these data in conjunction with other types

of data collection, such as the community listening sessions and stakeholder interviews, which are better positioned to capture data from underrepresented populations.

Process for gathering comments on previous CHNA

Written comments were solicited on the 2016 CHNA and 2017-2019 CHIP reports, which were made widely available to the public via posting on the internet in December 2016 (CHNA) and May 2017 (CHIP), as well as through various channels with our community-based organization partners.

Summary of any comments received

No written comments were received on the 2016 PNMC Community Health Needs Assessment and 2017-2019 Community Health Improvement Plan.

COMMUNITY INPUT

Summary of Community Input

To better understand the community's perspective, opinions, experiences, and knowledge, Providence's Community Health Division, in partnership with Center for Outcomes Research and Education (CORE) completed a community health survey and held listening sessions and stakeholder interviews in which community members and nonprofit and government stakeholders discussed the issues and opportunities of the people, neighborhoods, and cities of the service area. Participants across the listening sessions included individuals with low-incomes and also attempted to obtain representation from older adults, young people, people identifying as LGBTQ+, Hispanic/Latinx people, people of color, recent immigrants, people experiencing homelessness, and rurally residing individuals through choosing specific stakeholders and various community leaders. Below is a high-level summary of the findings of these sessions. Full details on the protocols and attendees are available in Appendix 2.

Community Health Survey

In partnership with CORE, Providence's Community Health Division created a survey to assess several health domains, first used in the 2013 CHNA. Most survey items were selected from nationally validated tools during the design process; only minor changes were implemented in the 2019 survey to preserve the continuity of findings. The survey was fielded April through June using an address-based sampling methodology to capture a representative group of households in Yamhill County. Of the 1,000 surveys mailed, 118 were returned. Results were weighted by age based upon respondent demographics. Note that in the majority of these findings, lower income households (200% Federal Poverty and below based on self-reported household income and household size) reported greater challenges. The full survey and report from CORE are included in Appendix 6. Key takeaways included:

- **Mental health challenges** are present, especially in lower income households. The largest health disparities were based on family income, with those 200% or below FPL having significantly higher rates of many chronic health challenges.
- About 1 in 10 residents identified as having one or more **unmet health care need**, with 12.2% reporting an unmet need specifically for **dental care** in the previous 12 months.
- Key social determinants of health challenges include **food insecurity and housing instability**. Approximately 1 in 10 residents reported not having stable housing or having shortages of food in the last year. Respondents were more likely to report lacking nearly all types of basic needs in 2019 than in 2016.
- A **high prevalence of trauma** was identified, especially among lower income households and increasing between 2016 and 2019. The same populations reported a **higher prevalence of anxiety and PTSD.**

Key Stakeholder Interviews

Between August and September 2019, Providence conducted research with key stakeholders using a semi-structured interview methodology. Individuals were selected from those in community leadership roles and those leading community-based organizations who have strong connections with the populations we serve. Each was willing and able to speak to the needs of the community and the populations they represent. A full list of interviewed individuals and a question guide is included in Appendix 2. The key themes that emerged from these conversations included:

- Unmet social needs such as **housing and transportation** were frequently mentioned due to the county's rapidly rising home prices, pushing people into isolated rural areas. Latinx and senior populations were mentioned as most affected.
- There is a lack of access to **medical and dental care**, particularly in more rural areas outside McMinnville and Newberg.
- There is a need for more **bilingual** and culturally competent community health workers to help people navigate health and social services.
- **Behavioral health resources** are inadequate, coupled with identified issues surrounding anxiety, social isolation, stigma and discrimination, factors contributing to the need for behavioral health services.

Community Listening Sessions

Based upon responses from the Community Health Survey and other information available, Providence prioritized gathering feedback from the Latinx community in Yamhill County. The Community Health Division hosted two Spanish language guided conversations with a total of 14 participants, including community residents and volunteer community health workers (CHWs). The sessions emphasized three domains: vision for a healthy community, needs or barriers to achieving health, and existing resources. The question guide is included in Appendix 2. The following are summarized responses:

- *Vision for a healthy community* included better access to care, reliable and adequate social supports are available to all, better nutrition education, and opportunities to exercise and gather.

- *Key needs or barriers* included access to transportation, lack of programming directed to seniors and kids, men's health education, access to medication and medical care (particularly culturally responsive care), and behavioral health resources.
- *Identified community resources* were the Yamhill Community Action Program (YCAP) food bank, the Medical Teams International dental van, the Juntos Program, the Tomando Control Program, parish health promoters and telehealth programs (*Promotores*), and Oregon State University's extension nutrition education services.

Challenges in Obtaining Community Input

Scheduling listening sessions was the main challenge in obtaining community input, which required coordinating facilitators, note-takers, and support from community-based organizations recruiting participants. Listening sessions were held in the early evenings at local parishes to accommodate work schedules and provide participants a safe space.

For additional information, see Appendix 2: Community Input: Qualitative Data

SIGNIFICANT HEALTH NEEDS

ACCESS TO HEALTH SERVICES

Primary Care

Although greatly improved since 2013, access to primary care remains a priority. This includes insurance coverage, the number of primary care providers compared to the population, and general access to primary care. Yamhill County has fewer primary care physicians relative to population than elsewhere in the state (1,390:1 compared to 1,070:1 across Oregon). Hispanic/Latinx households reached in the Community Health Survey were more likely to report not having a place for regular or routine care compared to Non-Hispanic White households (31.8% vs 15.2%). Nearly one in five (18.1%) respondents to the Community Health Survey did not have someone they thought of as their primary care provider. Only half of adults on Oregon Health Plan (health coverage for people with low-incomes) had visited a doctor in 2017, and barely one third visited a dentist.

Rural residents in smaller towns and surrounding areas, noted that few medical resources were available in their immediate communities, and stakeholders mentioned a suspicion of unfamiliar providers in rural areas. This issue was further emphasized as the lack of reasonable public transportation made getting to hospitals and other clinical sites difficult. More details can be found under "Social Determinants of Health and Well-Being." Localized care brought to the Latinx communities through the Promotoras and telehealth programs was praised as an effective way to reach more disenfranchised populations.

Dental Care

Relatively little information is available regarding dental care access through state or county public health data. However, dental conditions remain one of the top reasons vulnerable adults (uninsured, Medicaid, and dual eligible) access the emergency department for conditions that are better treated in another setting. In 2018, 101 unique individuals came to the emergency department for dental conditions. Over one in ten (12.2%) of survey respondents experienced an unmet need for dental care in the last year. This response disproportionately represented individuals and families at or below 200% FPL (18.7%). Stakeholders noted there was underutilization of free dental services and that preventive dental care wasn't accessed, delaying until care was urgently needed. More dental health education and promotion was mentioned as a community need.

Culturally-Responsive Care

While access to primary care providers, including nurse practitioners and other advanced practice providers has improved in recent years, few of them are bilingual or bicultural. This challenge was apparent in the listening sessions and information shared regarding utilization of interpretive services by participants. Key stakeholders expressed specific need for Spanish-language and community outreach services, highlighting Providence's Promotoras program as an example of what is working. The need for care coordination services across all demographics was evident, with stakeholders and other respondents claiming the lack of navigation assistance results in underutilization of available services and poor health outcomes.

COMMUNITY MENTAL HEALTH/WELL-BEING & SUBSTANCE USE DISORDERS

Mental Health Treatment Services

There are slightly fewer mental health providers per 1,000 population than the state average in Yamhill County. Fourteen percent of survey respondents reported needing mental health care and 3% of those did not get all the mental health care they needed. More than 20% of survey respondents have been diagnosed with depression, 22% with anxiety, and over 8% with post-traumatic stress disorder. PTSD is more common in individuals at or below 200% FPL. An enduring problem with teen suicide is particularly concerning to stakeholders and other community members.

Substance Use Treatment

There are relatively few substance use treatment options available in Yamhill County, so many people travel to Portland for treatment. Lack of access to treatment was also a theme that emerged from key stakeholder interviews, particularly for current substance users and seniors. According to the Behavioral Risk Factor Surveillance Survey (BRFSS), approximately 15% of adults in Yamhill County drink excessively (the average for Oregon is just below 17%). Additionally, the 2017 Oregon Healthy Teens Survey found 10% of 8th grade students in Yamhill County and 29% of 11th grade students had used alcohol in the past 30 days, 18% of 11th graders had used marijuana or hashish, and 7.4% of 11th graders had used prescription drugs without a doctor's orders in the month prior to the survey.

Adverse Experience and Trauma Prevention

The Community Health Survey was one of the first tools developed to assess prevalence of trauma exposure in the county population. The results from the survey responses were weighted only by age, so are likely not generalizable to the entire population. However, the survey found that 44% of respondents had experienced three or more adverse life events. Rates of several types of self-reported adversity and trauma increased from 2016 to 2019, including abuse (16.1% vs 23.5%) and life-changing illness or injury (28.8% vs. 38.2%). The most common event was living with someone with mental illness or substance abuse (40%), followed by life-changing illness or injury (38.2%) and unexpected death of a loved one (34.6%). Individuals at or below 200% FPL were more likely to have been physically hurt or threatened by an intimate partner.

CHRONIC HEALTH CONDITIONS

This is a broad category that includes long-term illnesses. These conditions arise from a variety of factors including genetics, lifestyle and health behaviors, and environmental factors and are often linked to the social determinants of health. Issues with housing, food security, transportation, education, trauma and social isolation combine to create complex personal challenges that can contribute to deteriorating health and the rise or worsening of chronic disease.

Asthma

Asthma is the sixth most common reason for emergency department utilization, resulting in 378 visits during the study period (May 2018-April 2019). Approximately 8% of adults reported having been diagnosed with asthma. This diagnosis is most often related to and aggravated by environmental factors, but is largely controllable through access to regular primary care and appropriate medications.

Diabetes

As the second-most common reason for adult visits to the emergency department, type 2 diabetes resulted in 634 emergency department visits during the study period across 337 unique patients. Type 2 diabetes is generally considered a diet-related chronic condition, which can be controlled through diet, exercise, and healthy behaviors. However, use of the emergency department is a sign of poorly controlled diabetes and signals poor primary care access. About 5% of survey respondents in Yamhill County have been told by a doctor that they have diabetes, some of whom may be in treatment and others not. National statistics for diabetes prevalence are closer to 9.5%, showing a significant gap in the self-reported survey results than what would be expected.

Hypertension

Hypertension, or high blood pressure, remains the most common reason for potentially avoidable emergency department utilization amongst vulnerable adults. From April 2018 to

March 2019, 645 unique patients came to PNMC's Emergency Department 1,144 times as a result of hypertension. Twenty-six percent of survey respondents have been told by a doctor that they have high blood pressure, with the diagnosis being far more likely amongst Medicare beneficiaries (50%).

Obesity

More than 33% of Yamhill County's adult population is obese, which is higher than Oregon's overall percentage of 28.6% according to BRFSS. Almost 27% of 8th graders and 35% of 11th graders are overweight or obese. These values are similar to the state percentages of 29.1% for 8th graders and 32.3% for 11th graders. This was of particular concern to key stakeholders, especially those that worked with school-aged youth. Contributing factors to obesity are limited access to healthy foods and lack of recreational opportunities, both of which are considered social determinants of health. Further, being overweight or obese increases the chances of developing type 2 diabetes and is a major risk factor for hypertension.

SOCIAL DETERMINANTS OF HEALTH RESUTLING FROM POVERTY AND INEQUITY

The term "social determinants of health" refers to the social and economic factors that contribute to the health and well-being of individuals. In other words, variables of health occur where people live, work, learn, and play. Sometimes these factors can be related directly to health, but other times they are not commonly considered health factors, like access to affordable housing and transportation. However, all social determinants of health influence the health of a community.

Affordable housing

Access to safe, affordable housing has emerged as an issue across the State of Oregon over the last few years, reaching crisis levels in several of our cities and towns. Studies have demonstrated the importance of housing on health outcomes, which is why it is considered a social determinant of health. Despite being an area known for its relative wealth, nearly 12% of survey respondents reported not having stable housing or being worried about losing their housing in the last year. These responses were particularly common amongst respondents who were at or below 200% FPL or were in the Medicaid/uninsured/dual eligible insurance category. The 2019 point-in-time survey counted 1,433 individuals homeless individuals in Yamhill County.

Yamhill County is experiencing rapid and wide-spread gentrification due to the success of its wine industry and subsequent real estate price increases. These increases disproportionately push low income and minority populations into rural areas, leading to more transportation issues, potential social isolation, and further upstream consequences to social determinants of health. One stakeholder stated that "Yamhill County has a shameful livability issue."

Healthy Food Access

Access to healthy, affordable foods, such as fruits and vegetables, is important for keeping people well. In the 2015 Oregon Health Teens survey, 26.6% of 8th graders and 19.7% of 11th graders in Yamhill County reported eating less food than felt they should because there wasn't enough money to buy food. This is higher than the state-reported percentages of 14.4% for 8th grades and 17.8% for 11th graders. The Community Health Survey identified nearly 49% of people having fewer than two servings of fruit per day and 33% of people having fewer than two servings of vegetables per day. Medicare beneficiaries and those in the Medicaid/uninsured/dual eligible category were more likely to report having less than two servings of both fruits and vegetables. Although respondents mentioned the Yamhill Community Action Program (YCAP) and Food Bank alliance as a food resource, it is offered only in summer and limited to Dayton and McMinnville.

Transportation

Respondents to the YCCO Community Health Survey noted transportation as one of the main challenges to access to care, especially in more rural parts of the county. Respondents identified frequency, reliability, comfort, branding, eligibility, and diversity of options as key issues around improving transportation in Yamhill County. Getting across the county and/or between towns was described as an "all day event" by one respondent. In addition, key stakeholders were particularly concerned about transportation for seniors. As the elderly population in Yamhill County is growing, stakeholders and public health partners want to ensure that seniors have safe, effective means of transportation, and there is available ADA infrastructure for people with disabilities.

Services Coordination

As mentioned in the Access to Care section, social services navigation was seen as an area that had great potential to improve the community health status. One listening session respondent emphasized that calling 211 is not particularly helpful as more than an organization name and phone number is needed. Further, that calling those organizations directly often results in recorded messages, lack of capacity, or simply no return calls. Several responses included the need to educate individuals and families on prevention and basic health literacy, some of which could be accomplished with the help of more patient navigators or community health workers.

Potential Resources Available to Address Significant Health Needs

Understanding the potential resources available to address significant health needs is fundamental to determining current state capacity and gaps. Resources available to potentially address these needs exist in Yamhill County, but are likely inadequate or not seen as accessible to all county residents. The organized health care delivery systems include the Department of Public Health, Willamette Valley Medical Center, Newberg Urgent Care, and several other private practice groups. In addition, there are numerous social service non-profit agencies, faith-based organizations, and private and public-school systems that contribute resources to address these identified needs. A list of potential resources available to address significant health needs can be found in Appendix 3.

2019 PRIORITY NEEDS

Prioritization Process and Criteria

Based upon the various sources of information in this assessment, needs that were named by two or more sources were identified as priority health needs. These needs were then grouped into four actionable categories, which were discussed and refined by the PNMC Service Area Advisory Council. The identified priorities will guide our efforts in developing the Community Health Improvement Plan (CHIP). The prioritization criteria included worsening trends, values worse than state averages, and a disproportionate impact on communities of color, low-income, or otherwise marginalized groups. Additional prioritization regarding feasibility, effectiveness of interventions, and ability to partner with community organizations will be applied during CHIP development.

The list below summarizes the rank ordered significant health needs identified through the 2019 Community Health Needs Assessment Process:

Priority #1: Social determinants of health resulting from poverty and inequity – focus areas in housing, transportation, and food security; includes coordination of supportive services.

Priority #2: Chronic health conditions – focus on prevention of obesity, diabetes, hypertension, and depression.

Priority #3: Community mental health/well-being and substance use disorders - focus on prevention (particularly for youth), culturally responsive care and health education, social isolation, and community building.

Priority #4: Access to health services – Focus on services navigation and coordination, culturally responsive care and oral health.

EVALUATION OF IMPACT ON 2017-2019 COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP)

This report also evaluates the results from our most recent CHNA and CHIP. PNMC responded by making investments of direct funding, time, and resources to internal and external programs that were most likely to have an impact on the previously prioritized needs. This summary includes just a few highlights of our efforts across Yamhill County. In addition, we invited written comments on the 2016 CHNA and 2017-2019 CHIP reports through website and published contact information, made widely available to the public. No written comments were received on the 2016 CHNA and 2017-2019 CHIP. Below are some highlights of our impact under each priority:

Priority Need	Program or Service Name	Results/Impact	Type of Support
Social Determinants of Health and Well-being	Patient Support Program in conjunction with Project Access NOW	Connects patients to supports, medication, transitional housing, and recovery services upon discharge.	Program
	Helping Hands Reentry Outreach Centers	Provides emergency shelter and trauma-informed, program-based transitional housing to people experiencing homelessness. Served 981 people.	Grant
	Newberg FISH Emergency Services	Provided emergency food services to 8,679 individuals and 904 unique households.	Grant
Access to Care	Telehealth with Promotores de Salud	Partnered with 3 Yamhill County parishes, sponsoring 26 Promotores. Telehealth clinics screened 323 underserved Latinx community members, connecting 59 to a nurse practitioner.	Program Grant
	MTI Dental Van	Includes 8 Yamhill County emergency dental clinics, serving 75 patients, at a value of $39,900.	Program Grant
	Pacific University Dental Hygiene School	Includes 24 mobile preventive dental clinics held in Yamhill County, serving 141 patients (primarily Latinx).	Program Grant
	Latina Mammogram Fair	Includes 3 breast cancer screening clinics for uninsured Latinx women in Yamhill County, serving 88 women.	In-kind Staff time
Chronic Conditions	George Fox University	Addresses childhood obesity by promoting behaviors linked to overall health, including nutrition, physical exercise, and stress management for 116 children.	Grant
	Oregon State University Extension	Address childhood obesity through Healthier Kids, Together program for low-income and Latinx families.	Grant
	Living Well – Tomando Control de su Salud	Includes 9 Chronic Disease Self-Management (CDSMP) workshops, serving 102 community members.	Program

Behavioral Health	Lutheran Community Services	Provides targeted services, focusing on mental health in rural Yamhill County. Served 89 clients, mostly women and children.	Grant
	Yamhill Community Action Program (YCAP)	Newberg – Dundee Community Network Navigator Youth Outreach connects youth to behavioral health services. Served 41 youth with 76 services.	Grant
	Yamhill Community Action Program (YCAP)	Includes an integrated on-site youth counseling program providing mental health support for 26 at-risk youth in Newberg and Dundee.	Grant
	Pacific University School of Psychology	Latinx Emotional Health Program – trained Promotores conduct Community Conversations (Charlas). 2 Community Charlas held in Yamhill County, serving 40 community members.	Program Grant

Addressing Identified Needs

The Community Health Improvement Plan development for the PNMC service area will consider the prioritized health needs identified through this CHNA and develop strategies to address needs considering resources, community capacity, and core competencies. Those strategies will be documented in the CHIP, describing how PNMC plans to address the health needs. If the hospital does not intend to address a need or plans to have limited response to the identified need, the CHIP will explain why. The CHIP will not only describe the actions PNMC intends to take but also the anticipated impact of these actions and the resources the hospital plans to commit to address the health need.

Because partnership is important to addressing health needs, the CHIP will describe any planned collaboration between PNMC and community-based organizations in addressing the health need. The improvement plan will be approved and made publicly available no later than May 15, 2020.

2019 CHNA GOVERNANCE APPROVAL

This community health needs assessment was adopted on November 19th, 2019, by the PNMC Service Area Advisory Committee [authorized body of the hospital].[3] The final report was made widely available[4] on December 19th, 2019.

Lori Bergen — 12-6-19
Lori Bergen — Date
Chief Executive, Providence Newberg Medical Center

Lisa Vance — 12-05-19
Lisa Vance — Date
Chief Executive, Oregon Region

Joanne Warner — 12/09/2019
Joanne Warner — Date
Chair, Oregon Community Ministry Board

12/11/2019
Joel Gilbertson — Date
Senior Vice President, Community Partnerships
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Request a printed copy without charge, provide comments or view electronic copies of current and previous community health needs assessments: CommunityBenefit@providence.org

[3] See Appendix 4: Providence Newberg Community Health Needs Assessment Committee Sector: Hospital, Community Based Organization, Education, Affordable Housing
[4] Per § 1.501(r)-3 IRS Requirements, posted on hospital website

APPENDICES

Appendix 1

As a health care system, we recognize that some of our own information can provide important perspective to unmet community health needs as well. We reviewed data from our hospital medical record system over the 12 month period through April 2019, including percent of avoidable Emergency Department cases, top reasons for hospital utilization, and the prevalence of all self-harm instances. Providence St. Joseph Health implemented a standard definition of Avoidable Emergency Department (AED) visits based on research and standards from New York University and Medi-Cal. As appropriate, this data and data from other public sources are noted in the report.

a) Health Professions Shortage Area

The Federal Health Resources and Services Administration designates Health Professional Shortage Areas as areas with a shortage of primary medical care, dental care, or mental health providers. They are designated according to geography (i.e., service area), demographics (i.e., low-income population), or institutions (i.e., comprehensive health centers). Yamhill County is a designated primary, dental, and mental HPSA, with specific designations for low-income, homeless, and/or migrant farmworkers. (https://data.hrsa.gov/tools/shortage-area/hpsa-find)

b) Medical Underserved Area/Medical Professional Shortage Area

Medically Underserved Areas and Medically Underserved Populations are defined by the Federal Government to include areas or population groups that demonstrate a shortage of healthcare services. This designation process was originally established to assist the government in allocating community health center grant funds to the areas of greatest need. Medically Underserved Areas are identified by calculating a composite index of need indicators compiled and with national averages to determine an area's level of medical "under service." Medically Underserved Populations are identified based on documentation of unusual local conditions that result in access barriers to medical services. Medically Underserved Areas and Medically Underserved Populations are permanently set, and no renewal process is necessary. Willamina/Grande Ronde service area, including parts of Yamhill County, are designated MUAs (https://data.hrsa.gov/tools/shortage-area/mua-find).

Appendix 2: Community Input

To better understand the community's perspective, opinions, experiences, and knowledge, Providence's Community Health Division, in partnership with Center for Outcomes Research and Education (CORE) completed a community health survey and held listening sessions and stakeholder interviews where community members and nonprofit and government stakeholders discussed the issues and opportunities of the people, neighborhoods, and cities of the service area. Participants across the listening sessions included individuals with low-incomes and also attempted to obtain representation from older adults, young people, people identifying as LGBTQ+, Hispanic/Latinx people, people of color, recent immigrants, people experiencing homelessness, and rurally residing individuals. In some instances, we relied on the input of community leaders who work closely with the targeted populations.

Community Input Type (e.g. Listening Sessions, community forum, etc.)	City, State	Date (Month, Day, Year)	Language information was gathered
Stakeholder Interview	McMinnville, OR	August 13, 2019	English
4 Separate Stakeholder Interviews	Newberg, OR	August 13, 2019	English
4 Separate Stakeholder Interviews	Newberg, OR	August 14, 2019	English
Listening Session	Dayton, OR	August 8, 2019	Spanish
Listening Session	Newberg, OR	August 9, 2019	Spanish
Community Survey	Yamhill County, OR	May/June/July, 2019	English/Spanish

Key Community Stakeholder Participants

Stakeholders	City, State	Organization
Jordan Robinson	McMinnville, OR	Lutheran Family Services
Katie Stokes	Newberg, OR	Yamhill Community Action Partnership
Dr. Luke Neff	Newberg, OR	Superintendent Newberg Schools
Elise Yarnell	Newberg, OR	Newberg Behavioral Health Coalition
Rick Rodgers	Newberg, OR	Newberg Mayor
Erin Bryant	Newberg, OR	Providence Family Medicine Newberg
Jaime Flores	Newberg, OR	Promotores of Yamhill
Dr. Raji Matthews	Newberg, OR	Capital Dental
Linda Mann	Newberg, OR	Yamhill Oral Health Coalition

Key Community Stakeholder Interview Guide

Key Community Stakeholder	**Hospital Representatives**
Date and Time of Interview **Location**	**(Please list all attendees)**
Key Community Stakeholder Names/Titles (please list all attendees)	
Organization Name	
Preferred Contact	

Interview Questions	
Purpose	**Question**
To understand the role of the stakeholder's organization and community served	**1. How would you describe your organization's role within the community?**
	2. How would you describe the community your organization serves? Please include the geographic area.
To identify and prioritize unmet health related needs in the community, including the social determinants of health	**3. Please identify and discuss specific unmet health-related needs in your community for the persons you serve. We are interested in hearing about needs related to not only health conditions, but also the social determinants of health, such as housing, transportation, and access to care, just to name a few.**
	4. **Can you prioritize these issues? What are your top**

	concerns*? [Note to interviewer: encourage ranking of at least top three health needs in order of priority]*
	5. Using the table, please identify the five most important "issues" that need to be addressed to make your community healthy (1 being most important). [see table below]
To identify populations disproportionately affected by the unmet health-related needs	**6. Are there specific populations or groups in your community who are disproportionately affected by these unmet health-related needs? We have a particular concern for those that are low income, vulnerable or are experiencing health inequities.**
To identify gaps in services that contribute to unmet health-related needs	7. **Please identify and discuss specific gaps in community services for the persons you serve that contribute to the unmet health-related needs you identified earlier.**
To identify barriers that contribute to unmet health-related needs	**8. Please identify and discuss specific barriers for the persons you serve that contribute to the unmet health-related needs you identified earlier.**
To identify community	**9. What existing community health initiatives or programs in**

assets that can be leveraged, such as initiatives that are already addressing these health-related needs	**your community are helpful in addressing the health-related needs of the persons you serve, especially in relation to the health related needs you identified earlier? Can you rank them in terms of effectiveness?**
To identify opportunities for collaboration between organizations	**10. What suggestions do you have for organizations to work together to provide better services and improve the overall health of your community?**
Anything else	**11. What other things do you think we should hear about?**
Other comments:	

Question 5: Using the table below, please identify the five most important "issues" that need to be addressed to make your community healthy (1 being most important).			
	Aging problems (e.g. memory loss/hearing/vision loss)		Access to oral health providers
	Air quality, e.g. pollution, smoke		Access to safe, nearby transportation
	Obesity		Lack of community involvement
	Bullying/verbal abuse		Affordable daycare and preschools
	Domestic violence, child abuse/neglect		Job skills training
	Few arts and cultural events		Accessibility for people with disabilities
	Firearm-related injuries		Safe and accessible parks/recreation
	Gang activity/violence		Behavioral health challenges (includes both mental health and substance use

			disorder)
	HIV/AIDS		Poor schools
	Homelessness/lack of safe, affordable housing		Racism/discrimination
	Food insecurity		Unemployment/lack of living wage jobs
	Access to medical care		Safe streets for all users (e.g. crosswalks, bike lanes, lighting, speed limits)
	Access to behavioral health care		Other:

Community Listening Session Facilitator Guide

INTRODUCTION

Good morning/evening and welcome to our listening session. Thank you for taking the time to join our conversation. My name is [FACILITATOR NAME], and I work with Providence St. Joseph Health, a health care system. For this session, I am working with [HOSPITAL NAME(S)] to complete their community health needs assessment. This process is completed every three years to better understand the health needs and strengths of the communities. That's why we're talking with community members like all of you.

The information from this session will become part of the community health needs assessment report, which [HOSPITAL NAME(S)] will use to help improve the health and wellbeing of the community. Your responses will be anonymous. We may use some quotes from the session, but we will not include your name. We will not be recording this session, but two people will be helping to take notes during the conversation. Their names are [NAMES].

I will facilitate the conversation, but I will not be participating. I will ask some questions of the group. I may need to move the conversation to the next question to ensure we have time to cover all of the questions.

I hope that all of you can share your experiences and opinions with us during this hour together. Please feel free to get water or use the restroom during the session. Participation today is optional and you may leave at any time.

During this conversation I want everyone to have a chance to talk and share your thoughts. Feel free to respond to one another and give your opinion even if it is different from someone else's. Before we start I want to set some expectations for the group. First, everyone should participate, but only one person will speak at a time. Second, there are no right or wrong answers, we must all be respectful of one another. Third, please keep what you hear today

within this room.

Before we begin, are there any questions?

Great, does everyone consent to participation? Would anyone like to leave?

INTRODUCTORY ACTIVITY

We have a little over an hour to talk, and I'd like to start with a creative activity. I'd like you to start by thinking about your community. People might think of "community" in different ways. Maybe it's family, or maybe its neighbors, or maybe its coworkers or friends. For the next 5 minutes, draw a picture that represents **your community**.

Pause, give people ~5 minutes to draw. Facilitator should draw too.

So let's go around in a circle—tell me your name, and tell us something about the community represented in your drawing. We will each have about thirty seconds to share. I'll start.

Facilitator introduces self, models talking about community.

Then everyone goes in a circle, introducing self and saying a few words about their community.

Thank you all for sharing. That leads into what we're going to talk about next: the health of your community. This is going to be an informal discussion. We want to hear about your ideas, experiences and opinions. Everyone's comments are important. They might be similar or very different, but they all should be heard. The goal today is to record everyone's opinions.

CONTEXT

What we were hoping to talk about today is: ***What makes a healthy community?***

That's a difficult question, because it involves two ideas. First, there's ***HEALTH***. What do we mean by health? Do we mean freedom from disease? Having enough to eat? Feeling generally good about life? Being financially healthy?

Then there's the idea of ***COMMUNITY***. What do we mean by community? Are we talking about each one of you, individually? Are we talking about your friends and family? Your neighborhood? Your church? Your racial or ethnic group? Your city or town?

We're not going to define these things for you. We're going to keep it open.

QUESTION 1. VISION.
Now take a minute to think about your community—that community that is represented in your drawing. **How can you tell when your community is healthy?**

Probes if needed:

- *You have all spoken about physical health. What about other kinds of health and wellbeing?*
- *What does a healthy community look like for people going through a difficult time?*
- *What does a healthy community look like for families?*
- *What does a healthy community look like for your children or young people?*
- *What does a healthy community look like for older adults?*
  Instructions: write ideas on the poster.

QUESTION 2. NEEDS.
So we've talked about what a healthy community looks like. Now let's talk about what's not there or what you need more of.

What's needed? What more could be done to help your community be healthy?

Probes if needed: Consider relating probes to question one. What's needed to help community members reach their specific ideas of a healthy community? For example:

- *What's needed to help your community be physically healthy?*
- *What's needed to help your community be mentally and emotionally healthy?*
- *What's needed to help your community be safe?*
- *What's needed to ensure all members of your community can lead healthy lives?*

  Instructions: write ideas on the poster.

QUESTION 3. STRENGTHS.
So you've told us what a healthy community looks like and what the needs are in your community. Let's explore this idea a little more. Communities have certain **resources** that can help them be healthy. It might be programs. It might be a park or a community center. It might be a really great teacher at your local school. It might be a local business or a local organization that helps people be healthy.

My question for you is:

What's working? What are the resources that CURRENTLY help your community to be healthy?

Probes if needed:

- *Are there people that help your community be healthy?*
- *Are there places people can go that help them be healthy?*
- *Are there programs that help your community be healthy?*
- *How do community members help each other be healthy?*
  Instructions: write ideas on the poster.

Thank you all for sharing your thoughts and opinions with the group today. All of this information is really helpful. Before we finish, **is there anything else related to the topics we discussed today that you think I should know that I haven't asked or that you haven't shared?**

Wrap-Up: Thank participants for coming, describe any next steps. Make sure folks signed in for an appropriate count, and distribute gift cards/incentives as they leave.

To be completed by interviewer after interview is complete
1. Was the interview recorded? YES / NO *[please circle]* a. If yes, how long is the recording: _____ minutes, ____ seconds b. Title of the recording:
2. Were there any questions the stakeholder did not seem to understand or struggled to answer?
3. Are there any questions you would recommend editing or removing?
Other comments:

Appendix 3: Resources potentially available to address the significant health needs identified through the CHNA

PNMC cannot address the significant community health needs independently. Improving community health requires collaboration between community stakeholders and organizations. Below outlines a list of community resources potentially available to address identified community needs. This list is non-exhaustive and with likely changes in services and office locations over time, the information may need to be updated accordingly.

