Washington State Department of Health

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CERTIFICATE OF NEED PROGRAM
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WASHINGTON STATE **CERTIFICATE OF NEED PROGRAM**
RCW 70.38 AND WAC 246-310

APPLICATION FOR CERTIFICATE OF NEED HOME HEALTH CARE PROJECTS
(Excludes amendments)

Certificate of Need applications must be submitted with a fee in accordance with the instructions on page 2 of this form. Application is made for a Certificate of Need in accordance with provisions in Revised Code of Washington (RCW) 70.38 and Washington Administrative Code (WAC) 246-310 adopted by the Washington State Department of Health. I hereby certify that the statements made in this application are correct to the best of my knowledge and belief.

Signature and Title of Responsible Officer: **Brent Weil, President & Chief Executive Officer Date:** **October 14, 2019**	**Person To Whom Questions Regarding This Application Should Be Directed:** **Michael Rogers, Corporate Attorney** **EmpRes Healthcare Management** **4601 NE 77th Avenue** **#300 Vancouver WA 98662** **Telephone Number: 360-514-9358**
Legal Name of Applicant: Eden Home Health of Clark County, LLC **Address of Applicant:** EmpRes Healthcare Management 4601 NE 77th Avenue #300 Vancouver WA 98662 **Telephone Number: 360-514-9358**	**Type of Project (check all that apply):** [X] New Agency [ ] Existing Medicare Certified/Medicaid Eligible Agency Expanding into Different County [ ] Existing Licensed-Only Home Health Agency to Become Medicare Certified/Medicaid **Eligible.**
Project Summary: **Establish a new Medicare-certified home health agency in Clark County** **Estimated capital expenditure:** **$38,000**	

EmpRes
HEALTHCARE MANAGEMENT
100% Employee Owned

VIA FEDERAL EXPRESS OVERNIGHT

October 21, 2019

Nancy Tyson, Executive Director
Health Facilities and Certificate of Need
Washington State Department of Health
PO Box 47852
Olympia, WA 98504-7852

RE: Eden Home Health of Clark County, LLC dba Eden Home Health

Dear Ms. Tyson:

Attached is the Eden Home Health of Clark County, LLC certificate of need application signed coversheet, signed letter of financial commitment and the application fee required for review of this application. Per the Program's instructions, EmpRes Healthcare Management, LLC is submitting a PDF of the application via e-mail. Please advise if the program determines that additional paper copies are required.

We appreciate the Program's consultation regarding this project and have surveyed home health agencies and skilled nursing facilities operating within Clark County.

Thank you again for the Program's assistance and EmpRes Healthcare Management, LLC is committed to providing any additional information that may be required in this important review.

Sincerely,

Jamie Brown
Vice President of Home Services
EmpRes Healthcare Management, LLC
Phone: (360) 604-4210
Fax: (360) 816-8193
jbrown3@eden-health.com

Eden Home Health of Clark County, LLC

Certificate of Need Application Proposing the Establishment of a Medicare/Medicaid Certified Home Health Agency in Clark County

2019

Section 1
Applicant Description

A. Provide the legal name(s) of applicant(s).

The applicant is Eden Home Health of Clark County, LLC "The applicant is Eden Home Health of Clark County, LLC. The applicant is 100% owned by EmpRes Home Health, LLC. It is part of the family of companies owned by EmpRes Healthcare Group, Inc. Please see Attachment B for an organization chart that depicts the relationships.

B. For each licensed applicant, please provide the professional license number and specialty represented. If the license was not issued by Washington State, please identify the state it was issued.

None of the applicants hold professional license numbers.

C. For existing facilities, provide the name and address of the facility.

Eden Home Health of Clark County, LLC is not currently providing services and is not otherwise an "existing facility" as defined above.

D. Identify the type of ownership (public, private, corporation, non-profit, etc.).

Eden Home Health of Clark County, LLC is a for profit, limited liability corporation. It is registered as a domestic company with the Washington Secretary of State to do business in Washington.

E. Provide the name and address of owning entity at completion of project (unless same as applicant).

Eden Home Health of Clark County, LLC is a for profit Washington LLC.

F. Provide the name and address of operating entity at completion of project (unless same as applicant).

Eden Home Health of Clark County LLC
4601 NE 77th Avenue, Suite 300,
Vancouver, WA 98662

G. Identify the corporate structure and related parties. Attach a chart showing organizational relationship to related parties.

Please see Attachment B for a chart showing corporate structure and related parties.

H. Provide a general description and address of each facility and other related business(es) owned and/or operated by applicant (include out-of-state facilities, if any).

Please see Attachment C for a list of facilities owned by EmpRes Healthcare Group.

I. For existing facilities, identify the geographic primary service area.

NA - Eden Home Health of Clark County, LLC is not an existing facility.

J. Identify the facility licensure/accreditation status.

NA - Eden Home Health of Clark County, LLC is not an existing facility.

K. Is the applicant reimbursed for services under Titles XVIII, and XIX of Social Security Act?

NA - Eden Home Health of Clark County, LLC is not an existing facility

L. If applicable, identify the medical director and provide his/her professional licenses number, and specialty represented.

Upon approval of the certificate of need application, Eden Home Health will select the Medical Director for Eden Home Health of Clark County, LLC. At that time, the Washington physician license number will be submitted.

M. If applicable, please identify whether the medical director is employed directly by or has contracted with the applicant. If services are contracted, please provide a copy of the contract.

Please see a draft of the proposed medical director contract at Attachment D.

N. For existing facilities, please provide the following information broken down by discipline (i.e., RN/LPN, OT, PT, home health aide, social worker, etc.) for each county currently serving:

1. **Total number of home health *visits* per year for the last three years; and**

2. **Total number of unduplicated home health *patients* served per year for the last three years.**

NA - Eden Home Health of Clark County, LLC is not an existing facility.

Section 2
Project Description

A. Provide the name and address of the proposed facility.

The office address of the proposed Clark County home health agency is:

Eden Home Health of Clark County LLC
8401 NE 8th Way
Vancouver, WA 98664

No separate address has been assigned to the proposed leased space.

B. Describe the project for which Certificate of Need approval is sought.

Certificate of Need approval is sought in connection with the home health division of EmpRes Healthcare Group, Inc., a 100% employee-owned organization that operates 78 rehabilitation facilities in 9 states. In 2014, EmpRes Healthcare established its home health care division through the acquisition of an Ammon, Idaho home health agency called Amedisys Home Health. The EmpRes home health division operates under the brand Eden Home Health.

In 2014, the Eden Home Health division acquired Option Care Enterprises, the Medicare-certified home health agency formerly operated by Walgreen's Infusion Services in Whatcom, Skagit, Island, and Snohomish Counties. Upon acquisition of Option Care, Eden Home Health began instituting its management and clinical improvement protocols in Whatcom County where 70% of the acquired agency's patients resided at that time.

Eden Home Health agencies provide skilled nursing, rehabilitation therapies, medical social services and certified home health aide services to homebound patients throughout the Whatcom, Skagit, Snohomish and Island county areas and now in King County. This Certificate of Need application seeks approval to expand the Eden Home Health division's service offerings to Clark County through establishment of a new Medicare-certified home health agency to provide in-home skilled nursing, rehabilitation therapies, medical social services and certified home health aide services.

Eden Home Health's in-home services will include the full range of care defined by the Medicare home health Conditions of Participation. Eden Home Health also incorporates tele-health and the Coleman Model of Care Transitions services in the monitoring and care for its patients.

C. List new services or changes in services represented by this project. In the following table, please indicate (by marking an 'X' in the appropriate column) which services would be provided directly by the agency and which services would be contracted.

Services to be provided include:

	Direct	Contracted
Skilled Nursing	X	
Physical Therapy	X	
Occupational Therapy	X	
Speech Therapy	X	
Medical Social Work	X	
Home Health Aide	X	
Medical Director		X
Respite Care		
IV Therapy		
Other: Telemedicine	X	

D. General description of the types of patients to be served by the project.

Eden Home Health of Clark County, LLC will serve homebound Clark County residents who require intermittent skilled nursing, rehabilitation therapy, medical social work, or certified home health aide services as a result of illness or injury. The average age will be within a range of 74 - 77 years old. Eden does not, at this time, plan to provide "mother/baby" care; the typical patient will be over age 18.

E. List the equipment proposed for the project:

1. Description of equipment proposed; and

2. **Description of equipment to be replaced, including cost of equipment, disposal or use of the equipment to be replaced.**

Proposed equipment for which the cost will be capitalized includes:

Furnishings, telephone, copier/printer, computers, network server/firewall. Please see Attachment L for a list and estimated capital costs.

Telephone/hand-held units, medical records, and telehealth license applications will be acquired through third-party annual lease/license contracts. The annual cost of these items is identified as an expense line item in the three-year proforma operating statement at Attachment L.

No equipment is being replaced as part of this project.

F. Provide drawings of proposed project:

1. Single line drawings, *approximately to scale,* of <u>current</u> locations which identify current department and services; and

2. **Single line drawings, *approximately to scale,* of <u>proposed</u> locations which identify proposed services and departments; and**

3. **Total net and gross square feet of project.**

   a) This is an office in an existing building.

   b) Please see Attachment F for a single-line drawing of the proposed location.

   c) Net square feet: 200 sq. ft.

   As a tenant, and included in the lease price, Eden-HHS will be able to schedule the intermittent use of conference rooms available at the leased premises.

G. Identify the anticipated dates of both commencement and completion of project.

Eden Home Health will commence establishment of the Clark County agency as soon as, but not before, a Certificate of Need is granted. Eden's services to Clark County residents will be provided by a new agency (Eden Home Health of Clark County, LLC) under a new Medicare provider number.

Official completion of the project will not occur until the required Medicare certification is in place. Eden Home Health of Clark County, LLC will seek Accreditation by Accreditation Commission for Health Care (ACHC).

The applicant recognizes that DOH defines "completion" of the project as "Initiation of

H. Describe the relationship of this project to the applicant's long-range business plan and long-range financial plan (if any).

The EmpRes Healthcare family of companies is organized as an Employee Stock Ownership Plan and as such is a 100% employee-owned organization. The company operates 78 separate entities in 9 states. The Eden Home Health division, was established to provide clinical integration and continuity of care for residents and patients as they progress through the post-acute care process. The Eden Home Health division now includes 8 home health in 5 states including EmpRes Home Health of Bellingham, LLC, d/b/a Eden Home Health located in Bellingham Washington which serves Whatcom, Skagit, Snohomish and Island counties and Eden Home Health of King County, LLC which serves King County.[1]

The Patient Protection and Affordable Care Act also requires the Center of Medicare and Medicaid Services (CMS) to develop triple aim or value-based care approaches to improve quality of care, customer satisfaction at a lower overall cost. EmpRes believes that our ability to provide home health services as part of the continuum of care we provide will allow us to improve quality of care outcomes through improved care coordination systems focused on the

[1] An employee stock ownership plan (ESOP) is a qualified defined-contribution employee benefit (ERISA) plan.

triple aim of providing better quality outcomes and customers service at an overall lower cost for both Medicare and Medicaid patients.

EmpRes already offers skilled nursing and services in Clark County as well as in Cowlitz County. The addition of a Clark County home health agency to the Eden Home Health division responds to key market and care improvement opportunities identified in the applicant's community assessment and resulting business plan:

- The Affordable Care Act imposes financial sanctions for hospitals whose patients are re-admitted within 30 days of discharge. The downstream effect of these sanctions results in increasing demand for post-acute facilities and the rehabilitation services offered there.

- EmpRes Healthcare's skilled nursing facility in Clark County frequently faces difficulty finding home health agencies that can respond timely to referrals of - EmpRes discharged patients to their homes.

- The EmpRes Healthcare/Eden Home Health 2020 business plan, therefore, calls for developing home health capacity to provide improved coordination and more rapid transfer of Clark County patients ready to go home.

- Specific to this project, EmpRes Healthcare is seeking approval of a new home health agency in Clark County that will be certified to serve Medicare and Medicaid patients as well as patients in all payer categories.

I. Provide documentation that the applicant has sufficient interest in the site or facility proposed. "Sufficient interest" shall mean any of the following:

1. Clear legal title to the proposed site; or

2. A lease for at least one year with options to renew for not less than a total of three years; or

3. A legally enforceable agreement (i.e., draft detailed sales or lease agreement, executed sales or lease agreement with contingencies clause) to give such title or such lease if a Certificate of Need is issued for the proposed project.

The Clark office space will support administrative functions not provided centrally by EmpRes Healthcare in Vancouver Washington. Please see Attachment G for a copy of a signed sublease agreement with the lessor.

Section 3
Project Rationale

A. Need

1. Identify the proposed geographic service area.

Eden Home Health of Clark County, LLC proposes to serve the entire geographic area of Clark County Washington.

2. If the proposed service area is designated as a Medically Underserved Area (MUA) as defined by HCFA or a Health Professional Shortage Area (HPSA), please provide documentation verifying the designation.

The principal shortage in Clark County is primary care for low income residents of Clark County. Discussions with the Office of Rural Health indicate that the shortage falls in the moderate range. Please see the map at Attachment H that describes the geographic areas.[2]

3. Identify and analyze the unmet home health service needs and/or other problems toward which this project is directed.

a. Identify the unmet home health needs of the patient population in the proposed service area(s). *Note that the unmet patient need should not include physical plant deficiencies and/or increase facility operating efficiencies.*

Overview

This project is directed toward providing additional resources, consistent with federal and state priorities and initiatives to improve health status, health care and manage increasing costs. This project is vitally needed to address five key service needs and problems facing patients referred now and in the future to home health services by their caregivers in Clark County:

1) Need for additional providers to address the increasing demand for and in-home health care.

2) Need to support prompt admission to home health via timely access to home health services in the face of burgeoning demand.

3) Need for additional home health providers to improve health outcomes and health factors for Washington residents which currently are in the second highest quartile to the highest quartile of healthy outcomes. In 2019, other Western Washington counties including King, Snohomish and Thurston counties were in the highest health outcomes quartile of Washington counties. Health disparity based on health outcomes and health factors limit life span, increases the chronic disease burden of

[2] Discussion with Sam Watson, Office of Rural Health. September 17, 2019

residents of Clark County and adjacent counties and reduces the quality of life for residents.

4) Need for financially accessible and geographically accessible home health services for Clark County residents.

5) Need to provide expanded home health agency capacity to continue to support Washington State initiatives that rely on outreach and in-home services, e.g., the Medicare-Medicaid Financial Alignment Initiative, Medicare-Medicaid Managed Fee-for-Service (MFFS) demonstration now in its second extension through 2020; and the Department of Social and Health Services Long-Term Services and Supports (LTSS) Rebalancing that has yield substantial, estimated Medicaid Savings of $4.4 billion from all funding sources from SFY 2000 to SFY 2018.

The following discussion details the unmet need related to the capacity of providers in Clark County, and the availability and accessibility issues surrounding this need. Washington State's 1987 home health agency need model is outdated because it is nonresponsive to the home health requirements required to support the State Medicaid initiatives and hospital/skilled nursing requirements. This review demonstrates that Eden Home Health of Clark should not be viewed as an "unnecessary duplication" of services but instead it is a necessary enhancement in both capacity and required capabilities.

1) Need for additional providers in Clark County to meet growing demand.

To identify unmet Medicare home health care needs in a planning area, the Department of Health uses a numeric need method and standards published in the 1987 Washington State Health Plan (SHP). (See Attachment J for a copy of the method and standards for an agency to be counted in existing supply.) The Certificate of Need Program has applied that methodology, with some revisions, in its review of all recent applications to establish new home health agencies in Clark and all other counties statewide.

The methodology combines projected planning area population by age cohort with expected home health use rates for each of those age cohorts. The target year number of projected/needed home health visits is divided by 10,000 to determine the total number of home health agencies required to meet the needs of the population of the planning area in that target year. Where there are fewer existing agencies than the number required, the Certificate of Need Program consistently approves the need for additional agencies. This application has adopted the Certificate of Need Program's methodology to document the need it expects to meet in Clark County.

The 1987 model was well conceived to address the principal driver for home health services which is the age of the population. This approach readily takes into account changes in the size of existing and forecast age cohorts over the projection period particularly in this period with the Baby Boom population rapidly increasing in the older age cohorts.

Table 1 provides overall U.S. Census and OFM population estimates for the period 2010 through 2019. This data documents that the non age-adjusted population base that drives

home health utilization has been increasing at a greater annual rate (1.5%) than the statewide annual population increase rate for the same period (1.3%).

Table 1

Percentage Population Increase from 2010 Through 2019: Clark County and Washington State					
County	Jurisdiction	2010 Population Census	2019 Population Estimate	Total Increase	Annualized Increase
.	.	.	.		
Clark	Clark County	425,363	488,500	114.8%	1.5%
Clark	Unincorporated Clark County	203,339	226,890		
Clark	Incorporated Clark County	222,024	261,610		
.	.	.	.		
State	State Total	6,724,540	7,546,410	112.2%	1.3%
State	Unincorporated State Total	2,478,323	2,635,501		
State	Incorporated State Total	4,246,217	4,910,909		
	OFM Population Estimates				

The State formula presented in **Table 1** uses the 2017 OFM age cohort projection rate to project home health service volume for the 2020 through 2023 time period.

Applicants are also expected to assess the general health of the service area population to see if modifications to the general formula are warranted. Eden undertook such an assessment relying on four studies:

1) The Washington State Department of Health Chronic Disease Profile for Clark County (Attachment Q)

2) The Washington State Department of Health Demographics and Social Characteristics o for Clark County 2017 (Attachment R)

3) 2019 Health Rankings Report, a collaboration of the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute (Attachment S)

4) 2019 Community Health Needs Assessment prepared by the Health Columbia and Willamette Collaborative -- participants include Clark County, WA, Multnomah County, OR, and Washington County (Attachment T)

5) The Area Agency on Aging and Disabilities of Southwest Washington 2016 – 2019 Area Plan (Attachment V).

The Area Agency on Aging and Disabilities of Southwest Washington Area Plan General Public Survey and Partner Agency Survey identified the primary need/concern

of older adults and adults living with disabilities in Southwest Washington **is.*" staying in their home as long as possible and needing supports to do so."*** [3] The survey had 636 responses.[4]

Table 2 data, drawn from the Washington State Department of Health Chronic Disease Profile, is an excellent health data source. This is supplemented by the 2015 age-adjusted death rates for Washington State, Clark County and King County prepared by the Center for Health Statistics, Washington State Department of Health presented in Table 5. Together these data sources present an excellent overview of the relative health of the Clark County population compared with King County and the state as a whole. In this comparative analysis, Clark County was compared with King County and can be used to make adjustments in the relative need for home health services using the 1987 Washington State projection model.

The King County profile data is included because EmpRes relies on the operating characteristics of its SNFs and its home health agency in Western Washington to generate operating assumptions for the proposed home health agency in Clark County.
Table 2 shows that the Chronic Disease Burden for Clark County is higher than both King County and the State as a whole indicating that more individuals than average may need home health at a greater volume than other areas in the State.

Table 2

2013 - 2015 Lifetime Self-Reported Prevalence of Chronic Disease Age 18+ Per Cent			
	Clark	**King**	**State**
Chronic Disease			
Cancer	13%	10%	12%
Arthritis	27%	19%	25%
Heart Disease	6%	4%	6%
Diabetes	9%	7%	9%
Asthma	12%	8%	10%
Data Source: Washington Behavioral Risk Factor Surveillance System 2013-2015.			

Table 3 shows that the self-reported disabilities (by seniors 65 and older), require home health services at a higher rates than respondents in King County and the State as a whole.

.

[3] The Area Agency on Aging and Disabilities of Southwest Washington 2016 – 2019 Area Plan. Page 1
[4] *Ibid,* Page 56

Table 3

Per Cent Seniors 65 and Older with Self-Reported Health Risks: 2013 - 2015			
	Clark	**King**	**State**
Living with Chronic Disease	78%	73%	77%
Difficulty with 1 or More Activities of Daily Living	33%	29%	31%
Cognitive Difficulties	8%	7%	9%
Difficulty Walking	25%	22%	24%
Data Source: Washington Behavioral Risk Factor Surveillance System 2013-2015.			

The self-report data in Table 2 and Table 3 show increased morbidity that would lead to higher need for home health and home support services to prevent early death and a loss of independent living status.

Populations with higher burdens of chronic disease and higher disability levels require a greater level of home health and in-home services. In fact, the Department of Social and Health Services conducted a variety of analyses included in Attachment U drawn from David Mancuso, PhD, Director, DSHS Research and Data Analysis Division. These seminal analyses for DSHS Long-Term Services and Support for the aging population led to initiatives and demonstration projects within DSHS aimed at managing burgeoning healthcare costs for at-risk populations by dramatically increasing outreach, in home and residential services that has dramatically improved Washington residents' ability to live independently while significantly reducing skilled nursing admissions and long-term skilled nursing care (Attachment U).

The conclusion from the DSHS LTSS efforts and the CMS – Washington State Medicare-Medicaid Financial Alignment Initiative current 4-year, ongoing demonstration project is that addressing the chronic illness burden with lower cost treatment options reduce hospital and skilled nursing length of stay, readmissions and additional chronic illness burdens (such as falls after stroke or nutritional illnesses). It is imperative to expanded home healthcare and community outreach in Clark County. Eden Home Healthcare's presence in Clark County will reduce longer hospital stays, hospital readmissions and higher dependency on community services. Eden will also be involved in providing the health community with educational resources related to home healthcare. Nearly all patients with chronic illness as a cause of hospitalization should receive home health services as part of their continuum of care whether it starts with inpatient rehabilitation services, skilled nursing services or is the primary supportive discharge service. **Given the chronic illness burden in Clark County, adding home health resources above the statewide average is absolutely called for.**

Health outcomes in the County Health Rankings represent measures of how long people live and how healthy people feel. Length of life is measured by premature death (years of potential life lost before age 75) and quality of life is measured by self-reported health status (percent of people reporting poor or fair health and the number of physically and mentally unhealthy days within the last 30 days) and the % of low birth weight newborns

The green map in Figure 1 below shows the distribution of Washington's health outcomes, based on an equal weighting of length and quality of life. The map is divided into four quartiles with less color intensity indicating better performance in the respective summary rankings. While Clark County is in ranked in the second best quartile, its actual position among counties in the State is 11th for Health Outcomes and 12th for Health Factors as shown on Page 10 of the 2019 Health Rankings Report which is a collaboration of the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. The full report is included in Attachment S. The individual county rankings are listed on Page 10.

Figure 1
Washington State 2019 County Health Outcomes Rankings

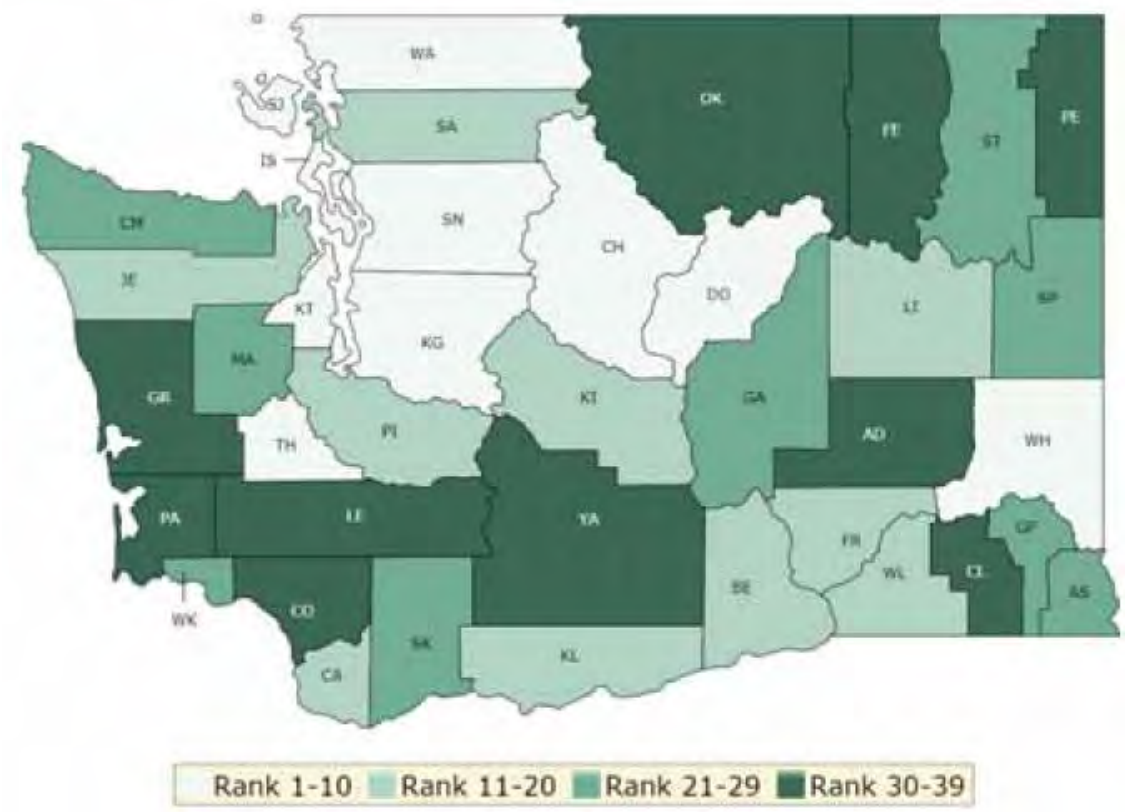

Table 4 shows that even with self-reported higher levels of chronic illness, the population has premature death rates that are close to statewide averages but significantly higher than King County. Clark County has a s significantly higher, age-adjusted premature death rates than King County or the State as a whole.

Table 4

Premature Mortality per 100,000 Persons by Age Group: 2013 - 2015			
	Clark	**King**	**State**
Premature death less than Age 50	112	81	97
Premature death less than Age 65	264	187	221
Data Source: Washington State Department of Health, Center for Health Statistics, Death Certificate Data, 2013-2015.			

Table 5 on the following page demonstrates that even with premature death rates mirroring the state as a whole, health disparity results in higher death rates across a spectrum of chronic conditions when compared with King County and the State as a whole. This is another marker of systemic problems in the health care status of residents requiring a greater concentration of services such as home health services. Table 5 shows that health disparity result in higher death rates across a spectrum of chronic conditions, Home healthcare services can play an important role in managing patients facing the risk of death and disability from these chronic conditions if there is a greater supply of these services. This confirms the need for a broader array of health care services and other supportive services than the State as a whole.

Table 5

Mortality Table C7. Diseases of the Heart, Ischemic Heart Diseases, and Cerebrovascular Diseases by County of Residence, 2015

	Diseases of the Heart (I00-I09,I11,I13,I20-I51)			Ischemic Heart Disease (I20-I25)			Cerebrovascular Disease (I60-I69)		
County	Number	Crude Rate[1]	Age-Adj Rate[2]	Number	Crude Rate[1]	Age-Adj Rate[2]	Number	Crude Rate[1]	Age-Adj Rate[2]
State Total	**10,987**	**155.6**	**138.3**	**6,338**	**89.8**	**79.5**	**2,693**	**38.1**	**34.4**
King	2,533	123.4	122.3	1,474	71.8	71.0	620	30.2	30.3
Clark	832	170.4	142.4	445	91.1	76.2	266	54.5	46.0

Mortality Table C6. Diabetes, Alzheimer's Disease, and Major Cardiovascular Disease by County of Residence, 2015

	Diabetes (E10-E14)			Alzheimer's Disease (G30)			Major Cardiovascular Disease (I00-I78)		
County	Number	Crude Rate[1]	Age-Adj Rate[2]	Number	Crude Rate[1]	Age-Adj Rate[2]	Number	Crude Rate[1]	Age-Adj Rate[2]
State Total	**1,805**	**25.6**	**22.5**	**3,489**	**49.4**	**44.9**	**14,858**	**210.4**	**187.6**
King	375	18.3	17.9	903	44.0	44.3	3,471	169.1	168.2
Clark	170	34.8	29.6	300	61.4	51.9	1,186	242.9	203.4

Mortality Table C8. Influenza & Pneumonia, Chronic Lower Respiratory Disease, and Chronic Liver Disease & Cirrhosis by County of Residence, 2015

	Pneumonia and Influenza (J10-J18)			Chronic Lower Resp. Dis. (J40-J47)			Chronic Liver Disease & Cirrhosis (K70,K73-K74)		
County	Number	Crude Rate[1]	Age-Adj Rate[2]	Number	Crude Rate[1]	Age-Adj Rate[2]	Number	Crude Rate[1]	Age-Adj Rate[2]
State Total	**851**	**12.1**	**10.7**	**3,151**	**44.6**	**39.9**	**1,021**	**14.5**	**12.4**
King	190	9.3	9.2	564	27.5	28.5	230	11.2	10.1
Clark	76	15.6	13.6	322	65.9	56.2	91	18.6	16.2

[1] Rate per 100,000 population.

[2] Rate per 100,000 age-adjusted to U.S. 2000 population. Does not include deaths where age is unknown.

[*] Rate not calculated because number of deaths was less than 5.

Note: Codes for International Classification of Diseases, Tenth Revision (ICD-10) are in parentheses after each group heading.

Rates based on fewer than 20 deaths are likely to be unstable and imprecise.

Source: Center for Health Statistics, Washington State Department of Health, 07/2016.

Table 6 presents the relative percentages of death by cause and in this case, Clark County is different from the State and King County in two key areas – "Cancer" and "Other" causes of death. It is also important to point out that the age-adjusted death rates for Clark for most chronic disease categories below are higher than the State, or King County.

Table 6

Per Cent Cause of Death 2013 - 2015			
	Clark	**King**	**State**
Cancer	19%	21%	24%
Heart Disease	9%	12%	13%
Diabetes	5%	4%	5%
Stroke	3%	3%	3%
Alzheimer's	5%	6%	6%
COPD or Asthma	6%	6%	6%
Other	51%	48%	41%

Data Source: Washington State Department of Health, Center for Health Statistics, Death Certificate Data, 2013-2015.

Table 7 presents a comparison of hospital utilization discharges to home, home health, skilled nursing facilities and inpatient rehabilitation hospitals. The percentage of hospital discharges to home health agencies represents only 3% of total discharges in Clark County versus 6% for the State of Washington. **Of greater concern is that the discharge rate to home health for Clark County residents (which is 22.8 discharges per 100,000 persons) is less than 44% of the overall Washington State discharge rate to home health(which is 52.1 discharges per 100,000 persons)**. The data confirms that hospital use of home health in Clark County is *much* lower than the State, which indicates that home health service capacity in Clark County needs to be greater to assure that there is adequate home health capacity to support referrals from hospitals, physicians, and skilled nursing facilities.

Table 7 – CHARS DATA

2017 Discharges per 100,000 Persons & Per Cent Total Discharges: Washington State & Clark County						
	Washington State	Per Cent of Total	Discharges per 100,000 Persons	Clark County	Discharges per 100,000 Persons	Per Cent of Total
2017 Population	7,310,300			471,000		
Discharge Category						
Discharged Home	477,989	76%	653.9	26,496	562.5	80%
Expired	13,946	2%	19.1	0	0.0	0%
Discharged to Home Health	38,089	6%	52.1	1,073	22.8	3%
Discharged to SNF	55,053	9%	75.3	2,698	57.3	8%
Discharged to Inpatient Rehab.	5,407	1%	7.4	551	11.7	2%
Discharged to Long -Term Care Hospital	888	0%	1.2	68	1.4	0%
Other	40,613	6%	55.6	2,167	46.0	7%
TOTAL	631,985	100%	864.5	33,053	701.8	100%

Table 8 examines the current capacity of home health agencies to meet the standard for initiating home health services in a timely fashion. On an overall basis, 92% of Washington State home health agencies met the timeliness standard in 2019 –the national basis standard was met by 95% of home health agencies. In Clark County, four of the 6 home health agencies with reportable data met the timeliness standard at a rate higher than Washington State or national averages, while 2 met the timeliness standard at rates *lower* than the Washington State and national average. **One home health agency did not meet the timeliness standard in over 30% of the cases**. This result is a leading indicator that Clark County needs a larger home health agency capacity.

Table 8 *also* presents the CMS Quality of Care Star Ratings for home health agencies. Only *one* of the 6 reporting home health agencies have a quality of care star rating that equaled the Washington State and National averages, but 5 agencies' quality of care star rating was *below* the Washington State and national averages. This is a second indicator that Clark County home health agencies are burdened by demand for services.

Table 8

Clark County Home Health Agencies Timeliness to Treatment and Quality of Care Performance		
CMS Reported Data: 2019		
Agency	% of Cases Meeting the Timeliness Standard for Initiation of Treatment	Quality of Care Star Rating
National Average	94.8%	3.5
Washington State Average	92.1%	3.5
Clark County CoN Approved Home Health Agencies		
Kaiser	86.7%	2.5
Community Home Health & Hospice	98.4%	3.5
Kindred at Home	97.9%	3.0
Peace Health at Home	69.4%	2.0
PSA Health Certified	Not Available	Not Available
Touchmark at Fairway	97.2%	2.5
Visiting Health Services	95.7%	3.0
Healthy Living at Home (new CoN approval)	Not Available	Not Available

The key findings of this need assessment are the following:

1. The annual population increase in Clark County from 2010 to 2019 was 1.5% compared to the State annual population increase of 1.3%. Of greater importance is the fact that the population in Clark County is aging. OFM 2017 forecasts for the period 2020 through 2020 indicate that demand for home health services per the SHP formula will be for 14 agencies.

2. The chronic disease burden for the Clark County population is higher than both the State and King County based on the self-reported prevalence of chronic disease and the overall, age-adjusted, condition-specific death rates for the Clark population.

3. Changing treatment plans as well as the chronic disease burden and the age-adjusted premature death rates described above lead to higher utilization of hospital discharges to inpatient rehabilitation, skilled nursing homes and home health as shown in Table 6.

4. While Clark County death rates are higher, the actual mix of chronic conditions and associated death rates that drive home health referrals such as heart disease, stroke, COPD/asthma and Alzheimer's conditions are very similar. This means that while the need for home health agency visits in Clark County is higher than King County or the State as a whole, the expected therapy mix (e.g., home health visits, physical therapy visits etc.) should be similar to the mix of services provided by home health agencies in Western Washington;. Eden Home Health can rely on its estimates of service mix in its existing operations in Western Washington as well as benchmark data to serve as the template for this application.

5. EmpRes also reviewed the comparative health and disparity status of Clark County residents when compared with residents in the Portland metropolitan area that also includes Clark County. Generally, Clark County compares favorably with Portland area counties for chronic illness burden and death rates (even though unfavorably with Washington State).

6. There is one important variable that is related to independent living where Clark County falls short in the Portland metropolitan area. Clark County has the highest level of social isolation as measured by the Rate of Social Membership Associations where Clark County residents reported 7.1 associations per 10,000 persons while the median of the *four* counties in region is 10.2 membership associations per 10,000 persons.[5] Home Health is specifically targeted to populations experiencing social isolation. Isolation results in higher death rates across a spectrum of chronic conditions.

6. **The most important conclusion is that greater home health resources are required in Clark County to prevent a serious health disparity crisis in Clark County. Initiative 1 for improving health of the population that is part of the federal and state Triple Aim commitment. An increase in home health resources will directly support the ongoing initiatives and demonstration projects that can control the burgeoning costs related to the higher disease burden in Clark County. Use of home health maintains individuals in the community and reduces overall healthcare costs for more expensive modalities including acute care, inpatient rehabilitation hospital and skilled nursing facilities. Any access barrier to home health in Clark County will directly lead to much higher healthcare costs than would be experienced on a statewide basis.**

Of near equal importance is that additional home health services will be required to support the DSHS LTSS aging program efforts and the CMS – Washington State Medicare-Medicaid Financial Alignment Initiative in Clark County.
Clark County's higher home health resource requirement particularly comes into play in the second phase of determining home health agency need – determining the impact of a new home health agency provider on the existing system. Clearly, with the reservoir of unmet need, there is a substantial need for additional home health agency capacity that is well beyond the *expected* need generated by the 1987 SHP methodology. The SHP guidelines are not promulgated as a CoN rule for determining need but is instead a suggested estimating approach as is the rules-based examination of service area general health need.

To quantify this need, EmpRes conducted a disparity analysis to measure the difference in age-adjusted death rates from chronic illness between Clark County, King County to see if changing demographic patterns would result in modifying the age-based methodology in the State Health Plan.

[5] 2019 Community Health Needs Assessment prepared by the Health Columbia and Willamette Collaborative -- participants include Clark County, WA, Multnomah County, OR, and Washington County, Page 20

Table 9 presents the comparative death rates for these illnesses and uses the median difference in age-adjusted death rates between Clark County residents and Washington State residents to determine health disparity. The results are that Clark County median adjusted death rates for listed conditions are 7% lower than Washington State death rates and 13% greater than King County. Eden Home Health concludes that there is no demonstrable disease-based requirement to adjust the 1987 incidence-based SHP home health visit methodology. The adjustment requirements applicable to Clark County would be adjustments to reflect the changing higher use of home health by insurers and hospitals that are increasingly turning to home health and in-home services to improve outcomes and reduce dependency among patients with chronic illness or who are recovering from acute care hospital stays. (see Table 7).

Table 9

Home Health Agency Adjustment Factor for Higher Chronic Illness Burden Due to Health Disparity

Cause of Death	Clark County Age Adj. Death Rate	King County Age Adj. Death Rate	State Age Adj. Death Rate	Clark County Age Adj. Death Rate as % of King County	Clark County Age Adj. Death Rate as % of State
Diseases of Heart	140.2	122.3	155.6	115%	90%
Ischemic Heart Disease	74.1	71.0	79.5	104%	93%
Cerebrovascular Disease	35.0	30.2	38.1	116%	92%
Diabetes	24.8	17.9	22.5	139%	110%
Alzheimer's Disease	47.2	44.3	44.9	107%	105%
Maj. Cardiovascular Disease	189.8	168.2	187.6	113%	101%
Pneumonia/Influenza	9.3	9.2	10.7	101%	87%
Chronic Lower Respiratory Disease	38.8	28.5	39.9	136%	97%
Chronic Liver Disease and Cirrhosis	10.2	10.1	12.4	101%	82%
Median Rate Comparison				**113%**	**93%**
Home Health Adjustment Factor				**113%**	**93%**

Source: Center for Health Statistics, Washington State Department of Health, 07/2016.

Table 10 presents the unadjusted home health agency need for Clark County through 2022 based on the agency analysis listed in Table using the existing 1987 state methodology.

Table 10										
1987 State Health Plan Methodology - Home Health										
County:	**Clark**									
Years:	**2020-2022**									
2020		**Age Cohort**	*	**County Population**	*	**SHP Formula**	*	**Number of Visits**	=	**Projected Number of Visits**
		0-64		417,273		0.005		10		20,864
		65-79		64,681		0.044		14		39,843
		80+		17,444		0.183		21		67,037
								TOTAL:		**127,744**
						Number of Expected Visits per Agency				*10,000*
						Projected Number of Needed Agencies				**12.77**
						Existing MM Agencies				**9.00**
						Net Need				**3.77**
						Need Rounded Down				**3.00**
2021		**Age Cohort**	*	**County Population**	*	**SHP Formula**	*	**Number of Visits**	=	**Projected Number of Visits**
		0-64		421,901		0.005		10		21,095
		65-79		67,002		0.044		14		41,273
		80+		18,684		0.183		21		71,803
								TOTAL:		**134,171**
						Number of Expected Visits per Agency				*10,000*
						Projected Number of Needed Agencies				**13.42**
						Existing MM Agencies				**9.00**
						Net Need				**4.42**
						Need Rounded Down				**4.00**

2022		Age Cohort	*	County Population	*	SHP Formula	*	Number of Visits	=	Projected Number of Visits
		0-64		426,529		0.005		10		21,326
		65-79		69,323		0.044		14		42,703
		80+		19,924		0.183		21		76,568
								TOTAL:		**140,597**
						Number of Expected Visits per Agency				*10,000*
						Projected Number of Needed Agencies				**14.06**
						Existing MM Agencies				**9.00**
						Net Need				**5.06**
						Need Rounded Down				**5.00**

The Home Health Agency numeric need approach used by the Department of Health is contained in the 1987 Washington SHP. It is a population-based formula utilized for nearly 30 years. The Department of Health ("Department") has used this same methodology to project home health agency need in each county. This methodology projects need for at least six additional agencies in Clark County *before* the health disparity adjustment is applied.

WAC 246-310-010(30) defines a home health agency as:

"...an entity which is, or has declared its intent to become, certified as a provider of home health services in the Medicaid or Medicare program."

The methodology determines the projected number of home health visits in each planning area (e.g., County) using the following factors:

- Identifying projected population of the County, broken down by age groups (0 -64; 65-70; & 80 and older);
- Applying estimated home health use for each age group;
- Applying an estimate of number of visits per age group; and
- Dividing the number of projected visits by an assumed average of 10,000 visits per agency.

In order to determine the 'net need' for a new home health provider, EmpRes calculated "'supply", based on a list of CoN agencies and State licensed agencies that could qualify as home health agencies. The footnotes below support the list EmpRes obtained the provider list from the Department."[6]

[6] Beth Harlow, 6/25/2018 E-mail list of CoN and state approved home health agencies serving Clark County, CoN

The list of agencies included 7 Certificate of Need approved agencies serving Clark County (including recently approved and opened Healthy Living at Home) and 4 state-only agencies serving Clark County. Table 10 provides an analysis of the number of CoN approved agencies and state-licensed agencies that should be included in the Need analysis as well as two agencies that should be excluded. This list of facilities was compiled from three sources with documentation provided in Attachment I:

- Clark County List of Potential Providers compiled by the Program in June 2018
- List of Potential Providers in CN 18-09 Sept. 2018, Table 4, Pages 14 -15
- Clark County List of Potential Providers compiled by the Program in Aug. 2019

In table 10, the **unadjusted** pre-survey analysis of home health agency "need" in 2022 is 11. As noted, Table 6 indicated no required adjustment that should be made in overall home health agency need to address health disparity that would is related to shortened life span for Clark County residents. An adjustment in home health agency need is appropriate to considering the higher chronic disease burden and changing healthcare practices that rely on higher utilization of home health services, but a methodology is not currently available. Table 10 presents the home health agency need based on the 1987 State Health Plan methodology through 2022 which is 11 home health agencies.

Table 11 is the September 14, 2018 Department analysis of existing home health agencies in Clark County. The evaluation states "*in analysis of the information contained in this table, the department determined that only **four** of the 10 agencies serving Clark County are available to residents*." Since the 2018 evaluation, the data has changed (see Table 11A)

The bold-faced agency described in Table 11 should be excluded - of Providence Home Health, a state-licensed facility, representatives from Providence in two separate interviews indicate that they do not provide home health services in Clark County.[7]

18-09 agency analysis (page 9,) Nidermayer-Kido e-mail list 8/27/19

[7] CN 18-09, Sept. 14, 2018. Page 9

Table 11

Department Analysis of Existing Home Health Agencies in Clark County Based on The Clark Home Health Evaluation Dated September 14, 2018. The Department determined that only ***four*** of the 10 agencies serving Clark county (plus the approved Healthy at Home) are now available to all residents. The data has changed since 2018 (see table 11A).

Agency Name	Services and Limitations	Medicare/Medicaid Certified	Available to all Residents	Source
Community Home Health and Hospice	CN Approved, Skilled Nursing, Occupational Therapy, I.V. Services, Speech Therapy, Medical Social Services, Physical Therapy, Home Health Aide	Yes	Yes	CN historical records
Divine Home Health Care Inc.	Skilled Nursing, Home Health Aide, I.V. Services, Personal Care, Homemaker/Chore, Respiratory Therapy, Transportation	No/No	No State license only	ILRS
Kaiser Permanente Continuing Care Services	CN Approved, Skilled Nursing, Physical Therapy, Medical Social Services, Bereavement Counseling, Speech Therapy, Home Health Aide, I.V. Services	Yes	Limited to HMO members	ILRS & agency website
Kindred at Home	CN Approved, Skilled Nursing, Medical Social Services, Occupational Therapy, Physical Therapy, Home Health Aide, Speech Therapy	Yes	Yes	CN historical records
Northwest Healthcare	CN Approved, Skilled Nursing, nutritional counseling, personal care homemaker/chore, transportation, home health aide, medical social services and respite care	No	No Homecare State license only	
PeaceHealth Homecare	CN Approved, Skilled Nursing Home Health Aide, IV Services, Personal Care, Homemaker/Chore. Respiratory Therapy and Transportation	Yes	Yes	CN Historical Records
Providence Home Health	**CN Approved, Physical Therapy, LV. Services, CN Approved, Physical Therapy, LV. Services, Health Aide, Speech Therapy, Occupational Therapy**	**Yes**	**Yes**	**ILRS**

Agency Name	Services and Limitations	Medicare/Medicaid Certified	Available to all residents	Source
Peace Health Homecare	CN Approved, Skilled Nursing, Home Health Aide, I.V. Services, Personal Care, Homemaker/Chore, Respiratory Therapy, Transportation	Yes	Yes	CN historical records
Touchmark Home Health	CN Approved, Home Health Aide, Occupational Therapy, Medical Social Services, Skilled Nursing, Speech Therapy, Physical Therapy	Medicare Only	No	ILRS & agency website
Healthy Living at Home	CN Approved, Home Health Aide, Occupational Therapy, Medical Social Services, Skilled Nursing, Speech Therapy, Physical Therapy	Yes	Yes	CN
Vancouver Comfort Keepers	Skilled Nursing, Home Health Aide, Personal Care, Homemaker/Chore, Respite Care, Transportation	No	No. Home Care and state licensed	ILRS, survey response, & agency website
Vancouver Home Health Agency, LLC	Skilled Nursing, Home Health Aide, Speech Therapy, Respiratory Therapy, Medical Social Services, Occupational Therapy, Nutritional Counseling, Bereavement Counseling, Physical Therapy, Personal Care, Respite Care, Homemaker/Chore	No	No. State licensed only	ILRS, survey response, & agency website

We have confirmed that since the 2018 CoN Evaluation for Health Living at Home:

1) Providence no longer provides home healthcare in Clark;
2) Northwest Healthcare does not provide home healthcare in Clark;
3) PSA Healthcare (not listed above) is Pediatric Only;
4) Vancouver Home Health Agency (in 2017) only provided 3 visits;
5) Healthy Living at Home - Vancouver does not have a functing website and therefore can not yet be proven to function in Clark.
6) only four agencies provide Medicare and/or Medicad, and
7) only 3 agencies appear to be *fully* operational.

The 2018 utlization survey enumerated less than 24,000 visits as being reported in 2017. This reported volume is *well* below the projected need described in Table 10 which ranges 127,744 visits in 2020 to 140,597 visits in 2020. With the low Clark County survey response there is scant data as to why the aging polulation is Clark is not getting access to home healthcare services. Health disparity is being declared as major contrinbutor to a state-wide health crisis in Washington. In this application we use facts and data provided by the State of Washington *proving* that Clark County leads the State in early death and poorer health. To compound this problem, only 5 out of nine agencies are avaialble for Medicare patients, only 4 (of nine) agencies are avaiable for Medicaid patients, and the Kaiser Health Plan is *only* available to its members for Medicare and Medicaid home health services.

Table 11A

Agency Name	Services and Limitations	Medicare Medicaid Certified	# of HHC Visits Provided in 2017
Community Home Health and Hospice	CN Approved, Skilled Nursing, Occupational Therapy, I.V. Services, Speech Therapy, Medical Social Services, Physical Therapy, Home Health Aide	Yes	22,922
Divine Home Health Care Inc.	Skilled Nursing, Home Health Aide, I.V. Services, Personal Care, Homemaker/Chore, Respiratory Therapy, Transportation	No	
Kindred At Home	CN Approved, Skilled Nursing, Medical Social Services, Occupational Therapy, Physical Therapy, Home Health Aide, Speech Therapy	Yes	

Kaiser Permanente Continuing Care Service*	CN Approved, Skilled, Nursing, Physical Therapy, Medical Social Services, Bereavement Counseling, Limited to ILRS & Continuing Care Speech Therapy, Home Yes HMO agency. Services Health Aide, I.V. Services	Yes	
Peace Health Homecare	CN Approved, Skilled Nursing, Home Health Aide, I.V. Services, Personal Care, Homemaker/Chore, Respiratory Therapy, Transportation	Yes	
Touchmark Home Health	health support after surgery, an illness, or accident	No	
Healthy Living at Home	CN Approved, Home Health Aide, Occupational Therapy, Medical Social Services, Skilled Nursing, Speech Therapy, Physical Therapy	Yes	0
Vancouver Comfort Keepers	Skilled Nursing, Home Health Aide, Personal Care, Homemaker/Chore, Respite Care, Transportation	No	
Vancouver Home Health Agency, LLC	Skilled Nursing, Home Health Aide, Speech Therapy, Respiratory Therapy, Medical Social Services, Occupational Therapy, Nutritional Counseling, Bereavement Counseling, Physical Therapy, Personal Care, Respite Care, Homemaker/Chore	No	3

Table 12				
Summary Net Home Health Agency Need: Net of 11 potential agencies in Table 11 and Eden Analysis in Table 11-A				
		2020	**2021**	**2022**
Total HHA Need		12.77	13.42	14.06
Existing Agencies		9	9	9
Net HHA Need		3.77	4.42	5.06
NET HHA Need Rounded Down		3	4	5

b. Identify the negative impact and consequences of unmet home health needs and deficiencies.

Overview

For over 30 years the Department of Health (Department) has used the same methodology to project home health agency need in each County as described in the previous section. This methodology projects net need for at least 5 additional agencies in Clark County by **2022, the target projection year.** In addition to collecting the required information to carry out the methodology used by the Department, EmpRes evaluated each step of the methodology to obtain a better understanding of home health agency need as it applies to the Clark County population and the various adjustments that should be applied to the need estimate. The steps that EmpRes used to understand need and to address unmet need and assess its consequences are based on the following elements:

EmpRes fully evaluated the health statistics compiled by the Clark Health District, the Washington Department of Health Death Statistics[8], the Washington Department of Health Chronic Disease Profile for Clark County report[9], 2019 County Rankings Report compiled by the Robert Wood Johnson – University of Wisconsin collaboration[10], the 2019 Community Health Needs Assessment compiled by the Healthy Columbia Willamette Collaborative (Clark County is a member)[11], Achievements in Long-Term Services and Support: Rebalancing and the Age Wave[12], the Area Agency on Aging and Disabilities of Southwest Washington 2016 – 2019 Area Plan[13] and conducted interviews with senior administrators and epidemiologists working with the Clark Health District.

- EmpRes, per recommendations from Department staff, has contacted 10 nursing

[8] See Attachment R
[9] See Attachment Q
[10] See Attachment S
[11] See Attachment T
[12] See Attachment U
[13] See Attachment V

home by phone within Clark County to identify unmet need and the potential for referrals. Generally, respondents indicated a need for additional home health services within the County. Detailed responses may still be received and will be submitted in the next several weeks when the survey period is closed out.[14]

- EmpRes reviewed the available HIPSA and MUA data prepared for Clark County

- EmpRes reviewed the 2017 CHARS data that shows discharges from acute care hospitals to Skilled Nursing Facilities is only 44% of the statewide referral rate on a referrals per 100,000 discharges basis for Washington State (see Table 7). The Washington State Healthcare Authority has documented that emphasizing community-based service through the health home model substantially reduces overall costs associated with inpatient and skilled nursing facility modalities.

- EmpRes reviewed Avalere Health which provides a proprietary analysis of the Medicare fee-for-service patient referrals from skilled nursing homes located within Clark County to home health agencies.

- EmpRes also applied its experience and referral data gleaned from operating skilled nursing facilities in Clark County as well as Cowlitz County.

The overall conclusion from this review of available data and interviews with skilled nursing facility managers is that the overall higher burden of chronic illness in Clark County when compared to all of Washington State requires additional agency resources such as home health agencies that specialize in supporting individuals with chronic illness and who provide services to lower income populations such as the Medicaid population. Additional home health resources in Clark County will substantially improve the ability of individuals to remain at home while reducing overall healthcare costs to payers, families and patients.

1) **<u>Need for additional providers in Clark County to meet growing demand</u>**

This key need is the focus of the prior section's as summarized in Table 12. **There is a current shortage of home health agencies based on the 1987 methodology that does not take into account changes in healthcare practices mandated by the Medicare Program as well as undertaken by the Medicaid Program.** No additional adjustments were made to meet the identified health disparity in terms of disease death rates compared in Table 9. Table 9 indicates that the age adjusted death rates from disease categories is 93% of the Washington State average and 113% of the King County age adjusted death rates. There was not a robust difference between Clark County disparity rate and the remainder of the State to directly address health disparity, although health disparity can be reduced in Clark County as noted by David Mancuso, Ph.D. in the Achievements in Long-Term Services and Supports: Rebalancing and the Age Wave report previously discussed and included as Attachment U.

[14] Attachment W* provides the interview results

2) Need for rapid admission to home health via timely access to home health services

The second key need addressed by this application is the need for patients referred to home health to receive rapid admission for care. Evidence of the admission to care access barrier and Medicare data on "timeliness" of the start of care in Clark County is provided in Section 9 (b

Findings: Need for Rapid Admission

Our review of Medicare quality of care data and the results of our interviews with nursing home providers indicates that home health agencies are not achieving appropriate results in meeting the current need for rapid admission (See Table 8), which is in great part due to a lack of home health resources. 3 of 10 nursing homes contacted in September, 2019 reported home health resource barriers to meeting the 48-hour timely access standard. Prior to the approval and opening of Healthy at Home this would have included an additional nursing home – 40% of the 10 facilities studied. This finding is consistent with Medicare CMS findings.

The rapid increase in the target population due to the Baby Boom population moving into the higher use categories and pressure on hospitals and other providers to rapidly transfer patients to lower levels of care will further expose the documented, fragile chronically ill Clark County population to even greater need for home health services, particularly for home health agencies that take a proportionate share of low-income patients.

Significant **current** delays in appropriate home health placement will increase. If additional capacity is not provided at this time, health disparity could become a major factor in reducing health status within Clark County as measured by reduced life span. Survey results will be in included in Attachment W.

3) Need for the additional providers to prevent growing health disparity that limits life span and increases the chronic disease burden of residents of Clark County and adjacent counties.

This key need was the focus of the prior section.

4) Need for financially accessible home health services.

This problem of access affects patients referred to home health services, particularly the dual option Medicare-Medicaid patients where "affordable care" is not limited just to the direct patient service but in the patient's ability to maintain independent living, which is the highest

priority of 636 respondents to a Southwest Washington Needs prioritization survey conducted by the Area Agency on Aging and Disabilities of Southwest Washington.[15] As detailed in the discussion of "health disparity" the cost of home health services and health home services compared to the incomes of many who need these services make it currently impossible to live a healthy life-style. Without additional intervention by home health and other lower cost health care providers, lower income patients' health will be further exacerbated. Additional home health agencies that are Medicare and Medicaid certified can help these patients address their chronic illness so that they live a longer and higher quality life.

Regarding income disparity, it is important to point that Eden Home Health has a robust charity care policy to help low income patients receive free or low-cost home health services (see Attachment K)

Findings on the Need for Accessible Home Health Services

Part of the solution is simply greater resource capacity for home health services which is addressed by this project. Without this capacity, the 20-year efforts of the Department of Social and Health Services Long-Term Services and Supports (LTSS) Rebalancing and the Washington State Medicare-Medicaid Financial Alignment Initiative ,Medicare-Medicaid Managed Fee-for-Service (MFFS) may not achieve maximum effectiveness in addressing the chronic illness burden in Clark County and the resulting affordability for patients as well as managing increases in healthcare costs.[16] The MFFS project demonstrated that if real-world results are not achieved programs will be cut back.

Reforms in the delivery and payment for healthcare are driving increased use of in-home services. The use of in-home care post discharge supports the cost-effective care of post-acute patients after injury, surgery, hospitalization or skilled nursing/nursing home care. Based on requirements of the Affordable Care Act, Medicare set standards and has begun monitoring the re-admission of inpatients who require greater attention to rehabilitation and healing at home.

Hospitals with high re-admission rates are being *penalized financially* by Medicare until the institution's performance reaches a required federal standard for re-admissions. Likewise, patients of post-acute skilled nursing facilities also require follow-up care and therapies upon discharge. Many require immediate post-discharge admission to and

[15] *Op cit.* Page 1

[16] In 2016 the Washington State Legislature temporarily suspended the Washington Medicare-Medicaid Financial Alignment Initiative ,Medicare-Medicaid Managed Fee-for-Service (MFFS) demonstration project because of questions about the cost-savings that CMS would provide Washington State if the project yielded savings.

treatment by home health service providers.

These changes and the financial incentives supporting them, emphasize the need for keeping patients clinically stable immediately after discharge. The practice requires rapid admission to home health care of patients determined by their physicians to require such care. Not only must the patient be admitted to the agency, but the patient must receive the appropriate level and frequency of care prescribed by the physician. Patients who cannot access or do not receive timely and adequate home health services may experience a number of health-related such as:

- Longer lengths of stay for inpatients
- Poor management of required post hospital medications; patient non-compliance or errors
- Unnecessary falls due to inadequate attention to safety issues in the home
- Lack of progress in rehabilitation, e.g., required therapies for joint replacement
- Inadequate monitoring for post-acute complications and worsening of conditions leading to increased morbidity and mortality
- Poor adherence to post-acute dietary instructions, e.g. low salt diet for CHF
- Unnecessary morbidity and earlier mortality at the system level due to an inadequate supply of home health services means:
  - Overall longer lengths of inpatient stays in the highest cost settings
  - Higher capital and operating costs to develop and maintain greater inpatient capacity than would otherwise be needed
  - Additional demand for nursing and other staffing across the system
  - Poor hospital through-put and patient warehousing

In mid-2016, the Department of Health revised its method of counting available home health service capacity in the county for which an applicant files a letter of intent. Starting with 2012 HHA evaluations, DOH began including "licensed-only" agencies in existing capacity and it began providing a list to applicants that combined the CON-approved and "licensed-only" agencies for use in the applicant's calculation of the 1987 SHP Home Health Need Estimation Method.[17] Given the heightened chronic illness burden in Clark County, reducing capacity by counting State-only

[17] This change in methodology has a minimal effect on counties surrounded by rural areas such as Clark County.

agencies might have been a problem but our analysis is that this approach has not had any adverse impact at this time (e.g., reducing potential supply) within Clark County since there is a substantial need for additional Medicare and Medicaid certified home health agencies.

4. **Define the types of patients that are expected to be served by the project. The types of patients expected to be served can be defined according to specific needs and circumstances of patients (i.e., culturally diverse, limited English speaking, etc.) or by the number of persons who prefer to receive the services of a recognized school or theory of medical care.**

Eden Home Health of Clark County, LLC will serve homebound Clark County residents without regard to race, religion, national origin, sex, sexual orientation and handicap who require intermittent skilled nursing, rehabilitation therapy, medical social work, and/or certified home health aide services as a result of illness or injury ordered by their primary physician. Further, Eden Home Health of Clark County, LLC will have at its disposal appropriate resources and personnel available to serve deaf/hard-of-hearing and patients who have limited English speaking ability.

The types of patients Eden Home Health of Clark County, LLC will serve in Clark County will be consistent with the experience in other markets with a similar demographic profile. It is expected that Eden Home Health of Clark County, LLC will serve minority populations consistent with their representation within the age stratification detailed below. The average age range of the patients served is expected to be 74 - 77 , which is very similar to national peer group averages. Ages 18 to 64 will make up approximately 21% of the patients served while the age group from 64 – 94 will be approximately 76% of the total. Those over the age of 94 will be less than 4%.

The following lists provide additional detail about the types of patients Eden Home Health of Clark County, LLC expects to see in Clark County:

Percent by clinical area:

- Rehabilitation Therapy - 24 %
- Circulatory - 22%
- Respiratory - 10%
- Diabetes-5%
- Psychiatric / Behavioral - 2%
- All Other - 47%

Expected referral sources:

- Acute Care Hospitals
- Skilled Nursing Facilities/Rehabilitation Centers
- Adult Living Facilities
- Physician Practices
- Clinics (CHF/COPD, Diabetes, Wound Care)

- Senior Clinics
- Community (Retirement communities, Elder Care Attorneys)
- Family members/ Caregivers

5. For existing facilities, include a patient origin analysis for at least the most recent three-month period, if such data is maintained, or provide patient origin data from the last statewide patient origin study. Patient origin is to be indicated by zip code. Zip codes are to be grouped by city and county and include a zip code map illustrating the service area.

NA - Eden Home Health of Clark County, LLC is not an existing facility.

6. For existing facilities, please identify the number of patients currently receiving skilled services, broken down by type(s) of services (i.e., skilled nursing), by county served.

NA - Eden Home Health of Clark County, LLC is not an existing facility.

7. Please provide utilization forecasts for the following, broken down by discipline (i.e., RN/LPN, OT, PT, social worker, etc.) for each county proposing to serve:

A. Total number of home health *visits* per year for the first three years; and

B. Total number of unduplicated home health *patients* served per year for the first three years.

Table 13 provides the total number of visits for the first partial year and the first three complete years of operation as well as unduplicated home health patients.

Table 13
Utilization Visit Forecasts: Eden Home Health of Clark County LLC

VISITS	2020	2021	2022	2023	% Visits by Discipline
Skilled Nursing	155	2066	5225	8326	40.6%
Physical Therapy	142	1895	4878	7546	37.2%
Occupational Therapy	44	587	1512	2338	11.5%
Speech Pathology`	14	185	476	736	3.6%
Medical Social Service	6	82	210	325	1.6%
Home Health Aide	21	274	706	1092	5.4%
Total Visits	381	5092	13107	20274	100%
Unduplicated Patients	20	270	695	1075	

8. Provide the complete step-by-step quantitative methodology used to construct each utilization forecast. All assumptions related to use rate, market share, intensity of service, and others must be provided.

Planning area growth in demand

Table10, prepared in response to the 1987 SHP Need Estimate methodology shows, the Clark County target population for home health services is expanding rapidly. Taking Eden Home Health of Clark County, LLC's 2020 partial year of operation as a baseline, the SHP Need Estimate shows a growth in need between 2020 and 2023 of 12,853 home health visits. In the SHP methodology, this additional demand for care is driven by a combination of overall Clark County population growth and by the aging of both the 65 -79-year age cohort and the cohort over age 79. From 2020 through 2022, the population under age 65 will grow by 2.2% while the population in the two older cohorts, 65 – 79 year-old cohort will grow by 7.1% and the age cohort over age 79 will grow by 14.2%. This fuels an overall increase in home health visits of over 10% for this 3-year time period.

This analysis shows that, even if all SHP need is being met in 2019, growth from 2020 through 2022 would support nearly two new agencies (1.3 agencies).

Market share

Taking only the Medicare-certified agencies as the relevant competitors, Eden Home Health of Clark County, LLC reviewed the potential market share impact of its 2023 volume estimate. Spreading Eden Home Health of Clark County, LLC's volume of 13,107 visits in 2023 when the project will achieve results in a - 9% market share.

Projected referral sources and assumptions:

1) Skilled nursing

As part of its volume estimates, Eden Home Health of Clark County, LLC contacted each of the skilled nursing homes in Clark County per the Department's suggestion. The responding Discharge Planners and Social Workers on staff at those facilities are responsible for coordinating the discharge of each patient referral to home or another facility. EmpRes owns a 92-bed skilled nursing home in Clark County. Currently, this facility refers over 7-8 per month. Eden Home Health and other skilled nursing homes indicated by survey that they would refer 15 – 20 patients per month to a new home health agency which would support the new patient projections for the first 2 full years of operation and we expect referrals from hospitals in Clark County which are required to present patients with home health agency options regarding home health agency selection, to provide the remaining growth in new patients.

Other service results include:

4 (of ten) SNFs contacted said they had trouble finding home healthcare in a timely manner (within 48 hours);

2 (of 10) SNFs said they experience a great deal of trouble finding home healthcare services;

2 (of 10) SNFs said they occasionally experience trouble finding home healthcare services; and no SNF's opposed the idea of another home healthcare service choice in Clark County.

In the 2018 home health evaluation for Healthy Living at Home, quotes from SNF support letters were included by the Department. We are certain the support has not waivered. And while Healthy Living at Home Vancouver LLC is a new service, the Vancouver location website only a graphic of the director's name card. Therefore, it's reasonable to assume Healthy Living at Home Vancouver LLC has not fully launched their home healthcare service.

2) Coleman Model: Care Transitions Program

In alignment with the company-wide continuum of care strategy, Eden Home Health of Clark County, LLC will provide the Coleman Model of Care Transitions to the EmpRes skilled nursing facilities and seek partnership from other skilled nursing facilities and hospitals in the area. The Coleman Model's Care Transitions Program provides education and coaching support for patients transitioning from one care setting to another, such as from skilled nursing to home. As conditions and personal needs change, the Care Transitions Program allows patients to self-manage their care in the home environment, thus helping patients achieve greater long-term independence.

The Transitions Program model of care is fully congruent with the very successful health home model of care operated by the Washington Health Care Authority through that has an extended demonstration project through 2020 for CMS.

Assumption: By year three, patient referrals through the EmpRes Care Transitions Program to Eden Home Health of Clark County LLC will reach 50% of all such referrals.

3) Hospitals and physicians and other providers

To estimate potential referrals from hospitals and physicians, Eden Home Health of Clark County, LLC drew on its home health agency experience in 4 other markets. It reviewed the growth in volumes experienced by its affiliate, Eden Home Health of Bellingham, LLC since it acquired the Option Care Enterprises home health agency serving Whatcom, Skagit, Snohomish and Island Counties. Based on the combination of the following:

- Care Transitions program,
- Tele-health initiatives, and
- Availability to see newly referred patients from its first day of operation.

The volume of referrals in this service area has grown substantially - from a 200-patient census to 500 patient census in just two years.

In 2017, nearly 6,200 Clark County residents were referred to home health agencies serving Clark County. The programs that EmpRes employs along with the Health Home services operated through the Health Care Authority should generate substantial referrals that will support the volume projections.

Assumption:
In addition to referrals from EmpRes Care Transitions Program, another portion of referrals will come from a broader referral base of physician practices and hospitals.

Eden Home Health Environmental Assessment of Home Health Need

Eden Home Health reviewed four separate assessment approaches to verify that there is a current need for an additional home health agency and a need for 2 home health agencies beginning in 2017.

1) CHARS Hospital Home Health Referrals

Table 14 summarizes home health agency referrals for Clark County hospital inpatients treated in all CHARS reporting hospitals as well as all Washington inpatient home health referrals occurring in all CHARS reporting hospitals for 2017. The data show that the overall rate of referrals per 1,000 persons is ***over twice the rate the State rate as a whole***. As analyzed in Table 9, no adjustment was made for greater health disparity.

Table 14
2014 Home Health Agency Referrals for Clark County and Washington State Residents from All Hospitals (CHARS Data)

2017 Discharges per 100,000 Persons & Per Cent Total Discharges: Washington State & Clark County						
	Washington State	Per Cent of Total	Discharges per 100,000 Persons	Clark County	Discharges per 100,000 Persons	Per Cent of Total
2017 Population	7,310,300			471,000		
Discharge Category						
Discharged Home	477,989	76%	653.9	26,496	562.5	80%
Expired	13,946	2%	19.1	0	0.0	0%
Discharged to Home Health	38,089	6%	52.1	1,073	22.8	3%
Discharged to Skilled Nursing Facilities	55,053	9%	75.3	2,698	57.3	8%
Discharged to Inpatient Rehabilitation	5,407	1%	7.4	551	11.7	2%
Discharged to Long -Term Care Hospital	888	0%	1.2	68	1.4	0%
Other	40,613	6%	55.6	2,167	46.0	7%
TOTAL	631,985	100%	864.5	33,053	701.8	100%

2) Review of the Clark County Demographic Data

Eden Home Health also examined three determinants of need and demand for home health agency visits; population growth, changes in age mix of the population and changes in the affordability of health care. Table . Population Total and Percent Change, Clark County: 2010 to 2019 (OFM Annual Estimates)shows that Clark County has experienced population growth of approximately 1.5% per year versus the State population average annual increase of 1.2%. This indicates need and demand increasing over time.

Percentage Population Increase from 2010 Through 2019: Clark County and Washington State					
County	Jurisdiction	2010 Population Census	2019 Population Estimate	Total Increase	Annualized Increase
.	.	.	.		
Clark	Clark County	425,363	488,500	114.8%	1.5%
Clark	Unincorporated Clark County	203,339	226,890		
Clark	Incorporated Clark County	222,024	261,610		
.	.	.	.		
State	State Total	6,724,540	7,546,410	112.2%	1.3%
State	Unincorporated State Total	2,478,323	2,635,501		
State	Incorporated State Total	4,246,217	4,910,909		
	OFM Population Estimates				

These increases in insurance coverage would be expected to increase the need and demand for new home health agencies.

3) Access to Care

The Patient Protection and Affordable Care Act was signed into law in 2011. As of 2014, the new law increased the mandatory minimum income eligibility level for Medicaid to 133% of the federal poverty level. There is also a standard 5% income disregard for most individuals, thereby allowing eligibility to individuals with 138% of the poverty level and below.

The Affordable Care Act also made it mandatory for all U.S. citizens to have health insurance. Those who choose not to sign up for insurance will have to pay a penalty. However, not all residents are eligible for insurance, including undocumented immigrants and some people who may be exempt from the requirement to have insurance.

Another key provision was that the Affordable Care Act created a new marketplace for each state to offer health benefits to individuals, families and small businesses. The Washington Health Benefit Exchange (created in 2011) is responsible for the creation of Washington Health plan finder, a website on which Washingtonians can find, compare and enroll in qualified health insurance plans. An in-person assistance network was also developed to make support broadly available for those who need additional assistance enrolling via Health plan finder.

4) Health Professional Shortage Areas (HPSA) and Medically Underserved Areas (MUA) Analysis

Eden Home Health reviewed the HPSA and MUA shortage area data for Clark County to determine if there were key shortage areas that could result in increased or decreased need or demand for home health agencies. Attachment H provides HPSA

and MUA information for Clark County which indicates only small geographic areas of shortage. We then verified that there were no large designated shortage areas that would affect the home health agency need analysis for Clark County with the staff of Washington Community Health Systems.[18]

5) Review of the Impact on Home Health Demand as result of CMS New Emerging Reimbursement Model as Included in Attachment U

The U.S. Department of Health and Human Services CMS – Washington State Medicare-Medicaid Financial Alignment Initiative is in its third phase in addressing fee-for-service for the dual eligible Medicare-Medicaid population. In addition, in Washington State all Medicare fee-for-service home health services are provided under risk-based contracts.

All these CMS initiatives along with Medicare Advantage and commercial insurance plans are looking at the post-acute care as an area for significant savings while improving the quality of care outcomes for patients. Based on national literature, consultants as well as in depth discussions with numerous active ACOs and Model 2 BPCI groups, all of these groups share a common strategy surrounding skilled nursing facilities: 1) shift hospital discharges from SNFs to home health and 2) for those patients that still must go to a SNF reduce the average length of stay at those SNFs.

The results of these earlier efforts have created a unique situation in Washington State where the Health Home Program Medicare waiver calls for enhanced funding through 2020 with savings sharing from CMS to Washington State for implementing programs that reduce healthcare costs primarily costs associated with hospitalization and skilled nursing.

EmpRes knows that these new models will increase demand for home health services and is currently assessing whether a higher home health agency need adjustment factor is sufficient to provide adequate capacity to address the unique disease burden in Clark County and support federal and state initiatives.

[18] *Op cit:* Phone communication with Healthcare access analyst, Office of Community Health Systems

9. Provide detailed information on the availability and accessibility of similar existing services to the defined population expected to be served. This section should concentrate on other facilities and services which "compete" with the applicant.

a. Identify all existing providers of services (licensed only and certified) similar to those proposed and provide utilization experience of those providers that demonstrates that existing services are not available to meet all or some portion of the forecasted utilization.

The Department of Health surveyed all home health agencies in late 2018 with an annual survey to measure utilization in the prior year. Only three agencies serving Clark County responded to the survey including Providence Home Health which no longer serves Clark County. As a result, there is no information on patient visits and payor mix for most of the home health agencies serving Clark County.

Eden Home Health of Clark County Analysis of State-Only Licensed Agencies

Consistent with the Program's revised approach to calculating supply, Eden Home Health started with a list, provided to us by the CN Program, of all licensed in-home services providers that claim to serve Clark County. This list was generated through the state licensing database and is included in Attachment I. The list includes 10 agencies. For each agency we either: 1) reviewed their website or 2) contacted the agency (by phone) to gather information about who and which types of patients they serve. Our findings are detailed in Table 15 and includes 10 agencies (note that PSA is a double count. Our Table 15 analysis lists 9 agencies excluding the double count for Pediatric Services of America (PSA). If PSA is excluded as in the Healthy at Home certificate of need analysis then only 8 agencies should be counted.

Table 15

Home Health Agencies Serving Clark County: September 2019 (Certificate of Need Program					
License Number	Name	License Status	Location	Service Area	M/M Certified
IHS.FS.00000422	Pediatric Services of America, Inc.	ACTIVE	Clark (CoN a	Clark	Yes
IHS.FS.00000423	Pediatric Services of America, Inc.	ACTIVE	Clark	About 20 counties listed in ILRS.	No
IHS.FS.00000454	Waterford at Fairway Village LLC	ACTIVE	Clark	Clark	No
IHS.FS.60331226	PeaceHealth Southwest Medical Cente	ACTIVE	Clark	Clark	Yes
IHS.FS.60450910	Vancouver Comfort Keepers LLC	ACTIVE	Clark	Clark	No
	Kaiser Health Plan (CoN approved)		Portland	Clark	Yes
IHS.FS.60660459	Vancouver Home Healthcare Agency LL	ACTIVE	Clark	Clark	No
IHS.FS.60803573	Divine Home Health Care Inc.	ACTIVE	Clark	Clark	No
IHS.FS.60814521	Healthy Living at Home - Vancouver LL	ACTIVE	Clark	Clark	Yes
IHS.FS.00000262	Comunity Home Health and Hospice	ACTIVE	Cowlitz	Clark	No

b. If existing services are available and accessible, justify why the proposed project does not constitute an unnecessary duplication of services.

Existing services are not available and accessible for the following reasons:

- Need – there is a current need for 3 home health agencies in 2020 and 5 agencies by 2022 per the SHP analysis provided in Table 9 and assuming no additional agencies are added from the state-licensed list analyzed in Table 11-A.

- CHARS data shows hospital referrals to home health for Clark County inpatients are only **44%** of the average rate for all Washington inpatients.

- Eden surveyed 10 skilled nursing facilities by telephone in Clark County with 8 nursing homes responding. 4 nursing homes indicated that they had difficulty placing patients in Clark County.

- Eden will fully participate in CMS and LTSS quality initiatives that will improve continuity of care and reduce overall healthcare costs which will stimulate demand for home health services.

In addition, with Medicaid expansion under the Affordable Care Act (ACA), the Clark County residents without health insurance into health insurance plans who previously did not have health insurance declined from 15% of the population to 5% of the population from 2013 – 2015 and most of those patients are Medicaid patients.[19] Medicaid will only pay for home health services in CMS certified home health agencies although it is studying new approaches under legislative direction.

10. Document the manner in which low-income persons, racial and ethnic minorities, women, people with disabilities, and other under-served groups will have access to the services proposed.

Eden Home Health of Clark County, LLC is not an existing agency. Our admissions and charity care policy and commitment to obtaining a Medicaid contract document that we will accept all patients in need who we are qualified to treat, regardless of race, religion, disability, sex, or income. We have submitted draft admission and charity care and non-discrimination policies that will be reviewed and approved by the Department. Copies of these draft polices are included in Attachment K A: Admission Information and 8 B: Charity Care Policy and 8C: Charity Care Notice and Charity Care Income Schedule.

11. Please provide copies (draft is acceptable) of the following documents:

a. Admissions policy; and
b. Charity care policy; and
c. **Patient referral policy, if not addressed in admissions policy.**

As noted in response to the previous question, a copy of Eden Home Health of Clark County, LLC draft polices are included in Attachment K

[19] 2015 Demographics and Social Characteristics: Clark County 2017; Clark Regional Health District. January 2018 . Page 9

12. As applicable, substantiate the following special needs and circumstances that the proposed project is to serve.

a. The special needs and circumstances of entities such as medical and other health professions' schools, multi-disciplinary clinics, and specialty centers that provide a substantial portion of their services, resources or both, to individuals not residing in the health services areas in which the entities are located or in adjacent health services areas.

b. The special needs and circumstances of biomedical and behavioral research projects which are designed to meet a national need and for which local conditions offer special advantages.

c. The special needs and circumstances of osteopathic hospital and non-allopathic services which the proposed facility/service would be affiliated.

This question is not applicable.

Section 4
Project Rationale

B. Financial Feasibility

1. If applicable provide the proposed capital expenditure for the project.

The proposed capital expenditure is limited to equipment and is detailed as follows:

Table 17
Project Capital Expenditure Estimates

Eden Home Health of Clark County, LLC Agency Project Costs	
a. Construction costs (Remodeling)	$ 0
b. Moveable Equipment	$38,000
c. Fixed Equipment	(Included above in a)
d. Architect and Engineering, Permits and Fees	(Included above in a)
e. Sales Tax (@9.5%)	(Included a & b)
f. Other (Certificate of Need Review Fee)	Not Included
Total Cost	$38,000

2. Explain in detail the methods and sources used for calculating estimated capital expenditures.

This capital expenditure for this project is limited to small equipment purchases – lap top computers, phone equipment. These costs were based upon Eden Home Health experience in establishing a home health agency in Arizona as well as our experience in Washington State.

3. Document the project impact on: (a) Capital costs (b) Operating costs and charges for health services.

The capital costs for the project are small and limited to equipment and minor remodeling. In terms of operating costs, home health is a cost-effective adjunct for implementing the Affordable Care Act (ACA). The ACA is focused on improving quality while lowering costs. To do this, there is increasing emphasis on providing services that 1) reduce hospital readmissions and emergency department use and 2) provide coordinated care delivery. The expansion of home health services in Clark County is expected to support the ACA by reducing re-hospitalizations and coordinating care as well as providing additional patient choice in care providers.

CMS has Implemented the Home Health Quality Initiative in Home Health Services

Home health is a covered service under the Part a Medicare benefit. It consists of part-time, medically necessary skilled care (nursing, physical therapy, occupational therapy, and speech-language therapy) that is ordered by a physician. In 2010, there were over 10,800 Medicare certified home health agencies throughout the United States. In 2010, 3,446,057 beneficiaries were served, and 122,578,603 visits made.

Home Health Quality Goals

Quality health care for people with Medicare is a high priority for the Department of Health and Human Services, and the Centers for Medicare & Medicaid Services (CMS).

CMS has adopted the mission of The Institute of Medicine (IOM) which has defined quality as having the following properties or domains:

- **Effectiveness** Relates to providing care processes and achieving outcomes as supported by scientific evidence.
- **Efficiency** Relates to maximizing the quality of a comparable unit of health care delivered or unit of health benefit achieved for a given unit of health care resources used.
- **Equity** Relates to providing health care of equal quality to those who may differ in personal characteristics other than their clinical condition or preferences for care.
- **Patient Centeredness** Relates to meeting patients' needs and preferences and providing education and support.
- **Safety** Relates to actual or potential bodily harm.
- **Timeliness** Relates to obtaining needed care while minimizing delays.

CMS has now implemented a multi-phased innovation initiative, the Bundled Payments for Care Improvement (BCPI). BPCI affords the opportunity to devote resources to integrating our post-acute network to provide episodic value-based care to achieve triple-aim goals – better satisfaction, better outcomes. All Washington State home health agencies participate in this risk-based model that is designed to improve care relative to triple-aim goals (e.g., better satisfaction, better outcomes, lower cost). Eden Home Health, LLC will participate in this initiative.

4. **Provide the total estimated operating revenue and expenses for the first three years of operation (please show each year separately) for the items on the following page, as applicable.**

Table 14 identifies the operating revenues and expenses for 2020 and the first three complete years through (the 3rd full year of operation). Detailed operating revenue and expenses are included in Attachment L.

Table 18
Proforma Operating Statement - Eden HHA - Clark County

	2020	2021	2022	2023
Total Net Revenue	**0**	**680,274**	**1,751,076**	**2,708,499**
Total Costs	**167,062**	**941,086**	**1,731,651**	**2,374,636**
EBITDA	**(167,062)**	**(260,812)**	**19,425**	**333,863**
Depreciation	3,294	7,905	7,905	7,905
EBIT	**(170,356)**	**(268,716)**	**11,520**	**325,958**

5. **Please note: according to revised HCFA regulations, home health agencies must have enough reserve funds (determined by an authorized fiscal intermediary) to operate for three months after becoming Medicare/Medicaid certified. Please provide the following information in relation to this requirement:**

a. Provide the name and address of the fiscal intermediary you will be using to determine capitalization;

The fiscal intermediary has not been appointed but we expect that the intermediary will be National Government Services. The address is:

National Government Services
P.O. Box 100142
Colombia, South Carolina 29202-3142

b. Provide a copy of the forms you are providing to the fiscal intermediary.

Eden Home Health's fiscal intermediary requires the Form 855 filing to be finalized within 60 days after initial filing. Completion and review of this application will take more than 60 days. Therefore, Eden would agree to submission of the form as a condition to receipt of a Certificate of Need.

6. **Identify the source(s) of financing (loan, grant, gift, etc.) for the proposed project. Provide all financing costs, including reserve account, interest expense, and other financing costs. If acquisition of the asset is to be by lease, copies of any lease agreements, and/or maintenance repair contracts should be provided. For debt amortization, provide a repayment schedule showing interest and principal amount for each year over which the debt will be amortized.**

On receipt of the Washington Certificate of Need, the members of Eden Home Health of Clark County, LLC will fund the working capital account of Eden Home

Health of Clark County, LLC at a level sufficient to support the start-up cash flow requirements of the expansion into Clark County. Please see Attachment M for a letter of commitment from the CFO.

The historical cash flow issues of new or expanding home health services agencies have been considerably resolved due to Medicare's policy of providing 60% of each patient episode charge at the beginning of service.

7. **Provide documentation that the funding is, or will be, available and the level of commitment for this project.**

Please see Attachment M for a letter of commitment from Michael Miller, Vice President and Chief Financial Officer.

8. **Provide a cost comparison analysis of the following alternative financing methods: purchase, lease, board-designated reserves, and inter fund loan or bank loan. Provide the rationale for choosing the financing method selected.**

Since financing involves unnecessary interest expense, Eden Home Health of Clark County, LLC has elected to fund the establishment of the agency with available cash.

9. **Provide a pro forma (projected) balance sheet and expense and revenue statements for the first three years of operation.**

Please see Attachment L for pro forma balance sheet expense and revenue statements for 2020 - 2023.

10. **Provide a capital expenditure budget through the projected completion and for three years following completion of the project.**

Please see Attachment L for the project's 2020 - 2023 capital expenditure budget.

11. **Identify the expected sources of revenue for the applicant's total operations (e.g., Medicare, Medicare Managed Care, Medicaid, Health Options, Blue Cross, Labor and Industries, etc.) for the first three years of operation, with anticipated percentage of revenue from each source. Estimate the percentage of change per year for each payer source.**

Table 19, "Eden Home Health of Clark County, LLC Payer Mix, Percent" indicates the estimated percentage payer mix for the proposed project. The percentages are not expected to change over time.

Table 19
Eden Home Health Payer Mix, Clark , %

Payer	Percent
Medicare	74%
Medicaid	5%
Commercial	19%
Charity	2%

12. If applicant is an existing provider of health care services, provide expense and revenue statements for the last three full years.

Eden Home Health of Clark County, LLC is not an existing provider of health services.

13. If the applicant is an existing provider of health care services, provide cash flow statements for the last three full years.

Eden Home Health of Clark County, LLC is not an existing provider of health services.

14. If applicant is an existing provider of health care services, provide balance sheets detailing the assets, liabilities, and net worth of facility for the last three full fiscal years.

Eden Home Health of Clark County, LLC is not an existing provider of health services.

15. For existing providers, provide actual costs and charges per visit broken down by discipline (i.e., RN/LPN, OT, PT, social worker, etc.) and by payer source for each county proposing to serve.

Eden Home Health of Clark County, LLC is not an existing provider of health services.

16. Provide anticipated costs and charges per visit broken down by discipline (i.e., RN/LPN, OT, PT, social worker, etc.) and by payer source for each county proposing to serve.

Anticipated direct personnel costs per discipline are summarized in Table 20 below. Overall charges per visit by therapy are provided below and are based on the overall Medicare charges for the following:

Table 20
Anticipated Direct Personnel Costs and Calculated Total Charges per Visit
2021-2023

	2021		2022		2023	
	Direct Costs	Calculated Charges	Direct Costs	Calculated Charges	Direct Costs	Calculated Charges
Skilled Nursing	$60	$182	$60	$182	$60	$182
Physical Therapy	$82	$182	$82	$182	$82	$182
Speech Therapy	$82	$182	$82	$182	$82	$182
Occupational Therapy	$92	$182	$92	$182	$92	$182
Social Work	$100	$182	$100	$182	$100	$182
Home Health Aide	$32	$182	$32	$182	$32	$182

17. Indicate the addition or reduction of FTEs with the salaries, wages, and employee benefits for each FTE affected, for the first three years of operation. Please list each discipline separately.

Table 21 below provides Eden Home Health of Clark County, LLC wages and salaries and the number of FTEs by each discipline. The employee benefits are estimated at 25% of wages and salaries for each discipline.

Table 21
Staffing Summary - Eden Clark HHA Positions, Salaries, and FTE's, 2020-2023

STAFFING INPUT - BY FTE'S OPERATIONS		2020	2021	2022	2023
Physician (Medical Director)	contracted				
Director of Professional Services	$ 120,000	1.00	1.00	1.00	1.00
Clinical Supervisor	$ 90,000	-	1.00	1.00	1.00
RN	$ 62,400	0.29	1.59	4.09	6.33
PT	$ 85,280	0.26	1.46	3.75	5.80
OT	$ 85,280	0.08	0.45	1.16	1.80
ST	$ 76,960	0.03	0.18	0.46	0.71
MSW	$ 62,400	0.02	0.10	0.27	0.42
HH Aide	$ 33,280	0.04	0.21	0.54	0.84
TOTAL		**1.72**	**5.99**	**12.27**	**17.88**

ADMINISTRATIVE

Administrator	150,000	0.33	0.33	0.36	0.50
Office Manager	52,000	1.00	1.00	1.00	1.00
Team Assistant	37,440	-	1.00	1.00	1.00
Community Outreach	80,000	-	0.04	1.00	1.00
TOTAL	**0**	**1.33**	**2.37**	**3.36**	**3.50**

TOTAL FTE'S		**3.05**	**8.36**	**15.62**	**21.38**

18. Please describe how the project will cover the costs of operation until Medicare reimbursement is received. Provide documentation of sufficient reserves.

A majority of Eden Home Health of Clark County, LLC's patients will be Medicare enrollees. For home health services, Medicare pays 60% of the established rate at the beginning of service to each patient. For this reason, managing cash flow and covering costs of operation while waiting for Medicare reimbursement is not a substantial issue. The signed CFO letter of commitment is being submitted under separate cover to be included as Attachment M.

Section 5
Project Rationale

C. Structure and Process (Quality) of Care

1. Please provide the current and projected number of employees for the proposed project, using the following:

Eden Home Health of Clark County, LLC is not an existing provider of health services. Table 22 provides the projected FTEs for 2020 through 2023 (the third full year of agency operation). Apart from the Medical Director, all positions are presented as employee FTEs.

Table 22
Eden Home Health of Clark County, LLC Projected Number of Employees

STAFFING INPUT - BY FTE'S		2020	2021	2022	2023
OPERATIONS					
Physician (Medical Director)	contracted				
Director of Professional Services	$ 120,000	1.00	1.00	1.00	1.00
Clinical Supervisor	$ 90,000	-	1.00	1.00	1.00
RN	$ 62,400	0.29	1.59	4.09	6.33
PT	$ 85,280	0.26	1.46	3.75	5.80
OT	$ 85,280	0.08	0.45	1.16	1.80
ST	$ 76,960	0.03	0.18	0.46	0.71
MSW	$ 62,400	0.02	0.10	0.27	0.42
HH Aide	$ 33,280	0.04	0.21	0.54	0.84
TOTAL		**1.72**	**5.99**	**12.27**	**17.88**
ADMINISTRATIVE					
Administrator	150,000	0.33	0.33	0.36	0.50
Office Manager	52,000	1.00	1.00	1.00	1.00
Team Assistant	37,440	-	1.00	1.00	1.00
Community Outreach	80,000	-	0.04	1.00	1.00
TOTAL		**1.33**	**2.37**	**3.36**	**3.50**
TOTAL FTE'S		**3.05**	**8.36**	**15.62**	**21.38**

2. Please provide your staff to visit ratio.

The staff -to-visit ratios is detailed in Table 23 below.

Table 23
Staff to Visit Ratios by Year

	2020	2021	2022	2023
	FTES By Year			
RN	0.29	1.59	4.09	6.33
PT	0.26	1.46	3.75	5.80
OT	0.08	0.45	1.16	1.80
ST	0.03	0.18	0.46	0.71
MSW	0.02	0.10	0.27	0.42
HH Aide	0.04	0.21	0.54	0.84
	Visit Volume by Year			
Skilled Nursing	155	2,069	5,325	8,236
Physical Therapy	142	1,895	4,878	7,546
Occupational Therapy	44	587	1,512	2,338
Speech Pathology	14	185	476	736
Medical Social Service	6	82	210	325
Home Health Aide	21	274	706	1,092
	Visits by FTE Classification Ratio			
RN	542.5	1,302.0	1,302.0	1,302.0
PT	542.5	1,302.0	1,302.0	1,302.0
OT	542.5	1,302.0	1,302.0	1,302.0
ST	434.0	1,041.6	1,041.6	1,041.6
MSW	325.5	781.2	781.2	781.2
HHaide	542.5	1,302.0	1,302.0	1,302.0

3. Explain how this ratio compares with other national or state standards of care and existing providers for similar services in the proposed service area.

Eden Home Health of Clark County, LLC used its existing home health agency experience in Washington State and benchmarks its staffing ratios with other home health agencies on a regional and national basis using the Strategic Healthcare Partners, LLC analytics consulting firm.

4. **Identify and document the availability of sufficient numbers of qualified health manpower and management personnel. If the staff availability is a problem, describe the manner in which the problem will be addressed.**

As a large multi-state organization, EmpRes and Eden have employees and visibility and contacts across numerous job markets. Specific to Clark County, EmpRes operates a skilled nursing homes and a retirement facilities within Clark County as well as operating facilities throughout the Portland metropolitan area and Southwest Washington. In addition EmpRes and Eden maintain corporate offices within Clark County. Thus, Eden has a thorough knowledge of the service area Staff mobility between markets supports recruitment and retention efforts.

- As an employee-owned organization, EmpRes and Eden experience lower turn-over rates than many other health care providers.

- The EmpRes commitment to Employees/Residents reflected in the company name is also reflected in management efforts to prioritize employees and residents as core to any success.

5. **Please identify and provide copies of (if applicable) the in-service training plan for staff. (Components of the training plan should include continue education, home health aide training to meet Medicare criteria, etc.).**

Please see Attachment N.

6. **Describe your methods for assessing customer satisfaction and quality improvement.**

Eden Home Health of Clark County, LLC will contract with Pinnacle Quality Insight to provide Home Health CAHPS (Consumer Assessment of Healthcare Providers and Systems) for formal customer satisfaction surveys. Pinnacle Quality Insight is a CMS-approved vendor for formal customer satisfaction surveys. These satisfaction surveys follow the standard CMS guidelines and will provide benchmarking regarding Eden Home Health of Clark County, LLC's results as well as recommendations and areas on which to focus performance improvement projects.

Strategic Health Care, LLC is the vendor Eden Home Health of Clark County, LLC will for outcome-based quality improvement. SHP Strategic Health Partners analysis identifies detailed and overall trending with benchmark comparison. From this analysis, Eden Home Health of Clark County, LLC will be able to select target outcomes, review process of care, formulate action plans, identify best practices, and evaluates resulting changes for effectiveness.

Please see Attachment N for the Eden Home Health Organization Performance Improvement Plan.

7. **Identify your intended hours of operations. In addition, please explain how patients will have access to services outside the intended hours of operation.**

Eden Home Health of Clark County's office hours will be 8:30 a.m. to 5:00 p.m., Monday thru Friday (excluding major holidays).

Eden Home Health of Clark County's on-call service will take calls after hours. An on-call nurse will be available to respond to any calls after hours.

8. **Identify and document the relationship of ancillary and support services to proposed services, and the capability of ancillary and support services to meet the service demands of the proposed project.**

EmpRes operates Fort Vancouver Post Acute, a 92-bed Medicare skilled nursing home as well as facilities throughout the Portland metropolitan area and Southwest Washington. Eden Home Health of Clark County, LLC will build upon these existing relationships to meet the demands for ancillary and support services for the new agency.

Eden Home Health will utilize several vendors to support the home health agency which are included in Attachment P.

9. **Explain the specific means by which the proposed project will promote continuity in the provision of health care to the defined population and avoid unwarranted fragmentation of services. This section should include the identification of existing and proposed formal working relationships with hospitals, nursing homes, and other health service resources serving your primary service area. This description should include recent, current, and pending cooperative planning activities, shared services agreements, and transfer agreements. Copies of relevant agreements and other documents should be included.**

When entering a new market, Eden local team focuses on relationships with institutions that refer large numbers of their current patients to home health agencies. Especially with skilled nursing facilities under the same ownership, Eden staff is key to implementing the Transitions program that is an evidence-based, 30-day program offered to patients who meet certain criteria and is provided at no cost to the patient.

Participating patients are tracked for re-hospitalization for 60 days from the day of discharge. The goals of the Care Transitions program are to improve patient outcomes, reduce avoidable readmissions as well as reduce health care costs by training or "coaching" as well as encouraging patients to be more involved in their health care.

Eden Home Health partners with LG technologies for its tele-health/virtual care technology

platform. With this technology, Eden can obtain vitals for blood pressure, body weight and oxygen saturation are measured daily and monitored at the Eden Home Health office on working business days. Vitals that are outside physician specified parameters are reviewed by a nurse and a subsequent intervention such as a nursing visit and MD notification occurs. In other markets, Eden Home Health has been able to partner with local physicians for video visits to be completed in the patient's home.

10. **Fully describe any history of the applicant entity and principles in Washington with respect to criminal convictions, denial or revocation of license to operate a health care facility, revocation of license to practice a health profession, or decertification as a provider of services in the Medicare or Medicaid program. If there is such history, provide clear, cogent, and convincing evidence that the proposed project will be operated in a manner that ensures safe and adequate care to the public to be served and in conformance with applicable federal and state requirements.**

    a. **Have any of the applicants (see definition of applicant on page 4 of this application) been adjudged insolvent or bankrupt in any state or federal court?**

    No

    b. **Have any of the applicants been involved in a court proceeding to make judgment of insolvency or bankruptcy with respect to the applicant).**

    No

11. **List the licenses and/or credentials held by the applicant(s) and principals in Washington, as well as other states, if applicable. Include any applicable license numbers.**

Please see Attachment C for a list of all facilities, including NPI and provider numbers. Attachment E includes the regulatory agency contact list.

12. **Provide the background experience and qualifications of the applicant(s).**

The Eden Health family of agencies operates eight home health, agencies in five states including the following:

- EmpRes Home Health of Bellingham, LLC (Washington)
- Eden Home Health of King County, LLC (Washington)
- Quality Health Care Corporation (Nevada)
- Eden Home Health of Idaho Falls, LLC (Idaho)
- Eden Home Health of Sandpoint, LLC (Idaho)
- Eden Home Health of Elk Grove, LLC (California)
- Eden Home Health of Safford, LLC (Arizona)

- Eden Home Health of Sierra Vista, LLC (Arizona)

Each Eden Health agency employs competent and qualified staff, paired with organized and responsive management. Additionally, senior level leadership is provided by the agency's management company, EmpRes Healthcare Management, LLC, located in Vancouver Washington.

Each Eden home health agency has developed an excellent reputation within their respective communities and has built strong relationships with their referral sources and healthcare partners. Eden Home Health of Clark County, LLC d/b/a Eden Home Health ("Eden Home Health") will establish its agency office at its existing skilled nursing home facility location. Clark County is home to a skilled nursing facility and a retirement facility and has a number of additional facilities throughout Southwest Washington and the Portland metropolitan area. All these entities are affiliates under common ownership with Eden Home Health and which are also managed by EmpRes Healthcare Management, LLC.

The Eden Health family of agencies expanded its provision of home health services into two new locations in the last three years: Idaho Falls, Idaho in 2014 and Elk Grove, California in 2016 and is currently establishing its new agency in Seattle, Washington. In the short time that these agencies have been operating, they have successfully managed a steady increase in patients served. Each agency at present has over 90 patients on service.

- In April 2017, the Idaho Falls agency was awarded a Certificate of Accreditation from Accreditation Commission for Health Care (ACHC) after passing the accreditation survey.
- The Elk Grove agency passed their state survey with no deficiencies in December 2016.

13. For existing agencies, provide copies of the last three licensure surveys as appropriate evidence that services will be provided (a) in a manner that ensures safe and adequate care, and (b) in accordance with applicable federal and state laws, rules, and regulations.

Eden Home Health of Clark County is not an existing provider of health services. However, in consultation with the Program on August 30, 2019, it was determined that Eden Home Health of Clark County should present agency surveys in response to the following criterion: ". . . **Please provide only the <u>most recent</u> survey and applicable plan of correction for the healthcare entities in Attachment C owned or operated by EmpRes Healthcare Group, Inc."** Attachment W provides the required current survey information.

Section 6
Project Rationale

D. Cost Containment

1. Identify the exploration of alternatives to the project you have chosen to pursue, including postponing action, shared service arrangements, joint ventures, subcontracting, merger, contract services, and different methods of service provision, including different spatial configurations you have evaluated and rejected. Each alternative should be analyzed by the following:

a. Decision making criteria *(cost limits, availability, quality of care, legal restrictions, etc.);*
b. Advantages and disadvantages, and whether the sum of either the advantages or disadvantages outweighs each other by application of the decision-making criteria;
c. Capital costs;
d. Staffing impact.

The alternatives to the proposed project that Eden Home Health of Clark County considered include:

1. Postponing action
2. Purchasing an existing Clark County agency
3. Establishing a new agency

Eden Home Health of Clark County's decision-making criteria:

- Response to community need including synergy with Transitions program.
- Availability
- Quality of care

Alternative 1. Postpone Service Development: Eden Home Health has relied on existing healthcare providers for our patients and residents requiring home health services. This alternative is no longer in the best interests of our patients and residents. The need analysis using the 1987 methodology documents a substantial existing need for an additional 3 agencies which will increase to 5 agencies by 2022.

Our surveys of other skilled nursing home facilities and a review of CMS data did uncover systemic delays in placing patients which is consistent with the delay in initiation treatment as shown in Table 8.

Our research also indicated that home health agencies should play a more dominant role in addressing healthcare disparity so that health disparity measured by lifespan and disease burden can be controlled.

Finally, our review of the ongoing requirements of the DSHS LTSS aging initiative and the CMS – Washington State Medicare-Medicaid Financial Alignment Initiative demonstration project requires substantial increases in in-home resources including home health. Our home health agency solution is efficient in that capital costs and operating costs are minimized by being able to use a portion of our existing skilled nursing home as a separate home health agency office.

Summary: Overall, waiting and thereby postponing action was rejected as a reasonable alternative given the substantial evidence of additional agency need at this time. Eden Home Health of Clark County sees the immediate need to improve timeliness of response to institution referral requests and patient clinical requirements.

Eden Home Health therefore rejected the Alternative 1 – postponing service development.

Alternative 2: Purchasing an existing Clark County agency: Purchasing an existing agency would allow Eden Home Health of Clark County to more rapidly address identified community need. However even if an agency were available for purchase it would come at the added expense of not adding choice for residents within Clark County and it would not provide the clear need for additional agencies as identified in the home health agency quantitative analysis. With the growing concern regarding health disparity in life span and chronic illness, Clark County like other communities should add additional home resources because Washington State evidence-based conclusion document that adding home services such as home health markedly improves outcomes for all patients.

Summary: Eden Home Health rejected this alternative.

Alternative 3: Establishing a new home health agency in Clark County:

Establishing a new home health agency is consistent with the evidence-based need for 3 – 5 new agencies from 2020 through 2022. CMS data shows that current agencies are stressed with the delay in initiation of treatment running at higher levels than for the State as well as national levels for several agencies even though referrals from hospitals to home health are at levels 42% lower than the statewide average in 2017. Finally, the State Medicaid Demonstration project has documented that new, increased in-home services markedly improves patient outcomes and reduces costs. Eden has demonstrated that its innovative approaches are consistent with the findings in the demonstration project and improve outreach services.

Summary: Adding a new home health agency would provide further choices and would allow Eden's innovative approaches to tele-health and Care Transitions to be tested in the Clark service area to help reduce the current health disparity within the County. **Eden Home Health of Clark County, LLC selected this alternative.**

2. Describe how the proposal will comply with the Medicare conditions of participation, without exceeding the costs caps.

Eden Home Health of Clark County does not expect to become focus for Medicare home health services cost caps. These are more typically a concern in hospice. For home health, Eden Home Health has consistently reported cap related values substantially below the national trigger for such cost caps.

3. Describe the specific ways in which the project will promote staff or system efficiency or productivity.

Support systems from corporate offices in Vancouver WA

Eden has developed strong central support systems for administrative and clinical functions. Among those are infrastructure and systems located in Vancouver that do not have to be re-created in each local agency office. Eden's company-wide use of tele-health adds improved patient monitoring and tailoring of home health visits to each patient's current clinical needs. Those administrative support services provided by EmpRes Healthcare Vancouver Service Office are:

- Legal Services
- Payer Contracting
- Benefits Administration
- Human Resources
- Payroll Processing
- Finance/General Ledger/Accounting/Cash Reconciliation
- Accounts Payable
- Billing/Accounts Receivable
- Authorizations for all payers except traditional Medicare
- Technical Support/Services
- Electronic Health Record Support/Services
- Publications (marketing resources, policies and procedures, etc.)

Supporting timely access to care

The proposed development of a Medicare-certified home health agency in Clark County will increase the availability of Medicare home health services in the planning area. Home health services are a critical component of cost savings strategies for Clark County's acute and post-acute hospital and skilled nursing providers. When in-home services are not sufficiently available, inpatient providers have difficulty discharging patients on a timely basis. When a patient's condition allows discharge, it is not only wasteful of money but also of staff time to maintain the patient in the inpatient setting. Our survey work indicates that Clark County is already facing shortages. To address the health disparity issues that could lead to higher chronic illness burden in Clark County requires a significant increase in home health and other rehabilitation strategies to be successful.

Reducing re-hospitalization and ER visits

Furthermore, when a patient recovering from an illness or injury that requires acute care is discharged to the home setting, there is an increased risk of re-injury as the patient adjusts back to the home environment with compromised function. Sufficient in-home services and support can prevent this re-injury and reduce the risk of unnecessary re-admission to the acute setting and the resulting waste of medical care dollars. In addition, if a patient is discharged without adequate home health support in place, there is an increased risk of unnecessary emergency room visits and the additional morbidity and waste of financial resources that result.

Supporting the DSHS LTSS Aging Services Initiatives and the CMS – Washington State Medicare-Medicaid Financial Alignment Initiative Demonstration Project

This application has documented a significant shortage of home health resources in Clark County to support the 20-year effort of DSHS LTSS aging initiatives into the future to improve the health of aging senior citizens while managing rising healthcare costs. More importantly, Clark County represents a priority county for addressing the high-risk Medicare-Medicaid target population that is being served through the CMS – Washington State Medicare-Medicaid Financial Alignment Initiative.

Adding home health to the EmpRes post-acute network to work with Fort Vancouver Post Acute , Skilled Nursing Facility will give the community another strategy to improve on the triple aim goals. Eden Home Health, LLC fully expects this project to promote continuity in care delivery, support independent living and support the needs of home health patients and their families who now have difficulties in obtaining successful referrals for home health services. In addition, adding home health to our services promotes timely discharge for hospital patients. This reduces hospital readmissions and l length of stay, a key focus of health care reform initiatives.

4. **If applicable, in the case of construction, renovation, or expansion, capital cost reductions achieved by architectural planning and engineering methods and methods of building design and construction. Include an inventory of net and gross square feet for each service and estimated capital cost for each proposed service. Reference appropriate recognized space planning guidelines you have employed in your space allocation activities.**

    - There are no capital costs related to construction, renovation, or expansion.

5. **If applicable, in the case of construction, renovation or expansion, an analysis of the capital and operation costs of alternative methods of energy consumption, including the rationale for choosing any method other than the least costly. For energy-related projects, document any efforts to obtain a grant under the National Energy Conservation Act.**

This question is not applicable.

List of Attachments

Attachment A: Letter of Intent

Attachment B: Organizational Structure of EmpRes Healthcare Group

Attachment C: List of Facilities

Attachment D: Draft Medical Director Contract

Attachment E: List of Regulatory Agency Contacts

Attachment F: Single Line Drawing

Attachment G: Documentation of Site Control by Eden Home Health of Clark, County, LLC

Attachment H: MUA and HPSA Designations for Clark County

Attachment I: Clark County Home Health Provider List, September 2019

Attachment J: 1987 State Health Plan Methodology and Standards

Attachment K: Draft Admissions & Discharge Policy Documents & Charity Care Policy

Attachment L: Staffing, Capital Expenditure and Pro Forma

Attachment M: Letter of Financial Commitment (Under Separate Cover)

Attachment N: Training, Education and Quality Improvement Policies

Attachment O: Intentionally Left Blank

Attachment P: Vendor List

Attachment Q: Washington State Department of Health Chronic Disease Profile for each County

Attachment R: Demographics and Social Characteristics: Clark County 2017

Attachment S: 2019 Health Rankings Report, (RWJ and University of Wisconsin Collaboration)

Attachment T: 2019 Community Health Needs Assessment (Columbia Willamette Collaborative)

Attachment U: David Mancuso, PhD, DSHS Research and Data Analysis Division LTSS Studies

Attachment V: Area Agency on Aging & Disabilities of Southwest Washington 2016 – 2019 Area Plan

Attachment W: Nursing Home Survey Results

Attachment X: Licensing Surveys of EmpRes Owned Facilities Compiled May /2019

Eden Home Health of Spokane County, LLC Certificate of Need Application Proposing the Establishment of a Medicare/Medicaid Certified Home Health Agency in Clark County

ATTACHMENT A

Letter of Intent

EmpRes Healthcare Management, LLC
4601 NE 77th Avenue, Suite 300, Vancouver, WA • Ph. (360) 892-6628 • Fax (360) 882-5793

July 19, 2019

Janis Sigman, Manager
Certificate of Need Program
Washington State Department of Health
PO Box 47852
Olympia, Washington 98504-7852

Dear Ms. Sigman:

This letter is issued on behalf of Eden Home Health of Clark County, LLC to notify the Department of Health that Eden Home Health of Clark County, LLC, a subsidiary of EmpRes Healthcare Group, Inc., intends to seek Certificate of Need approval to establish a Medicare and Medicaid-certified home health agency in Clark County. This letter constitutes our letter of intent.

Upon receipt of a Certificate of Need, Eden Home Health of Clark County, LLC will, on referral by physicians, provide in-home Medicare and Medicaid nursing and rehabilitation services to homebound residents of Clark County.

Our current estimate of capital costs is $40,000.

Please provide us with all criteria and standards by which you will evaluate our application.

Thank you for your assistance in this application process.

Sincerely,

Mike Miller, Vice President & Chief Financial Officer
EmpRes Healthcare Management, LLC
4601 NE 77th Avenue #300
Vancouver, WA 98662

mpRes
'HCARE MANAGEMENT
NE 77th Avenue, Suite 300
uver, WA 98662

Janis Sigman, Manager
Certificate of Need Program
Washington State Department of Health
PO Box 47852
Olympia, WA 98504-7852

SENDER: *COMPLETE THIS SECTION*

- Complete items 1, 2, and 3.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:
Janis Sigman, Manager
Certificate of Need Program
Washington State Dept of Health
P.O. Box 47852
Olympia WA 98504-7852

9590 9402 4131 8092 0011 39

2. Article Number *(Transfer from service label)*
7019 0140 0000 8268 3454

PS Form 3811, July 2015 PSN 7530-02-000-9053 Domestic Return Receipt

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

B. Received by *(Printed Name)* C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☑ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

PLACE STICKER AT TOP OF ENVELOPE TO THE RIGHT OF THE RETURN ADDRESS, FOLD AT DOTTED LINE
CERTIFIED MAIL®

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7019 0140 0000 8268 3454

U.S. Postal Service™
CERTIFIED MAIL® RECEIPT
Domestic Mail Only

For delivery information, visit our website at *www.usps.com®*.

