



**LEGACY**  
HEALTH

Legacy Good Samaritan Hospital and Medical Center

DBA

# Legacy Good Samaritan Medical Center

## Community Health Needs Assessment

FY24–FY26

*(April 1, 2023–March 31, 2026)*

## **Mission**

*Our legacy is good health for our people, our patients, our communities and our world. Above all, we do the right thing.*

## **Vision**

*To be essential to the health of the region.*

## **Values**

*Respect • Service • Quality • Excellence  
Responsibility • Innovation • Leadership*



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# Legacy Good Samaritan Medical Center Community Health Needs Assessment

## Executive Summary

This Legacy Good Samaritan Medical Center Fiscal Year (FY)24–FY26 Community Health Needs Assessment (CHNA) report is a multipurpose document providing information on key community-related activities. It provides a brief overview of the 2019 Healthy Columbia Willamette Collaborative (HCWC) CHNA,<sup>1</sup> which formed the basis for the Legacy Good Samaritan FY21–FY23 CHNA.<sup>2</sup> The 2019 HCWC CHNA identified nine core issues and several drivers that affected community health and well-being within the quad-county region (Clackamas, Multnomah and Washington counties in Oregon and Clark County in Washington).<sup>1</sup>

Legacy Good Samaritan focused its community-based efforts over the past three fiscal years on health equity and two of the core issues (*access to health care and chronic conditions*) identified in the 2019 HCWC CHNA. The implementation plan for these community-focused efforts is described in detail in the Legacy Good Samaritan FY21–FY23 Community Health Improvement Plan (CHIP).<sup>3</sup>

This FY24–FY26 CHNA report highlights results from the impact evaluation of the Legacy Good Samaritan FY21–FY23 CHIP implementation. This report also reveals the set of community-identified priority areas and issues (*access to affordable health care, culturally and linguistically responsive health care, economic opportunity, educational opportunity, culturally specific and healthy foods, and physical safety in the community*) that will be addressed by Legacy Health, Legacy Good Samaritan and the Legacy Community Benefit Department in the quad-county region during the FY24–FY26 period. Selection of these priority areas and issues was informed by the 2022 HCWC CHNA.<sup>4</sup> The accompanying Legacy Good Samaritan FY24–FY26 CHIP outlines the goals, objectives and proposed strategies that will guide our efforts to make an impact on these priority areas and issues.<sup>5</sup>

Legacy Good Samaritan CHNAs and CHIPs are produced in accordance with the Patient Protection and Affordable Care Act (ACA), IRS Section 501(r)(3), which requires tax-exempt hospital organizations to conduct a CHNA and adopt an implementation plan every three years.<sup>6</sup> In compliance with IRS requirements, the CHNAs and CHIPs are approved by the Legacy Health Board of Directors and made available to the public.

Finally, the full 2022 HCWC CHNA<sup>4</sup> is provided at the end of this report.

## About Legacy Health

Legacy Health is a nonprofit health system that offers a unique blend of health services across the Portland/Vancouver metropolitan area and the mid-Willamette Valley. From wellness and urgent care to dedicated children's services and advanced medical centers, Legacy cares for patients of all ages when and where they need us. Our partnerships tackle vital issues, such as food insecurity and access to health-related services, to create and maintain healthier communities.

Legacy strives to help everyone live healthier and better lives, with the vision of being essential to the health of the region. The Legacy Health system currently includes:

- Six hospitals; dedicated children's care at Randall Children's Hospital at Legacy Emanuel
- More than 70 primary, specialty and urgent care clinics
- Approximately 14,000 employees
- Nearly 3,000 doctors and other advanced providers
- Laboratory, research and hospice services
- Partnership with PacificSource health plan.<sup>7</sup>

Randall Children's Hospital at Legacy Emanuel is a regional center for the dedicated care of infants, children and teens. Unity Center for Behavioral Health, licensed under Legacy Emanuel Medical Center, is a collaboration between Legacy Health, Adventist Health, Kaiser Permanente and the Oregon Health & Science University that provides emergency and inpatient behavioral health services.<sup>8</sup> In addition, Legacy Emanuel serves as the employer and donates the infrastructure for Child Abuse Response and Evaluation Services (CARES) Northwest.<sup>9</sup>

### Legacy Good Samaritan Medical Center

Legacy Good Samaritan Medical Center is known for its specialty programs and clinical excellence. The Medical Center features nationally renowned doctors in cancer care, ophthalmology, neurology, kidney transplantations, weight-loss surgery and more. Legacy Good Samaritan also contains the only 24-hour urgent care clinic in Oregon located adjacent to a separate emergency department.<sup>7</sup>

### Service area

Legacy Health hospitals define their service areas by geographic location and where their patients live. Legacy Good Samaritan Medical Center is located in Northwest Portland.

Multnomah County, Oregon, is the primary service area for Legacy Good Samaritan Medical Center. The surrounding Oregon counties, Clackamas and Washington, are served by Legacy and other health systems but are secondary catchment areas for

Legacy Good Samaritan. Sociodemographic and health-related data for the service counties can be found in the 2022 HCWC CHNA,<sup>4</sup> which is provided at the end of this report.

## **Assessing the needs and assets of the communities we serve: A collaborative approach**

The Healthy Columbia Willamette Collaborative (HCWC) is a public-private partnership consisting, in 2019, of seven hospital systems, four county health departments and one coordinated care organization serving the quad-county region. This unique partnership serves as a platform for collaboration around community-wide health assessments. It allows for a more comprehensive view of community assets and needs, informs priorities for HCWC member organization improvement plans and supports collaboration by HCWC stakeholders and partners to meet community health needs.<sup>10</sup>

From 2016 through 2019, the HCWC conducted their 2019 CHNA, which provided a comprehensive evaluation of the health and social needs and assets of communities within the quad-county region. The assessment framework, data collection and analytic methods and findings are described in detail in the 2019 CHNA document.<sup>1</sup>

Nine core issues affecting diverse communities throughout the quad counties were identified. The findings also supported the idea that discrimination, racism and trauma should be acknowledged, addressed and understood as a part of all programs and projects, given that they are key drivers of these core issues. The nine core issues are listed below:

### **Key drivers of all core issues**

1. Discrimination and racism
2. Trauma

### **Health outcomes**

3. Behavioral health
4. Chronic conditions
5. Sexually transmitted infections

### **Social factors**

6. Access to health care, transportation and resources
7. Community representation
8. Culturally responsive care
9. Isolation<sup>1</sup>

## Our impact on the issues affecting our community: FY21–FY23

The comprehensive 2019 HCWC CHNA<sup>1</sup> was used as the basis for the Legacy Good Samaritan Medical Center FY21–FY23 CHNA.<sup>2</sup> However, out of the nine community-identified core issues and drivers described in the 2019 HCWC CHNA, Legacy Good Samaritan specified three as its priority areas for action: **access to health care, chronic conditions** and **health equity**. The implementation plan designed to impact these priority areas is described in the FY21–FY23 Legacy Good Samaritan Medical Center CHIP.<sup>3</sup>

Over the last three fiscal years, and despite challenges resulting from the COVID-19 pandemic, Legacy Health invested time, funding and other resources to implement programs and services to address these priority areas within the communities we serve. The following tables highlight the impact of some of the Legacy Health, Legacy Good Samaritan Medical Center and Legacy Community Benefit Department efforts to meet the needs of the Legacy Good Samaritan service community related to access to health care, chronic conditions and health equity from FY21 through FY23.

<b>TABLE 1 Legacy Health impact on ACCESS TO HEALTH CARE within the quad-county region, FY21–FY23</b>	
<b>GOAL</b>	<b>Community members have access to health care services and resources to improve their health status</b>
<b>OBJECTIVES</b>	<b>IMPACT</b> <i>April 1, 2020, through March 31, 2023</i>
<b>More people experience access to quality, culturally appropriate medical care and health coverage</b>	<p>In the fall of 2018, Legacy Health partnered with Providence Health &amp; Services, PeaceHealth and Kaiser Permanente NW to establish the “Health Systems Access to Care Fund” through the Oregon Community Foundation. The monies donated by these health systems are awarded to community-supported health clinics in Oregon and SW Washington to strengthen their infrastructure and capacity to respond to changing patient needs resulting from Medicaid transformation, ongoing healthcare reform, and insufficient access to health services. From 2020 through 2021, the Fund distributed \$1,210,000 to 11 organizations to enhance access to care for some of the most marginalized people in the quad-county region.</p> <p>Legacy Health is one of several local health systems and clinics in Clackamas, Multnomah and Washington counties in Oregon that have invested in Project Access NOW (PANOW), a local program that has provided financial assistance and health care for low-income and uninsured community members since 2008. During FY21 through FY23, PANOW connected 8,214 community members to donated health services, 2,133 received assistance paying insurance premiums and 9,721 were helped with insurance enrollment.</p>

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**TABLE 1 Legacy Health impact on ACCESS TO HEALTH CARE within the quad-county region, FY21–FY23**

<b>GOAL</b>	<b>Community members have access to health care services and resources to improve their health status</b>
<b>OBJECTIVES</b>	<b>IMPACT</b> <i>April 1, 2020, through March 31, 2023</i>
<p><i>(Continued)</i></p> <p><b>More people experience access to quality, culturally appropriate medical care and health coverage</b></p>	<p>From FY21–FY23, an average of 29% of the individuals who received health services through Legacy Health in the quad-county region were low-income, underinsured, Oregon Health Plan members or other Medicaid users. However, the average was 37% for patients using Legacy <i>hospitals</i> in either Oregon or Washington.</p> <p>In FY21, approximately 11% of Legacy patients who were Medicaid or Oregon Health Plan (OHP) members received a preventive health care examination and/or preventive services through Legacy Health Clinics. This proportion was 11.4% by the end of FY23, an increase of 3.6% across the three-year period. The increase was 24% among OHP members (5.4% in FY21 to 6.7% in FY23) and 7.6% (22.4% in FY21 to 24.1% in FY23) among Medicaid patients in Washington.</p> <p>Legacy Health offered health interpreters for patient encounters in about 200 languages. In addition, by the end of FY23 (March 31, 2023), 325 Legacy employees had been approved through the Bilingual Competency Program to use their non-English skills to provide language-concordant care throughout the health system.</p> <p>Between FY21 and FY23, Legacy Health was able to connect approximately 3,000 OHP or uninsured patients to Medication Assistance Programs, where they received essential medications at low or no cost.</p> <p>Community Benefit Community Health grants were awarded to several organizations to improve access to quality and culturally appropriate health care. One organization used the award to launch a mental health program. In their first year, they provided 30 individuals with low-cost sessions with four culturally responsive providers and conducted 14 <i>Beyond Trauma: A Healing Journey for Women</i> workshops with over 150 people.</p> <p>Grant funding also was used to support the development of the Behavioral Health Emergency Coordination Network (BHECN), which is bringing together stakeholders from across Multnomah County to coordinate resources to establish new sobering, stabilization and triage services to meet community behavioral health needs. The Community Benefit grant specifically assisted with the set-up of the Lived Experience Consultant Directory and paid consultant stipends. The consultants represent historically marginalized communities, individuals who have experienced behavioral health challenges, people who have interacted with local behavioral health services and other stakeholders impacted by behavioral health crises. These consultants guide the BHECN project’s governance, design and implementation.</p>

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**TABLE 1 Legacy Health impact on ACCESS TO HEALTH CARE within the quad-county region, FY21–FY23**

<b>GOAL</b>	<b>Community members have access to health care services and resources to improve their health status</b>
<b>OBJECTIVES</b>	<b>IMPACT</b> <i>April 1, 2020, through March 31, 2023</i>
<b>More community members are screened for their health-related social needs</b>	Within the quad-county region 27,710, patients were screened (20% of all patients) for food insecurity at Legacy Hospitals and/or Legacy Medical Group (LMG) clinics during FY22 and 82,092 (58% of all patients) during FY23, an 182% increase in the proportion of patients screened in one year. The increase within Oregon hospitals and/or clinics was 146%, but an almost five-fold increase was observed within Washington clinics.
<b>More communities benefit from integrated care that meets their social, non-medical needs</b>	<p>A Community Benefit Community Health grant helped finance the construction of 95 units of supportive housing in two locations in outer east Portland. The 95 individuals who gained housing had been chronically homeless or at risk of homelessness and had dual diagnoses of mental health and substance use disorders or another disabling condition. This funding also supported the employment of a Qualified Mental Health Professional and a Licensed Medical Professional who provided on-site behavioral health services and dispensed medicine related to residents’ persistent mental or behavioral health disorders.</p> <p>Legacy Health has been evaluating the feasibility of using the Unite Us/ Connect Oregon resource and referral program with its patients. During FY23, 88 patients were referred to community-based organizations to address identified social needs. Most needs were for housing and shelter, clothing and household goods and individual and family supports. For the 88 patients, 112 referrals were made, with 30 (26.8%) of those referrals being accepted by organizations that could address the identified need(s).</p> <p>During FY23, 4,210 Legacy patients (16% in Washington state) in the quad-county region who were low-income, uninsured or on OHP/Medicaid received food from Legacy Hospitals and/or LMG clinics (48% of all persons receiving food).</p>

**TABLE 2 Legacy Health impact on CHRONIC CONDITIONS within the quad-county region, FY21–FY23**

<b>GOAL</b>	<b>Promote prevention and management of chronic conditions to improve health status</b>
<b>OBJECTIVES</b>	<b>Impact April 1, 2020, through March 31, 2023</b>
<b>Increased participation in chronic disease education</b>	Over the three-year period, Legacy Health offered 12 Diabetes Prevention Program groups, serving a total of 179 participants.
	The number of patient outreach encounters at Legacy Health that involved behavior modification education or related activities increased over the CHIP period from 2,703 during FY21 to 6,382 in FY23, an expansion of 136%.
<b>Increased community engagement in chronic disease programs</b>	Several organizations applied Community Benefit Community Health grant funding toward increasing community member engagement in chronic disease programs. Three of these organizations focus on youth.
	During the three-year grant period, almost 1,700 youth received education on healthy eating, physical activity and reducing risky behaviors.
	Funding also was used to enhance the capacity of community health workers to assist with the management of chronic conditions and to control risk factors (e.g., poor nutrition, inactivity, etc.) associated with the development of chronic conditions and their related complications.
<b>Increased engagement in chronic disease prevention partnerships</b>	Legacy employees were engaged participants in chronic disease prevention and/or treatment-related coalitions and collaboratives/networks such as the Comagine diabetes prevention collaborative and the Healthy Living Collaborative, with each participant contributing over 40 hours per year to these efforts.
	Legacy employees also were active members on the Boards of Directors of local organizations that address the prevention, management and treatment of chronic conditions, contributing over 24 hours per year per member.
<b>Reduce the impact of chronic conditions</b>	During the three-year CHIP period, the range of reported weight loss across participant groups in the Legacy Health Diabetes Prevention Program was 3-8.2%, and the average reported physical activity ranged from 149-260 minutes per week.
	From FY21 through FY23, 1,502 patients received behavior modification education or related activities from the Legacy Health Medical Clinics Care Management Program, of whom 46% were OHP members.

**TABLE 3 Legacy Health impact on HEALTH EQUITY within the quad-county region, FY21–FY23**

<b>GOAL</b>	<b>Achieve health equity and mitigate unintended health system trauma and institutional bias by creating and investing in systems, policies and organizations that will advance trauma-informed care and strengthen our health system’s capacity to identify and address structural racism</b>
<b>OBJECTIVES</b>	<b>Impact</b> <i>April 1, 2020, through March 31, 2023</i>
<b>Invest in workforce development and higher education opportunities for priority populations</b>	<p>Legacy Health and Community Benefit made significant investments in workforce development and higher education opportunities for priority populations during the FY21–FY23 CHIP period. Community Health grants were awarded to several organizations engaging with individuals from underrepresented populations, particularly youth.</p> <p>An organization that provides health education and health-professions mentorship to students from vulnerable communities used their grant monies to engage 822 youth in health education and chronic condition-related activities, pair them with learning mentors and introduce them to a variety of healthcare career opportunities through interactions with professionals from multiple career tracks.</p> <p>Similarly, another awardee conducted employer site visits, provided students with information on pathways to enter the health-related workforce and connected participants with health care professionals who provided educational and career advice. During the grant period, 1003 high school students took part in these activities, of whom 93 participated in their nursing mentor program.</p> <p>Grant funds were used by another organization to deliver a wide range of programming and experiences, including Science, Technology, Engineering and Math (STEM) activities, career exploration, educational attainment and healthy living (e.g., physical activity, nutrition, healthy sexuality, mental health support, avoidance of risky behaviors, etc.), among other topics. Over the three-year grant period, 141 individuals aged 14-17 completed a STEM focused program, and more than 100 youth aged 8-13 participated in one or more of nine group activities.</p> <p>Community Benefit grant funding also supported a program to address poverty and financial stability by improving participants’ financial literacy, building their savings and providing access to jobs. This program served a total of 150 individuals through activities such as job searches, resume writing, career coaching, financial education and educational assistance.</p> <p>Recognizing that the health workforce is lacking in diversity, Legacy established the Health Occupation Profession and Education (HOPE) program to provide students from underrepresented populations with training opportunities in different health professions. HOPE scholars are provided with summer employment in departments throughout the Legacy Health system. Scholars are paid between \$15 and \$18 per hour to work with health professionals, and they may work up to 400 hours during the summer. HOPE participants also receive college scholarships between \$3,000 and \$10,000 annually. For each year of the three-year CHIP period, Legacy Health provided five HOPE participants with scholarships and health-related practical placements.</p>

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**TABLE 3 Legacy Health impact on HEALTH EQUITY within the quad-county region, FY21–FY23**

<b>GOAL</b>	<b>Achieve health equity and mitigate unintended health system trauma and institutional bias by creating and investing in systems, policies and organizations that will advance trauma-informed care and strengthen our health system’s capacity to identify and address structural racism</b>
<b>OBJECTIVES</b>	<b>Impact</b> <i>April 1, 2020, through March 31, 2023</i>
<b>Enhance data collection processes to identify and address health disparities</b>	<p>Legacy Health enhanced its data collection processes to identify health disparities both within the system and in the external community. The Population Health Division created a Disparity Index that measures the degree of difference in health care-related quality indicators by sociodemographic characteristics, such as race, ethnicity, gender and language. The Index is used to identify areas to target for intervention and to evaluate efforts.</p> <p>Legacy Health also updated its harm reporting system (ICARE) to facilitate reporting of incidents of racial harassment, discrimination and bias against employees and patients.</p> <p>The Community Benefit Department contracted a team from EcoNW to assess the feasibility of partnering with community-based organizations, other health systems and public agencies to create a Community Health Index that would combine data on community-level factors known or suspected to influence health outcomes into a single metric. This value can provide public and private organizations with an objective assessment of community health-related conditions, helping them tailor operations, investments and interventions to meet identified community needs and address observed health and social inequities.</p>
<b>Provide culturally and linguistically responsive, trauma-informed and multi-tiered health services and supports to all children and families</b>	<p>Community Benefit Community Health grants supported the educational and workforce development of community health workers (CHW) during the FY21–FY23 period. With this funding, one organization provided continuing education and professional development training for 377 individuals on topics such as providing services across care and community settings; assisting with access to care, chronic conditions, nutrition, physical activity, addiction and recovery; and social determinants of health. Legacy funds also were used to review and update the Foundational CHW Training curriculum, course materials and evaluation tools and approaches, as well as implement two 90-hour Foundational Training courses.</p> <p>A second organization used Community Benefit grant funding to support the training and professional development of their two full-time CHW (Promotores de Salud) and their volunteer promotores. These promotores brought health and social-related services and resources, such as conducting 11 vaccination clinics and providing one-on-one health navigation activities, to 650 Latinx community members and families within Washington County.</p> <p>The number of traditional health workers (e.g., health navigators, peer mentors, doulas, etc.) employed throughout Legacy Health tripled during the CHIP period, with several other workers contracted for their services.</p>

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**TABLE 3 Legacy Health impact on HEALTH EQUITY within the quad-county region, FY21–FY23**

<b>GOAL</b>	<b>Achieve health equity and mitigate unintended health system trauma and institutional bias by creating and investing in systems, policies and organizations that will advance trauma-informed care and strengthen our health system’s capacity to identify and address structural racism</b>
<b>OBJECTIVES</b>	<b>Impact</b> <i>April 1, 2020, through March 31, 2023</i>
<b>Implement standards for workforce development that address bias and improve the delivery of equitable, trauma-informed and culturally and linguistically responsive services</b>	<p>Several policies, rules, regulations and other actions to address bias and improve the delivery of equitable, trauma-informed and culturally and linguistically responsive services were developed and implemented within the Legacy Health system between FY21 and FY23.</p> <p>In FY21, a racism, diversity, equity and inclusion policy and a recruitment policy for diversity sourcing for leadership roles were established. In FY22, a monthly Health Equity Speaker Series debuted, covering topics such as structural racism, community engagement and linguistic disparities. In FY23, the annual Provider Education training module was expanded to include content on racial inequities in clinical encounters, and the pre-employment drug screening policy was abolished to remove its disparate impact on African American job applicants.</p> <p>More than 4,000 trainings related to implicit bias and/or discrimination, inclusive work environments, cultural competency and related topics were completed by Legacy employees in the quad-county region to assist them in providing equitable, trauma-informed and culturally and linguistically responsive services and/or supports.</p> <p>By March 31, 2023, 28.9% of the Legacy Health workforce in the quad counties self-identified as non-white, an increase of 21.5% from the beginning of the CHIP period.</p>

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**TABLE 3 Legacy Health impact on HEALTH EQUITY within the quad-county region, FY21–FY23**

<b>GOAL</b>	<b>Achieve health equity and mitigate unintended health system trauma and institutional bias by creating and investing in systems, policies and organizations that will advance trauma-informed care and strengthen our health system’s capacity to identify and address structural racism</b>
<b>OBJECTIVES</b>	<b>Impact</b> <i>April 1, 2020, through March 31, 2023</i>
<p><b>More young people from diverse and low-income backgrounds complete post-secondary education or training and attain employment</b></p>	<p>During the FY21–FY23 CHIP period, several Community Benefit Community Health grants were awarded to organizations whose work focused on enhancing educational opportunities and workforce development for priority populations to ensure that more people from these groups obtain employment or complete additional education or training.</p> <p>One awardee conducted a program that connected students with paid leadership-track internships in Oregon and SW Washington. Throughout the three-year grant period, more than 500 18–24–year-old youth from diverse and low-income backgrounds were matched to paid internships with over 200 employers, including Legacy Health. More than 70 of these interns also participated in formal mentoring programs. Of those interns who completed an internship and for whom data were available (n=373), 16.4% had their internship extended and 26.3% obtained part-time or full-time employment, either with their internship company or another employer.</p> <p>Another grantee used their Community Benefit funds to provide services and supports (e.g., books, transportation, stipends, etc.) that enabled youth to obtain their GED®, develop skills necessary for employment and academic success and identify and pursue a career path. During the grant period, their program served more than 300 18–24–year-old individuals who were diverse in terms of race, ethnicity, gender and disability status. As a result of the program, 24 youth completed educational programs and 46 youth obtained employment.</p> <p>An additional program engages youth from underrepresented groups in early college planning and preparation activities; works to increase college admission and enrollment rates; and addresses common academic, social and financial barriers to college and throughout college completion. During the FY21–FY23 grant period, 984 high school juniors and seniors from eight schools in Multnomah and Washington counties participated in the program. Of these students, 77% identified as Black, Indigenous or people of color (BIPOC), 70% reported being female and 85% were first-generation college students. Approximately 64% of program participants graduated college, which is twice the national average for students with similar demographic characteristics.</p>

## Legacy Good Samaritan Medical Center continues to address the issues affecting our community

### 2022 HCWC CHNA

In 2022, the HCWC, now comprised of six hospital systems, four county health departments and two coordinated care organizations, completed its fourth regional CHNA. The development and implementation of the 2022 HCWC CHNA were led by a Community Action Team (CAT)<sup>4</sup> (p. 4, 67) comprised of community leaders who represented the diverse populations in the quad-county region. The CAT partnered with the Oregon Health Equity Alliance, Health Management Associates and members of the HCWC to complete the CHNA. Funding for the project was provided by the HCWC member organizations.<sup>4</sup>

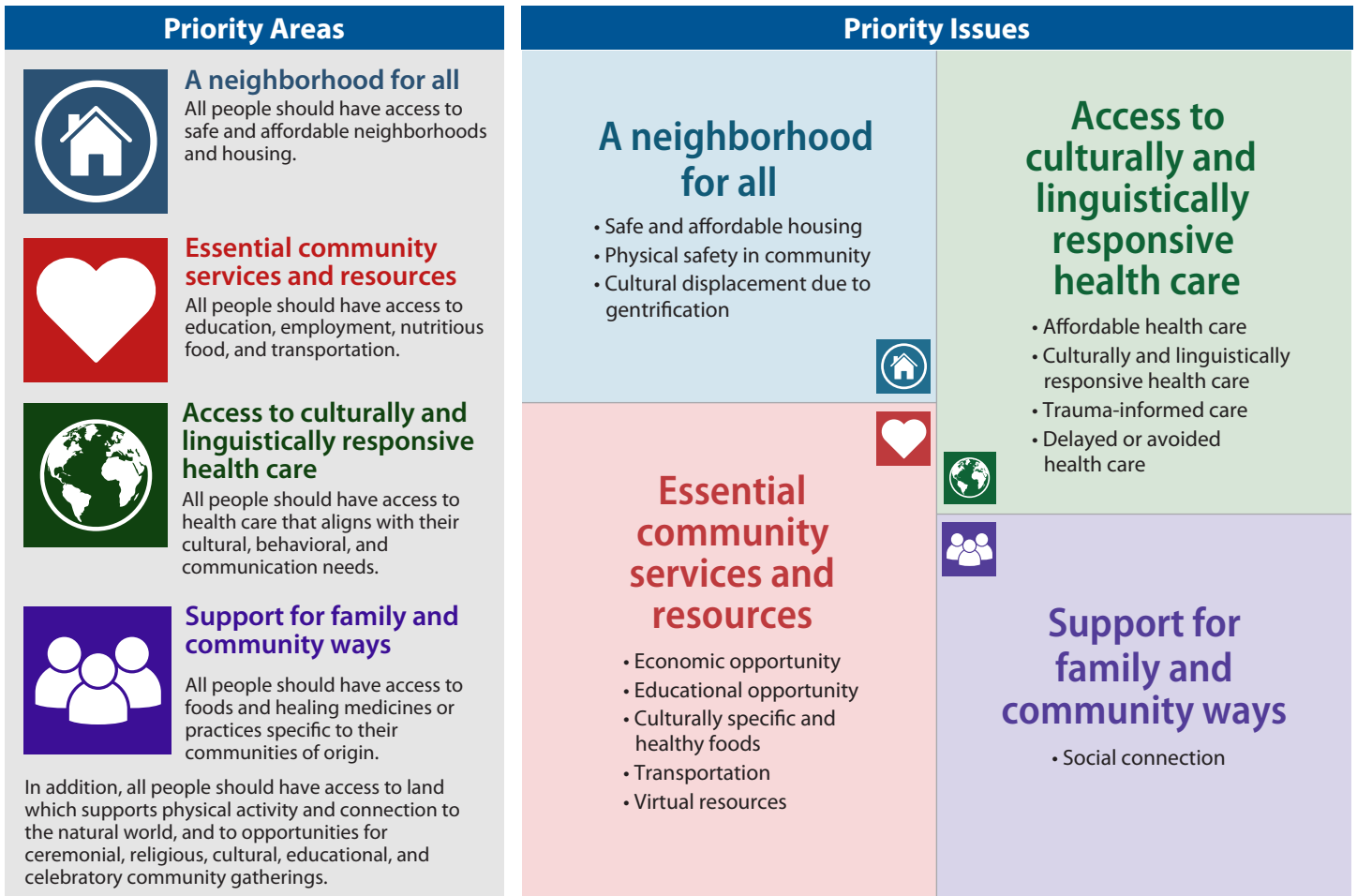
The 2022 HCWC CHNA team used a modified version of the Mobilizing for Action through Planning and Partnership (MAPP) process to guide this assessment. MAPP is a multi-phase, evidence-based framework created by the National Association of County and City Health Officials (NACCHO) that involves multiple assessments, the identification of strategic issues, and the development, implementation and evaluation of strategies to address these issues.<sup>11</sup>

Data were collected and analyzed using a mixed methods approach. Quantitative secondary data on community health and social status were retrieved from population-based (e.g., *American Communities Survey*, *Behavioral Risk Factor Surveillance System*, *Oregon Student Health Survey*, *Washington Healthy Youth Survey*), institutional (e.g., *Department of Education*) and hospital (e.g., *Oregon Public Health Assessment Tool (OPHAT)*, *state of Washington's Community Health Assessment Tool (CHAT)*) data sources. These quantitative data were used to identify health trends and compare changes over time.<sup>4</sup>

Primary data collection methods were used to elicit information directly from community members using both quantitative and qualitative approaches. An online survey, available in 10 languages, was completed by 503 individuals. Another 311 community members participated in one of 37 community engagement sessions, seven of which were conducted in a language other than English. Data collected through these methods assessed community health and social assets and needs, the root causes of observed poor health and social outcomes and how best to take action to improve social conditions and community health.<sup>4</sup>

Analyses of these data provided a description of the diverse communities in the quad-county region. Four community-determined priority areas, containing thirteen priority issues, were identified. These issues all disproportionately impact low-income populations, communities of color and other marginalized groups; severely

affect the well-being of the local community; and have known feasible and effective solutions.<sup>4,12</sup> The 2022 HCWC CHNA priority areas and issues are provided below:



Figures 1 and 2: 2022 HCWC CHNA community-identified priority areas and issues.<sup>4 (p.7, p.21)</sup>

## FY24–FY26 Legacy Good Samaritan Medical Center CHNA

The Legacy Good Samaritan Medical Center designated the 2022 HCWC CHNA<sup>4</sup> as its FY24–FY26 CHNA. The Legacy Community Benefit Advisory Committee (CBAC) and Community Benefit Department then implemented a prioritization process to determine which of the original thirteen priority issues within the four priority areas of the 2022 HCWC CHNA would be the focus of Legacy Good Samaritan’s community health improvement activities for the next three fiscal years.

The priority areas and issues that emerged from the 2022 HCWC CHNA inequitably affect communities of color, low-income populations and other disenfranchised groups.<sup>4</sup> This burden, in addition to the availability of evidence-based and prevention-focused solutions and the knowledge, skills and resources provided by Legacy Health to intervene in these community-identified priority areas and



issues, were factors considered during the prioritization process. Six issues within three areas were selected to be addressed in the Legacy Good Samaritan Medical Center FY24–FY26 CHIP:

<b>Priority Areas and Issues — Legacy Health FY24–FY26 CHIP and CHNA: Legacy Good Samaritan Medical Center</b>	
<b>Priority area 1</b>	<b>Access to Culturally and Linguistically Responsive Health Care</b>
Priority issues	Access to Affordable Health Care Culturally and Linguistically Responsive Health Care
<b>Priority area 2</b>	<b>Essential Community Services and Resources</b>
Priority issues	Economic Opportunity Educational Opportunity Culturally Specific and Healthy Foods
<b>Priority area 3</b>	<b>A Neighborhood for All</b>
Priority issue	Physical Safety in the Community

### **For questions or more information**

If you have any questions or wish to obtain a copy of this assessment, please email us at [CommunityBenefit@LHS.org](mailto:CommunityBenefit@LHS.org) or visit [www.legacyhealth.org/Giving-and-Support/community-engagement/CHNAs](http://www.legacyhealth.org/Giving-and-Support/community-engagement/CHNAs).