Organization Type	Organization or Program	Services offered	Address	Significant Health Need Addressed
Social Services	Chehalem Youth and Family Services	Counseling, youth development, family strengthening programs	501 E 1st St, Newberg, OR 97132	Behavioral Health
University	George Fox University	Education programs, particularly for mental health professional	414 N. Meridian Street, Newberg, OR 97132	Behavioral Health
Social Services	Love, INC	Providing a variety of resources to local families, including dental services, school supplies, clothing, and meals	209 S Main St, Newberg, OR 97132	Access to care; social determinants of health and well-being
Social Services	Lutheran Community Services NW	A Family Place relief nursery and outreach program	435 NE Evans, Suite A McMinnville, OR 97128	Behavioral health
Social Services	Newberg FISH Emergency Services	Local food pantry focused on providing healthy food options for low-income families and seniors	125 S Elliott Rd, Newberg, OR 97132	Social determinants of health and wellbeing
University	Pacific University	Dental assistant program	2043 College Way Forest Grove, OR 97116	Access to care
Social Services	St. Peter Parish	Catholic parish in Newberg	2315 N Main St, Newberg, OR 97132	Access to care
Social Services	Virginia Garcia	Federally-Qualified Health Center serving Yamhill	2251 E Hancock St Ste 103,	Access to care

		County	Newberg, OR 97132	
Healthcare	Yamhill Community Care Organization	The local coordinated care organization providing care for Oregon Health Plan members	807 NE 3rd St, McMinnville, OR 97128	Access to care; all
Healthcare	Yamhill County Public Health	County public health agency with WIC and other health outreach programs	412 NE Ford Street McMinnville, OR 97128	All
Healthcare	Yamhill Oral Health Coalition	Convenes partners to work collectively at addressing unmet oral health needs in Yamhill County	412 NE Ford Street McMinnville, OR 97128	Access to care (dental)
Social Services	Yamhill Community Action Partnership	Assists County residents in accessing housing and energy services, the regional food bank, and youth services	1317 NE Dustin Ct, McMinnville, OR 97128	Access to care; social determinants of health and well-being

Appendix 4: Addressing Identified Needs through the 2020-2022 Community Health Improvement Plan

Will be completed in May 2020.

Appendix 5: PNMC Service Area Advisory Council

Name	Title	Organization	Sector
Mary Peterson, Chair	Professor and Program Director	George Fox University	Higher Education; Behavioral Health
Les Hallman, Vice chair	Assistant Chief	Tualatin Valley Fire and Rescue	Pre-Hospital Emergency Services
Shaun Davis	Psychologist, Owner	Cornerstone Clinical Services	Behavioral Health, Private Practice
Elaine Owen	Owner	Lady Hill Winery	Agriculture
Kate Stokes	Director	Yamhill Community Action Partnership (YCAP)	Public Service
Rick McCloskey	Entrepreneur	At Large	Entrepreneur, Private Sector
Luke Neff	Director of Instructional Technology	Newberg Public Schools	Public Education
Brian Casey	Chief of Police	Newberg-Dundee Police Department	Law Enforcement
Ryan Griffiths, MD	President of PNMC Medical Staff	Oregon Kidney and Hypertension	Hospital

Appendix 6: Yamhill Community Health Survey Final Report 2019

2019 COMMUNITY HEALTH SURVEY

Yamhill Service Area

August 2019

CONTENTS

CORE TEAM:
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Aisha Gilmore, MPH
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CORE | Center for Outcomes Research and Education

INTRODUCTION & METHODS

1 OVERVIEW

This report summarizes results from a *community health survey* completed as part of Providence St. Joseph Health's 2019 community health needs assessment (CHNA) process. The purpose of the community survey was to use a representative population sample to provide statistically valid estimates of health and health needs throughout the community, including needs related to the social determinants of health. The survey was conducted by CORE in the Spring of 2019.

Data from this survey represent one lens on the community's health and health needs. They are best used in conjunction other elements of the CHNA process, such as community stakeholder interviews or other publically available data, to provide a comprehensive set of data supports for developing a community health action plan.

2 SURVEY DESIGN

The survey instrument was based on the same form used in the 2016 community needs assessment. This included a set of questions designed to capture a range of health and health-related needs including access to essential health services, social determinants of health screenings and assessments, subjective health and well-being outcomes, and others. Most survey items were selected from nationally validated tools during the 2016 design process; only minor changes were implemented in the 2019 survey in order to preserve continuity of findings. Surveys were available in English and Spanish; Spanish translation was performed by a certified translator and all materials underwent plain-language review. A copy of the survey is available in the appendix.

The mail survey was fielded via a multi-stage mailing protocol supported by automated phone reminder calls:

Multi-Stage Mail Survey Process

SURVEY	AUTO CALL	SECOND SURVEY	THANK YOU & INCENTIVE
An initial survey and explanation letter, with a postage-paid return envelope.	Automated phone outreach asking participants to look for the survey in their mail and call with questions.	Second survey sent to participants that did not return the initial survey.	A thank you card and $10 incentive was provided upon receipt of the completed survey.

3 SAMPLE & RESPONSE RATE

We used address-based sampling to capture a representative group of households in the Yamhill region. Beginning with a list of all residential addresses in the community, we randomly selected 1,000 households to receive the survey.

We used census data to identify zip codes where at least 10% of households reported that Spanish was spoken at home; in those zip codes households received surveys in both English and Spanish. Fielding efforts revealed that surveys for 102 of the sampled households were not ultimately deliverable, leaving a final deliverable sample of 898 households. We received 118 completed surveys, yielding a 13% response rate.

Responses from 118 randomly selected households

4 DATA QUALITY & LIMITATIONS

Data from these surveys are distinct from results gained by handing surveys out in community settings. Because they are representatively sampled, these data can provide good overall estimates of the true prevalence of certain health conditions and challenges for a community.

However, data collected via population mail surveys also have important limitations. They necessarily only include respondents from people with addresses who can respond to written surveys, and thus may underrepresent those who are unstably housed, challenged by language or literacy barriers, or other vulnerable or underserved populations. Households from diverse racial-ethnic backgrounds or where the primary language is not English are also less likely to respond to population-based mail surveys. Because of these limitations, we recommend using these data in conjunction with other types of data collection, such as hand-fielded surveys or results from community sessions or stakeholder interviews, which are better positioned to capture data from populations likely to be underrepresented.

5 ANALYSIS & WEIGHTING

We entered all data in tabular form and analyzed it with a statistical software package (R version 3.3.3). Results were displayed for all respondents and for three key subgroups:

- **Race/ethnicity:** Non-Hispanic white respondents vs. respondents who identify as Hispanic, Latina(o), or other.
- **Household income:** Households reporting earnings less than 200% of the federal poverty level (FPL) vs households reporting earnings 200% of FPL or higher.
- **Coverage type:** Households reporting health coverage from a private employer vs Medicare coverage vs either Medicaid coverage or no coverage.

Testing for Disparities: To test for statistically significant differences between these key subgroups in our data, we used two-tailed chi-square tests of association. We flagged results with a p-value of .10 or less flagged as "statistically significant," indicating a high degree of confidence that the indicated difference between subgroups was not present in the data by simple chance.

Weighting: Since respondents to population surveys are often proportionally older than the actual community, and age is associated with prevalence of many health conditions, we weighted our results to account for the population's actual age distribution. Weighting allows our blended results to be more representative of the actual population in a region. We did not weight results by race/ethnicity, education, or any other variable. Details on our weighting methodology are available on request from CORE.

6 PRESENTATION OF RESEARCH FINDINGS

All data tables in this report (except where specifically noted otherwise) display the weighted percentage -- which adjusts our data by age to match population distributions -- as well as the *actual number of surveys* we received from which those weighted results were computed. Percentages are weighted by age to ensure our estimates are representative of the actual community population.

Major results are presented for each of four survey domains (right). For each survey question, we report the total weighted percentage of respondents who indicated a particular answer. We then break out responses by the three key subgroups of race/ethnicity, income, and insurance. Responses to key survey items are summarized in the body of the report, but complete results for every survey item are available in the **supplementary data tables.**

KEY RESULTS DOMAINS
Access to Care
Health & Health Status
Health Behaviors
Social Determinants of Health

OVERVIEW OF RESPONDENTS

Respondents to the 2019 Yamhill survey looked largely similar to those who responded in 2016. Distributions by gender, race/ethnicity, and income looked very similar between 2016 and 2019. On average, 2019 respondents were somewhat younger and more educated than in 2016, but these differences are probably attributable to random variation in sample selection and not a substantive shift in the region's population. Results in this report have been weighted to account for the population's age distribution, so this difference should not impact comparability of results.

Overall, respondents to population surveys are often older and more likely to be white than the full population, because those populations are generally more likely to respond. These response patterns are a known weakness of population-based mail surveys, and are one reason data such as this should be supplemented with information collected by other means, including direct or enhanced outreach into diverse communities. When conducting a community needs assessment, data from surveys should always be considered in tandem with other sources of community information.

	2016		2019	
	Total (N)	Percent	Total (N)	Percent
GENDER				
Male	95	42.0%	42	37.3%
Female	128	56.6%	71	62.7%
Transgender, non-binary, nonconforming, or no answer	1	0.4%	0	0.0%
AGE				
18 to 39 years	26	11.5%	39	34.4%
40 to 64 years	110	48.7%	50	43.9%
65 to 79 years	56	24.8%	18	16.1%
80+ years	30	13.3%	6	5.6%
RACE & ETHNICITY				
White, non-Hispanic	200	88.5%	94	79.6%
Other race/ethnicity	26	11.5%	24	20.4%
INCOME				
100% FPL or lower	16	7.1%	14	11.7%
101% to 200% FPL	18	8.0%	12	10.4%
201% FPL or higher	167	73.9%	79	67.1%
Did not answer	25	11.1%	13	10.8%
EDUCATION				
Less than high school	6	2.7%	0	0.0%
High school diploma/GED	**57**	25.2%	30	25.1%
Vocational or 2 year degree	47	20.8%	23	19.3%
4-year degree or more	113	50%	64	53.9%
Did not answer	3	1.3%	2	1.7%

KEY RESULTS: ACCESS TO CARE

1 INSURANCE COVERAGE

Overall, the estimated uninsured rate remained very stable between 2016 (1.3%) and 2019 (2.3%). Rates of uninsurance did not differ significantly by subgroup.

DO YOU CURRENTLY HAVE ANY KIND OF HEALTH INSURANCE?

CURRENT INSURANCE COVERAGE	2016	2019	2019 BY SUBGROUP:			
	Total (n=220)	Total (n=118)	Non-Hispanic White (n=92)	Hispanic/ Latino/Other (n=20)	200% FPL or lower (n=26)	201% FPL or higher (n=79)
No Insurance	1.3%	2.3%	2.9%	0.0%	5.4%	1.6%

* No significant differences by subgroup. Tests only performed if n=20 or more.

TYPE & CONTINUITY OF INSURANCE: More than half (62.6%) of respondents reported having private insurance, with Medicare (14.5%) and Medicaid (20.7%) making up the balance. When asked about their coverage for other types of services, common coverage gaps included long-term care coverage (with 45.1% indicated they had coverage for all of the last year) and vision (with 73.2% indicating coverage for all of the last year). Most respondents reported having dental coverage over the past year (81.9%).

MOST COMMON COVERAGE TYPES	2016	2019
	n=220	n=115
Private Insurance	67.6%	62.6%
Medicare	20.2%	14.5%
Medicaid	10.1%	20.7%
Uninsured	2.0%	2.3%

2 CONNECTION TO PRIMARY CARE

Most respondents had a usual source of care: only 9.3% reported that they do *not* have a place to go for non-emergency health care. However, nearly one in five (18.1%) reported not having anyone they think of as their personal doctor or health care provider, a common indicator of strong connections to primary and preventive care. Rates were stable between 2016 and 2019, but connections to primary care and having a usual place to go for non-emergency healthcare varied significantly by subgroup: in particular, Hispanic/Latino(a) respondents were more likely to report not having a "personal doctor" than non-Hispanic white respondents. We also found that and those with private coverage were actually more likely to report not having a usual source of care (13.9%), indicating a possible access challenge in traditional primary care settings.

QUESTIONS ON CONNECTIVITY TO PRIMARY CARE

CONNECTIONS TO CARE	2016	2019	2019 BY SUBGROUP:						
	Total (n=220)	Total (n=118)	Non-Hispanic White (n=92)	Hispanic/ Latino/Other (n=20)	200% FPL or lower (n=26)	201% FPL or higher (n=79)	Private (n=74)	Medicare (n=17)	Medicaid, Uninsured, Other (n=27)
No usual place for non-emergency care	5.1%	9.3%	9.3%	12.3%	10.8%	10.3%	13.9%*	0.0%*	1.7%*
Does not have a personal doctor or provider	25.0%	18.1%	15.2%*	31.8%*	23.6%	16.2%	19.1%	5.3%	24.2%

* Significant differences between subgroups. Tests only performed if n=20 or more.

3 ACCESS TO MEDICAL CARE

Most respondents (79.8%) reported needing some kind of medical care in the preceding 12 months, slightly more than in 2016. There were no significant trends over time in access to medical care, but we did see significant differences among subgroups based on income level and insurance type: those with lower incomes and Medicaid were significantly more likely to go without needed care. We did not see evidence of major differences by race/ethnicity.

ACCESS TO MEDICAL CARE IN LAST YEAR	2016	2019	2019 BY SUBGROUP:						
	Total (n=220)	Total (n=118)	Non-Hispanic White (n=92)	Hispanic/ Latino/Other (n=20)	200% FPL or lower (n=26)	201% FPL or higher (n=79)	Private (n=74)	Medicare (n=17)	Medicaid, Uninsured, Other (n=27)
Needed Care & Got ALL the care they needed	74.5%	69.4%	71.9%	60.7%	57.1%*	74.7%*	77.1%*	87.7%*	37.5%*
Needed Care & Sometimes Went Without	11.5%	10.4%	9.5%	17.4%	19.8%*	6.0%*	5.4%*	4.7%*	27.1%*
Did Not Need Care	13.9%	20.2%	18.6%	21.9%	23.1%*	19.3%*	17.5%*	7.6%*	35.5%*

* Significant differences between subgroups. Tests only performed if n=20 or more.

TYPES OF UNMET MEDICAL NEED: The survey asked respondents who reported having gone without needed care (n=12) if the care they missed was any of several specific types of care. Of the 11 respondents who went without care, 2 went without care for an illness or injury, while no respondents said they had gone without routine checkups or care for their chronic health conditions. The remainder went without a kind of care that was not listed among our options.

4 ACCESS TO DENTAL CARE

This question was new to the Yamhill region survey in 2019. A little more than one in ten of respondents (12.2%) reported experiencing an unmet need for dental care in the last 12 months—about the same as the 10.4% who went without needed medical care. Rates varied significantly by income level and insurance type.

ACCESS TO DENTAL CARE IN LAST YEAR	2016	2019	2019 BY SUBGROUP:						
	Total (n=220)	Total (n=118)	Non-Hispanic White (n=92)	Hispanic/ Latino/Other (n=20)	200% FPL or lower (n=26)	201% FPL or higher (n=79)	Private (n=74)	Medicare (n=17)	Medicaid, Uninsured, Other (n=27)
Needed Care & Got ALL the care they needed	n/a	71.0%	70.2%	68.2%	49.7%*	77.5%*	79.6%*	73.6%*	45.1%*
Needed Care & Sometimes Went Without	n/a	12.2%	13.9%	7.2%	18.7%*	10.2%*	7.2%*	8.2%*	29.0%*
Did Not Need Care	n/a	16.8%	15.9%	24.6%	31.6%*	12.3%*	13.3%*	18.2%*	25.9%*

* Significant differences between subgroups. Tests only performed if n=20 or more.

TYPES OF UNMET DENTAL NEED: The survey asked respondents who had to go without dental care (n=14) to identify which types of dental care they went without. Of the 14 (12.2%) who went without care, most (10, or 58.9%) said they went without dental check-ups or teeth cleaning, while another 6 (33%) reported a toothache or mouth pain going untreated. The remainder went without some other kind of dental care not listed among our options.

ACCESS TO MENTAL HEALTH CARE

Access to mental health care was a new addition to the Yamhill survey this year. Just over 1 in 10 (14%) of respondents indicated needing mental health care, with only 3% of all respondents indicating they had experienced an unmet need for mental health care. Rates varied significantly by race, with Hispanic or Latino(a) respondents more likely to report unmet mental health care needs. We did not see evidence of significant differences in mental health care access by income or coverage group.

ACCESS TO MENTAL HEALTH CARE IN LAST YEAR	2016	2019	2019 BY SUBGROUP:						
	Total (n=220)	Total (n=118)	Non-Hispanic White (n=92)	Hispanic/ Latino/Other (n=20)	200% FPL or lower (n=26)	201% FPL or higher (n=79)	Private (n=74)	Medicare (n=17)	Medicaid, Uninsured, Other (n=27)
Needed Care & Got ALL the care they needed	n/a	11.0%	13.0%*	0.0%*	11.4%	8.6%	12.4%	2.5%	12.6%
Needed Care & Sometimes Went Without	n/a	3.0%	1.4%*	10.9%*	8.3%	1.7%	1.8%	0.0%	8.9%
Did Not Need Care	n/a	86.0%	85.5%*	89.1%*	80.3%	89.8%	85.9%	97.5%	78.5%

* Significant differences between subgroups. Tests only performed if n=20 or more.

TYPES OF MENTAL HEALTH NEED: Unmet need for mental health care was relatively rare in Yamhill among survey respondents, but we asked those who did report going without mental health care to identify which types of care they went without. The most common response (47.8%) was going without treatment for a mental health condition such as PTSD, depression, or anxiety. Other responses included going without substance use treatment (1 respondent) or support/counseling for personal problems (1 respondent).

KEY RESULTS: HEALTH STATUS

1 OVERALL HEALTH – SELF ASSESSMENT

A little more than five percent (6.4%) of respondents rated their own health as "poor" or "fair" (vs good, very good, or excellent) – slightly less than the 9.6% who did so in 2016. We did not see any significant differences in subjective health assessments between subgroups.

SELF-REPORTED OVERALL HEALTH (FAIR OR POOR VS GOOD, VERY GOOD, OR EXCELLENT)

SUBJECTIVE HEALTH	2016	2019	2019 BY SUBGROUP:						
	Total (n=220)	Total (n=118)	Non-Hispanic White (n=92)	Hispanic/ Latino/Other (n=20)	200% FPL or lower (n=26)	201% FPL or higher (n=79)	Private (n=74)	Medicare (n=17)	Medicaid, Uninsured, Other (n=27)
Fair or Poor (vs. Good or better)	9.6%	6.4%	5.8%	10.9%	18.6%	3.3%	5.8%	5.4%	8.9%

* No significant differences by subgroup. Tests only performed if n=20 or more.

2 CHRONIC DISEASE PREVALANCE

OVERALL PREVALANCE OF COMMON CHRONIC ILLNESSES: 45.4% of respondents reported having been diagnosed with at least one of the chronic physical conditions listed on our survey, and 27.2% report at least one chronic behavioral health condition. 11.0% have at least one of each. Trends were stable from 2016, but we found evidence of significant differences in complex health challenges by race, income and coverage type:

CHRONIC CONDITIONS OVERVIEW	2016	2019	2019 BY SUBGROUP:						
	Total (n=220)	Total (n=118)	Non-Hispanic White (n=92)	Hispanic/ Latino/Other (n=20)	200% FPL or lower (n=26)	201% FPL or higher (n=79)	Private (n=74)	Medicare (n=17)	Medicaid, Uninsured, Other (n=27)
Has at least 1 physical chronic condition	46.6%	45.4%	44.7%	49.8%	36.3%	48.9%	42.0%*	79.4%*	33.1%*
Has at least 1 behavioral health condition	26.7%	27.2%	25.3%	39.3%	40.7%*	22.7%*	23.3%*	17.7%*	44.0%*
Has at least 1 of each	13.9%	11.0%	6.9%*	28.3%*	20.2%	8.5%	9.3%	9.5%	16.9%

* Significant differences between subgroups. Tests only performed if n=20 or more.

PREVALANCE OF SPECIFIC CONDITIONS: The most common chronic condition diagnoses reported by the Yamhill Service Area population were high blood pressure (26.0%) and high cholesterol (25.4%). Common mental health challenges included anxiety (22.2%) and depression (20.3%). Prevalence rates for most conditions in 2019 were roughly comparable to those of the 2016 survey respondents. We did find evidence of differences in diagnoses by payer type, with Medicaid/uninsured residents reporting higher rates of key mental health challenges, especially anxiety (36.6% v 21.6% among commercially insured) and PTSD (20.8% vs 3.5% among the commercially insured).

Prevalence Estimates of Key Chronic Health Conditions

CHRONIC CONDITION PREVALANCE	2016 Total (n=220)	2019 Total (n=118)	2019 BY SUBGROUP: Non-Hispanic White (n=92)	Hispanic/ Latino/Other (n=20)	200% FPL or lower (n=26)	201% FPL or higher (n=79)	Private (n=74)	Medicare (n=17)	Medicaid, Uninsured, Other (n=27)
High Blood Pressure	28.3%	26.0%	25.9%	32.4%	24.9%	27.3%	25.0%*	50.5%*	13.3%*
High Cholesterol	22.3%	25.4%	26.8%	19.4%	16.1%	28.7%	23.2%*	51.8%*	15.1%*
Asthma	10.8%	8.3%	8.8%	6.5%	4.6%	10.2%	6.4%	19.5%	6.2%
Diabetes	9.9%	5.1%	6.1%	0.0%	11.6%	3.8%	1.2%*	18.9%*	7.0%*
Depression	21.4%	20.3%	18.8%	32.8%	30.8%	17.3%	17.6%	15.3%	30.8%
Anxiety	17.0%	22.2%	21.4%	32.8%	31.5%	19.5%	21.6%*	2.4%*	36.6%*
PTSD	6.5%	8.2%	5.7%*	21.9%*	20.5%*	5.4%*	3.5%*	8.2%*	20.8%*
Another ongoing health condition	n/a	21.2%	22.5%	21.4%	8.4%	22.8%	19.7%	22.9%	24.2%

* Significant differences between subgroups. Tests only performed if n=20 or more.

ANXIETY & DEPRESSION SYMPTOMS

In addition to asking people to identify conditions they have been diagnosed with by a health professional, the survey included questions designed to assess whether a respondent might *currently be* experiencing symptoms of anxiety or depression (as opposed to having received a diagnosis). These questions are identical to those used in many clinical settings as an initial screener for potential anxiety or depression, and are a good way to capture potential depression or anxiety that is not currently well controlled. Overall, we found that only 1.8% of respondents were currently experiencing symptoms of anxiety and 2.7% had active symptoms of depression, indicating that most people with these diagnoses were experiencing good control over their conditions. Symptoms were significantly more common among lower-income respondents.

Symptoms of Anxiety or Depression (GAD-2 and PHQ-2 Screening Tools).

SYMPTOM PREVALANCE	2016 Total (n=220)	2019 Total (n=118)	2019 BY SUBGROUP: Non-Hispanic White (n=92)	Hispanic/ Latino/Other (n=20)	200% FPL or lower (n=26)	201% FPL or higher (n=79)	Private (n=74)	Medicare (n=17)	Medicaid, Uninsured, Other (n=27)
Current symptoms of anxiety	8.7%	1.8%	0.0%*	10.9%*	8.3%*	0.0%*	0.0%*	0.0%*	8.0%*
Current symptoms of depression	5.1%	2.7%	3.4%	0.0%	3.8%*	0.0%*	3.0%	0.0%	3.7%

* Significant differences between subgroups. Tests only performed if n=20 or more.

OBESITY/BMI

The survey asked respondents to report their height and weight, which allowed us to calculate self-reported Body Mass Index (BMI). We used these data to estimate age-adjusted estimates of how many Yamhill residents could be classified as overweight or obese. Overall, about one in three (30.9%) of respondents were overweight (with BMIs between 25-29) and another third (32.5%) were obese according to their own reporting, with BMIs of 30 or more. Taken together, over 6 in 10 (63.4%) of respondents in Yamhill were either overweight or obese. These numbers were largely consistent across survey years and subpopulations.

Estimated Body Mass Index (Based on Self-Reported Height and Weight)

BMI PREVALANCE	2016	2019	2019 BY SUBGROUP:						
	Total (n=220)	Total (n=118)	Non-Hispanic White (n=92)	Hispanic/ Latino/Other (n=20)	200% FPL or lower (n=26)	201% FPL or higher (n=79)	Private (n=74)	Medicare (n=17)	Medicaid, Uninsured, Other (n=27)
Overweight (BMI 25-29)	33.7%	30.9%	30.9%	30.4%	38.6%	28.1%	29.0%	21.8%	42.1%
Obesity (BMI 30+)	27.3%	32.5%	34.4%	28.3%	25.6%	37.1%	30.7%	38.2%	34.0%

* No significant differences between subgroups. Tests only performed if n=20 or more.

KEY RESULTS: HEALTH BEHAVIORS

1 QUALITY OF DIET

Less than half (48.9%) of Yamhill respondents reported eating fewer than two servings of fruit per day, and 33% report fewer than two servings of vegetables per day – numbers roughly equivalent to results from 2016. Those in the lower income subgroup were more likely to report eating fewer vegetables than those in the higher income subgroup (56.9% vs 26.7%).

Fruit and Vegetable Consumption (per day)

FRUIT & VEGETABLE CONSUMPTION	2016 Total (n=220)	2019 Total (n=118)	2019 BY SUBGROUP: Non-Hispanic White (n=92)	Hispanic/ Latino/Other (n=20)	200% FPL or lower (n=26)	201% FPL or higher (n=79)	Private (n=74)	Medicare (n=17)	Medicaid, Uninsured, Other (n=27)
Fewer than two servings of fruit	39.6%	48.9%	47.4%	45.8%	41.2%	50.2%	49.1%	51.1%	46.7%
Fewer than two servings of vegetables	37.0%	33.0%	28.7%*	56.7%*	56.9%*	26.7%*	25.5%*	45.3%*	46.7%*

*Significant differences between subgroups. Tests only performed if n=20 or more.

2 HEALTH RISK BEHAVIORS

We assessed the prevalence of other health risk behaviors, including the use of tobacco, indicators of potential alcohol misuse, and drug use. Prevalence rates were roughly comparable to those seen in 2016 for indicators that were assessed on both surveys, with the exception of potentially problematic "binge" drinking, which increased from 9.4% in 2016 to 22.2% in 2019. Rates of smoking were significantly higher among low-income and Medicaid/uninsured respondents.

Health Risk Behaviors

HEALTH BEHAVIOR	2016 Total (n=220)	2019 Total (n=118)	2019 BY SUBGROUP: Non-Hispanic White (n=92)	Hispanic/ Latino/Other (n=20)	200% FPL or lower (n=26)	201% FPL or higher (n=79)	Private (n=74)	Medicare (n=17)	Medicaid, Uninsured, Other (n=27)
Current smoker	3.6%	8.6%	6.1%*	21.9%*	25.4%*	1.6%*	4.8%*	0.0%*	25.4%*
Four or more drinks per week	21.1%	18.2%	23.4%*	0.0%*	0.0%*	19.8%*	22.8%	12.4%	3.0%
Three or more drinks per day of drinking	9.4%	22.2%	21.9%	27.2%	35.7%	17.3%	23.6%	16.8%	21.2%
Marijuana use	13.3%	5.1%	6.6%	0.0%	10.3%	4.3%	3.5%	13.0%	4.7%
Any other drug use	1.1%	6.6%	7.1%	0.0%	4.9%	4.9%	7.1%	0.0%	9.5%

*Significant differences between subgroups. Tests only performed if n=20 or more.

KEY RESULTS: SOCIAL DETERMINANTS OF HEALTH

1 BASIC NEEDS

We asked respondents to tell us whether they had recently had difficulty meeting any basic needs. 16.4% of respondents reported that they or someone in their household had gone without one or more of the listed basic needs (stable housing, food, utilities, transportation, clothing, or child care) in the past 12 months, an increase from 8.2% in 2016. All areas of need increased modestly in 2019 compared to 2016. As might be expected, unmet basic needs was highly sensitive to family income, with lower income residents were far more likely to suffer from at least one such need than others.

Percent Going without Basic Needs in the Last 12 Months

PERCENT GOING WITHOUT BASIC NEEDS	2016	2019	2019 BY SUBGROUP:						
	Total (n=220)	Total (n=118)	Non-Hispanic White (n=92)	Hispanic/ Latino/Other (n=20)	200% FPL or lower (n=26)	201% FPL or higher (n=79)	Private (n=74)	Medicare (n=17)	Medicaid, Uninsured, Other (n=27)
Food	4.6%	7.0%	4.2%*	21.9%*	18.2%*	1.6%*	7.6%	0.0%	9.5%
Clothing	2.6%	5.8%	7.4%	0.0%	6.5%	3.8%	8.7%	0.0%	1.5%
Transportation	2.5%	8.5%	6.1%*	21.9%*	16.7%*	4.4%*	7.6%	0.0%	16.1%
Child Care	1.5%	5.5%	2.4%*	21.9%*	8.3%	2.8%	8.8%	0.0%	0.0%
Utilities	1.1%	4.8%	3.8%	10.9%	8.3%*	1.6%*	7.6%	0.0%	0.0%
Stable Housing or Shelter	0.4%	2.2%	2.8%	0.0%	1.6%	0.0%	3.0%	2.4%	0.0%
One or more of the above needs	8.2%	16.4%	11.6%*	43.8%*	41.4%*	8.1%*	14.6%*	2.4%*	30.4%*

*Significant differences between subgroups. Tests only performed if n=20 or more.

2 HEALTH NEEDS

We also asked respondents to tell us whether anyone in their household had gone without health needs in the last 12 months. The most commonly reported unmet health need was for dental care, with 12.5% reporting unmet needs – roughly the same as the 9.0% reported in 2016. All unmet health needs varied significantly by income level, and unmet needs for medical care were much higher among Hispanic/Latino(a) respondents.

Percent Going without Health Needs in the Last 12 Months

PERCENT GOING WITHOUT BASIC NEEDS	2016	2019	2019 BY SUBGROUP:						
	Total (n=220)	Total (n=118)	Non-Hispanic White (n=92)	Hispanic/ Latino/Other (n=20)	200% FPL or lower (n=26)	201% FPL or higher (n=79)	Private (n=74)	Medicare (n=17)	Medicaid, Uninsured, Other (n=27)
Dental Care	9.0%	12.5%	13.6%	10.9%	31.9%*	6.5%*	11.6%	8.2%	17.6%
Medical Care	2.5%	7.8%	5.3%*	21.9%*	17.2%*	6.0%*	7.6%	8.2%	8.1%
Medicine	2.1%	8.6%	8.6%	10.9%	17.1%*	4.4%*	7.6%	5.9%	12.8%
One or more of the above	9.7%	17.3%	17.4%	21.9%	36.9%*	9.2%*	17.5%	8.2%	22.3%

*Significant differences between subgroups. Tests only performed if n=20 or more.

3 CURRENT HOUSING STABILITY

In addition to asking if respondents had experienced housing insecurity in the last 12 months, we asked questions about respondent's *current* housing stability. 11.6% of respondents expressed at least some housing worries – either a lack of stable housing (6.1%) or worries that they were about to lose their stable housing (5.5%). Rates of housing instability were roughly comparable to those observed in 2016, and varied significantly by race, income and insurance status. It is important to note that because the survey sample was based on residential addresses, the true prevalence of housing insecurity in the region may be higher than what is estimated here.

Current Housing Situation

HOUSING INSECURITY	2016 Total (n=220)	2019 Total (n=118)	2019 BY SUBGROUP: Non-Hispanic White (n=92)	Hispanic/ Latino/Other (n=20)	200% FPL or lower (n=26)	201% FPL or higher (n=79)	Private (n=74)	Medicare (n=17)	Medicaid, Uninsured, Other (n=27)
Have housing, not worried about losing it	91.6%	81.6%	90.4%*	45.3%*	54.8%*	94.4%*	88.1%*	89.5%*	59.0%*
Have housing, but worried about losing it	6.9%	5.5%	4.6%	10.9%	3.1%	4.4%	7.6%	2.4%	1.5%
Do not have stable housing	1.5%	6.1%	3.0%*	21.9%*	23.5%*	1.3%*	0.0%*	5.3%*	23.0%*

*Significant differences between subgroups. Tests only performed if n=20 or more.

4 SOCIAL SUPPORT

We asked participants a series of questions drawn from the Social Support Index (SSI) and designed to assess whether they usually have access to certain kinds of social support in their lives. We report the percent of respondents whose answers indicated a **lack** of strong social support in each domain. Overall, Yamhill respondents indicated levels of social support comparable to those reported in 2016, with about one in five reporting poor social support for most domains. Low-income respondents were especially likely to report low social support.