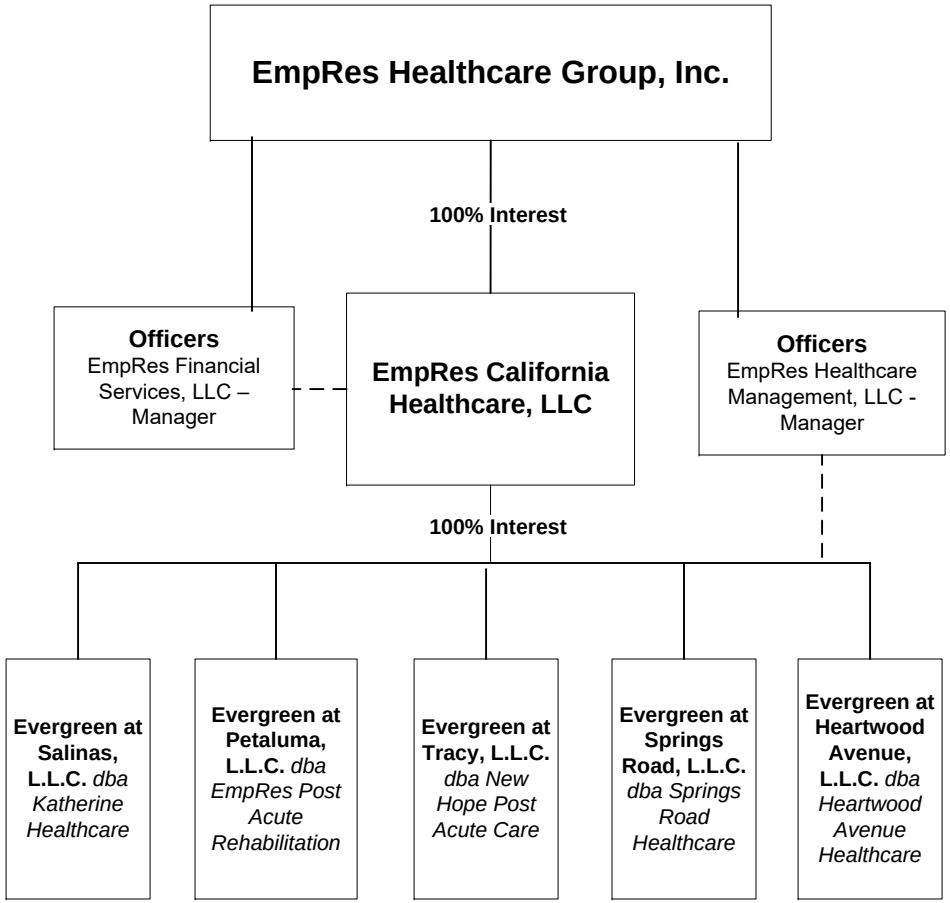
OFFICIAL USE

Certified Mail Fee
$
Extra Services & Fees *(check box, add fee as appropriate)*
☐ Return Receipt (hardcopy) $
☐ Return Receipt (electronic) $
☐ Certified Mail Restricted Delivery $
☐ Adult Signature Required $
☐ Adult Signature Restricted Delivery $
Postage
$
Total Postage and Fees
$
Postmark Here
Sent To Janis Sigman, Manager
Certificate of Need
Street and Apt. No., or PO Box No.
City, State, ZIP+4®
PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions

ATTACHMENT A

ATTACHMENT B

Organizational Structure of EmpRes Healthcare Group



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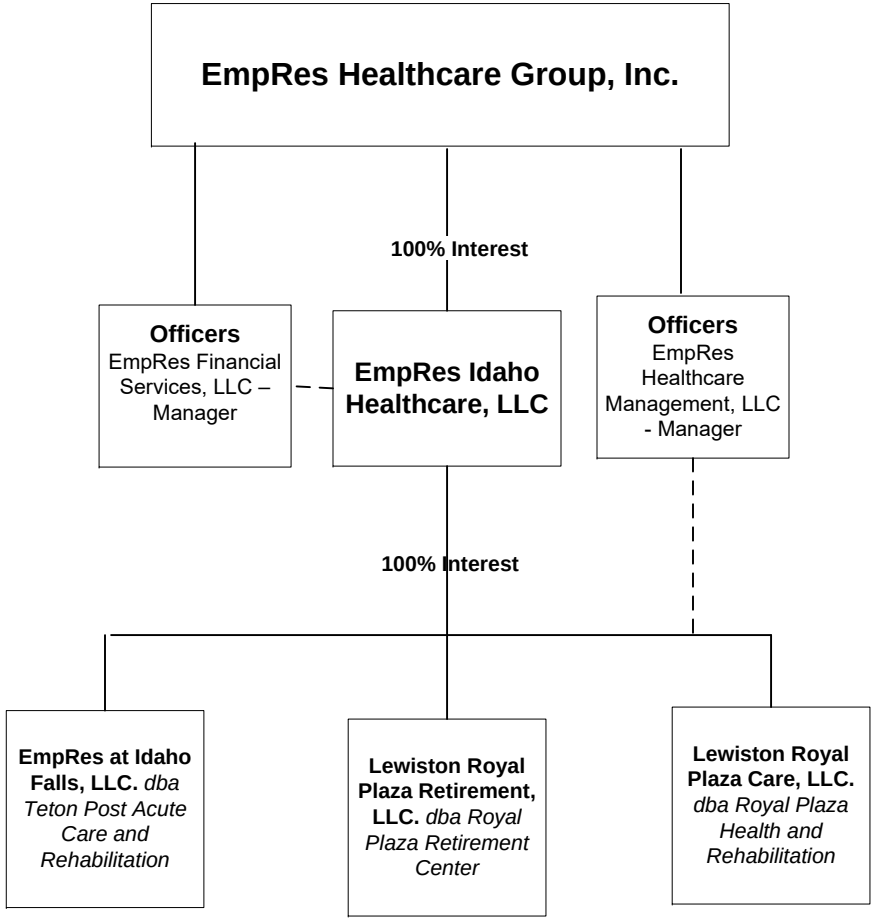

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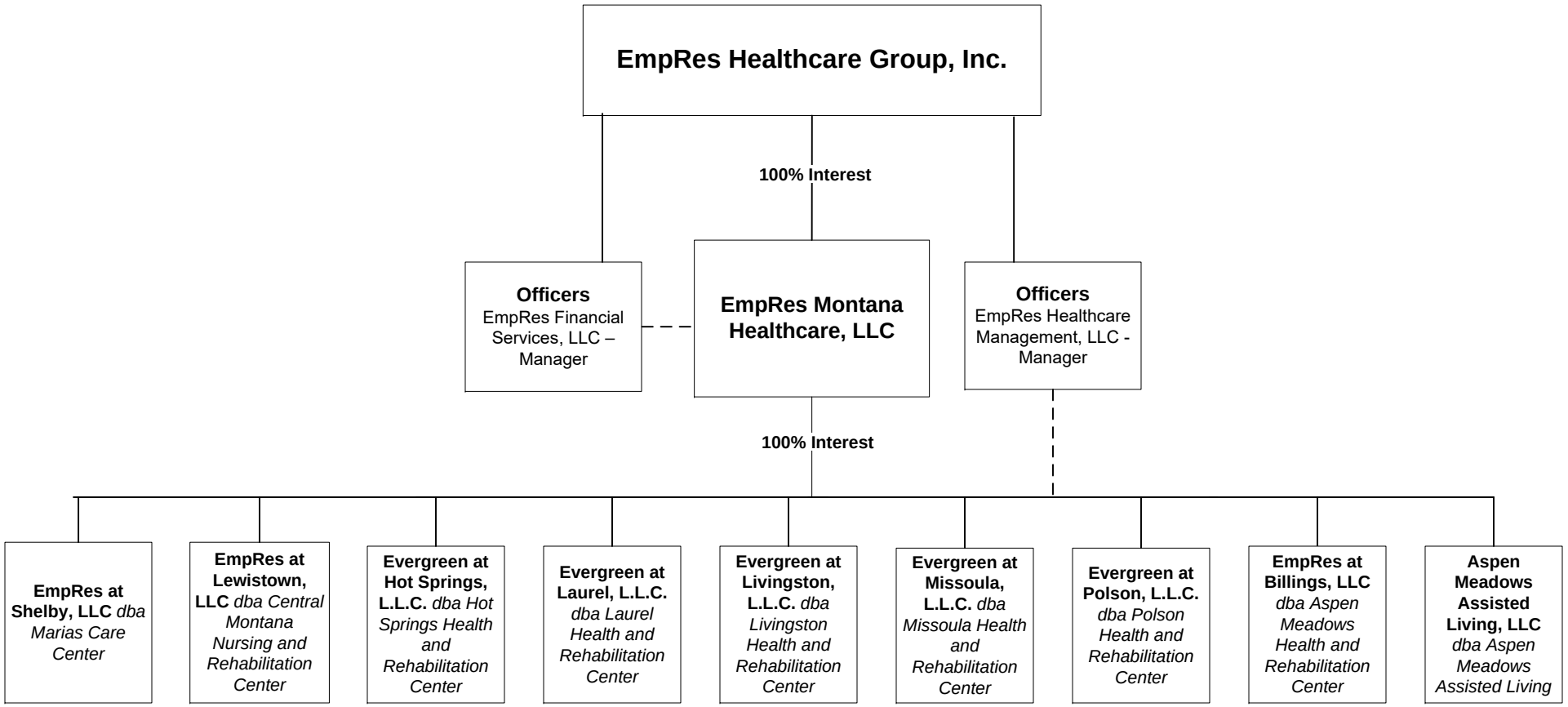

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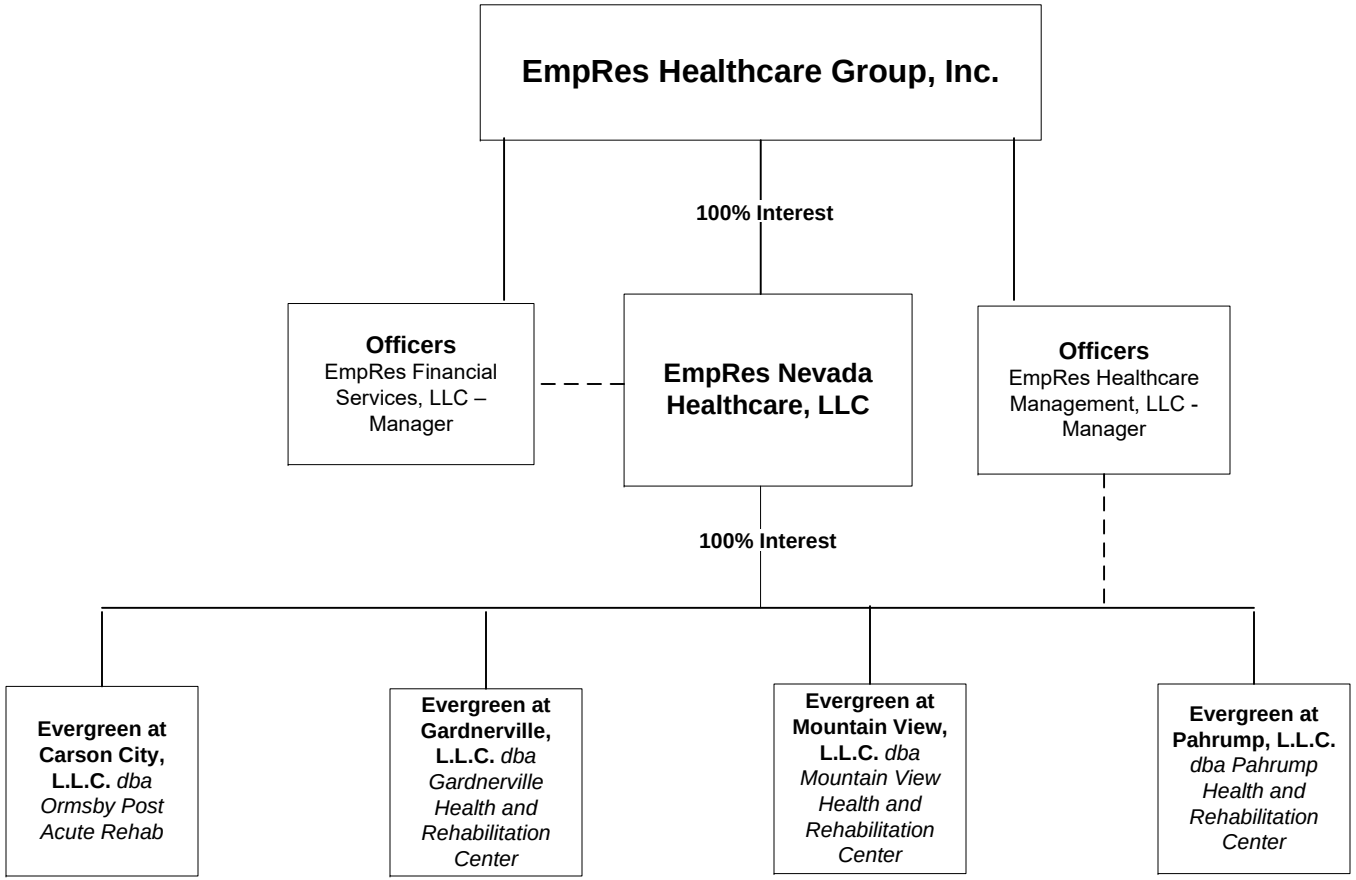

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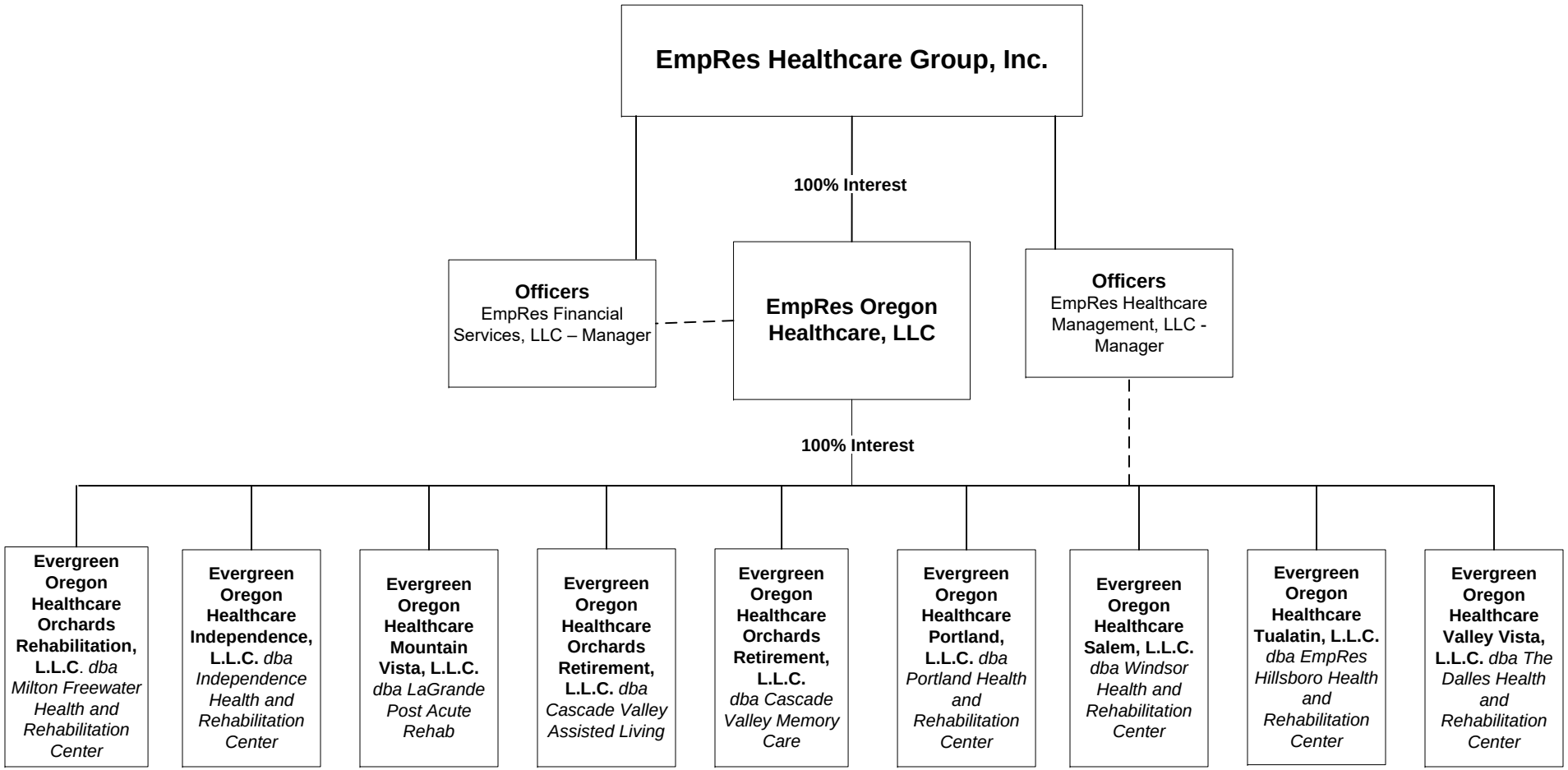

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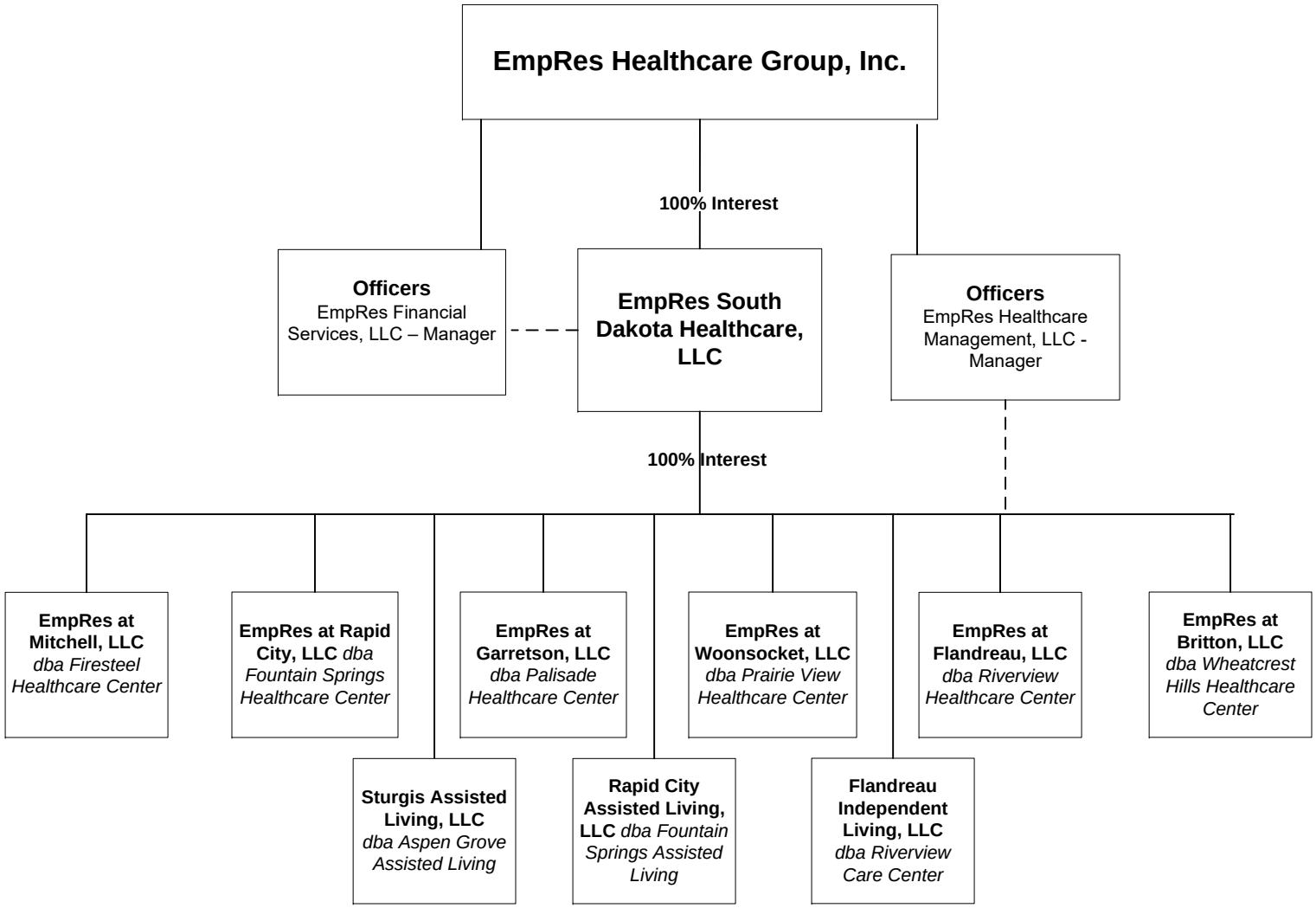

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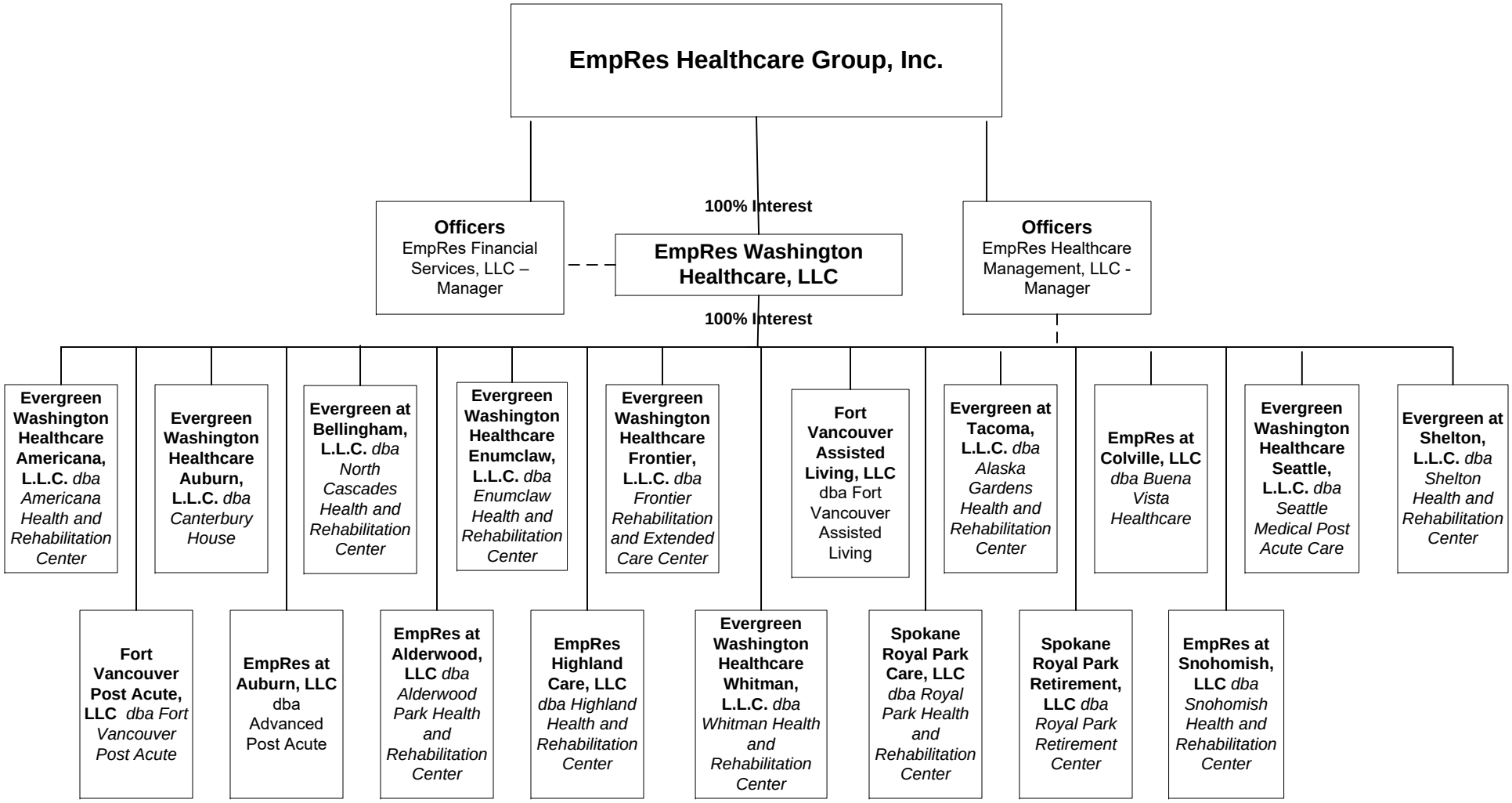

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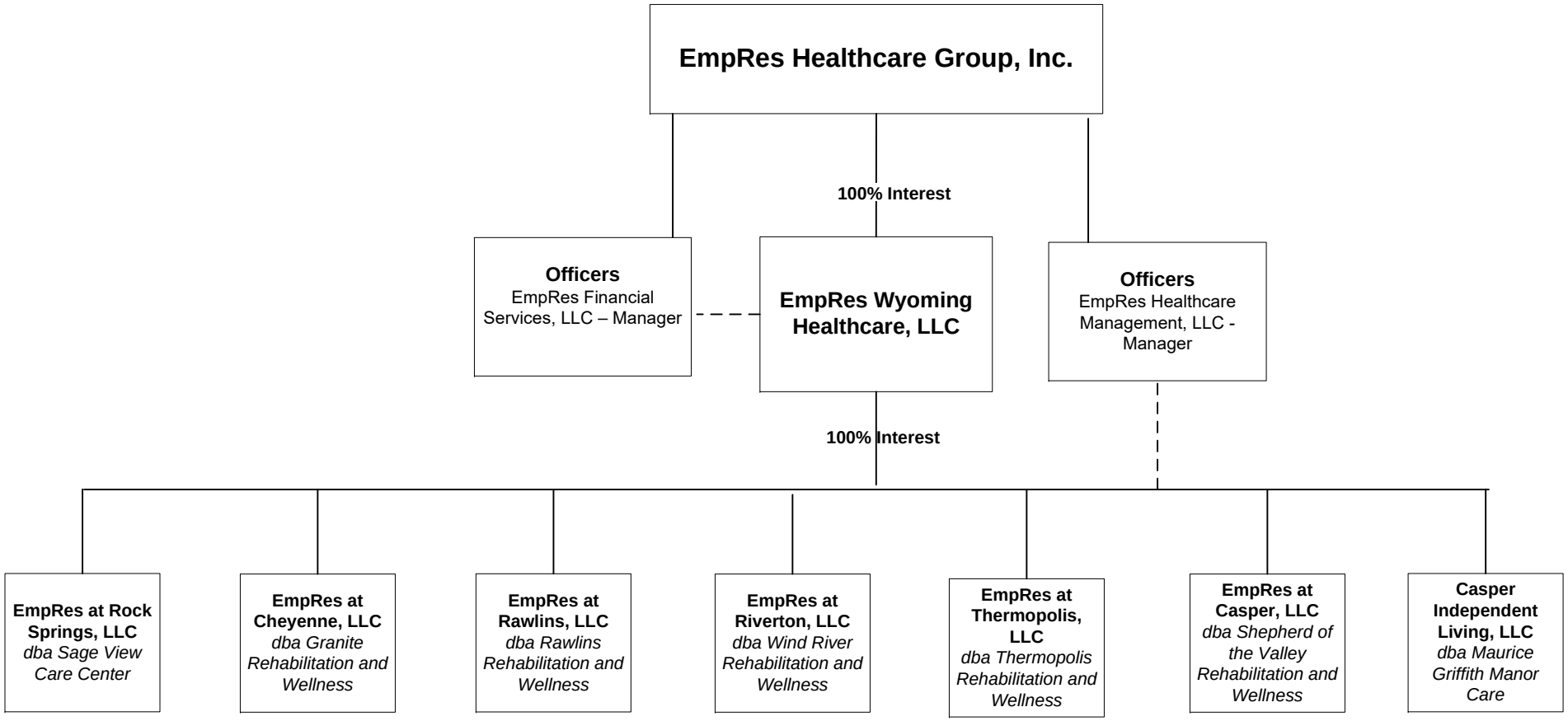

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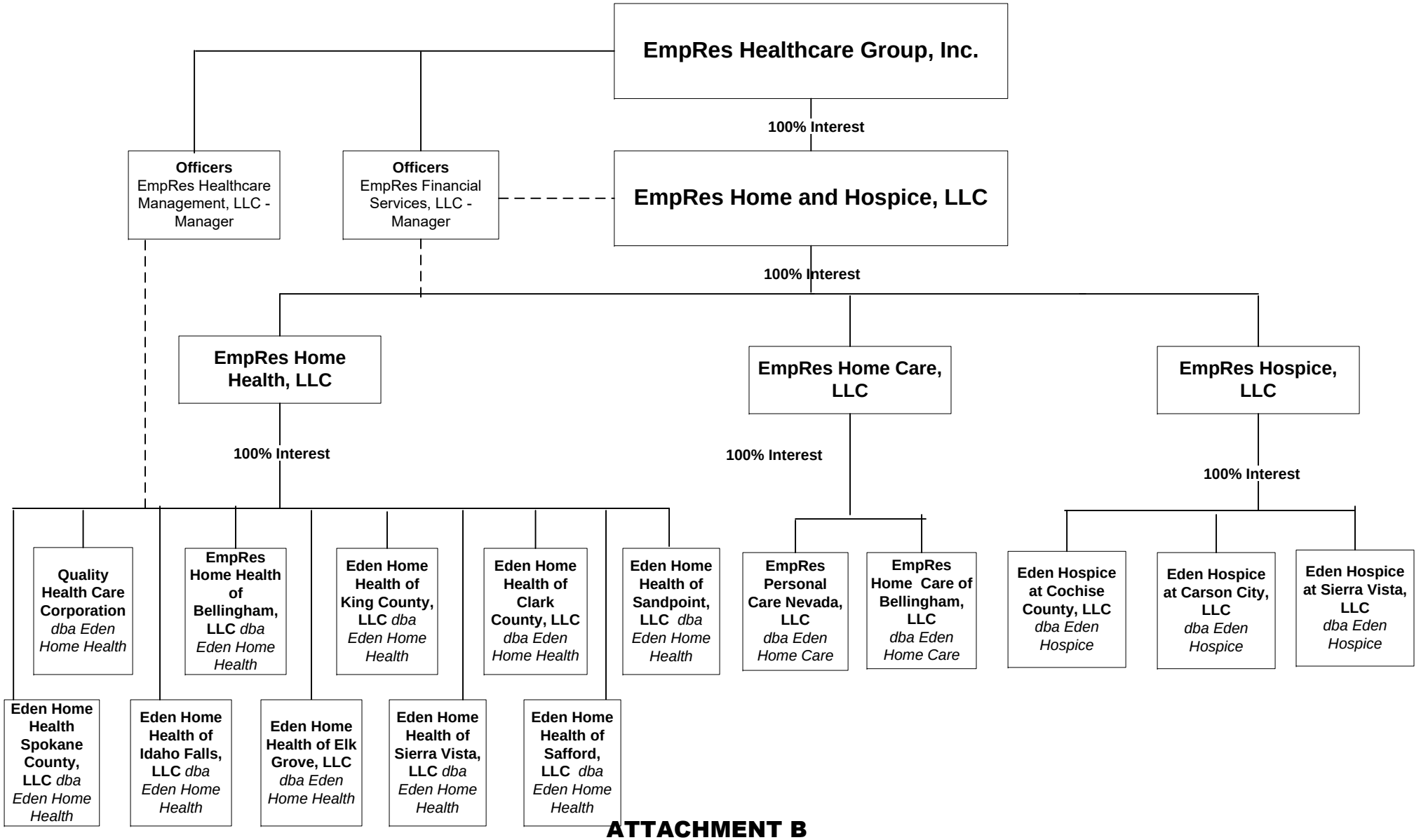


ATTACHMENT B

Eden Home Health of Spokane County, LLC Certificate of Need Application Proposing the Establishment of a Medicare/Medicaid Certified Home Health Agency in Clark County

ATTACHMENT C

Updated Facility List

Legal Name	DBA
OPERATING ENTITIES	
ARIZONA	
Eden Hospice at Sierra Vista, LLC	Eden Hospice
Eden Home Health of Sierra Vista, LLC	Eden Home Health
Eden Home Health of Safford, LLC	Eden Home Health of Safford
Eden Hospice at Cochise County, LLC	Eden Hospice in Chochise
CALIFORNIA	
Evergreen at Petaluma, L.L.C.	EmpRes Post Acute Rehabilitation
Evergreen at Salinas, L.L.C.	Katherine Healthcare
Evergreen at Tracy, L.L.C.	New Hope Post Acute Care
Evergreen at Heartwood Avenue, L.L.C.	Heartwood Avenue Healthcare
Evergreen at Springs Road, L.L.C.	Springs Road Healthcare
Eden Home Health of Elk Grove, LLC	Eden Home Health
IDAHO	
EmpRes at Idaho Falls, LLC	Teton Post Acute Care and Rehabilitation
Lewiston Royal Plaza Care, LLC	Royal Plaza Health and Rehabilitation
Lewiston Royal Plaza Retirement, LLC	Royal Plaza Retirement Center
Eden Home Health of Idaho Falls, LLC	Eden Home Health
Eden Home Health of Sandpoint, LLC	Eden Home Health
MONTANA	
Evergreen at Polson, L.L.C.	Polson Health and Rehabilitation Center

Legal Name	DBA
Evergreen at Hot Springs, L.L.C.	Hot Springs Health and Rehabilitation Center
Evergreen at Missoula, L.L.C.	Missoula Health and Rehabilitation Center
Evergreen at Laurel, L.L.C.	Laurel Health and Rehabilitation Center
Evergreen at Livingston, L.L.C.	Livingston Health and Rehabilitation Center
EmpRes at Lewistown, LLC	Central Montana Nursing & Rehabilitation Center
EmpRes at Shelby, LLC	Marias Care Center
EmpRes at Billings, LLC	Aspen Meadows Health and Rehabilitation Center
Aspen Meadows Assisted Living, LLC	Aspen Meadows Assisted Living
NEVADA	
Evergreen at Pahrump, L.L.C.	Pahrump Health and Rehabilitation Center
Evergreen at Carson City, L.L.C.	Ormsby Post Acute Rehab
Evergreen at Mountain View, L.L.C.	Mountain View Health and Rehabilitation Center
Evergreen at Gardnerville, L.L.C.	Gardnerville Health and Rehabilitation Center
EmpRes Personal Care Nevada, LLC	Eden Home Care
Quality Health Care Corporation	Eden Home Health
Eden Hospice at Carson City, LLC	Eden Hospice
OREGON	
Evergreen Oregon Healthcare Mountain Vista, L.L.C.	LaGrande Post Acute Rehab
Evergreen Oregon Healthcare Independence, L.L.C.	Independence Health and Rehabilitation Center
Evergreen Oregon Healthcare Tualatin, L.L.C.	EmpRes Hillsboro Health and Rehabilitation Center

Legal Name	DBA
Evergreen Oregon Healthcare Orchards Rehabilitation, L.L.C.	Milton Freewater Health and Rehabilitation Center
Evergreen Oregon Healthcare Orchards Retirement, L.L.C.	Cascade Valley Assisted Living and Memory Care Cascade Valley Assisted Living Cascade Valley Memory Care
Evergreen Oregon Healthcare Valley Vista, L.L.C.	The Dalles Health and Rehabilitation Center
Evergreen Oregon Healthcare Portland, L.L.C.	Portland Health and Rehabilitation Center
Evergreen Oregon Healthcare Salem, L.L.C.	Windsor Health and Rehabilitation Center
SOUTH DAKOTA	
EmpRes at Mitchell, LLC	Firesteel Healthcare Center
EmpRes at Rapid City, LLC	Fountain Springs Healthcare Center
Rapid City Assisted Living, LLC	Fountain Springs Assisted Living
Sturgis Assisted Living, LLC	Aspen Grove Assisted Living
EmpRes at Garretson, LLC	Palisade Healthcare Center
EmpRes at Woonsocket, LLC	Prairie View Healthcare Center
EmpRes at Flandreau, LLC	Riverview Healthcare Center
Flandreau Independent Living, LLC	Riverview Care Center
EmpRes at Britton, LLC	Wheatcrest Hills Healthcare Center
WASHINGTON	
Evergreen Washington Healthcare Frontier, L.L.C.	Frontier Rehabilitation and Extended Care
Evergreen Washington Healthcare Americana, L.L.C.	Americana Health and Rehabilitation Center
Evergreen Washington Healthcare Whitman, L.L.C.	Whitman Health and Rehabilitation Center
Evergreen Washington Healthcare Seattle, L.L.C.	Seattle Medical Post Acute Care
Evergreen Washington Healthcare Enumclaw, L.L.C.	Enumclaw Health and Rehabilitation Center
Evergreen Washington Healthcare Auburn, L.L.C.	Canterbury House

Legal Name	DBA
Evergreen at Shelton, L.L.C.	Shelton Health and Rehabilitation Center
Evergreen at Bellingham, L.L.C.	North Cascades Health and Rehabilitation Center
Evergreen at Tacoma, L.L.C.	Alaska Gardens Health and Rehabilitation Center
EmpRes at Alderwood, LLC	Alderwood Park Health and Rehabilitation
EmpRes Highland Care, LLC	Highland Health and Rehabilitation
EmpRes at Snohomish, LLC	Snohomish Health and Rehabilitation
Spokane Royal Park Care, LLC	Royal Park Health and Rehabilitation
Spokane Royal Park Retirement, LLC	Royal Park Retirement Center
EmpRes at Colville, LLC	Buena Vista Healthcare
Fort Vancouver Post Acute, LLC	Fort Vancouver Healthcare Fort Vancouver Post Acute
Fort Vancouver Assisted Living, LLC	Fort Vancouver Assisted Living
EmpRes at Auburn, LLC	Advanced Post Acute
EmpRes Home Health of Bellingham, LLC	Eden Home Health
EmpRes Home Care of Bellingham, LLC	Eden Home Care
Eden Home Health of King County, LLC	Eden Home Health
Eden Home Health of Clark County, LLC	Eden Home Health
Eden Home Health of Spokane County, LLC	Eden Home Health

Legal Name	DBA
WYOMING	
EmpRes at Rock Springs, LLC	Sage View Care Center
EmpRes at Cheyenne, LLC	Granite Rehabilitation and Wellness
EmpRes at Rawlins, LLC	Rawlins Rehabilitation and Wellness
EmpRes at Riverton, LLC	Wind River Rehabilitation and Wellness
EmpRes at Thermopolis, LLC	Thermopolis Rehabilitation and Wellness
EmpRes at Casper, LLC	Shepherd of the Valley Rehabilitation and Wellness
Casper Independent Living, LLC	Maurice Griffith Manor Care

ATTACHMENT D

Draft Medical Director Agreement

DIRECTORSHIP INDEPENDENT CONTRACTOR AGREEMENT

THIS DIRECTORSHIP INDEPENDENT CONTRACTOR AGREEMENT ("Agreement"), entered into effective as of the day of 20 ("Effective Date"), is by and between Eden Home Health of Clark County, LLC ("Agency"), and [LEGAL NAME OF PHYSICIAN OR PHYSICIAN'S PRACITICE]("Physician").

RECITALS:

A. Agency provides medical care and treatment to patients including the provision of home care services; and

B. Agency has determined that the retention of a physician to provide professional medical direction relating to home care services as the Medical Director of Agency is in the best interest of patients, the community, and Agency; and

C. Physician is duly licensed to practice medicine in the state where Agency operates and has expertise in the provision of home care services; and

D. Agency and Physician mutually desire to enter into this Agreement, which will facilitate the delivery of home care services in Agency through the provision of Physician's medical director services.

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which is acknowledged by the parties, the parties agree as provided above and as follows:

1. DEFINITIONS: For purposes of this Agreement, the following terms shall have the meanings ascribed thereto unless clearly required by the context in which such term is used.

1.1. Agency Policies. The term "Agency Policies" shall mean the established policies, practices, and procedures of the Agency, all adopted, approved, or amended by the Agency pursuant to normal procedure.

1.2. Medical Director Services. The term "Medical Director Services" shall mean those certain services listed in Section 2.3 herein.

1.3. Patients. The term "Patients" shall mean the patients of Agency.

1.4. Term. The term "Term" shall mean the contract period provided for under the Agreement.

2. **COVENANTS OF PHYSICIAN**

2.1. Appointment of Physician. Agency hereby appoints Physician as Medical Director of Agency, and Physician accepts such appointment, to provide administrative services for Agency in accordance with the terms of this Agreement and in accordance with 45 C.F.R. § 484.14(d).

2.2. Qualifications of Physician. Physician must at all times during the Term of this Agreement (i) hold a valid and unrestricted license to practice medicine in the state in which the Agency is located, and (ii) be fully capable and qualified, in accordance with good medical practice, to provide Medical Director Services as required by this Agreement.

2.3. Duties of Physician. Physician shall be available for consultation relating to the delivery of home care services ("Program") at the Agency and shall provide the following Medical Director

Services:

2.3.1. Quality Improvement. Physician will participate in the quality improvement/utilization review process, review and update protocols periodically and make recommendations to improve quality of Program services.

2.3.2. Education/Program Development. Physician agrees to be utilized to teach assessment skills to the Program clinical staff, develop new patient care protocols and assist/review development of staff and patient education materials.

2.3.3. Executive/Administrative Consultant. Physician will serve on the Program's Advisory Council in order to provide a medical perspective to administrative decision making and help articulate the mission, goals and policies of the Program. The functions of the Advisory Council are to establish and annually review the Program's policies governing the scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications and Program evaluation.

2.3.4. Community Liaison. The physician agrees to intervene in case of physician/Program problems and will advocate for home care to the physician community. Community Liaison duties do not include marketing Program to other physicians or referral sources.

2.3.5. Health Policy/Regulation. Physician agrees to provide medical input or interpretation of social, political, regulatory or economic factors that impact patient care or the Program and act as a physician spokesperson and resource in representing the Program position in dealing with regulatory or accrediting organizations.

2.3.6. Ethical Issues Consultant. Physician agrees to participate in the development of ethical policies and decisions and provide medical input on patient care issues of an ethical nature.

2.3.7. Planning. Participate in the planning and development activities for the Program.

2.3.8. Medical Records. Monitor the maintenance, retention and required confidentiality of records and information associated with patient care in the Program.

2.4. Miscellaneous Actives. In addition, Physician shall perform such other administrative duties as may from time to time be agreed to between Physician and the Agency. Physician shall perform the duties described in this Section in accordance with Agency Policies.

2.5. Financial Obligation. Physician shall not have the right or authority to, and hereby expressly covenants to, enter into a contract in the name of Agency, or otherwise bind Agency in any way to any financial obligation, without the express written consent of Agency. Physician shall hold Agency harmless from any loss attributable to a violation of this covenant.

2.6. Reports and Records. Physician shall prepare such reports relating to the provision of Medical Director Services as are reasonably requested by Agency. The ownership and right of control of all reports, and supporting documents submitted to or by Physician shall rest exclusively with Agency.

2.7. Confidentiality of Information. Physician agrees to keep confidential and not to use or to disclose to others either during the Term or during any other period of association with Agency extending beyond the Term and for a period of six (6) years thereafter, except as expressly consented to in writing by Agency, any secrets or proprietary information, patient lists,

marketing programs, or trade secrets of Agency (which shall be deemed to include all provisions of this Agreement), or any matter or thing ascertained by Physician through Physician's association with Agency, the use or disclosure of which matter or thing might reasonably be constructed to be contrary to the best interest of Agency. Physician further agrees that should this Agreement be terminated, Physician will neither take nor retain, without prior written authorization from Agency, any papers, policies, forms, patient lists, fee documentation, patient records, quality improvement materials, files or other documents or copies thereof or other confidential information of any kind belonging to Agency pertaining to patients or to Agency's business, sales, financial condition, or products. Physician will comply with all applicable privacy and security regulations as specified in Health Insurance Portability and Accountability Act of 1996 (HIPAA) and subsequent rules. Physician agrees to abide by all state and federal law relevant to the confidentiality of patient identifiable health information including but not limited to the HIPAA. Physician is not to share the protected information with any third party unless there is a stated need to share the information with an identified third party. Any such protected information is to be destroyed or returned to Agency according to Agency policy. Without limiting other possible remedies to Agency for the breach of this covenant, Physician agrees that injunctive or other equitable relief shall be available to enforce this covenant, such relief to be without the necessity of posting a bond, cash or otherwise. Physician further agrees that if any restriction contained in this Section is held by any court of competent jurisdiction to be unenforceable or unreasonable, a lesser restriction shall be enforced in its place and remaining restrictions contained herein shall be enforced independently of each other.

2.8. Exclusivity and Protection of Proprietary Information. Physician shall not provide similar Medical Director Services for any other Agency without the prior written consent of Agency. Further, Physician acknowledges that the manner of operating the Program is proprietary information of Agency, and Physician shall not disclose any such information without the prior written consent of Agency. Nothing herein shall prohibit Physician from engaging in the regular practice of medicine (inclusive of care plan oversight) and/or Physician's participation in clinical consultation services for non-competing business or industries, nor shall it obligate Physician to direct referrals of medical business to a particular provider.

2.9. Time Records. Physician shall record promptly and maintain all information that, in the judgment of Agency, is necessary or desirable in order for Agency to have time records documenting the Medical Director Services furnished by Physician hereunder. The form of such time records shall be determined, and may be from time to time amended, by Agency, and Physician agrees to consult with Agency from time to time regarding the form and content of such records. Physician agrees to submit such time records no later than the fifth (5^{th}) day of the month following the month in which the Medical Director Services are furnished.

3. COVENANTS OF AGENCY

3.1. Amount of Compensation. In consideration of the Medical Director Services rendered each month by Physician pursuant to this Agreement, Agency shall pay to Physician the amount of $150 per hour, rounded up to the nearest quarter hour. Physician agrees that such amount shall be Physician's sole compensation for Medical Director Services furnished pursuant to this Agreement. Physician's provision of professional medical services to patients, regardless of whether patient is also a patient of agency, and the compensation therefore, shall not be governed by this Agreement.

3.2. Payment of Compensation. Upon receipt, review and approval of the physician's invoice, Agency shall remit to Physician compensation amount set forth in Section 3.1 hereof in accordance with Agency's accounts payable cycle.

4. TERM AND TERMINATION OF AGREEMENT

4.1. Term. This Agreement shall be effective as of the Effective Date for a term of one (1) year therefrom; subject however, to Sections 4.2 through 4.5 hereof. This Agreement will be automatically renewed annually by the parties for additional one-year terms unless terminated pursuant to this Article 4. This Agreement will be reviewed annually by the Agency.

4.2. Immediate Termination for Cause by Agency. Agency may, as its option, terminate this Agreement immediately by written notice to Physician upon the occurrence of any of the following events: (i) Physician's failure to meet any of the qualifications set forth in Section 2.2; (ii) failure of the Physician to fulfill the duties set forth in Section 2.3, (iii) the death or disability of Physician; or (iv) failure of Physician to attend scheduled Professional Advisory Council meetings without at least a 2 hour notice.

4.3. Termination. At any time during the Term of this Agreement, either party may terminate this Agreement without cause upon the giving of thirty (30) days advance written notice to the other party.

4.4. Termination or Notice for Default. In the event that either party shall give written notice to the other that such other party has breached a material provision of this Agreement (other than those specified in Section 4.2 above), and such breach remains uncorrected for a period of ten (10) days after receipt of such written notice, the party giving such notice may, at its option, after the expiration of the aforesaid ten (10) day period, terminate this Agreement immediately.

4.5. Termination Due to Legislative or Administrative Changes. This Agreement is intended to comply with all relevant state and federal statutes and regulations relating to the delivery of Program services and to reimbursement of Program services under the Medicare, Medicaid, or other third-party payor programs and the federal statutes and regulations governing entities exempt from federal taxation. In the event that there shall be: (i) a change in the statutes, regulations, or instructions relating to the Medicare, Medicaid or other third-party payor programs, or the exemption of entities from federal taxation, including a change in the interpretation or enforcement thereof by government agencies; (ii) the adoption of any new legislation or regulations applicable to this Agreement; or (iii) the initiation of an enforcement action by a governmental entity with respect to legislation, regulations, or instructions applicable to this Agreement any of which affects the continuing viability or legality of this Agreement, then both parties agree to negotiate in good faith to amend the Agreement to conform with the existing laws or regulations. If agreement cannot be reached with respect to such amendments within thirty (30) days after the effective date of such change, adoption, enforcement, or notice (or such earlier time as may be required by such legislation or regulations), then either party may terminate this Agreement by written notice to the other party. Physician agrees to reimburse Agency for any payment that is determined by a court or government agency to be illegal.

5. MISCELLANEOUS

5.1. Status of Physician. It is expressly acknowledged by the parties hereto that Physician, in performing Physician's duties and obligations under this Agreement, is an "independent contractor" and nothing in this Agreement is intended nor shall be construed to create an employer/employee relationship, a joint venture relationship, or to allow Agency to exercise control or direction over the manner or method by which Physician performs the services which are the subject matter of this Agreement; provided, always, that the services to be furnished hereunder by Physician shall be provided in a manner consistent with Program Policies, the standard governing such services, and the provisions of this Agreement. Physician understands and agrees that, unless otherwise required under applicable federal income tax

laws or the term of any agreement between Agency and the Internal Revenue Service, (i) Physician will not be treated as an employee for federal tax purposes; (ii) Agency will not withhold on behalf of Physician pursuant to this Agreement any sums for income tax, unemployment insurance, social security, retirement benefits, or any other withholding pursuant to any law or requirement of any governmental body relating to Physician, or make available to Physician any of the benefits afforded to employees of Agency; (iii) all of such payments, withholdings, and benefits, if any, are the sole responsibility of Physician; and (iv) Physician will indemnify and hold harmless Agency from any and all loss or liability arising with respect to such payments, withholding, or benefits, if any.

5.2. Applicable Standards. Physician shall, as a condition precedent to Agency's obligations under this Agreement and the provision of services by Physician hereunder, provide the Medical Director Services in such a manner as may be required by any standard, ruling, or regulation of the State, the U.S. Department of Health and Human Services or any other applicable federal, state, or local governmental agency, corporate entity, or such other entity exercising authority with respect to Agency. Physician shall perform the Medical Director Services in conformance with all requirements of the state and federal constitutions and all applicable state and federal statutes and regulations.

5.3. Access to Records. If this Agreement has a value or cost to Agency of $10,000 or more over any twelve-month period, Physician shall perform the obligations as may be from time to time specified for subcontractors in Social Security Act 1861(v)(1)(I) and the regulations promulgated in implementation thereof (currently codified at 42 C.F.R. 420.300.304), including, but not limited to, retention and delivery of records related to this Agreement. In the event any request for this Agreement, or Physician's books, documents, and records is made pursuant to Social Security Act 1861(v)(1)(I) and associated regulations, Physician shall promptly give notice of such request to Agency and provide Agency with a copy of such request and thereafter, consult and cooperate with Agency concerning the proper response to such request. Additionally, Physician shall provide Agency with a copy of each book, document, and record made available to one or more persons and agencies pursuant to Social Security Act 1861(v)(1)(I) or shall identify each such book, document, and record to Agency and shall grant Agency access thereto for review and copying.

5.4. Representations and Warranties Regarding Compensation. Each party represents and warrants on behalf of itself, that all decisions regarding the medical care of patients shall be based solely upon the professional medical judgement of the patients' attending physicians and shall be made in the best interests of patients, that the aggregate benefit given or received under this Agreement, whether in cash or in kind, has been determined in advance through a process of arms-length negotiations that were intended to achieve an exchange of goods and/or services consistent with fair market value in the circumstances, and that any benefit given or received under this Agreement is not intended to induce, does not require, and is not contingent upon, the admission, recommendation or referral of any patient, directly or indirectly, to Agency or Physician. Further, Physician and Agency understand and agree that, while Physician may also serve as an attending physician to patients of the Agency, Physician's roles and functions as a Medical Director under this Agreement are separate from Physician's roles and functions as an attending physician, which involves primary responsibility for the medical care of individual patients.

5.5. Notices. All notices, requests, demands, or other communications hereunder shall be in writing and shall be deemed to have been given or delivered if either personally delivered or mailed by registered mail, return receipt requested, postage prepaid

5.6. Assignment. Physician may not assign or transfer any of Physician's rights, duties, or obligations under this Agreement, in whole or in part, without the prior written consent of

Agency.

5.7. No Waiver. The failure of either party to insist at any time upon the strict observance or performance of any provision of this Agreement or to exercise any right or remedy as provided in this Agreement shall not impair any right or remedy of such party or be construed as a waiver or relinquishment thereof with respect to subsequent defaults or breaches. Every right and remedy given by this Agreement to the parties hereto may be exercised from time to time and as often as may be deemed expedient by the appropriate party.

5.8. Additional Assurances. The provisions of this Agreement shall be self-operative and shall not require further agreement by the parties, except as may be herein specifically provided to the contrary; provided, however, Physician and Agency each shall promptly and duly execute and deliver to the other such additional documents and assurances and take any and all other actions as either party may reasonably request in order to carry out the intent and purpose of this Agreement during the Term hereof.

5.9. Governing Law. This Agreement has been executed and delivered in, and shall be interpreted, construed, and enforced pursuant to and in accordance with the laws of the State of Washington. If any suit or action is filed by any party to enforce or interpret this Agreement, venue shall be in the federal or state courts of Multnomah County, Oregon or Clark County, Washington.

5.10. Master List. Pursuant to 42 CFR 411.357(d)(1)(ii) a master list of contracts which reflects all arrangements and/or agreements between Agency and Physician or Physician's immediate family members, to the extent any such arrangements or agreements exists, is provided by Physician to Agency and maintained by Agency.

5.11. Compliance Certification. Physician acknowledges Agency's Corporate Compliance Program and receipt of AGENCY's Code of Conduct. Physician represents and warrants that each of its employees who provide patient care to Federal health care program beneficiaries at Agency shall read and review Agency's Code of Conduct prior to commencement of services under this Agreement. Physician agrees to obtain and retain a signed certification from its employees providing services under this Agreement that they have received, read and understand Agency's Code of Conduct and agree to abide by the requirements of Agency's Corporate Compliance Program. Such certification shall be obtained prior to commencement of services under this Agreement, shall be maintained by Physician and shall be made available for review by Agency or Agency's agents upon reasonable request.

5.12. Enforcement. In the event Agency resorts to legal action to enforce the terms and provisions of this Agreement, Agency shall be entitled to recover the costs of such action so incurred, including without limitation, reasonable attorney's fees.

5.13. Warranty of Authority. Agency represents and warrants to Physician that it has the full power and authority to enter into this Agreement, that all required corporate action has been duly taken in connection herewith, and that upon execution of this Agreement by Agency, this Agreement shall become a binding obligation of Agency, enforceable against Agency in accordance with its terms and applicable law. Physician represents and warrants to Agency that Physician has the full power and authority to enter into this Agreement, that Physician has no other contract or agreement that conflicts with this Agreement and that this Agreement shall become a binding obligation of Physician, enforceable against Physician in accordance with its terms and applicable law.

5.14. Severability. If any term, covenant, or condition of this Agreement, or the application thereof to any person or circumstance, shall be invalid or unenforceable, the remainder of this

Agreement, and the application of any term or provision to persons or circumstances other than those as to which it is held invalid or unenforceable, shall not be affected thereby, and all other terms shall be valid and enforceable to the fullest extent permitted by the law.

5.15. Entire Agreement: Amendments. This Agreement sets forth all of the representations, promises, agreements, conditions, and understandings between the parties relating to the subject matter of this Agreement, and supersedes any prior or contemporaneous representations, promises, agreements, conditions, and understandings between the parties in any manner relating to the subject matter hereof. This Agreement may be amended but only by a written agreement signed by both parties, such amendment(s) to become effective on the date stipulated in such amendment(s).

5.16. Counterparts. This Agreement may be executed in counterparts, and via facsimile or electronically transmitted signature (i.e. emailed scanned true and correct copy of the signed Agreement), each of which will be considered an original and all of which together will constitute one and the same agreement. At the request of a party, the other party will confirm facsimile or electronically transmitted signature page by delivering an original signature page to the requesting party.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date above first written.

[SIGNATURE PAGE FOLLOWS ON NEXT PAGE]

AGENCY	PROVIDER
by its Manager, EmpRes Healthcare Management, LLC,	
By: _____	By: _____
Name: Michael Miller	Name: _____
Title: CFO	Title: _____
Date: _____	Date: _____
	UPIN #: _____

REQUIRED DOCUMENTS FOR CONTRACT COMPLETION
Copy of Liability/Malpractice Insurance - $1M / $3M Liability Limits
Office Address and Phone Number
Copy of Current State of Practice License; Business Card
Copy of applicable Business Licenses
PROVIDER-signed Business Associate Agreement

Business Associate Agreement

This **BUSINESS ASSOCIATE AGREEMENT** ("Agreement") between Eden Home Health of Clark County ,LLC ("Covered Entity") and [FULL LEGAL NAME OF PHYSICIAN OR PHYSICIAN'S PRACTICE] ("Business Associate") is effective upon signature and retroactive to the date that Business Associate first provided services.

For purposes of complying with the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations promulgated thereunder (collectively, "HIPAA") and the requirements of Subtitle D of the Health Information Technology for Economic and Clinical Health Act and the regulations promulgated thereunder (collectively "HITECH"), if and only to the extent that Business Associate is acting as a business associate (as defined by HIPAA) of Covered Entity, the parties agree as follows:

Recitals

A. Covered Entity(further defined below) wish to disclose certain information to Business Associate (further defined below) pursuant an agreement for the provision of products and/or services.

B. It is the intention of the Covered Entity and Business Associate herein to protect the privacy and provide for the security of PHI disclosed to the BUSINESS ASSOCIATE in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information and Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act").

C. As part of the HIPAA Regulations, the Privacy Rule and Security Rule (defined below) an Agreement containing specific requirements relating to the disclosure of PHI, as set forth in, but not limited to, Title 45, Sections 164.14(a), 164.502(e), and 164.504(e) of the Code of Federal Regulations ("CFR") is contained in this Agreement.

Definitions.

1. Capitalized terms used, but not otherwise defined in this Agreement, shall have the same meaning as those terms in the HIPAA regulations and HITECH, and the following capitalized terms shall be given the following meanings:

1.1 "**Breach**" means the acquisition, access, use, or disclosure of protected health information in a manner not permitted under the Privacy Rule, which compromises the security or privacy of the protected information.

1.2 "**Business Associate**" shall have the meaning given to such term under the Privacy Rule, the Security Rule, and the HITECH Act, including, but not limited to, 42 U.S.C. Section 17938 and 45 C.F.R. Section 160.103.

1.3 "**Compliance Date**" means, in each case, the date by which compliance is required under the referenced provision of HITECH.

1.4 "**Covered Entity**" shall have the meaning given to such term under the Privacy Rule and the Security Rule, including, but not limited to, 45 C.F.R. Section 160.103.

1.5 "**Designated Record Set**" shall have the meaning given to such term under the Privacy Rule and the Security Rule, Including, but not limited to, 45 C.F.R. Section 160.103.

1.6 "**Disclose**" and "**Disclosure**" mean, with respect to Protected Health Information, the release, transfer, provision of access to, or divulging in any other manner of Protected Health Information outside Business Associate's internal operations or to individuals other than its employees as well as to disclosures of Protected Health Information outside of Business Associate's operations to third parties which are required by applicable law (e.g. law enforcement, Health and Human Services, subcontractors, etc.).

1.7 "**Electronic Protected Health Information**" means Protected Health Information that is maintained in or transmitted by electronic media.

1.8 "**Electronic Health Record**" shall have the meaning given to such term in the HITECH Act, including, but not limited to, 42 U.S.C. Section 17921.

1.9 "**Health Care Operations**" shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

1.10 "**HITECH**" means the Health Information Technology for Economic and Clinical Health Act, enacted as part of the American Recovery and Reinvestment Act of 2009, Pub. Law No. 111-5, and any regulations promulgated thereunder. References in this Agreement to a section or subsection of title 42 of the United States Code are references to provisions of HITECH. Any reference to provisions of HITECH in this Agreement shall be deemed a reference to that provision and its existing and future implementing regulations, when and as each is effective.

1.12 "**Minimum Necessary Standard**" means to engage reasonable efforts to limit the use of PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request and shall otherwise have the meaning given to such term under the Privacy Rule and the Security Rule, including, but not limited to, 45 C.F.R. Sections 164.502(b) and 164.514(d).

1.13 "**Privacy Rule**" means the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Part 160 and Part 164, Subparts A and E.

1.14 "**Protected Health Information**" or "PHI" means any information, whether oral or recorded in any form or medium, that (a) relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual; (b) that identifies the individual (or for which there is reasonable basis for believing that the information can be used to identify the individual); and (c) is received by Business Associate from or on behalf of Covered Entity, or is created by Business Associate for Covered Entity, or is made accessible to Business Associate by Covered Entity, and shall have the meaning given to the term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501. Protected Health Information includes Electronic Protected Health Information [45 C.F.R. Sections 160.103, 164.501].

1.15 "**Protected Information**" shall mean PHI provided by the COVERED ENTITY to BUSINESS ASSOCIATE or created or received by BUSINESS ASSOCIATE on behalf of any COVERED ENTITY.

1.16 "**Security Rule**" means the Security Standards for the Protection of Electronic Protected Health Information that is codified at 45 C.F.R. Parts 160 and 164, subparts A and C.

1.17 "**Unsecured Protected Health Information**" or "**Unsecured PHI**" means Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary in the guidance issued pursuant to the HITECH ACT including, but not limited to, 42 U.S.C. Section 17932(h).

1.18 "**Use**" or "**Uses**" mean, with respect to Protected Health Information, the sharing, employment, application, utilization, examination or analysis of such Protected Health Information within Business Associate's internal operations.

2. **Confidentiality Obligation**. Business Associate will not Use or Disclose PHI other than as permitted by this Agreement or as otherwise Authorized by Law.

3. **Permitted Uses and Disclosures of PHI**. Business Associate shall Use or Disclose PHI only as necessary to perform services under the Agreement or as otherwise Required by Law, including but not limited to such Use or Disclosure as is necessitated by the services provided to Covered Entity. Such Use or Disclosure may occur only under circumstances that would not: (i) violate the Privacy Rule, Security Rule, other applicable provisions of HIPAA or HITECH if done by Covered Entity; or (ii) violate the minimum necessary standard.

4. **Safeguards**. Business Associate shall protect PHI from any improper oral, written, or electronic disclosure by enacting and enforcing safeguards to maintain the security of and to prevent any Use or Disclosure of PHI other than is permitted by law. Such safeguards shall include administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any electronic PHI that it creates, receives, maintains, or transmits on behalf of Covered Entity. Business Associate shall comply with the Security rule requirements set forth at 45 C.F.R. Section 164.308, 164.310, 164.312, and 164.316, as well as additional requirements established by HITECH that relate to security and are applicable to Covered Entity. Business Associate shall also comply with the requirements of Subtitle D of HITECH that relate to privacy and are applicable to Business Associates in performing services on behalf of Covered Entity.

5. **Access and Amendment**. Upon the request of Covered Entity, Business Associate shall: (1) make the PHI specified by Covered Entity available to Covered Entity or to the Individual(s) identified by Covered Entity as being entitled to access in order to meet the requirements under 45 C.F.R. Section 164.524; and (b) make PHI available to Covered Entity for the purpose of amendment and incorporate changes or amendments to PHI when notified to do so by Covered Entity.

6. **Accounting**. Upon Covered Entity's request, Business Associate shall provide to Covered Entity or, when directed in writing by Covered Entity, directly to an Individual in a time and manner specified by Covered Entity, an accounting of each Disclosure of PHI made by Business Associate or its employees, agents, representatives or subcontractors as would be necessary to permit Covered Entity to respond to a request by an Individual for an accounting of Disclosures of PHI in accordance with 45 C.F.R. Section 164.528. Any accounting provided by Business Associate under this subsection shall include: (a) the date of the Disclosure: (b) the name, and address if known, of the entity or person who received the PHI; (c) a brief description of PHI disclosed; and (d) a brief statement of the purpose of the Disclosure. For each Disclosure that could require an accounting under this subsection, Business Associate shall document the information specified in (a) through (d), above, and shall securely retain this documentation for six (6) years from the date of the Disclosure.

7. **Access to Books and Records**. Business Associate shall make its internal practices, books and records relating to the Use and Disclosure of PHI pursuant to this Agreement available to the Secretary of the Department of Health and Human Services for purposes of determining Covered Entity's compliance with HIPAA. Covered Entity shall have the right to access and examine ("Audit") the books, records, and other information of Business Associate related to this Agreement. Such Audit rights shall be in addition to and notwithstanding any audit provisions set forth in the Agreement. Business Associate shall cooperate fully with any such Audit(s) and shall provide all books, records, data and other documentation reasonably requested by Covered Entity. Covered Entity may make copies of such documentation. To the extent possible, Covered Entity will provide Business Associate

reasonable notice of the need for an Audit and will conduct the Audit at a reasonable time and place. Notwithstanding the foregoing, Covered Entity will not have access to any books, records, data and/or documentation related to any of the Business Associate's other clients.

8. **Agents and Subcontractors**. Business Associate shall require all subcontractors and agents to which it provides PHI received from, or created or received on behalf of Covered Entity, to agree to all of the same restrictions and conditions concerning such PHI to which Business Associate is bound in this Agreement.

9. **Reporting of Violations**. Business Associate shall report to Covered Entity any Use or Disclosure of PHI not authorized by this Agreement immediately upon becoming aware of it. This reporting obligation includes, without limitation, the obligation to report any Security Incident, as that term is defined in 45 C.F.R. Section 164.304.

9.1 **Breach Notification**. Business Associate also shall notify Covered Entity of any Breach of Unsecured PHI. Such notification shall occur without unreasonable delay and in no case later than fifteen (15) calendar days after Business Associate discovers the Breach in accordance with 45 C.F.R. Section 164.410. The notification shall comply with the Breach notification requirements set forth at 42 U.S.C. Section 17832 and its implementing regulations at 45 C.F.R. Section 164.410 and shall include: (a) to the extent possible, the identification of each person whose Unsecured PHI has been, or is reasonably believed by Business Associate to have been, accessed, acquired, or Disclosed during such Breach; and (b) any other available information about the Breach, including: (i) a description of what happened, including the dates of the Breach and discovery of the Breach, if known; (ii) a description of the types of Unsecured PHI involved in the Breach; (iii) any steps affected persons should take to protect themselves from potential harm resulting from the Breach; and (iv) the steps Business Associate is taking to investigate the Breach, mitigate harm to individuals, and to protect against any further Breaches. Business Associate shall provide Covered Entity with such additional information about the Breach either at the time of its initial notification to Covered Entity or as promptly thereafter as the information becomes available to Business Associate.

10. **Term and Termination**.

10.1 This Agreement remains in effect during the performance of services by Business Associate for or on behalf of the Covered Entity and to the extent that Business Associate maintains PHI in any form unless otherwise terminated.

10.2 In addition to and notwithstanding the termination provisions set forth herein, the Agreement may be terminated by Covered Entity in the event that Covered Entity determines Business Associate has violated a material term of this Agreement and such violation has not been remedied within fifteen (15) days following written notice to Business Associate.

10.3. Except as provided below, upon termination of this Agreement, Business Associate shall either return or destroy all PHI in the possession or control of Business Associate or its agents and subcontractors and shall retain no copies of such PHI. However, if Covered Entity determines that neither return nor destructions of PHI is feasible, Business Associate may retain PHI provided that it extends the protections of this Agreement to the PHI and limits further Uses and Disclosures to those purposes that make the return or destruction of the PHI infeasible, for so long as Business Associate maintains such PHI.

11. **Inconsistent Terms; Interpretation**. If any portion of this Agreement is inconsistent with the terms of the Agreement, the terms of this Agreement shall prevail. Except as set forth above, the remaining provisions of the Agreement are ratified in their entirety. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule, Security Rule, other applicable provisions of HIPAA, and HITECH and any regulations promulgated thereunder.

12. **Regulatory References**. A reference in this Agreement to a section in the Privacy Rule, Security Rule, other applicable provisions of HIPAA or HITECH or any regulations promulgated thereunder means the section as in effect or as amended.

13. **Amendment**. Covered Entity and Business Associate agree to take such action as is necessary to amend this Agreement from time to time as it necessary for the parties to comply with the requirements of the Privacy Rule, Security Rule, other applicable provisions of HIPAA, or HITECH and any regulations promulgated thereunder. Notwithstanding the foregoing, Covered Entity may unilaterally amend this Agreement as is necessary to comply with the applicable law and regulations and the requirements of applicable state and federal regulatory authorities. Covered Entity will provide written notice to Business Associate of such amendment and its effective date. Unless such laws, regulations or regulatory authorities require otherwise, the signature of Business Associate will not be required in order for the amendment to take effect.

14. **Indemnification**. Each Party to this Agreement shall indemnify, defend, and hold harmless the other Party from any and all claims, losses, damages, suits, fees, judgments, costs and expenses, including reasonably incurred attorneys fees, that the Indemnitees may suffer or incur arising out of any acts or omissions of the Indemnifying Party in the performance of this Agreement.

15. **Survival**. The respective rights and obligations of the Parties under section 7, subsection 10.3 and section 14 of this Agreement shall survive the termination of this Agreement.

16. **Entire Agreement**. This Agreement, together with the exhibits attached hereto, constitutes the entire agreement between the parties with respect to the services and all other subject matter hereof and merges all prior and contemporaneous communications and agreements with respect to such subject matter. It will not be modified except by a signed writing dated subsequent to the date of this Agreement and signed on behalf of the parties by their respective duly authorized representatives. No waiver consent, modification, or change of any term of this Agreement will bind either party unless the same is in writing and signed by both parties and all necessary state approvals have been obtained. Such express waiver, consent, modification, or change, if made, will be effective only in the specific instance and the specific purpose set forth in such signed writing.

16. **Counterparts**. This Agreement may be executed in counterparts, and via facsimile or electronically transmitted signature (i.e. emailed scanned true and correct copy of the signed Agreement), each of which will be considered an original and all of which together will constitute one and the same agreement. At the request of a party, the other party will confirm facsimile or electronically transmitted signature page by delivering an original signature page to the requesting party.

IN WITNESS WHEREOF, the Parties hereto have caused their authorized representatives to execute this Business Associate Agreement effective and retroactive as above written.

COVERED ENTITY:	**BUSINESS ASSOCIATE:**
By: _____ by EmpRes Healthcare Management, LLC, Manager by Michael Miller, CFO	By: _____ Name: _____ Title: _____
Date: _____	Date: _____

ATTACHMENT E

List of Regulatory Agency Contacts

California – Arvin, Bakersfield, Twin Oaks, Lakeport, Petaluma, Katherine, New Hope, Heartwood, Springs Road and Elk Grove

State of California
Department of Public Health
Licensing and Certification Program
Santa Rosa/Redwood Coast District Office
2170 Northpoint Parkway
Santa Rosa, CA 95407
Telephone: (707) 576-6775
Attn: Dana Forney, District Manager
Arnold Garza, Health Facilities Evaluator Supervisor

State of California
Department of Public Health
Licensing and Certification Program
Bakersfield District Office
4540 California Avenue, Suite 200
Bakersfield, CA 93309-7042
Telephone: (661) 336-0543
Attn: Jean Chiang, District Manager II
Janet Collins, Health Facilities Evaluator Supervisor

State of California
Department of Public Health
Licensing and Certification Program
126 Mission Ranch Blvd.
Chico, CA 95926
Telephone: (530) 895-6711
Attn: Joanne Gilchrist, District Manager II
Susan McBride, Health Facilities Evaluator Supervisor

State of California
Department of Public Health
Licensing and Certification Program
San Jose District Office
100 Paseo de San Antonio, Suite 235
San Jose, CA 95113
Telephone: (408) 277-1784
Attn: Maria Escudero, District Manager
Myrna Mangalindan, Unit Supervisor

State of California
Department of Public Health
Licensing and Certification Program
Sacramento District Office
3901 Lennane Drive, Suite 201
Sacramento, CA 95834-2956
Telephone: (916) 263-5800
Attn: Jacqueline Phillips, District Manager
Charlotte Rice, Health Facilities Evaluator Supervisor

Idaho – Sandpoint ALF, Teton, Lewiston SNF and Lewiston ALF

State of Idaho
Department of Health and Welfare
Division of Licensing and Certification
Bureau of Facility Standards
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
Telephone: (208) 334-6626, Option 2
Attn: David Scott, Long Term Care Supervisor
Nina Sanderson, Long Term Care Supervisor
Telephone: (208) 364-1962
Attn: Jamie Simpson, ALF Program Supervisor
Lisa Bennett, ALF Health Facility Surveyor

Eden Home Health of Idaho Falls, Eden Hospice at Idaho Falls and Eden Hospice at Carson City

Accreditation Commission for Health Care, Inc.
139 Weston Oaks Court
Cary, NC 27513
Telephone: (919) 785-1214, ext. 301
Attn: Cathie O'Connor, Account Advisor

Montana – Polson, Hot Springs, Missoula, Laurel, Livingston, Central Montana, Marias, Aspen Meadows SNF and Aspen Meadows ALF

State of Montana
Department of Public Health and Human Services
Quality Assurance Division
Certification Bureau
2401 Colonial Drive, 2nd Floor
P.O. Box 202953
Helena, MT 59620
Telephone: (406) 444-2099
Attn: Todd Boucher, Certification Bureau Chief

Nevada – Pahrump, Ormsby, Mountain View, Gardnerville and Eden Home Health

State of Nevada
Department of Health and Human Services
Division of Public and Behavioral Health
Bureau of Health Care Quality and Compliance
4220 South Maryland Parkway, Suite 810, Building D
Las Vegas, NV 89119
Telephone: (702) 486-6515
Attn: Ellen Clark, Health Facilities Inspector III
Jennifer Dunaway, Health Facilities Inspector III
Paul Shubert, Bureau Chief

Oregon – La Grande, Independence, Hillsboro, Milton-Freewater, Cascade Valley, The Dalles, Portland and Windsor

State of Oregon
Department of Human Services
Aging and People with Disabilities
Safety, Oversight and Quality Unit
Office of Licensing and Regulatory Oversight
3406 Cherry Avenue, NE
Salem, OR 97303
Telephone: (503) 373-2227
Attn: Joanne Birney (503) 373-1964
Dave Allm, Nursing Facility Licensing Manager
Cory Oace, Survey Manager
Keith Ramey, Nursing Facility Survey Unit Manager

P.O. Box 14530
Salem, OR 97309
Telephone: (503) 373-0222
(503) 373-0200
(503) 373-0231
Attn: Cynthia Vargo, Nursing Facility Survey Unit Manager
Sheryl Luper (503) 602-5162

Washington – Frontier, Americana, Whitman, Seattle Medical, Enumclaw, Canterbury, North Seattle, Talbot, Shelton, Park Royal, North Cascades, Alaska Gardens, Alderwood, Highland, Snohomish, Royal Park SNF, Royal Park ALF, Buena Vista, Fort Vancouver SNF, Fort Vancouver ALF, Auburn and Eden Home Health

State of Washington
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
P.O. Box 45600
Olympia, WA 98504
Telephone: (360) 664-8422
Attn: Sonya Conway, Acting Field Manager

State of Washington
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
20425 72nd Avenue South, Suite 400
Kent, WA 98032-2388
Telephone: (253) 234-6044
Attn: Loretta Maestas, Region 2 Field Manager

State of Washington
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
P.O. Box 98907
Lakewood, WA 98496
Telephone: (253) 983-3837
Attn: Ruth Futch, Region 3 Acting Field Manager

State of Washington
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
3906 172nd Street NE, Suite 100
Arlington, WA 98223
Telephone: (360) 651-6864
Attn: Kathy Gold, Region 2 Field Manager

State of Washington
Department of Social and Health Services
Aging and Long-Term Support Administration
Division of Residential Care Services
316 West Boone Avenue, Suite 170
Spokane, WA 99201
Attn: Cindy CoVille, Region 1 Field Manager (509) 323-7316
Susan Bergeron, Region 1 Field Manager (509) 323-7324

State of Washington
Department of Social and Health Services
Aging and Long-Term Support Administration
Division of Residential Care Services
800 NE 136th Avenue, Suite 220
Vancouver, WA 98684
Telephone: (360) 397-9549
Attn: Karyl Ramsey, Region 3 Field Manager

Wyoming – Sage View, Granite, Rawlins, Wind River and Thermopolis

State of Wyoming
Aging Division
Healthcare Licensing and Surveys
6101 Yellowstone Road, Suite 186C
Cheyenne, WY 82002
Telephone: (307) 777-7123
Attn: Laura Hudspeth, State Survey Agency Director

Arizona

Phoenix Main Office
150 North 18th Ave. Suite 400
Phoenix, AZ 85007
Phone: 602-364-2536
Fax: 602-364-4808

Tucson Office
400 W. Congress, Suite 100
Tucson AZ, 85701
Phone: 520-628-6965
Fax: 520-628-6991

Long Term Care Licensing
Phone: 602-364-2690
Fax: 602-364-0993

Medical Facilities Licensing
Phone: 602-364-3030
Fax: 602-364-4764

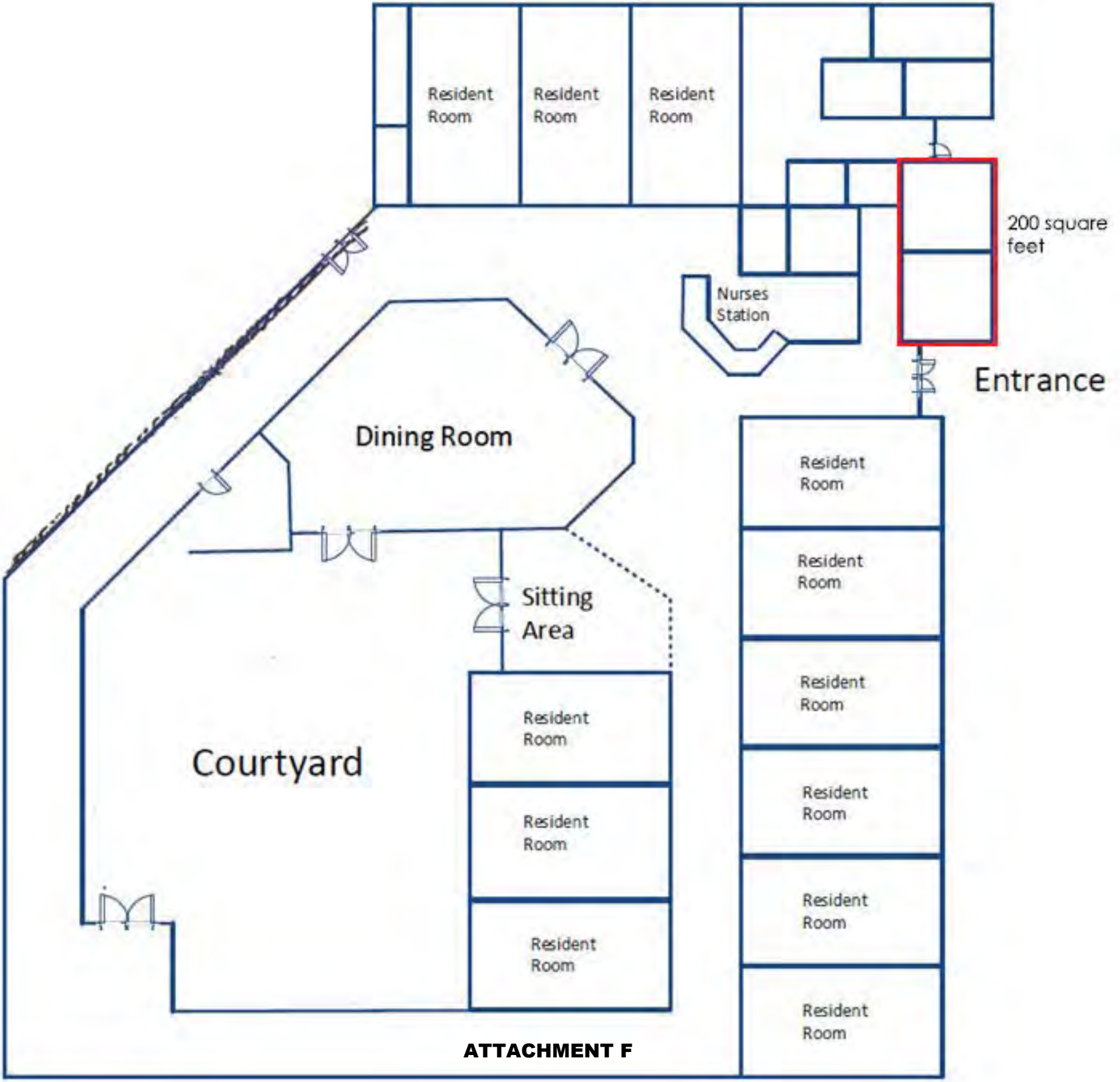
Residential Facilities Licensing
Phone: 602-364-2639
Fax: 602-364-5872

Special Licensing
Includes Audiologists, Hearing Aid Dispensers, Speech Language Pathologists, DD Group Home Inspections
Phone: 602-364-2079
Fax: 602-364-4769

South Dakota
Health Facilities Licensure and Certification
Chris Qualm
Phone: 605-773-3356

ATTACHMENT F

Single Line Drawing



ATTACHMENT F

Eden Home Health of Spokane County, LLC Certificate of Need Application Proposing the Establishment of a Medicare/Medicaid Certified Home Health Agency in Clark County

ATTACHMENT G

Documentation of Site Control by Eden Home Health of Clark County, LLC

SUB-SUBLEASE

This Sub-Sublease dated _____ __, 2019 is by and between Fort Vancouver Memory Care, LLC, a Washington limited liability company ("Sublessor"), and Eden Home Health of Clark County, LLC, a Washington limited liability company ("Sublessee").

RECITALS

This Sub-Sublease is made and entered into with reference to the following facts:

A. WHEREAS, on June 29, 2015, Master Tenant Four, LLC, a Washington Limited Liability Company (“Lessor”) and various affiliates of Omega Healthcare Investors, Inc. (collectively, “Master Lessor”) entered into a lease agreement (the “Master Lease”) for the lease of the premises located at 8501 NE 8th Way, Vancouver, Washington 98664.

B. WHEREAS, on June 29, 2015, Lessor, and Sublessor entered into a sublease (the "Sublease") for the lease of the premises located at 8401 NE 8th Way, Vancouver, WA 98664.

C. WHEREAS, Sublessor desires to sublease to Sublessee and Sublessee desires to sublease the Demised Premises Identified on Exhibit A on the terms and conditions set forth below.

NOW, THEREFORE, in consideration of the mutual covenants and agreements contained herein, and for other good and valuable consideration, the receipt, sufficiency and mutuality of which are hereby acknowledged, it is agreed as follows:

1. Term: The initial term of this Sub-Sublease shall commence on the date of receipt Sublessee’s receipt of a Certificate of Need from the State of Washington ("Commencement Date") and shall continue for a year period ("Initial Term"). Provided that Sublessee is not in default under this Sub-Sublease, term of this Sub-Sublease shall automatically continue for 3 subsequent 1-year periods (the "Renewal Terms", and together with the Initial Term, the "Term"). This Agreement may be terminated by Sublessee upon at least 30 days notice prior to the end of the Initial Term or any subsequent Renewal Term.

2. Base Rent:

2.1.1. Beginning on the Commencement Date and through the end of the Initial

Term, Sublessee shall pay Sublessor the monthly amount of $600.00 (“Monthly Base Rent”). Monthly Base Rent shall be negotiated by the parties prior to the beginning of any Renewal Term.

2.2. Monthly Base Rent shall be paid in advance on the first day of each and every calendar month during the Term hereof. The Base Rent for any fractional month shall be prorated. All Base Rent hereunder shall be due and payable without diminution or offset.

2.4. All payments of money other than monthly Base Rent required to be made by Sublessee pursuant to the terms of this Sub-Sublease shall be deemed "Additional Rent."

3. Insurance:

3.1. At all times during the term of this Sub-Sublease, Sublessee shall keep and maintain, at its own cost and expense, the following policies of insurance:

3.1.1. Property Insurance provided by a Causes of Loss-Special Form. Such Insurance shall, at all times be maintained in an amount equal to the full replacement cost of the Demised Premises. Such Insurance shall, at all times, also be maintained in the full replacement cost of the Personal Property located at or used in connection with the Demised Premises. As used herein the term "full replacement cost" shall mean coverage for the actual replacement cost of the Demised Premises. The term "full replacement cost" shall also mean coverage for the actual replacement cost of the Personal Property located at or used in connection with the Demised Premises.

3.1.2. Commercial General Liability Insurance Nursing Home or Long-Term Care Professional Liability Insurance in the amount of $1,000,000 per occurrence and $3,000,000 aggregate for the Sublessee and all affiliates of common ownership. Coverage may be a claims made basis.

3.1.5. If the coverage provided under Section 4.1.4 is on a claims made basis, Sublessee is responsible for purchasing extended reporting period (tail) coverage providing protection for Lessor and Sublessor for one year, and

3.1.6. Worker's compensation insurance or other similar insurance which may be required by governmental authorities or applicable legal requirements in an amount not less than the minimum required by law.

3.2. Sublessee shall provide Master Lessor and Sublessor with copies or certificates or other evidence reasonably satisfactory to Sublessor establishing that Sublessee has obtained and continues to hold the policies of insurance required under Section 4.1,

above. All such policies shall be in such form and content, including, without limitation, the amount of the deductible, and shall be issued by such company or companies as are approved by Sublessor, which shall not be unreasonably withheld.

3.3. All policies of insurance required hereunder shall provide that they may not be canceled, lapse, expire, or be materially altered except with thirty (30) days prior written notice to Sublessor.

4. Indemnification:

4.1. As a material part of the consideration to Sublessor, except for the gross negligent or willful acts of Sublessor, its employees and agents and those matters covered by insurance carried by Sublessee hereunder, Sublessee hereby expressly waives any and all claims against Sublessor for damages or liability for injury to persons or property in, on or about the Demised Premises from any cause whatsoever arising after the commencement of the term of this Sub-Sublease,

4.2, Sublessee shall indemnify, defend and hold harmless Sublessor, its agents, members, employees, officers, and directors, against each and every demand, claim, assertion, damages, actions, fees, including, without limitation, reasonable attorneys' fees, court costs and other expenses, paid, incurred or suffered arising or alleged to have arisen on or after the Commencement Date or out of any act or omission of Sublessee, its agents, members, employees, officers, directors, guests, invitees or licensees, or in connection with the use or occupation of the Demised Premises, including, without limitation, injury, death or damage to Sublessee's residents resulting from negligence, or relating to Sublessee's introduction, use, or remediation of hazardous materials, as defined in Section 51.8, below.

5. Use of Premises: The Demised Premises shall be used solely as general office space for the management of home services agency operations. No patient cares services will be conducted within the Demised Premises.

6. Sublessor Not to Maintain: Sublessor shall not be required to repair or maintain, or pay for the repair or maintenance of, the Demised Premises. Sublessor may, but shall not be obligated to, perform any repairs or maintenance which is the obligation of Sublessee under this Sub-Sublease, after giving Sublessee thirty (30) days written notice to perform the repairs or maintenance or to begin such repairs and maintenance if the work may not reasonably be completed within thirty (30) days of receipt of written notice from Sublessor.

7. Alterations:

7.1. Except in the event of an emergency, Sublessee shall not make or allow to be made, without obtaining Sublessor's prior written consent, any structural alterations or improvements to the Demised Premises or any part thereof. In the event Sublessee intends to undertake any alterations or improvements to the Demised Premises as provided herein, Sublessee shall provide to Sublessor written notice describing the nature of the alterations or improvements, the estimated cost thereof and stating the date the work related to the alterations or improvements is scheduled to commence and end. Sublessor shall respond within thirty (30) days of receipt of Sublessee's written notice of intent to make alterations or improvements.

7.2. Sublessee shall fully pay and discharge all claims for labor and materials furnished in connection with the repair, reconstruction, remodeling or alteration of the Demised Premises, to obtain lien releases for labor or materials for which payment has been made, and to take all other reasonable steps to forestall the assertion of lien claims against the Demised Premises.

7.3. All work done in connection with the repair, reconstruction, remodeling or alteration of the Demised Premises shall be performed in compliance with all applicable laws, ordinances, rules and regulations.

7.4. The repair, reconstruction, remodeling or alteration of the Demised Premises shall be performed in a workman like manner and in accordance with all applicable laws and regulations.

7.5. No repair, reconstruction, remodeling or alteration of the Demised Premises shall be effected unless and until Sublessee has obtained all required permits and consents from all governmental entities or agencies having jurisdiction over the Demised Premises.

7.6. All alterations and improvements constructed by Sublessee upon the Demised Premises shall, upon termination of this Sub-Sublease, belong to Master Lessor.

7.7. Sublessee shall save and hold Sublessor harmless from any and all liability of any kind on account of the repair, reconstruction, remodeling or alteration of the Demised Premises by Sublessee.

7.8. Prior to commencement of any work, alteration or repair to or of the Demised Premises by anyone other than Sublessee or the employees of Sublessee, Sublessee shall post or affix notices on or to the Demised Premises of Sublessor's non-responsibility for the performance of the work, alteration or repair and any claims or liabilities which may arise

8. Licensing Requirements: Sublessee shall maintain at all times during the term hereof and any extensions or renewals hereof all governmental licenses, permits and authorizations necessary for the establishment and operation of the Demised Premises for the purposes permitted under this Sub-Sublease.

9. Waste and Nuisance: Sublessee shall not commit, or allow to be committed, any waste upon the Demised Premises, or any public or private nuisance. Sublessee shall not use, nor allow the Demised Premises to be used, for any improper, immoral, unlawful or objectionable purpose. Sublessee shall not allow objectionable odors or excessive noise to emanate from the Demised Premises.

10. Continuous Operation: Sublessee shall at all times during the entire term of this Sub-Sublease continuously operate the Demised Premises for the purposes permitted under this Sub-Sublease, and no other, subject to casualty, condemnation and remodeling. Sublessee shall use Sublessee's reasonable efforts to operate the Demised Premises efficiently in accordance with all Laws. Sublessee shall use Sublessee's reasonable efforts to optimize the census of patients at the Demised Premises.

11. Events of Default:

11.1 The occurrence of any of the following shall be deemed to constitute an event of default on the part of Sublessee hereunder:

11.1.1 The failure to pay rent, real or personal property taxes and assessments, utilities, or premiums for insurance under this Sub-Sublease;

11.1.2 The failure to pay other monetary obligations under this Sub-Sublease within fifteen (15) days after receipt of written notice;

11.1.3 In the reasonable and good faith judgment of Sublessor, any act or omission that places in jeopardy the continued licensing and/or certification of the facilities at the Demised Premises as then currently licensed, and/or its certification as either a Medicare or Medicaid provider, or that causes harm or embarrassment to the reputation and good will of the Demised Premises in the community if, within twenty-four (24) hours after written notice thereof from Sublessor to Sublessee, Sublessee shall not have either (i) cured such failure, or (ii) obtained an injunction or other order preventing revocation or suspension of licensing and/or decertification of the facilities at the Demised Premises by virtue of such failure or alleged failure, or (iii) provided Sublessor with assurances satisfactory to Sublessor in Sublessor's sole discretion that the facilities at the Demised Premises will not be subject to

license suspension or revocation and/or decertification as a result of such failure or alleged failure;

11.1.4 The failure to perform or comply with any other term or provision of this Sub-Sublease within fifteen (15) days after written notice of default, except for defaults that have longer cure periods under the Master Lease in which cure the cure periods and standards of the Master Lease shall apply;

11.1.5 An assignment by Sublessee of its property for the benefit of creditors;

11.1.6 The appointment of a receiver, trustee or liquidator for Sublessee, or any of the property of Sublessee, who or which is not discharged within ninety (90) days;

11.1.7 The levy of a writ of attachment against this Sub-Sublease which is not discharged within sixty (60) days;

11.1.8 Sublessee or any assignee of this Sub-Sublease files a voluntary petition under the federal Bankruptcy Act or of the law of any state, to be adjudicated a bankrupt or for any arrangement or other debtor's relief, or any such petition is filed against Sublessee by any other party and not dismissed within sixty (60) days after filing thereof; or

11.1.9 Any financial statements provided to Sublessor by Sublessee during the term of this Sub-Sublease are known by Sublessee to be materially false or misleading when given.

11.1.10 Any action taken by Sublessee that causes a default under the Master Lease and is not cured within the applicable time periods under the Master Lease.

11.2 In the event of the occurrence of any event of default mentioned in this Section 25, Sublessor shall have the right, at its election, by written notice to Sublessee, in addition to all other remedies, to terminate this Sub-Sublease.

12. Sublessor's Recovery From Sublessee: Upon termination of this Sub-Sublease by Sublessor, Sublessor shall be entitled to all remedies available under law.

13. No Waiver: No waiver by Sublessor of any breach of the covenants, conditions or agreements of this Sub-Sublease shall be construed to be a waiver of any succeeding breach of the same or of any other covenants, condition or agreement hereof.

14. Damage by Fire or Other Casualty:

14.1 In the event of a fire, earthquake or other casualty causing damage or destruction of the Demised Premises, subject to force majeure and the provisions of the

Master Lease Sublessee shall promptly commence and diligently complete the repair or reconstruction of the Demised Premises to the condition that existed prior to such damage or destruction. The net insurance proceeds shall be used for the repair or reconstruction of the Demised Premises. Sublessor shall execute all documents reasonably necessary to make the net insurance proceeds available to Sublessee to repair or rebuild the Demised Premises.

14.2 Subject to the provisions of the Master Lease, at the election of Sublessor, fire and extended peril insurance proceeds shall not be payable to Sublessee but shall instead be deposited in escrow with a bank or other federally-insured financial institution selected by Sublessor on terms and in accordance with procedures reasonably satisfactory to Sublessor and Sublessee, with funds released during the course and at completion of the repair or reconstruction, upon completion of the repair or reconstruction, and receipt by such third party escrowee of lien waivers from the contractors, subcontractors, and suppliers relating to the work completed.

14.3 Subject to the terms of the Master Lease, if there remains any surplus of insurance proceeds after the completion of the repair or reconstruction of the Demised Premises, such surplus shall belong to and be paid to Sublessee.

14.4 In any event during any time that Sublessee is unable to use and occupy the Demised Premises or any portion thereof as a result of damage or destruction occurring without fault of Sublessee, or as a result of any repairs thereof, the rent hereunder shall be abated to the extent, and only to the extent, of the proceeds of Sublessee's business interruption insurance made available to Sublessor or Master Lessor.

14.5 Sublessor shall have no liability whatsoever with respect to any goods, fixtures, equipment or other personal property of Sublessee, nor shall Sublessor have any liability for loss of revenues or income resulting from fire or other casualty.

15. Condemnation:

15.1 If during the term of this Sub-Sublease, the whole of the Demised Premises is taken or condemned by any competent public or quasi-public authority this Sub-Sublease shall terminate. If during the term of this Sub-Sublease, there is a partial taking the consequences of that taking shall be governed by Article 16 of the Master Lease.

15.2 Except as provided by the Master Lease all compensation upon any taking or condemnation of the Demised Premises shall belong to Master Lessor, except that Sublessee shall receive any compensation separately awarded for relocation, plus any sum separately

awarded to compensate Sublessee for the value of any of Sublessee's personal property taken by condemnor.

15.3 Except as provided above, this Sub-Sublease shall not terminate and shall remain in full force and effect in the event of a taking or condemnation of the Demised Premises, or any portion thereof; provided, however, that the Base Rent hereunder shall be adjusted for the remainder of the term of this Sub-Sublease in the same manner as the Base Rent is adjusted in the Master Lease.

16. Assigning and Subletting:

16.1 Sublessee may not assign this Sub-Sublease or any portion of the term hereof, or sublet the Demised Premises, or any portion thereof.

17. Covenants Against Liens: Except as expressly provided in this Sub-Sublease, Sublessee shall not, during the term hereof, suffer or permit any lien, including, without limitation, any tax, mechanic's or judgment lien or conditional sales agreement, to be attached to or upon the Demised Premises or any part thereof, including but not limited to Sublessor's personal property, by reason of any act or omission on the part of Sublessee, and hereby agrees to save and hold harmless Sublessor from or against any such lien or claim of lien.

18. Attornment And Subordination: Sublessee acknowledges and agrees that its rights under this Sub-Sublease are subject and subordinate to the term of the Master Lease, and to all amendments, renewals and extensions thereof, and to the matters to which the Master Lease is or shall be subject or subordinate and that in the event of termination of the Master Lease as a result of a default by Sublessor or reentry or dispossession of Sublessor as the tenant thereunder by Master Lessor, Master Lessor may, at its option, take over all of the right, title and interest of Sublessor, as sublessor under this Sub-Sublease and in such event provided Sublessee has not committed an event of default and no event has occurred which with the passage of time or giving of notice or both would constitute an event of default, Sublessee shall attorn to Master Lessor pursuant to the then executory provisions of this Sub-Sublease and Master Lessor shall not disturb Sublessee's quiet possession of the Demised Premises nor deprive Sublessee of any of its rights under the Sublease. In the event Sublessee receives a written Notice from the Master Lessor or Master Lessor's assignees, if any, stating that Sublessor is in default under the Master Lease, Sublessee shall thereafter be obligated to pay all Rent accruing under this Sub-Sublease directly to the party giving such Notice, or as such party may direct. All Rent received from Sublessee by Master Lessor or

Master Lessor's assignees, if any, as the case may be, shall be credited against the amounts owing by Sublessor under the Master Lease.

19. Relationship of Parties: Nothing contained in this Sub-Sublease shall be deemed to constitute Sublessor and Sublessee as partners or joint venturers, or any other relationship other than that of lessor and lessee.

20. Further Assurances: Sublessor and Sublessee shall execute such further documents and instruments as shall be necessary or appropriate to carry out the provisions of this Sub-Sublease. Sublessee shall execute such further documents and instruments and take such further action as is necessary to transition the operation of the Demised Premises back to Sublessor or Sublessor's designated agent upon the expiration or termination of this Sub-Sublease without interruption or discontinuation of the services being provided at the Demised Premises.

21. Estoppel Certificates: Sublessor and Sublessee shall, within ten (10) days after written request from the other, execute and deliver to the other, in recordable form, a certificate stating that this Sub-Sublease is unmodified and in full force and effect, or in full force and effect as modified, and stating the modifications, and that the other party is not in default hereunder, or is in default and specifying the nature and extent of the alleged default. Failure to deliver the certificate within said ten (10) days shall be conclusive upon the party to whom the request has been given that this Sub-Sublease is in full force and effect and has not been modified except as may be represented by the requesting party and that the requesting party is not in default hereunder.

22. Notices:

22.1 All notices or other documents required or permitted to be given hereunder shall be personally delivered, sent by private overnight courier, or sent by registered or certified mail, postage prepaid, return receipt requested, addressed to the parties as follows:

Sublessor:

Master Tenant Four, LLC
4601 NE 77th Ave., Ste. 380
Vancouver, WA 98662
Attn: Legal/Contracts

Sublessee:

Fort Vancouver Memory Care, LLC

4601 NE 77th Ave. Ste. 300

Vancouver, WA 98662

Attn: Legal/Contracts

22.2 Notices sent by registered or certified mail shall be deemed received the third business day after posting and notices sent by private overnight courier shall be deemed received the first business day after delivering the same to the private overnight courier during regular business hours.

23.3 Sublessor and Sublessee may change their addresses and/or telephone numbers for purposes of this Sub-Sublease by giving notice thereof in accordance with the provisions of Section 46.1, above.

24. Quiet Enjoyment: Provided that Sublessee is not in default under this Sub-Sublease beyond all applicable cure periods, Sublessor shall not interfere with the peaceful and quiet occupation and enjoyment of the Demised Premises by Sublessee or Sublessee's permitted assignees, sublessees, or residents.

25. Authority: Sublessee shall deliver to Sublessor upon execution of this Sub-Sublease a certified copy of a resolution of its board of directors or members, as applicable, authorizing the execution of this Sub-Sublease and naming the person(s) who is/are authorized to execute this Sub-Sublease on its behalf.

26. Intentionally Omitted.

27. Applicable Law: This Sub-Sublease shall be governed by, and construed in accordance with, the laws of the State of Washington.

28. Headings: The descriptive headings used in this Sub-Sublease are for convenience only and shall not control or affect the meaning or construction of any of its provisions.

29. Attorneys' Fees: If Sublessor or Sublessee brings any action to interpret or enforce this Sub-Sublease, or for damages for any alleged breach hereof, the prevailing party in any such action or arbitration shall be entitled to reasonable attorneys' fees as awarded by the court in addition to all other recoverable damages and costs.

30. Definitions: As used in this Sub-Sublease, following terms are defined as follows:

30.1 The term "days" shall refer to calendar days unless otherwise specified.

30.4 The term "hazardous materials" as used in this Sub-Sublease shall mean any substance, material, or waste which has been or becomes regulated by any local

governmental authority, the State of California, or the United States government, including, but not limited to, "petroleum" as defined in 42 U.S.C. Section 6991(8), asbestos, lead paint, polychlorinated biphenyls, designated as a "hazardous substance" pursuant to Section 311 or listed pursuant to Section 307 of the Clean Water Act, defined as a "hazardous waste" pursuant to Section 1004 of the Resource Conservation and Recovery Act, defined as a "hazardous substance" pursuant to Section 101 of the Comprehensive Environmental Response, Compensation, and Liability Act, or defined as "underground storage tank" under 42 U.S.C. Section 6991.

31. Severability: In the event any part or provision of this Sub-Sublease shall be determined to be invalid or unenforceable under the laws of the State of California, the remaining portion of this Sub-Sublease shall, nevertheless, continue in full force and effect.

32. Time: Time is of the essence of each and every provision of this Sub-Sublease.

33. Counterparts: This Sub-Sublease may be executed in any number of counterparts, each of which shall be deemed an original, but all of which shall constitute one and the same agreement.

34. Binding, Etc: This Sub-Sublease shall be binding upon, and inure to the benefit of, Sublessor and Sublessee, and their respective personal representatives, successors in interest and permitted assigns.

35. Master Lease. This Sub-Sublease shall be subject and subordinate to the terms and conditions set forth in the Master Lease. Sublessee hereby acknowledges that it has been provided a copy of the Master Lease and that the terms and conditions of the Master Lease are incorporated herein by reference and Sublessor and Sublessee agree to comply with the terms of the Master Lease as if the obligations of Master Lessor were the obligations of Sublessor and the obligations of Lessee were the obligations of Sublessee. To the extent of a conflict between the Master Lease and this Sub-Sublease the terms of the Master Lease shall control. Sublessee hereby agrees that it shall abide by the terms of the Master Lease and it shall not take any action which shall create a default or Event of Default under the Master Lease. Notwithstanding anything contained in this Sub-Sublease to the contrary, Sublessee's obligations hereunder are expressly conditioned upon Sublessee's receipt of a Consent to Sublease Agreement from Master Lessor in a form reasonably acceptable to Sublessee.

[Signatures on following page]

IN WITNESS WHEREOF, Sublessor and Sublessee have executed this Sub-Sublease the day and year first above written.

Sublessor:

Master Tenant Four, LLC,

a Washington limited liability company

_____
by EmpRes Financial Services, LLC, Manager
by Michael J. Miller, CFO

Sublessee:

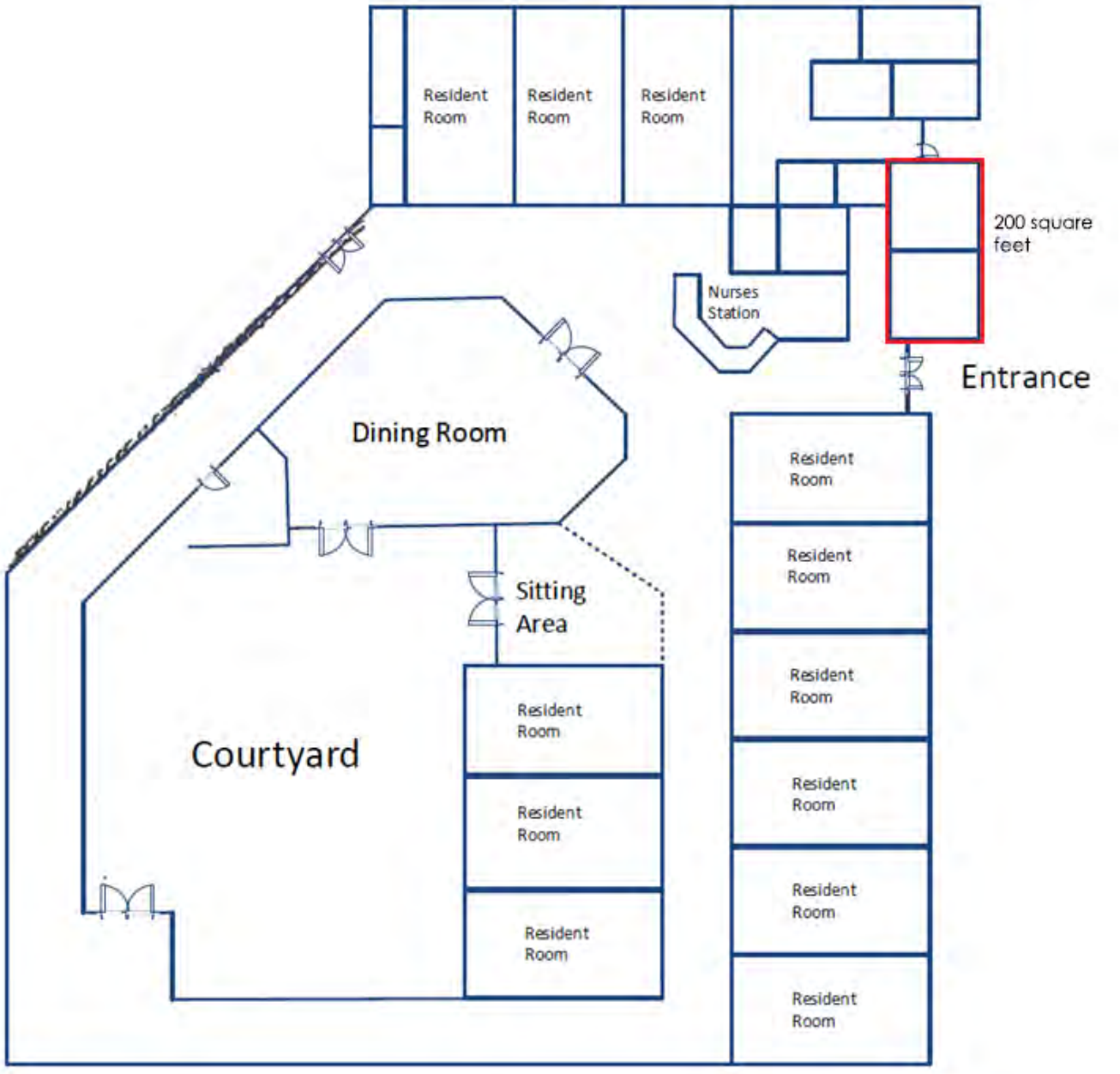
Fort Vancouver Memory Care, LLC,

a Washington limited liability company

_____
by EmpRes Healthcare Management, LLC, Manager
by Michael J. Miller, CFO

Exhibit "A"

Floor Plan

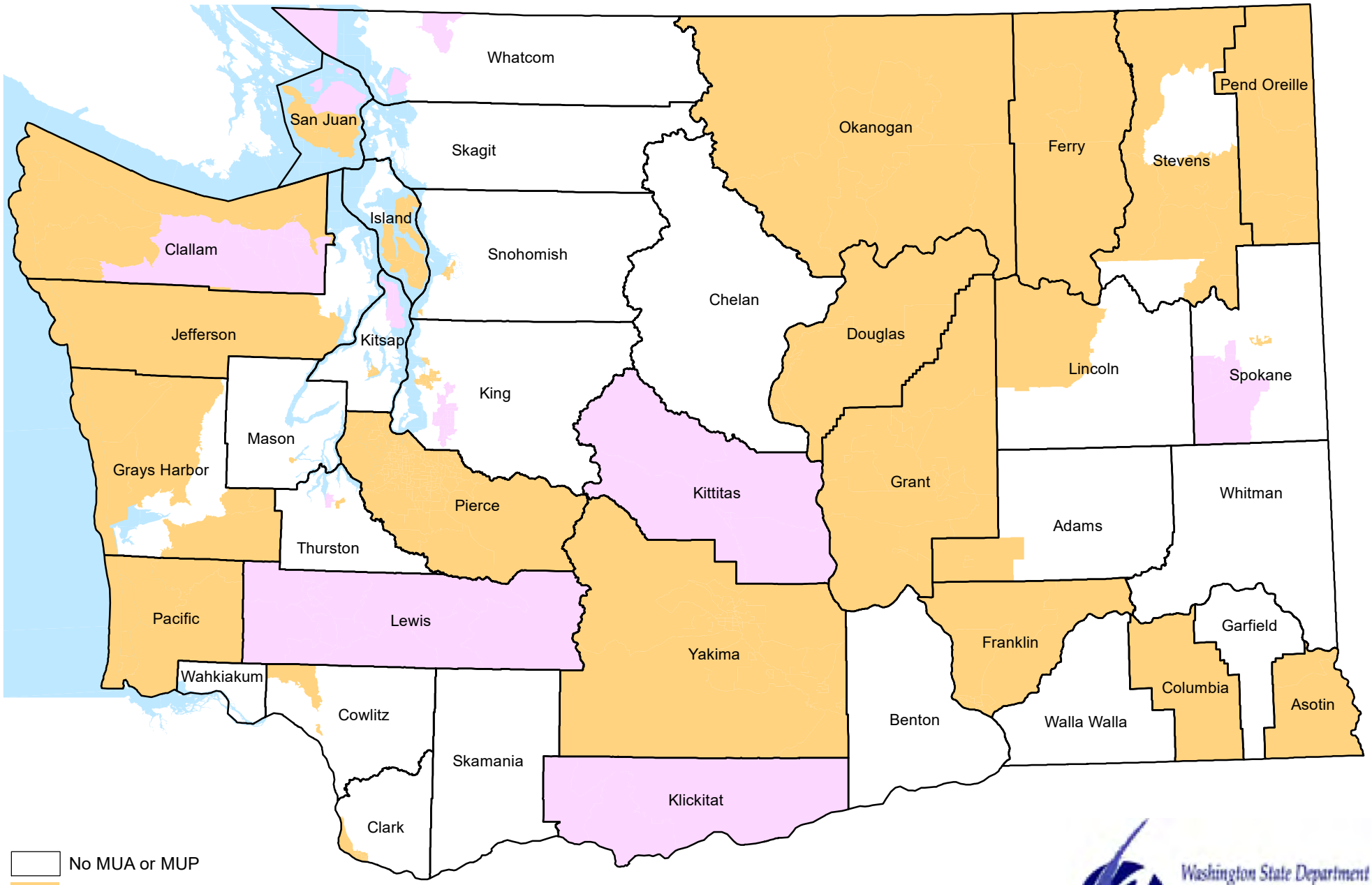


ATTACHMENT G

ATTACHMENT H

MUA and HPSA Designations for Clark County

Medically Underserved Area & Medically Underserved
May 29, 2019



Designation data from the Office of Community Health Systems.
Designation status changes frequently.
For current information contact Laura Olexa (360) 236-2811.

ATTACHMENT H

Washington State Department of Health

Eden Home Health of Spokane County, LLC Certificate of Need Application Proposing the Establishment of a Medicare/Medicaid Certified Home Health Agency in Clark County

ATTACHMENT I

Potential Providers

Provided by the Program

Clark County List of Potential Providers compiled by the Program in June 2018

List of Potential Providers in CN 18-09 Sept. 2018, Table 4, Pages 14 -1

Clark County List of Potential Providers compiled by the Program in Aug. 2019

Clark County List of Potential Providers compiled by the Program in June 2018

Credential	Name	License Status	Exp Date	Address	State	County Li	Service Area 1	Service Area 2	Service Area 3	M/M Certified
IHS.FS.00000422	Pediatric Services of America, Inc.	ACTIVE	5/31/2020	9105 NE Highway 99, #202, Vancouver, WA 98665	WA	Clark	Clark	Cowlitz	Wahkiakum	Yes
IHS.FS.00000423	Pediatric Services of America, Inc.	ACTIVE	6/30/2020	9105 NE Highway 99, #202, Vancouver, WA 98665	WA	Clark	About 20 counties listed in ILRS.			No
IHS.FS.00000454	Waterford at Fairway Village LLC	ACTIVE	4/30/2020	2927 SE Village Loop Ste 100 Vancouver, WA 98683-8119	WA	Clark	Clark			No
IHS.FS.60331226	PeaceHealth Southwest Medical Center	ACTIVE	2/6/2020	PO Box 2369 Vancouver, WA 98668-2369	WA	Clark	Clark	Cowlitz		Yes
IHS.FS.60450910	Vancouver Comfort Keepers LLC	ACTIVE	4/15/2020	406 SE 131st Ave Ste 205 Vancouver, WA 98683-4013	WA	Clark	Clark	Cowlitz		No
IHS.FS.60660459	Vancouver Home Healthcare Agency LLC	ACTIVE	2/14/2020	PO Box 2988 Vancouver, WA 98668-2988	WA	Clark	Clark	Cowlitz		No
IHS.FS.60803573	Divine Home Health Care Inc.	ACTIVE	12/4/2020	2210 W Main St Ste 107 #314 Battle Ground, WA 98604-4232	WA	Clark	Clark	Cowlitz		No
IHS.FS.60814521	Healthy Living at Home - Vancouver LLC	ACTIVE	7/30/2021	1499 SE Tech Center Pl Ste 140 Vancouver, WA 98683-9575	WA	Clark	Clark			No
IHS.FS.00000262	Comunity Home Health and Hospice	ACTIVE	4/30/2020	PO Box 2067, Longview, WA 98632-8189	WA	Cowlitz	Clark	Cowlitz	Wahkiakum	No

ATTACHMENT I

temporary or permanent residence. A person administering or providing nursing services only may elect to be designated a home health agency for purposes of licensure. [RCW 70.127.010(7)]

Using this information and these definitions, the department completed an analysis to determine which of the agencies listed in Table 1 met these definitions and were considered available to all residents of Clark County. The department considered licensing information, historical files, home health survey results, and publicly available information from an agency website as parts of the information used. The department analysis is summarized in Table 4 below.

Table 4
Department Analysis of Existing Home Health Agencies in Clark County

Agency Name	Services and Limitations	Medicare/Medicaid Certified	Available to all residents	Source
Community Home Health and Hospice	CN Approved, Skilled Nursing, Occupational Therapy, I.V. Services, Speech Therapy, Medical Social Services, Physical Therapy, Home Health Aide	Yes	Yes	CN historical records
Divine Home Health Care Inc.	Skilled Nursing, Home Health Aide, I.V. Services, Personal Care, Homemaker/Chore, Respiratory Therapy, Transportation	No	No. State licensed only	ILRS, survey response
Kaiser Permanente Continuing Care Services	CN Approved, Skilled Nursing, Physical Therapy, Medical Social Services, Bereavement Counseling, Speech Therapy, Home Health Aide, I.V. Services	Yes	Limited to HMO members	ILRS & agency website
Kindred at Home	CN Approved, Skilled Nursing, Medical Social Services, Occupational Therapy, Physical Therapy, Home Health Aide, Speech Therapy	Yes	Yes	CN historical records
Northwest Healthcare	Skilled nursing, nutritional counseling, personal care, homemaker/chore, transportation, home health aide, medical	No	No. Home Care and state licensed only	ILRS, survey response, & agency website

Agency Name	Services and Limitations	Medicare/Medicaid Certified	Available to all residents	Source
	social services, and respite care.			
PeaceHealth Hospice and PeaceHealth Homecare	CN Approved, Skilled Nursing, Home Health Aide, I.V. Services, Personal Care, Homemaker/Chore, Respiratory Therapy, Transportation	Yes	Yes	CN historical records
Providence Home Health	CN Approved, Physical Therapy, I.V. Services, Skilled Nursing, Home Health Aide, Speech Therapy, Occupational Therapy	Yes	Yes	ILRS
Touchmark Home Health	CN Approved, Home Health Aide, Occupational Therapy, Medical Social Services, Skilled Nursing, Speech Therapy, Physical Therapy	Medicare Only	No. Not available to Medicaid	ILRS & agency website
Vancouver Comfort Keepers	Skilled Nursing, Home Health Aide, Personal Care, Homemaker/Chore, Respite Care, Transportation	No	No. Home Care and state licensed only	ILRS, survey response, & agency website
Vancouver Home Health Agency, LLC	Skilled Nursing, Home Health Aide, Speech Therapy, Respiratory Therapy, Medical Social Services, Occupational Therapy, Nutritional Counseling, Bereavement Counseling, Physical Therapy, Personal Care, Respite Care, Homemaker/Chore	No	No. State licensed only	ILRS, survey response, & agency website

Based on the analysis of the information contained in table 4, the department determines that only four of the ten agencies serving Clark County are available to all residents.

The department also compared the number of home health visits reported by the two Medicare certified agencies responding to the department's survey, the 2019 projected number of home

Below are Clark and Cowlitz counties – same format.

Credential #	Facility Name	Site County	Serving Clark?	Serving Cowlitz?
IHS.FS.00000229	Assured Home Health and Hospice	Lewis	N/A	CN Approved
IHS.FS.00000231	Avail Home Health	Yakima	State Only	State Only
IHS.FS.00000262	Community Home Health and Hospice CHHH Community Home Care Hospice Thrift Shop	Cowlitz	CN Approved	CN Approved
IHS.FS.00000300	Kindred at Home	Clark	CN Approved	N/A
IHS.FS.00000353	Kaiser Permanente Continuing Care Services	Multnomah	CN Approved	CN Approved
IHS.FS.00000422	PSA Healthcare	Clark	CN Approved	CN Approved
IHS.FS.00000452	Total Care	Yakima	State Only	State Only
IHS.FS.00000454	Touchmark Home Health	Clark	CN Approved	N/A
IHS.FS.60083889	Popes Kids Place	Lewis	State Only	State Only
IHS.FS.60108399	Providence Home Health	Multnomah	State Only	State Only
IHS.FS.60282684	Maxim Healthcare Services	Washington	State Only	N/A
IHS.FS.60331226	PeaceHealth Hospice	Clark	CN Approved	CN Approved
IHS.FS.60660459	Vancouver Home Healthcare Agency LLC	Clark	State Only	State Only
IHS.FS.60803573	Divine Home Health Care Inc.	Clark	State Only	State Only

I know I mentioned this over the phone, but I'd recommend checking out each of these agency's websites for service limitations. I've already weeded out the DME and infusion-only agencies, but haven't gone into the level of research to identify agencies with geographic or other limitations.

ATTACHMENT J

1987 State Health Plan Methodology and Standards

(5) Any Type A or Type B CCRC proposing a nursing home project may, at its discretion, designate it as an application against the special statewide pool of CCRC nursing home beds established under the Nursing Home Bed Need Projection Method (General Provision (f) ii and Step 2). No single project shall be considered simultaneously under both the CCRC statewide bed pool and the bed allocation of the Nursing Home Planning Area in which the project is located.

d. Home Health Agencies (HH)

Home health agency means an entity coordinating or providing the organized delivery of home health services.

Home health services means the provision of nursing services along with at least one other therapeutic service or with a supervised home health aide service to ill or disabled persons in their residences on a part-time or intermittent basis, as approved by a physician.

(1) The performance standards policies presented below are interim. The health planning system shall evaluate these standards and revise them as necessary, when data on the costs and use of home health services in the state are available.

(2) The following home health planning areas in each health planning region shall be used to determine population requirements for home health services:

Health Planning Region I

(a) Clallam/West Jefferson
(b) Whatcom
(c) Skagit
(d) San Juan
(e) Island (minus Camano Island)
(f) East Jefferson
(g) Snohomish/Camano Island
(h) King
(i) Pierce
(j) Kitsap

Health Planning Region II

(a) Grays Harbor/Pacific
(b) Thurston/Mason
(c) Lewis
(d) Cowlitz/Wahkiakum
(e) Clark/Skamania/Klickitat

Health Planning Region III

(a) Okanogan
(b) Chelan/Douglas
(c) Kittitas/Yakima
(d) Grant
(e) Benton/Franklin

Health Planning Region IV

(a) Ferry/Stevens/Pend Oreille
(b) Lincoln/Adams
(c) Spokane
(d) Walla Walla/Columbia
(e) Garfield/Asotin/Whitman

(3) The total annual number of home health visits needed in a home health planning area in the next year shall be estimated using the Interim Home Health Agency Need

ATTACHMENT J

Estimation Method described below. As utilization data become available, estimates used in this method shall be evaluated and adjusted.

