



2018 CCO Metrics

DEEPER DIVE

Emergency department utilization for physical health reasons among members with mental illness

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Oregon Health Authority
Office of Health Analytics

2018

is the sixth year of Oregon's pay-for performance-program, under which the Oregon Health Authority (OHA) uses a "bonus quality pool" to reward coordinated care organizations (CCOs) for the quality of care provided to Medicaid members. This model increasingly rewards CCOs for outcomes, rather than utilization of services, and is one of several key health system transformation mechanisms for achieving Oregon's triple aim vision for better health, better care, and lower costs.

Emergency department utilization among members with mental illness was a new incentive measure beginning in 2018. The goal of this measure is to encourage CCOs to focus on the large health disparities seen in members experiencing serious mental illness, who die an average of 25 years earlier than other Americans, largely due to treatable medical conditions.¹ Emergency department utilization for physical health reasons is two-and-a-half times greater among adult CCO members experiencing mental illness than among those without.² These high rates of emergency department use indicate room for improvement in case management and coordination of care for this population.

This report takes a "deeper dive" into the data on a few measures related to members with specific mental health diagnoses. In addition to diving further into the claims-based measure, we also looked at surveys, qualitative interviews, and even data from the US Department of Agriculture.

The goals of these analyses are to help develop a better understanding of potential drivers of quality improvement, and suggest areas where further focus could be targeted for improvements. These analyses are not intended to uncover specific answers; rather, we hope to spark further conversation and encourage CCOs to dig more deeply into their own data and reveal potential areas for further analysis to help CCOs reduce disparities.

Questions or comments about this report?

Contact the metrics team:

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In 2017, emergency department use for physical health reasons was two-and-a-half times higher among adult CCO members with mental illness than without mental illness.

¹ Xu, et al., NCHS Data Brief 2016 Colton and Manderscheid, 2006 Preventing Chronic Disease: Public Health Research, Practice and Policy.

² See the 2017 Deeper Dive for the top 20 reasons for ED visits among adult CCO members with and without mental illness: <https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2017-cco-mid-year-deeper-dive.pdf#page=25>

'DISPARITY MEASURE' BY CCO

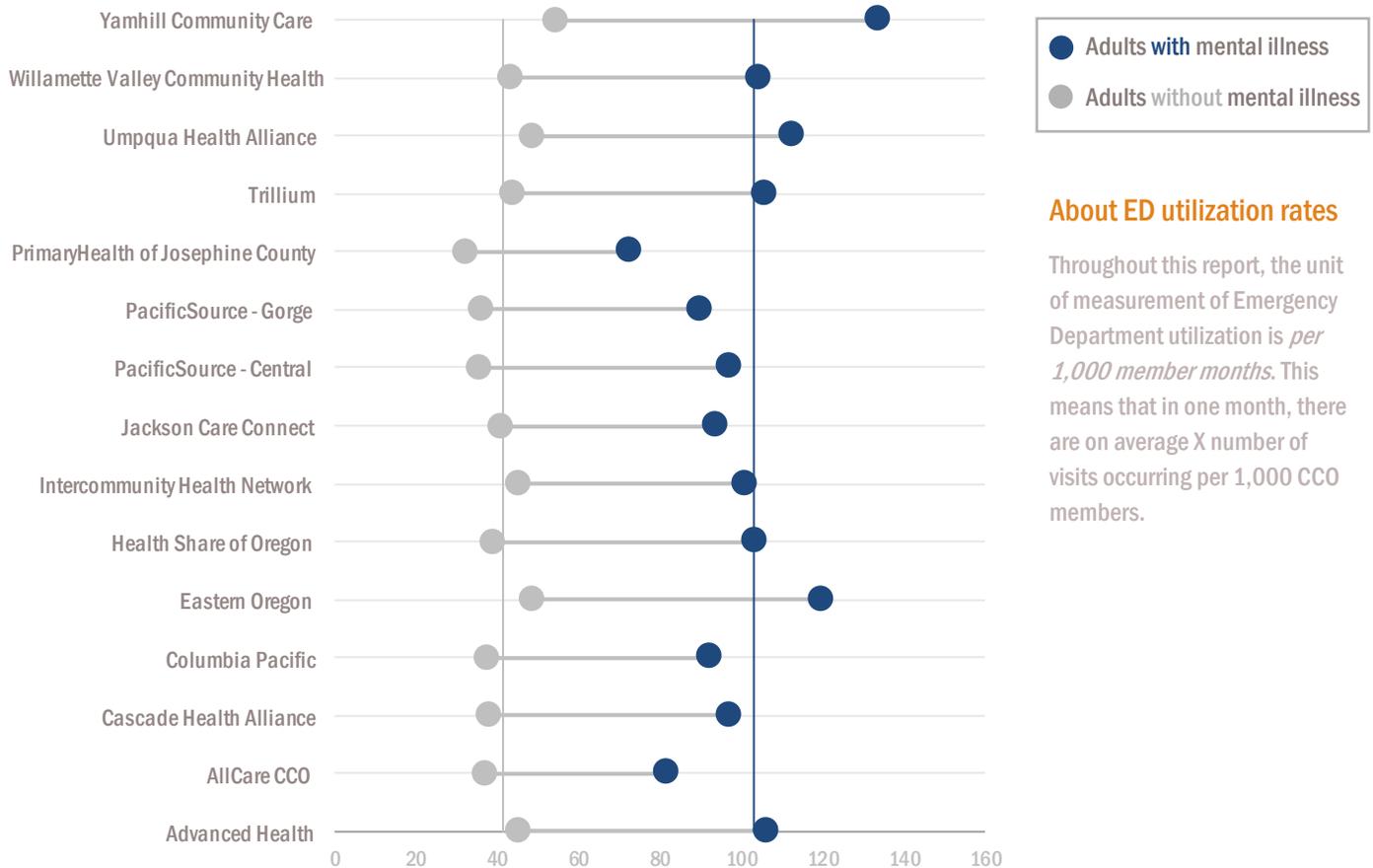
Emergency department utilization among members with mental illness was selected by the Metrics and Scoring Committee as part of its continuing effort to address disparities and inequities among different populations. The measure *Emergency department utilization* looks at emergency department (ED) visits among all CCO members and has been incentivized since the program took effect in 2013. While ED utilization has decreased among both adults with and without mental illness diagnoses, the disparity has remained steady. Adults with mental health diagnoses use the ED at rates more than two-and-a-half times greater than other adults.