## References

1. Healthy Columbia and Willamette Collaborative. Community Health Needs Assessment, 2019. 2019. [https://www.healthshareoregon.org/storage/app/media/documents/About%20Us/HCWC%20reports/HCWC-Community-Health-Needs-Assessment-Report-July2019\\_0.pdf](https://www.healthshareoregon.org/storage/app/media/documents/About%20Us/HCWC%20reports/HCWC-Community-Health-Needs-Assessment-Report-July2019_0.pdf). Accessed February 3, 2023.
2. Legacy Health. Legacy Good Samaritan Medical Center Community Health Needs Assessment: FY21–FY23. 2021. <https://www.legacyhealth.org/Giving-and-Support/community-engagement/CHNAs/GS-CHNA>. Accessed February 3, 2023.
3. Legacy Health. Legacy Good Samaritan Medical Center Community Health Improvement Plan: FY21–FY23. 2021. <https://www.legacyhealth.org/Giving-and-Support/community-engagement/CHNAs/GS-CHNA>. Accessed February 3, 2023.
4. Healthy Columbia and Willamette Collaborative. Community Health Needs Assessment, 2022. 2022. <https://www.healthshareoregon.org/storage/app/media/documents/Health%20Equity/Reports/CHNA/HCWC%20CHNA%202022.pdf>. Accessed September 22, 2022.
5. Legacy Health. Legacy Good Samaritan Medical Center Community Health Improvement Plan: FY24–FY26. 2023. <https://www.legacyhealth.org/Giving-and-Support/community-engagement/CHNAs/GS-CHNA>.
6. Requirements for 501(c)(3) Hospitals Under the Affordable Care Act – Section 501(r). U.S. Internal Revenue Service (IRS) website. <https://www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r>. Updated July 15, 2022. Accessed May 1, 2023.
7. Legacy Health Profile. Legacy Health website. <https://www.legacyhealth.org/about/who-we-are>. Updated 2022. Accessed June 1, 2023.
8. Unity Center for Behavioral Health website. <https://unityhealthcenter.org>. Accessed September 22, 2022.
9. Child Abuse Response and Evaluation Services (CARES) Northwest website. <https://www.caresnw.org>. Accessed February 3, 2023.
10. Healthy Columbia Willamette Collaborative. Health Share of Oregon website. <http://www.healthshareoregon.org/about/healthy-columbia-willamette-collaborative>. Updated 2023. Accessed May 22, 2023.
11. National Association of County & City Health Officials (NACCHO). Mobilizing for Action through Planning and Partnerships (MAPP). <https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment/mapp>. Accessed September 22, 2022.
12. Robert Wood Johnson Foundation. What works for health. Take action to improve health. County Health Rankings & Roadmaps. <https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health>. Accessed November 11, 2022.

The remainder of this document contains the full 2022 HCWC CHNA.

**Legacy Health**

1919 N.W. Lovejoy St. • Portland, OR 97209  
[legacyhealth.org](http://legacyhealth.org)





# Healthy Columbia Willamette Collaborative

## **Community Health Needs Assessment**

2022

A community-informed and equity-centered health assessment of  
Clackamas, Multnomah, and Washington counties, Oregon, and  
Clark County, Washington

## Readers' Guide

This report presents the results of the 2022 Community Health Needs Assessment (CHNA) for the quad-county region of Clark County in Washington and Clackamas, Multnomah, and Washington counties in Oregon.

A Community Action Team (CAT), composed of community leaders representing the diverse communities in the region, led the development of the CHNA, with support from Healthy Columbia Willamette Collaborative (HCWC) partners and subcontractors Health Management Associates and Oregon Health Equity Alliance. The partnership's approach was informed by a peer review group of data professionals of color, with expertise in engaging in decolonized, community-centered, data approaches and/or deeply connected to an anti-racist, Indigenous practice of performing health equity work.

This report is divided into eight sections:

1. Executive Summary
2. Overview and Approach to the CHNA
3. The HCWC Regional Profile
4. The Four Priority Areas in Creating a Healthier Community
5. Linking Health Priority Areas to Health Outcomes
6. Recommendations
7. About the CAT
8. Appendix

The first part of this report—Overview and Approach to the CHNA—provides context for the remainder of the report. Using its own experience, coupled with larger community member data collection, the CAT defined a healthier community and the priority areas, each of which has its own section. Priority areas describe the drivers of the health behaviors and outcomes in the region. This section is then followed by the three priority health outcomes identified by the CHNA. The CHNA concludes with recommendations for HCWC partners and other community members for their health improvement planning efforts.

Additional information about the preceding is included in the report appendices, which are linked throughout the report and provided at the end. A glossary of acronyms and key terms is also provided as Appendix A.

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## Letter from the Community Action Team

The Community Action Team (CAT) represents a group of community leaders from Clackamas, Multnomah, and Washington counties in Oregon and Clark County, Washington, who collaborated together over the past two years to develop this Community Health Needs Assessment (CHNA) for our region, in partnership with the Oregon Health Equity Alliance and Health Management Associates. This project was funded by the Healthy Columbia Willamette Collaborative, a collaboration of health systems, public health departments, and coordinated care organizations serving our local communities.



The CAT met monthly to guide the process and to ensure the stories and information collected and presented in this report are reflective of and aligned to our communities' experiences. We are committed to realizing change within our communities and we understand that change begins with community-informed approaches that elevate and honor our communities' lived experiences, wisdom, strengths, and decisions. To that end, we have adopted a storytelling model for this CHNA and within our CAT meetings. Our meetings served as opportunities for storytelling, wherein we learned from one another and our respective cultures, centering our health and well-being through the stories we shared.

We strived to record the community stories typically missed or excluded in CHNAs. These voices often include the incarcerated; rural; unhoused; Black, Indigenous, and People of Color (BIPOC); Lesbian, Gay, Bisexual, Transgender, Queer, Two-spirit and Asexual (LGBTQ2IA); immigrants and refugees; non-English speaking people; youth; older adults; and people with disabilities.

It is sincere our hope that the individuals who read this report find the information useful, easy to access, and representative of our diverse communities in the region, and that this report will serve as a catalyst for change and improvement to ensure our communities obtain the services and supports necessary to thrive.

Be well,  
The Community Action Team

## Letter from the HCWC Partners

The Healthy Columbia Willamette Collaborative (HCWC) partnership is committed to responding to identified needs within our shared communities. Our partnership, which includes seven hospital systems, four County health departments, and two Coordinated Care Organizations, is uniquely positioned to assess and strengthen the health of our region. We accomplish this by collaborating on a Community Health Needs Assessment (CHNA), creating Community Health Improvement Plans (CHIPs), and through Community Investments. The CHNA outlines important regional priorities and is a critical tool supporting community engagement, grant applications, and collaborative strategic alignment across community-based organizations and health systems. The following are three examples of regional collaboration and investments made by HCWC partners in response to priorities identified in the 2019 CHNA.

### Supportive Housing

Several HCWC partners worked in tandem to expand access to safe, affordable, and supportive housing. They established a Regional Supportive Housing Impact Fund (RSHIF) to serve as a flexible funding source to promote housing stability and health equity by connecting people experiencing homelessness and complex health challenges to affordable supportive housing options and services necessary to remain stable and housed. RSHIF's start-up was funded with support from HCWC partners and community foundations for a collective investment of \$5.7M, which supported service delivery and infrastructure development. These funds resulted in returning more than 390 homeless seniors with disabling conditions to stable, affordable housing.

### Investments to Address Health Inequities

Since 2017, the region's major health providers have collectively invested in Project Access NOW, a non-profit focused on improving community health and equity by providing access to care, services, and resources for the underserved and uninsured. The regional health systems have invested more than \$40 million to support health services for Project Access NOW clients, primarily low-income, non-native English-speaking persons and those identifying as Black, Indigenous, or people of color. Project Access NOW has become a critical link for health access and education, particularly for underserved communities.

### COVID-19 Response

Over the last two years, regional public health authorities, health systems, and coordinated care organizations partnered with dozens of community-based organizations to directly support their communities with essential resources and education. We held hundreds of vaccine and testing clinics and reached people with whom a more conventional approach might have been missed. The foundational partnership work we perform throughout the CHNA and CHIP processes enables us to respond faster together when emergencies arise.



## Land Acknowledgement

The quad-county region, composed of Clackamas, Multnomah, and Washington counties in Oregon and Clark County in Washington, is unceded indigenous land, now colonized and resting on traditional village sites of the Multnomah, Wasco, Cowlitz, Cathlamet, Clackamas, Bands of Chinook, Tualatin, Kalapuya, Molalla, and many other tribes that made their homes along the Columbia River. We want to express our deep appreciation and respect to these peoples and all indigenous communities who hold ancestral ties to this land and acknowledge that the policies and actions of the United States, both in the past and currently, systematically harm and oppress these communities. While this land acknowledgment cannot repair the harm done to these tribal communities, it serves as an invitation to recognize and respect the deep ties tribal communities have to the land, demonstrate the role stories play in honoring the experiences of our communities, and connecting those stories and experiences to practices of healing for today and future days.



## Executive Summary

Various factors within a community determine community health. A Community Health Needs Assessment (CHNA) is a report that describes a community's perception of its population's well-being. A coalition of partners, known as the Healthy Columbia Willamette Collaborative (HCWC), from Clackamas, Multnomah, and Washington counties in Oregon and Clark County, Washington, have partnered for the fourth time to fund this regional CHNA.

The CHNA is designed to serve as a community-informed process that:

- Deepens community partnerships
- Centers and emphasizes community wisdom
- Tells a story reflective of lived experiences
- Informs and influences critical decision-making on behalf of communities

This approach, one that relied upon the input of a Community Action Team (CAT), originated from HCWC's desire to increase the role of communities in developing these needs assessments and committing to advancing health equity. The CAT identified and prioritized conditions and characteristics into four key priority areas (Figure 1).

The CHNA relied upon the voices of community members in the region to identify and define the root causes of poor health and used secondary data to understand the health outcomes. Community health improvement efforts should lead with these prioritized causes of poor health and inequities in the region. The community shared ideas on where to begin addressing the issues detailed in Figure 2.



### A Neighborhood For All

All people should have access to safe and affordable neighborhoods and housing.



### Essential Community Services and Resources

All people should have access to education, employment, nutritious food, and transportation.



### Access to Culturally- and Linguistically-Responsive Health Care

All people should have access to health care that aligns with their cultural, behavioral, and communication needs.



### Support for Family and Community Ways

All people should have access to foods and healing medicines or practices specific to their communities of origin.

In addition, all people should have access to land which supports physical activity and connection to the natural world, and to opportunities for ceremonial, religious, cultural, educational, and celebratory community gatherings.

FIGURE 1 Four Key Priority Areas

### **A Neighborhood for All**

1. Engage local politicians, including city councils and commissioners, as necessary advocates for creating a neighborhood where community members are safe, have access to quality housing, and enjoy healthier living environments.
2. Invest proactively, as opposed to reactively, in equity-centered and community-informed solutions to rising violent crime rates.
3. Support sustainable civic engagement and education programs, particularly for recent immigrant and refugee communities.

### **Access to Culturally- and Linguistically-Responsive Health Care**

1. Support additional trauma-informed physical and mental health services and supports, clinics, and/or community centers.
2. Increase workforce development pipelines to health care workers that reflect and represent the region's diversity in language, ability, culture, sexual orientation, and gender.
3. Expand investments in traditional health workers to increase community representation in the workforce.
4. Invest in building/repairing trust between the health care system and priority populations.
5. Invest in efforts to address gaps in insurance eligibility for Hispanic/Latinx and multi-racial populations.
6. Ensure adequate resources for language accessibility in services and education and invest in health literacy efforts.

### **Essential Community Services and Resources**

1. Create more opportunities and capacity for workforce development programs that enable individuals to earn a living wage.
2. Invest in ways to support the delivery of services, along with the infrastructure and capacity to sustain those services.
3. Invest in addressing areas with limited grocery store options and ensuring culturally relevant and healthy food access to communities most impacted by these geographic disparities.
4. Work to eliminate education disparities, beginning with equitable access to affordable and quality child care and preschools.
5. Invest in technology infrastructure to increase access to virtual resources.
6. Ensure any community engagement efforts in the region include resources to address Internet access barriers.

### **Support for Family and Community Ways**

1. Offer culturally-specific community spaces for community and educational events.
2. Build awareness and engagement of health resources and supports through supporting and leveraging existing collaborative efforts with community organizations to reach those in need.
3. Invest in non-academic youth development programs and peer mentorship programs to improve access to peer education services.
4. Invest in and prioritize data collection concerning race and ethnicity, sexual orientation, ability, and gender to guide policymaking and allocation of resources.

FIGURE 2 Ideas for Addressing Community Health Issues

## Overview

Various factors within a community determine community health. A Community Health Needs Assessment (CHNA) is a report that describes a community's perception of its population's well-being. It typically involves garnering insight and feedback from community members about their strengths, resources, gaps, and health needs. Hospitals, public health, community-based organizations, and more use the CHNA to create programs and services to improve the health of a community.

A coalition of partners in the region, known as the Healthy Columbia Willamette Collaborative (HCWC), has joined in funding a regional CHNA, the fourth they have funded. Jointly supporting a single CHNA enables the partners to maximize resources, avoid duplication of efforts and overburdening the community, and identify regional trends and opportunities for programs and services.

**“ Health is all about understanding the needs of not only yourself but those close to you and your community. And when you understand your needs and your community needs, then that's when things can start to change. –**  
BIPOC Youth Community Session Participant **”**

### HCWC Partners

Adventist Health  
CareOregon  
Clackamas County Health, Housing, and Human  
Services  
Clark County Public Health  
Health Share of Oregon  
Hillsboro Medical Center  
Kaiser Permanente  
Legacy Health  
Multnomah County Health Department  
Oregon Health & Science University  
Providence Health and Services  
Trillium Community Health Plan  
Washington County Public Health

For more on the partnership structure for this CHNA, see Appendix B.



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# Approach to the CHNA

The CHNA is designed to serve as a community-informed process that:

- Deepens community partnerships
- Centers and emphasizes community wisdom
- Tells a story reflective of lived experiences
- Informs and influences critical decision-making on behalf of communities

## A Community-Informed Process

A community-informed approach, reliant upon the input of a Community Action Team (CAT), originated from HCWC's desire to increase the role of communities in developing these needs assessments and committing to advancing health equity.

The CAT was established early in the project and served as the driving force behind realizing this vision. The CAT guided every aspect of this CHNA, including the data collection, analysis, and writing, to ensure the processes and final products reflect the communities in the region and a commitment to a health equity-centered approach.

Whenever people consider what impacts a person's health the most, they often consider individual choices, such as whether or how often they exercise and visit a doctor. However, focusing only on individual behaviors makes it difficult to view the structural causes of health inequities. Community members engaged in the CHNA process spoke to the types of structural causes.

These health inequities result from a history of unjust, inequitable resource allocation, systematic bias, institutional racism, classism, and ableism, which contribute to poorer health outcomes for some.[1]



FIGURE 3 HCWC MAP



"I think a lot of the stresses that our bodies face come from everyday discriminations and oppressions that we face". - BIPOC Youth Community Session Participant



"I don't drive. I use public transportation. Living in the outer Southeast region, trying to get to a place with fresh food takes me a long time". - BIPOC Community Session Participant



"I think the biggest thing for me about the native community, is that our treaty rights need to start being honored and respected. [This is the] root of everything". - Native and Indigenous Community Session Participant

FIGURE 4

[1]Centers for Disease Control and Prevention. 2021. Racism is a Serious Threat to the Public's Health. November 24. Accessed April 20, 2022

Health inequities are revealed in individuals' lives and community stories in the following ways:

- Government policies and programs that drive displacement, exclusion, and segregation in their respective regions and communities.
- Generational poverty creates persistent barriers to achieving financial well-being and building wealth.[2]
- Remaining invisible in the data used to make policy and program decisions, eliminating the experiences of whole communities.

Findings presented in the CHNA are not based on any single source of information; instead, they are the result of considering multiple data sources in analysis before arriving at findings. Data includes quantitative and qualitative data from primary (data collected first-hand through CAT engagement, surveys, and focus groups) and secondary data sources (data collected by another entity or for another purpose), as described in Figure 5.

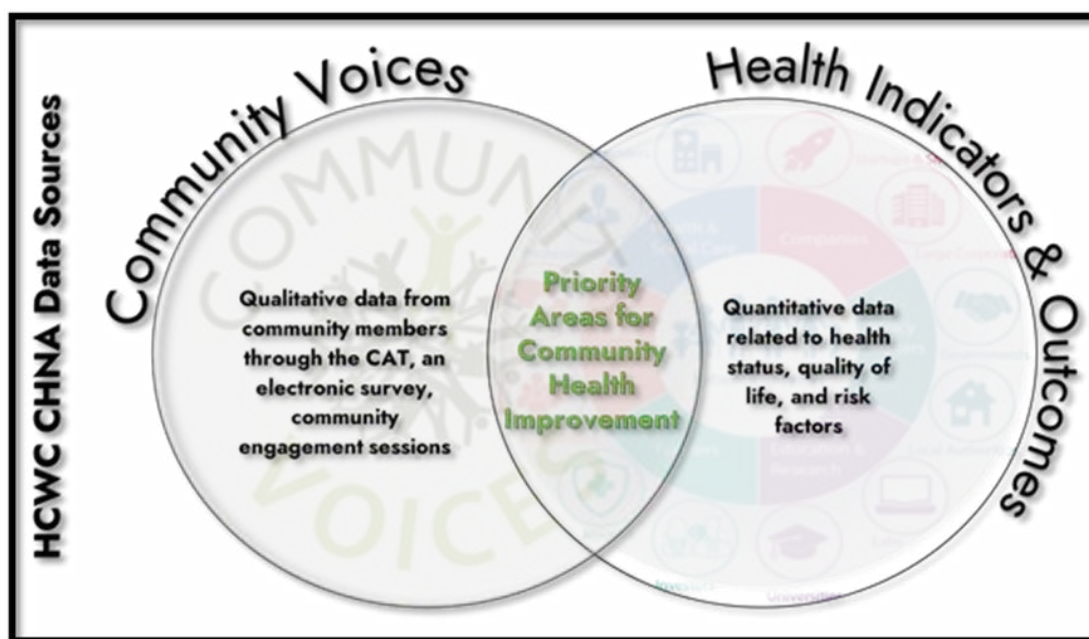


FIGURE 5 HCWC CHNA PROCESS

## Community Voices

The CHNA relied upon community voices and stories to identify and define the root causes of poor health outcomes to be addressed through community improvement efforts. More than 300 people participated in community meetings and over 500 responded to an online survey. Additional outreach activities included:

- Completion of 37 community engagement sessions, seven conducted in a language other than English, engaging 311 community members
  - The top three race and ethnicity groups represented were Hispanic/Latinx, Black/African American, and White community members. Half of the community members spoke a language other than English. See Appendix C for community engagement session protocol and Appendix F for participant demographics.

[2]"Generational poverty" is defined as having been in poverty for at least two generations.

- Launching of the community survey on September 30, 2021, which was open to the public for three weeks and available in ten languages
  - Five hundred three (503) people completed the survey. See Appendix C for the survey instrument and Appendix G for survey respondent demographics.

## Health Indicators and Outcomes

Quantitative data was used in the CHNA to compare and identify health trends by examining how an indicator has changed over time. This helps to understand the changing needs of communities to plan and prioritize ways to approach disease prevention and health promotion. The data sources<sup>[3]</sup> used in the CHNA are noted in Figure 6.



Figure 6 Data Sources

[3] For more on the methodology regarding the influences of change assessment, see Appendix D.

\*Includes birth and death data, hospitalization data, and emergency department data provided via the Oregon Public Health Assessment Tool (OPHAT) and Washington's Community Health Assessment Tool (CHAT).



## Forces of Change

Local, state, and nationwide issues and policies drive the problems affecting the quad-county region. HCWC partners completed the Forces of Change assessment in January 2021. Discussions with the CAT further informed the assessment. A summary of the forces of change, challenges, and opportunities identified by the partners is listed in Figure 7. For more on the methodology regarding the forces of change assessment, see Appendix D.

## Populations of Focus

The CAT identified key populations to focus on for this assessment based on two primary criteria:

- Lack of current and local research data on these populations that, in turn, impacts the ability of these communities to organize, shift programming, and advocate for more funding.
- A desire to strengthen community voices historically silenced or excluded by dominant cultural practices and research methods.

Once selected, these populations became the focus of the community engagement efforts. The CAT partnered with several local organizations serving these communities and community groups and networks to collect stories and input for the CHNA.

## Forces of Change

**COVID-19 PANDEMIC**  
**ECONOMY**  
**RACIAL JUSTICE MOVEMENT AND UPRISINGS**  
**ENVIRONMENTAL EVENTS (WILDFIRES AND EXTREME HEAT)**  
**POLITICAL UNREST/DIVISIVE ENVIRONMENT**  
**CHANGING WHITE HOUSE ADMINISTRATION**

### CHALLENGES

Lack of more recent data necessary to truly understand the impact of the pandemic on the prevalence of violence, mental health issues, academic achievement, and employment

Continued increase in mental health issues, exacerbated by COVID-19

School districts struggling to meet the demand of mental health concerns among students

Balancing working from home and online school during a pandemic

Mental health workforce issues and ensuring individuals access to appropriate levels of care

Lack of political will to support increased transportation access, particularly in rural areas

Increased prevalence of unhoused individuals

### OPPORTUNITIES

Increased awareness of the social and health inequities and the contribution of racism to the disparities

Heightened awareness of the effect of social isolation on health as a result of COVID-19

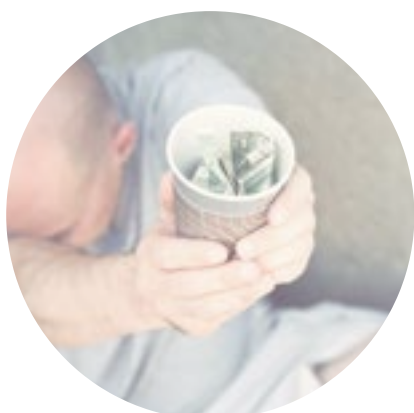
Desire to have greater cultural competency in the way health care is delivered

New conversations occurring on economic justice issues, including minimum wage increases

Businesses and other organizations seeking to better understand the contribution of their policies and procedures to perpetuate racism and discrimination

Political will to improve access to housing and increase initiatives and research on strategies to shelter individuals experiencing homelessness

FIGURE 7 Forces of Change: Challenges and Opportunities



The list of prioritized communities included:

- Black, Indigenous, People of Color, and American Indian/Alaska Native people (BIPOC-AI/AN) populations
- People who identify as Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Two-Spirit, Intersex, and Asexual (LGBTQ2IA) that fall outside of cisgender and heterosexual paradigms
- People with disabilities
- Older adults, 65 years and older people impacted by incarceration
- Rural communities
- Unhoused or people experiencing houselessness
- Immigrant populations
- Non-English-speaking communities
- People with substance use disorders
- Youth

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# HCWC Regional Profile

The demographic characteristics of a population are critical to understanding the health risks, challenges, strengths, and opportunities of a region.

Aspects, such as race and ethnicity, age, and gender, are closely linked to health outcomes. Socio-economic factors, such as income and education, are likewise associated with health risk and protective factors and outcomes.

Subsequent sections of the CHNA specify the reasons for variation in characteristics among different demographic groups. In short, this variation reflects the impacts of structural and systemic barriers and oppression, such as racism, colonialism, ableism, sexism, and other determinants of health and equity. This section displays important demographics for the region. Appendix E includes demographic profiles by county.

# Demographics

## Quad-County Region

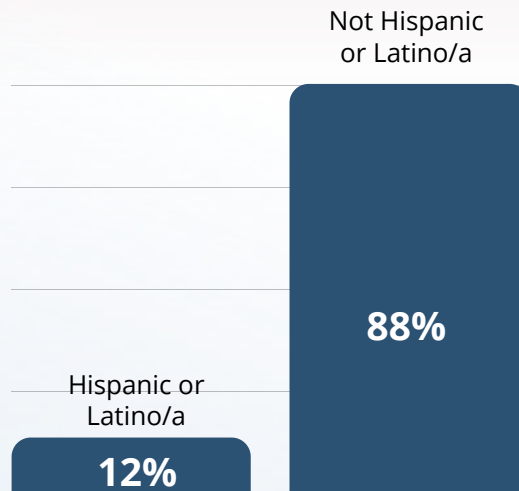
**Total Population:**  
**2,277,802**

All data is a 2015-2019 combined estimate unless otherwise noted

Increase from 2009: 13%

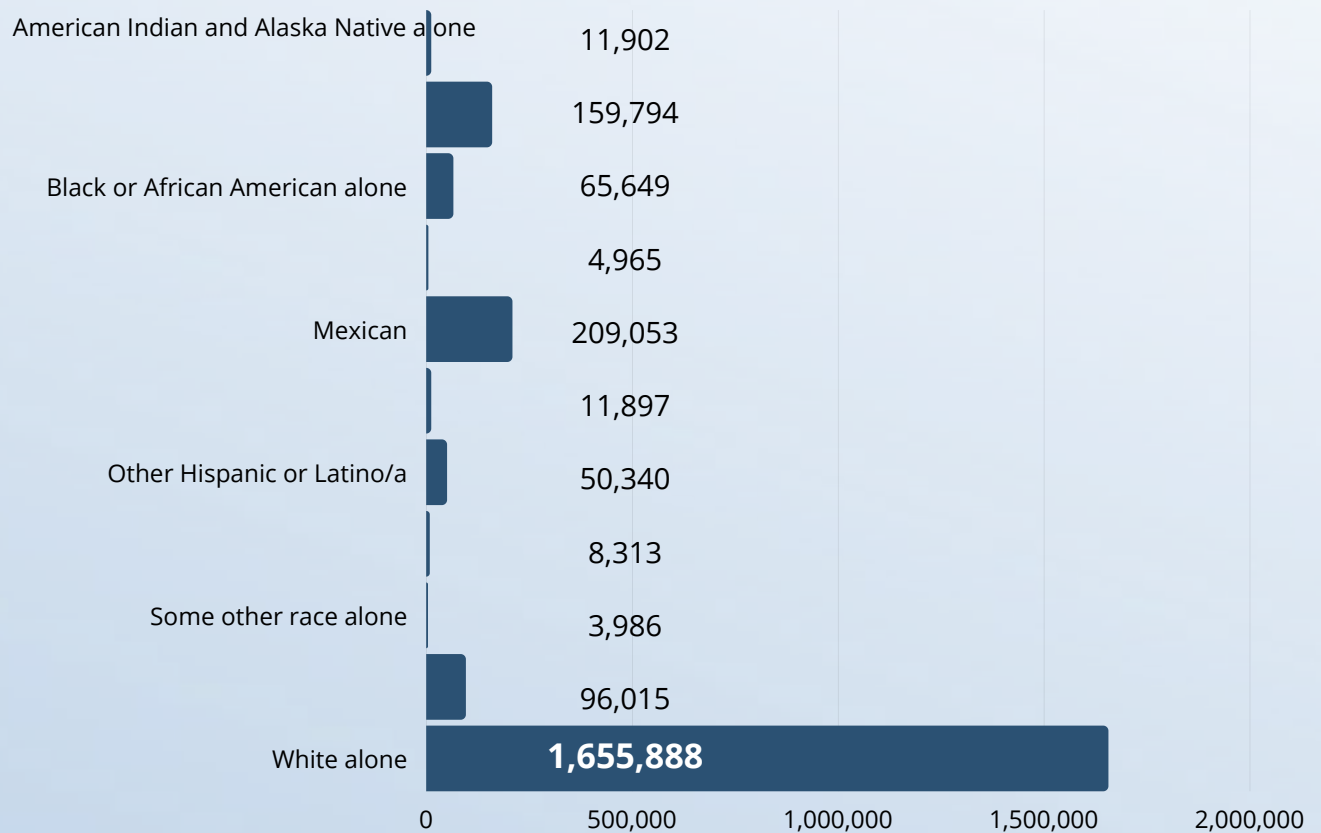
Not Hispanic or Latino/a: 88.0%

Hispanic or Latino/a (of any race): 12.0%



## Race and Ethnicity

Count of individuals by racial group



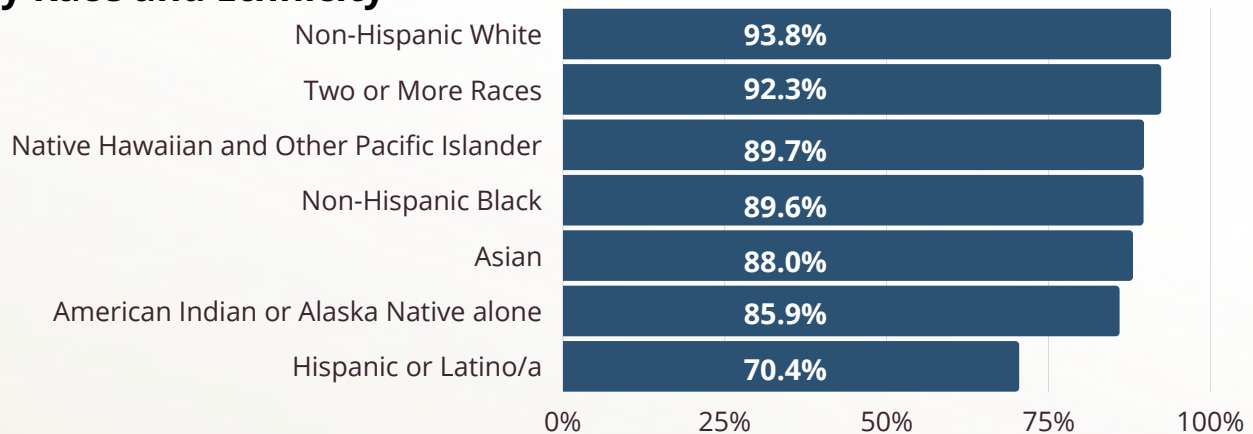
# Educational Attainment

## Quad-County Region

### Highschool Diploma or Equivalent

Total Population (all races and ethnicities): 2,101,235 individuals, or 92%. An increase of 1.2% since 2009.