(People under 65 x .005) x 10 visits
+ (People 65-79 x .044) x 14 visits
+ (People 80+ x .183) x 21 visits

= TOTAL VISITS

(4) The appropriate number of home health agencies in each home health planning area shall be determined based on the following policies:

(a) For planning purposes ten thousand (10,000) home health agency visits shall be considered to be the target minimum operating volume for a home health agency.

(b) Two home health agencies may be permitted in each home health planning area to allow competition and consumer choice. Where the projected aggregate need is less than 10,000 visits per year, the burden of proof shall be on a proposed new home health agency to demonstrate that competing agencies will result in greater levels of efficiency, effectiveness and equity in such an environment. In this regard, they shall address at least the considerations in Policies (5)(a)-(g) below.

(c) The maximum number of home health agencies permitted in a home health planning area shall not exceed the number of agencies derived by dividing the visits estimated under Step 3 above by the number 10,000.*

(d) For the purpose of determining the need for additional home health agencies in a home health planning area, existing home health agencies in the planning area are those agencies which can serve the area without further state approval and which provide service use and cost data requested by the health planning system.

(5) Considerations for which preference may be given in reviewing competing proposals to meet a limited need in a planning area are presented below. Preference shall be given to the project that meets the greatest number of the following criteria for preference:

*Note: Fractional numbers derived under this calculation would be rounded down to the nearest whole number.

ATTACHMENT J

(a) The proposed agency will meet state certification requirements.

(b) The proposed agency will serve either directly or through formal agreements with other providers the entire planning area in which it is proposed to be located.

(c) The proposed agency has a written policy and budget to serve clients without regard to their source of payment.

(d) The agency has a lower charge per visit compared to similarly-organized agencies providing comparable services in the home health planning area. "Organization" refers to whether the agency is freestanding or hospital-based.

(e) The agency assures continuity of care by having documented formal linkages to other levels of care.

(f) The agency has arrangements to provide charity care to clients who are unable to pay for services.

(g) The agency demonstrates a mechanism for measuring and responding to community concerns.

e. Hospice Services (HS)

Hospice means a private or public agency or part thereof that administers or provides hospice care.

Hospice care means care supervised by the attending physician and provided by the hospice to the terminally ill. Hospice care is primarily palliative or medically necessary care provided by a hospice multidisciplinary team with care available 24 hours per day 7 days a week.

Hospice multidisciplinary teams means a team of individuals that provides or supervises care and services offered by the hospice and that is composed of at least a physician (consultant), registered nurse, social worker, and a pastoral, spiritual or other counselor.

Hospice services are provided in a coordinated program of care organized for the purpose of providing palliative and supportive care which is designed to meet the psychosocial, psychological, and spiritual needs of patients and their families (which includes those persons related by blood, marriage, or other significant relationship as designated by the patient). Bereavement services are an essential part of hospice care.

ATTACHMENT K

Draft Admissions & Discharge Policy Documents & Charity Care Policy

Reference#	1003
Effective:	04/17/14
Last Revised:	03/08/18

INTAKE POLICY

PURPOSE:

- To accept patients for care, treatment, and/or services that are in compliance with the organization's mission, philosophy, scope of services, and with applicable laws and regulations.
- To accept only those patients for care, treatment, and/or services who's identified needs can be reasonably met in the patient's place of residence.

POLICY:

1. Eden Home Health provides care, treatment, and/or services to adult patients, in other words, patients who are over the age of 18.

2. Eden Home Health accepts most private healthcare insurance (please refer to the Agency brochure for further details), Medicare, and Medicaid.

3. A home health patient referral is accepted in accordance with Eden Home Health policies and State Professional Practice Guidelines.

4. Patients are accepted for treatment on the reasonable expectation that Eden Home Health can meet or facilitate the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence.

5. Patients are admitted for service based upon the following criteria:
   - **a.** The patient's needs are compatible with Eden Home Health scope of care, mission, and philosophy.
   - **b.** The patient resides within the geographic area serviced by Eden Home Health.
   - **c.** If the patient is covered by Medicare, he/she is considered to be homebound, as outlined by Federal regulations.
   - **d.** Eden Home Health is able to meet the needs of the patient.
   - **e.** The patient or caregivers are able to assist in the care of the patient.
   - **f.** There is a reasonable expectation that the patient's medical, nursing, and social needs are able to be met adequately in the home environment.
   - **g.** There is a preferred physician taking medical responsibility for the patient's care that performs the face-to-face encounter and establishes and periodically reviews the plan of care.

PROCEDURE:

1. Referrals are accepted telephonically, by fax, e-fax.

2. Referrals are accepted from doctors of medicine, osteopathy, and podiatry, discharge planners, case managers, insurance companies, patients, and families/caregivers.

3. Patient insurance is verified and authorization is received, as appropriate.
   - **a.** Ongoing authorization is obtained, as appropriate.

Reference #:	1021
Effective:	03/16/18
Last Revised:	03/16/18

ADMISSIONS POLICY

PURPOSE:

- The agency develops and maintains written policies and processes governing admissions.

PROCEDURE:

1. The admission policies establish uniform guidelines for personnel to follow when admitting patients to the agency.

2. The admission policies apply to all patients admitted to the Agency without regard to race, color, creed, national origin, age, sex, religion, handicap, ancestry, marital, veteran status, sexual orientation and/or payment source.

3. The objectives of the Agency's admission policies are to:

- **a.** Provide uniform guidelines in the admission of patients to the Agency.
- **b.** Admit patients who can be adequately cared for by the Agency.
- **c.** Reduce patient and family fears and anxieties during the admission process.
- **d.** Review the Agency's policies and processes relating to patient rights, patient care, financial obligations, etc. with the patient and/or the patient's responsible party.
- **e.** Receive appropriate medical and financial records relating to the patient prior to or at admission.

4. The Executive Director (ED) or designee validates that the Agency and the patient follow established admission policies as applicable.

5. The Executive Director adopted the policies outlined within this section as those that best reflect the needs and operational requirements in the admission of patients to the Agency.

6. Admission policies and processes are reviewed for revisions and updates as necessary, but at least annually.

Reference #:	7001
Effective:	04/17/14
Last Revised:	11/27/17

TRANSFER AND DISCHARGE POLICY

PURPOSE:

- To define the circumstances when a patient is transferred or discharged.
- To standardize the process for transferring/discharging patients from Eden Home Health.
- To uphold the patient's right to receive information about his/her care, treatment, and services and to be involved in the decision-making process when appropriate.
- To maintain the continuity of care, treatment, and/or services to meet the patient's needs.
- To exchange appropriate information related to the care, treatment, and/or services with other staff and the receiving healthcare provider when patients are transferred/discharged from Eden Home Health.

POLICY:

1. Eden Home Health is professionally and ethically responsible to provide care, treatment, and services within its financial and service capabilities, mission, and applicable laws and regulations, once a patient has been admitted to the Agency.

2. Eden Home Health retains responsibility and continues to provide care, treatment, and/or services until an appropriate transfer/discharge can be completed.

3. Transfer/discharge of patients occurs in an appropriate manner, guaranteeing that relevant information is communicated to appropriate parties and in such a way as to prevent harm to the patient.

4. The referring and primary care physician is notified of the patient transfer/discharge.

5. The patient and family, as appropriate, is an active participant, when possible, in planning the transfer/discharge.

6. Eden Home Health provides the transfer and discharge policies to the patient and the patient's legal representative (if any) as required.

7. Eden Home Health may transfer or discharge a patient based on the Transfer/Discharge Criteria. The Transfer/Discharge Criteria includes:

a. The transfer or discharge is necessary for the patient's welfare because Eden Home Health and the physician who is responsible for the home health plan of care agree that Eden Home Health can no longer meet the patient's needs, based on the patient's acuity. Eden Home Health must arrange a

safe and appropriate transfer to other care entities when the needs of the patient exceed Eden Home Health's capabilities.

b. The patient or payer will no longer pay for the services provided.

c. The physician who is responsible for the home health plan of care and the HHA agree that the measurable outcomes and goals set forth in the plan of care have been achieved, and the HHA and the physician who is responsible for the home health plan of care agree that the patient no longer needs the HHA's services.

d. The patient refuses services, or elects to be transferred or discharged.

e. The HHA determines, under The *Discharge For Cause* Policy, that the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the HHA to operate effectively is seriously impaired.

f. The patient dies.

g. Eden Home Health is closing out a particular service or all of its services.

TRANSFER PROCEDURE:

1. The appropriate time point OASIS data set items are collected in accordance with Federal regulatory requirements and AGENCY's OASIS policies.

2. A transfer summary (Episode Summary Report) is completed and provided to receiving service entity as specified:

a. For a *planned* transfer: within 2 business days, if the patient's care will be immediately continued in a health care facility.

b. For an *unplanned* transfer: within 2 business days of becoming aware of the transfer, if the patient is still receiving care in a health care facility at the time when the agency becomes aware of the transfer.

i. Patient is identified as "on hold" status in Electronic Medical Record.

3. Transfer Summary includes but is not limited to:

a. Date of transfer.

b. Patient identifying information.

c. Emergency Contact.

d. Destination of patient transferred.

e. Date and name of person receiving report.

f. Patient's physician and phone number.

g. Diagnosis related to the transfer.

h. Significant health history.

i. Transfer orders and instructions.

j. Brief description of services provided and ongoing needs that cannot be met.

k. Status of patient at the time of transfer as appropriate.

If the transfer results in the patient no longer receiving services from Eden Home Health, then a discharge/transfer OASIS is completed to the next healthcare provider per the procedure below:

1. Transfers Per Physician Order:
- **a.** The patient and/or family are informed of the transfer by Eden Home Health staff and are active participants in planning the patient's transfer whenever possible.
- **b.** The Clinical Supervisor/Case Manager coordinates the transfer with the receiving organization and provides the organization with relevant and pertinent information.

2. Patient Requires Services Not Provided by Eden Home Health:
- **a.** The Clinical Supervisor/Case Manager notifies the patient/family/ representative and referring physician that the required care, treatment, and/or services is not provided by Eden Home Health and encourages the patient/family to be an active participant in the referral/transfer process whenever possible and appropriate.
- **b.** The physician approves the referral/transfer.
- **c.** The patient is referred/transferred to other organizations or providers for the required care, treatment, and/or services.
- **d.** The transfer/referral is coordinated with the receiving organization/provider with active participation from the patient/family when possible and appropriate.
- **e.** The physician is notified of the referral/transfer verbally and in writing.
- **f.** Instructions/communications are documented in the medical record.

3. Patient's needs can no longer be met by the HHA according to the HHA and the physician who is responsible for the home health plan of care.
- **a.** The HHA must arrange a safe and appropriate transfer to other care entities when the needs of the patient exceed the HHA's capabilities.
- **b.** The Clinical Supervisor/Case Manager notifies the patient/family/ representative and physicians involved in plan of care of transfer or discharge as appropriate.
- **c.** The transfer/referral is coordinated with the receiving organization/provider with active participation from the patient/family when possible and appropriate.
- **d.** Instructions/communications are documented in the medical record.

4. Patient elects to be transferred or discharged:
- **a.** All attempts are made to resolve grievances per the *Patient Concerns and Grievances Policy.*
- **b.** The HHA will assist with transfer as appropriate.
- **c.** The Clinical Supervisor/Case Manager notifies physician involved in plan of care that the patient has requested transfer or discharge.

d. The patient is referred/transferred to other care entities for the required care, treatment, and/or services.
e. The transfer/referral is coordinated with the receiving organization/provider with active participation from the patient/family when possible and appropriate.
f. Instructions/communications are documented in the medical record.

DISCHARGE PROCEDURE:

1. Updated comprehensive assessments are required:
   a. Within 48 hours of, or knowledge of, discharge to the community or death at home (discharge OASIS assessment with OASIS data items integrated).

2. A discharge summary is completed and OASIS data is collected and documented in medical record.
   a. The Discharge Summary is sent to the patient's primary care practitioner within five (5) business days of discharge.

3. Discharge Summary includes but is not limited to:
   a. Date of transfer/discharge.
   b. Patient identifying information.
   c. Patient's physician and phone number.
   d. Diagnosis.
   e. Reason for Discharge.
   f. Brief description of services provided.
   g. Status of patient at the time of discharge as appropriate.
   h. Instructions given to the patient or responsible party.

4. Medicare and Medicare HMO patients are issued a Notice of Medicare Non-Coverage (NOMNC) at least 48 hours prior to termination of services as appropriate.

REFERENCES:

Centers for Medicare and Medicaid Services (CMS), Home Health Quality Initiatives, OASIS-C, Version 12.2, 2009

Reference #:	7006
Effective:	01/04/18
Last Revised:	01/04/18

DISCHARGE COLLABORATION FOR UNEXPECTED OR UNPLANNED DISCHARGE POLICY

PURPOSE:

- To identify the process for communication for an unexpected or unplanned discharged.

- To provide guidance on the completion of the discharge assessment when an unexpected or unplanned discharge is to take place.

POLICY:

1. When an unplanned or unexpected discharge must take place, the last qualifying clinician who saw the patient completes the discharge comprehensive assessment based on information from his/her last visit.

2. The assessing clinician may supplement the discharge assessment with information documented from patient visits from the agency prior to the unexpected discharge.

3. If the patient had visits within the last 5 days that the patient received care from the agency, those visits can be used to supplement information. The 5 days are defined as the date of the last patient visits, plus the four preceding days.

Reference #:	7002
Effective:	12/22/17
Last Revised:	10/05/18

DISCHARGE FOR CAUSE POLICY

PURPOSE:

- To define the circumstances when a patient may be discharged for cause.
- To uphold the patient's right to receive information about his/her care, treatment, and services, and to be involved in the decision-making process when appropriate.
- To maintain the continuity of care, treatment, and/or services meet the patient's needs.
- To standardize the process for discharging patients for cause from Eden Home Health.
- To exchange appropriate information related to the care, treatment, and/or services with other staff and the receiving healthcare provider when patients are discharged for cause from Eden Home Health.

POLICY:

1. Eden Home Health is professionally and ethically responsible to provide care, treatment, and services within its financial and service capabilities, mission, and applicable laws and regulations, once a patient has been admitted to the Agency.

2. The patient and family, as appropriate, is an active participant, when possible, in planning the discharge.

3. Eden Home Health provides the transfer and discharge policies in the patient or legal representative's primary language.

4. Discharge for Cause Criteria includes:

- **a.** The patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the HHA to operate effectively is seriously impaired.

5. Discharge of patients occurs in an appropriate manner, guaranteeing that relevant information is communicated to appropriate parties and in such a way as to prevent harm to the patient.

- **a.** Patients are provided verbal or written notice of discharge 48 hours prior to discharge. Notice of discharge is not required if worker safety, signification patient noncompliance or patient's failure to pay for services rendered.
  - **i.** Documentation of discharge notification and patients understanding documented in patients' medical record.

Reference #:	7002
Effective:	12/22/17
Last Revised:	10/05/18

PROCEDURE:

1. Prior to discharging a patient for cause, Eden Home Health:

- **a.** Advises the patient/representative for the home health plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) that a discharge for cause is being considered.
- **b.** Makes efforts to resolve the problem(s) presented by the patient's behavior, the behavior of other persons in the patient's home, or situation.
- **c.** Provides the patient and representative (if any), with contact information for other agencies or Providers who may be able to provide care.
- **d.** If there is a concern about patient's' ongoing care and safety, submits a report to appropriate state agencies.
- **e.** Documents the problem(s) and efforts made to resolve the problem(s) and enters this documentation into the clinical records.

ATTACHMENT K

ATTACHMENT L

Staffing, Capital Expenditure and Pro Forma

Proforma Operating Statement - Eden HHA - Clark County				
	2020	**2021**	**2022**	**2023**
	20	*270*	*695*	*1075*
REVENUE		*1250%*	*157%*	*55%*
Medicare	52,286	698,268	1,797,394	2,780,142
Medicaid	2,322	31,010	79,822	123,466
Commercial/Other	13,345	178,219	458,750	709,577
Charity Care	1,307	17,457	44,935	69,504
Total Gross Revenue	**69,260**	**924,954**	**2,380,901**	**3,682,689**
Deductions from Revenue				
Contractual Allowances	15,629	208,724	537,272	831,033
Bad Debt	52,324	18,499	47,618	73,654
Adj. For Charity Care	1,307	17,457	44,935	69,504
Total Net Revenue	**0**	**680,274**	**1,751,076**	**2,708,499**
PATIENT CARE COSTS				
Salaries and Benefits:				
Director of Professional Services	50,000	120,000	120,000	120,000
Clinical Manager	-	90,000	90,000	90,000
Home Care Specialist	-	-	-	-
RN	7,423	99,139	255,192	394,722
PT	9,295	124,133	319,528	494,233
OT	2,880	38,462	99,005	153,137
ST	1,023	13,666	35,178	54,412
MSW	489	6,525	16,797	25,981
HHaide	525	7,012	18,050	27,920
Benefits	14,324	124,735	238,438	340,101
Total Salaries and Benefits	**85,960**	**623,674**	**1,192,188**	**1,700,506**
Contract Labor:				
Physician (Medical Director)	300	1,200	1,200	1,200
PT	0	0	0	0
OT	0	0	0	0
Speech	-	-	-	-
MSW	-	-	-	-
HHA	-	-	-	-
Other	-	-	-	-
Total Contract Labor	**300**	**1,200**	**1,200**	**1,200**
Medical Supplies	763	10,184	26,214	40,547
Mileage & Medical transportation	1,525	20,368	52,429	81,095
Total Patient Care Costs	**88,548**	**655,425**	**1,272,030**	**1,823,348**
Gross Patient Margin	**(88,548)**	**24,849**	**479,046**	**885,151**
ADMINISTRATIVE COSTS				
Advertising	2,500	6,000	6,000	6,000
Allocated Costs	0	34,014	87,554	135,425
B & O Taxes	0	12,245	31,519	48,753
Dues & Subscriptions	6,250	15,000	15,000	15,000
Employee Benefits	10,573	35,568	55,798	61,110
Information Tech/Computers/R&M	3,500	8,400	8,400	8,400
Insurance	250	600	600	600
Legal & Professional	1,000	2,400	2,400	2,400
Licenses & Fees	4,150	9,960	9,960	9,960
Lease Agreement	3,000	7,200	7,200	7,200
Administrative S & W non variable	42,292	142,273	223,190	244,440
Supplies and Expensed Equipment	8,800	6,000	6,000	6,000
Mileage - admin/sales	2,500	6,000	6,000	6,000
Misc Operating Expenses	-	-	-	-
Total Administrative Costs	**78,515**	**285,660**	**459,621**	**551,288**
Total Costs	**167,062**	**941,086**	**1,731,651**	**2,374,636**
EBITDA	**$ (167,062)**	**$ (260,812)**	**$ 19,425**	**$ 333,863**
Depreciation	3,294	7,905	7,905	7,905
Amortization	-	-	-	-
EBIT	**(170,356)**	**(268,716)**	**11,520**	**325,958**
Interest Expense	-	-	-	-
Earnings before Taxes	**(170,356)**	**(268,716)**	**11,520**	**325,958**

ATTACHMENT L

Eden Home Health of Clark County, LLC				
Proforma Balance Sheet				
2020-2023				
	2020	**2021**	**2022**	**2023**
ASSETS				
Current Assets				
Cash & Cash Equivalents	38,213	(207,292)	(322,138)	(113,652)
Accounts Receivable (Net)	0	113,379	291,846	451,416
Prepaid Expenses				
Total Current Assets	**38,213**	**(93,913)**	**(30,292)**	**337,765**
Property and Equipment				
Fixed Assets	19,800	19,800	19,800	19,800
Accumulated Depreciation	3,294	11,198	19,103	27,008
Total Property and Equipment	16,506	8,602	697	(7,208)
Other Assets				
Intangibles	-	-	-	-
Loan Fees				
Accumulated Amortization	-	-	-	-
Total Other Assets	-	-	-	-
Total Assets	54,719	(85,312)	(29,595)	330,557
LIABILITIES AND CAPITAL				
Current Liabilities				
Accounts Payable & Accrued Expenses	16,220	26,451	44,955	56,177
Accrued Payroll & Related Payables	8,855	27,309	53,001	75,973
Notes Payable				-
Current Portion LT Debt				
Total Current Liabilities	25,075	53,760	97,957	132,150
Long-Term Liabilities				
Long Term Note Payable	-	-	-	-
Less: Current Portion of LTD				
Total Long-Term Liabilities	-	-	-	-
Total Liabilities	25,075	53,760	97,957	132,150
Capital	200,000	100,000		
Retained Earnings	-	(170,356)	(439,072)	(427,552)
Shareholder Equity				
Net Income	(170,356)	(268,716)	11,520	325,958
Total Capital	29,644	(339,072)	(427,552)	(101,594)
Total Liabilities & Capital	54,719	(285,312)	(329,595)	30,557
Diff. between Assets & Liab+Equity	-	(200,000)	(300,000)	(300,000)

ATTACHMENT L

Eden Home Health of Clark County, LLC				
Proforma Cash Flow				
	2020	**2021**	**2022**	**2023**
Cash Flows from operating activities				
Net Income	(170,356)	(268,716)	11,520	325,958
Adjustments to reconcile net income to cash provided by Operations				
Accumulated Depreciation & Amortization	3,294	7,905	7,905	7,905
Accounts Receivable	(0)	(113,379)	(178,467)	(159,570)
Prepaid Expenses	-	-	-	-
Accounts Payable	16,220	10,231	18,504	11,222
Payroll Related Expenses	8,855	18,455	25,692	22,972
Current Portion L.T. Debt				
Line of Credit & Short Term Debt			-	-
Total Adjustments	28,369	(76,789)	(126,366)	(117,472)
Net Cash provided by Operations	(141,987)	(345,505)	(114,846)	208,486
Cash Flows from investing activities Used For:				
Capital equipment and furniture	(19,800)	-	-	-
Sale of Fixed Assets				
Intangibles & other assets				
Net cash used in investing	(19,800)	-	-	-
Cash Flows from financing activities				
Proceeds From:				
Note Payable Increase				
Capital Contributions	200,000	100,000	-	-
Used For:				
Note Payable Repayment	-	-	-	-
Note Payable Shareholder				
Less: Current Portion of LTD				
Dividends	-	-	-	-
Net cash used in financing	200,000	100,000	-	-
Net increase <decrease> in cash	38,213	(245,505)	(114,846)	208,486
Summary				
Cash Balance at End of Period	38,213	(207,292)	(322,138)	(113,652)
Cash Balance at Beg of Period	-	38,213	(207,292)	(322,138)
Net Increase <Decrease> in Cash	38,213	(245,505)	(114,846)	208,486

ATTACHMENT L

Proposed Capital Expense

Eden Home Health of Clark County, LLC

Item	Estimated Expense
Network, telemedicine equip	$ 20,000.00
Phone Switch	$ 5,000.00
Hand-helds/laptops	$ 13,000.00
Total	**$ 38,000.00**

-

Depreciation Schedule

	Items	Years	Annual '20-'23
Network, telemedicine equip	$ 20,000.00	7	$ 2,857
Phone Switch	$ 5,000.00	7	$ 714
Hand-helds/laptops	$ 13,000.00	3	$ 4,333
Total:	**$ 38,000.00**		**$ 7,905**

ATTACHMENT M

Letter of Financial Commitment

EmpRes
HEALTHCARE MANAGEMENT
100% Employee Owned

VIA FEDERAL EXPRESS OVERNIGHT

October 21, 2019

Nancy Tyson, Executive Director
Health Facilities and Certificate of Need
Washington State Department of Health
PO Box 47852
Olympia, WA 98504-7852

RE: Eden Home Health of Clark County, LLC dba Eden Home Health

Dear Ms. Tyson:

The Certificate of Need Program's application for a Medicare-certified home health agency asks for a financial letter of commitment.

The members of Eden Home Health of Clark County, LLC have committed the necessary working capital to finance the establishment and operation of the proposed Medicare-certified home health agency in Clark County.

On receipt of the Washington Certificate of Need, the members of Eden Home Health of Clark County, LLC will contribute sufficient funds currently estimated at approximately $150,000 to the working capital account of Eden Home Health of Clark County, LLC.

Sincerely,

Brent Weil
Chief Executive Officer
EmpRes Healthcare Management, LLC

4601 NE 77th Avenue, Suite 300, Vancouver, WA 98662 • P: (360) 892-6628 • F: (360) 882-5793

ATTACHMENT M

ATTACHMENT N

Training, Education and Quality Improvement Policies

Reference#	10104
Effective:	04/17/14
Last Revised:	01/12/17

CONTINUING EDUCATION PROGRAMS POLICY

PURPOSE:

- To provide planned ongoing educational activities for Eden Home Health staff that:
  - Develop and enhance staff skills.
  - Broaden and increase staff knowledge base.
  - Maintain and improve staff competency.

POLICY:

1. This Agency provides educational programs appropriate to the staff's patient care, treatment, and services responsibilities specific to the needs of the patient population served, and as required by applicable laws, regulations, and standards.

2. Educational programs are provided to those staff members whose responsibilities have changed.

3. An annual educational program is planned and implemented based on identified staff needs.

4. Home Health Aides receive a minimum of 12 hours of inservice training every 12 months. Inservice training may occur when an aide is furnishing care to a patient under the supervision of an RN.

5. Staff are evaluated annually and as needed to identify educational needs.

6. Patient care, treatment, and services staff are required to attend or produce evidence of having attended the appropriate number of continuing education programs required by law and regulation to maintain currency of licensure and/or certification.

7. Staff are required to attend, or provide proof of having participated in, mandatory inservice programs. These mandatory inservice training programs include:

- **a.** OSHA/Bloodborne Pathogens
- **b.** Infection Prevention and Control
- **c.** Domestic Violence
- **d.** Workplace Violence Prevention
- **e.** Personal Safety
- **f.** CPR
- **g.** Fire Safety
- **h.** Emergency Management
- **i.** Pain Management
- **j.** Death and Dying
- **k.** Adverse Event Reporting

8. Eden Home Health administration retains the right to designate other inservice programs as mandatory programs.

INSERVICE RESPONSIBILITIES:

1. The Clinical Manager or designee is responsible for providing current and factual information to his/her staff regarding performance of their job duties. New procedures or policies governing such duties are conveyed to the staff in a manner that is understandable and reasonable to those involved. Records of such programs are retained as described in this policy.

2. The administration provides up-to-date and factual information to staff regarding policies, procedures, and benefits. In most cases, policies and procedures are conveyed to department managers, who convey such information to their staff.

PROCEDURE - INSERVICE ATTENDANCE:

1. *Mandatory Inservice Meetings:* Those meetings which have been determined necessary for staff within a particular department or group of common interest are considered to be mandatory. Mandatory attendance is at the discretion of the Clinical Manager or designee with approval of the Executive Director/Administrator or Director of Clinical services.

- **a.** Mandatory meetings are generally those that provide vital and necessary information to staff involved, and attendance is requested with prior notice to those required to attend. Staff receive their regular rate of pay for attendance at mandatory meetings, unless their attendance is not specifically requested. If attendance at a mandatory meeting involves overtime for staff during that work week, specific approval from the department manager is required if an alternate attendance time cannot be arranged.

2. *Voluntary Inservice Meetings:* Those meetings for which attendance is not deemed necessary and vital to a particular department or group of common interest are considered to be voluntary. Attendance at voluntary meetings is at the discretion of the staff member, based on his/her interest in the subject being presented.

3. Credit for Attendance at Inservice Programs:

- **a.** In order to receive proper credit for attendance, the staff member signs his/her name on the sign-in sheet provided at each meeting.
- **b.** The staff member attends the entire program in order to receive credit for attendance.

4. Continuing Education Credits:

- **a.** Programs for which continuing education credits are offered are advertised as such.
- **b.** The number of credit hours is listed with the program information.

c. In order to receive appropriate continuing education credits and a certificate, participants:
  i. Attend the entire program.
  ii. Sign the attendance sheet.

5. Internal Scheduling of Inservice Programs:
  a. *Equipment and Supplies:* Audiovisual and other inservice equipment is maintained by the Business Office Manager. Those who desire use of this equipment submit a written request as early in advance as possible.
    i. Supplies necessary for inservice programs are the responsibility of the individual conducting the program. Prior administrative approval is required for expenditures made for inservice program supplies.
  b. *Meeting Room Availability:* Meeting rooms are reserved in advance as early as possible through administration.

6. Record Keeping for Education Programs:
  a. Records of education programs are maintained in the employee's personnel file or electronically. Proper record keeping contains the following information:
    i. Names and signatures of staff who attended the program.
    ii. Title of the program, name of the individual conducting the program, dates, and times the program was conducted, and the location of the program.
    iii. A description of the content of the program, its relation to the department, and/or staff and voluntary/mandatory status of the program.
  b. Results of education program evaluation are compiled and summarized by the Clinical Manager.
  c. Summary reports of educational activities and the results of program evaluations are submitted to the Performance Improvement Committee quarterly.

ATTACHMENT N

Reference#	16001
Effective:	04/17/14
Last Revised:	12/22/17

QUALITY ASSURANCE PERFORMANCE IMPROVEMENT (QAPI) POLICY

PURPOSE:

1. The Agency's Quality Assurance Performance Improvement (QAPI) plan is designed to:
- **a.** Delineate expectations and plan and manage processes to measure, assess, and improve Eden Home Health's Agency's governance, management, clinical, and support activities.
- **b.** Promote positive patient outcomes through the application of optimal patient care, treatment, and services based on clinically sound principles and current knowledge.
- **c.** Identify, on an ongoing basis and in a coordinated and collaborative manner, areas for improvement in the quality of care, treatment, and services.
- **d.** Evaluate, monitor, improve, and resolve areas of concern.

2. The Quality Assurance Performance Improvement (QAPI) plan, established by the senior management of the organization in collaboration with staff members and the Performance Improvement Committee, with the support and approval of the Governing Body, is comprehensive in scope and provides a vehicle to monitor patient care, treatment, and services with the goal of identifying and resolving processes, functions, and services that may adversely impact patient care, treatment, and services, while striving to continuously facilitate positive patient outcomes.

POLICY:

1. The Home Health Agency develops implements and maintains an ongoing, effective, data driven Quality Assurance Performance Improvement (QAPI) program.

2. The Governing Body guarantees the following;
- **a.** The program reflects the complexity of its organization and services.
- **b.** Involves all Home Health agency services (including those under contract or arrangement).
- **c.** Focuses on indicators related to improved outcomes including;
  - **i.** Use of emergency care services.
  - **ii.** Hospital admissions and readmissions.
  - **iii.** Takes actions that address the performance across the spectrum of care.
  - **iv.** Prevention and re-education of medical errors.

Eden Home Health's Quality Assurance Performance Improvement (QAPI) plan is evaluated at least annually and revised as necessary.

3. The Quality Assurance Performance Improvement (QAPI) activities are planned in a collaborative, interdisciplinary manner throughout the organization.

4. In keeping with the organization's mission of providing quality, cost-effective patient care, treatment, and services, the Quality Assurance Performance Improvement (QAPI) plan allows for a systematic, coordinated, and continuous approach to improving performance, focusing upon the process and functions that address these principles.

GOALS:

1. The primary goals of the organizational Quality Assurance Performance Improvement (QAPI) Plan are to continually and systematically plan, design, measure, assess, and improve performance of organization wide key functions and processes relative to patient care, treatment, and services.

2. To achieve this goal, the plan strives to:

- **a.** Incorporate quality planning throughout the organization.
- **b.** Collect data to monitor performance.
- **c.** Provide a systematic mechanism for the organization's appropriate individuals, departments, and professions to function collaboratively in their Quality Assurance Performance Improvement (QAPI) efforts providing feedback and learning throughout the Agency.
- **d.** Provide for an organization-wide program that assures the Agency designs processes (with special emphasis on design of new or revisions in established services) well and systematically measures, assesses, and improves its performance to achieve optimal patient health outcomes in a collaborative, cross-departmental, interdisciplinary approach. These processes include mechanisms to assess the needs and expectations of patients and their families, staff, and others. Process design contains the following focus elements:
  - **i.** Consistency with the organization's mission, vision, values, goals, and objectives and plans.
  - **ii.** Meets the needs of individuals served, staff, and others.
  - **iii.** Fosters the safety of patients and the quality of care, treatment, and services.
  - **iv.** Supports a culture of safety and quality.
  - **v.** Use of clinically sound and current data sources (e.g. use of practice/clinical guidelines, information from relevant literature and clinical standards).
  - **vi.** Is based upon best practices as evidenced by accrediting bodies.
  - **vii.** Incorporates available information from internal sources and other organizations about the occurrence of medical errors and sentinel events to reduce the risk of similar events in this organization.
  - **viii.** Utilizes reports generated from OASIS data, including the following OASIS reports:
    - Outcome-Based Quality Monitoring (OBQM) Potentially Avoidable Events Report and Patient Listing.
    - Outcome-Based Quality Improvement (OBQI) Outcome Report.

- Error Summary Report.

ix. Utilizes the results of Quality Assurance Performance Improvement (QAPI), patient safety, and risk reduction activities.

x. Management of change and Quality Assurance Performance Improvement (QAPI) supports both safety and quality through the Agency.

e. The organization incorporates information related to these elements, when available and relevant, in the design or redesign of processes, functions, or services.

f. Assure that the improvement process is organization wide, monitoring, assessing, and evaluating the quality and appropriateness of patient care, treatment, and services, patient safety practices, and clinical performance to resolve identified problems and improve performance.

g. Appropriate reporting of information to the Governing Body to provide the leaders with the information they need in fulfilling their responsibility for the quality of patient care, treatment, and services, and safety is a required mandate of this plan.

3. Necessary information is communicated among departments/services when opportunities to improve patient care, treatment, and/or services and patient/staff safety practices impact more than one department/service.

4. The status of identified problems is monitored to assure improvement or resolution.

5. Information from departments/services and the findings of discrete Quality Assurance Performance Improvement (QAPI) activities are analyzed to detect trends, patterns of performance, or potential problems that may impact more than one department/service.

6. The objectives, scope, organization, and mechanisms for overseeing the effectiveness of monitoring, assessing, evaluation, and problem-solving activities in the Quality Assurance Performance Improvement (QAPI) program are evaluated at least annually and revised as necessary.

7. Important key aspects of care to the health and safety of patients are identified. Included are those that occur frequently or affect large numbers of patients; place patients at risk of serious consequences of deprivation of substantial benefit if care is not provided correctly or not provided when indicated; or care provided is not indicated, or those tending to produce problems for patients, their families, or staff.

8. Internal structures can adapt to changes in the environment.

SCOPE OF ACTIVITIES:

1. Eden Home Health measures, analyzes, and tracks quality indicators to enable the agency to assess processes of care, services, and operations.

2. The scope of the organizational Quality Assurance Performance Improvement (QAPI) program includes an overall assessment of the efficacy of Quality Assurance Performance Improvement (QAPI) activities with a focus on continually improving care, treatment, and services, and patient and staff safety practices.

3. The Home Health agency's performance improvement activities must;
- **a.** Focus on high risk, high volume, or problem-prone areas.
- **b.** Consider incidence, prevalence, and severity of problems in those areas.
- **c.** Lead to an immediate correction of any identified problem that directly or potentially threaten the health and safety of patients.

4. Performance activities must track adverse patient events, analyze their causes, and implement preventative actions.

5. Assessment of the performance of the following patient care and organizational functions may include but not limited to:
- **a.** Environment of Care.
- **b.** Emergency Management, including:
- **c.** Review of the annual emergency management planning reviews.
- **d.** Review of emergency response exercises.
- **e.** Review of response to actual emergencies.
- **f.** Human Resources.
- **g.** Infection Prevention and Control.
- **h.** Information Management.
- **i.** Leadership.
- **j.** Medication Management.
- **k.** Provision of Care, Treatment, and Services.
- **l.** Performance Improvement.
- **m.** Record of Care, Treatment, and Services.
- **n.** Rights and Responsibilities of the Individual.
- **o.** Waived Testing.

PERFORMANCE IMPROVEMENT PROJECTS:

1. Home Health Agencies must conduct performance improvement projects.

2. The number and scope of distinct improvement projects conducted annually must reflect the scope, complexity, and past performance of the Home Health Agencies services and operations.

3. The Home Health Agency must document the quality improvement projects undertaken, the reasons for conducting these projects, and the measureable progress achieved on these projects.

ORGANIZATION:

1. To achieve fulfillment of the objectives, goals, and scope of the organizational Quality Assurance Performance Improvement (QAPI) plan, the organizational structure of the program is designed to facilitate an effective system of monitoring, assessment, and evaluation of the care, treatment, and services provided within the Agency.
    - **a.** The Governing Body is ultimately responsible for the quality of patient care, treatment, and services provided.
        - **i.** The Governing Body requires staff, through the Performance Improvement Committee and Administration, to implement and report on the activities and the mechanisms for monitoring, assessing, and evaluating patient safety practices and the quality of patient care, treatment, and services, for identifying and resolving problems and for identifying opportunities to improve patient care, treatment, and services or performance throughout the organization. This process addresses those departments/disciplines that have a direct or indirect effect on patient care, treatment, and services, including management and administrative functions.
        - **ii.** The Governing Body, through the VP of Home Health and Hospice, Director of Clinical Service, and the Agency Administrator/Executive Director, provide for resources and support systems for the Quality Assurance Performance Improvement (QAPI) functions and risk management functions related to patient care, treatment, and services and safety.
    - **b.** The governing body is responsible for guaranteeing;
        - **i.** The ongoing program for quality improvement and patient safety is defined, implemented, and maintained.
        - **ii.** The Home Health Agency wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improved actions are evaluated for effectiveness.
        - **iii.** That clear expectations for patient safety are established, implemented, and maintained.
        - **iv.** That any findings of fraud or waste are appropriately addressed.

ANNUAL EVALUATION AND APPROVAL:

1. The organizational Quality Assurance Performance Improvement (QAPI) program is evaluated for effectiveness at least annually and revised as necessary to assure appropriateness of the approach to planning processes of improvement: setting priorities for improvement; assessing performance systematically; using statistically valid methods; implementing improvement activities on the basis of assessment; and sustaining achieved improvements.

CONFIDENTIALITY:

1. Information related to Quality Assurance Performance Improvement (QAPI) activities in accordance with this plan is confidential.

- **a.** Confidential information may include, but is not limited to, staff committee meetings, Quality Assurance Performance Improvement (QAPI) Executive Report, electronic data gathering and reporting, medical record reviews, and untoward incident reporting.
- **b.** Some information may be disseminated on a "need to know basis" as required by agencies such as federal review agencies, regulatory bodies, or another organization with a proven "need to know basis" as approved by the Agency's Administration and/or the Governing Body.

Reference#	10102
Effective:	04/17/14
Last Revised:	03/10/17

AIDE ORIENTATION POLICY

PURPOSE:

- To provide a consistent and formalized orientation program for Certified Home Health Aides.

POLICY:

1. Certified Home Health Aides hired by Eden Health participate in an orientation program before receiving patient care assignments.

2. Orientation of new Certified Home Health Aides is the joint responsibility of the Clinical Manager or designee.

PROCEDURE:

1. The Clinical Supervisor or designee is responsible for orienting newly hired Certified Home Health Aides to Eden Health's general Orientation as well as specific Home Health Aide orientation.

2. The Clinical Supervisor or designee is responsible for verifying that newly hired Certified Home Health Aides can demonstrate knowledge of and/or are competent in the following:

- **a.** Basic verbal and written English communication skills.
- **b.** Observation, reporting, and documentation of patient status and the care or service furnished.
- **c.** Reading and recording temperature, pulse, and respiration.
- **d.** Basic infection control procedures.
- **e.** Basic elements of body functioning and changes in body function that are reported to an aide's supervisor.
- **f.** Maintenance of a clean, safe, and healthy environment.
- **g.** Recognizing emergencies and knowledge of emergency procedures.
- **h.** The physical, emotional, and developmental needs of and ways to work with the populations served by the HHA, including the need for respect for the patient, his or her privacy, and his or her property.
- **i.** Appropriate and safe techniques in personal hygiene and grooming that include:
  - **i.** Bed bath.
  - **ii.** Sponge, tub, or shower bath.
  - **iii.** Shampoo, sink, tub, or bed.
  - **iv.** Nail and skin care.
  - **v.** Oral hygiene.
  - **vi.** Toileting and elimination.
  - **vii.** Safe transfer techniques and ambulation.
  - **viii.** Normal range of motion and positioning.
  - **ix.** Adequate nutrition and fluid intake.

x. Another task that the HHA may choose to have the home health aide performs.

j. The following competencies are evaluated while the aide is performing the tasks with a patient (tasks may be performed on a pseudo-patient such as another aide or volunteer in a laboratory setting):

i. Reading and recording temperature, pulse, and respiration.

ii. Safe transfer techniques and ambulation.

iii. Normal range of motion and positioning.

iv. Appropriate and safe techniques in personal hygiene and grooming that include:

- Bed bath.
- Sponge, tub, or shower bath.
- Shampoo, sink, tub, or bed.
- Nail and skin care.
- Oral hygiene.
- Toileting and elimination.
- The other subject areas in this section may be evaluated through written examination, oral examination, or after observation of a Home Health Aide with a patient.

ATTACHMENT N

Eden Home Health of Spokane County, LLC Certificate of Need Application Proposing the Establishment of a Medicare/Medicaid Certified Home Health Agency in Clark County

ATTACHMENT O

ATTACHMENT P

Vendor List

C: Structure and Process of Care
#8
Appendix P:
Eden Home Health Vendor Listing

1. Medical Supplies – Medline
2. Quality and Outcomes Vendor – Strategic Healthcare Partners (SHP)
3. HHCAHPS – Strategic Healthcare Partners (SHP)
4. Electronic Health Record – Homecare Homebase
5. Clearing House – Zirmed
6. Telephone/Internet Services – Verizon Wireless and Comcast
7. Shredding – Iron Mountain
8. Answering Service (after-hours) – TeleMed
9. Virtual Care Technology/Telehealth – Healthcare Recovery Services (HRS)
10. Coding – Coding Department
11. Learning Management System – Fazzi Academy
12. Online Patient Education – Krames
13. Shipping/Postage – FedEx
14. Payroll System – Kronos
15. Hazardous Waste Disposal – Stericycle
16. Interpretation – Language Line Services
17. Recruiting – Indeed, Social Media Platforms (Facebook, LinkedIn, etc.)
18. Applicant Tracking System – Newton
19. Background Checks – Assure Hire
20. OIG Searches – Certiphino Screening
21. Office Supplies/Promotional Products – Office Depot

ATTACHMENT Q

Washington State Department of Health Chronic Disease Profile for each County

Clark County

Chronic Disease Profile

Introduction

This report summarizes key health statistics related to chronic disease burden and risk for local populations in Washington State. The Department of Health uses established population and health surveillance systems to describe the current prevalence[i] of important health indicators within specific populations, and also to provide comparisons of the prevalence within specific populations to the state overall.

These data can be used to plan interventions or describe the importance and need for health interventions. Interventions may be directed to specific health conditions, or to factors that impact many aspects of health, such as income, education and housing. Therefore, this report may be useful for community members, leaders or other stakeholders who are working to improve the health status of the community.

Life Course Approach[ii]

Health and quality of life at all stages in life depend on the cumulative effects of behaviors and exposures earlier in life, and on social, genetic, and epigenetic effects[iii] that span generations. A mother's experiences even prior to conception can alter the development of the fetus and child. Choices made by adolescents grow out of the experiences of childhood, and can shape behavior later in adulthood. A lifetime of risky behavior or exposure to toxic or stressful conditions can lead to chronic disease, poor quality of life and early death.

This report is organized based on a life course approach. We begin with data on the demographic, social and economic context. Next we show data related to birth and early childhood. We follow these in turn by data for youth (grade 10), adults (age 18+) and seniors (age 65+). Lastly, we provide patterns of mortality.

Health Risk Indicators

Many pieces of health data can be presented in either a positive or negative manner. For example, we could either talk about reducing obesity, or achieving healthy weight. For other data, only the negative presentation makes sense. For example, it would be awkward to discuss increasing the prevalence of people without diabetes. For consistency and ease of comparison, this document presents all data in terms of risk.

Health data are estimated with some degree of statistical uncertainty. We present the degree of uncertainty by surrounding each estimate in graphs with error bars that represent the 95% confidence interval. See appendix for further detail.

Data sources, explanatory notes, and a glossary of terms are provided in the appendix.

ATTACHMENT Q

Geography and Sample Size

Whenever possible, we report local data at the county level. Due to small sample sizes in health surveys, this is not always possible. Estimates based on a sample of less than 50 people, or where less than 10 reported the condition of interest, or where the relative standard error[iv] is > 30% are not considered to be reliable. In these cases, we present local data for a multi-county region containing the county of interest, and place an asterix (*) in the chart. Geographic regions used in this report are shown in the maps below.

Map 1. Multi-county regions are based on US Census Bureau Public Use Microdata Areas (PUMA). We use PUMA-County regions when necessary for most data in this report.

Map 2. We use larger multi-county regions when necessary for Pregnancy Risk Assessment Monitoring System (PRAMS) data.

For people with disabilities, this document is available on request in other formats.
To submit a request, please call 1-800-525-0127 (TDD/TTY call 711).

ATTACHMENT Q

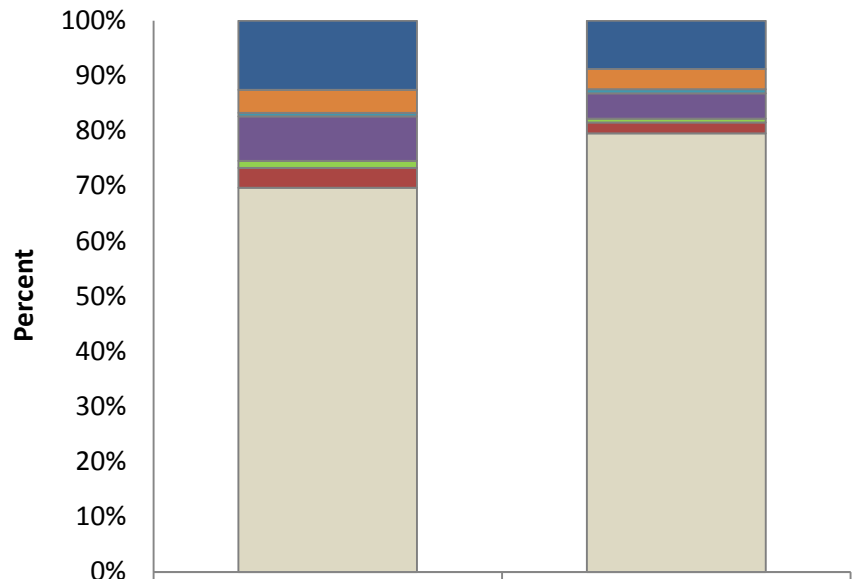
Population

Clark County Population: 461,011 = 6% of state

Age Distribution

- Washington State: 15% are age 65+; 23% are age < 18
- Clark County: 15% are age 65+; 24% are age < 18

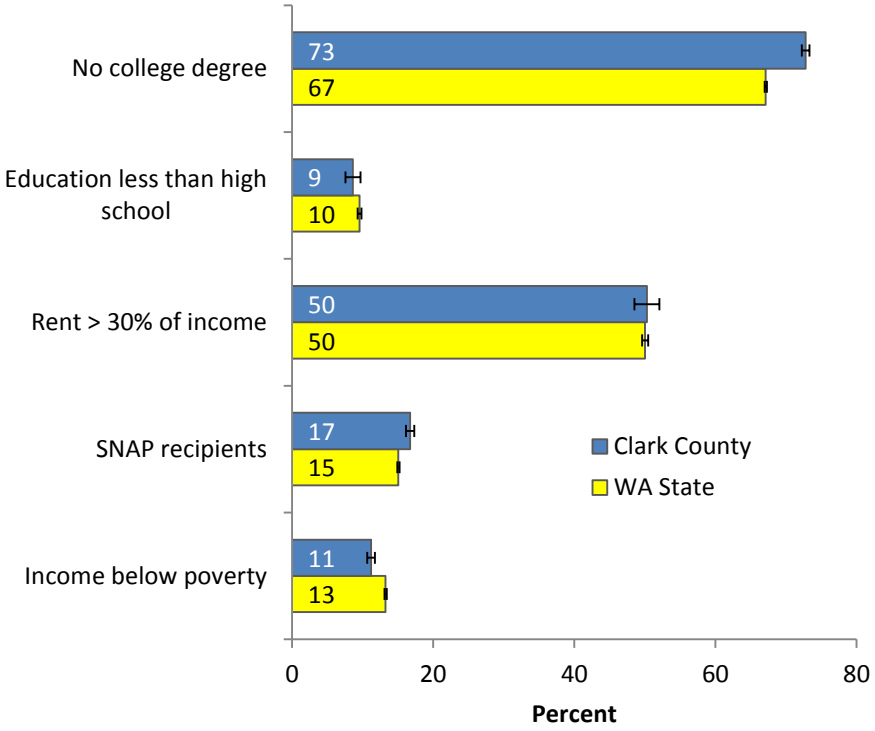
Population by Race / Ethnicity



	WA State	Clark County
Hispanic	12.6%	8.8%
Non-Hispanic Multiracial	4.1%	3.7%
Non-Hispanic Native Hawaiian / Pacific Islander	0.7%	0.7%
Non-Hispanic Asian	8.0%	4.6%
Non-Hispanic American Indian / Alaska Native	1.3%	0.7%
Non-Hispanic Black	3.6%	2.0%
Non-Hispanic White	69.7%	79.6%

Data Source: Washington State Office of Financial Management, Forecasting Division, single year intercensal estimates, 2016

Social and Economic Risk Factors



Income Disparity

- Washington State: Gini index of income disparity = 0.45.
- Clark County: Gini index of income disparity =0.42.

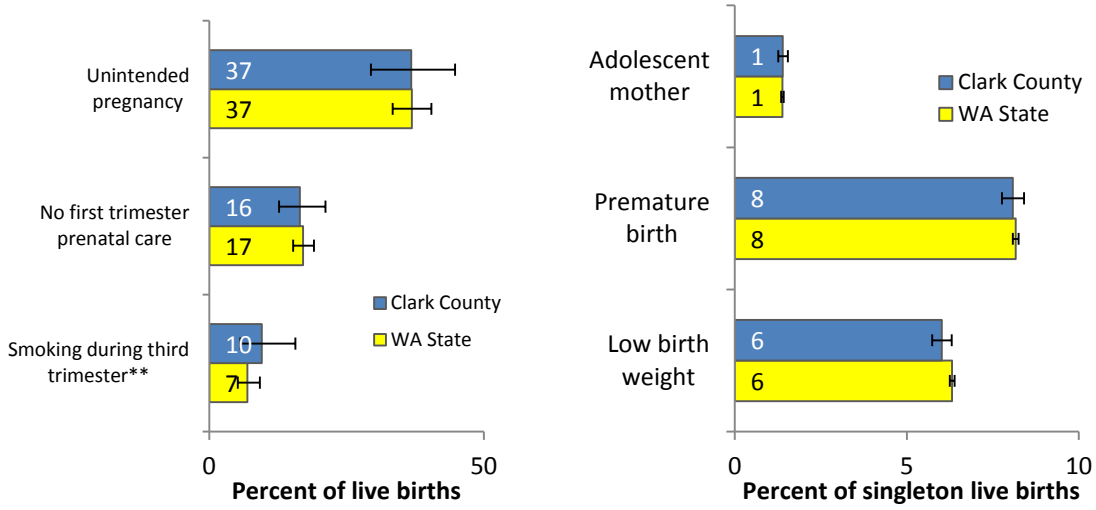
Gini index measures inequality in income. Values range from zero (perfect equality) to one (total inequality).

Indicator Notes

1. Federal Poverty Level (FPL) is determined based on household income and household size. In 2015, the federal poverty level household income for a family of four was $24,250.
2. Highest educational attainment is among adults 25 and older.

Data Source: US Census Bureau, American Community Survey (ACS), 2011-2015

Prenatal and Birth Health Risk Factors



**Insufficient data for county level analysis; estimates are for multi-county regions (See Map 2).

Pregnancy Rate

- Washington State: 64 pregnancies per 1000 reproductive age women (age 15-44)
- Clark County: 64 pregnancies per 1000 reproductive age women (age 15-44)

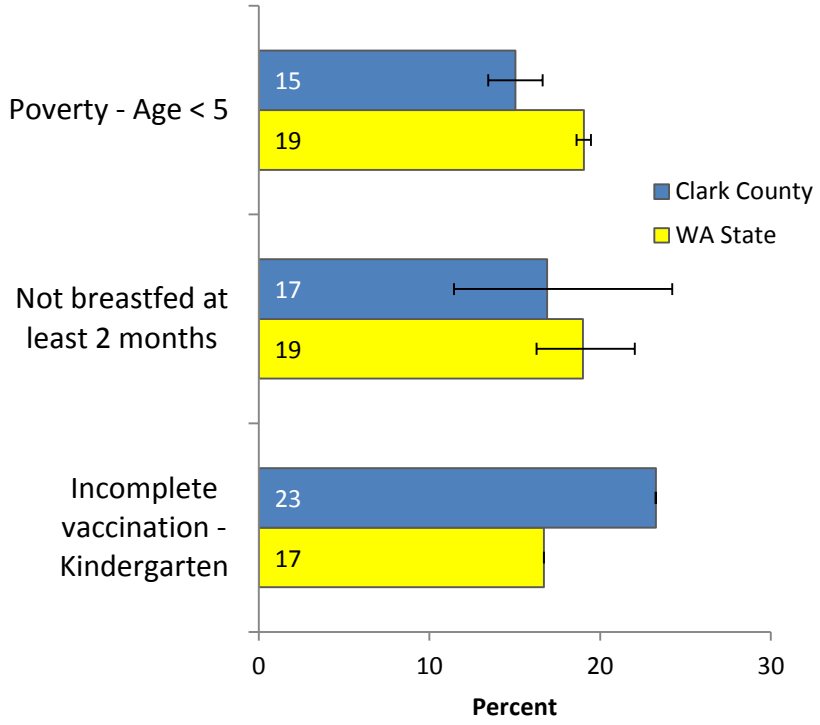
Indicator Notes

1. Third trimester smoking: Smoked one or more cigarettes on an average day during the last three months of pregnancy.
2. Prenatal care includes visits to a doctor, nurse, or other healthcare worker before the baby was born to get checkups and advice about pregnancy.
3. Unintended pregnancy: When asked “Thinking back to just before you got pregnant with your new baby, how did you feel about becoming pregnant?” responded “I wanted to become pregnant later” or “I didn’t want to be pregnant then, or in the future.”
4. Low birth weight is defined as a birth under 2,500g but no lighter than 227g. Infants born less than 227g are considered pre-viable.
5. Premature delivery is defined as gestation < 37 weeks.
6. Adolescent mother is defined as age 15-17.

Data Sources:

- Prenatal: Washington State Department of Health, Pregnancy Risk Assessment Monitoring System (PRAMS), 2012-2014.
- Birth outcomes: Washington State Department of Health, Center for Health Statistics (CHS), Birth Certificate Data, 2011-2015.
- Pregnancy rate: Washington State Department of Health, Center for Health Statistics (CHS), Birth Certificate Data, fetal deaths, and induced abortions, 2013-2015.

Early Childhood Health Risk Factors



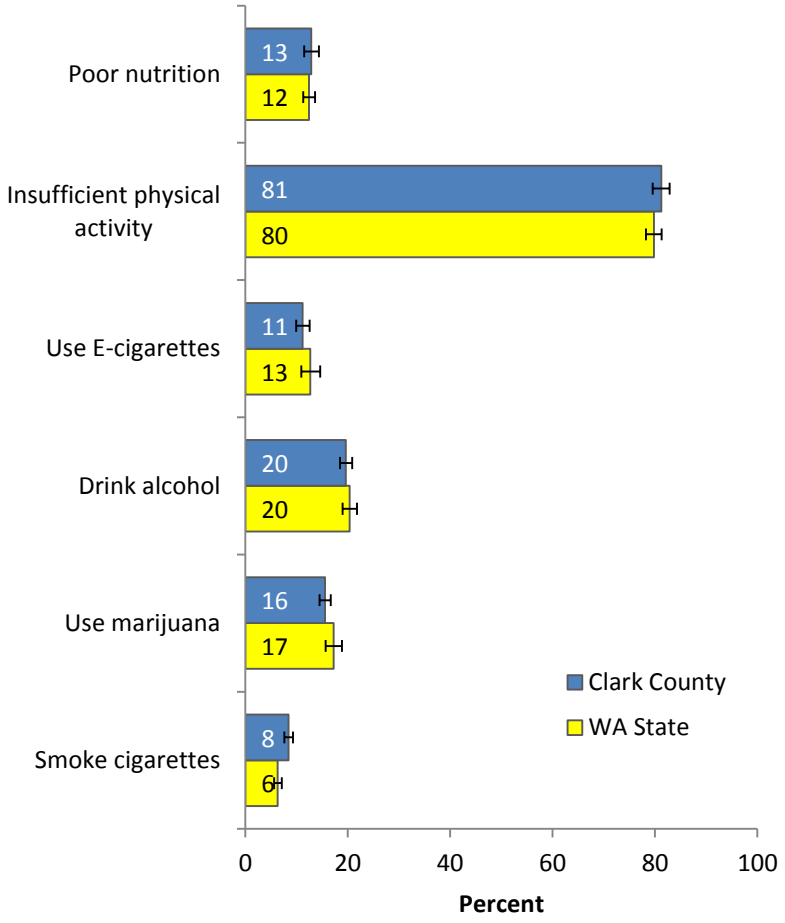
Indicator Notes

1. Incomplete vaccination: Student does not meet all the school-entry requirements for age and grade.
2. Breastfeeding: did not breastfeed baby, or breastfed for less than 8 weeks.
3. Child poverty: Age 0-4, living in a household with income less than FPL.

Data Sources:

- Child poverty: American Community Survey 2011-2015
- Breastfeeding: Pregnancy Risk Assessment Monitoring System 2012-2014
- Vaccination: Washington State Department of Health, Office of Immunization and Child Profile.2015-2016

Youth (10th grade) Health Risk Behaviors

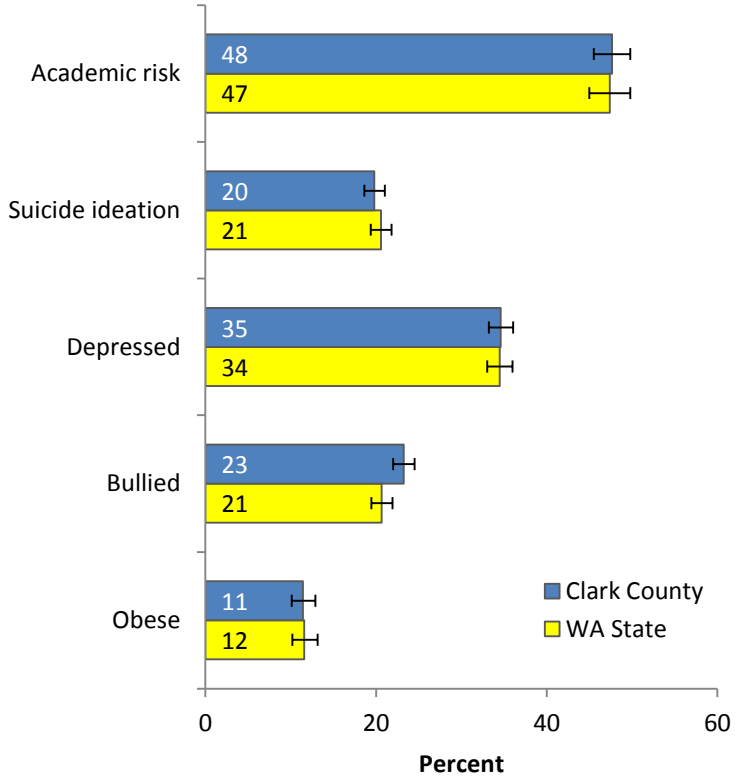


Indicator Notes

1. Youth smoking, marijuana, alcohol, e-cigarettes: Students are asked "during the past 30 days, how many times did you… Smoke cigarettes; Use marijuana or hashish (grass, hash, pot); Drink a glass, can, or bottle of alcohol (beer, wine, wine coolers, hard liquor); use electronic cigarettes or e-cigs?"
2. The Centers for Disease Control and Prevention (CDC) recommends 60 minutes moderate or vigorous physical activity every day for youths.
3. Poor nutrition is indicated by eating fruits and vegetables less than once a day.

Data Source: Washington State Healthy Youth Survey 2016.

Youth (10th grade) Health Risk Conditions

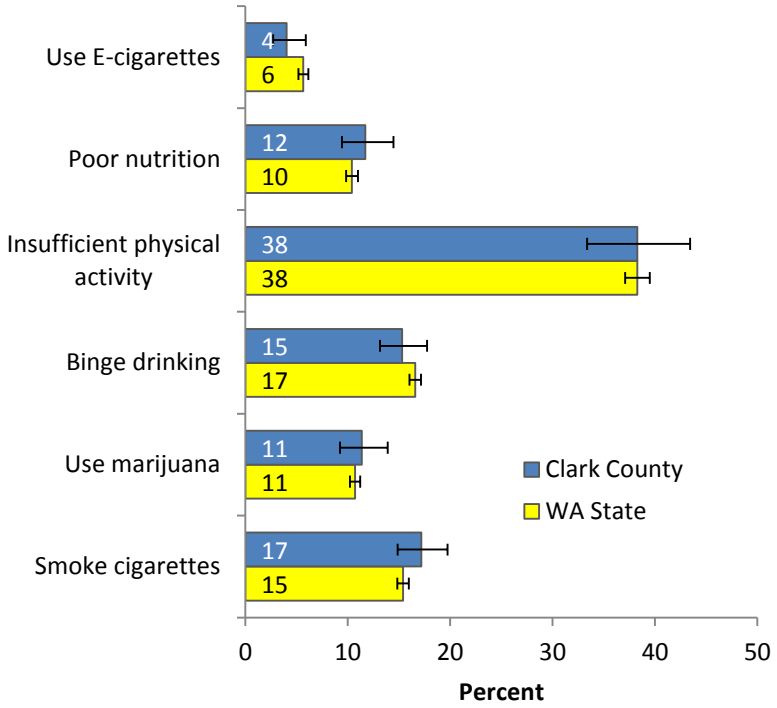


Indicator Notes

1. Youth obesity: Youth are classified as obese if they are in the 95th percentile for body mass index by age and sex based on growth charts developed by the CDC (2000).
2. Bullied: Students are asked "A student is being bullied when another student, or group of students, say or do nasty or unpleasant things to him or her. It is also bullying when a student is teased repeatedly in a way he or she doesn't like. It is NOT bullying when two students of about the same strength argue or fight. In the last 30 days, how often have you been bullied?"
3. Depression: Students were asked "During the past 12 months, 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?"
4. Suicide ideation: Students were asked "During the past 12 months, did you ever seriously consider attempting suicide?
5. Academic risk: Risk of academic failure including usually getting low grades and grades worse than others, and low commitment to school including school not meaningful or important for future, and cut school.

Data Source: Washington State Healthy Youth Survey 2016.

Adult (Age 18+) Health Risk Behaviors

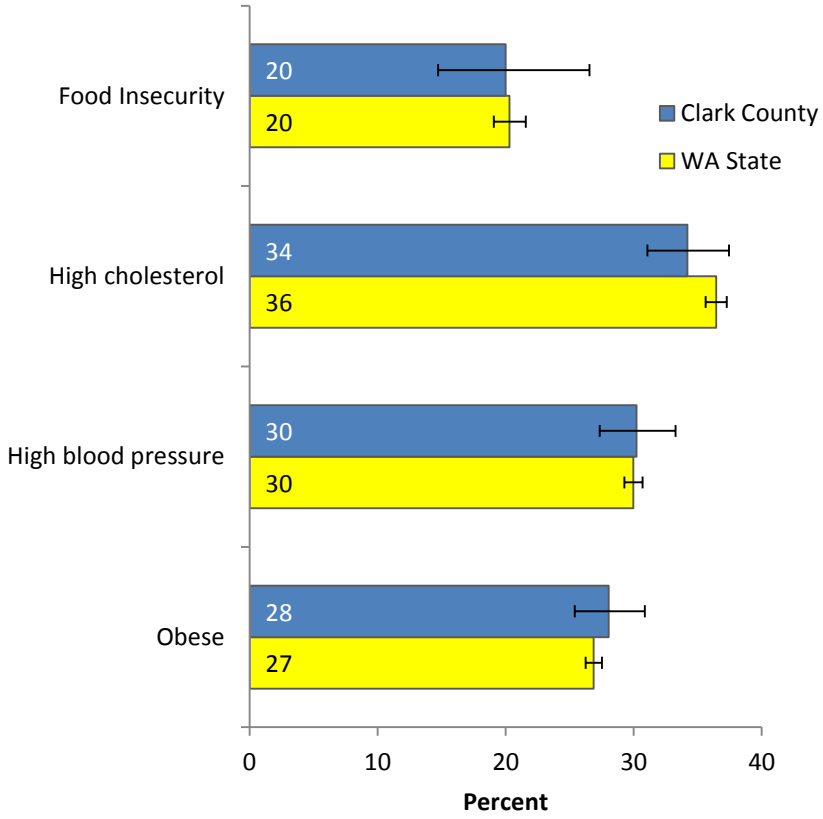


Indicator Notes

1. Adult smoking: Respondents are asked “Have you smoked at least 100 cigarettes in your lifetime?” and “Do you still smoke?”
2. Adult marijuana: Respondents were asked “During the past 30 days, on how many days did you use marijuana or hashish?”
3. Binge drinking: Past 30 days, adult men having five or more drinks or adult women having four or more drinks on one occasion.
4. CDC recommends 150 minutes of moderate aerobic physical activity or 75 minutes of vigorous aerobic physical activity a week, combined with some form of muscle strengthening activity three times a week. People whose work involves mostly walking meet the aerobic recommendation. People whose work involves heavy labor meet both the strength and aerobic recommendations.
5. Nutrition: Respondents are asked a series of questions about fruits and vegetables eaten in the past month. CDC recommends three servings of vegetables and two servings of fruit a day. Very poor nutrition is defined here as eating fruits and vegetables less than once a day.
6. E-Cigarettes: Respondent is asked “During the past 30 days, on how many days did you use electronic cigarettes, also called E-cigarettes or vape pens?”

Data Source: Washington Behavioral Risk Factor Surveillance System 2013-2015.

Adult (Age 18+) Health Risk Conditions

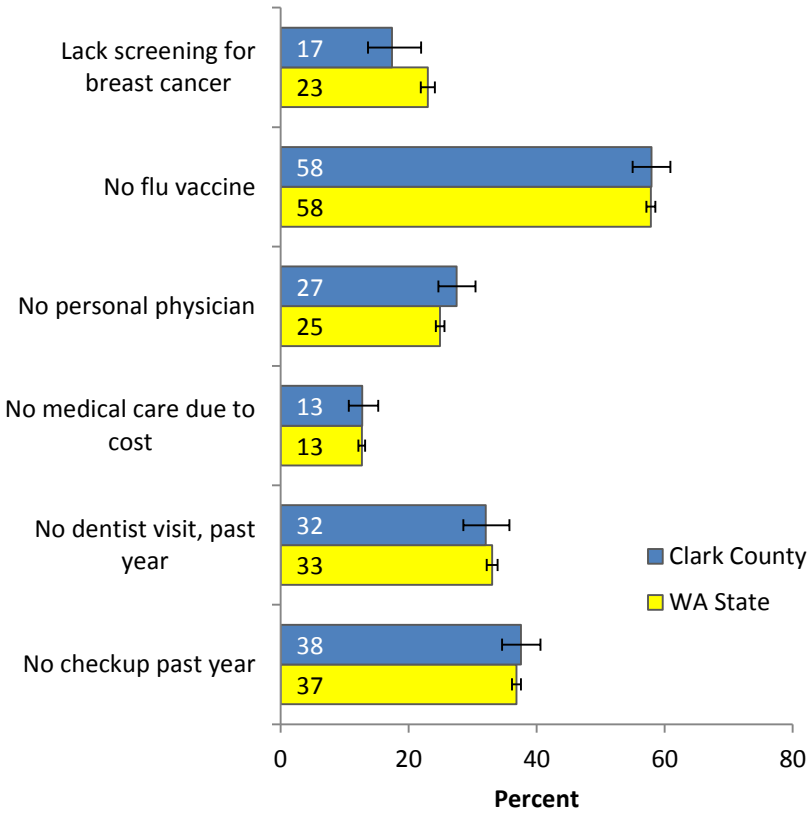


Indicator Notes

1. Obesity in adults is defined as body mass index ≥ 30 kg /m^2 based on self reported height and weight.
2. Self reported lifetime prevalence – Survey respondent answered "yes" to "have you ever been told by a healthcare professional that you have high blood pressure / high cholesterol?"
3. Food Insecurity: Respondents were asked "How often in the past 12 months would you say you were worried or stressed about having enough money to buy nutritious meals?" Responses of "sometimes", "usually", or "always" were considered to be food insecure.

Data Source: Washington Behavioral Risk Factor Surveillance System 2013-2015.

Adult (Age 18+) Preventive Care

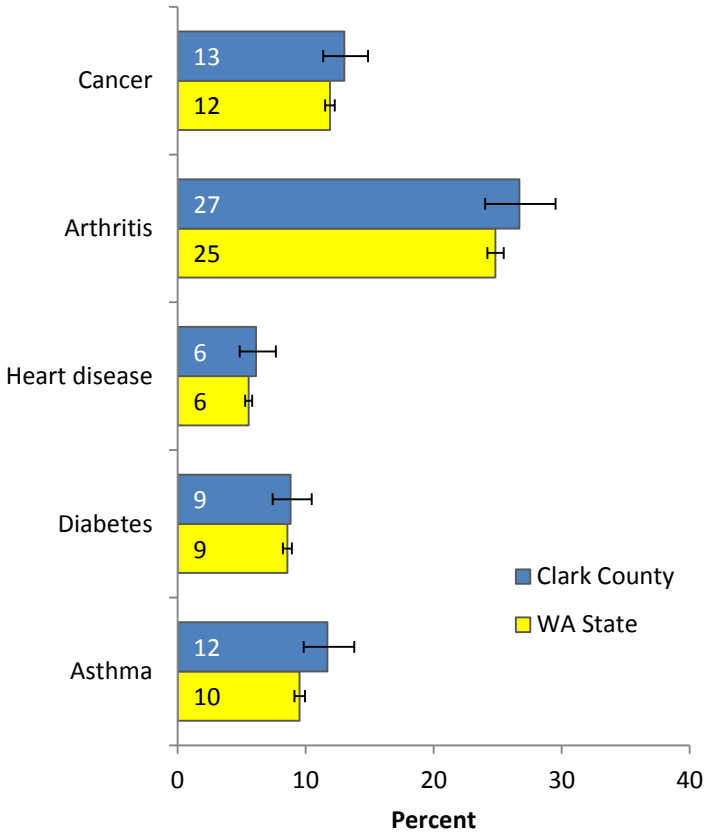


Indicator notes

1. The Department of Health recommends women age 50 or older should have a mammogram every two years.
2. Flu vaccine: Respondent has not had a flu vaccine in the past year.
3. Personal physician: Respondent is asked: “Do you have one person you think of as your personal doctor or health care provider?”
4. Respondent reports needing to see a doctor, but could not due to cost in the past year.
5. No dental visit: Respondent reports it has been more than a year since they visited a dentist for any reason.
6. No checkup: Respondent reports it has been more than a year since they had a routine medical checkup.

Data Source: Washington Behavioral Risk Factor Surveillance System 2013-2015.

Adult (Age 18+) Chronic Disease

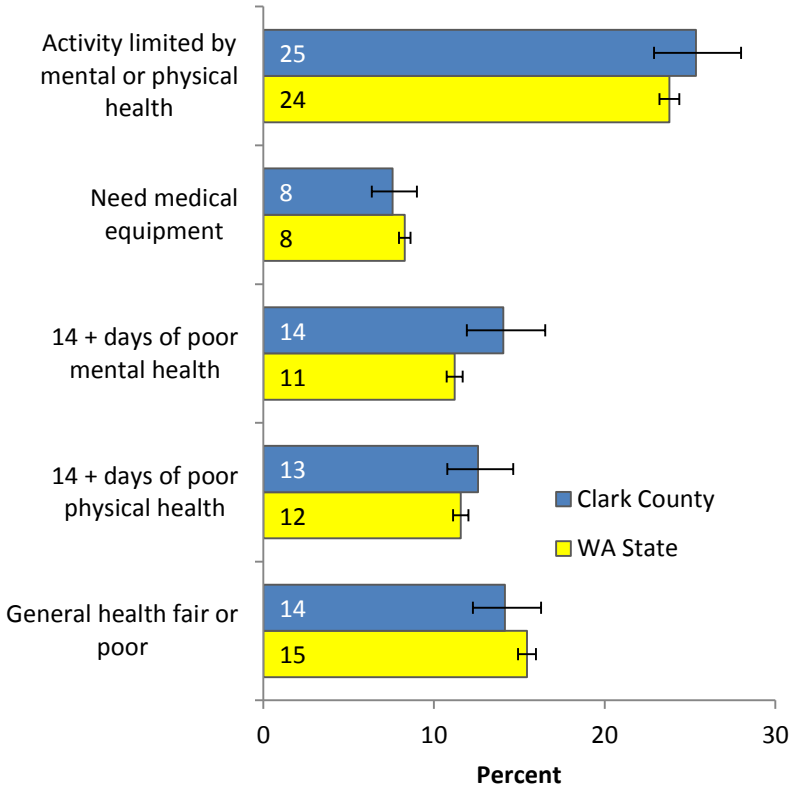


Indicator Notes

1. Self reported lifetime prevalence – Survey respondent answered “yes” to “have you ever been told by a healthcare professional that you have asthma / diabetes / heart attack, coronary heart disease, or angina / arthritis / cancer?”

Data Source: Washington Behavioral Risk Factor Surveillance System 2013-2015.

Adult (Age 18+) Quality of Life

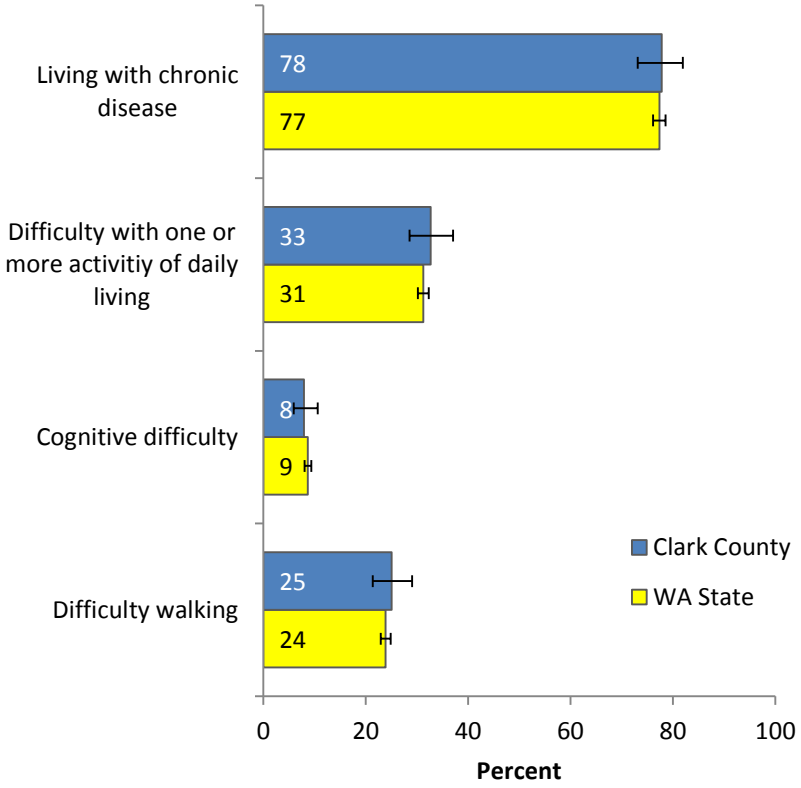


Indicator Notes

1. General health: respondent reports, in general, health is fair or poor.
2. Poor physical health: Respondent reports that on 14 or more of the past 30 days, their physical health was not good.
3. Poor mental health: Respondent reports that on 14 or more of the past 30 days, their mental health was not good.
4. Need medical equipment: Respondents are asked “Do you now have any health problem that requires you to use special equipment, such as a cane, a wheelchair, a special bed, or a special telephone?”
5. Activity limitation: Respondent is asked “Are you limited in any way in any activities because of physical, mental, or emotional problems?”

Data Source: Washington Behavioral Risk Factor Surveillance System 2013-2015.

Senior (Age 65+) Health Risks

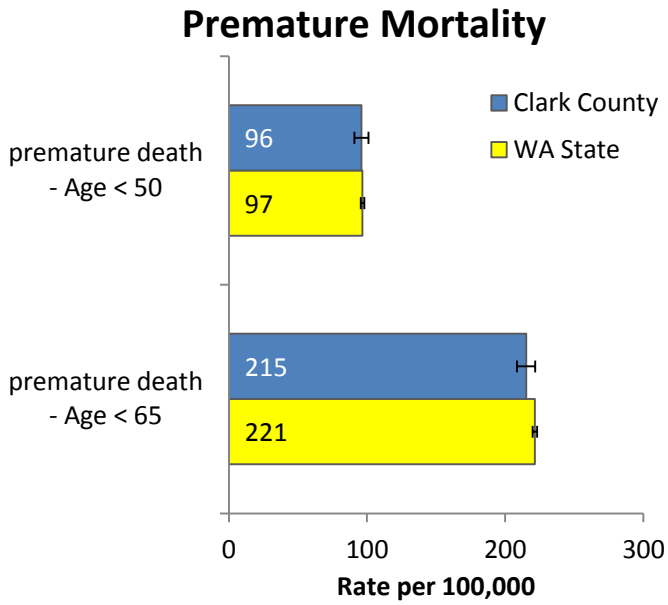


Indicator Notes

1. Living with chronic disease: Respondent is asked have you ever been told by a doctor or health care professional that you have … arthritis / asthma / COPD / cancer / diabetes, heart disease / stroke / kidney disease.
2. Activities of daily living: Respondent is asked if they have serious difficulty …seeing even with glasses / concentrating remembering or making decisions / walking or climbing stairs / dressing or bathing / doing errands alone such as visiting a doctor or shopping

Data Source: Washington Behavioral Risk Factor Surveillance System 2013-2015.

Mortality



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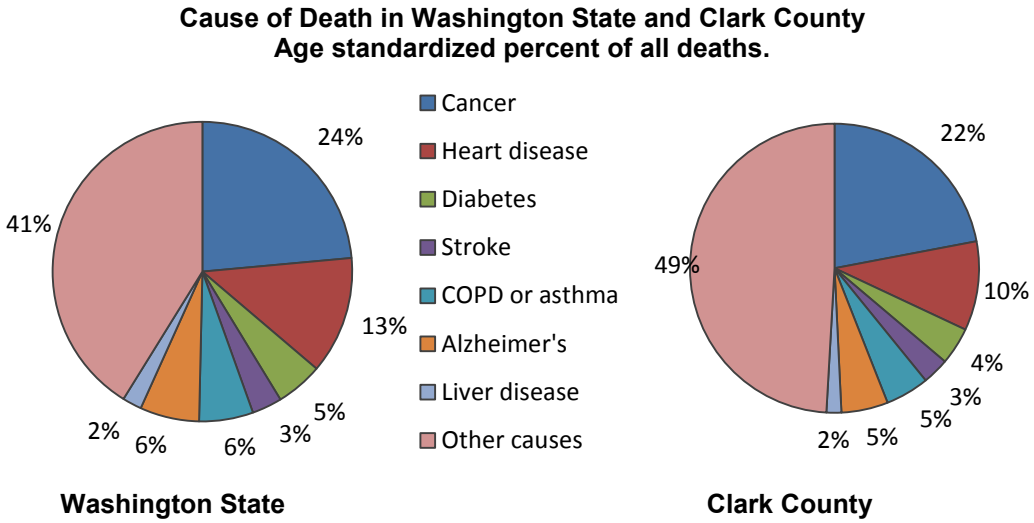


Data Source: Washington State Department of Health, Center for Health Statistics, Death Certificate Data, 2013-2015.

Appendix: Data Sources & Definitions

The following provides references for more information on each data system and definitions of technical terms used in this report. Analyses for this report were completed using Stata/IC 13.0. Some estimates were obtained from previously published reports.

DATA SYSTEMS:

Office of Financial Management (OFM) Population Estimates

- For more information on OFM intercensal population estimates, go to: http://www.ofm.wa.gov/pop/default.asp

American Community Survey (ACS) and Public Use Microdata Sample (PUMS)

- For more information on the American Community Survey, go to: http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml
- For more information on Public Use Microdata Sample go to: http://www.census.gov/acs/www/data_documentation/public_use_microdata_sample/

Pregnancy Risk Assessment Monitoring Survey (PRAMS)

- For more information on PRAMS, go to: http://www.doh.wa.gov/DataandStatisticalReports/HealthBehaviors/PregnancyRiskAssessmentMonitoringSystem.aspx

Washington Birth Certificate Data

- For more information on birth data, go to: http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/BirthData.aspx

Washington State Department of Health, Office of Immunization and Child Profile

- For more information on immunization data, go to: http://www.doh.wa.gov/DataandStatisticalReports/SchoolImmunization.aspx

Washington State Healthy Youth Survey (HYS)

- For more information on the HYS, go to: http://www.doh.wa.gov/DataandStatisticalReports/HealthBehaviors/HealthyYouthSurvey.aspx or http://www.askhys.net/

- For technical notes on the HYS, go to: http://www.doh.wa.gov/DataandStatisticalReports/HealthBehaviors/HealthyYouthSurvey/TechnicalNotes.aspx

Behavioral Risk Factor Surveillance System (BRFSS)

- For more information on Washington State BRFSS, go to: http://www.doh.wa.gov/DataandStatisticalReports/HealthBehaviors/BehavioralRiskFactorSurveillanceSystemBRFSS.aspx
- For more information on national BRFSS, go to: http://www.cdc.gov/brfss.

Washington State Death Certificate Data

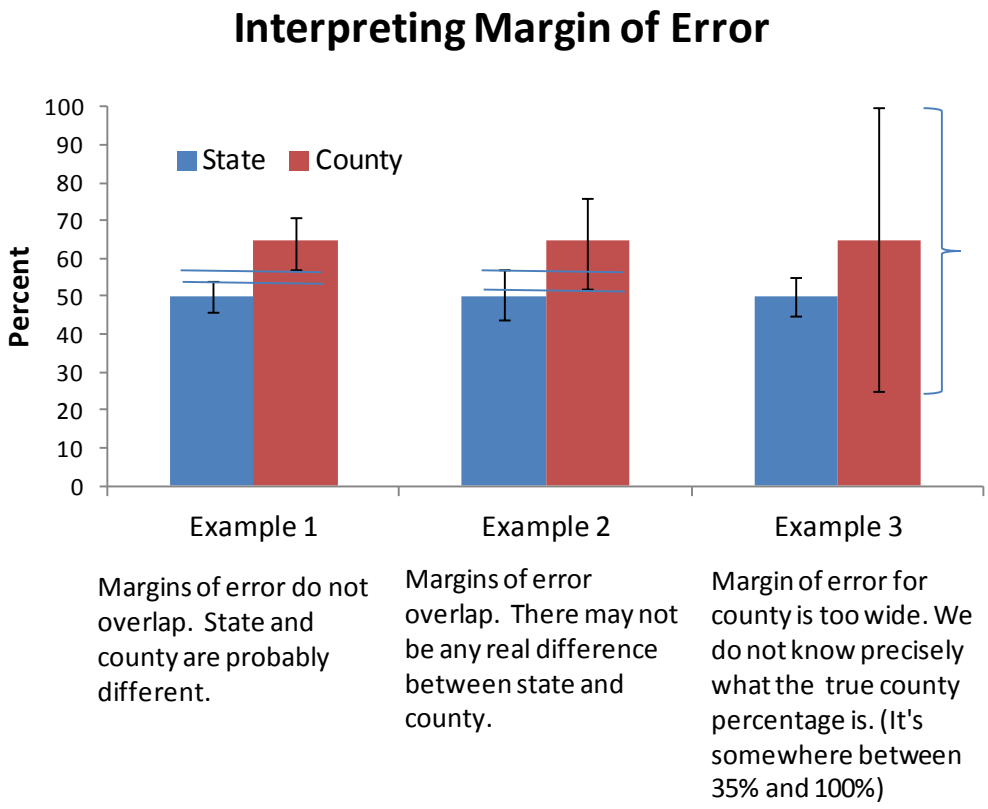
- For more information on death records, go to: http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/DeathData.aspx

Washington State Cancer Registry (WSCR)

- For more information on WSCR, go to: https://fortress.wa.gov/doh/wscr/WSCR/

CONFIDENCE INTERVALS:

Most of the estimates provided in this report come with some intrinsic level of uncertainty due to the random nature of the data. Statistical uncertainty can be summarized by a 95% confidence interval, also called the margin of error. 95% confidence means that, if the survey were repeated in exactly the same way with a different random sample of people, the new estimate would fall within the confidence interval 95% of the time. Confidence intervals are represented on graphs by whisker bars above and below the estimate.



UNRELIABLE DATA:

Estimates based on too few respondents are considered to be unreliable, and may constitute a breach of confidentiality in some circumstances. In this report data with a numerator < 10, or a denominator < 50, or a relative standard error > 30% are not reported. In these cases, local data is presented for multi-county regions for which reliable estimates can be made.

GLOSSARY:

[i] Prevalence: The fraction of the population with a condition at a particular point in time, typically expressed as a percent.
[ii] Life course approach: A philosophy of public health that recognizes the importance of promoting health at all life stages.
[iii] Epigenetic: Conditions in the mother prior to conception can affect how certain genes are expressed in the child.
[iv] Relative standard error (RSE): Standard Error (SE) is a measure of the degree of statistical uncertainty or noise in the data, typically about half the MOE. Relative standard error (RSE) is SE expressed as a percent of the estimate.

ATTACHMENT R

Demographics and Social Characteristics: Clark County 2017

Updated August 2018

CLARK COUNTY WASHINGTON
PUBLIC HEALTH

Clark County, Washington

Clark County is located in the southwest area of Washington state. Clark County borders Oregon on both the south and west sides, Cowlitz County to the north, and Skamania County to the east. The area was part of a large tract of western land first known in 1844 as "Vancouver District." In 1849, Clark County was formed, named in honor of explorer William Clark of the famous Lewis and Clark Expedition.[1] Clark County was one of the first two counties in what would later become Washington State

2016 Population

Clark is the 5th most populous county in the state, with a 2016 population of 461,010. From 2010 to 2016, the county's population grew by 35,647 people, or 8%. This was the fourth-fastest rate of growth in the state.[2]

In 2016, just over half of the Clark County population (53%) lived in incorporated cities. The 4 largest were:[2]

- Vancouver, county seat: 173,500
- Camas: 21,810
- Battle Ground: 19,640
- Washougal: 15,560

Language Spoken at Home

In 2016, 84% of residents over age 5 only spoke English at home and 16% spoke a language other than English at home. 36% of residents who spoke a language other than English at home speak English *less than* "very well." The most common languages spoken by these residents were:[8]

Language Spoken	% speak English less than very well
• Indo-European[9]:	33.9%
• Spanish:	34.9%
• Asian/Pacific Islander:	42.2%
• Other:	22.7%

Race/Ethnicity

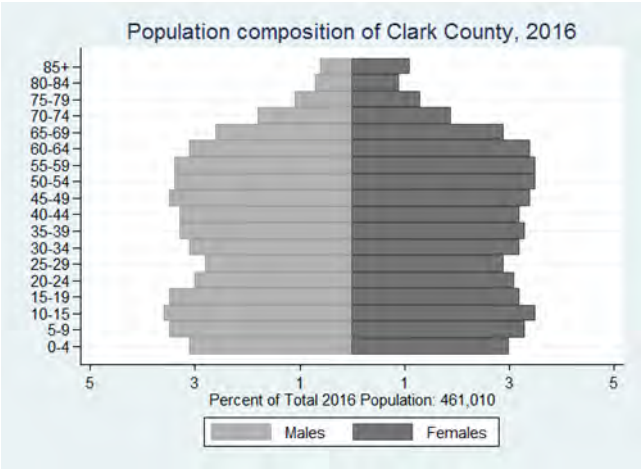
Clark County's racial/ethnic demographics for 2016 were:[7]

- White (NH): 79.6% (366,774)
- Hispanic: 8.8% (40,499)
- Asian (NH): 4.6% (21,029)
- 2+ Races (NH): 3.7% (16,903)
- Black /African Amer. (NH): 2.0% (9,180)
- Pacific Islander (NH): 0.7% (3,400)
- Amer. Indian/Alaska Native (NH): 0.7% (3,225)

(NH) = Non-Hispanic

Age/Sex Characteristics

The median age of Clark County residents in 2016 was 38.0 years.[10] The percent of the Clark County population broken down by age group and gender can be seen below.[11]



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Updated August 2018

CLARK COUNTY WASHINGTON
PUBLIC HEALTH

Education

In 2016, 92.4% of Clark County residents over age 25 had graduated from high school. Over one-fourth (29.5%) of residents had obtained a bachelor's degree or higher.[3]

Disability

In 2016, 12.0% of the noninstitutionalized population in Clark County was living with a disability. [12]

Income

The median annual household income in 2016 in Clark County was $69,062.[4]

Poverty

In 2016, 8.8% of Clark County residents were living below the Federal Poverty Level.[5] Additionally, 9.6% of children under 18 in Clark County were living in poverty.[5] The Federal Poverty Level for a family of four in 2016 was $24,300.[6]

Education by Race/Ethnicity[3], 2016

Race/Ethnicity	% High school grad or higher	% Bachelor's Degree or higher
White (NH)	94.8%	29.9%
Black/African Amer.	90.9%	28.2%
Amer. Indian/Alaska Native	81.8%	28.3%
Asian	88.2%	46.6%
2+ Races	90.8%	27.2%
Hispanic	66.0%	14.9%

Disability by Race/Ethnicity[12], 2016

Race/Ethnicity	% with Disability
White (NH)	12.7%
Black/African Amer.	15.7%
Amer. Indian/Alaska Native	23.0%
Asian	6.9%
2+ Races	12.1%
Hispanic (any race)	6.7%

NH=Non-Hispanic

Income by Race/Ethnicity[4], 2016

Race/Ethnicity	Median Income
White (NH)	$71,642
Black/African Amer.	$54,398
Amer. Indian/Alaska Native	$26,984
Asian	$79,042
Pacific Islander	$48,694
2+ Races	$54,034
Hispanic (any race)	$50,254

Poverty by Race/Ethnicity & Gender[5], 2016

Race/Ethnicity	% Below Poverty Level
White (NH)	8.0%
Black/African Amer.	17.5%
Asian	9.7%
2+ Races	12.3%
Hispanic (any race)	8.2%

Gender	% Below Poverty Level
Male	7.6%
Female	9.8%

CLARK COUNTY WASHINGTON
PUBLIC HEALTH

Poverty by Disability[13], 2016

Population 18-64 years by Disability	% Below Poverty Level
With Disability	26.9%
Without Disability	6.9%

Poverty by Education[5], 2016

Educational Attainment	% Below Poverty Level
Population 25+ years	8.2%
Less than high school grad.	13.7%
High school grad. or equivalent	11.4%
Some college, associate's degree	8.3%
Bachelor's degree or higher	4.0%

Data Sources

[1] Clark County, Washington. Proud Past. Retrieved December 2014 from http://www.co.clark.wa.us/aboutcc/proud_past/index.html

[2] Washington Office of Financial Management. State of Washington 2016 Population Trends. Retrieved January 2017 from www.ofm.wa.gov/pop/april1/

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[5] U.S. Census Bureau. American Community Survey, 2016 (1-year Estimates). Data Profiles for Clark County, WA. Poverty Status in the Past 12 Months (Table S1701). Retrieved July 2018 from http://factfinder.census.gov

[6] U.S. Department of Health and Human Services. 2016 Poverty Guidelines. Retrieved July 2018 from http://aspe.hhs.gov/poverty

[7] Washington Office of Financial Management. State of Washington 2016 Age, Sex, Race and Hispanic Origin Estimates. Retrieved July 2018 from www.ofm.wa.gov/pop/

[8] U.S. Census Bureau. American Community Survey, 2016 (1-year Estimates). Data Profiles for Clark County, WA. Language Spoken at Home (Table S1601). Retrieved July 2018 from http://factfinder.census.gov

[9] Wikipedia. Indo-European Languages include most of the major languages of Europe as well as many spoken in South, Southwest, and Central Asia. Retrieved December 2014 from http://en.wikipedia.org/wiki/Indo-European_languages

[10] U.S. Census Bureau. American Community Survey, 2016 (1-year Estimates). Data Profiles for Clark County, WA. Age and Sex (Table S0101) Retrieved July 2018 from http://factfinder/census.gov

[11] Washington Office of Financial Management. Postcensal estimates of population by age and sex, 2010-2016. Retrieved January 2017 from http://www.ofm.wa.gov/pop/asr/

[12] U.S. Census Bureau. American Community Survey, 2016 (1-year Estimates) Data Profiles for Clark County, WA. Disability Characteristics (Table S1810) Retrieved July 2018 from http://factfinder.census.gov

[13] U.S. Census Bureau. American Community Survey, 2016 (1-year Estimates). Data Profiles for Clark County, WA. Age by Disability Status by Poverty Status (Table C18130). Retrieved July 2018 from http://factfinder.census.gov

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ATTACHMENT S

Demographics and Social Characteristics: Clark County 2017

County Health Rankings & Roadmaps

Building a Culture of Health, County by County

A Robert Wood Johnson Foundation program

Washington

2019 County Health Rankings Report

A collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute

University of Wisconsin Population Health Institute
SCHOOL OF MEDICINE AND PUBLIC HEALTH

Support provided by
Robert Wood Johnson Foundation

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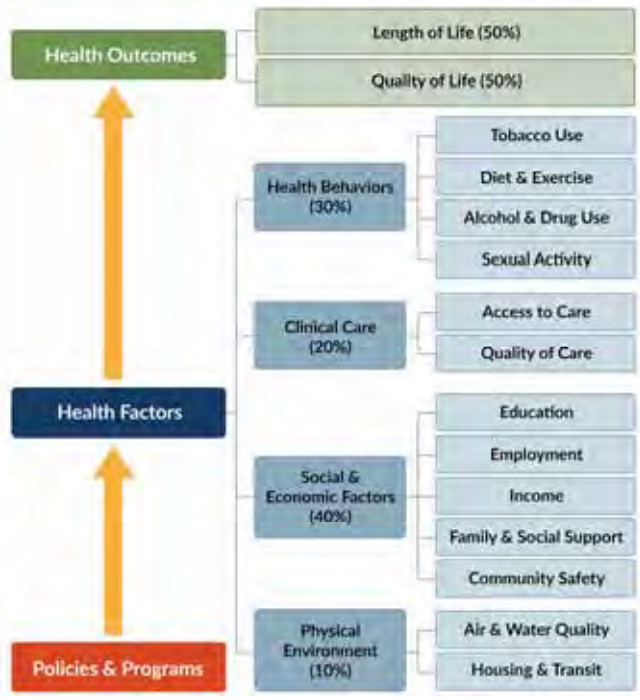
The County Health Rankings & Roadmaps (CHR&R) brings actionable data, evidence, guidance, and stories to communities to make it easier for people to be healthy in their neighborhoods, schools, and workplaces. Ranking the health of nearly every county in the nation (based on the model below), CHR&R illustrates what we know when it comes to what is keeping people healthy or making them sick and shows what we can do to create healthier places to live, learn, work, and play.

What are the County Health Rankings?

Published online at countyhealthrankings.org, the Rankings help counties understand what influences how healthy residents are and how long they will live. The Rankings are unique in their ability to measure the current overall health of each county in all 50 states. They also look at a variety of measures that affect the future health of communities, such as high school graduation rates, access to healthy foods, rates of smoking, obesity, and teen births.

Communities use the Rankings to garner support for local health improvement initiatives among government agencies, health care providers, community organizations, business leaders, policymakers, and the public.



Moving with Data to Action

The Take Action to Improve Health section of our website, countyhealthrankings.org, helps communities join together to look at the many factors influencing health, select strategies that work, and make changes that will have a lasting impact. Take Action to Improve Health is a hub of information to help any community member or leader who wants to improve their community's health and equity. You will find:

- What Works for Health, a searchable menu of evidence-informed policies and programs that can make a difference locally;
- The Action Center, your home for step-by-step guidance and tools to help you move with data to action;
- Action Learning Guides, self-directed learning on specific topics with a blend of guidance, tools, and hands-on practice and reflection activities;
- The Partner Center, information to help you identify the right partners and explore tips to engage them;
- Peer Learning, a virtual, interactive place to learn with and from others about what works in communities; and
- Action Learning Coaches, located across the nation, who are available to provide real-time guidance to local communities interested in learning how to accelerate their efforts to improve health and advance equity.

The Robert Wood Johnson Foundation (RWJF) collaborates with the University of Wisconsin Population Health Institute (UWPHI) to bring this program to cities, counties, and states across the nation.

ATTACHMENT S

Opportunities for Health Vary by Place and Race

Our country has achieved significant health improvements over the past century. We have benefited from progress in automobile safety, better workplace standards, good schools and medical clinics, and reductions in smoking and infectious diseases. But when you look closer, there are significant differences in health outcomes according to where we live, how much money we make, or how we are treated. The data show that, in counties everywhere, not everyone has benefited in the same way from these health improvements. There are fewer opportunities and resources for better health among groups that have been historically marginalized, including people of color, people living in poverty, people with physical or mental disabilities, LGBTQ persons, and women.

Differences in Opportunity Have Been Created, and Can Be Undone

Differences in opportunity do not arise on their own or because of the actions of individuals alone. Often, they are the result of policies and practices at many levels that have created deep-rooted barriers to good health, such as unfair bank lending practices, school funding based on local property taxes, and discriminatory policing and prison sentencing. The collective effect is that a fair and just opportunity to live a long and healthy life does not exist for everyone. Now is the time to change how things are done.

Measure What Matters

Achieving health equity means reducing and ultimately eliminating unjust and avoidable differences in health and in the conditions and resources needed for optimal health. This report provides data on differences in health and opportunities in Washington that can help identify where action is needed to achieve greater equity and offers information on how to move with data to action.

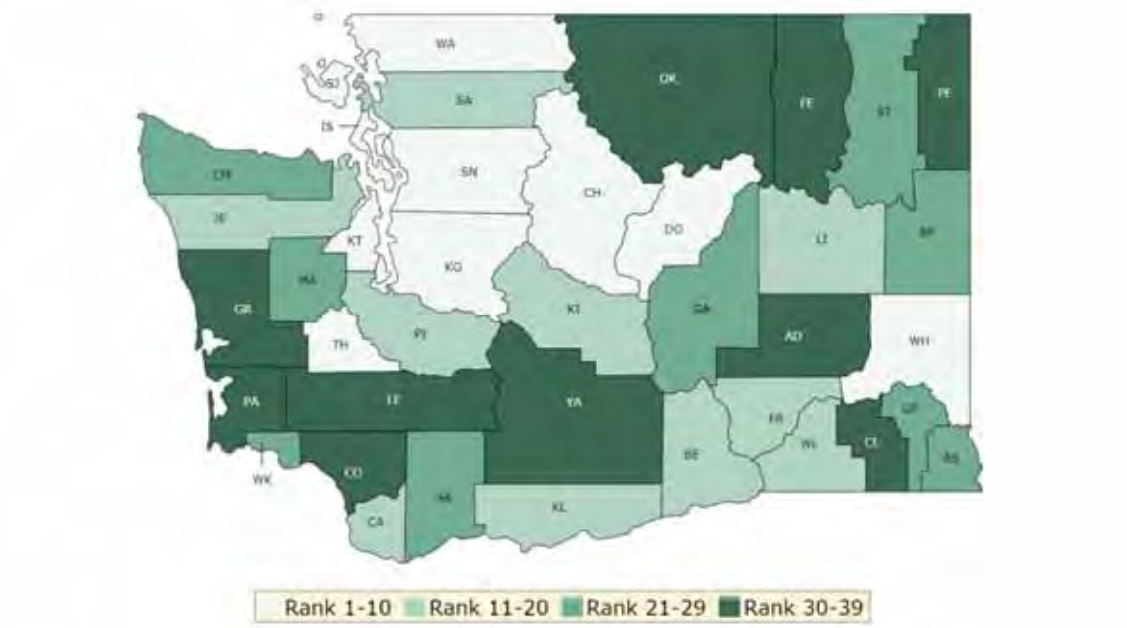
Specifically, this report will help illuminate:

1. Differences in health outcomes within the state by place and racial/ethnic groups
2. Differences in health factors within the state by place and racial/ethnic groups
3. What communities can do to create opportunity and health for all

Differences in Health Outcomes within States by Place and Racial/Ethnic Groups

How Do Counties Rank for Health Outcomes?

Health outcomes in the County Health Rankings represent measures of how long people live and how healthy people feel. Length of life is measured by premature death (years of potential life lost before age 75) and quality of life is measured by self-reported health status (percent of people reporting poor or fair health and the number of physically and mentally unhealthy days within the last 30 days) and the % of low birth weight newborns. Detailed information on the underlying measures is available at **countyhealthrankings.org**



The green map above shows the distribution of Washington's **health outcomes**, based on an equal weighting of length and quality of life. The map is divided into four quartiles with less color intensity indicating better performance in the respective summary rankings. Specific county ranks can be found in the table on page 10 at the end of this report.

How Do Health Outcomes Vary by Race/Ethnicity?

Length and quality of life vary not only based on where we live, but also by our racial/ethnic background. In Washington, there are differences by race/ethnicity in length and quality of life that are masked when we only look at differences by place. The table below presents the five underlying measures that make up the Health Outcomes rank. Explore the table to see how health differs between the healthiest and the least healthy counties in Washington, and among racial/ethnic groups.

Differences in Health Outcome Measures among Counties and for Racial/Ethnic Groups in Washington

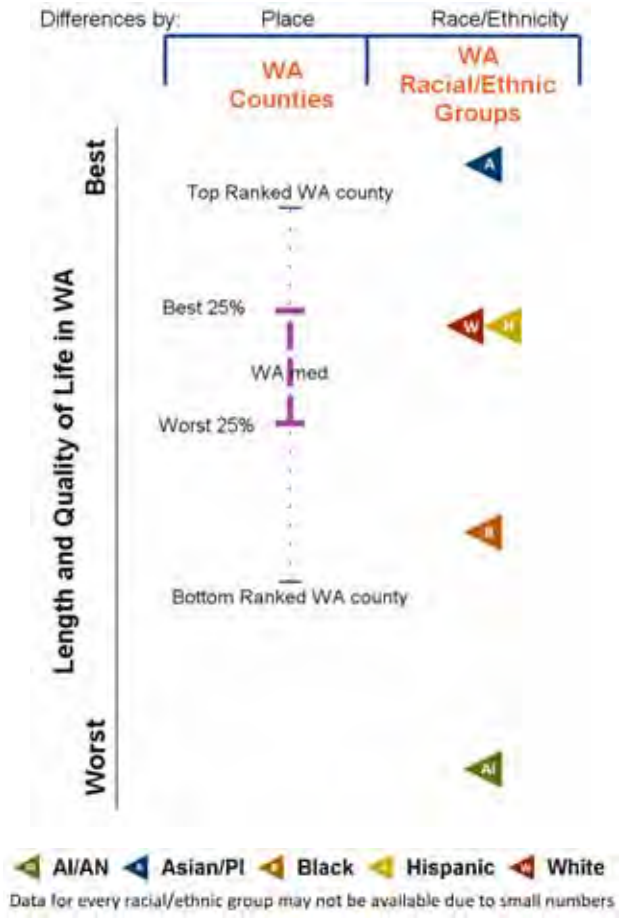
	Healthiest WA County	Least Healthy WA County	AI/AN	Asian/PI	Black	Hispanic	White
Premature Death (years lost/100,000)	4,800	10,400	12,200	3,300	7,900	4,400	5,700
Poor or Fair Health (%)	11%	18%	24%	9%	21%	26%	12%
Poor Physical Health Days (avg)	3.3	4.6	6.6	2.1	4.0	3.8	3.7
Poor Mental Health Days (avg)	3.6	4.6	5.3	2.2	4.2	3.5	4.0
Low Birthweight (%)	3%	7%	8%	8%	10%	6%	6%

American Indian/Alaskan Native (AI/AN), Asian/Pacific Islander (Asian/PI)

N/A = Not available. Data for all racial/ethnic groups may not be available due to small numbers

ATTACHMENT S

Health Outcomes in Washington



The graphic to the left compares measures of length and quality of life by place (Health Outcomes ranks) and by race/ethnicity. To learn more about this composite measure, see the technical notes on page 14.

Taken as a whole, measures of length and quality of life in Washington indicate:

- American Indians/Alaskan Natives are less healthy than those living in the bottom ranked county.
- Asians/Pacific Islanders are healthier than those living in the top ranked county.
- Blacks are most similar in health to those living in the least healthy quartile of counties.
- Hispanics are most similar in health to those living in the middle 50% of counties.
- Whites are most similar in health to those living in the middle 50% of counties.

(Quartiles refer to the map on page 4.)

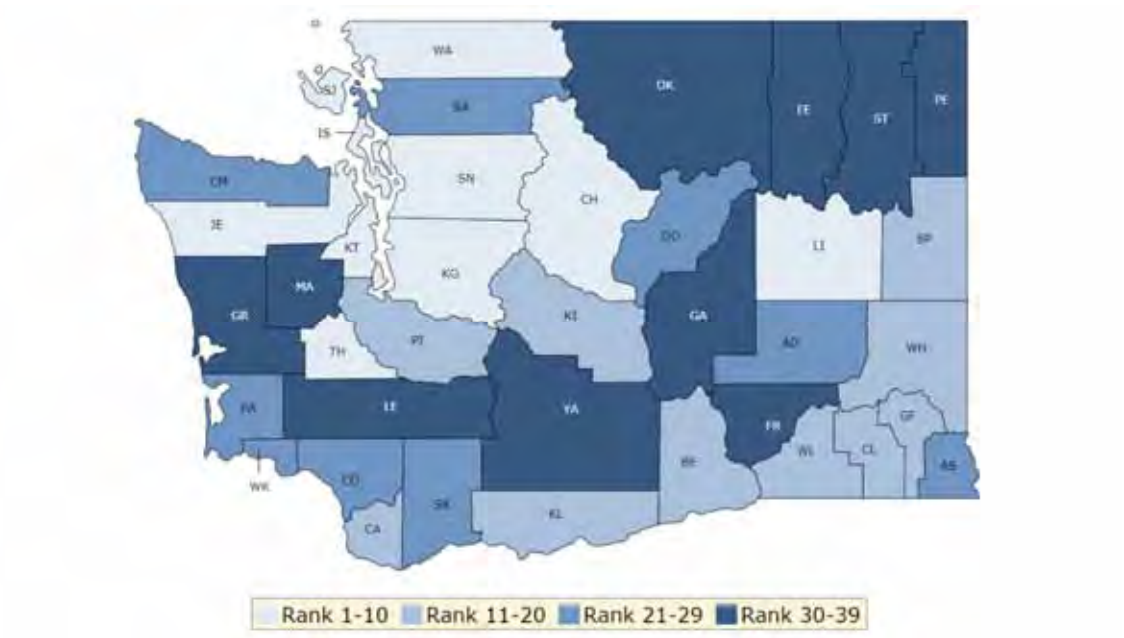
AI/AN -American Indian/Alaskan Native/Native American
Asian/PI - Asian/Pacific Islander

Across the US, values for measures of length and quality of life for Native American, Black, and Hispanic residents are regularly worse than for Whites and Asians. For example, even in the healthiest counties in the US, Black and American Indian premature death rates are about 1.4 times higher than White rates. Not only are these differences unjust and avoidable, they will also negatively impact our changing nation's future prosperity.

Differences in Health Factors within States by Place and Racial/Ethnic Groups

How Do Counties Rank for Health Factors?

Health factors in the County Health Rankings represent the focus areas that drive how long and how well we live, including health behaviors (tobacco use, diet & exercise, alcohol & drug use, sexual activity), clinical care (access to care, quality of care), social and economic factors (education, employment, income, family & social support, community safety), and the physical environment (air & water quality, housing & transit).



The blue map above shows the distribution of Washington's **health factors** based on weighted scores for health behaviors, clinical care, social and economic factors, and the physical environment. Detailed information on the underlying measures is available at **countyhealthrankings.org.** The map is divided into four quartiles with less color intensity indicating better performance in the respective summary rankings. Specific county ranks can be found in the table on page 10.

What are the Factors That Drive Health and Health Equity and How Does Housing Play a Role?

Health is influenced by a range of factors. Social and economic factors, like connected and supportive communities, good schools, stable jobs, and safe neighborhoods, are foundational to achieving long and healthy lives. These social and economic factors also interact with other important drivers of health and health equity. For example, housing that is unaffordable or unstable can either result from poverty or exacerbate it. When our homes are near high performing schools and good jobs, it's easier to get a quality education and earn a living wage. When people live near grocery stores where fresh food is available or close to green spaces and parks, eating healthy and being active is easier. When things like lead, mold, smoke, and other toxins are inside our homes, they can make us sick. And when so much of a paycheck goes toward the rent or mortgage, it makes it hard to afford to go to the doctor, cover the utility bills, or maintain reliable transportation to work or school.

How Do Opportunities for Stable and Affordable Housing Vary in Washington?

Housing is central to people's opportunities for living long and well. Nationwide, housing costs far exceed affordability given local incomes in many communities. As a result, people have no choice but to spend too much on housing, leaving little left for other necessities. Here, we focus on stable and affordable housing as an essential element of healthy communities. We also explore the connection between housing and children in poverty to illuminate the fact that these issues are made even more difficult when family budgets are the tightest.

What can work to create and preserve stable and affordable housing that can improve economic and social well-being and connect residents to opportunity?

A comprehensive, strategic approach that looks across a community and multiple sectors is needed to create and preserve stable, affordable housing in our communities. The way forward requires policies, programs, and systems changes that respond to the specific needs of each community, promote inclusive and connected neighborhoods, reduce displacement, and enable opportunity for better health for all people. This includes efforts to:

Make communities more inclusive and connected, such as:

- Inclusive zoning
- Civic engagement in public governance and in community development decisions
- Fair housing laws and enforcement
- Youth leadership programs
- Access to living wage jobs, quality health care, grocery stores, green spaces and parks, and public transportation systems

For more information about evidence-informed strategies that can address priorities in your community, visit What Works for Health at countyhealthrankings.org/whatworks

Facilitate access to resources needed to secure affordable housing, particularly for low- to middle-income families, such as:

- Housing choice vouchers for low- and very low-income households
- Housing trust funds

Address capital resources needed to create and preserve affordable housing, particularly for low- to middle-income families, such as:

- Acquisition, management, and financing of land for affordable housing, like land banks or land trusts
- Tax credits, block grants, and other government subsidies or revenues to advance affordable housing development
- Zoning changes that reduce the cost of housing production

This report explores statewide data. To dive deeper into your county data, visit Use the Data at countyhealthrankings.org

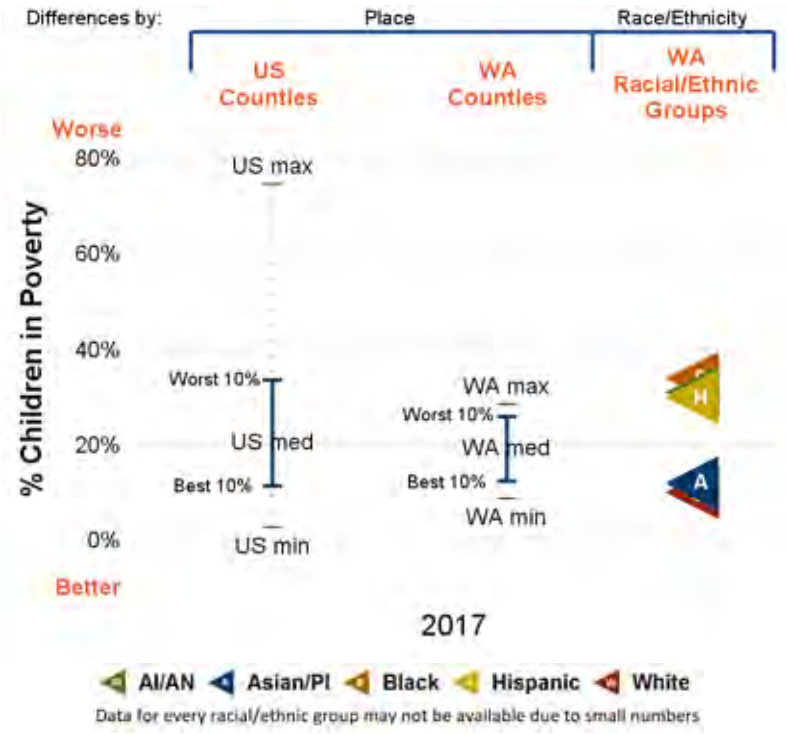
Consider these questions as you look at the data graphics throughout this report:

- What differences do you see among counties in your state?
- What differences do you see by racial/ethnic groups in your state?
- How do counties in your state compare to all U.S. counties?
- What patterns do you see? For example, do some racial/ethnic groups fare better or worse across measures?

Children in Poverty

Poverty limits opportunities for quality housing, safe neighborhoods, healthy food, living wage jobs, and quality education. As poverty and related stress increase, health worsens.

- In Washington, 14% of children are living in poverty.
- Children in poverty among Washington counties range from 9% to 29%.
- Child poverty rates among racial/ethnic groups in Washington range from 10% to 34%.