It's important to note that the disparity measure and this report look at ED visits for **physical health**, not mental health, reasons. Why? People with mental illness often have a difficult time managing their physical chronic conditions. On average, a person with a serious mental illness lives 25 years fewer than someone without mental illness.¹ Improved integration plus coordination between physical and mental health care is a cornerstone of the CCO system and Oregon's Health System Transformation and a key goal of CCO 2.0.

The chart below shows the disparity, by CCO, among adults with and without mental illness in 2017. The vertical lines show the statewide average for each population. This comparison to the statewide averages highlights some interesting patterns. For example, some CCOs are near the statewide average for members without mental illness, but much higher or lower for their members with mental illness. On a similar note, the variation in performance between CCOs is much greater among members with mental illness diagnoses.

Emergency department utilization among adults **with** and **without** mental illness, by CCO.

Lines show overall statewide average for each population.



About ED utilization rates

Throughout this report, the unit of measurement of Emergency Department utilization is *per 1,000 member months*. This means that in one month, there are on average X number of visits occurring per 1,000 CCO members.

¹Xu, et al, NCHS Data Brief 2016 Colton and Manderscheid, 2006 Preventing Chronic Disease: Public Health Research, Practice and Policy

MENTAL HEALTH DIAGNOSES

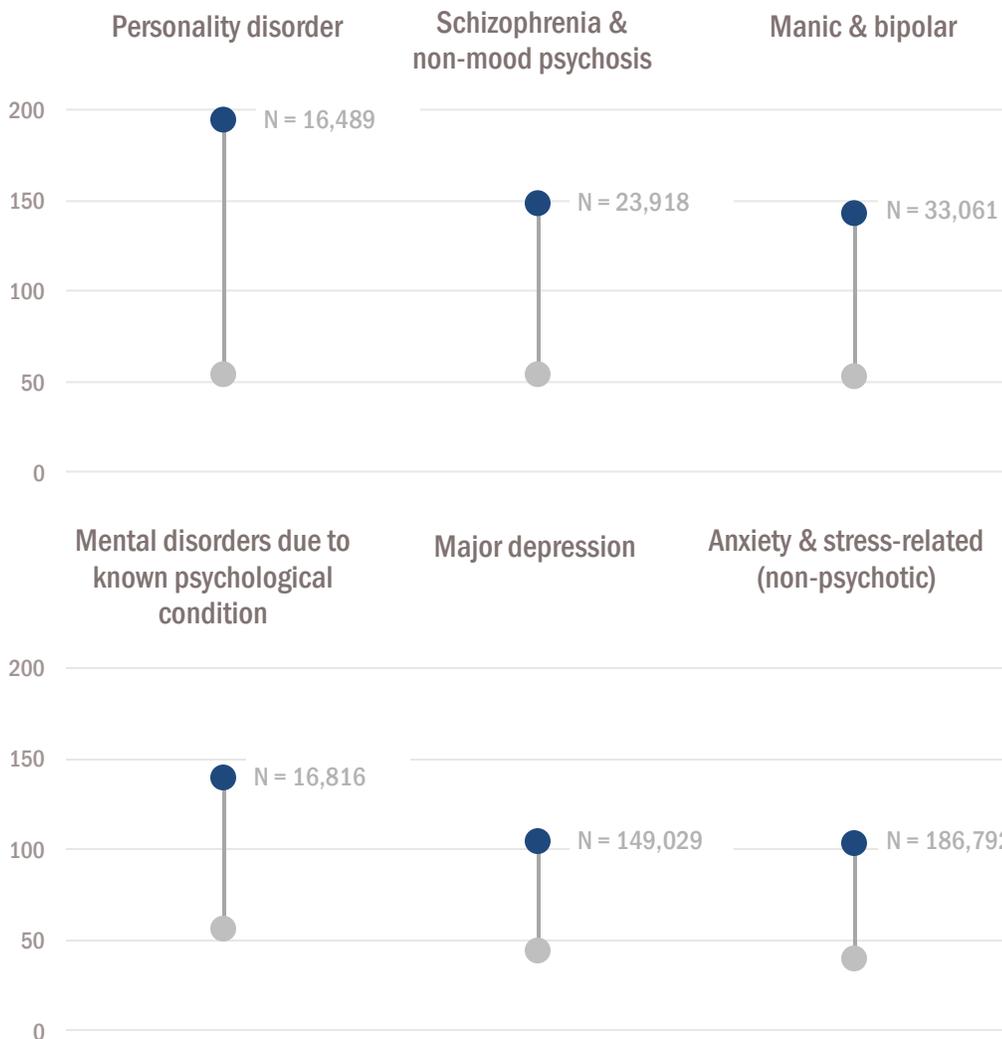
The CCO disparity metric (*Emergency department utilization among members experiencing mental illness*) looks at adult CCO members who had two or more mental illness diagnoses at any point in the past three years. The measure counts any diagnoses (not just primary) and can occur in any service setting (primary care, behavioral health clinic, etc.). The numerator is emergency department utilization for physical health reasons.