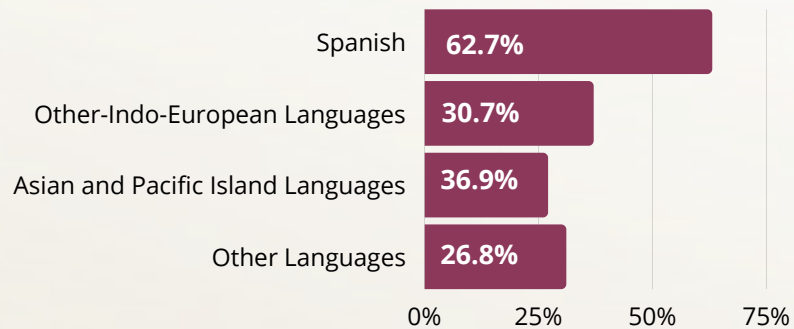
#### By Race and Ethnicity



#### Languages Spoken Other than English

A multitude of Asian and Pacific Island and Indo-European languages exist and are spoken; however, a significant limitation is that data with greater specificity is not publicly available due to relatively small sample sizes. This limitation is crucial because it groups people with diverse and varied backgrounds, experiences, and needs.

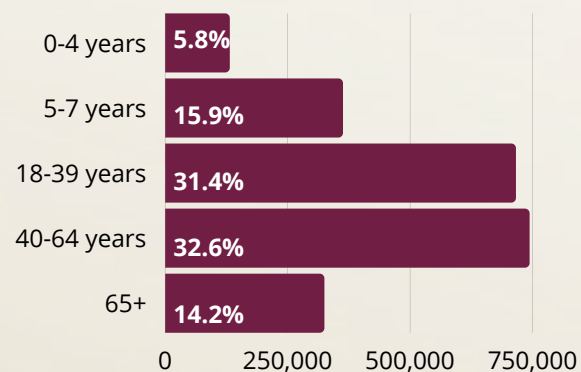
**Linguistically Isolated Households**  
(No member of the household 14 years or older speaks English "very well")  
(2019): 3.2% or 72,890 individuals



#### Languages Spoken by Age

Language and literacy are central to understanding health information and navigation. Twenty-one percent (21%) or 500,000 people in the region speak a language other than English.

**Residents five years or older who speak a language other than English:**  
21% or 500,000 individuals



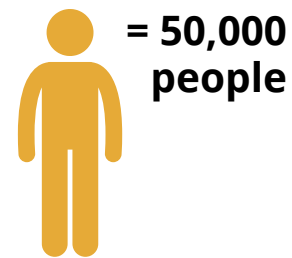
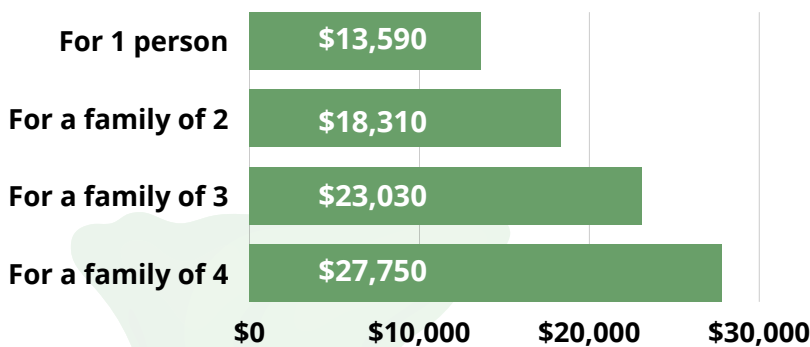
# Financial Security

## Quad-County Region

Community members noted it can be challenging to find employment where the salary compensates for the subsequent loss of government benefits, known as a “benefits cliff.” When income increases, individuals and families sometimes lose some or all economic supports (e.g., Supplemental Nutrition Assistance Program [SNAP]; school nutrition programs; health care; child care assistance; Temporary Assistance for Needy Families [TANF]; and housing).

**2020 Minimum Wage: \$13.30**

2022 Federal Poverty Guidelines  
Maximum Annual Household Income



### Individuals living at or below the poverty level



Individuals in families whose income is below the federal poverty level

### Individuals living in deep poverty



4.8% or 109,335 individuals in families whose income is **less than half** of the federal poverty level

### People with at least one disability living at or below the poverty level



11.6% or 265,224 individuals

### Children 17 years or younger living in poverty



26.4% or 64,963 children

### People born outside the US living at or below the poverty level



13.1% or 298,392 individuals

## Priority Areas in Creating a Healthier Community

A healthy community is one in which all citizens have what they need to become as healthy as possible—access to social and economic resources; quality education; clean environments; quality and culturally-responsive health care; and safe, inclusive neighborhoods. These interconnected conditions impact the health outcomes for the community members of the HCWC region. This CHNA explored these conditions, or drivers of health, to better understand the steps needed to improve the health and well-being of all who reside in the region.

Across the priority populations, a key factor identified in protecting, supporting, sustaining, and advancing health, healing, and wellness for their communities was a sense of connection or community connectedness. Many community members stated they rely upon their social networks when they do not wish to or are unable to access or use the health care system. Research suggests that supportive relationships with family and friends, coupled with healthy behaviors (e.g., engaging in physical activity and getting better sleep) appear to protect against the harmful effects of the pandemic on both physical and mental health. For many, the government-mandated social isolation requirements and lockdowns during the COVID-19 pandemic deprived people of social support from friends, family, and other community support systems.

Understanding the conditions and characteristics that promote or hinder health is necessary to create a healthier community. The CAT identified and prioritized needs and characteristics into four key priority areas and assessed them in the CHNA.

Each priority area includes a set of prioritized issues based upon shared community stories and other data, as depicted in Figure 8. In-depth information on each priority area is provided in this report.

# Priority Areas



FIGURE 8 Priority Areas



---

# A Neighborhood for All



## All People

should have access to safe and affordable neighborhoods and housing.

## A Neighborhood for All

All people should have access to safe and affordable neighborhoods and housing. Yet, for many families, particularly in communities of color, many barriers exist in the public health, social and public service, and private development systems that make equal access difficult or impossible.

A neighborhood for all refers to the built environment where we live, work, and play, and the extent to which it is safe, affordable, and accessible. It includes our homes, buildings, streets, and open spaces. A neighborhood influences individuals' ability to make positive choices for their health. This may consist of eating healthy, available cultural foods and the ability to be physically active. Neighborhoods also influence access to support systems for connection, inclusion, and resources.

Community members shared many stories about how they received the support they required to feel safe and well. The challenge of first getting this support was a common theme among these stories. When community members received support, they described the support as high quality.

### **Three priority issues emerged in a neighborhood for all:**

- Safe, affordable housing
- Physical safety in the community
- Cultural displacement due to gentrification

## A Neighborhood for All

### Cultural Displacement Due to Gentrification

- Displacement due to gentrification disproportionately impacts people of color who are often pushed away before they can benefit from increased property values and opportunities in revitalized neighborhoods (HCWC CHNA Community Engagement).
- Data suggests communities of color within the region are at greater risk of cultural displacement due to gentrification (Urban Institute, 2020).
- Community members shared stories of relocation efforts due to their inability to pay expensive mortgages and rent and how this process can negatively impact their general health, mental health, and well-being (HCWC CHNA Community Engagement).

### Physical Safety in the Community

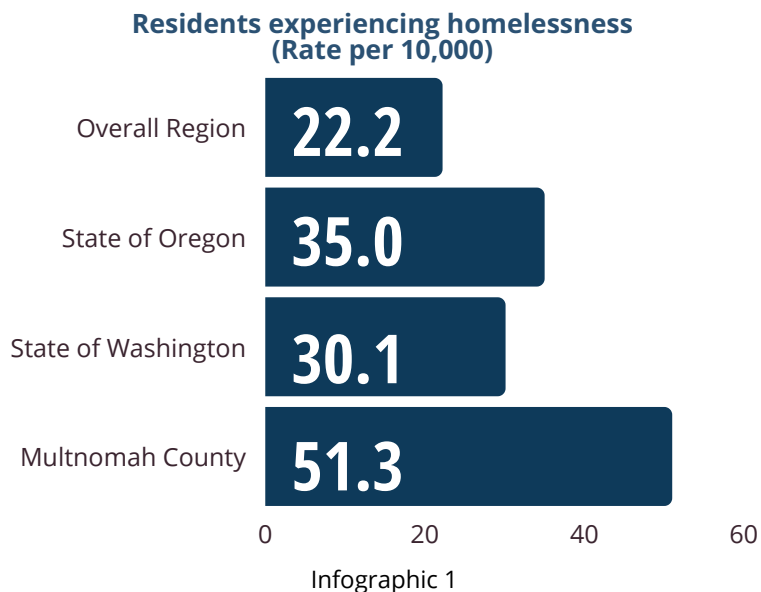
- While over half of survey participants (53%) reported they were satisfied or very satisfied with the safety of their community, people of color, LGBTQ2IA, and people with disabilities were less likely to feel the same way. Just 35% to 42% of the priority populations reported satisfaction (HCWC CHNA Community Survey).
- Violent crime, including homicide, criminal sexual assault, robbery, aggravated assault, and aggravated battery increased in the region. Multnomah has significantly higher violent crime rates compared to the region (FBI Crime Data Explorer, 2016-2020).
- Multnomah survey respondents were least likely to report feeling satisfied/very satisfied with the safety in their community (32%), compared to respondents from other counties. In Clark, Clackamas, and Washington, this rate was 58%, 59%, and 63% of respondents, respectively (HCWC CHNA Community Survey).

### Safe and Affordable Housing

- Access to safe and affordable housing was decreasing in the region, as indicated by the increasing rates of houselessness and the faster increase in housing costs, compared to median household income (American Community Survey (ACS), 2015-2019).
- While median household income was increasing, the cost of housing was increasing at a higher rate. This translates to more people experiencing challenges finding and keeping safe and affordable housing. This was particularly true for renters (ACS, 2015-2019).
- These data are supported by what is heard from community members—the need for safer, more affordable housing that is physically accessible (HCWC CHNA Community Engagement).

## Safe and Affordable Housing

Safe and affordable housing can provide a safe place for families to live, learn, grow, and form social bonds. The average number and rate of people experiencing houselessness in the region is generally lower at 22.2 per 10,000 people, compared to Oregon or Washington at 35.0 and 30.1, respectively.[4] Thus, for every 10,000 people in the region, there were about 22 people experiencing houselessness. Multnomah has significantly higher unhoused rates than the region at 51.3 per 10,000 people.



Since 2016, the total unhoused population in Oregon has increased 2.0 percentage points, from 33.0 to 35.0 per 10,000 people. This represents a 9.1% increase in the number of people unhoused, from 13,328 people in 2016 to 14,655 people in 2020, respectively.

Since 2016, the total unhoused population in Washington has increased by 1.0 percentage points, from 29.1 to 30.1 per 10,000 people. This represents a 10.0% increase in unhoused people, from 20,827 in 2016 to 22,923 in 2020, respectively.

Housing is often the single most significant expense for a family. When too much of a paycheck is allotted to paying rent or mortgage, this housing cost burden can force people to choose between paying for other basic needs, such as utilities, food, transportation, or medical care. Among all households in the region, the severe housing cost burden decreased two percentage points, from 16.5% in 2015 to 14.6% in 2019, respectively, while dropping one percentage point among renting households, from 24.4% to 23.4%, respectively.[5][6] While the median household income increased 16.1% between 2015 and 2019, respectively, the change in average rent rose 18.9% over the same period (from \$1,114 in 2015 to \$1,360 in 2019).[7][8]

Increase in median household income:  
2015 to 2019  
**16.1%**

Increase in average rent:  
2015 to 2019  
**18.9%**

[4]National Alliance to End Homelessness. 2022. Oregon. Accessed April 20, 2022.  
 [5]Severe housing cost burden is defined as the percent of households spending more than 50% of income on housing.  
 [6]American Community Survey. 2019. Tables B25070/25091: Gross Rent as a Percentage of Household Income in the Past 12 Months. US Census Bureau.  
 [7]American Community Survey. 2019. Table B19013 Median Household Income in the past 12 Months. US Census Bureau.  
 [8]American Community Survey. 2019. Table B25064 Median Gross Rent (Dollars). US Census Bureau.

Using data from the Rental Assistance Priority Index, Figure 9 on the page that follows indicates the need for rental assistance by Zip code. The level of need is based upon individuals' risk for unstable housing due to historical and COVID-19 risk factors.[9]

Community members throughout the region described how the lack of safe and affordable housing negatively affected their health and well-being and impacted their children, including their emotional health and success at school. They also described the community's need for more affordable housing options and physical accessibility for housing.

Community members described homeownership as a privilege; many mentioned the meaning and benefits of 'home.' Homeownership offers a sense of control over one's own life, freedom, empowerment, and security related to having a home.

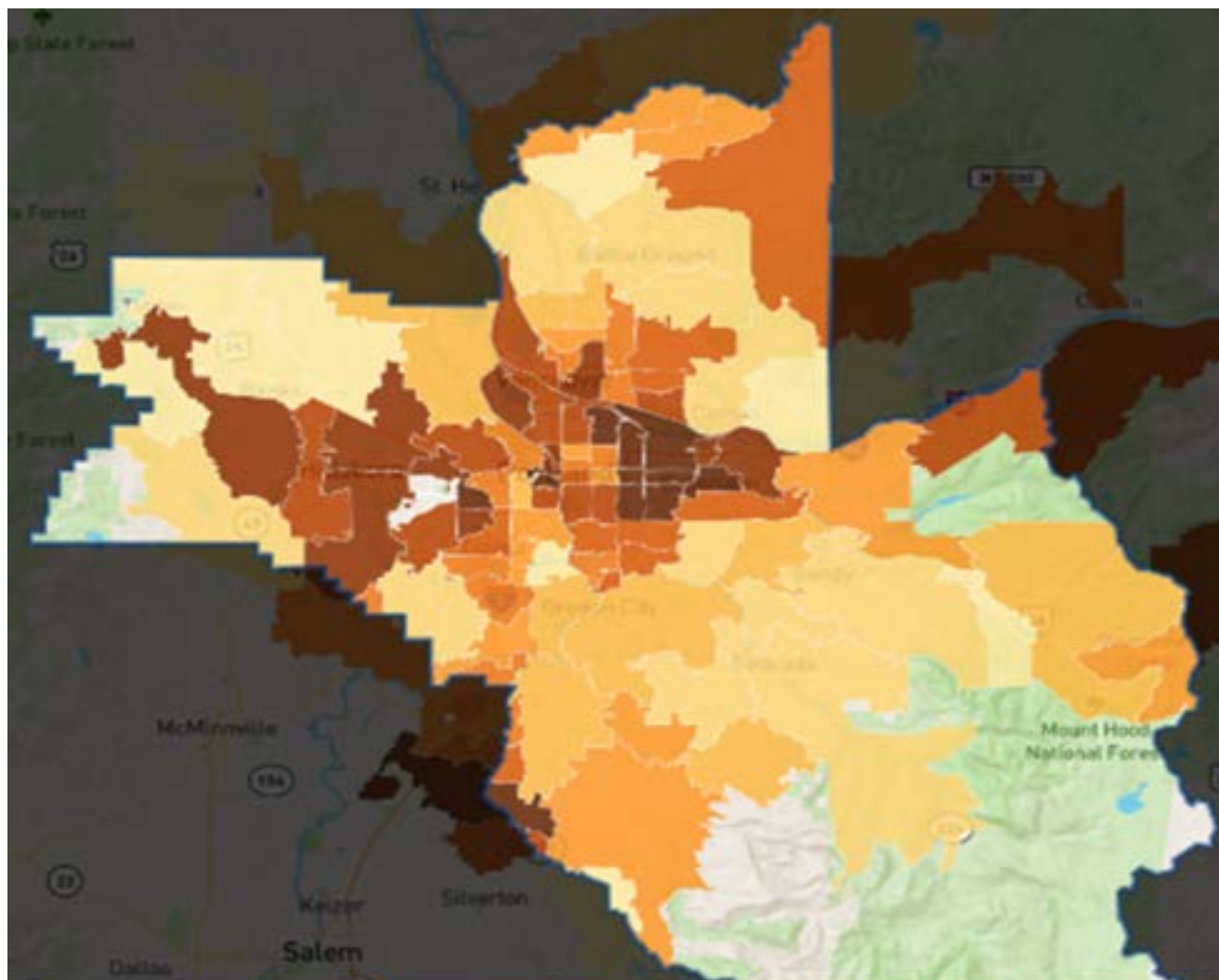
**“Neighbors and local businesses provided tremendous support during the challenges of this past year in the COVID 19 pandemic.**

Clackamas Community Survey Respondent

**I was able to connect to neighbors through little neighborhood get-togethers, go to COVID-safe outdoor events centering trans and queer people, collaborate with other disabled people online, and pool resources to buy things that none of us could afford alone. -**

Transgender Community Survey Respondent, Multnomah

[9] The index estimates the level of need in a census tract by measuring the prevalence of low-income renters who are at risk of experiencing housing instability and homelessness. To do this, it examines neighborhood conditions and demographics. For more information about the index, see: [https://www.urban.org/sites/default/files/2020/08/24/where\\_to\\_prioritize\\_emergency\\_rental\\_assistance\\_to\\_keep\\_renters\\_in\\_their\\_homes\\_technical\\_appendix.pdf](https://www.urban.org/sites/default/files/2020/08/24/where_to_prioritize_emergency_rental_assistance_to_keep_renters_in_their_homes_technical_appendix.pdf)



**FIGURE 9 NEED FOR RENTAL ASSISTANCE**

Dark brown map areas reflect areas with increased need for rental assistance and most at risk for unstable housing.

## Physical Safety in the Community

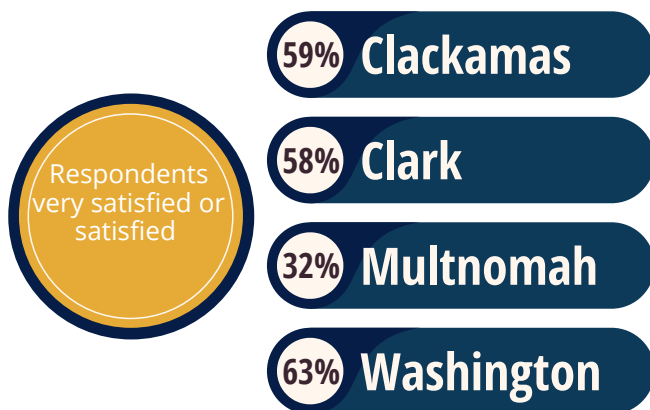
Whenever there is prevalent violent crime in a community, people may feel less safe. Higher crime rates can also deter residents from following healthy behaviors, such as exercising outdoors. Additionally, exposure to crime and violence is shown to increase stress, worsening high blood pressure and other stress-related disorders, including upper respiratory disease and asthma.[11] Regionally, from 2016 to 2020, the violent crime rate was 342.7 crimes per 100,000 residents. This rate is higher than both Washington and Oregon States, at 291.9 and 293.7, respectively.[12] The violent crime rate for the region has increased 13% in the last five years, from 302.8 to 342.7 crimes per 100,000 residents. The crime rate has not changed in the United States.

Multnomah experienced the highest rate at 541.0, Clark at 296.3, Washington at 222.6, and Clackamas at 185.4 crimes per 100,000 residents. The rate in Clark increased by 22% between 2016 and 2020, while increasing by 13% in the region.

As a result of systemic racism and other structural oppressions, racial and ethnic minorities and people with low incomes are more likely to live in neighborhoods with a higher risk of violence or other safety risks.[13] While over half of the CHNA community survey participants (53%) reported they were satisfied or very satisfied with the safety of their community, people of color, LGBTQ2IA, and people with disabilities were less likely to report the same. Protection from violence and safety as pedestrians were the main drivers for these community members.

By county, Multnomah survey respondents were least likely to report feeling satisfied/very satisfied with the safety in their community (32%), compared to respondents from other counties.

### SURVEY RESPONDENTS' PERCEPTIONS OF COMMUNITY SAFETY ALL RESPONDENTS 53%



Infographic 2

[11] Gould, Ingrid Ellen, Tod Mijanovich, and Keri-Nicole Dillman. 2016. "Neighborhood Effects on Health: Exploring the Links and Assessing the Evidence." Journal of Urban Affairs 391-408.

[12] FBI. 2016-2018. Uniform Crime Reporting Program. Hate crime statistics and self-reported victimization data were not identified for both Oregon and Washington. For purposes of this CHNA we used crime statistics from the FBI. It is important to acknowledge the racist history (and present) of this data source. Additionally, it is always important that the conditions behind the rise in crime (some are described in this CHNA) and the rise in crime itself are examined at the same time to avoid further inequities in the communities most impacted.

[13] Johnson, Sarah Lindstrom, Barry S. Solomon, Wendy C. Shields, Eileen M. McDonald, Lara B. McKenzie, and Andrea C. Gielen. 2009. "Neighborhood Violence and its Association with Mothers' Health: Assessing the Relative Importance of Perceived Safety and Exposure to Violence." Journal of Urban Health 86(4): 538-550.

Community members reflected on the importance of community safety related to their health. Not feeling safe deters them from obtaining services, such as grocery shopping, participating in outdoor activities, or getting the care they need. For other community members, the health burden of living in constant stress was associated with living in an unsafe neighborhood.

### Cultural Displacement Due to Gentrification

Gentrification is a process of neighborhood change resulting from wealthy, college-educated individuals moving to poor or working-class communities. Some areas of the region are seeing improvements due to local and federal programs that invest resources into areas to “revitalize” them.

One such program, the 2017 Federal Opportunity Zones, continues to promote the renewal of areas confronted with lost investment. While investments can improve neighborhood conditions, reduce crime rates, and increase property value, they come at the cost of increased police presence, as well as financially inaccessible housing options and the cost of living that pushes out long-time residents. It can equally foster adverse conditions associated with poorer health outcomes, such as separating social groups, loss of cultural organizations and neighborhood businesses, and increases in stress.

Displacement disproportionately impacts people of color, who are often pushed away before they can benefit from increased property values and opportunities in revitalized neighborhoods, as shown in Table 1. In both Oregon and Washington, the proportion of Black and Hispanic or Latino/a populations was higher in the designated opportunity zones than in all other regions. For example, in Oregon, the Hispanic or Latino/a population represents 17.6% of the people living in designated opportunity zones, higher than all of Oregon’s tracts at 11.6%. These populations have the potential to benefit from programs, such as the Opportunity Zones, if they have the resources to stay.

Table 1

### Average Percent of White, Black, and Hispanic/Latino/a Population

Demographic (average percent)	Oregon		Washington	
	Designated Opportunity Zones	All state census tracts	Designated Opportunity Zones	All state census tracts
White alone	70.3%	78.2%	62.6%	71.6%
Black alone	2.1%	1.7%	5.3%	3.4%
Hispanic/Latino/a	17.6%	11.6%	15.4%	11.3%

Source: Urban Institute, 2020. Population: The American Community Survey, 2015-2019 combined estimates.



Community members spoke about the issue of not owning land, displacement, and problems with gentrification. They also shared stories of having to relocate due to their inability to pay expensive mortgages and rent, and how this process can negatively impact their general health, mental health, and well-being.

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**“It is much too expensive to stay [in my current home] long-term. Finding a place I can afford quickly enough, that feels safe enough, is difficult.**

**Four places in over three years. This process is exhausting and expensive.” –**  
Washington Community Survey Respondent

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# Essential Community Services and Resources

 **All people**

should be afforded access to opportunities for education, employment, nutritious food, and transportation.

## Essential Community Services and Resources

### Educational Opportunity

- As a result of historical and ongoing racism, discrimination, and exclusion, the same educational opportunity does not exist for all. The likelihood of attaining at least a high school diploma is greater for some race and ethnicity groups, including White and multiracial groups. Hispanic or Latino/a and some other race/ethnicity groups were least likely (ACS, 2015-2019).
- Access to affordable and quality child care in the region is limited. While child care subsidies are available from state and other municipalities, families become ineligible at an income that is often far below the income required to pay the full cost of care (HCWC CHNA Community Engagement, Self-Sufficiency Standard).
- In 2015-2019, 49.4% of the region's 3- and 4-year-olds were enrolled in school. There were differences in preschool enrollment by county, with Multnomah experiencing a significantly higher rate at 56.4% compared to the region and Clark experiencing a significantly lower rate at 39.2% (ACS, 2015-2019).

### Virtual Resources

- Community members discussed opportunities created by providing increased virtual care. However, they also noted concerns about accessibility to this virtual care for all people (HCWC CHNA Community Engagement).
- As of January 2022, 26.1% adults in Oregon and 21.8% adults in Washington used telemedicine to access care. In both Oregon and Washington, one in five households (22.8% and 19.0%, respectively) use telemedicine for their child (Center for Disease Control's (CDC) Household Pulse Survey, 2022).
- Telemedicine was predominately used for mental health conditions (CDC Household Pulse Survey, 2022).
- Community members expressed how lack of Internet access had significant limitations in access to relevant educational materials and capacity to engage in civic happenings during the COVID-19 pandemic (HCWC CHNA Community Engagement).

### Cultural and Healthy Foods

- Access, defined using factors of proximity and affordability, to healthy and diverse foods was a core theme when community members discussed essential community resources (HCWC CHNA Community Engagement).
- In 2019, 20.5% of all residents in the region or 50,387 people were low income and experienced living more than one mile from a grocery store (USDA Food Access Research Atlas).

## Transportation

- Community members reported access to transportation, including both motor and non-motor transportation options, presents a daily challenge. This was particularly true among people with disabilities. Community members expressed a lack of transportation options, including opportunities to walk or bike, due to pedestrian and neighborhood safety concerns (HCWC CHNA Community Engagement).

## Economic Opportunity

- Economic support was the second most noted factor among community members required to improve and/or maintain their health and wellness after health care supports. Access to services and affordability are drivers of whether community members receive support (HCWC CHNA Community Survey).
- People of color and people with disabilities are historically more likely to experience barriers to employment. The unemployment rate among Black/African Americans and people with disabilities was nearly twice as high as the general population in both 2019 and 2021 (Bureau of Labor Statistics, ACS).
- In 2015-2019, 5.3% residents in the region were employed but remained in poverty. The average minimum wage in the region was \$13.30. The minimum wage was an inadequate economic support (ACS, 2015-2019).

## Essential Community Services and Resources

All people should be afforded access to opportunities for education, employment, nutritious food, and transportation. Access to essential community services and resources is foundational to ensuring a healthier community. Economic opportunity, social connection, and geography drive the services or resources available to a community. Having a living wage, secure employment, and education can strengthen access to health care. Increased choice in housing, education, health care, childcare, and food also impact individual and community health.

### Five priority issues emerged in the area of essential community services and resources:

- Economic opportunity
- Educational opportunity
- Culturally-specific and healthy foods
- Transportation
- Virtual resources



## Economic Opportunity

Economic opportunity refers to the belief in upward mobility for everyone. Excellent and diverse jobs within a community result in improved health. Income allows for the purchase of health insurance and medical care and provides options for healthy lifestyle choices, such as nutritious food and safe housing. Families experiencing poverty in the region significantly decreased 23.7% between 2010-2014 and 2015-2019, respectively, from 13.8% to 10.5%. Nearly half (4.8%) of these families lived in deep poverty in 2015-2019.[14]

The ongoing stress and challenges associated with low incomes can result in numerous impacts on both physical and mental health. For example:

- Chronic illness is more likely to affect those with the lowest incomes and children in low-income families are less healthy than their high-income counterparts.[15]
- Low-income mothers are more likely to have pre-term or low birthweight babies and are at higher risk for chronic diseases and behavioral problems.[16]

When community members were asked to think about the times over the past year when they required and received the support necessary to improve and maintain their health and wellness, economic support was the second most noted support among five types of support (including economic; health care; support to feel safe or well in my neighborhood; social and community connection; and education). Access and affordability are drivers of whether support was received.

### Employment Status by Race and Ethnicity, 2021

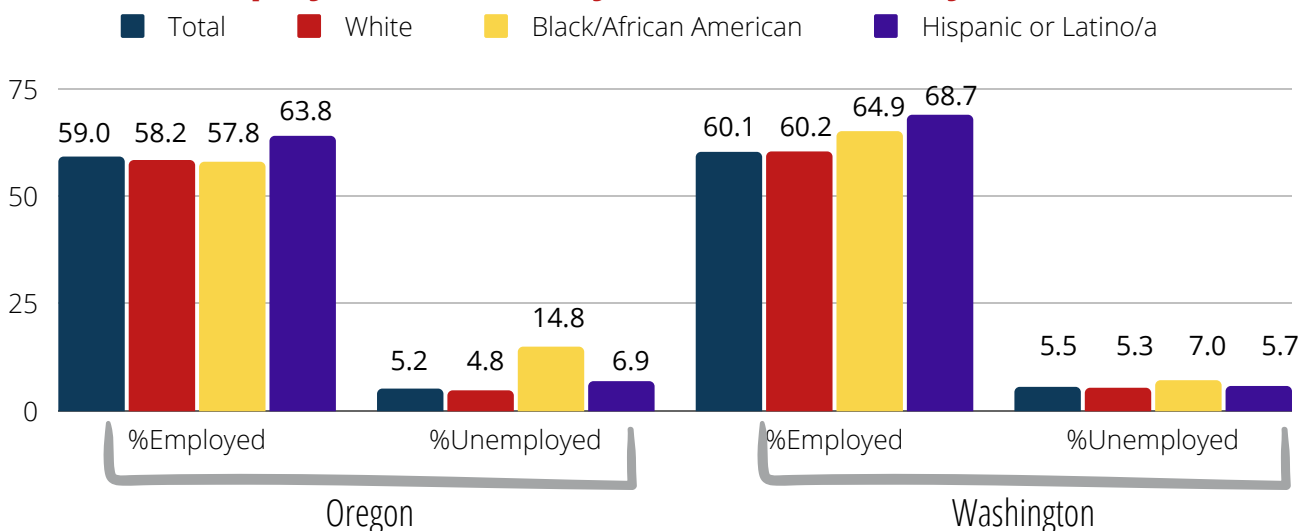


FIGURE 10 Employment Status by Race and Ethnicity, 2021

Note: County data by race and ethnicity are not yet available for 2021. Source: Bureau of Labor Statistics. Geographic Profile of Employment and Unemployment, 2021. Retrieved on 2/9/2022.

[14]American Community Survey. 2019. "Table C17002: Ratio of Income to Poverty Level in the Past 12 Months." United States Census Bureau. Deep poverty is defined as a state in which an individual household's annual income falls below 50 percent of the poverty line.

[15]Cunningham, Peter J. 2018. "Why Even Healthy Low-Income People Have Greater Health Risks Than Higher-Income People." The Commonwealth Fund, September 27.

[16]Braveman, P, S Egerter, and C Barclay. 2011. "Income, Wealth and Health." Robert Wood Johnson Foundation, April 1.

One-third of the community members’ stories described the economic support required and received as “easy to access” and “high quality.” Among community members who shared stories of needing but not receiving economic support, the economic support was not easy to access (easy to obtain) or not affordable. As shown in Figure 10 on the previous page, non-Hispanic Black/African Americans were more likely to be unemployed than other race and ethnicity groups in Oregon and Washington. This was true at all levels of educational attainment.[17]

This disparity among people of color and people with disabilities was true before the COVID-19 pandemic. The regional unemployment rate in 2015-2019 was 4.7%.[18] Among people with any disability, the unemployment rate doubled to 10.8%. Black/African American (8.6%), American Indian and Alaska Natives (8.1%), and Multiracial (7.4%) groups experienced higher rates of unemployment, compared to the total population.[19]

This meant that these groups were also underrepresented in the workforce. Non-White race and ethnicity groups were less likely to be represented in the workforce than in the population. For example, in Oregon’s State workforce in 2019, Hispanic/Latino/a workers represented the largest non-White racial group. Still, they were the most underrepresented group across Oregon’s workforce (8% of its workforce but 13% of Oregon’s working-age population).[20]

In 2015-2019, 5.3% of residents in the region were employed but remained in poverty.[21] The average minimum wage in the area is \$13.30. According to the Center for Women’s Welfare Self-Sufficiency Standard[22], the minimum wage to be a single self-sufficient adult in the region is higher at \$16.22. This increases to \$31.90 if that adult is caring for an infant. The current minimum wage is inadequate economic support for the region’s residents.