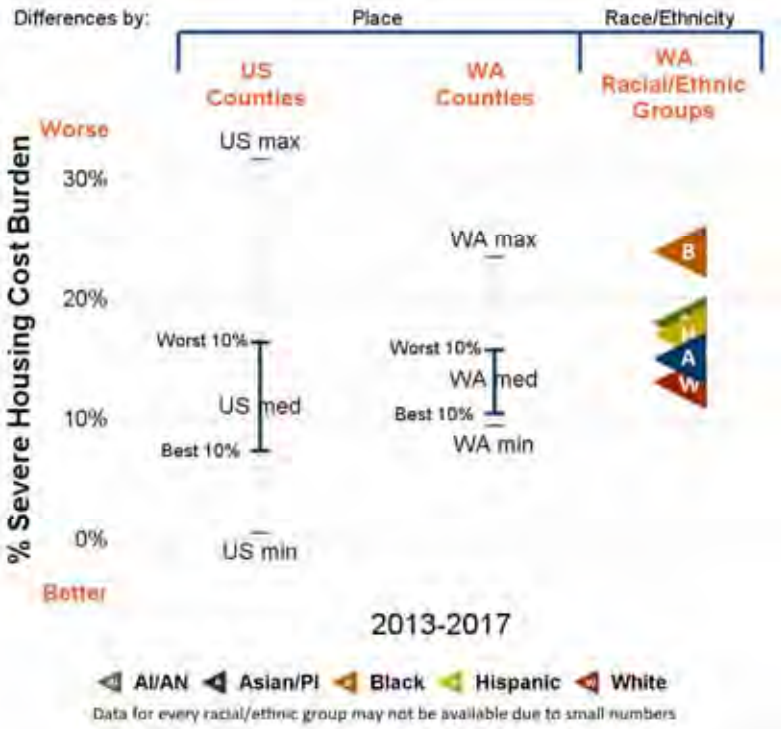
US and state values and the state minimum and maximum can be found in the table on page 12

American Indian/Alaskan Native/Native American (AI/AN) Asian/Pacific Islander (Asian/PI)

Severe Housing Cost Burden

There is a strong and growing evidence base linking stable and affordable housing to health. As housing costs have outpaced local incomes, households not only struggle to acquire and maintain adequate shelter, but also face difficult trade-offs in meeting other basic needs.

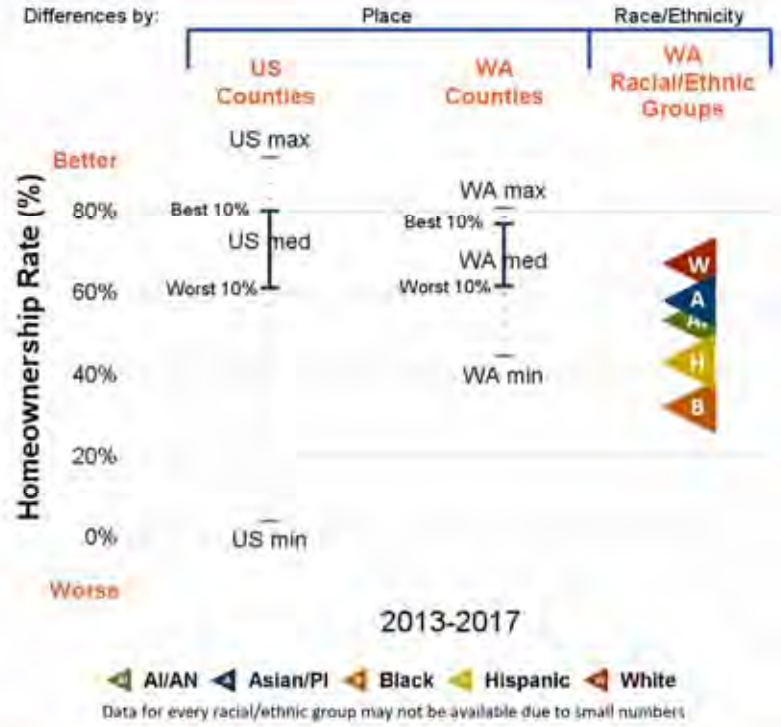
- In Washington, 14% of households spend more than half of their income on housing costs.
- Across Washington counties, severe housing cost burden ranges from 9% to 23% of households.
- Severe housing cost burden ranges from 13% to 24% among households headed by different racial/ethnic groups in Washington.



Homeownership

Homeownership has historically been a springboard for families to enter the middle class. Owning a home over time can help build savings for education or for other opportunities important to health and future family wealth. High levels of homeownership are associated with more stable housing and more tightly knit communities.

- In Washington, 63% of households own their home.
- Homeownership rates among Washington counties range from 44% to 81% of households.
- Homeownership rates among racial/ethnic groups in Washington range from 32% to 67%.



2019 County Health Rankings for the 39 Ranked Counties in Washington

County	Health Outcomes	Health Factors
Adams	33	29
Asotin	24	22
Benton	15	20
Chelan	7	10
Clallam	25	24
Clark	11	12
Columbia	38	17
Cowlitz	31	28
Douglas	10	21
Ferry	39	39

County	Health Outcomes	Health Factors
Franklin	13	33
Garfield	29	13
Grant	26	34
Grays Harbor	36	35
Island	4	5
Jefferson	16	8
King	2	1
Kitsap	8	3
Kittitas	12	16
Klickitat	17	15

County	Health Outcomes	Health Factors
Lewis	30	32
Lincoln	14	9
Mason	28	37
Okanogan	34	36
Pacific	37	27
Pend Oreille	35	31
Pierce	20	18
San Juan	1	2
Skagit	19	23
Skamania	21	25

County	Health Outcomes	Health Factors
Snohomish	3	4
Spokane	23	19
Stevens	27	30
Thurston	5	6
Wahkiakum	22	26
Walla Walla	18	14
Whatcom	9	7
Whitman	6	11
Yakima	32	38

Stay Up-To-Date with County Health Rankings & Roadmaps

For the latest updates on our Rankings, community support, RWJF Culture of Health Prize communities, and more visit countyhealthrankings.org/news. You can see what we're featuring on our webinar series, what communities are doing to improve health, and how you can get involved!

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2019 County Health Rankings for Washington: Measures and National/State Results

Measure	Description	US	WA	WA Minimum	WA Maximum
HEALTH OUTCOMES					
Premature death	Years of potential life lost before age 75 per 100,000 population	6900	5,600	4,500	10,400
Poor or fair health	% of adults reporting fair or poor health	16%	14%	11%	24%
Poor physical health days	Average # of physically unhealthy days reported in past 30 days	3.7	3.7	3.0	4.9
Poor mental health days	Average # of mentally unhealthy days reported in past 30 days	3.8	3.8	3.2	4.6
Low birthweight	% of live births with low birthweight (< 2500 grams)	8%	6%	3%	9%
HEALTH FACTORS					
HEALTH BEHAVIORS					
Adult smoking	% of adults who are current smokers	17%	14%	9%	18%
Adult obesity	% of adults that report a BMI ≥ 30	29%	28%	20%	37%
Food environment index	Index of factors that contribute to a healthy food environment, (0-10)	7.7	8.1	5.0	8.9
Physical inactivity	% of adults aged 20 and over reporting no leisure-time physical activity	22%	16%	13%	26%
Access to exercise opportunities	% of population with adequate access to locations for physical activity	84%	87%	12%	98%
Excessive drinking	% of adults reporting binge or heavy drinking	18%	18%	15%	21%
Alcohol-impaired driving deaths	% of driving deaths with alcohol involvement	29%	33%	0%	100%
Sexually transmitted infections	# of newly diagnosed chlamydia cases per 100,000 population	497.3	435.9	101.4	853.1
Teen births	# of births per 1,000 female population ages 15-19	25	20	3	52
CLINICAL CARE					
Uninsured	% of population under age 65 without health insurance	10%	7%	5%	14%
Primary care physicians	Ratio of population to primary care physicians	1,330:1	1,220:1	11,510:1	850:1
Dentists	Ratio of population to dentists	1,460:1	1,240:1	11,840:1	930:1
Mental health providers	Ratio of population to mental health providers	440:1	310:1	2,210:1	240:1
Preventable hospital stays	# of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees	4,520	2,914	550	4,359
Mammography screening	% of female Medicare enrollees ages 65-74 that receive mammography screening	41%	39%	22%	46%
Flu vaccinations	% of Medicare enrollees who receive an influenza vaccination	45%	44%	16%	49%
SOCIAL AND ECONOMIC FACTORS					
High school graduation	% of ninth-grade cohort that graduates in four years	85%	79%	75%	95%
Some college	% of adults ages 25-44 with some post-secondary education	65%	70%	36%	84%
Unemployment	% of population aged 16 and older unemployed but seeking work	4.4%	4.8%	3.7%	11.0%
Children in poverty	% of children under age 18 in poverty	18%	14%	9%	29%
Income inequality	Ratio of household income at the 80th percentile to income at the 20th percentile	4.9	4.5	3.7	6.7
Children in single-parent households	% of children that live in a household headed by a single parent	33%	28%	20%	41%
Social associations	# of membership associations per 10,000 population	9.3	8.7	6.6	21.3
Violent crime	# of reported violent crime offenses per 100,000 population	386	294	38	458
Injury deaths	# of deaths due to injury per 100,000 population	67	64	41	147
PHYSICAL ENVIRONMENT					
Air pollution – particulate matter	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5)	8.6	7.4	5.8	11.7
Drinking water violations	Indicator of the presence of health-related drinking water violations. Yes - indicates the presence of a violation, No - indicates no violation.	N/A	N/A	No	Yes
Severe housing problems	% of households with overcrowding, high housing costs, or lack of kitchen or plumbing facilities	18%	18%	12%	25%
Driving alone to work	% of workforce that drives alone to work	76%	72%	60%	81%
Long commute – driving alone	Among workers who commute in their car alone, % commuting > 30 minutes	35%	36%	6%	48%

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2019 County Health Rankings: Ranked Measure Sources and Years of Data

	Measure	Source	Years of Data
HEALTH OUTCOMES			
Length of Life	Premature death	National Center for Health Statistics – Mortality files	2015-2017
Quality of Life	Poor or fair health	Behavioral Risk Factor Surveillance System	2016
	Poor physical health days	Behavioral Risk Factor Surveillance System	2016
	Poor mental health days	Behavioral Risk Factor Surveillance System	2016
	Low birthweight	National Center for Health Statistics – Natality files	2011-2017
HEALTH FACTORS			
HEALTH BEHAVIORS			
Tobacco Use	Adult smoking	Behavioral Risk Factor Surveillance System	2016
Diet and Exercise	Adult obesity	CDC Diabetes Interactive Atlas	2015
	Food environment index	USDA Food Environment Atlas, Map the Meal Gap	2015 & 2016
	Physical inactivity	CDC Diabetes Interactive Atlas	2015
	Access to exercise opportunities	Business Analyst, Delorme map data, ESRI, & U.S. Census Files	2010 & 2018
Alcohol and Drug Use	Excessive drinking	Behavioral Risk Factor Surveillance System	2016
	Alcohol-impaired driving deaths	Fatality Analysis Reporting System	2013-2017
Sexual Activity	Sexually transmitted infections	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB	2016
	Teen births	National Center for Health Statistics – Natality files	2011-2017
CLINICAL CARE			
Access to Care	Uninsured	Small Area Health Insurance Estimates	2016
	Primary care physicians	Area Health Resource File/American Medical Association	2016
	Dentists	Area Health Resource File/National Provider Identification file	2017
	Mental health providers	CMS, National Provider Identification file	2018
Quality of Care	Preventable hospital stays	Mapping Medicare Disparities Tool	2016
	Mammography screening	Mapping Medicare Disparities Tool	2016
	Flu vaccinations	Mapping Medicare Disparities Tool	2016
SOCIAL AND ECONOMIC FACTORS			
Education	High school graduation	State-specific sources & EDFacts	Varies
	Some college	American Community Survey	2013-2017
Employment	Unemployment	Bureau of Labor Statistics	2017
Income	Children in poverty	Small Area Income and Poverty Estimates	2017
	Income inequality	American Community Survey	2013-2017
Family and Social Support	Children in single-parent households	American Community Survey	2013-2017
	Social associations	County Business Patterns	2016
Community Safety	Violent crime	Uniform Crime Reporting – FBI	2014 & 2016
	Injury deaths	CDC WONDER mortality data	2013-2017
PHYSICAL ENVIRONMENT			
Air and Water Quality	Air pollution – particulate matter*	Environmental Public Health Tracking Network	2014
	Drinking water violations	Safe Drinking Water Information System	2017
Housing and Transit	Severe housing problems	Comprehensive Housing Affordability Strategy (CHAS) data	2011-2015
	Driving alone to work	American Community Survey	2013-2017
	Long commute – driving alone	American Community Survey	2013-2017

*Not available for AK and HI.

ATTACHMENT S

2019 County Health Rankings: Additional Measure Sources and Years of Data

	Measure	Source	Years of Data
HEALTH OUTCOMES			
Length of Life	Life expectancy	National Center for Health Statistics - Mortality Files	2015-2017
	Premature age-adjusted mortality	CDC WONDER mortality data	2015-2017
	Child mortality	CDC WONDER mortality data	2014-2017
	Infant mortality	CDC WONDER mortality data	2011-2017
Quality of Life	Frequent physical distress	Behavioral Risk Factor Surveillance System	2016
	Frequent mental distress	Behavioral Risk Factor Surveillance System	2016
	Diabetes prevalence	CDC Diabetes Interactive Atlas	2015
	HIV prevalence	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2015
HEALTH FACTORS			
HEALTH BEHAVIORS			
Diet and Exercise	Food insecurity	Map the Meal Gap	2016
	Limited access to healthy foods	USDA Food Environment Atlas	2015
Alcohol and Drug Use	Drug overdose deaths	CDC WONDER mortality data	2015-2017
	Motor vehicle crash deaths	CDC WONDER mortality data	2011-2017
Other Health Behaviors	Insufficient sleep	Behavioral Risk Factor Surveillance System	2016
CLINICAL CARE			
Access to Care	Uninsured adults	Small Area Health Insurance Estimates	2016
	Uninsured children	Small Area Health Insurance Estimates	2016
	Other primary care providers	CMS, National Provider Identification File	2018
SOCIAL & ECONOMIC FACTORS			
Education	Disconnected youth	American Community Survey	2013-2017
Income	Median household income	Small Area Income and Poverty Estimates	2017
	Children eligible for free or reduced price lunch	National Center for Education Statistics	2016-2017
Family and Social Support	Residential segregation - black/white	American Community Survey	2013-2017
	Residential segregation - non-white/white	American Community Survey	2013-2017
Community Safety	Homicides	CDC WONDER mortality data	2011-2017
	Firearm fatalities	CDC WONDER mortality data	2013-2017
PHYSICAL ENVIRONMENT			
Housing and Transit	Homeownership	American Community Survey	2013-2017
	Severe housing cost burden	American Community Survey	2013-2017
DEMOGRAPHICS			
All	Population	Census Population Estimates	2017
	% below 18 years of age	Census Population Estimates	2017
	% 65 and older	Census Population Estimates	2017
	% Non-Hispanic African American	Census Population Estimates	2017
	% American Indian and Alaskan Native	Census Population Estimates	2017
	% Asian	Census Population Estimates	2017
	% Native Hawaiian/Other Pacific Islander	Census Population Estimates	2017
	% Hispanic	Census Population Estimates	2017
	% Non-Hispanic white	Census Population Estimates	2017
	% not proficient in English	American Community Survey	2013-2017
	% Females	Census Population Estimates	2017
	% Rural	Census Population Estimates	2010

Technical Notes and Glossary of Terms

What is health equity? What are health disparities? And how do they relate?

Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty and discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

Health disparities are differences in health or in the key determinants of health such as education, safe housing, and discrimination, which adversely affect marginalized or excluded groups.

Health equity and health disparities are closely related to each other. Health equity is the ethical and human rights principle or value that motivates us to eliminate health disparities. Reducing and ultimately eliminating disparities in health and its determinants of health is how we measure progress toward health equity.

Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. What is Health Equity? And What Difference Does a Definition Make? Robert Wood Johnson Foundation. May 2017

How do we define racial/ethnic groups?

In our analyses by race/ethnicity we define each category as follows:

- Hispanic includes those who identify themselves as Mexican, Puerto Rican, Cuban, Central or South American, other Hispanic, or Hispanic of unknown origin.
- American Indian/Alaskan Native includes people who identify themselves as American Indian or Alaskan Native and do not identify as Hispanic. This group is sometimes referred to as Native American in the report.
- Asian/Pacific Islander includes people who identify themselves as Asian or Pacific Islander and do not identify as Hispanic.
- Black includes people who identify themselves as black/African American and do not identify as Hispanic.
- White includes people who identify themselves as white and do not identify as Hispanic.

All racial/ethnic categories are exclusive so that one person fits into only one category. Our analyses do not include people reporting more than one race, as this category was not measured uniformly across our data sources.

We recognize that "race" is a social category, meaning the way society may identify individuals based on their cultural ancestry, not a way of characterizing individuals based on biology or genetics. A strong and growing body of empirical research provides support for the notion that genetic factors are not responsible for racial differences in health factors and very rarely for health outcomes.

How did we compare county ranks and racial/ethnic groups for length and quality of life?

Data are from the same data sources and years listed in the table on page 14. The mean and standard deviation for each health outcome measure (premature death, poor or fair health, poor physical health days, poor mental health days, and low birthweight) are calculated for all ranked counties within a state. This mean and standard deviation are then used as the metrics to calculate z-scores, a way to put all measures on the same scale, for values by race/ethnicity within the state. The z-scores are weighted using CHR&R measure weights for health outcomes to calculate a health outcomes z-score for each race/ethnicity. This z-score is then compared to the health outcome z-scores for all ranked counties within a state; the identified-score calculated for the racial/ethnic groups is compared to the quartile cut-off values for counties with states. You can learn more about calculating z-scores on our website under Rankings Methods.

How did we select evidence-informed approaches?

Evidence-informed approaches included in this report represent those backed by strategies that have demonstrated consistently favorable results in robust studies or reflect recommendations by experts based on early research. To learn more about evidence analysis methods and evidence-informed strategies that can make a difference to improving health and decreasing disparities, visit What Works for Health.

Technical Notes:

- In this report, we use the terms disparities, differences, and gaps interchangeably.
- We follow basic design principles for cartography in displaying color spectrums with less intensity for lower values and increasing color intensity for higher values. We do not intend to elicit implicit biases that "darker is bad".
- In our graphics of state and U.S. counties we report the median of county values, our preferred measure of central tendency for counties. This value can differ from the state or U.S. overall values.

ATTACHMENT S

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County Health Rankings & Roadmaps

Building a Culture of Health, County by County

A Robert Wood Johnson Foundation program

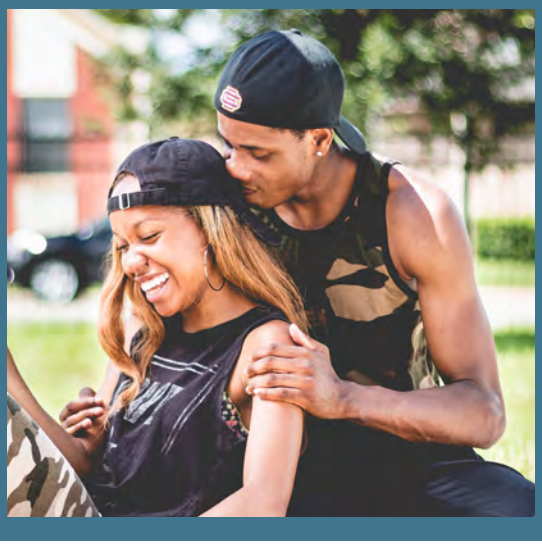
ATTACHMENT S

ATTACHMENT T

2019 Community Health Needs Assessment

(Columbia Willamette Collaborative)

2019
Community Health Needs Assessment
Healthy Columbia Willamette Collaborative



Healthy Columbia Willamette
Assessing Community Needs, Improving Health

Clark County, Washington

health share
Health Share of Oregon

Multnomah County
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Reader's Guide

This report presents results of a 2016–2019 community health needs assessment of the quad-county region: Clark County, Washington, and Clackamas, Multnomah, and Washington counties in Oregon.

This report is divided into five main sections:

1. Beginning: glossary of terms used in this report, summary, and overview
2. Social determinants of health
3. Core issues
4. Looking ahead (conclusions)
5. Appendices

Reading the first part of the report—from the Summary and Overview, through the social determinants of health—will provide context for the rest of the report. Healthy Columbia Willamette Collaborative (HCWC) identified nine core issues for this community health needs assessment, which each have their own section. The report includes links throughout to enable readers to easily jump from section to section as needed. Links to references cited in this report are also included.

Additional information about the following is included in the report appendices:

- HCWC background and workgroups: Appendix A
- Methodology for this community health needs assessment: Appendix B
- Additional information about social determinants of health not included in the main report: Appendix C
- Additional data about income, education, and literacy in the quad-county region: Appendix C
- Demographic information about listening session participants: Appendix D
- Health indicators including ED visit rates and mortality data for region: Appendix E
- HCWC's literature review for this assessment: Appendix F
- County-specific information: Appendix G

HCWC hopes readers will find this report useful in understanding the state of health in the communities, and that the assessment will inform future health initiatives and programs in this region.

Table of Contents

Summary

This report presents results of the third community health needs assessment (CHNA) conducted by the Healthy Columbia Willamette Collaborative (HCWC). Consisting of seven hospitals systems, four county health departments and one coordinated care organization, the HCWC region covers Clark County, Washington, and Clackamas, Multnomah, and Washington counties in Oregon.

This unique public/private partnership serves as a platform for collaboration around health needs assessments. It allows for a more comprehensive view of community needs, informs priorities for HCWC member organization improvement plans, and supports a shared understanding for HCWC stakeholders and partners who collaborate on how to best meet community health needs. This group focuses on broad issues impacting the health of the region, including chronic conditions, language barriers, economic instability, isolation, and others. HCWC identified discrimination, racism, and trauma as the overarching issues that shape the lives and health of community members.

Equity and Community Voice

HCWC is committed to centering community voice and health equity[1] in its work and as integral to its vision. HCWC prioritized equity throughout the data collection, analysis, and reporting process for this CHNA (see Appendix A for more explanation).

HCWC prioritized community input and lived experiences of priority populations and leaders from community-based organizations across the region. Volunteer participants shared their insights on the vision, strengths, challenges, and needs of their communities in town halls and listening sessions.

Four town halls were conducted—one in each county—and community-based organizations hosted 18 community listening sessions across the quad-county region, with more than 200 participants.

The town halls were guided by these questions:

- What are the major issues impacting the health – and access to health care – of residents in the quad-county area?
- What has shaped their experiences with the health care systems and how has this impacted their current health and well-being?

The listening sessions were guided by these questions:

- How can you tell if your community is healthy?
- What gets in the way of your community being healthy?
- What's currently working?
- What are the resources that currently help your community to be healthy?
- What is needed? What more could be done to help your community be healthy?

See Methodology in Appendix B for more about the town halls and listening sessions.

Social Determinants of Health

HCWC heard directly from community members that racism, discrimination, and trauma impact the health and well-being of communities. These are key drivers of each of the core issues identified in this report.[2]

In shaping this CHNA, the HCWC used Healthy People 2020's definition and five categories[3]:

1. **Social and Community Context:** civic participation, discrimination, incarceration, social cohesion
2. **Education:** early childhood education and development, enrollment in higher education, high school graduation, language and literacy
3. **Health and Health Care:** access to health care, access to primary care, health literacy
4. **Economic Stability:** employment, food insecurity, housing instability, and poverty
5. **Neighborhood and Built Environment:** access to foods that support healthy eating patterns, crime and violence, environmental conditions, and quality of housing

See page 18 for more information about social determinants of health.

Key Findings of CHNA: Nine Core Issues

Through the listening sessions and town halls, the HCWC gathered feedback directly from community members to identify important issues. As supported by quantitative data collected and analyzed for this CHNA, HCWC identified nine core issues as central to the needs of the region.

Discrimination and Racism and Trauma are the driver issues to all the core issues. The other core issues are broken into two categories, as shown below:

- **Key Drivers of all Core Issues:**
  - **Discrimination and Racism**
  - **Trauma**
- **Health Outcomes**
  - Behavioral Health
  - Chronic Conditions
  - Sexually Transmitted Infections
- **Social Factors**
  - Access to: Health Care, Transportation, and Resources
  - Community Representation
  - Culturally Responsive Care
  - Isolation

The key findings from each core issue are summarized below.

Discrimination and Racism

Discrimination and racism impact all aspects of a person's health and well-being and intersect with all major systems of society—education, governing/political, law enforcement, health care, and others. The impacts of discrimination and racism are deep rooted and multi-generational.
These are just a few of the effects discussed as part of HCWC's listening sessions and town halls:

- Health inequity
- Collective historical trauma
- Toxic stress
- Lack of representation

Trauma

Trauma has a profound impact on people. Adverse childhood experiences can have long-lasting adverse effects on people and correlate directly with poorer health outcomes.

As understanding of the long-term social and health impacts of trauma grows, trauma-informed care practices, policies, and resources will continue to grow and develop to respectfully and compassionately support needs of people in the community.

Behavioral Health

Behavioral health includes mental and emotional health, and conditions such as anxiety, depression, substance use disorders, and many others.

Across the quad-county region, almost a quarter of the population has been diagnosed with depression. Depression and suicide are major concerns for adults and youth alike.

- More access to behavioral health services is needed, as well as more providers who can provide culturally and linguistically competent behavioral health services (also see Culturally Relevant Care).

Chronic Conditions

HCWC identified the following chronic conditions as significantly impacting residents of the region, with communities of color having higher rates than whites:

- Heart disease
- Diabetes
- Hypertension
- Liver disease

Listening session participants highlighted several needs in this area, including for more peer navigators to help people access comprehensive health care and for intergenerational lifestyle change programs to improve health.

Sexually Transmitted Infections

Rates of chlamydia and gonorrhea are increasing in the region. Youth in listening sessions raised the issue of STIs and the need for more resources and education about STIs.

Access to Health Care, Transportation, and Resources

Access to these three areas is a major issue in the region.

Access: To Health Care

Access to health care is a challenge for those without insurance and for those with Medicaid, Medicare, and commercial insurance. Cost, location, and availability of services are key factors influencing access.

- More focus on prevention, including understanding and acknowledging what has happened in a person's lives before they come to a health provider (for example, what was happening in their life before they're admitted to a hospital?).

Access to Health Care, Transportation, and Resources (continued)

- Cost is a major barrier. Even for those who are insured, copays can be barriers to service if they are struggling financially
- Language can be a barrier to care (see Culturally Responsive Care below)
- More coordination between types of services and providers is needed to help people access and navigate care. Peer navigators and community health workers were frequently mentioned in listening sessions and town halls as great ways to help people navigate the health care system.

Access: To Transportation

Through this assessment, HCWC found transportation to be both a strength and an area for improvement, depending on where residents live and their particular needs.

- Challenge for residents of rural areas; impacts abilities to access health care. Geographic isolation (see Isolation below). Centralized services are ideal.

Access: To Resources

HCWC identified many strengths and areas for improvement in the area of resources. Communities in the region have many valuable resources like food banks, emergency shelters, multicultural centers, and LBGTQ+ organizations.

These are key areas that fall under community resources:

- Safe and affordable housing
- Community spaces
- Safe spaces for children and youth
- Resources for low-income people

Participants in the HCWC listening sessions often mentioned the following as areas of need:

- More preventive care and screening for mental health issues
- More financial counseling
- More resources for parents, particularly those who are immigrants or refugees and/or whose primary language is not English (see Community Representation for more)
- Better coordination of existing community resources

For community-based organizations, obtaining sufficient and consistent funding for their programs is a major challenge. They also find the lack of coordination between agencies and organizations as an area for improvement—more awareness of each others' available resources could help the communities they serve.

Community Representation

The lack of representation in local governments, particularly of communities of color, is a core issue. The lack of diversity and representation extends to all areas, including schools, workplaces, and the organizations that serve communities. This representation gap contributes to perpetuating policies that are outdated and misinformed.

- Increased representation and civic engagement among underrepresented communities helps elevate voices at the table that both represent and understand the lived experiences of community members.
- Increased representation and cultural awareness in health care settings increases clear communication, trust and understanding of how to best manage health (see Culturally Responsive Care below).

Culturally Responsive Care

For those in immigrant or refugee communities, and for those whose English is limited, language barriers and a lack of translators in health care settings poses significant challenges to accessing health care. Lack of cultural awareness by health care providers can also be a barrier.

Participants in the HCWC listening sessions and town halls often mentioned the following as key to culturally responsive care:

- Community health workers
- Peer navigators
- Translators
- More translated resources in non-English languages

Isolation

Geographic and social isolation adversely impact health and well-being. Geographic and physical isolation decrease people's ability to access to services. This is often an issue in rural areas where there are limited, if any, public transportation options and limited health care providers and health care centers in those areas.

Social isolation, which occurs in both rural and urban areas, means limited support through family or a social circle and limited involvement with the community. For some immigrants, social isolation can mean feeling culturally isolated.

- To address geographic isolation in rural areas, medical mobile units and other outreach efforts are important.
- For social isolation, community outreach and social services are key to supporting better social connections.

Glossary

Abbreviations

- ACEs: Adverse Childhood Experiences
- BRFSS: Behavioral Risk Factor Surveillance System
- CHNA: community health needs assessment
- HCWC: Healthy Columbia Willamette Collaborative
- STI: sexually transmitted infection

Definitions

- **Achievement gaps:** Achievement gaps, which begin as opportunity gaps, are disparities in academic performance between groups of students (for example, between students of different socioeconomic backgrounds, gender, and between different racial and ethnic groups).
- **Built environment:** The human-made space in which people live and work on a daily basis. Built environment can include access to healthy foods, community gardens, mental and physical health services, walkability, and bike-ability (such as bike paths or bike lanes).[i]
- **Community:** Group of people with diverse characteristics who are linked by social ties, common perspectives, and who may be engaged in joint action in geographical locations or settings. This is but one definition. Community can be defined in multiple ways depending on the people asked and what groups have in common.[ii]
- **Discrimination:** Socially structured action that is unfair or unjustified and harms individuals or groups. Occurs on both structural and individual levels. For a robust explanation and definition, please see Healthy People 2020's definition.[iii]
- **Food insecurity:** Limited or uncertain access to adequate food because of lack of money and other resources.[iv,v]
- **Gentrification:** Influx of new residents to an area, usually middle class or wealthier, that causes an increase in rent and housing costs and displaces the original or long-time residents of that area. Gentrification can have adverse effects on health for those being displaced.[vi]

[i] https://en.wikipedia.org/wiki/Built_environment
[ii] MacQueen KM, McLellan E, Metzger DS, et al. What is community? An evidence-based definition for participatory public health. *Am J Public Health.* 2001. Dec;91(12):1929-38. https://www.ncbi.nlm.nih.gov/pubmed/11726368
[iii] Healthy People 2020. Office of Disease Prevention and Health Promotion. Social Determinants of Health topics: Discrimination: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/discrimination
[iv] U.S. Department of Agriculture. Definitions of Food Security: https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/definitions-of-food-security.aspx
[v] Healthy People 2020. Office of Disease Prevention and Health Promotion. Food Insecurity: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/food-insecurity#1
[vi] Centers for Disease Control and Prevention. Health Effects of Gentrification: https://www.cdc.gov/healthyplaces/healthtopics/gentrification.htm

Glossary

Definitions (continued)

- **Health equity:** Means everyone has a fair and just opportunity to be as healthy as possible.[vii] HCWC, using an adapted definition from the World Health Organization,[viii] defines health equity as when all people can reach their full potential and are not disadvantaged by social or economic class, race, ethnicity, religion, age, disability, gender identity, sexual orientation or socially determined circumstance. Optimal health depends on mitigating or eliminating avoidable inequities in the access to and utilization of resources and opportunities. Health equity demands intentionally and systematically addressing poor health outcomes by purposefully engaging the root and intersectional causes of adverse health status such as racism, structural disadvantage and differential privilege.
- **Health justice:** The health of the quad-county region is not only defined by the quality of health care, it is assessed by the complete physical, social, and mental well-being of the population.[ix] It Is defined by the World Health Organization as necessary for human wellbeing, providing intrinsic value for comfort, contentment, and the pursuit of the joys of life.[x] The network for health justice defines it as: giving human dignity to everyone, regardless of who they are or where they come from. It means access to equitable and affordable, quality care for all.[xi]
- **Health literacy:** The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. It is dependent on individual and systemic factors: communication skills of lay persons and professionals.[xii]
- **Housing insecurity:** Circumstance in which you have no residence or have an unexpected cost/catastrophic event that results in not having enough money for rent/housing.[xiii]
- **Isolation:** Isolation is a key determinant of health. It is different from loneliness, though they are often discussed together. In this report, isolation means either geographic, physical, and/or social isolation. It pertains to social contacts or network that can include family and friends, but also the broader environment through social activities. Isolation also means being geographically isolated (where you live is a long way from other people, services).[xiv]

[vii] Robert Wood Johnson Foundation. "What Is Health Equity?" 2017. https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html

[viii] World Health Organization. Equity. https://www.who.int/healthsystems/topics/equity/en/

[ix] Daniels N. Justice, Health, and Healthcare. The American Journal of Bioethics. 2001. 1:2, 2-16; DOI: 10.1162/152651601300168834.

[x] Ruger JP. Health and social justice. Bulletin of the World Health Organization. 2011; 89:78-78. https://www.who.int/bulletin/volumes/89/1/10-082388/en/

[xi] The Network for Public Health Law. Health Justice: Empowering Public Health and Advancing Health Equity. 2018. https://www.networkforphl.org/the_network_blog/2018/09/12/1031/health_justice_empowering_public_health_and_advancing_health_equity/

[xii] U.S. Department of Health and Human Services. Quick Guide to Health Literacy. https://health.gov/communication/literacy/quickguide/factsbasic.htm

[xiii] APHA: https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2018/01/18/housing-andhomelessness-as-a-public-health-issue

Glossary

Definitions (continued)

- **Life-course theory:** Refers to studying people in a more holistic way including their lives, structural context, and social change. This discipline includes history, sociology, demography, developmental psychology, biology, and economics. Focus on the connection between individual lives and the historical and socioeconomic context which influence/encompass lives.[xv]
- **Morbidity:** rate of a disease or diseases
- **Mortality:** rate of death
- **Non-binary:** gender identity and/or gender expression falling outside the categories of man and woman
- **Qualitative data:** Non-numerical data based on traits or characteristics (for example, types of chonic health conditions someone may have)
- **Quantitative data:** Numerical data calculated and collected through established methods (for example, number of times a year someone visits the doctor or hospital, etc.)
- **Racism:** "A system of structuring opportunity and assigning values based on the social interpretation of how one looks (which is what we call "race"), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources." - APHA Past President Camara Jones, MD, PhD, MPH [xvi]
- **Social determinants of health:** Are the conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels.[xvii]
- **Transgender:** gender identity and/or gender expression different from what is typically associated with the sex assigned at birth [xviii]
- **Trauma:** A deeply distressing or disturbing experience

[xiv] Menec VH, Newall NE, Mackenzie CS, et al. Examining individual and geographic factors associated with social isolation and loneliness using Canadian Longitudinal Study on Aging (CLSA) data. PLOS ONE. 2019. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6358157/
[xv] Life Course Theory: https://www.encyclopedia.com/reference/encyclopedias-almanacs-transcripts-and-maps/life-course-theory
[xvi] American Public Health Association. Racism and Health. https://www.apha.org/topics-and-issues/health-equity/racism-and-health
[xvii] World Health Organization. Social Determinants of Health: https://www.who.int/social_determinants/sdh_definition/en/
[xviii] GLAAD. Media Reference Guide: https://www.glaad.org/reference/transgender

Community Health Needs Assessment Overview

Overview

HCWC is dedicated to advancing health equity by identifying health assets and challenges facing communities in the quad-county region. This 2019 community health needs assessment (CHNA) seeks to highlight the community's needs and provide a road map for future collaborations and health improvement projects. It will also inform the individual community health improvement plans of partner organizations.

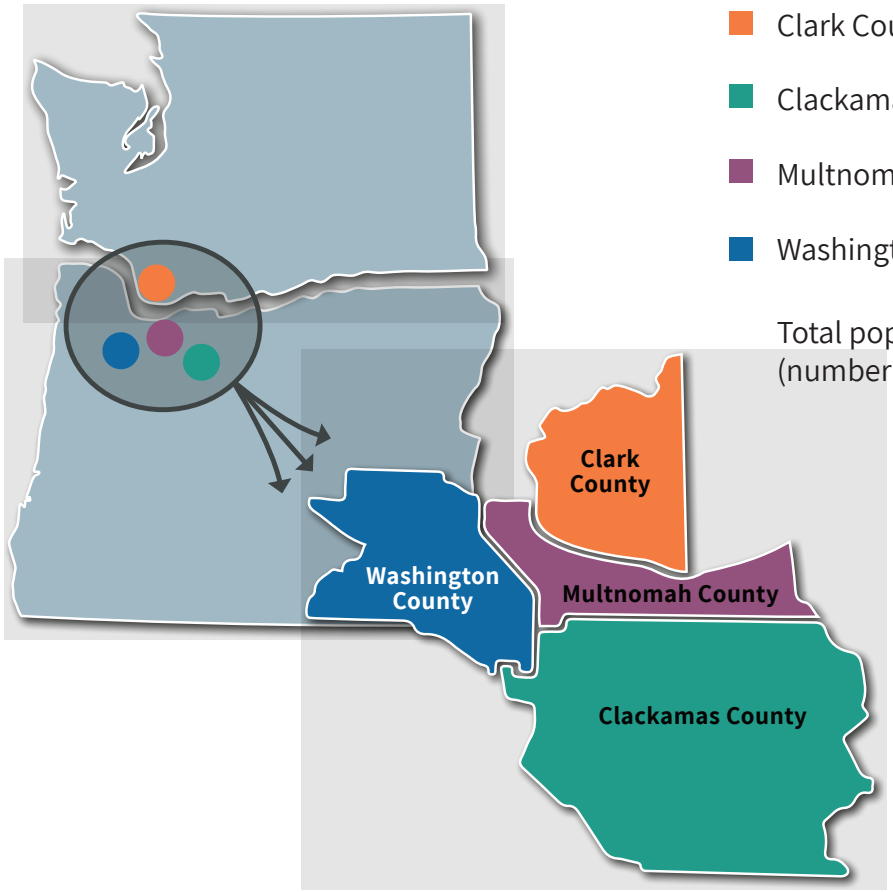
In past cycles, the opioid crisis was highlighted and led to statewide focus and work to reduce opioid-related harms. The "Housing is Health Initiative," with Central City Concern, began as a result of a previous CHNA, which addressed social determinants affecting the overall health of the community. The 2016 CHNA report is available here.

HCWC members:

- Adventist Health
- Clackamas County Health, Housing and Human Services
- Clark County Public Health
- Health Share of Oregon
- Kaiser Permanente
- Legacy Health
- Multnomah County Health Department
- Oregon Health & Science University (OHSU)
- PeaceHealth Southwest Medical Center
- Providence Health and Services
- Tuality Healthcare
- Washington County Public Health

Quad-County Region

This CHNA covers the quad-county region of Clark County, Washington, and three counties in Oregon: Clackamas, Multnomah, and Washington.



- Clark County - 450,893
- Clackamas County - 394,967
- Multnomah County - 778,193
- Washington County - 564,088

Total population (number of people): 2,188,141

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Quad-County Region (continued)

The demographics of the region shows the importance of having a community health system that is responsive to diversity. Tables 1–3 show basic demographic characteristics of the quad-county region's population.

Table 1. Selected Demographic Characteristics of the Region.

	Clark	Clackamas	Multnomah	Washington	Region
	450,893	394,967	778,193	564,088	2,188,141
Gender					
Male	49.5%	49.2%	49.3%	49.4%	49.4%
Female	50.5%	50.8%	50.7%	50.6%	50.6%
With a disability	13.3%	11.9%	10.2%	12.6%	12.0%
Foreign born	13.9%	8.0%	17.0%	10.4%	12.9%
Language other than English spoken at home	19.7%	12.1%	24.1%	15.0%	17.4%

Source: American Community Survey 5-year estimates 2012–2016.

Table 2. Quad-County Region: Ages.

	Clark	Clackamas	Multnomah	Washington	Region
Age					
Median age (years)	36.7	41.4	36.2	37.8	38.0
Under 5 years	5.9%	5.5%	6.6%	6.4%	6.1%
5 to 19 years	15.9%	19.1%	19.9%	21.1%	18.6%
20 to 44 years	41.1%	30.3%	36.4%	32.2%	36.1%
45 to 64 years	25.2%	29.0%	25.2%	26.6%	26.2%
65 years and older	11.9%	16.1%	11.8%	13.7%	13.0%

Source: American Community Survey 5-year estimates 2012–2016.

Table 3. Quad-County Region: Race and Ethnicity.

	Clark	Clackamas	Multnomah	Washington	Region
Race/ethnicity					
American Indian and Alaska Native	0.8%	0.7%	0.6%	0.6%	0.7%
Asian	6.9%	4.1%	9.5%	4.3%	6.5%
Black or African American	5.4%	0.9%	1.8%	1.9%	3.0%
Hispanic or Latino (of any race)	11.1%	8.2%	16.2%	8.7%	11.4%
Native Hawaiian and Other Pacific Islander	0.6%	0.3%	0.4%	0.8%	0.5%
Two or more races	5.2%	3.4%	4.9%	4.6%	4.7%
White	78.2%	89.0%	77.6%	84.6%	81.3%

Source: American Community Survey 5-year estimates 2012–2016.

Influencers of Change

Many issues affecting the quad-county region are driven by local, state and national issues and policy. A brief summary of factors, trends, and events includes:

- Local, state, and nationwide election cycles and policy shifts
- Wildfire, flooding, and other natural disasters affecting landscape, housing, and health
- Historic racism and discrimination (see Discrimination and Racism)
- Other reports evaluating the region for priority areas of focus to affect resourcing
- Housing, opioids, and education are focus factors in the quad-county region

For more information about these impactful trends and events, see Appendix C.

Community Voice

Community-based organizations hosted 18 community listening sessions focusing on the following priority populations:

- Senior (65+) LGBTQ+ persons
- Senior (65+) Low-Income
- Senior (65+) Rural
- Farmworkers
- Hispanic/Latinx
- LGBTQ+ Homeless Youth
- Middle Eastern
- Military Connected
- Pacific Islanders
- People of Color with Housing Concerns
- People with Mental Health Concerns
- Rural
- Slavic
- Youth
- Youth of Color

Community Voice (continued)

The listening sessions were discussions with community members focusing on their lived experiences and perspectives regarding the strengths and challenges facing their communities. This information was analyzed to support the findings in this report. See Appendix D for demographic information about participants in these listening sessions.

HCWC conducted four town halls, one in each county, with participants that represented community organizations. At the town halls, representatives of community-based organizations, public health professionals, and community leaders gathered to review morbidity and mortality data and reflect on their experiences supporting community health and well-being. Their input was collected and analyzed.

Methodology

HCWC used a mixed methods approach for the CHNA. HCWC prioritized community voice and input in this assessment (qualitative data), while also including data from public health surveys, hospitals, and other sources (quantitative data). HCWC used a modified version of the Mobilizing for Action through Planning and Partnerships (MAPP) model to guide the needs assessment (see Figure 1). The MAPP model is an iterative process combining health data and community input to identify and prioritize community health needs.

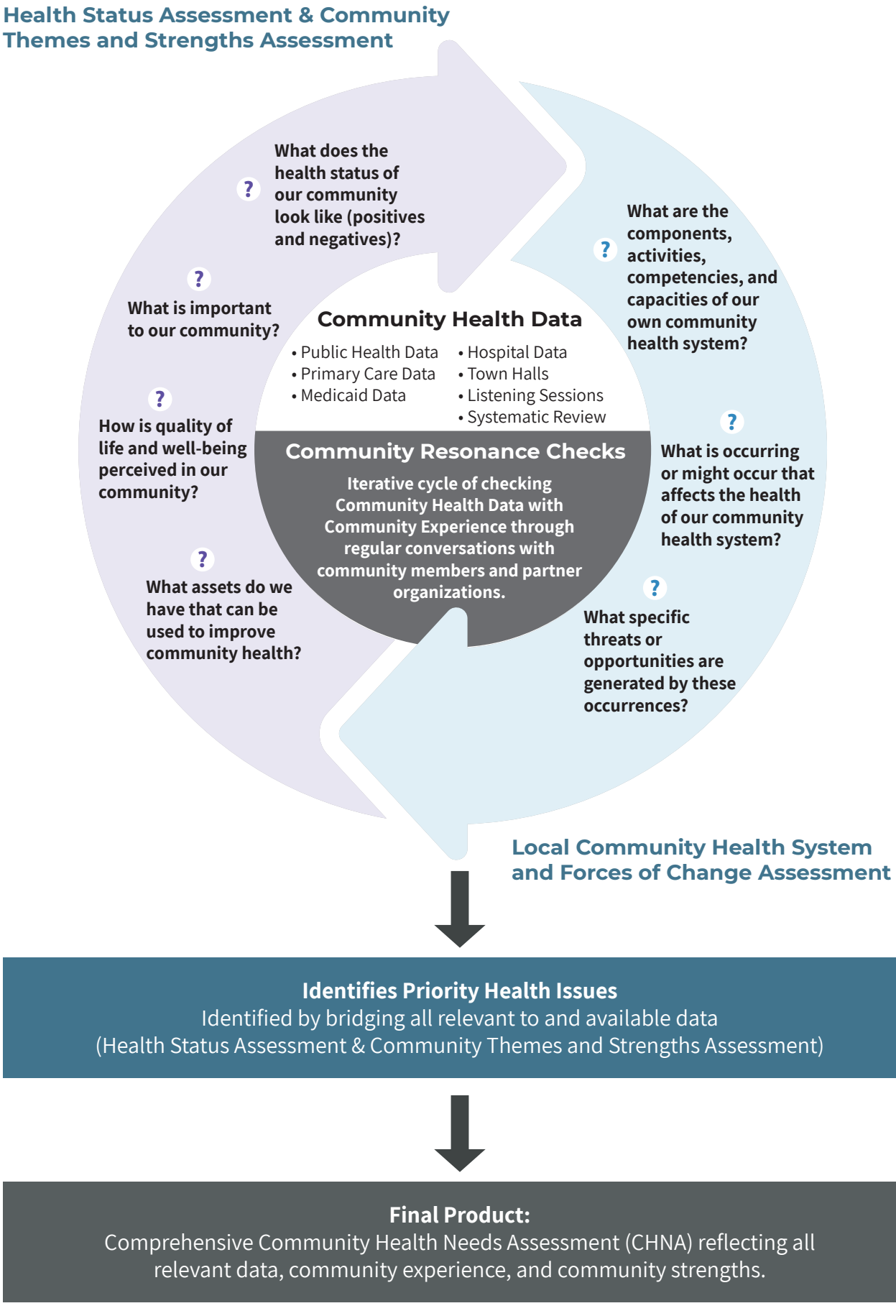
In this report, HCWC examines conditions by ethnic and racial categories, whenever possible, to focus on how health differs within communities of color, who are often most impacted by health disparities. Because comparing communities of color on a single health issue in a single chart can unintentionally contribute to racism by reinforcing scarcity-based thinking and creating competition between groups for limited resources, the assessment is organized in some sections by race or ethnicity rather than by health condition.

There are limitations on how race and ethnicity are collected and categorized in the data systems used in this report. Most data collection systems use a limited number of racial and ethnic categories that are not always self-reported by an individual, leading to bias in data collection. The categorization of people who identity with multiple races or ethnicities is limited.

Both Oregon's and Washington's populations are predominantly white with 84.4% and 75.4% of the population identifying as white, non-Hispanic. The region's large white population makes it hard to collect data that would allow for a robust analysis of health disparities and health outcomes in communities of color. Due to sample sizes for some populations, data connecting the themes of the qualitative data collection to the quantitative data is limited.

For more information about the methodology, see Appendix B.

Figure 1. HCWC 2019 Assessment Model.



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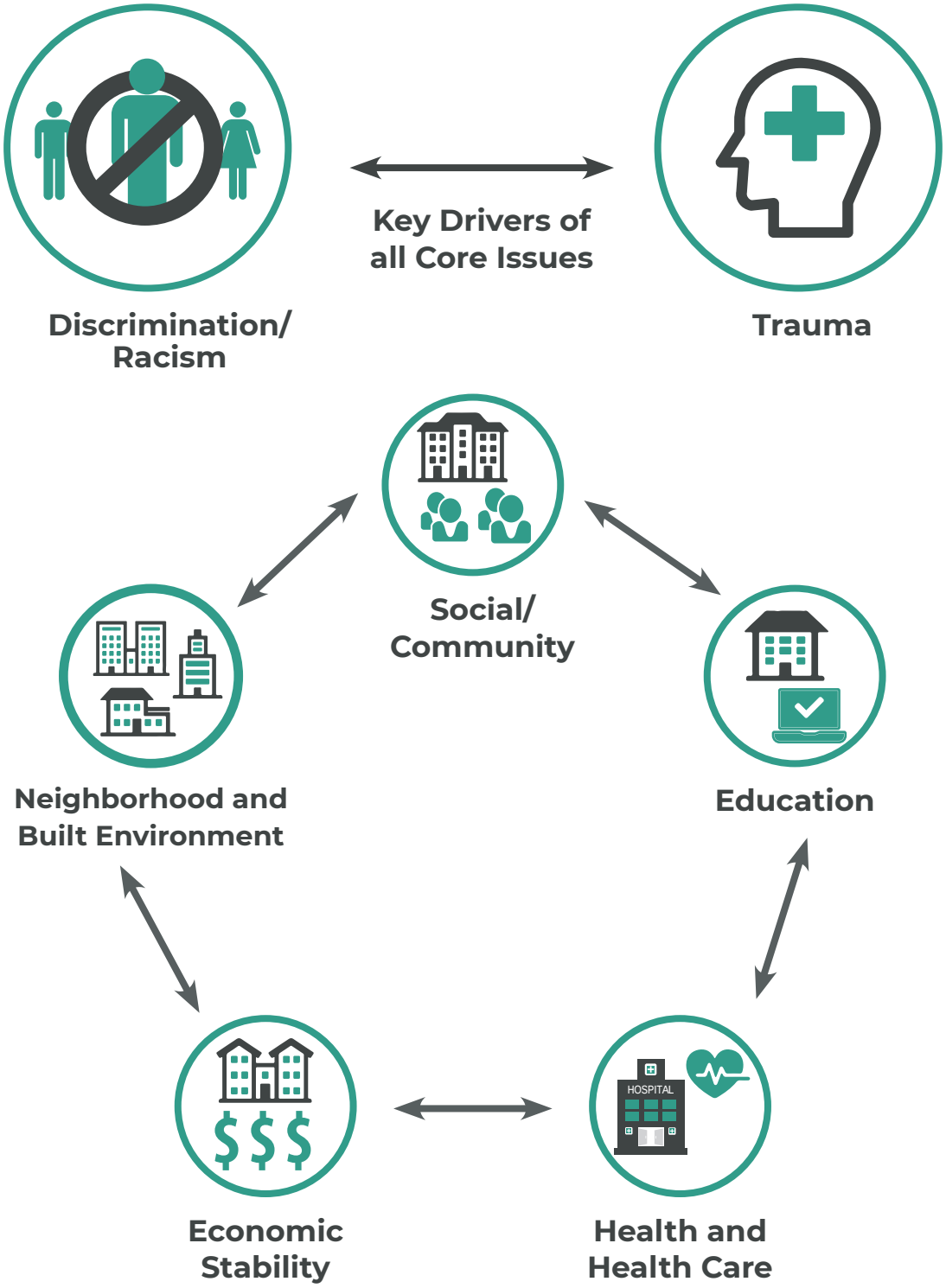


Social Determinants of Health

Social and Community Context

Social and community connections and context are crucial to the health and well-being of the region. Civic participation, discrimination, racism, incarceration, and social cohesion affects the lives of individuals throughout the region in a myriad of ways. Strong social and community connections are key to addressing health outcomes. All the social determinants of health are intrinsically linked with discrimination and racism. Discrimination and racism impact all aspects of community members' lives.

Discrimination and Racism

Discrimination and racism across the region continue to impact the health of community members. The policies and structures that are in place across the region limit opportunities for some individuals. The link between discrimination and racism and health is clear. Differences in health between racial groups in the United States are significant and persistent, even after controlling for known factors. The physical impact of discrimination and racism can cause people to live in a constant state of stress,[4] which over time leads to chronic conditions. It also impacts the mental health of those experiencing it.

Discrimination

Discrimination, while often tied to racism, is not entirely the same. Discrimination is the unjust or prejudicial treatment of categories of people based on race, age, sex, sexual orientation, gender identity, disability status, mental health status, cultural identity, and other factors. Similar to racism, discrimination affects the everyday lives of community members across the region through large and small actions taken by individuals and institutions.

> ***"As a society we have an unwillingness or inability to acknowledge the role of structural racism in informing people's health, including how we decide what data are 'valid' and 'statistically significant.'"***
> **- Town Hall Participant**

Community members who experience unjust treatment based on race may also experience discrimination. Some people whose race aligns with the white majority (see quad-county region demographics, page 14) experience discrimination based on other identities.

This discrimination can include:

- harassment such as inappropriate jokes, insults, or visual displays
- wage discrimination, where an employer offers a lower wage to one person versus another based on their identity
- hiring discrimination where an employer asks inappropriate questions about life circumstances or declines to hire a person based on disabilities or health limitations
- housing discrimination where a landlord may refuse to rent to, for example, a family or a young person

Racism

Race and racism are social constructs. Racism structures opportunity and assigns value based on the social interpretation of the way people look. It unfairly disadvantages some individuals and communities, while unfairly giving other individuals and communities advantages. Racism saps strength from society by undermining the realization of full potential for some communities based on their race (Camara Jones, MD, PhD, MPH).[5]

Racism affects people's everyday lives through small and large actions at the individual, community, and system level.

> ***"Racism and prejudices from childhood are a hard boulder to move."***
> **– Listening Session Participant**

Effects of Historical Racism

The region's history influences the racism and discrimination of today. This includes the genocide and removal of Native American tribes from their ancestral land, national immigration restrictions limiting immigrants from certain countries or regions, and redlining against African Americans, which is the practice of denying or limiting financial services (like home loans) to certain neighborhoods.[6,7]

These policies and events continue to impact people of color across the region today. Gentrification of neighborhoods historically populated by communities of color, perpetuates racism as people are driven out of their communities. At the same time, national policies affect immigrant and refugee communities.

Isolation and Social Cohesion

Poor family support, minimal contact with others, and limited involvement in community life are associated with increased disease and early death. Studies have shown that the magnitude of health risk associated with social isolation are similar to that of smoking cigarettes.[8] Social networks have been shown to be predictors of health behaviors, suggesting people with strong social networks will make healthier lifestyle choices than those without social support.[9] See Isolation section for more.

Across the region there are significant differences in the rate of social associations, which are the number of membership associations in a population.[10] Lower rates of social associations can indicate isolation from the larger community.

Rate of Social Associations per 10,000 population:

- **Clark County 7.1**
- **Clackamas County 9.0**
- **Multnomah County 11.4**
- **Washington County 7.3**

Source: 2018 County Health Rankings & Roadmaps.

Education, Literacy and Language

Education is a powerful driver of wellness and can improve health outcomes, health behaviors, and social outcomes into adulthood.[11] Achievement gaps, which begin as opportunity gaps, are disparities in academic performance between groups of students; for example, between students of different socioeconomic backgrounds and between different racial and ethnic groups.[12,13] Achievement gaps are evident in children as young as nine months,[2] suggesting that early childhood services and education are necessary to support achievement. This sentiment was echoed by participants in listening sessions who expressed a desire for skills and education development supporting better employment opportunities for community members, especially those with limited access to housing or stable income.

Below are some notable literacy and education findings about the region:

- Youth literacy in the region:
  - 56% of students in all grades met Oregon's English language arts standard in 2016–2017
  - 67% of Grade 10 students in Clark County met Washington's English language arts standard
- Between 2012 and 2016, 6.5% of preschool age children were enrolled in nursery school or preschool across the region (does not include daycares or other types of childcare).
- Five-year graduation rates in Clark County in Washington have been increasing since 2013.[14]
- Across the quad-county region, 8.9% of the population has an associate's degree, 23.9% has a bachelor's degree, and 14.7% has a graduate or professional degree.[15]

During the 2016–2017 academic year an average of 16 languages were spoken in schools and nearly one-quarter (23%) of students in Clackamas, Multnomah, and Washington counties were English language learners.[16] In Clark County, the percentage of students who were English language learners was much lower (5%).[17]

Limited English proficiency creates additional hurdles to accessing health care services and understanding health information.[18] Listening session and town hall participants from the Hispanic/Latino community described feeling discriminated against after being turned away by health care providers due to lack of insurance and language barriers. Participants cited language barriers and a lack of translators as significant challenges to health.

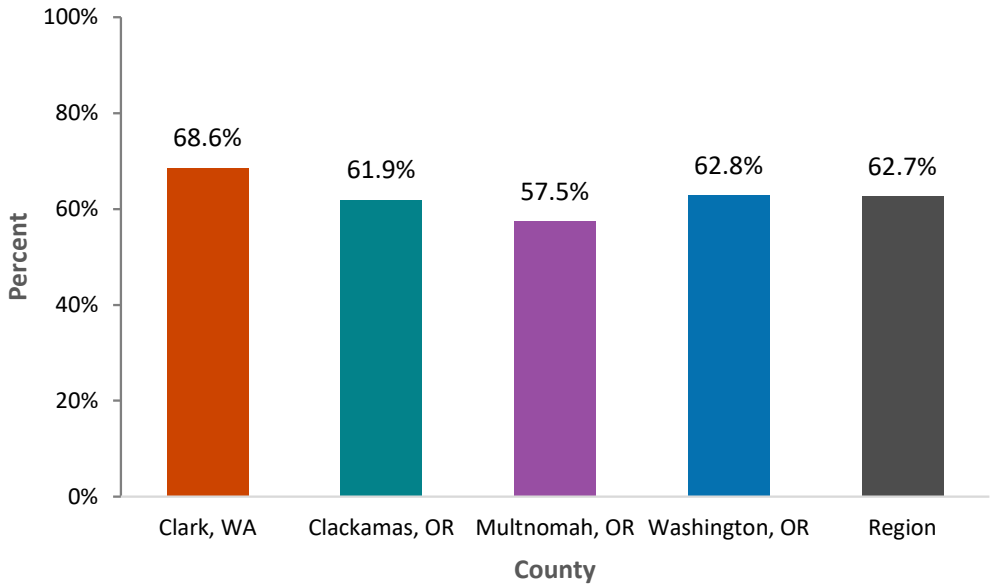
See Appendix C for more about education and literacy in the quad-county region.

Health and Health Care

Access to health care is fundamental to the improved health and well-being of the region. Across the region, about 90% of the population has some form of health insurance,[19] but accessing health care services continues to be a challenge for many communities.

As shown in Figure 2, fewer than 70% of people across the region reported they had a routine check-up with a health care provider in the last year.

Figure 2. Percentage of Population Who Had a Routine Check-up in the Last Year (2012–2015).



Source: BRFSS, 2012-2015.

Health and Health Care (continued)

Some data suggests that the number of providers available across the region varies significantly based on location. Data from County Health Rankings shows that across the United States, the top-performing counties have a primary care provider to population ratio of 1 to 1,030. Only Multnomah County has a better ratio than that (1:712), with Clark County having significantly fewer primary care providers per population. See Appendix E for specific ratios by county and provider type.

> ***"Insurance issues are a nightmare in this country."***
> **– Listening Session Participant**

Even though most quad-county residents have health insurance, many face challenges related to the cost and coverage of services.

Over 10% of the population in every county reported not being able to access health care services due to cost.

This challenge was echoed by listening session participants, some of whom noted the choice they had to make between accessing health care services and paying for their basic needs. The financial burden of medical care, notably the high cost of insurance and co-pays, limited access to health services. Often participants had to choose between affording health care or medications and providing for their families.

In addition:

- Listening session participants who identify as transgender or non-binary noted the lack of coverage for services related to body dysphoria and transitioning.
- Participants with disabilities noted difficulty in accessing medical equipment and transportation to medical care.
- Immigrant communities noted that the cost of co-pays and insurance deductibles affected their decisions about accessing health care services.

Health literacy is also related to multiple facets of health. Limited literacy is a barrier to health knowledge access, proper medication use, and utilization of preventive services.[20-22] Individuals with limited literacy face additional difficulties following medication instructions, communicating with health care providers, and attaining health information, which may have negative implications for health.[23]

Economic Stability

Economic stability is a crucial part of community health and well-being. Socioeconomic status, job stability, access to financial assistance programs, affordable housing, and access to education and job training are all factors that determine economic opportunity and stability for people living in the region.

Racism and Discrimination, Health, and Poverty

Poverty is a strong indicator of overall health. People who live below the poverty line are more likely to suffer from chronic diseases and mental health concerns.[24] Income inequality can exacerbate mental health issues.

Some listening session participants expressed feeling isolated and indicated their poor mental health was being exacerbated by the financial stressors in their lives.

Non-dominant racial and ethnic groups, the LGBTQ+ community, women, single-parent households and people with disabilities are more likely to experience poverty.[25-29] Due to historic and systemic barriers, and the lack of available resources, people in affected communities are often unable to access systems, such as financial systems of support or higher education, that lead to economic stability. These barriers reinforce discriminatory practices that create additional obstacles to professional advancement and financial security.

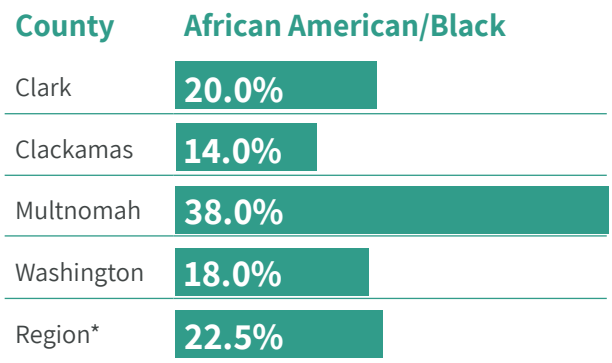
These issues greatly impact the likelihood of experiencing adverse outcomes of health and well-being across the course of one's life.

Communities of color are more economically insecure than other communities in the region. The intersection between racial and ethnic disparities, gender disparities, rates of houselessness, experiences in foster care, incarceration rates, education access, and unemployment rates are exacerbated by systemic and institutional forms of discrimination. See page 37 for more about how discrimination and racism impact these issues and more.

As shown in Figures 3–9, residents of Multnomah County who identified as African American, Native Hawaiian/Pacific Islander, Native American/Alaska Native, and Hispanic/Latino were, on average, twice as likely to live below the poverty line than white individuals. Consistently, white and Asian individuals were significantly less likely to live below the poverty line in the region than other races/ethnicities. Overall, a lower percentage of the white population lives below the poverty line in the quad-county region.

Figures 3–9. Percentages of Individuals below the Poverty Line by Racial/Ethnic Group and County.

Figure 3.



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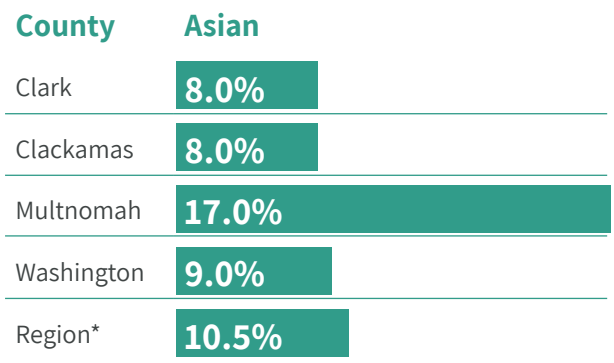
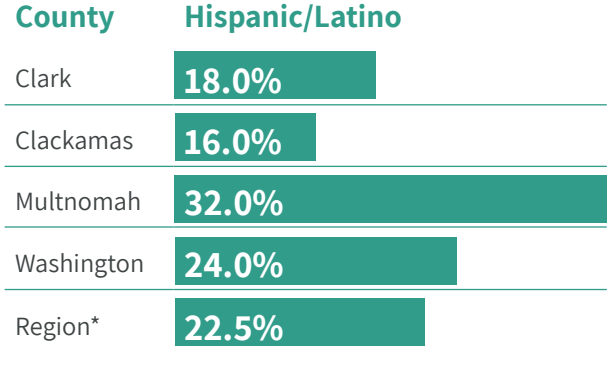


Figure 5.



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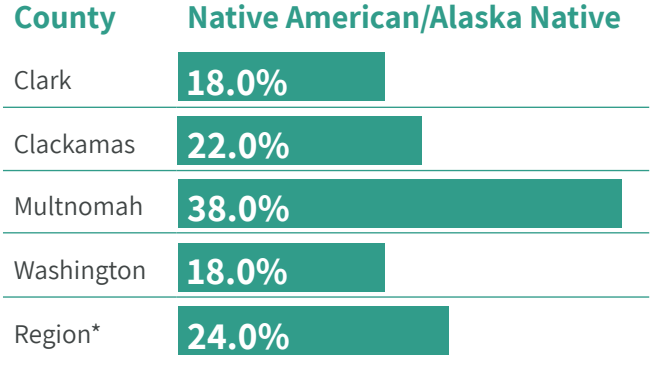

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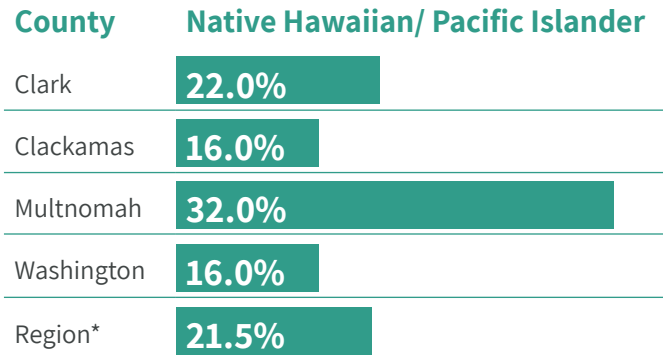


Figure 8.

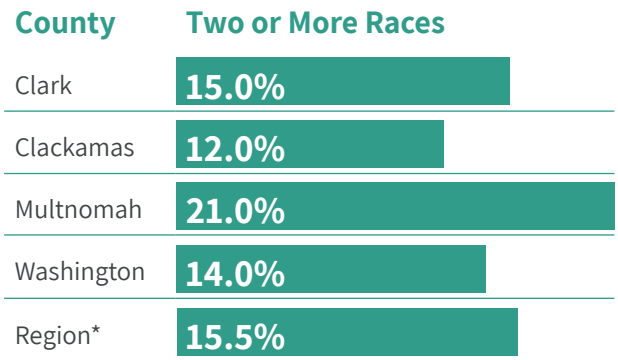
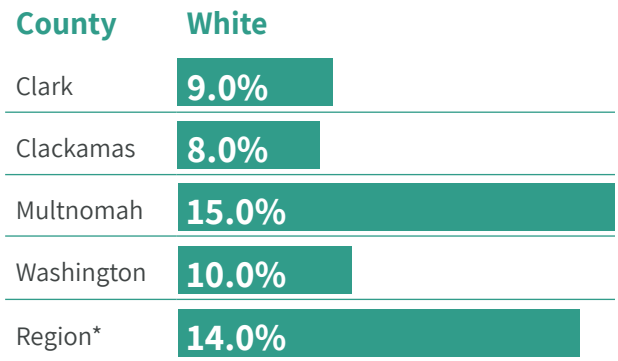


Figure 9.



Source: American Community Survey 5-year estimates 2012–2016.
*Regional percentages calculated by unweighted averages.

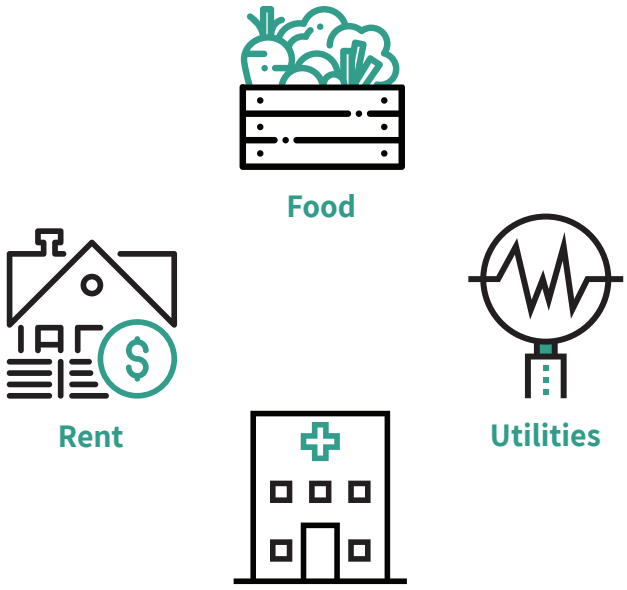
Racism and Discrimination, Health, and Poverty (continued)

Listening session participants described obstacles to economic stability as multi-faceted and intersectional, including:

- Housing security
- Financial burden of medical care
- Discrimination and representation
- Trauma
- Mental health concerns
- Socioeconomic status

They described limited opportunities to transcend barriers, keeping their communities economically unstable.

Many face a cycle of difficult decisions to achieve or maintain economic stability. Often, these difficult choices entail choosing between:



Participants described struggling against a common cultural misconception that they could simply pull themselves up by their bootstraps and climb out of poverty, regardless of the hurdles in their way. This sentiment neglects to acknowledge the barriers in the overall systems that prevent many from attaining, and maintaining, economic stability despite their hard work and merit.

Inequity in the Employment Sector

Town hall and listening session participants described inequities in the workforce as barriers to professional advancement of minority populations in the region.

They described their communities as unable to escape the cycle of poverty due to structural and institutional barriers, including:

- the inability to secure stable jobs that pay a living wage
- lack of insurance benefits
- the inability to advance due to work-place discrimination

> ***"I thought that diversity [in the work place] was important, but now I see that's a cover up – yeah, let's hire a few blacks, let's hire a few trans people – but they basically deny you from moving up."***
> **– Listening Session Participant**

For individuals with disabilities, communities of color, LGBTQ+ communities, single parent families, and immigrant and refugee communities, workplace discrimination is an additional barrier to economic stability. These economic disparities are much worse for women, non-binary people, people who are transgender, and for others with identities from underrepresented communities.[30]

Participants in the listening sessions for immigrants and refugees described financial challenges due to discrimination (see Discrimination and Racism section on page 36) and cultural misunderstandings, such as lack of credit history, to assist in financial endeavors.

While many immigrants and refugees came to the United States with transferrable job skills and education from their home countries, their credentials were not transferrable. This hurdle often required finances to fund additional education or changing careers.

One solution offered by participants to help close this gap would be to invest in community-centered small businesses, particularly family-oriented and culturally specific businesses. Participants want to see investment in their communities to encourage economic growth and financial security for all community members.

Income Gap

The income gap between many communities of color and the white population, as show in Table 4, reflects the unequal opportunities described by listening session and town hall participants. Individuals who identified themselves as Two or More Races and individuals who identified as Hispanic/Latino made significantly less money per capita than individuals in the region who identified as white. On average, across the region, Hispanic/Latino and those identifying Two or More Races had a lower median per capita income than other groups.

Table 4. Median Per Capita Income by Race and County.

	Clark	Clackamas	Multnomah	Washington	Region*
African American/Black	$24,854	$27,741	$17,805	$26,730	$24,282
Asian	$32,306	$34,355	$27,896	$37,972	$33,382
Hispanic/Latino	$15,171	$20,162	$17,335	$15,255	$16,981
Native American/Alaska Native	$24,928	$20,676	$16,534	$24,245	$21,596
Native Hawaiian/Pacific Islander	$21,686	$24,676	$15,905	$21, 765	$21,008
Two or More Races	$15,935	$20,720	$17,335	$17,030	$17,755
White	$31,704	$36,674	$36,751	$35,540	$35,167

Source: American Community Survey 5-year estimates 2012–2016.
*Regional percentages calculated by unweighted averages.

Pathways to Economic Stability

Many people who participated in the listening sessions expressed the need for services linked to longer-term pathways to improving living standards, while still maintaining the immediate basic needs. Participants who were a part of immigrant and refugee communities described receiving more outreach efforts and resources when they first arrived, but not for the long-term.

To achieve economic stability, participants stated they need more pathways to education, to transfer existing job skills, and to access financial coaching and job assistance to establish credit and develop a long-term plan to support their families. See more in the Access section on page 56.

Neighborhood and Built Environment

The natural and built environment strongly influences the health and well-being of the region and contributes to quality of life. As the region's population continues to grow, the restructuring of neighborhoods, transportation infrastructure, the accessibility of parks and community spaces, environmental exposure, and safety remain important topics and contributors to community health. Individuals with low socioeconomic status, communities of color, rural communities, and other communities traditionally underrepresented in the region's data measures are often the most impacted by these influencers on health (see Discrimination/Racism, on page 37).

Impact on Health

Both town hall and listening session participants described healthy neighborhoods and built environment as crucial to living a healthy life. For a healthy community to thrive, participants highlighted the power of a united neighborhood that has strong community ties, and access to support and resources that are affordable and located within their neighborhoods (see Access to Health Care, Transportation and Resources on page 56 for more).

Neighborhood and built environment factors contributing to health include, but are not limited to:

- Transportation
- Sidewalk accessibility
- Environmental pollution
- Public safety
- Access to technology
- Housing
- Access to healthy foods
- Access to recreational and educational settings

Many chronic health conditions are mapped back to stressors originating in neighborhoods and built environments, which are one of the most powerful influencers on population health. A person's ZIP code and the surrounding area is a strong indicator for access to resources, long-term health outcomes, and economic advantages.[31,32]

Listening session participants expressed concerns about their environment, including exposure to pollutants and other human-related hazards that have an impact on the health of the community.[33] Exposure to environmental pollutants, notably air pollution, is linked to an increase in developing chronic health conditions such as diabetes, hypertension, asthma, chronic obstructive pulmonary disease, emphysema, and obesity.[34] Participants were concerned by what they are exposed to, both in their natural environment as well as in hazardous housing conditions. They also voiced concerns about how transportation and infrastructure contributed to the air quality of the region.

Participants wanted more geographically accessible spaces that offer pathways to healthy lifestyle choices, such as healthy eating, cooking classes, after-school youth activities, family-centered exercise classes, and classes to help manage chronic diseases.

Affordable Housing

A pillar of a healthy community is access to affordable housing. While rent and the cost of living continue to rise in the United States, income and hourly wages remain stagnant.[35]

Over 93% of housing units are occupied in the region.[36] Listening session participants highlighted challenges in attaining and maintaining adequate living conditions. Evictions and instability in housing, even in emergency housing, was a consistent theme among both town hall and listening session participants. Being denied housing due to immigration status and race/ethnicity was also cited as major issue among participants.

Unaffordable housing costs and rent hikes greatly contribute to the stress community members face.

Many community members in the region are housing insecure, and many more struggle to pay their rent. As shown in Figure 10, a higher percentage of households in Multnomah County were paying 35% or more of their income on rent compared to the rest of the region.

Figure 10. Percent of Households Paying 35% or More of their Household Income on Rent, by County and Region.

Source: American Community Survey 5-year estimate 2012-2016.
*Regional percentages calculated by unweighted averages.

Affordable Housing (continued)

The issue of the houseless crisis[37] arose as two distinct concerns for participants, often expressed simultaneously:

1. The fear of community safety due to the amount of houseless people in their neighborhoods, and
2. The fear many community members face of being one step away from houselessness themselves due to lack of financial security and stability in their housing.

Listening session participants with mental health concerns said that case workers are pivotal to solving the housing crisis, and for addressing mental health issues that can lead to eviction, but that hospitalization is the main route to gain access case workers. Youth who are LGBTQ+ and housing insecure described the need for more resources available for adults over the age of 25, especially housing and day-time programs that kept them safe and connected to their community and resources. Many described feeling adrift when they aged out of services for "youth"; this age gap disqualified many youth in need from access to services that they rely on to survive.

Among those who had stable housing, there were concerns about negligent landlords not addressing property maintenance, safety, and sanitation issues.

> ***"[Housing sanitation and apartment management is] Impacting people's physical, emotional, and mental wellbeing. It is stressful living in a neglected community"***
> **– Listening Session Participant**

Overall, town hall and listening session participants expressed the struggle to access resources that provided affordable housing, emergency shelters, assistance in paying utility bills, and wished for these topics to be higher priorities in their communities.

See the next page for more about houselessness in the region. For more information about the social determinants of health shaping the region, see Appendix C.

Houselessness in the Quad-County Region

According to the U.S. Department of Housing and Urban Development, the number of individuals experiencing houselessness in Oregon and Washington have increased in recent years: by 12.8% in Oregon from 2007 to 2018 and by 23.6% in Washington.[i]

Based on the "single night count" from January 2018, Oregon had an estimated 14,476 people experiencing houselessness statewide, and Washington had 22,304. In Oregon, more than half (64%) of individuals experiencing houselessness were staying in unsheltered locations, which was one of the highest rates in the country. Oregon also has one of the highest rates of unaccompanied youth experiencing houselessness in the country.

In the quad-county region, the numbers of people experiencing houselessness has increased in the past two years in Multnomah and Clark counties.

In Oregon, about 30% of people experiencing houselessness in the state are in Multnomah County.[ii]

- Multnomah County had about 4,177 experiencing houselessness in January 2017.
- Clackamas County had 497 in 2017, a slight increase from 494 in 2015.
- Washington County had 544 individuals experiencing houselessness, a decrease from 2015.

Based on the January 2019 point-in-time count in Clark County, 958 people were experiencing houselessness, which is a 21% increase from the 795 people in January 2018.[iii]

- About half (487) of these people were sleeping unsheltered (for example, sleeping in tents, cars, the street, or other places where people are not meant to sleep), while 471 had shelter of some sort (sleeping in an emergency shelter or transitional housing).

Other notes of interest:

- About 9% of people experiencing houselessness in Oregon are veterans, according to the 2017 point-in-time report.[iv]
- In Clark County, about 6% of those experiencing houselessness are adult survivors of domestic violence, according to the 2019 point-in-time report.[v]
- In the Springwater Trail report from Clackamas County, people experiencing houselessness who were living on the trail reported they felt, "isolated from family, but connected to 'street family.'"

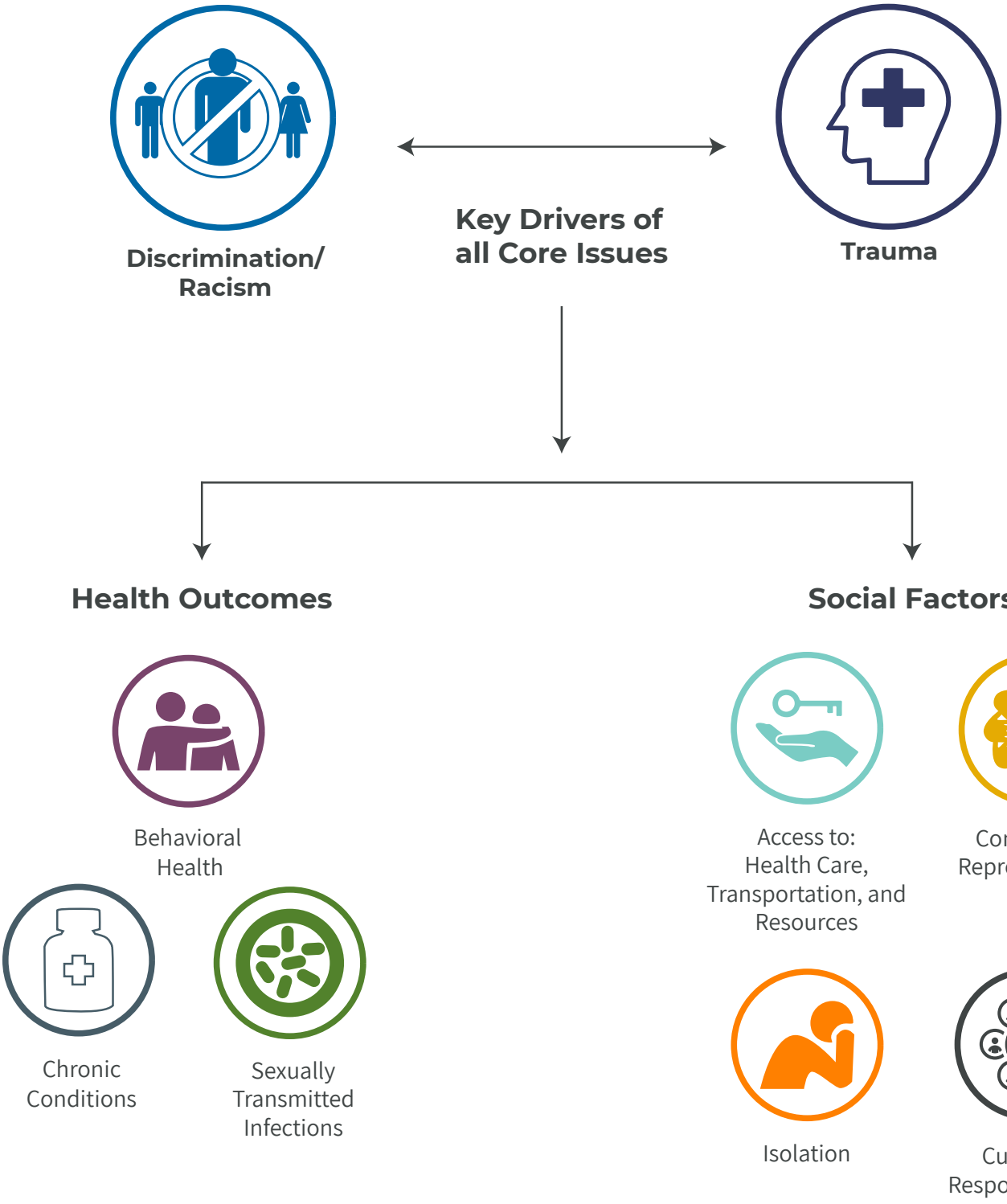
[i] U.S. Department of Housing and Urban Development. The 2018 Annual Homeless Assessment Report to Congress. December 2018. https://files.hudexchange.info/resources/documents/2018-AHAR-Part-1.pdf

[ii] Oregon Housing and Community Services. 2017 Point-in-Time Estimates of Homelessness in Oregon. https://www.oregon.gov/ohcs/ISD/RA/2017-Point-in-Time-Estimates-Homelessness-Oregon.pdf

[iii] Council for the Homeless. 2019 Point-in-time count of people experiencing homelessness in Clark County. https://www.councilforthehomeless.org/data-system-numbers/

[iv] Oregon Housing and Community Services. 2017 Point-in-Time Estimates of Homelessness in Oregon. https://www.oregon.gov/ohcs/ISD/RA/2017-Point-in-Time-Estimates-Homelessness-Oregon.pdf

[v] Council for the Homeless. 2019 Point-in-time count of people experiencing homelessness in Clark County. https://www.councilforthehomeless.org/data-system-numbers/


Discrimination/ Racism
Key Drivers of all Core Issues
Trauma
Health Outcomes
Social Factors
Behavioral Health
Chronic Conditions
Sexually Transmitted Infections
Access to: Health Care, Transportation, and Resources
Community Representation
Isolation
Culturally Responsive Care

Core Issues

Core Issues

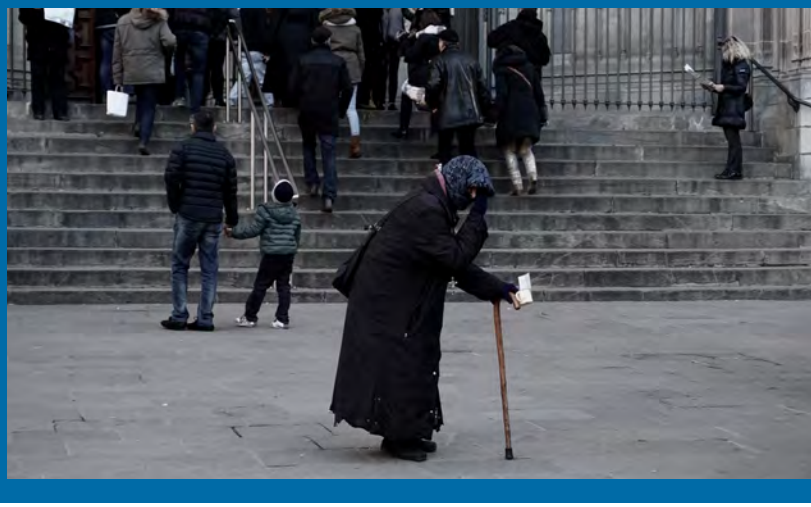
A host of issues impacts the health of communities in the quad-county region. Yet nine issues consistently emerged in feedback from community members and community organizations and from data sources. HCWC designated these nine as the core issues, central to the needs of the region as supported by data collected and analyzed for this needs assessment.

In considering programs and actions to address the issues, discrimination and racism and trauma should be acknowledged, addressed and understood as a part of all programing and projects. HCWC is committed to health equity and understands that it cannot be achieved if acknowledging and addressing discrimination, racism, and trauma are not central to programs and initiatives to improve the health of the region.

The other core issues are broken into two categories, as shown below:

- **Key Drivers of all Core Issues**
  - o Discrimination and Racism
  - o Trauma
- **Health Outcomes**
  - o Behavioral Health
  - o Chronic Conditions
  - o Sexually Transmitted Infections
- **Social Factors**
  - o Access to: Health Care, Transportation and Resources
  - o Community Representation
  - o Culturally Responsive Care
  - o Isolation

It is important to note that the focus on these nine does not mean that other issues do not remain important issues in the community.



Discrimination and Racism

Discrimination and Racism

Discrimination: Socially structured action that is unfair or unjustified and harms individuals or groups. Occurs on both structural and individual levels.

Racism: "A system of structuring opportunity and assigning values based on the social interpretation of how one looks (which is what we call "race"), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources." - APHA Past President Camara Jones, MD, PhD, MPH.

The HCWC region is home to diverse communities with their own strengths and challenges to address unique health needs. Many communities – LGBTQ+, rural, people living with disabilities, people living with mental health concerns, immigrants, refugees, and people of color – face greater challenges in accessing resources, health care, and attaining overall well-being, due to discrimination and racism.

Discrimination and racism across the region continue to hamper the health of community members. The policies and structures that are in place across the region limit the opportunities for some individuals. This is an overarching core issue, which must be considered in all programs to adequately address the other core issues. Addressing the other core issues in isolation will continue to perpetuate racist and discriminatory systems.

What's Being Done

HCWC members are supporting this core issue through:

- Consulting and partnering with community groups to address racism
- Participating in organizational equity, diversity, and inclusion work
- Conducting analysis with an equity lens
- Analyzing how experiences of racism exacerbate the impacts of ACEs in communities of color

"There is a lack of acknowledgment that racism is a chronic health issue."
– Town Hall Participant

Impact of Discrimination and Racism on Health and Well-Being

Below is what community members said about discrimination and racism and how it has impacted their lives.

- Community members frequently cited the impact of racism on health and well-being. Due to historical trauma, the stress of microaggressions, violence, discrimination, and oppression, the effects of racism are a significant driver of racial and ethnic health disparities.
- Experiences of racism and collective historical trauma in institutional and health care settings have created a culture of distrust, where community members do not trust the institutions or systems to support their needs.
- The intersectionality between racism and systems (such as political and educational), representation in leadership, and opportunities for employment and advancement were highlighted as integral factors impacting health disparities.

Impact of Discrimination and Racism on Health and Well-Being (continued)

People experience significant stress, often because of discrimination, racism, and exclusion from the dominant culture due to their race/ethnicity, socioeconomic status, LGBTQ+ identities, disability status, and citizenship status. Participants cited racism as a driving factor for health inequity in communities of color, emphasizing ignorance, social media, and the political climate as drivers for their experiences.

"Hate crimes and fascist groups make a living environment feel unsafe. I definitely don't feel safe when I hear that the Proud Boys are waltzing around downtown."
– Listening Session Participant

The region has diverse populations, yet many service organizations have predominately white staff, which can hinder community members from receiving services due to a lack of cultural understanding.

- The larger systems (health care, especially) should be assets to health equity, but these systems were a hindrance to communities who felt they had limited knowledge about how best to navigate the system.

Neighborhoods and Daily Life

Listening session and town hall participants described how profiling, discrimination, and racism contributed to feeling unsafe in their neighborhoods (see Neighborhood and Built Environment, on page 30 for more).

Communities of color, immigrants and refugees, and LGBTQ+ participants described fears and experiences of discrimination and profiling by the police, which leads them to feel unwelcome in certain areas, especially in their own neighborhoods. The impacts of gentrification on these communities, including a lack of culturally specific business owners, black-owned businesses, and being pushed out of neighborhoods that were historically a part of their communities and to the margins of the city, are large stressors. Gentrification, including the destruction of community centers and community gathering spaces, has left many people feeling ostracized in their own neighborhoods, workplaces, schools, and communities due to the lack of diversity.

- Participants directly linked experiences of profiling and discrimination with having limited access to housing security, job security, and other opportunities.

Being a part of neighborhoods, workplaces, schools, and communities where there was little diversity limits opportunities to advance for people of color.

Safety

Participants distrusted law enforcement, citing racial profiling and negative interactions their communities have had with the police. Participants described their fear of the police, racial profiling, and fears of deportation and Immigrant and Customs Enforcement as contributing factors to their community's health and feeling unsafe.

Additionally, participants discussed an inability to exercise outdoors or let their kids play in the park, not only because of fear of deportation and racial profiling, but due to

Safety (continued)

other factors such as the large amounts of trash in their neighborhoods, vandalism, and drugs present in their community (see Neighborhood and Built Environment, on page 30 for more).

Conversely, some listening session participants wanted an increased police presence as a solution to feelings of unsafety.

Representation

When people feel unrepresented by decision-makers, government, and organizations that serve their communities, the policies created do not align with community needs. Establishing institutional change and shared power in decision making could address this power imbalance. Communities emphasized making their voices known, both through voting and social media, to influence decision makers. See the Community Representation section for more.

These findings are consistent with other reports in the region (see the literature review in Appendix F). The reports noted that discrimination and racism impact all aspects of the lives of those who experience them. A lack of translation services, exclusion from decision-making processes, and stress were frequently noted as challenges to health. These challenges place a higher burden on communities of color and communities that do not identify with the dominant cultural, racial, and ideological identity of the region.

"We need more representation of our society in the city government."
– Listening Session Participant

"The demographic makeup of people in leadership positions is a barrier; elected officials and other decision-makers don't reflect the communities most impacted."
- Town Hall Participant

Data Representation and Community Trust

Underrepresented communities, notably communities of color, LGBTQ+ community, immigrants and refugees, and women and children, all experience morbidities (rates of diseases), mortalities (deaths), and stressors that influence social determinants of health.[38, 39] Due to small population sizes, and mistrust of data collection processes, these communities are often misrepresented, inaccurately accounted for, or completely absent in quantitative data.

- Town hall participants wanted better tracking for outcomes in communities of color and encouraged more data collection to focus on qualitative data collection methods and community narrative.

Fears of surveillance and a lack of transparency in data are a hindrance to equitable data collection for immigrant communities, refugee communities, and communities of color. Historical misrepresentation, violence, profiling, and exploitation of these populations for the sake of scientific discovery[40,41,42] means they are less likely to voluntarily self-disclose information because they mistrust researchers and the medical field. Within communities, there is a wariness of methods aiming to understand and address these disparities due to fear of how the data collected may be used.

Trauma

Trauma

Trauma was identified across the region as an underlying core issue affecting health and well-being of community members. Individuals and groups who have experienced trauma see increased risk of disease and death.[43] This is an overarching core issue, which must be considered in all programs to adequately address the other core issues.

What's Being Done

HCWC members are supporting this core issue through:

- Trauma-informed care
- Working to address trauma in schools
- Providing community trainings on adverse childhood experiences (ACEs) and resiliency
- Continued attention to the ways in which regulation can be triggering

Stress and Trauma as Determinants of Health

Experiences of toxic stress[44] and trauma over the course of life can hinder every aspect of health and wellbeing. The barriers to health and equity begin early in life and build into adulthood, and are tied to systemic, institutional, cultural, and social factors.[45] People who experience more adverse life events are at high risk for chronic conditions, housing insecurity, mental health concerns, and substance use disorders overall.[43] Additionally, childhood experiences of trauma, discrimination, racism, and biases produce a cycle of difficult circumstances—financial, social, psychological—that is difficult to break.[46]

Adverse Childhood Experiences

Trauma and toxic stress experienced in childhood have long-lasting effects into adulthood. ACEs include all types of abuse or neglect, and other potentially traumatic experiences that happen to a person before age 18. ACEs correlate directly with poorer health outcomes including substance abuse, STIs, suicide attempts, and chronic diseases (such as heart disease).[47]

People with high ACE scores experience greater levels of physical, sexual and verbal abuse throughout their life.[48] They are more likely to experience economic insecurity (i.e., having to go without needed food, clothing, transportation, and stable housing); higher rates of homelessness; and partner abuse.[49]

ACEs are tied to systemic, institutional, cultural, and social factors.[50]

- Many reports suggested that more studies should focus on life-course theory (see Glossary for definition) to examine how trauma, life experiences, and stressors influence health and well-being over time.[51,52,53]

Historical, Generational Trauma

Trauma experienced throughout one's life can also be tied to historical trauma. Many generations of people from communities marginalized by the dominant culture have been subjected to long-term mistreatment and abuse, which correlates with a higher disease burden and greater health disparities.[54] When generations of families experience significant trauma and toxic stress, this can cause poorer health in future generations due to actual genetic changes and the ongoing stress of their social environments.[55]

For many, the opportunity to access appropriate, safe, and culturally relevant health care; education; food; and employment requires relying on institutions that historically have not been a safe space for communities of color, the LGBTQ+ community, women, and survivors of abuse. Community members expressed this during listening sessions and wanted to see more efforts to competently address underlying trauma, life experiences, and stressors that influence health and well-being.

As with Social Determinants Of Health, it should be noted that while experiences of stress and trauma in childhood and adulthood can influence health outcomes, the impact of adverse life experiences can be mitigated by resilience, community support, policies, and resources.

- Trauma-informed policies, health care, and resources can better help to address these issues and can serve as a protective factors to toxic stress and trauma's impact on health.[56]

Behavioral Health

Health Outcome

Definition of Behavioral Health

Behavioral health includes mental and emotional health. Behavioral health conditions include anxiety, depression, substance use disorders, and many others.

What's Being Done

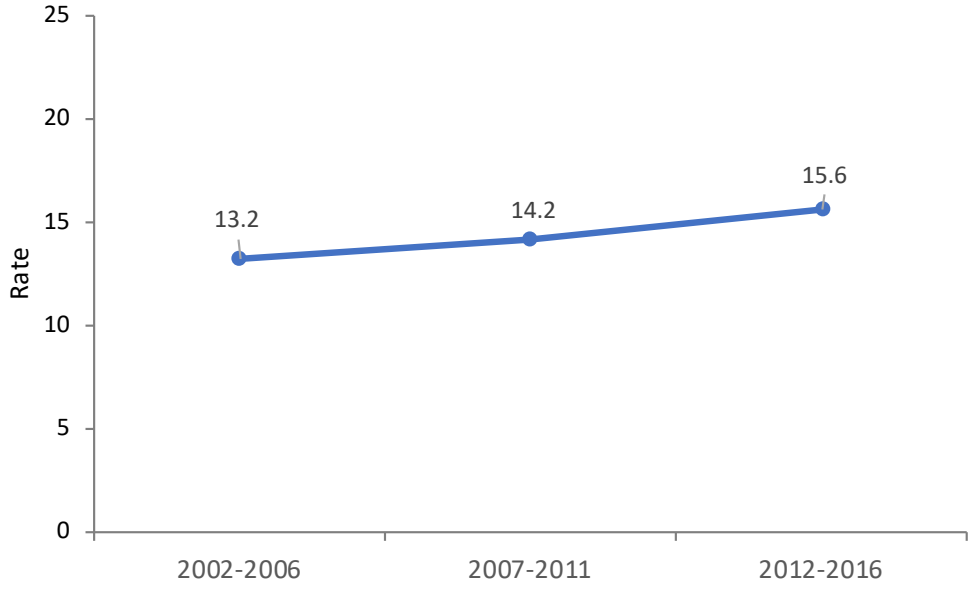
HCWC members are addressing this core issue through:

- Implementing universal depression screenings
- Supporting the Unity Center for Behavioral Health
- Conducting opioid prevention work
- Implementing drug takeback programs
- Forming suicide prevention coalitions
- Working on various housing initiatives, including Housing Is Health that was informed by previous HCWC CHNA work.

Depression and Suicide: Adults

Meeting behavioral health needs is critical, particularly with the high rates of depression and suicide in the region. Across the region almost a quarter (24.1%) of the population has been diagnosed with depression. [57] Figure 11 shows the suicide mortality rate for adults in the region (based on BRFSS data).

Figure 11. Adult Mortality Rates – Suicide.



All rates are per 100,00 population and are age-adjusted to the 2000 U.S. standard population.
Source: Community Health Assessment Tool (CHAT), Oregon Public Health Assessment Tool (OPHAT).

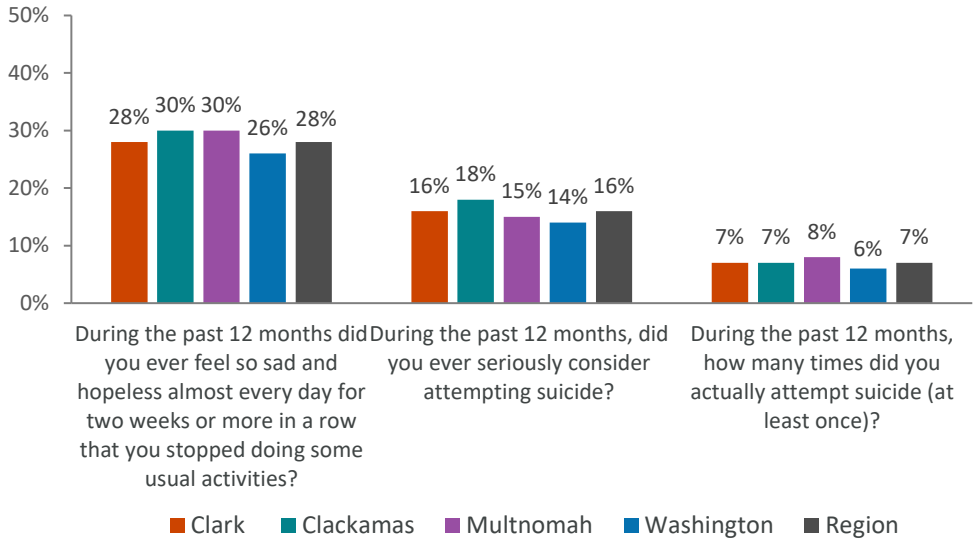
Depression and Suicide: Youth

Suicide is the third leading cause of death for youth between the ages of 10 and 24. More youth survive suicide attempts than die by suicide.[58] Nationally, 16% of students reported seriously considering suicide; 13% created a plan; and 8% reported trying to take their own life in the 12 months prior to taking the survey.[58]

Results from the 2017 Healthy Teens Survey in Oregon and the 2016 Healthy Youth Survey in Washington are similar to those reported nationally (see Figures 12–14).

In the quad-county region, 28% of students in eighth grade reported feeling sad or hopeless for two or more weeks in a row and that this prevented them from doing their usual activities. Also, 16% of eighth grade students indicated that they had considered attempting suicide in the past 12 months.

Figure 12. Youth (Grade 8): Depression and Suicide.



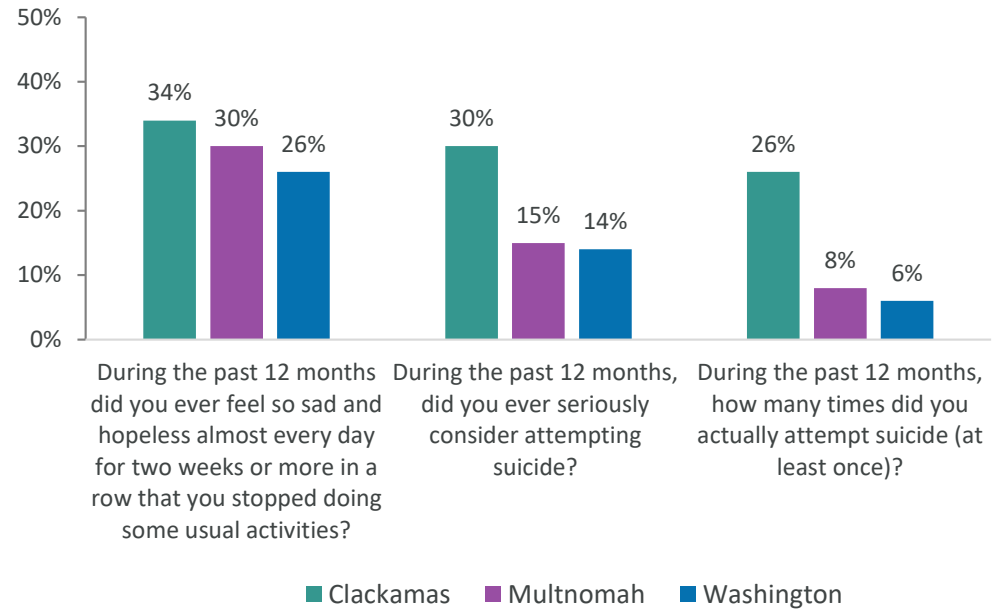
Source: 2017 Oregon Healthy Teens Survey [59] and the 2016 Washington Healthy Youth Survey.[60]

Figure 13. Youth (Grade 10): Depression and Suicide in Clark County.

Source: 2016 Washington Healthy Youth Survey.

Depression and Suicide: Youth

Figure 14. Youth (Grade 11): Depression and Suicide in Clackamas, Multnomah, and Washington Counties.

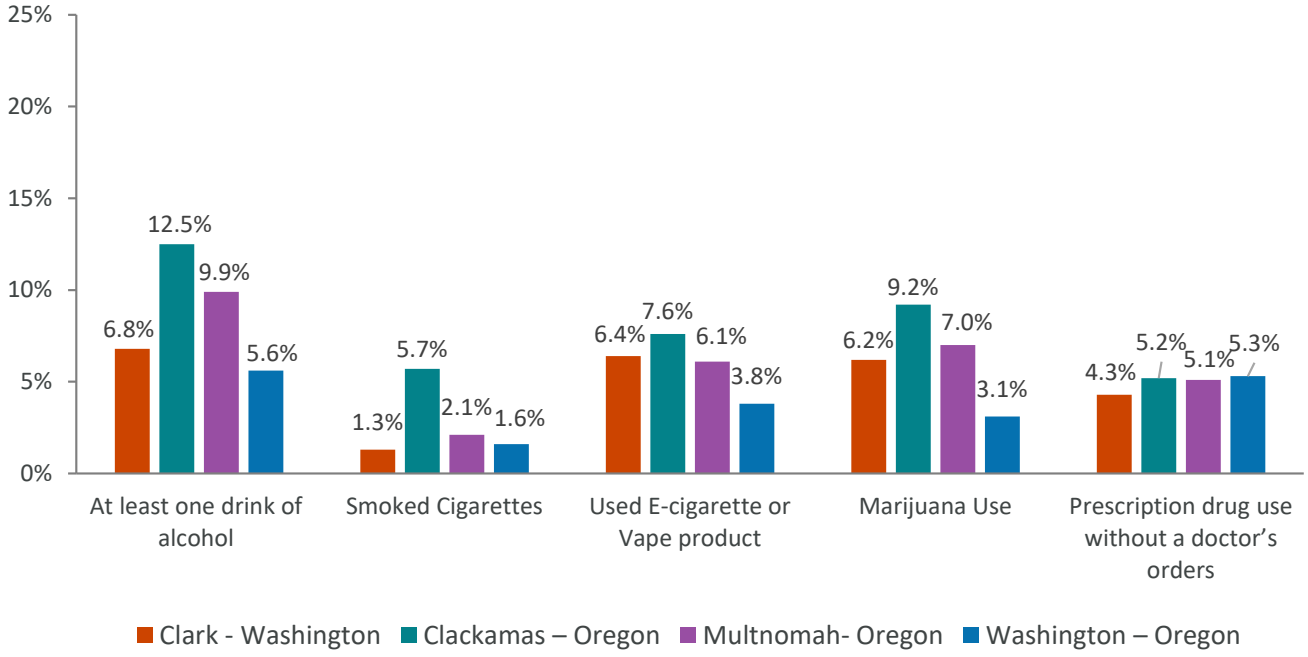


Source: 2017 Oregon Healthy Teens Survey.

Substance Use by Teens

Many listening session participants worried that their children were using substances. Figure 15 shows the percentage of teens who reported drinking alcohol, smoking cigarettes, vaping, using marijuana, or taking prescriptions without a doctor's orders in the last 30 days.

Figure 15. Percent of Teens (8th Grade) who Used Substances in the Last 30 Days.



Source: 2017 Oregon Healthy Teens Survey and 2016 Washington State Healthy Youth Survey.

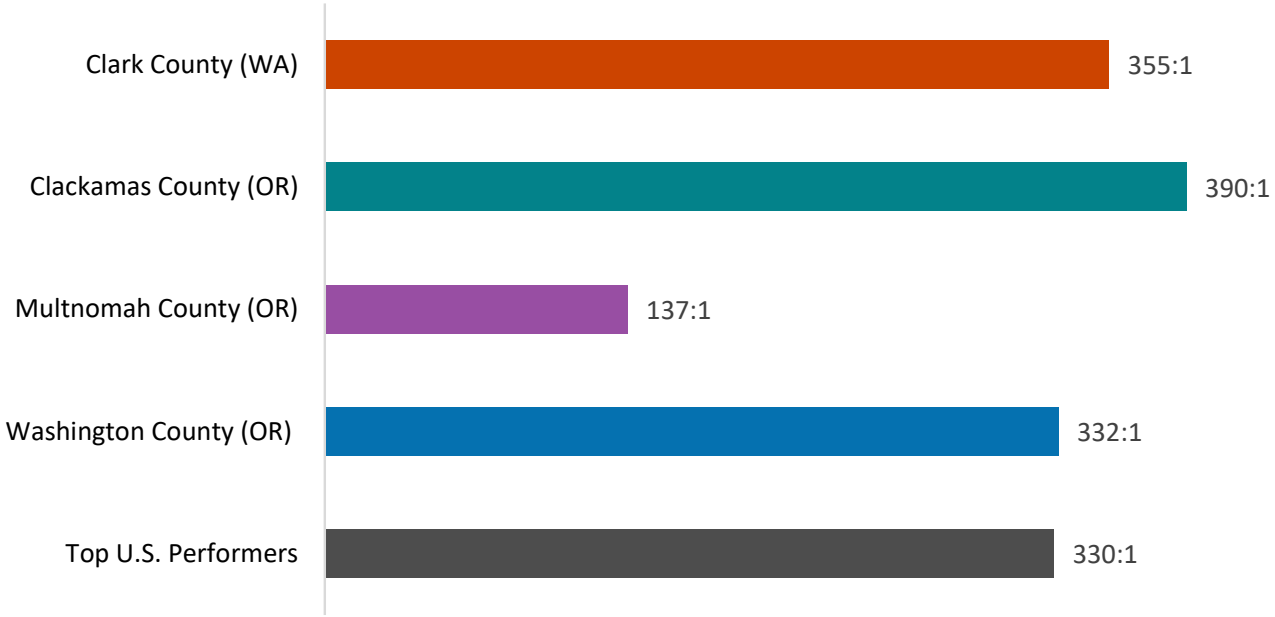
Access to Behavioral Health Care

Peoples' limited access to behavioral health care providers makes this core issue challenging to address. Community members also want culturally relevant behavioral health services and easier access to services even if they do not have health insurance (see Access to Health Care).

The ratio of mental health providers to the population varies substantially, with the highest concentration of providers in Multnomah County, as shown in Figure 16.

Town hall participants highlighted the importance of addressing stigmas associated with mental health treatment and advocating for greater emphasis on preventive care and screening for mental health conditions. Family, community members, and friends were important sources of connection and social support, and participants wanted more access to mental health resources such as greater numbers of providers, school-based interventions, and family-focused programs.

Figure 16. Ratio of Population to Mental Health Providers.



Source: 2017 Oregon Healthy Teens Survey.

The need for culturally and linguistically competent behavioral health services was frequently discussed by both town hall and listening session participants. Listening session participants discussed the lack of mental health providers who look like them or identified with their identities and experiences (see Culturally Responsive Care for more). This disconnect between the providers and participants' experiences made accessing mental health care challenging.

"There aren't a lot of therapists who look like us."
– Listening Session Participant

"We need a Starbucks on every corner, but for mental health."
– Listening Session

Participants also emphasized the importance of ensuring access to mental health services and resources for residents who may not have health insurance.

Chronic Conditions

Health Outcome

Chronic Conditions: Definition

Chronic diseases are conditions that last one year or more and require ongoing medical attention and/or limit activities of daily living.[61] Risk factors for chronic disease include:

- Tobacco use
- Secondhand smoke
- Poor nutrition
- Lack of physical activity
- Excessive alcohol
- Other substance use

What's Being Done

HCWC members are addressing this core issue through:

- Nutrition and chronic condition self-management classes
- Partnering with community-based organizations to support healthy lifestyles
- Tobacco prevention programs
- Healthy food access
- Public policies that address the leading causes of death and injury

Chronic Condition Prevalence in the Quad-County Area

Increased rates of chronic conditions put strain on the health care delivery and public health systems, taking away resources from other areas.

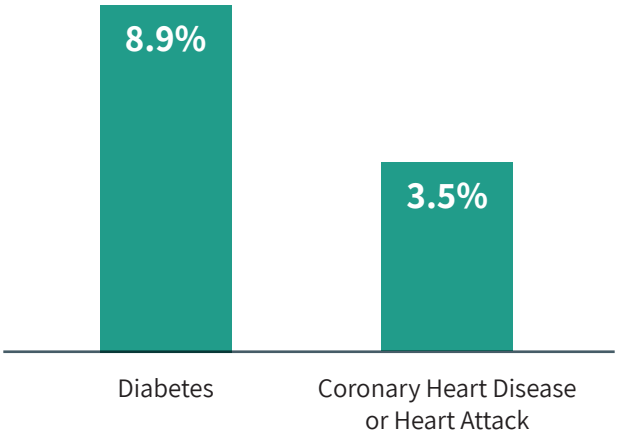
HCWC identified the following four conditions as significant conditions affecting the health of the region, with communities of color having higher rates of the conditions than their white counterparts.

- Heart disease
- Diabetes
- Hypertension
- Liver disease

For county-specific chronic disease rates, see Appendix G.

One measure of the prevalence of chronic disease is the Behavioral Risk Factor Surveillance System (BRFSS) that collects data from U.S. residents on their chronic health conditions through phone surveys (see Figure 17).

Figure 17. Self-Reported Prevalence of Two Chronic Diseases in Quad-County Area: 2012 – 2015.

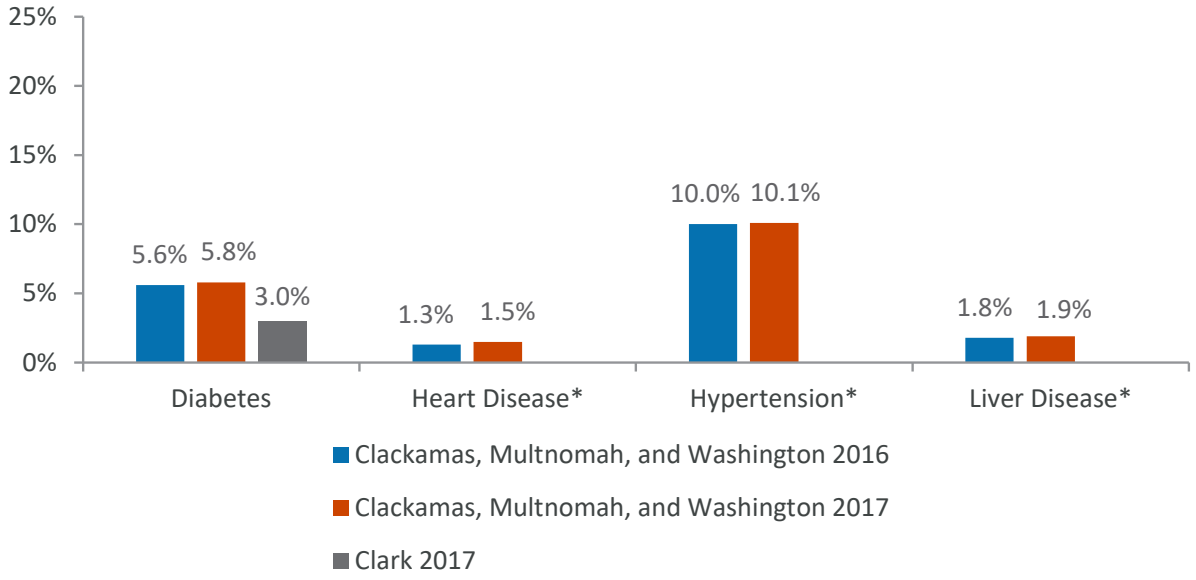


Note: N = 15,527 to 16,779
Source: Behavioral Risk Factor Surveillance System (2012–2015).

Chronic disease prevalence in the region was also identified through data provided on Medicaid members who received services in 2016 and 2017 through Health Share of Oregon and in 2017 from people who were insured by Apple Health in Clark County.

Figure 18 shows the rates for heart disease, diabetes, hypertension, and liver disease in the region.

Figure 18. Chronic Disease Prevelence by County.



*Data not available for Clark County.
Note: 2016 Oregon N = 299,119; 2017 Oregon N = 280,812. Clark County is based on population estimates.
Source: Health Share of Oregon and Health Washington Dashboard.

The prevalence of the chronic conditions was highest for the following Health Share of Oregon members who receive services through Medicaid:

Diabetes	Heart Disease	Hypertension	Liver Disease
- Asian (12%) - Black (9-10%)	- Black (3%) - Pacific Islander (2%) - White (2%)	- Asian (17-18%) - Black (17%) - White (13-14%)	- American Indian (2%) - Asian (2%) - Black (2%) - White (2-3%)

The prevalence of the chronic conditions was highest for the following Apple Health of Washington members who receive services through Medicaid:

Diabetes (Clark County only)
- American Indian/Alaska Native: 5% - Asian: 4% - Native Hawaiian/Pacific Islander: 4%

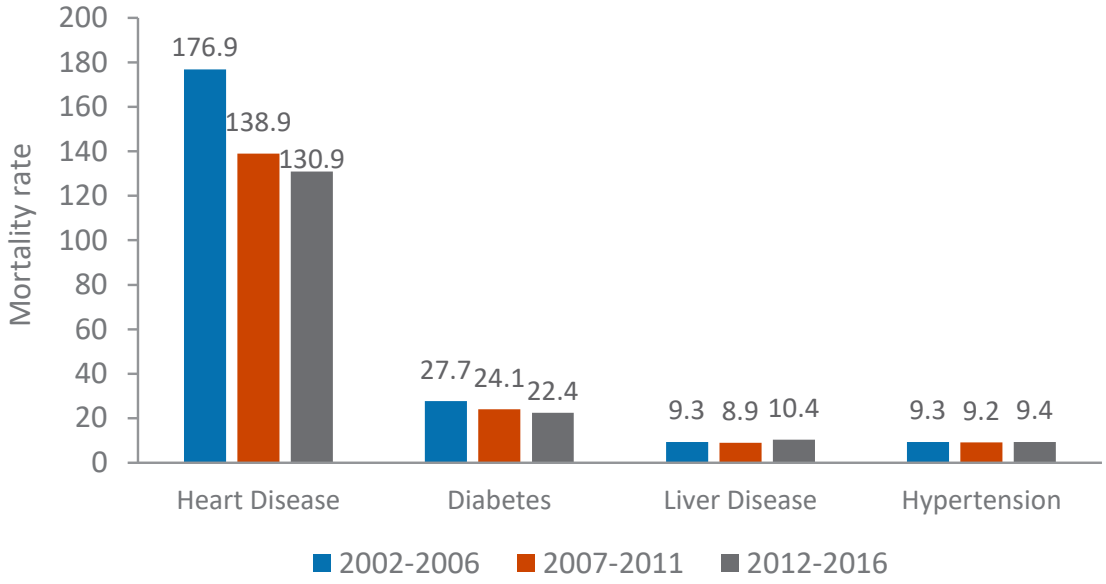
Town hall participants discussed how comprehensive, accessible health care and access to peer navigators and community health workers (see page 56) could have a positive influence on reducing the prevalence of chronic conditions in the region. While listening session participants did not frequently address the chronic conditions by name, such as diabetes and heart disease, they discussed belonging to communities that needed more preventive resources and education to improve chronic condition self-management.