The charts below dive deeper into this metric by showing emergency department utilization among members with and without specific types of diagnoses. Adult members diagnosed with personality disorder use the emergency department for physical health reasons at almost four times the rate of adult members without this diagnosis.

CCOs receive a monthly dashboard from OHA that includes member-level detail as well as easy-to-use filters such as the mental health diagnoses highlighted in the charts below.

Emergency department utilization among adults **with** and **without** specific mental health diagnoses.

Note: Population with the specific categories below are not mutually exclusive. Rates are per 1,000 member months.



Legend

- ED utilization among adults **with** specific diagnosis (e.g. all adults diagnosed with manic & bipolar)
- N = number of individuals with diagnosis
- ED utilization among adults **without** specific diagnosis (e.g. all adults who are not diagnosed manic & bipolar)

Dive Deeper...

CCOs can use the monthly dashboard they receive from OHA to dive into their own data and see the *reasons* for emergency department visits among members with each diagnosis.

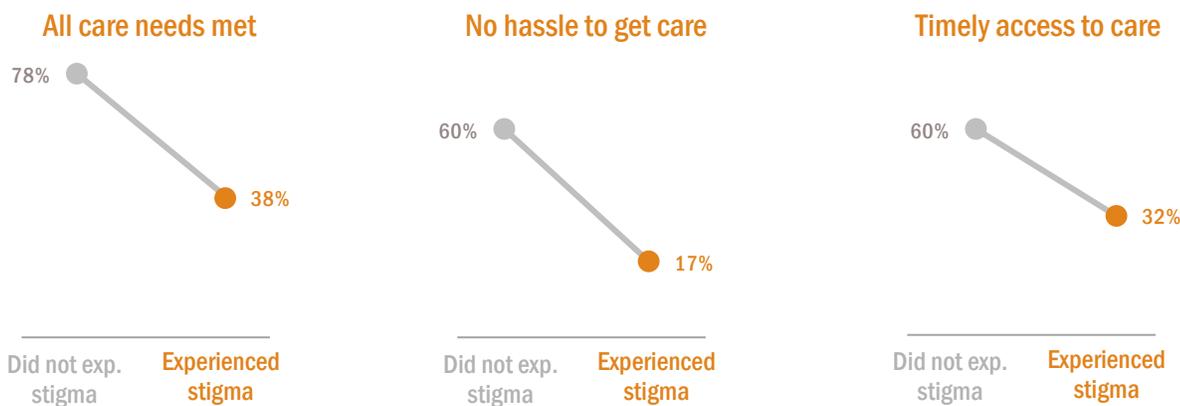
THE ROLE OF STIGMA

People with mental illness may experience stigma or prejudices in the health care setting. This can impact relationships with physicians; compliance with plans of care; and whether patients receive care in the right place and at the right time, or instead end up visiting the emergency department for reasons better suited to primary care.

In 2018, two Oregon partners — the Center for Outcomes Research & Education (CORE) at Providence and the Center for Health Systems Effectiveness (CHSE) at Oregon Health & Sciences University (OHSU) — conducted a study that looked at whether patients who felt stigma were less likely to get their health care needs met (among other things).

The study¹ included more than 2,500 adult patients, about half of whom had a mental health condition and who had insurance through Medicaid, Medicare, or a commercial plan. More than a quarter (28 percent) of patients reported having recently felt stigmatized by their primary care provider. Patients who had experienced stigma had much worse health outcomes.

Patients who had experienced stigma had much worse health outcomes.



Further, they found that integrated care training — which included specific trauma-informed care and behavioral health training for providers — was associated with reduced patient stigma.

The study also included extensive interviews. In talking with patients, they found that past stigma experiences were salient and formative. Patients were often reluctant to engage in the system because of past experiences, especially around chronic pain.

In a separate 2014 study conducted by Providence CORE and Columbia University, researchers looked at the role of stigma in access to health care for Oregonians who were eligible to receive Medicaid (which at the time meant earning up to 100% of the federal poverty level) and found that an experience of stigma was associated with unmet health needs, poorer perception of care, and worse health.²

While the focus in this instance wasn't specifically on members experiencing mental illness, we know that this population is especially vulnerable to experiencing stigma — both from the general public, and specifically from health care providers.³ The next page includes excerpts from qualitative interviews in the above-mentioned studies to help illustrate how the experience of stigma can impact patients interact with the health care system.