Percent who would NOT usually have someone available to support them by…

PERCENT WITHOUT STRONG SOCIAL SUPPORT	2016 Total (n=220)	2019 Total (n=118)	2019 BY SUBGROUP: Non-Hispanic White (n=92)	Hispanic/ Latino/Other (n=20)	200% FPL or lower (n=26)	201% FPL or higher (n=79)	Private (n=74)	Medicare (n=17)	Medicaid, Uninsured, Other (n=27)
Love and make feel wanted	14.3%	23.1%	22.9%	21.9%	41.8%*	17.0%*	16.0%*	26.1%*	41.3%*
Give good advice	14.4%	19.4%	20.7%*	0.0%*	24.9%	14.3%	15.0%	21.2%	30.9%
Get together with to relax	19.6%	26.9%	22.5%	32.8%	52.4%*	18.7%*	17.4%*	33.4%*	49.8%*
Confide in, talk about problems	16.6%	24.0%	23.0%	21.9%	40.3%*	18.8%*	16.2%*	23.6%*	46.3%*
Help if confined to a bed	n/a	30.5%	27.5%	32.8%	62.9%*	20.9%*	21.0%*	35.8%*	53.6%*

*Significant differences between subgroups. Tests only performed if n=20 or more.

5 ADVERSITY & TRAUMA ACROSS THE LIFE COURSE

A large body of literature has associated adverse life experiences with poor health outcomes. We asked participants to tell us the extent to which they had experienced any of a series of difficult or traumatic events in their lives. Results reveal a high prevalence in the Yamhill region of many types of adversity events.

- **Overall Prevalence:** Respondents reported a wide range of adversities in their lives. Nearly half of respondents (44%) have experienced three or more from the surveys' list of challenges.
- **Trends:** Among questions that were asked in both 2016 and 2019, there were increases in the percent of respondents reporting abuse (from 16.1% to 23.5%) or living with someone with mental illness or substance abuse (from 24.6% to 40.0%). This may reflect an actual increase in prevalence, rising awareness of these issues prompting greater rates of reporting, or other factors.
- **Differences:** Low-income respondents were significantly more likely to report many adverse experiences, including intimate partner violence (20.2% vs 4.8%).

Percent who have experienced each type of adverse event in their lives…

PERCENT WITHOUT STRONG SOCIAL SUPPORT	2016	2019	2019 BY SUBGROUP:						
	Total (n=220)	Total (n=118)	Non-Hispanic White (n=92)	Hispanic/ Latino/Other (n=20)	200% FPL or lower (n=26)	201% FPL or higher (n=79)	Private (n=74)	Medicare (n=17)	Medicaid, Uninsured, Other (n=27)
Life-changing illness or injury	28.8%	38.2%	38.5%	41.3%	47.5%	39.1%	39.8%	36.0%	35.1%
Lived with someone with mental illness or substance abuse	24.6%	40.0%	43.2%	30.4%	33.1%	45.4%	45.9%	37.7%	25.2%
Witnessed or experienced violence	23.2%	21.6%	22.4%	23.9%	20.2%	25.5%	26.2%	15.3%	12.8%
Abuse	16.1%	23.5%	23.5%	23.9%	34.5%	23.7%	20.4%	16.6%	36.5%
Neglect	9.0%	13.2%	12.7%	13.0%	20.2%	13.0%	11.7%	13.0%	17.5%
Physically hurt or threatened by intimate partner	8.1%	7.7%	7.5%	10.9%	20.2%*	4.8%*	3.5%*	17.7%*	12.8%*
Made to do something sexual didn't want to	7.2%	7.7%	8.5%	0.0%	18.6%*	5.4%*	7.0%	8.2%	9.5%
Suicide attempt by close friend or family	-	23.7%	24.2%	21.9%	17.9%	25.5%	27.4%	14.7%	19.0%
Parents separated as child	-	21.8%	20.8%	32.8%	19.8%	25.5%	28.6%*	9.5%*	11.0%*
Unexpected death of a loved one	28.6%	34.6%	37.2%	32.8%	36.5%	34.7%	36.8%	32.9%	29.7%
3 or more of the above	11.7%	44.0%	45.0%	45.8%	47.9%	46.5%	51.4%	31.9%	31.5%

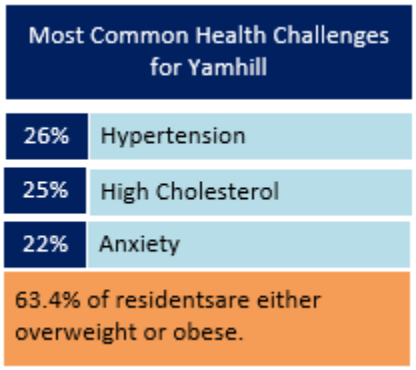
*Significant differences between subgroups. Tests only performed if n=20 or more.

SUMMARY OF KEY TAKEAWAYS

Responses from the Yamhill region's survey are an important source of information for assessing community needs. Because the survey uses a representative random sampling technique, its results are a good way to estimate the level of key health and social needs throughout the community. Key takeaways from the survey include:

1 MENTAL HEALTH CHALLENGES, ESPECIALLY IN LOWER INCOME HOUSEHOLDS.

Most respondents report that they are in good, very good, or excellent health – only 6.4% characterized their own health as "fair" or "poor." The top three most common health challenges are hypertension, high cholesterol, and anxiety, with the latter reported by one in five (22%) of residents. Yamhill residents also reported high rates of obesity, with 63.4% of respondents being either overweight (BMI 25-29) or obese (BMI of 30+) according to their own self-reported height and weight.



There were significant disparities in many health challenges by family income, with lower income families (those earning 200% or less of FPL) having significantly higher rates of many chronic health challenges. Of particular note was the high prevalence of PTSD (24.5% vs. 5.4%) and anxiety (31.5% vs 19.5 %).

2 ABOUT ONE IN TEN RESIDENTS HAVE UNMET CARE NEEDS.

Most residents reported having a place to go for regular or routine care, though those with private insurance were more likely to report not having such a place (13.9%) than other insurance subgroups, indicating a possible access gap. Unmet need for medical care was reported by 10.4% of residents, and 12.2% reported an unmet need for dental care in the previous 12 months.

3 KEY SDH CHALLENGES INCLUDE FOOD & HOUSING STABILITY.

Social determinants of health (SDH) are important predictors of long-term health outcomes, and Yamhill residents face several key challenges. Over one in ten residents (11.6%) report either not having stable housing or being worried about the stability of their housing situation. Nearly one in ten (8.5%) also reported shortages of food in the past year, a jump from the 2.9% in 2016. Respondents were more likely to report nearly all types of basic needs in 2019 than in 2016, indicating a general increase in need across the region.

4 A HIGH PREVALANCE OF TRAUMA, ESPECIALLY AMONG LOWER INCOME HOUSEHOLDS.

Rates of several types of self-reported adversity and trauma were higher in 2019 than in 2016, including living with someone with mental illness or substance abuse (24.6% vs 40.0%), abuse (16.1% vs 23.5%) and having a life-changing illness or injury (28.8% vs 38.2%). These trends may reflect increasing awareness of these issues, an actual increase in prevalence, or both. Slightly less than half (44.0%) of residents reported having experienced three or more of the adverse life events included in the survey, suggesting a significant potential trauma burden in the Yamhill community. Prevalence of adverse experiences was especially high among lower income households, who – perhaps not coincidentally -- also reported higher prevalence of anxiety and PTSD.

FROM KNOWLEDGE TO ACTION

These key takeaways, combined with other information collected as part of the needs assessment process, may suggest several areas of potential focus for community health improvement efforts. To further explore the results of this survey, please refer to the complete data tables accompanying this report.

APPENDIX A. Community Health Survey

COMMUNITY HEALTH SURVEY

INSTRUCTIONS: For each question, please fill in the circle that best represents your answer. Your results are completely private, and you can skip any question you do not want to answer. When you are finished, place the survey in the postage-paid envelope we have provided and drop it in the mail. If you have questions about this survey, please read the included letter or call us at 1-877-215-0686.

PART 1 YOUR HEALTH CARE

1 Do you currently have any kind of health insurance?
- ◯ Yes
- ◯ No → **(Go to Question 3)**

2 What kind of health insurance do you have? *Mark all that apply.*
- ◯ Medicaid/Oregon Health Plan (OHP)
- ◯ Medicare
- ◯ VA, TRICARE or other military health care
- ◯ Private coverage through an employer or family member's employer
- ◯ A private plan I pay for myself
- ◯ Other (tell us): _____
- ◯ I don't have any insurance now
- ◯ I don't know

3 If you **don't** currently have any kind of health insurance, what are the main reasons why? *Mark all that apply.*
- ◯ It costs too much
- ◯ I don't think I need insurance
- ◯ I am waiting to get coverage through a job
- ◯ Signing up is too confusing
- ◯ I haven't had time to deal with it
- ◯ Other (tell us): _____

4 For how many of the **last 12 months** did you have some kind of health insurance?
- ◯ Not insured during the last 12 months
- ◯ 1-3 months
- ◯ 4-6 months
- ◯ 7-9 months
- ◯ 10-11 months
- ◯ Insured for ALL of the last 12 months

5 For how many of the **last 12 months**, did you have insurance for the following health care?

	All 12 months	**Some** of the 12 months	**None** of the 12 months
Medical Care	◯	◯	◯
Dental Care	◯	◯	◯
Vision	◯	◯	◯
Long-term Care	◯	◯	◯

6 Do you have a place to go for health care when it is not an emergency?
- ◯ Yes
- ◯ No → **(Go to Question 8)**

7 Where do you usually go to receive health care when it is not an emergency? *Mark only one.*
- ◯ A private doctor's office or clinic
- ◯ A public health clinic or community health center
- ◯ A tribal health clinic
- ◯ A VA facility
- ◯ A hospital-based clinic
- ◯ A hospital emergency room
- ◯ An urgent care clinic
- ◯ Other (tell us): _____
- ◯ I don't have a usual place

8 Do you have **one person** you think of as your personal doctor or health care provider?
- ◯ Yes
- ◯ No

9 In the **last 12 months**, did **you** need any **medical** care?
- ◯ Yes
- ◯ No → **(Go to Question 11)**

10 Did **you** get all the **medical** care you needed?
- ◯ Yes → **(Go to Question 11)**
- ◯ No → Which types of medical care did you have to go without? *Mark all that apply.*
  - ◯ Checkup or physical exam
  - ◯ Visits for an illness or injury
  - ◯ Visits about a chronic health condition like diabetes or high blood pressure
  - ◯ Other kinds of care

CHS-YAMHILL PAGE 1 OF 5 PLEASE CONTINUE ON THE NEXT PAGE →

11 In the **last 12 months**, did **you** need any **dental** care?

- ◯ Yes
- ◯ No → **(Go to Question 13)**

12 Did **you** get all the **dental** care you needed?

- ◯ Yes → **(Go to Question 13)**
- ◯ No → Which types of dental care did you have to go without? *Mark all that apply.*
  - ◯ Dental check-up or teeth cleaning
  - ◯ Tooth ache or mouth pain
  - ◯ Other kinds of care

13 In the **last 12 months**, did **you** need **counseling or mental health treatment?**

- ◯ Yes
- ◯ No → **(Go to Question 16)**

14 Did **you** get all the **counseling or mental health** care you needed?

- ◯ Yes → **(Go to Question 15)**
- ◯ No → Which types of counseling or mental health care did you have to go without? *Mark all that apply.*
  - ◯ Support for a personal problem
  - ◯ Treatment for a mental health condition like PTSD, depression, or anxiety
  - ◯ Counseling to quit tobacco, alcohol, or drug use
  - ◯ Other kinds of care

15 In the **last 12 months**, where did you **mostly** go to get counseling or mental health care? *Mark only one.*

- ◯ My primary care doctor's office
- ◯ Mental Health clinic
- ◯ VA Clinic
- ◯ Phone, Online, texting, or video chat service
- ◯ From a pastor, minister, or priest
- ◯ Hospital emergency room
- ◯ Other: _____

16 If **you** went without **any** of the needed medical, dental, counseling or mental health care, or drug or alcohol abuse treatment in the last 12 months, what were the reasons why? *Mark all that apply.*

- ◯ I did not go without care. I got all the care I needed
- ◯ It cost too much
- ◯ Getting to the clinic was too hard
- ◯ The doctor or clinic did not understand my culture, lifestyle, identity, or my language
- ◯ There was no local doctor that accepted my insurance
- ◯ I did not know where to go
- ◯ I was afraid
- ◯ Other: _____

PART 2 YOUR HEALTH & LIFESTYLE

17 In general, would you say your health is:

- ◯ Excellent
- ◯ Very Good
- ◯ Good
- ◯ Fair
- ◯ Poor

18 Have you **ever** been told by a doctor or other health professional that you have any of the following?

	Yes	No
Diabetes or sugar diabetes	◯	◯
Asthma	◯	◯
High blood pressure	◯	◯
High cholesterol	◯	◯
Depression	◯	◯
Post-traumatic stress disorder	◯	◯
Anxiety	◯	◯
Substance use problem	◯	◯
Another health condition	◯	◯

Please tell us: _____

19 During the **past 2 weeks**, about how often have you been bothered by the following problems:

	Not at all	Several days	Over half the days	Nearly every day
Little interest or pleasure in doing things	○	○	○	○
Feeling down, depressed, or hopeless	○	○	○	○
Feeling nervous, anxious, or on edge	○	○	○	○
Not being able to stop or control worrying	○	○	○	○

20 Do you have any children (under 18 years of age)?

- ○ Yes
- ○ No → **(Go to Question 24)**

21 In the **last 12 months**, how many times did your child go to the emergency room to get care?
Your best estimate is fine.

- ○ None → **(Go to Question 23)**
- ○ 1 time
- ○ 2 times
- ○ 3 times or more

22 The **most recent time** your child went to the emergency room, what was the main reason you went there instead of somewhere else for health care? *Mark all that apply.*

- ○ My child needed medical care
- ○ Doctors' offices/clinics were closed
- ○ I couldn't get an appointment to see a regular doctor soon enough
- ○ My child didn't have a regular doctor
- ○ I couldn't afford the co-pay for my child to see the doctor
- ○ My child needed a prescription drug
- ○ I didn't know where else to take my child
- ○ Other (tell us): _____
- ○ My child did not go to the emergency room in the last 12 months
- ○ I don't know

23 Have you **ever** been told by a doctor or other health care professional that any of your children have any of the following?

	Yes	No
Diabetes or sugar diabetes	○	○
Asthma	○	○
A behavioral or mental health diagnosis (such as depression, anxiety, or ADHD)	○	○
A developmental delay or learning disability (such as Autism or Dyslexia)	○	○
Post-traumatic stress disorder	○	○
Another ongoing health condition (tell us): _____	○	○

24 To what extent have you had hard times or traumatic events in your life?

	Not at all	Some	A lot
Life changing illness or injury	○	○	○
Neglect of any kind	○	○	○
Lived with someone with mental illness	○	○	○
Lived with someone with substance abuse issues	○	○	○
Witnessed or experienced violence	○	○	○
Made to do something sexual that you did not want to do	○	○	○
Physically hurt or threatened by an intimate partner	○	○	○
Abuse of any kind	○	○	○
Parents were separated or divorced during your childhood (ages newborn to 18)	○	○	○
A suicide attempt by a close friend or family member	○	○	○
Unexpected death of a loved one	○	○	○
Other traumatic event	○	○	○

25 To what extent do you feel the hard times or traumatic events you have had still impact you today?

- ○ Not at All
- ○ Some
- ○ A lot

26 During a **typical** day, how many servings of fruit do you usually eat? *A serving is one piece of fruit or about a cup of cut-up fruit. Don't count juices.*

_____ servings per day

27 During a **typical** day, how many servings of vegetables do you usually eat? *A serving is about a cup of vegetables like green beans, salad or potatoes. Don't include fried foods like french fries.*

_____ servings per day

28 Do you **currently** smoke cigarettes or e-cigarettes?

- ◯ Every day
- ◯ Some days
- ◯ Not at all

29 Which of the following have you used in the **last 30 days**? *Mark all that apply.*

- ◯ Smoking tobacco (cigarette, cigar, etc.)
- ◯ Chewing tobacco
- ◯ Electronic smoking systems (vape, juul, etc.)
- ◯ Marijuana products (smoked, vaped, or edibles)

30 Do you want to quit using tobacco or smoking systems?

- ◯ Yes
- ◯ No

31 How often did you have a drink containing alcohol in the **past year**?

- ◯ Never → **(Go to Question 34)**
- ◯ Monthly or less
- ◯ 2-4 times a month
- ◯ 2-3 times a week
- ◯ 4 or more times a week

32 How many days per week do you drink alcohol?

- ◯ 0 to 1
- ◯ 2 to 3
- ◯ 4 to 5
- ◯ 6 to 7

33 On the days when you did drink alcohol, how many drinks did you usually have **per day**? *A 'drink' is one beer, one glass of wine or one shot of liquor.*

- ◯ 1 or 2
- ◯ 3 or 4
- ◯ 5 or 6
- ◯ 7 to 9
- ◯ 10 or more

34 In the **last 12 months**, have you or anyone in your household used any of the following? *Mark all that apply.*

- ◯ Opioids not as prescribed (oxycodone, heroin, morphine, methadone, codeine, etc.)
- ◯ Amphetamine-type stimulants (meth, speed, diet pills, ecstasy, etc.)
- ◯ Any other street drug
- ◯ I did not use any of these in the last 12 months

35 Which of the following best describes your housing situation today? *Mark all that apply.*

- ◯ I have housing of my own, and I'm NOT worried about losing it
- ◯ I have housing of my own, but I AM worried about losing it
- ◯ I'm staying in a hotel
- ◯ I'm staying with friends or family
- ◯ I'm staying in a shelter, in a car or on the street
- ◯ Other (tell us): _____

36 In the past 12 months, have you or someone in your household had to **go without** any of the following when it was really needed because you were having trouble making ends meet?

	Yes	No
Food	◯	◯
Utilities	◯	◯
Transportation	◯	◯
Clothing	◯	◯
Stable Housing or Shelter	◯	◯
Medical Care	◯	◯
Medicine	◯	◯
Child Care	◯	◯
Dental Care	◯	◯

Appendix 7: 2019 Yamhill Community Care Organization Community Health Assessment

2019 COMMUNITY HEALTH ASSESSMENT

Yamhill COMMUNITY CARE

Contents

WHO WE ARE

COMMUNITY HEALTH ASSESSMENT VISION

Our healthy community is accessible and inclusive, has diverse resources, and focuses on social determinants of health and trauma-informed care. Our healthy community provides and promotes regular preventative care, in partnership with medical providers, to support healthy families and individuals.

YCCO VISION

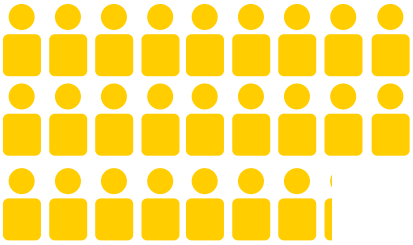
A unified healthy community that celebrates physical, mental, emotional, spiritual, and social well-being.

YCCO MISSION

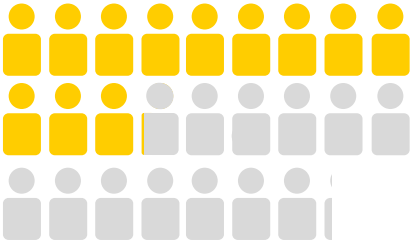
Working together to improve the quality of life and health of Yamhill Community Care Organization members by coordinating effective care.

OUR MEMBERS*

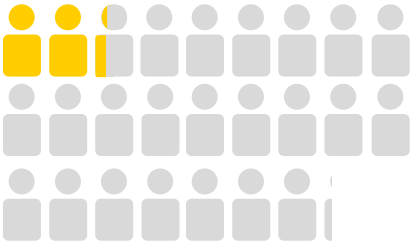
25,072 members



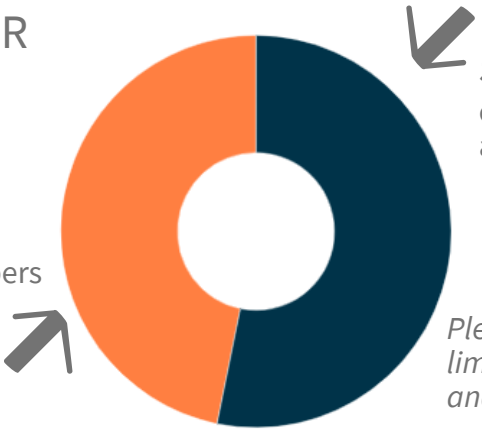
12,066 (48%) are 19 or under



2,277 (9%) are 60 or older

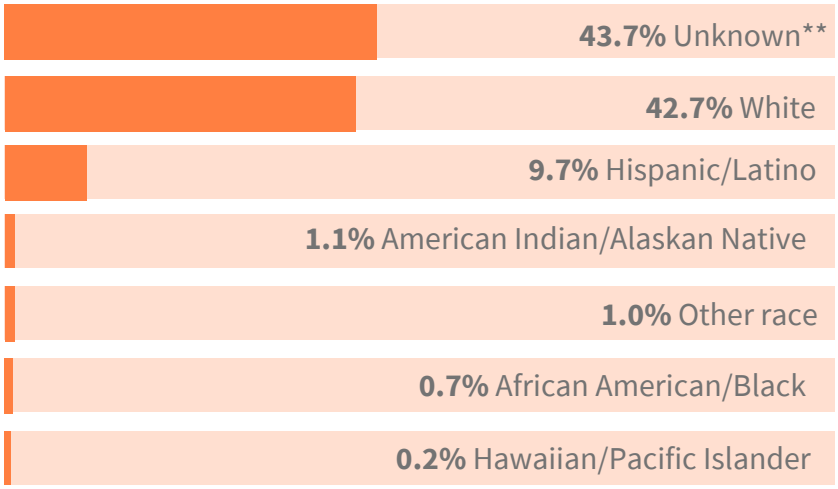


GENDER



Please note that data is limited to binary sex, and not gender identity.

RACE/ETHNICITY



LANGUAGE

12.9% of members speak a language other than English.

Our members speak over **22** languages.

The most frequently spoken languages are English and Spanish.

> *Everyone is self-sufficient and independent, [but] if there is a need the community will swarm together to help out.*
>
> **-Grand Ronde SIT**

*Information compiled from 2017 data

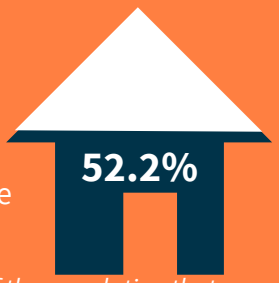
** YCCO data on its members' race and ethnicity is very limited. We do not know the race of more than four out of every ten members. This is an area of focus moving forward.*

= 1,000 people

SOCIAL DETERMINANTS OF HEALTH

AFFORDABLE HOUSING

52% of County residents don't have affordable housing.



**Based on the percent of the population that pays more than 30% of their income on rent.*

1,386 people were counted as living in shelters, in unsheltered locations, or couch surfing during the 2018 YCAP Homeless Count.

In need of housing support?

Reach out to YCAP by calling 503-472-0457 or visiting yamhillcap.org/shelter.

> *People are leaving the whole county because there's not housing anywhere...they are on housing waiting lists for years and years.*
>
> **-Newberg SIT**

These are the main factors, or social determinants, that influence and impact the health outcomes of individuals and groups.

TRANSPORTATION

In rural communities the bus only runs 5 times a day during the week and not at all on the weekend.

YCCO offers free transportation to medical appointments for all OHP members.

Call 1-844-256-5720 to schedule a ride.

> *There are a lot of resources, but if families can't make it to them it's not helpful.*
>
> **-Grand Ronde SIT**

> *Even available childcare is all booked up; people can't leave children to go to work.*
>
> **-Grand Ronde SIT**

FAMILY & YOUTH

#1 Respondents voted that access to affordable healthy food was the top factor that might improve children's well being in Yamhill County.

As of 2018, the median annual price of toddler care in Yamhill County is

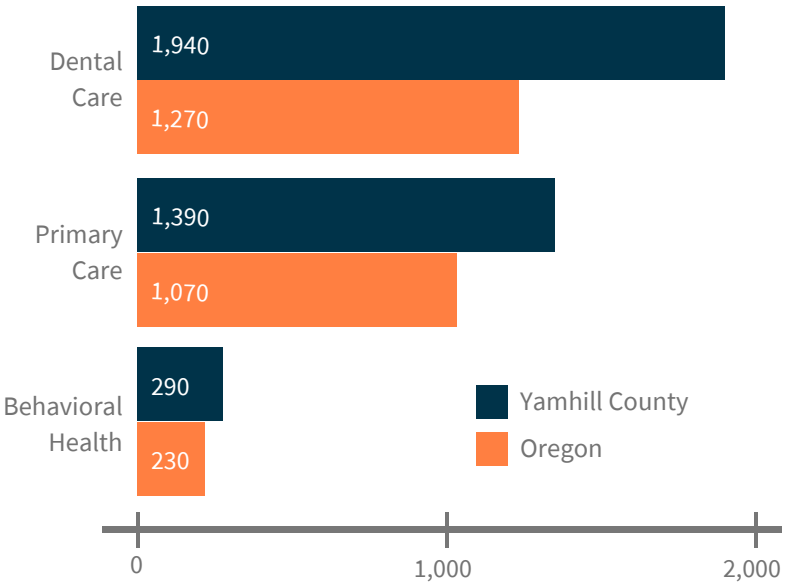
$11,844

DO YOU KNOW?

67% of single mothers in Yamhill County live under the poverty line.

HEALTH FACTORS

NUMBER OF COUNTY RESIDENTS PER PROVIDER IN 2018



HOW MANY YCCO MEMBERS ARE GETTING TO THE DOCTOR?

50% adults
66% kids
had a doctor visit (2017)

35% adults
68% kids
had a dentist visit (2018)

7% adults
4% kids
had a mental health or addictions visit to an HHS clinic (2017)

TOP HEALTH PRIORITIES IN 2019

YAMHILL-CARLTON
Mental Health
More Doctors
Health Education
Extended hours

WEST VALLEY
Health Education
Mental Health
Alternative Health Care

NEWBERG-DUNDEE
Mental Health
Transportation
Housing

MCMINNVILLE AREA
Mental Health
Alternative Health Care
More doctors

PRIORITIES IN 2014

Extended hours
Health education
More doctors

> *[I] can't get in [to the doctor's office] the same day anymore, but I used to. They want you to go to the ER instead of trying to fit you in...[you] feel like you're just a number.*
>
> **-WVMC focus group**

MOBILIZING FOR ACTION

NEXT STEPS

Yamhill Community Care surveyed 571 people in the community, held over 15 focus groups, and used national, state, local, and health plan data to understand what is going on in the community. This information will be used to inform and guide the development of goals and strategies to address identified needs in the Community Health Improvement Plan (CHIP) with the overall goal of improving the health of Yamhill CCO members.

OUR GOALS

Identify gaps that need filling

Spark interest among fellow community members

Improve the health and well-being of every person in Yamhill County

Foster community connections

GET INVOLVED!

Attend Community Health Improvement Planning sessions

Send feedback!
info@yamhillcco.org

Have your organization or agency adopt a strategy to achieve our community goals

> *El tener una comunidad latina vibrante, que les gusta estar aquí.*
>
> **-Promotores de Salud focus group**

> *Yamhill County has more services and resources than other [counties]; they reach out more.*
>
> **-Dayton SIT**

Executive Summary

Yamhill Community Care is required by the state of Oregon to create an assessment of its community's health at least once every five years. This is because CCOs cannot assume what their members and their community need without asking them, and YCCO values the voices of those it serves. From its beginning in 2012, Yamhill Community Care has been a community-based, grassroots organization. When the call for CCO applications went out, the community decided it didn't want an outside agency coming in and making choices for those who actually live here. Instead, local health leaders came together and chose to form their own small CCO, with the help of some benevolent bigger players like CareOregon out of Portland and the local Health and Human Services. CCOs are designed to return control to the members, and YCCO strives to remain true to that vision. The Community Health Assessment is one way to understand what is going on in the neighborhoods, schoolyards, gathering places, and homes of people in the area YCCO serves. While the focus of YCCO, as a health plan, is to address needs of people who require the most help affording their healthcare, it is also to improve quality of life for the whole community, based on the community's recommendations.

This assessment was not done in a vacuum. It was informed by the assessments that came before it. A key part of this process was building relationships with other agencies and being able to share understanding and information, so work does not get duplicated and everyone can share knowledge freely with one another, without competition or ownership. More data is better data! Yamhill County Public Health Department completed a robust, 14-month Community Health Assessment of its own that formed the foundation of YCCO's. Providence Hospital in Newberg completes its own CHA and CHIP, and YCPH and Providence were both great partners to YCCO in its efforts. The YCCO CHA was informed by other local assessments, like the Yamhill County Transit Area assessment, and a survey done locally by the Oregon Community Foundation.

These partnerships will continue. The YCCO CHA is an iterative process. More information will always change the team's understanding of its community and its strategies. This document sets baselines for what is going on right now; this data will continue to be processed, updated, refined, revised, and altered as the available information changes and improves.

YCCO will also continue to hold focus groups, send out surveys, chat with members and agencies, and perpetually seek out better knowledge. This document shows a great many

gaps in knowledge and attempts to be transparent about those. Agencies can collectively always do better, especially in collecting demographics, where understanding things like race and ethnicity, gender identity and sexual orientation, housing situation, and other parts of community members' identity would help ensure all people have fair and equal access to good health care well-suited to their needs.

One of YCCO's biggest assets is its Community Advisory Council. This council is made up of members of YCCO's health plan and people who work closely with OHP/YCCO members. This group of passionate people generously offer their time to solve problems together, ask hard questions, give honest feedback, and ultimately drive the entire Community Health Assessment and Improvement Plan process. They created the following vision, which hints at the goals within the CHA and CHIP and will provide a focal point for the work to follow.

"Our healthy community is accessible and inclusive, has diverse resources, and focuses on social determinants of health and trauma-informed care. Our healthy community provides and promotes regular preventative care, in partnership with medical providers, to support healthy families and individuals."

Yamhill Community Care has been proud to serve this vibrant community for the past six years and looks forward to more.

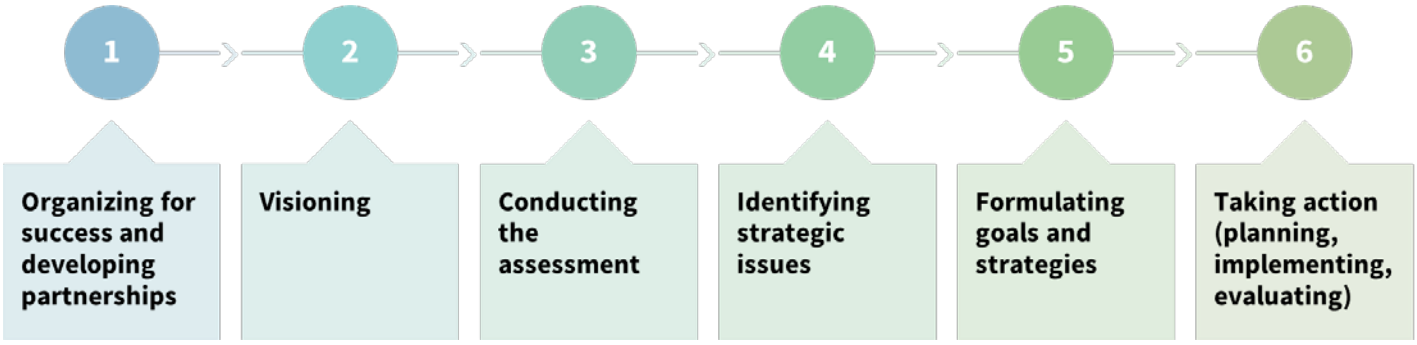
Best,

Seamus McCarthy, PhD
President & CEO, Yamhill Community Care

PROCESS

A Community Health Assessment (CHA) identifies health status indicators to provide a snapshot of a community's health. It describes areas for health improvement and builds on community knowledge and efforts. This is accomplished through the collection and analysis of health data and input from community stakeholders. Yamhill Community Care Organization worked with its Community Advisory Council (CAC), Quality and Clinical Advisory Panel (QCAP), and Board of Directors to identify, collect, analyze, and share information about the health assets, strengths, resources, and needs of its members. The Community Advisory Council, or CAC, is made up of people who are, have been, or care for someone on Oregon Health Plan. They understand the experience of being an OHP member, and this group guided the entire CHA and CHIP process, asking the questions they wanted answered, choosing and voting on the topics that matter most to them, and assisting in building the feedback process.

While the CAC guided the process, YCCO followed a structure called Mobilizing for Action through Planning and Partnerships, or MAPP. Most population and public health-oriented organizations doing health assessments use this process to help community members get feedback, prioritize public health concerns, and identify assets to address them. Yamhill County Public Health and Oregon Health Authority both use this process for their CHA. YCCO did a simplified version, building on the work that public health performed over 14 months of information gathering. The results create an accurate picture of "health" in Yamhill County.