Many participants indicated that their community was in poor health and their interest in multi-generational lifestyle change programs conveyed their concerns and desire to prevent chronic conditions (see Access to Health Care on page 56).

Mortality Rate

The mortality rate is the number of deaths per 100,000 people in a defined population over a specific time period. Figure 19 shows the mortality rates for each of the four chronic conditions that were identified as regional issues.

Figure 19. Overall Mortality Rates for Quad-County Region.



Note: All rates are per 100,00 population and are age-adjusted to the 2000 U.S. standard population.
Source: Community Health Assessment Tool (CHAT), Oregon Public Health Assessment Tool (OPHAT).

HCWC also examined mortality rates by race:

- **Heart disease**: highest for the black, Native American, Pacific Islander, and white populations
- **Diabetes**: highest for the black, Pacific Islander, and Native American populations
- **Liver disease**: highest for the Hispanic, Pacific Islander, and Native American populations
- **Hypertension**: highest for the black and Pacific Islander populations

Figures 20–26 show the mortality rates of the leading causes of death (the mortality rate is the number of deaths per 100,000 people in the defined population). See Appendix G for mortality rates by county.

Figure 20. Mortality Rate for Four Chronic Conditions: Asian.

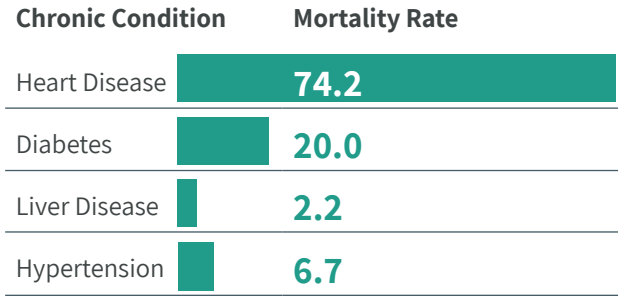
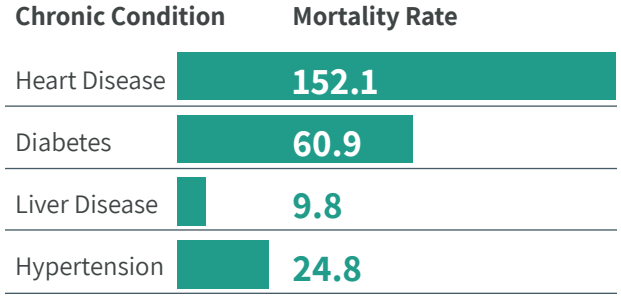


Figure 21. Mortality Rate for Four Chronic Conditions: Black.



Chronic Diseases and Other Conditions in Emergency Departments

Chronic disease accounts for two-thirds of emergency medical conditions and roughly 80% of all health care costs. Regional emergency department (ED) discharge data from the calendar year 2016 were analyzed to identify whether ED utilization differed by age and insurance type. See Appendix E for these data.

Figure 22. Regional Mortality Rate for Four Chronic Conditions: Hispanic.

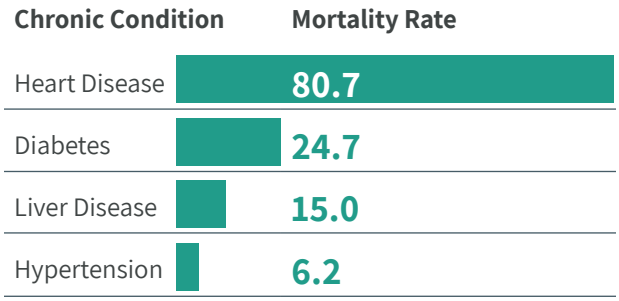


Figure 23. Regional Mortality Rate for Four Chronic Conditions: Native American.

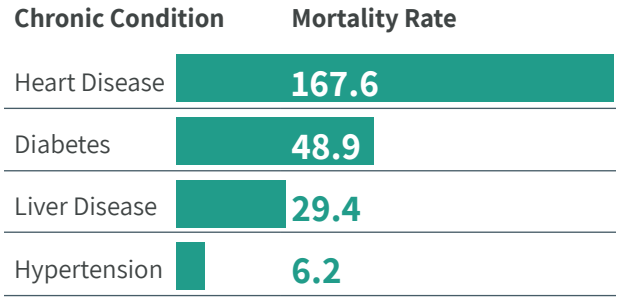


Figure 24. Regional Mortality Rate for Four Chronic Conditions: Pacific Islander.

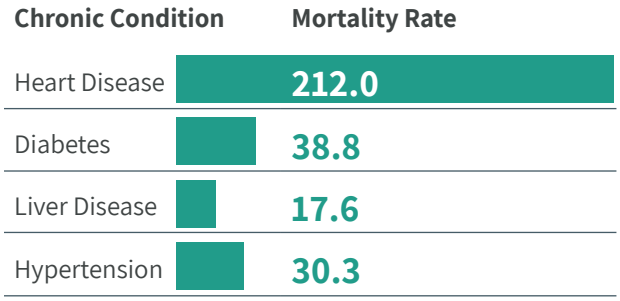


Figure 25. Regional Mortality Rate for Four Chronic Conditions: Two or More Races.

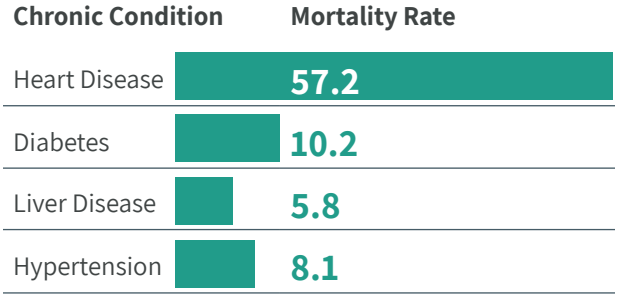
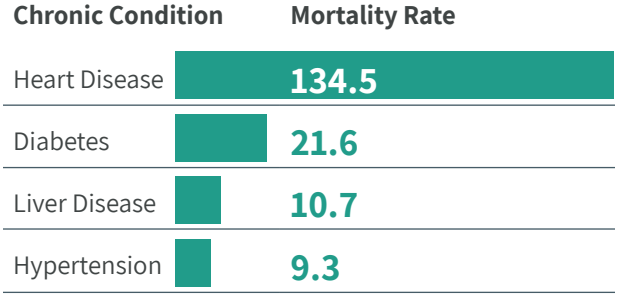


Figure 26. Regional Mortality Rate for Four Chronic Conditions: White.



Sexually Transmitted Infections

Health Outcome

Sexually Transmitted Infections (STIs)

Communicable diseases are infections, usually viral or bacterial, that are spread from person to person (see Appendix E and Appendix G for more data).[62] Between 2002 and 2016, the incidence of some communicable diseases has increased in the quad-county region, including STIs.[63] Rates of chlamydia and gonorrhea have been increasing in the region, as shown below (Figure 27).

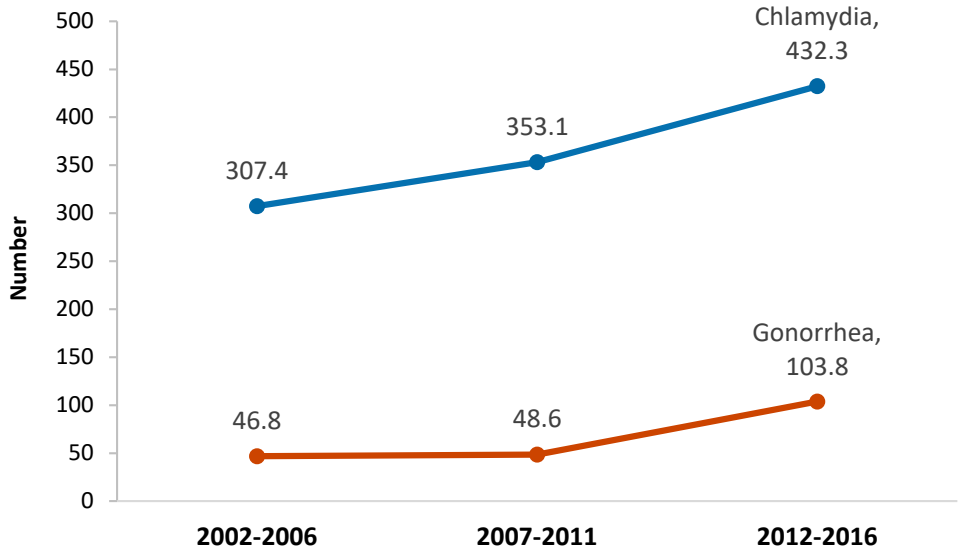
What's Being Done

HCWC members are addressing this core issue through:

- STI prevention, case investigations, contact tracing, treatment and partner therapy
- Sexual and reproductive health coalitions

While data on racial and ethnic differences in rates are available, they are not always reliable. Public health partners are working on improving the ability to collect and share more accurate data. Understanding the differences in racial and ethnic rates of STIs is key to developing and implementing targeted strategies for outreach and interventions.

Figure 27. Crude Incidence Rates* of Chlamydia and Gonorrhea in the Region.



*Crude incidence rates reflect the total number of cases diagnosed in a given time frame divided by the total population for that year and are expressed as a rate per 100,000.
Source: Community Health Assessment Tool (CHAT), Oregon Public Health Assessment Tool (OPHAT).

Chlamydia

Chlamydia is a common sexually transmitted disease that can be easily cured. If left untreated, chlamydia can make it difficult for a woman to get pregnant.[64]

Gonorrhea

Gonorrhea is a sexually transmitted infection that can affect both men and women and cause infections in the genitals, rectum, and throat. It is a very common infection, especially among young people ages 15–24 years.[65] In the youth listening sessions, participants requested more comprehensive sex education and access to sexual health resources which shows this is a concern, even if the specific conditions were not mentioned.

Access to Health Care, Transportation, and Resources

Social Factor

Access to Health Care, Transportation, and Resources

Community members identified the need for better access to the health care system, including culturally responsive health care, and support for navigating the health care system, including a better understanding of insurance as key areas for more focus.

Across the region, community members identified transportation as both a need and a strength. Those who were closer to the central Portland metro area and had access to consistent public transportation noted it was a great strength. Those living further from the central area and in Clark County noted the need for more reliable public transportation. In both cases, community members noted there is continued difficultly in what they referred to as the "last mile" of getting from the transit stop to their destination, which can be a hinderance for people with physical challenges.

Resources were consistently brought up as a need in the region. The lack of access to financial resources and services, including access to safe and affordable housing, is a barrier to achieving optimal health in the region. Many community members noted that resources are available, but they are not aware of specifics about the resources or how to access them.

"I think my community would be more healthy if we were supported by good health insurance, good resources for jobs and education, and had cultural and social centers."
- Listening Session Participant

What's Being Done

HCWC members are addressing this core issue through:

- Financial assistance programs for patients
- Expanded primary care clinics; improved patient navigation services
- Supporting school-based health centers
- Convening and facilitating collaboratives, such as the Reproductive Health Collaborative in Washington County
- Providing grants to community-based organization to support their work
- Participating in planning and discussion about transportation

Access to Health Care Services

Participants in town halls and listening sessions described many difficulties facing communities in accessing the health care system, including:

- Geographic isolation and transportation
- Language barriers
- Insurance coverage and cost
- System navigation
- A lack of providers
- Limited culturally responsive care
- Limited behavioral health access

A lack of providers and other challenges related to access may explain why some conditions, such as asthma, urinary tract infection, and depression, continue to be seen the emergency department (ED) rather than being treated in an outpatient setting. Data on ED use by insurance type does not indicate that people with any one type of insurance, or those who are uninsured, are utilizing these services more often than others. Across the region, some people face continual challenges in accessing routine care for treatable conditions; see Appendix E, for rates of ED use by condition and insurance type.

Listening session participants suggested that the inability to build relationships with their primary care providers, due to language barriers, technology, affordability, and scheduling, resulted in more frequent emergency department and urgent care visits.

"Funding often requires diagnosis (i.e., you can't get paid until the person is sick enough)." – Town Hall Participant

Focused Prevention

Town hall and listening session participants described the lack of focus on prevention and "upstream" approaches as a serious impediment to improving health outcomes in the region (upstream means looking at the whole picture; in health care, it's what has happened in a person's life before they come to a clinic, hospital, or dentist). Participants pointed to higher rates of STIs, low vaccination rates (see Appendix E), cardiovascular conditions, and mental health conditions (including substance abuse) that could be improved with increased screening and prevention programs.

Challenges of System Navigation

Many listening session participants discussed the need for better access to care, and more aids for navigating the health care system. Even those who were insured experienced long wait times, difficulties scheduling appointments, and confusion about which part of their insurance covered needed services. And for many people, accessing available resources when they do not have a government-issued identification card is a challenge.

Challenges of System Navigation (continued)

Participants discussed how trauma and stress make it challenging to ask for, and receive, health care services. Immigrant participants noted that services are particularly difficult to access for senior members of their communities, due to language and cultural barriers (see Culturally Relevant Care).

"Health care isn't a right here. There are a lot of situations where the community you live in dictates a lot of the resources you have access to."
– Listening Session Participant

Participants also discussed how organizations lack the capacity to conduct thorough community outreach and are unable to help community members navigate services to reach the most suitable resources. Participants noted that services are fragmented among health sectors or are offered only through referrals.

"The wait time for any physical intervention has become a massive issue in lower income communities."
– Listening Session Participant

Access to Resources Outside Traditional Health System

Listening session and town hall participants want access to more comprehensive, holistic, and integrated health care. They want access to alternative therapies such as acupuncture, massage therapy, counseling services, naturopathy, and chiropractic services that could be integrated into their existing health care plans.

Listening session participants noted that while the region is flush with alternative health care options, participants expressed feeling that these services were only for the wealthy. Low-cost or free clinics, as well as more options for those with Medicaid or Medicare coverage, would place these resources within the reach of the people who have traditionally been prevented from accessing them.

Access to Transportation

Transportation emerged as both a community strength and a community need during listening sessions. Participants who did not have limited physical mobility and living in an urban/metro area near bus and light rail lines described robust public transportation as a great asset. For many without a vehicle, public transportation in the metro area helped to connect them to resources, community spaces, grocery stores, and medical care, and helped to get them to work. The number of bus stops, frequency of stops, and Trimet's affordable low-income fare are all community assets.

For those outside a transportation hub area, lack of public transportation infrastructure in much of the region leaves residents without access to services, healthy foods, and quality housing.

"Transportation is a huge barrier to health and to connecting to resources."
- Town Hall Participant

Listening session participants discussed the cost of transportation, travel time, and traumas or anxieties related to transportation as barriers. Additionally, they noted an inability to access the clinics they can afford, and that transportation is often unaffordable or unreliable, causing them to miss appointments, and potentially face financial penalties.

Town hall participants noted the detrimental effect a lack of reliable transportation options has on individual and community health, noting that individuals without reliable transportation are less likely to access preventive services.

Listening session participants wanted more places to be accessible by foot, particularly grocery stores, farmer's markets, and community events, and expressed that people living in their communities without a car were socially isolated.

The efficiency of having services available in one location, which was commonly cited by participants as the way services are provided in their neighborhoods, can be a barrier for rural residents or residents who live outside of inner-city hubs because they lack the ability to reach these service locations.[66] Participants noted that health care services are not available in many rural areas, and when services are available, they require a vehicle to get to them, which isolates community members who are not able to drive or do not have transportation (see Isolation for more).

Participants identified a need for more transportation services that can accommodate the geographic limitations faced by residents, such as mobile medical units providing outreach to people experiencing houselessness, or offering virtual appointments with providers.

Transportation

72.3%
Of most residents in the quad-county region commute to work by driving

11.1%
Multnomah County residents have the highest percentage of commuters using public transportation

The mean commute times for counties in the region are similar, with a mean time of **26.2 minutes** for the region.

Access to reliable transportation is crucial to economic stability and staying connected to community and resources, but this access is very dependent on:

Figure 28. Commuting to Work by County.

Commuting to Work	Clark	Clackamas	Multnomah	Washington	Region*
Car, Truck, or Van – drove alone	78.9%	76.8%	60.3%	73.2%	72.3%
Car, Truck, or Van – carpooled	9.0%	9.3%	9.5%	10.4%	9.6%
Public Transportation	2.3%	2.9%	11.1%	6.5%	5.7%
Walked	1.9%	2.0%	5.4%	2.5%	2.9%
Other Means	1.5%	1.6%	6.7%	1.9%	2.9%
Mean Travel Time to Work (Minutes)	26	28	26.1	24.8	26.2

*Regional percentages calculated by unweighted averages.
Source: American Community Survey 5-year estimate 2012-2016.

Access to Resources

Existing Community Resources and Supports

Listening session and town hall participants described their communities as resilient, connected, and community-oriented. Participants described a wealth of resources that, if provided, can help people thrive economically.

Town hall and listening session participants described many valuable community resources for the houseless and housing insecure, including organizations that provide supplementary food and programs that assist with utility payments.

Participants mentioned the following as valuable assets to their communities:

- safe spaces at schools
- multicultural centers
- LGBTQ+ organizations
- community-based programs
- culturally specific programs
- resources for low-income families
- fundraising to help keep their communities clean and safe

Participants in both town halls and listening sessions described the importance of community spaces. These hubs provide space and connect community members, reducing isolation, and also provide opportunities to learn about available resources, including training and skill development supporting career growth and financial stability. Expansion of these valuable spaces, and the support services and opportunities for connection they bring, is a community priority.

Community health workers' engagement in communities was listed as a driving factor in increasing access to resources and improving health outcomes. Town hall and listening session participants described community health workers as an excellent bridge between community members and the health care system, as well as other available resources (see for more about Community Health Workers, page 70).

The resources that were most valued for their contribution to economic stability (see Social Determinants of Health, page 18) via assistance with costs associated with health care were:

- low-cost health care clinics
- access to free or cost-reduced preventive care and health screenings
- affordable government insurance

Participants also mentioned the variety of resources available to assist them with job training, education and skill development, public transit costs, and food access, and resources that helped connect them to affordable housing. They described resources such as food banks, emergency shelters, low-cost clinics, and services that help to pay utility bills as necessary and beneficial, but desired more continuity in these services. (See Social Determinants of Health, page 18, for more information about these areas.)

Community Needs

The areas for improvement that participants most often cited included:

- Access to financial counseling
- Acknowledgment of mental health concerns that can keep individuals in a cycle of poverty
- Greater emphasis on affordable, low-cost preventive care and screening of mental health conditions
- Increased capacity to provide emergency, temporary, and transitional shelter or alternative housing units to the many people in the region who are in need (see page 33 for more information about houselessness in the region)

Community Needs (continued)

- No-cost, school-based interventions and family-focused community center programs to provide access to resources to help community members establish and achieve economic stability
- Access to mental health services and resources for residents who may not have health insurance, or who are culturally or geographically isolated (see Isolation section, page 71, for more)
- More community representation (see Community Representation, page 55, for more) in policymaking, government, and health care

Financial and Coordination Barriers

Both town hall and listening session participants frequently cited "siloed" organizational resources as a barrier that made it difficult for people to get connected to the available resources in the region.

Town hall participants included public health professionals, representatives of community-based organizations and community leaders. They frequently cited "siloed" organizational resources and funding strain in the region as they reflected on what was making their job difficult. The siloed nature of funding streams creates a lack of integration between health care and life needs, resulting in organizations treating symptoms rather than the whole.

Obtaining sufficient funding to serve the community is a large burden to organizations and adversely affects their ability to impact community health. Town hall participants described financial strain due to a culture of competition between organizations. When funding was provided, they noted that the funding was not sustainable, and most often focused on short-term or emergency services that did not address issues over time. Also, some town hall participants were unaware that resources were available that could potentially provide programs to supplement gaps in assistance.

"It is difficult to address the larger issues of disparities as an organization when you're really only being funded and asked to address the small problems. That only becomes just a short-term bandage."
- Town Hall Participant

Town hall participants referenced a lack of "upstream" program funding (for example, grants or other funding sources), making it difficult to address the needs of the community. Similarly, listening session participants expressed the need for more preventive resources, more collaborative resource hubs, and assistance focusing on the long-term needs instead of the most immediate or urgent concerns at immigrants' and refugees' point of arrival.

Coordination and Navigation

Participants also discussed how organizations lack the capacity to conduct thorough community outreach resulting in the inability to help community members navigate services to reach the most suitable resources.

Listening session participants noted that it was difficult for people to navigate all the services the organizations in their county could provide, and wished for more peer navigators and community health workers who could connect and educate them on what was available (see Community Health Workers section for more).

Town hall participants described a lack of awareness among organizations regarding each others' scope and resources, with a solution being to form more partnerships between agencies to support the community's health.

Parent and Child Resources

Participants expressed great concern that there are not enough resources available for parents and children, including childcare, safe play spaces, lifestyle coaching, drug use prevention, mental health services, and food assistance. Multi-generational and culturally specific resources to help parents succeed were often referenced by listening session participants, especially Hispanic/Latino participants (see Community Representation section on page 65 for more details).

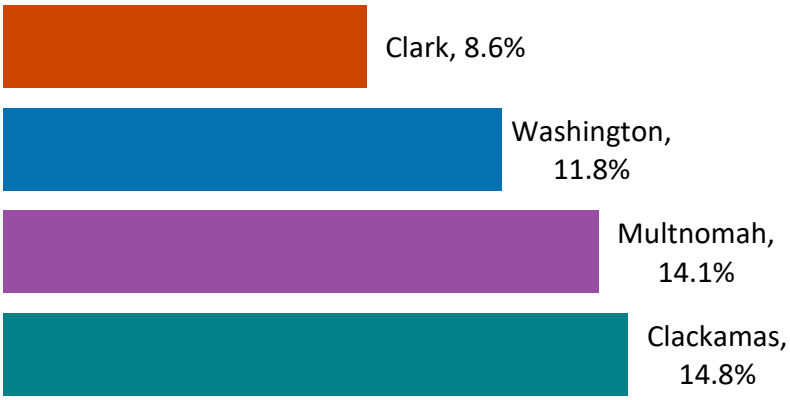
Food security remains an issue. Food deserts, defined as areas where residents live one mile from a grocery store (urban) or 10 miles from a grocery store (rural), contribute to the issue of adequate access to affordable, healthy foods. Many people living in rural parts of the region experience food insecurity and are in food deserts.[67]

Figure 29 shows that a significant percentage of youth in the region reported experiencing food insecurity.

The health and safety of children, from access to safe outdoor recreation spaces to school programs that offer mental health services, was a high priority for listening session participants. Parents wanted resources to help engage their children in conversations about substance abuse (see Behavioral Health section on page 43), mental health, school safety, and bullying.

Parents who are immigrants and refugees, or those whose primary language is not English, expressed feeling isolated from technology, social media, and school influences that could be negatively impacting their children and wished for more parenting resources to help them learn how to monitor their children. (See Language and Isolation sections for more.)

Figure 29. Percent of Food Insecure Youth (8th Grade).



Sources: 2017 Oregon Healthy Teens Survey and 2016 Washington Healthy Youth Survey.

Community Representation

Social Factor

Community Representation: Definition

Community: A group of people with diverse characteristics linked by social ties, common perspectives, and who may be engaged in joint action in geographical locations or settings. Community can be defined in multiple ways depending on the people asked and what groups have in common.

What's Being Done

HCWC members are addressing this core issue through:

- Increasing workforce diversity
- Supporting networks of community-based organization leaders
- Including diverse community members on workgroups, committees, and coalitions

Lack of Community Representation

Communities of color consistently identified the need for increased community representation. These community members noted the influence that decision makers and policy play in the lives of their communities and the perceived lack of influence they have in making those decisions. Community members wanted to be at the table and have a voice when decisions about their communities are made. They also supported increased civic engagement through education and workshops about the electoral process to increase the number of community members who engage and vote.

Listening session participants in all four counties (most notably in rural communities and communities of color) discussed at length how the dominant population and politics of Portland shape laws, policies, and what the state focuses on. Some communities within the Portland metro area described feeling like minority communities. They do not see their interests and needs reflected unless they align with the demographic majority of Portland. Participants discussed feeling they were not properly represented in the decision-makers, government, employers, and organizations that serve their community.

Due to this lack of representation, participants noted current policies regarding their communities were often outdated, or misinformed due to inaccurate data.

As a solution, community members discussed the need to establish institutional solutions and to have shared power in decision making. Community members desire greater cultural awareness in health care, and more culturally specific providers. There was an emphasis on communities making their voices known, both through voting and social media, to influence decision makers. Participants expressed being a part of neighborhoods, workplaces, schools, and communities where there was little diversity and limited opportunities to advance for people of color.

"We need more representation of our society in the city government."
– Listening Session Participants

Community Spaces

Participants in town halls and listening sessions described their community spaces as hubs that connect them to support and provide a space to share resources and information with fellow community members. Community spaces were a source of economic stability, providing professional development training, culturally specific resources, job postings, and community programs to connect people to resources and trainings that would help establish or maintain financial security.

Participants described the benefit of having spaces supporting intersectional communities and community gathering places near their homes. They appreciated what was available, and they strived to expand the number of community hubs.

Culturally Responsive Care

Social Factor

Culturally Responsive Care: Definition

Health care that is responsive to the cultural needs of patients is critical to ensure that all community members live their fullest and healthiest lives. The current health care system is working to be responsive but has work to do to meet the needs of all patients. Specifically, community members wanted more providers who share their cultural background, more community health workers who can assist patients in navigating the system and living their healthiest lives, and information provided in more languages than English and Spanish.

What's Being Done

HCWC members are addressing this core issue through:

- Contracting with culturally specific providers
- Supporting the Oregon Community Health Workers Association
- Integrating traditional health workers into the health care delivery system
- Conducting internal training for providers and organization leaders
- Providing grants to community-based organizations to support culturally specific programs

"...lack of culturally responsive and affirming care, which in turn creates a culture of distrust and disdain towards health and institutions."
- Town Hall Participant

Access to Culturally Responsive Care

Participants in town halls and listening sessions discussed how providers lack the bilingual and bicultural backgrounds necessary to serve all communities in the region, particularly in the mental health sector. They described limited culturally responsive services, culturally relevant information, and linguistic resources available across the region. In some areas of the region, this is particularly true, with community members who travel great distances to access services that are culturally and linguistically responsive.

Language

When self-reporting about health status, health behaviors, access to care, and timeliness of care, Hispanic adults who responded to a survey in Spanish were more likely to report worse health status. Compared with people who responded in English, they more often lacked health insurance, did not have a personal doctor, and postponed seeing a doctor because of the cost of care.[68] Older individuals with limited English proficiency are more likely to have no usual source of health care, report lower self-rated health, and report feeling sad most or all of the time compared with older individuals who only speak English.[69]

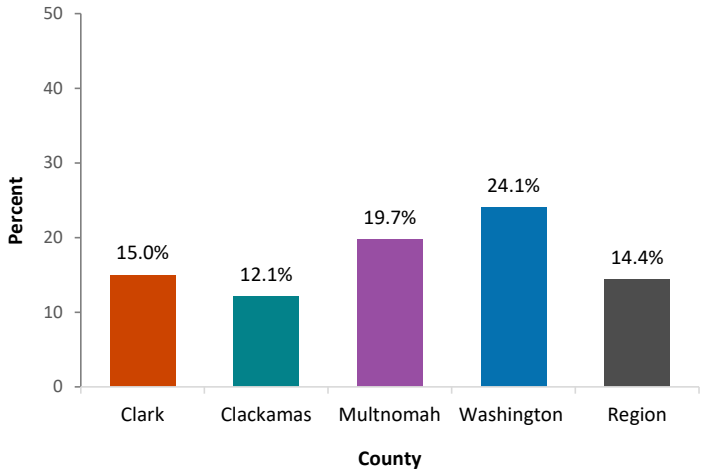
Participants from the Hispanic/Latino community described being turned away by health care providers because of discrimination due to lack of insurance and language barriers.

Participants cited language barriers and a lack of translators as significant challenges to health.

Language (continued)

Across the region, the percentage of the population that speaks a language other than English at home varies by county, with Washington County having the highest proportion at 24% (see Figure 30). Forty percent of listening session participants who completed a brief demographic survey reported speaking either English and another language, or a language other than English, at home.

Figure 30. Percentage who speak a language other than English at home.



Source: American Community Survey 5-year estimate 2012-2016.

Spanish-speaking listening session participants described being turned away by providers because they require non-English services, noting language barriers make everything in their lives more difficult. Other participants whose primary language was not English mentioned relying on their children or family members to be their translators, both because of a fear of inaccurate translation services, and a lack of trust that translators will maintain confidentiality within their larger community. Non–English-speaking participants emphasized the need for translators who were not fellow community members to help ensure privacy. The inability to access emergency services in languages other than English was noted as a specific challenge for non–English-speaking communities.

"There is a lack of culturally-specific and language-specific programs to improve adjustment and integration into the system." – Listening Session Participant

Also vital is empowering people by enabling communication in their own languages, creating space for cultural expression. Participants at the Iraqi/Syrian listening session noted the lack of certified training programs for Arabic-speaking community health workers as a challenge in increasing this workforce for their community.

Provider Education and Resources

There is a lack of provider education about how to work with people who are culturally different from them. A reliance on stereotypes, and a failure to address cultural aspects of health concerns such as nutrition or mental health, are associated with feelings of cultural insensitivity and a lack of trust in health institutions. Information and resources are often not available in non-digital form or are available only in English. Or, if materials are available in non-English languages, sometimes the translations are not good or accurate.

Lack of translation resources, targeted resources, and few community partnerships create even more barriers for racial and ethnic minority groups.

Community members advocated for more bilingual and bicultural providers, as well as community health workers (see sidebar), to facilitate connections, advocate for, and empower communities.

Participants want more culturally relevant, long-term services that focus on comprehensive, community-oriented programs emphasizing holistic health and preventive health care services (for more about this, see Access section). Also, community members noted the need for additional behavioral health services and supports across the region.

Community Health Workers

Participants noted that system navigation was a challenge for those from different cultural and linguistic backgrounds. More representation of minority populations within the organizations and among providers serving the region would go a long way to rectify these barriers to health and wellness. Community health workers and peer navigators are two resources that could improve access to non-traditional health services.

Community health workers frequently came up as a positive resource in many of the areas discussed in this report. They are highly valued and are a resource communities would like to have more access to. Community health workers help alleviate the navigation challenge, but more are needed in the diverse communities across this region. Participants see community health workers as invaluable in providing education and support to community members.

Isolation

Social Factor

Isolation

Isolation is a key determinant of health. It is different from loneliness, though they are often discussed together. In this report, isolation means either geographic, physical, and/or social isolation. It pertains to social contacts or network that can include family, friends, but also the broader environment through social activities. Isolation also means being geographically isolated (where you live is along way from other people, services). Isolation has particularly detrimental effects on low-income seniors who, in urban settings, tend to be clustered in areas with high proportions of low-income older adults.

Physical and cultural isolation were identified throughout the region as core issues, with rural community members noting the difficulty in accessing services in their communities and the need to travel long distances for services. Other communities, particularly immigrant communities, shared how social isolation from their homeland, friends, and families impacts their health.

Many community members shared their love of community spaces and organizations which bring them together with other people but wanted more spaces to share and learn together. For example, community members from across the region wanted more multi-cultural community centers and spaces.

What's Being Done

HCWC members are addressing this core issue through:

- Elder care being provided in homes
- Addressing social cohesion as a part of programming

Geographic Isolation and Transportation

Limited transportation options in some areas of the region were identified in town halls as a challenge to communities' access to resources and services. Town hall participants discussed the disconnect between the location of services and where communities reside. The cost of transportation, time it takes to travel, and lack of access to transportation when community members did not own their own vehicles or reside in a population-dense transportation hub were also described as challenges by town hall participants. There is a need for services that can accommodate the limitations faced by communities, such as mobile medical units, to provide medical outreach for people experiencing houselessness or virtual appointments with providers.

Listening session participants echoed the challenges noted in the town halls of a robust public transit system in some areas of the region, but this needs improvement in rural communities. Additionally, listening session participants noted an inability to access the clinics they can afford, and that transportation is often unaffordable or unreliable, causing them to miss appointments and potentially face financial penalties.

Participants noted health care services are not available in rural areas, and when services are available, they require a vehicle to get to them, which isolates community members who are not able to drive or do not have transportation.

See Access to Health Care, Transportation and Resources, page 56 for more about the challenges of lack of access to health care, resources, and transportation.

Social Isolation

Social isolation can ocur in rural or urban areas. As described in the Social Determinants of Health section, poor family support, minimal contact with others, and limited involvement in community life are associated with increased disease and early death.

Looking Ahead

Looking Ahead

For the past three years, HCWC has partnered with people and organizations in the community and evaluated data to learn about the health and lived experiences of the quad-county region. This closing section contains the key takeaways from this work.

Community Strengths

Listening session and town hall participants described their communities as resilient, connected, and community-oriented. Participants described a wealth of resources that, if provided, can help people thrive.

Town hall and listening session participants mentioned the following as community assets:

- Organizations providing resources for the houseless and housing insecure
- Resources for low-income families
- Organizations providing supplementary food
- Community organizations, such as those providing professional development training, culturally specific resources, job postings, and community programs
- Community health workers' engagement in their communities
- Multicultural centers
- Safe spaces at schools
- LGBTQ+ organizations
- Culturally-specific programs
- Fundraising to help keep their communities clean and safe

Resources such as **food banks, emergency shelters, low-cost clinics, and services** that help to pay utility bills are necessary and beneficial, but there is a need for more continuity in these services so community members can understand how to access these resources effectively. Community members described needing consistency in these support services rather than having them only on an emergency/episodic basis.

Transportation was another strength and need identified through town halls and listening sessions. Those who live closer to central public transportation noted it was a great strength, while those outside of Portland metro area—especially those in rural areas—emphasized lack of transportation options as an area for improvement.

Calls to Action

HCWC identified nine core issues needing attention in the quad-county region, with discrimination, racism, and trauma as the overarching issues that must be considered when addressing the other core issues.

Discrimination and Racism

Discrimination and racism adversely affect all areas of people's lives and health, and the health of their communities.

Communities that are not white and not of the dominant culture have faced extensive discrimination and racism at every level, historically and today, in both overt and implicit ways, from education to employment and income levels to housing security and health.

Communities of color have higher rates of chronic diseases and poorer health outcomes compared with other groups. Experiences of racism and collective historical trauma in institutional settings, including health care, have created a culture of distrust. Misunderstandings and poor communication contribute to a lack of trust in institutions that are supposed to address and support their needs.

Lack of Safety

Communities of color, immigrants and refugees, and LGBTQ+ participants described fears and experiences of discrimination and racial profiling by the police, which leads them to feel unwelcome in certain areas, including their own neighborhoods. There is also fear of deportation by the Immigration and Customs Enforcement agency.

Additionally, participants discussed an inability to exercise outdoors or let their kids play in the park, not only because of fear of deportation or racial profiling, but due to factors such as large amounts of trash in their neighborhoods, vandalism, and presence of drug use in their community.

Gentrification

Gentrification significantly impacts communities and displaces community members. Many who originally occupied neighborhoods have been pushed out of their historic communities. This disrupts communities, businesses, relationships, and other sources of support as people are forced to the margins of an area—or out of their communities altogether. This displacement is one of many significant community stressors. (See Housing below, under Access to Resources.)

Lack of Representation

People want to see more of themselves and their communities reflected in the institutions that are supposed to be there to serve them, including local government, health care providers, and community organizations.

Lack of Representation and Accurate Data

Fears of surveillance and a lack of transparency in data hinder equitable data collection for immigrant communities, refugee communities, and communities of color.

Communities of color, the LGBTQ+ community, immigrants and refugees, and women and children all experience morbidities (rates of diseases), mortalities (deaths), and stressors that influence social determinants of health.

Due to small population sizes, and mistrust of data collection processes, these communities are often misrepresented, inaccurately accounted for, or completely absent in quantitative data.

- Better tracking for outcomes in communities of color is needed, as well as focus on qualitative data collection methods and community narratives (for example, listening to community members describe their experiences).

Challenges for Immigrants and Refugees

Participants in the listening sessions for immigrants and refugees described experiencing financial challenges due to discrimination and cultural misunderstandings, such as absence of credit history to assist in financial endeavors. Although many came to the United States with transferrable job skills and education from their home countries, their credentials were not transferrable. This hurdle often required finances to fund additional education or a switch in careers.

Trauma

Toxic stress and trauma affect every aspect of a person's health and well-being. These issues often begin in childhood and frequently continue through to adulthood, affecting the health and well-being of many in the region.

Generational trauma and toxic stress are often not well understood in dominant culture communities and can be dismissed or ignored. In fact, generational trauma can often cause actual genetic changes for those who experience it, leading to higher risk of chronic health conditions, housing insecurity, mental health issues, and substance use disorders. It is important to note that childhood experiences of trauma, discrimination, racism, and biases produce a cycle of difficult circumstances—financial, social, and psychological—that is difficult to break.

More awareness and understanding of how trauma impacts people's lives is needed in all areas of health care, as well as in the larger community narrative and understanding.

Areas for improvement:

- Trauma-informed policies, health care, and resources can serve as protective factors to counteract the impact of toxic stress and trauma on health.
- Support for policies and programs that provide "wraparound" services (holistic, family-driven) to families and other impacted populations.

Health Outcomes

Behavioral Health

Participants often mentioned the lack of mental health providers who look like them or identified with their identities and experiences (see Discrimination and Racism and Culturally Responsive Care). This disconnect between the providers' and participants' experiences made accessing mental health care challenging.

Areas for improvement:

- Ensuring access to mental health services and resources for residents who may not have health insurance
- Greater access to mental health resources, such as more providers, school-based interventions, and family-focused programs
- Greater emphasis on preventive care and screening for mental health conditions
- Addressing stigmas associated with mental health treatment
- Culturally and linguistically competent mental health services (see more areas for improvement under below)

Chronic Conditions

Chronic disease accounts for two-thirds of emergency medical conditions and roughly 80% of all health care costs.

Participants frequently mentioned how comprehensive, accessible health care and access to peer navigators and **community health workers** (see below) could help reduce chronic conditions in the region.

Areas for improvement:

- Access to comprehensive health care
- More peer navigators and community health workers
- More preventive resources and education to improve chronic condition self-management
- Multi-generational lifestyle change programs

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Sexually Transmitted Infections

Rates of two STIs, chlamydia and gonorrhea, have increased in the quad-county region.

Areas for improvement:

- More comprehensive sex education and access to sexual health resources (mentioned by youth during listening sessions)
- Of note, this issue was addressed more directly by youth and hardly mentioned in adult listening sessions. There may be opportunity here to raise awareness and/or address a barrier/embarrassment factor that prevents it from being overtly introduced in a group session (where that was not the main topic).

Social Factors

Access: Health Care, Transportation and Resources

Access to Health Care

Even though most of the quad-county region has health insurance coverage, community members face challenges related to coverage and cost. Over 10% of the population in every county reported not being able to access health care services due to cost.

Areas for improvement:

- Access to comprehensive, holistic, and integrated health care
- Access to alternative therapies such as acupuncture, massage therapy, counseling services, naturopathy, and chiropractic services
- More peer navigators and community health workers
- Improving health literacy: poor general literacy often means poor health literacy, which puts people at risk for mismanaging medications and misunderstanding treatment protocols

Access to Transportation

For many residents without a vehicle, public transportation in the Portland metro area helped to connect them to resources, community spaces, grocery stores, and medical care, and helped to get them to work. However, for those living outside a transportation hub, the lack of public transportation reduced their access to medical services, healthy food, and quality housing, among other things important to healthy living.

Areas for improvement:

- Multiple services in one location (e.g., health care and complementary support services)
- More public transportation options (see Isolation below for more)

Access to Resources

Areas for improvement realted to community resources, funding:

- More and consistent/reliable funding for community-based organizations
- More collaborative resource hubs
- Increased awareness of available community resources (both for community members and between community service provider organizations)
- Assistance navigating various, often disconnected, resources—more **peer navigators and community health workers**

Areas for improvement related to housing:

- Increased emergency, temporary, and transitional shelter or alternative housing
- Financial counseling
- Addressing underlying issues that have contributed to a person's unstable housing situation, including
  - Economic instability
  - Discrimination and racism
  - Past trauma
  - Mental health issues
  - Other health conditions

Areas for improvement related to economic stability:

- Access to financial counseling and job assistance
- No-cost, school-based interventions and family-focused community center programs to provide access to resources to help community members establish and achieve economic stability
- Investment in community-centered small businesses, particularly family-oriented and culturally specific businesses, which will encourage economic growth and financial security for all community members.

Areas for improvement for children and families:

- Safe outdoor recreation spaces
- Resources to help engage children in conversations about substance abuse, mental health, school safety, and bullying

Areas for improvement for immigrants and refugees:

- Addressing long-term needs, not just the immediate needs of immigrants and refugees

Areas for improvement for "transitional age" youth:

- More services for transitional age youth
- Daytime programs for youth who are housing insecure

Community Representation

Areas for improvement:

- Institutional solutions and shared power in decision making (their voices being heard, having input on policy, etc.)
- Greater cultural awareness in health care and more culturally specific providers (see below)
- More spaces supporting intersectional communities and community gathering places near their homes

Culturally Responsive Care

Areas for improvement:

There is a need for more **bilingual and bicultural providers** and **community health workers** to facilitate, advocate for and empower communities.

Other ways for care to become more culturally responsive include:

- More culturally relevant, long-term services that focus on comprehensive, community-oriented programs emphasizing holistic health and preventive health care services
- Access to emergency services in languages other than English
- Culturally and linguistically competent mental health services
- Accurate translations of informational materials in non-English languages
- Certified training programs for Arabic-speaking community health workers
- Multi-generational and culturally specific resources to help parents succeed

Isolation

Physical and cultural isolation was identified throughout the region as a core issue, with rural community members noting the difficulty in accessing services in their communities and having to travel long distances for services.

Geographic isolation

For those living in rural communities, as well as those who may live in urban areas but face limitations in accessing services.

Areas for improvement:

- More mobile medical units
- Options of virtual appointments
- More medical outreach (for example, to those experiencing houselessness)

Social isolation

Areas for improvement:

- More social outreach
- Shared community spaces and resources

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Appendices

Appendix A: HCWC Leadership and Workgroups
Appendix B: Methodology
Appendix C: Additional Social Determinants of Health Information
Appendix D: Listening Session Demographic Information
Appendix E: Health Indicators
Appendix F: Literature Review
Appendix G: County-Specific Data

- Clark County
- Clackamas County
- Multnomah County
- Washington County

Appendix A: HCWC Leadership Group and Workgroups

This report was prepared by Comagine Health (formerly HealthInsight) convener staff: Meghan Haggard, Maria Danna, Jennifer Hendrickson and Karen Drill. Special thanks to the Data Workgroup participants Eva Hawes, Erin Jolly, Kathleen Lovgren, Chris Goodwin, Kristine Rabii, Maria Tafolla, Marilou Carrera, Anna Menon, Katherine Galian, Diana Netter, Jesse Gelwicks, and Dr. Frank Franklin, who volunteered to provide feedback on initial drafts.

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Community Partners

Town Hall Organization Participants

ASAC
City of Lake Oswego
Clackamas Behavioral Health Division
Clackamas County Aging Services Advisory Council
Clackamas County Community Action Board
Clackamas County Disaster Management
Clackamas County Public Health Division
Clackamas County Social Services
Clackamas Workforce
Clark County Community Services
Clark County Public Health
Coalition of Community Health Clinics
Kaiser Permanente
Legacy Health
Micronesian Islander Community
NAYA Family Center
Northwest Family Services
Oregon AIDS Education & Training Center
Oregon Community Health Workers Association
Oregon Dairy and Nutrition Council
Oregon Food Bank
Oregon Health Equity Alliance
Oregon Office on Disability and Health
Oregon Oral Health Coalition
Planned Parenthood
Project Access NOW
Providence ElderPlace
Providence Health and Services
Quest Center for Integrative Health
Society of St. Vincent de Paul
Vibrant Future Coalition/NW Family Services
YMCA of Columbia Willamette

Community Listening Session Hosts

Adelante Mujeres

AntFarm

Cascade AIDS Project – Aging Well

Central City Concern

Community Partnership for Affordable Housing

Estacada Community Center

Faith Organization in Multnomah County

Friendly House

Individual Facilitators, Arabic Community

Individual Facilitator, Farmworkers

Iraqi Society of Oregon

Latino Network

Momentum Alliance

NAMI, Clackamas County

Outside In

Pacific Islander Coalition

SW WA Accountable Community of Health

Veterans of Foreign Wars

Workgroups

The collaborative worked together in a variety of areas on this project. HCWC has deep appreciation for all member organization staff who volunteered their time and expertise to help tell part of the community story. Listed below are the workgroups that were part of the collaborative.

Communications Workgroup

- Chris Goodwin, Clark County Public Health
- Gianoux Knox, Oregon Health & Science University (OHSU)
- Philip Mason, Clackamas County Health, Housing and Human Services
- Rachel Burdon, Kaiser Permanente
- Brian Willoughby, Legacy Health
- Gerald Ewing, Tuality Healthcare
- Rebecca Naga, Health Share of Oregon

Stakeholder Engagement Workgroup

- Ed Hoover, Adventist Health Portland
- Susan Berns-Norman, Clackamas County Health, Housing and Human Services
- Kirsten Ingersoll, Clackamas County Health, Housing and Human Services
- Erin Jolly, Washington County Public Health
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- Mariotta Gary-Smith, Health Share of Oregon
- Daesha Ramachandran, Health Share of Oregon
- Kristen Brown, Providence Health and Services
- Maria Tafolla, Health Share of Oregon (and also a member, formerly of FamilyCare)
- Kamar Haji-Mohamed, Family Care (prior to closing)

Data Workgroup

- Anna Menon, Clackamas County Health, Housing and Human Services
- Ayni Amir, IRCO
- Celia Higueras, Oregon Community Health Workers Association (ORCHWA)
- Chris Goodwin, Clark County Public Health
- Claire Smith, Multnomah County Health Department

- Diana Netter, Legacy Health
- Erin Jolly, Washington County Public Health
- Eva Hawes, Washington County Public Health
- Dr. Frank Franklin, Multnomah County Health Department
- Gianou Knox, OHSU
- Jesse Gelwicks, Kaiser Permanente
- Joseph Ichter, Providence Health and Services
- Katherine Galian, Clark County Public Health
- Kathleen Lovgren, Clark County Public Health
- Kristine Rabii, Tuality Healthcare
- Maria Tafolla, Health Share of Oregon
- Marilou Carrera, Oregon Health Equity Alliance
- Mary Rita Hurley, Our House of Portland
- Peter Morgan, Adventist Health Portland

HCWC Leadership Group Members 2018–2019

- Daesha Ramachandran, Health Share of Oregon
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- Dawn Emerick, Clackamas County Health, Housing and Human Services
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- Michael Anderson-Nathe, Health Share of Oregon
- Molly Haynes, Kaiser Permanente
- Pamela Mariea-Nason, Providence Health and Services
- Pei-Ru Wang, Multnomah County Health Department
- Peter Morgan, Adventist Health Portland
- Phyusin Myint, Washington County Public Health
- Rujuta Goankar, Kaiser Permanente
- Tricia Mortell, Washington County Public Health

Descriptions of Leadership Group and Workgroups

Leadership Group

The Leadership Group is the steering committee and main decision-making body for the HCWC. It has final say on budget decisions and other issues that affect work scope and deliverables. The Leadership Group is comprised of one to two members from each organization that are either direct decision-makers for their organization, or who have a direct report line to those in the organization with that authority. They come to the table to oversee the process, vet new opportunities, solve problems, and ensure the process meets the needs of the collaborative while keeping its focus on the community.

Subgroups are formed to participate in more hands-on portions of the community health needs assessment creation and work.

Data Workgroup

The Data Workgroup is in charge of telling the data story. It was decided early on that the qualitative and quantitative data would be done concurrently to ensure the goal of raising community voice was achieved.

This group developed data frameworks, made decisions regarding scope and worked with all other groups to ensure an equity lens was rigorously applied to the process. Members also participated in developing Town Hall and Listening Session frameworks and processes.

Communications Workgroup

This group was started at the beginning of cycle three to develop communications for suggested use regarding cycle two's 2016 report. The group's charge was to focus on key messaging and develop preliminary presentations and talking points for circling back to the community. Additionally, they developed summaries of information from the 2016 report for suggested use for internal and external stakeholders (key points).

Late in the cycle, this group merged with the Stakeholder Engagement Workgroup since these two workgroups no longer needed to be separate once the Cycle Two circle back was completed.

Now merged with the Stakeholder Engagement Workgroup, this group focused on developing outreach and presentation materials that may be needed/requested by the community when the Cycle Three report is completed.

Stakeholder Engagement Workgroup

This Workgroup's main charge is to circle back with the community member organizations and community members touched in the previous cycle to ensure they were aware the report was published, address any questions, and make presentations to groups who were interested in knowing more.

Significant time, outreach, and effort were involved. This group also took the initial PowerPoint framework created by the Communications Workgroup and added to it based on experience and feedback. Scripting was added, and workgroup members often presented to CBOs and/or supported other presenters. See merged charter beginning on following page.

Table A-1. Date Workgroup Plan for Operationalizing Equity.

CHNA Development Phases	Because we recognize…	We will strive to…	By…
Governance & Decision Making	• That decision-making power is not always explicitly articulated • We must operate in an open and transparent manner to safeguard and deepen the trust of all stakeholders in the system, as well as to foster accountability	• List organizations with decision-making power • Name constraints/limitations of decision-making power • Ensure every community member who participates in work groups has the same decision-making power as other workgroup members	• Defining terms (i.e., power) frequently and how they influence the group
Community & Stakeholder Engagement	• That historical abuses and mistrust of health care and research institutions influence how people may participate (or not) in the HCWC • Community members are often asked to volunteer their wisdom and lived experience and that this information is not an accessory but central to a community needs assessment • Community and individual participation is critical to eliminating health disparities, and that active participation may necessitate going beyond invitation and encouragement	• Design intentional strategies to engage communities and demonstrate the integrity and transparency embedded in our core values. • Compensate community members for their participation on the work groups • Actively review potential barriers to participation, assess low turnout events • Discuss experiences of inclusion in engagement process with community leaders	• Inviting more community members to the Data Workgroup at every step • Compensating community members for their input • Considering meeting time and attendance • Investigating why current community members are not attending Data Workgroup meetings

Methods development	• Continuous data collection, including stratification by racial and ethnic subgroups, and other disparity variables is one way to monitor disparities and to adapt strategies to address them.	• Articulate clear and transparent methods that are designed to enable iterative, rapid adaptation, and incremental evolution to meet current and future needs of stakeholders. • Routinely and systematically integrate demographic and social factors into all analytics and decision-making processes	• Developing methods that focus on strengths, not just needs. • Identifying and acknowledging limitations of methods. • Being clear about describing methods and how they were chosen.
Data collection	• That historically underrepresented communities experience interview fatigue. • Dominant culture institutions often possess or have access to considerable information about historically underrepresented/ oppressed communities	• Seek to answer questions about the community from information that has already been shared in existing community reports. • Refrain from pulling data for the sake of it – we will have clear answers to the who, what, why.	• Identifying priority populations • Holding mutually beneficial Listening Sessions, e.g., providing opportunities for community organizations to learn about accessing funding. • Improving outreach and participation for a broader perspective and reach. • Using existing data (i.e., leading w/race). • Determining an inclusive data collection process.

Data analysis	• That dominant culture organizations prioritize numerical data.	• Integrate narrative and qualitative information and use it to inform quantitative data analysis	• Making data actionable and accessible • Mapping SDOH to Health Outcomes (including racism)
Development of final product	• All should benefit from the public good derived from the HCWC and that the HCWC Needs Assessment has not historically been designed to be useful for community members • Community engagement plays an essential role in operationalizing value • Accessibility cannot be determined by those providing access, but must be measured by those attempting to access. • The narratives we choose to create, share and perpetuate are products of power • Narratives of underrepresented communities often emphasize a deficit narrative	• Ensure accessibility will be executed in different ways to reach different audiences, understanding that diverse communities have different needs. • Contains information that is useful to multiple community stakeholders • Create a report that is easy to navigate and share • Create an online portal to selectively view information that is most important to the reader • Accessible in multiple languages and formats • Ensure community members participate in the development of the needs assessment narrative • Use language intentionally, focusing on an asset-based narrative	• Determining how to integrate SDOH, quantitative, and qualitative data together. • Identifying the audience and purpose of the report • Determining what an asset-based narrative look likes.

Dissemination	• That sometimes institutions fail to return to communities and share the final outcome of projects	• Present information from the report in person to groups in the community	• Exploring report dissemination avenues • Sharing data back with the community • Developing a presentation template (video, etc.)

Project Charter: HCWC Data Workgroup

OVERVIEW

Project title: Data Workgroup

Project: HCWC Member Institutions

Lead: Meghan Haggard (with support from workgroup members as appropriate)

Staff support: Maria Danna, Jennifer Hendrickson, Karen Drill and Zoe Larson

Kickoff date: March 21, 2017

DESCRIPTION

Project Aim and Goals:

- Develop a product timeline for 2019 Community Health Needs Assessment (CHNA) by September 30, 2017.
- Use a mixed methods data collection approach to gather and analyze information for the 2019 CHNA.
- Embed resonance checks with the community through qualitative data collection methodology.
- Collect and analyze data for the 2019 CHNA by February 2019.
- Collaborate with the Stakeholder Engagement Workgroup to build relationships with community-based partners through the 2019 CHNA. Combine group meetings as appropriate.
- Provide quarterly updates to the Leadership Group on progress.

Description:

The Data Workgroup is responsible for:

- Collecting, and informing the analysis of data for the 2019 CHNA cycle
- Ensuring processes and values align with the HCWC vision and mission, including the identification and analysis of Social Determinants of Health affecting community health outside of healthcare
- Leading the aggregation of information
- Identification of themes within the data
- Identification of priority health issues
- Development of a report outline

The Data Workgroup will consist of subject matter experts in qualitative, quantitative, and/or mixed methods data collection and analysis. The Data Workgroup will identify project team focus areas as needed throughout the process. Community members will be actively engaged in the process.

HealthInsight/Q Corp is responsible for report writing and editing.

The Data Workgroup will meet twice monthly for two hours per meeting, project teams will meet more frequently as needed.

BOUNDARIES

Includes:

- CCOs, Hospitals, and Public Health have differing needs that should be reasonably addressed.
- Reasonable data collection from each HCWC partner to produce the 2019 CHNA.
- Coordination with other HCWC workgroups to complete the stated goals and objectives of the collaborative in creating the 2019 CHNA.

Excludes:

- This is a collaborative CHNA and will not meet all individual stakeholder needs.
- The process cannot address the needs of each organizational CHIP.

MAJOR TASK SCHEDULE

Note: Final project timeline will be collaboratively developed once workgroup has active project stakeholder participation. Dates listed are intended for discussion and revision.

Table A-2. Original Schedule for Major Tasks.

TASK	START	END
Update framework to be used for the data collection process	May 2017	June 2017
Complete a data gap analysis	June 2017	August 2017
Update or develop data collection protocols	July 2017	October 2017
Identify priority populations/areas for data collection	September 2017	October 2017
Collect and analyze data	November 2017	December 2018
Develop report framework	October 2018	December 2018
Review report drafts and provide feedback	January 2019	April 2019

PROJECT TEAM

Table A-3. HCWC Project Team.

FUNCTION	REPRESENTATIVE	ORGANIZATION
Project Facilitator/Lead	Meghan Haggard	HealthInsight/Q Corp
Project Staff	Maria Danna	HealthInsight/Q Corp
Project Staff	Jennifer Hendrickson	HealthInsight/Q Corp
Project Staff – Intern	Zoe Larson	HealthInsight/Q Corp
Project Analyst	Karen Drill	HealthInsight/Q Corp Consultant
	Anna Menon	Clackamas County Public Health
	Celia Higueras	Oregon Community Health Workers Association
	Chris Goodwin	Clark County Public Health
	Claire Smith	Multnomah County Public Health
	Dianna Netter	Legacy
	Dr. Daesha Ramachandran	Health Share
	Erin Jolly	Washington County Public Health
	Eva Hawes	Washington County Public Health
	Dr. Frank Franklin	Multnomah County Public Health
	Gianou Knox	Oregon Health & Science University
	Jesse Gelwicks	Kaiser Permanente
	Joseph Ichter	Providence Health & Services
	Katherine Galian	Community Action
	Kathleen Lovgren	Clark County Public Health

	Marilou Carrera	Oregon Health Equity Alliance
	Mary Rita Hurley	Our House of Portland
	Peter Morgan	Adventist Health

Project Charter: HCWC Communications/Stakeholder Engagement Workgroup

OVERVIEW

Project title: Communications and Stakeholder Engagement Workgroup

Project sponsor: HCWC member institutions

Co-chair(s): Ed Hoover, Chris Goodwin

Staff support: Maria Danna and Jennifer Hendrickson, HealthInsight

Kickoff date: July 16, 12:30-1:00 p.m.

DESCRIPTION

Project Aims and Goals

- To begin, in Cycle 3, so prepare for the other goals and aims listed once the report is released
- To organize key communication points for internal and external partners regarding the HCWC CHNA to our Collaborative members. Those members will take that information to their individual organizations to get approval and use as determined by their processes [Communications/Marketing/Legal/Other departments] (as done in Cycle 2)
- To develop any communications needed for further community engagement and/or follow up post Town Halls and Listening Sessions
- To build and strengthen community relationships and connections through collecting, organizing and packaging information
- To build systems and structures for sharing 2019 CHNA information with the community
- To develop a system to organize, track, disseminate, and collect information from 2016 and 2019 cycles
- To learn from this process and determine areas where there are gaps to address
- To support the work of the Data Workgroup and the larger collaborative as applicable

Description

Two groups were combined for the last half of the Cycle 3 work (Communications and Stakeholder Engagement Workgroups (SEW)). This was done as the circle back from Cycle 2 (2016 CHNA) was completed by the SEW and the SEW's future work had synergistic overlap with the Communications Workgroup.

This combined group is responsible for:

- Reporting back to community stakeholders our findings from Cycle 3 CHNA and how our stakeholders are using this information to inform their community and public

health work via CHIPs (Community Health Improvement Plans) or other work
- Building and maintaining community relationships for the next cycle (Cycle 4 CHNA)
- Developing Leadership Group presentations to external stakeholders regarding the HCWC Collaborative and the CHNA (Cycle 3/2019) as requested by community partners and organizations
- Key communication recommendations/highlights from the 2019 CHNA (Cycle 3) -- internal and external stakeholder communication (for use/review by Collaborative member communications departments)
- Other communications functions as determined appropriate by the Leadership Group
- Collaboration with other workgroups as relevant

Project Risks
- Low engagement by workgroup members
- Not enough input from appropriate stakeholders
- Lack of ability for all 12 organizations to agree on sharing or using communications pieces created
- Timeline constraints
- Lack of representation of different HCWC entity types
- Product inaccessible to the communities we reach out to

Boundaries

Includes:
- Stakeholder groups surveyed and interviewed in HCWC CHNA cycle
- Stakeholder groups TBD/outreach for 2019 cycle
- Evaluation of community stakeholder input (dissonance, areas of concern, etc. to inform 2019 process).

Concern: CCOs, Public Health, and Hospitals have differing needs that should be reasonably addressed.

Excludes:

- The Stakeholder Engagement and Communications Workgroup will not be the only members responsible for presentations and feedback collection

Concern: Cannot address the needs of each organizational CHIP.

This is a collaborative CHNA, and will not meet all individual stakeholder needs.

Appendix B: Methodology

This appendix contains HCWC's overall approach to this study, as well as summaries of our methodology for each area of data collection for this assessment:

Overall Methodology

The HCWC Data Workgroup implemented a mixed methods approach to data collection and analysis, which prioritized community voice and input in the assessment model.

Town Hall Methodology

In June 2018, HCWC hosted a series of Town Hall events across the quad-county region. These events were designed to bring together community leaders and representatives from community-based organizations, to provide feedback on early data findings and illicit conversations about communities to target for listening session outreach. Below are the methods used to collect and analyze the data from these events.

Methods for collecting data

The HCWC Data Workgroup guided the development of the event structure and format. The group decided to host one three-hour meeting in each of the HCWC region counties with invited participants to meet the following goals:

- Gather reactions from community stakeholders to numerical data to include in the CHNA
- Develop a list of considerations for current or future cycles of the CHNA
- Identify a list of populations HCWC should connect with to collect additional information in smaller focus group setting

During the event, participants reviewed numerical data during a gallery walk and then returned to preassigned tables to discuss a series of questions. Gallery walk data was presented on posters and an HCWC representative explained the poster to the participants during a rotation.

Each table discussion was facilitated by a trained HCWC representative and notes where taken by the facilitator on flip charts. Each facilitator was provided just-in-time training in the one hour prior to the event. All written information from the events was collected by the conveners, this included the facilitator flip chart notes and the activity sheets that participants completed identifying assets and barriers.

Methods for analyzing data

All written data from each event was transcribed by convener staff. The information collected from each table was transcribed and coded separately to identify both similarities and differences between tables in the analysis.

Once transcription was complete, the convener staff used a consensus coding model and the qualitative analysis software NVivo to code the data into thematic categories. The data analyzed came from notes taken during the sessions. Two independent coders used a collaborative, open-coding process to analyze the data and ensure reliability (Harry, Sturges, & Klingner, 2005). After the coders came to consensus on the themes, they presented them to

convener staff to ensure the findings resonated with all staff members' experience of the town halls. Once themes were consensus coded, the coders went back to refine the coding to pull out specific participant examples and quotes to contextualize the themes.

Code List (Top 6):

- Siloed Organizational Resources and Funding Strain
- Obtaining Status, Security, Opportunity
- Lack of Cultural Competency
- Mental Health
- Racism
- Transportation

Data limitations

The data collected was limited to amount of information that was collected by each table facilitator, as well as the conversation had by the attendees. There is a selection bias in those who chose to attend the event and provide feedback. While table facilitators were trained and asked to moderate the conversation and allow for all voices to be heard equally, it is impossible to tell if this occurred.

Documentation

Table B-1 shows a sample agenda from one of the events.

Table B-1. Sample Event Agenda.

Time	Topic	Lead
1:05-1:40	**Welcome & Introduction**	**HCWC Representative from County**
1:40-2:45	**Data Gallery** • Attendees will move through the posters with their table group	**Poster Facilitators**
2:45-3:50	**Table Group Discussion** • Small group discussion to answer structured questions	**Table Facilitators**
3:50-4:00	**Thank you & Closing** • Please complete the evaluation!	**HCWC Convener**

Discussion questions

Question 1: Based on your understanding of the poster information, what does the data tell us? What does the data not tell us?

Question 2:

Part 1: Please pick an issue of concern (with barriers) in your community (it can be one you think is surfaced by the data, or not surfaced by the data. ***Follow instructions on guide. You can do as many of these as you have time to fill out during the allotted time. One item per activity sheet.***

Part 2: Please pick an issue of concern (with assets) in our community (it can be one you think is surfaced by the data, or not surfaced by the data. ***Follow instructions on guide. You can do as many of these as you have time to fill out during the allotted time. One item per activity sheet.***

Question 3: What support do you need to connect communities with resources and/or what is making your job difficult?

Question 4: For our community member listening sessions, what *specific communities* do you recommend outreach to?

What specific questions do you recommend we ask these community members? (Hopefully in ways, or about things, they haven't been asked before. *Are there issues hidden by data and standard interview/group session questions that we can help bring to light?)*

Listening Session Methodology

In October through December 2018, HCWC hosted 18 listening sessions across the quad-county region. These events were designed to bring together community members to provide feedback on their lived experience. Below are the methods used to collect and analyze the data from these events.

Methods for collecting data

The Data Workgroup guided the development of the event structure and format. The group decided to host listening sessions with priority populations that were identified based on feedback from the town halls, the groups reached during the previous CHNA cycle, and members knowledge and connections with communities that are not typically heard from during outreach exercises.

After the identification of priority populations, Data Workgroup members worked to reach out to organizations across the region that work with the populations. After outreach occurred, and organizations expressed interest in hosting a session, the conveners contracted with the organizations and scheduled the sessions.

Each session was based on the same format, using the facilitation guide outlined below. Hosting organization were asked to provide a facilitator for the session and Data Workgroup members and convener staff supported them as co-facilitators and note-takers as needed. Data was captured at each session by the assigned note takers. Facilitators and note-takers were provided just-in-time training for their roles prior to the sessions.

Methods for analyzing data

All written data from each session was transcribed by convener staff. Each session was transcribed and coded individually before being recoded to identify regional themes.

Once transcription was complete, the convener staff used a consensus coding model and the qualitative analysis software NVivo to code the data into thematic categories. The data analyzed came from notes taken during the sessions. Two independent coders used a collaborative, open-coding process to analyze the data and ensure reliability (Harry, Sturges, & Klingner, 2005). After the coders came to consensus on the themes, they presented them to convener staff to ensure the findings resonated with all staff members' experience of the listening sessions. Once themes were consensus coded, the coders went back to refine the coding to pull out specific participant examples and quotes to contextualize the themes. The individual listening session reports were shared with each hosting organization, who shared the reports with participants, to ensure their experiences were captured. This feedback was incorporated into the listening session reports that followed.

Code list:

- Access to Health Care
- Community Spaces and Support
- Concerns for Safety
- Discrimination and Racism
- Family Welfare
- Financial Barriers
- Geographical and Cultural Isolation
- Language Barriers
- Representation
- Transportation

Data limitations

The data collected was limited to amount of information that was collected by note-takers, with some sessions having more robust notes available for analysis than others. Hosting organizations recruited participants and those who attended the session self-selected. Participants may have also be influenced to participate by the incentive which was provided ($25 gift card).

Documentation

Table B-2 lists each of the 18 listening sessions, the host organization, date, county, and number of participants.

Table B-2. Listening Sessions.

Priority Population	Hosting Organization	Date of Session	County of Session	Participants
Elderly (65+) LGBTQ persons	Cascade AIDS Project – Aging Well	10/24/18	Multnomah	17
Middle Eastern	Iraqi Society of OR	10/27/18	Multnomah	16
People with Mental Health Concerns	NAMI Clackamas County	10/18/18	Clackamas	8
Youth of Color	Momentum Alliance	10/27/18	Multnomah	11
LGBTQ Homeless Youth	Outside In	10/24/18	Multnomah	12
Hispanic/Latinx	Adelante Mujeres	11/13/18	Washington	17
Elderly (65+) Low-Income	Friendly House	11/16/18	Multnomah	11
Farmworkers	Plaza Del Robles	11/16/18	Clackamas	10
People of Color with Housing Concerns	Central City Concern	11/17/18	Multnomah	19

Priority Population	Hosting Organization	Date of Session	County of Session	Participants
Slavic	Church	11/18/18	Clark	11
Rural	Southwest Washington ACH	11/19/18	Clark	10
Pacific Islander	Pacific Islander Coalition	11/26/18	Multnomah	16
Hispanic/Latinx	Latino Network	11/27/18	Multnomah	14
Arabic		11/30/18	Washington	9
Military Connected	Veterans of Foreign Wars	12/1/18	Washington	10
Elderly (65+) Rural	Estacada Community Center	12/5/18	Clackamas	6
Youth	AntFarm	12/5/18	Clackamas	10
Elderly Low-Income	Community Partnership for Affordable Housing	12/7/18	Washington	10

Facilitation guide

HCWC INTRODUCTION

Welcome and thank you for joining us for a Healthy Columbia Willamette Collaborative (HCWC) community Listening Session event. We are delighted to have you join us today as we work collectively to gather information for our 2019 Community Health Needs Assessment.

A little background on how we got here. In 2011, leaders from the hospitals systems and public health departments came together to figure out how to better collaborate to produce a regional Community Health Needs Assessment. When coordinated care organizations were formed in 2012, they joined the collaborative as well. These leaders include: Health Share, Providence, Kaiser Permanente, Legacy, OHSU, Adventist, Tuality, PeaceHealth and the Public Health Departments of Clackamas, Multnomah, Washington, and Clark Counties. Now in our third cycle, the collaborative has published two regional assessments of the health of our communities. In order to complete these assessments, we have looked at what the numbers tell us and what the community tells us.

We appreciate your willingness to participate and answer questions about your community experience. We recognize that you may be asked questions from different groups. Part of the goal of HCWC is to attempt to limit duplicative outreach. By working together as a collaborative, we strive to ensure your time is respected, questions are relevant, and information is collected and shared back in a coordinated and transparent manner.

The information from each of the completed regional Needs Assessments (CHNA's) has been used by HCWC member organizations to develop and implement improvement plans. For example, the 2016 CHNA information from last cycle established housing concerns as a high priority area of focus for HCWC member organizations. In fall of 2016, six health organizations participating in HCWC announced they would invest 21.5 million dollars towards the Housing is Health Initiative through Central City Concern.

The Housing is Health Initiative aided Central City Concern in building a new health care clinic and 379 units of new housing in North and East Portland. Prior to that, information from the first CHNA in 2013 identified opioids as an area of concern for the region. HCWC supported the establishment of a workgroup focused on opioids that has continued working across the region since that time.

SESSION INTRODUCTION

We are excited to hear from each of you about your experiences. By being here today and sharing your experiences, you are helping to improve the health of your community. We're hoping to learn about community experiences, so your concerns can be addressed by HCWC partners. Your voice matters. This information will be used by HCWC members and community partners, who will be developing strategies based off the information you provide to better serve your communities.

Please note that this session is being recorded by note-takers and the information gathered will be used by HCWC in the upcoming July 2019 Community Health Needs Assessment. We may capture direct quotes but those won't be tied to you personally. We are committed to sharing what we learn.

Okay, we have a little over an hour to talk. I'd like to start with a creative activity. Here's paper and crayons. Start by thinking about your community. People might think of "community" in different ways. Maybe it's family, or maybe it's neighbors, or maybe it's 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 your drawing. 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. So you all told us your name and told us something about how you see your community. 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 hear from everyone.

CONTEXT

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

PAUSE, for thought time, not answers. Be sure attendees understand that.

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?

PAUSE, for thought time, not answers. Be sure attendees understand that.

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? Maybe you feel part of multiple communities, or maybe you identify primarily with one community.

We're not going to define these things for you. They are for you to decide.

QUESTION 1: VISION. Now take a minute to think about your community or communities.

How can you tell if your community is healthy?

> ***Probes:***
> *What does health look like in your community?*
> *What does health feel like in your community?*
> *Maybe you feel part of multiple communities, does health feel or look the same in each one?*
> ***Instructions: Ensure participants know this is where we want discussion. Capture ideas on flip chart.***

QUESTION 2: CHALLENGES. We've talked about what a healthy community looks like. Now let's talk about what's not there to support community health.

What gets in the way of your community being healthy?

> ***Probes:***
> *Can you give some examples of challenges your community faces?*
> *Do you ever notice disparities, or unfairness, between what your community has and what other communities have or experience?*
> ***Instructions: Ensure participants know this is where we want discussion. Capture ideas on flip chart.***

QUESTION 3: STRENGTHS. So, you've told us what a healthy community looks like and what the challenges 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 currently working? What are the resources that currently help your community to be healthy?

> ***Probes:***
> *What are the strengths within your community?*
> *If someone was new to your community, and looking for resources, where would you tell them to go?*
> *How do these resources help your community to be healthy?*

Instructions: Ensure participants know this is where we want discussion. Capture ideas on flip chart.

QUESTION 4: NEEDS. So, you've now shared with us what a healthy community looks like, as well as what the challenges and strengths are in your community. Now let's talk about how we can improve your community for the future.

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

Probes:
What are sources of stress or tension in your community?
What do you think is important to address to improve the health of your community?
Instructions: Ensure participants know this is where we want discussion. Capture ideas on flip chart.

Conclusion:

We've come to the end of our time together today. We greatly appreciate your contributions and sharing your thoughts, thank you again for participating in the session. As we mentioned at the beginning, HCWC will be compiling this information with other information to create a Community Health Needs Assessment which will be released in July 2019. HCWC is committed to sharing that report with participants through our organization. If you have any questions after this session, please let us know and we will connect with HCWC to get them answered.

Population Health Methodology

Overview

An important part of the CHNA is the collection and analysis of population morbidity and mortality burdens. To this end, the Data Workgroup developed a robust methodology for collecting and analyzing this data.

Methods for collecting data

Data was collected from the Oregon Public Health Assessment Tool (OPHAT), Community Health Assessment Tool (CHAT) - Washington, and the Oregon State Cancer Registry. The convener was granted direct access to OPHAT and CHAT through partnership agreements with Clackamas and Clark counties, respectively.

Cancer mortality and morbidity information is not available in OPHAT for Oregon counties, therefore the convener collected summarized data on cancer morbidity and mortalities for the Oregon counties from the Oregon State Cancer Registry.

The convener's data scientist collected the necessary data for analysis from each system:

- Mortality by race and ethnicity, per county
- Morbidity by race and ethnicity, per county
- Cancer mortality and morbidity by race and ethnicity, per county

Methods for analyzing data

The data scientist analyzed the data at both the county and regional level for multiple time periods, data was age-adjusted and analyzed by race and ethnicity when that information was available.

The Data Workgroup determined that one-year periods were not appropriate for analyzing Morbidity and Mortality. A five-year period was used for the mortality analysis (2012-2016) and a three-year period for the morbidity analysis (2014-2016). Periods were selected based on data available with more historical data being available for mortality analysis than for morbidities.

Age-adjusted rates are adjusted to the projected 2000 U.S. population. The weights have not been recalculated based on the actual 2000 Decennial Census population because the National Center for Health Statistics still uses the original weights.

The population weights by age group are show in Table B-3.

Table B-3. Population Weights.

Age Group	Weight
Under 1 year	0.013818
1 to 4 years	0.055316
5 to 14 years	0.145563
15 to 24 years	0.138646
25 to 34 years	0.135575
35 to 44 years	0.162614
45 to 54 years	0.134835
55 to 64 years	0.087249
65 to 74 years	0.066035
75 to 84 years	0.044841
85 years and over	0.015509

The age-adjusted rates were analyzed by race and ethnicity for mortalities: White Non-Hispanic; Black Non-Hispanic; Hispanic; Asian Non-Hispanic; Pacific Islander Non-Hispanic; Native American Non-Hispanic; and Two or More Races Non-Hispanic. The White Non-Hispanic population was used as a reference population to determine statistical significance. Statistical significance was determined using a 95% Confidence Interval. The age-adjusted rates were also analyzed for disparities in sex using a rate ratio to determine statistical significance.

Data is suppressed based on the requirements of the data source, with data from OPHAT and CHAT suppressed when numerator is 5 or below and data from the Oregon State Cancer Registry suppressed when it is 10 or below.

Data limitations

Morbidity data is not available by race and ethnicity for Clark County, Washington. Race and ethnicity information was not consistently available between Oregon and Washington and, therefore, was not analyzed regionally for morbidities.

Hospital Discharge Data Methodology

Overview

The Data Workgroup determined that it was important to analyze data from each of the organization types participating in the collaborative to address issues that affect the health system. The Hospital Discharge files for each hospital were determined to be the best source of data about hospital access and usage by the community.

Sample

The descriptive analysis of emergency department (ED) and inpatient primary diagnoses included patient visits between January 1, 2016, and December 31, 2016, and was based on primary diagnosis at discharge. Patient-level hospital discharge data were provided to the convener from:

- Adventist Medical Center Portland
- Legacy Emmanuel Medical Center
- Legacy Good Samaritan Medical Center
- Legacy Mount Hood Medical Center
- Legacy Salmon Creek Medical Center
- Kaiser Foundation Hospital Westside
- Kaiser Foundation Hospital Sunnyside
- Oregon Health & Science University
- PeaceHealth
- Providence Milwaukie Hospital
- Providence Portland Medical Center
- Providence St. Vincent Medical
- Providence Willamette Falls Medical Center
- Tuality

The ED and inpatient analytic samples overall and by county are provided in Tables B-4 and B-5, and only include patients with a primary diagnosis and insurance type reported at discharge.

Table B-4. Total ED Visits by County: 2016.

County	N	%
Clackamas	61,512	17.0%
Clark	71,934	20.0%
Multnomah	156,524	43.5%
Washington	70,165	19.5%
All	**360,135**	**100.0%**

Table B-5. Total Inpatient Stays by County: 2016.

County	N	%
Clackamas	19,838	14.2%
Clark	16,635	11.9%
Multnomah	52,068	37.4%
Washington	50,665	36.4%
All	**139,206**	**100.0%**

Methods for analyzing data

Descriptive analyses of emergency department utilization and inpatient utilization for a select list of conditions were based on patients' primary diagnosis at discharge.

The conditions analyzed were identified by reviewing the ambulatory care sensitive conditions that were analyzed in the previous CHNA and conditions which aligned with HCWC member priorities. The list was narrowed to the top 12 conditions of interest for this analysis.

The codes used for identifying the conditions were based on the CMS Chronic Condition Warehouse and HEDIS Value Sets for the identified conditions. Codes were reviewed by an ICD coding expert employed by the convener.

Data limitations

Data from Legacy hospitals and PeaceHealth did not include a unique identifier for each patient, the analysis included some duplicate records. The data was a point in time of usage of the emergency department and inpatient stays, data was not collected or analyzed regarding the usage of outpatient services for the chronic conditions identified.

Documentation

Table B-6 shows the ICD-10 codes used in data collection.

Table B-6. Code Set.

Conditions	ICD-10 Codes
Asthma	DX J44.0, J44.1, J44.9, J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998,J45.90
Chronic Heart Failure	I42.0, I42.1, I42.2, I42.3, I42.4, I42.5, I42.6, I42.7, I42.8, I42.9, I43, I50.1, I50.20, I50.22, I50.23, I50.30, I50.32, I50.33, I50.40, I50.42, I50.43, I50.810, I50.811, I50.812, I50.813, I50.814, I50.82, I50.83, I50.84, I50.89, I50.9
Chronic Liver Disease/Cirrhosis	K76.89, K76.9, K76.3, K76.0, K74.69, K74.60, K70.31, K70.30, K70.9, K70.2, K70.0, K75.89, K75.9, K75.0, K71.10, K71.9, K71.6, K70.10, K70.11, K73.0, K73.1, K73.2, K73.8, K73.9, K74.0, K74.1, K74.2, K74.3, K74.4, K74.5, K75.4, K71.6, K71.9, K75.0, K75.9, K75.89, K76.3, K76.9,K74.69
Chronic Obstructive Pulmonary Disease (COPD)	J410, J411, J449, J441, J440, J418, J42, J439, J479, J471, J449, J209, J210, J218
Depression	F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.75, F31.76, F31.77, F31.78, F31.81, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.9, F34.1, F43.21, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.75, F31.76, F31.77, F31.78, F31.81, F34.1, F43.21
Diabetes	E08.00, E08.01, E08.10, E08.11, E08.21, E08.22, E08.29, E08.311, E08.319, E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359, E08.36, E08.39, E08.40, E08.41, E08.42, E08.43, E08.44, E08.49, E08.51, E08.52, E08.59, E08.610, E08.618, E08.620, E08.621, E08.622, E08.628, E08.630, E08.638, E08.641, E08.649, E08.65, E08.69, E08.8, E08.9, E09.00, E09.01, E09.10, E09.11, E09.21, E09.22, E09.29, E09.311, E09.319, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E09.36, E09.39, E09.40, E09.41, E09.42, E09.43, E09.44, E09.49, E09.51, E09.52, E09.59, E09.610, E09.618, E09.620, E09.621, E09.622, E09.628, E09.630, E09.638, E09.641, E09.649, E09.65, E09.69, E09.8, E09.9, E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.3211, E10.3212, E10.3213, E10.3219, E10.3291, E10.3292, E10.3293, E10.3299, E10.3311, E10.3312, E10.3313, E10.3319, E10.3391, E10.3392, E10.3393, E10.3399, E10.3411, E10.3412, E10.3413, E10.3419, E10.3491, E10.3492, E10.3493, E10.3499, E10.3511, E10.3512, E10.3513, E10.3519, E10.3521, E10.3522, E10.3523, E10.3529, E10.3531, E10.3532, E10.3533, E10.3539, E10.3541, E10.3542, E10.3543, E10.3549, E10.3551, E10.3552, E10.3553, E10.3559, E10.3591, E10.3592, E10.3593, E10.3599, E10.36, E10.37x1, E10.37x2, E10.37x3, E10.37x9, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.10, E11.11, E11.21, E11.22, E11.29, E11.311, E11.319, E11.3211, E11.3212, E11.3213, E11.3219, E11.3291, E11.3292, E11.3293, E11.3299, E11.3311, E11.3312, E11.3313, E11.3319, E11.3391, E11.3392, E11.3393, E11.3399, E11.3411, E11.3412, E11.3413, E11.3419, E11.3491, E11.3492, E11.3493, E11.3499, E11.3511, E11.3512, E11.3513, E11.3519, E11.3521, E11.3522, E11.3523, E11.3529, E11.3531, E11.3532, E11.3533,

Coordinated Care Organization Methodology

Overview

The Data Workgroup determined that it was important to analyze data from each of the organization types participating in the collaborative to address issues that affect the health system. Due to the mid-cycle closure of FamilyCare Coordinated Care Organization, that left Health Share of Oregon as the single entity from which to receive this data. Health Share hosts a data tool for their partners known as Bridge. Because Bridge 2.0 was still in development, data were requested directly from Health Share of Oregon.

Methods for collecting data

Aggregated, unduplicated data for Health Share of Oregon members were requested for the calendar years 2016 and 2017 using the same ICD-10 codes referenced earlier in Table B-6. Members were included in the aggregated file if the condition was diagnosed in any position on the claim (1–13) and occurred one or more times during the year of inquiry.

Member age was calculated at the end of each inquiry period (December 31 in 2016 and 2017). County, race, and gender were based on the most recently known value. Subpopulation data were suppressed if the count was low (< 10).

Methods for analyzing data

Data were analyzed descriptively by race and gender, comparing the calendar years 2016 and 2017.

Data limitations

The data did not allow for a lookback period and is a point-in-time count of certain conditions and should not be compared to previous analyses done by HCWC.

Appendix C: Social Determinants of Health – Additional Information

This appendix contains additional information about influencers of change in the quad-county region, and further information about education and literacy than what is included in the main report.

Influencers of Change

Issues affecting the quad-county region are driven by both local, state and nationwide issues and policies. This section attempts to identify and summarize some of these forces of change.

Events: one-time occurrences, such as natural disaster or passage of legislation

Elections, both nationally and at the state level, change policies and funding streams to address, support and move toward community solutions. In both states of the quad-county region, barriers to receiving health care are being addressed by coordinated care organizations (Oregon) and accountable communities of health (Washington) but challenges remain. In both states, even in this urban setting, the outlying rural areas experience isolating factors related to both community spaces and isolation.

Behavioral health

Behavioral health encompasses both mental health and substance use conditions. Behavioral health issues are a continuing need for both resources and coordination in the region. Efforts in the legislature, as well as in health care delivery systems, city and county supports, and community-based organizations continue. Oregon's recent passage of House Bill 4143 (HB 4143) requires a study of barriers to effective treatment for, and recovery from, substance use disorders including opioids and opiates. A report of recommendations is due to the legislature no later than June 30, 2018.[1]

In Washington, SB 6491 aims to increase the availability of assisted outpatient behavioral health treatment. This bill, effective April 1, 2018, also covers many other aspects of crisis responder decisions and involuntary treatment.[2]

[1] Oregon State Legislature. 2018 Regular Session.
https://olis.leg.state.or.us/liz/2018R1/Measures/Overview/HB4143
[2] Washington State Legislature. SB 6491. 2017-2018.
https://app.leg.wa.gov/billsummary?BillNumber=6491&Year=2017

Community representation and culturally responsive care

An issue continually raised during the HCWC listening sessions, as well as in other reports in the region (see the Literature Review in Appendix D), was the lack of adequate community representation, culturally responsive care, and community spaces. While no specific legislation addresses these issues at a granular level, various regional reports mention these priorities and the work being done to address these disparities by rethinking the systems and structures that created them. Communities have been invited into that conversation.[3]

Clark County and Washington State agencies also continue to focus on diversifying state staff to reflect the communities they serve. Continuing to improve and enhance the equity and inclusion mission by reflecting it in staff and values to better represent, understand, and serve communities.[4] Culturally responsive care is one of the core issues identified in this report. While there is ongoing work this arena, the focus, formality, and rigor differ. It is a known gap and area for improvement in the quad-county region.

Isolation

Isolation can affect those living not just rural areas, but urban areas as well. Isolation can limit access to services, housing (due to availability, cost or access), transportation, and community places.

No specific legislation addresses all these issues in either state. In Oregon, House Bill (HB) 4130 established a grant program for the Department of Education to award grants to school districts for percentage of transportation costs when the district does not receive any amount from the State School fund related to transit activities. The goal is to have funding for educational transportation in challenged areas.[5]

HB 4010 established a task force to address racial disparities in home ownership – another isolation and equity issue.[6] HB 4006 requires the Housing and Community Services Department to annually provide each city with populations greater than 10,000, data showing the percentage of renter households that are severely rent burdened.[7]

In Washington State, the Clark County Commission on Aging spent a year learning about local transportation and access for senior citizens. Lack of connectivity was an issue as people sought alternatives to driving that wouldn't limit their ability to go about their daily lives, maintain independence, and interact with their community. All recommendations are being evaluated.[8]

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[3] Oregon Metro. Strategic Plan to Advance Racial Equity, Diversity and Inclusion. June 2016. https://www.oregonmetro.gov/sites/default/files/2017/10/05/Strategic-plan-advance-racial-equity-diversity-inclusion-16087-20160613.pdf

[4] Washington State Department of Health. Diversity and Inclusion Council Strategic Plan. Jan.-Feb. 2018. https://www.doh.wa.gov/Portals/1/Documents/9400/Diversity%20and%20Inclusion%20Council%20Strategic%20Plan%202017-2018.pdf

[5] Oregon House Bill 4130. 2018 Oregon Legislative Session. https://gov.oregonlive.com/bill/2018/HB4130/

[6] Oregon House Bill 4010. 2018 Oregon Legislative Session. https://gov.oregonlive.com/bill/2018/HB4010/

[7] Oregon House Bill 4006. 2018 Oregon Legislative Session. https://gov.oregonlive.com/bill/2018/HB4006/

[8] Hastings P. Report Urges Clark County to Help Aging Population Stay Connected to the Community. *The Columbian.* Jan. 2019. https://www.columbian.com/news/2019/jan/16/report-urges-clark-county-to-help-aging-population-stay-connected-with-community/

Housing

Housing continues to be an issue that continues to be addressed, focused on, financed, and collaborated on in the quad-county region. In Oregon, one recent bill, Senate Bill 608 (SB 608), passed in February 2019, makes Oregon the first state in the nation with statewide rent control.

Washington State passed House Bill 1570 concerning access to housing and assistance.[9] This law became effective June 7, 2018.

Additionally, Washington passed SHB 2538, exempting Impact Fees for Low-Income Housing Development, by limiting the definition of "development activity" to exclude shelters for homeless and domestic violence victims for impact fee purposes.

Trends: Migration and gentrification

In both Oregon and Washington, migration and gentrification are ongoing issues. The State of Washington's population grew by 1.6% as of April 2018. Migration accounted for 71% of the state's population growth this year.[10] Clark County, Washington, exceeded Multnomah County for new residents in 2017, growing by 1.95 percent.[11] Ranking sources vary, but Oregon and Washington continue to be in the top 10 "inbound states" in the nation (the most population influx/people moving there).[12] Oregon's population increased more than 10% between 2000 and 2010, and the Portland Metro area continues to outpace the national average for population growth. As with Washington, the increased population can bring economic stability, but also exacerbate scarcity issues and vulnerabilities.

As regions with historically majority white populations (after settlement) and long histories of racism and discrimination, the increase in diversity is positive for the region. It also exacerbates the positive and negative economic factors the quad-county region is continually trying to tackle. It is an economic boon in some sectors, and increases the needs and impacts to others. Exploding growth has caused housing prices to increase past the reach of many community members, contributing to an increase in houselessness that continues to be a focus for health care delivery, public health, and legislative sectors.

Washington and Oregon continue to have higher than average unemployment and underemployment.[13,14]

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[9] Washington State Legislature. HB 1570. 2017-2018. https://app.leg.wa.gov/billsummary?BillNumber=1570&Year=2017

[10] Washington State Office of Financial Management. Strong population growth in Washington continues. June 2018. https://www.ofm.wa.gov/about/news/2018/06/strong-population-growth-washington-continues

[11] Hastings P. Clark County outpaces Multnomah County for new residents. *The Columbian*. Mar. 2018. https://tdn.com/news/state-and-regional/clark-county-outpaces-multnomah-county-for-new-residents/article_81b6f1ad-ec21-5532-b2a0-e0bc99cfdcb4.html

[12] CNY Central. Movers study: New York ranks fourth in "Most Moved from States." Jan. 2019. https://cnycentral.com/news/local/movers-study-new-york-ranks-fourth-in-most-moved-from-states

[13] World Population Review. 2019. http://worldpopulationreview.com/us-cities/portland-population/

[14] Washington State Office of Financial Management. Unemployment Rates: Washington and U.S. https://www.ofm.wa.gov/washington-data-research/statewide-data/washington-trends/economic-trends/unemployment-rates

Other forces shaping quad-county region

Natural events also impact lives in the Pacific Northwest. Droughts and other natural disasters affect all communities, especially vulnerable populations. The wildfire season along the West Coast continues to intensify each year at great cost to property, human lives/health, and natural areas. Wildfire smoke exacerbates health concerns and conditions, such as asthma, and flooding displaces many temporarily or permanently from their homes. Climate change patterns are predicted to continue creating more extreme weather patterns that will exacerbate many issues and make them a more constant than intermittent issue. The region continues to grapple with effective planning for predicted earthquakes of significant magnitude.

Education and Literacy

Education is a powerful driver of wellness and can improve health outcomes, health behaviors, and social outcomes into adulthood.[15] Achievement gaps are evident in children as young as nine months old,[16] suggesting that early childhood services and education are necessary to correct gaps.

This sentiment was echoed by participants in listening sessions who talked about wanting skills and education development to provide better employment opportunities for community members, especially those with limited access to housing or stable income. The education profile of the region includes early childhood education, language, literacy, high school graduation, and higher education.

Literacy

Literacy is related to multiple facets of health. Limited literacy is a barrier to health knowledge access, proper medication use, and utilization of preventive services.[17,18,19] Individuals with limited literacy face additional difficulties following medication instructions, communicating with health care providers, and attaining health information which may have negative implications for health.[20]

Regarding youth literacy in the region, 56% of students in all grades met the Oregon's English Language Arts standard in 2016–2017. In the same year in Washington's Clark County, 67% of Grade 10 students met the state's English Language Arts standard.

Early childhood education

Early childhood programs are critical for fostering the mental and physical development of young children. High-quality early childhood development and education programs include highly educated teachers, smaller classes, and lower child-staff ratios. These programs have been shown to increase a child's earning potential later in life and encourage and support educational attainment throughout childhood and into adulthood. Between 2012 and 2016, 6.5% of preschool age children were enrolled in nursery school or preschool across the region (note: this does not include day care or other sorts of child care; just preschools and nursery schools).

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[15] Robert Wood Johnson Foundation. Can Early Childhood Interventions Improve Health and Well-Being? Mar. 2016. https://www.rwjf.org/en/library/research/2016/03/can-early-childhood-interventions-improve-life-outcomes-.html

[16] http://allhandsraised.org/content/uploads/2012/10/AN20UNSETTLING20PROFILE.pdf

[17] Andrulis DP, Brach C. Integrating literacy, culture, and language to improve health care quality for diverse populations. *Am J Health Behav.* 2007; 31(Suppl 1): S122-S133.

[18] Kripalani S, Henderson LE, Chiu EY, Robertson R, Kolm P, Jacobson TA. Predictors of medication self-management skill in a low-literacy population. *J Gen Intern Med*. 2006; 21(8): 852–56.

[19] Berkman ND., Sheridan SL, Donahue KE, Halpern DJ, Viera A, Crotty K, Holland A. Health literacy interventions and outcomes: an updated systematic review. 2011; 1-941. Report no.: 199.

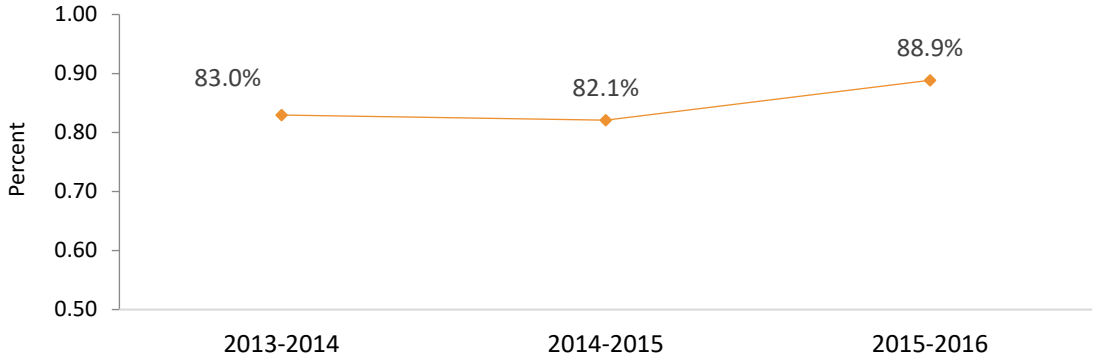
[20] Williams MV, Baker DW, Honig EG, Lee TM, Nowlan A. Inadequate literacy is a barrier to asthma knowledge and self-care. *Chest*. 1998; 114(4):1008–15.

High school graduation

Increased educational attainment provides individuals with the opportunity to earn a higher income and gain access to better living conditions, healthier foods, and health care services.[21-22] Moreover, the employment prospects and lifelong earning potential are better for high school graduates.[23]

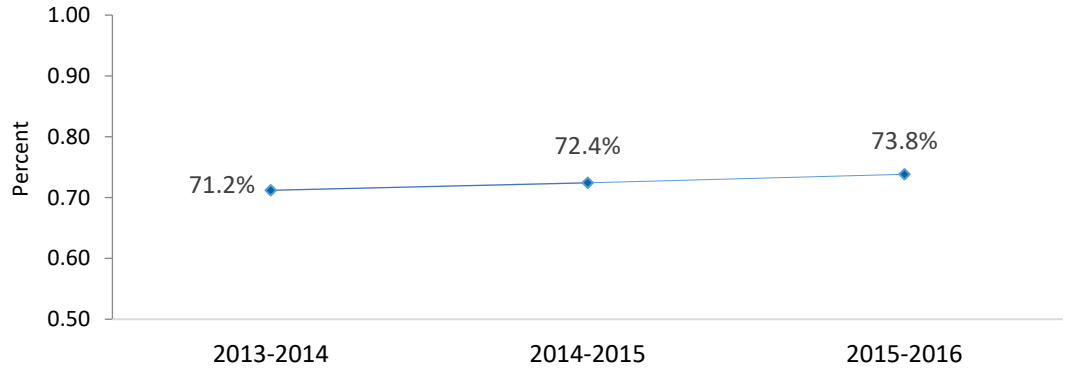
As shown in Figure C-1, five-year graduation rates in Clark County, Washington, have been increasing since 2013.

Figure C-1. Five-Year Graduation Rate in Clark County.



Source: Washington Office of Superintendent of Public Instruction.

Figure C-2. Four-Year Graduation Rate in Clackamas, Multnomah, and Washington Counties.



Source: Oregon Department of Education.

[21] Ross CE, Wu CL. The links between education and health. *Am Sociol Rev*. 1995; 60(5):719–45.
[22] Day JC, Newburger EC. The big payoff: educational attainment and synthetic estimates of work-life earnings. Special Studies. Current Population Reports. Washington (DC): U.S. Census Bureau; 2002. Report No.: P23-210.
[23] Levin H, Belfield C, Muennig P, Rouse C. The costs and benefits of an excellent education for all of America's children (Vol. 9): Teachers College, Columbia University New York; 2007.

Higher education

Higher education can lead to improved health and well-being through a positive impact on employment options, better-paying jobs with fewer safety hazards, and better access to housing.[24] Higher education also can lead to improved health and well-being.[25] Individuals with more education are less likely to report chronic conditions including heart disease, high blood pressure, diabetes, anxiety, and depression.[26]

Across the quad-county region, nearly half of the population has at least an associate's degree and almost one quarter of the population has a bachelor's degree (see Table C-1).

Table C-1. Higher Education in the Region.

Degree	n	%
Associate	11,838	8.9%
Bachelor	78,748	23.9%
Graduate or professional degree	31,279	14.7%
Total	**121,865**	**47.5%**

Source: American Community Survey 5-Year estimate (2012–2016).

[24] Kawachi I, Adler NE, Dow WH. Money, schooling, and health: mechanisms and causal evidence. *Ann NY Acad Sci.* 2010; 1186(1):56–68.
[25] Cutler DM, Lleras-Muney A. Education and health: evaluating theories and evidence. No. W12352. Cambridge (MA): National Bureau of Economic Research; 2006.
[26] Cutler DM, Lleras-Muney A. Education and health: evaluating theories and evidence. No. W12352. Cambridge (MA): National Bureau of Economic Research; 2006.

Appendix D: Listening Sessions: Self-Reported Demographic Information

This appendix contains the demographics of the HCWC listening session participants, presented below as they were self-reported by the participants.

Table D-1 shows participants' gender identities.

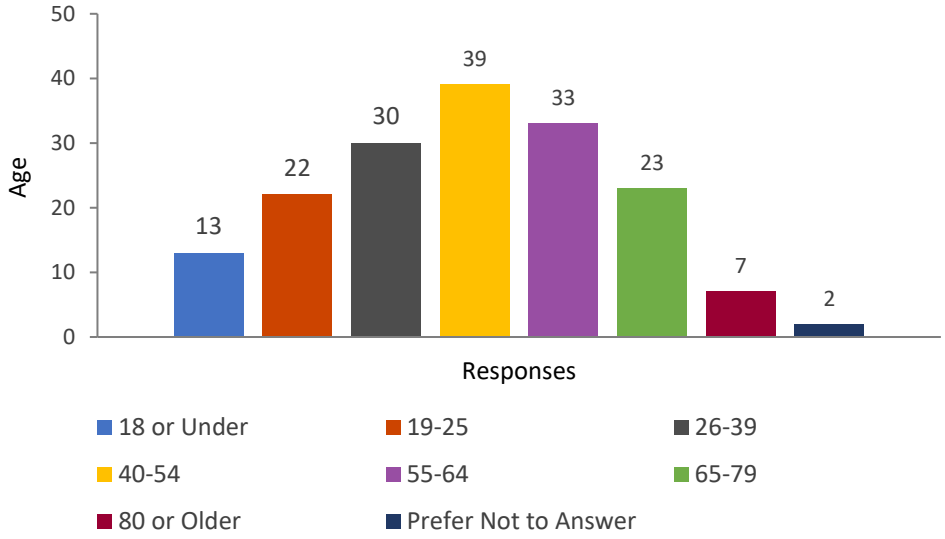
Table D-1. Participants' Gender Identity (N=170).

Gender Identity	Responses
Male	85
Female	71
Non-Binary	4
Two-Spirit	2
Female, Trans	2
Gender Non-Conforming	1
Trans	1
Male, Non-Binary, Two-Spirit	1
Trans, Non-Binary, Other: Black	1
Other: Agender	1
Other: Why	1

Below are the participants' age groups (also shown in Figure D-1):

- 18 or Under 13
- 19–25 22
- 26–39 30
- 40–54 39
- 55–64 33
- 65–79 23
- 80 or older 7
- Prefer not to answer 2
- Blank 1

Figure D-1. Participants' Ages, by Group (N=170).*



**There was one blank response.*

The following tables show sexual orientation, ethnicity, racial groups, birthplace, and primary language (Tables D-2 to D-6).

Table D-2. Sexual Orientation (N=170).

Sexual Orientation	Responses*
Asexual	4
Bisexual	5
Gay	15
Gay, Bisexual, Pansexual, Heterosexual, Asexual	1
Gay, Queer	1
Heterosexual	83
Heterosexual, Asexual, Questioning or Unsure	1
Lesbian	2
Lesbian, Queer	1
Other	8
Other: Demi-everything	1
Pansexual	3
Prefer Not to Answer	14
Queer	4
Queer, Asexual	1
Questioning or Unsure	2

**There were 24 blank responses.*

Table D-3. Ethnicity (n=170).

Ethnicity	Responses*
Hispanic	39
Non-Hispanic	111

**There were 20 blank responses.*

Table D-4. Racial Groups (N=170).

Racial Group	Responses*
African American	15
African (Black)	4
African American, African (Black)	1
African American, Other, Unknown	1
All	1
American Indian	6
American Indian, African American	2
American Indian, African American, Other White, Other Asian, Other: Mongolian	1
American Indian, Hispanic or Latino Mexican, Japanese, Other Pacific Islander, African American, Western European	1
American Indian, Hispanic or Latino Mexican, Other White	1
American Indian, Indigenous Mexican, Central American or South American, Hispanic or Latino Mexican, Other Asian	1
American Indian, Indigenous Mexican, Central American or South American, Hispanic or Latino Mexican, Western European, Northern African	1
American Indian, Indigenous Mexican, Central American or South American, Hispanic or Latino Mexican, Unknown	1
American Indian, Other Pacific Islander, Western European	1
American Indian, Western European, Eastern European	1
Caribbean	1
Declined to answer	2
Eastern European	3
Filipino/a	1
Filipino/a, Native Hawaiian	1
Filipino/a, Samoan	1
Hispanic or Latino Central American, African American, Western European	1
Hispanic or Latino Mexican	20
Hispanic or Latino Mexican, Western European	2
Hispanic or Latino South American	1
Indigenous Mexican, Central American or South American	1
Indigenous Mexican, Central American or South American, Hispanic or Latino Mexican	8

Racial Group	Responses*
Indigenous Mexican, Central American or South American, Hispanic or Latino Mexican, Native Hawaiian, African (Black), Other White	1
Japanese	1
Middle Eastern	13
Native Hawaiian	1
Northern African	1
Other Asian	2
Other Asian, Middle Eastern	3
Other Black: Black American	1
Other Hispanic or Latino, African American, African (Black), Eastern European	1
Other Pacific Islander, Western European	1
Other White	13
Samoan	2
Samoan, Other Pacific Islander	1
Unknown	1
Vietnamese	1
Vietnamese, African American, Western European, Eastern European	1
Vietnamese, Western European	1
Western European	23
Western European, Other White	5
Western European, Slavic	1
White	3

**There were 13 blank responses.*

Table D-5. Birthplace (N=170).

Birth to age 16 location	Responses*
Inside the U.S.	116
Outside the U.S.	44
Prefer not to answer	2
The colonized country of Hawaii	1

**There were 7 blank responses.*

Table D-6. Primary Language (N=170).

Primary Language Spoken at Home	Responses*
Arabic	14
Arabic, Other	2
English	101
English, Arabic	2
English, Arabic, Other: Kurdish	1
English, Other: Somali	1
English, Russian, Arabic	1
English, Spanish or Spanish Creole	5
English, Tagalog	2
English, Vietnamese	1
Japanese	1
Other	2
Other: Samoan	1
Spanish or Spanish Creole	28
Spanish or Spanish Creole, Mixteco	1
Vietnamese	1

**There were 6 blank responses.*

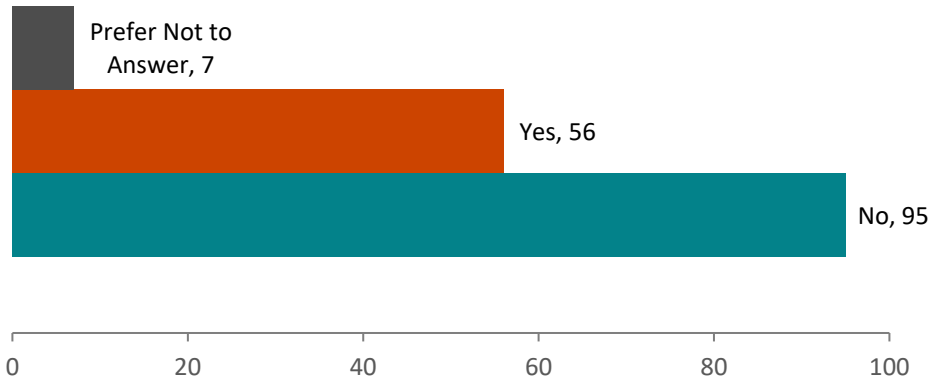
Table D-7 shows participants' veteran status, Figure D-2 shows disability status, and Figure D-3 shows education level.

Table D-7. Veteran Status (N=170).

Veteran	Responses*
No	138
Yes	20
Prefer not to answer	1

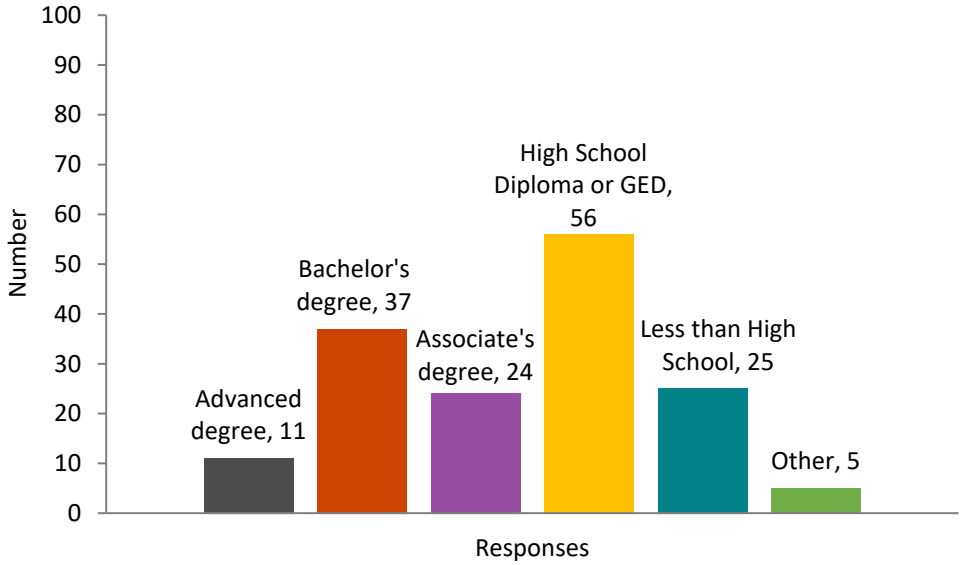
**There were 11 blank responses.*

Figure D-2. Disability Status (N=170).*



**There were 12 blank responses.*

Figure D-3. Education Level (N=170).*

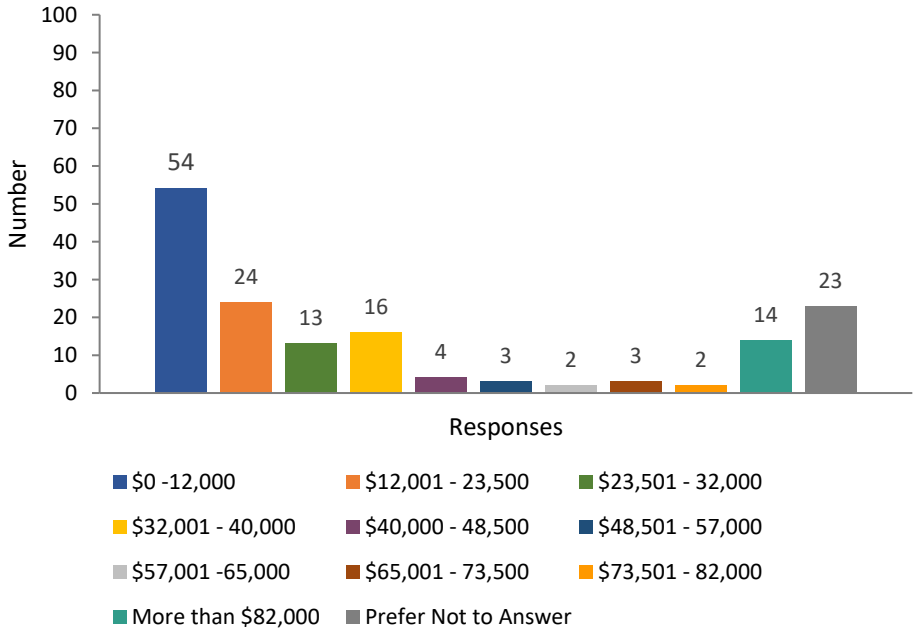


**There were 12 blank responses.*

Below are the household income ranges for participants (also shown in Figure D-4):

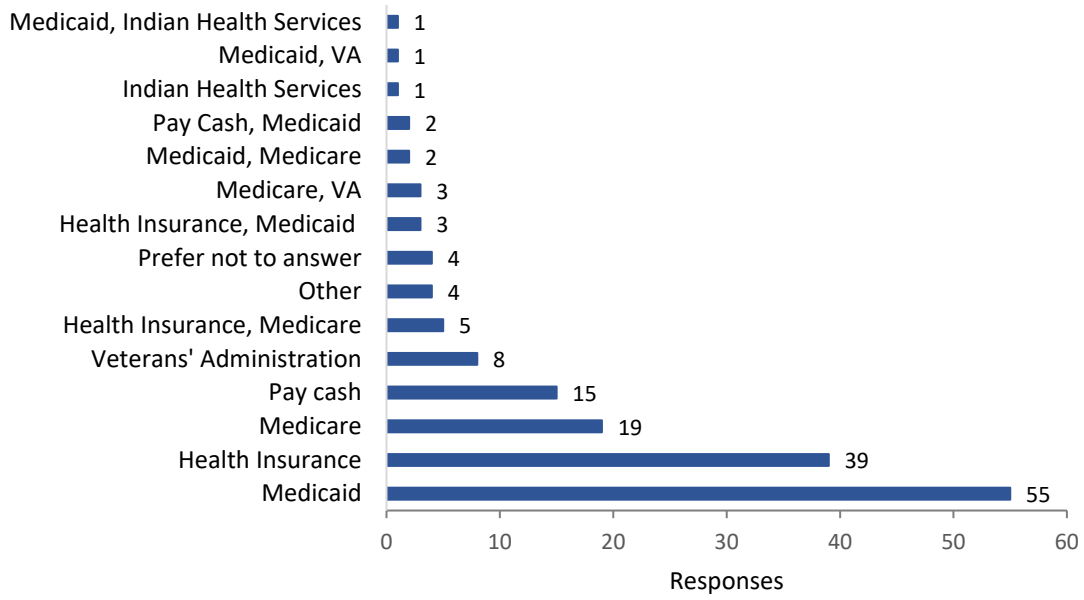
- $0 –12,000 54
- $12,001–23,500 24
- $23,501–32,000 13
- $32,001–40,000 16
- $40,000–48,500 4
- $48,501–57,000 3
- $57,001–65,000 2
- $65,001–73,500 3
- $73,501–82,000 2
- More than $82,000 14
- Prefer Not to Answer 23
- Blank 12

Figure D-4. Household Income (N=170).*



**There were 12 blank responses.*

Figure D-5. Types of Insurance (N=170).*



**There were 8 blank responses.*

Appendix E: Additional Health Data

This appendix contains additional data not included in the main report.

Provider Ratios by County

Data from County Health Rankings shows that across the United States, the top-performing counties have a primary care provider to population ratio of 1:1,030. Only one county in the quad-county region, Multnomah, has a better ratio than that, with Clark County having significantly fewer primary care providers per population.

Table E-1. Ratio of Primary Care Physicians to Population.

County	Ratio
Clark, WA	1:1527
Clackamas, OR	1:1128
Multnomah, OR	1:712
Washington, OR	1:1092
Top U.S. Performers	1:1030

Source: County Health Rankings 2018.

Similar ratios are found with dentists across the region. With only Multnomah and Washington counties having a better dentist to population ratio than the top-performing U.S. counties.

Table E-2. Ratio of Dentists to Population.

County	Ratio
Clark, WA	1:1502
Clackamas, OR	1:1287
Multnomah, OR	2:1055
Washington, OR	1:1089
Top U.S. Performers	1:1280

Source: County Health Rankings 2018.

Insurance Coverage

Table E-3. Percentage of Population with Health Insurance.

County	Percent
Clark, WA	90.7%
Clackamas, OR	91.9%
Multnomah, OR	89.6%
Washington, OR	90.5%
Region	**90.5%**

Source: American Community Survey 5-year estimate 2012–2016.

Table E-4. Percentage of Population Under 18 without Health Insurance.

County	Percent
Clark - Washington	4.1%
Clackamas – Oregon	3.9%
Multnomah- Oregon	3.0%
Washington – Oregon	3.8%
Region	**3.6%**

Source: American Community Survey 5-year estimate 2012–2016.

As shown below, over 10% of the population in every county reported not being able to access health care services due to the cost.

Table E-5. Percentage of population unable to see a health care provider in the last year due to cost.