### Minimum Wage Compared to Sufficiency Wage



[17]Economic Policy Institute. 2019. State of Working America Data Library. Accessed April 21, 2022.

[18][19] American Community Survey, 2015-2019 Combined Estimates, Table S2301.


American Community Survey. 2019. "Table B17005: Poverty Status by in the Past 12 Months of Individuals by Sex and Employment Status." US Census Bureau.

[20]Hispanic/Latino/a workers represent the largest nonwhite racial group in the workforce but are the most underrepresented group across the State workforce (8% of the State’s workforce but 13% of Oregon’s population).

[21]American Community Survey. 2019. Table B17005: Poverty Status by in the Past 12 Months of Individuals by Sex and Employment Status. US Census Bureau

[22]Center for Women’s Welfare, University of Washington. Available at <https://selfsufficiencystandard.org/>

Community members highlighted that it can be challenging to find employment where the salary compensates for the subsequent loss of government benefits, known as a “benefits cliff.” When income increases, individuals and families sometimes lose some or all economic supports (e.g., Supplemental Nutrition Assistance Program [SNAP]; school nutrition programs; health care; childcare assistance; Temporary Assistance for Needy Families [TANF]; and housing). Community members described the value of career development training and employment pipeline opportunities. These opportunities were thought to help bring more individuals into the formal workforce and provide a living wage and professional advancement opportunities. There was a sense there were insufficient kinds of these options.



**“I can get a job and I have a master’s degree. The problem is being able to figure out how to make enough money to balance out losing those benefits, while being able to work. Quite frankly, I would need at least 50 grand a year starting to be able to provide for my medical and health needs and my financial needs.” –**

Community Session Participant with a Physical Disability



## Educational Opportunity

Educational opportunity refers to the belief in quality education for everyone. Education benefits individuals and society, with more education linked to higher incomes, better employment options, and increased social support.[22] Historical and ongoing racism, discrimination, and exclusion prevent a quality educational opportunity for all.[23] As shown in Figure 11, the likelihood of having at least a high school diploma is more significant for some race and ethnicity groups, including White and multiracial groups. Some other race and Hispanic/Latino/a groups were least likely.

### Adults Age 25 or Older With at Least a High School Diploma by Race and Ethnicity

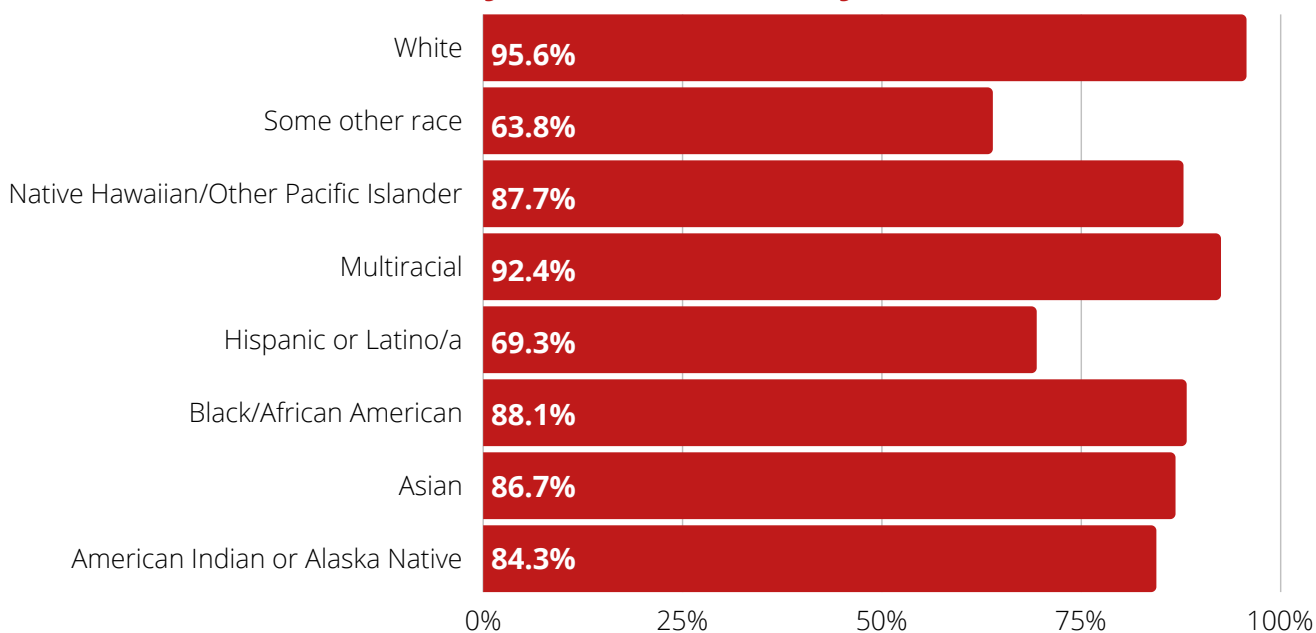


FIGURE 11 Adults Age 25 or Older With at Least a High School Diploma by Race and Ethnicity (Source: ACS, 2015-2019)

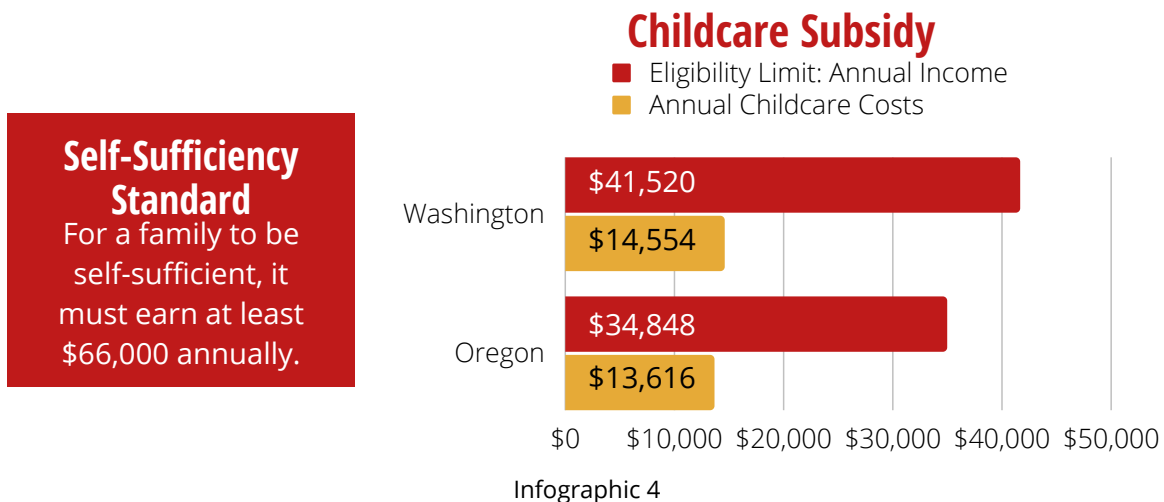
This disparity in having a high school diploma begins, in part, with access to early childhood education. Childcare is critical to young children’s early development and supports caregivers with their education, work, or health care needs. It also improves kindergarten readiness. Children who enter school with early skills are more likely than their peers without such skills to achieve academic success, attain higher levels of education, and secure employment.

[22]Virginia Commonwealth University Center on Society and Health. 2015. "Education: It Matters More to Health and Ever Before." <https://societyhealth.vcu.edu/work/the-projects/education-it-matters-more-to-health-than-ever-before.html>.

[23]Rothstein, Richard. 2014. "The Racial Achievement Gap, Segregated Schools, and Segregated Neighborhoods: A constitutional Insult. Race and Social Problems." *Race and Social Problems*, 6(4).

In 2015-2019, prior to the pandemic, 49.4% of the region’s three- and four-year-old children were enrolled in school. While this reflected a (non-significant) increase from 45.5% in 2010 through 2014, enrollment dropped for the first time in 11 years to 46.6% in 2016 through 2020. [24] In 2015-2019, there were differences in preschool enrollment by county, with Multnomah experiencing a significantly higher rate at 56.4%, compared to the region, and Clark experiencing a substantially lower rate at 39.2%.

While COVID-19 is a recent barrier to preschool enrollment, preschool costs are not new and worsened with the pandemic. In both states, the average annual cost of infant care was greater than the average cost of one year of rent. While childcare subsidies are available from state and other municipalities, families become ineligible for assistance at an income level that is often far below the threshold required to pay the total cost of childcare. Based upon the Self-Sufficiency Standard, the annual salary for self-sufficiency for an individual with one infant in the region is approximately \$66,000. In Washington, a family of this size would lose assistance earning a salary of \$41,520.[25] In Oregon, a family of this composition cannot have an annual salary that exceeds \$34,848 at the initial point of qualification (\$51,516 at renewal).[26]



This means that childcare costs create a gap between families who can access subsidies versus families who can pay out-of-pocket. Challenges in the availability of high-quality care intensify this cost. Before the pandemic, the task force estimated four children under the age of 12 for every childcare slot. A quarter of childcare facilities in Washington closed by August 2020.[26] As of March 2020, there were seven infants and toddlers for each childcare slot in Oregon.[27]

Community input spoke to the value of education across the age span, specifically highlighting the critical role that access to high-quality childcare and early learning (for children under five) plays a significant role in a family’s life.

[24]American Community Survey. 2015-2019 Combined Estimate. "B14003: Percentage of 3- and 4-year-olds enrolled in school." US Census Bureau.

[25]WA State Department of Children Youth and Families. 2022. Working Connections Child Care. Accessed April 21, 2022.

[26]OR Department of Human Services. 2022. Child Care Assistance: Information for Families. March 1. Accessed April 21, 2022.

[25]Economic Policy Institute. 2020. Childcare Costs in the United States

[26]Kunkler, Aaron. 2021. "Child care task force issues legislative recommendations." Washington State Wire, August 25.

[27]Pratt, Megan, and Michaella Sektnan. 2021. Oregon’s Child Care Deserts 2020: Mapping Supply by Age Group and Percentage of Publicly Funded Slots. Oregon State University, College of Public Health and Human Sciences, Oregon Child Care Research Partnership.

## Culturally-Specific and Healthy Foods

There is strong evidence that living far away from a grocery store is a health risk. Studies have found that wealthy urban communities have several supermarkets, with an abundance of fresh fruits and produce, whereas predominantly low-income and minority communities do not; they must shop at convenience stores or smaller grocery stores that lack choices for healthy food options.

In 2019, as shown in Figure 12, 2.5% of all residents, or 50,387 people, were low-income and experienced living far away from a grocery store.[28] Socioeconomic barriers that come with living in poverty, such as lack of reliable transportation necessary to visit a grocery store, make obtaining food for this population more difficult.

Food insecurity means that a person may lack access, at times, to enough food for an active, healthy life and has limited or uncertain availability of healthy foods.[29] The COVID-19 pandemic has impacted food insecurity in the region. As shown in Figure 13, data suggest:

- Children experienced greater food insecurity compared to adults.
- There was geographic variation in the rates of food insecurity.
- Food insecurity was returning to pre-pandemic levels, as shown in 2021 projected data.[30]

### FOOD ACCESS: NUMBER OF LOW-INCOME RESIDENTS WHO EXPERIENCE LIVING FAR AWAY FROM A GROCERY STORE, 2019

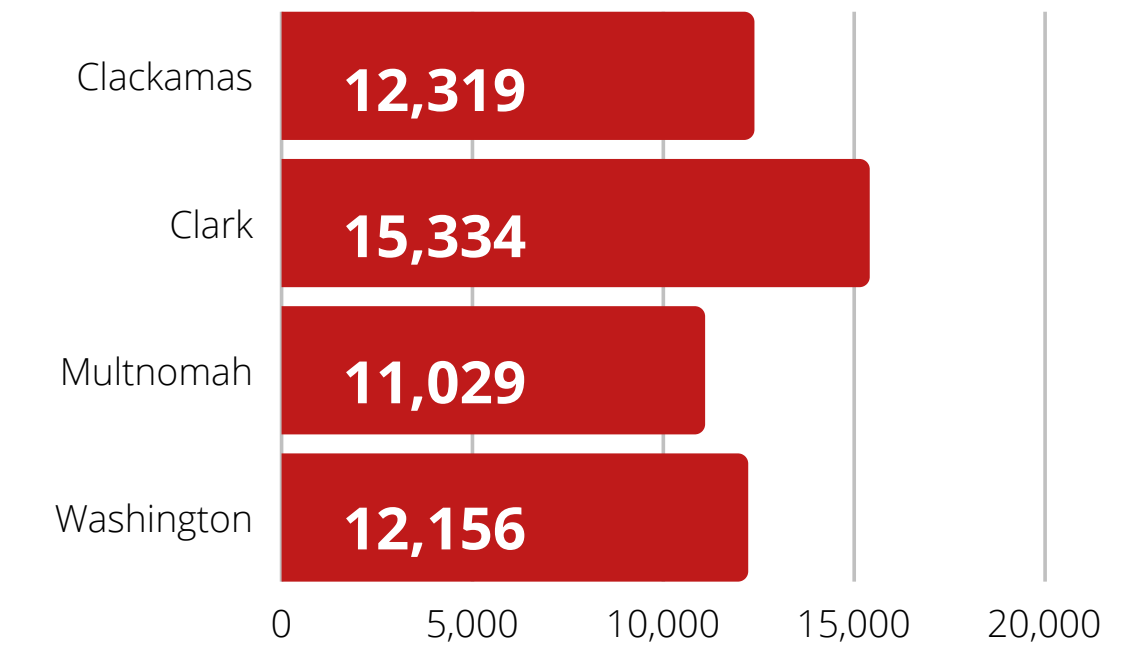


FIGURE 12 Food Access: Number of Low-Income Residents Living Far Away from a Grocery Store, 2019

[28]Living far away from a grocery store is defined as “being low-income and further than one mile from a supermarket (urban) or twenty miles (rural).” Source: USDA Food Access Research Atlas.

[29][30]USDA Feeding America. 2021. Feeding America Highlights Public/Private Partnership That Helped Mitigate Food Insecurity in 2020. September 8. Accessed April 21, 2022. <https://www.feedingamerica.org/about-us/press-room/USDA-food-security-report-2020>.

### PERCENT OF POPULATION WITH FOOD INSECURITY

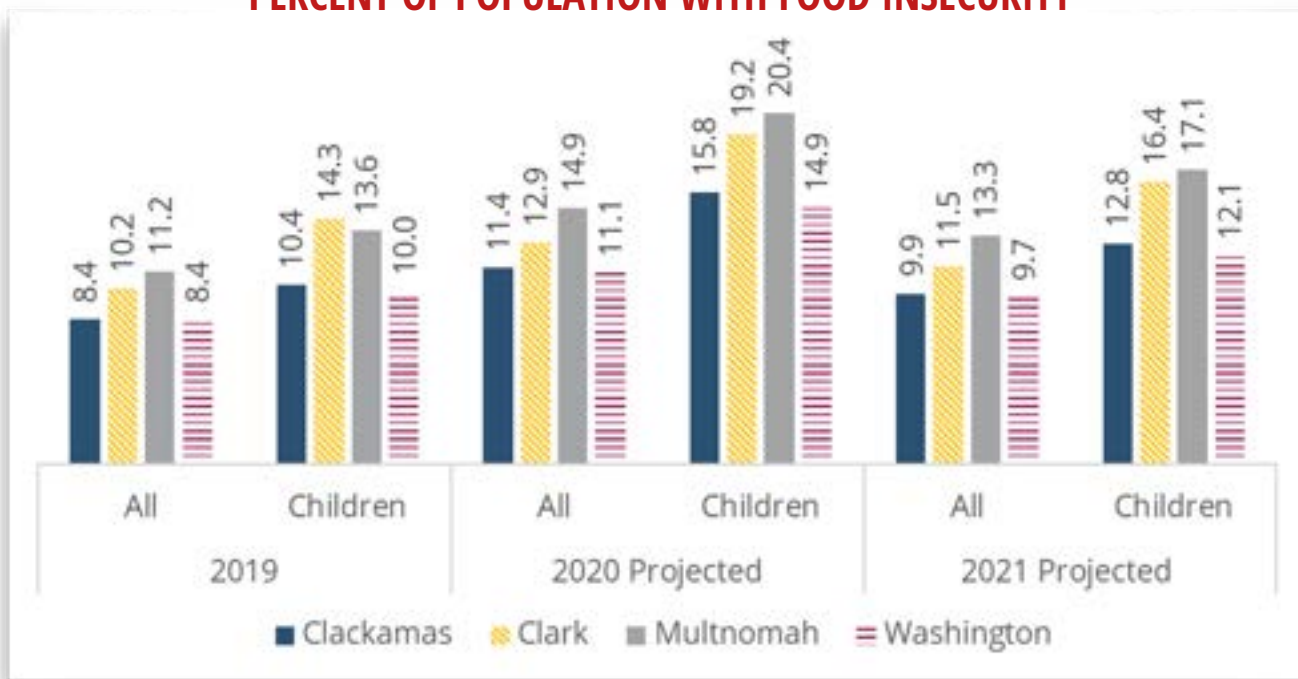


FIGURE 13 Percent of Population with Food Insecurity

### PERCENT OF HOUSEHOLDS WITH INCOME IN THE PAST 12 MONTHS BELOW THE POVERTY LEVEL WHO DID NOT RECEIVE FOOD STAMPS (SNAP)

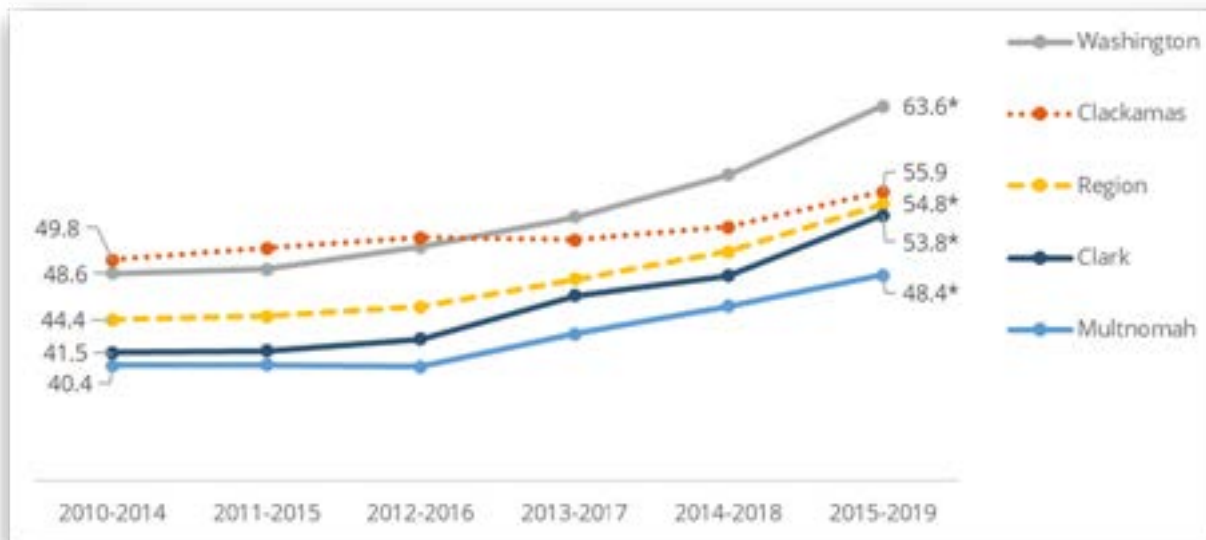


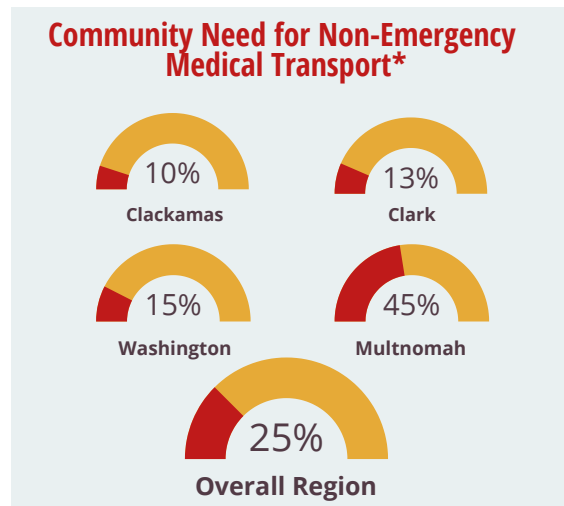
FIGURE 14 Percent of Households with Income in the Past 12 Months Below the Poverty Level Who Did Not Receive Food Stamps

\*Significantly higher rate in 2015-2019 compared to 2010-2014. Source: American Community Survey (Table B22003). Source: USDA Feeding America. 2021. Feeding America Highlights Public/Private Partnership That Helped Mitigate Food Insecurity in 2020. September 8. Accessed April 21, 2022. <https://www.feedingamerica.org/about-us/press-room/USDA-food-security-report-2020>.

## Transportation

Walking, biking, and public transportation in neighborhoods safe for pedestrians (e.g., sidewalks, crosswalks) and with access to outdoor spaces for recreation enable people to get where they need to go. It can also reduce their exposure to air and noise pollution, minimize the risk and severity of crashes, and improve access to various resources that contribute to health, including parks, trails, medical and social services, jobs, and schools.[31]

Community members expressed a lack of transportation options, including opportunities to walk or bike, due to pedestrian and neighborhood safety concerns. Specifically, the lack of transportation to access non-emergency health care was a central theme among community members. This was particularly true among people living with a disability. Infographic 5 shows the percentage of people who have self-reported living difficulty or self-care difficulty who required non-emergency medical transportation. In summary, 25% of the region had a significant need for non-emergency transport. This need was highest in Multnomah at 45%.



Infographic 5

\*Community is defined by census tract, which is the smallest geographic region defined for the purpose of taking a census.

## Virtual Resources

Community members spoke of the opportunities created by providing increased virtual care (e.g., more access to a broad range of providers). However, they also noted concerns about accessibility for those who might have less comfort navigating virtual spaces and do not have reliable access to broadband Internet. The percentage of households in the region without access to the Internet was decreasing. In 2013, 13.6% or 88,897 households did not have access to the Internet. In 2019, it was 6.1% or 69,136 households.

There was a significant geographic disparity. In 2019, Clackamas and Multnomah had significantly more households with no access to the Internet, compared to the region. Washington had substantially less.[32]

The shift to offering health services virtually, known as telehealth or telemedicine, increased rapidly because of the COVID-19 pandemic and the need to limit in-person contact. Telemedicine use in Oregon was higher, compared to the United States and Washington, according to the Center for Disease Control's Household Pulse Survey.[33] In Oregon, as of January 2022, 26.1% of adults used telemedicine to access care and 21.8% of adults in Washington in the four weeks prior. In both Oregon and Washington, 22.8% and 19.0%, respectively, families used telemedicine to access care for their child in the four weeks prior.

### Households without Access to Reliable Internet Service



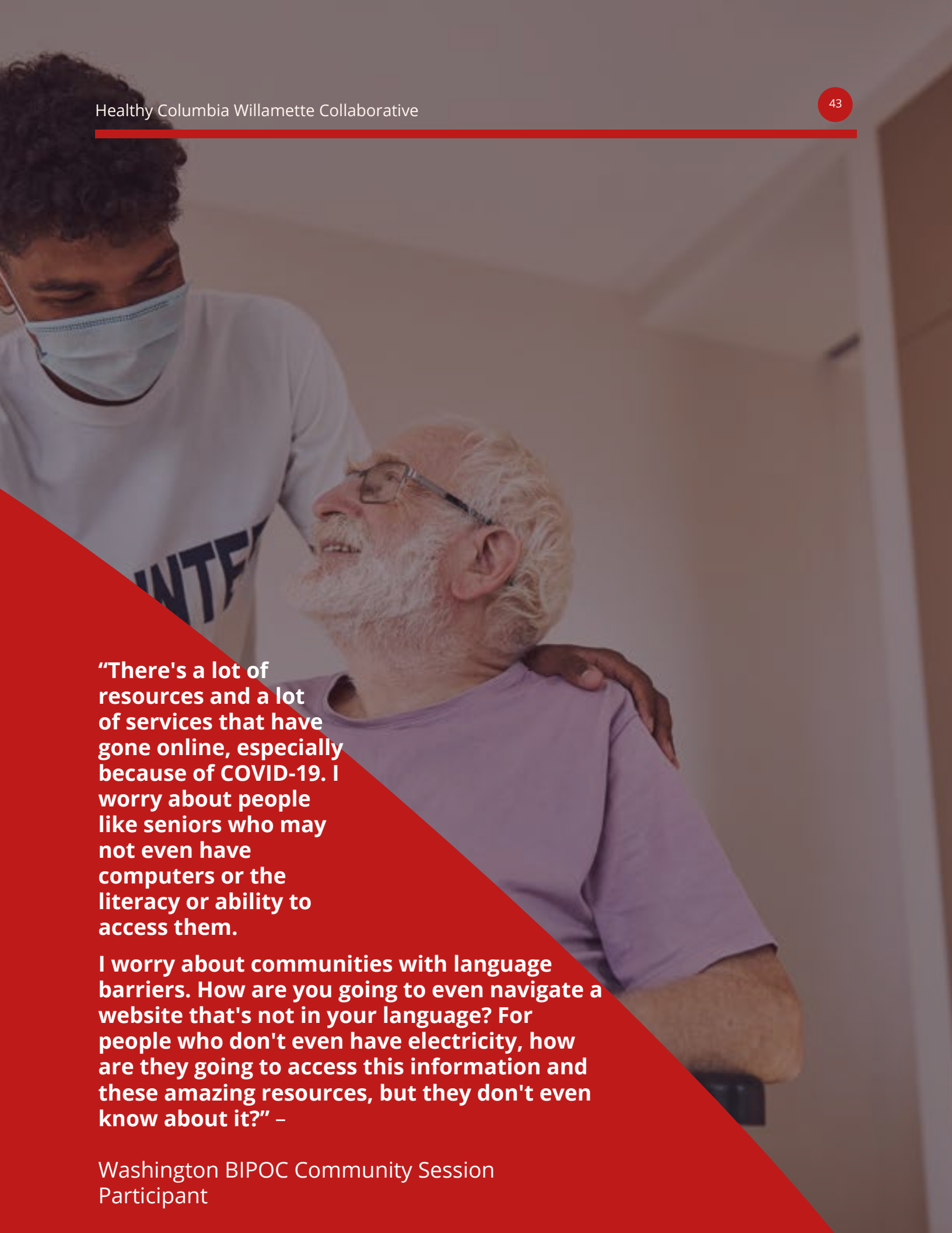
In 2013, 13.6% of households in the region did not have access to Internet service. That percentage dropped to 6.1% in 2019.

Infographic 6

[31]Raynault, Eloisa, and Ed Christopher. 2013. "How Does Transportation Affect Public Health." U.S. Department of Transportation Federal Highway Administration Public Roads, May/June: Vol. 76 No. 6.

[32]American Community Survey. 2019 Combined Estimate. Table: B28002: Presence and Types of Internet Subscriptions in Household.

[33]Centers for Disease Control and Prevention. 2022. "Telemedicine Use in the Last 4 Weeks." April 20. Accessed April 21, 2022.



**“There's a lot of resources and a lot of services that have gone online, especially because of COVID-19. I worry about people like seniors who may not even have computers or the literacy or ability to access them.**

**I worry about communities with language barriers. How are you going to even navigate a website that's not in your language? For people who don't even have electricity, how are they going to access this information and these amazing resources, but they don't even know about it?” -**

Washington BIPOC Community Session  
Participant

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# Access to Culturally- and Linguistically- Responsive Health Care



## All people

should be afforded access to health care that aligns with their cultural, behavioral, and communication needs.

# Access to Culturally- and Linguistically-Responsive Health Care

## Access to Affordable Healthcare

- In the region, residents without health insurance decreased by more than half from 13.1% or 277,194 residents in 2010-2014, to 6.0% or 136,662 residents in 2015-2019. However, geographic, socioeconomic, and race/ethnic disparities persist (ACS).

## Culturally- and Linguistically-Responsive Health Care

- Community members believe that having a culturally- and linguistically-responsive workforce is important to a healthier community, yet the region's health care work does not match the region's diversity (HCWC CHNA Engagement Sessions).
- Ability to provide care in other languages is limited, with only 20% of Oregon's health care workforce reporting they speak a language other than English, of which only 9% report speaking a language other than English with a patient.
- People of color, except for providers of Asian descent, tend to be underrepresented, relative to Oregon's and Washington's population among primary care, behavioral health, and oral health care professionals (OHA Office of Analytics 2021, WA Medical Commission, 2019).
- Among BIPOC survey respondents, barriers to care among community members related to understanding and finding health care information included not knowing the services or resources available, complicated application forms, and language barriers (HCWC CHNA Community Survey).
- In the region, 21% or 500,000 people speak a language other than English in 2015-2019 (ACS).
- Among people who speak a language other than English, 41% said they speak English very well. This decreases to approximately 30% of people who speak a language who are not Spanish- or English-speaking. Efforts are needed to ensure individuals with limited English proficiency are served with health information and resources (ACS).