¹ Wright, B. (2018). *Caring for the Whole Person: A Patient-Centered Assessment of Integrated Care Models in Vulnerable Populations*. <https://www.pcori.org/research-results/2014/effect-integrating-mental-and-physical-health-patients-experiences-care>

² Allen, H., Wright B.J., Harding, K., & Broffman, L. (June 2014). *The Role of Stigma in Access to Health Care for the Poor*. *The Milbank Quarterly*, 92(2), 289-318 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4089373/>

³ Thornicroft, G., Rose, D., & Kassam, A. (April 2007). *Discrimination in health care against people with mental illness*. *International Review of Psychiatry*. 19(2). 113-122. <https://www.ncbi.nlm.nih.gov/pubmed/17464789>

THE ROLE OF STIGMA

I felt like I was being judged for not having health insurance and for not taking care of me. I didn't like how he made me feel at all. When I left there, I was just real sad. I was supposed to reschedule an appointment. **But since he was rude to me, I didn't reschedule that appointment.**²

I was feeling really tired and I thought I should see my local GP, and I said "Can you please do a physical examination" because I wasn't feeling very well. **At the end of the day he said "Have you had any mental problems before?"** I was really angry. I was really, really, really angry with him. Was he trying to say that the reason I was coming to see him was because I had had a mental problem? **I left medical clinic that day feeling really, really, really badly.**³



The worst I have come across is medical people. I suffer badly from stomach problems. I have always had a sensitive stomach. But when I tried to get help from my doctor, they say "Oh it's your depression" or my phobia. I'm far from stupid and I'm well aware of the difference between IBS pain and what symptoms I get because of my phobia. **From the time doctors are aware of my mental problems, they talk at me, instead of to me, like I haven't a mind of my own.**³

"They're supposed to be there for you. **I just felt judged.** I felt like, because of how I told them about my anxiety, needing help so desperately, and crying to them because I am not getting the help I needed, **they thought I was crazy.**"¹

¹ Wright, B. (2018). *Caring for the Whole Person: A Patient-Centered Assessment of Integrated Care Models in Vulnerable Populations*. <https://www.pcori.org/research-results/2014/effect-integrating-mental-and-physical-health-patients-experiences-care>

² Allen, H., Wright B.J., Harding, K., & Broffman, L. (June 2014). *The Role of Stigma in Access to Health Care for the Poor*. *The Milbank Quarterly*, 92(2), 289-318 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4089373/>

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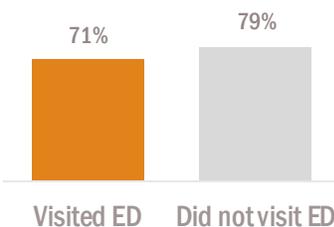
CAHPS SURVEY

Patients' perceptions of the health care system and their relationships with providers are crucial to how, whether, and when they seek care. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey asks consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services.

In this analysis, we look at CAHPS results from calendar year (CY) 2017 for a series of questions that may help illustrate why members use the emergency department. For example, adults who used the emergency department during the measurement year were less likely to think that it was easy to get needed care (or, looking at it the other way: members who thought it was difficult to get needed care were more likely to end up in the emergency department). Furthermore, adults who lived in neighborhoods (ZIP codes) where more households didn't have a car reported lower rates of getting needed care (see page 10 for technical notes regarding ZIP code-level data).

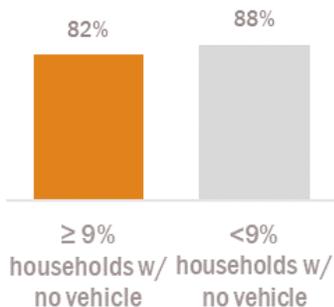
Adults who used the emergency department reported lower rates of "getting needed care" than those who did not.

Data sources: CAHPS and MMIS

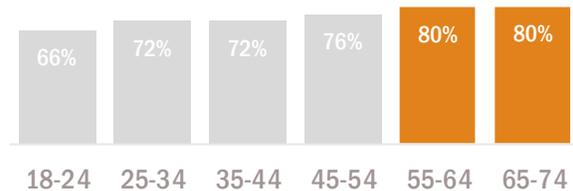


Adults who lived in neighborhoods where more households didn't have a car reported lower rates of "getting needed care."

Data sources: CAHPS and US Department of Agriculture.



Older members are more likely to report "getting care quickly."



Definitions

"Getting needed care"

Percent of respondents who report that it's 'always' or 'usually' easy to get necessary care, tests, or treatment; and to get appointment with a specialist as soon as needed.

"Getting care quickly"

Percent of respondents who report that they 'always' or 'usually' got care for illness or injury as soon as needed; and got non-urgent appointments as soon as needed.

"How well doctors communicate" (see next page)

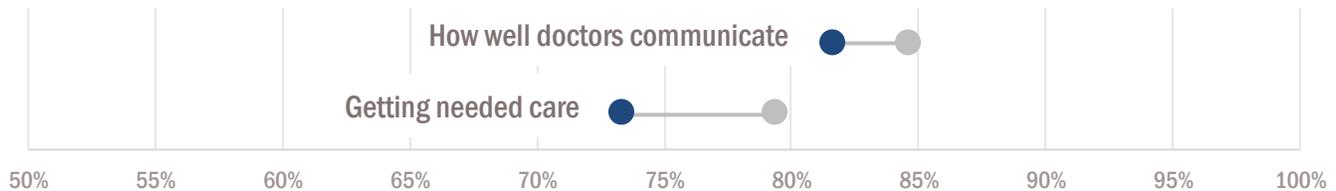
Percent of respondents who report that their doctor 'always' or 'usually':

- ✓ Explained things in a way that was easy to understand;
- ✓ Listened carefully;
- ✓ Showed respect for what the person had to say;
- ✓ Spent enough time with them.