County	Percent
Clark - Washington	11.1%
Clackamas – Oregon	13.2%
Multnomah- Oregon	14.3%
Washington – Oregon	12.4%
Region	**12.8%**

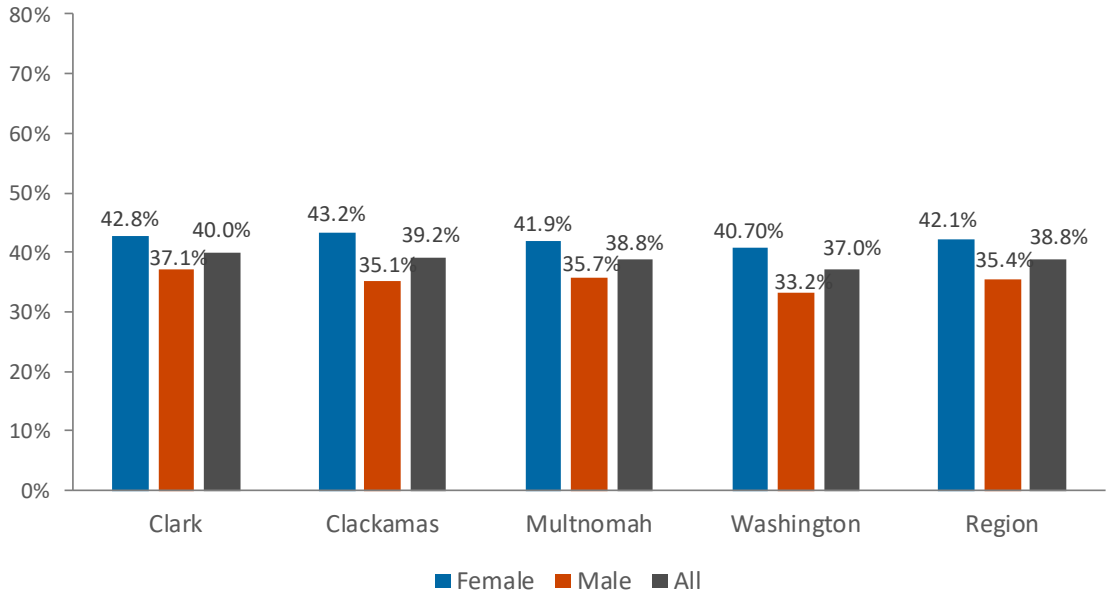
Source: BRFSS, 2012–2015.

Vaccinations

Influenza

As shown in the chart below, nearly 40% of population in the quad-county reported being vaccinated for influenza, with more females than males reporting vaccination—42% and 35%, respectively, for the region.

Figure E-1. Influenza Vaccination by Sex.

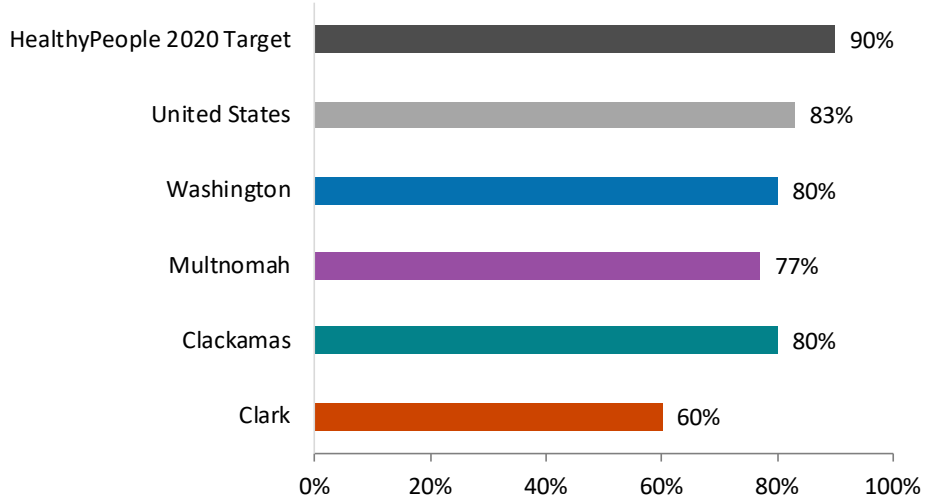


Source: BRFSS (2012–2015).

Diphtheria, Tetanus, and Pertussis (DTaP)

The percentage of children who are receiving the recommended four doses of the DTaP vaccine varies across the quad-county region, with all counties falling well below the HealthyPeople 2020 target (see Figure E-2).

Figure E-2. Children who Received Four Doses of DTaP.



Note: Oregon age = 2 years; Washington age = 19–35 months.

Communicable Diseases

Communicable diseases are infections, usually viral or bacterial, that are spread from person to person. Figures E-3–E-5 present the crude incidence rates for the 10 most common communicable diseases in the region, grouped by their level of prevalence in the region.

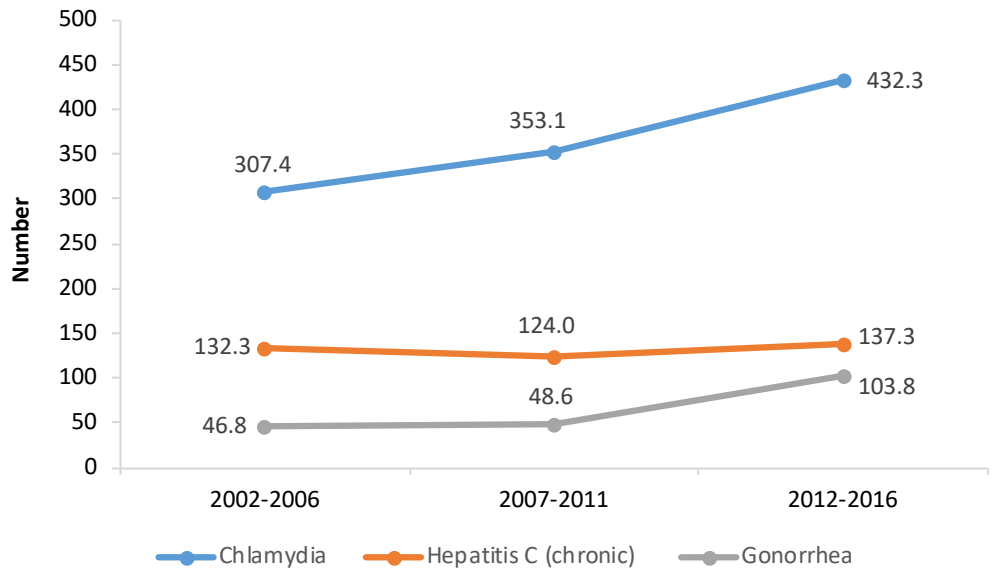
Between 2002 and 2016, the incidence of the following communicable diseases **increased**:

- **Chlamydia**: a sexually transmitted disease
- **Gonorrhea**: a sexually transmitted disease
- **Campylobacteriosis:** a foodborne illness or contaminated water
- **Giardiasis:** an infection in the small intestine from contaminated food or water
- **Pertussis:** whooping cough

During the same period, focusing the incidence of the following communicable diseases **decreased**:

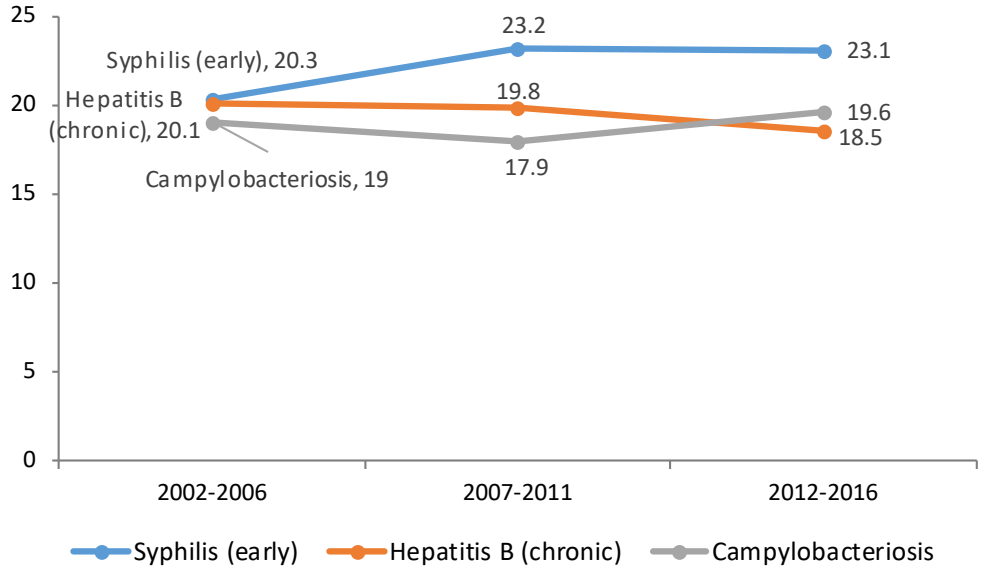
- **Hepatitis B:** chronic inflammation of the liver transmitted through infected blood, unprotected sex, unsterile or contaminated needle, or from an infected woman to her newborn during childbirth
- **HIV/AIDS**[1]

Figure E-3. Communicable Diseases with the Highest Prevalence.



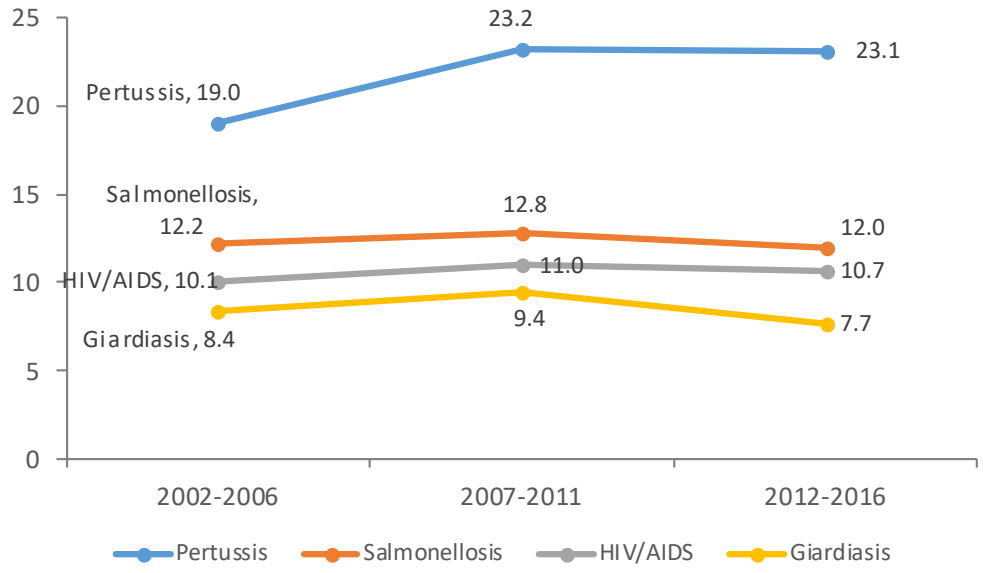
Source: Oregon Public Health Assessment Tool (OPHAT) and Community Health Assessment Tool (CHAT).

Figure E-4. Communicable Diseases with Moderate Prevalence.



Source: Oregon Public Health Assessment Tool (OPHAT) and Community Health Assessment Tool (CHAT).

Figure E-5. Communicable Diseases with Lower Prevalence.



Source: Oregon Public Health Assessment Tool (OPHAT) and Community Health Assessment Tool (CHAT).

Chronic Disease and Other Conditions in Emergency Departments

Chronic disease accounts for two-thirds of emergency medical conditions and roughly 80% of all health care costs. The analysis of emergency department (ED) chronic conditions included visits between January 1, 2016, and December 31, 2016, and is based on patients' primary diagnosis at discharge. Because data from Legacy hospitals and PeaceHealth did not include a unique identifier for each patient, the analysis included some duplicate records.

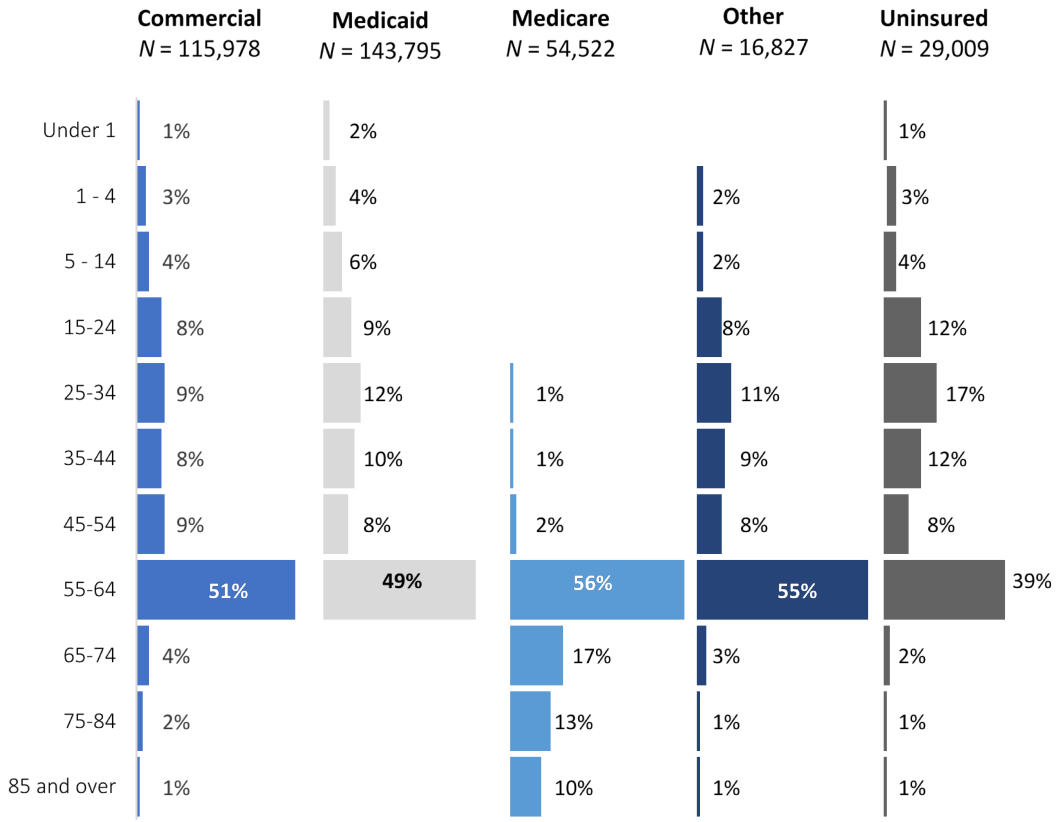
Patient-level hospital discharge data were provided by:

- Adventist Medical Center Portland
- Legacy Emmanuel Medical Center
- Legacy Good Samaritan Medical Center
- Legacy Mount Hood Medical Center
- Legacy Salmon Creek Medical Center
- Kaiser Foundation Hospital Westside
- Kaiser Sunnyside Medical Center
- Oregon Health Sciences University
- PeaceHealth
- Providence Milwaukie Hospital
- Providence Portland Medical Center
- Providence St. Vincent Medical
- Providence Willamette Falls Medical Center
- Tuality

Insurance type by age

As shown in Figure E-6, about half of insured ED patients were between the ages of 55 and 64. The majority of patients who were uninsured were under 55 years old (57%).

Figure E-6. Emergency Department Patients by Insurance Type and Age Group.

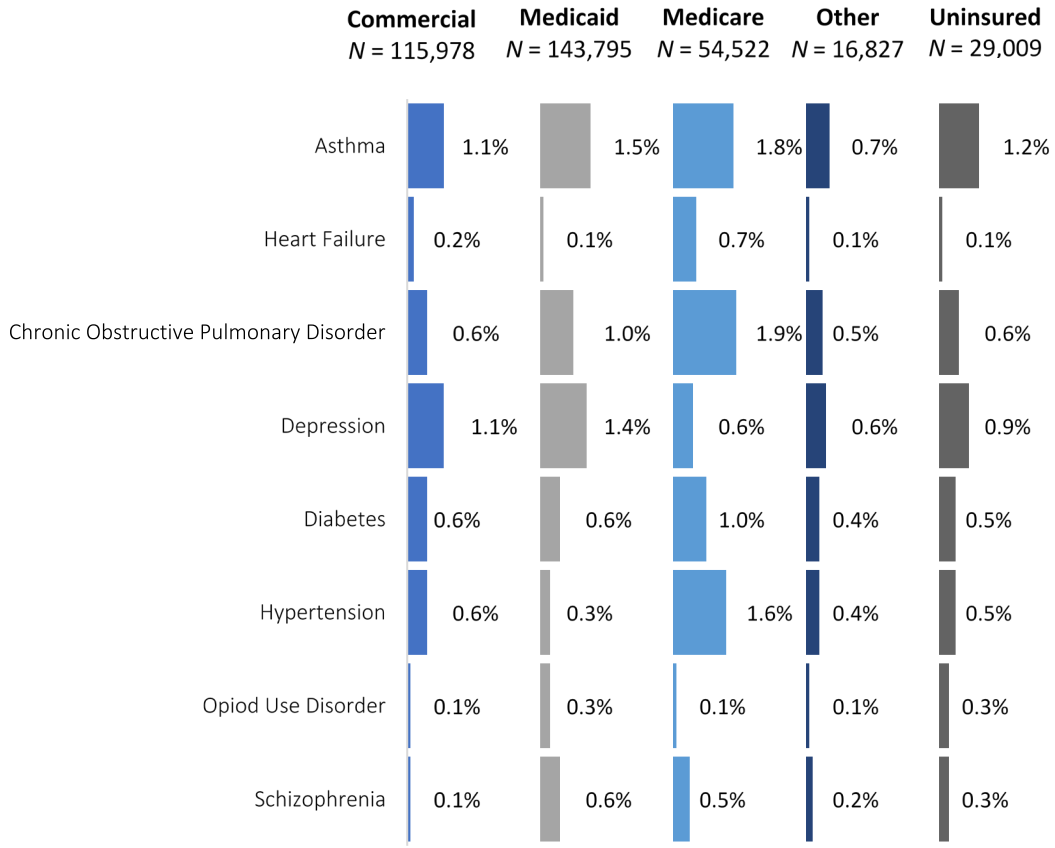


Source: Hospital Discharge Data 2016.

Chronic disease and other conditions by insurance type

As shown in Figure E-7, patients tended to use the ED for asthma, chronic obstructive pulmonary disorder, and depression. Patients with insurance coverage through Medicare were diagnosed at discharge with heart failure, diabetes, and hypertension more frequently than patients covered by other insurance types.

Figure E-7. Emergency Department Utilization for Chronic Conditions.



Source: Hospital Discharge Data 2016.

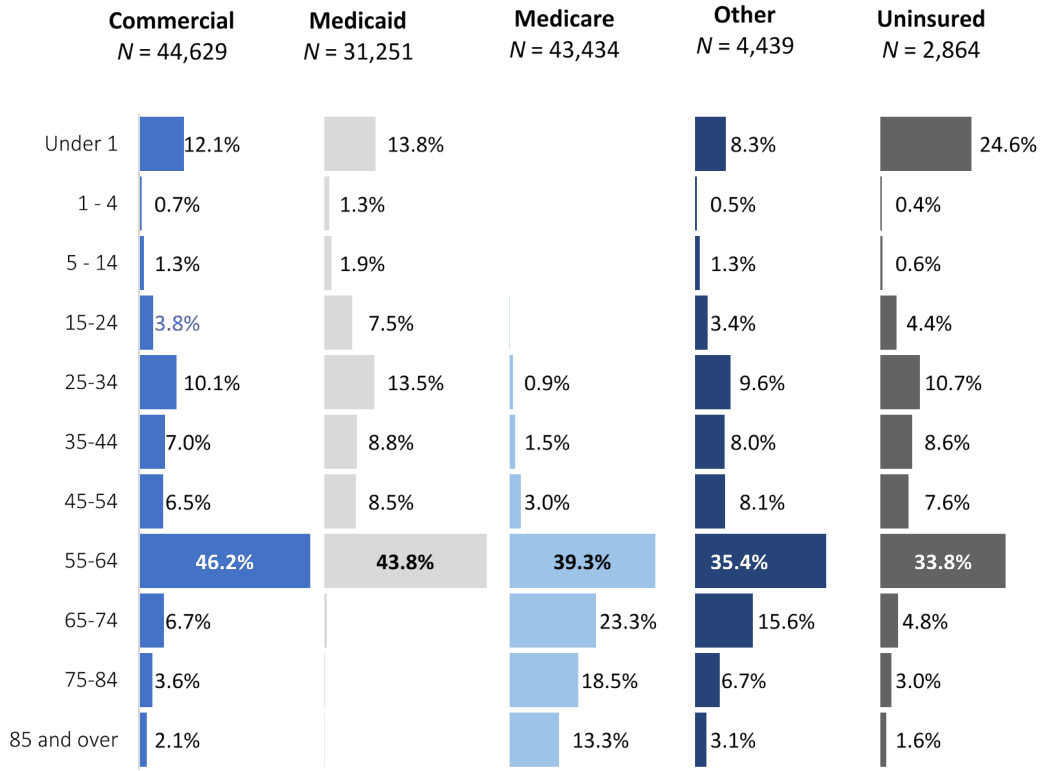
Chronic diseases and other conditions for inpatients

Regional inpatient discharge data from the calendar year 2016 was analyzed to identify if inpatient utilization differed by age and insurance type. Next, the same data were analyzed to assess the degree to which chronic conditions varied by insurance type.

Insurance type by age

As shown in Figure E-8, the greatest number of patients seen as inpatients for chronic conditions were insured by either commercial insurance or Medicare. Most insured patients discharged from inpatient units were between the ages of 55 and 64. The next most frequent age range was between 25 and 34 years old.

Figure E-8. Inpatient Stays by Insurance Type.

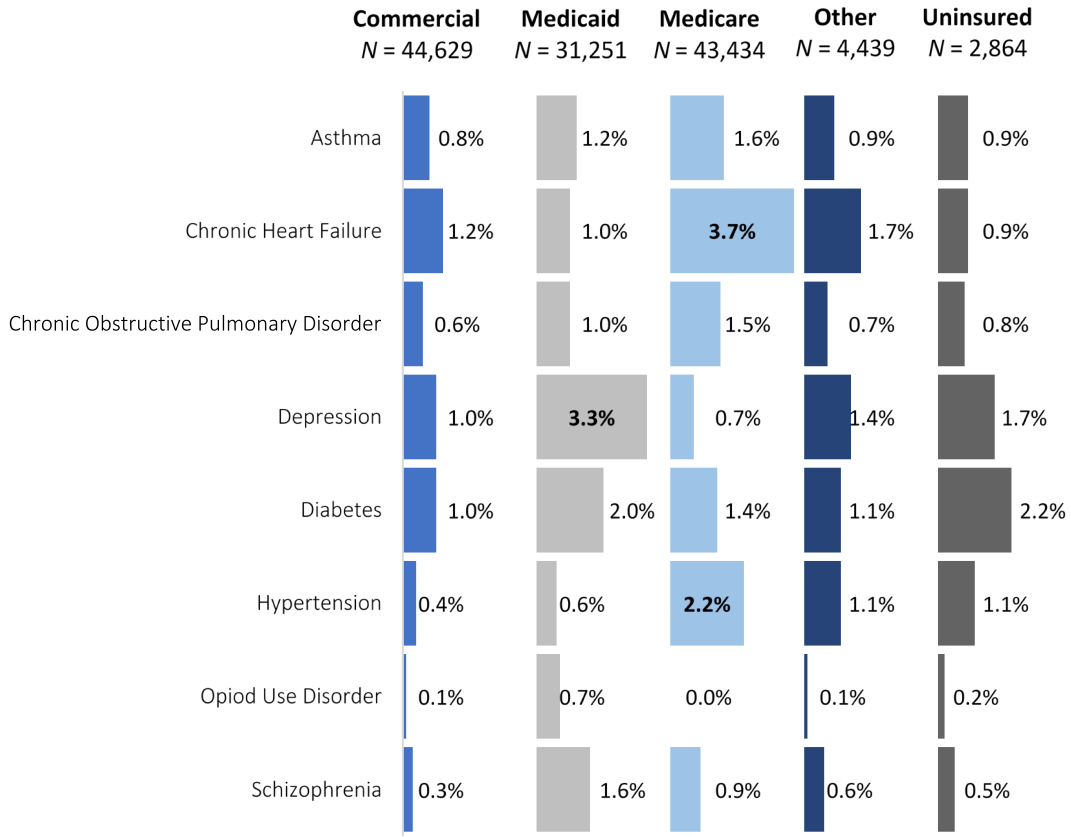


Source: Hospital Discharge Data 2016.

Chronic diseases and other conditions by insurance type

As shown in Figure E-9, people tended to be in inpatient units for heart failure, depression and diabetes. Those with insurance coverage through Medicare were diagnosed with chronic heart failure, chronic obstructive pulmonary disorder and hypertension at a greater frequency than people covered by other insurance types.

Figure E-9. Primary Diagnosis when Discharged from an Inpatient Stay.



Source: Hospital Discharge Data 2016.

Appendix F – Literature Review

HCWC Document Review Summary

The emergent themes and conclusions in this document review summarize the findings that were salient between the primary and secondary reviewers. This summary is broken down into categories based on emergent themes, reflecting both the similarities and differences found among the reports.

The reports covered in this review are listed at the end. These reports were selected by the HCWC Data Workgroup and cover a range of communities living in the HCWC counties.

Quality of Life in Communities of Color

Every document reviewed for this report discussed the many ways that racism impacts all aspects of life, health, and resources for communities of color. The many cultural barriers of access to healthcare, housing, and food security were highlighted throughout the reports. As summarized in many of the themes below, communities of color suffer disproportionately to their white counterparts in all issues highlighted by the reports: gender disparities, houselessness rates, experiences in foster care, incarceration rates, education access, and unemployment rates.

One takeaway is that more culturally specific providers and culturally specific social services need to be operationalized in order to rectify the disparities we see in the HCWC counties. This needs to be implemented on a policy level, and accompanied by actionable steps that can be taken by providers, community leaders, educators, and other outreach groups to operationalize policy level changes.

Immediate Needs Versus Long-Term Needs

Refugee and immigrant communities expressed the need for services linked to longer-term pathways of improving living standards, while still maintaining the immediate basic needs. Communities felt as if the majority of the focus of outreach efforts and resources were on point-of-arrival and not over time.

There is not much longitudinal data available to track immigrant/refugee outcomes, with most focused on status upon arrival.

Surveillance and Data Transparency

Surveillance is a hindrance to equitable data collection for immigrant communities, refugee communities, and communities of color. Much of what the review analyzed was prefaced with the statement that communities of color are less likely voluntarily self-disclosure data due to mistrust. Historical misrepresentation, violence, profiling, and discrimination of these populations has led to this mistrust of the government and much data collection.

Life Course Theory and Adverse Childhood Experiences (ACEs)

ACE scores are acknowledged in many of the reports, noting that the barriers to health and equity begin early in life and build into adulthood, and are tied to systemic, institutional, cultural, and social factors. Adults who had been through the foster care system as children had higher ACE scores and reported high levels of physical, sexual and verbal abuse. Difficult experiences continued into adulthood; economic insecurity (having to go without needed food, clothing, transportation, and stable housing); higher rates of homelessness and partner abuse. Many reports suggested that more longitudinal studies focusing on emergent issues for populations should be focused on a life course theory to examine how trauma, life experiences, and stressors influence health and well-being.

Housing Insecurity and Houselessness

When surveyed for the Springwater Corridor report, the common reasons that houseless individuals cited for their circumstances were: job loss (unemployment rate for sample was 91%), eviction, substance use, physical illness, domestic violence, mental health, loss of benefits, and rent increase.

On a policy front, greater outreach capacity is needed. More shelter and transitional housing types need to be developed for chronically houseless. Increased capacity to provide emergency, temporary, and transitional shelter or alternative housing.

Gender and Barriers to Success

Several reports mentioned the difficulties of assessing gender gaps as the majority of the accessible data sources provide only gender-blind data. Highlighting the issue of disparities between men and women in outcomes and longitudinal data is difficult to access due to the bias of the collectors and methods. Further parsing this out, the reports lack adequate information on communities who have gender identities outside of the Male/Female gender binary. The reports in the review do not adequately cover LGBTQ+ communities, which reflects the lack of intersectionality of available data. Systemic sexism and racism are intertwined. Intersectional minorities (e.g., transwomen of color) have disproportionate barriers to success. Women of color experience more violence (sexual and physical), higher poverty rates, and are more likely to lack economic security (having to go without needed food, clothing, transportation, and stable housing).

Education and Employment Gaps

Achievement gaps (beginning as an opportunity gap) are evident in children as young as 9 months old. These education gaps are correlated to unemployment. Communities of color experience higher rates of unemployment than their white counterparts (in Multnomah

County, unemployment is 35.7% higher for people of color). With unpaid care labor and the cost of caregiving being some of the least affordable in the nation, women struggle with a larger unemployment gap than their male counterparts. The achievement gaps can be attributed to the themes found in the reports above: economic insecurity, discrimination, lack of resources, language barriers, and lack of role models who come from similar backgrounds. Thus, a broad community approach is necessary to create lasting improvements. Skills need to be fostered in this setting for future success, and early childhood services and education are necessary to correct gaps.

Policy and Action: Concluding Remarks

While the reports all agree on the multiple gaps and disparities in the health and well-being of the populations in the four HCWC counties, the changes the reports suggest in order to address, improve, and provide outreach to these communities varies in specificity. The various suggestions on how to improve outcomes touch on the shortcomings of the current data collection methods and quantitative analysis. These data collection methods don't capture complexities and intersectionality of multiple identities or specific populations. Community-specific needs and priorities were stressed as action items, as well as more focus on first-hand narratives and qualitative research that more accurately captures priority populations' experience and identities. All reports acknowledged the visibility of these issues in mainstream social media, as well as ongoing advocacy efforts.

While there have been some baseline improvements, the quad-county region has much work to do to be comparable to other counties across the nation. Policy efforts should focus on housing stability, psychosocial support, partnerships between agencies to support physical/mental health of priority populations. Overall, the reports lack concrete action that should be taken to rectify these issues.

Reports Reviewed

1. **Foster Care: Life Course Experiences, Health, and Health Care**
   Providence Center for Outcomes Research and Education, 2017
   HCWC counties included: Washington, Multnomah, Clackamas
   Web link

2. **Count Her In: A Report about Women and Girls in Oregon**
   Women's Foundation of Oregon, 2016
   HCWC counties included: Washington, Multnomah, Clackamas
   Web link

3. **State of Black Oregon**
   Urban League of Portland, 2015
   HCWC counties included: Washington, Multnomah, Clackamas
   Web link

4. **Springwater Corridor Survey of Houselessness**
   Clackamas County Health, Housing & Human Services
   HCWC counties included: Clackamas
   Web link

5. **Coalition of Communities of Color, an Unsettling Profile**
   Coalition of Communities of Color and Portland State University, 2010
   HCWC counties included: Washington, Multnomah, Clackamas
   Web link

6. **IRCO Community Needs Assessment**
   Immigrant and Refugee Community Organization (IRCO), 2017
   HCWC counties included: Washington, Multnomah, Clackamas
   Web link

7. **State of Our Children & Families Report (SW Washington)**
   Support for Early Learning & Families (SELF), 2017
   HCWC counties included: Clark
   Web link

8. **Risk and Protection Profile for Substance Abuse Prevention in Clark County**
   Washington State Department of Social & Health Services, 2017
   HCWC counties included: Clark
   Web link

Appendix G: County-Specific Data

1. Clark County
2. Clackamas County
3. Multnomah County
4. Washington County

G.1. Clark County Overview

Demographics

Table G.1-1 includes basic demographic characteristics of the Clark County population: number of people, ages, racial/ethnic identity, disability status, immigration status, language, and sex.

Table G.1-1. Selected Demographic Characteristics in Clark County: Total Population: 450,893.

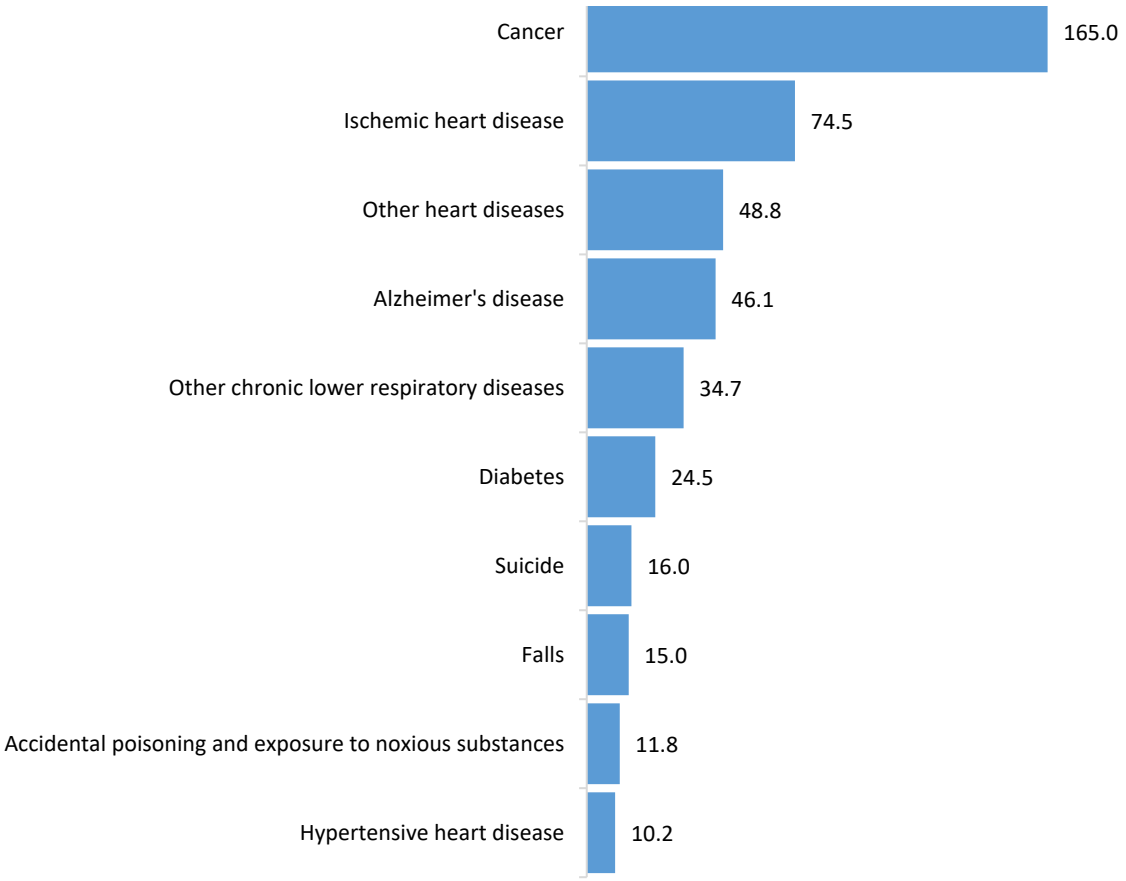
Demographic characteristic	% of Population
Gender	
Male	49.4%
Female	50.6%
Age	
Median age (years)	37.8
Under 5 years	6.4%
5 to 19 years	21.1%
20 to 44 years	32.2%
45 to 64 years	26.6%
65 years and older	13.7%
Race/ethnicity	
American Indian and Alaska Native	0.6%
Asian	4.3%
Black or African American	1.9%
Hispanic or Latino (of any race)	8.7%
Native Hawaiian and Other Pacific Islander	0.8%
Two or more races	4.6%
White	84.6%
With a disability	12.6%
Foreign born	10.4%
Language other than English spoken at home	15.0%

Source: American Community Survey 5-year estimates 2012–2016.

Mortality Rate

The mortality rate is the number of deaths per 100,000 people in a defined population over a specific time period. Figure G.1-1 shows the mortality rates of the leading causes of death in Clark County between 2012 and 2016.

Figure G.1-1. Clark County Mortality Rates 2012–2016.



Note: All rates are per 100,00 population and are age-adjusted to the 2000 U.S. standard population.
Source: Community Health Assessment Tool (CHAT).

Chronic Disease in the Clark County Medicaid Population

Medicaid is the second largest source of health insurance in the United States after employer-provided insurance and historically has covered low-income children and parents, pregnant women, and people with disabilities.[1] Data on the estimated percentage of Medicaid recipients with asthma, depression, and diabetes in Clark County were downloaded from the Healthier Washington Dashboard.[2]

The following tables present the percentage estimates for the Medicaid population in Clark County diagnosed with asthma, depression, and diabetes by race (Tables G.1-2–G.1-8) and gender (Tables G.1-9–G.1-10) in 2017.

Table G.1-2. Clark County Medicaid Population 2017: Asian.

Condition	Percentage
Asthma	2%
Depression	5%
Diabetes	4%

Source: Healthy Washington Dashboard.

Table G.1-3. Clark County Medicaid Population 2017: Black/African American.

Condition	Percentage
Asthma	4%
Depression	8%
Diabetes	3%

Source: Healthy Washington Dashboard.

Table G.1-4. Clark County Medicaid Population 2017: Caucasian

Condition	Percentage
Asthma	3%
Depression	11%
Diabetes	3%

Source: Healthy Washington Dashboard.

[1] Centers for Medicare & Medicaid Services. 2013 CMS Statistics. U.S. DHHS, Baltimore, MD; 2013.
[2] https://www.hca.wa.gov/about-hca/healthier-washington/data-dashboard

Table G.1-5. Clark County Medicaid Population 2017: Hispanic.

Condition	Percentage
Asthma	3%
Depression	2%
Diabetes	3%

Source: Healthy Washington Dashboard.

Table G.1-6. Clark County Medicaid Population 2017: Native American.

Condition	Percentage
Asthma	4%
Depression	12%
Diabetes	5%

Source: Healthy Washington Dashboard.

Table G.1-7. Clark County Medicaid population 2017: Native Hawaiian and Pacific Islander[3]

Condition	Percentage
Asthma	3%
Depression	11%
Diabetes	3%

Source: Healthy Washington Dashboard.

Table G.1-8. Clark County Medicaid Population 2017: Race Not Provided.

Condition	Percentage
Asthma	2%
Depression	4%
Diabetes	2%

Source: Healthy Washington Dashboard.

Table G.1-9. Clark County Medicaid Population 2017: Female.

Condition	Percentage
Asthma	3%
Depression	12%
Diabetes	3%

Source: Healthy Washington Dashboard.

Table G.1-10. Clark County Medicaid Population 2017: Male.

Condition	Percentage
Asthma	2%
Depression	7%
Diabetes	3%

Source: Healthy Washington Dashboard.

[3] Native Hawaiian and Pacific Islander are combined on the Healthier Washington Dashboard.

Communicable Disease

Communicable diseases are infections, usually viral or bacterial, that are spread from person to person. The following table (G1.11) presents the age-adjusted incidence rates for the 10 most common communicable diseases in Clark County across three time periods.

Table G.1-11. Top 10 Communicable Diseases in Clark County.

Rank	Communicable Disease	2007–2009	2009–2011	2014–2016
1	Chlamydia	271.7	347.0	411.5
2	Gonorrhea	36.8	37.7	68.7
3	Herpes initial genital infection	17.2	19.3	46.9
4	Pertussis	5.8	16.2	34.4
5	Campylobacterios	15.5	23.4	17.7
6	Salmonellosis	15.0	16.9	13.7
7	Giardiasis	8.4	11.1	7.5
8	*E. Coli*	3.2	5.6	7.4
9	Late latent syphilis	0.4	1.3	4.2
10	Suspected Rabies Exposure	0.0	0.1	2.9

Note: All rates are per 100,00 population and are age-adjusted to the 2000 U.S. standard population.

G.2. Clackamas County Overview

Demographics

Table G.2-1 shows basic demographic characteristics of the Clackamas County population: number of people, age, racial/ethnic identify, disability status, immigration status, language, and sex.

Table G.2-1. Selected Demographic Characteristics in Clackamas County (Total Population=394,967).

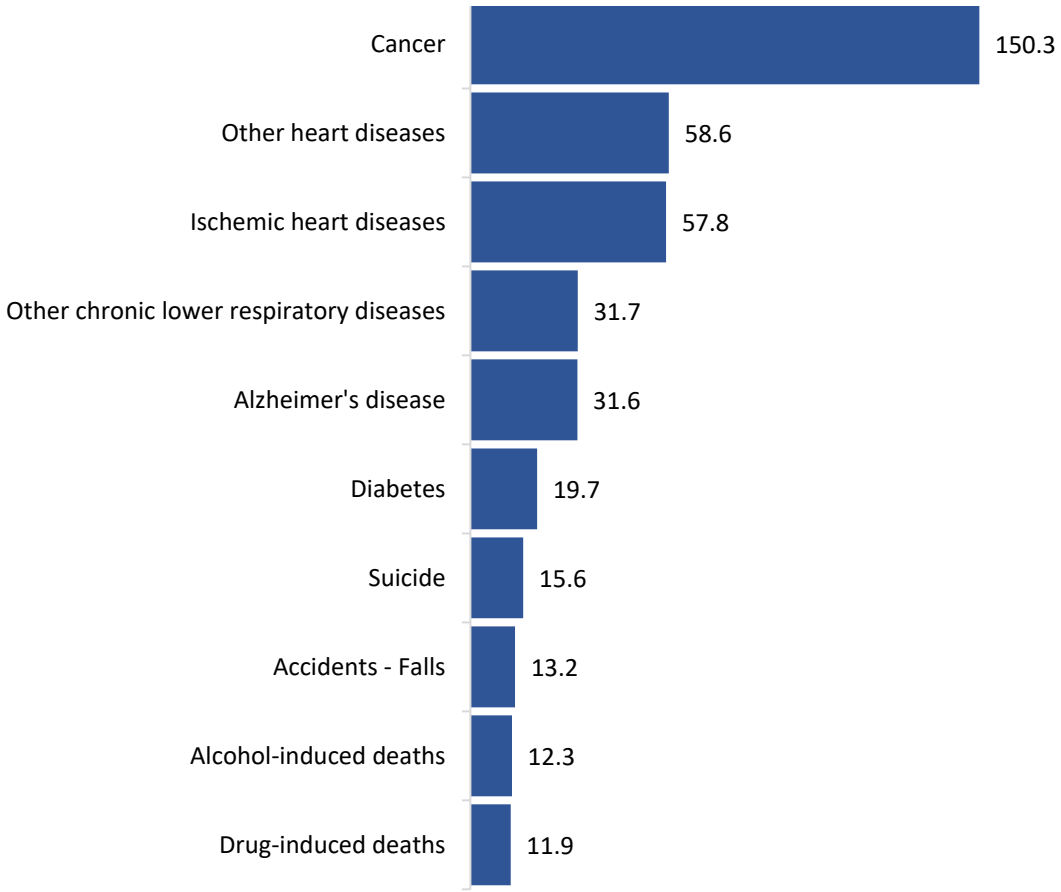
Demographic Characteristic	% of Population
Gender	
Male	49.2%
Female	50.8%
Age	
Median age (years)	41.4
Under 5 years	5.5%
5 to 19 years	19.1%
20 to 44 years	30.3%
45 to 64 years	29.0%
65 years and older	16.1%
Race/ethnicity	
American Indian and Alaska Native	0.7%
Asian	4.1%
Black or African American	0.9%
Hispanic or Latino (of any race)	8.2%
Native Hawaiian and Other Pacific Islander	0.3%
Two or more races	3.4%
White	89.0%
With a disability	11.9%
Foreign born	8.0%
Language other than English spoken at home	12.1%

Source: American Community Survey 5-year estimates 2012–2016.

Mortality Rate

The mortality rate is the number of deaths per 100,000 people in a defined population over a specific time period. Figure G.2-1 shows the mortality rates of the leading causes of death in Clackamas County between 2012 and 2016.

Figure G.2-1. Clackamas County Mortality Rates 2012–2016.



Note: All rates are per 100,00 population and are age-adjusted to the 2000 U.S. standard population.
Source: Oregon Public Health Assessment Tool (OPHAT).

Chronic Disease in the Clackamas County Medicaid Population

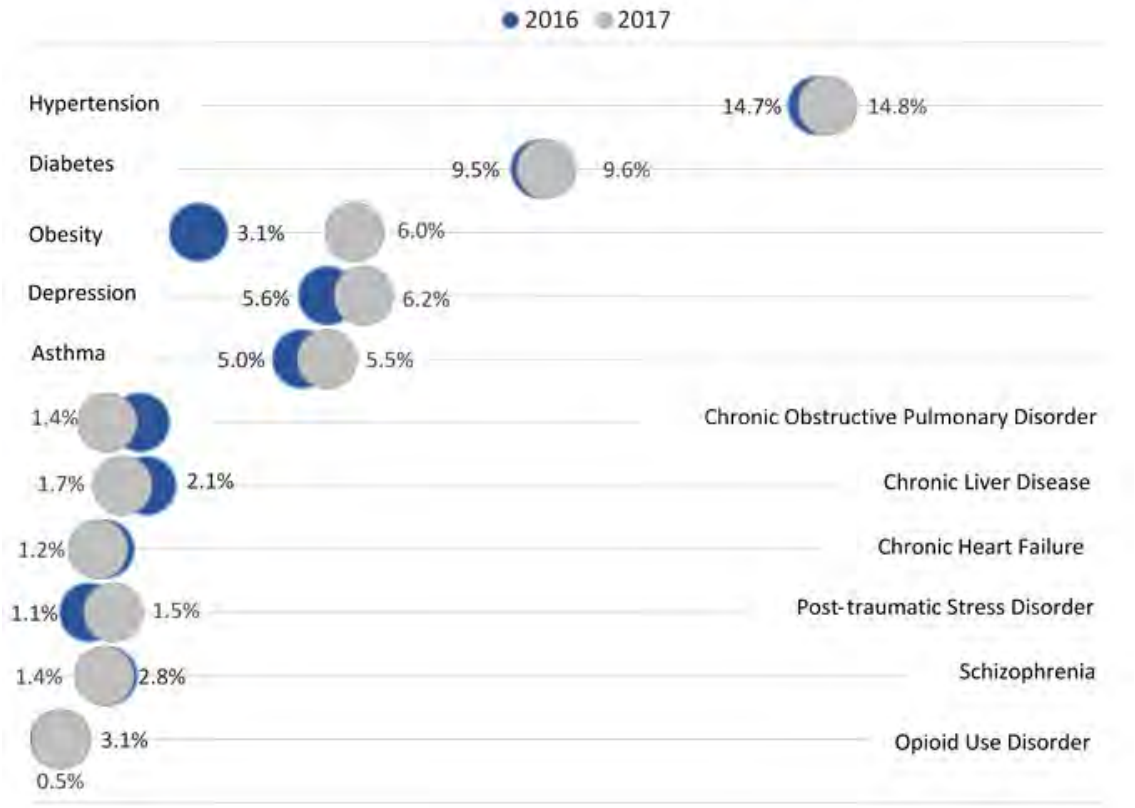
Medicaid is the second largest source of health insurance in the United States after employer-provided insurance and historically has covered low-income children and parents, pregnant women, and people with disabilities.[1]

In Clackamas County, Medicaid beneficiaries are covered through Health Share of Oregon. To identify the prevalence of chronic conditions in the region's Medicare population, Health Share of Oregon provided member utilization data from 2016 and 2017.

Asian

Between 2016 and 2017, the prevalence o**f obesity had the greatest increase** for Asian Health Share of Oregon members in Clackamas County (Figure G.2-2).[2]

Figure G.2- 2. Health Share of Oregon 2016 and 2017: Asian.



Note: 2016 *N* = 1,548; 2017 *N* = 1,455.

Source: Health Share of Oregon.

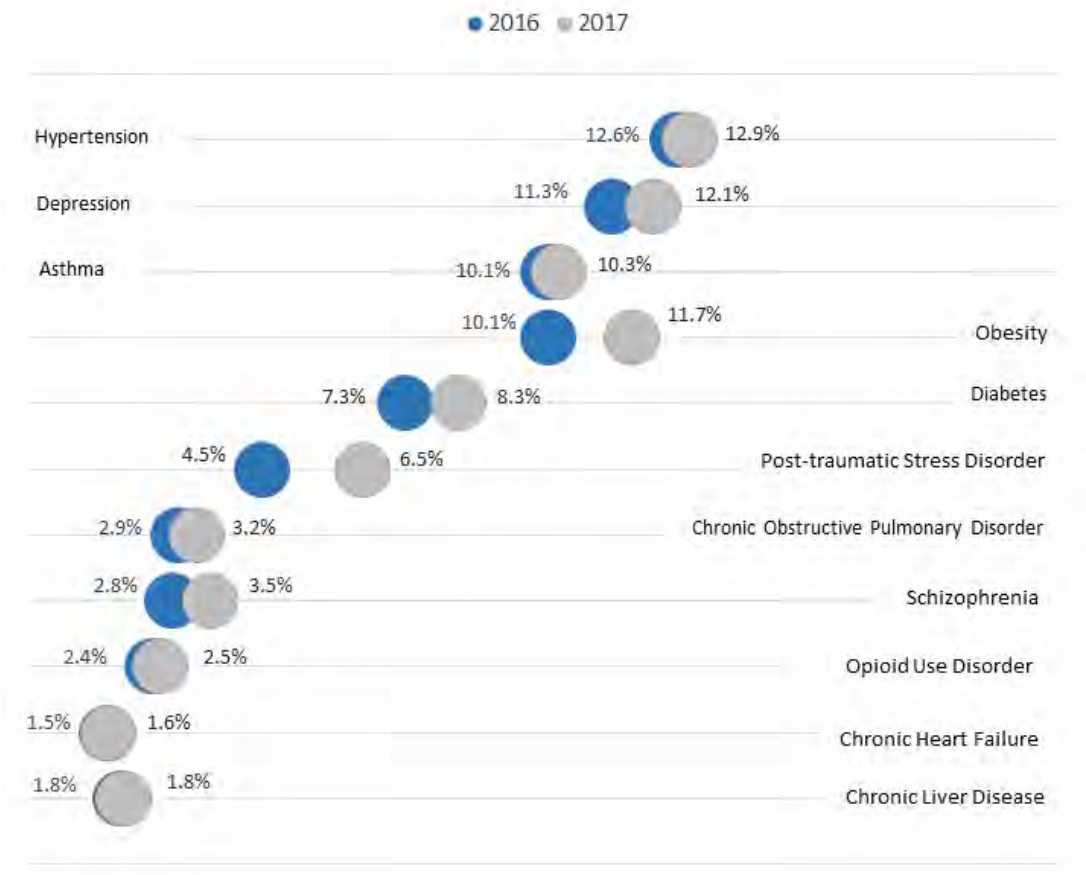
[1] Centers for Medicare & Medicaid Services. 2013 CMS Statistics. U.S. DHHS, Baltimore, MD; 2013.

[2] "Asian" at Health Share of Oregon includes Chinese, Vietnamese, Korean, Hmong, Laotian, Filipino/a, Japanese, South Asian, Asian India, Other Asian, and Asian.

Black/African American

Between 2016 and 2017, the prevalence **of obesity, diabetes, and post-traumatic stress disorder had the greatest increase** for Black/African American Health Share of Oregon members in Clackamas County (Figure G.2-3).

Figure G.2-3. Health Share of Oregon 2016 and 2017: Black/African American.



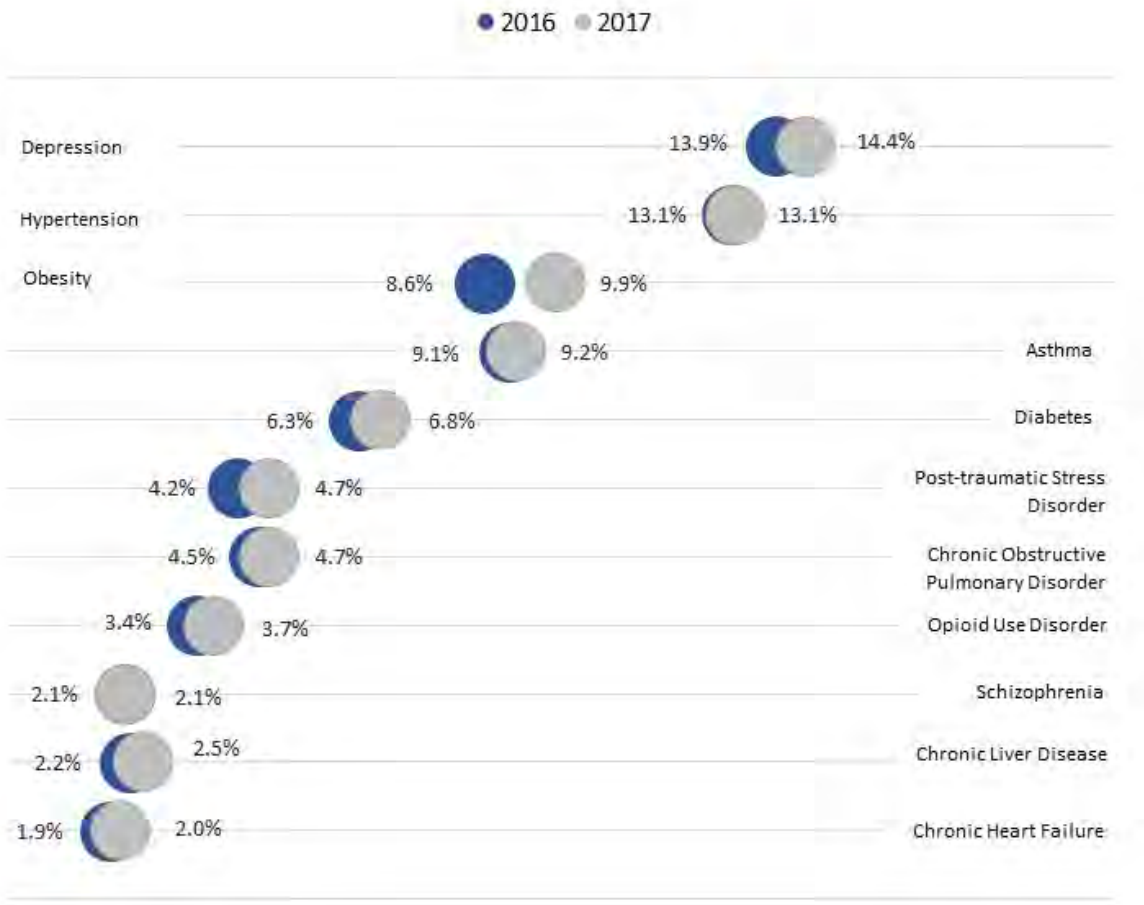
2016 *N* = 793; 2017 *N* = 708.

Source: Health Share of Oregon

Caucasian

Between 2016 and 2017, the prevalence of **obesity had the greatest increase** for Caucasian Health Share of Oregon members in Clackamas County (Figure G.2-4).

Figure G.2-4. Health Share of Oregon 2016 and 2017: Caucasian.



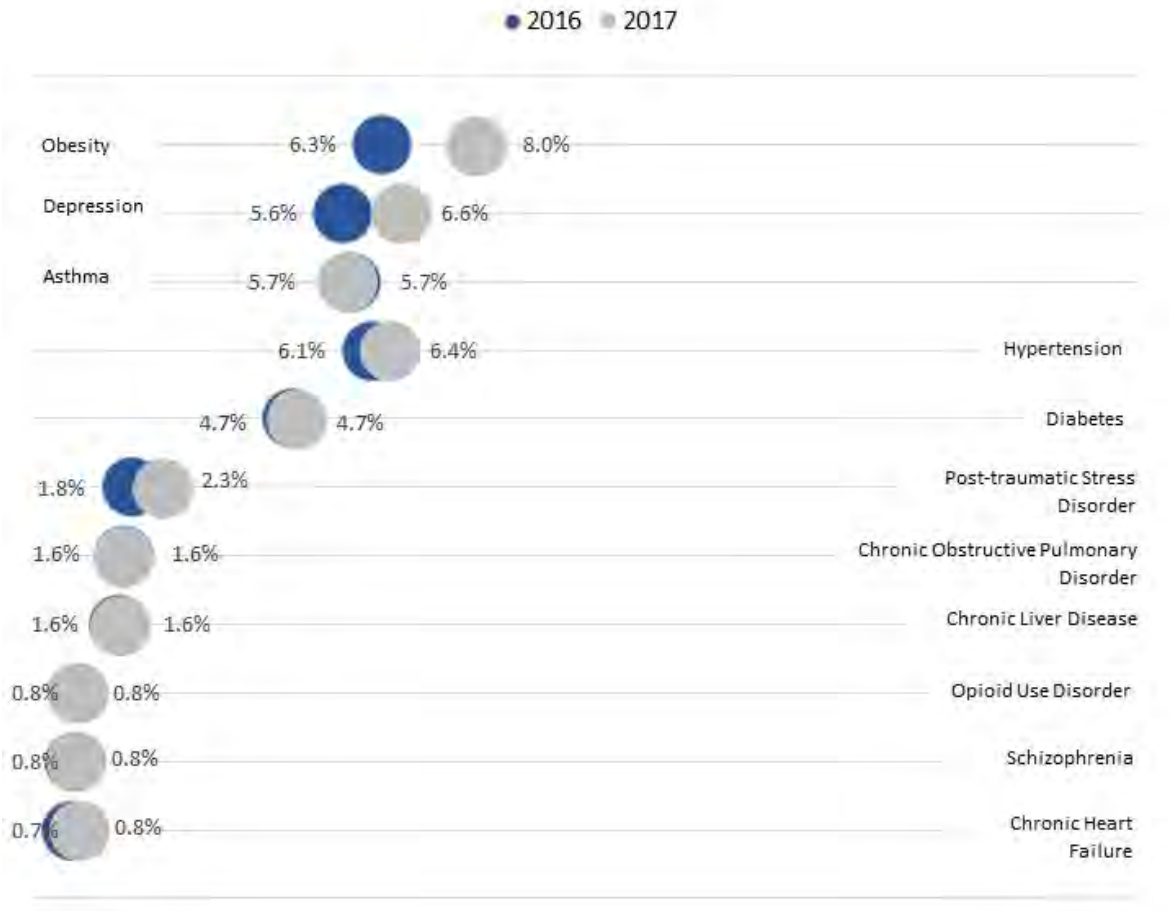
2016 N = 28,149; 2017 N = 25,378.

Source: Health Share of Oregon.

Hispanic

Between 2016 and 2017, the prevalence of **obesity and depression had the greatest increase** for Hispanic (of any race) Health Share of Oregon members in Clackamas County (Figure G.2-5).

Figure G.2-5. Health Share of Oregon 2016 and 2017: Hispanic.



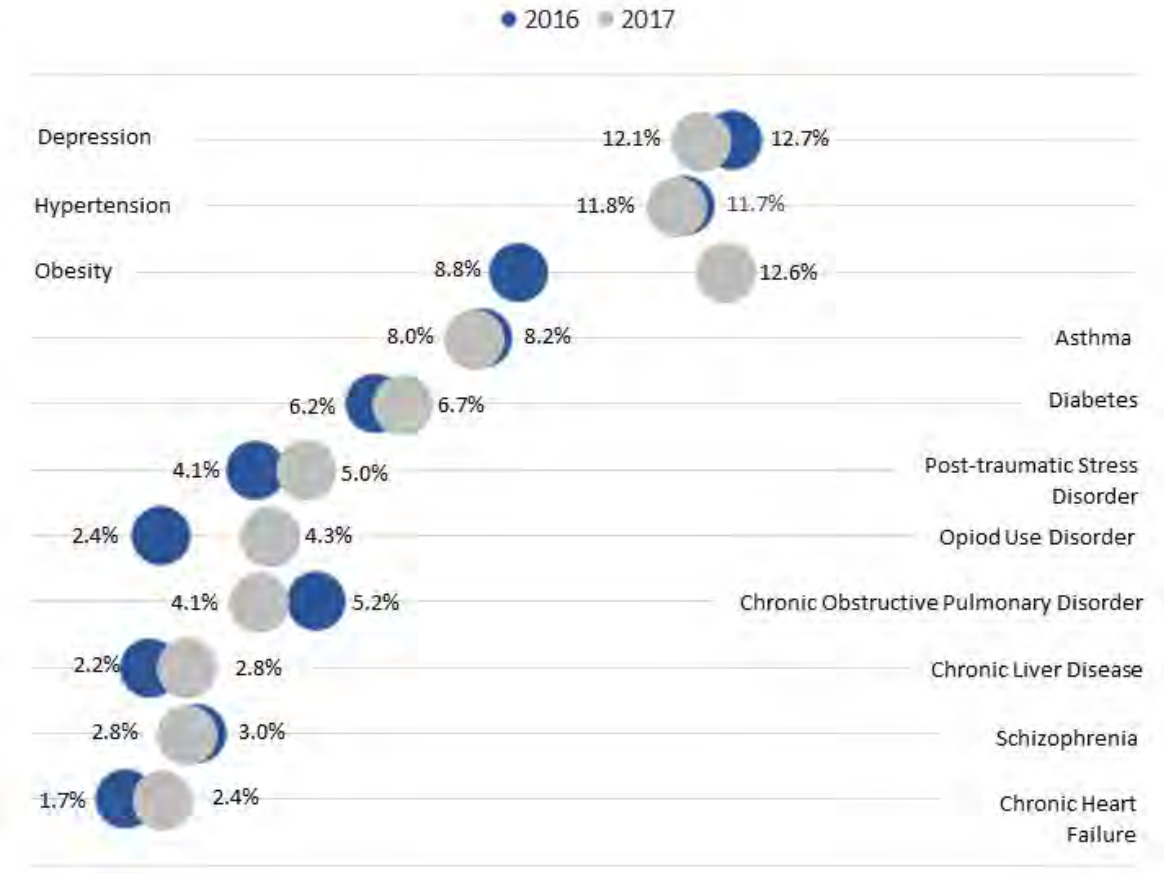
2016 *N* = 3,956; 2017 *N* = 3,390.

Source: Health Share of Oregon.

Native American

Between 2016 and 2017, the prevalence of **obesity and opioid use disorder** had the greatest increase for Native American Health Share of Oregon members in Clackamas County (Figure G.2-6).

Figure G.2-6. Health Share of Oregon 2016 and 2017: Native American.



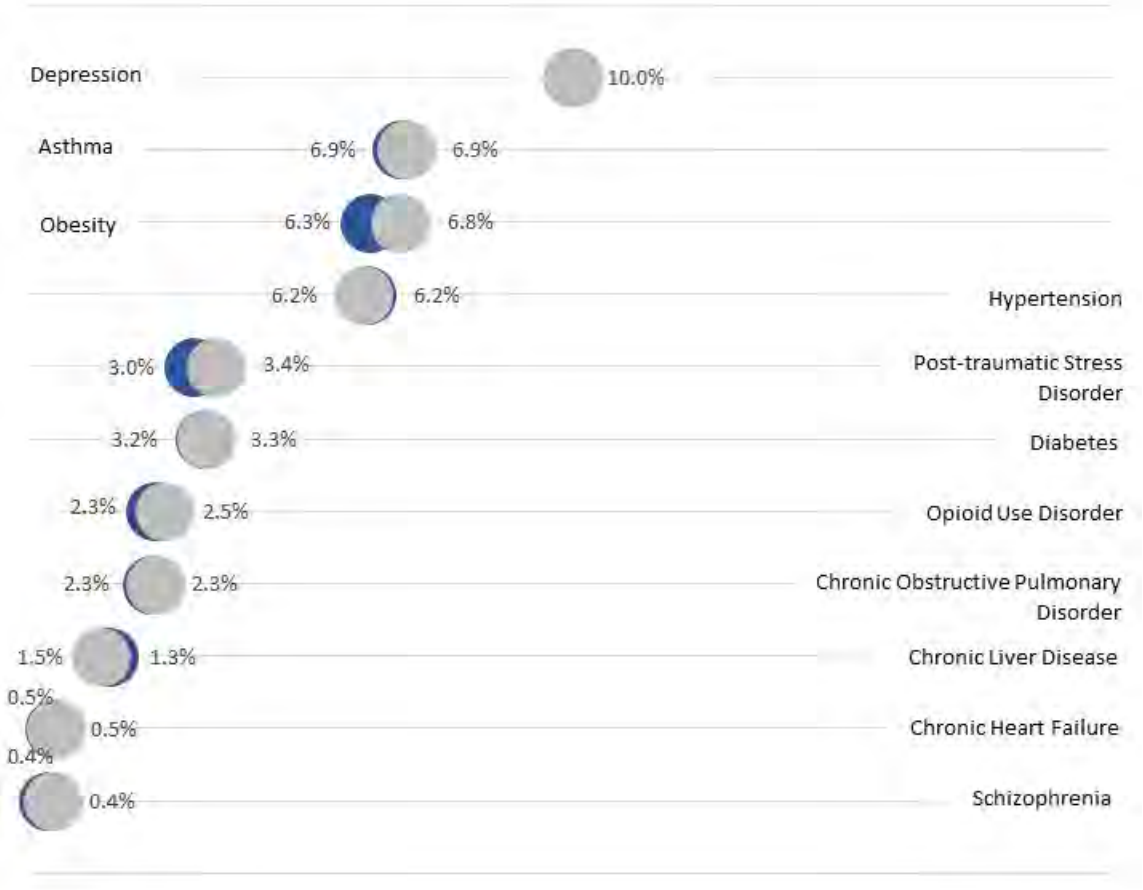
Note. 2016 *N* = 465; 2017 *N* = 462.

Source: Health Share of Oregon.

Race Not Provided

In 2016 and 2017, the prevalence of chronic conditions remained relatively unchanged for Health Share of Oregon members in Clackamas County who did not provide their race or ethnicity at intake (Figure G.2-7).

Figure G.2-7. Health Share of Oregon 2016 and 2017: Race Not Provided.



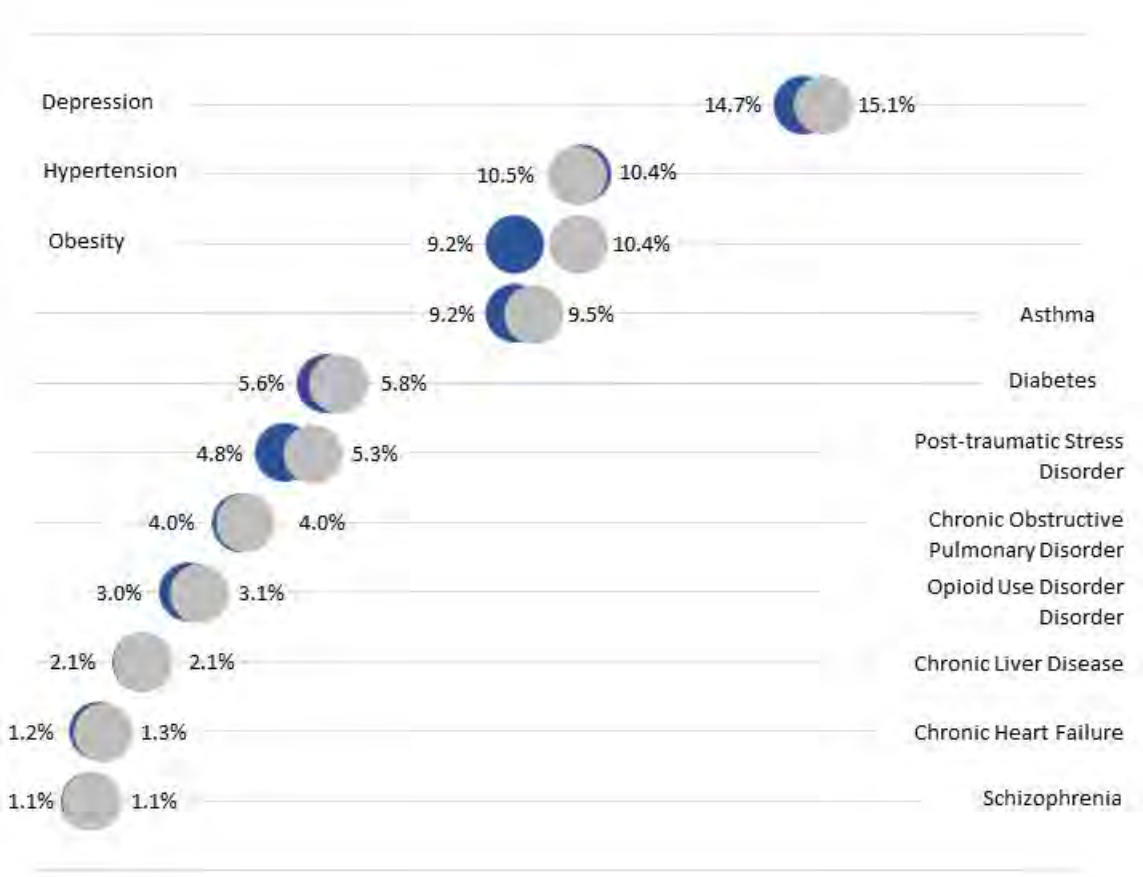
2016 *N* = 18,644; 2017 *N* = 19,071.

Source: Health Share of Oregon.

Female

Between 2016 and 2017, the prevalence of **obesity had the greatest increase** for female Health Share of Oregon members in Clackamas County (Figure G.2-8).

Figure G.2-8. Health Share of Oregon 2016 and 2017: Female.

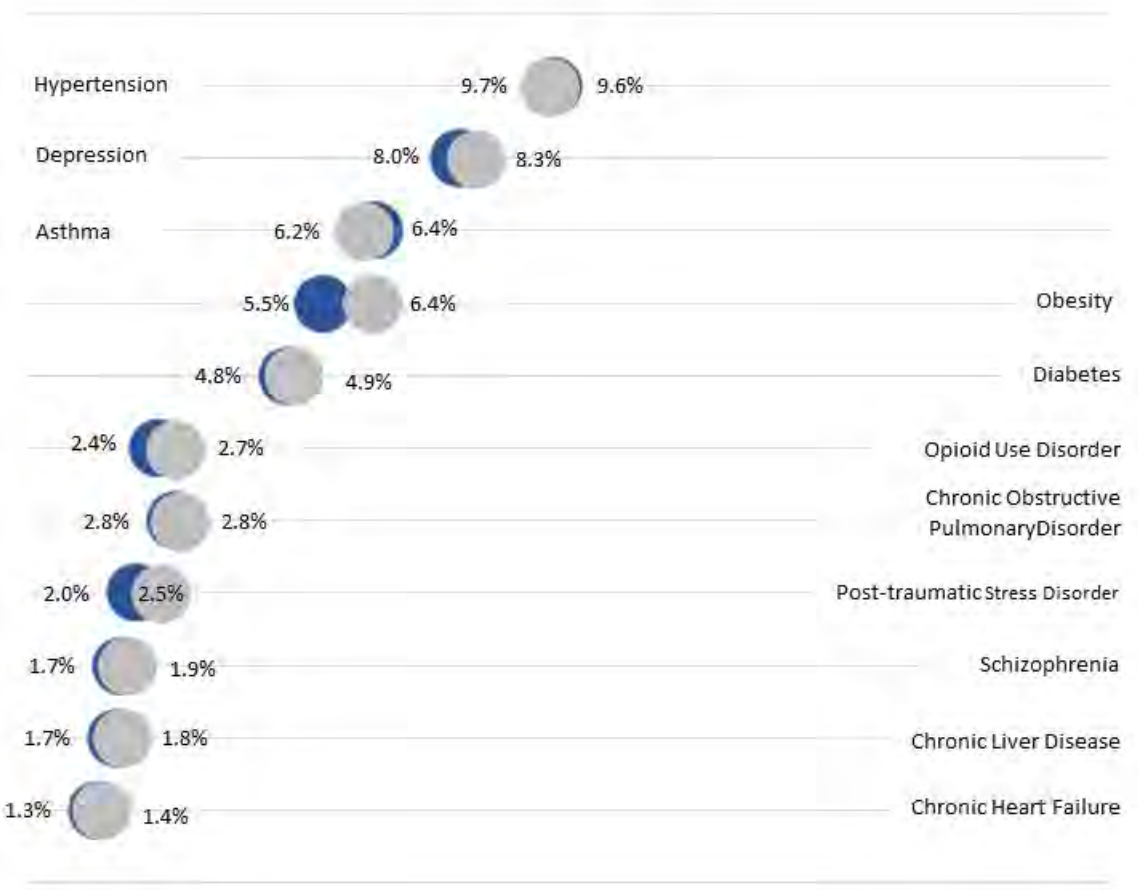


2016 *N* = 29,165; 2017 *N* =27,521
Source: Health Share of Oregon.

Male

Between 2016 and 2017, the prevalence of **obesity had the greatest increase** for male Health Share of Oregon members in Clackamas County.

Figure G.2-9. Health Share of Oregon 2016 and 2017: Male.



2016 *N* = 25,340; 2017 *N* = 23,679.
Source: Health Share of Oregon.

Communicable Disease

Communicable diseases are infections, usually viral or bacterial, that are spread from person to person. Table G.2-2 presents the age-adjusted incidence rates for the 10 most common communicable diseases in Clackamas County across three time periods.

Table G.2-2. Top 10 Communicable Diseases in Clackamas County.

Rank	Communicable Disease	2007–2009	2009–2011	2014–2016
1	Chlamydia	236.2	272.8	326.0
2	Hepatitis C (chronic)	91.3	71.7	96.8
3	Gonorrhea	21.9	22.6	56.0
4	Campylobacteriosis	17.5	19.7	23.0
5	Pertussis (whooping cough)	5.1	10.4	13.9
6	Salmonellosis (non-typhoidal)	11.4	11.7	11.6
7	Cryptosporidiosis	7.3	9.5	10.2
8	Hepatitis B (chronic)	11.4	9.5	9.9
9	Syphilis (Early)	1.3	2.7	8.5
10	Giardiasis	8.2	7.8	6.4

Note: All rates are per 100,00 population and are age-adjusted to the 2000 U.S. standard population.

Source: Oregon Public Health Assessment Tool (OPHAT).

G.3. Multnomah County Overview

Demographics

In Table G.3-1, basic demographic characteristics of the population are outlined: number of people in Multnomah County, age, racial/ethnic identify, disability, immigration status, language, and sex.

Table G.3-1. Selected Demographic Characteristics in Multnomah County: Total Population=778,193.

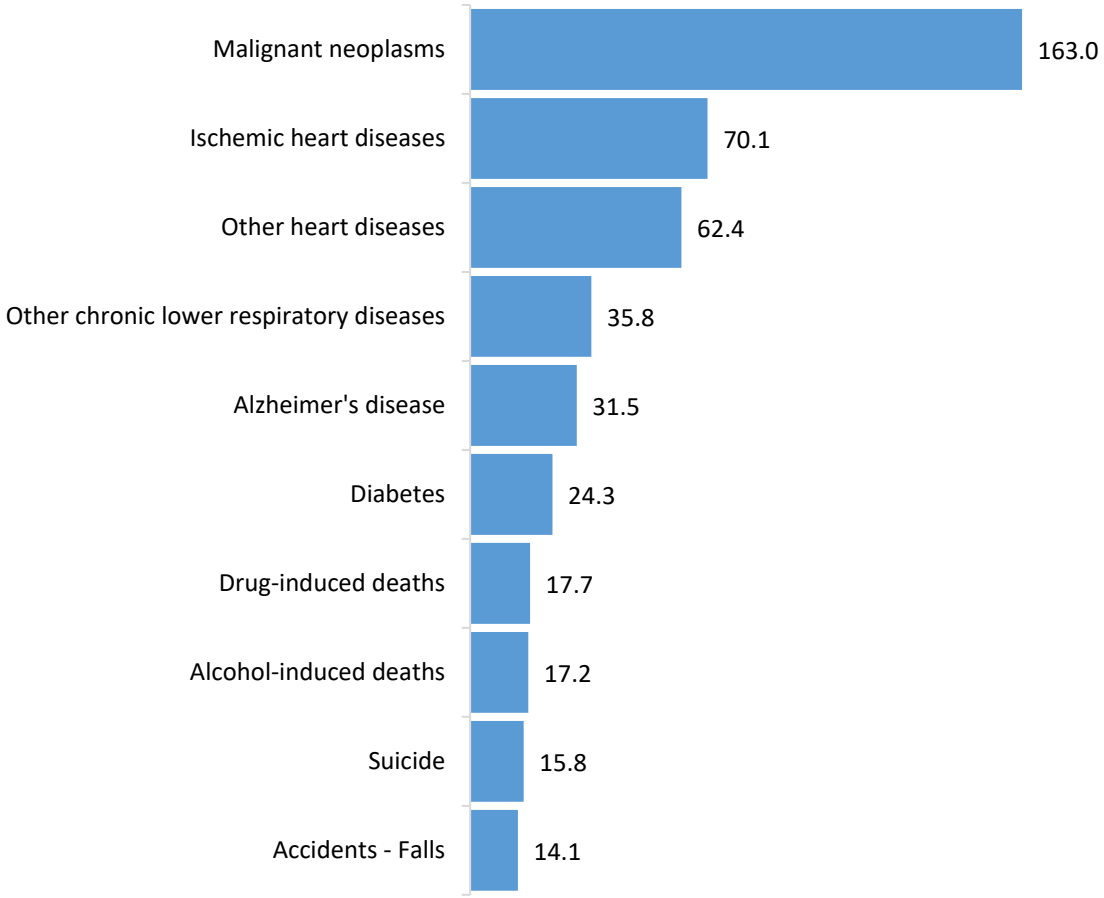
Demographic characteristic	% of Population
Gender	
Male	49.5%
Female	50.5%
Age	
Median age (years)	36.7
Under 5 years	5.9%
5 to 19 years	15.9%
20 to 44 years	41.1%
45 to 64 years	25.2%
65 years and older	11.9%
Race/ethnicity	
American Indian and Alaska Native	0.8%
Asian	6.9%
Black or African American	5.4%
Native Hawaiian and Other Pacific Islander	0.6%
Hispanic or Latino (of any race)	11.1%
Two or more races	5.2%
White	78.2%
With a disability	13.3%
Foreign born	13.9%
Language other than English spoken at home	19.7%

Source: American Community Survey 5-year estimates 2012-2016.

Mortality Rate

The mortality rate is the number of deaths per 100,000 people in a defined population over a specific time period. The following figure (G.3-1) shows the mortality rates of the leading causes of death in Multnomah County between 2012 and 2016.

Figure G.3-1. Multnomah County Mortality Rates 2012–2016.



Note: All rates are per 100,00 population and are age-adjusted to the 2000 U.S. standard population.
Source: Community Health Assessment Tool (CHAT).

Chronic Disease in the Multnomah County Medicaid Population

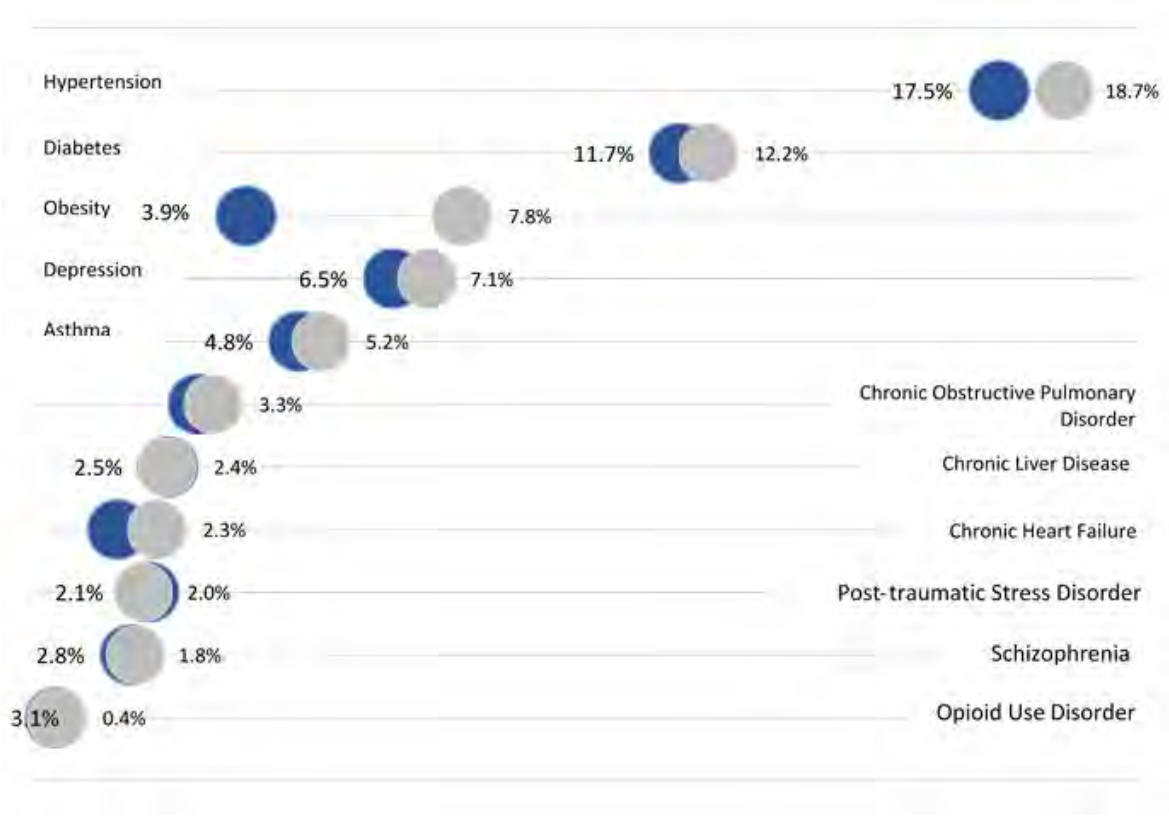
Medicaid is the second largest source of health insurance in the United States after employer-provided insurance and historically has covered low-income children and parents, pregnant women, and people with disabilities.[1]

In Multnomah County, Medicaid beneficiaries are covered through Health Share of Oregon. To identify the prevalence of chronic conditions in the region's Medicare population, Health Share of Oregon provided member utilization data from 2016 and 2017.

Asian

Between 2016 and 2017, the prevalence of **hypertension and obesity had the greatest increase** for Asian Health Share of Oregon members in Multnomah County (Figure G.3-2).[2]

Figure G.3-2. Health Share of Oregon 2016 and 2017: Asian.



N = 10,708; 2017 N = 10,117.

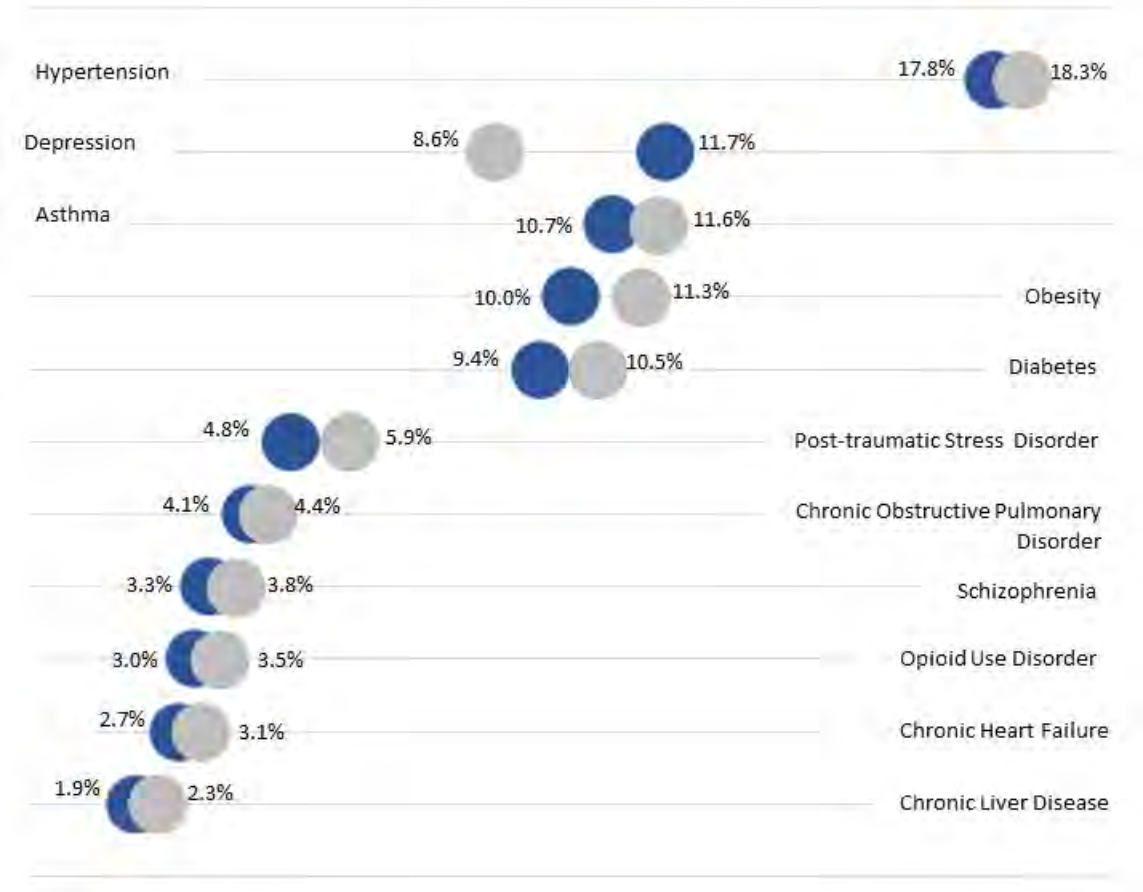
Source: Health Share of Oregon.

[1] Centers for Medicare & Medicaid Services. 2013 CMS Statistics. U.S. DHHS, Baltimore, MD; 2013.
[2] Asian at Health Share of Oregon includes Chinese, Vietnamese, Korean, Hmong, Laotian, Filipino/a, Japanese, South Asian, Asian India, Other Asian, and Asian.

Black/African American

Between 2016 and 2017, the prevalence **of depression, obesity, diabetes, and post-traumatic stress disorder had the greatest increase** for Black/African American Health Share of Oregon members in Multnomah County (Figure G.3-3).

Figure G.3-3. Health Share of Oregon 2016 and 2017: Black/African American.



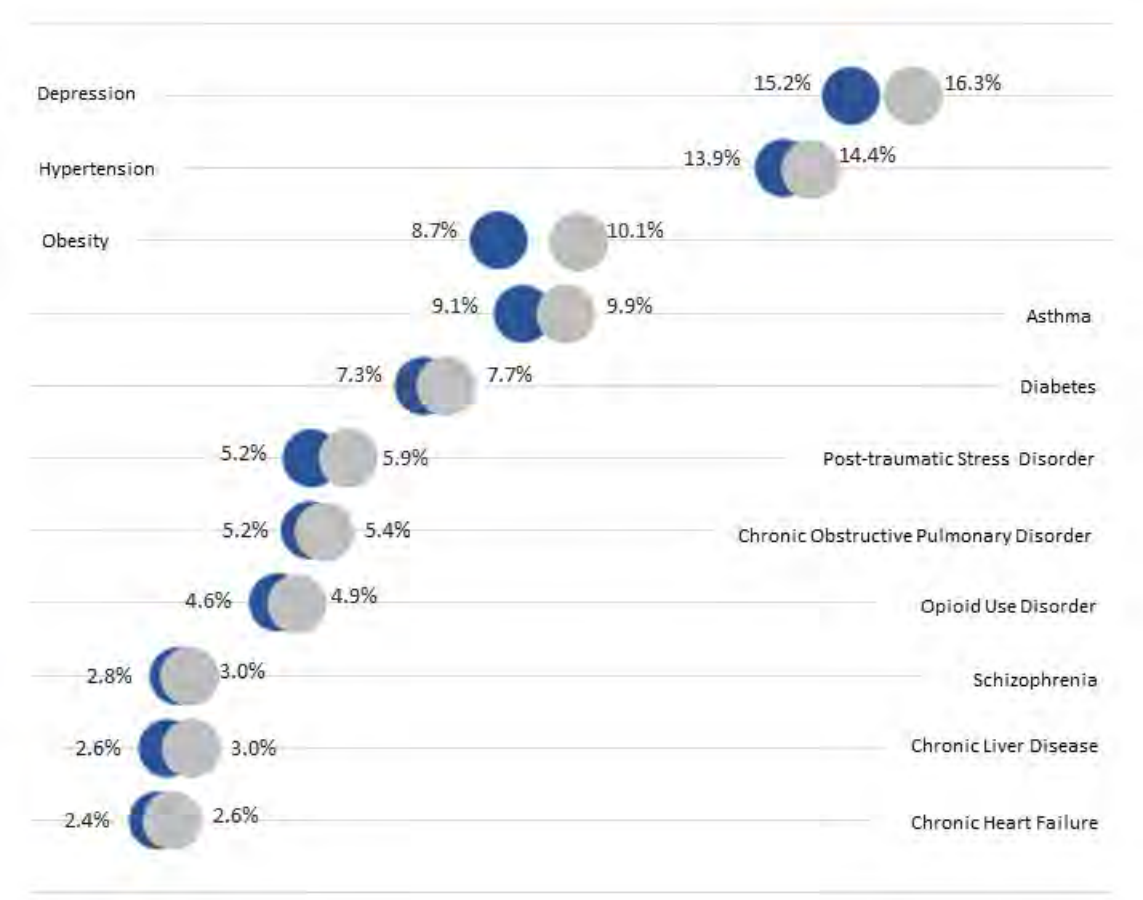
2016 *N* = 13,879; 2017 *N* = 12,770.

Source: Health Share of Oregon.

Caucasian

Between 2016 and 2017, rates of **depression and obesity had the greatest increase** for Caucasian Health Share of Oregon members in Multnomah County (Figure G.3-4).

Figure G.3-4. Health Share of Oregon 2016 and 2017: Caucasian.



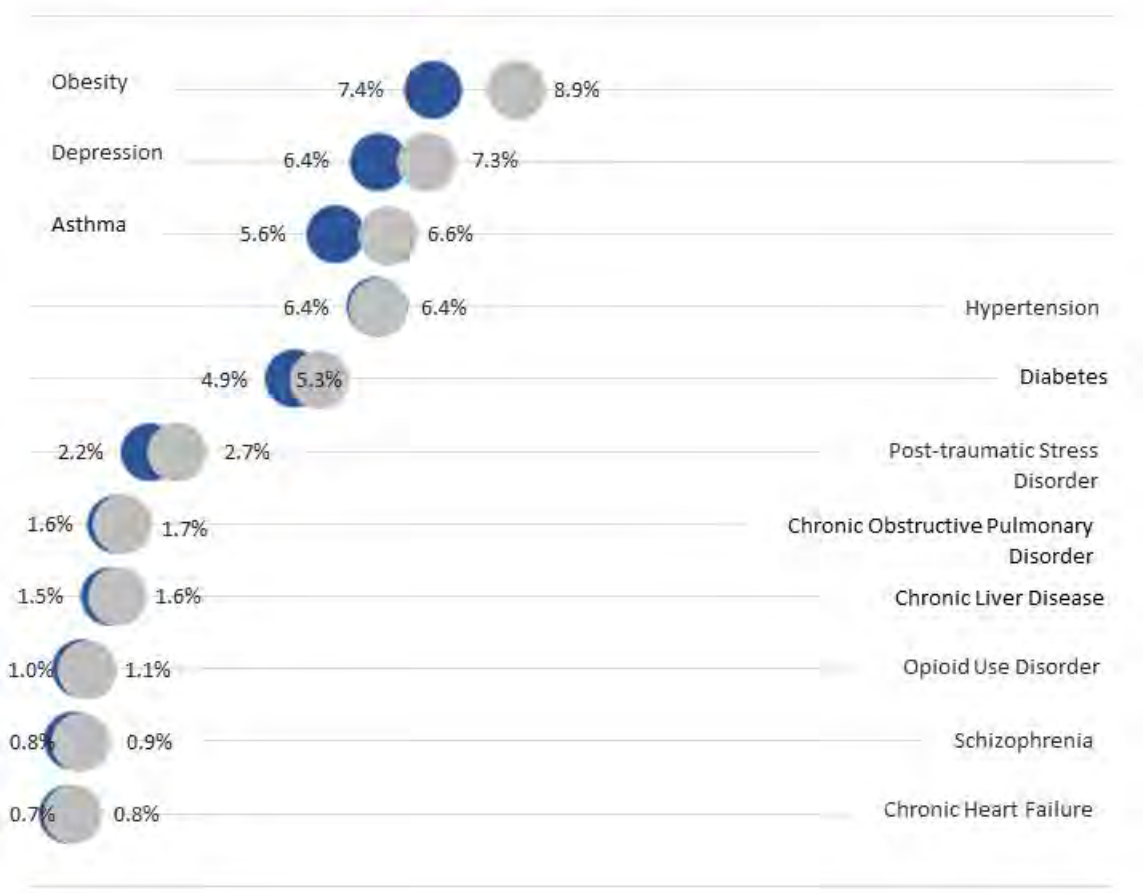
2016 N = 61,357; 2017 N = 55,255.

Source: Health Share of Oregon

Hispanic

Between 2016 and 2017, the prevalence of **obesity, depression, and asthma had the greatest increase** for Hispanic (of any race) Health Share of Oregon members in Multnomah County (Figure G.3-5).

Figure G.3-5. Health Share of Oregon 2016 and 2017: Hispanic.



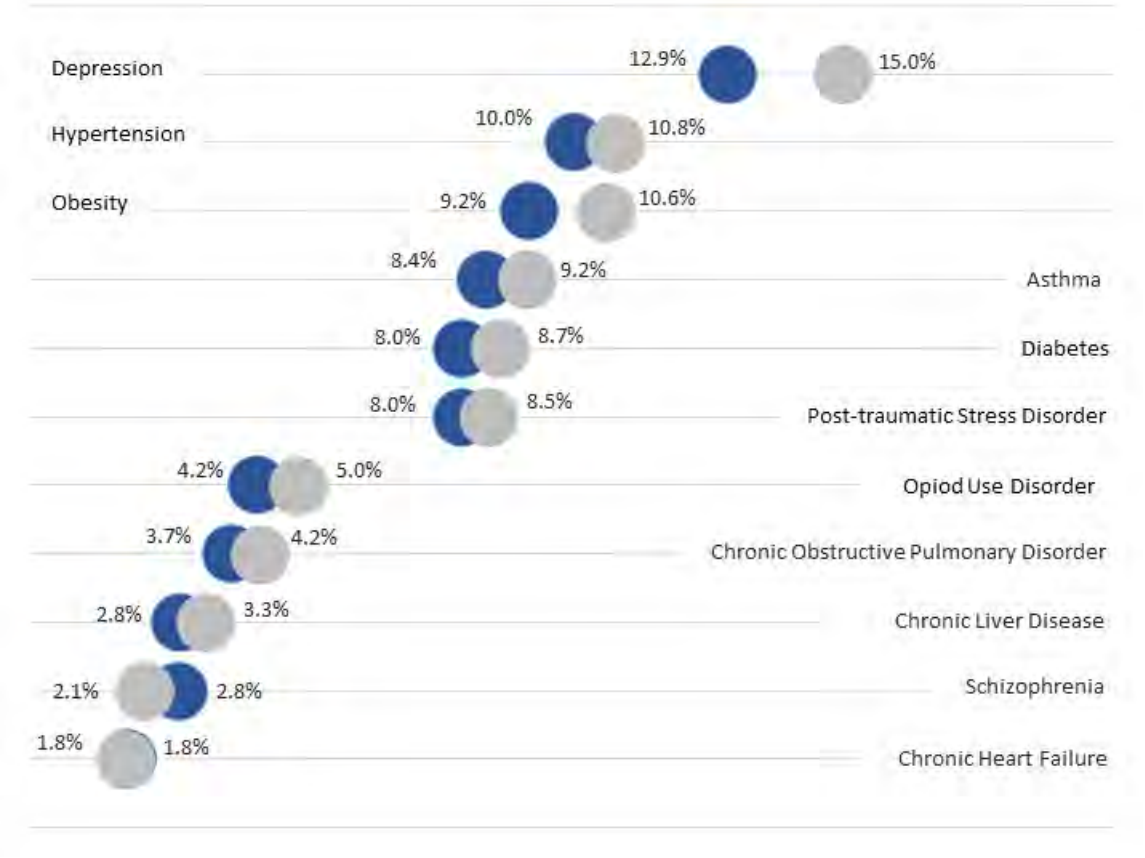
2016 *N* = 12,834; 2017 *N* = 11,116.

Source: Health Share of Oregon

Native American

Between 2016 and 2017, the prevalence of **depression and obesity** had the greatest increase for Native American Health Share of Oregon members in Multnomah County (Figure G.3-6).

Figure G.3-6. **Health Share of Oregon 2016 and 2017: Native American.**



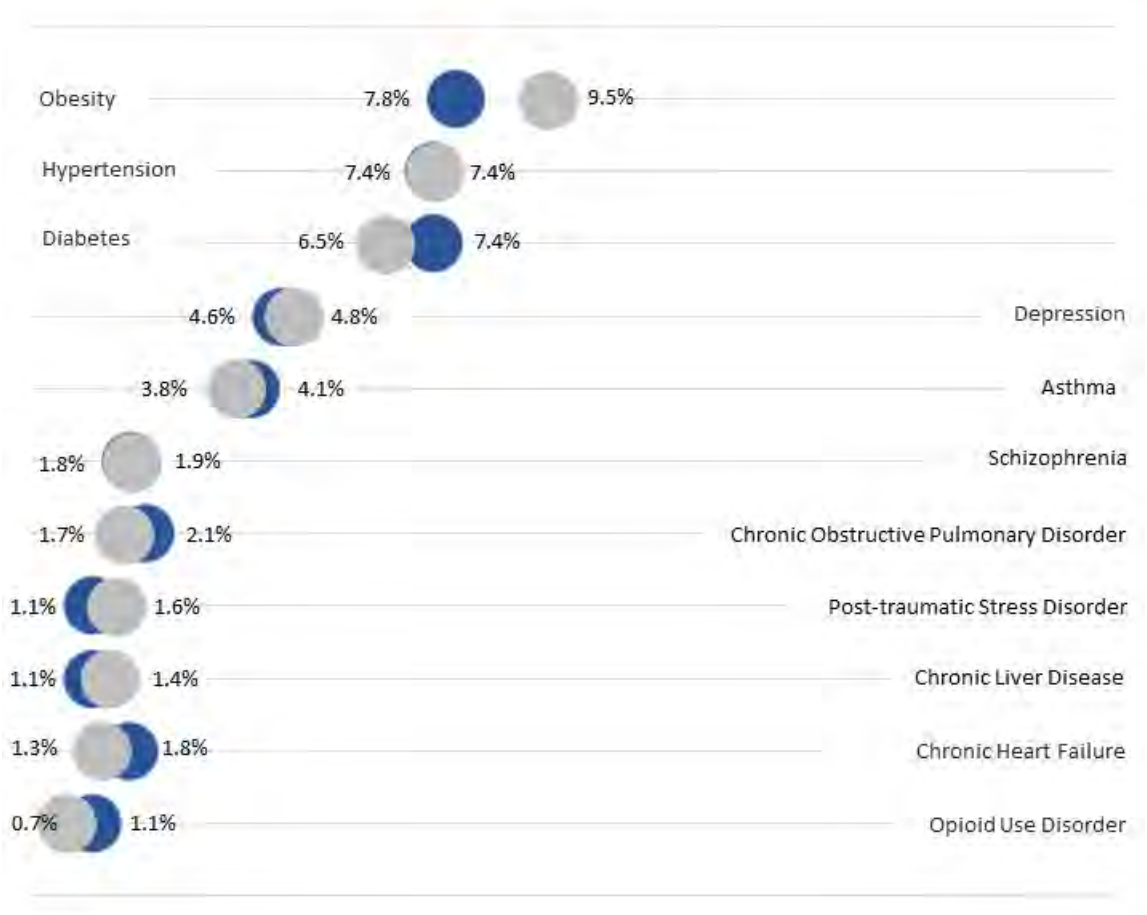
2016 *N* = 1,614; 2017 *N* = 1,535.

Source: Health Share of Oregon

Pacific Islander

Between 2016 and 2017, the prevalence of **obesity had the greatest increase** for Pacific Islander Health Share members in Multnomah County (Figure G.3-7). Rates of **diabetes, chronic obstructive pulmonary disorder, chronic heart failure, and opioid use disorder decreased**.

Figure G.3-7. Health Share of Oregon 2016 and 2017: Pacific Islander



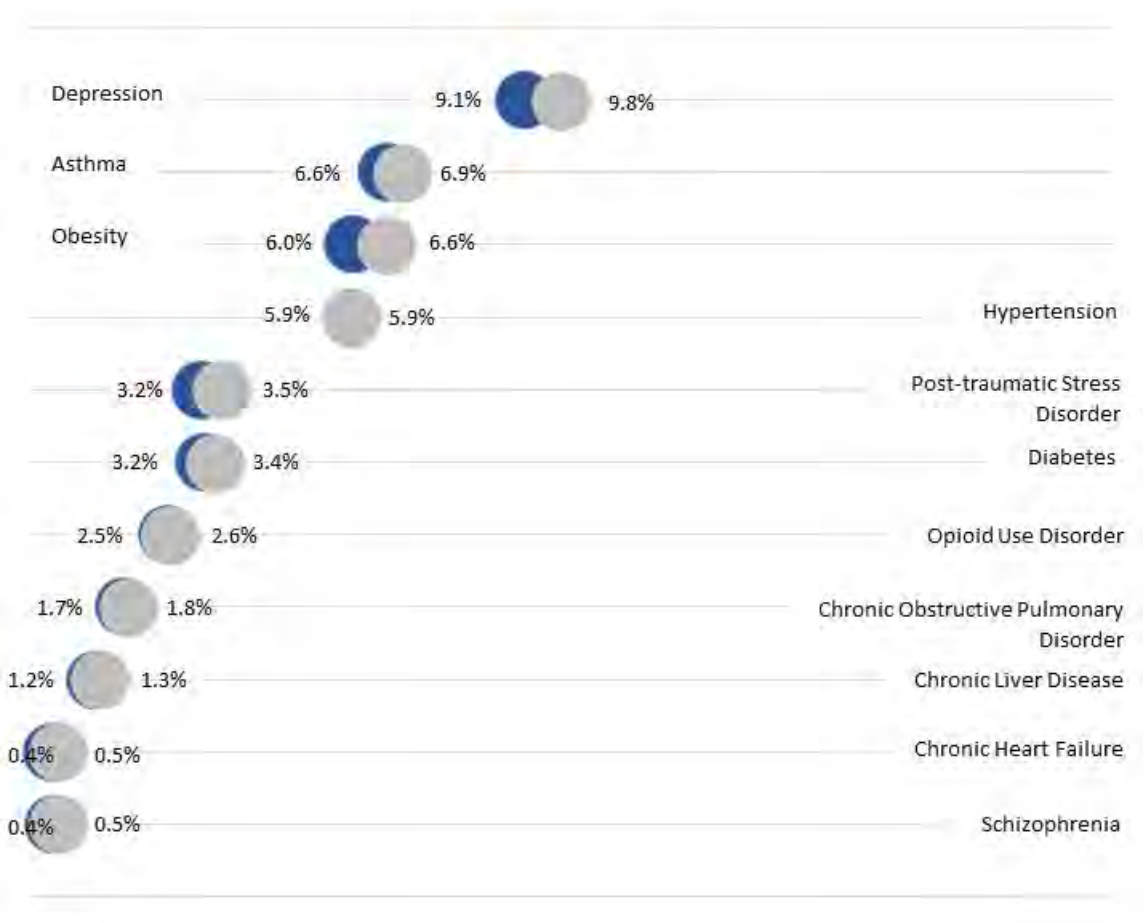
2016 *N* = 714; 2017 *N* = 767.

Source: Health Share of Oregon

Race Not Provided

In 2016 and 2017, the prevalence of **depression and obesity had the greatest increase** for Health Share of Oregon members in Multnomah County who did not provide their race or ethnicity at intake (Figure G.3-8).

Figure G.3- 8. Health Share of Oregon 2016 and 2017: Race Not Provided



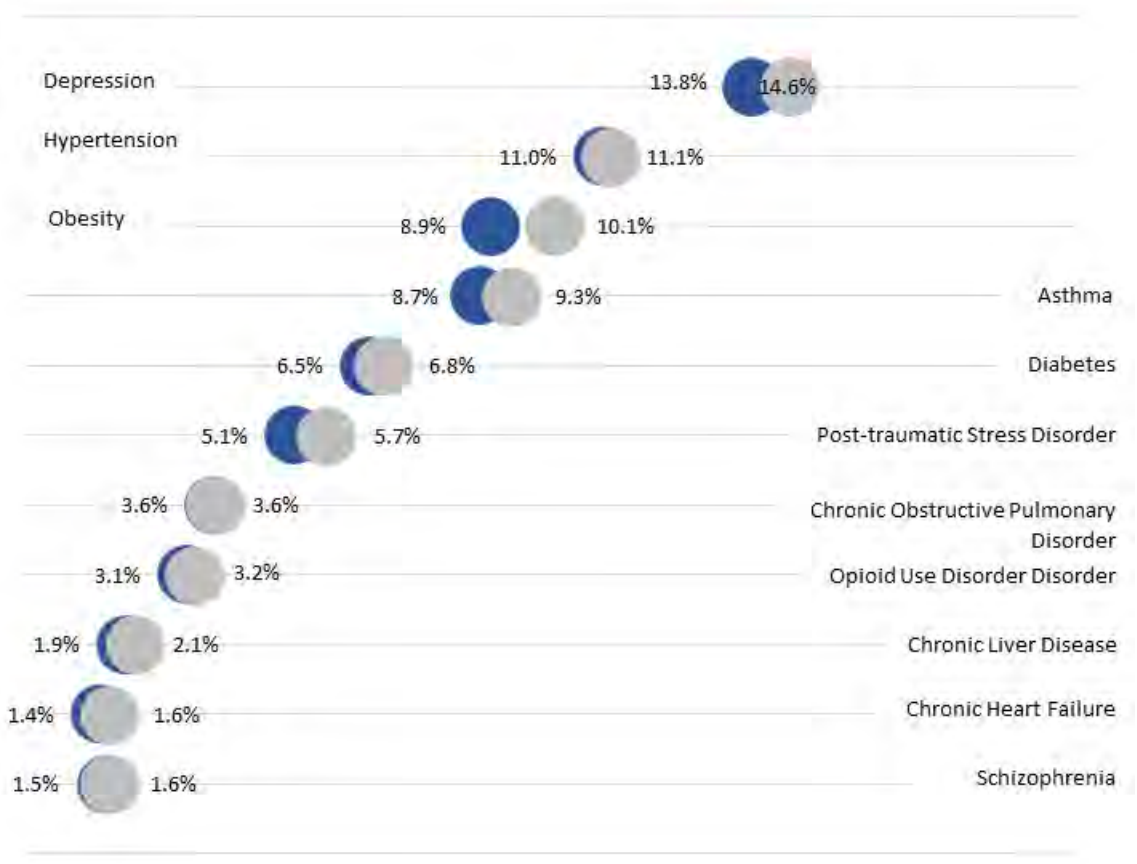
2016 *N* = 57,297; 2017 *N* = 57,669.

Source: Health Share of Oregon

Female

Between 2016 and 2017, the prevalence of **depression and obesity had the greatest increase** for female Health Share of Oregon members in Multnomah County (Figure G.3-9).

Figure G.3-9. Health Share of Oregon 2016 and 2017: Female.



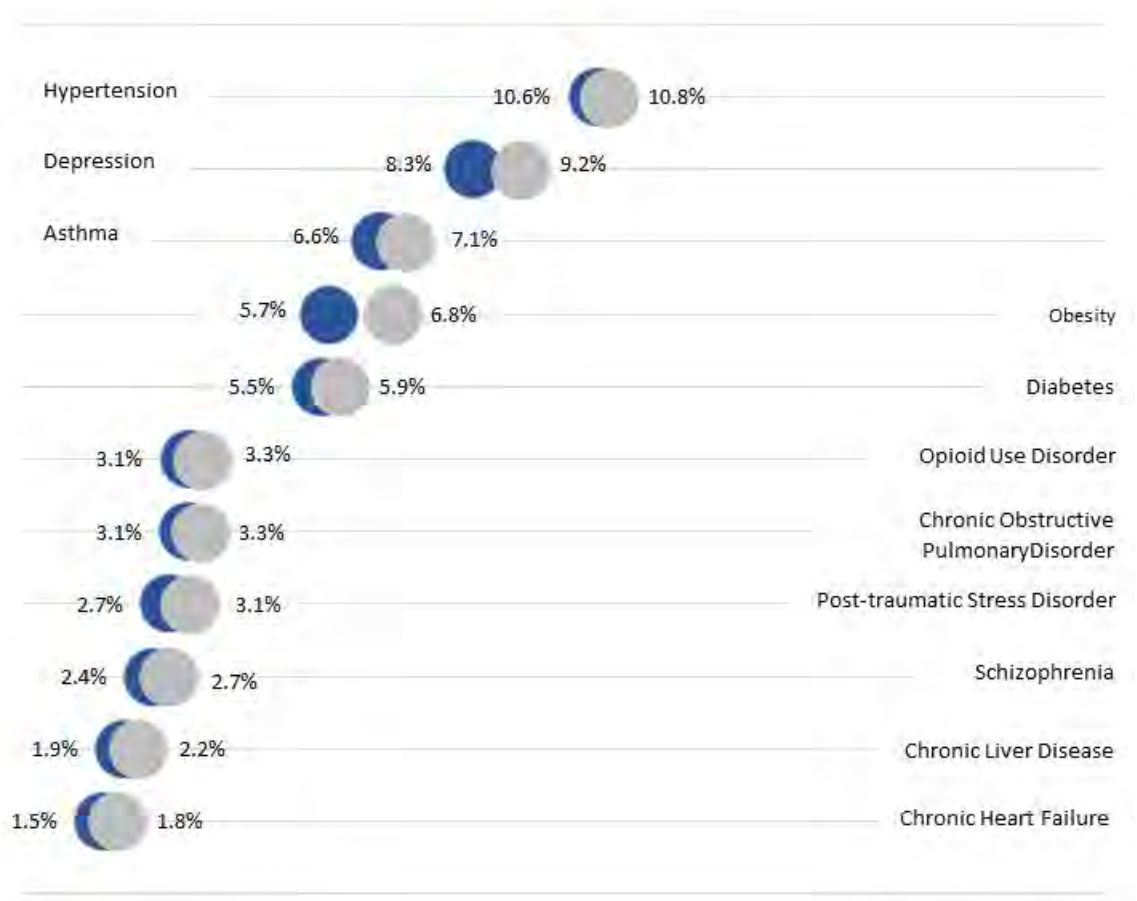
2016 *N* = 83,561; 2017 *N* =78,970

Source: Health Share of Oregon

Male

Between 2016 and 2017, **the prevalence of depression and obesity had the greatest increase** for male Health Share of Oregon members in Multnomah County (Figure G.3-10).

Figure G.3-10. Health Share of Oregon 2016 and 2017: Male.



2016 *N* = 77,542; 2017 *N* = 72,300.

Source: Health Share of Oregon

Communicable Disease

Communicable diseases are infections, usually viral or bacterial, that are spread from person to person. The following table presents the age-adjusted incidence rates for the 10 most common communicable diseases in Multnomah County across three time periods.

Table G.3-2. Top 10 Communicable Diseases in Multnomah County.

Rank	Communicable Disease	2007–2009	2009–2011	2014–2016
1	Chlamydia	435.6	484.0	605.7
2	Gonorrhea	83.1	88.2	178.8
3	Hepatitis C (chronic)	207.9	174.9	158.2
4	Syphilis (Early)	4.0	10.0	30.6
5	Campylobacteriosis	20.8	24.7	26.4
6	Hepatitis B (chronic)	25.8	24.0	24.6
7	Giardiasis	20.2	21.9	18.7
8	Salmonellosis (non-typhoidal)	11.6	12.7	11.9
9	HIV/AIDS	15.8	14.6	11.4
10	Pertussis (whooping cough)	5.5	11.2	8.3

Note. All rates are per 100,00 population and are age-adjusted to the 2000 U.S. standard population.

G.4. Washington County Overview

Demographics

In Table G.4-1, basic demographic characteristics of the population are outlined: number of people in Washington County, age, racial/ethnic identify, disability, immigration status, language, and sex.

Table G.4-1. Selected Demographic Characteristics in Washington County: Total Population=564,088.

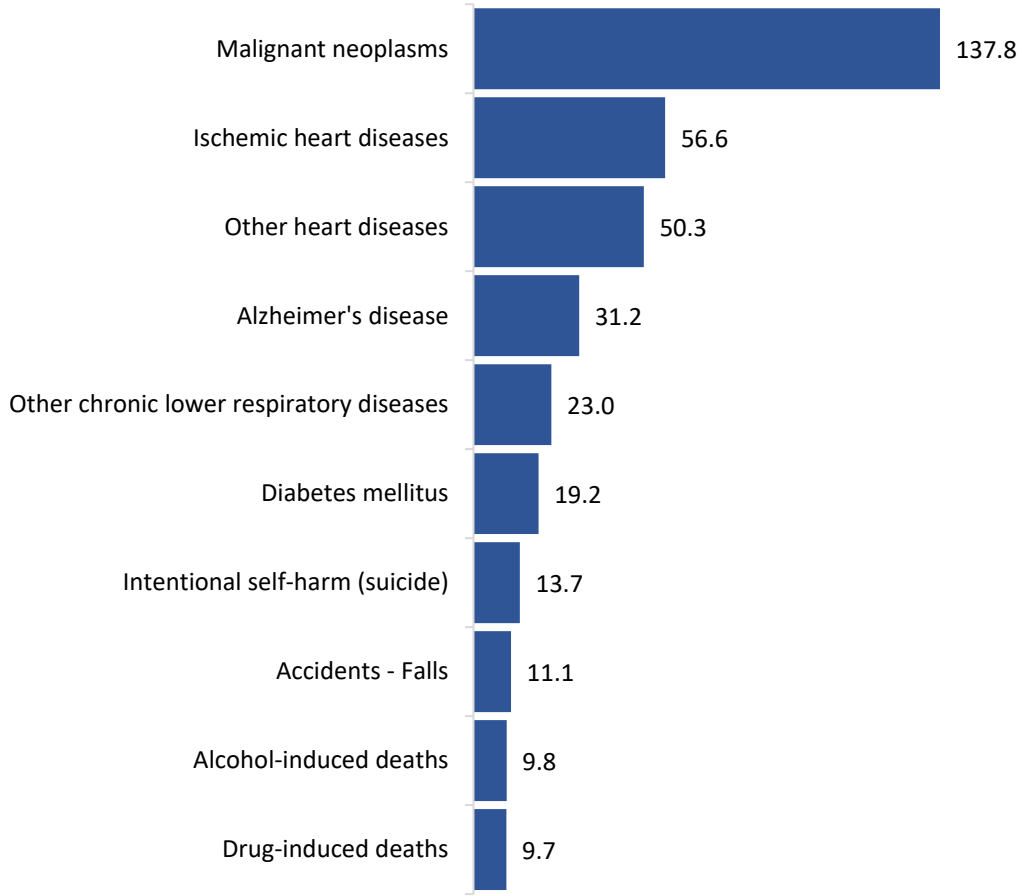
Demographic characteristic	% of Population
Gender	
Male	49.3%
Female	50.7%
Age	
Median age (years)	36.2
Under 5 years	6.6%
5 to 19 years	19.9%
20 to 44 years	36.4%
45 to 64 years	25.2%
65 years and older	11.8%
Race/ethnicity	
American Indian and Alaska Native	0.6%
Asian	9.5%
Black or African American	1.8%
Hispanic or Latino (of any race)	16.2%
Native Hawaiian and Other Pacific Islander	0.4%
Two or more races	4.9%
White	77.6%
With a disability	10.2%
Foreign born	17.0%
Language other than English spoken at home	24.1%

Source: American Community Survey 5-year estimates 2012-2016.