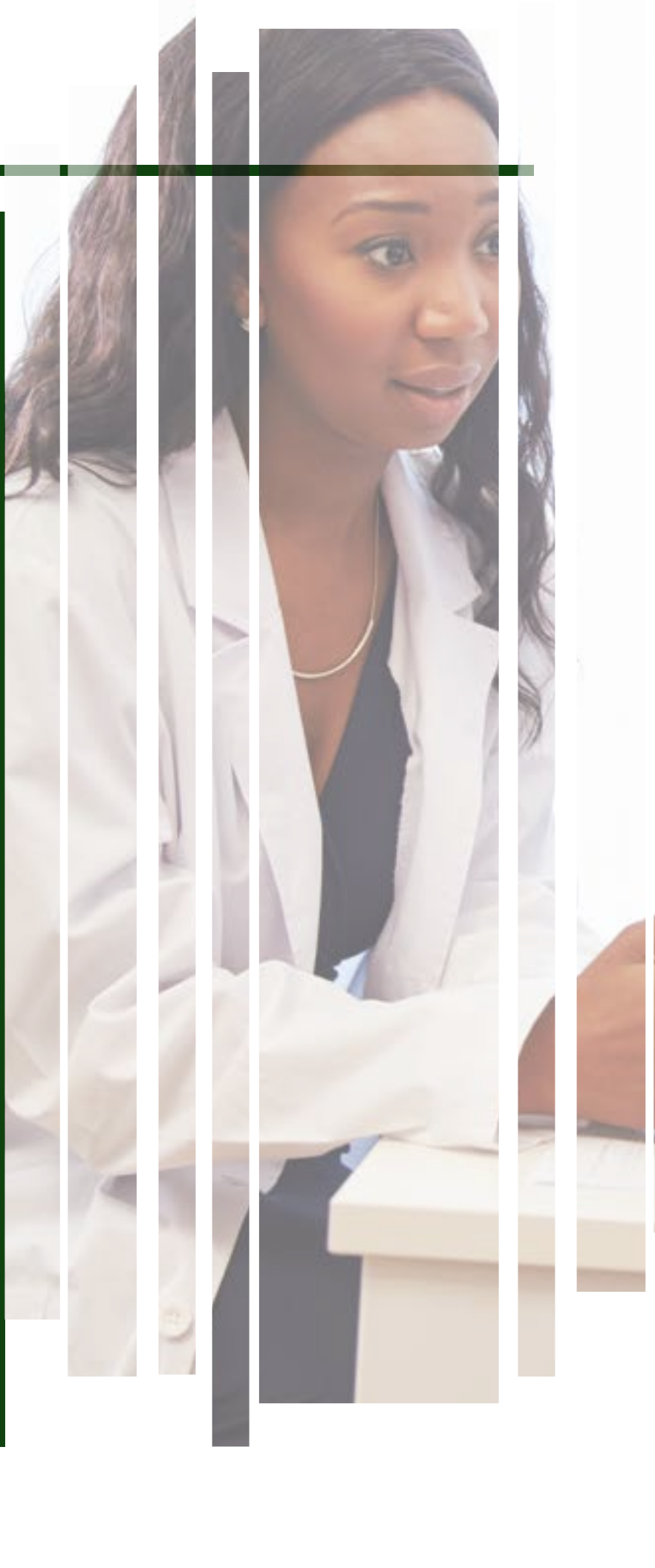
## Trauma-Informed Care

- Community members expressed their desire for health care that is attentive to healing marginalized communities' experiences, past traumas, and historical inequities (HCWC CHNA Engagement Sessions).
- While 13% of community survey respondents reported being discriminated against by the health care system, this increased to between 20% and 30% among the CHNA's priority populations (HCWC CHNA Community Survey).



## Delayed or Avoided Health Care Due to Trust

- The CHNA's priority populations reported delaying obtaining health care due to fear or discomfort at nearly twice the rate of all respondents, and were more likely to report lack of trust with the health care system (HCWC CHNA Community Survey).
- Age, experiencing a specific health condition, and experiencing a disability were the top three reasons respondents avoided or delayed health care. This was due to worries or concerns they would not be taken seriously or treated fairly (HCWC CHNA Community Survey).



## Access to Culturally- and Linguistically-Responsive Health Care

All people should be afforded access to health care that aligns with their cultural, behavioral, and communication needs. Community members reported a desire for health care not focused on clinical needs alone. Instead, health care should be holistic, person-centered, and community-centered. Social, economic, and cultural factors influence the ways in which people seek and receive care. A health care system that is aware of and reflective of these factors will improve well-being and health and increase access to care.

### Four priority issues emerged in access to culturally- and linguistically-responsive health care:

- Access to affordable health care
- Culturally- and linguistically-responsive health care
- Trauma-informed care
- Delayed or avoided health care

## Affordable Health Care

Health insurance makes it easier to obtain preventive services for chronic conditions, such as diabetes, heart disease, or cancer. Health insurance makes it easier for children to obtain care for conditions, such as asthma or preventive dental care, immunizations, and well-child visits.[34]

In the region, residents without health insurance decreased nearly half from 13.1% or 277,194 residents in 2010-2014, to 6.0% or 136,662 residents in 2015-2019.[35] This decrease was primarily due to the Affordable Care Act and the expansion of Medicaid.[36] Despite this improvement, gaps include:

- Multnomah residents experienced a significantly higher uninsured rate of 6.7% than the region. [37]
- Community members lacking health insurance experienced lower median household incomes and less education than residents with insurance.[37]

As shown in Figure 16 on the page that follows, regionally, people of color (except for Asian populations) were disproportionately represented in the uninsured population, compared to the general population. This was particularly true for the Hispanic/Latino/a populations. This is likely due to structural barriers regarding Medicaid eligibility and citizenship status.[38]

[34]Office of Disease Prevention and Health Promotion. 2022. "HealthyPeople.gov." Access to Health Services. February 6. Accessed April 21, 2022. <https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Access-to-Health-Services>.

[35]American Community Survey. 2015-2019 Combined Estimate. "B27001/C27001: Health Insurance Coverage Status by Sex by Age." United States Census Bureau.

[36]U.S. Department of Health & Human Services. 2022. About the Affordable Care Act. March 17. Accessed April 21, 2022. <https://www.hhs.gov/healthcare/about-the-aca/index.html>.

[37]American Community Survey. 2015-2019 Combined Estimate. "Table S2702: Selected Characteristics of the Uninsured in the United States." United States Census Bureau.

[38]Artiga, Samantha, Latoya Hill, and Anthony Damico. 2021. "Health Coverage by Race and Ethnicity, 2010-2019." KFF, June 16.

## REGIONAL PERCENT OF THE POPULATION AND UNINSURED BY RACE AND ETHNICITY, 2015-2019

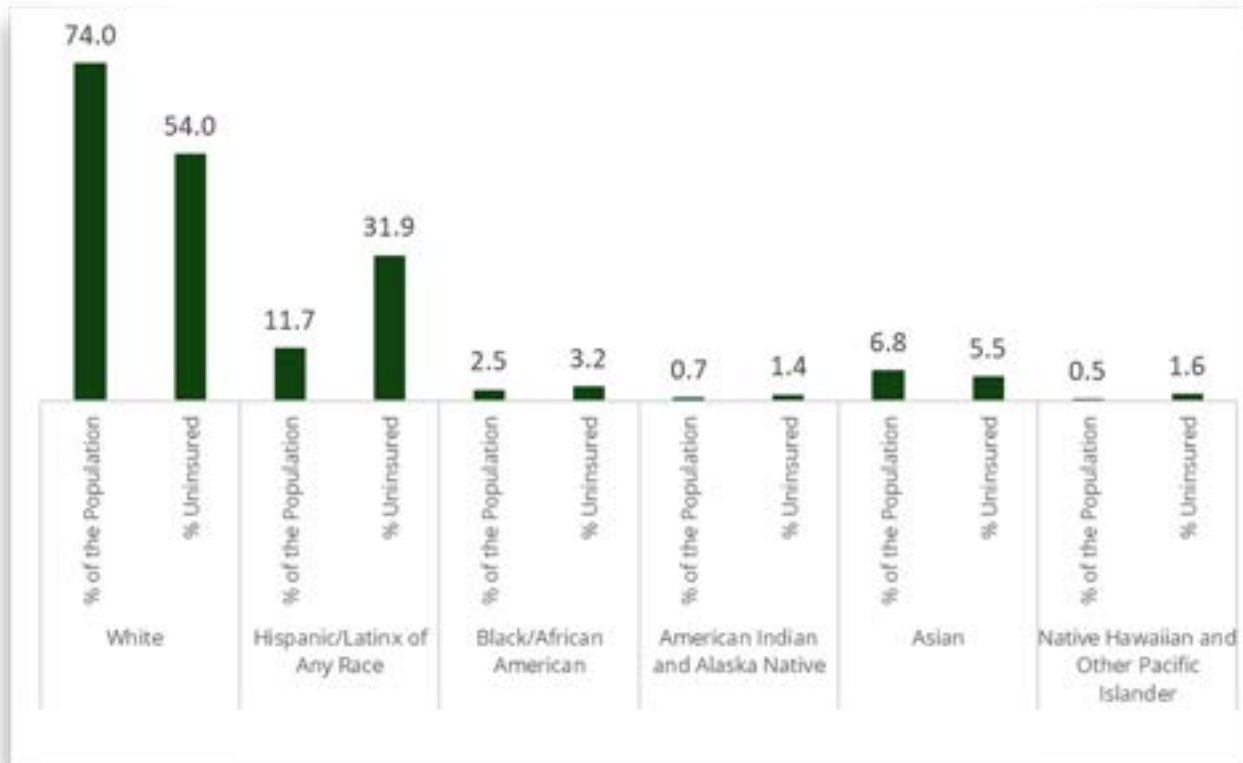


FIGURE 16 Regional Uninsured Rate by Race and Ethnicity

## Culturally- and Linguistically-Responsive Health Care

Access to care is challenged by the lack of culturally- and linguistically-responsive health care services and supports. This includes a lack of translation of written materials, the availability of materials for persons who have visual or audio support needs, and inadequate interpretation services. Community members reported wanting to be cared for by health care providers who have shared experiences, cultures, and languages. They also shared that training alone in cultural competency is not enough.

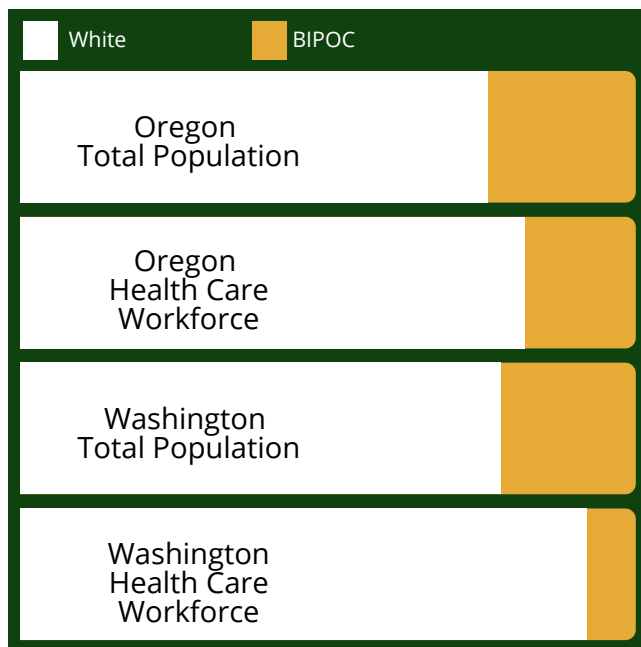
Oregon and Washington State data show that cultural and linguistic representation in the workforce does not reflect the region’s residents. In 2020, Oregon’s licensed health care workforce was less racially and ethnically diverse than the population being served.[39]

[39] Oregon Health Authority Office of Health Analytics. 2021. The Diversity of Oregon’s Licensed Health Care Workforce. Oregon Health Authority Office of Health Analytics.

People of color, except for providers of Asian descent, tended to be under-represented, relative to Oregon’s and Washington’s populations, among primary care, behavioral health, and oral health care professionals. [40] For example, while 76% of Oregon’s population was White, the health care workforce was 82% White in 2020. In Washington, 8% of Washington’s providers were BIPOC (not including Asian descent), while 22% of Washington’s population were BIPOC in 2018.[41][42]

Regarding language, 20% of Oregon’s health care professionals reported speaking languages other than English; however, only 11% reported advanced skills or being a native speaker of another language. Of this group, 9% reported using a language other than English with a patient.

Community members expressed that under-representation was, in part, due to the barriers experienced by BIPOC students to finishing their studies, including less economic and social support necessary to continue a career and attain a doctoral degree.



INFOGRAPHIC 7

**“We don’t have providers who speak our language, who share our own experiences, who have our lived experiences. At the end of the day, when we go to the doctor and we have an interpreter there, the interpreter does everything they can to translate and to interpret what we are feeling, but it’s not enough. It’s never like having a provider who speaks your own language and can deliver that.” – Muslim Community Session Participant**

Language and literacy are central to understanding health information and navigation. Twenty-one percent (21%) or 500,000 people speak a language other than English in the region. Figure 17 shows that 68% of people speak a language other than English and speak English well. This suggests great diversity in the language spoken within the region and the bi-lingual capacity for English.

However, only 31% (137,867) of people felt they could speak English very well among people who speak a language other than English or Spanish. Simplifying health information for people with limited English is one approach to addressing this language gap and improving access to linguistically and culturally-responsive health care.

[40] Oregon Health Authority Office of Health Analytics. 2021. The Diversity of Oregon’s Licensed Health Care Workforce. Oregon Health Authority Office of Health Analytics.  
 [41] Washington Medical Commission. 2019. Physician Demographic Census Aggregate Report. Report, Olympia, Washington: Washington Medical Commission.  
 [42] Oregon Health Authority. 2021. Office of Health Analytics. January. Accessed April 21, 2022.

## NUMBER OF PEOPLE (5 YEARS AND OLDER) WHO SPEAK ANOTHER LANGUAGE AND SPEAK ENGLISH VERY WELL

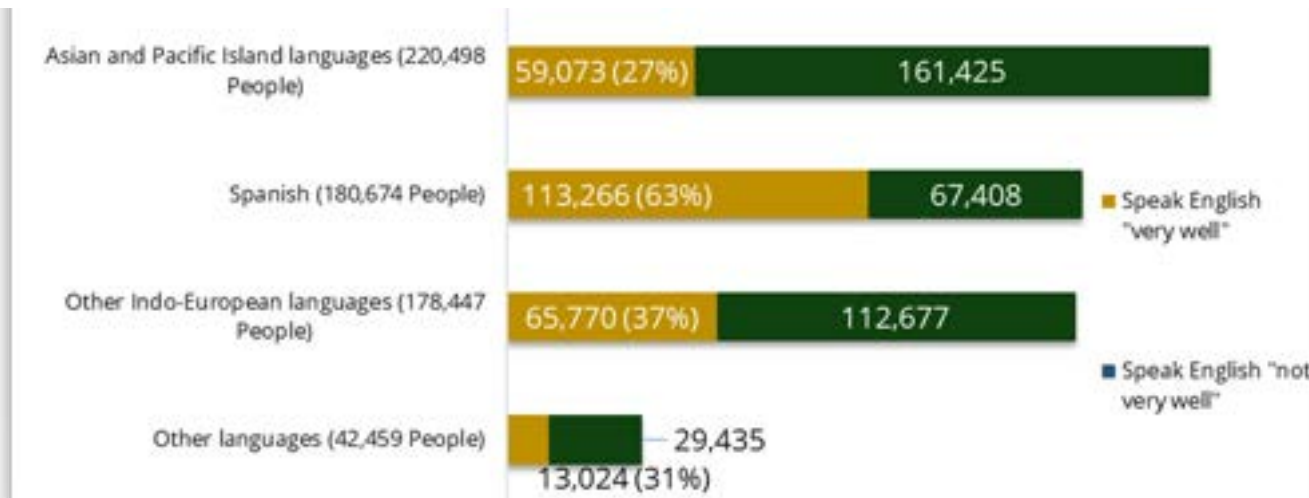


FIGURE 17 Language Spoken

Note: A limitation of the data source is the combination of people who speak Asian and Pacific Islander languages.  
 Source: American Community Survey, Combined 2015-2019 estimates.

## Trauma-Informed Care

Surveyed community members shared whether the health care system discriminated against them. Precisely, 13% of all respondents reported being discriminated against by the health care system. This increased to between 20% and 31% for the CHNA’s priority populations, except for older adults at 7%, as shown in Figure 18.

Community members expressed that health care should focus on the whole person. This includes mental, spiritual, economic, and social needs, in addition to clinical or physical needs. These needs are often dependent upon shared historical traumas and experiences that affect how people seek and receive care.

### HAVE YOU EVER BEEN DISCRIMINATED AGAINST BY THE HEALTH CARE SYSTEM?

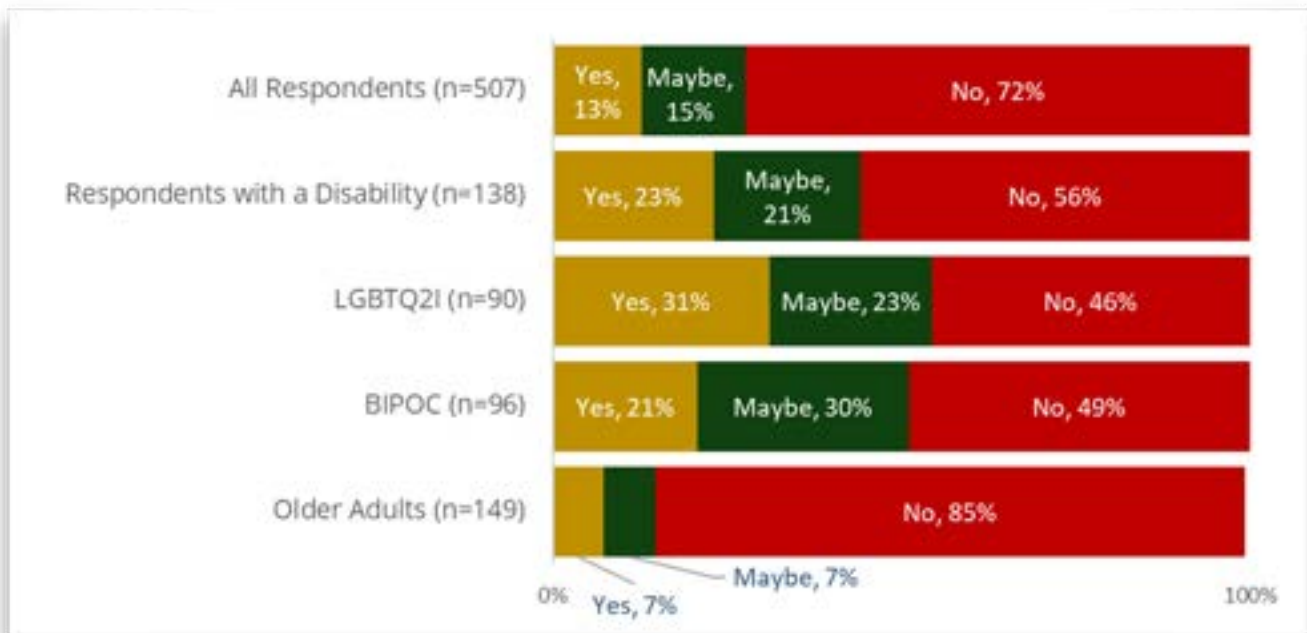


FIGURE 18 Have you ever been discriminated against by the health care system?

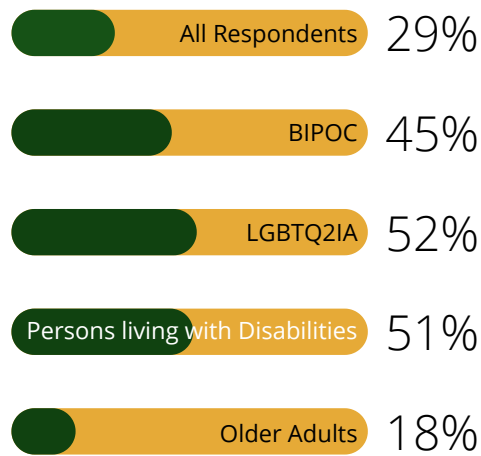
Note: “Discriminated” was defined as, “I would not be treated fairly.” Source: HCWC CHNA Community Survey

## Delayed Or Avoided Health Care

Some community members shared their distrust of the health care system, primarily because it was not responsive to their cultural and language needs, and delayed or avoided health care altogether as a result.

Nearly half (between 45% and 52%) of survey respondents representing priority populations said they avoided or delayed critical health care services because of fear or discomfort. This was compared to 29% of all respondents. Age, experiencing a specific health condition, and experiencing a disability were the top three reasons respondents avoided or delayed health care.

### Percent of respondents who avoided or delayed health care services because of fear or discomfort



Infographic 8

Respondents felt they would not be taken seriously or they would not be treated fairly. Trust of the health care system was a barrier to obtaining care, with priority populations reporting less trust than all respondents, as shown in Figure 19. Community members took the opportunity to describe why they avoided or delayed health care, many of whom expressed a sense that their age, culture, language, and/or beliefs were not respected or heard.

## DO YOU TRUST THE HEALTH CARE SYSTEM TO MEET YOUR NEEDS AND SUPPORT YOUR WELL-BEING?

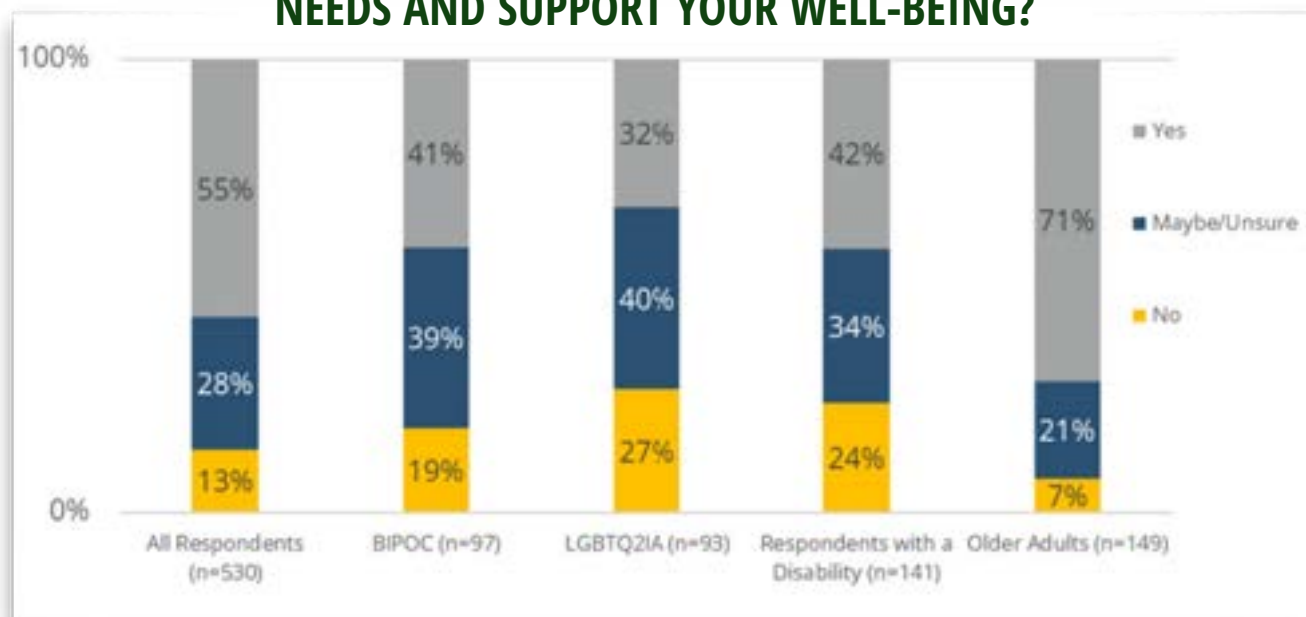


FIGURE 19 Do you trust the health care system to meet your needs and support your well-being?

# Support for Family and Community Ways



## All people

people should be afforded access to foods and healing medicines or practices specific to their communities of origin.



## SUPPORT FOR FAMILY AND COMMUNITY WAYS

### Social Connection

- While social support and connection are vital to health, secondary data on social connection and health are limited (HCWC Community Engagement Sessions).
- Support for family and community connection was frequently noted among community members as a strength. Local efforts to bring about inclusiveness has connected many to required resources (HCWC Community Engagement Sessions).
- Community members reported needing more physical space and community events (HCWC Community Engagement Sessions).

All people should be afforded access to foods and healing medicines or practices specific to their communities of origin. In addition, all people should have access to land, which supports physical activity and connection to the natural world, as well as to opportunities for ceremonial, religious, cultural, educational, and celebratory community gatherings. These gatherings foster community cohesion and share the necessary life skills or teachings necessary for youth to grow up in a good and healthy way. “Ways” refers to, but is not limited to, the traditions, practices, histories, customs, and rites that support community connectedness and wellness.

### One priority issue emerged in support for family and community ways:

- Social connection

The absence of social connections can profoundly affect our overall health.[44] Strong communities are critical, serving as a central source of social connection and belonging. Social support involves having family, friends, and other people to turn to in times of need or crisis to afford individuals a broader focus and positive self-image.

Social support also enhances the quality of life and helps whenever people experience unfortunate life events.[45] Communities with strong social support help to decrease an individual’s level of stress, increase motivation, and encourage healthy behaviors.[46] Therefore, offering support of family and community connections is an essential strategy for improving health and wellness. It is about facilitating opportunities for people to come together to solve problems and celebrate the good moments of their lives. This includes space for families and friends, as well as space to encourage cultural connection and understanding.

[44]Wooll, Maggie. 2021. "Community for the win - how collectivesolutions help individual problems." BetterUp, November 3.

[45]Towey, Sue. 2016. Taking Charge of Your Health & Wellbeing: Social Support. Accessed April 21, 2022. <https://www.takingcharge.csh.umn.edu/social-support>.

[46]VHAB. 2022. "Importance of A Support Community." Accessed April 21, 2022. <https://www.vhab.com/importance-of-a-support-community/>.

## Social Connection

Support for family and community ways was frequently noted as a strength among community members. Efforts to bring about inclusiveness and “close the cultural gap” has connected many to required resources. Social connection begins with learning and sharing knowledge of language barriers, cultural differences, and experiences.

When community members were asked to think about the times over the past year when they required and received the support necessary to improve and/or maintain their health and wellness, social and community connection supports was the fourth most common support reported (out of five options).

This cultural gap did not close for all. Community members shared 129 stories about struggling with receiving supports required to improve and maintain their health and wellness in a way that aligned with who they were.

Among the community member stories shared via the survey about when social and community connection supports were required and received, 55% described the supports as “easy to access” or obtain, followed by “affirming of one’s culture and practices” (48%) and “high quality” (42%).

Among the stories shared about not obtaining the support required, 47% of the stories reported they were “not easy to access.” Two common gaps in these types of support noted by community members were:

- A need for peer-to-peer support and the employment of more people who have lived experience
- A need for ways to exchange information and educational resources among community members



Infographic 9

**"My vision was that our people would be on the other end of that line where a native person was talking to a native person and saying, "Hey, here's a resource that I think might work for you...I really am envisioning our community coming together to help each other and create or develop these resources for our people, for our communities." -**

Community Session  
Participant Impacted by  
Incarceration

**"Within my high school community and with my peers, I think inclusivity and accessibility is definitely something that I'm seeing a lot more of and helping to spreading awareness on health issues that affect marginalized communities." -**

Rural Community Session  
Participant

Community members commonly noted that spiritual gatherings, sharing ceremonies, conferences, and cultural events were important to discussing past traumas and working toward healing together.'

Additionally, community members shared the following:

- The importance of holistic care and various methods of self-care
- A need for a shared physical space in the community, where people can meet to discuss recipes, harvest, and cook traditional foods together and learn traditional medicine
- The importance of building awareness on health issues that affect marginalized communities, such as LGBTQ2IA and BIPOC youth

Young adults reported needing peer education in their high schools to share and learn about these topics with other youth who have similar backgrounds and experiences. They expressed the desire for specific health committees or the creation of community youth groups.

## LINKING HEALTH PRIORITY AREAS TO HEALTH OUTCOMES

Health outcomes represent the physical and mental well-being of residents within the HCWC region through measures signifying the length of life, as well as the quality of life. Until now, the CHNA has described many factors that influence health—from access to culturally- and linguistically-competent health care, to the availability of good jobs, safe transportation options, social connections, culture-specific and healthy foods, and affordable housing. In addition to these factors are the challenges faced when seeking care.

There is a strong link between health outcomes and access to quality care.[47] Routine prevention-focused health care can reduce rates of disease, death, and emergencies that require hospital stays. This includes routine health screenings, tests, treatment, and vaccinations. However, as shown in Figure 20, 60% of community members noted they experience challenges obtaining the care they need or want. Among the CHNA’s priority populations, this ranged higher from 63% to 76%.

The top three challenges to accessing required care among survey respondents are described in Table 2. Across all respondents, knowing what, where, and when services and resources were available were leading barriers. Additionally, the eligibility and affordability of those services were barriers to care.

### PERCENT OF COMMUNITY SURVEY RESPONDENTS WHO EXPERIENCE CHALLENGES OBTAINING THE CARE THEY NEED OR WANT



FIGURE 20 Percent of respondents who experience challenges obtaining the care they need or want  
Source: HCWC CHNA Community Survey

[47]Office of Disease Prevention and Health Promotion. 2022. "HealthyPeople.gov." Access to Health Services. February 6. Accessed April 21, 2022.

# Top Three Challenges Among Respondents Who Experienced Barriers to Care by Priority Population

Top Three	All Respondents (n=280)	BIPOC (n=61)	LGBTQ2IA (n=61)	Respondents with a Disability (n=93)	Older Adults (n=63)
1	Required evening and weekend hours of service (30%)	Unaware of the services and resources available (44%)	Required evening and weekend hours of service (41%)	Unaware of the services and resources available (34%) Ineligible for services (34%) Not easy to travel to/lacked transportation (34%)	Not easy to travel to/lacked transportation (23%) High out-of-pocket costs (23%)
2	Unaware of the services and resources available (29%)	Ineligible for services (38%)	High out-of-pocket costs (39%)	Required services not offered in my area (33%)	Required evening and weekend hours of service (20%)
3	High out-of-pocket costs (29%)	Required evening and weekend hours of service (36%)	Unaware of the services and resources available (35%)	Required evening and weekend hours of service (31%)	Unaware of the services and resources available (17%)

TABLE 2

Source: HCWC CHNA Community Survey

## COMMUNITY VOICE: IMPORTANT DISEASES AND CONDITIONS

The community survey asked, “What are the THREE most important health diseases and conditions in your community?” The top three health diseases and conditions selected were:

- Mental health (e.g., stress, anxiety, depression, grieving, etc.)
- Chronic disease (e.g., diabetes, heart disease and stroke, high blood pressure)
- Vaccine preventable diseases (e.g., COVID-19, measles, influenza, mumps, pertussis, etc.)

The top three health diseases and conditions were the same in Clackamas and Clark counties. Multnomah and Washington, however, ranked substance use as the third most important. Table 3 shaded cells indicate an issue where the proportion of respondents was higher than the region.

The four priority populations responded similarly to all respondents, with the exception of a higher ranking on the need for improved dental/oral health. BIPOC respondents ranked cancer and sexually transmitted infections (STIs) as health diseases or conditions as important, more so than all respondents. LGBTQ2IA ranked rape/sexual assault/sex trafficking as important, more so than all respondents.