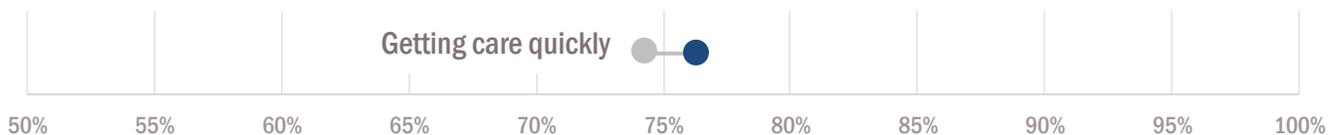
CAHPS SURVEY

In this analysis, we looked at CAHPS results from CY 2017 for members **with mental health diagnoses** (as defined in the 2018 CCO incentive metric) compared with those without mental health diagnoses.

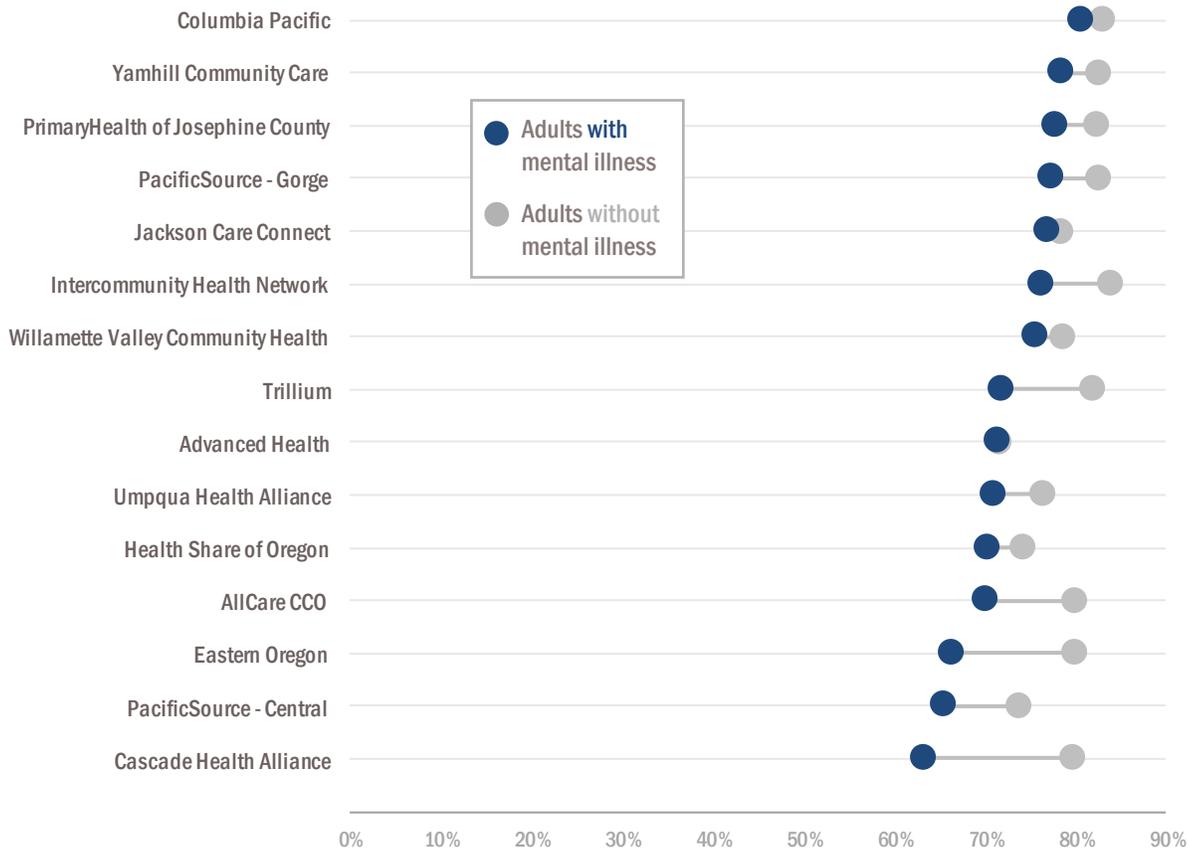
Adults with mental health diagnoses reported lower rates of “doctors communicating well” and “getting needed care.”



However **adults with mental health diagnoses** reported slightly higher rates of “getting care quickly.” (This could be due to higher rates of ED utilization among these clients)



Adults with mental health diagnoses reported lower rates of “getting needed care” in all 15 CCOs.