Mortality Rate

The mortality rate is the number of deaths per 100,000 people in a defined population over a specific time period. Figure G-4-1 shows the mortality rates of the leading causes of death in Washington County between 2012 and 2016.

Figure 1. Washington County Mortality Rates 2012–2016.



Note: All rates are per 100,00 population and are age-adjusted to the 2000 US standard population.
Source: Oregon Public Health Assessment Tool (OPHAT).

Chronic Disease in the Washington County Medicaid Population

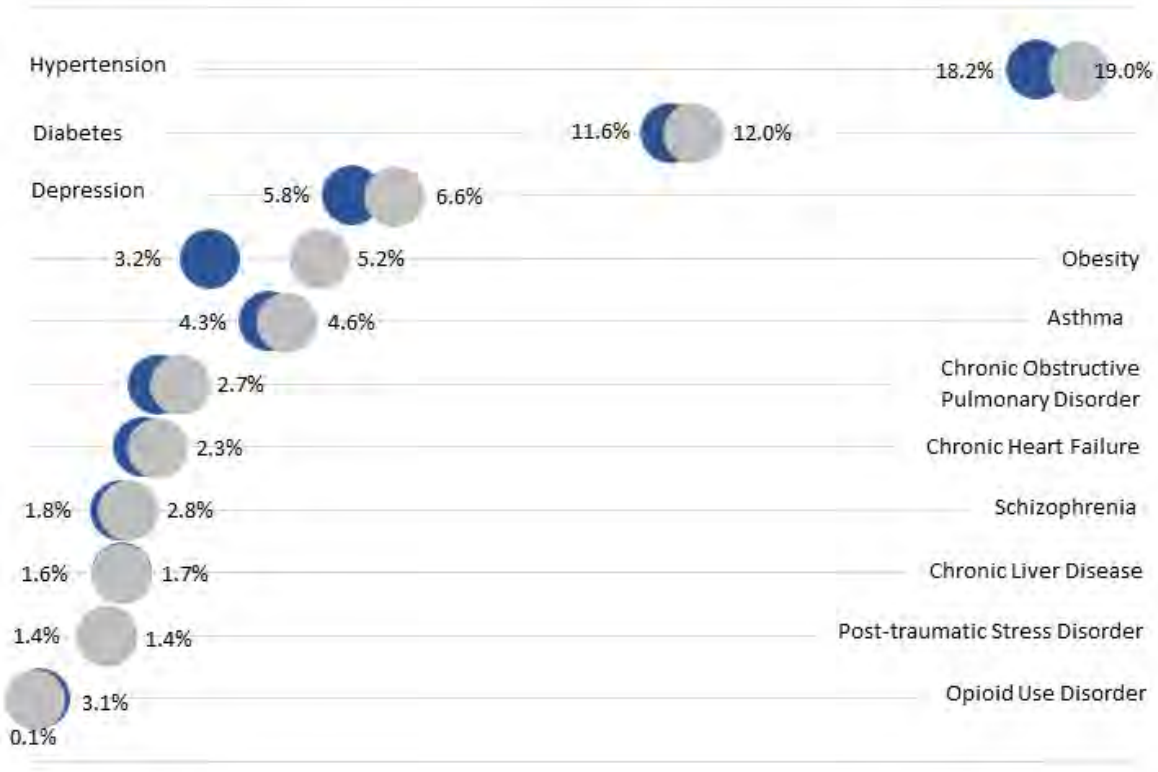
Medicaid is the second largest source of health insurance in the United States after employer-provided insurance and historically has covered low-income children and parents, pregnant women, and people with disabilities.[1]

In Washington County, Medicaid beneficiaries are covered through Health Share of Oregon. To identify the prevalence of chronic conditions in the region's Medicare population, Health Share of Oregon provided member utilization data from 2016 and 2017.

Asian

Between 2016 and 2017, the prevalence of **obesity had the greatest increase** for Asian Health Share of Oregon members in Washington County[2].

Figure G.4-2. Health Share of Oregon 2016 and 2017: Asian.



Note: 2016 N = 10,708; 2017 N = 10,117.

Source: Health Share of Oregon.

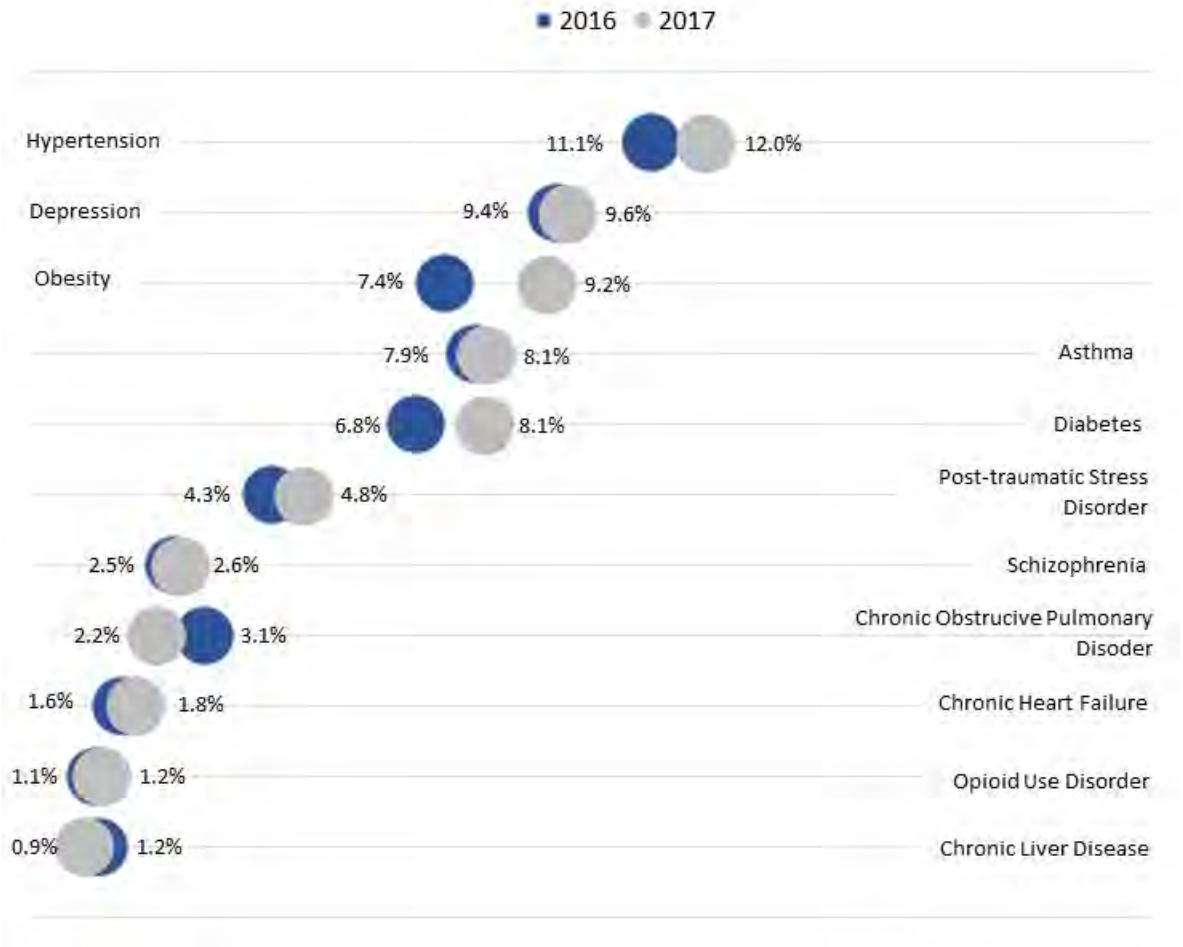
[1] Centers for Medicare & Medicaid Services. 2013 CMS Statistics. U.S. DHHS, Baltimore, MD; 2013.

[2] Asian at Health Share of Oregon includes Chinese, Vietnamese, Korean, Hmong, Laotian, Filipino/a, Japanese, South Asian, Asian India, Other Asian, and Asian.

Black/African American

Between 2016 and 2017, the prevalence of **hypertension and obesity** the greatest increase for Black/African American Health Share of Oregon members in Washington County.

Figure G.4-3. Health Share of Oregon 2016 and 2017: Black/African American.



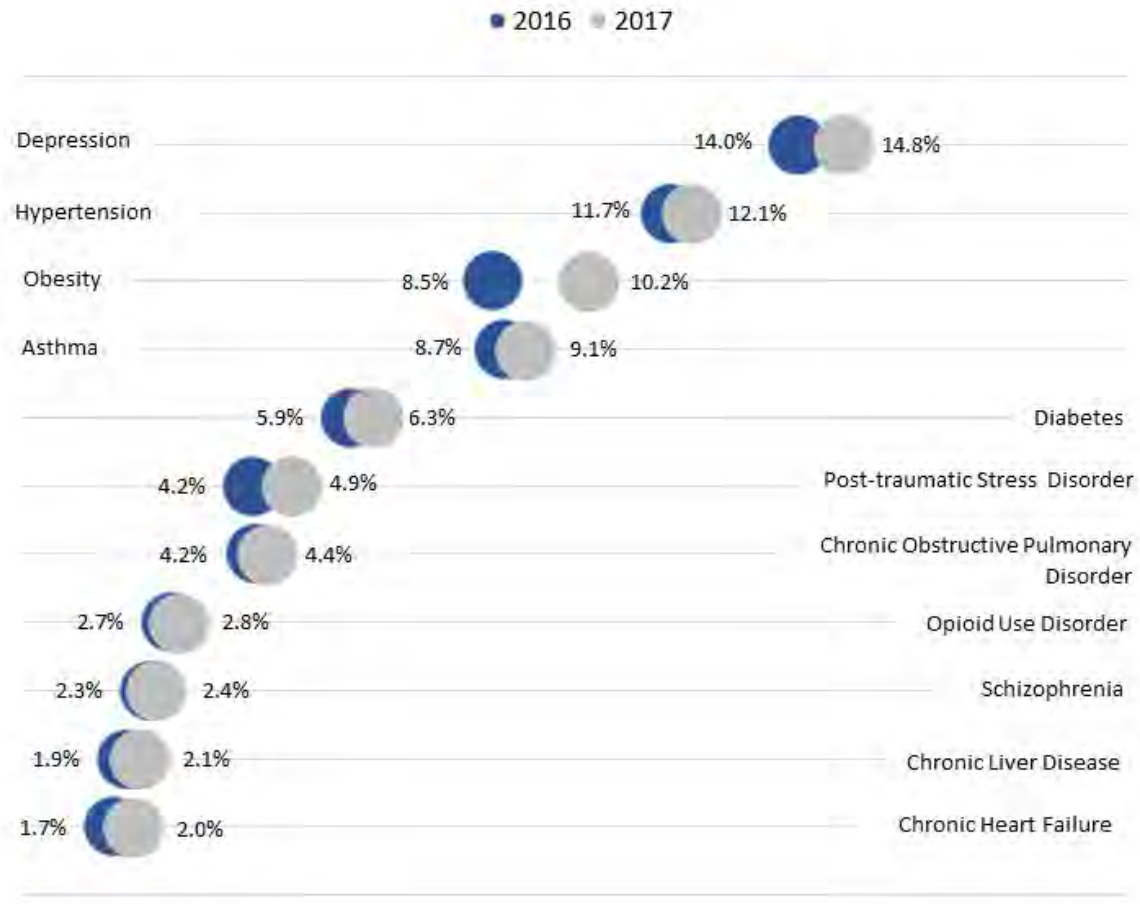
Note: 2016 N = 13,879; 2017 N = 12,770.

Source: Health Share of Oregon.

Caucasian

Between 2016 and 2017, rates of **depression and obesity had the greatest increase** for Caucasian Health Share of Oregon members in Washington County.

Figure G.4-4. Health Share of Oregon 2016 and 2017: Caucasian.



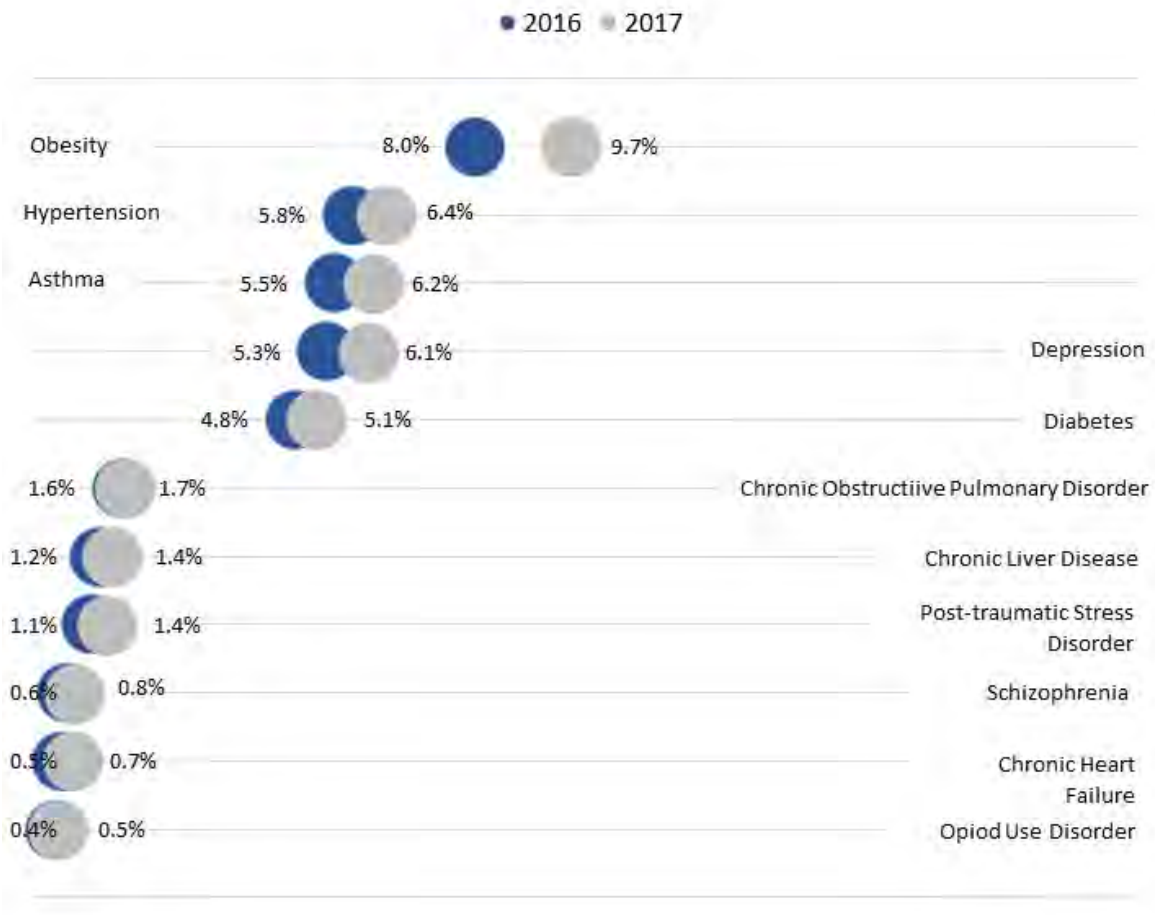
Note: 2016 N = 61,357; 2017 N = 55,255.

Source: Health Share of Oregon.

Hispanic

Between 2016 and 2017, the prevalence of **obesity had the greatest increase** for Hispanic (of any race) Health Share of Oregon members in Washington County.

Figure G.4-5. Health Share of Oregon 2016 and 2017: Hispanic.



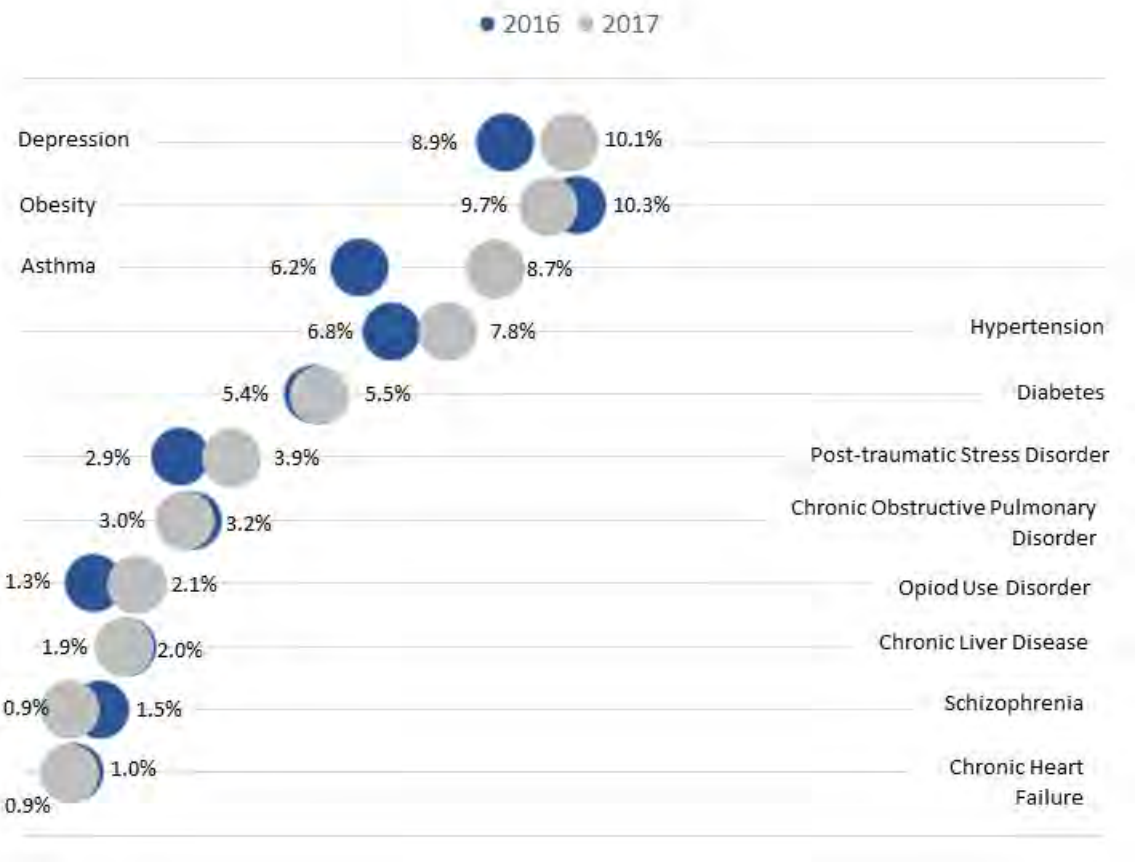
Note: 2016 N = 12,834; 2017 N = 11,116.

Source: Health Share of Oregon.

Native American

Between 2016 and 2017, the prevalence of **depression, asthma, and hypertension** had the greatest increase for Native American Health Share of Oregon members in Washington County.

Figure G.4-6. Health Share of Oregon 2016 and 2017: Native American.



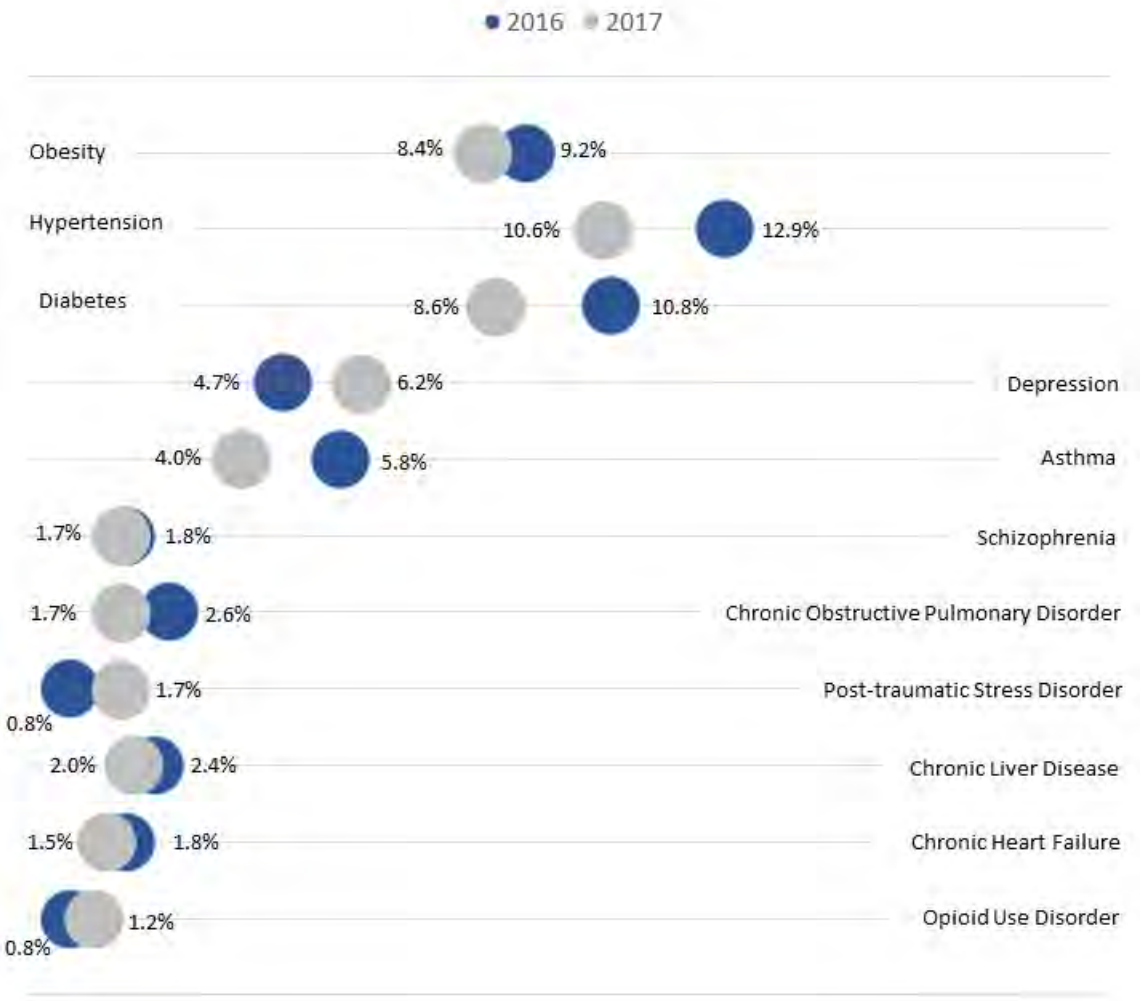
Note: 2016 N = 1,614; 2017 *N* = 1,535.

Source: Health Share of Oregon.

Pacific Islander

Between 2016 and 2017, the prevalence of **depression had the greatest increase** for Pacific Islander Health Share members in Washington County. Rates of **hypertension, diabetes, asthma, and chronic obstructive pulmonary disorder decreased**.

Figure G.4-7. Health Share of Oregon 2016 and 2017: Pacific Islander.



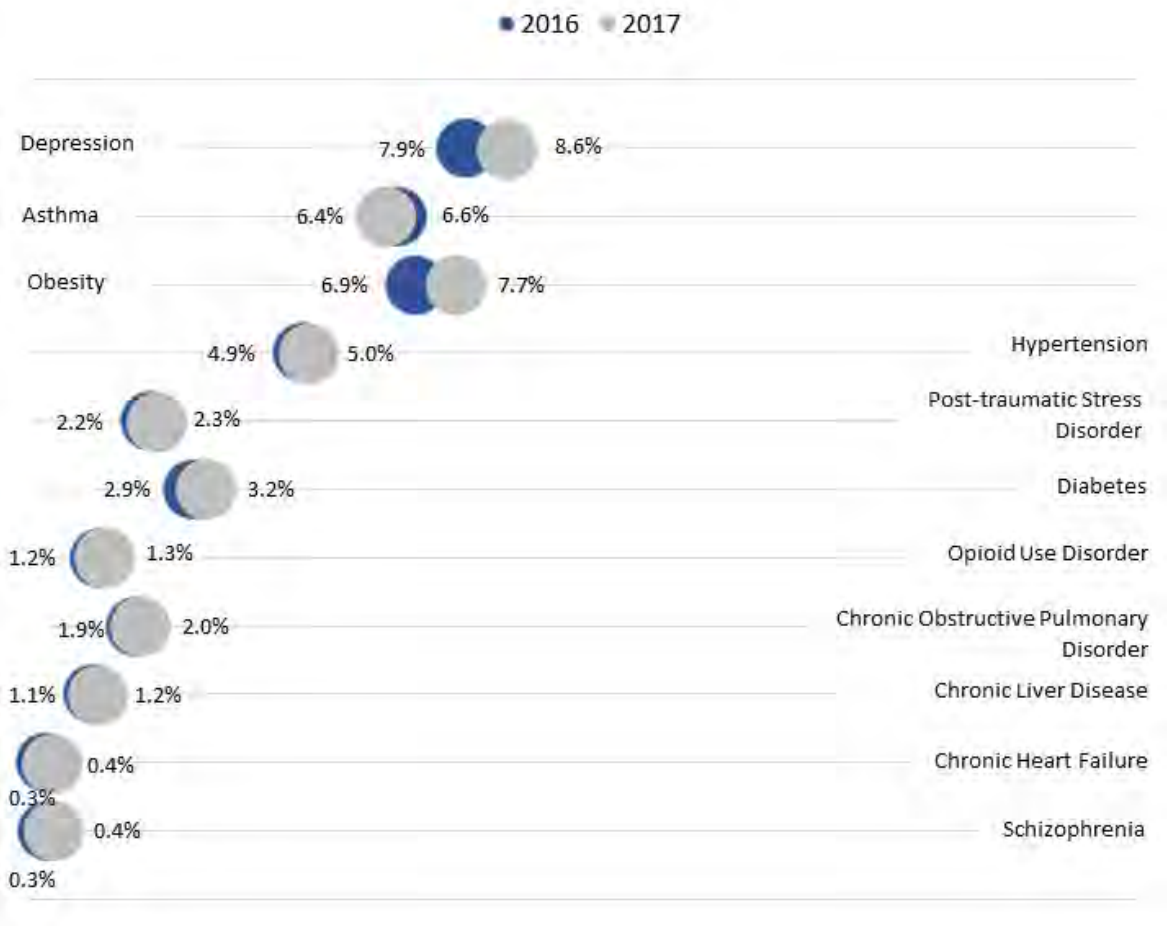
2016 *N* = 714; 2017 *N* = 767.

Source: Health Share of Oregon.

Race Not Provided

In 2016 and 2017, the prevalence of **depression and obesity had the greatest increase** for Health Share of Oregon members in Washington County who did not provide their race or ethnicity at intake.

Figure 8. Health Share of Oregon 2016 and 2017: Race Not Provided.

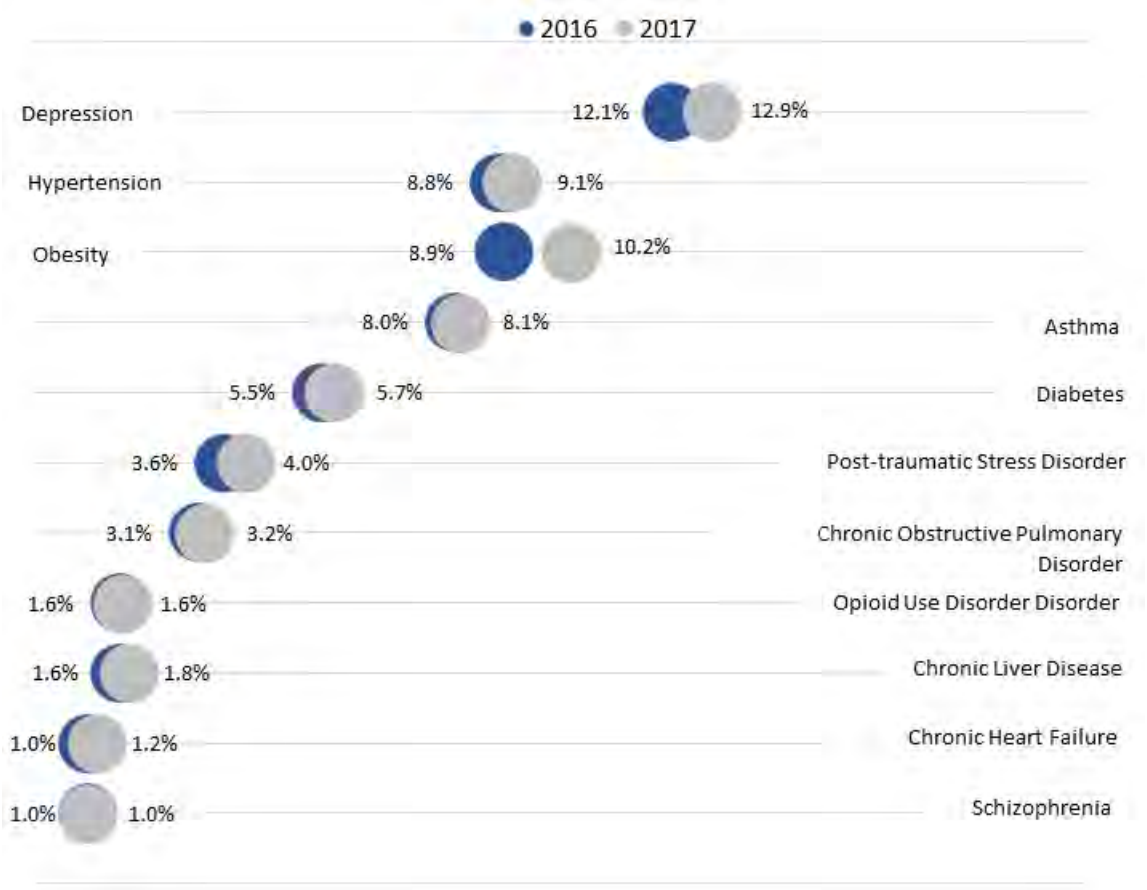


2016 N = 57,297; 2017 N = 57,669.
Source: Health Share of Oregon

Female

Between 2016 and 2017, the prevalence of **depression and obesity had the greatest increase** for female Health Share of Oregon members in Washington County.

Figure G.4-9. Health Share of Oregon 2016 and 2017: Female.

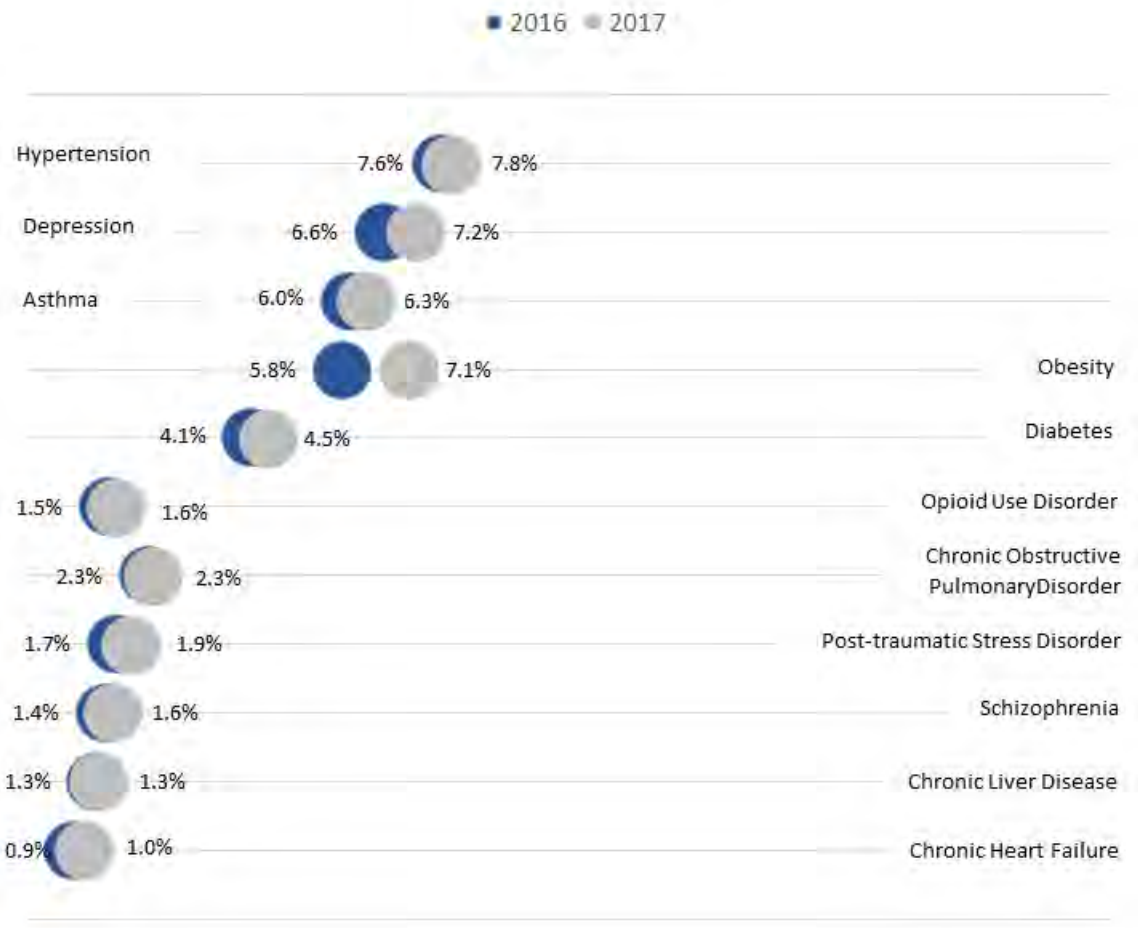


2016 N = 83,561; 2017 N =78,970.

Source: Health Share of Oregon.

Male

Between 2016 and 2017, the prevalence of **depression and obesity had the greatest increase** for male Health Share of Oregon members in Washington County.



2016 N = 77,542; 2017 N = 72,300.

Source: Health Share of Oregon.

Communicable Disease

Communicable diseases are infections, usually viral or bacterial, that are spread from person to person. The table below presents the age-adjusted incidence rates for the 10 most common communicable diseases in Washington County across three time periods.

Table G.4-2. Top 10 Communicable Diseases in Washington County.

Rank	Communicable Disease	2007-2009	2009-2011	2014-2016
1	Chlamydia	229.2	282.0	383.6
2	Hepatitis C (chronic)	99.6	74.3	87.0
3	Gonorrhea	20.5	20.5	57.7
4	Campylobacteriosis	19.0	21.3	20.2
5	Hepatitis B (chronic)	17.9	14.5	18.6
6	Syphilis (Early)	0.9	3.2	14.1
7	Salmonellosis (non-typhoidal)	11.9	11.4	11.1
8	Pertussis (whooping cough)	3.6	4.4	10.1
9	Giardiasis	8.3	8.8	7.0
10	HIV/AIDS	6.9	5.6	5.9

Note: All rates are per 100,00 population and are age-adjusted to the 2000 US standard population.
Source: Oregon Public Health Assessment Tool (OPHAT).

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David Mancuso, PhD, DSHS Research and Data Analysis Division LTSS Studies

Achievements in Long-Term Services and Supports: Rebalancing and the Age Wave

David Mancuso, PhD

Director, DSHS Research and Data Analysis Division

October 19, 2017

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Overview

PART 1

The Impact of LTSS Rebalancing: Estimated Medicaid Savings from SFY 2000 to SFY 2018

PART 2

An Illustration of Program Innovation Supporting Rebalancing: The Roads to Community Living (RCL) Program

PART 3

The Impact of the Age Wave

Appendix

Supplemental Data by County

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PART 1

LTSS Rebalancing: Estimated Medicaid Savings from SFY 2000 to SFY 2018

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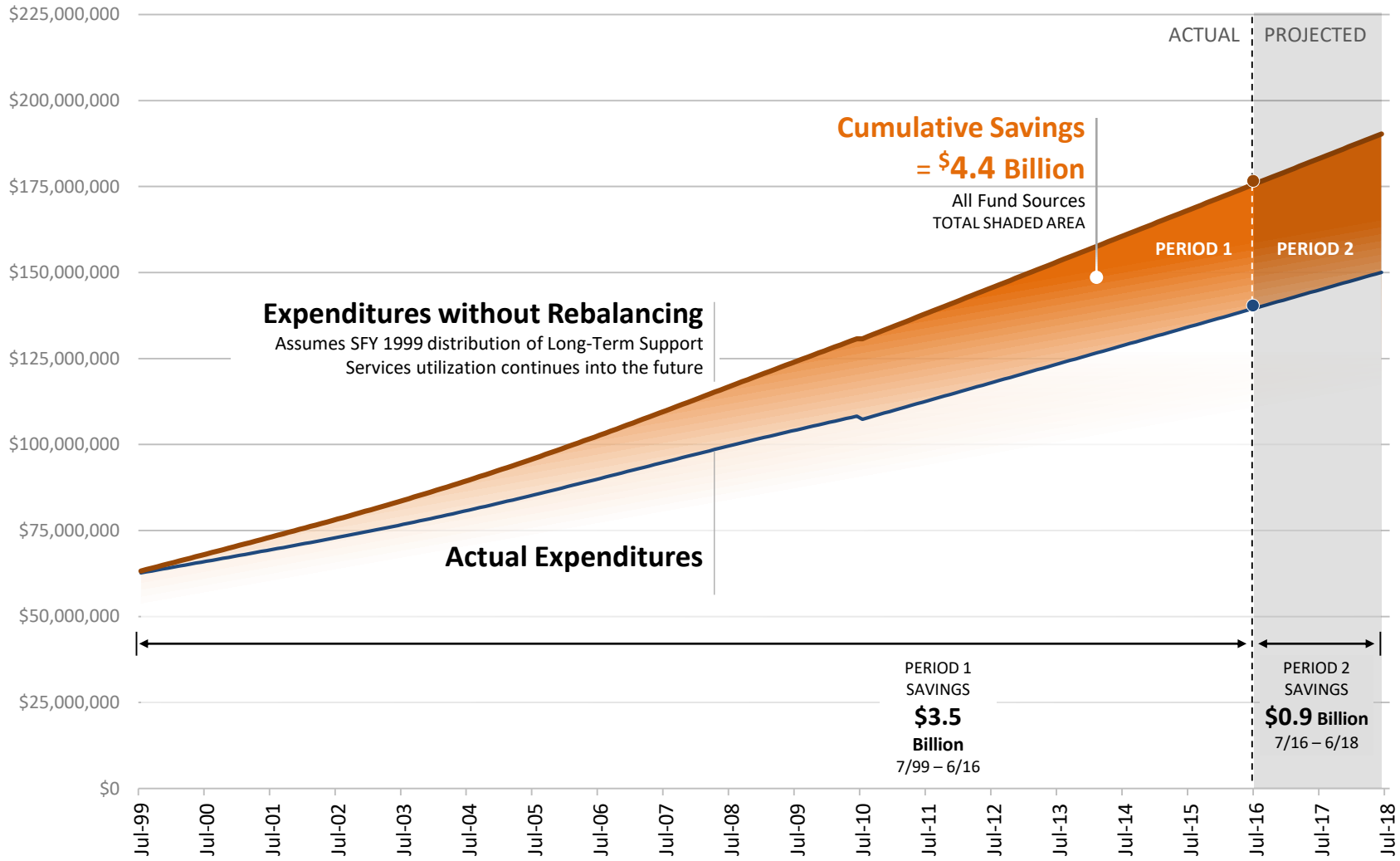
LTSS Rebalancing Financial Impact Methodology

- **Calculate the percentage distribution of ALTSA LTSS clients across major service modalities in SFY 1999: In-home Personal Care, Adult Family Homes, Assisted Living, Adult Residential Centers, and Nursing Homes**
- **Simulate the caseloads that would have been experienced by major modality if percentage distribution of LTSS caseloads across modalities over the SFY2000-2018 period had remained the same as experienced in SFY 1999**
- **Simulate the expenditures that would have been experienced by applying actual SFY 2000-2018 per capita costs by service modality to the simulated caseload distribution**
- **Compare the total costs of the simulated caseload distribution to the actual and forecast total LTSS costs incurred over the SFY 2000-2018 period**
- **The difference comprises the estimated savings (all funds)**

ALTSA LTSS Rebalancing Savings

Monthly Service Expenditures • All Fund Sources • SFY 2000-2018



DATA SOURCE: RDA EMIS. For In-home Services, RDA EMIS caseload data are adjusted to Caseload Forecast Council caseload data from July 2003 to January 2005.

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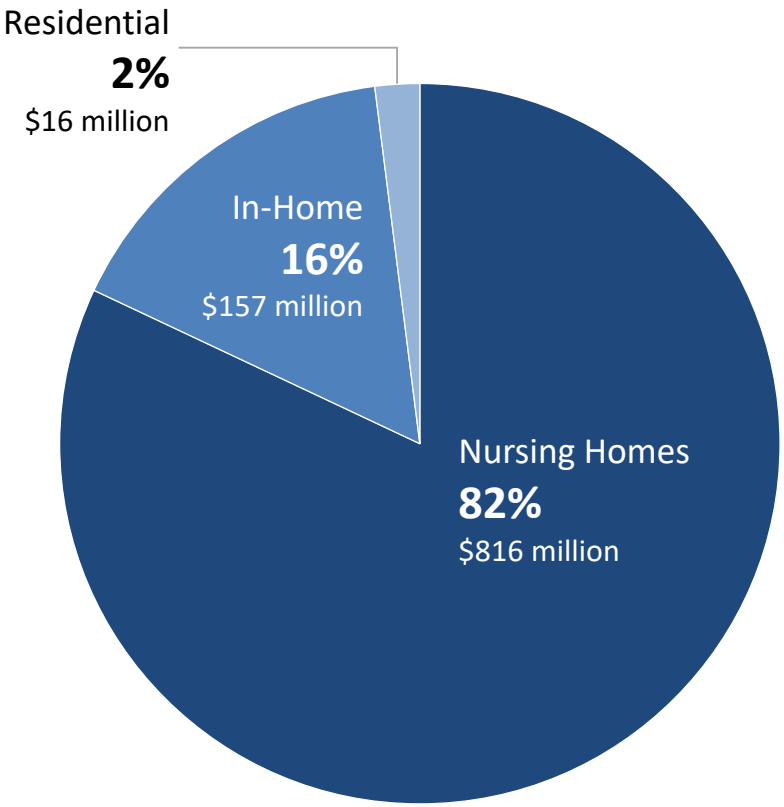
Long-Term Services and Supports Expenditure Shift

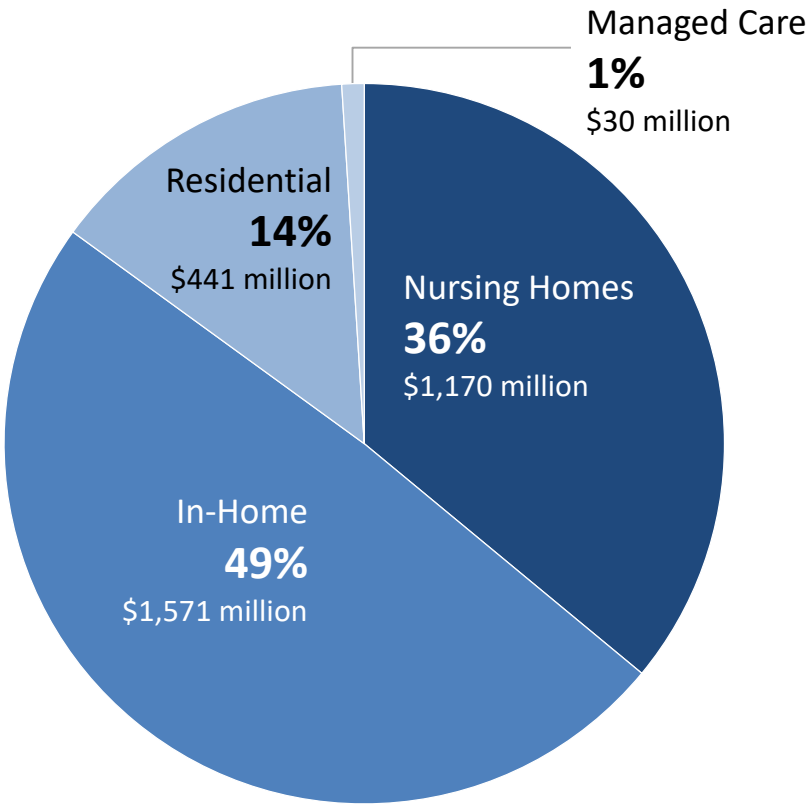
1991-93 Biennium

TOTAL BUDGET = $1 BILLION
CASELOAD FOR ALL SERVICES APPROXIMATELY 38,000 CLIENTS



2013-15 Biennium

TOTAL BUDGET = $3 BILLION
CASELOAD FOR ALL SERVICES APPROXIMATELY 60,000 CLIENTS



SOURCE: Washington State Department of Social and Health Services, Aging and Long-Term Support Administration.

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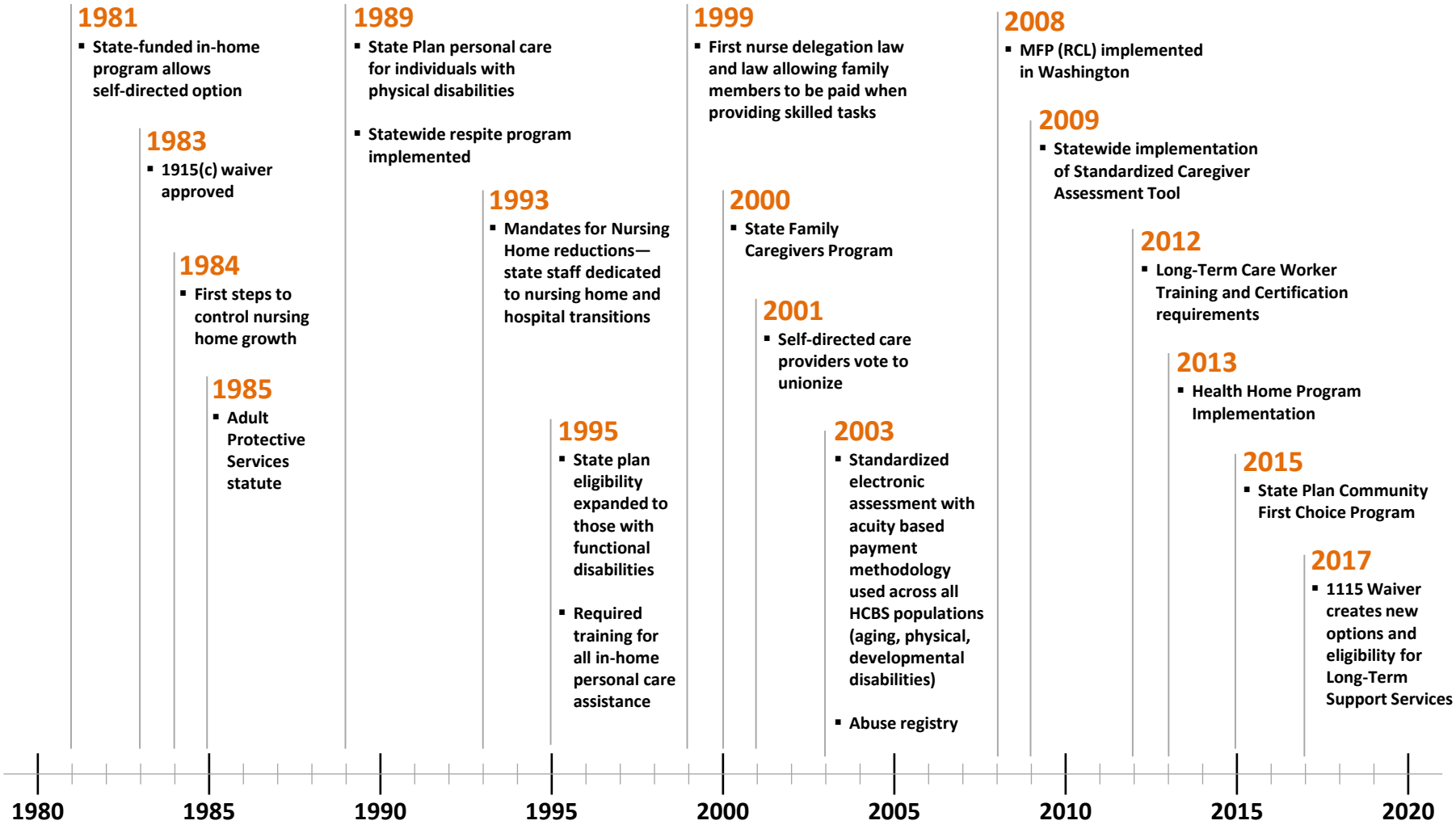
LTSS Program Innovations Supporting Rebalancing



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PART 2

Impact of the Roads to Community Living (RCL) Demonstration on Medicaid Long-Term Services and Supports Costs

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Background

RCL demonstration services

- Person-centered care plan tailored to individual needs
- Services needed during the move and transition back into the community
- Access to additional services and supports not currently available through existing Medicaid waivers for one year after the person has moved into the community

Examples of RCL demonstration services

- Community choice guide
- Challenging behavior consultation
- Transitional mental health services
- Professional therapy services
- Informal caregiver support services
- Substance abuse services
- Respite services
- Adult day trial services
- Assistive technology
- Demonstration transition items
- Residential environmental modifications

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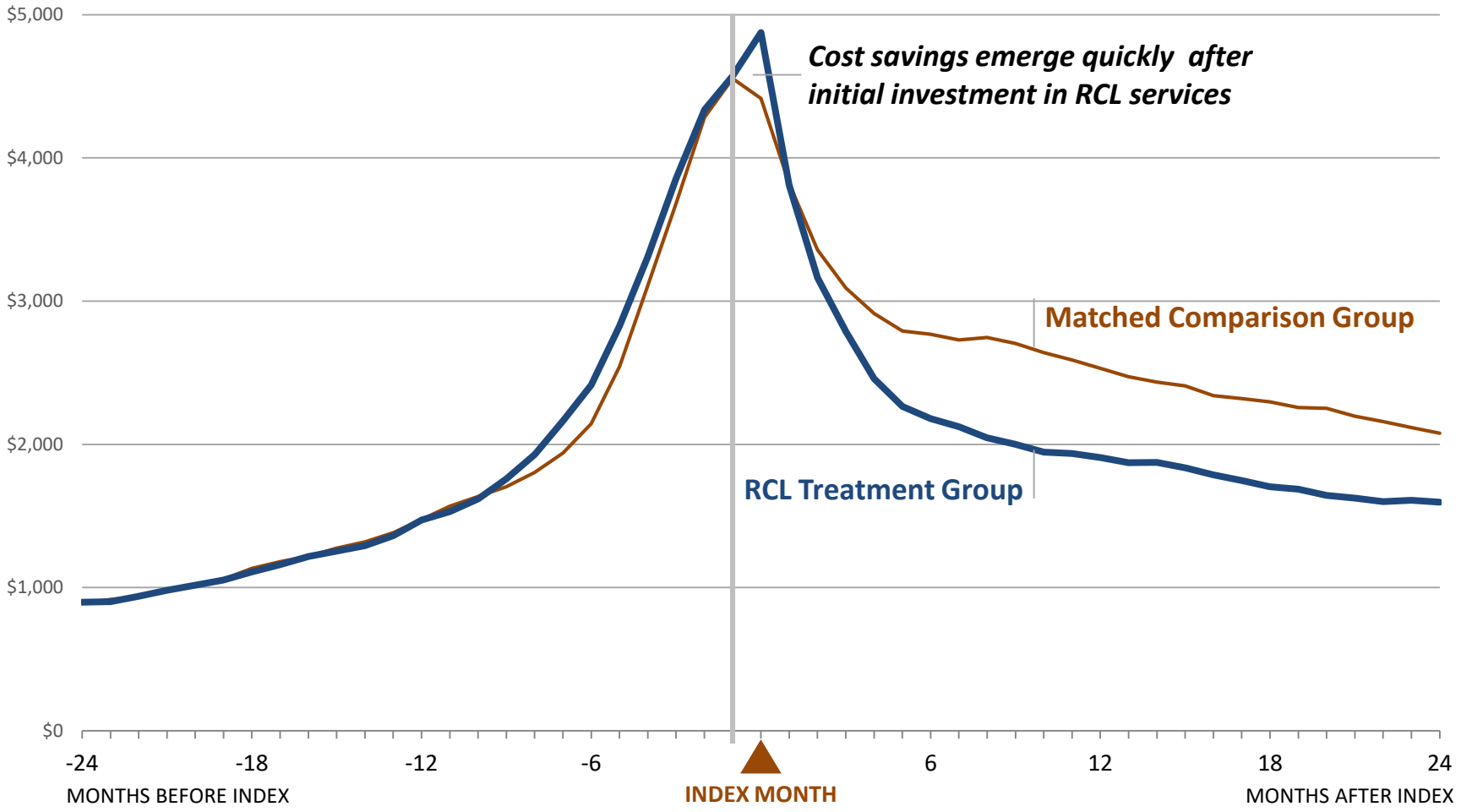
Evaluation Overview

- **Study Goal**
  - Evaluate the impact of the "Roads to Community Living" demonstration on use of LTSS services
- **Who is eligible for the RCL demonstration?**
  - Living in a nursing facility for 3 months or longer ***AND*** receiving Medicaid to pay for care
- **RCL treatment group**: clients initiating RCL services in the study intake window and meeting inclusion criteria
- **Matched comparison group:**
  - One-to-one matching links each RCL treatment group member to their "best match" – the person most similar to the RCL treatment group member when they began receiving RCL services
- **Index month**: month of first receipt of an RCL service
- **Sample size after matching**
  - RCL treatment group: 1,738 persons
  - Matched comparison group: 1,738 persons
- **Study data sources**
  - Minimum Data Set (MDS)
  - CARE assessment to identify Home and Community Services intakes
  - DSHS Integrated Client Database for LTSS services
  - Medicaid and Medicare claims data (nursing facility stays, inpatient hospitalizations)

TOTAL – ALL COSTS, INCLUDING RCL DEMONSTRATION COSTS

HCBS, Nursing Home and RCL Demonstration Services Costs

MONTHLY AVERAGE COST ACROSS ALL RCL TREATMENT AND MATCHED COMPARISON GROUP MEMBERS
INCLUDING CLIENTS WITH NO COSTS WHO DID NOT RECEIVE LTSS SERVICES IN THE MONTH



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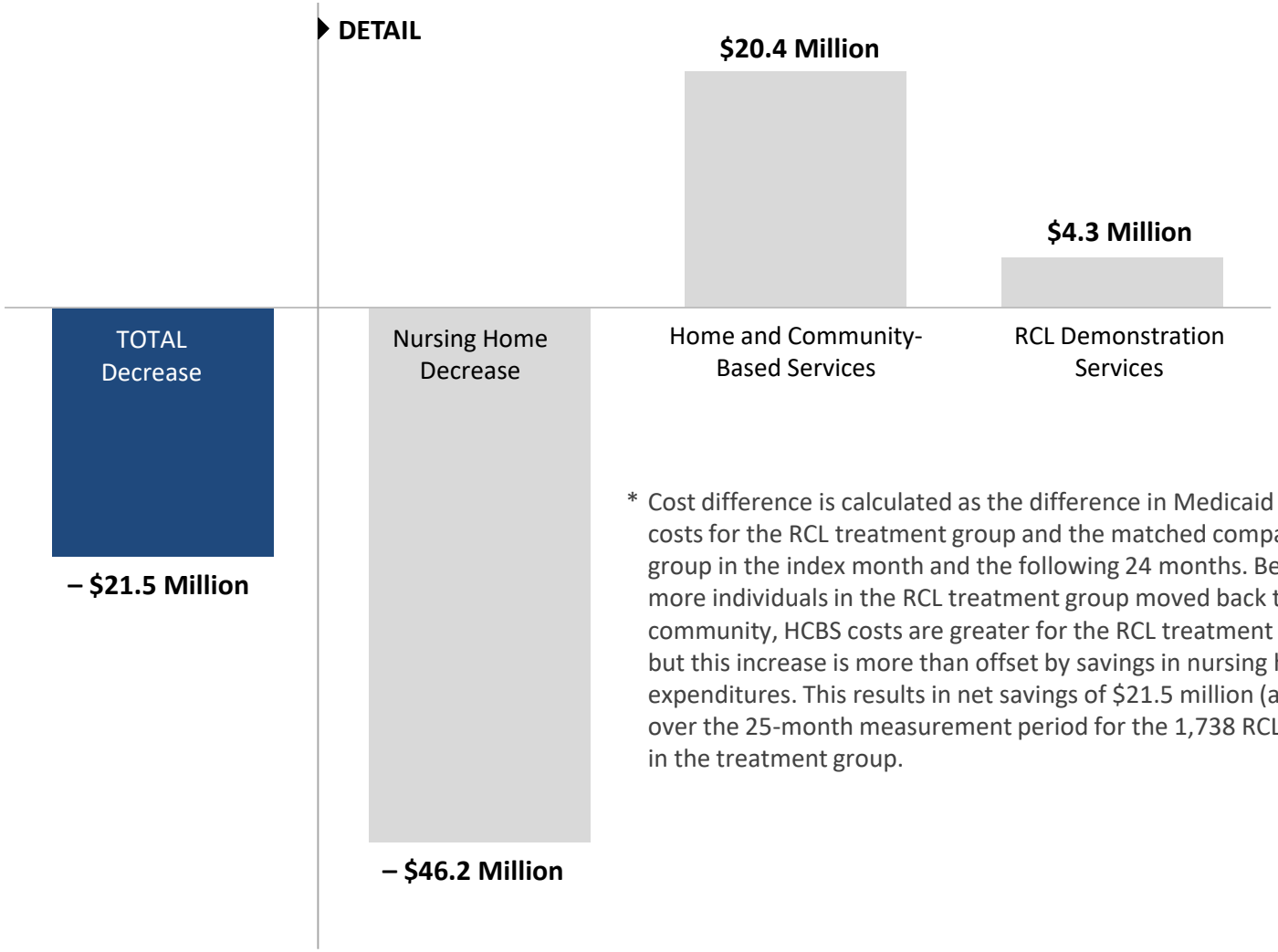
DSHS Research and Data Analysis Division, Client Outcomes Database, August 2016

Overall Cost Impact Summary (all funds)

OVERALL COST DIFFERENCE* BETWEEN RCL TREATMENT GROUP AND MATCHED COMPARISON GROUP
OVER THE INDEX MONTH AND THE 24-MONTH FOLLOW-UP PERIOD



* Cost difference is calculated as the difference in Medicaid LTSS costs for the RCL treatment group and the matched comparison group in the index month and the following 24 months. Because more individuals in the RCL treatment group moved back to the community, HCBS costs are greater for the RCL treatment group, but this increase is more than offset by savings in nursing home expenditures. This results in net savings of $21.5 million (all funds) over the 25-month measurement period for the 1,738 RCL clients in the treatment group.

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Source: Research and Data Analysis Division, Client Outcomes Database, August 2016


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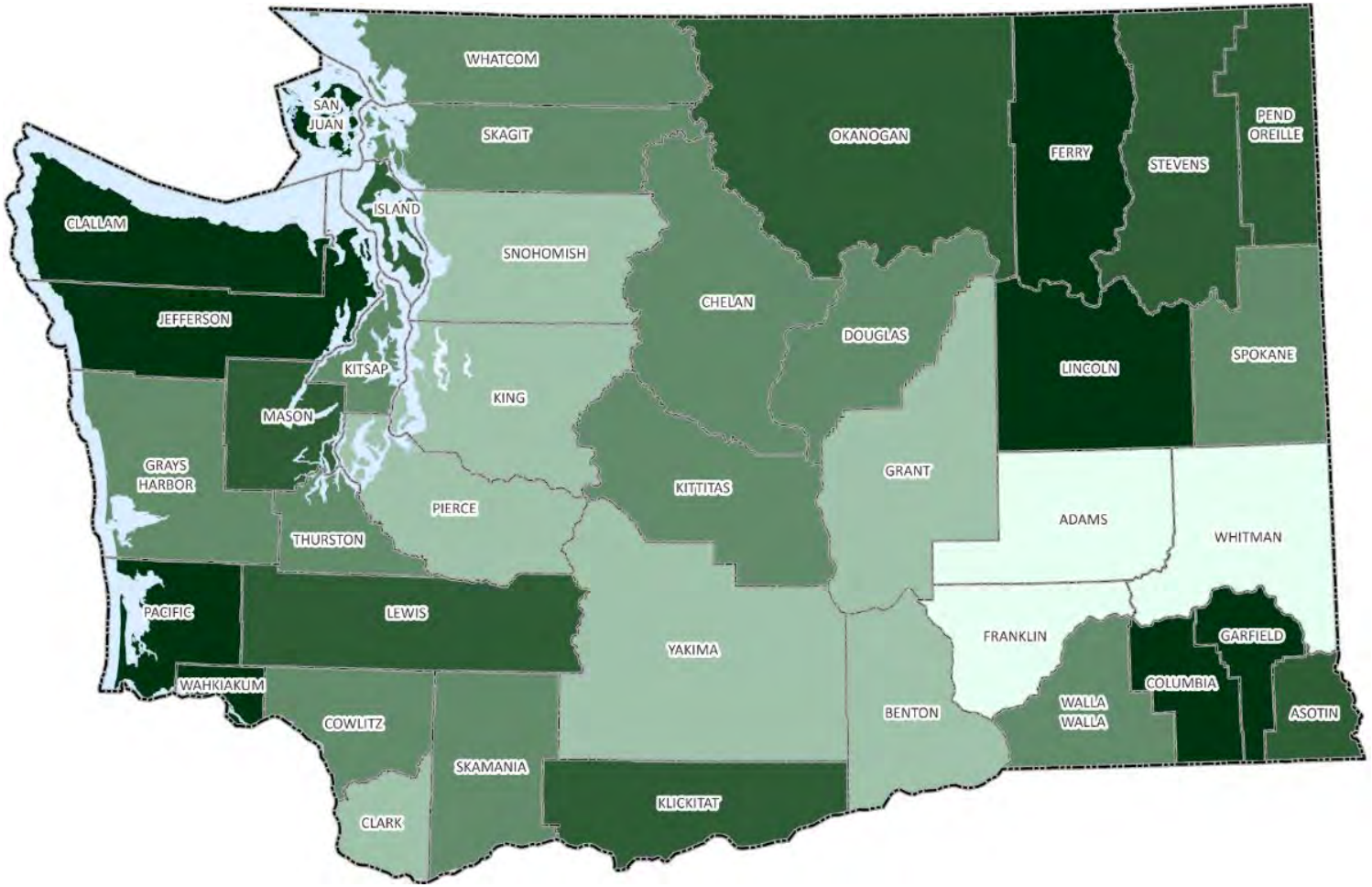
PART 3
The Impact of the Age Wave

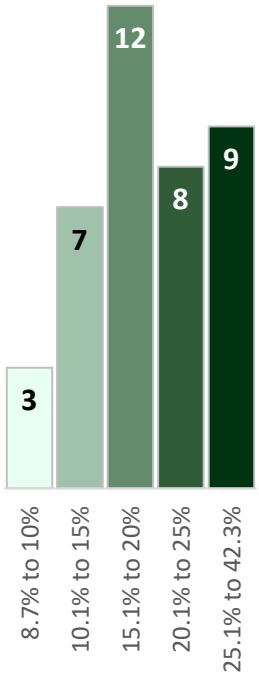
Persons 65+ as a Percentage of the Total Population

Estimates and Projections by County

2016



Number of counties



PERCENT OF SENIORS AGE 65+

8.7% to 10% | 10.1% to 15% | 15.1% to 20% | 20.1% to 25% | 25.1% to 42.3%

SOURCES: Washington State Office of Financial Management, 2012 County Growth Management Population Projections by Age and Sex: 2010-2040. Small Area Demographic Estimates (SADE) by Age, Sex, Race and Hispanic Origin: Counties, Version: 20161203_R03_VM.

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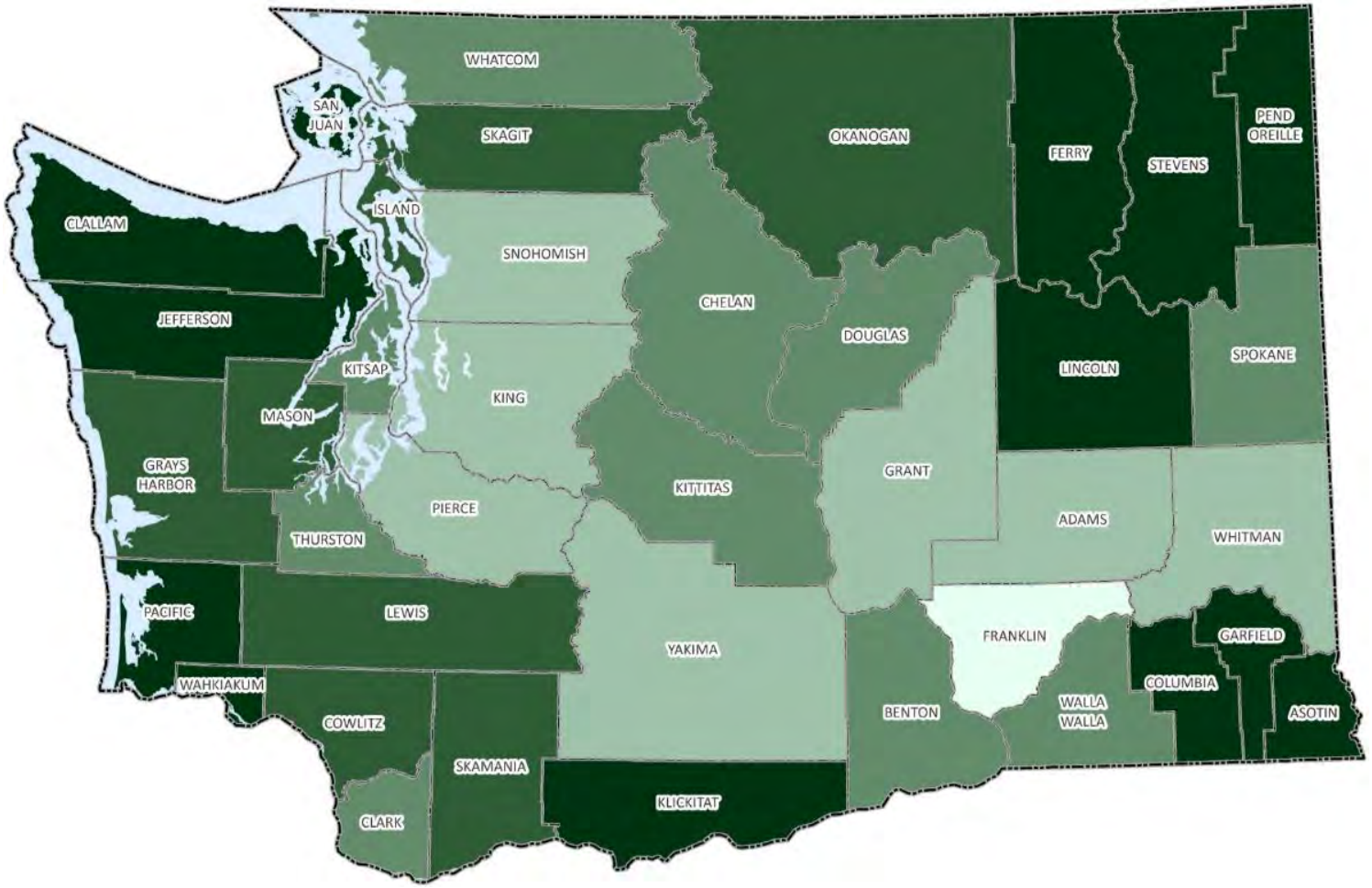
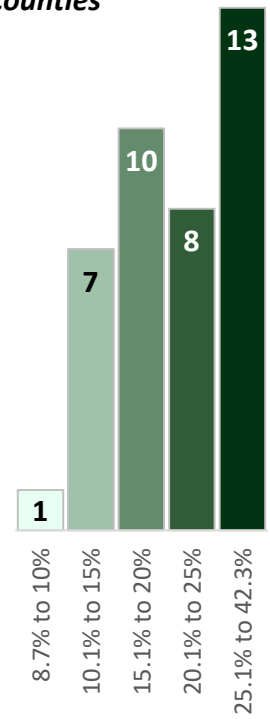
Persons 65+ as a Percentage of the Total Population

Estimates and Projections by County

2020



Number of counties



PERCENT OF SENIORS AGE 65+

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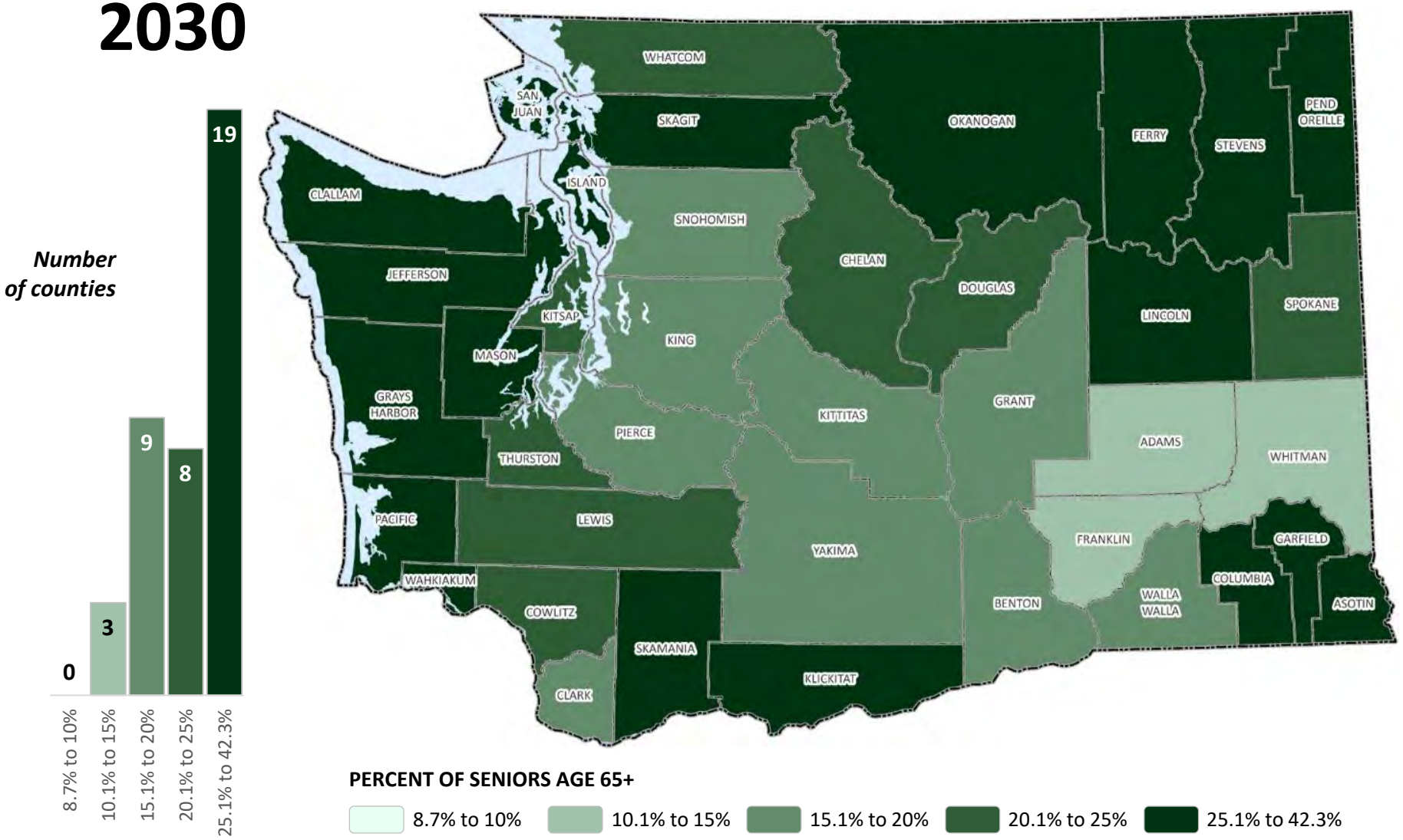
Persons 65+ as a Percentage of the Total Population

Estimates and Projections by County

2030



SOURCES: Washington State Office of Financial Management, 2012 County Growth Management Population Projections by Age and Sex: 2010-2040. Small Area Demographic Estimates (SADE) by Age, Sex, Race and Hispanic Origin: Counties, Version: 20161203_R03_VM.

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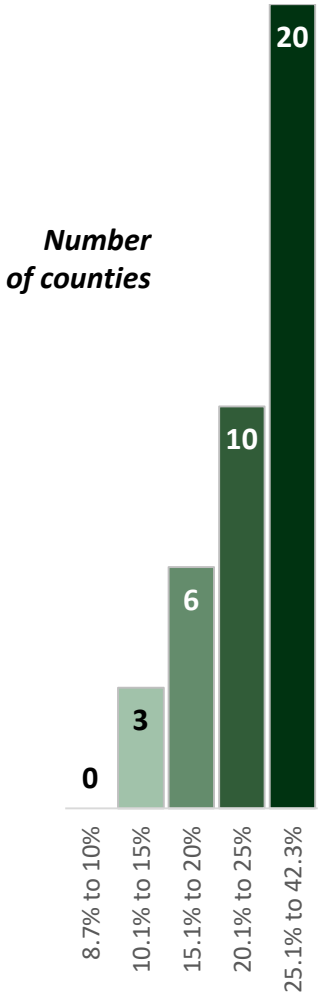
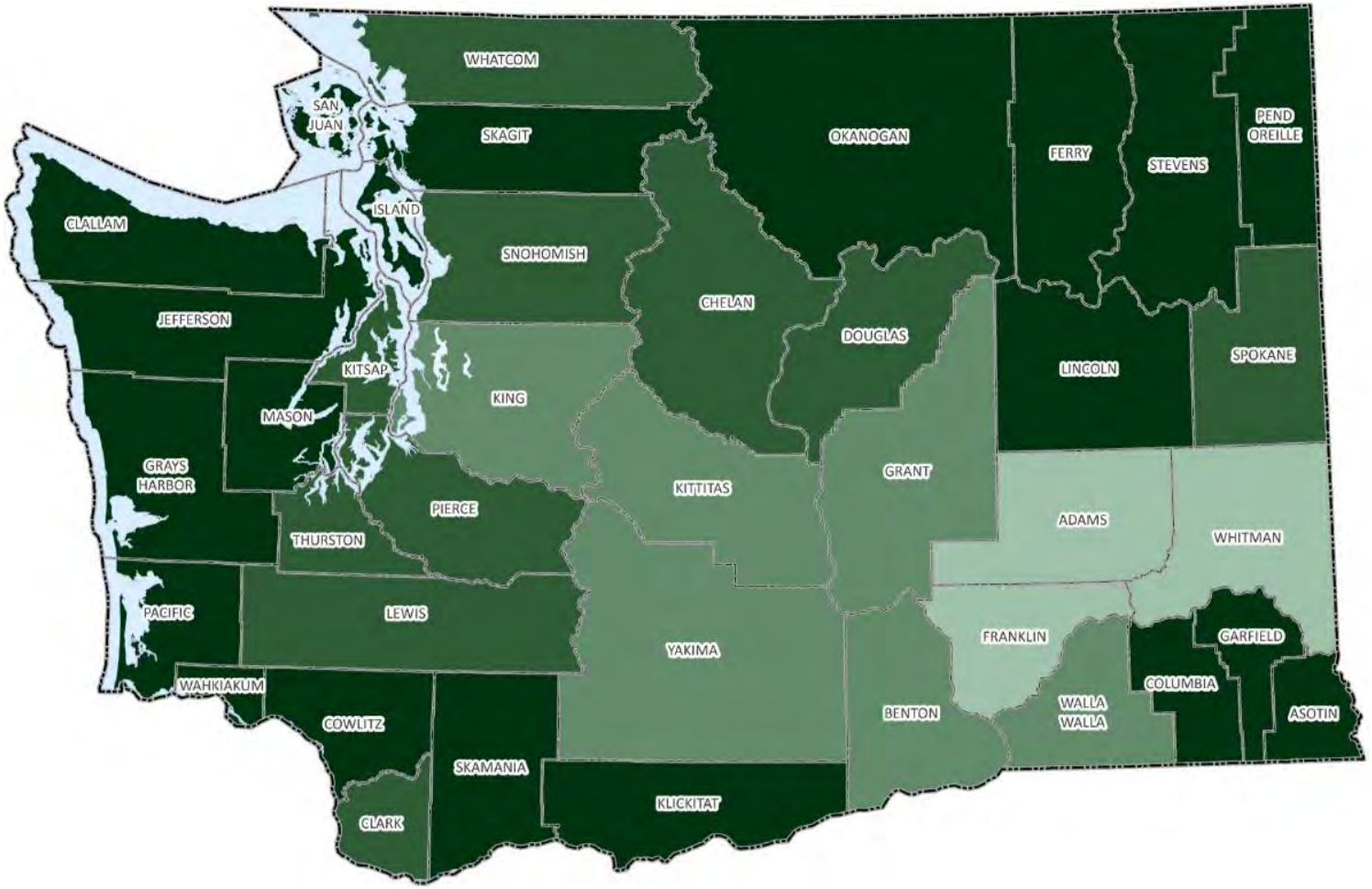
Persons 65+ as a Percentage of the Total Population

Estimates and Projections by County

2040





PERCENT OF SENIORS AGE 65+

8.7% to 10% | 10.1% to 15% | 15.1% to 20% | 20.1% to 25% | 25.1% to 42.3%

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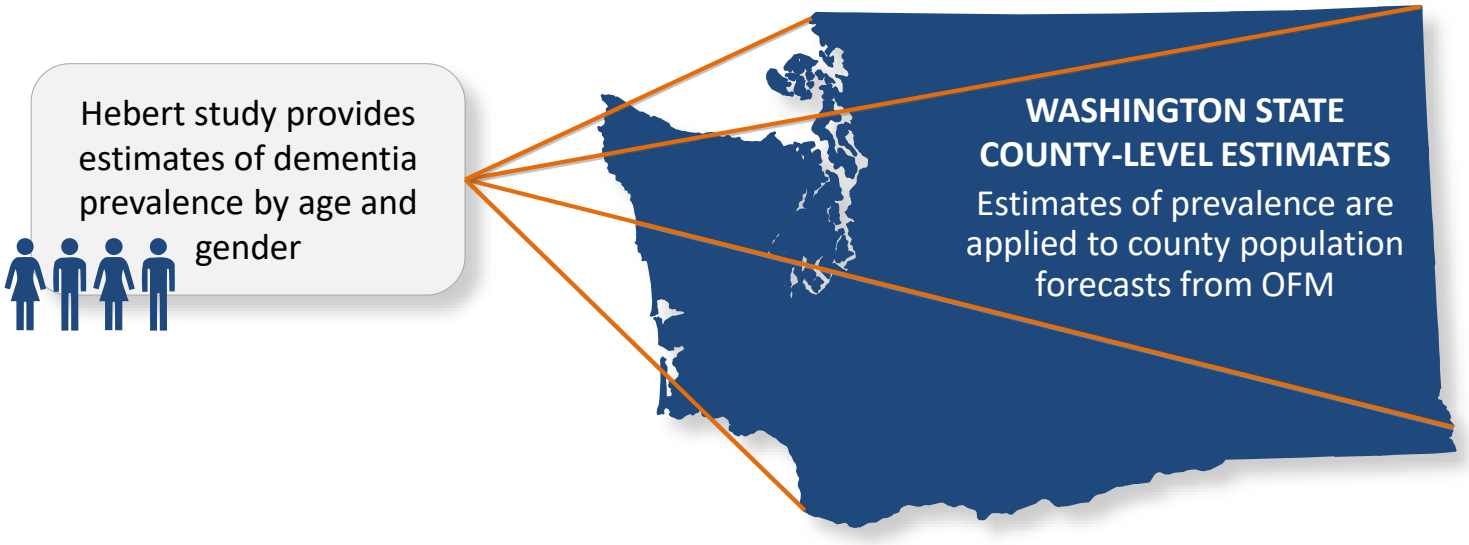
Forecasting Dementia Prevalence

Data on dementia prevalence

- Prevalence estimates are derived from clinical studies or population surveys (in this case, Hebert et al, 2013)
- Prevalence rates by age and gender are calculated from the study population, then applied to state population estimates



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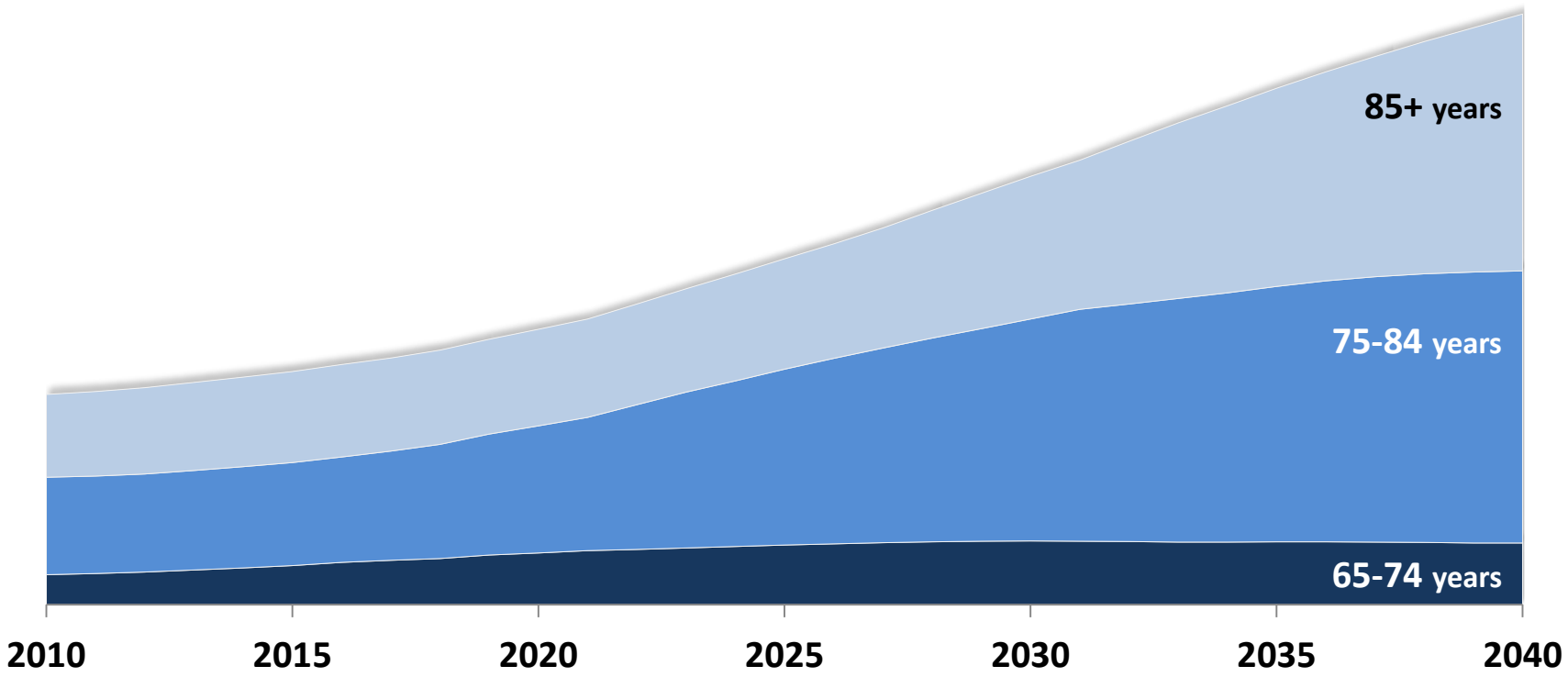
Projections of Alzheimer's Dementia in Washington State, 2010 – 2040

Synthetic projections using national prevalence rates from Hebert *et al* (2013)



	2010		2020		2030		2040	
	NUMBER	PREVALENCE	NUMBER	PREVALENCE	NUMBER	PREVALENCE	NUMBER	PREVALENCE
65 -74 years	13,717	3.0%	23,600	3.1%	29,180	3.3%	28,187	3.4%
75 - 84 years	44,561	17.6%	58,251	16.7%	101,581	17.2%	124,500	18.0%
85+ years	37,879	32.3%	44,121	32.2%	65,255	32.9%	117,535	34.6%
Total 65+	**96,156**	**11.6%**	**125,973**	**10.1%**	**196,015**	**11.7%**	**270,222**	**14.5%**

DATA SOURCES

Total Population 65 and Over, by Age: Washington State Office of Financial Management, Forecasting and Research Division. Forecast of the State Population by Age and Sex: 2010-2040. Nov. 2013**. National Prevalence of Alzheimer's Dementia for Persons 65+, by Age:** Hebert L.E., Weuve J., Scherr P.A., and D.A. Evans. Alzheimer disease in the United States (2010–2050) estimated using the 2010 census. Neurology May 7, 2013 80:1778-1783.

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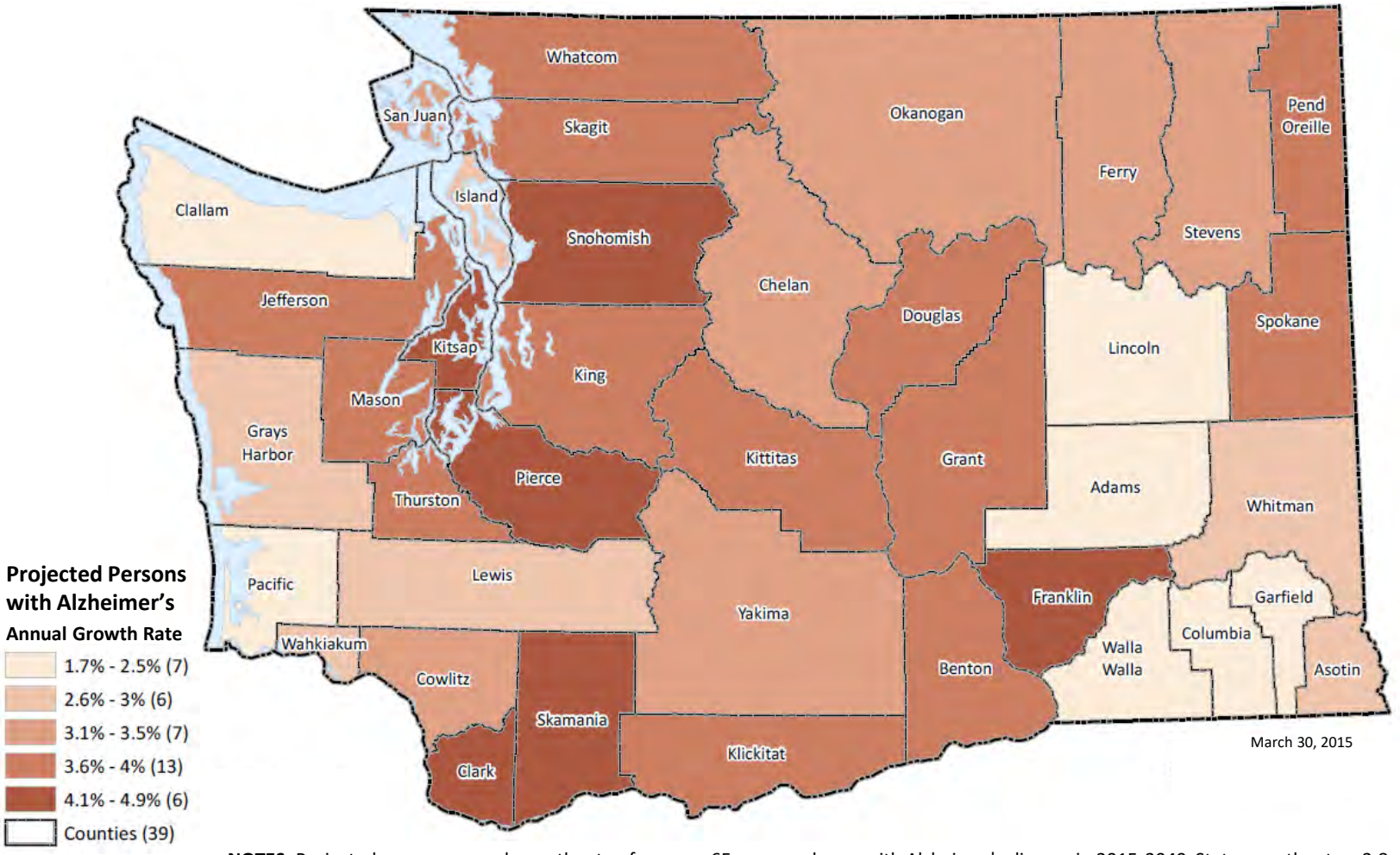
Persons 65+ Years with Alzheimer's Disease, Average Annual Growth Rate, 2015 – 2040

2040 Synthetic Projections by County



NOTES: Projected average annual growth rate of persons 65 years and over with Alzheimer's disease in 2015-2040. State growth rate = 3.8 percent. Projections use national prevalence rates of Alzheimer's disease from Hebert et al (2013).

SOURCES: Washington State Office of Financial Management, 2012 County Growth Management Population Projections by Age and Sex: 2010-2040. Prevalence of Alzheimer's disease: Hebert L.E., Weuve J., Scherr P.A., and D.A. Evans. Alzheimer disease in the United States (2010–2050) estimated using the 2010 census. Neurology. 2013;80:1778-1783.

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Questions?

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Appendix

Supplemental Data by County

Medicare and Social Security Recipients

Calendar Year 2016

	Medicare[1]		Social Security[2]	
	Hospital and/or Medical	Prescription Drug	Total (All Categories)	Age 65 and Older
WASHINGTON	**1,236,619**	**781,597**	**1,291,198**	**969,835**
Adams	1,605	1,090	2,580	1,860
Asotin	5,766	3,812	6,490	4,585
Benton	31,594	21,263	34,210	24,915
Chelan	11,491	7,608	17,045	13,200
Clallam	24,395	14,669	25,545	20,145
Clark	81,194	58,200	83,365	62,445
Columbia	1,156	682	1,330	995
Cowlitz	22,530	16,628	27,185	19,100
Douglas	12,087	7,912	7,880	6,135
Ferry	1,808	993	2,340	1,685
Franklin	9,022	5,993	10,230	7,015
Garfield	645	407	660	505
Grant	15,187	10,020	15,870	11,585
Grays Harbor	18,500	11,554	20,150	13,885
Island	21,376	11,693	21,785	17,800
Jefferson	11,270	6,759	11,990	10,015
King	302,950	199,396	288,475	229,965
Kitsap	50,492	23,349	51,370	39,010
Kittitas	7,303	4,104	8,350	6,505
Klickitat	5,458	3,260	6,160	4,615
Lewis	19,615	12,802	21,600	15,210
Lincoln	2,903	1,776	3,105	2,390
Mason	15,256	8,308	17,450	12,860
Okanogan	9,951	5,895	10,805	8,005
Pacific	7,085	4,537	8,005	6,025
Pend Oreille	3,529	2,119	4,125	2,975
Pierce	137,475	80,371	148,600	104,865
San Juan	5,195	3,398	5,230	4,565
Skagit	28,327	17,766	29,615	23,045
Skamania	1,814	1,030	2,500	1,815
Snohomish	109,162	73,745	119,060	89,520
Spokane	96,426	62,587	101,100	71,740
Stevens	10,356	6,003	12,695	9,080
Thurston	53,220	26,994	57,625	42,100
Wahkiakum	1,354	893	1,500	1,150
Walla Walla	12,072	7,227	12,575	9,620
Whatcom	41,140	27,194	43,060	33,160
Whitman	5,484	2,794	5,795	4,445
Yakima	40,343	26,718	43,745	31,300
Unknown	86	51	N/A	N/A

SOURCES: [1]https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/Dashboard.html
[2]https://www.ssa.gov/policy/docs/statcomps/oasdi_sc17/

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Projected Persons 65+ with Alzheimer's Disease in Washington Counties: 2015 – 2014

Based on National Prevalence Rates (Herbert, 2013)

County	Projected Persons 65+ with Alzheimer's Disease				Prevalence Rate				Average Annual Growth Rate			
	2015	2020	2030	2040	2015	2020	2030	2040	2015-2020	2020-2030	2030-2040	2015-2040
STATE	**106,788**	**127,271**	**197,144**	**271,340**	**10.4%**	**10.1%**	**11.7%**	**14.5%**	**3.6%**	**4.5%**	**3.2%**	**3.8%**
Adams	237	255	331	406	11.2%	10.8%	12.0%	13.3%	1.5%	2.6%	2.1%	2.2%
Asotin	566	680	958	1,175	11.3%	11.5%	13.5%	17.1%	3.7%	3.5%	2.1%	3.0%
Benton	2,672	3,229	4,973	6,764	10.4%	10.2%	11.8%	14.7%	3.9%	4.4%	3.1%	3.8%
Chelan	1,479	1,681	2,520	3,424	11.2%	10.4%	11.9%	15.4%	2.6%	4.1%	3.1%	3.4%
Clallam	2,182	2,468	3,269	3,958	11.4%	11.2%	12.5%	16.0%	2.5%	2.9%	1.9%	2.4%
Clark	6,346	7,944	13,052	18,530	10.1%	10.1%	12.1%	14.6%	4.6%	5.1%	3.6%	4.4%
Columbia	121	145	200	222	10.7%	11.4%	14.0%	18.1%	3.7%	3.3%	1.1%	2.5%
Cowlitz	1,995	2,359	3,493	4,509	10.4%	10.3%	12.1%	15.0%	3.4%	4.0%	2.6%	3.3%
Douglas	718	888	1,372	1,881	10.7%	10.8%	12.5%	15.4%	4.4%	4.4%	3.2%	3.9%
Ferry	171	225	330	380	9.5%	9.9%	12.9%	16.9%	5.6%	3.9%	1.4%	3.2%
Franklin	739	934	1,582	2,454	10.1%	9.7%	11.3%	12.7%	4.8%	5.4%	4.5%	4.9%
Garfield	68	70	93	104	12.5%	10.9%	13.0%	16.7%	0.3%	2.9%	1.2%	1.7%
Grant	1,338	1,626	2,441	3,424	10.4%	10.5%	11.7%	13.8%	4.0%	4.1%	3.4%	3.8%
Grays Harbor	1,447	1,670	2,416	2,995	10.2%	10.1%	11.9%	15.0%	2.9%	3.8%	2.2%	3.0%
Island	1,810	2,169	3,071	3,830	10.3%	10.5%	12.3%	15.6%	3.7%	3.5%	2.2%	3.0%
Jefferson	949	1,183	1,807	2,293	9.7%	10.1%	12.5%	16.5%	4.5%	4.3%	2.4%	3.6%
King	27,887	32,382	48,984	67,797	10.7%	10.2%	11.6%	14.1%	3.0%	4.2%	3.3%	3.6%
Kitsap	4,316	5,463	9,029	12,124	9.8%	9.8%	12.1%	15.5%	4.8%	5.2%	3.0%	4.2%
Kittitas	633	781	1,193	1,575	10.1%	10.2%	11.9%	14.7%	4.3%	4.3%	2.8%	3.7%
Klickitat	450	590	910	1,101	9.5%	9.9%	12.9%	16.2%	5.6%	4.4%	1.9%	3.6%
Lewis	1,631	1,845	2,496	3,080	10.9%	10.8%	12.0%	15.0%	2.5%	3.1%	2.1%	2.6%
Lincoln	280	322	424	482	10.9%	11.0%	12.7%	16.5%	2.8%	2.8%	1.3%	2.2%
Mason	1,391	1,702	2,575	3,486	10.4%	10.3%	11.6%	15.0%	4.1%	4.2%	3.1%	3.7%
Okanogan	902	1,113	1,638	1,968	10.0%	10.2%	12.7%	16.1%	4.3%	3.9%	1.9%	3.2%
Pacific	644	758	1,010	1,160	10.7%	10.9%	13.1%	16.6%	3.3%	2.9%	1.4%	2.4%
Pend Oreille	307	406	629	761	9.4%	9.9%	12.7%	16.9%	5.7%	4.5%	1.9%	3.7%
Pierce	10,903	12,972	20,904	30,195	10.2%	9.8%	11.1%	13.9%	3.5%	4.9%	3.7%	4.2%
San Juan	457	586	879	1,029	9.4%	9.9%	13.2%	17.0%	5.1%	4.1%	1.6%	3.3%
Skagit	2,472	2,955	4,593	6,267	10.6%	10.3%	12.0%	15.0%	3.6%	4.5%	3.2%	3.8%
Skamania	192	257	419	568	9.3%	9.5%	11.4%	15.4%	6.0%	5.0%	3.1%	4.4%
Snohomish	9,460	11,617	19,841	30,186	10.1%	9.6%	10.9%	14.0%	4.2%	5.5%	4.3%	4.8%
Spokane	7,949	9,188	14,209	19,165	10.7%	10.1%	11.8%	14.9%	2.9%	4.5%	3.0%	3.6%
Stevens	930	1,187	1,770	2,175	9.6%	10.0%	12.4%	15.7%	5.0%	4.1%	2.1%	3.5%
Thurston	4,200	5,131	8,167	11,166	10.2%	9.9%	11.9%	14.5%	4.1%	4.8%	3.2%	4.0%
Wahkiakum	128	163	233	244	9.5%	10.4%	14.3%	17.4%	4.8%	3.7%	0.5%	2.6%
Walla Walla	1,179	1,269	1,650	2,020	12.1%	11.5%	12.7%	15.7%	1.5%	2.7%	2.0%	2.2%
Whatcom	3,472	4,253	6,821	9,320	10.4%	10.1%	12.3%	15.0%	4.1%	4.8%	3.2%	4.0%
Whitman	544	627	882	1,109	11.2%	10.9%	12.3%	14.8%	2.9%	3.5%	2.3%	2.9%
Yakima	3,622	4,178	5,978	8,017	10.9%	10.7%	12.0%	14.4%	2.9%	3.6%	3.0%	3.2%

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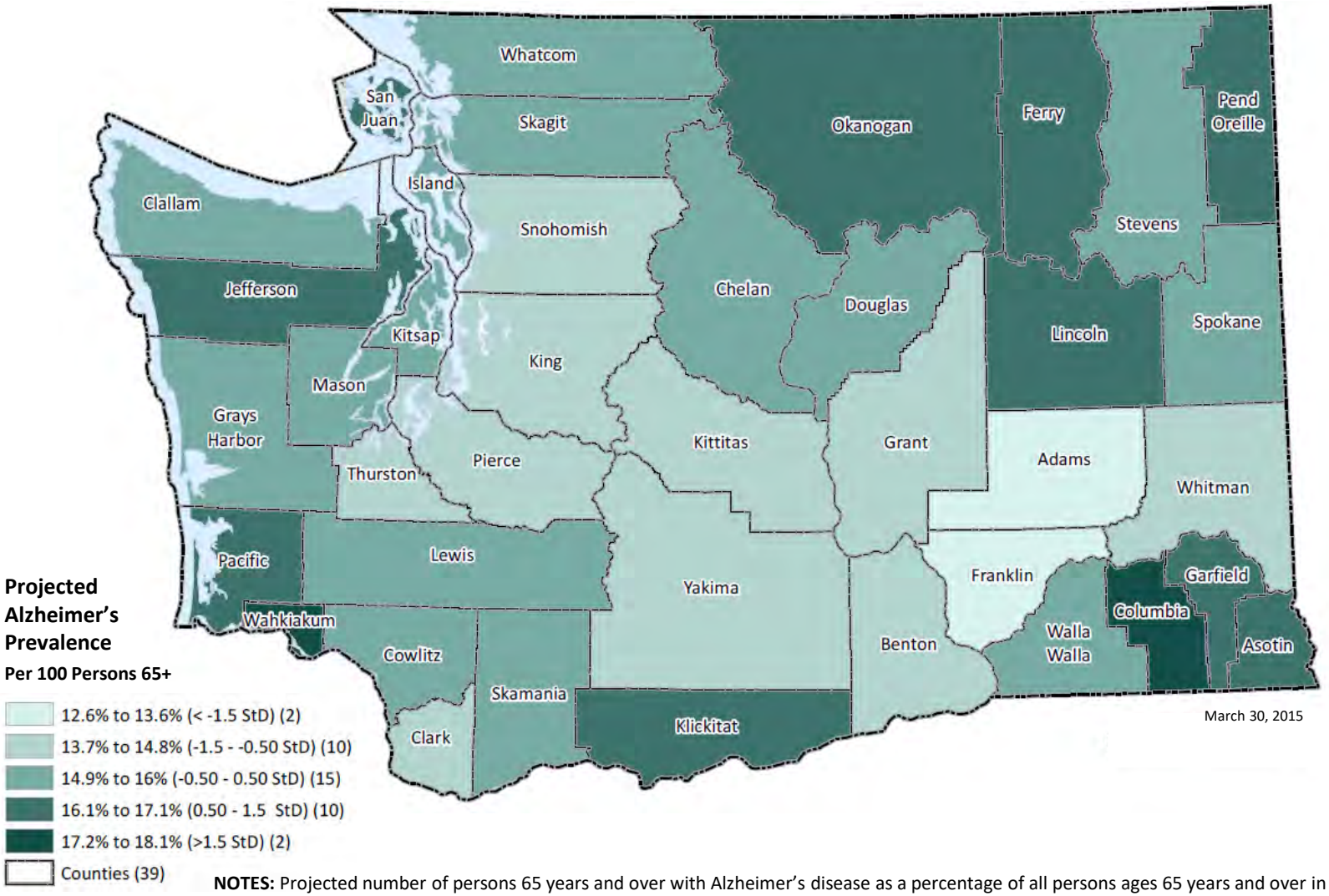
April 22, 2015

Persons with Alzheimer's Disease per 100 Persons Ages 65 and Over

2040 Synthetic Projections by County



NOTES: Projected number of persons 65 years and over with Alzheimer's disease as a percentage of all persons ages 65 years and over in the year 2040. Projections use national prevalence rates of Alzheimer's disease from Hebert et al (2013).

SOURCES: Washington State Office of Financial Management, 2012 County Growth Management Population Projections by Age and Sex: 2010-2040. Prevalence of Alzheimer's disease: Hebert L.E., Weuve J., Scherr P.A., and D.A. Evans. Alzheimer disease in the United States (2010–2050) estimated using the 2010 census. Neurology. 2013;80:1778-1783.

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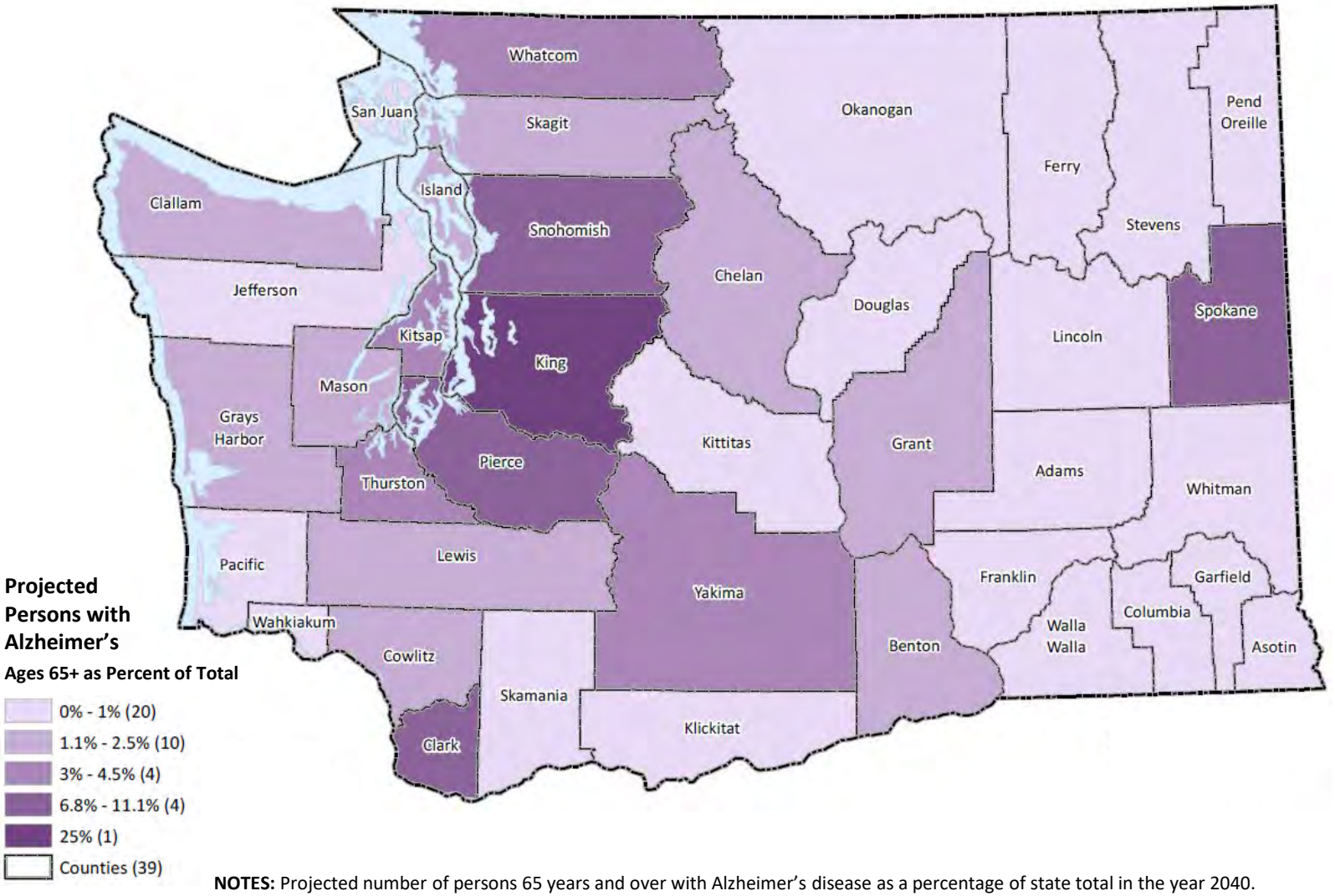
Washington State Department of Social & Health Services
Transforming lives

Persons 65+ with Alzheimer's Disease, County Share of State Total

2040 Synthetic Projections by County



NOTES: Projected number of persons 65 years and over with Alzheimer's disease as a percentage of state total in the year 2040. Projections use national prevalence rates of Alzheimer's disease from Hebert et al (2013).

SOURCES: Washington State Office of Financial Management, 2012 County Growth Management Population Projections by Age and Sex: 2010-2040. Prevalence of Alzheimer's disease: Hebert L.E., Weuve J., Scherr P.A., and D.A. Evans. Alzheimer disease in the United States (2010–2050) estimated using the 2010 census. Neurology. 2013;80:1778-1783.

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Washington State Department of Social & Health Services
Transforming lives

ATTACHMENT V

Area Agency on Aging & Disabilities of Southwest Washington

2016 – 2019 Area Plan

Area Agency on Aging & Disablities of Southwest Washington 2016-2019 Area Plan October 05, 2015

AREA AGENCY ON
Aging & Disabilities
OF SOUTHWEST WASHINGTON

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Clark ♦ Cowlitz ♦ Klickitat ♦Skamania ♦ Wahkiakum

ATTACHMENT V

Table of Contents

Executive Summary

This four-year Area Plan outlines strategies to be executed over the 2016-2019 time period to address identified needs of older adults, adults with disabilities and family caregivers living in our five county Planning and Service Area. It also provides information about planning activities, fiscal and program priorities, and projected discretionary revenue used to fund key programs and services intended to help people stay in their home as they age.

> *"I would like to emphasize that the boom is already here. This is not something we can leisurely prepare for. It is time to begin working on action planning. It is time to act."*
>
> Bob Stevenson
> Past Chair
> Washington State
> Council on Aging

To hear what is on the hearts and minds of our target populations, we gathered information using various methods and multiple sources; most notable are the General Public Survey and Partner Agency Survey. The results from both surveys showed the primary need/concern of older adults and adults living with disabilities is ***staying in their home as long as possible and needing supports to do so.***

Current growth in the older adult population is unprecedented. Nationally, beginning January 2011 and continuing until 2030, 10,000 individuals turn age 65 every day (AARP, 2011). According to data provided by Washington State Department of Social & Health Services, the aging population in SW Washington will also experience an exceptional growth rate.

- Age 60 – 84 population will increase 28.5% between 2015 (121,205) and 2025 (155,804)
- Age 85+ population, those considered most vulnerable, will increase 31% between 2015 (10,608) and 2025 (13,844)
- By 2025, 1 in 4 residents will be age 60+

> *"There are only four kinds of people in the world – those who have been caregivers, those who are caregivers, those who will be caregivers and those who will need caregivers"*
>
> - Rosalynn Carter
> Former First Lady

As the population ages and people live longer, family members are counted on to provide more and more support to aging parents, grandparents, spouses, brothers, sisters, aunts and uncles. In a July 2015 report (Valuing the Invaluable: 2015 Update) AARP estimates 828,000 unpaid family caregivers in Washington State provided 771 million hours of care to a family member in 2013.

Since our Planning and Service Area accounts for approximately 8% of Washington State's total population, we can estimate there are 66,000 unpaid family caregivers living in SW Washington. Providing support services such as respite care, support groups, workshops, education and information for these caregivers, the backbone to our community's long-term care support system, is crucial.

> *"The rapidly graying of America will fundamentally change our culture and present us with some of the most critical policy issues of our times."*
>
> - Paul Hodge, Generations Policy Program, Harvard University

This Area Plan identifies specific outcomes that will enhance the lives of seniors, adults with disabilities and their loved ones in the SW Washington region. We will, over the next four years, implement the programs of the Federal Older Americans Act, Washington State sponsored initiatives, and our locally generated resources to help our target populations thrive in the setting of their choice.

Sincerely,

David Kelly
Executive Director
Area Agency on Aging & Disabilities of Southwest Washington

Raymond Thygesen
Advisory Council Chair
Area Agency on Aging & Disabilities of Southwest Washington

AREA AGENCY ON AGING PLANNING AND PRIORITIES

Introduction

Who are we?
Area Agency on Aging & Disabilities of Southwest Washington (AAADSW) is a regional government agency working in partnership with local governments, agencies and service providers in five southwest Washington counties: Clark, Cowlitz, Klickitat, Skamania and Wahkiakum.

Our Role:
AAADSW is one of 13 designated Area Agencies on Aging (AAA) in Washington State. As an Area Agency on Aging, AAADSW is responsible for planning, advocacy and administration of Federal and State funds targeted to provide a range of community-based supports and services. These services are designed to address the long-term care needs of older adults (age 60+), adults with disabilities and family caregivers.

How we are governed:
AAADSW is governed by the Southwest Washington Council of Governments on Aging and Disabilities. This Council is comprised of one county commissioner from each of the five southwest Washington counties listed above. Additionally, AAADSW seeks and receives advice from its eighteen-member Advisory Council which includes consumers, service providers, and community representatives. One member represents the advisory council on the State Council on Aging.

What this plan is about:
AAADSW conducts community-based planning to identify needs of the target populations. Additionally, AAADSW is required to address specific Issue Areas required by federal and state governments.

This four-year Area Plan outlines strategies, executed over the 2016-2019 time period, to address identified needs of older adults, adults with disabilities and family caregivers living in our five county Planning and Service Area (PSA). It also provides information about planning activities, fiscal and program priorities and projected discretionary revenue used to fund key programs and services intended to help people stay in their home as they age. These programs/services include the following:

- Adult Day Care
- Aging & Disability Resource Network
  - Information, Awareness, and Referral
  - Options Counseling & Assistance
  - Transitional Care
- Alzheimer's/Dementia Care
- Care Coordination
- Case Management
- Nursing Services
- Personal Care
- Roads to Community Living
- Senior Health & Wellness
  - EnhanceFitness
  - Senior Dental
  - Staying Active and Independent for Life

• Chronic Disease Self-Management • Family Caregiver Support • Home Delivered Meals • Kinship Caregiver • Legal Assistance • Long-Term Care Ombudsman • Medicare Improvement for Patients and Providers	○ Strong Women ○ Walking with Ease • Senior Farmers Market Nutrition • Senior Transportation • Steps to Employment • Veteran Directed Home and Community-Based Services

Mission, Vision, Values:

AAADSW's mission is to promote independence, choice, well-being, and dignity for older adults, adults with disabilities and family caregivers in our five-county Planning and Service Area (PSA) through a comprehensive, coordinated system of home and community-based services. AAADSW's mission is supported by the agency's primary functions:

- Inform the public of the services available to persons 60 years of age and older, adults with disabilities, and family caregivers
- Plan for community-based service coordination to meet the needs of target populations
- Provide, or contract for, community-based long-term services and supports including Senior Information & Assistance, case management, in-home personal care, nursing services, senior nutrition, senior transportation, legal services, and caregiver support
- Evaluate and improve the quality of service delivery
- Address complaints
- Administer federal, state and private funds as well as develop new funding sources
- Advocate for persons 60 years of age and older, adults with disabilities and family caregivers at federal, state and local levels
- Support advocacy efforts of the Advisory Council.

AAADSW's vision is that every older adult, adults living with disabilities and their family members have access to information, programs and services which help them thrive in the setting of their choice. In fulfilling its vision, AAADSW incorporates the following values:

- **Choice**
  We encourage and respect individual choice, especially regarding a person's choice to live in the setting that he/she most desires.
- **Independence**
  We promote client empowerment and focus on preserving client independence.
- **Family support**
  We recognize that care and nurturing provided by family and friends are vital; therefore, we work to support this resource.

- **Responsiveness**
  We listen to feedback from those we serve in order to improve our services and delivery methods.
- **Quality**
  We are committed to delivering quality services in a cost-effective manner.
- **Teamwork**
  We value the contributions of our dedicated employees, embrace creative problem solving and foster a teamwork based environment that focuses on results.
- **Diversity**
  We encourage an environment in which differences are accepted and all cultures are appreciated.
- **Leadership**
  We foster strong community partnerships and provide solution focused leadership.

Planning and Review Process

AAADSW used a variety of methods for identifying and verifying unmet needs among older persons, adults with disabilities and their family caregivers in its Planning and Service Area. Those methods include:

- General Public Survey
- Partner Agency Survey
- Input from AAADSW staff
- Input from Advisory Council members
- Input from three public hearings
- Input from AAADSW contractors
- Input from Cowlitz Indian Tribe Health and Human Services (7.01 Plan)
- Input from Yakima Indian Tribe (7.01 Plan)
- Washington State Department of Social & Health Services (DSHS), Aging & Long-Term Services Administration 2014 State Plan on Aging Survey Report, September 2014
- The United States of Aging Survey 2015 Results

Additionally, AAADSW used the following sources for population, demographic and service data:

- U.S. Census Bureau, 2010 Census
- Washington State DSHS Office of Financial Management - Forecasting May 2012
- Washington State DSHS Research and Data Analysis – Population and Aging Service Utilization Forecast, May 28, 2015, AAADSW 2013 and 2014 Service Activity Report.