### The Most Important Health Diseases and Conditions By County

	Region (n=530)	Clackamas (n=259)	Clark (n=72)	Multnomah (n=87)	Washington (n=87)
1	Mental health (71%)	Mental health (67%)	Mental health (75%)	Mental health (83%)	Mental health (79%)
2	Chronic disease (60%)	Chronic disease (65%)	Chronic disease (58%)	Chronic disease (59%)	Chronic disease (59%)
3	Vaccine preventable diseases (41%)	Vaccine preventable diseases (47%)	Vaccine preventable diseases (46%)	Substance use (39%)	Substance use (38%)

TABLE 3  
Source: HCWC CHNA Community Survey

## IN YOUR OPINION, WHAT ARE THE THREE MOST IMPORTANT HEALTH DISEASES AND CONDITIONS IN YOUR COMMUNITY? (N=530 RESPONDENTS)

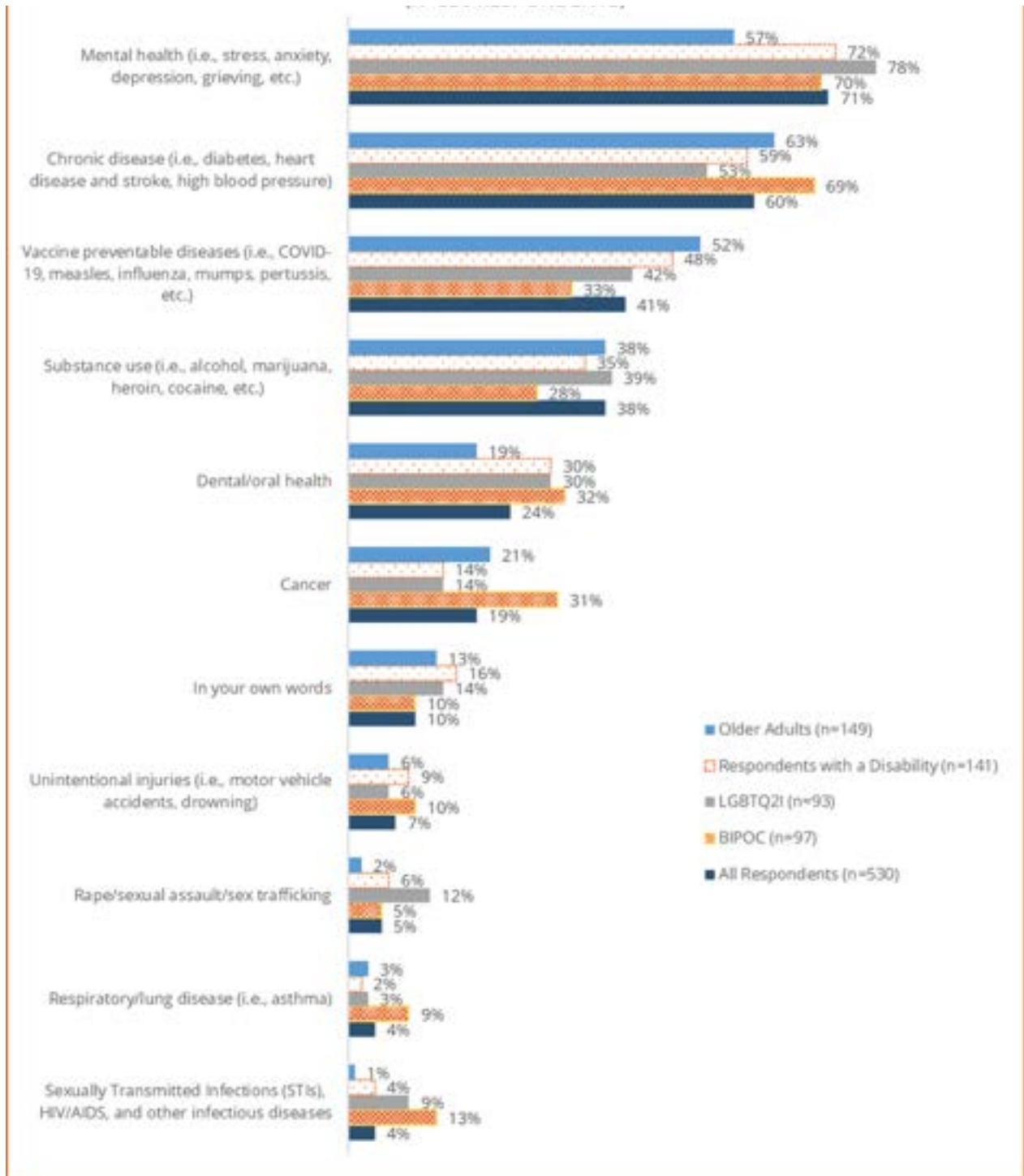


FIGURE 21 Most Important Health Diseases and Conditions

Through analysis of these community data, together with population health outcome data, the CHNA provides an understanding of the health of the community and those programs the community may require. For example, the expansion of language interpreters in health centers may impact access to primary care, resulting in improved management of chronic diseases and longer lives. Additionally, it is important to examine differences in health outcomes based upon the presence of various community health factors and demographics. The CHNA describes three priority areas on which to focus; they reflect both the community perspective and the population health data. For additional data on health outcomes, including maternal and child health, see Appendix I.

## #1: Mental Well-Being

Mental health disorders are medical conditions that disrupt a person's thinking, feeling, mood, ability to relate to others, and their ability to routine daily activities, such as going to work, attending school, or raising a family.

<b>25%</b>	In 2019, nearly <b>25%</b> of adults (18 years or older) reported being diagnosed with depression. This is higher than the United States at 19%. <sup>[48]</sup>
<b>36% to 42%</b>	Among high school students in the region (10th and 11th grade), <b>36% to 42%</b> reported they felt so sad or hopeless they stopped doing usual activities almost every day for 2+ consecutive weeks over the past year (2018, 2019). <sup>[49]</sup>
<b>62%</b>	In 2020, 7% of preventable hospital stays were due to a primary mental health diagnosis. This rate increased to <b>62%</b> when more than one diagnosis was included as a reason for the stay. While representing only 5% of 2020 preventable hospital stays, the age group 15 to 24 years accounted for: <ul style="list-style-type: none"> <li>• 23% of all suicides</li> <li>• 28% of depression</li> <li>• 22% of all other mental illness-related inpatient stays.<sup>[50]</sup></li> </ul>
<b>1,197</b>	There were <b>1,197</b> suicide deaths in the region (2018-2020) for an (unweighted) average rate of 16.3 suicide deaths per 100,000 people. The number of deaths increased from 1,057 in 2014-2016 to 1,197 deaths. <sup>[51]</sup>

TABLE 4

[48]Centers for Disease Control and Prevention. 2021. PLACES: Local Data for Better Health. Accessed April 21, 2022.  
 [49]Oregon Health Authority. 2019. Oregon Healthy Teens Survey 2019 Results. Accessed April 21, 2022.  
 [50]Oregon Health Authority. 2022. Hospital Reporting Program - Hospital Discharge Data. Accessed April 21, 2022.  
 [51]Oregon Health Authority. 2022. Oregon Death Data. April 5. Accessed April 21, 2022.



## #2: Chronic and Communicable Disease Management

Chronic disease is a health condition lasting three months or longer that generally cannot be prevented by vaccines and does not “get better” or disappear on its own.[52]

<p><b>18.9%</b></p>	<p>Regionally, <b>18.9%</b> reported binge drinking in 2019 and this was significantly higher than the United States at 17.9%. Reported binge drinking among adults was higher in Multnomah and Clark counties.[53]</p>
<p><b>9.8%</b></p>	<p>Adults with asthma was significantly higher in the region at <b>9.8%</b>, compared to the United States at 8.9%. Other chronic diseases included high blood pressure (27.4% of adults) and high cholesterol (26.1% of adults), while the two most prevalent in the region were significantly lower than rates in the United States.[54]</p>
<p><b>37.3%</b> <b>28.9%</b> <b>14.4%</b></p>	<p>Among all avoidable hospital stays in 2020, the top three leading chronic disease-related causes include:</p> <ul style="list-style-type: none"> <li>• Diabetes at <b>37.3%</b></li> <li>• Chronic heart failure at <b>28.9%</b></li> <li>• Chronic obstructive pulmonary disease (COPD) at <b>14.4%</b></li> </ul> <p>It is important to note this trend likely was affected by COVID-19 and the public being dissuaded from visiting the hospital.[55]</p>
<p><b>33,596</b> <b>11,681</b> <b>1,521</b></p>	<p>The incidence of STIs Chlamydia, Gonorrhea, and Syphilis increased in the region between 2016 and 2019.[56] The number of cases in the region during 2019 was:</p> <ul style="list-style-type: none"> <li>• Chlamydia: <b>33,596</b> cases, representing a 14.7% increase from 430.7 to 494.0 per 100,000 people</li> <li>• Gonorrhea: <b>11,681</b> cases, representing a 69.7% increase from 90.1 to 152.9 per 100,000 people</li> <li>• Syphilis: <b>1,521</b> cases, representing a 28.8% increase from 13.9 to 17.9 per 100,000 people (significantly higher only in Multnomah and Clark)</li> </ul>
<p><b>11,065</b> <b>9,614</b></p>	<p>Cancer and heart disease continue to be the top two causes of death in 2018-2020, representing:</p> <ul style="list-style-type: none"> <li>• <b>11,065</b> deaths due to cancer</li> <li>• <b>9,614</b> deaths due to heart disease</li> </ul> <p>While deaths due to cancer and heart disease decreased between 2014-2016 and 2018-2020, cerebrovascular diseases, such as stroke, increased from 18.7 to 30.3 per 100,000 deaths.[57]</p>

TABLE 5

[52]Centers for Disease Control and Prevention National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP). 2021. About Chronic Diseases. April 28. Accessed April 21, 2022.

[53]CDC. BRFSS. Regional estimates are unweighted averages.

[54]CDC. BRFSS. Regional estimates are unweighted averages. County estimates were not significantly different compared to the region.

[55]Oregon Health Authority. 2022. Hospital Reporting Program - Hospital Discharge Data. Accessed April 21, 2022.

[56][57]Oregon PHAT and Washington CHAT.

## #3: Accidental Injury

Accidental injuries can be caused by events, such as falls, motor vehicle crashes, firearms, drug overdose, and suicide. Accidents are among the top 15 killers of Americans of all ages and, according to the CDC, are the leading cause of death for Americans from birth to age 44.[58]

<p><b>3,132</b></p>	<p>Over <b>3,132</b> deaths in the region were due to accidental injury, making it the third leading cause of death in 2018-2020.[59]</p>
<p><b>88%</b> <b>85%</b></p>	<p>Children under the age of 1 and adults age 65 and older were particularly vulnerable to experiencing an accidental death. For injury-related deaths:</p> <ul style="list-style-type: none"> <li>• Among children less than 1 years old, <b>88%</b> were accidental (compared to 12% of injury deaths due to violence or suicide)</li> <li>• Among older adults 65 years and older, <b>85%</b> were accidental (compared to 15% of injury deaths due to violence or suicide)[60]</li> </ul>
<p><b>49%</b></p>	<p>Age groups 15 to 24 years were particularly vulnerable to experiencing a violent or suicide-related injury death:</p> <ul style="list-style-type: none"> <li>• <b>49%</b> were accidental (compared to 51% of injury deaths due to violence or suicide)[61]</li> </ul>
<p><b>13.7 per 100,000</b></p>	<p>Falls were the leading cause of accidental injury death in the region, with an average (unweighted) rate of <b>13.7 per 100,000</b> people or 1,048 deaths in 2018-2020. While the rate increased for each county between 2014-2016 and 2018-2020, the change was not significant.[62]</p>
<p><b>13.3 per 100,000</b></p>	<p>Drug overdose death was the second leading cause of accidental death in 2018-2020 at a regional (unweighted) rate of <b>13.3 per 100,000 people</b>. Drug overdose significantly increased in the region, from 9.8 in 2014-2016 to 13.3 per 100,000 in 2018-2020. This was in part due to the increase in Multnomah from 13.1 to 20.9 per 100,000 during the same period.[63]</p>
<p><b>8.1 per 100,000</b></p>	<p>Motor vehicle accidents were the third leading cause of accidental death in 2018-2020 at a regional (unweighted) rate of <b>8.1 per 100,000</b> people or 566 deaths. While the rate increased for each county between 2014-2016 and 2018-2020, the change was not significant.[64]</p>

TABLE 6

[58]Centers for Disease Control and Prevention. February 2022. Injuries and Violence Are Leading Causes of Death. Accessed April 21, 2022. <https://www.cdc.gov/injury/wisqars/animated-leading-causes.html>

[59]Oregon Health Authority. 2022. Oregon Death Data. April 5. Accessed April 21, 2022.

[60-64]Oregon PHAT and Washington CHAT.

## RECOMMENDATIONS

The CHNA relied upon the regional community voice to identify and define the root causes of poor health and used secondary data to understand the health outcomes. Communities are coming together, despite differences, to address health disparities and to mitigate systems of oppression. Community health improvement efforts should be led with the prioritized causes of poor health and inequities in the region. The community shared ideas on where to begin when considering the best ways to address these issues.

### A Neighborhood for All



1. Engage local politicians, including city councils and commissioners, as necessary advocates for creating a neighborhood where members of the community are safe, afforded access to quality housing, and afforded healthier living environments.
2. Invest proactively, as opposed to reactively, in equity-centered and community-informed solutions that examine the root cause of rising violent crime rates.
3. Support sustainable civic engagement and education programs, particularly for recent immigrant and refugee communities.

### Essential Community Services and Resources



1. Create more opportunities and capacity for workforce development programs that support individuals to earn a living and thriving wage.
2. Invest in ways to support the delivery of services and the infrastructure and capacity necessary to sustain those services.
3. Invest in addressing areas with limited grocery store options and ensure culturally-relevant and healthy food access to communities most impacted by these geographic disparities.
4. Work to eliminate education disparities, beginning with equitable access to affordable and quality child care and preschools.
5. Invest in technology infrastructure to increase access to virtual resources.
6. Ensure any community engagement efforts in the region include resources necessary to address Internet access barriers.

## Access to Culturally- and Linguistically-Responsive Health Care



1. Support additional trauma-informed physical and mental health services and supports, clinics, and community centers.
2. Increase workforce development pipelines for health care workers that reflect and represent the region's diverse language, ability, culture, sexual orientation, and gender.
3. Expand investments in traditional health workers to increase community representation in the workforce.
4. Invest in building/repairing trust between the health care system and priority populations.
5. Invest in efforts to address gaps in insurance eligibility for Hispanic/Latino/a and multi-racial populations.
6. Ensure adequate resources for language accessibility in services and education and invest in health literacy efforts.

## Support for Family and Community Ways



1. Offer culturally-specific community spaces for community and educational events.
2. Build awareness and engagement of health resources and supports through supporting and leveraging existing collaborative efforts with community organizations to reach those in need.
3. Invest in non-academic youth development programs, as well as peer mentorship programs and access to peer education services.
4. Invest in and prioritize data collection with respect to race and ethnicity, sexual orientation, ability, and gender to guide policymaking and allocation of resources.

The stories of the CHNA ring true beyond the region’s borders. Table 7 illustrates the alignment between Oregon’s and Washington’s most recent state health improvement plans and the CHNA’s four priority areas. The boxes indicate areas of overlap.

State Health Improvement Plan Priority Areas		HCWC CHNA Priority Areas			
		A Neighborhood for All	Essential Community Services and Resources	Access to Culturally and Linguistically Responsive Health Care	Support for Family and Community Ways
Oregon PartnerSHIP 2020-2024	Institutional bias			■	
	Adversity, trauma, and toxic stress		■	■	■
	Behavioral health	■	■	■	■
	Economic drivers of health, such as housing, transportation and living wage jobs	■	■		
	Access to equitable preventive health care			■	
Washington State Health Improvement Plan 2014-2018	Nutrition, physical activity and obesity		■	■	
	Access to care			■	
	Invest in the health and well-being of our youngest children and families				■
	Support development of healthy neighborhoods and communities	■	■		
	Broaden health care to promote health outside the medical system		■	■	■

TABLE 7

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# About the CAT

## Community Action Team (CAT)

Composed of community leaders representing the diverse communities in the region, the CAT led the development of the CHNA, with support from HCWC partners and subcontractors Health Management Associates and Oregon Health Equity Alliance. The partnership's approach was informed by a peer review group of data professionals of color, with expertise in engaging in decolonized, community-centered, data approaches and/or deeply connected to an anti-racist, Indigenous practice of performing health equity work.

CAT member biographies are shared in this section.



**Jacinta S.  
Galea'i**

**Jacinta Galea'I** is of Samoan descent and the executive director of Samoa Pacific Development Corporation, which serves Samoans and Pacific Islanders in Oregon. She is committed to lifting up Pasifika voices and strengthening the community, working to preserve Pasifika languages and cultures, and building communities where all people have equitable access to opportunities and resources. She is a member of the Oregon Pacific Islander Coalition, the Pacific Islander Coalition of Multnomah County, and, as a resident of Washington, she has worked closely with the Pacific Islander Community Association of Washington. She holds a doctoral degree from the University of Hawai'i-Manoa, lives on Cowlitz and Chinook lands in Washington, and works in Multnomah County in Oregon

**Trish  
Jordan**

**Executive Director, Trish Jordan**, wears a variety of hats. Red Lodge is a small culturally specific organization, primarily focused on women returning from jails, prisons, and treatment centers. Red Lodge runs a small women's transition center outside Oregon City. Many Native Americans still incorporate traditional medicine teachings with western medicine. Red Lodge recognizes the barriers and cultural issues (lack of trust) some Native Americans experience when accessing western models of health care. The Portland Metro area has approximately 50,000 people who self-identify as Native Americans. Trish looks forward to making health care more accessible and meaningful for our community members. It is exciting for her to contribute to the CHNA report!

## Cheryl Carter

**Cheryl Carter** is a community leader representing HCAT/ MCPHAB (Multnomah County Public Health Advisory Board) and PAC, which focuses on the homeless community and of which she has been a part for several years. She is also a participant in the Oregon Health Authority (OHA) smoke-free campaign. Cheryl served as spokesperson for our voter's rights campaign, as well as chair of the Oregon Voters Community in 2004, which won the rights to increase wages, and food service, which is still in play (SNAP). She has participated in the Home Forward's campaign to encourage residents to become part of the Residential Involvement Committee. She is also a member of the Portland Lesbian Choir and Transition Projects (TPI). At TPI, she is involved in their community trainings for employees to improve participant care and their fundraising campaign. She also supported Multnomah County's interviewing candidates for their first-ever liaison position focused on the houseless community.

## Waddah Sofan

**Waddah (He/Him)** is the Community Outreach/Education coordinator of Oregon Spinal Cord Injury Connection. Waddah is a trusted member and leader in the disability and immigrant community. He has extensive experience working with people with disabilities, people of color, immigrants, and refugees to overcome the challenges and barriers they face daily. Waddah is deeply connected with groups representing Middle Eastern, Muslims, people living with disabilities, and people of color. He joined the CAT because there are many potential benefits of engaging and broadening his experience serving unprecedented communities or those who have no voice in decision-making.







**Maria  
Delgado**

**Maria (Ella/Ella)** es una líder y activista. Soy una madre soltera que tuvo que aprender a navegar los sistemas en base a mis propias experiencias, donde me involucré en diferentes grupos de defensa, capacitaciones y he podido participar en la creación de una Poliza del Distrito Escolar , propuestas de leyes como HB 3499 (Inglés como segundo idioma) Licencias para todos, apoyando a mujeres con violencia doméstica, participando en un grupo de equidad con OYA para jóvenes en detención. Me gusta ponerme en espacios como el CAT donde puedes participar y tener la oportunidad de opinar, en base a mi propia experiencia, de mi Comunidad y cultura, romper barreras y estereotipos, hacer cambios que beneficien a las personas de color, identificar y mejorar sistemas, estar en lugares que me apasionen y que sean de acción, con mentalidad de Equidad e Igualdad para todos.

**Maria (She/Her)** is a leader, activist, and single mother who learned to navigate the systems based upon her own experiences, where she became involved in different advocacy groups and training, and has participated in the creation of a school district policy, legislation proposals, such as HB 3499 (English as a second language), Licensing for All, supporting women with domestic violence, and participating in an equity group with OYA for youth in detention. Maria places herself in spaces, such as the CAT, where she can participate and offer her opinion based upon her own community and cultural experience, break barriers and stereotypes, make changes that benefit people of color, identify and improve systems, and be in places she is passionate about and that are based in action, with a mindset of equity and equality for all.





**Kianna  
Juda-  
Angelo**

Born in the Republic of the Marshall Islands, **Kianna Juda-Angelo** was adopted and raised in America since her earliest childhood. Kianna founded the international non-profit organization, Living Islands, and co-founded the social justice organization, COFA Alliance National Network (CANN). She continues to serve as executive director for Living Islands. Kianna serves on the Oregon Pacific Islander Coalition, is a consulting member for the Pacific Resilience Fund of Pacific Peoples' Partnership in Canada, a representative of the Portland Harbour Community Coalition, a member of the United Nations Association, and recently joined the Food for All Oregonians steering committee. Kianna is a firm believer in international community work and a fierce supporter and member of the United Nations Association. She is always connecting governments, organizational partners, commercial interests, and Pacific Islanders communities worldwide. Kianna is committed to bringing her humanitarian and health work to everyone. She joined CAT to ensure the Micronesian communities are equally included and represented in their work.



**Jaxon  
Mitchell**

**Jaxon Mitchell** has worked in the field of sexual health and harm reduction for 17 years, providing HIV/STI prevention services to men who have sex with men, the transgender community, people who use injection drugs, and individuals who work in the sex industry. He came to this work through community-organizing with grassroots projects focused on issues of labor, the environment, incarceration, and health care. He currently manages the Multnomah County Public Health HIV/STI/harm reduction prevention and intervention program, which provides field-based services, such as syringe and Naloxone distribution, mobile HIV/STI testing, and partner notification services for individuals who test positive for STIs. He lives in rural Clackamas County and enjoys fishing, cooking, and raising animals in his free time.





## Benita Presley

**Benita Presley** is a community advocate and leader who has worked in the N/NE community for more than 40 years. She is a self-bred activist who, at times, must stand alone to fight the battles of oppression to get the job done. She is a voice for the voiceless. She is a peer-to-peer mentor, trauma-informed worker, domestic violence advocate, and serves clients who face barriers obtaining services from various agencies. She has repeatedly seen her clients of color and community be denied or experience a delay in services that should be readily available. Through her work on the CAT, she hopes to advocate for these individuals to ensure they have their voices and needs heard and to ensure improved services that are equitable for her communities.



## Suzie Kuerchner

**Suzie Kuerchner** is a Fetal Alcohol Spectrum Disorder consultant and a child and family development specialist working from the contexts of education and behavioral health to develop culturally-congruent systems and strategies for trauma-informed, strength-based therapeutic support to children, families, and the systems serving them. Her work includes program development and delivery for over 45 years, in which she has developed multiple early childhood development centers, early intervention, Interagency, and family resource programs within the context of state, county, tribal, and public schools and treatment settings, along with integrating federal, state, county, and tribal services. She has worked with Juvenile Justice and adult corrections in cognitively retailoring strategies and services within those settings and provides court and judicial assistance in designing appropriate sentencing for individuals impacted by an FASD.





**Joannie  
Mon Yee  
Tang**

**Joannie Mon Yee Tang (they/she)** is a neurodivergent, community, and patient advocate, living with severe and limiting disabilities, whose work is informed by the intersection of racial equity, disability justice, and LGBTQ rights. Joannie was raised on the rural Oregon coast on Hanis Coos, Miluk Coos, Umpqua, and Siuslaw lands and is a first-generation immigrant, a first-generation college graduate, a fellow of the Asian Pacific Islander Community Leadership Institute, and a graduate of Unite Oregon's Pan-Immigrant Leadership and Organizing Training program. Their experience spans disciplines, including academic research, medicine, public health, education, and social work. Joannie currently serves on the Multnomah County Public Health Advisory Board, Healthy Columbia Willamette Collaborative Community Action Team, Metro Parks and Nature Equity Advisory Committee, and Disability Rights Oregon's COVID-19 Task Force. They are a co-admin of the Portland Disability Justice Collective and are a co-founder of two equity-centered neighborhood groups.





**Sisilia  
Afemui**

**Dominique  
Horn**

**Chenoa  
Landry**

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# Appendix A: HCWC CHNA Glossary of Terms

# Appendix A: HCWC CHNA Glossary of Terms

## Abbreviations

**ACA:** Affordable Care Act

**AI/AN:** American Indian/Alaska Native

**BIPOC:** Black, Indigenous, and People of Color

**BRFSS:** Behavioral Risk Factor Surveillance System

**CAT:** Community Action Team

**CBO:** Community-based organization

**CCOs:** Coordinated Care Organizations

**CHNA:** Community Health Assessment

**HCWC:** Healthy Columbia Willamette Collaborative

**HEDA:** Health Equity Data Analysis approach

**LGBTQ2I:** Lesbian, gay, bisexual, transgender, queer, two-spirit, and intersex

**OHEA:** Oregon Health Equity Alliance

**SDoH:** Social Determinants of Health

**STIs:** Sexually Transmitted Infections

**SNAP:** Supplemental Nutrition Assistance Program

**TANF:** Temporary Assistance for Needy Families

## Definitions

**Anti-Racism:** A critical awareness of race and racism; an active process against racism that seeks to understand how racial ideology is manufactured and how it impacts the lived experiences of people daily. Anti racism rejects the false notion of human difference, acknowledging the lived experiences shaped along racial lines, learning from diverse forms of knowledge and experiences and challenging systems of racial inequity. (Pollock, 2008).

**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).<sup>1</sup>

**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

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<sup>1</sup> [https://en.wikipedia.org/wiki/Built\\_environment](https://en.wikipedia.org/wiki/Built_environment)  
HCWC COMMUNITY HEALTH NEEDS ASSESSMENT, 2022



settings. This is but one definition. Community can be defined in multiple ways depending on the people asked and what groups have in common.<sup>2</sup>

**Culturally responsive practices<sup>3</sup>:** Practices using familiar cultural information and processes to scaffold learning and engagement. Culturally responsive practices emphasize a communal orientation that is focused on relationships, cognitive scaffolding, and critical social awareness.

Culturally relevant practices are strengths based approaches that use cultural knowledge, prior experiences, frames of reference, and performance styles of ethnically diverse persons to make encounters more relevant and effective for them.

- Seeing cultural differences as assets
- Creating caring service communities where culturally different individuals and heritages are valued
- Using cultural knowledge of ethnically diverse cultures, families, and communities to guide service development, interaction strategies, and relationships with children and families
- Challenging racial and cultural stereotypes, prejudices, racism, and other forms of intolerance, injustice, and oppression
- Being change agents for social justice and social equity
- Mediating power imbalances in services based on race, culture, ethnicity, ability, and class

**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.<sup>4</sup>

**Dominant Culture<sup>5</sup>:** Dominant culture of a society refers to the main culture in a society that is shared or accepted without any opposition by the majority of a population. The "dominant group" in the United States is white of European descent whose unquestioned

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<sup>2</sup> MacQueen KM, McLellan E, Metzger DS, et al. What is community? An evidence-based definition for participatory public health. *Am J Public Health*.

<sup>3</sup> Source: Culturally Responsive Teaching & the Brain, Z. Hammond 2015, Teel and Obidah (2008) (2) Hammond (2015).

<sup>4</sup> 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>

<sup>5</sup> 1. Sociologytwynham.com, 3. Racial Equity Tools.org, 2. Paying Attention to White Culture and Privilege: A Missing Link to Advancing Racial Equity, Gulati-Partee, G., OpenSource Leadership Strategies, and Potapchuk, M., *The Foundation Review* 2014 Vol 6:1

norms, traditions, beliefs, and historical and present systems of functioning are recognized by the vast majority of institutions in the country. Dominant culture is so normalized that it is difficult to see at the conscious level for those who are members of the dominant culture, which adds to its power. In many ways, the dominant culture in this country and its norms are not distinguishable from what people refer to as “American culture”. Also known as “white culture”, the dominant culture defines standards and norms in the U.S for what is considered normal, professional, of quality, good, and effective as well as what is abnormal, unprofessional, of poor quality, bad, and ineffective.

**Food insecurity:** Limited or uncertain access to adequate food because of lack of money and other resources.<sup>6, 7</sup>

**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.<sup>8</sup>

**Health equity:** Means everyone has a fair and just opportunity to be as healthy as possible.<sup>9</sup> HCWC, using an adapted definition from the World Health Organization,<sup>10</sup> 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.

**Implicit Bias<sup>11</sup>:** Refers to the attitudes, beliefs, and stereotypes developed over one’s lifetime that impact one’s understanding, actions, social behaviors towards others based on

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<sup>6</sup> 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>

<sup>7</sup> 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>

<sup>8</sup> Centers for Disease Control and Prevention. Health Effects of Gentrification: <https://www.cdc.gov/healthyplaces/healthtopics/gentrification.htm>

<sup>9</sup> Robert Wood Johnson Foundation. “What Is Health Equity?” 2017. <https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html>

<sup>10</sup> World Health Organization. Equity. <https://www.who.int/healthsystems/topics/equity/en/>

<sup>11</sup> 1. The Kirwan institute For the Study of Race and Ethnicity, Ohio State University, 2. Stanford Encyclopedia of Psychology, Stanford University, 3. *Culturally Responsive Teaching & The Brain*, Hammond, Z. 2015

components of another's identity, (such as racial identity, ethnic identity, socio-economic status, physical mobility, disability, language, gender, gender identity, religious identity, sexual orientation, etc.). Both positive and negative biases live deep within one's subconscious and do not necessarily align with one's outwardly communicated beliefs. They are often automatic or involuntary and activated without intention. Implicit bias is malleable and can be unlearned over time through intentional identification deconstruction.

**Inclusion**<sup>12</sup>: Authentic invitation to and participation of traditionally excluded groups or individuals into a process, activity, decision-making, etc. Inclusion involves authentic and empowered interaction and participation by all stakeholders who then share a sense of belonging.

**Intersectionality**<sup>13</sup>: Components of one's identity have overlapping influences and cannot be examined in isolation from each other. They interact and impact a person's lived experience in society, social systems and institutions. Also known as identity contingencies.

**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).<sup>14</sup>

**Primary data**: Data collected first-hand through CAT engagement, surveys and focus groups.

**Qualitative data**: Non-numerical data based on traits or characteristics (for example, types of chronic health conditions someone may have).

**Quantitative data**: Numerical data that is measurable, and expresses a certain quantity, amount, or range. It is used to quantify a problem, or determine "how many", "how often", or "how much". It is data that is produced through a systematic process that is verifiable, replicable and in and of itself is not subject to interpretation.

**Secondary data**: Data collected by another entity or for another purpose.

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<sup>12</sup> Race Equity and Inclusion Guide, Annie E. Casey Foundation, 2. Crossroads Charlotte Individual Initiative Scorecard for Organizations Scorecard Overview

<sup>13</sup> WPC Handbook, 2013, 2. *Critical Race Theory*, Delgado, R. & Stephanic, J. 2012, 3. *Whistling Vivaldi*, Steele, C., 2010

<sup>14</sup> 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/>

**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.<sup>15</sup>

**Systems of oppression:** Conscious and unconscious, non-random, and organized harassment, discrimination, exploitation, discrimination, prejudice and other forms of unequal treatment that impact different historically marginalized groups while preserving privilege for others who have not been historically marginalized

**Transgender:** gender identity and/or gender expression different from what is typically associated with the sex assigned at birth <sup>16</sup>

**Trauma:** A deeply distressing or disturbing experience

**Two-spirit:** Traditionally, Native American two-spirit people were male, female, and sometimes intersexed individuals who combined activities of both men and women with traits unique to their status as two-spirit people. In most tribes, they were considered neither men nor women; they occupied a distinct, alternative gender status. In tribes where two-spirit males and females were referred to with the same term, this status amounted to a third gender. In other cases, two-spirit females were referred to with a distinct term and, therefore, constituted a fourth gender. <sup>17</sup>

**Racial Justice<sup>18</sup>:** The systematic fair treatment of people of all races, resulting in equitable opportunities and outcomes for all. Racial justice—or racial equity—goes beyond “anti-racism.” It is not just the absence of discrimination and inequities, but also the presence of deliberate systems and supports to achieve and sustain racial equity through proactive and preventative measures.