NEIGHBORHOOD CHARACTERISTICS

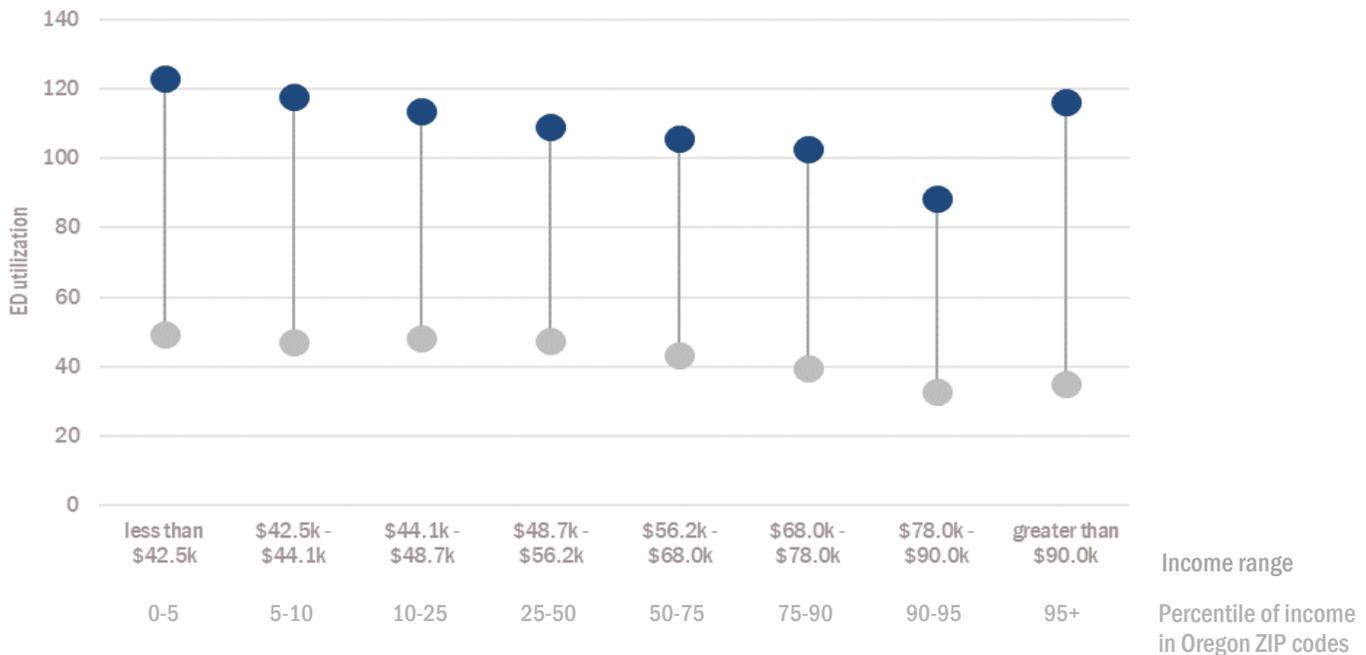
Communities provide many services and resources to vulnerable members. We wanted to see if we could better understand how social and environmental factors might impact the way members access services and receive their supportive care.

In this analysis, we explored the possibility of whether emergency department utilization is related to where the member lives, using US Department of Agriculture (USDA) dataset on the characteristics of the 'neighborhood' (census tract and ZIP code).

In general, as the neighborhood (ZIP code) that the CCO member lives in gets wealthier, emergency department utilization rates get lower. However, there is a sharp spike in utilization among members with mental illness who live in the very wealthiest neighborhoods (see chart below). For instance, the Pearl District neighborhood in Portland has many high-income residents, as well as many supportive services for people experiencing homelessness.

For more information on how these measures were calculated, see Technical Notes on the next page.

ED utilization among Medicaid members **with** and **without** mental illness, by neighborhood median family income.



While members living in higher-income neighborhoods generally have lower ED utilization, **there is a sharp spike in ED utilization among members with mental illness who live in very high-income neighborhoods.**

NEIGHBORHOOD CHARACTERISTICS

In addition to median household income by ZIP code, we looked at other characteristics that might make a neighborhood more vulnerable, such as a higher proportion of food stamp (SNAP) recipients, or a higher proportion of households without a vehicle. In each instance, emergency department utilization (among both members with and without mental illness) is higher than the statewide average.

ED utilization among members **with** and **without** mental illness, by neighborhood characteristic.



See Appendix (pages 12-13) for more detailed tables that show some characteristics of the twenty neighborhoods (ZIP codes) with the highest and lowest emergency department rates in Oregon.

Technical Notes

The neighborhood analysis is based on the Food Access Research Atlas dataset¹ from US Department of Agriculture (USDA), which is released at census tract level. OHA utilizes a tract-to-zip-code crosswalk table² developed by US Department of Housing and Urban Development (HUD) to reaggregate USDA's data to zip code level. CCO metrics data is also aggregated to zip code level according to members' address information in MMIS. As a result, the analyses are conducted at the zip code level to compare the characteristics of the neighborhood and results of the CCO metrics. The analyses are restricted to zip codes with 300 or more OHP members in 2017.

These thresholds used in the analyses are based on statewide average:

High Poverty

Member living in zip code with population poverty rate (below 100% Federal Poverty Level (FPL)) $\geq 19\%$

High SNAP

Member living in zip code with $\geq 22\%$ households receiving Supplemental Nutrition Assistance Program (SNAP) benefits

High No Vehicle

Member living in zip code with $\geq 9\%$ households without a vehicle

¹ Link to USDA Food Access Research Atlas dataset:

<https://www.ers.usda.gov/data-products/food-access-research-atlas/download-the-data/#Current%20Version>

² Link to HUD zip code crosswalk files: https://www.huduser.gov/portal/datasets/usps_crosswalk.html#codebook

TRANSFORMATION CENTER

TECHNICAL ASSISTANCE

To prepare CCOs and their partners for the new *Emergency Department Use for those with Mental Illness* metric, the Transformation Center (TC) launched technical assistance (TA) for this metric in 2017.