Advisory Council (AC) members played a significant role in the Area Plan development and review process. In particular, the Planning and Allocations Committee assisted in the design and refinement of the General Public Survey (GPS) and Partner Agency Survey (PAS) used to gather information on needs and concerns of our target populations.

Throughout March, April and May of 2015, many AC members, along with AAADSW staff distributed GP surveys at all 21 senior congregate meal throughout the PSA. During each meal site visit, an AAADSW representative provided a short presentation about the purpose and importance of the GPS and requested meal site attendees to complete the survey. Larger meal sites, such as Battle Ground and Luepke Center, received multiple visits to ensure ample opportunities were provided to complete the survey.

The PSA was used to gather information from other agencies serving older adults, adults with disabilities and family caregivers regarding their perspective on the needs, concerns and service gaps for our target populations.

Other survey distribution efforts included:

- March 12, 2015, AAADSW sponsored community Lunch & Learn, Cowlitz County PUD Auditorium, Longview, WA
- March 17, 2015, Clark County Commission on Aging Meeting, Vancouver, WA
- March 26, 2015, Press Release sent to The Columbian, The Daily News, Wahkiakum Eagle, Senior Messenger, Goldendale Sentinel, Skamania County Pioneer, The Enterprise, The Reflector, Camas-Washougal Post-Record
- March 27, 2015, survey link emailed to agency contacts via Constant Contact
- March 29, 2015, survey link posted on agency web site, www.HelpingElders.org
- March 30, 2015, link to survey emailed to 21 Clark County Neighborhood Associations
- March 31, 2015, link to survey emailed to Skamania and Klickitat Community Network
- April 3, 2015, link to survey emailed to all legislators in our PSA
- April 14, 2015, Chronic Disease Self-Management Class, Cathlamet, WA
- April 14, 2015, Accessible Transportation Coalition members
- April 27, 2015, EnhanceFitness Class, Vancouver, WA.

English and Russian language surveys were distributed in paper and electronic format. We estimate a combined 4,000 GPS and PAS were distributed throughout the PSA. The total number of PG surveys completed is 636. The total number of PA surveys completed is 254.

AAADSW AC members played a key role in the 2016-2019 AP review and approval process. AC members were updated on the AP process at monthly AC meetings and approved the draft AP prior to public hearings. Several members attended the public hearing in their respective service area as a show of support. After minor changes were made, the AC unanimously approved the AP on September 16, 2015.

Three AP public hearings were conducted: (1) in Vancouver (Clark County) on August 25, 2015, (2) in White Salmon (Klickitat County) on August 26, 2015 and (3) in Longview (Cowlitz County) on August 31, 2015. The opportunity to review the AP was available at each hearing and on AAADSW's web site at www.HelpingElders.org.

Below are comments from community members made during Public Hearings:

- Clark County Area Plan Public Hearing, Vancouver, WA, August 25, 2015
  - Seems like people don't know about the services the Agency provides. How are we getting the information to the target population?
  - The social workers at the hospitals and lots of therapists don't know about the agency.
  - Primary Care physicians are a good source to ask questions and get resource info.
  - Short-term respite care is hard to find, expensive and hard to schedule. Caregivers get frustrated. There other expenses related to respite care that are costly to caregivers.
  - Each county has differing resources for guardians. We need to better support them
  - Big gap in skilled home health nurses, therapists, etc. Medicaid reimbursement rate is low so there are fewer providers. The rate in WA is half what it is in OR. The Agency's advocacy would be welcome.
  - Gap in (affordable senior) housing and information.
  - Medicaid clients need more housing care and can't find housing with additional care. Seniors in unsafe living situations (i.e. fall prevention) can't get to the top of the waiting lists, even though safer housing could prevent falls.

- Skamania County and Klickitat County Area Plan Public Hearing, White Salmon, WA, August 26, 2015
  - Would like to see Chronic Disease Self-Management class in Klickitat County
  - In White Salmon everyone goes to the grocery store and there's a bulletin board everyone checks. This is a good place to post information.
  - Counseling services for caregivers (through Family Caregiver Support Program) is not available in Klickitat County
  - Lack of resources for Multiple Sclerosis patients in Klickitat County
  - Transportation services in Klickitat County have been cut back in recent years and would like to see services restored
  - Really need transportation for shopping
  - Meal sites aren't as prevalent as they used to be
  - There is nothing in the area for MS patients

- Cowlitz County and Wahkiakum County Area Plan Public Hearing, Longview, WA, August 31, 2015
  - Many seniors don't use computers and we need to make sure our Aging & Disability Resource Network addresses that concern

- Lack of medical care (providers) in Cathlamet
- We (AAADSW) need to make sure people know how to find the information
- Need for Long-Term Care Ombudsman program staff to work more closely with Mental Health Ombudsman for Cowlitz County
- It would be nice to see where the money (WA State Budget) actually goes.
- Tribal culture is different in some cases, because often their history isn't written.
- Regarding mental health and seniors, depression and dementia can be complicated by various doctors and meds. Seniors are often overlooked in their level of need and ability to ask for help.

The AP was approved by AAADSW's governing board, Council of Governments on Aging & Disabilities of SW Washington, at its September 24, 2015 Council of Governments board meeting.

Prioritization of Discretionary Funding

AAADSW administers a variety of federal, state, and local grant funds for services to older adults, adults with disabilities and their families in its five-county PSA area. AAADSW's 2016 AP budget is $15,101,906, which $2,300,000 is designated as discretionary funding. The remaining funds are restricted for specific programs and services.

An allocation methodology is used to determine discretionary funding for programs in each of the four service areas (Clark County, Cowlitz/Wahkiakum Counties, Klickitat County and Skamania County). The methodology includes the following:

- Number of persons age 60+
- Number of persons 60+ at or below federal poverty level
- Square miles in service area
- Number of minority persons age 60+
- Number of Limited English Proficiency (LEP) persons 60+
- Minimum threshold needed to support a program(s)

Services considered for funding in 2015 are prioritized with the following questions in mind.

1) Does the program/service align with the AAADSW's mission?
2) Does the program/service support the client's ability to remain at home as long as possible?
3) Does the program/service reach our target populations, including those:
    - with low incomes?
    - with physical or mental disabilities?
    - who are LEP or have other language barriers?
    - are homebound or geographically isolated?
    - who are culturally or socially isolated due to racial or ethnic status?
4) Does the program/service help accomplish the AP goals and objectives?

Other factors considered:

5) Service utilization
6) Most often requested services through AAADSW's Information and Assistance program
7) Availability of services within the community
8) Feedback/input from AC members
9) Results of 2016-2019 AP GPS and PAS

The following services were identified as most important to AAADSW's clients:

1) Aging & Disability Resource Network (ADRN)/Information & Assistance
2) Services that support family caregivers
3) Services that help individuals remain in their home
4) Services that improve individuals health and wellness
5) Elder Abuse Prevention

AAADSW will use the above prioritization criteria when changes in discretionary funding occur. Any reductions will be based on documented needs and historic utilization of programs with priority given to the needs of the most vulnerable older adults and adults with disabilities. There will be an equitable split in reductions from administration and direct services. Stakeholders, including the AC, will be asked for input when a review of prioritization criteria and allocation methods is determined necessary.

Planning and Service Area Profile

Population Profile

AAADSW's Planning and Service Area's Counties

Clark ♦ Cowlitz ♦ Klickitat ♦ Skamania ♦ Wahkiakum

Planning & Service Area (PSA) General Population Overview

- AAADSW's PSA's population based on Census 2010 Demographic Profile is estimated at 563,136 representing an increase of 19.6% since Census 2000.
- AAADSW's PSA's has grown approximately 1.96% a year over the past 10 years.
- Clark County (part of the Portland Vancouver metropolitan) is considered urban.
- Cowlitz, Klickitat, Skamania and Wahkiakum counties are considered rural.

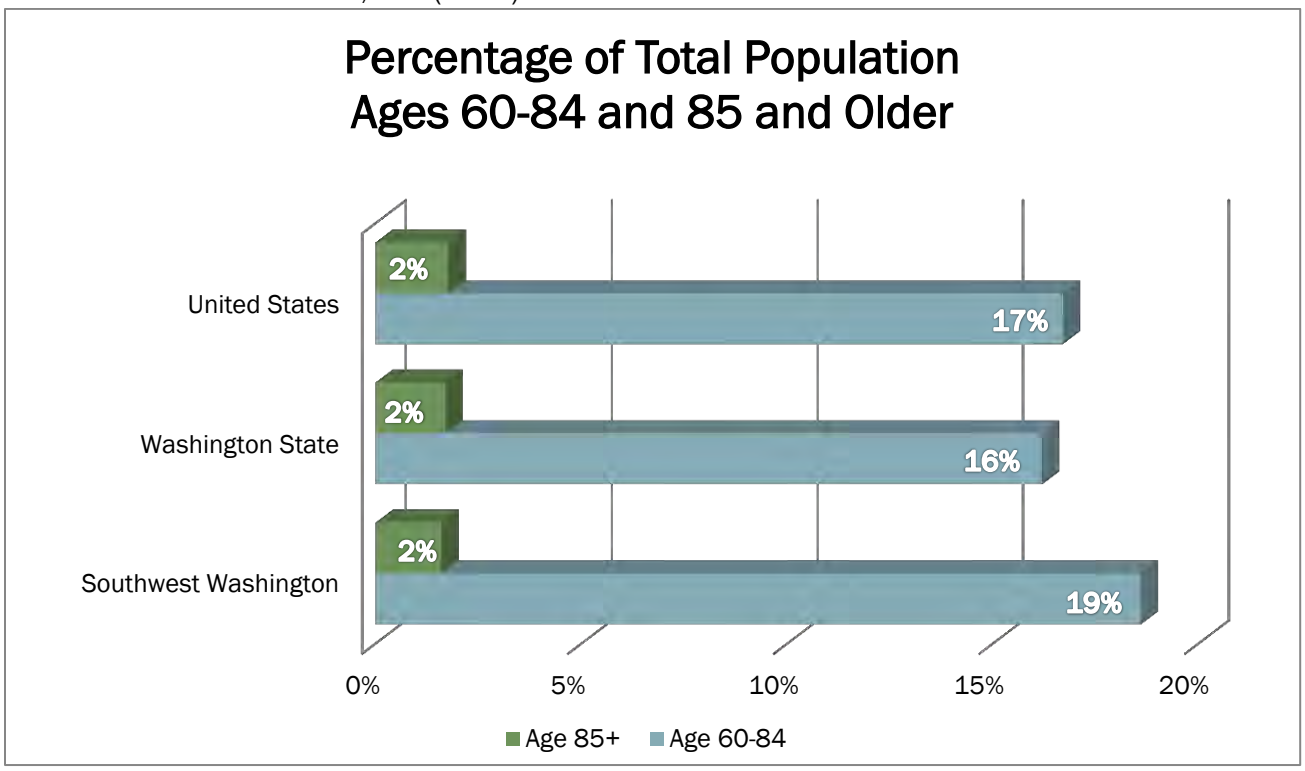
AAADSW's PSA's Population Age 60 and Over and Adults with Disabilities

- The 60-84 population is estimated at 104,378 in 2010 by the U.S. Census Bureau. This represents 18.6% of the PSA's total population.
- The 85 and over population is estimated at 9,185 according to Census 2010 data. The represents 1.6% of the PSA's total population.

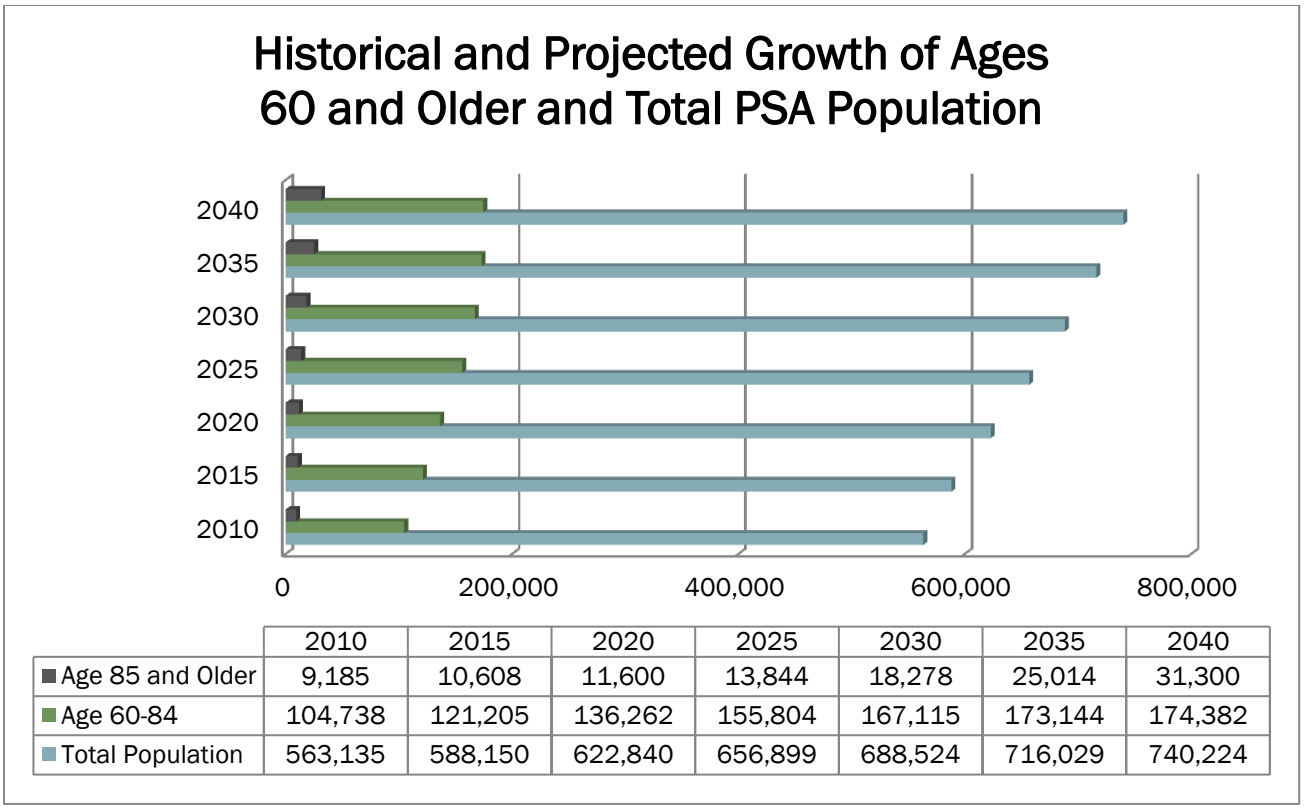
- The 60 and over population has increased by more than 70% since Census 2000.
- Thirty percent of the 60 and over population resides in rural areas of the PSA according to Census 2010 data.
- The 18 and over disabled population is forecasted at 28,270 for 2015 and is expected to increase by 2.4% per year by 2020, according to the DSHS Research and Data Analysis Division.

Family Caregivers

- The number of unpaid family caregivers in Washington State was estimated at 828,000 in 2013 by AARP – Valuing the Invaluable: 2015 Update
- The estimated number of unpaid family caregivers in AAADSW's PSA is 66,240 (8% of total estimated caregivers in Washington State)
- Estimated number of unpaid family caregivers by County in AAADSW's PSA:
  - Clark – 50,012 (75.5%)
  - Cowlitz – 12,055 (18.2%)
  - Klickitat – 2,384 (3.6%)
  - Skamania – 1,325 (2.0%)
  - Wahkiakum – 464 (0.7%)



Source: U.S. Census Bureau, Census 2010



	2010	2015	2020	2025	2030	2035	2040
Age 85 and Older	9,185	10,608	11,600	13,844	18,278	25,014	31,300
Age 60-84	104,738	121,205	136,262	155,804	167,115	173,144	174,382
Total Population	563,135	588,150	622,840	656,899	688,524	716,029	740,224

Source: Office of Financial Management, Forecasting, May 2012

60+ Population, Minority, American Indian, Federal Poverty Level and Disabled

	WA	PSA	Clark	Cowlitz	Klickitat	Skamania	Wahkiakum
Total Population[1]	6,724,540	563,136	425,363	102,410	20,318	11,066	3,978
60-84[1]	1,092,493	95,547	66,553	20,449	4,954	2,257	1,334
85+[1]	117,271	9,185	6,408	2,169	352	151	105
60+ Minority[2]	216,114	9,414	7,199	1,448	451	232	84
60+ Am. Indian [2] Cowlitz Indian Tribe (Title VI Programs)	16,902	836	448	198	118	61	11
60+ LEP[2]	65,073	4,704	3,388	942	213	106	55
60+ at or below 100% FPL[2]	98,740	9,525	7,086	1,803	374	169	93
60+ at or below 100% FPL and minority[2]	25,375	896	685	144	39	22	6
18+ and Disabled[2]	506,087	43,668	31,135	9,101	1,986	979	467

2020 Projected 60+ Population, Minority, American Indian, Federal Poverty Level and Disabled

	WA	PSA	Clark	Cowlitz	Klickitat	Skamania	Wahkiakum
Total Population[3]		622,840	477,884	108,588	20,943	11,548	3,877
60+[2]	1,670,619	146,558	103,514	29,956	7,531	3,689	1,868
60+ Minority[2]	250,907	10,713	8,163	1,650	536	275	89
60+ Am. Indian [2] Cowlitz Indian Tribe (Title VI Programs)	19,039	935	498	215	138	72	12
60+ LEP[2]	74,418	5,358	3,866	1,051	260	122	59
60+ at or below 100% FPL[2]	105,646	10,194	7,708	1,836	384	181	85
60+ at or below 100% FPL and minority[2]	28,421	945	722	154	40	23	6
18+ and Disabled[2]	536,016	46,724	33,520	9,551	2,117	1,045	491

[1]Census 2010 Summary File 1, prepared by the Washington State Office of Financial Management, Forecasting Division
[2]Selected Population and Aging Service Utilization Forecast, Southwest Washington AAA, DSHS Research and Data Analysis Division, May 28, 2015
[3]Office of Financial Management, Forecasting, May 2012

Targeting Services

The target populations within the PSA include individuals who are considered low-income, minority individuals, Limited English Proficiency (LEP) individuals, older adults residing in rural areas, older Gay, Lesbian, Bisexual, and Transgender (GLBT) individuals and adults with disabilities and their family caregivers.

Improving access to information and services for LEP individuals remains a priority for AAADSW. To improve access for LEP populations in Southwest Washington, the agency provides key program brochures in Spanish and Russian languages. AAADSW staff members conduct presentations and in-service trainings to community partner agencies specializing in serving these populations.

As described in the Population Profile, Clark County is considered urban while the other four counties in the PSA are rural. Reaching older adults and adults with disabilities in these rural counties requires a concerted effort. Klickitat and Skamania counties are sub-contracted agencies that serve as focal points and service providers. Klickitat County Senior Services (KCSS) and Skamania County Senior Services (SCSS) distribute regular newsletters to help the target populations and the general public remain informed of issues, programs and services that impact their lives.

In addition to AAADSW's main office in Clark County, there is an office in Cowlitz County providing Senior Information & Assistance, case management and other community based services. AAADSW continues to staff an Information & Assistance Office in Wahkiakum County as well.

Outreach to the target populations is further enhanced via the agency website, participation in local health/senior fairs, board and committee participation and email marketing. Since 2010, AAADSW and its sub-contractors provide Gatekeeper trainings to community organizations and members. These trainings have been conducted with community "Gate Keepers" such as public utility employees, bank personnel, postal carriers and police and fire personnel for the purpose of identifying and referring older adults, who appear to have problems that may place them at risk for premature institutionalization, to their local Senior Information & Assistance office.

Outreach efforts also include developing and sustaining strategic partnerships with staff at organizations currently serving low-income, minority individuals, LEP, older individuals residing in rural areas, older GLBT individuals, adults with disabilities and family caregivers. AAADSW sends regular updates to leaders in the GLBT community about available programs and services via Constant Contact. AAADSW staff members participate on committees including Southwest Washington Elder Abuse Prevention, Clark County Commission on Aging, Cowlitz/Wahkiakum Living Well Aging Well, Clark and Cowlitz Counties Cross Continuum Care Transitions Collaborative, Community Health Access Resource Group, Emergency Medical Services Community Healthcare Coalition, Elder Alliance, Professionals in Aging, Senior Services Networking and Skamania and Klickitat Interagency Meetings.

Lastly, AAADSW's sub-contractors are required to refer any vulnerable adult they come in contact with to their local Senior Information & Assistance office.

AAA Services

AAADSW provides a wide variety of services, both directly and through subcontractors. To the degree feasible, all services are provided throughout the five county PSA (please see attached table for programs/services by county).

The following programs are provided by AAADSW via Older American Act, Washington State Senior Citizens Services Act and grant funding:

Case Management (CM) – Aging Network provides assistance in the form of access, advocacy and/or care coordination in circumstances where older persons and/or their caregivers are experiencing a decline in their ability manage their daily lives. CM activities include comprehensive assessment of an individual's needs, developing a detailed service plan, authorizing services, coordinating and monitoring service delivery and follow-up.

Congregate Nutrition Services help meet the social and the nutritional needs of older adults. Other services include nutritional outreach, education and social activities.

Disease Prevention and Health Promotion services help older persons prevent the onset of serious diseases by providing evidence-based health and wellness programs. These including the following:

- EnhanceFitness is an exercise program designed specifically for active and frail older adults
- Chronic Disease Self - Management (aka Living Well with Chronic Conditions) are classes offered once a week for six weeks for people with different chronic health problems.
- Oral Health Services provides oral health and dental services to people age 60 and older without dental insurance
- Stay Active and Independent for Life (SAIL) is astrength, balance and fitness program for adults 65 and older
- StrongWomen is a community exercise and nutrition program targeted to midlife and older women
- Walk with Ease is a workshop to teach participants how to safely make physical activity part of their everyday lives

Elder Abuse Prevention services are intended to prevent abuse, neglect, and exploitation of older individuals. The services may include public education, outreach, receipt of complaints or reports of abuse and voluntary case referrals to appropriate agencies. Services provided through the Long-Term Care Ombudsman Program assist in this effort.

Family Caregiver Support Program (FCSP) provides information, resources, education and support services to unpaid family caregivers who provide continuous care for a functionally disabled adult 18 years of age or older. These services enable caregivers to continue at-home care and allow the care recipients to remain in their familiar environments. Activities under this program are performed and authorized by CM staff and subcontractors.

FCSP Access & Support Services

- Counseling Services support caregivers by providing up to six sessions per 12 month cycle, of individual, family, short term, solution-focused counseling so the caregiver may continue his/her role as primary caregiver.
- Powerful Tools for Caregivers (PTC) is a six-week educational program providing family caregivers with tools to increase their self-care and confidence.
- Caregiver Education is provided through workshops, books, DVDs, pamphlets and websites. Educational opportunities help the caregiver obtain information about services and resources, develop coping skills and build caregiving skills.
- Star-C is a program designed to help family caregivers who are caring for someone with Alzheimer's disease or a related dementia. This is a clinically tested program proven to lower depression in caregivers and decrease problem behaviors in the person with dementia.
- Caregiver Yoga - Wellspring Workshops are specially designed for caregivers in need of enhancing their self-care skills. The workshops combine time for reflection and sharing among caregivers with gentle yoga practice for body, mind and heart. Caregivers are encouraged to nourish themselves on many levels as they do three things — reflect, reconnect, and relax.
- Staying Connected is a four-week evidence-based program to engage individuals with Alzheimer's and dementia and their care partners by facilitating social support and engagement through positive pleasant activities.

FCSP Assessment & Coordination

- TCARE is an award winning evidence-based caregiver assessment tool.
- Consultation/Coordination assists caregivers with coordinating services. Caregivers may also consult with CM as needed or when there are any significant changes in the health or well-being of either the caregiver of care receiver.

FCSP Supplemental Services

- Assistive Devices include items such as grab bars, raised toilet seats, etc. Devices typically help reduce a caregiver's work burden and help maintain safety for the caregiver and/or care receiver.
- Assistive Supplies include items such as incontinent supplies and typically aid the caregiver in attending to the activities of daily living needs of the care receiver.
- Assistive Equipment includes items such as ramps and typically reduces a caregiver's work burden. They may also help to maintain a safe environment for the caregiver and care receiver.

FCSP Respite Services

- Both In-Home and Out-of-Home Respite Care are available and provided on an hourly and/or daily basis, including 24-hour care for several consecutive days. Licensed and trained care workers provide supervision, companionship and personal care services in place of the primary caregiver. Services appropriate to the needs of individuals with dementia and related illnesses are also provided.
- Adult Day Care offers primary caregivers relief from care giving and provides the care recipient with opportunities for socialization. Services are available on a regular or irregular basis and designed to address the social needs of participants as well as the needs of families for a safe, comfortable place for adults eighteen years or over with functional disabilities.

Family Caregiver Support Program - Services to Grandparents/Relatives

- Grandparents or other relatives age 55 and over who are raising a child are able to receive the same FCSP services contained in the aforementioned FCSP section. This program is available only in Clark County.

Gatekeeper Program educates professionals and community members how to identify adults who may be isolated, living alone and in potential trouble and in need of assistance to maintain their independence.

Home-Delivered Meals provide meals and other nutrition services to older adults, and those eligible under Title XIX. Services are intended to maintain and improve the health status of these individuals, support their independence, prevent premature institutionalization, and allow earlier discharge from hospitals, nursing homes or other residential care facilities.

Information & Assistance – Aging & Disability Resource Network provides people from all backgrounds, with information about a broad range of community, social, health and government services. It opens doors into the human service delivery system and helps people obtain access to the services they need. To support local access to services in large rural areas, Information & Assistance services are subcontracted to Klickitat and Skamania county government. As part of ADRN, we also provide the following:

- Options Counseling
- Dementia Capable Options Counseling
- Transitional Care Services empowers individuals to successfully transition back to the community following a hospital or nursing home stay. Transitional Care Coordinators partner with individuals to provide tools, information and guidance to help manage health conditions and avoid readmission into more costly settings.

Kinship Caregivers Support Program provides financial support to grandparents and relatives who are the primary caregivers to children under the age of 19. One time per year per recipient funding is provided for basic needs, such as legal services, transportation, school and youth activities, interpreter services, counseling services, etc.

Kinship Navigator Program connects grandparents and other relatives, who are raising children, with community resources such as health, financial and legal.

Long-Term Care Ombudsman services include investigating and resolving complaints, identifying problems which affect a substantial number of residents, recommending changes in federal, state and local legislation, regulations and policies to correct identified problems and assisting in the development of resident councils and citizen organizations concerned about the quality of life in long-term care facilities.

Newsletters are regularly printed publications distributed primarily to persons age 60 and over for the primary purpose of informing older adults of programs and/or public benefits which will enhance their ability to remain independent.

Personal Care Services - Aging Network program provides personal care and household chores to allow the client to remain in the least restrictive setting. These services are subcontracted to the local home care agency provider.

Registered Dietician conducts visits to congregate meal sites to ensure compliance with program standards. Annual training and technical assistance to nutrition staff, and review and approval of menus, is also provided.

Senior Drug Education provides information and training to persons 65 years of age and older regarding the safe and appropriate use of prescription and non-prescription medications.

Senior Farmers Market Nutrition Program provided vouchers to eligible seniors that can be redeemed for fresh fruits, vegetables, edible herbs and honey at participating farmer's markets and farm stores throughout the service area. Nutrition education is also provided.

Senior Legal Assistance assists older persons in advocating for their rights, benefits and entitlements. Services in non-criminal matters are provided by attorneys and paralegals, and range from advice and drafting of simple legal documents to representation in complex litigation. Services include disseminating information about legal issues to: older adults, service groups and bar associations through lectures, group discussions and the media.

Senior Transportation services transfer older persons who have no other means of transportation, to and from social services, medical and health care services, meal programs, senior centers, shopping, and recreational activities. Personal assistance for those with limited physical mobility is also provided.

Steps to Employment is a pilot program designed to support an individual, receiving Medicaid Long-Term Care Support Services, in their effort to gain and maintain employment.

Veterans Directed Home Care program assists Veterans, determined by the Veterans Administration, to be at risk of institutional placement. Veterans receive financial assistance and use this funding to purchase, at their discretion, a mix of goods and services that help them live more independently.

The following programs are provided by/through AAADSW by Medicaid funding:

Title XIX (Medicaid) Case Management & Nursing Services assists functionally limited seniors and disabled adults who are at risk of institutionalization with accessing and effectively utilizing services necessary to maintain the highest level of independence in the least restrictive setting, usually the client's own homes. Activities to achieve this goal include a comprehensive assessment of individual's needs, developing a detailed service plan, authorizing services, coordinating and monitoring service delivery, follow-up and re-assessment. Nursing services provide health related consultation to Title XIX case managers, Developmental Disabilities Division, and to clients and caregivers involved in community-based care services. Upon referral from a case manager,

Personal Care Services (In-Home), provide assistance with personal care tasks, activities of daily living, transportation and household chores to eligible adults who have met income and resource guidelines, and are at risk of institutionalization. Services are provided by a licensed home care agency or Individual Provider.

COPES (Community Options Program Entry System) is the statewide Medicaid waiver program which funds in-home and related services for eligible adults who would otherwise receive like services in a nursing home. Services include personal care, transportation, housework (as it relates to personal care), adult day care, environmental modifications, specialized medical equipment and supplies, skilled nursing, client training, and Personal Emergency Response Systems (PERS).

Roads to Community Living services and supports successfully help people with complex long-term care needs transition from institutional to community settings.

Health Home Care Coordination includes six services provided by Health Home Care Coordination Organization.

1) Comprehensive care management
2) Care coordination and health promotion
3) Comprehensive transitional care from inpatient to other settings, including appropriate follow-up
4) Individual and family support, which includes authorized representatives
5) Referral to community and social support services
6) Use of Health Information Technology (HIT) to link services as feasible and appropriate.

Interpreter Services are available by phone, in person and in writing, by certified interpreters, to non-English and LEP clients.

Services Provided by AAADSW

Number of Providers/ Sites by County
* Available but not in County
N/A: Not Available

SERVICE or PROGRAM	CLARK	COWLITZ	KLICKITAT	SKAMANIA	WAHKIAKUM
Legal Assistance	1	1	1	1	1
Access Services					
Transportation	2	1	1	1	1
Information & Assistance	1	1	1	1	1
Transitional Care	1	1	1	1	1
Case Management – Aging Network	1	1	1	1	1
In-home Services					
Personal Care - Aging Network	7	5	3	2	5
Nutrition Services					
Congregate Meal Sites	8	5	5	1	2
Home Delivered Meals	1	1	1	1	1
Registered Dietitian	1	1	1	1	1
Senior Farmers Market Vouchers	1	1	1	1	1
Social & Health Services					
Senior Drug Education	1	1	1	1	1
Fitness/Exercise	2	1	1	1	*
Chronic Disease Self-Management	1	1	*	1	1
Oral Health Care	1	1	*	*	*
GateKeeper Program	1	1	1	1	1
Kinship Care Support	1	1	1	1	1
Kinship Navigator	1	1	1	1	1
Family Caregiver Support Program Assessment & Coordination					
TCARE	1	1	1	1	1
Consultation & Coordination	1	1	1	1	1
Family Caregiver Support Program Access & Support Services					
Powerful Tools For Caregivers	1	1	1	1	1
Caregiver Yoga	1	1	*	*	*
Star-C	1	1	1	1	1
Counseling	2	2	*	2	1
Family Caregiver Support Program Supplemental Services					
Assistive Devices	Multiple providers available in all counties				
Assistive Supplies					
Assistive Equipment					
Family Caregiver Support Program Respite Services					

Respite	7	5	3	2	5
Family Caregiver Support Program Services to Grandparents/Relatives					
	1	N/A	N/A	N/A	N/A
Long Term Care Ombudsman					
	1	1	1	1	1
Newsletters					
	1	1	2	2	1
Medicaid Services					
Case Management & Nursing Services	1	1	1	1	1
Personal Care (In Home)	6	5	3	2	5
COPES (Community Options Program Entry System) Services (In-Home)	6	5	3	2	5
Roads to Community Living	8	8	4	2	1
Health Home/Care Coordination	1	1	1	1	1
Interpreter	5	5	5	5	5

Non-AAA Services Available in the Planning and Service Area (PSA)

The following services and programs are available in the PSA but administered by other organizations. AAADSW partners with these organizations to enhance service(s). Additionally, AAADSW educates our target populations about the availability of all services.

Information & Assistance (I&A) Programs & Services

- 211Info call center for the Portland Metro & Clark County provides Information & Referral for residents of Clark, and Skamania Counties.
- Greater Columbia 211 provides Information & Referral for residents of Cowlitz, Wahkiakum and Klickitat Counties.
- Disability Services Organizations
  - Goodwill
  - LifeWorks
  - The Arc of Southwest Washington
- Education and Counseling Programs
  - Statewide Health Insurance Benefits Advisors (SHIBA). SHIBA volunteers assist citizens with healthcare insurance questions regarding HMOs, Medicare, Medicaid, and long term care. The SHIBA helpline is available in Clark, Skamania,

Cowlitz and Wahkiakum counties through Lower Columbia Community Action Program. Klickitat County Senior Services I&A staff members work closely with SHIBA in Yakima County to serve individuals in Klickitat County.

- Retired & Senior Volunteer Program (RSVP) is a program designed to assist seniors and baby boomers to increase community involvement and civic engagement. This program is available in Clark County at Human Services Council and Cowlitz and Wahkiakum counties at Lower Columbia Community Action Program.

Transportation Services:

- Three public transportation organizations serve AAADSW's Planning and Service Area (PSA) and complement the agency's transportation services. Additional transportation services/programs are listed below.
  - C-TRAN provides bus and C-VAN (ADA-adapted vans) services in Clark County.
  - River Cities Transit provides bus and Para Transit (ADA-adapted vans) services in Cowlitz County.
  - Skamania County Public Transportation offers both public transit and dial-a-ride service.
- Wahkiakum on the Move provides transportation services to destinations beyond Wahkiakum County.
- Cowlitz Indian Tribe Transportation program provides transportation to Cowlitz Tribal Members and the general public residing in rural areas of Cowlitz County.
- Medical Transportation Brokerage, operated by Human Services Council, coordinates Title XIX Medicaid transportation to eligible clients throughout AAADSW's five-county PSA.
- Reserve-A-Ride Transportation program provides transportation to life-sustaining medical appointments for older adults, people with disabilities, or low-income residents of Clark and Cowlitz Counties living in an area where public transportation is not available.
- Sponsor-A-Ride Senior Transportation program provides transportation for seniors in Clark County who are not eligible for publicly funded programs and cannot afford private pay options.
- Employment Transportation Services assist adults with disabilities and/or low income adults with travel to employment sites.
- Mt. Adams Transportation provides transport services to Klickitat County residents. Their dial-a-ride service provides transportation to eligible residents for doctor's appointments, social and human service appointments, educational opportunities, shopping and other essential services.
- Gorge TransLink is an alliance of rural providers offering public transportation services throughout the Mid-Columbia River Gorge and to more distant destinations, such as the metropolitan cities of Portland, Oregon and Vancouver, Washington. Gorge TransLink alliance members are committed to providing efficient, reliable and accessible transportation services to residents and visitors of Klickitat and Skamania

Counties in Washington and Hood River, Sherman, and Wasco Counties in Oregon. Transportation services are available to everyone – regardless of age or income.

Health & Wellness Services

- Mental Health agencies, both public and private, provide services in the PSA.
  - Columbia River Mental Health, in Clark County, and Columbia Wellness, in Cowlitz County, serve public and private clients through case management, therapy, medication management, crisis intervention and chemical dependency treatment programs.
  - Similar services as listed above are available throughout the PSA.
- Free Clinics
  - There are four free health clinics in AAADSW's PSA. The three free clinics located in Clark County are: Free Clinic of Southwest Washington, New Heights Clinic and Battle Ground Healthcare. The Cowlitz Free Clinic is located in Cowlitz County.
  - There are three free dental clinics in Clark County Battle Ground Healthcare, Free Clinic of Southwest Washington Dental Van and New Heights Dental Clinic.
- Community Healthy Aging Partners offer programs and disease specific workshops through local hospitals and senior community living centers.
  - A variety of exercise programs, aimed at older adults, include: Silver and Fit, Tai Chi, SAIL, Strong Women and Better Bones and Balance.
  - The Commission on Aging of Clark County, provides leadership, advocacy, community awareness and partnerships for the purpose of developing all-age-friendly, livable community. Focus areas include: housing, transportation/mobility, healthy communities, supportive services and community engagement.
  - Public health districts throughout the PSA provide information on influenza and pneumonia vaccinations.
  - Peace Health Southwest and Peace Health St. John offer a wide variety of healthy aging workshops through their You 101 – How to Improve You initiative. Topics include: healthy diet, sleep, stroke, arthritis, skin cancer, advanced care planning and senior driving.

Vulnerable Adults, Limited English Speaking and Title VI Populations

- Seniors and Law Enforcement Together, also known as Triad is a program in Clark County that joins the senior and law enforcement community together to work towards a safer community.
- DSHS Adult Protective Services investigates complaints of elder abuse and provides protective services to vulnerable adults.
- Clark County Elder Justice Center serves as a hub for investigating and prosecuting crimes against vulnerable adults. Supported by the Friends of Elder Justice Center, it aspires to create a future where all elder and vulnerable adults in Clark County live safe, valued, and dignified lives.

- The Southwest Washington Elder Abuse Prevention coalition serves Clark, Cowlitz, Klickitat, Skamania and Wahkiakum Counties. Its mission is to educate citizens, businesses and service agencies on awareness, recognition and prevention of vulnerable adults and elder abuse.
- YWCA, Salvation Army and local churches provide limited case management, housing, nutrition and other community-based services.
- Lutheran Community Services assists LEP populations and refugees with resources and operates the Crime Victim Advocacy Program.
- Ethnic Support Council assists non-English LEP populations in Cowlitz County.
- Cowlitz Indian Tribe Health & Human Services provides primary care, mental health, chemical dependency, vocational rehab, domestic violence, nutrition and transportation programs. Additionally, Tribal Benefits Counselors assist tribal members with applying for: prescription drug programs, Medicaid, veteran's benefits, social security and other public benefits programs.

Other Supports and Services

- 12 Senior Centers in the PSA: six in Clark County, two in Cowlitz County, two in Klickitat County, one in Skamania County and one in Wahkiakum County.
- Five Housing Authorities in the PSA: These agencies provide affordable housing, housing subsidies and rental assistance to eligible individuals.

Housing Authority	County
Vancouver Housing Authority	Clark
Columbia Gorge Housing Authority	Klickitat, Skamania
Longview Housing Authority	Cowlitz, Wahkiakum
Kelso Housing Authority	Cowlitz
Kalama Housing Authority	Cowlitz

- Energy Assistance/Weatherization Programs
  - Energy assistance and weatherization programs are administered by the respective county governments in our PSA with the exception of Cowlitz County, where Lower Columbia Community Action Program administers the program(s).
  - Cowlitz Indian Tribe provides energy assistance and weatherization programs to eligible members (elders) in Clark, Cowlitz and Skamania counties.

- Case Management
  - Home & Community Services staff members provide functional and financial assessments to determine eligibility for Medicaid long-term care services. Additionally, they provide ongoing case management for Medicaid long-term care clients in skilled nursing facilities, assisted living facilities and adult family homes. Area Agency on Aging case managers provide case management and nursing services to Medicaid long-term care clients residing in their own home.

- Private case management services are available to private pay clients. Some service providers use a sliding fee scale based upon the client's ability to pay.

- Alzheimer's Disease/Dementia Support Programs
  - Clark County offers bi-monthly groups to support caregivers and those with memory loss.
  - Hope, A dementia support group offers seven weekly meetings in Clark County.
  - Alzheimer's Association offers two support groups that meet monthly in Clark County.
  - Koelsch Senior Communities offers four memory care support groups in Cowlitz County that meet monthly.
  - A family caregiver support group meets monthly in Goldendale.

Issue Areas, Goals and Objectives

Long Term Services and Supports

Medicaid Case Management program, the largest program at AAADSW, provides case management services to Medicaid long-term care clients. These services help clients remain in a care setting of their choice with a provider of their choice.

AAADSW is dedicated to providing person-centered case management services which result in positive outcomes for clients while meeting DSHS contract requirements. To maintain a high level of customer service, we provide ongoing training to case managers, conduct internal reviews of assessments, service plans and authorized services and participate in state and federal audits.

The number of clients served through AAADSW is directly related to Washington State's changes in Medicaid eligibility and case-handling ratios. As caseloads rise, we hire additional staff to stay within the case-handling ratios while working closely with our community partners to identify and address gaps in care.

Goal: Enhance AAADSW's Medicaid Case Management program to further support clients' needs, changes in client caseloads, and changes in healthcare.		
Objective 1: Develop strategies to manage caseloads should the State continue to raise case-handling ratios to accommodate the budget and rising client populous.	**Tactics**	**Date**
	survey other AAA's in Washington State to identify strategies to ensure processes are effective and efficient while meeting the needs of clients	7/30/2015
Objective 2: Align quality assurance metrics with outcomes consistent with integrated care models.	continue conducting quarterly monitoring of case manager performance related to the ALTSA's quality assurance monitoring tool identify how current monitoring practices relate to industry performance standards and updated practices as needed	3/31/2016
Objective 3: Raise awareness, education and skill levels of case management staff in how best to work effectively with target population.	provide ongoing training to case managers	12/31/2017
Objective 4: Identify and close gaps in services due to lack of contracted providers and new state programs.	hire a Medicaid Contracts Specialist to educate, advertise and contract with providers to meet the needs of the clients and the demand for services	9/30/2016

Delay of Medicaid-Funded Long Term Services and Supports, Health Promotion and Disease Prevention

<u>Aging and Disabilities Resource Network (Community Living Connections)</u>
AAADSW continues to expand the I&A program with the intention of becoming an Aging and Disabilities Resources Network (ADRN). The ADRN is part of a federal initiative to provide quality information and education about disability and aging supports and services, as well as assistance to access them. Individuals and families confronting challenges around disabilities and aging will be able to access relevant options for services and supports that

maximize independence and quality of life in their home and community, by connecting with the ADRN.

Information, Awareness and Referral

These services inform the public of options and provide personalized assistance to individuals for navigating the complex array of long-term services and supports while helping them better understand program eligibility and application materials that could otherwise seem overwhelming.

ADRN services include the Community Living Connections consumer website for individuals, service organizations and private businesses seeking information. The website provides a range of general information, educational materials, opportunities to connect directly to the ADRN, and a searchable statewide resource directory.

Goal: Implement a fully functioning Aging and Disability Resource Network database system and increase service delivery.		
Objective 1: By December 31, 2018 fully operationalize the Community Living Connections (CLC) GetCare technology system.	**Tactics**	**Date**
	a minimum of 80% of AAADSW resources within CLC GetCare will meet CLC Style Guide standards and align with Policy and Procedure	12/31/2016
	develop and launch a local outreach campaign promoting the CLC GetCare consumer site	6/30/2017
Objective 2: Increase Information, Assistance & Referral service delivery by a minimum of 5% each year of the Area Plan.	establish and maintain relationships with 40 community partners to increase awareness of ADRN and its capacity to provide the public with information about programs and services and how to access support	12/31/2018
	provide Information, Assistance or Referral to a minimum of 11,400 consumers	12/31/2016
	provide Information, Assistance or Referral to a minimum of 11,970 consumers	12/31/2017
	provide Information, Assistance or Referral to a minimum of 12,568 consumers	12/31/2018
	provide Information, Assistance or Referral to a minimum of 13,196 consumers	12/31/2019

Options Counseling and Assistance

The ADRN's Options Counseling and Assistance services facilitates informed decision making about Long-Term Services and Supports (LTSS) and serves as a key role in streamlining access to supports. It represents a critical service of the ADRN by providing a clear pathway for individuals to access LTSS.

Options Counseling includes the following components:

1) Personal interview to discover strengths, values, and preferences of the individual and the usage of screenings for public programs
2) Decision support process which explores resources and service options and supports the individual in weighing pros and cons
3) Long term support plan and assistance in applying for and accessing support options
4) Quality assurance and follow-up to ensure supports and decisions are working for the individual

Goal: Offer Options Counseling as a service of the ADRN.		
Objective:	**Tactics**	**Date**
By December 31, 2016, fully operationalize Options Counseling as a service of the ADRN.	train staff on Options Counseling policy, procedures and standards	6/30/2016
	develop a referral process and train staff on the process	12/31/2016
	provide Options Counseling Service to a minimum of 50 clients	12/31/2016
	provide Options Counseling Service to a minimum of 55 clients	12/31/2017
	provide Options Counseling Service to a minimum of 60 clients	12/31/2018
	provide Options Counseling Service to a minimum of 65 clients	12/31/2019

Streamlined Eligibility Screening for Public Programs

This component of the ADRN serves as a seamless point of entry to all publicly-funded long-term and home and community-based service and support options, including those funded by Medicaid, the Older Americans Act and other state and federal programs and services. Seamless point of entry means consumers experience an uninterrupted pathway to services for which they are eligible, even though behind the scenes, multiple coordinated steps may be involved.

Goal: Develop a streamlined eligibility screening process for public programs.		
Objective:	**Tactics**	**Date**
By December 31, 2016, provide eligibility screening for public programs as a component of the	train staff on policy and procedures for providing streamlined eligibility screening for public programs	12/31/2016

ADRN.	develop a referral process and train staff on the process	12/31/2016
	offer screening for public programs to a minimum of 50 clients in 2017	12/31/2017
	offer screening for public programs to a minimum of 55 clients in 2018	12/31/2018
	offer screening for public programs to a minimum of 60clients in 2019	12/31/2019

Evidence-based Transitional Care Services

The Transitional Care service component of the ADRN creates formal links between and among the major pathways people travel while transitioning from one setting of care to another.

Care transitions occur when an individual moves from one provider or setting to another (e.g., from hospital to home or nursing home or from facility to home). Transitional Care services ensure individuals and their caregivers understand post-discharge instructions for medication and self-care, recognize symptoms that signify potential complications requiring immediate attention, and make and keep follow-up appointments with their primary care physicians.

If people have information, access and support to manage their own care and understand when and who to contact for support once they leave, or enter institutional care, they can be successful in remaining in their homes as long as possible. If this can be achieved, it has the added benefit of reducing hospital/institutional readmissions while improving medical outcomes and quality of care.

Goal: Develop a strategic plan to enhance implementation of Transitional Care Services.		
Objective:	**Tactics**	**Date**
By December 31, 2017 develop a Transitional Care services strategic plan.	develop local policy and standards	6/30/2016
	identify strategic partnership priorities	12/31/2016
	develop and implement a quality/performance monitoring process	12/31/2017
	explore contracting with a minimum of two hospitals or health insurers to provide reimbursable or for pay services related to Transitional care, home and community based supports and services	12/31/2017

Family Caregiver Support Program

This program supports unpaid caregivers (i.e. family caregivers) who provide continuous care for a functionally disabled adult 18 years of age or older. These services enable

caregivers to continue at-home care and allow care receivers to remain in their familiar environment.

AAADSW surveyed the general public and individuals from community services agencies in our PSA to assess the needs of family caregivers. Analysis of the survey indicated family caregivers most need information on community resources, education, support and respite care.
AAADSW will continue to network with community partners to increase awareness of information, support and services available to unpaid caregivers.

Information on Community and Caregiver Resources
Information and resources are readily available through local I&A offices, community presentations and other outreach activities. All I&A Specialists are trained in FCSP offerings and are able to guide caregivers when they are seeking services from AAADSW as well as other community resources.

Support Groups
Caregiver support groups are available in Clark, Cowlitz and Klickitat Counties. AAADSW maintains a current list of these groups that are available to caregivers and community partners upon request.

Respite Care Services
In-home respite care is available through local home care agencies throughout the PSA. Currently, adult day care and out of home overnight respite are only available in Clark County due to lack of available resources in the four rural counties. AAADSW is actively pursuing alternate options for caregivers to access out of home options in the rural counties.

Outreach
AAADSW routinely sustains public awareness of unpaid caregiver services available. Outreach efforts include developing and sustaining strategic partnerships with staff at organizations currently interacting with unpaid caregivers and regular participation in a variety of social service networks.

Outreach to target population is further enhanced through AAADSW's website, participation in local health/senior fairs and email marketing.

Goal: Conduct outreach, public awareness and culturally-relevant services to:
a) caregivers in the greatest economic and social need,
b) limited English-speaking and ethnic caregivers, including Native Americans,
c) caregivers providing care to persons with Alzheimer's and other dementias,
d) caregivers providing care to persons at risk of institutionalization,
e) non-traditional family members such as Gay, Lesbian, Bi-sexual and Transgender partners and those not legally married, and
f) caregivers providing care to adults under the age of 60.

Objective:	Tactics	Date

Maintain existing relationships with community partners by contacting them a minimum of once a quarter.	conduct outreach to target population by contacting community partners once a quarter and replenish outreach materials	12/31/2019
	conduct outreach to target population by submitting information about events and programs for inclusion in community partners' communication tools (community calendars, websites and newsletters)	12/31//2019
	conduct outreach to the target population by continuing to provide outreach and education materials in Spanish and Russian languages	12/31/2019

<u>Caregiver Education</u>

Workshops, classes, books and DVDs are available for unpaid caregivers. Topics include self-care for the caregiver, practical hands-on caregiving skills and other areas of interest to caregivers such as Caring for Your Loved One at Home. This series was launched in 2012 and remains part of the FCSP education services. In 2013, AAADSW launched the Yoga for Caregivers class that combines low-impact yoga as well as reflection times for caregivers. This class is offered in two formats depending on geographic area (six-week session or 1-day workshop). Additional caregiver education opportunities are described below in the Alzheimer's and Dementia Care and Support Services section.

Goal: Expand Caregiver Education Services		
Objective: Provide a minimum of twelve Caregiver Education events annually in the PSA.	**Tactics**	**Date**
	provide three Powerful Tools Classes a year in Clark County	12/31/2019
	provide two Powerful Tools Classes a year in Cowlitz/Wahkiakum counties	12/31/2019
	provide one Powerful Tools class a year in Klickitat County	12/31/2019
	provide one Powerful Tools class a year in Skamania County	12/31/2019
	provide one Caregiver Conference a year in Clark County	12/31/2019
	provide one Caregiver conference per year in Cowlitz/Wahkiakum service area	12/31/2019
	provide two Caring for Your Loved One at Home class per year in Clark County	12/31/2019
	provide one Caring for Your Loved One at Home class per year in Cowlitz/Wahkiakum Counties	12/31/2019
	provide two Caregiver Yoga sessions per	12/31/2019

	year in Clark County	
	provide one Caregiver Yoga workshop per year in Cowlitz County	12/31/2019

Kinship Services

FCSP Services for Grandparents and Relatives Raising Children provides information, assistance and support both over the phone and in person. Parenting classes and group respite are also available.

Kinship Caregiver Support Program provides financial support to grandparents and relatives who are the primary caregivers to children under the age of 19. Once in a 12-month cycle, recipient funding is provided for basic needs, such as rental and utility assistance, legal services, transportation, interpreter services and counseling services.

Kinship Navigator Program connects grandparents and other relatives who are raising children with community resources such as health, financial, and legal.

AAADSW contracts with Children's Home Society of Washington, Vancouver to provide all three kinship programs.

Goal: Sustain service delivery of Kinship Programs and Services.		
Objective:	**Tactics**	**Date**
Conduct a minimum of four outreach activities annually to promote services available to grandparents and relatives raising children throughout the planning and service area.	distribute a newsletter six times a year	12/31/2019
	attend quarterly interagency meetings in Skamania and Klickitat Counties	12/31//2019
	conduct a minimum of 12 presentations annually	12/31/2019
	promote availability of Kinship Caregiver Support services on AAADSW and CHS websites	12/31/2019

Alzheimer's and Dementia Care and Support Services

AAADSW provides service and supports which help address the needs of persons living with Alzheimer's disease or dementia and their families. The limited availability of services is a significant barrier to serving clients in the four rural counties of the PSA. With this in mind, AAADSW intentionally selected Alzheimer's and Dementia Care services for their efficacy and capacity to replicate services throughout the PSA.

AAADSW currently participates in a Dementia Capable Systems grant that pilots two new services in Southwest Washington, in the fall of 2015. Staying Connected is a four-week series that engages individuals in the early stages of Alzheimer's and their caregivers by facilitating social support and engagement through positive pleasant activities. Specialized Options Counseling services to families and individuals living with dementia, is the second service offered through this grant.

AAADSW also offers the Teepa Snow Positive Approach to Care training. This training helps family and professional care partners better understand how it feels to live with dementia and related challenges. The Positive Approach™ provides training on techniques and strategies on dementia awareness, knowledge, skill and competence.

Education opportunities offered through AAADSW provide resources and information about Alzheimer's and dementia on an as needed basis. Dementia education materials are also available through the caregiver resource libraries.

The AAADSW FCSP began piloting Dementia Activity Kit project in Cowlitz County to provide sensory activities to care receivers with dementia. These kits are tailored to the care receivers' specific needs. The intent of this project is to help reduce the stress of the caregiver by providing pleasant activities for the care receiver while also reducing the occurrence of challenging behaviors by the care receiver. This pilot project will be evaluated for effectiveness and capacity for replication in the other service area counties.

Goal: Provide support and services to individuals with Alzheimer's or a related dementia and their family caregivers.		
Objective:	**Tactics**	**Date**
By December 31, 2017 expand dementia care services and education to include a minimum of three new services.	train Options Counseling staff on policy and procedures for Dementia Capable Options Counseling	1/31/2016
	provide a minimum of two Positive Approach to Care workshops per year	12/31/2017
	provide a minimum of four sessions per year of Staying Connected in Clark County	8/31/2019
	provide a minimum of two sessions of Staying Connected in Cowlitz County	12/31/2019
	provide a minimum of two sessions of Staying Connected in Klickitat County	12/31/2019
	provide a minimum of two STAR-C consultations per year in Cowlitz and Wahkiakum Counties	12/31/2019
	provide a minimum of six STAR-C consultations per year in Clark and Skamania Counties	12/31/2019
	pilot Dementia Activity Kits	7/31/2017

<u>Senior Health and Wellness</u>

The Administration for Community Living requires that all Older American Act Title IIID Health Promotion Disease Prevention funding support evidence-based programs that improve the health and wellbeing, or reduce disease, disability and/or injury among older adults.

AAADSW meets this requirement and provides a range of health and wellness services to support older adults and adults with disabilities. Evidenced-based programs offered by AAADSW and its sub-contractors include TCARE, Powerful Tools for Caregivers, STAR-C, Enhance Fitness, Staying Active and Independent for Life, Strong Women, Walking with Ease, Transitional Care Services and Chronic Disease Self-Management Program.

Goal: Comply with the Administration for Community Living requirements of Older American Act IIID Health Promotion Disease Prevention funding utilization.		
Objective:	**Tactics**	**Date**
By October 1, 2016 assure all AAADSW Senior Health and Wellness Programs meet the Administration for Community Living Requirements for Health Promotion Disease Prevention Programming.	continue to offer a minimum of two health promotion and disease prevention programs per year in each county	12/31//2019
	review each program annually to determine that they continue to meet evidence-based requirements	12/31/2019

<u>Quality Assurance and Continuous Quality Improvement</u>
This helps ensure services meet the highest standards and are producing measurable results.

AAADSW encourages individuals, their families and partner organizations to offer input and evaluation about their experience utilizing services. This is done through GPS and PAS, client satisfaction surveys and regular consumer evaluation of educational services.

Goal: Annually assess the quality and performance outcomes of the ADRN and FCSP.		
Objective:	**Tactics**	**Date**
By 12/31/2017, develop a local quality assurance and continuous quality improvement written process for ADRN and FCSP.	conduct a follow up survey with a random 5% of assistance contacts to determine if information given by I&A was successfully utilized	12/31/2016 (repeat annually)
	At least once per year review and address concerns expressed by consumers in the ADRN consumer follow-up surveys	12/31/2016 (repeat annually)
	assure program/agency licenses, certifications or registrations are current for all active PSA 7 listings in CLC GetCare	12/31//2019

	provide a minimum of four technical assistance consultations to staff and contractors for FCSP and ADRN improvement through data analysis	12/31/2016 (repeat annually)
	host a meeting of ADRN sites and partners to facilitate collaborative learning by sharing challenges, successes and best practices	12/31/2017
	conduct quarterly quality assurance monitoring of FCSP Assessment and Coordination Services	12/31/2016 (repeat annually)
	distribute and analyze a FCSP client satisfaction survey annually	12/31/2016 (repeat annually)

Consumer Populations and Stakeholder Involvement of Service Design and Delivery

AAADSW values involvement from consumers, community partners and other stakeholders in service design and delivery. The agency employs several strategies to secure regular feedback.

The AC is comprised of residents from each of the five counties it serves. Membership of the Council includes older adults, adults with disabilities and family caregivers. The AC advises AAADSW on all matters relating to the development and administration of the AP. The Council sponsors public hearings, forums, and conferences to solicit information from older adults, adults with disabilities and family caregivers. AC members draw upon their circle of influence to develop a relationship based approach to outreach. Furthermore, the AC helps set program and funding priorities for the PSA.

Family caregivers routinely evaluate educational services and offer suggestions for future events. Feedback from stakeholders influences the genesis of new services. Staff regularly discus program gaps and barriers to services, which help shape program development. An example of this type of program development is Dementia Activity Kits project described in the Alzheimer's and Dementia Care and Support Services section.

AAADSW routinely consults with other FCSP Program Coordinators throughout the state to learn about best practices, guest speakers for educational events and innovative services to expand service delivery to family caregivers. This collaboration resulted in AAADSW bringing Teepa Snow, national dementia care expert, to the service area to educate family caregivers and healthcare professionals.

To better meet needs in the community, AAADSW regularly develops partnerships with other providers. In Clark and Cowlitz Counties, AAADSW collaborates with Emergency Medical Services (EMS) to better meet the needs of vulnerable older adults and adults with disabilities.

At a minimum of once every four years, AAADSW solicits feedback from the general public and community partners through surveys and public hearings regarding gaps in services and the needs of older adults, adults with disabilities and family caregivers.

Goal: Engage target population and stakeholders in service design and delivery		
Objective: From January 1, 2016 through December 31, 2019, sustain existing practices to solicit feedback from consumers, community partners and other stakeholders in service design and delivery.	**Tactics**	**Date**
	provide evaluation surveys for a minimum of 80% of all FCSP educational events	12/31/2016 (repeat annually)
	survey partners, clients and stakeholders to identify service needs and barriers to accessing services	7/31/2019
	host regional meetings to solicit feedback from clients, community members and partners on service design and delivery	9/30/2019
	seek feedback from staff on gaps and barriers in services, quarterly.	12/31/2016

Partnerships and Networks

Forming and maintaining meaningful community partnerships remains a high priority to AAADSW. In an effort to expand community awareness of AAADSW programs and services, staff develops and sustains strong partnerships with professional peers in Healthcare, EMS, Housing Authorities, Dementia Support Group providers, Senior Centers and a broad range of other community-based service organizations.

AAADSW participates in numerous networks including Southwest Washington Elder Abuse Prevention, Clark County Commission on Aging, Cowlitz/Wahkiakum Living Well Aging Well, Clark and Cowlitz Counties Cross Continuum Care Transitions Collaborative, Community Health Access Resource Group, Emergency Medical Services Community Healthcare Coalition, Elder Alliance, Professionals in Aging, Senior Services Networking, Faith Community Nursing Health Ministers, Healthy Living Collaborative, Regional Health Alliance/Accountable Community of Health and Skamania and Klickitat Interagency Meetings.

Needs and Gaps

Nearly 900 individuals throughout the PSA completed a GPS or PAS in 2015. Analysis of survey responses from each county in the PSA identified four common themes.

1. Older adults and adults living with a disability want to stay in their own homes and need a variety of services to do so. These include caregivers, transportation, handyman, home modification, durable medical equipment and assistance with household chores.
2. Access to dental care is a growing need for older adults and adults living with disabilities as well as access to primary care in rural areas.
3. People need information about programs and services and don't know where to find it.

4. Family caregivers need respite, information on community resources, education and support.

AAADSW Community Services Programming and Case Management staff identified the following gaps in services to older adults, adults with disabilities and family caregivers.

1. Resources for adults with disabilities between the ages of 18-59
2. Minor home repair
3. Moving and clean out assistance
4. Transportation
5. Out of home respite services in rural counties
6. Respite care services for working caregivers

Goal: AAADSW program staff will consult with stakeholders from each county regarding the needs identified in their respective county's survey results.		
Objective: Convene semi-annual meetings with individual county stakeholders to address each county's concerns about older adults staying at home with in-home care, transportation and better access to health and dental care.	**Tactics**	**Date**
	Identify stakeholders in each county to include AAADSW Advisory Council members, Senior Services, representation from healthcare, and interagency meeting attendees.	3/31/2016
	Hold an initial meeting in each county to review concerns and begin to develop a plan of action to address concerns.	6/30/2016
	Convene a second meeting in each county to review progress on individual county plans of action.	12/16/2016
	Convene semi-annual meetings during years 2-4 of the 2016-2019 Area Plan to review progress on individual plans of action.	12/31/2019

Goal: Explore opportunities to address the gaps in service delivery to older adults, adults with disabilities and family caregivers through advocacy, expanding programs and outreach.		
Objective: By December 31, 2016 AAADSW will develop a program plan to address needs and gaps in services.	**Tactics**	**Date**
	consult with the Center for Independence in Lakewood, Washington and The Arc of Southwest Washington at least once per quarter to remain informed of resources for adults with disabilities	12/31/2016
	explore grant opportunities to expand service delivery that supports older adults and adults with disabilities remain at home	12/31/2019

	introduce a minimum of one new service to assist older adults and adults with disabilities remain in their homes	12/31/2017
	transition Oral Health Services from a pilot program to the suite of AAADSW Senior Health and Wellness services to improve access to dental care	1/31/2016
	advocate for improved access to primary care in rural areas	12/31/2019
	Continue advocating for the needs of working caregivers to FCSP funders	12/31/2019

Service Integration and System Coordination

AAADSW participates in opportunities for health care reform in Health Home services. Health Home services further integrate systems of care by assisting clients with chronic conditions access, understand and advocate for improved personal health outcomes through a meaningful goal setting process. These efforts are highly successful, resulting in trusted relationships between care coordinators and clients who become empowered to take an active role in their healthcare outcomes. These positive healthcare outcomes include reduction of unnecessary medical care and a focus on preventative care.

AAADSW has contracts with Health Home lead entities and managed care organizations. These partnerships are paving the road to programmatic sustainability and continued successful outcomes for our shared clients.

Goal: Continue current strategies used to achieve successful outcomes and program success of Care Coordination and Health Home services.		
Objective 1: Continue to accept referrals from all contracted providers and build sufficient staffing capacity to respond to increase in referrals.	**Tactics**	**Date**
	continue to accept referrals from all contracted providers	3/31/2016
	train Care Coordinators in motivational interviewing and client engagement strategies	
Objective 2: Maintain funding streams to continue to offer care	continue existing contracts with Managed Care Organizations	6/30/2016

coordination services to clients with chronic conditions and who are costly to the Medicaid system.	provide Managed Care Organizations with community-based care coordination services to improve health outcomes and reduce unnecessary medical expenditures.

Policy 7.01 Implementation Plan for Area Agencies on Aging (AAAs)

Biennium Timeframe: January 1, 2016 to December 31, 2017

Plan Due Dates:

- October 1st of each odd numbered year a complete Implementation plan is due for the coming biennium.
- October 1st of even numbered years a progress report is due.

Implementation Plan Cowlitz Tribe				Progress Report
(1) Goals/Objectives	**(2) Activities**	**(3) Expected Outcome**	**(4) Lead Staff and Target Date**	**(5) Status Update for the previous year.**
Continue working relationship with Cowlitz Indian Tribe Health & Human Services (CITH&HS).	Communicate with CITH&HS representatives to analyze past coordination efforts and review Policy 7.01 Implementation Plan.	Develop a stronger relationship between Area Agency on Aging & Disabilities of SW WA (AAADSW) and Cowlitz Indian Tribe. Ensure 7.01 Plan objectives are met.	AAADSW Community Services Manager, Mike Reardon Semi-Annually 2016 - 2017	
Increase Tribal awareness and utilization of long term services and supports (LTSS).	Coordinate information exchange about available programs, services and events and how to access them.	Improve awareness of and access to LTSS and programs and services available through AAADSW.	AAADSW Community Services Supervisor – Kelso Office – Kelli Sweet. Quarterly meetings beginning 2016 through 2017.	
Improve support for Native American informal caregivers	1. Offer one Powerful Tools for Caregivers class to Cowlitz Tribal members annually. Class facilitators will be one trained Cowlitz Indian Tribe staff member or tribal member and one trained AAADSW staff member.	Knowledge and skills of Native American informal caregivers have improved.	1. AAADSW Program Coordinator, Lexie Bartunek. December 31, 2016 December 31, 2017 2. AAADSW	

	2. Inform CITH&HS of *caregiver support (Powerful Tools, Direct Skills)* classes offered through AAADSW. 3. Inform CITH&HS of annual Cowlitz/Wahkiakum and Clark County Family Caregiver Conference		Community Services Supervisor – Kelso Office – Kelli Sweet. 30 days prior to scheduled class. 3. AAADSW Community Services Supervisor – Kelso Office – Kelli Sweet. 30 days prior to scheduled conference.	
Increase agency staff awareness of culturally sensitive issues	CITH&HS to provided cultural awareness in-service training at AAADSW All-Staff meeting.	Agency staff has increased awareness of Native American culture.	Community Services Manager, Mike Reardon. May 2016.	
Increase cultural awareness of AC members	CITH&HS to provided cultural awareness in-service training at AAADSW Advisory Council meeting.		Community Services Manager, Mike Reardon March 2016.	
Improve nutritional health of older Native Americans	1. Allocate 16 Senior Farmers Market Nutrition Program voucher packets to Cowlitz Indian Tribe. 2. Send to CITH&HS days, times and locations of all congregate nutrition meals sites in AAADSWs five-county service area.	1. 16 eligible elders of Cowlitz Indian Tribe each will receive one Senior Farmers Market Nutrition Program voucher packets which includes $40 in vouchers, nutrition education and location of authorized farmers' markets and farm stores in Washington state.	1. AAADSW Program Coordinator, Lexie Bartunek. June 1, 2016 June 1, 2017 2. Community Services Manager,	

		2. Older Native Americans will know where, when and time of all congregate meal sites.	Mike Reardon January 31, 2016.	
Improve physical health of Native American elders.	1. Share information about Senior Health & Wellness (SH&W) classes and activities in Cowlitz County. 2. Research evidence-based dance classes,	1. Older Native Americans will receive information about AAADSW sponsored SH&W classes and activities. 2. Improve physical health of Native American elders.	1. AAADSW Community Services Supervisor – Kelso Office – Kelli Sweet. On-going. 2. Elders Program Manager, Deb Mizner January 31, 2016	

AREA PLAN BUDGET (See also Excel AP Budget Attachment)

Area Plan Budget Summary

AAADSW DRAFT 2016 AREA PLAN BUDGET

Program Expenditure Summary

	Fund Sources						
PROGRAMS	OAA	Medicaid	State	MSC	Other Sources	Included Match #2	Total
Administration/Contract Management	192,148	413,050	216,451	14,000	200,000		1,035,649
Coordination	310,000		-	-			310,000
Legal Assistance	81,000		-	-		25,000	106,000
Transportation	127,000		158,172	-		225,000	510,172
Information & Assistance	155,180	30,000	307,108	-		125,000	617,288
Case Management	31,000	6,942,321	6,000	-		7,000	6,986,321
DDD Nursing	-	10,000	-	-			10,000
Personal Care Services	8,000		77,000	-		7,000	92,000
Congregate Meals (inc NSIP)	413,671		-	-		275,000	688,671
Home Delivered Meals (inc NSIP)	501,031		-	-		350,000	851,031
Dietitian	8,700		-	-			8,700
Senior Farmers Market	-	-	64,814	-			64,814
Senior Drug Education	-		12,535	-			12,535
Disease Prevention/Health Promotion	30,564		6,000	-			36,564
Chronic Disease Self Management	-		-		12,000		12,000
Kinship Services	-		172,884	-			172,884
FCSP-Access	33,000		123,524	-			156,524
FCSP-Assessment	60,968		186,093	-			247,061
FCSP-Respite	65,100		461,472	-			526,572
FCSP-Supplemental	35,000		18,568	-			53,568
FCSP-Grandparents	19,602		-	-		6,000	25,602
Elderly Abuse Prevention/Ombudsman	11,830		2,400	135,000		1,500	150,730
MIPPA	-		8,740	-			8,740
Senior Dental Services					50,000		50,000
Demensia Capibility			10,480				10,480
Steps to Employment			88,000				88,000
Health Homes/Care Coordination					1,600,000		1,600,000
Veterans Directed Home Services			20,000				20,000
Aging and Disabilities Resources Network					80,000		80,000
Care Giver Training	-		300,000	-			300,000
Agency Worker Health Insurance	-		70,000	-			70,000
Computer Replacements #1					200,000		200,000
TOTAL	$ 2,083,794	$ 7,395,371	$ 2,310,241	$ 149,000	$ 2,142,000	$ 1,021,500	$ 15,101,906

#1=Requierd per State replacement policy

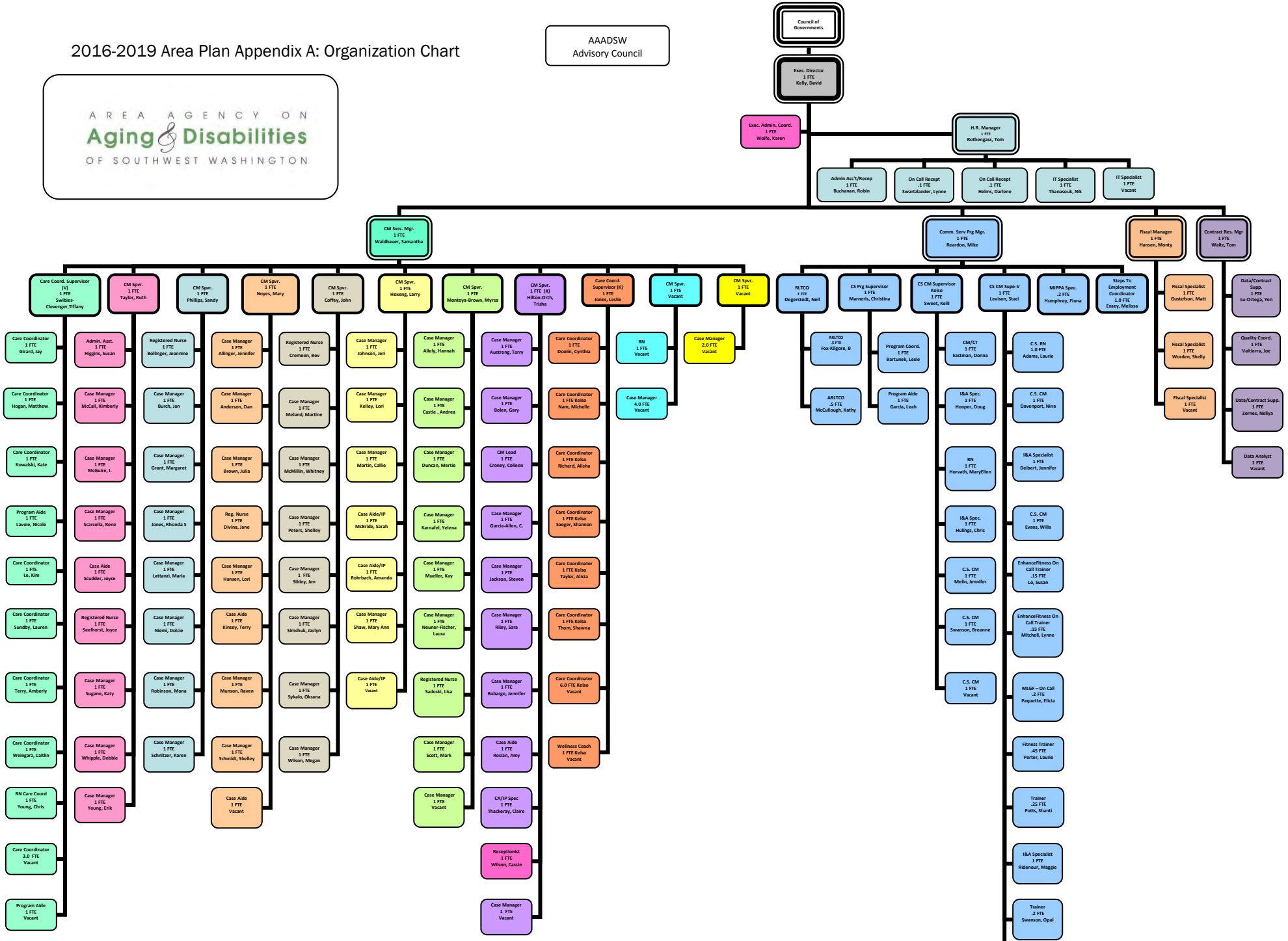
#2=Non ADSA Match

ATTACHMENT V

2016-2019 Area Plan Appendix A: Organization Chart

AAADSW
Advisory Council

AREA AGENCY ON
Aging & Disabilities
OF SOUTHWEST WASHINGTON



January 1, 2016

ATTACHMENT V

Area Agency on Aging and Disabilities of SW WA
Staffing Plan January 1, 2016

Position Title	FTE	Position Description	# of staff
Executive Director	1.0	Serves as chief administrator with the major responsibility of managing social and health services for older adults and persons with disabilities. Coordinates legislative advocacy and community networking activities. Responsible for the direct administration, organization, and coordination of the Agency.	1
Fiscal Manager	1.0	Provides direction and leadership in the business planning, accounting, asset management and budgeting of the agency. Advises Director on financial policies, strategies, and procedures.	1
Fiscal Specialist-AP	1.0	Provides fiscal support to the agency such as establishing and maintaining a comprehensive system for recording AP fiscal activity, coordinating purchasing functions and expenditure control, or maintaining revenue account records.	1
Fiscal Specialist – Payroll	1.0	Acts as primary payroll specialist for Agency and performs semi-monthly payroll processing and all related payroll support functions as noted below. Also provides fiscal support to the agency such as establishing and maintaining a comprehensive system for recording fiscal activity, coordinating purchasing functions and expenditure control, and/ or maintaining revenue/cash account records.	1
Fiscal Specialist – AR (Vacant)	1.0	Provides fiscal support to the agency such as establishing and maintaining a comprehensive system for recording AR fiscal activity, coordinating purchasing functions and expenditure control, or maintaining revenue account records.	
HR Manager	1.0	Provides generalist human resources support to the agency and staff. Provides advice and assistance on staff policies, regulations, recruitment, compensation, performance management, disciplinary procedures, job descriptions, labor relations, and training. Administers benefits (insurance, Washington State Retirement programs) including enrollments and terminations. Is responsible for the safety committee, reception function, ordering and facility.	1
IT Specialist	1.0	In support of the agency's information systems and users, independently performs analysis, design, acquisition, installation, configuration, maintenance, quality assurance, troubleshooting and/or technical support for applications, hardware and software products, databases, website, support products, network	1

Area Agency on Aging and Disabilities of SW WA
Staffing Plan January 1, 2016

		infrastructure equipment, or telecommunications infrastructure, software or hardware.	
IT Coordinator (Vacant)	1.0	In support of the agency's information systems and users, independently performs analysis, design, acquisition, installation, configuration, maintenance, quality assurance, troubleshooting and/or technical support for applications, hardware and software products, databases, website, support products, network infrastructure equipment, or telecommunications infrastructure, software or hardware.	
Contracts and Resources Manager	1.0	Develops, monitors, and assesses service provision by subcontractors, provides or arranges for technical assistance and training for service providers, and participates in the implementation of procurement and contracting processes. Develops and manages resource development activities.	1
Contracts & Data Support Specialist (1 Vacant)	3.0	Supports program coordinator in administration of programs and services by maintaining all data collection records and producing reports.	2
Community Services Program Manager	1.0	Responsible for development, oversight, and management of Title III, SCSA, and Elder Abuse programs and services including Long-Term Care Ombudsman, Senior Transportation, Senior Nutrition, Minor Home Repair, Adult Day Care, Adult Day Health, Aging Network Case Management, Senior Personal Care, Disease Prevention /Health Promotion, Senior Farmers' Market, Registered Dietician, Medication Management, and Senior Drug Education. Oversees Family Caregiver Support, Kinship Caregiver Support, Kinship Navigator and Information & Assistance programs.	1
Community Services Program Supervisor	1.0	Responsible for development, oversight, and management of Older American Act Title III, Senior Citizens Services Act, Elder Abuse and Grant funded programs and services including but not limited to Aging & Disability Resource Center (ADRC), Family Caregiver Support, Senior Transportation , Senior Nutrition, Senior Health & Wellness, Kinship caregiver Support and Kinship Navigator programs across agency's five-county planning and service area.	1

Area Agency on Aging and Disabilities of SW WA
Staffing Plan January 1, 2016

Community Services Case Mgt. Supervisor	2.0	Supervise and manage Case Managers and part-time staff/trainers and related programs/services. Accountable for supervising the effective coordination and application of specific applicable components of standardized assessment tools in collaboration with individual caregiver/client input to develop customized plans of care which will enable caregiver/client to maintain the highest level of independent living possible. Responsible for initiation, identification, referral and coordination efforts with public community service resources, and promotes and performs outreach and marketing activities by developing and delivering presentations/educational trainings/information on a variety of Agency related programs and services to the general public, providers, professionals and other diverse populations.	2
Community Services Program Coordinator	1.0	Responsible for coordination and oversight of Federal, State, and private grant funded programs including but not limited to Family Caregiver Support, Senior Health & Wellness, Senior Nutrition, Senior Transportation, Kinship Caregiver and Navigator, and Legal Services.	1
Employment Support Coordinator	1.0	Responsible for assisting clients in obtaining and maintaining competitive employment in the community.	1
Community Services Case Manager (2 Vacant)	7.0	Assess needs of clients utilizing standardized assessment tools. Clients include family caregivers, older persons and adults with disabilities. Develop and administer client centered service plans which will result in maintaining the client (or client's care receiver) at the highest level of independent living possible. Authorize and obtain in-home and community based services in accordance with the client's service plan. Support unpaid caregivers who have primary responsibility for the care or supervision of an adult (age 18 or older) with one or more functional disabilities. Provide outreach and promotion of the Family Caregiver and Community Services programs.	5
Regional Long Term Care Ombudsman	1.0	Serves as an effective and visible advocate for the well being of long-term care residents, promotes both individual and systematic complaint resolution activities including community involvement, administrative and legislative monitoring and reporting.	1

Area Agency on Aging and Disabilities of SW WA
Staffing Plan January 1, 2016

Asst. Regional Long Term Care Ombudsman	1.0	Assists Regional Long Term Care Ombudsman as an effective and visible advocate for the wellbeing of long-term care residents, promotes both individual and systematic complaint resolution activities including community involvement, administrative and legislative monitoring and reporting.	2
I&A Specialist	4.0	Provides information and assistance/referral to the senior population and individuals with disabilities and their caregivers. Screens and authorizes services for seniors and assists people to access and arrange needed in-home and community services.	4
Admin. Exec. Coordinator	1.0	Provides general admin. support to Exec. Dir. And Mgt. Staff.	1
Quality Assurance Coordinator	1.0	Coordinates and assures compliance and quality of ADSA contracted and SWAAD sub-contracted TXIX case management services and core service contracted client and provider records.	1
Receptionist	1.2	Acts as receptionist and provides administrative support to agency staff.	3
TXIX Case Management Services Manager	1.0	Program Management and policy development for the Case Management Program. Responsibilities include the identification and implementation of new program standards and corrective actions required, ongoing program and policy development, and oversight, development and monitoring of contracts assigned to this program.	1

Area Agency on Aging and Disabilities of SW WA
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TXIX Case Management Supervisors (2 Vacant)	9.0	Supervises and manages primarily Medicaid funded case management services. Develops and coordinates service delivery, promotes public access to services, including seniors and adults with disabilities receiving in-home and community-based long-term care (LTC) services.	7
TXIX Registered Nurses (1 Vacant)	6.0	Receives client referrals based on assessment of Medicaid Personal Care (MPC), Community Options Entry System (COPES), and/or Senior Personal Care (SPC). Reviews and assesses client's health status, personal care needs and current service plans, identifies and coordinates medically related referrals and follow-up visits/reviews as needed in client's home, adult family home or adult residential facility, reviews performance of client's care provider, implements training or makes training referrals, coordinates with medical professionals and provides information related to the health/medical condition of at-risk clients as necessary.	5
Community Svcs. RN	2.0	Work with Community Services Team to support clients transitioning from one care setting to another (i.e. hospital to home).	2
Care Coordination Supervisor	2.0	Responsible for development and supervision of the Care Coordination Organization across the agency's five-county planning and service area to meet the requirements of the Health Home lead contracts for service provision in the six functions of Health Homes; care management, care coordination, health promotion, individual and family/caregiver support, transitional care and referral management.	2
RN Care Coordinator	1.0	Provides support for designated clients which includes coordinating an array of services designed to improve the health of high needs, high risk clients. Care coordination responsibilities will include assessment, care planning and monitoring of client status, implementation and coordination of services. Provides support to clients for effective care transitions, improved self-management skills and enhanced client-provider communication. Facilitates interdisciplinary consultation, collaboration and care continuity across care settings. This position	1

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		will not involve providing direct care or treatment.	
Care Coordinator (10 Vacant)	23.0	Provides support for designated clients which includes coordinating an array of services designed to improve the health of high needs, high risk clients. Care coordination responsibilities will include assessment, care planning and monitoring of client status, implementation and coordination of services.	13
Care Coordination Program Aide (1 Vacant)	2.0	Assists RN & CA Care Coordinators with referral and assistance in delivering effective care coordination services.	1
TXIX Case Manager Lead	1.0	Assists CM Supervisor with reviewing Client and IP files new in the office, transferring out of the office, and being closed. CM Lead will assist with training and education of staff. Manages a partial client caseload as needed to balance the case manager to client and staff ADSA ration standards	1
TXIX Case Manager (8 Vacant)	51	Assist adults with disabilities and older persons to assess their needs, authorize and obtain in-home and community based services to: (1) maintain their independence in the community; (2) be diverted from nursing home or other institutional settings (3) make a timely return home following a short hospital or residential stay; and (4) remain at home with support despite functional impairments. Develops and administers a service plan which will result in maintaining the client at the highest level of independent living possible while still addressing the issues which arise in acute situations.	43
TXIX Case Aide (2 Vacant)	8.0	Provides information, referral and assistance to older persons with disabilities and their caregivers.	6
Admin. Assistant	2.0	Provides administrative and technical support for case management unit.	2
Community Services Program Aide	1.0	Provides program and administrative support to Community Services Program staff and Supervisors to include: program implementation, program/contract monitoring, contract Statement of Work and Special Terms and Conditions, program report writing, data	1

Area Agency on Aging and Disabilities of SW WA
Staffing Plan January 1, 2016

		collection, and web site updates.	
Trainer/Researcher	1.2	Trainers teach classes to members of the public in Enhance Fitness and Powerful Tools for Caregivers.	5
Memory Loss Group Facilitator	.2	Facilitates memory loss participant discussions in group setting.	1
MIPPA Specialist	.2	Outreach, Medicare LIS and MSP enrollments, coordination with other agencies, data gathering, data sharing & preventative services education.	1

Total number of full-time equivalents = 144.8
Total number of staff = 124
Total number of minority staff = 14
Total number of staff over 60 = 32
Total number of staff indicating a disability = 27

Emergency Response Plan

As an agency serving vulnerable populations, we are committed to ensuring the safety of our most vulnerable clients in the event of an emergency.

Goal: Develop a plan that addresses the needs of high-risk AAADSW clients and the continuation of AAADSW's business in the event of an emergency.		
Objective 1: Maintain a high-risk client log that identifies accurate client contact information accessible in electronic and hard copy format.	**Tactics** Case Management Services Manager or designee will continue maintaining a tracking system of high-risk clients. High-risk client criteria: Client lacks informal supports Client is either geographically isolated, technology dependent or who are severely cognitively impaired. Case managers will update high-risk client logs electronically and provide supervisors with printed copies.	**Date** Monthly Ongoing
Objective 2: Continue agency emergency preparedness committee	Case Management Services Manager or designee will provide emergency preparedness training on high-risk populations to committee members. Train case managers on high-risk client tracking criteria and protocol.	Quarterly Ongoing
Objective 3: Create a tracking system for expenditures during an emergency.	Fiscal Manager will develop an emergency response expense report form.	August 2016
Objective 4: Develop partnerships with local emergency response/disaster preparedness organizations.	Fiscal Manager will contact local American Red Cross and County emergency response departments to begin identifying emergency response roles and responsibilities for assisting high-risk clients. Signed Letters of Agreement with local emergency operations leadership	June 2016 December 2017
Objective 5: Develop an internal business continuity plan	Fiscal Manager will develop a Business Continuity Plan to include communication protocols, a plan to back-up agency data and identify emergency service delivery options	December 2017

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2016 ADVISORY COUNCIL MEMBERSHIP

Members by County:

Clark County	Cowlitz County	Klickitat County	Skamania County	Wahkiakum County
Brown, Elizabeth	Dieter, Jon	Johnson, Lanae	Knudson, June	Cameron, Sue
Cecka, Carl	McCully, Tina	Quigley, Martha	Miller, Donald	Holmes, Suzanne
Van Dinter, Shari	*Vacant*	Thygesen, Raymond	*Vacant*	*Vacant*
Lewis, Carole				
Hadley, Diane				
Vacant				

Demographic Data:

Category	Number of AC Members
# age 60 and over	11
# age 59 and under	3
# of males	4
# of females	10
# with self-identified disability	2
Minority	0

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Public Process

AAADSW used a variety of methods for identifying and verifying unmet needs among older persons, adults with disabilities, and family caregivers in its five-county Planning and Services Area (PSA). Those methods include:

- General Public Survey
- Partner Agency Survey
- Input from AAADSW staff
- Input from Advisory Council members
- Input from three public hearings
- Input from AAADSW contractors
- Input from Cowlitz Indian Tribe Health and Human Services (7.01 Plan)
- Input from Yakima Indian Tribe (7.01 Plan)
- Aging & Long-Term Services Administration 2014 State Plan on Aging Survey Report, September 2014,
- The United States of Aging Survey 2015 Results

Additionally, AAADSW used the following sources for population, demographic and service data:

- U.S. Census Bureau, 2010 Census,
- DSHS Office of Financial Management - Forecasting May 2012,
- DSHS Research and Data Analysis – Population and Aging Service Utilization Forecast, May 28, 2015,
- AAADSW 2013 and 2014 Service Activity Report

Advisory Council (AC) members played a significant role in the development, refinement, distribution and collection of General Public Surveys (GPS) and Partner Agency Surveys (PAS) used to gather information on needs and concerns of our target populations.

During March, April and May of 2015, many AC members, along with AAADSW staff distributed GPS at all 21 senior congregate meal sites in the PSA. During each visit meal an AAADSW representative provided a short presentation about the purpose and importance of the survey and asked meal site participants to complete it. Larger meal sites such as Battle Ground and Luepke Center received multiple visits to ensure meal site participants were provided an opportunity to complete a survey.

The PAS was used to gather important information from other agencies serving older adults, adults with disabilities and caregivers about what they see are the needs, concerns and service gaps for the respective populations.

Other survey distribution efforts include:

- March 12, 2015, AAADSW sponsored community Lunch & Learn, Cowlitz County PUD Auditorium, Longview, WA
- March 17, 2015, Clark County Commission on Aging Meeting, Vancouver, WA

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- March 26, 2015, Press Release sent to The Columbian, The Daily News, Wahkiakum Eagle, Senior Messenger, Goldendale Sentinel, Skamania County Pioneer, The Enterprise, The Reflector, Camas-Washougal Post-Record
- March 27, 2015, link emailed Agency contacts via Constant Contact
- March 29, 2015, link posted on Agency web site, www.HelpingElders.org
- March 30, 2015, link to survey emailed to 21 Clark County Neighborhood Associations
- March 31, 2015, link to survey emailed to Skamania and Klickitat Community Network
- April 3, 2015, link to survey emailed to all legislators in our PSA
- April 14, 2015, Chronic Disease Self-Management Class, Cathlamet, WA
- April 14, 2015, Accessible Transportation Coalition members
- April 27, 2015, EnhanceFitness Class, Vancouver, WA

The surveys were distributed in paper and electronic form in both English and Russian. We estimate a combined 4,000 GPS and PAS were distributed throughout the five-county PSA. The total number of PGS completed is 636. The total number of PAS completed is 254.

Area Plan Review and Approval Process

AAADSW AC members played a key role in the 2016-2019 AP review and approval process. AC members were updated on the AP process at monthly AC meetings; and reviewed and approved the draft AP prior to public hearings. Many members attended the public hearing in their respective service area as a show of support. After minor changes were made, they unanimously approved the Area Plan on September 16, 2015.

Three AP public hearings were conducted: (1) in Vancouver (Clark County) on August 25, 2015, (2) in White Salmon (Klickitat County) on August 26, 2015 and (3) in Longview (Cowlitz County) on August 31, 2015. The opportunity to review the AP was available at each hearing and on AAADSW's web site at www.HelpingElders.org.

Below are comments from community members made during Public Hearings:

- Clark County Area Plan Public Hearing, Vancouver, WA, August 25, 2015
  - Seems like people don't know about the services the Agency provides. How are we getting the information to the target population?
  - The social workers at the hospitals and lots of therapists don't know about the agency.
  - Primary Care physicians are a good source to ask questions and get resource info.
  - Short-term respite care is hard to find, expensive and hard to schedule. Caregivers get frustrated. There other expenses related to respite care that are costly to caregivers.
  - Each county has differing resources for guardians. We need to better support them

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  - Big gap in skilled home health nurses, therapists, etc. Medicaid reimbursement rate is low so there are fewer providers. The rate in WA is half what it is in OR. The Agency's advocacy would be welcome.
  - Gap in (affordable senior) housing and information.
  - Medicaid clients need more housing care and can't find housing with additional care. Seniors in unsafe living situations (i.e. fall prevention) can't get to the top of the waiting lists, even though safer housing could prevent falls.

- Skamania County and Klickitat County Area Plan Public Hearing, White Salmon, WA, August 26, 2015
  - Would like to see Chronic Disease Self-Management class in Klickitat County
  - In White Salmon everyone goes to the grocery store and there's a bulletin board everyone checks. This is a good place to post information.
  - Counseling services for caregivers (through Family Caregiver Support Program) is not available in Klickitat County
  - Lack of resources for Multiple Sclerosis patients in Klickitat County
  - Transportation services in Klickitat County have been cut back in recent years and would like to see services restored
  - Really need transportation for shopping
  - Meal sites aren't as prevalent as they used to be
  - There is nothing in the area for MS patients

- Cowlitz County and Wahkiakum County Area Plan Public Hearing, Longview, WA, August 31, 2015
  - Many seniors don't use computers and we need to make sure our Aging & Disability Resource Network addresses that concern
  - Lack of medical care (providers) in Cathlamet
  - We (AAADSW) need to make sure people know how to find the information
  - Need for Long-Term Care Ombudsman program staff to work more closely with Mental Health Ombudsman for Cowlitz County
  - It would be nice to see where the money (WA State Budget) actually goes.
  - Tribal culture is different in some cases, because often their history isn't written.
  - Regarding mental health and seniors, depression and dementia can be complicated by various doctors and meds. Seniors are often overlooked in their level of need and ability to ask for help.

The Area Plan was approved by AAADSW's governing board, Council of Governments on Aging & Disabilities of SW Washington, during the September 24, 2015 Council of Governments board meeting.

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Report on Accomplishments of 2014-2015 Area Plan Update

NOTE: This Appendix will be completed and submitted to Department of Social and Health Services, Aging and Long-Term Support Administration, by the March 31, 2016 deadline.

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Statement of Assurances and Verification of Intent

For the period of January 1, 2016 through December 31, 2019, the Agency on Aging & Disabilities of SW Washington (AAADSW) accepts the responsibility to administer this Area Plan in accordance with all requirements of the Older Americans Act (OAA) (P.L. 106-510) and related state law and policy. Through the Area Plan, AAADSW shall promote the development of a comprehensive and coordinated system of services to meet the needs of older individuals and individuals with disabilities and serve as the advocacy and focal point for these groups in the Planning and Service Area. AAADSW assures that it will:

Comply with all applicable state and federal laws, regulations, policies and contract requirements relating to activities carried out under the Area Plan.

Conduct outreach, provide services in a comprehensive and coordinated system, and establish goals objectives with emphasis on: a) older individuals who have the greatest social and economic need, with particular attention to low income minority individuals and older individuals residing in rural areas; b) older individuals with significant disabilities; c) older Native Americans Indians; and d) older individuals with limited English-speaking ability.

All agreements with providers of OAA services shall require the provider to specify how it intends to satisfy the service needs of low-income minority individuals and older individuals residing in rural areas and meet specific objectives established by AAADSW for providing services to low income minority individuals and older individuals residing in rural areas within the Planning and Service Area.

Provide assurances that the Area Agency on Aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with significant disabilities, with agencies that develop or provide services for individuals with disabilities.

Provide information and assurances concerning services to older individuals who are Native Americans, including:

A. Information concerning whether there is a significant population of older Native Americans in the planning and service area, and if so, an assurance that the Area Agency on Aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under the Area Plan;

B. An assurance that the Area Agency on Aging will, to the maximum extent practicable, coordinate the services the agency provides with services provided under title VI of the Older Americans Act; and

C. An assurance that the Area Agency on Aging will make services under the Area Plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans.

Provide assurances that the Area Agency on Aging, in funding the State Long Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of Title III funds expended by the agency in fiscal year 2000 on the State Long Term Care Ombudsman Program.

Obtain input from the public and approval from the AAA Advisory Council on the development, implementation and administration of the Area Plan through a public process, which should include, at a minimum, a public hearing prior to submission of the Area Plan to DSHS/ADS. AAADSW shall publicize the hearing(s) through legal notice, mailings, advertisements in newspapers, and other methods determined by the AAA to be most effective in informing the public, service providers, advocacy groups, etc.

Date	David Kelly, Director Area Agency on Aging & Disabilities of SW Washington
Date	Raymond Thygesen, Advisory Council Chair Area Agency on Aging & Disabilities of SW Washington
Date	Chris Brong, Skamania County Commissioner Chair of Southwest Washington Council Of Governments on Aging & Disabilities

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Acronyms

AAADSW	Area Agency on Aging & Disabilities of SW Washington
AAADSWAC	Area Agency on Aging & Disabilities of SW WA Advisory Council
AC	Advisory Council
ACA	Affordable Care Act
ACH	Accountable Communities of Health
ADL	Activity of Daily Living
ADRC/N	Aging & Disability Resource Center/Network
AFH	Adult Family Home
ALF	Assisted Living Facility
ALTSA	Aging & Long-Term Support Administration
ANCM	Aging Network Case Management
APS	Adult Protective Services
BHO	Behavioral Health Organization
CCoA (CoA)	Clark County Commission on Aging
CDSMP	Chronic Disease Self-Management Program
CFC	Community First Choice
CG	Care Giver
CLC	Community Living Connections
CMS	Center for Medicare and Medicaid Services
CNS	Congregate Nutrition Services
COG	Council of Governments
COPES	Community Options Progam Entry System
CR	Care Receiver
CRU	Complaint Resolution Unit
DDA	Development Disabilities Administration
DSHS	Department of Social and Health Services
EA	Early Adopter
EF	EnhanceFitness
EJC	Elder Justice Center
FCSP	Family Caregiver Support Program
GPS	General Public Survey
HCA	Health Care Authority
HCS	Home & Community Services
HDM	Home-Delivered Meals
HLC	Healthy Living Collaborative
I&A	Information & Assistance Program
ILC	Independent Living Center
IP	Individual Provider
IPA	In-Person Assister Program
KCSP	Kinship Caregiver Support Program

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KCSS	Klickitat County Senior Services
KNP	Kinship Navigator Program
LCCAP	Lower Columbia CAP
LIS	Low Income Subsidy
LTC	Long-Term Care
LTCOP	Long-Term Care Ombudsman Program
MCO	Managed Care Organization
MIPPA	Medicare Improvement for Patients and Providers Act
MoWP	Meals on Wheels Program
MSP	Medicare Savings Program
N4A	National Association of Area Agencies on Aging
NCOA	National Council on Aging
NWP	Northwest Justice Project
OAA	Older Americans Act
OAM	Older Americans Month
OC	Options Counseling
PAS	Public Agency Survey
PSA	Planning and Service Area
PTC	Powerful Tools for Caregivers
RCL	Roads to Community Living
RCS	Residential Care Services
RFP	Request for Proposal
RFQ	Request for Qualifications
RHA	Regional Healthcare Alliance
SCOA	State Council on Aging
SCSA	Senior Citizens Services Act
SCSS	Skamania County Senior Services
SFMP	Senior Farmers Market Program
SHIBA	Statewide Health Insurance Benefits Advisors
SHW	Senior Health & Wellness
SNF	Skilled Nursing Facility
SSA	Social Security Administration
SSD	Social Security Disability
SSI	Supplemental Social Security Income
SSDI	Supplemental Social Security Disability Income
SWAAD	See AAADSW
SWEAP	Southwest Washington Elder Abuse Prevention Coalition
TCARE	Tailored Care Assessment & Referral
TCS	Transitional Care Services
VCS	Volunteer Chore Services
W4A	Washington Association of Area Agencies on Aging
501-C-3	Another name for a non-profit organization

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AREA AGENCY
Aging & Disabili
OF SOUTHWEST WASHIN

2016 - 2019 Area Plan Survey
Partner Agency

The Area Agency on Aging & Disabilities of Southwest Washington (AAADSW) is responsible to plan for and ensure delivery of services for older adults (60 years of age and older), family caregivers and adults living with disabilities in five Southwest Washington Counties: Clark, Cowlitz, Klickitat, Skamania and Wahkiakum.

As a partner agency serving older adults, adults living with disabilities and family caregivers you see first-hand their needs and concerns. Your participation in this ten minute survey is vital; it helps assure we continue providing meaningful services that best meet the needs of your community. Your responses are anonymous.

Agency's Service Area: ☐Clark ☐Cowlitz ☐Klickitat ☐Skamania ☐Wahkiakum

Identify Top Needs/Concerns

Examples of Needs/Concerns:

- Transportation
- Staying in my home
- Buying basic necessities such as food and prescription medications
- Information about available services
- In-home care services
- Home-Delivered Meals
- Senior Community Meals
- Dental Care
- Information/Education about Frauds/Scams
- Access to health care
- Information and support for specific health concerns (i.e. Alzheimer's disease, stroke, Parkinson's Disease, etc.

1. What are the top three needs for <u>older adults</u> living in your county?

1A._____ 1B._____ 1C._____

2. What are the top three needs for <u>adults 18 years of age and older living with disabilities</u> in your county?

2A._____ 2B._____ 2C._____

3. What are the top three needs for <u>caregivers</u> providing support to a friend, relative or adult son/daughter?

3A._____ 3B._____ 3C._____

4. What services for older adults, adults living with disabilities or family caregivers do you want in your county?

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AREA AGENCY ON Aging & Disabilities OF SOUTHWEST WASHINGTON

2016 - 2019 Area Plan Survey
Partner Agency

Information

Where do your clients get information on programs/services for older adults, adults living with disabilities or family caregivers? (Check all that apply)

☐Family ☐Friends/Neighbors ☐Newspaper

☐Television ☐Radio ☐Senior Center

☐Phone Book ☐Community Bulletins ☐Church/Place of Worship

☐Internet ☐Other(s): _____

Healthy Aging

What health/wellness programs are available in your County? (Check all that apply)

☐ Physical Fitness ☐ Managing Chronic Illness ☐ Memory Improvement

☐ Support Group ☐ Don't Know

☐ Other(s): _____

What health/wellness programs are needed in your County? (Check all that apply)

☐ Physical Fitness ☐ Managing Chronic Illness ☐ Memory Improvement

☐ Support Group ☐ Don't Know

☐ Other(s): _____

What keeps people from participating in health and wellness programs? (Check all that apply)

☐ No Transportation ☐ Too far to travel ☐ Lack of knowledge about available programs

☐ Cost or Finances ☐ No Programs Available

☐ Other(s): _____

AREA AGENCY ON Aging & Disabilities OF SOUTHWEST WASHINGTON

2016 - 2019 Area Plan Survey Partner Agency

Family Caregiving (Providing assistance to a friend or relative so he/she can remain at home)

What help is most beneficial to family caregivers? (Check all that apply)

- ☐ Information about Community Resources
- ☐ Caregiver Support Groups
- ☐ A break from caregiving a few hours per week
- ☐ Educational Materials (books, etc.)
- ☐ Other(s): _____

Transportation

What do you think are your clients' transportation needs? (Check all that apply)

- ☐ None
- ☐ Information on transportation services
- ☐ Financial assistance to use public transportation
- ☐ Help getting from home to public transportation/bus stop
- ☐Other: _____

Nutrition

What do your clients need for a healthy diet? (Check all that apply)

- ☐ Nothing
- ☐ Financial assistance to purchase nutritious food
- ☐ Grocery Delivery
- ☐ Home-Delivered Meals
- ☐ Dental Care
- ☐ Education about healthy eating habits
- ☐ Other: _____

AREA AGENCY ON Aging & Disabilities OF SOUTHWEST WASHINGTON

2016 - 2019 Area Plan Survey
Partner Agency

Remain Independent at Home

What do your clients need to remain in their own home? (Check all that apply)

- ☐ Know what help/information is available
- ☐ In-home supports (laundry, cooking, cleaning)
- ☐ Modification to my house (Wheelchair Ramp, Walk-In Shower, Doors Widened, Hand Rails)
- ☐ Equipment (Bath Chair, Hand Held Shower, Raised Toilet Seat)
- ☐ Using home computer to stay connected to my health care provider(s)
- ☐ A personal bracelet or pendant you wear to call for help in an emergency
- ☐ Understanding your County's process to obtain a building permit
- ☐ Other: _____

Comments/Questions/Suggestions

In the space provided, please write any comments, questions or suggestions.

Keep Informed - OPTIONAL

If you want to know survey results and their impact on programs/services, please provide your contact information.

Name: _____

Address: _____

Phone Number: _____ Email Address: _____

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AREA AGENCY ON Aging & Disabilities OF SOUTHWEST WASHINGTON

2016 - 2019 Area Plan Survey
Partner Agency

The Area Agency on Aging & Disabilities of Southwest Washington (AAADSW) is responsible to plan for and ensure delivery of services for older adults (60 years of age and older), family caregivers and adults living with disabilities in five Southwest Washington Counties: Clark, Cowlitz, Klickitat, Skamania and Wahkiakum.

It is important to complete this survey because the answers you provide help determine what programs and services are available in ***your*** county, and how funding is allocated. The survey takes approximately ten minutes to complete. Your responses are anonymous.

Select Your County of Residence: ☐Clark ☐Cowlitz ☐Klickitat ☐Skamania ☐Wahkiakum

Identify Top Needs/Concerns

Examples of Needs/Concerns:

- Transportation
- Staying in my home
- Buying basic necessities such as food and prescription medications
- Information about available services
- In-home care services
- Home-Delivered Meals
- Senior Community Meals
- Dental Care
- Information/Education about Frauds/Scams
- Access to health care
- Information and support for specific health concerns (i.e. Alzheimer's Disease, stroke, Parkinson's Disease, etc.)

1. What are the top three needs of <u>older adults</u> living in your county?

   1A._____ 1B._____ 1C._____

2. What are the top three needs of <u>adults 18 years of age and older living with disabilities</u> in your county?

   2A._____ 2B._____ 2C._____

3. What are the top three needs of <u>caregivers</u> providing support to a friend, relative or adult son/daughter?

   3A._____ 3B._____ 3C._____

4. What services for older adults, adults living with disabilities and caregivers do you want in your county?

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AREA AGENCY ON Aging & Disabilities OF SOUTHWEST WASHINGTON

2016 - 2019 Area Plan Survey
Partner Agency

Information

Where do you get information on programs/services for older adults, adults living with disabilities or family caregivers? (Check all that apply)

☐Family ☐Friends/Neighbors ☐Newspaper

☐Television ☐Radio ☐Senior Center

☐Phone Book ☐Community Bulletins ☐Church/Place of Worship

☐Internet ☐Other(s): _____

Healthy Aging

What health/wellness programs are available in your County? (Check all that apply)

☐ Physical Fitness ☐ Managing Chronic Illness ☐ Memory Improvement

☐ Support Group ☐ Don't Know

☐ Other(s): _____

What health/wellness programs are needed in your County? (Check all that apply)

☐ Physical Fitness ☐ Managing Chronic Illness ☐ Memory Improvement

☐ Support Group ☐ Don't Know

☐ Other(s): _____

What keeps people from participating? (Check all that apply)

☐ No Transportation ☐ Too far to travel ☐ Lack of knowledge about available programs

☐ Cost ☐ No Programs Available

☐ Other(s): _____

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AREA AGENCY ON Aging & Disabilities OF SOUTHWEST WASHINGTON

2016 - 2019 Area Plan Survey
Partner Agency

Family Caregiving

What help is most beneficial to family caregivers? (Check all that apply)

- ☐ Information about Community Resources
- ☐ Caregiver Support Groups
- ☐ A break from caregiving a few hours per week
- ☐ Educational Materials (books, etc.)
- ☐ Other(s): _____

Transportation

What is your transportation need (Check all that apply)

- ☐ None, I drive or a friend/family member drives me
- ☐ Information on transportation services
- ☐ Financial assistance to use public transportation
- ☐ Help getting from home to public transportation/bus stop
- ☐ Other: _____

Nutrition

What do you need for a healthy diet? (Check all that apply)

- ☐ Nothing
- ☐ Financial assistance to purchase nutritious food
- ☐ Grocery Delivery
- ☐ Meal Delivery (Home-Delivered Meals)
- ☐ Dental Care
- ☐ Education about healthy cooking
- ☐ Other: _____

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AREA AGENCY ON Aging & Disabilities OF SOUTHWEST WASHINGTON

2016 - 2019 Area Plan Survey
Partner Agency

Remain Independent in your own Home

What help do you need to remain in your own home? (Check all that apply)

- ☐ Know what help/information is available
- ☐ In-home supports (laundry, cooking, cleaning)
- ☐ Modification to my house (Wheelchair Ramp, Walk-In Shower, Doors Widened, Hand Rails)
- ☐ Equipment (Bath Chair, Hand Held Shower, Raised Toilet Seat)
- ☐ Using home computer to stay connected to my health care provider(s)
- ☐ A personal bracelet or pendant to wear to call for help in an emergency
- ☐ Understanding my County's process to obtain a building permit
- ☐ Other: _____

Demographic Information

Gender: ☐ Female ☐ Male

How old are you? ☐ Under 50 ☐ Age 50-59 ☐ Age 60-74 ☐ Age 75-84 ☐ Age 85 or older

Comments/Questions/Suggestions

In the space provided, please write any comments, questions or suggestions.

Keep Informed - OPTIONAL

If you want to know survey results and their impact on programs/services, please provide your contact information.

Name: _____

Address: _____

Phone Number: _____ Email Address: _____

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AREA AGENCY ON Aging & Disabilities OF SOUTHWEST WASHINGTON

Региональный плановый опрос, 2016 - 2019 гг.

Для широкого круга лиц

Отделение региональной организации по делам престарелых и инвалидов юго-западного сектора штата Вашингтон (AAADSW) несет ответственность за составление и осуществление плана по предоставлению услуг пожилым людям (в возрасте 60 лет и старше), лицам, осуществляющим уход за членом семьи, а так же совершеннолетним лицам, имеющим инвалидность, которые проживают в следующих округах юго-западного сектора штата Вашингтон: Clark, Cowlitz, Klickitat, Skamania и Wahkiakum.

Прохождение данного опроса важно, так как ваши ответы помогут определить, какие программы и услуги предоставляются в ***вашем*** округе и как осуществляется их финансирование. Прохождение опроса займет около десяти минут. Ваши ответы останутся анонимными.

Укажите округ, в котором проживаете: ☐ Clark ☐ Cowlitz ☐ Klickitat ☐ Skamania ☐ Wahkiakum

Укажите ваши основные потребности/проблемы

Примеры потребностей/проблем:

- Транспортные услуги
- Пребывание дома
- Покупка товаров первой необходимости, например, продуктов питания и рецептурных лекарств
- Информация о предоставляемых услугах
- Услуги по уходау на дому
- Доставка питания на дом
- Обеды для лиц преклонного возраста
- Стоматологическое обслуживание
- Информация/разъяснительная работа, касающаяся схем мошенничества/обмана
- Доступ к медицинскому обслуживанию
- Предоставление информации и оказание поддержки при возникновении определенных проблем со здоровьем (например, болезнь Альцгеймера, инсульт, болезнь Паркинсона и т.п.)

1. Назовите три основных потребности <u>пожилых людей</u> в вашем округе.

   1A. _____ 1B. _____ 1C. _____

2. Назовите три основных потребности <u>имеющих инвалидность совершеннолетних лиц в возрасте старше 18 лет</u>, проживающих в вашем округе.

   2A. _____ 2B. _____ 2C. _____

3. Назовите три основных потребности <u>лиц, осуществляющих уход</u> за своим другом, родственником или совершеннолетним сыном/дочерью.

   3A. _____ 3B. _____ 3C. _____

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4. Какие услуги, на ваш взгляд, должны предоставляться в вашем округе пожилым людям, совершеннолетним лицам, имеющим инвалидность, и лицам, осуществляющим уход?

Информация

Откуда вы получаете информацию о программах/услугах для престарелых, совершеннолетних граждан, имеющих инвалидность, и лиц, осуществляющих уход? (отметьте все применимые варианты)

☐Семья ☐Друзья/Соседи ☐Газеты

☐Телевидение ☐Радио ☐Центры для пожилых людей

☐Телефонная книга ☐ Общественные бюллетени ☐Церковь/молитвенный дом

☐Интернет ☐Другое: _____

Здоровье пожилых людей

Какие программы здоровья/оздоровления доступны в вашем округе? (отметьте все применимые варианты)

☐ Физкультура ☐ Лечение хронических заболеваний ☐ Улучшение памяти

☐ Группа поддержки ☐ Не знаю

☐ Другое: _____

Какие программы здоровья/оздоровления необходимо иметь в вашем округе? (отметьте все применимые варианты)

☐ Физкультура ☐ Лечение хронических заболеваний ☐ Улучшение памяти

☐ Группа поддержки ☐ Не знаю

☐ Другое: _____

Что мешает людям принять участие в программах? (отметьте все применимые варианты)

☐ Отсутствие транспорта ☐ Слишком большие расстояния ☐ Недостаток знаний о имеющихся программах

☐ Стоимость ☐ Отсутствие программ

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☐ Другое: _____

Уход за членом семьи

Какая помощь будет наиболее полезной для лиц, осуществляющих уход за членом семьи? (отметьте все применимые варианты)

☐ Информация о ресурсах для местного населения

☐ Группы поддержки для лиц, осуществляющих уход

☐ Предоставление лицу, осуществляющему уход за больным, отпуска в размере нескольких часов в неделю

☐ Обучающие материалы (книги и т.п.)

☐ Другое: _____

Транспортные услуги

Укажите ваши потребности в транспортных услугах (отметьте все применимые варианты)

☐ Таких нет, я езжу на машине, или друг/член семьи отвозит меня

☐ Информация о транспортных услугах

☐ Оказание финансовой помощи лицам, пользующимся общественным транспортом

☐ Помощь, чтобы добраться из дома до остановки общественного транспорта /автобусной остановки

☐ Другое: _____

Питание

Что вам необходимо для здорового питания? (отметьте все применимые варианты)

☐ Ничего

☐ Финансовая помощь для покупки продуктов для полноценного питания

☐ Доставка продуктов из продовольственного магазина

☐ Доставка готовых продуктов питания на дом

☐ Стоматологическое обслуживание

☐ Обучение приготовлению здоровой пищи

☐ Другое: _____

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Сохранение независимости в собственном доме

Что вам нужно, чтобы чувствовать себя независимо в собственном доме? (отметьте все применимые варианты)

- ☐ Знание того, какую помощь/информацию можно получить
- ☐ Служба поддержки на дому (стирка, приготовление еды, уборка)
- ☐ Реконструкция дома (пандус/съезд для инвалидной коляски, специально оборудованная душевая кабина, расширение дверных проемов, перила)
- ☐ Оборудование (кресло-каталка, переносной душ, приподнятое сиденье унитаза)
- ☐ Использование компьютера для постоянной связи с моими поставщиками медицинских услуг
- ☐ Персональный браслет или подвеска для обращения за помощью в случае возникновения чрезвычайной ситуации
- ☐ Понимание порядка оформления документов в округе для получения разрешения на ведение строительных работ
- ☐ Другое: _____

Демографические данные

Пол: ☐ Женский ☐ Мужской

Сколько вам лет? ☐ до 50 ☐ 50-59 ☐ 60-74 ☐ 75-84 ☐ 85 или старше

Замечания/Вопросы/Предложения

Ниже вы можете написать любые замечания, вопросы или предложения.

Держать меня в курсе событий –(по Вашему желанию)

Если вы хотите узнать результаты опроса и то, как они повлияли на программы/услуги, сообщите нам вашу контактную информацию.

Имя и фамилия: _____

Адрес: _____

Телефон: _____ Адрес электронной почты: _____

ATTACHMENT V

AREA AGENCY ON
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OF SOUTHWEST WASHINGTON

2016 – 2019 Area Plan Public Meetings

Tuesday, August 25, 2015, 2:00pm – 4:00pm
Marshall Community Center, Oak Room
1009 E. McLoughlin Blvd., Vancouver, WA

Wednesday, August 26, 2016, 2:00pm – 4:00pm
Pioneer Center
201 NE Washington Street
White Salmon, WA

Monday, August 31, 2015, 2:00pm – 4:00pm
Cowlitz County PUD Auditorium
961 12th Avenue
Longview, WA

AGENDA

Opening Remarks	David Kelly
Introduction	Mike Reardon
Planning and Review Process	Mike Reardon
Target Populations	Christina Marneris
List of Current Services Provided	Christina Marneris
Issue Area C-1 LTSS	Mike Reardon
Issue Area C-2 Pre-Medicaid Services	Christina Marneris
Issue Area C-3 Service Integration & Coordination	Mike Reardon
Issue Area C-4 7.01 Plan	Mike Reardon
Funding/Budget/Prioritization of Discretionary Funding	Mike Reardon
Advisory Council	Mike Reardon
Staffing Plan	Mike Reardon
Public Comment	Mike Reardon

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