Racial Justice [is defined] as the proactive reinforcement of policies, practices, attitudes and actions that produce equitable power, access, opportunities, treatment, impacts and outcomes for all.

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<sup>15</sup> World Health Organization. Social Determinants of Health: [https://www.who.int/social\\_determinants/sdh\\_definition/en/](https://www.who.int/social_determinants/sdh_definition/en/)

<sup>16</sup> GLAAD. Media Reference Guide: <https://www.glaad.org/reference/transgender>

<sup>17</sup> Indian Health Service. Two Spirit. <https://www.ihs.gov/lgbt/health/twospirit/>

<sup>18</sup> Source: Race Forward, "Race Reporting Guide" Catalytic Change: Lessons Learned from the Racial Justice Grantmaking Assessment Report, Philanthropic Initiative for Racial Equity and Applied Research Center, 2009.

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## Appendix B: HCWC CHNA Governance Structure

## Appendix B: HCWC CHNA Governance structure

### Vision

- ▶ Assessing community needs, improving health.
- ▶ To develop a comprehensive, community-driven, equity-focused regional community health needs assessment which informs health improvement plans, and regional investments in community health, of the participating hospitals, Coordinated Care Organizations (CCOs), and local public health authorities.

### Values

- ▶ Sharing Power
- ▶ Leading with Sharing Power
- ▶ Leading with Transparency
- ▶ Practicing Active Accountability
- ▶ Centering humanity
- ▶ Accessible for all stakeholders
- ▶ Community-Centered
- ▶ Collaborative
- ▶ Strong community partnership
- ▶ Mutually beneficial
- ▶ Authenticity - Represents communities' narratives
- ▶ Transparency
- ▶ Practicing Active Accountability
- ▶ Centering humanity
- ▶ Accessible for all stakeholders
- ▶ Community-Centered
- ▶ Collaborative
- ▶ Strong community partnership
- ▶ Mutually beneficial
- ▶ Sharing Resources
- ▶ Equity
- ▶ Respect
- ▶ Honoring lived experiences and journeys
- ▶ Action-oriented

### Purpose

The purpose of HCWC is to align efforts of hospitals, public health, CCOs, and the residents of the communities they serve to develop a shared community health needs assessment across the four-county region of Clackamas, Multnomah, and Washington Counties, Oregon and Clark County, Washington. This unified and comprehensive approach will assess the health needs of all community members, but also with a focus on marginalized and underserved communities, to inform the health improvement plans and community investments of the participating organizations. It aims to eliminate duplicative efforts, prioritize needs, leverage resources, and enable collaborative efforts in implementing and tracking improvement activities.

This collaborative approach enables the creation of an effective, sustainable process; stronger relationships between communities, CCOs, hospitals and public health; meaningful community health needs assessments; helps to advance health equity within our region; and informs health improvement plans and activities that leverage collective resources to improve the health and wellbeing of our communities.

In order to be intentional about our commitment to community-centered approaches and equity as a project value, we have completed a Racial Justice chartering process which has been integrated into this document:

## Values in Action

<b>Key Project Moment</b>	<b>Value in Action</b>
<b>Governance and Infrastructure</b>	<ul style="list-style-type: none"> <li>▶ Identify Opportunities to share decision-making between HCWC Leadership Group and CAT</li> <li>▶ Partnership (ownership) with HCWC Leadership Group and CAT in decision making (Community Accountability)</li> </ul>
<b>Budget/ Resource Allocation</b>	<ul style="list-style-type: none"> <li>▶ Community partners and members project participation is supported through resources</li> <li>▶ Share proposal decision with Community Action Team</li> </ul>
<b>Data Framing</b>	<ul style="list-style-type: none"> <li>▶ Define the interpretive scope (Community Accountability)</li> <li>▶ Data will focus on a strength-based approach -- balanced of both deficit/strength, placed based perspective.</li> <li>▶ Reporting will not compare communities or utilize white as the norm</li> <li>▶ Use a SDoH frame to gain and understand how community partners categorize health/where it lives</li> <li>▶ Always consider how this data would be useful for the community, and design communications its utilization</li> </ul>
<b>Quantitative Data Collection</b>	<ul style="list-style-type: none"> <li>▶ Sharing data in collaboration</li> <li>▶ Transparency in acknowledging data sources have limitations w/ community partners</li> </ul>

<b>Key Project Moment</b>	<b>Value in Action</b>
	<ul style="list-style-type: none"> <li>▶ CAT guides this process</li> <li>▶ Request that CAT create questions for listening sessions that may differ somewhat between groups (does not need to be one size fits all interview script)</li> </ul>
<b>Qualitative Data Collection</b>	<p>Making it clear/ directly stating that we are not asking community members to speak for/ represent their entire community</p> <p>Demonstrate authenticity valuing experience and wisdom</p> <ul style="list-style-type: none"> <li>▶ Language spoken at home</li> <li>▶ Engagement/participation</li> <li>▶ Vet questions by invested communities for cultural responsiveness</li> </ul>
<b>Data Interpretation</b>	<ul style="list-style-type: none"> <li>▶ Look to the CAT to help lead the analysis.</li> <li>▶ Ensure we vet our interpretation with other groups (learn from other groups)</li> </ul>
<b>Report Drafting</b>	<ul style="list-style-type: none"> <li>▶ Provide tables to review for personal interpretation</li> <li>▶ CAT guides within existing framework</li> <li>▶ Ensure report utility is strong for all audiences</li> </ul>
<b>Communications</b>	<ul style="list-style-type: none"> <li>▶ HCWC Leadership Group (LG) ↔ CAT communication is bi-directional</li> <li>▶ Look to CAT + listening session participants on how this report should be shared out</li> <li>▶ Alternative formats for final reports - e.g. One pager, graphic novel format, etc.</li> <li>▶ Return to listening sessions at the end of process to re-engage</li> <li>▶ Any other ways of presenting the data to the community / other systems that we can utilize</li> <li>▶ Ensure report is simple, straightforward, and easy to interpret</li> <li>▶ Do not overload w/ data</li> <li>▶ One pager</li> </ul>



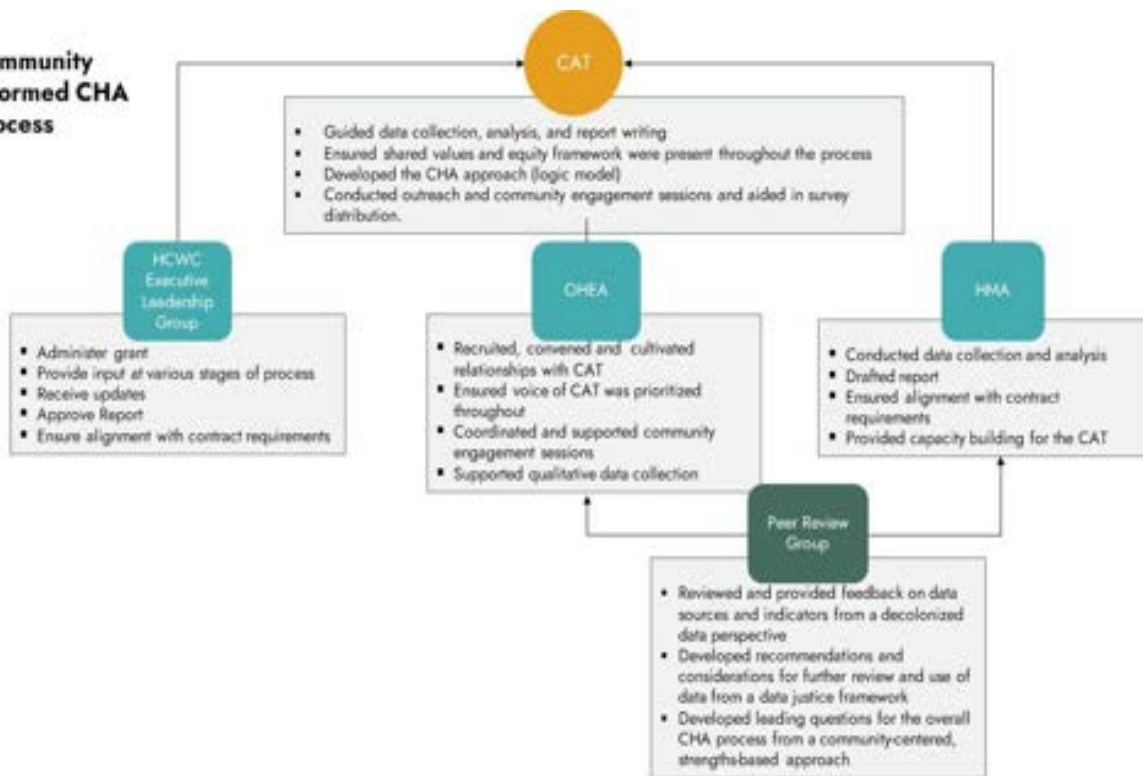
## Governance and Decision-Making

Five partners came together to ensure a community-centered CHA process.

THE COMMUNITY ACTION TEAM (CAT)	THE PEER REVIEW GROUP	OREGON HEALTH EQUITY ALLIANCE (OHEA)	HEALTH MANAGEMENT ASSOCIATES (HMA)	THE HEALTHY COLUMBIA WILLAMETTE COLLABORATIVE (HCWC)
<p>Comprised of leaders representing the diverse communities within the four-county region. The CAT met monthly to guide every step of the CHA, helping to ensure community voice, wisdom, and experience were central.</p>	<p>A collection of data professionals of color who have expertise in engaging in decolonized, community-centered, data approaches and/or are deeply connected to an anti-racist, Indigenous practice of doing health equity work.</p>	<p>A people of color-led collaborative, organized to center and uplift the wisdom of communities of color through racial justice informed health equity policies and practices. As one of six regional health equity coalitions across the Oregon, OHEA has deep roots in communities most impacted by health inequities, and experience in convening and engaging these communities.</p>	<p>Supports communities with tackling the problems that impact health outside the walls of hospital, provider, and payer offices, such as inadequate housing and food access, health equity and disparities, violence, discrimination, unemployment and underemployment.</p>	<p>A partnership comprised of health systems, public health partners, and Coordinated Care Organizations that jointly funded this CHA across the four-county region of Clackamas, Multnomah, and Washington Counties, Oregon and Clark County, Washington.</p>

The contributions of each partner are illustrated in the figure below.

## Community Informed CHA Process



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## **Appendix C: About the CHNA Data Approach**

## Appendix C: About the CHNA Data Approach

The data collection approach describes five overlapping phases involving eight steps in the community inclusive process for the Community Health Needs Assessment (CHNA) of the Healthy Columbia Willamette Collaborative (HCWC). This approach served as a guide for the development of the HCWC CHNA in partnership with the Community Advisory Team (CAT). Through this partnership, we developed a Health Equity Data Analysis (HEDA) plan to uncover:

- Not only overall health outcomes but also how health varies between population groups within the quad county region
- Not only individual behaviors but also the social and economic conditions that impact health and well-being
- The policies and systems that influence health through those social and economic conditions

The goals of this community inclusive CHNA were to:

- Deepen community partnerships
- Center community wisdom
- Tell a story that reflects lived experience
- Inform and influence key decision-making

This approach was used to guide the community engagement and data collection, analytic, and reporting process for the CHNA. This approach was informed and refined by the CAT.

Specifically,

- Driving CHNA framework and data agreements
- Informing the qualitative data process
- Co-facilitating and advising community engagement
- Informing data analysis
- Informing communications and accountability

### IDEA PHASE

Alignment with Racial Justice Charter:

- Define the interpretive scope (Community Accountability)
- Data will focus on a strength-based approach -- balanced of both deficit/strengths, placed based perspective
- Reporting will not compare communities or use white as the norm
- Use a Social Determinant of Health frame to gain and understand how community partners categorize health/where it lives
- Always consider how this data will be useful for the community and design communications around its utility

## **STEP 1: NEEDS ASSESSMENT PLANNING**

From a review of past needs assessments, this step asked the following questions:

- Are there clear priority population(s)?
- What are the differences in health outcomes or health behaviors between population group(s)?
- What are the understood connections between specific social and economic conditions and health among priority population(s)?

## **STEP 2: SETTING THE DIRECTION OF THE ASSESSMENT**

- Developing and using a community vision (i.e., what should the community be like in five years). This step asked questions such as:
  - What things do you want to see improved in the community?
  - What are the living and working conditions (i.e. material circumstances such as education, work environment, unemployment, health care services or housing, and the social and community networks) that create health differences between population groups?
  - What are the causes of difference in living and working conditions between population groups?
  - What would it look like if there were improvements in living and working conditions?
  - What words best describe the improvements?
  - Which areas are most important?
- Deciding what stakeholders want to know and why (should align with the community vision). Asked questions such as:
  - Why is this information important currently?
  - Will this information help move communities closer to their vision, mission, or goals?
  - Where can this information be found?
  - Who knows this information?
  - Has the information already been collected?
  - By when is the information needed?
- Apply a focus on assets and concerns regarding community health and well-being. Asked questions such as:
  - As it relates to vision and the information that the group wants to know and why, what are the community strengths and challenges?
  - Where is there information available about assets?
  - Who knows this information?
  - Has the information already been collected?
  - By when is the information needed?

## DESIGN PHASE

### STEP 3: DEFINING THE INDICATORS

- Start with the vision, what the community wants to know, and the final assessment topics. For each topic, identify the different ways to *measure it*; these then become the “indicators”.
- Reviewed indicators that have been traditionally and historically used in the HCWC CHNA process, and develop a protocol by which to assess each indicator (i.e., disparity by race/ethnicity; disparity by sex; trend over time, relative comparison to state estimate or other counties; magnitude, severity).
- Selected which indicators to prioritize for the assessment based on the criteria and assessment topics.

### STEP 4: CHOOSE THE DATA COLLECTION METHODS NEEDED FOR EACH INDICATOR

- Reviewed and synthesized strengths and challenges associated with various types of data collection methods
- Assessed resources available for data collection methods and prioritize data collection if resources are limited
- Asked questions such as:
  - What do you want to know?
  - What assessment topics do you want to cover and what indicators do you want to use?
  - Who would know this information (neighborhood residents, students, teachers, etc.)?
  - What resources (time, money, volunteers, etc.) are available for data collection?

## DATA COLLECTION PHASE

Alignment with Racial Justice Charter:

Quantitative Data Collection:

Sharing data in collaboration

- Transparency in acknowledging data sources have limitations w/ community partners
- Community Action Team guides this process

**Qualitative Data Collection:**

Making it clear/ directly stating that we are not asking community members to speak for/ represent their entire community and when reporting the findings, articulate the themes as such.

- Request that CAT create questions for listening sessions that may differ somewhat between groups (does not need to be one size fits all interview script)

Demonstrating authenticity that values experience and wisdom

- Consider language spoken at home
- Encourage engagement/participation
- Vet questions by invested communities for cultural responsiveness

### STEP 5: DRAFTING QUESTIONS AND RECRUITMENT METHODS FOR ANY DATA COLLECTION

In this step, we considered methods for drafting questions and recruiting participants for data collection methods, such as surveys or community forums.

- Reviewed and synthesized best practice approaches in data collection methods, including developing questions (i.e., survey and/or community forum) and engagement (i.e., participant recruitment, survey distribution)
- Data collection implementation

#### Community Engagement Protocols

Visit: [https://drive.google.com/file/d/1xfO1-0qYMIvePZq4q4vJ9ZI0xjdwr0\\_C/view?usp=sharing](https://drive.google.com/file/d/1xfO1-0qYMIvePZq4q4vJ9ZI0xjdwr0_C/view?usp=sharing)

#### Community Survey

Visit: <https://docs.google.com/document/d/1cxQBZylFcCMXux9ZDcGAgzDgkbV7-BQv/edit?usp=sharing&oid=115656647515966616299&rtpof=true&sd=true>

#### Community Survey Communication Materials

Visit:

[https://drive.google.com/drive/folders/1L1B1x5i2I5QVxGr65\\_QGBEAtkmYaiDaX?usp=sharing](https://drive.google.com/drive/folders/1L1B1x5i2I5QVxGr65_QGBEAtkmYaiDaX?usp=sharing)

## DATA ANALYSIS PHASE

Alignment with Racial Justice Charter:

### **Data interpretation**

- Look to the CAT to help lead the analysis
- Ensure interpretations are vetted with other groups (learn from other groups)

## STEP 6: CONDUCT DATA ANALYSIS

A data analysis plan was created, including both opportunities for qualitative and quantitative data analysis. Regarding qualitative data analysis, more than one HMA person reviewed the qualitative data independently with the CAT offering resonance checks on the themes. For quantitative data analysis, the a step included revisiting original data analysis and assessing whether interpretation of data had changed, and if so, how and why.

Alignment with Racial Justice Charter:

### **Report Drafting**

- Provide tables to review for personal interpretation
- CAT guides within existing framework
- Ensure report utility is strong for all audiences

### **Communications**

- LG ↔ CAT communication is bi-directional
- Look to CAT + listening session participants on how this report should be shared out
- Alternative formats for final reports - e.g. One pager, graphic novel format, etc.
- Return to listening sessions at the end of process to re-engage
- Any other ways of presenting the data to the community / other systems that we can utilize
- Ensure report is simple, straightforward, and easy to interpret
- Do not overload w/ data
- One pager

## DATA REPORTING / COMMUNICATIONS PHASE

### STEP 7: DISCUSSION ON COMMUNICATING THE ASSESSMENT FINDINGS

HMA and OHEA engaged the CAT in a communications work session to inform development of a communications plan for the CHNA. This exercise included exploration of questions around communicating assessment findings, including but not limited to:

- What data are most important to share, and why?
- What is the best way to present the results so they can be understood by diverse audiences, including those with limited English proficiency and low data literacy?



- How should the results be distributed?

### **STEP 8: DEVELOP CHNA REPORT AND COMMUNICATION MATERIALS**

The CAT-informed communications plan will outline a detailed process for developing the written CHNA report and other communications materials, such as individual county fact sheets, as well as proposed processes for future development of additional materials, like written documents trans-created in prevalent non-English languages, videos, or an interactive website.

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# Appendix D: Forces of Change Methodology and Themes

## Appendix D: Forces of Change Methodology and Themes

### About the Forces of Change Assessment

Issues affecting the quad-county region are driven by both local, state and nationwide issues and policies. Changes that are often outside of the HCWC partner control

The Forces of Change Assessment seeks to summarize these issues, inquiring into:

- What is occurring or might occur that affects the health of our community or the local public health system?
- What specific threats or opportunities are generated by these occurrences?

The CHNA process was the beginning of a significant effort to fully understand the short- and long-term impacts of these influencers on community well-being and health, and if and how priorities need to be shifted. These forces bring about both opportunities and threats across multiple health and social determinant of health issues.

### Methodology

Step 1: Initially, HCWC Executive Group (EG) members were asked on January 28, 2021 to brainstorm Forces of Change and if and how they interact with pre-identified issue areas. The areas were:

- |                                   |                                 |
|-----------------------------------|---------------------------------|
| 1. Housing and Homelessness       | 1. Public Safety                |
| 2. Education                      | 2. Jobs/ Economy                |
| 3. Health Care                    | 3. Structural Racism            |
| 4. Transportation                 | 4. Social / Culture / Inclusion |
| 5. Physical and Built Environment | 5. Technology                   |

Step 2: The CAT, with OHEA facilitation, were asked to brainstorm Forces of Change, add to/refine the list of forces by the EG.

Step 3: HMA, OHEA, and the CAT finalized list of forces and identified the threats and opportunities provided by each force.

Step 4: Forces of Change assessment and findings were used to 1) inform a root cause of the health issues and trends, 2) inform the areas of inquiry for the CHNA community survey and community engagement sessions, and 3) inform prioritization and recommendations for Community Health Improvement Plan(s).

## Summary of Executive Group (EG) Discussions

### WHAT KINDS OF FORCES EXIST?

The EG identified 6 overarching forces of change, including:

1. COVID-19 pandemic
2. Economy
3. Racial justice/uprising
4. Wild fires
5. Political unrest/divisive environment
6. New White House administration

These forces bring about both opportunities and threats across multiple health and social determinants of health issues. Issues discussed and/or raised by the EG include:

### HOUSING AND HOMELESSNESS

- Pandemic, economy, and wild fires had impacted access to housing and prevalence of homelessness.
- Potentially positive force of change was an upcoming Oregon state housing bond
- The seemed to be greater awareness of the increasing housing and homelessness in Portland, with counties calling on state leadership for more help and support; initiatives and research showing how neighborhoods could shelter individuals experiencing homelessness; growth of camps and concerns around increased trash.
- Concerns about the eviction moratorium ending or the “rental cliff”. The moratorium and other interventions (state unemployment insurance, CARES Act weekly \$600 unemployment supplement) helped keep families afloat but did not resolve the larger issues with rent affordability. These interventions were scheduled to end in July 2021 and evictions would be legal again.

### ACCESS TO EDUCATION

- At the time of the assessment, everything was viewed through a COVID-19 lens. Education was challenging without in-person classes and there were concerns about school disenrollment and whether that would be sustained
- The issue of student loans was concerning, and there was a stated need to understand how best to alleviate that burden for students and families

- Education, as a force, was recognized as one that impacted other parts of the economy. COVID and the increase in remote learning impacted individuals' ability to remain in the work force, with greater impacts specifically on women.

## **HEALTH EQUITY**

- Related to racial justice/uprising, a positive impact was increased awareness of racism and the impact on health equity.
- Increased awareness of the need for cultural competence in the way health care was delivered, and how to infuse more cultural responsiveness and cultural healing in to health care.
- Resurgence of economic justice conversations, minimum wage increases, etc.
- Companies/businesses are working to understand how best to respond and for many, was prompting organizations (and systems) to do an internal assessment of their policies and procedures in regard to anti-racism first.
- One positive impact was that the new resources dedicated to health equity.

## **SOCIAL ISOLATION**

- In light of COVID-19, the issue of social isolation was exacerbated among older adults but had become an issue for all age groups.

## **MENTAL HEALTH**

- There was the perception that mental health issues, from mild to serious mental illness, continued to increase, and was exacerbated by COVID-19.
- School districts struggled to meet the demand of mental health concerns among students (i.e., Hillsborough school district has 6 week waiting lists for student to see a school psychologist or counselor)
- Mental health workforce issues persisted and the challenge of getting individuals the appropriate level of care
- It was still unknown the longer-term impacts COVID-19 as it related to mental health and concerns regarding increased deaths of despair and suicidality.

## **PUBLIC SAFETY**

- Violent crime, homicide, gun violence were perceived to be dramatically increasing.
- Perception among the community was that perhaps it's the lack of police response.
- Concerns with perceived (or real?) increase in child abuse and domestic violence.

## **HEALTH CARE DELIVERY**

- Telehealth was thought to be reaching more people in need of health care.

## **CLIMATE CHANGE**

- Climate emergency.
- Impact on utility costs for low-income people.

## **TRANSPORTATION**

- Recent state level metro transportation bond that would expand transportation access but believe it got voted down. In particular east county geography of Portland had disparity in transportation access.
- Rural areas and transportation was a challenge; non-emergency medical transportation benefit exists for CCO members, however the transportation can be slow.

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## Appendix E: Demographic Profiles by County

## Appendix E: Demographic Profiles by County

### Clackamas County, Oregon

**Population (2019):** 410,463 individuals **Increase from 2016: 3.92%**

Demographic Characteristic	% of Population (2012-2016)	% of Population (2015-2019)
<b>Gender</b>		
Male	49.2%	49.3%
Female	50.8%	50.7%
<b>Age</b>		
Median age (years)	41.4	41.6
Under 5 years	5.5%	5.4%
5 to 19 years	19.1%	16.3%
20 to 44 years	30.3%	26.5%
45 to 64 years	29.0%	34.2%
65 years and older	16.1%	17.6%
<b>Race/ethnicity</b>		
American Indian and Alaska Native	0.7%	0.8%
Cherokee tribal grouping	0.1%	0.2%
Chippewa tribal grouping	0.1%	0.0%
Navajo tribal grouping	0.0%	0.0%
Sioux tribal grouping	0.0%	0.0%
Asian	4.1%	4.3%
Asian Indian	0.4%	0.4%
Chinese	1.1%	1.1%
Filipino	0.5%	0.5%
Japanese	0.3%	0.3%
Korean	0.4%	0.5%
Vietnamese	0.5%	0.6%
Other Asian	0.9%	1.0%
Black or African American	0.9%	0.9%
Hispanic or Latinx (of any race)	8.2%	8.7%
Native Hawaiian and Other pacific Islander	0.3%	0.3%
Native Hawaiian	0.1%	0.1%
Guamanian or Chamorro	0.0%	0.1%
Samoan	0.1%	0.0%
Other Pacific Islander	0.1%	0.2%
Two or more races	3.4%	4.1%
White	89.0%	87.5%
<b>With a disability</b>	11.9%	11.8%
<b>Foreign born</b>	8.0%	8.2%
<b>Percent of occupied households in which no member 14 years old and over speaks English "very well."</b>		1.6%



## Clark County, Washington

Population (2019): 473,252 individuals Increase from 2009: 4.96%

Demographic Characteristic	% of Population (2012-2016)	% of Population (2015-2019)
<b>Gender</b>		
Male	49.4%	49.4%
Female	50.6%	50.6%
<b>Age</b>		
Median age (years)	37.8	38.4
Under 5 years	6.4%	6.2%
5 to 19 years	21.1%	20.4%
20 to 44 years	32.2%	32.3%
45 to 64 years	26.6%	26.1%
65 years and older	13.7%	15.0%
<b>Race/ethnicity</b>		
American Indian and Alaska Native	0.6%	0.6%
Cherokee tribal grouping	0.0%	0.1%
Chippewa tribal grouping	0.0%	0.0%
Navajo tribal grouping	0.0%	0.0%
Sioux tribal grouping	0.0%	0.0%
Asian	4.3%	4.6%
Asian Indian	0.5%	0.5%
Chinese	0.8%	1.0%
Filipino	0.7%	0.7%
Japanese	0.4%	0.4%
Korean	0.5%	0.5%
Vietnamese	0.7%	0.8%
Other Asian	0.6%	0.7%
Black or African American	1.9%	1.8%
Hispanic or Latino (of any race)	8.7%	9.6%
Native Hawaiian and Other pacific Islander	0.8%	0.8%
Native Hawaiian	0.1%	0.1%
Guamanian or Chamorro	0.2%	0.2%
Samoan	0.1%	0.1%
Other Pacific Islander	0.3%	0.5%
Two or more races	4.6%	5.1%
White	84.6%	84.6%
<b>With a disability</b>	12.6%	12.3%
<b>Foreign born</b>	10.4%	10.6%
<b>Percent of occupied households in which no member 14 years old and over speaks English "very well."</b>		2.8%

## Multnomah County, Oregon

Population (2019): 804,606 individuals Increase from 2016: 3.39%

Demographic Characteristic	% of Population (2012-2016)	% of Population (2015-2019)
<b>Gender</b>		
Male	49.5%	49.5%
Female	50.5%	50.5%
<b>Age</b>		
Median Age	36.7	37.2
Under 5 years	5.9%	5.5%
5 to 19 years	15.9%	15.6%
20 to 44 years	41.1%	41.2%
45 to 64 years	25.2%	24.8%
65 years and older	11.9%	13.0%
<b>Race/ethnicity</b>		
American Indian and Alaska Native	0.8%	0.9%
Cherokee tribal grouping	0.0%	0.1%
Chippewa tribal grouping	0.0%	0.1%
Navajo tribal grouping	0.0%	0.0%
Sioux tribal grouping	0.0%	0.0%
Asian	6.9%	7.4%
Asian Indian	0.3%	0.4%
Chinese	1.7%	1.9%
Filipino	0.6%	0.6%
Japanese	0.4%	0.5%
Korean	0.4%	0.4%
Vietnamese	2.0%	2.2%
Other Asian	1.5%	1.4%
Black or African American	5.4%	5.5%
Hispanic or Latino (of any race)	11.1%	11.6%
Native Hawaiian and Other pacific Islander	0.6%	0.6%
Native Hawaiian	0.1%	0.1%
Guamanian or Chamorro	0.0%	0.1%
Samoan	0.1%	0.1%
Other Pacific Islander	0.4%	0.4%
Two or more races	5.2%	5.4%
White	78.2%	77.9%
<b>With a disability</b>	13.3%	12.5%
<b>Foreign born</b>	13.9%	13.8%
<b>Percent of occupied households in which no member 14 years old and over speaks English "very well."</b>		3.8%

## Washington County, Oregon

Population (2019): 589,481 individuals Increase from 2009: 4.50%

Demographic Characteristic	% of Population (2012-2016)	% of Population (2015-2019)
<b>Gender</b>		
Male	49.3%	49.5%
Female	50.7%	50.5%
<b>Age</b>		
Median Age	36.2	36.7
Under 5 years	6.6%	6.1%
5 to 19 years	19.9%	19.3%
20 to 44 years	36.4%	36.6%
45 to 64 years	25.2%	24.9%
65 years and older	11.8%	13.0%
<b>Race/ethnicity</b>		
American Indian and Alaska Native	0.6%	0.6%
Cherokee tribal grouping	0.0%	0.0%
Chippewa tribal grouping	0.0%	0.0%
Navajo tribal grouping	0.0%	0.0%
Sioux tribal grouping	0.0%	0.0%
Asian	9.5%	10.6%
Asian Indian	2.3%	2.9%
Chinese	1.8%	1.9%
Filipino	1.0%	1.2%
Japanese	0.6%	0.8%
Korean	1.1%	1.1%
Vietnamese	1.3%	1.3%
Other Asian	1.5%	1.5%
Black or African American	1.8%	2.0%
Hispanic or Latino (of any race)	0.4%	16.7%
Native Hawaiian and Other pacific Islander	0.2%	0.4%
Native Hawaiian	0.1%	0.2%
Guamanian or Chamorro	0.0%	0.0%
Samoan	0.1%	0.0%
Other Pacific Islander	16.2%	0.2%
Two or more races	4.9%	5.4%
White	77.6%	75.9%
<b>With a disability</b>	10.2%	9.9%
<b>Foreign born</b>	17.0%	17.7%
<b>Percent of occupied households in which no member 14 years old and over speaks English "very well."</b>		3.9%

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# Appendix F: Community Engagement Sessions Methodology and Themes

## Appendix F: Community Engagement Sessions Methodology and Themes

Community members facilitated the Community Engagement (CE) Sessions which each lasted 2 hours and 15 minutes. The CAT identified community partner organizations and networks in all four counties. We offered partner organizations support and incentives for hosting the CE Sessions. Each partner organization recruited participants for the sessions. CE session participants received a \$100 gift card for their time. The CAT, OHEA, and HMA designed the [CE Session discussion protocol](#). OHEA delivered a “how to” facilitation guide and training to the CE Session facilitators, who were staff of partner organization. The CE Session agenda was as follows:

- ▶ Welcome and Grounding (15 min, discussion)
- ▶ What’s a CHNA? Why are we here? (5 min, video)
- ▶ Interactive Storytelling (40 min)
- ▶ Break (10 min)
- ▶ Focus Group Questions (50 min)
- ▶ Closing and next steps (10 min)

A total of 37 CE Sessions were conducted, of which seven were in a language other than English or in a bilingual format. The sessions were recorded, transcribed into English, and uploaded to Dedoose, a web-based platform for analyzing qualitative and mixed methods data. Four HMA data analysts and the CAT analyzed CE Session transcripts. Using Dedoose, HMA analysts reviewed all transcripts and coded text into 8 (parent) codes and 69 sub (child) codes. The data were reviewed and organized by the codes to identify emergent themes as informed by CHNA data approach (See Appendix C)

For the CE Session analysis specifically, the DEPICT Model was adapted. The model is an approach to collaborative qualitative data analysis designed to involve individuals with varying levels of research proficiency<sup>19</sup> in this analysis process. This model incorporates opportunities for capacity building with involved community members, in addition to incorporating their perspectives into the interpretation of results, as is common in

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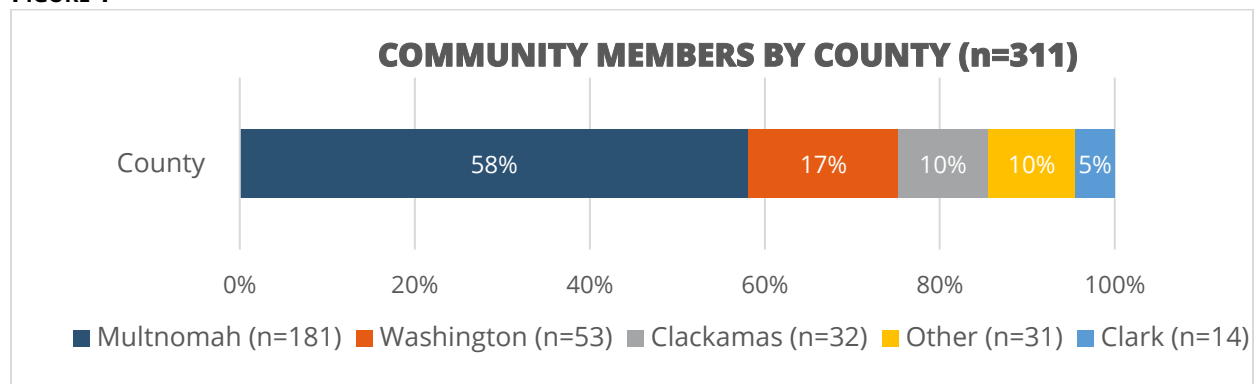
<sup>19</sup>Flicker, S. and Nixon, S. (2014). The DEPICT model for participatory qualitative health promotion research analysis piloted in Canada, Zambia and South Africa. Health Promotion International. Retrieved from [https://www.academia.edu/5880861/The\\_DEPICT\\_model\\_for\\_participatory\\_qualitative\\_health\\_promotion\\_research\\_analysis\\_piloted\\_in\\_Canada\\_Zambia\\_and\\_South\\_Africa](https://www.academia.edu/5880861/The_DEPICT_model_for_participatory_qualitative_health_promotion_research_analysis_piloted_in_Canada_Zambia_and_South_Africa)

participatory research.<sup>20</sup> The DEPICT Model has six steps in which community members participate: dynamic reading; engaged codebook development; participatory coding; inclusive reviewing and summarizing of categories/themes; collaborative analyzing; and translating. Due to time constraints of the project, as well as issues of CAT member time and capacity, CAT members were unable to participate in all aspects of the project as the team had envisioned. The CAT weighed in on the steps of qualitative analysis where they would prioritize their involvement and decided to prioritize involvement in analysis and interpretation. Therefore, HMA focused on building CAT capacity for analysis and interpretation through interactive meetings over a period of three months.