In 2017, the TC held four webinars focused on this metric. The webinars focused on measure specifications, how to identify primary drivers of emergency department utilization, examples of multi-system care coordination, and innovations for managing patient pain. An average of 43 people attended each webinar, and 89% of evaluation respondents rated them as valuable or very valuable.

In 2018, the TC offered peer-learning consultation calls with subject matter experts focused on identifying quality improvement opportunities for innovative care coordination and transitions of care. The six-month retrospective evaluation found all respondents (five of the eight participants) had taken action as a result of the calls. Three had improved organizational processes, two had developed new partnerships, and one had implemented PreManage (a product that allows hospital event information to be sent in real time to health plans and providers) to improve data collection and sharing. One CCO also observed measurable cost savings and improvement in the way care was delivered as a result of the calls. Eight CCOs participated and four CCOs participated in 20 hours of follow-up TA to focus on improving care coordination across their local systems. Follow-up projects included a community convening to inform a collaborative approach; building staff capacity to improve systems of care and data-informed decision-making; and standardizing use of care plans using PreManage.

In 2019, the TC is continuing to support this metric through learning opportunities. In partnership with Oregon Rural Practice-based Research Network (ORPRN), the TC is holding a webinar series focused on whole health in populations experiencing mental illness. Additionally, the TC is working with ORPRN on two virtual learning collaboratives series: Systems Improvement for Populations Experiencing Mental Illness, and Behavioral and Physical Health Integration – Lessons from the Field.

Starting in 2017, the TC began collaborating with Oregon Health Leadership Council and promoting their technical assistance for the Collective/PreManage platform as a key health information technology support to reduce emergency department utilization.

All resources, including webinars, remain online. Find these and future technical assistance opportunities at www.TransformationCenter.org

An evaluation of the peer-learning calls found that all respondents had taken action as a result of the calls, including:



Improved organizational processes



New partnerships



Improved data collection



Measurable cost savings

CCO 2.0

THE FUTURE OF COORDINATED CARE

Individuals with mental health challenges face significant barriers in maintaining their physical health, in part due to systemic barriers such as stigma and access issues. In October 2018 the Oregon Health Policy Board approved a comprehensive set of policies designed to improve the health of Oregon Health Plan members, address health disparities, control program costs, and continue to transform health care delivery in our state. These policy priorities will be written into the 2020-2024 CCO contracts, which represent the next phase of health care transformation, known as "CCO 2.0."

One priority area of the CCO 2.0 policies is to improve the behavioral health system and address barriers to access to and integration of care. The next round of CCO contracts will seek to ensure Oregon Health Plan members have better access to integrated, whole-person care.

Policies aimed at improving access and integration include:

- Use metrics to incentivize and measure the outcomes of behavioral health integration.
- Expand programs that integrate primary care into behavioral health settings.
- Require providers to implement trauma-informed care practices.
- Ensure an adequate provider network.
- Provide access to behavioral health care that meets standards for timely access to care.

New metrics will provide goals for CCOs to improve behavioral health outcomes. The metrics will capture integration at the CCO level and treatment system level. They will also enable OHA to monitor and enforce accountability for the behavioral health benefit.

Behavioral health homes integrate physical health into behavioral health to provide effective person-centered care for individuals with complex needs. The creation of behavioral health homes will enable OHA to identify, promote and expand programs that integrate primary care in behavioral health settings. Health home models result in decreased emergency department (ED) visits, reduced hospital admissions, reduced homelessness, and fewer withdrawal management visits. Behavioral health homes also reduce stigma for individuals that have been reluctant to seek services in the health care system. Another policy to reduce stigma directs CCOs to require physical and behavioral health providers to be trained in trauma-informed care.

An adequate provider network should be comprehensive and include prescribers, licensed and unlicensed behavioral health providers, and peers. OHA has developed timely access to care standards for urgent/emergency and routine behavioral health care. Providing access to the appropriate level of behavioral health care in a timely manner will decrease ED utilization. To meet the timely access standards, CCOs will need to ensure they have an adequate provider network to meet the behavioral health needs of the community.

The CCO 2.0 recommendations of the Oregon Health Policy Board can be found on the OHA website:

<https://www.oregon.gov/oha/OHPB/CCODocuments/2018-OHA-CCO-2.0-Report.pdf>

APPENDIX:

NEIGHBORHOOD CHARACTERISTICS

The table below shows the twenty neighborhoods (ZIP codes) that have the lowest emergency department utilization rates among Medicaid members.

ZIP codes with lowest overall emergency department rates tend to have lower poverty rates and lower percentages of members with mental health (MH) diagnoses or substance use disorder (SUD). Those in urban areas have high median family income and very low poverty rates.

Furthermore, the leftmost column shows whether that ZIP code also falls in the “lowest twenty” category for the CCO disparity measure *ED utilization among members with mental illness* (ED-MI).

See page 10 for technical notes on how these ZIP code-level characteristics are calculated.