This report focuses on the assessment portion of the process, particularly the Community Health Status Assessment and the Community Themes and Strengths Assessment. Every community member brought a unique perspective as to what specific health data would be included in the CHA and helped identify available assets and barriers.

YCCO conducted a Community Survey (Appendix A), which gathered information about the things that matter to the people who live, work, and play in the Yamhill County area. The survey asked a series of demographic questions about what people think affects health in the community, what issues matter most for children and families, and what survey respondents' individual experiences were regarding things like trauma, safe environments, and chronic pain. Surveys were created in English and Spanish, and people were given the opportunity to complete them anonymously online, on paper, or on the phone if requested. YCCO sent the survey out through email to more than 2000 partners and contacts, encouraging partner organizations to share surveys and feedback opportunities with their clients, patients, and partners. Posters and paper copies of surveys were strategically placed in peer drop-in centers, sites of community meals, churches, and other locations that specifically outreach to homeless individuals.

Focus groups supplemented the surveys (Appendix 2), giving YCCO the opportunity to hear more about the information gathered and add narratives and anecdotes to further inform the data being collected. Focus group outreach included a Spanish-language session with a community health worker group in Newberg, a county developmental disabilities committee, at a senior center, and with the Virginia Garcia Patient Advisory Council. Other focus groups had representation from members who have disabilities, members with children with disabilities, are members of the LGBTQ community, community members on Medicare, members experiencing mental illness, and others that were likely not disclosed.

Results from the community survey identified four top priority areas highlighted throughout the assessment:

2014 Survey Priorities	2019 Survey Priorities
Extended clinic hours	Mental health
Health education	More doctors
More doctors	Health education
	Alternative health care

The input gathered for the CHA was used to inform and guide the development of strategies in the Community Health Improvement Plan (CHIP) with the overall goal of improving the health of Yamhill CCO members. The CHIP was developed and implemented with the Triple Aim of improving patient care, improving health, and reducing costs. After the CHA was completed, community members were given the opportunity to attend three forums to develop and prioritize CHIP strategies (Appendix 3). The CHIP was also formed in alignment with other CCO plans like the overall Strategic Plan, Early Learning Hub Strategic Plan, and Transformation and Quality Strategy, which includes more clinical and health plan-based strategies.

Despite the comprehensive CHA assessment, there are some important limitations to the data. Secondary data sources had limited geographical and demographically stratified data to assess subgroups like different ethnic populations and people living in different parts of the county. To assess social determinants of health, it is vital to have consistent local and state data sources for comparison. The primary data source, the community survey, was implemented with a convenience sampling methodology due to capacity and financial restraints. This means it was sent widely and the people who took it did so voluntarily. The focus group assessment was also a convenience sampling method with an incentive program. Some focus group participants were selected based on a collaborative project with Yamhill County Public Health, which focused on assessing participants over 40 and had interest in cancer barriers. This assessment may have caused bias in focus group responses because it targeted those participants specifically and asked questions specifically about cancer. Other methods focus on making sure the people answering a survey represent the exact population being studied, but this often means fewer people respond and data collection takes much longer. Convenience sampling increases selection bias and risks higher sampling error, but it can still give a sense of what is going on in a community.

Acknowledgments

On behalf of the Community Health Assessment Workgroup, thanks to all the people who completed the community health survey or attended focus groups and shared their views. Please see Appendix 4 for a more complete list of partners.

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Gary Dawson	Community Representative
Jerry Dawson	Community Representative
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Michael Peterson	Community Representative
Ginny Rake	Chair, Project Able
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Jeff White	Community Representative

Section 1: Introduction

- Our Community -

The Yamhill County area is relatively small geographically but has a wide range of landscapes, industries, and people. It is considered rural; its largest town is McMinnville, with 34,617 people.[1] Focus groups and community members report differences in how each community operates, but all reported appreciating the small-town feel and community closeness.

Yamhill County is the 10th largest county in the state, with a population of a little more than 100,000.[2] It is 45 miles south of the Portland metropolitan area and 30 miles from Salem. Many residents are commuters, but a fair amount of people both live and work locally. Yamhill County is the heart of the Willamette Valley, which is a lush viticultural area, and the area has grown largely because of tourism. The majority of people in Yamhill County are centralized to either McMinnville, the county seat, or Newberg (pop. 23,884), with the remaining half living in smaller towns scattered throughout this diverse county.[3] Sheridan, in the west part of the county, is a 30-minute drive from McMinnville and has 6,206 people.[4] The west part of the county includes territory of the Confederated Tribes of Grand Ronde and the Spirit Mountain Casino. Yamhill County's rural, dispersed population often make access to services a long and arduous process, especially without private transportation.

Yamhill Community Care serves most of the people who have Oregon Health Plan (OHP) in and near Yamhill County. Approximately one fourth of people in the area are on OHP, and so YCCO serves most of those people; 48% of people in the county on OHP are children.

Yamhill County and the surrounding area is known for its wineries and its robust agricultural community but sees a wide disparity in wages among those who live there. More than half of renters in the area spend more than a third of their income on housing. In the 2018 Yamhill Community Action Partnership homeless population count, 1,386 people in Yamhill County were estimated to be homeless. Affordable housing and easily accessible transportation rise to the top as barriers within the area; most services are local to the McMinnville and Newberg areas.

"Living in rural areas it's easy to become isolated. Public transportation isn't an option because buses don't go to rural areas as much. Everything is spaced very far apart which makes it hard to get to a doctor."

-McMinnville Focus Group

- Community Health Assessment-

The Community Health Assessment for Yamhill Community Care Organization will be used to inform the prioritization of health issues and the development of a Community Health Improvement Plan (CHIP). A CHIP is an action-oriented plan for addressing the most significant issues identified by community partners.

YCCO used the Yamhill County Public Health Community Health Assessment to begin the data collection process because the Yamhill Community Care Organization service area covers all of Yamhill County and a few areas outside of Yamhill County. To gather more information specific to the members served, YCCO community surveys (Appendix 1) were distributed to community partners and community members via email, social media, and paper copies. Surveys were distributed through the Service Integration Teams, Early Learning Hub mailing lists to early childhood partners, parents, and caregivers, and through a variety of local agencies, libraries, schools, and businesses. Posters, cards, and paper surveys were delivered throughout each town in the YCCO service area, giving community members the chance to fill out and provide feedback on important issues that impact their health. Focus groups were held in every community in Yamhill County, and gave an opportunity to learn more about the things people in the community care about. Follow-up workgroups and public forums again gave community members the opportunity to share their opinions, experiences, and feedback. Together, this community formed the health assessment.

YCCO is required to complete CHA and CHIP under the Oregon Health Authority requirements OAR 410-141-3145 and ORS 414.627. As a part of the integrated care coordination rules, this process fosters alignment and coordination between agencies to get the most information to best understand this population.

- Mobilizing for Action through Planning and Partnerships (MAPP) -

YCCO CHA Workgroup adopted the Mobilizing for Action through Planning and Partnership (MAPP) process as its planning framework to guide the CHA process. The MAPP tool, which was developed by the National Association of County and City Health Officials (NACCHO), was chosen to capture an in-depth picture of community health status through quantitative and qualitative data collection methods. The MAPP framework includes four assessments. Of these, three assessments were selected for the 2019 CHA:

The **Community Themes and Strengths Assessment** provides a deep understanding of the issues that residents and community leaders feel are important to the health of their communities. This process used a YCCO Community Health Survey and various focus groups.

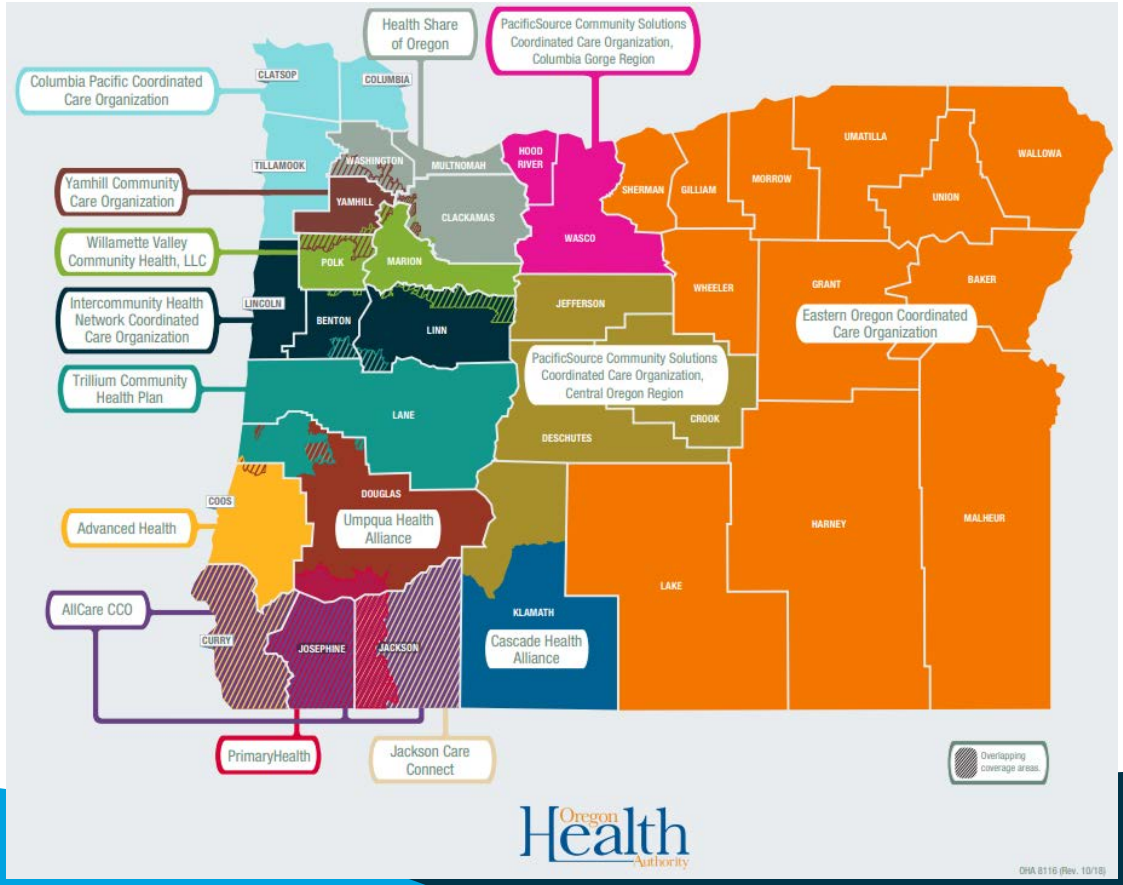
The **Forces of Change Assessment** measures environmental forces affecting the health of Yamhill County residents. CAC members performed this assessment to contextualize the issues and strategies in the CHA and CHIP, respectively.

The **Community Health Status Assessment** uses national, state, and local county data to figure out the health status of Yamhill County and its residents, who will be served by the Yamhill Community Care Organization.

- Coordinated Care Organizations and Medicaid -

Coordinated Care Organizations are a model designed to provide better care to improve health and lower cost. They help medical providers communicate with one another and with the insurance plan (YCCO) to make sure patients get the best care possible. CCOs also focus on preventative care and are working to shift the culture from sick-care, where symptoms and illnesses are treated, to well-care, which catches risks before they become illnesses. CCOs are designed to help foster a partnership between medical providers and patients, in which patients receive team-based care where they are a member of their health care team.

The Yamhill Community Care Organization (YCCO) coordinates care for enrollees in the Oregon Health Plan (OHP), or Medicaid, in Yamhill County and parts of surrounding counties. YCCO is a 501(c) grassroots nonprofit committed to building a unified, healthy community that celebrates physical, mental, emotional, spiritual, and social well-being.



YCCO is the only community care organization in the state to be awarded an Early Learning Hub by the Oregon Department of Education's Early Learning Division. The map above shows the 15 CCOs that currently serve Oregon, including Yamhill Community Care's Service area in the Yamhill County region.

- Health Equity and Social Determinants of Health -

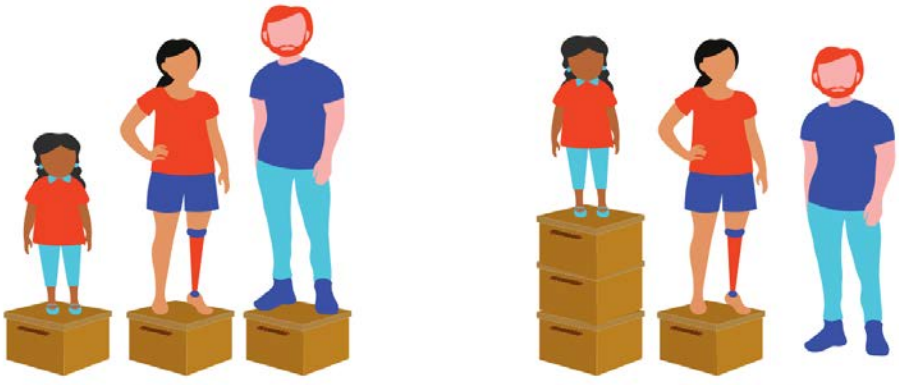
The CHA project looks at the community's health through a wide lens. When people think of health, they may think of it only in relation to disease or illness, but health is part of every aspect of daily life.

Social determinants of health are "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems."[5] These factors affect a wide range of health outcomes and impact the health of people in different population groups and geographic areas. These disparities generally stem from deeper causes such as poverty and inadequate housing and can impact every part of a person's life. Differences in health are best faced by moving "upstream," from focusing on one person's role in their health to a focus on changing systems that create places where anyone can have better health outcomes, no matter their environment or background. Put simply, it is more effective to improve someone's environment and fill it with walkable spaces and affordable fruits and vegetables than it is to tell people to exercise and eat healthy.

Social determinants of health capture a broad range of factors, such as opportunities for employment, transportation, access to healthy foods, and freedom from racism. These factors can affect people directly and influence how they act and the number of healthy decisions they make. A person's access to healthy food or a safe environment in which to exercise, work, or play can greatly affect their well-being. Different parts of a person's identity or environment can also indirectly affect their health. Policies and other interventions influence the availability and distribution of resources. Social groups, including those defined by socioeconomic status, race/ethnicity, sexual orientation, sex, disability status, and geographic location all have a correlation with health. Principles of social justice influence these multiple interactions and the resulting health outcomes. Unequal distribution of resources contributes to health disparities and health inequity, whereas equitable distribution of social determinants of health makes people healthier overall. Appreciation of how societal conditions, health behaviors, and access to health care affect health outcomes can increase understanding about what is needed to make a healthy future for all.

SOCIAL DETERMINANTS OF HEALTH

THE ISSUE	THE INPUT	THE OUTCOME
Disparities based on: Socioeconomic status Race/ethnicity Sexual orientation Gender Disability Geographic location	Policy Change Community Resiliency Health Promoting Behavior	Health Equity **Social:** strong social networks and civic engagement **Economic:** job opportunities and food security **Physical Environment:** access to housing, good education and health care



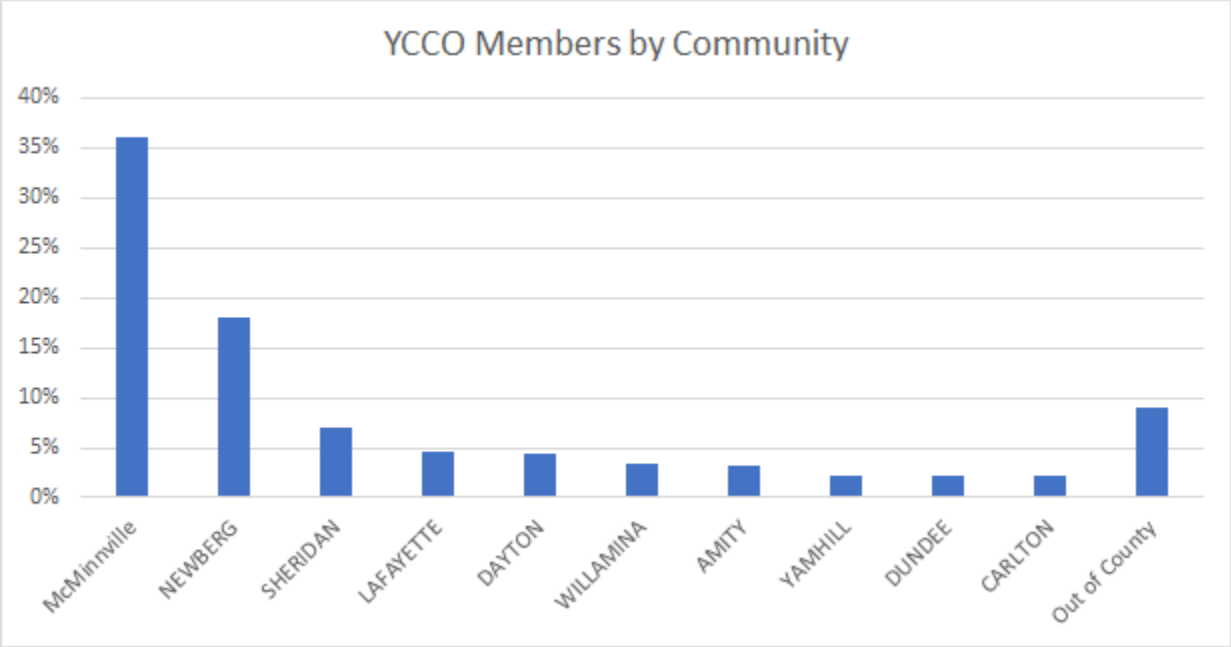
EQUALITY

EQUITY

Section 2: Who We Are

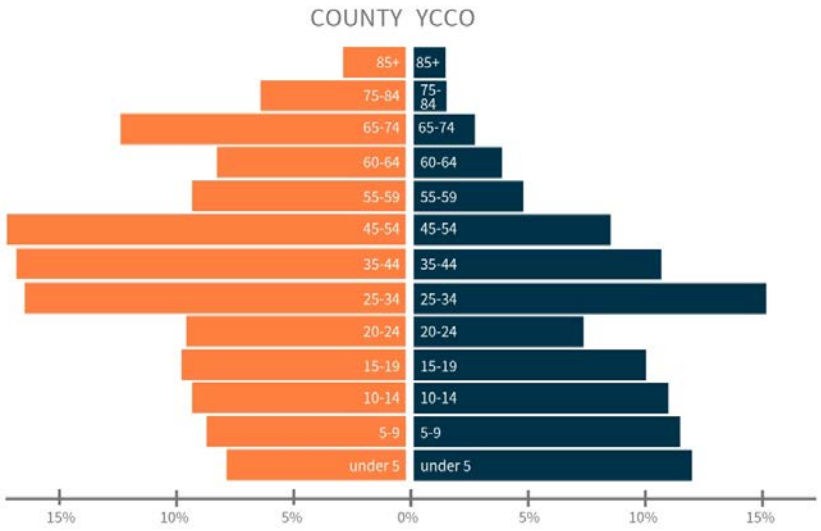
- Geography and Rural Living -

Yamhill County is home to approximately 103,000 people. Approximately 23 percent of Yamhill County residents live in rural areas.[6] Rural geography often isolates families and individuals which is increased by limited public transportation options and the variable cost of gasoline.



- Age -

Children represent a larger portion of the YCCO population than in the county population. This is because the requirements for children to be covered by OHP are broader than those for adults. Additionally, *OHP Now Covers Me!* was passed in 2018, which allows undocumented children to receive OHP benefits. In the future older individuals who are on Medicare but are also eligible for OHP will be automatically enrolled in CCOs. This change will affect the age distribution of the YCCO population. The graph on the next page compares the age distribution between YCCO members and Yamhill County.



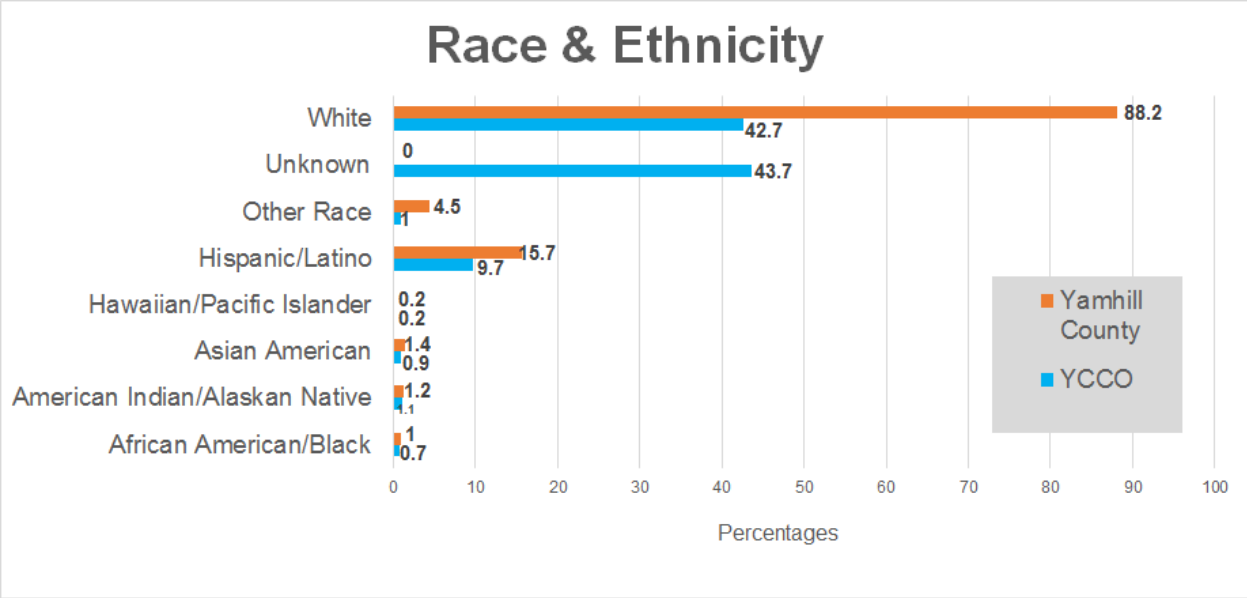
Source: ACS 2017 5-year average; YCCO member data 2018

- Gender identity and sexual orientation -

Gender identity and sexual orientation are not questions included in the OHP application, so YCCO does not have an accurate sense of those figures among its members. The Community Health Survey also does not give an accurate sense of this population: only one respondent identified as something other than cisgender (or identified as the same gender as the sex they were assigned at birth). 7.6% identified as something other than heterosexual, although the population responding was disproportionately women (80%). Statewide, Oregon residents are approximately 5.6 % LGBTQ+ (lesbian, gay, bisexual, transgender, queer, etc.).[7] A successful assessment and plan must equip the agency to serve the unique needs of all its populations, and the first step of building this understanding is having an accurate picture of the population. Therefore, much more work is needed to collect data about member demographics and provider knowledge about serving often-marginalized people.

- Race and Ethnicity -

The graph below shows the race and ethnicity of YCCO members compared to the race/ethnicity of the county as a whole. The purpose of this graph is not necessarily to understand the racial or ethnic makeup of the YCCO population, but instead to highlight how much of a gap in understanding there is. A full 43.7% of YCCO members are of unknown race because that portion was left blank in their OHP application.

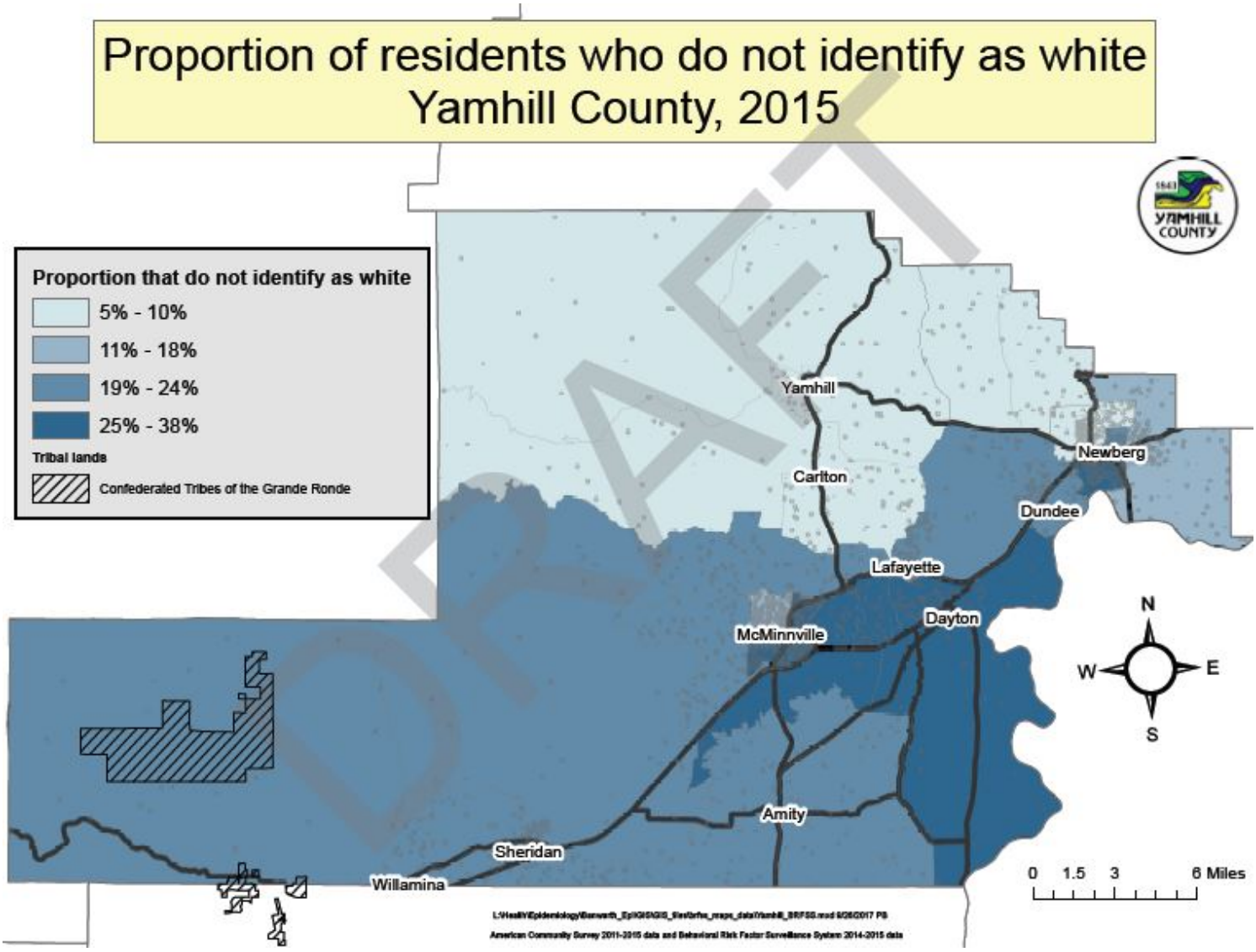


Source: U.S. Census Bureau, American Community Survey 5-year estimates, 2013-2017 and YCCO race/ethnicity data 2017

The county as a whole is 91.5% white, 16% Hispanic/Latino, 1.9% American Indian, and less than 2% African American/Black, Asian American, or Hawaiian/Pacific Islander.[8] The west part of the county includes Willamina, in which the school district serves students who are 58% white, 23% American Indian/Alaska Native, 9% Hispanic/Latino, and under 10% African American, Asian American, Hawaiian/Pacific Islander or other. Dayton, in contrast, serves students who are 56% white, 38% Hispanic/Latino, and 2% American Indian/Alaska Native, and less than 2% African American, Asian American, Hawaiian/Pacific Islander, and other.[9] Considering almost half of YCCO members are children, understanding this diversity across the county is vital to understanding how best to meet the needs of each individual community, and this data is currently lacking.

One tenth of Oregonians are immigrants, and approximately 110,000 undocumented immigrants live in Oregon, or 2.6% of the total population.[10,11] Documentation status can have lasting ramifications for access to health care. Through OHP Now Covers Me! or ¡Ahora OHP es Para Mí!, undocumented children can now receive OHP benefits, but their parents or caregivers often still remain without insurance.

The map below shows the distribution of non-white ethnicities throughout the county:



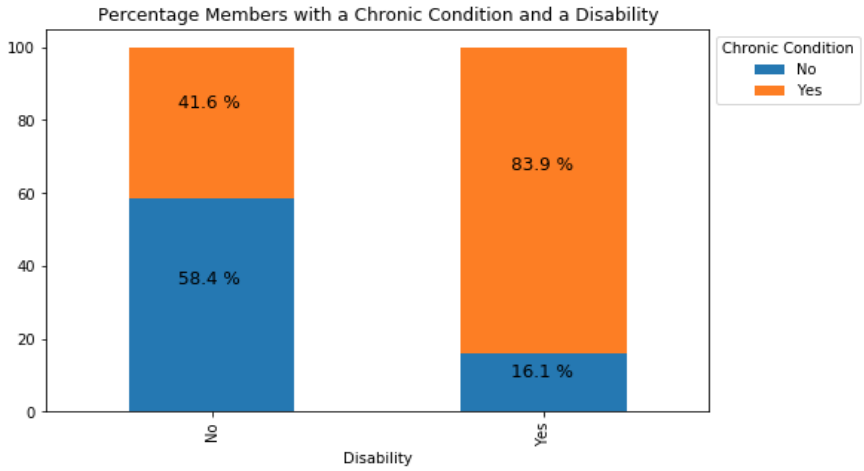
- Language -

YCCO has more accurate information around the main language spoken by its members. 87% of YCCO members speak English, and only 2% of members are "unknown." Spanish speakers make up 10% of the YCCO member population, with the next largest group being Cantonese, Mandarin, and other Chinese/Asian languages, with 36 total speakers. The dominance of English speakers can create barriers for non-English speaking members, as many agencies often aren't as prepared to offer multilingual services. YCCO continues to monitor its clinics and its own services for language availability and to improve processes around language access for its members.

- Disabilities -

A disability may include physical, intellectual, or sensory impairment, medical conditions, or mental illness. Such conditions may be permanent or short term, but typically affect day-to-day functioning.

People with disabilities need health care and health programs for the same reasons anyone else does—to stay well, active, and to reach their full potential. A clear relationship exists between disability status and poverty, which often makes it even harder for people living with a disability to access the right services to stay healthy, both mentally and physically. The graph below indicates that CCO members with a disability are also often more likely to have a chronic condition, meaning they must often manage multiple medical providers, medications, and conditions at the same time to stay healthy. Services like care coordination, Community Health Workers, and health education classes can help people manage all these factors, and YCCO offers all of these.



Section 3: Social Determinants of Health

People are constantly interacting with the environment they live in. Some of these interactions have the potential to improve health, while others can negatively impact it. The natural environment is made up of the air, water, open spaces, and weather or geologic activity. The human-made environment consists of homes, communities, and infrastructure.

Humans benefit from clean water and air, places to exercise and enjoy the outdoors, safe living and working spaces, and opportunities to engage in healthy behaviors such as active commuting and consuming healthy food. However, when an environment lacks these characteristics, the complex interactions of health and environment can worsen health issues. For example, poor air quality can raise the risk of asthma, heart attack, or stroke;[12] the design of communities can limit opportunities for recreation or access to healthy, affordable food;[13] and natural disasters can disproportionately affect vulnerable populations.

- Transportation -

Transit includes how walkable, bikeable, and drivable an area is and how much public transit there is between people's homes, work, and services needed. It also includes how roads and pathways are built, specific services are delivered, and how easily people can access things like medical transportation and places for physical activity and play. The number and quality of medical clinics, shelters, food pantries, grocery stores, and other services are vital to a successful and strong community, but these services are meaningless if people cannot get to them.

Yamhill County Transportation Department performed a survey in 2017 assessing the most pressing issues with the local public transportation system. The survey results on the next page show six significant issues:

Frequency	How long people must wait for services and how often they appear.
Reliability	Sometimes transport is late or does not meet the schedule.
Comfort	Some of the buses are old and need upgrades.
Branding	Transit isn't always easily recognizable.
Legibility	The system can be complicated to navigate.
Service diversity	More service in smaller towns would be helpful.

According to the YCCO Community Health Survey, community members identified transportation as one of the main challenges to access to care, particularly in more rural parts of the county.

- Housing -

Affordable, quality housing provides shelter that is safe and healthy for all people. Housing that costs more than 30 percent of household income is considered to be "unaffordable."[14] The following table shows the similarities in housing affordability between the state of Oregon, Yamhill County and the cities of McMinnville, Newberg and Willamina. Similar to State findings, 52% of renters in Yamhill County spend 30% or more of household income on housing rent. In Willamina, 63% of renters spend 30 percent or more of household income on housing.[15]

Category	**Occupants with housing cost burden more than 30% of income (2013-17)**				
	Oregon	Yamhill County	McMinnville	Newberg	Willamina
Household with no vehicles	7.7%	4.7 %	6.1%	5.3%	5.8%
Renters	38.3%	32.1 %	40.5%	38.2%	38.8%
Owners with mortgages	66.8%	70.0 %	65.9%	78.5%	78.5%
Owners without mortgages	33.2%	30.0 %	34.1%	21.5%	21.5%3832
30%> household income for Rent	52.4%	52.1%	51.5%	56.4%	62.7%

Source: U.S. Census Bureau, American Community Survey, 2013-2017

With many people unable to comfortably afford rent, the risk of homelessness is higher. Homelessness is defined in a wide range of ways. The Oregon's Ending Homelessness Advisory Council defines homelessness as being without a decent, safe, stable, and permanent place to live that is fit for human habitation.[16] It is difficult to accurately understand how many people are homeless in a given community because surveys and population counts often rely on the reliability of permanent addresses or phone numbers, which are less common among more transient populations.

Each January, Oregon Housing and Community Services requires communities to conduct a point-in-time count of their homeless population. This snapshot of the homeless population is limited in scope and depth. Canvassers visit shelters, transitional housing, and known homeless encampments. Individuals staying with other people out of economic necessity are not counted, nor are homeless people who are in areas not covered by the canvassing. Furthermore, the one-night count misses any individuals who are homeless at other points during the year. The point-in-time count has happened over many years, and so even if it does not capture everyone, it gives a sense of rate of change over time.

The most recent data on homeless populations is from 2018. In January of that year, there were 1,386 individuals identified in shelters, couch surfing and in unsheltered locations and more than 40% of the people counted were under age 18. Yamhill County has the second highest rate of homeless people who are fleeing domestic violence in the state (only Multnomah is higher), and the fifth highest number of people who are homeless and have serious mental illness.

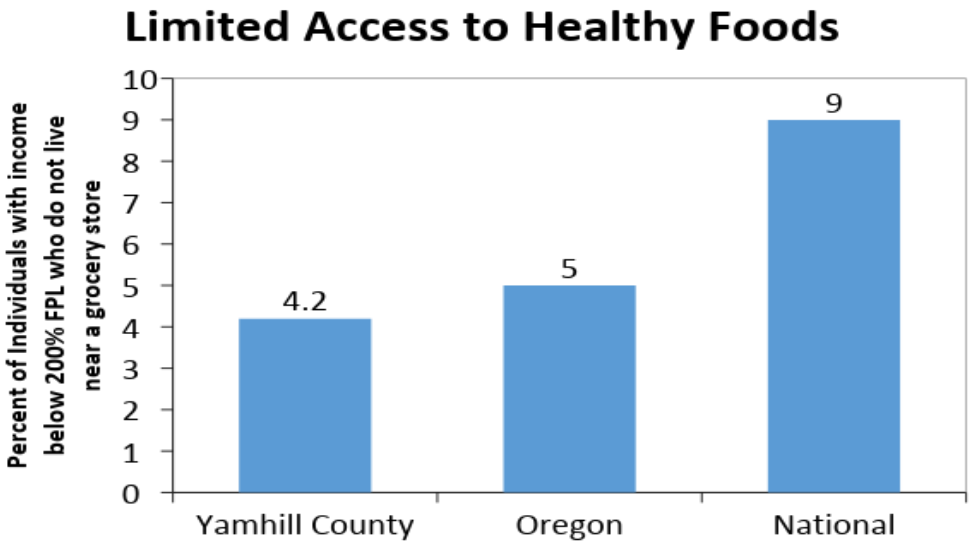
YCAP Homeless Count	2018
Total count	**1, 386**
Sheltered count	240
Unsheltered count	417
Couch Surfing	729
Male	680
Female	691
Transgender	3
Non-conforming and declined	11
Children under 18	569
Unaccompanied children under 18	98
Veterans	37
Fleeing Domestic Violence	137
Chronically homeless	114

Source: Yamhill Community Action Partnership, 2018.

- Healthy Foods -

Survey respondents listed access to healthy foods as the top thing that would help children in the area be healthier. The services in Yamhill County include many community meals and food pantries, but accessible affordable grocery stores are limited. The graph below looks at the proportion of people and families who have a low income (defined here as below 200% of the federal poverty level) and live more than one mile from a grocery store in urban areas and more than ten miles from a grocery store in rural areas. Limited access to supermarkets or grocery stores may make it harder for residents with a low income to eat a healthy diet.

Related to limited access to healthy food is food insecurity, which is defined as limited or uncertain availability of nutritionally adequate foods or uncertain ability to acquire these foods.[17]



Source: County Health Rankings, 2017

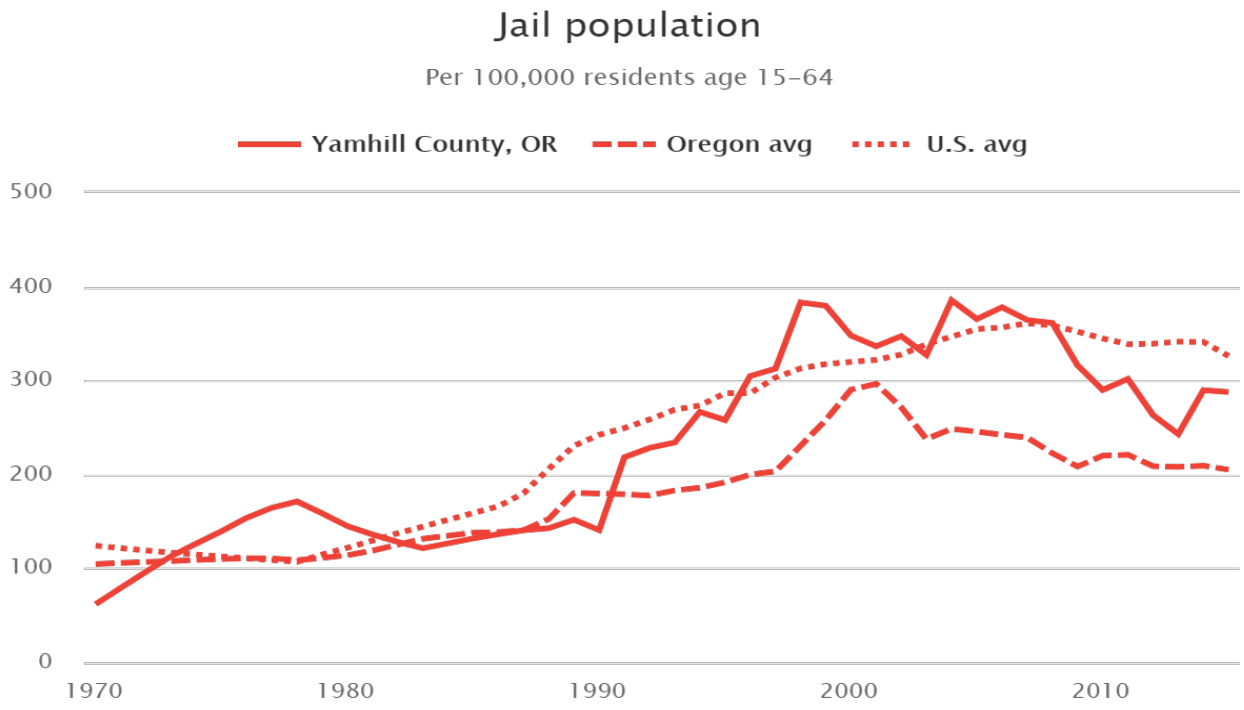
Children exposed to food insecurity are at risk of negative impacts on their health and development. Adequate nutrition is important for children because it affects their cognitive and behavioral development. Children who are food insecure are more likely to be hospitalized and may be at higher risk for developing obesity and asthma. They may also be at higher risk for behavioral and social issues including fighting, hyperactivity, anxiety, bullying, and difficulty concentrating on tasks.[18]

Obesity is linked to food insecurity because often access to food is limited to foods with limited nutritional value. If the only nearby affordable place to buy food is a gas station or a fast food restaurant, families will have a more difficult time finding fresh or frozen produce. Families face a multitude of barriers when it comes to preparing nutrient-dense foods or produce. Fresh vegetables, meats, and fruits spoil more quickly, requiring more frequent trips

to a grocery store. Preparing fresh foods is more time consuming and often uses valuable utilities and electricity. People with chronic conditions, disabilities, people who are homeless or people who hold multiple jobs may be unable to spend time traveling to a grocery store, farmer's market, or food pantry, so they must rely on affordable, nearby convenient foods. A plan to fight obesity in communities must also address these social factors.

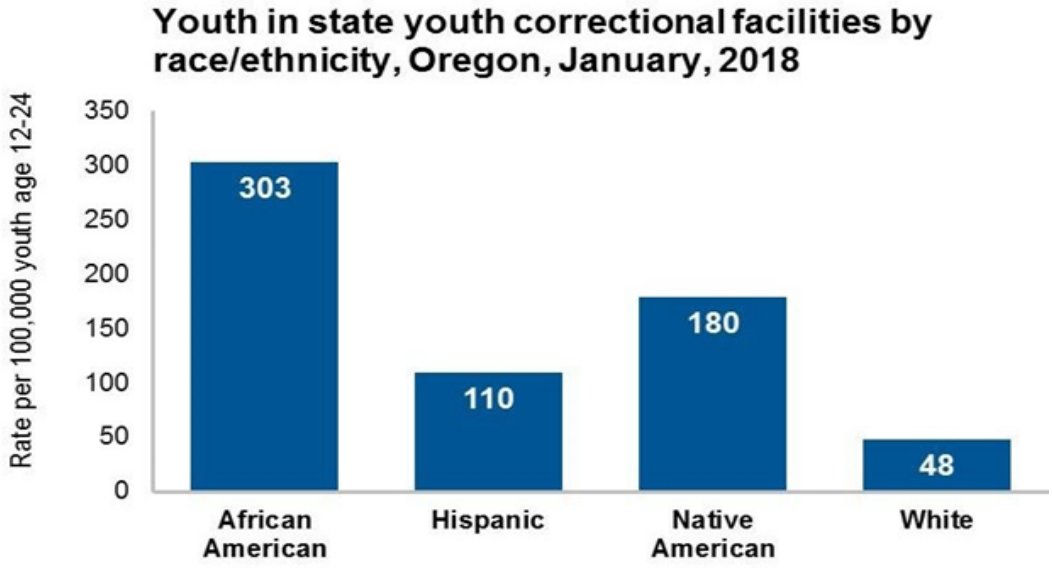
- Incarceration -

Incarceration rates in the United States are steadily increasing. With many prisons and jails reaching or exceeding capacity many facilities are only able to offer limited health services. This has led to an increase in adverse health conditions among incarcerated and formerly incarcerated individuals. Between 2001 and 2014 approximately 3,000 deaths occurred annually within state penitentiaries nationwide. Leading causes of death included cancer, heart disease, liver disease, respiratory disease, suicide and AIDs.[19] Individuals often face challenges integrating once they are released; struggles finding housing and employment can increase individual's risk of health problems and of returning to jail or prison.



Source: http://trends.vera.org/rates/yamhill-county-or

People in jail or in prison do not receive Oregon Health Plan benefits, but many are eligible once they leave. This is a unique population with unique needs, and current systems help incarcerated people enroll or reapply for OHP, so they can receive preventative or treatment services as soon as possible after being released.



Note: All other races shown exclude Hispanic ethnicity. Rates for other groups not available.

Source: Oregon Youth Authority

People of color are much more likely to be incarcerated, even when they commit the same crimes at similar rates as white people.[20] In the state of Oregon, African American youth are disproportionately incarcerated comparative to other races and ethnicities. According to the Oregon Youth Authority African American youth has a rate of 303 youth incarcerated compared to Caucasian of 48 per 100,000 population. In addition, the Oregon Department of Corrections reported in 2018 that 34.6% of adults in custody had moderate to high mental health needs. Sixty one percent of adults had dependence or addiction to one or more substances.[21]

- Income and Poverty -

Income is the strongest predictor of health among all social determinants of health. Not only do many studies show a strong association between income and health,[22] but income also affects all other social determinants of health, including education, food security, and housing. The National Longitudinal Mortality Survey found that people in the top five percent of incomes had life expectancies 25% longer than people in the bottom 5% of incomes.[23] While income is not a "one size fits all" measure of health, understanding the income of the region provides a solid foundation for measuring social determinants of health in Yamhill County.

Poverty is also closely associated with health outcomes. Poverty is related to limited income and lack of economic stability, limited choices in education, employment, and living conditions, and reduced access to safe places to live, work, and play. It can also frequently limit choices and access to healthy food. The United States Census Bureau determines the Federal Poverty Level (FPL) each year. The FPL was originally an estimate of the amount of money required to meet the cost of living for individuals or families. Currently, the FPL is a statistical threshold of poverty.[24] It is not generally recognized as an accurate measure of true poverty, but it is used for determining eligibility for assistance programs. The FPL for individuals and families is presented below, as well as additional FPL ratios that are used for eligibility and comparison purposes.

Family size	**Percent of Federal Poverty Level, 2018**				
	100%	138%	150%	200%	400%
Individual	$12,140	$16,753	$18,210	$24,280	$48,560
Three-person family	$20,780	$28,646	$31,170	$41,560	$83,120
Four-person family	$25,100	$34,638	$37,650	$50,200	$100,400

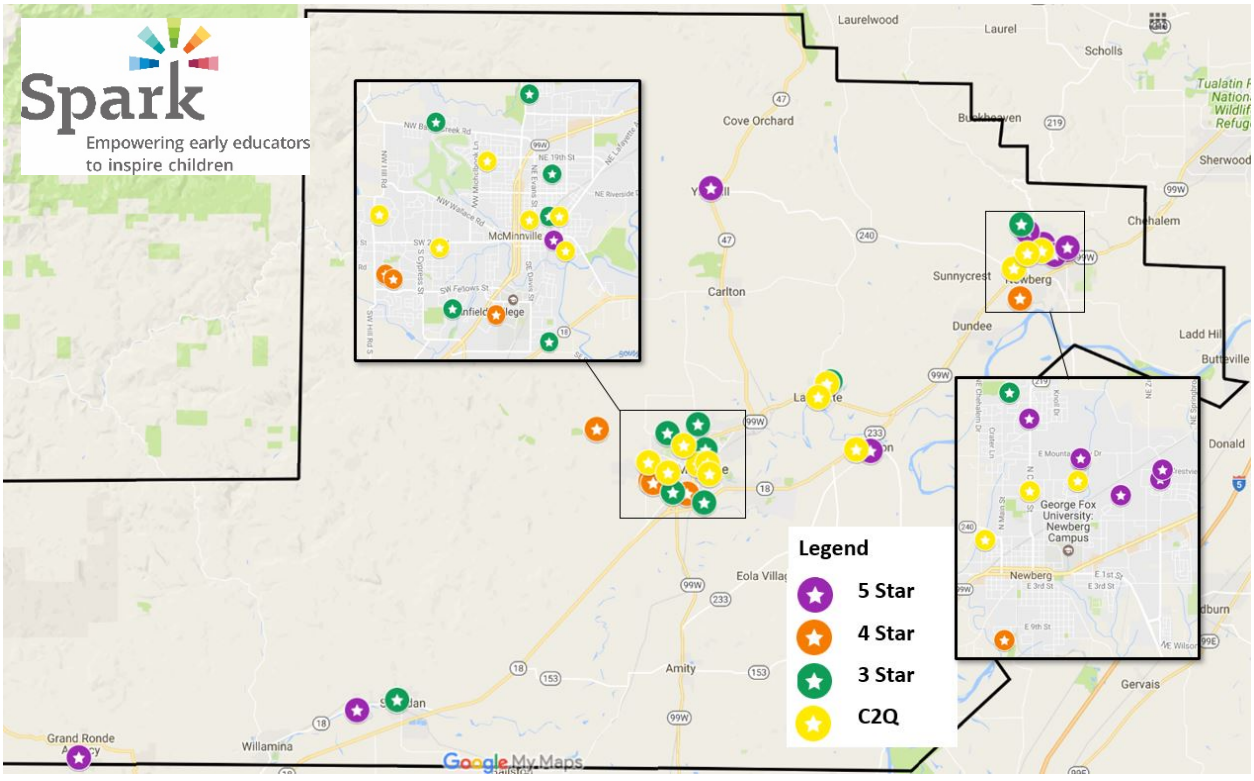
Source: U.S. Census Bureau, Historical Poverty Threshold Table, 2018

The poverty rate in Yamhill County is 16.6%, essentially equivalent to the state poverty rate (13.7%)., although nearly 25% of Yamhill County are YCCO members. Female heads of household with children under five years of age have the most severe poverty rates in the county, with 67% countywide and 77% within McMinnville area. Building in supports for these families is vital to creating a healthy community with healthy children, and YCCO and the Early Learning Hub work closely together to surround these families with support.

- Childcare -

Finding affordable childcare enables parents and caregivers to work, take breaks, and ensure children are receiving high-quality education from an early age. A child's brain undergoes a huge amount of development in the first few years of life and requires good nutrition and a stimulating environment to develop the most successfully.[25] To be best prepared to start school, children need to develop social and emotional skills like getting along with other people, listening, and sharing, as well as developing academic skills like learning numbers and letters. Children who receive high-quality childcare are more likely to be healthier and see better job and social outcomes.[26]

Affordable early childhood care is limited in Yamhill County; focus group feedback shared that Head Start (free to families) slots are limited. Head Start consistently has a waiting list. Other childcare or preschool is often too expensive for families who don't quite qualify for Head Start. The below map shows where SPARK -rate providers are in Yamhill County. Spark is a program that trains and certifies childcare providers to ensure safe, high-quality care for young children. The map shows how limited quality care is in the more rural parts of the county. The Early Learning Hub is working with partners like Head Start and Childcare Resource and Referral to both increase the number of trained providers and increase the level of skill for existing childcare providers.



Section 4: Access to Care

YCCO Community Health Survey and focus groups results showed that, regardless of insurance provider and income level, getting an appointment with a doctor or dentist quickly is often difficult. However, access to care is more than getting an appointment. It includes getting an appointment at a convenient time and place, with a provider (or interpreter) who speaks the best language for the patient to understand, and has any necessary cultural understanding required to offer the best care. Access also includes finding providers and clinic staff who understand trauma and treat patients with dignity and respect.

The Institute of Medicine (IOM) defines access to health care as "the timely use of personal health services to achieve the best health outcomes," with a special focus on the importance of health equity among different groups of people.[27]

According to the Agency for Healthcare Research and Quality (AHRQ) 2013 National Healthcare Disparities Report (NHDR), there are three steps to attaining adequate access to health care:

- Entering the healthcare system,
- Getting access to sites of care where patients can receive needed services, and
- Finding providers who meet the needs of individual patients and with whom patients can develop a relationship based on mutual communication and trust.[28]

- Health Insurance Coverage -

The Affordable Care Act (ACA), enacted on a federal level in 2010, made it illegal to deny coverage due to pre-existing medical conditions, mandated health coverage for most individuals, expanded Medicaid funding and coverage, and subsidized health insurance through exchanges for lower income individuals, among other provisions.[29] Health insurance exchanges were created so individuals can compare plans from different insurance companies and purchase individual health insurance. Individuals with a qualifying level of income can receive federal subsidies to help pay premiums on health insurance plans. As part of the ACA, Oregon accepted federal funding to expand Oregon Health Plan (OHP) membership, setting targets for enrollment and expanding the variety of services (e.g. dental services). Statewide, membership in OHP increased 104% over seven years, from 469,000 members in January 2010 to 957,000 members in January 2017. The 2012 ACA expansion raised the number of people eligible for OHP in the Yamhill County area to almost 25%. While

insurance coverage does not guarantee convenient access to the appropriate care, it does drastically improve health.

- Getting Care -

As seen in the graph below, use of primary care appears to be increasing over time. This means more patients are seeing their doctor for regular check-ups and sick visits; however, YCCO would like to see those numbers even higher. Only half of adults on YCCO had a doctor visit in 2017, barely one third had a dentist visit. Mental health visit data only represent visits to one network of providers, through Health and Human Services, and are not preventative care, but many more people could be using mental health supports.

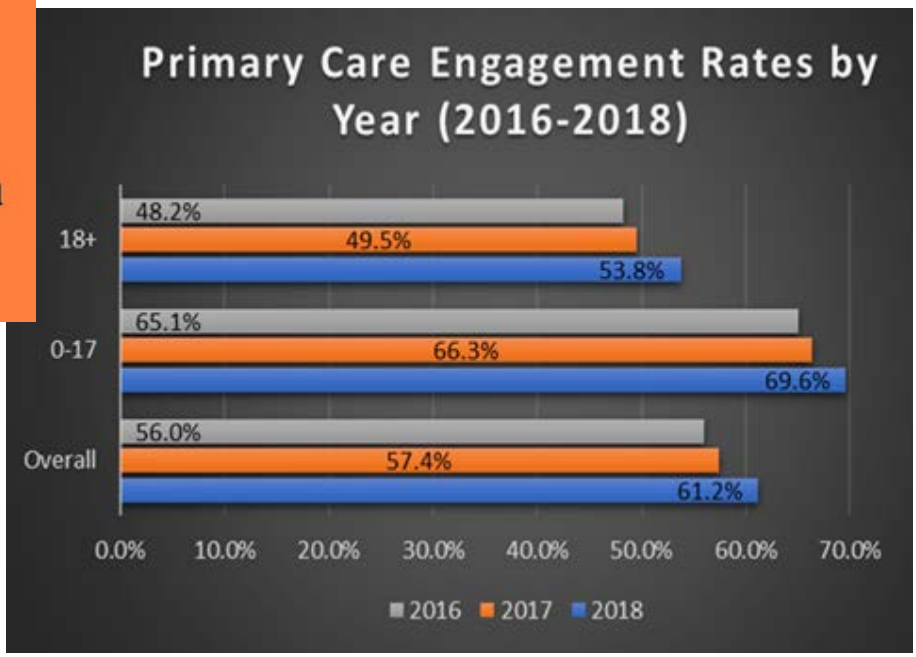
HOW MANY YCCO MEMBERS ARE GETTING TO THE DOCTOR?

50% adults
66% kids
had a doctor visit (2017)

35% adults
68% kids
had a dentist visit (2018)

7% adults
4% kids
had a mental health or addictions visit (2017)

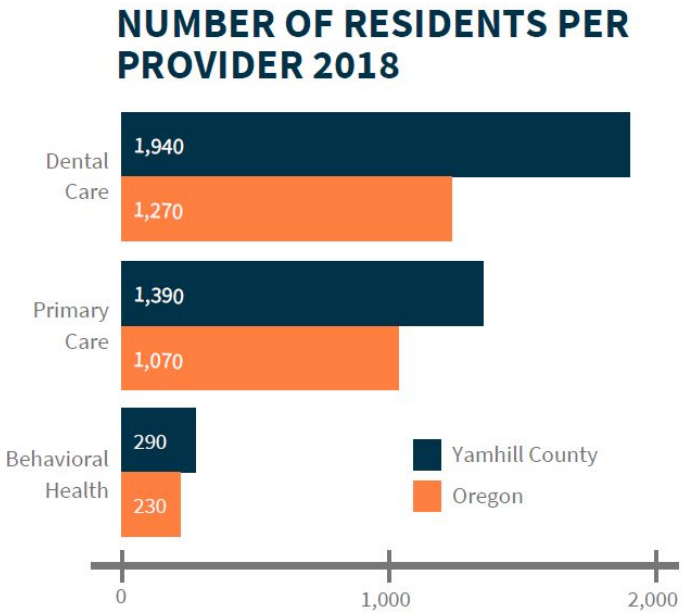
YCCO members' emergency room utilization, which often reflects barriers to timely care, has been the highest in the state for the last few years. The Yamhill County area has only one OHP-contracted urgent care center, which is in Newberg. Patients may not access preventative care for a variety of reasons. They may be overall healthy and not think they need regular care, but when lack of transportation, appointment times, and appropriate services keep them from care, these issues can be improved. Because of this, YCCO continues to provide more options for accessing care and promoting preventative health.



- Access to Doctors -

Yamhill County has fewer providers per resident than the state overall, which means that doctors, dentists, physicians' assistants, nurse practitioners, etc. are not as plentiful in this rural area than in other areas.

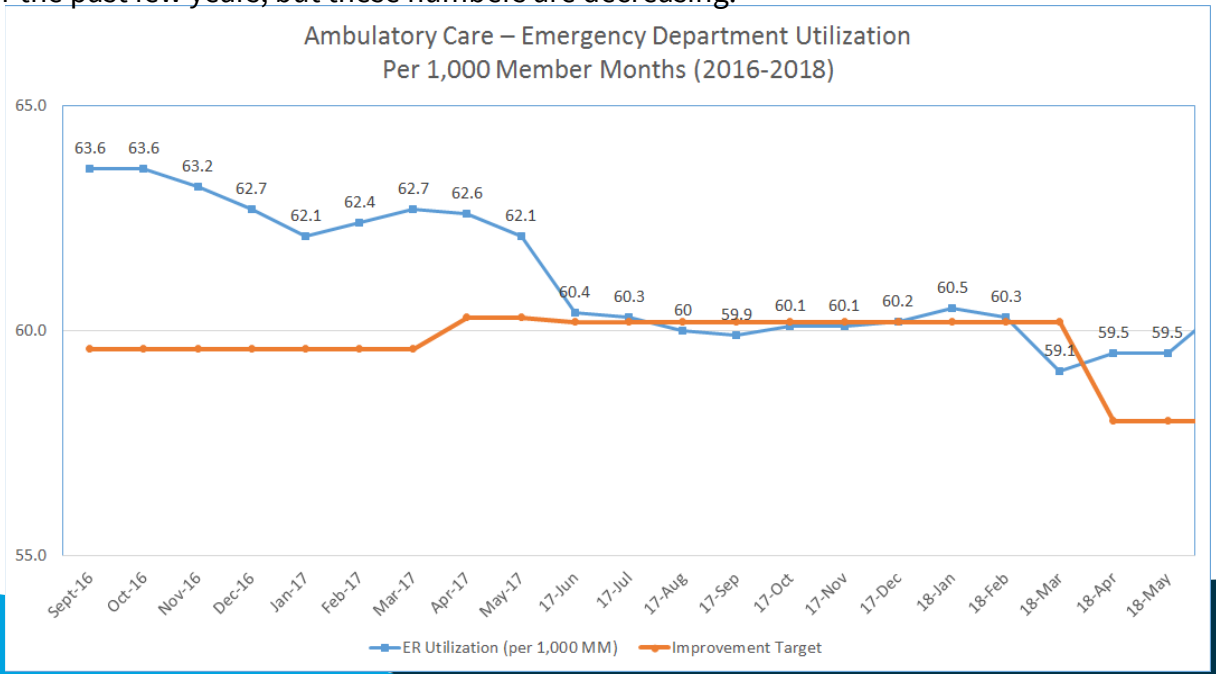
The availability of Primary Care Physicians (PCPs) was measured as the number of physicians in primary care (general practice, internal medicine, obstetrics and gynecology, or pediatrics) per 100,000 people.



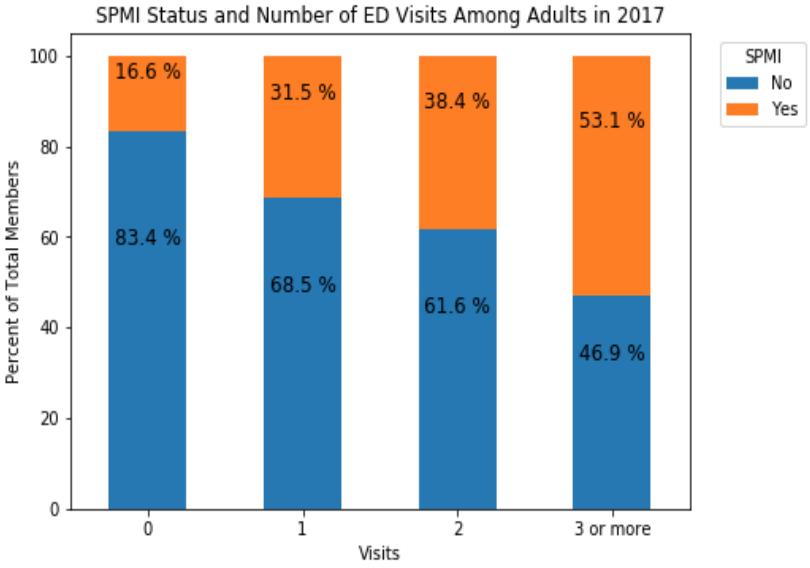
Having access to care requires not only having financial coverage but also access to providers. Having enough available primary care physicians is essential so that people can get preventive and primary care, and when needed, referrals to appropriate specialty care.

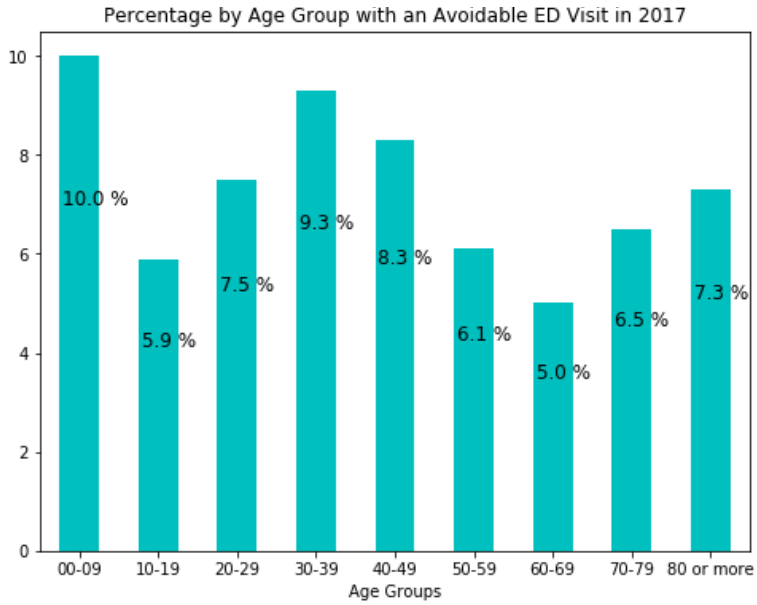
- Emergency Department Use -

YCCO members aren't exclusively using the emergency department (ED); most who use it also see their primary care physician (PCP). YCCO has led the state in ED use for non-emergencies for the past few years, but these numbers are decreasing.



Barriers to care can lead people to use the ED. YCCO called 159 people who had used the ED more than five times in one year. Nearly a third of them reported they used the ED because they were in some sort of acute distress, but another third reported things like their need occurred after clinic hours, the PCP could not see the patient, they could not get in touch with their PCP, the clinic is too far away, or their PCP told them to go to the ED.





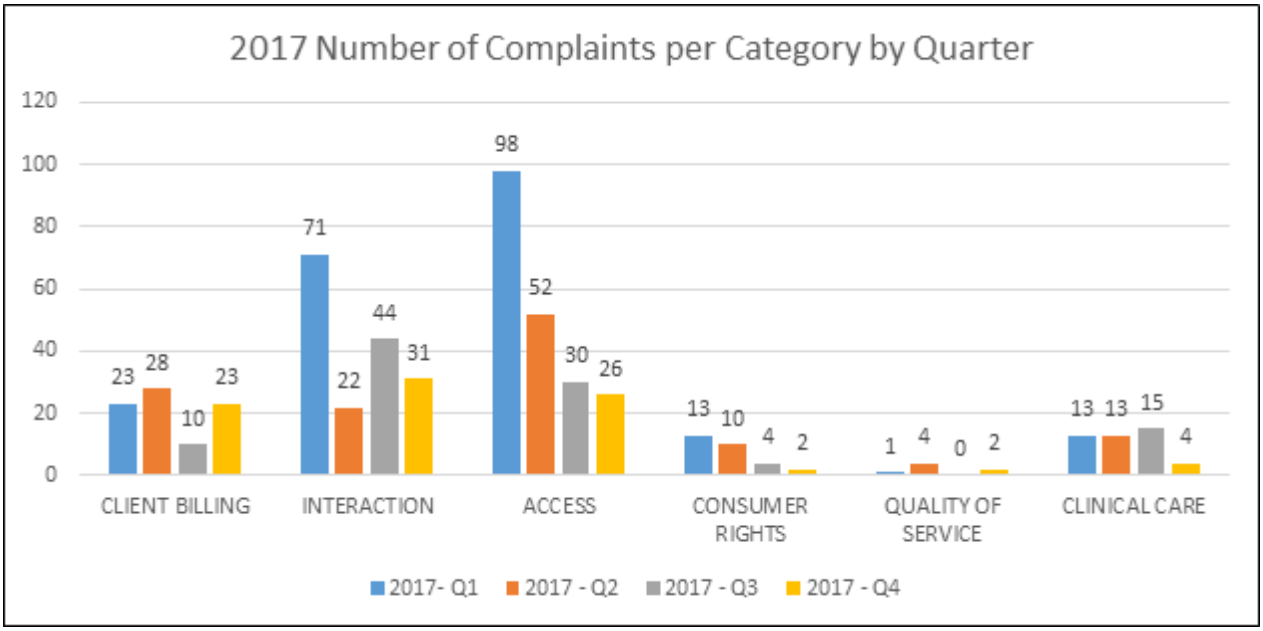
People with many different health needs are more likely to access services, simply because they have more emergent needs. The graph above shows one subgroup, people with what is considered severe and persistent mental illness (things like schizophrenia and bipolar disorder) and ED use. Many people with mental health issues are showing up to the ED with physical health complaints, which also highlights the need to prioritize and discuss mental health as part of whole-person wellness. The next graph shows that children are the population most represented at the emergency room for visits considered "avoidable," which is for things like stomachaches, coughs, and colds.