Interested in exploring these data further? You can download the full Excel data set online at: <https://www.oregon.gov/oha/HPA/ANALYTICS/Documents/Deeper-Dive-ZIP-level-tables.xlsx>

Twenty ZIP codes with LOWEST emergency department utilization overall

Lowest 20 ED-MI?	Designation	Income percentile	Median Income	ED rate overall	ED among members with MH diagnoses	% population below FPL	% population with MH diagnoses	% population with substance use disorder	Zip	County
●	Frontier	0-5	\$37.8 k	27.2	62.3	18%	21%	11%	97641	Lake
●	Rural		\$43.7 k	25.4	49.4	18%	9%	9%	97544	Josephine
●	Rural		\$44.5 k	24.9	58.9	15%	16%	9%	97707	Deschutes
●	Rural		\$47.7 k	28.3	51.5	14%	21%	11%	97415	Curry
●	Frontier	10-25	\$47.9 k	28.0	51.1	18%	21%	11%	97846	Wallowa
●	Rural		\$51.6 k	26.1	39.0	20%	17%	10%	97131	Tillamook
	Rural		\$52.9 k	26.9	84.0	17%	13%	5%	97633	Klamath
	Rural		\$53.5 k	24.1		15%	11%	3%	97632	Klamath
	Rural	25-50	\$56.0 k	28.6	85.9	19%	12%	4%	97026	Marion
	Rural		\$64.9 k	26.9	67.8	8%	16%	12%	97049	Clackamas
	Rural		\$64.9 k	23.7	70.5	16%	12%	4%	97041	Hood River
	Rural	50-75	\$65.8 k	28.6	90.0	15%	18%	8%	97759	Deschutes
	Rural		\$70.3 k	22.6		7%	13%	8%	97018	Columbia
●	Rural		\$71.1 k	27.9	52.6	8%	17%	9%	97067	Clackamas
	Urban	75-90	\$75.0 k	29.1	65.4	15%	21%	8%	97370	Benton
	Urban	90-95	\$81.3 k	29.2	71.6	11%	17%	10%	97703	Deschutes
	Urban		\$90.0 k	29.4	85.0	7%	18%	7%	97089	Clackamas
●	Urban		\$100.2 k	27.0	56.5	8%	18%	7%	97035	Clackamas
	Urban		\$117.4 k	28.9	71.3	5%	19%	6%	97229	Washington
	Urban	95+	\$120.0 k	28.5	74.5	8%	24%	10%	97221	Multnomah

APPENDIX: NEIGHBORHOOD CHARACTERISTICS

The table below shows the twenty neighborhoods (ZIP codes) that have the highest emergency department utilization rates among Medicaid members.

ZIP codes with the highest overall emergency department rates also had the highest emergency department rates among members with mental illness. These ZIP codes are mostly either in rural area below 50th percentile of median family income, or in urban areas with both high median family income and high poverty rates. These areas also have higher concentration of members with mental health diagnoses or substance use disorder.

Furthermore, the leftmost column shows whether that ZIP code also falls in the “highest twenty” category for the CCO disparity measure *ED utilization among members with mental illness* (ED-MI).

See page 10 for technical notes on how these ZIP code-level characteristics are calculated.

Interested in exploring these data further? You can download the full Excel data set online at:

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Twenty ZIP codes with HIGHEST emergency department utilization overall

Highest 20 ED-MI?	Designation	Income percentile	Median Income	ED rate overall	ED among members with MH diagnoses	% population below FPL	% population with MH diagnoses	% population with substance use disorder	Zip	County
●	Urban	0-5	\$29.1 k	154.8	270.9	49%	34%	49%	97204	Multnomah
●	Rural	5-10	\$44.0 k	78.3	165.1	15%	27%	13%	97118	Tillamook
●	Rural	10-25	\$44.7 k	83.2	169.0	22%	23%	12%	97741	Jefferson
	Rural		\$48.2 k	74.8	139.8	26%	28%	15%	97470	Douglas
●	Rural		\$48.5 k	75.1	154.4	20%	24%	13%	97754	Crook
●	Frontier	25-50	\$49.9 k	74.9	150.3	14%	21%	11%	97845	Grant
	Rural		\$53.1 k	71.6	135.8	17%	25%	12%	97396	Yamhill
	Rural		\$53.3 k	67.4	144.8	19%	22%	9%	97383	Marion
●	Rural		\$53.5 k	70.3	151.0	22%	27%	10%	97128	Yamhill
●	Rural		\$53.8 k	72.8	151.4	15%	26%	10%	97378	Yamhill
	Rural		\$55.3 k	67.4	126.4	16%	23%	13%	97347	Polk
	Rural		\$55.5 k	68.5	133.7	22%	23%	12%	97850	Union
●	Rural	50-75	\$57.1 k	78.4	172.5	16%	23%	12%	97344	Polk
●	Rural		\$58.0 k	68.5	149.6	17%	27%	10%	97338	Polk
●	Rural		\$61.5 k	68.4	152.8	10%	20%	8%	97358	Linn
	Urban	75-90	\$71.4 k	75.0	116.5	26%	40%	34%	97205	Multnomah
	Urban		\$71.5 k	68.3	137.5	12%	27%	13%	97321	Linn
	Urban		\$75.8 k	81.5	127.6	21%	33%	25%	97227	Multnomah
●	Urban	95+	\$90.1 k	125.6	205.7	20%	40%	41%	97209	Multnomah
	Rural		*n/a	90.0	*n/a (data not available)		16%	16%	97761	Jefferson



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