- Patient Experience -

Access also includes experience of care. Oregon conducts a yearly survey, called the Oregon Consumer Assessment of Healthcare Providers and Systems (CAHPS), which asks questions about people's opinions of their healthcare. In this survey 84.5% of YCCO member respondents said that they thought they received care when they needed it in 2017,

compared to 82.4% in 2016. When asked if they were satisfied with their care, 87.1% of members agreed; in 2016 85.8% of members agreed. Anecdotal reports from YCCO focus groups, however, say that patient access to care is consistently limited, and experience of care is generally positive but can be especially negative, especially for those with disabilities.

YCCO also tracks care experience by taking complaints and feedback through its clinics, calls to customer service, and written complaints and grievances. YCCO compiles and keeps track of these complaints and reports them to its Community Advisory Council (members), Quality and Clinical Advisory Panel (providers), and its other governance bodies as appropriate. Here is what was reported in 2017:



People reported rudeness as the most common complaint. When the actual complaints were reviewed, YCCO found that complaints were more likely to be about staff, customer service, or front desk employees than the main medical provider. Provider explanation, appointment timeliness, and office unresponsiveness were the other top complaints.

It is also worthy of note that very few complaints, less than 5%, were from Spanish speakers, even though 10% of members are Spanish-speaking. None came from people who speak languages other than English or Spanish. There will be more investigation to understand how complaints and feedback from non-English speakers can be better collected. There

Language Spoken by members filing complaints by percentage.		
	Q2.18	Q1.18
English	100%	96%
Undetermined	0%	0%
Spanish	0%	4%
Other Languages	0%	0%

may be cultural barriers to sharing feedback, and there may also be more fear of retribution or stigma against complaining.

A 2018 Health and Human Services satisfaction survey for people receiving mental or substance use help for themselves or their children showed that while 93% of people felt "safe to complain," 12% of people reported not knowing who to talk to or what to do if they had a complaint.

Getting feedback is a positive part of operating a health plan, or any business, and should never impact members negatively. Feedback allows YCCO to grow, improve, and serve its members better. The quickest way to offer feedback is to call customer service at 1-855-722-8205 or mail a letter to 807 NE 3rd St., McMinnville OR 97128.

- Meeting Cultural and Language Needs -

Of 627 currently registered interpreters in Oregon, only 42 (6.7%) serve Yamhill County. Yamhill County makes up 6.8% of the total population of Oregon, which indicates there are an even proportion of interpreters distributed throughout Oregon; however, only 42 interpreters serving over 100,000 people in Yamhill County is not enough. Standards for availability, skill level, and certification vary, and in many cases family members, friends, or uncertified staff or aides will interpret in situations they are not trained to interpret.

Providers can sometimes meet the needs of non-English speaking members, but there are again not sufficient numbers of providers to necessarily fully meet the needs of members. This table shows how many primary care providers speak the languages YCCO members speak.

Language	Members	Primary Care Providers
Arabic	1	19
Armenian	1	1
Hindi	2	30
Indonesian	1	2
Khmer	3	0
Korean	5	23
Lao	4	0
Punjabi	1	3
Portuguese	2	1
Russian	16	24
Samoan	1	0
Spanish	2913	671
Swahili	15	2
Thai	2	3
Vietnamese	14	24
Chinese	36	44
English	21,890	
Undetermined	154	

Access to care is a priority area in the CHIP because so many factors related to access affect health outcomes. The community health focus groups identified how many resources are present in the community, and how educating people about available services, reducing barriers, and connecting people to those services would have a great impact.

Section 5: Prevention & Chronic Disease

Chronic diseases typically last one or more years and need to have continuous treatment and/or inhibit activities of daily life.[31] Many chronic diseases like heart disease and diabetes are some of the leading causes of death in the United States.[31] Chronic diseases are influenced by lifestyle, such as tobacco use, nutrition, physical activity, and alcohol use,[31] but can also be caused by external factors. Environment, air quality, trauma, poverty, access to health foods, etc. all have a large impact on health. Approximately 47% of YCCO members have a chronic condition, meaning nearly half of this population must manage a series of lifestyle, medication, and doctor's appointments, and supporting them is vital to improving the health of the population.

Chronic disease is managed mostly outside of the doctor's office. Managing a chronic disease and preventing disease relies partly on lifestyle choices. Stopping tobacco use, or never starting, reduces an individual's risk for heart disease, cancer, type 2 diabetes, and lung disease.[32] Maintaining a healthy diet can prevent, delay, and manage heart disease, type 2 diabetes, and other illnesses.[32] Incorporating fruits and vegetables, proteins and fats into meals and limiting sugars and alcohol creates a balanced diet. However, many do not have access to affordable healthy food options which makes the creation and maintenance of a balanced diet difficult. Establishing a daily exercise routine of moderate activity can help prevent or manage chronic diseases.[32] However, many people cannot access safe places to exercise or find childcare or time to do so.

Chronic disease is also strongly linked to childhood trauma. That is, if someone has experienced trauma in their youth, their physical health will be negatively impacted later in life. This highlights the need to address social and environment safety for young children and families to prevent some of this chronic disease in the first place. See Section 8 for more information about the impact of trauma on chronic disease.

- Diabetes -

Diabetes is the seventh leading cause of death in the United States and roughly 84.1 million adults have prediabetes.[30] Diabetes is a good indicator of overall population health because diabetics must monitor their health regularly, and so YCCO places special focus on the health

and care management of its diabetic patients. Diabetes affects how the body turns food into energy, by making it harder to regulate blood sugar. When it is not managed properly, it can cause serious health problems, such as heart disease, vision loss, and kidney disease.

74.7% of CCO members had good control of their diabetes in 2017, meaning when screened, their blood sugar levels were within a safe range. Frequent screenings help assess the management of diabetes by telling them how well they are managing their diabetes. If their blood sugar is not controlled, they can work with their doctor to prevent complications. Diabetes is one chronic condition that represents how much health management falls into the patient's hands – people must take their medications, exercise frequently, maintain healthy eating habits, and check their blood sugar among other things. Care support like community health workers and peer support specialists, as well as classes like diabetes prevention and management classes, can help with all these things.

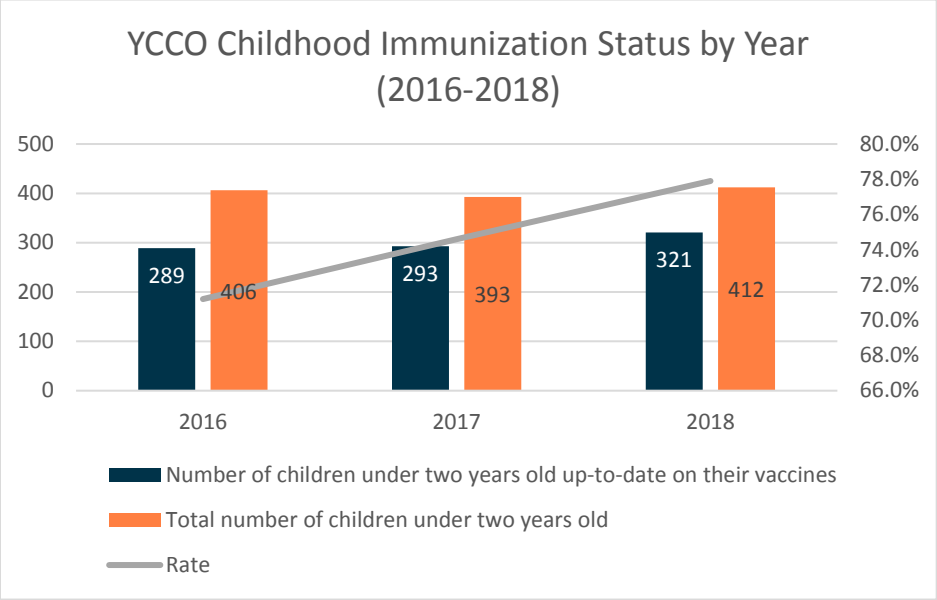
- Chronic Pain -

Chronic pain is not always defined in the same way, but YCCO uses the definition of having pain that typically lasts three or more months or past the time of normal healing.[31] Chronic pain can be caused by numerous underlying issues like a disease, injury, medical treatment, inflammation, while other times the cause of chronic pain isn't known. Assessment and treatment of chronic pain is often a challenge for health providers, as finding the best way for patients to control their pain takes time. Chronic pain can have clinical, psychological and social consequences including decreased physical activity, work productivity, and quality of life and stigma that goes along with the invisible condition. Members of racial and ethnic minorities, women, elders, person with cognitive impairment or cancer, and those at end of their life are most at risk for receiving inadequate pain treatment.[32]

There is a wide array of therapeutic options to treat chronic pain, including opioid pain medication.[33] Evidence has supported short-term use to reduce pain and improve function in noncancerous, nociceptive and neuropathic pain; however, there is not much research to assess long-term benefits of opioids for chronic pain, and it appears that the risks outweigh any benefits. Yamhill Community Care has been working collaboratively with healthcare providers to limit access and decrease the pill count of opioid pain medication prescriptions while working to understand the effectiveness of alternative pain therapies. However, Yamhill County has limited local alternative medicine options for community members needing services. See Section 6: Mental Health and Substance Use to read more about opioids.

- Immunization -

Vaccines are one of the most effective and important measures of preventive medicine. They have been able to completely eliminate diseases such as smallpox and rinderpest and continue to protect people from a whole host of other disease and infection.[34] According to Healthy People 2020, vaccines are among the most cost-effective clinical preventive services. Childhood immunization programs provide a very high return on investment. For example, vaccinating each birth cohort in the US with the routine immunization schedule saves 33,000 lives, prevents 14 million cases of disease, reduces direct health care costs by $9.9 billion, and saves $33.4 billion in indirect costs.[35]



Source: YCCO claims data, 2016-8

Child immunization rates are measured as the rate of two-year-olds who have had all the recommended vaccinations. These are vaccinations for diphtheria, pertussis and tetanus (DTaP), Polio, Measles, Mumps and Rubella (MMR), Hemophilus influenzae type b (Hib), Hepatitis B, and Varicella. In recent years, an anti-vaccination movement has increased fear around vaccinations and reduced the number of parents and caregivers choosing to vaccinate their children

The decreased vaccination has led to recent outbreaks of diseases like measles that were thought to be eliminated. The drop in immunizations poses a threat to herd immunity, which is the idea that vaccinating children and adults who are old enough or healthy enough to

receive vaccinations will protect those who are not able to be vaccinated. The only way to protect populations against rapidly spreading disease is when the majority is immune.

As the graph above shows, immunization rates for YCCO children jumped to 77.9% in 2018, which are some of the highest among CCOs in the state. YCCO works to make sure children have free access to vaccines that will protect them throughout their lives.

- Preventive Screenings -

Health care in the United States is often based on treating symptoms when they appear instead of catching and preventing them before they start. Prevention starts before birth, with ensuring planned, healthy pregnancies and complication-free births. It also includes ensuring that social and environmental factors that negatively affect children like poverty, abuse and neglect, and food scarcity are eliminated. Whether social and environmental needs are met, checking in with a doctor regularly helps make sure potential illnesses are caught before they become bigger problems. Prevention services that promote making healthy lifestyle choices are key for good health and well-being. Nationally, Americans use preventive services about half as much as recommended, with cost of services often a main cause for this discrepancy. With chronic disease accounting for 7 of every 10 deaths among Americans each year and 75% of health spending nationwide, it's crucial to have access to screening services.

- Colorectal Cancer Screening -

Cancer has a major impact on society, estimating $147.3 billion in medical care expenditure in the United States. The most common cancers are breast cancer, lung and bronchus cancer, prostate cancer, rectum cancer and melanoma of the skin.[36] Cancer mortality is higher among men than women (481.0 per 100,000 men and 417.1 per 100,000 women). The median age of diagnosis is estimated at 66 years old, but 17.8 % of cancer cases are being diagnosed between 35-54 years of age.[37]

Cancer screenings is a preventive measure to ensure early detection which can be life-saving. One screening that YCCO uses as an indicator of its members' health is colorectal cancer (CRC) screening, (screening for cancers of the colon or rectum). Colorectal cancer is the second deadliest cancer, but is very easy to prevent with regular screening, which does not always need to be a colonoscopy. CRC screening can happen at home with a mail-in kit, or through other procedures in the doctor's office. Rates of CRC screening for YCCO members were 49.9% in 2017, with 55.9% in Yamhill County and 64.8% statewide. Since people on Medicaid are not receiving these life-saving screenings at the same rate as the general population increasing screening rates is a focus area for improvement for YCCO.

There are myriad reasons people might not access preventative care, including the fact that it is often frightening or uncomfortable to get screened or a talk to a doctor about personal issues. A local Yamhill County survey found that the main reasons parents found it difficult to get to a doctor was time, not knowing the well-visit schedule, and perceiving that their child didn't need to go to the doctor when they're not sick. The top response for youth that took the survey was not needing to go to the doctor when not sick. Prevention requires a shift of culture to make well-care just as important as sick-care.

YCCO continues to increase its understanding of why people are not accessing care, especially within specific demographics and subgroups. While vaccination rates for young children on YCCO are higher than the population, CRC screening rates are lower. The more detailed data YCCO has about disparities within particular populations and illnesses, the more ability there is to address these issues effectively in the region.

Section 6: Mental Health and Substance Use

Mental health affects people of all race/ethnicities, ages, genders, gender identities, incomes, and social statuses. However, factors like discrimination, institutional racism, or stigma because of any aspect of someone's identity can increase the risk of struggling with mental health and can increase the risk of suicide. An estimated 26% of Americans age 18 years and older have been diagnosed with a mental health disorder in any given year and 46% will have a mental health disorder during their lifetime.[38] These diagnoses can include things like anxiety, substance use, depression, behavior disorders, persistent suicidal thoughts, schizophrenia, and Alzheimer's disease. The risk can be greater in rural areas where there is increased isolation from others and from treatment. Loneliness and isolation cause an increased risk of depression, cognitive decline, early onset of Alzheimer's disease, and many other risk factors.[39]

Behavioral health includes both mental health and substance use, which is the use of different substances like alcohol, marijuana, heroin, prescription drugs, and other legal and illegal drugs in order to change someone's state of mind or mood. Mental health problems and substance abuse are both issues that can be treated with help from professionals, group or individual therapy, and/or medications, in the same way physical health problems are treated by professionals.

- Getting Care -

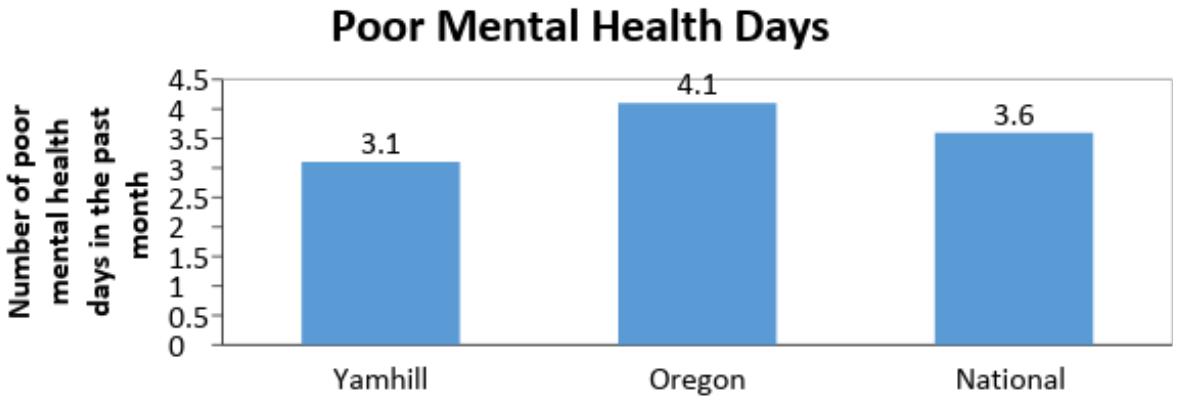
"With mental health crises, people may sit in the ED for days because there is nowhere else to go."

Developmental Disabilities Committee Focus Group, McMinnville

Mental health is equally as important as physical health, and the two are fully intertwined, but the two are not always associated and are often treated as separate from one another. Yet 96% of people responding to the YCCO Community Health Survey indicated that they agree or strongly agree that mental health affects the body. YCCO is working to integrate the two in other ways, placing people who address mental health in clinics for primary care and vice versa. There are behaviorists in every school district, yet respondents to the YCCO community survey still listed mental health as a key issue to address; it is one of the few issues that was not as highly ranked in the 2014 survey. Focus group respondents brought up mental health again and again. The most recent satisfaction survey from Yamhill County Health and Human Services indicates a high level of

happiness with services. Less than 6% of respondents said they felt staff treat them unfairly, and 97% of people said the staff treat them with dignity and respect at all times.

Part of collecting this information is understanding where the gaps are and continuing to ask questions to get a more complete picture. The graph below indicates that Yamhill County residents experience fewer poor mental health days than the state or the country, but this issue continues to be ranked as a top need. Mental health is more than attending therapy and/or taking medications, it includes social connections, finding purpose or fulfilling activities, and finding coping strategies like exercise or meditation.



Having good mental health sometimes means getting help. 2,803 people on YCCO received services at Yamhill County Health and Human Services (YCHHS) mental health clinics in 2017, which is only about 11% of the total members. However, there are other places people can access mental health services that YCCO does not have data on, and many people simply do not need or think they need mental health services, so these numbers are likely lower than reality. These numbers could still hint at barriers to getting services, including stigma or lack of providers with appropriate training to meet cultural needs. For example, only 2.4% of these were Spanish-speakers, even though Spanish speakers represent almost 10% of YCCO membership.

- Suicide -

Results from the 2018 Student Wellness Survey show that the rate of suicidal thoughts for youth in grades 8 and 11 are higher than the state. YCHHS reported three members both expressing suicidal ideation and completing suicide in 2017. Good mental health support, social support, and media messaging can all impact suicide rates. Prevention programs like the Good Behavior Game (GBG), a classroom intervention that builds connections and purpose among children, and Starting Strong, a program which support individual student mentors, are both examples of programs that can build protective factors for children.

4.2 Depression and Suicide Ideation

Suicide is the second leading cause of death among Oregon youth aged 10-24. Depression is the most common underlying cause of suicide. The following table reports the percentage of students who had signs of depression, thoughts about suicide, or actually attempted suicide during the last 12 months.

Table 22: Depression and Suicide Ideation by Students Past 12 Months

	Grade 6		Grade 8		Grade 11	
	County %	State %	County %	State %	County %	State %
Did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?	20.0	22.8	30.5	29.2	34.2	35.6
Did you ever seriously consider attempting suicide?	8.0	13.3	21.3	19.9	20.8	19.7
Actually attempted suicide?	4.8	7.5	10.8	10.2	6.1	8.1

• *Percentages exclude missing answers.*

2018 Student Wellness Survey

Social isolation, or spending a lot of time alone, can contribute to less-than-optimal mental health.[40] Older populations are more likely to live alone, and older people generally have higher suicide rates.

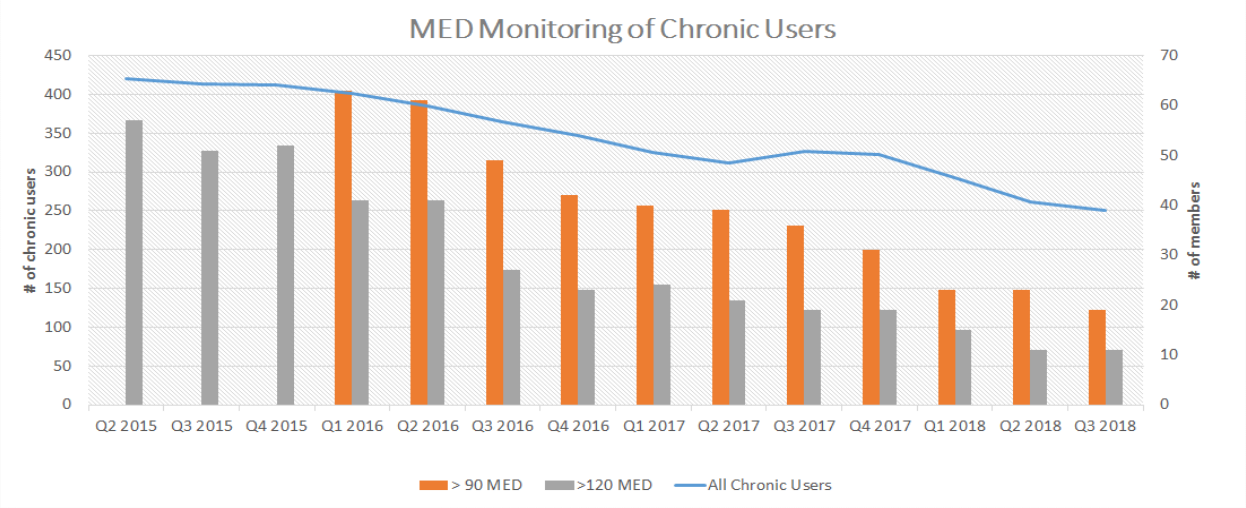
The below chart depicts number of people who live alone in three age brackets.[41] Fewer older Yamhill County people live alone than in the state or nation overall, but this risk factor will continue to be monitored.

Rates of Living Alone in 2017	Age 15-34:	Age 35-64:	Age 65-plus:
United States	22.8%	22.7%	42.9%
Oregon	20.5%	22.9%	43.2%
Yamhill County	11.1%	18.3%	40.6%

- Opioids -

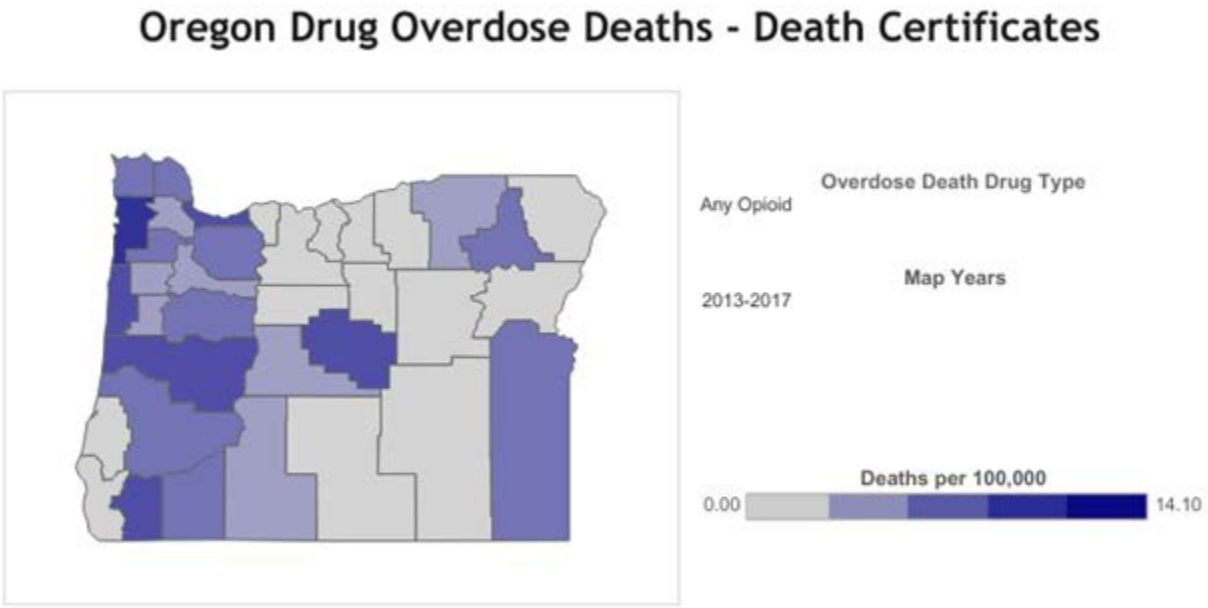
Opioid pain medication use has shown to present serious health risk including overdose and opioid use disorders. In the past decade, opioid death has increased rapidly in the United States, making it the leading cause of death in the country.[42] More people are dying from opioid overdoses than from car accidents. The increase of opioid pain medication prescriptions parallels the opioid-related overdose deaths.[43]

Opioid use and chronic pain are complicated issues that the community and the nation have been grappling with for years. One main strategy YCCO uses to create guidelines limiting the number of opiates doctors prescribe to their patients. This reduces the overall number of pills in the community.



Limiting prescriptions, however, creates a need for effective addiction treatment and alternatives to manage pain. Nationally, while deaths from methadone (usually prescribed pills) have fallen almost 10%, deaths from other opioids like heroin have increased.[44]

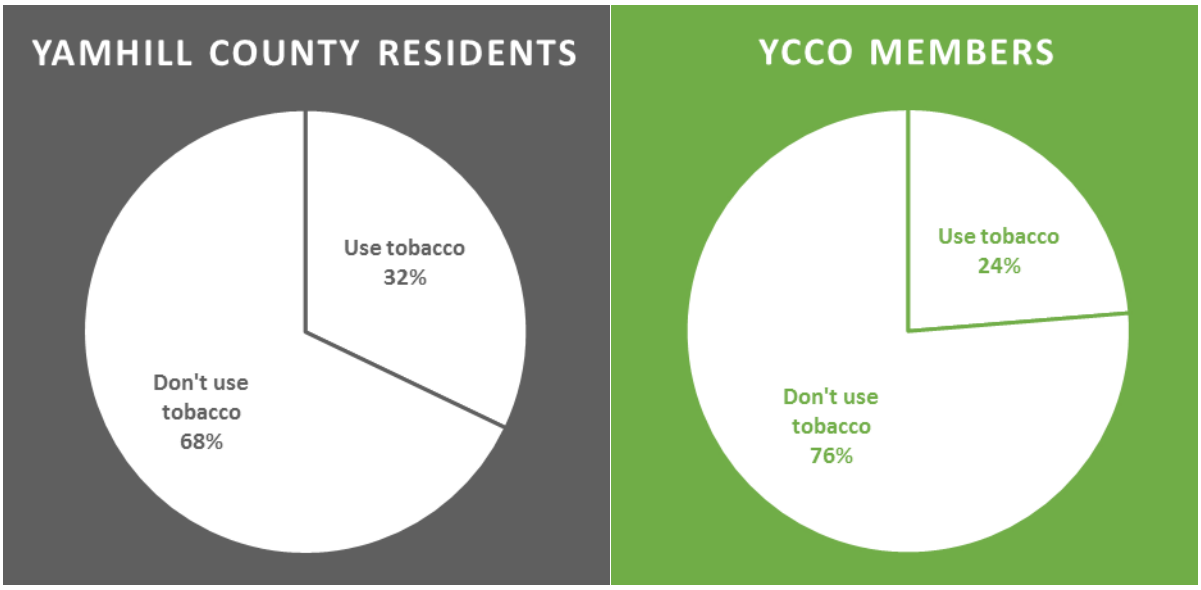
For residents that are struggling with opioid use disorders, Yamhill County has begun to offer medication-assisted treatment (MAT) services. MAT is a substance use disorder treatment that combines counseling with medication support. Currently four providers within the county provide Buprenorphine or Vivitrol MAT services in the County. There are no methadone MAT services in the county, meaning some people must travel to Salem or Portland to access these resources.



Yamhill County does not lead the state in opioid deaths, but people in the county see the impact of opioids regularly. In addition to MAT services, YCCO and Yamhill County are partnering to make Narcan more widely available, which can prevent death in the case of an overdose; explore alternative pain management resources; and to fund a needle exchange to help reduce the harm caused by reusing needles.

- Tobacco Use -

The biggest cause of death that could be prevented is smoking. Tobacco use is expensive and high-risk. Though many people want to quit smoking, quitting an addictive substance is incredibly difficult and much less likely to happen without support.[45] Increases in vaping and the use of e-cigarettes presents a new risk, especially for younger people; prevention is a key component of addressing the problem of tobacco use. The most recent information averaging 2013-2017 indicates that YCCO members are using tobacco at a slightly lower rate than the county as a whole, although typically tobacco use rates are higher for those on Medicaid (in Oregon, 25% of residents use tobacco, while 35% of OHP members do).



Source: Oregon Public Health Assessment Tool 2014-17

Resources to quit smoking tobacco in Yamhill County are fairly limited and underutilized. Quitline is a benefit to YCCO members and is also available through YC Public Health to anyone in the county. People can call Quitline when they are ready to quit and receive both phone counseling and nicotine replacement therapies, like patches and gum, for free. However, only 34 YCCO members used Quitline in 2017. The other service that has been available is the Willamette Valley Cancer Foundation's in-person tobacco cessation classes. These have an average of 32 attendees per year. The more times someone tries to quit, the more likely they are to quit, and so having a plethora of available ways to support quit attempts is a key strategy for YCCO.

Section 7: Oral Health

It is only within the past five years that OHP members could get dental care as a covered benefit. Many members still aren't aware they have dental, according to focus groups, although it seems many do: 93% of survey respondents with children on OHP reported that they knew their children have dental coverage.

Oral health is an essential aspect of an individual's whole-body health and its importance is often overlooked. 95% of survey respondents confirmed that oral health affects physical and mental health. Oral health impacts self-esteem, work and school attendance, ability to speak, smile, and eat. Oral health involves the wellness of the teeth, gums, and the mouth and face. Poor oral health can lead to the development of oral diseases like cavities, gum disease, and oral cancer. It is also linked to heart disease, premature and low birth weight babies and tooth loss.[46]

Despite all their risks, oral health issues are incredibly common. Nearly one-third of all adults in the United States have untreated tooth decay, or tooth cavities, and one in seven adults ages 35 to 44 years old has periodontal (gum) disease. By the age of 34, more than 80% of people have had at least one cavity and more than 40% of adults have felt pain in their mouth in the last year.[47] Tooth decay is the most prevalent chronic disease affecting children in the U.S. One in five children ages five to 11 and one in seven adolescents aged 12 to 19 have at least one untreated decayed tooth. Youth from low income families have a higher rate of untreated tooth decay than their peers from higher-income households.[48] It is difficult to have good oral health without access to good, nutritious foods low in sugars and simple carbohydrates, or access to oral health supplies and education.

Tooth decay or cavities occur when the enamel on the tooth is broken down by the acids created by bacteria from the plaque that gathers by the gum line and in the crevices on the chewing surfaces of the tooth. Periodontal or gum disease occur when the gums and bone that support the teeth become infected and inflamed. A weakened immune system, poor oral hygiene, diabetes, or genetics can all increase an individual's risk for gum disease.[49]

Fluoride is something that helps strengthen teeth and prevents dental diseases, but not everyone can buy fluoride toothpaste regularly or maintain consistent brushing and flossing habits. Fluoridating water is a key way to reduce cavities and improve oral health for individuals and families, especially those who face barriers to accessing dental health care or who cannot afford fluoridated products. Only two towns in Yamhill County incorporate fluoride into their water systems, McMinnville and Sheridan.

- Getting Care -

Going to the dentist regularly helps to keep on top of fighting plaque and gum disease. As shown in the table below, children who are YCCO members are more likely to be taken to the dentist than adult members. 68% of children who have dental coverage are using these services, while only 35% of adults are. Focus groups indicated some difficulty in getting appointments, but dental care has been steadily improving for YCCO members since the health plan started working with a single Dental Care Organization: Capitol Dental Care. Capitol has capacity to serve YCCO's entire membership, and YCCO will continue to track engagement and utilization as awareness of the benefit and coordination with Capitol goes on.

Capitol Dental: Oral Health Engagement 2018

Age segment	Enrolled	Seen	% Utilization
0-17	7,519	5,107	68%
18+	9,115	3,226	35%
Total	16,634	8,333	50%

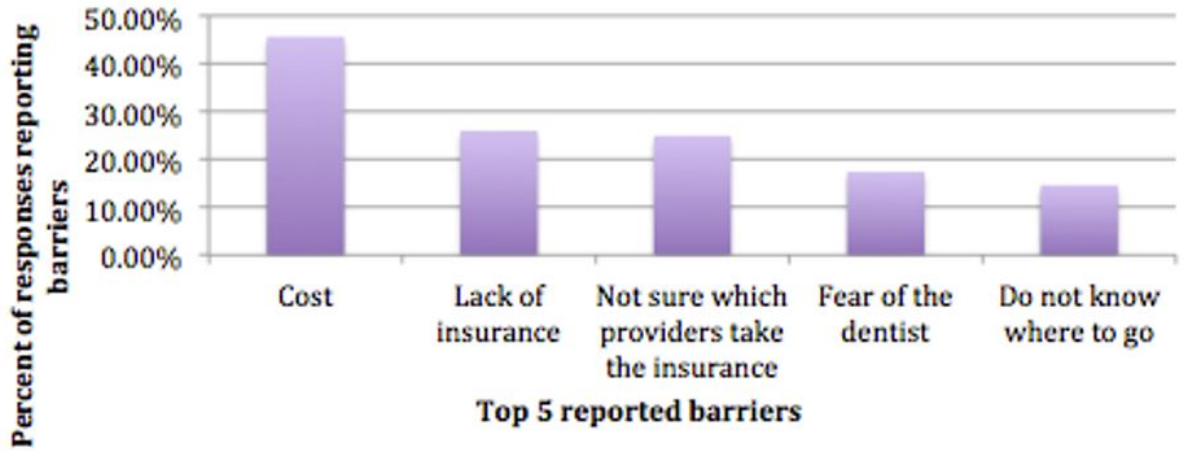
The percent of people going to the dentist is higher for YCCO members that identify as Hispanic. This many indicate that there are fewer language barriers in the dental setting for those who speak Spanish or stigma about going to the dentist for that population, but this will require a better understanding about access to dental care for each demographic group.

Ethnicity	Sum of Enrolled	Sum of Seen	% of enrolled population seen for care in 2018	% of population
Caucasian -English	13,180	6,205	48.7%	79.2%
Hispanic (includes Portuguese and Spanish speaking)	2,733	1,763	66.3%	16.4%
Other Undetermined	271	175	70.4%	1.6%
Native American	185	80	49.5%	1.1%
Asian	119	57	50.7%	0.7%
African-American	102	42	46.5%	0.6%
Pacific Islander	22	6	37.5%	0.1%
Swahili	13	3	37.5%	0.1%
Russian	7	2	50.0%	0.0%
Indian	2	0	0.0%	0.0%
Total	**16,634**	**0**	**100.0%**	**100.0%**

- Barriers -

Survey respondents to a 2016 Yamhill County Oral Health Needs Assessment indicated good oral health overall— 45% reported good oral health 12.4% very good, while 30% of respondents said their oral health was only fair and 13.4% said poor. Additionally, though most respondents to the YCCO Community Health Survey knew their children had dental benefits if they are on OHP, education around oral health is limited.

Figure 4. Barriers for Adults Accessing Dental Care



In a 2015 Oral Health Needs Assessment Survey of Yamhill County residents, respondents reported the barriers listed in the graph above, naming cost and insurance as key issues, yet this should not present as a barrier to most CCO members. Additionally, fear was listed as the fourth highest barrier, which necessitates addressing how to integrate trauma-informed care and more social supports into dental care.

Education around benefits could extend to education around oral health in general. Like any chronic disease, caring for dental health requires management outside of the clinic. One fifth of respondents to the survey said children should have their first dentist appointment after their second birthday, while children should be having a dentist appointment as soon as they get their first tooth, or their first birthday. Dentists and hygienists can help reduce fear for both adults and children, and offer education around good brushing and flossing habits, limiting infants' time with bottles, and restricting fruit juices and sodas.

- Dental Sealants for Children -

YCCO can track indicators of good dental health. One of those is sealants. Sealants are a substance brushed onto teeth, usually a child's first molars, to help keep bacteria and decay from taking hold on the teeth. Sealants are often administered in school settings, where dental providers can reach the most children, with their caregivers' consent.

In 2016, 19.7% of YCCO children between ages 6-14 received sealants on their molars, which will help them prevent decay in permanent teeth and reduce risk of cavities. In 2017, this number jumped to 23.2%, meaning more children are getting dental care. Much of this is due to programs in schools, which reach a large number of children at once, in an environment they feel comfortable.

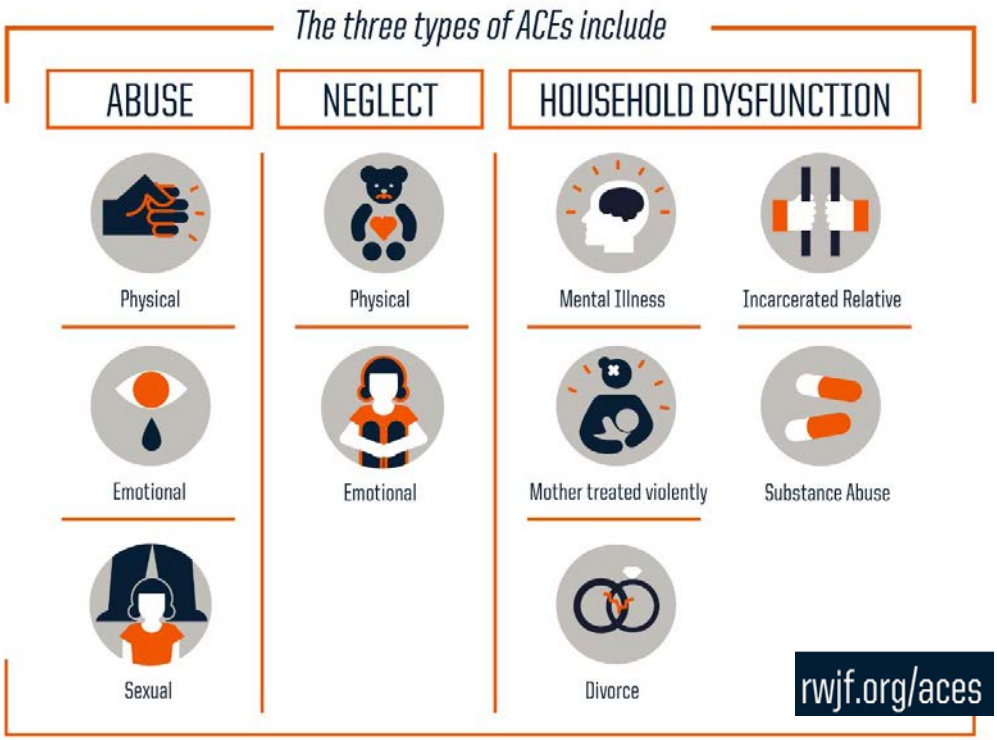
Two of the top three reasons people who were not engaged with primary care visited the emergency room in 2018 were related to dental issues. More education about dental needs, dental care, and accessing preventative dental services and advice outside of clinic hours can help reduce these issues and reduce the need to go the emergency room. Part of the intervention plan includes delivering dental care in an increased number of settings outside of a dental office, like in schools, as well as primary care or maternal medical homes and in places like peer support centers. In these settings, people may feel safer and more comfortable. Accessing dental care in general can be a traumatic or retraumatizing experience, and YCCO continues to develop and explore strategies to improve the experience of care for its members.

Section 8: Trauma & Resilience

- Adverse Childhood Experiences –

Adverse childhood experiences (ACEs) are events like neglect, abuse, violence and/or a distressed family environment that affect a person before they turn 18 years old. These events can disrupt stages of a child's development and make children more likely to have negative health effects later in life. Research has shown a link between ACEs and poor health outcomes including risky health behaviors, chronic health conditions, and even early death.[50] New discoveries about toxic stress also indicate that ACEs can actually change the way genes are expressed in a person.[51]

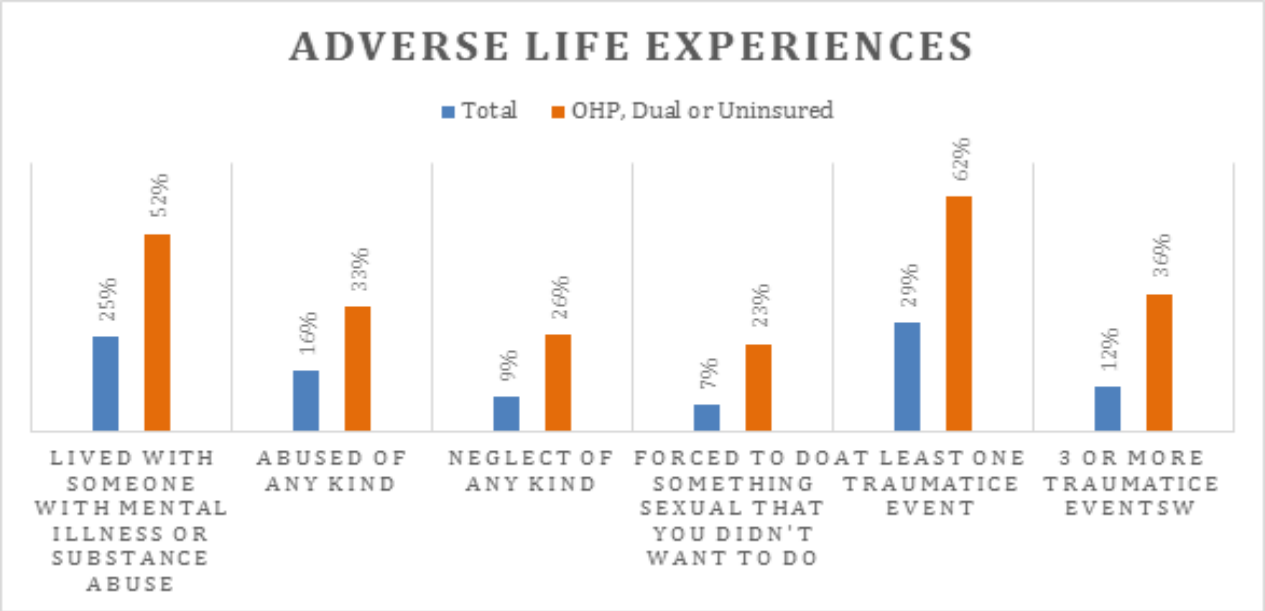
There are ten types of childhood trauma that are measured to determine ACEs score:



Each type of experience is counted as one "point"; the higher someone scores the higher the risk of negative health outcomes over the course of one's life. Other factors continue to expand beyond the original ten to also include things like racism and childhood bullying.

ACEs are not fate; they do not determine a persons' life, and with protective and supportive factors like good healthcare and social connections, people can thrive, living largely unaffected by ACEs. Focus group respondents and CAC members both highlighted how people who have experienced ACEs have additional resiliency, empathy, and strength. Of people reporting one or more ACEs in the YCCO Community Health Survey, 91% of those people also said they felt they could recover from stress or bad experiences.

The Providence Newberg Hospital conducted a community health survey that asked questions about the trauma people have experienced. The table below compares responses from individuals on OHP or who are uninsured with the total sample population. The results from the survey were only weighted by age and may not fully represent the Providence Newberg Hospital community population. The data shows that individuals on OHP or who are uninsured have higher rates of trauma exposure than the total sample population.

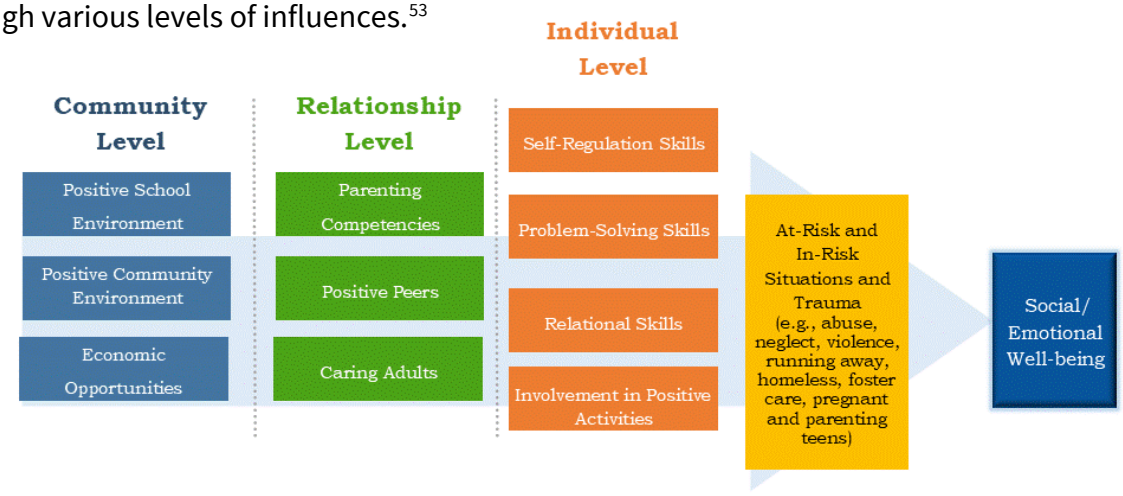


Nearly half of all people responding to the YCCO Community Survey indicated they had experienced at least one bad life event in their childhood that they still think affects them today. In a behavioral health survey performed by Health and Human Services in 2018, 68% of clients reported one or more traumatic event(s) in their or their child's life that has affected their mental health or influenced their use of drugs or alcohol. A huge number of people have experienced some sort of trauma. Those who have are not alone, and services are growing increasingly aware of how to address this. The original study was conducted on largely white, middle-class individuals; while some groups are more likely to experience trauma, it does not discriminate.

- Building Resiliency -

Protective factors or "buffers" are conditions that help reduce risk and promote healthy development and well-being of children and families. Adopting protective factors can help to strengthen families and build a foundational framework to prevent child abuse and neglect.[52] Programs like Lutheran Community Services' A Family Place, which offers home visiting, parenting education, diaper banks, and respite support for families help wrap supports around families. This can reduce the risk of abuse and neglect. Parenting is hard, and the many programs in the Yamhill County area can help.

Positive long-term outcomes related to health, school success and successful transitions to adulthood typically do not occur as the result of single intervention. Building protective factors by addressing social and environmental factors can reduce risk and create resilience for all children, youth and families. Below image provides a crosswalk between protective factors through various levels of influences.[53]



Nurturing and Community Resilience Framework

Social support is a vital piece of resiliency. Ninety-one percent of community survey respondents said they could rely on at least one close friend or family member when they need help, and 85% of respondents to the 2018 Oregon Healthy Teens Survey said they could rely on support from family and friends during times of stress and need. Seventy percent of 8th graders and 75% of 11th graders report having a teacher or other adult at school who cares about them.

A strong community is one that nurtures everyone who lives, works, and plays there. It creates systems of social, financial, health, and education support that are integrated and aligned in their missions. A healthy community is accessible and inclusive, has diverse resources, and has a focus on the social determinants of health and trauma-informed care. Building resilience and fostering health requires a community to address all of these factors and understand them.

Section 9: Community Health Improvement Plan

What's next? The information collected from other assessments; national, state, and local data; YCCO claims and health plan information; surveys; and focus groups was compiled and presented to the Community Advisory Council, CHIP planning workgroup, and in three public forums in Willamina, McMinnville, and Newberg. The issues that rose to the top were used to information strategy forming, and the seven CHIP priority areas were formed from this information, through multiple sessions and discussions: Behavioral health, including suicide, substance use, and tobacco; Trauma and Resiliency; Children and Families; Social Determinants of Health; Access to Care, including experience of care; and Oral Health. The first four align closely with Yamhill County Public Health, and the last three are specific to Yamhill CCO members and initiatives.

The strategies listed in the CHIP will be implemented over the next three to five years and will be closely tracked from baselines identified in 2019 to targets set in the goal year of their completion. Community members can look for regular updates on the YCCO website and through community newsletters like the Service Integration Team list serve.

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Community Health Survey

Your opinion matters!

Help us improve your health care! When you finish this survey, your view will be added to many others from this community. We use this information to bring people together to solve problems, and learn where our work will matter most to you and your neighbors.

This survey is private – no one will be able to tell who you are by your answers. Once you have finished the survey, you can add your contact info and get a chance to win a $75 gift card! There are 5 gift cards to give away and you can choose from over 10 different options!

We will only use your phone or email information to contact you if you won. It will be deleted after the winner is announced.

If you need this survey in another language contact ejohnson@yamhillcco.org or call 503-376-7428.

Si necesita esta encuesta en otro idioma, comuníquese con ejohnson@yamhillcco.org o llame al 503-376-7428.

A healthy life for everyone

Your view matters. This survey is about you and your neighbors in Yamhill County.

We are Yamhill Community Care. Our purpose is to guide better health, better care and lower costs by working together with others in the community. Our health plan covers people on Medicaid in Yamhill County, but we're all about helping everyone live a healthy life. You do not need to be an OHP member to fill out this survey! This survey is private. Please answer for yourself, and be honest. Allow 15 minutes to finish the survey.

Questions? Contact Emily Johnson at ejohnson@yamhillcco.org or 503-376-7428.

Your Health Coverage

1. Have you heard about Yamhill Community Care Organization before?

- ◯ Yes
- ◯ No

2. Do you spend most of your time in Yamhill County?

- ◯ Yes
- ◯ No

3. What kind of health insurance do you have right now? Check all that apply.

- ☐ Through my job or a family member
- ☐ Private insurance I buy on my own
- ☐ Insurance through the Marketplace (Healthcare.gov)
- ☐ Medicare
- ☐ Medicaid (Oregon Health Plan)
- ☐ Tribal Health Insurance
- ☐ Veteran's Administration (VA)
- ☐ Tricare (active military)
- ☐ Student health insurance
- ☐ I don't have health insurance
- ☐ Other

4. If you selected Oregon Health Plan, are you a member of Yamhill Community Care Organization?

- ◯ Yes
- ◯ No
- ◯ I don't know

Your Community

5. If you could pick three things to improve your community's access to health care, what would they be? Choose only 3.

- ☐ Health education and wellness programs (like healthy eating and diabetes programs, family planning services, and programs to help people stop smoking)
- ☐ Disease prevention and screening services (like cancer screening and vaccines)
- ☐ Alternative health care (acupuncture, naturopathy, etc.)
- ☐ Care that meets cultural needs (including language needs)
- ☐ Mental health services
- ☐ More doctors and health care providers
- ☐ Alcohol and drug treatment
- ☐ Other (please specify)

_____

- ☐ Medical visits after 5pm and on weekends
- ☐ Help with transportation
- ☐ More dentists
- ☐ More support for families with children
- ☐ More available childcare
- ☐ Housing programs

6. What are the top three things that would improve life for children in this community? Choose only 3.

- ☐ Better social supports for families (things like parent groups and places for families to meet each other)
- ☐ More childcare
- ☐ Mentorship or role model programs
- ☐ Affordable preschool
- ☐ Better access to health care
- ☐ Other (please specify)

_____

- ☐ More libraries
- ☐ More public places to play
- ☐ Affordable healthy foods
- ☐ Access to child abuse prevention resources
- ☐ More parenting classes or education

7. Think about the most recent time you or a family member did not get the health care they needed. What were the reasons why? Check all that apply.

- [ ] Cost
- [ ] Childcare
- [ ] Did not want to go
- [ ] Didn't know where to go
- [ ] Do not have a regular doctor
- [ ] Do not have insurance
- [ ] Not applicable
- [ ] Transportation
- [ ] Afraid of what might be wrong
- [ ] Couldn't get an appointment quickly
- [ ] Doctor's office wasn't open
- [ ] I waited for the problem to go away

Your Health

8. What kinds of things or services help you most when you are not feeling well (physically or mentally)? Check all that apply.

- [ ] Going to a doctor's office, dental clinic, or mental health clinic and talking to someone there
- [ ] Going to the emergency room
- [ ] Researching my symptoms on the internet
- [ ] Treating it myself
- [ ] Finding peer support (someone at places like Project ABLE, Champion Team, or Provoking Hope)
- [ ] Going to urgent care (includes places like Walgreens or Zoomcare)
- [ ] Calling a clinic or nurse hotline
- [ ] Asking a friend or relative for advice
- [ ] Talking to a community health worker or health advocate

9. Do you have chronic pain (pain in your body for more than three months at a time)?

- ( ) Yes
- ( ) No

10. If you answered yes, how do you manage your pain? Check all that apply.

- [ ] Prescription opioids (drugs like Vicodin, morphine, and Percocet)
- [ ] Alternative medicine (like acupuncture, chiropractic, or massage)
- [ ] Exercise (like yoga or other movement)
- [ ] Recreational drugs (drugs like marijuana, heroin)
- [ ] Over-the-counter or other prescription drugs (like Advil or Gabapentin)
- [ ] I don't use anything to manage my pain

11. How much does taking care of a person's mental health (things like counseling and treatment for addiction) affect their physical health, or the health of the rest of their body?

- ◯ Very much
- ◯ Somewhat
- ◯ Not very much
- ◯ Not at all
- ◯ I don't know

12. How much does taking care of a person's mouth and teeth affect their body and mind?

- ◯ Very much
- ◯ Somewhat
- ◯ Not very much
- ◯ Not at all
- ◯ I don't know

Your Experiences

13. Do you feel safe in the place you sleep most nights?

- ◯ Yes
- ◯ No
- ◯ Sometimes

14. Have you had a difficult or bad life event in your childhood that you think still affects you today?

- ◯ Yes, one event
- ◯ Yes, two events
- ◯ Yes, three or more events
- ◯ No
- ◯ I don’t know

15. I have one or more close friends or family members I can go to when I need help.

- ◯ Yes
- ◯ No
- ◯ I don’t know

16. I feel that I can recover from stress or bad experiences.

- ◯ Strongly agree
- ◯ Agree
- ◯ Disagree
- ◯ Strongly disagree

Your Family

17. Are you the main caregiver for a child or children under 18? If you answer no, please skip to question 23.

- ◯ Yes
- ◯ No

18. How many children are under your care?

- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5
- ◯ 6
- ◯ 7
- ◯ More than 7

19. How old is/are your child(ren)? Check all that apply.

- ☐ 0-3
- ☐ 4-6
- ☐ 7-10
- ☐ 11-15
- ☐ 16-18

20. What insurance(s) do(es) your child(ren) have? Check all that apply.

- ☐ Through my job or a family member
- ☐ Private insurance I buy on my own
- ☐ Insurance through the Marketplace (Healthcare.gov)
- ☐ Medicare
- ☐ Medicaid (Oregon Health Plan)
- ☐ Tribal Health Insurance
- ☐ Veteran's Administration (VA)
- ☐ Tricare (active military)
- ☐ Student health insurance
- ☐ My child doesn't have health insurance

21. What health insurance benefits do(es) your child(ren) have? Check all that apply.

- [ ] Physical health – They get check-ups and regular visits at a clinic when sick
- [ ] Vision health – They can go to an eye doctor and get an exam and glasses
- [ ] Dental health – They can get screenings, cleanings, and fillings at a dental clinic
- [ ] Transportation – They can get rides, repayment, or gas vouchers to doctor visits
- [ ] Mental health – They can see a mental health doctor or substance abuse counselor
- [ ] I don't know

22. When should a child first visit the dentist?

- ◯ Before their first birthday (12 months)
- ◯ After their third birthday (36 months)
- ◯ Between their first and second birthdays (12-24 months)
- ◯ I don't know
- ◯ Between their second and third birthdays (24-36 months)

Demographics

Yamhill Community Care works to give the best service to everyone, no matter what their background is. We try to make sure that every person in our county has a voice. Answering the next 13 questions helps us know we are getting the best picture of our community. You many skip any questions you prefer not to answer, but all answers are grouped so you will not be linked to your answers.

23. Zip code

24. Age

- ◯ Under 18
- ◯ 18-24
- ◯ 25-44
- ◯ 45-64
- ◯ 65-85
- ◯ 86+

25. How do you define your race, ethnicity, tribal affiliation, or ancestry?

26. Please choose the race, ethnicity, tribal affiliation, or ancestry that best fits you:

- ☐ American Indian or Alaska Native
- ☐ Hispanic or Latino/a
- ☐ Asian
- ☐ Native Hawaiian or Pacific Islander
- ☐ Black or African American
- ☐ White
- ☐ Other
- ☐ Unknown

27. What is your yearly income?

- ◯ Less than $10,000
- ◯ $10,000 - $24,999
- ◯ $25,000 - $49,999
- ◯ $50,000 – $74,999
- ◯ $75,000 - $99,999
- ◯ More than $100,000

28. How many people are in your household, including you?

- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5
- ◯ 6
- ◯ More than 6

29. What language do you prefer to speak?

- ◯ English
- ◯ Spanish
- ◯ Russian
- ◯ Other (please specify)
- ◯ Swahili
- ◯ Chinese
- ◯ Vietnamese

30. How well do you speak English?

- ◯ Very well
- ◯ Well
- ◯ Not very well
- ◯ I don’t speak English at all

31. Does a physical, mental, or emotional condition limit your daily activities in any way?

- ◯ Yes
- ◯ No
- ◯ I don't know

32. What is your current gender identity?

- ◯ Female
- ◯ Male
- ◯ Transgender man
- ◯ Transgender woman
- ◯ Non-binary
- ◯ Unknown
- ◯ Other (please specify)

33. What best represents how you currently think of yourself?

- ◯ Straight/heterosexual
- ◯ Gay or lesbian
- ◯ Bisexual
- ◯ Queer
- ◯ Questioning
- ◯ Unknown
- ◯ Other (please specify)

34. Do you have a car/reliable transportation?

- ◯ Yes
- ◯ No
- ◯ Sometimes

35. What is your housing like right now? Choose what fits you best.

- ◯ I own a home
- ◯ I am couchsurfing
- ◯ I rent with housing vouchers or government help
- ◯ I rent
- ◯ I live in shared housing
- ◯ I am homeless
- ◯ I live with friends or family

Thank you for completing our survey! You are helping make life better for people in our community! If you would like to enter for a chance to win a $75 gift card, please click this link to give us your contact information. This info will be completely separate from your survey responses.

www.surveymonkey.com/r/XVDYPKH

¡Su opinión importa!

¡Ayúdenos a mejorar su atención médica! Cuando termine esta encuesta, su opinión se sumará a muchas otras opiniones de la comunidad. Utilizamos esta información para ayudar a que las personas resuelvan los problemas, y para saber las áreas dónde nuestro trabajo importaría más para usted y sus vecinos.

¡Termine la encuesta y participe para ganar una tarjeta de regalo $75!

La encuesta es privada - nadie podrá saber quién es usted por sus respuestas. Cuando haya terminado la encuesta, usted puede ingresar su información de contacto para participar de un sorteo para ganar una tarjeta de regalo de $75.

Sólo utilizaremos su teléfono o correo electrónico para comunicarle si gano. Después de anunciar al ganador dicha información será borrada.

Si necesita esta encuesta en otro idioma, comuníquese con ejohnson@yamhillcco.org o llame al 503-376-7428.

Su opinión importa. Esta encuesta es sobre usted y sus vecinos en el condado de Yamhill.

Somos Yamhill Community Care. Nuestro objetivo es mejorar la salud, mejorar la atención y reducir los costos a través del trabajo conjunto con otros en la comunidad. Nuestro plan cubre a las personas que tienen Medicaid en el condado de Yamhill, pero nuestra intención es ayudar a que todos vivan una vida sana. ¡No necesitas ser miembro de OHP para completar el formulario!
La encuesta es privada. Por favor responda por sí mismo y sea honesto. Conceda 15 minutos para terminar la encuesta.

¿Tiene preguntas? Comuníquese con Emily Johnson a ejohnson@yamhillcco.org o llame al 503-376-7428.

Su cobertura de salud

1. ¿Escucho antes de Yamhill Community Care Organization?

- ◯ Sí
- ◯ No

2. ¿Pasa la mayor parte de su tiempo en el condado de Yamhill?

- ◯ Sí
- ◯ No

3. ¿Qué tipo de seguro de salud tiene en este momento?

- ◯ A través de mi trabajo o de un miembro familia
- ◯ Seguro privado, lo compro por mi cuenta
- ◯ Seguro a través del Mercado (Healthcare.gov)
- ◯ Medicare
- ◯ Medicaid (Plan de Salud de Oregón)
- ◯ Administración de Veteranos del Seguro de Salud Tribal (VA)
- ◯ Tricare (militar activo)
- ◯ Seguro de salud para estudiantes
- ◯ No tengo seguro de salud
- ◯ Otro

4. Si seleccionó el Plan de Salud de Oregón, ¿es miembro de Yamhill Community Care Organization?

- ◯ Sí
- ◯ No
- ◯ No lo sé

Su Comunidad

5. Si pudiera escoger tres cosas para mejorar el acceso al sistema de atención médica de su comunidad, ¿qué escogería? Elija 3 solamente.

- [ ] Programas de bienestar y educación de la salud (como programas de alimentación sana y diabetes, servicios de planificación familiar y programas para ayudar a las personas que quieren dejar de fumar)
- [ ] Servicios de prevención y de detección de enfermedades (como detección del cáncer y vacunas)
- [ ] Atención médica alternativa (acupuntura, naturopatía, etc.)
- [ ] Atención que satisface necesidades culturales (incluidas las necesidades lingüísticas)
- [ ] Servicios de salud mental
- [ ] Más médicos y proveedores de atención médica.
- [ ] Tratamiento de alcohol y drogas
- [ ] Otro (aclarar)

- [ ] Visitas médicas después de las 5 de la tarde y los fines de semana.
- [ ] Ayuda con el transporte
- [ ] Más dentistas
- [ ] Más apoyo para familias con niños.
- [ ] Más ayuda con el cuidado infantil
- [ ] Programas de vivienda

6. ¿Cuáles son las tres cosas más importantes que mejorarían la vida de los niños en la comunidad? Elija 3 solamente.

- [ ] Mejores servicios de apoyo para las familias (como grupos de padres y lugares para que las familias se conozcan)
- [ ] Más servicios para el cuidado infantil
- [ ] Programas de mentores o de modelos a seguir
- [ ] Escuelas preescolares a precios razonables
- [ ] Mejor acceso a la atención médica
- [ ] Otro (aclarar)

- [ ] Más bibliotecas
- [ ] Más lugares públicos para jugar
- [ ] Alimentos saludables a precios razonables
- [ ] Acceso a recursos de prevención del abuso infantil
- [ ] Más clases para padres o educación

7. Piense cuál fue la última vez en que usted o un miembro de su familia no recibió la atención médica que necesitaba. ¿Cuáles fueron las razones? Marque todo lo que corresponda.

- [ ] Costo
- [ ] de la atención infantil
- [ ] No quería ir
- [ ] No sabía a dónde ir
- [ ] No tengo un médico de cabecera
- [ ] No tengo seguro
- [ ] Transporte
- [ ] Temía cuál podía ser el problema
- [ ] No pude obtener una cita rápidamente
- [ ] La oficina del doctor no estaba abierta
- [ ] Esperé a que el problema pasara
- [ ] No aplica

Su Salud

8. ¿Qué tipo de cosas o servicios le ayudan más cuando no se siente bien (física o mentalmente)? Marque todo lo que corresponda.

- [ ] Ir al consultorio de un médico, clínica dental o clínica de salud mental y hablar con alguien allí
- [ ] Ir a la sala de emergencias
- [ ] Investigar mis síntomas en Internet
- [ ] Tratarme por mi cuenta
- [ ] Encontrar apoyo entre pares (alguien en lugares como Project ABLE, Champion Team o Provoking Hope)
- [ ] Ir a lugares que atienden urgencias (incluye lugares como Walgreens o Zoomcare)
- [ ] Llamar a una clínica o línea directa de enfermería
- [ ] Pedir consejo a un amigo o familiar
- [ ] Hablar con un trabajador comunitario de salud o con un intercesor de la salud

9. ¿Tiene dolor crónico (dolor en su cuerpo por más de tres meses a la vez)?

- ◯ Sí
- ◯ No

10. Si respondió Sí, ¿cómo controla el dolor? Marque todo lo que corresponda.

- [ ] Opioides recetados (medicamentos como Vicodin, morfina y Percocet)
- [ ] Medicina alternativa (como acupuntura, quiropráctica o masaje)
- [ ] Ejercicio (como yoga o de otro tipo)
- [ ] Drogas recreativas (drogas como la marihuana, heroína)
- [ ] Medicamentos de venta libre u otros medicamentos recetados (como Advil o Gabapentin)
- [ ] No uso nada para controlar el dolor.

11. ¿Cuánto afecta la atención de salud mental de una persona (como consejería, y el tratamiento de adicciones) a su salud física o la salud del resto de su cuerpo?

- [ ] Mucho
- [ ] Poco
- [ ] No mucho
- [ ] Nada
- [ ] No lo sé

12. ¿Cuánto afecta el cuidado de la boca y los dientes de una persona a su cuerpo y mente?

- ◯ Mucho
- ◯ Poco
- ◯ No mucho
- ◯ Nada
- ◯ No lo sé

Su Vida

13. ¿Se siente seguro en el lugar donde duerme casi todas las noches?

- ◯ Sí
- ◯ No
- ◯ A veces

14. Ha sufrido un evento difícil o malo en su infancia que cree que aún le afecta hoy?

- ◯ Sí, un evento
- ◯ Sí, dos eventos
- ◯ Sí, tres o más eventos.
- ◯ No
- ◯ No lo sé

15. Tengo uno o más amigos o familiares cercanos a los que puedo acudir si necesito ayuda.

- ◯ Sí
- ◯ No
- ◯ No lo sé

16. Siento que puedo recuperarme de una situación estresante o de una mala experiencia.

- ◯ Totalmente de acuerdo
- ◯ De acuerdo
- ◯ En desacuerdo
- ◯ Totalmente en desacuerdo

Su Familia

17. ¿Es usted el(la) cuidador(a) principal de un niño o niños menores de 18 años? Si respondió No, por favor pase a la pregunta 23.

- ◯ Sí
- ◯ No

18. ¿Cuántos niños tiene bajo su cuidado?

- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5
- ◯ 6
- ◯ 7
- ◯ Más de 7

19. ¿Qué edad tiene(n) su(s) hijo(s)? Marque todo lo que corresponda.

- ☐ 0-3
- ☐ 4-6
- ☐ 7-10
- ☐ 11-15
- ☐ 16-18

20. ¿Qué seguro o seguros tienen sus hijos? Marque todo lo que corresponda.

- ☐ A través de mi trabajo o de un miembro familiar
- ☐ Seguro privado, lo compro por mi cuenta
- ☐ Seguro a través del Mercado (Healthcare.gov)
- ☐ Medicare
- ☐ Medicaid (Plan de Salud de Oregón)
- ☐ Administración de Veteranos del Seguro de Salud Tribal (VA)
- ☐ Tricare (militar activo)
- ☐ Seguro de salud para estudiantes
- ☐ Mi hijo no tiene seguro de salud

21. ¿Qué tipo de beneficios ofrece el seguro de salud de su(s) hijo(s)? Marque todo lo que corresponda.

- [ ] Salud física - Reciben chequeos y visitas regulares en una clínica cuando se enferman
- [ ] Salud de la visión - Pueden acudir a un oculista para hacerse un examen y obtener anteojos
- [ ] Salud dental - Pueden obtener exámenes, limpiezas y empastes en una clínica dental
- [ ] Salud mental - Pueden ver a un médico de salud mental o un consejero de abuso de sustancias
- [ ] Transporte – Pueden obtener viajes, reembolsos o cupones de gasolina para visitar a un médico
- [ ] No lo sé

22. ¿Cuándo debería un niño visitar al dentista por primera vez?

- ◯ Antes de su primer cumpleaños (12 meses)
- ◯ Entre su primer y segundo cumpleaños (12-24 meses)
- ◯ Entre su segundo y tercer cumpleaños (24-36 meses)
- ◯ Después del tercer cumpleaños (36 meses)
- ◯ No lo sé

Demografía

Yamhill Community Care procura ofrecer el mejor servicio a todos, sin importar su origen. Tratamos de asegurarnos de que todas las personas del condado tengan voz. Su respuesta a las siguientes 13 preguntas nos ayuda a saber que estamos obteniendo la mejor descripción de nuestra comunidad. Puede omitir las preguntas que no quiera responder, pero todas las respuestas están agrupadas por lo tanto no estarán vinculadas a sus respuestas.

23. Código postal

24. Edad

- ◯ Menos de 18
- ◯ 18-24
- ◯ 25-44
- ◯ 45-64
- ◯ 65-85
- ◯ 86+

25. ¿Cómo definiría su raza, etnia, afiliación tribal o ascendencia?

26. Escoja la raza, etnia, afiliación tribal o ascendencia que mejor le corresponda:

- ☐ Nativo Americano o Nativo de Alaska
- ☐ Hispano o Latino/a
- ☐ Asiático
- ☐ Nativo de Hawái o de las Islas del Pacífico
- ☐ Negro o Afroamericano
- ☐ Blanco
- ☐ Otro
- ☐ Desconocido

27. ¿Cuál es su ingreso anual?

- ◯ Menos de $10,000
- ◯ $10,000 - $24,999
- ◯ $25,000 - $49,999
- ◯ $50,000 – $74,999
- ◯ $75,000 - $99,999
- ◯ Más de $100,000

28. Cuántas personas viven en su hogar, con usted incluido?

- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5
- ◯ 6
- ◯ Más de 6

29. ¿Qué idioma prefiere hablar?

- ◯ Inglés
- ◯ Español
- ◯ Ruso
- ◯ Otro (aclarar)
- ◯ Swahili
- ◯ Chino
- ◯ Vietnamita

30. ¿Qué tan bien habla inglés?

- ◯ Muy bien
- ◯ Bien
- ◯ No muy bien
- ◯ No hablo inglés

31. ¿Tiene una condición física, mental o emocional que limite sus actividades diarias de alguna manera?

- ◯ Sí
- ◯ No
- ◯ No lo sé

32. ¿Cuál es su identidad de género actual?

- ◯ Mujer
- ◯ Hombre
- ◯ Hombre transgénero
- ◯ Otro (aclarar)
- ◯ Mujer transgénero
- ◯ No binario
- ◯ Desconocido

33. ¿Cuál de las siguientes opciones representa mejor cómo se siente actualmente?

- ◯ Heterosexual
- ◯ Gay o lesbiana
- ◯ Bisexual
- ◯ Otro (aclarar)
- ◯ Queer
- ◯ Cuestionamiento
- ◯ Desconocido

34. ¿Tiene carro o transporte confiable?

- ◯ Sí
- ◯ No
- ◯ A veces

35. ¿Cuál es su situación actual de vivienda? Elija lo que mejor se aplique a usted.

- ☐ Soy dueño de una casa
- ☐ Estoy couchsurfing
- ☐ Alquilo con vales de vivienda o ayuda del gobierno
- ☐ Alquilo
- ☐ Vivo en una vivienda compartida
- ☐ No tengo hogar
- ☐ Vivo con amigos o familiares

Cuando haya terminado la encuesta, usted puede ingresar su información de contacto para participar de un sorteo para ganar una tarjeta de regalo de $75.

www.surveymonkey.com/r/XVDYPKH

Yamhill Community Care Organization-CHNA Focus Group Protocol

For the purposes of this discussion, "community" is defined as where you live, work, and play.

Opening Question (5 minutes)

1. To begin, why don't we go around the table and introduce ourselves. State your name (or whatever you would like us to call you) and what makes you most proud of your community.

General Community Questions (5 minutes)

I want to begin our discussion today with a few questions about health and quality of life in your community.

2. What makes a community healthy? Who are the healthy people here?
3. What do you believe are the 2-3 most important issues that must be addressed to improve health and people's lives in your neighborhood, town, or county?
    a. What are the biggest health problems/conditions in your community?

Health Services Questions (10 minutes)

We are curious about your experience getting health services here. This might be physical health, like check-ups with a doctor or specialist, mental health, substance use treatment with a clinic or counselor, and dental health care.

2. Much does taking care of a person's mouth and teeth affect their body and mind?
    a. Why or why is it not important?
3. How much does taking care of a person's mental health (with things like counseling and treatment for addiction) affect their physical health, or the health of the rest of their body?
    a. Why or why is it not important?
4. If you need to go to the doctor, what is that experience like? How does the process go for you?
    a. FOR PROVIDERS How do you perceive the experience of your clients when they need to go to the doctor?
5. Do you feel you have ever been treated differently because of some part of your identity? This might be your race/ethnicity, your gender, or how much money you make.
    a. FOR PROVIDERS In what ways have you seen clients experience discrimination?

Cancer-Related Questions (10 minutes)

6. How does Yamhill County promote cancer screenings? What have you noticed?
7. Do you have ideas for promotion that you think the county might consider?

8. In thinking about Yamhill County, how would you rate cancer care in the county from 1-5 with 5 being the best. Can you explain your rating for us? What factors went into your rating?

Improvement Questions (5 minutes)

9. What resources does your community have that can be used to improve community health?

10. How do you get your information?
    a. This could be health info, information about events and activities, or information about what's going on in the community.

Facilitator Summary & Closing Comments (5-10 minutes)

Let's take a few minutes to reflect on responses you provided today. We will review the notes we took and the themes we observed. This is your opportunity to clarify your thoughts or to provide alternative responses.

[Co-facilitator provides a brief summary of responses for each of the questions or asks clarifying questions if he/she thinks he/she may have missed something.]

Thank you for your participation in this focus group meeting. You have all raised a number of great issues for us to consider. We will look at what you have told us and use this information to make recommendations at the Community Health Improvement Planning Workshop.

Yamhill Community Care Organization-CHNA Focus Group Protocol

Para fines de este debate, "comunidad" se define como el lugar donde vive, trabaja y juega.

Pregunta inicial (5 minutos)

1. Para empezar, visitemos las otras mesas y presentémonos. Diga su nombre (o como quiera ser llamado) y comparta qué es lo que le hace sentir más orgulloso de su comunidad.

Preguntas generales de la comunidad (5 minutos)

Quiero comenzar el debate haciendo algunas preguntas sobre la salud y la calidad de vida en su comunidad.

2. ¿Cuáles cree que son los 2-3 problemas más importantes que se deben tratar para mejorar la salud y la vida de las personas en su vecindario, ciudad o condado?
    i. ¿Cuáles son los problemas / condiciones de salud más grandes en su comunidad?

Preguntas sobre servicios de salud (10 minutos)

Nos interesa saber su experiencia para obtener servicios aquí. Pueden ser servicios de salud física o salud mental, chequeos con un médico o especialista, tratamiento de abuso de sustancias en una clínica o con un consejero y atención de salud dental.

3. Si necesita ir al médico, ¿cómo fue esa experiencia? ¿Cómo va el proceso?
    a. PARA PROVEEDORES ¿Cómo percibe la experiencia de sus clientes cuando necesitan ir al médico?
4. ¿Siente que alguna vez le han tratado de manera diferente debido a alguna parte de su identidad? Esta podría ser su raza / etnia, su género o la cantidad de dinero que gana.
    a. PARA PROVEEDORES ¿De qué manera han visto a sus clientes experimentar discriminación?

Preguntas relacionadas con el cáncer (10 minutos)

5. ¿Cómo promueve el Condado de Yamhill las pruebas de detección de cáncer? ¿Qué ha notado?
6. ¿Tiene ideas para la promoción que cree que el condado podría considerar?
7. Al pensar en el condado de Yamhill, ¿cómo calificaría la atención del cáncer en el condado de 1 a 5, siendo 5 el mejor? ¿Podría explicarnos su valoración? ¿Qué factores entraron en su calificación?

Preguntas para implementar mejoras (5 minutos)

8. ¿Qué recursos tiene su comunidad que pueden usarse para mejorar la salud de la comunidad?

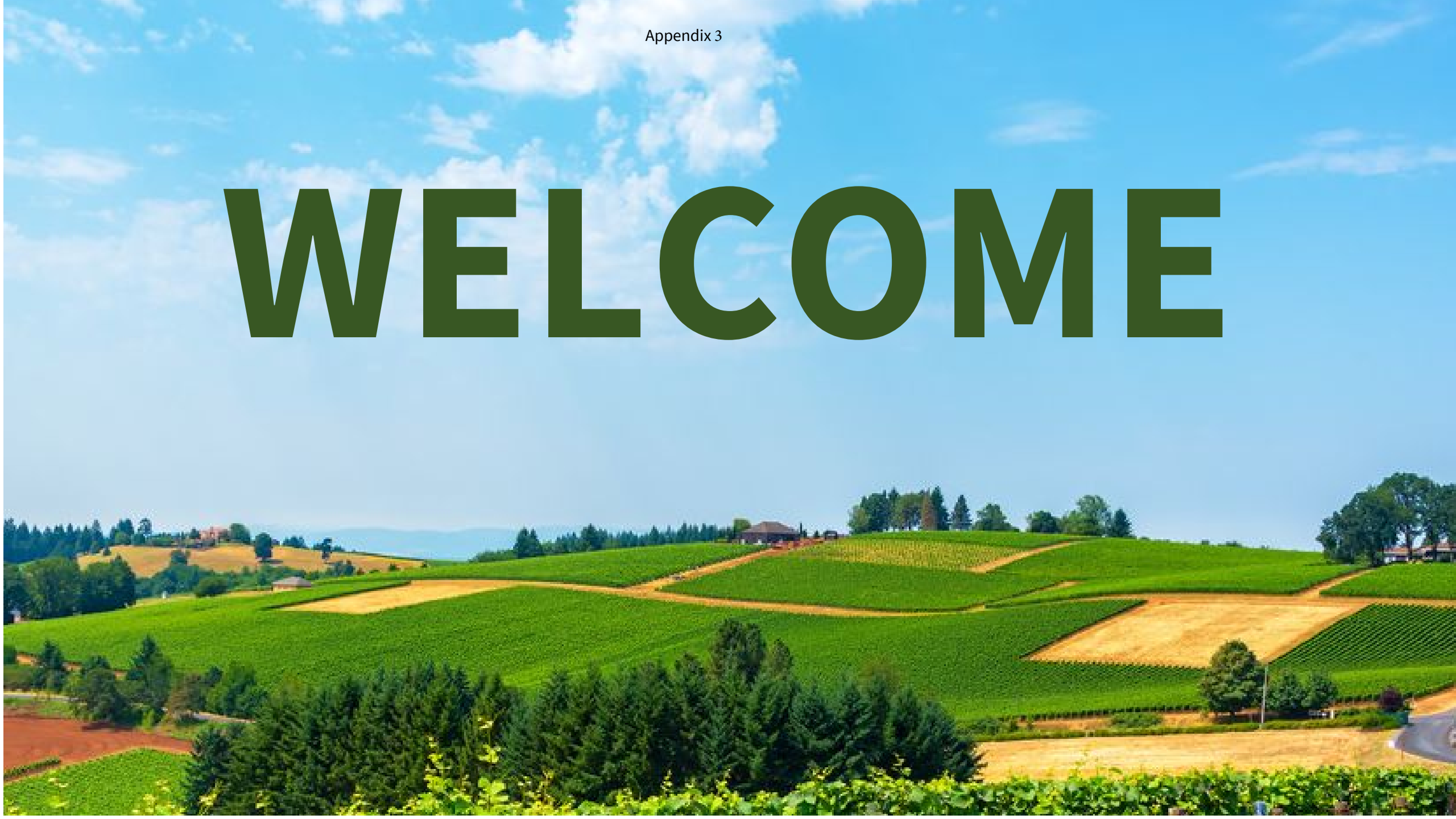
Resumen del facilitador y comentarios finales (5-10 minutos)

Tomemos unos minutos para reflexionar sobre las respuestas que brindó hoy. Repasaremos las notas que tomamos y los temas que escuchamos. Esta es su oportunidad para aclarar sus pensamientos o para ofrecer respuestas alternativas.

> [El Co-facilitador proporciona un resumen breve de las respuestas para cada una de las preguntas o hace preguntas aclaratorias si cree que se puede haber olvidado de algo.]

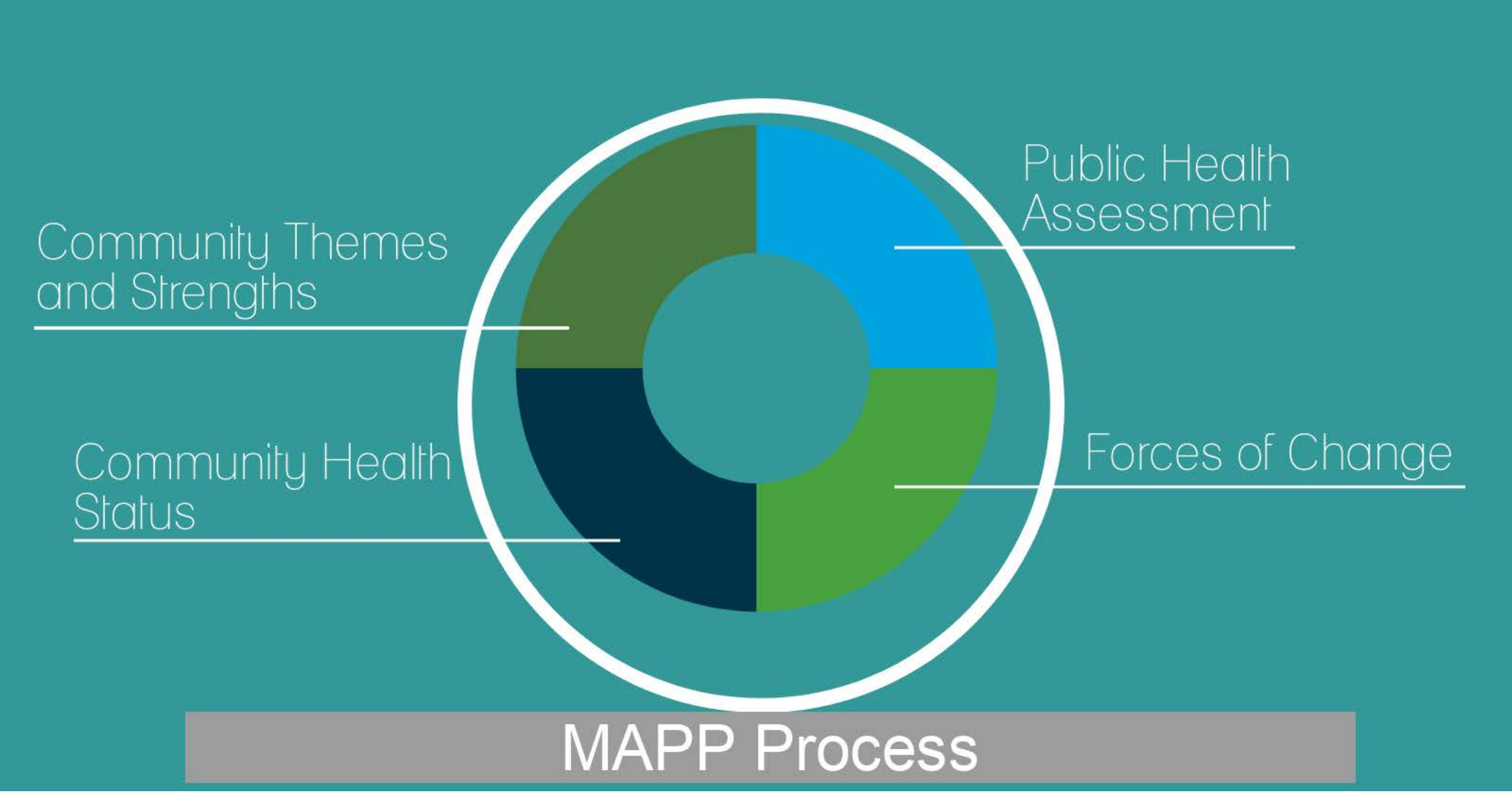
Gracias por participar en el grupo de enfoque. Ustedes han planteado una serie de problemas importantes para que tengamos en cuenta. Repasaremos lo que nos ha dicho y utilizaremos esta información para hacer recomendaciones en el Taller de Planificación de Mejora de la Salud de la Comunidad.

WELCOME



Yamhill COMMUNITY CARE

Understanding Community Needs


Public Health Assessment
Community Themes and Strengths
Forces of Change
Community Health Status
MAPP Process

Community Health Assessment

What are you proud of about our community?

- Sense of community; neighborly
- Efforts to improve Newberg area
- People are willing to listen to others
- So many organizations provide services

"Accepting"

"Beautiful"

What are the top most important issues to improve people's lives?

- Housing
- Transportation
- Translators and language barriers
- Affordable day care and preschool
- Mental health

"It's not necessarily neighborly if you can't afford to live here or get transportation to services"

Today's Focus

Oral health

Social determinants of health

Access to care

Other Focus Areas

Children & families

Mental health & addictions

Trauma & resilience

In Oregon, more than half of children 6-9 years old have tooth decay

Poor oral health is related to things like heart disease and premature birth

Only two towns in Yamhill County have fluoridated water

Almost one out of every three Oregon adults avoid smiling because of their teeth

Older people are at higher risk for isolation

People with fewer close friendships have lower self-esteem, don't adjust as well, and have a higher risk of suicide

1,386 people in Yamhill County were considered homeless in 2018 (this number is probably lower than reality)

More than half of people in Yamhill County are paying more than 30% of their pay on rent

94% of Oregonians have health insurance – when the ACA expanded Medicaid, the rate of uninsured people went down

Yamhill County has some of the highest rates of Emergency Department visits in the state

There are 42 certified language interpreters serving all of Yamhill County

There are 1,390 people for every one medical care provider in Yamhill County

Scope

What are the resources?

Who is at highest risk and needs the most help?

How long will it take?

Is it related to the health of people on OHP?

MAKING STRATEGIES

Do an action → To make a change → For a certain group of people

SAMPLE STRATEGIES: ORAL HEALTH

- Partner with local peer support agencies to improve access to dental care, including through locating dental services in peer support offices, to improve oral health for people experiencing homelessness and mental diversity
- Partner with the local Oral Health Coalition and Capitol Dental Care to explore teledentistry options at other non-clinical locations
- Explore community education options for increasing the number of fluoridated towns in Yamhill County

KEY PEOPLE

- Children and babies
- People with mental diversity
- People experiencing homelessness

SAMPLE STRATEGIES: YOUR NEIGHBORHOOD

- Provide travel vouchers to help people get to medical appointments, job interviews, and other family support functions
- Partner with rural libraries to conduct outreach to families of children 0-5 and connect them to school readiness, family support, and healthcare services
- Strengthen the Yamhill County Service Integration Teams by adding focus on housing to reduce the number of people facing homelessness
- Partner with local peer support agencies to reach out to the homeless population and connect them with services

KEY PEOPLE

- People experiencing homelessness in rural areas
- People with mental diversity
- Youth experiencing homelessness
- People experiencing isolation

SAMPLE STRATEGIES: ACCESS TO CARE

- Hold regular listening sessions and conduct regular surveys, in collaboration with clinics, to obtain feedback from patients, clients, and community members about needs
- Collaborate with local interpretation and translation agencies to ensure quality language services and a strong workforce
- Provide community education materials, outreach sessions, and media offering education about member benefits, rights, and advocacy options
- Partner with local faith community to improve awareness of and access to mental health services

KEY PEOPLE

- People who do not speak English very well or at all
- People who are not accessing health services but have OHP
- Adults and adolescents

Yamhill

COMMUNITY CARE

Small group discussion

- Choose or create your own strategies under your table's priority area
- Rotate tables when told

Large group discussion

- Do these strategies work for you?
- What are the next steps?

Keep in touch!

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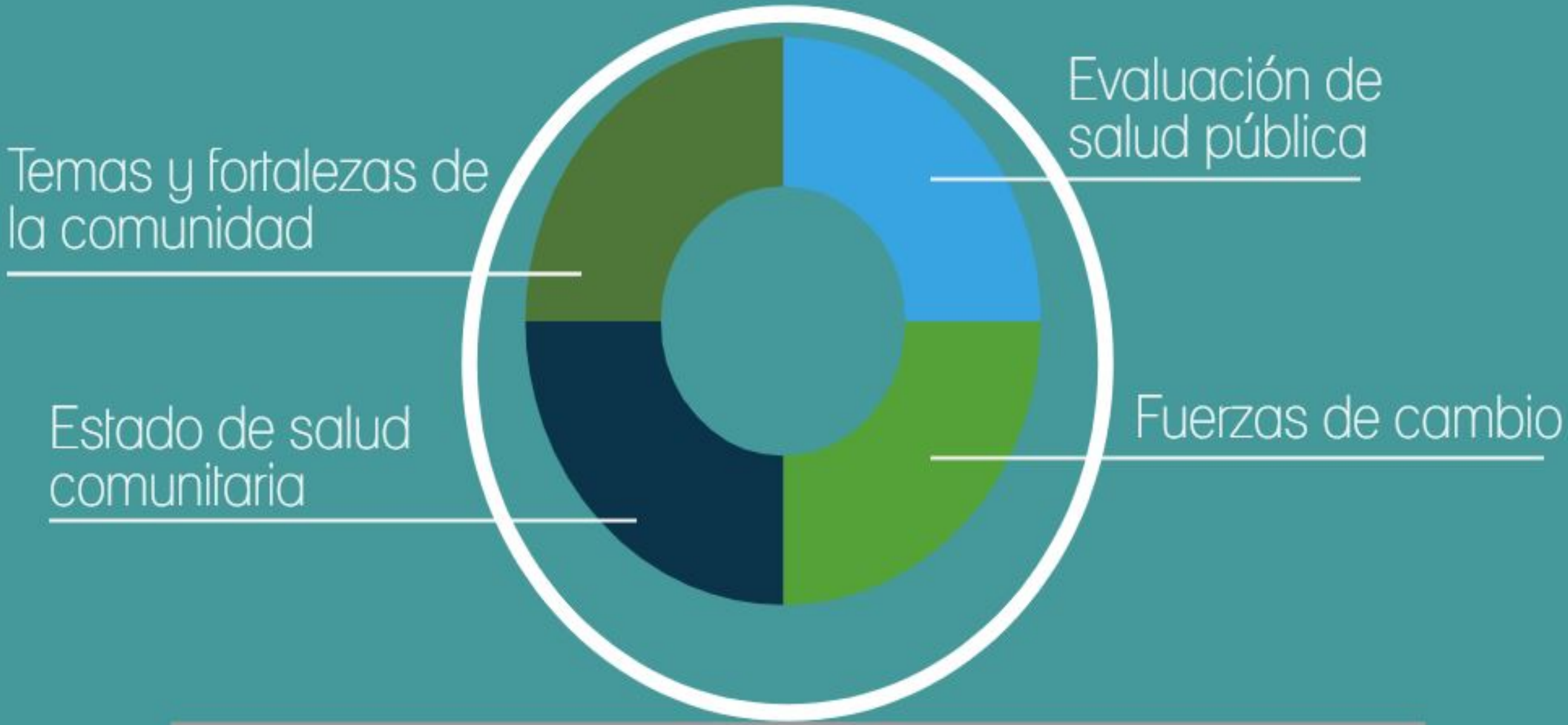
BIENVENIDOS

Yamhill COMMUNITY CARE

Entender las necesidades de la comunidad



Proceso MAPP

Evaluación
de salud comunitaria

¿Qué le enorgullece de la comunidad?

- Sentido de comunidad; amigable
- Esfuerzos para mejorar el área de Newberg
- La gente está dispuesta a escuchar a los demás.
- Hay muchas organizaciones que prestan servicios.

"Aceptar"

"Hermoso"

¿Cuáles de estos temas importa más para mejorar la vida de las personas?

- Vivienda
- Transporte
- Traductores y barreras idiomáticas
- Guardería accesible y preescolar
- Salud mental

Áreas prioritarias

Salud dental

Determinantes sociales de la salud

Acceso a la atención

Otro áreas prioritarias

Niños y familias

Salud mental y adicciones

Trauma y resiliencia

En Oregón, más de la mitad de los niños de 6 a 9 años tienen caries.

La mala salud bucal está relacionada a cosas como la enfermedad cardíaca y el parto prematuro

Hay solo dos ciudades en el condado de Yamhill que tienen agua fluorada

Casi uno de cada tres adultos en Oregón evita sonreír debido a sus dientes

Las personas mayores corren mayor riesgo de aislamiento

Las personas con menos amigos cercanos tienen menos autoestima, no se adaptan muy bien socialmente y corren mayor riesgo de suicidio

En el 2018 había 1,386 personas en el condado de Yamhill consideradas sin hogar (es probable que este número sea más bajo que la realidad)

Más de la mitad de las personas del condado de Yamhill pagan más del 30% de su salario en alquiler

El 94% de los residentes de Oregón tiene seguro de salud - cuando la ACA amplió los servicios de Medicaid, la tasa de personas sin seguro se redujo

El condado de Yamhill tiene algunas de las tasas más altas de visitas a la sala de emergencias del estado

Hay 42 intérpretes de idiomas certificados que prestan servicio en todo el condado de Yamhill

Hay 1,390 personas por cada proveedor de atención médica en el condado de Yamhill

Yamhill

COMMUNITY CARE

Objetivos

¿Cuáles son los recursos?

¿Quién corre el mayor riesgo y necesita la mayor ayuda?

¿Cuánto demorará?

¿Se relaciona con la salud de las personas del OHP?

ESTRATEGIAS

Hacer una acción → Hacer un cambio → Para un grupo de personas

EJEMPLO DE ESTRATEGIAS: SALUD DENTAL

- Asociarse con agencias de apoyo local para mejorar el acceso a la atención dental, incluso mediante la búsqueda de servicios dentales en consultorios que ofrecen grupos de apoyo para mejorar la salud dental de las personas sin hogar y con diversidad mental

- Asociarse con Oral Health Coalition y Capitol Dental Care para ver las opciones de servicios dentales a distancia (teleodontología) en lugares sin clínicas

- Estudiar las opciones de educación de la comunidad para aumentar el número de ciudades con agua fluorada en el condado de Yamhill

PERSONAS CLAVES

- Niños y bebes
- Personas con diversidad mental
- Personas sin hogar

EJEMPLO DE ESTRATEGIAS: SU VECINDARIO

- Proporcionar cupones de viaje para que las personas puedan asistir a sus citas médicas, entrevistas de trabajo y otros eventos de apoyo familiar

- Asociarse con bibliotecas rurales para realizar actividades de extensión para familias de niños de 0 a 5 años y conectarlos con servicios de preparación escolar, de apoyo familiar y servicios de salud.

- Fortalecer los Equipos de Integración de Servicios del condado de Yamhill con un enfoque en la vivienda para reducir el número de personas sin hogar

- Asociarse con agencias de apoyo local para llegar a la población sin hogar y conectarlos con los servicios

PERSONAS CLAVES

- Personas sin hogar en áreas rurales
- Personas con diversidad mental
- Jóvenes sin hogar
- Personas que sufren aislamiento

EJEMPLO DE ESTRATEGIAS: Acceso a la atención médica

- Organizar reuniones para escuchar a la gente y realizar encuestas periódicas junto a las clínicas para conocer la opinión de pacientes, clientes y miembros de la comunidad sobre sus necesidades.
- Colaborar con agencias locales de interpretación y traducción para garantizar servicios lingüísticos de calidad y una fuerza laboral sólida
- Proporcionar materiales de educación comunitaria, sesiones de extensión y educación a través de los medios sobre los beneficios, derechos y opciones de defensa de los miembros.
- Asociarse con la comunidad religiosa local para mejorar el conocimiento y el acceso a los servicios de salud mental

PERSONAS CLAVES

- Personas que no hablan inglés
- Personas que no visitan al médico
- Adultos

Discusión en grupos pequeños

- Crea o elija sus propias estrategias en el área de prioridad de su mesa
- Cambie de mesa cuando se lo digan

Discusión en grupos grandes

- ¿Le sirven estas estrategias?
- ¿Cuáles son los siguientes pasos?

¡Manténgase en contacto!

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Contributors & Collaborators

So many thanks to the partners, individuals, meeting-attenders, feedback-givers, survey respondents, colleagues, friends, community advocates, and members who contributed their time and expertise to this project. This is a community effort and would not exist without the agencies listed below.

211 Info
A Family Place
Amity Fire Department
Amity School District
Carlton Police Department
Champion Team
Chehalem Cultural Center
Chehalem Park and Recreation District
Child Care Resource and Referral
Children's Clinic Newberg
City of Newberg
Coyote Joe's
Dayton School District
Department of Human Services
Ford Family Foundation
Goodwill Job Connection
Gospel Rescue Mission
Grand Ronde Tribe Children & Family Services
Grand Sheramina Food Pantry
Head Start of Yamhill County
Henderson House
Hope on the Hill
Housing Authority of Yamhill County
Juliette's House
Linfield College
Love INC
McMinnville Cooperative Ministries
McMinnville Free Clinic
McMinnville Public Library
McMinnville School District
McMinnville Senior Center
MV Advancements
Newberg FISH Emergency Service
Newberg School District
Northwest Senior and Disability Services
Oregon Health Authority
PH Tech
Physicians' Medical Center
Polk County Service Integration Teams
Project ABLE
Promotoras de Salud
Providence Medical Center
Provoking Hope
Second Street Drop In Center
See Ya Later Foundation
Sheridan School District
Student Nutrition and Activity Clinic for Kids
United Way of the Mid-Willamette Valley
Virginia Garcia Memorial Health Center
Willamette Valley Cancer Foundation
Willamette Valley Medical Center
Yamhill-Carlton School District
Yamhill County Developmental Disability Services
Yamhill County Family and Youth
Yamhill County Health and Human Services
Yamhill County Transit Area
Yamhill Community Action Partnership
YOOP!
Youth Outreach
and many more organizations and individuals…