## Community Participant Demographics

Overall, 311 community members participated in the 37 CE Sessions across the Quad County region.

FIGURE 1

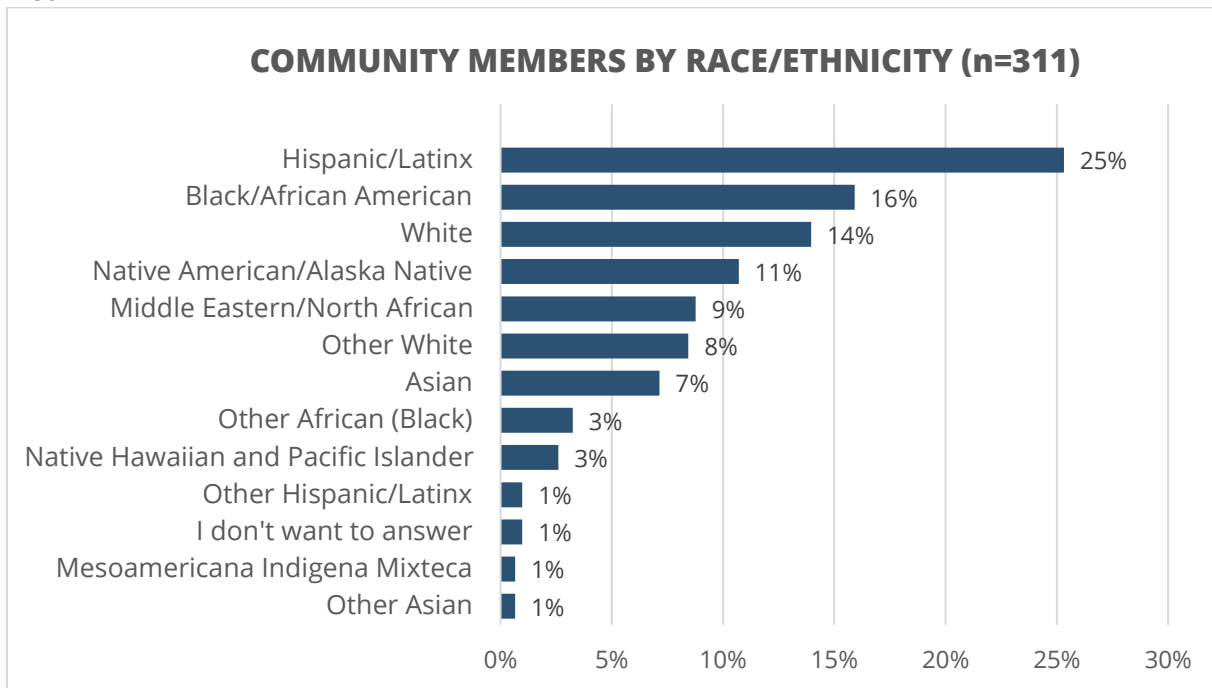


Seven of the CE Sessions were conducted in a language other than English, including Spanish (4), Arabic (2), and Chuukese, Marshallese, Samoa (1).

More than half (58%) of participants lived in Multnomah, followed by Washington (17%), Clackamas (10%), and Clark (5%). The top three race and ethnicity groups represented were Hispanic and Latino/a/x at 25%, followed by Black or African American (16%), and White (15%) community members. Specifically, participants identified as Mexican (20%), African American (16%), Western European (10%), Native American (9%), and Middle Eastern (9%). This allowed for a diverse representation of race and ethnicities in each county.

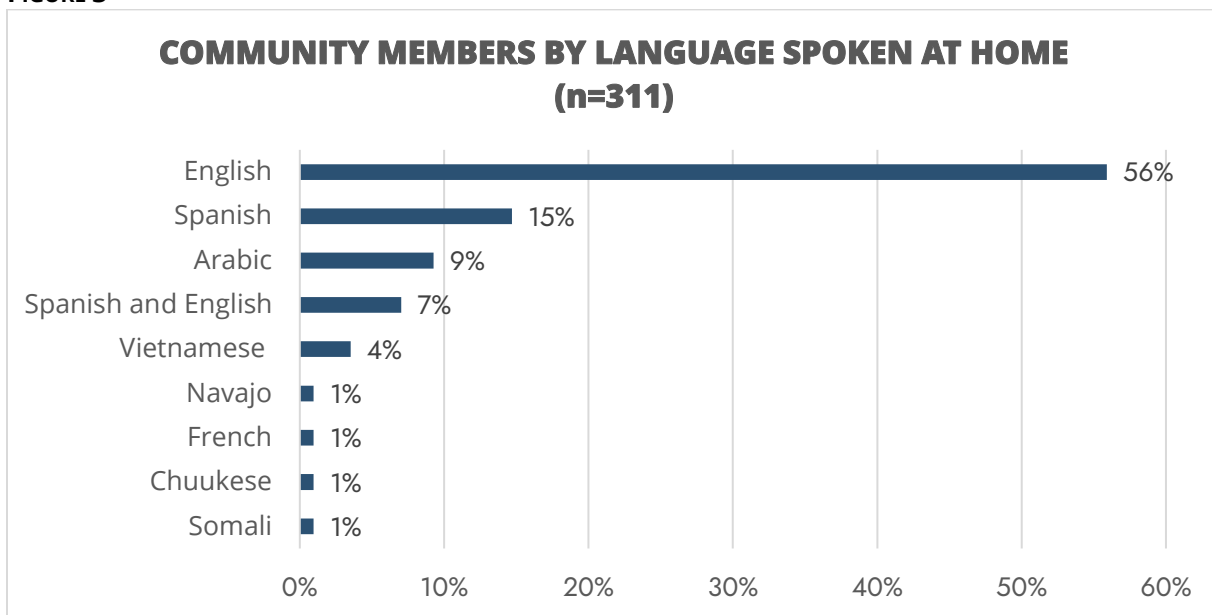
<sup>20</sup> Flicker, S., Savan, B., Kolenda, B. and Mildnerberger, M. (2008a). A snapshot of communitybased research in Canada: who? what? why? how? Health Education Research (23): 106–114.

**FIGURE 2**



English was the most common language spoken at home (56%), followed by Spanish (22%), Arabic (9%), and Vietnamese (4%).

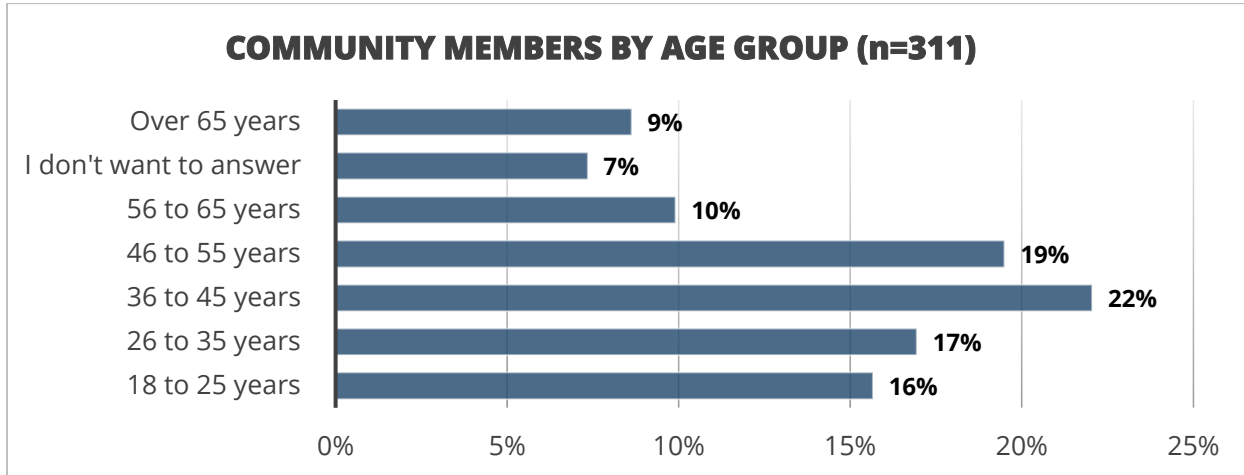
**FIGURE 3**



Note: Top 9 languages with 3 or more community members.

The most common age group was 36 to 45 years (22%), followed by 46-55 years (19%), and 26-45 years (17%).

**FIGURE 4**



Nearly 25% of participants identified as a non-heteronormative in sexual orientation. Twenty two percent of participants report some type of disability. The following tables offer additional participant demographics, including the number and percent of participants by the priority populations.

**FIGURE 5 NUMBER AND PERCENT OF PARTICIPANTS BY PRIORITY POPULATION**

Priority Population	Number of People	Percent of People
Latinx Communities - CHWs	24	8%
People who use drugs and insecurely housed	22	7%
Justice Involved	22	7%
Muslim Communities	21	7%
People living with Disabilities	18	6%
Latinx Communities	18	6%
Immigrant youth or BIPOC youth	17	5%
Native American and Alaska Native	16	5%
BIPOC	15	5%
Justice involved youth	13	4%
Vietnamese folks	11	4%
Intergenerational (youth and adults)	11	4%
API Communities	11	4%
Rural	10	3%
Arabic speaking community members	10	3%
Men's recovery group	10	3%
Insecurely Housed	9	3%
BIPOC and Insecurely Housed	9	3%
Older LGBTQ Adults	9	3%



Priority Population	Number of People	Percent of People
Pacific Islander communities	8	3%
Black and African American older adults, veterans, people with disabilities	7	2%
Black / African American	7	2%
Black and LGBT Populations	6	2%
Black/African American	6	2%
BIPOC youth	1	0%
<b>Total</b>	<b>311</b>	<b>100%</b>

**FIGURE 6 NUMBER AND PERCENT OF PARTICIPANTS BY COUNTY OF RESIDENCE AND PRIORITY POPULATION**

*Note: Use this table to understand representation of the priority populations within a county.*

Priority Population and County of Residence	Number of People	Percent of People
<b>Clackamas</b>	<b>32</b>	<b>10%</b>
Rural	9	3%
Justice Involved	4	1%
Men's recovery group	4	1%
People living with Disabilities	4	1%
API Communities	3	1%
Arabic speaking community members	2	1%
Latinx Communities - CHWs	2	1%
Native American and Alaska Native	2	1%
Black / African American	1	0%
Older LGBTQ Adults	1	0%
<b>Clark</b>	<b>14</b>	<b>5%</b>
Justice Involved	3	1%
Pacific Islander communities	3	1%
Latinx Communities - CHWs	2	1%
People living with Disabilities	2	1%
API Communities	1	0%
Black/African American	1	0%
Latinx Communities	1	0%
Muslim Communities	1	0%
<b>Multnomah</b>	<b>181</b>	<b>58%</b>
People who use drugs and insecurely housed	21	7%
Justice Involved	14	5%
Latinx Communities	14	5%
Muslim Communities	13	4%
Intergenerational (youth and adults)	11	4%
Native American and Alaska Native	11	4%
Immigrant youth or BIPOC youth	10	3%
Latinx Communities - CHWs	10	3%
BIPOC	9	3%
BIPOC and Insecurely Housed	9	3%
People living with Disabilities	9	3%

Priority Population and County of Residence	Number of People	Percent of People
Insecurely Housed	8	3%
Older LGBTQ	7	2%
Black / African American	6	2%
Arabic speaking community members	5	2%
Black and LGBT Populations	5	2%
Men's recovery group	5	2%
Black/African American	4	1%
API Communities	3	1%
Justice involved youth	2	1%
Black and African American older adults, veterans, people with disabilities	1	0%
BIPOC youth	1	0%
Pacific Islander communities	1	0%
Rural	1	0%
Vietnamese folks	1	0%
<b>Other</b>	<b>31</b>	<b>10%</b>
Justice involved youth	10	3%
Latinx Communities - CHWs	8	3%
Pacific Islander communities	4	1%
Native American and Alaska Native	3	1%
Black and LGBT Populations	1	0%
Insecurely Housed	1	0%
Justice Involved	1	0%
Latinx Communities	1	0%
People living with Disabilities	1	0%
People who use drugs and insecurely housed	1	0%
<b>Washington</b>	<b>53</b>	<b>17%</b>
Vietnamese folks	10	3%
Immigrant youth or BIPOC youth	7	2%
Muslim Communities	7	2%
Black and African American older adults, veterans, people with disabilities	6	2%
BIPOC	6	2%
API Communities	4	1%
Arabic speaking community members	3	1%
Latinx Communities	2	1%
Latinx Communities - CHWs	2	1%
People living with Disabilities	2	1%
Black/African American	1	0%
Justice involved youth	1	0%
Men's recovery group	1	0%
Older LGBTQ	1	0%
African American African seniors, vets, people with disabilities		0%
<b>Total</b>	<b>311</b>	<b>100%</b>

**FIGURE 7 NUMBER AND PERCENT OF PARTICIPANTS BY PRIORITY POPULATION AND COUNTY**

*Note: Use this table to understand which counties included representation by a priority population. Multnomah and Washington Counties included representation of Black and African American older adults, veterans, people with disabilities.*

Priority Population and County of Residence	Number of Participants	Percent of Participants
Black and African American older adults, veterans, people with disabilities	<b>7</b>	<b>2%</b>
Washington	6	2%
Multnomah	1	0%
API Communities	<b>11</b>	<b>4%</b>
Washington	4	1%
Clackamas	3	1%
Multnomah	3	1%
Clark	1	0%
Arabic speaking community members	<b>10</b>	<b>3%</b>
Multnomah	5	2%
Washington	3	1%
Clackamas	2	1%
BIPOC	<b>15</b>	<b>5%</b>
Multnomah	9	3%
Washington	6	2%
BIPOC and Insecurely Housed	<b>9</b>	<b>3%</b>
Multnomah	9	3%
BIPOC youth	<b>1</b>	<b>0%</b>
Multnomah	1	0%
Black / African American	<b>7</b>	<b>2%</b>
Multnomah	6	2%
Clackamas	1	0%
Black and LGBT Populations	<b>6</b>	<b>2%</b>
Multnomah	5	2%
Other	1	0%
Black/African American	<b>6</b>	<b>2%</b>
Multnomah	4	1%
Clark	1	0%
Washington	1	0%
Immigrant youth or BIPOC youth	<b>17</b>	<b>5%</b>
Multnomah	10	3%
Washington	7	2%
Insecurely Housed	<b>9</b>	<b>3%</b>
Multnomah	8	3%
Other	1	0%
Intergenerational (youth and adults)	<b>11</b>	<b>4%</b>
Multnomah	11	4%
Justice Involved	<b>22</b>	<b>7%</b>
Multnomah	14	5%

Priority Population and County of Residence	Number of Participants	Percent of Participants
Clackamas	4	1%
Clark	3	1%
Other	1	0%
<b>Justice involved youth</b>	<b>13</b>	<b>4%</b>
Other	10	3%
Multnomah	2	1%
Washington	1	0%
<b>Latinx Communities</b>	<b>18</b>	<b>6%</b>
Multnomah	14	5%
Washington	2	1%
Clark	1	0%
Other	1	0%
<b>Latinx Communities - CHWs</b>	<b>24</b>	<b>8%</b>
Multnomah	10	3%
Other	8	3%
Clackamas	2	1%
Clark	2	1%
Washington	2	1%
<b>Men's recovery group</b>	<b>10</b>	<b>3%</b>
Multnomah	5	2%
Clackamas	4	1%
Washington	1	0%
<b>Muslim Communities</b>	<b>21</b>	<b>7%</b>
Multnomah	13	4%
Washington	7	2%
Clark	1	0%
<b>Native American and Alaska Native</b>	<b>16</b>	<b>5%</b>
Multnomah	11	4%
Other	3	1%
Clackamas	2	1%
<b>Older LGBTQ</b>	<b>9</b>	<b>3%</b>
Multnomah	7	2%
Clackamas	1	0%
Washington	1	0%
<b>Pacific Islander communities</b>	<b>8</b>	<b>3%</b>
Other	4	1%
Clark	3	1%
Multnomah	1	0%
<b>People living with Disabilities</b>	<b>18</b>	<b>6%</b>
Multnomah	9	3%
Clackamas	4	1%
Clark	2	1%
Washington	2	1%
Other	1	0%

Priority Population and County of Residence	Number of Participants	Percent of Participants
People who use drugs and insecurely housed	<b>22</b>	<b>7%</b>
Multnomah	21	7%
Other	1	0%
Rural	<b>10</b>	<b>3%</b>
Clackamas	9	3%
Multnomah	1	0%
Vietnamese folks	<b>11</b>	<b>4%</b>
Washington	10	3%
Multnomah	1	0%
<b>Total</b>	<b>311</b>	<b>100%</b>

## CE Session Thematic Analysis and Findings

The word cloud presents the 876 excerpts identified and coded, illustrating the topics that community members spoke about and which HMA analysts coded. Community members most frequently discussed access to culturally and linguistically responsive health care and this code/theme appears across all parent codes.



The following page provides a high-level summary of findings by parent code.

1. Racism, Oppression, and Discrimination
2. Meaning of Health
3. Community Strengths
4. Essential Community Resources and Services
5. Access to Cultural and Linguistic Responsive Health Care
6. Civic Health
7. Support Family and Community Ways
8. Neighborhood for All

## Racism, Oppression, and Discrimination

As recommended by the peer review group, we focused on ensuring that any description of community health highlighted resiliency and avoided “blaming the victim” for poor group outcomes.<sup>21</sup> With this context, we can ensure that the CHNA will result in further understanding of the ways in which the cumulative effects of institutional and structural racism – rather than individual choices or behaviors – are responsible for poor group health outcomes.

Through the CE Sessions, we have begun to expand our understanding of the story. The community members discussed the multiple ways that racism, oppression, and discrimination influenced their individual health and well-being and that of their community. Community members discussed the **deep history of racism in their communities** and the impact it has had on their health, wellbeing, and quality of life. They identified racism and oppression as a root cause of health inequities and disparities and recognized that it is disproportionately experienced by racial and ethnic minorities. Many community members shared powerful stories about the impact of racism and oppression on health outcomes.

- *“A lot of the answers allude to finding refuge from white supremacy and whiteness here. It's literally getting away, which is how we find health. Being away from the system is how we find health.”*

**Overall, community members noted that opportunities to meaningfully engage community members and build shared power within communities would be key to engaging the community, ensuring better access to care, and improving experience with the health care system.**

Community members spoke about ways in which government-sponsored **displacement, exclusion, and segregation** have exacerbated racial disparities in their respective regions and communities, removing them from their land and homes. Members expressed a great, *“distrust of government who has the power to create policies and change; however, these policies do not benefit the people and communities who need them most.”* Several community members spoke about the issue of not being able to own land. Others spoke specifically to geographic displacement and issues of

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<sup>21</sup> [https://drive.google.com/file/d/1KNn\\_iuGDGi5Nn2tSneBRuJ7ExGBIrlcP/view](https://drive.google.com/file/d/1KNn_iuGDGi5Nn2tSneBRuJ7ExGBIrlcP/view)

gentrification. In addition, issues of persecution, conflict and human rights violations also emerged as themes.

- *“I think the biggest thing for me, thinking about the native community, is that our treaty rights need to start being honored and respected. [This is the] cause that's the root of everything. Like I want our land back. I want the American government to understand the word sovereign nations and we have a right to our land. We have a right to our culture. We have a right to so many things that we continue to be denied. It's like if our treaty rights were honored, they wouldn't be picking up supplies. They wouldn't have to deal with [issues like] food access and all these different things. And it's because the American government is actively trying to kill us. It's frustrating because that's like the root of it, of it all is that like we're actively, you know, fighting against genocide.”*
- *“You have talk about colonization and stealing land and then having to come back to your own land and not being able to access your land, or even have the opportunity to be healthy on it. It is absolutely beyond me. You're from your land and told to get the hell out. And then on top of that, just to make matters worse, you can't even be healthy on your own land, which is like ridiculous. And I don't, it we've now become another commodity for capitalism and [the] health system. And it's like, what body parts do you need help with so that we can make it expensive for you to like get help to heal yourself. It's almost like intention, the sicker that they make you, the more you're going to need the health system, the more money you're going to have to spend for yourself. So, it's, it's like almost like, is this intentional? Like, you're trying to kill us so that we can just spend more money in this health system and then make it hard for us to access it? So, it's just infuriating and just, it angers me so much.”*

A few community members spoke about ways in which **generational poverty** has disproportionately impacted communities of color and the persistent barriers toward financial well-being and building wealth. Specifically, a great deal of turmoil has been experienced by Native Americans and tribal communities, and there has been a lasting effect of past public policies that have resulted in housing instability and economic hardship.

- *“...but with our native culture and with our communities, our poor communities, you know, there's, there's nothing to really, for them to gain from it. So, it's almost like they don't care, you know, and we'd have to make them care.”*

In addition, community members expressed concerns with **underrepresentation in data** and not having their ethnicities and cultures represented. They discussed how research often lumps together racial and ethnic groups, which can eliminate experiences of certain communities of people. It is important for people to have representation in data and there is a lot of ambiguity that should be avoided, since data is used to look at where to focus efforts, resources, funding for programs and initiatives, etc.

- *“As Alaska Native, a lot of folks don't know that 227 of the 576 tribes are in Alaska. They're all very different. We're just a part of the acronym, AI/NA. Sometimes we get left out of data actually or in policy language. There have been a couple of times where I had the opportunity to read a house bill or something else and we were completely left out. I went recently to Epic imaging for a mammogram and the demographics options they had were*

*American Indian and Eskimo. They need to start having dropdowns for tribes and then also Alaska Natives to be included in that drop down. There's a lot, I mean, there's a good many Alaska Natives living down here."*

Lastly, many community members described the history of racism and discrimination as it pertains to access to health care. There has not been a great **acknowledgement of racism as a major health care and public health issue**, and community members desire a system that cares for them, works to combat systemic racism, and begins to identify changes that can make health care more inclusive and equitable.

- *"And yet I think so much of us experience oppression and discrimination from the medical system."*
- *"I think a lot of the stresses that our bodies face come from everyday discriminations and oppressions that we face. So, I think it would be super important to have a health care system that cares about us."*
- *"Sometimes when I go, it just makes me feel uncomfortable when they say, Oh, you have an accent, where are you from? And then it puts me back. I don't know if I want to say I'm from Egypt, they judge... we don't know how they're going to take it all. You just worry about saying where we are from. So, its fear, the fear of discrimination by the medical field."*
- *"We have this huge plethora of some of the greatest brains, but yet they don't know how to deal with non-white clients. There are stereotypes and tropes and, and there's microaggressions. The hidden biases. And sometimes they don't even care because they're arrogant. I'm the white man, I'm the male, and this is my job. And you're going to listen to me."*
- *"I think of health a lot more broadly holistically, not just am I able to function in this society to that extent that I need to function to just be productive, but safe, feeling welcome, feeling in community, feeling healthy in those ways. And that is extremely hard to navigate here. As folks have mentioned. It is so hard to get a therapist of color. I have one and I had to jump through some hoops. I have excellent insurance that I'm going to lose soon because we are separating, I had to jump through a lot of hoops to be able to get this person cause they're out of service. I literally had to have a conversation with a white person and explain to them how I have PTSD from white supremacist systems."*

## **The Meaning of Health**

When asked to describe the meaning of health, community members overwhelmingly aligned the meaning of health with a **holistic view of human functioning**. This holistic view holds physical, emotional, mental, spiritual, and community well-being as core and interrelated components of health. Several community member definitions stood out:

- *"Health is not just like the absence of illness, but also the proactive steps that people take to ensure overall wellness."*
- *"Health is about people being able to live out their values and live their life with meaning."*



- *“Health is all about understanding the needs of not only yourself, but those close to you and your community. And when you understand your needs and your community needs, then that’s when things can start to change.”*

**Storytelling:**

*We put an outdoor fire pit and I could tell you that that smoke therapy and our family, just all sitting around it, telling stories, telling traditional stories, coming to sing, you know...just laughing has been so healing for us.*

Many community members noted the **disconnect between holistic health and the narrower view of health care**, citing aspects of health care (e.g., yoga classes, meditation, consistent access to food) that are not paid for by insurance. Participants noted misalignment between the health care system and their values around health.

Participants highlighted **institutional racism and white supremacist systems as interfering with health**, noting that sometimes health can only be found outside of those systems. Many described **safety, belonging, and consistent access to resources as core to health** and identified ways that the current and predominant medical model does not address these needs and/or actively works against these needs.

Several community members highlighted the **essential role of community and spiritual traditions in health and healing**. One noted: *“One of the things that I really value from my culture is that health and wellness is looked at as like a community thing to participate in. [For instance, if] someone is sick, then it becomes like the community’s job to support that person.”*

Overwhelmingly, community members shared the view that health is about the whole person, and highlighted ways that that conceptualization needs to be incorporated throughout the health care system, from prevention to diagnosis to treatment.

## Community Strengths

In responding to the question about **what strengths, values, knowledge, or skills do you or your community share about health, healing and wellness**, community members mainly spoke about the idea of connectedness between these. Their ideas about the **connectedness of health, healing, and wellness** were not narrowly confined as such, but were expansive and inclusive of culture, history, and the environment. In sum, these are the strengths that exist within community to support, sustain, and advance health, healing, and wellness. Many community members shared that they relied on community strengths when they did not want to or could not access or utilize the health care system. Exemplary quotes include:

- *“Just telling our stories to each other, relating to each other, that’s part of how we connect and how we heal from our traumas.”*
- *“One of the strengths that we have within our community is relationships and word of mouth.”*

A strength of connectedness is the willingness and ability to, as one community member noted, *“show up and support each other.”* Community members agreed that cultural practices are vital to overall wellness and the ability to heal; one said, *“It’s like the things that our culture does and the way that we take care of one another.”*

Community members, particularly younger CE Session participants, noted that connecting to share information, and awareness building on certain health topics was critical to health and well-being. For example, one youth noted that *“within my high school community and alongside my peers, I think inclusivity and accessibility is definitely something that I’m seeing a lot more of and helping to spreading awareness on health issues that affect marginalized communities.”*

Community members identified a challenge to achieving desired levels of health and well-being within the existing health care system is that all too often the relationship or the connection does not exist. One said, *“(Health) also very relational. I think that like so many parts of like the health care system and the way that it exists, you are grasping for someone’s time.”*

**Storytelling:**

*“I’ll share a story on getting the COVID vaccine. When somebody that looks like me can communicate to me about the importance of getting the vaccine, then I might hear that. I was one of the first ones working on the front lines, seeing the pandemic, and walking folks through infections, and still, the vaccine hesitancy was right here in front of my face. I had to look to health care professionals that looked like me that were doing the research on the vaccine to trust, not my counterparts that are white or represent the dominant culture.”*

**Culture** was also noted as a community strength among participants. Culture is the patterns of ideas, customs and behaviors shared by a particular people or society. These patterns identify members as part of a group and distinguish members from other groups. Culture may include all or a subset of the following characteristics. Studies show that the influence of culture on health is significant, affecting perceptions of health, illness and death, beliefs about causes of disease, approaches to health promotion, how illness and pain are experienced and expressed, where patients seek help, and the types of treatment patients prefer.<sup>22</sup> Aspects of culture that were noted among community members include:

- **Songs and Story Telling:** *“I’ve learned that different songs, what the words mean and why we sing them each year that they’ve practiced them and learn the medicine they carry. They have helped me, the songs come to me now when I need them or when others do. And I see how the songs help the people. I love seeing when the elders get happy from singing.”*
- **Cultural Ceremonies:** *“I think that our cultural ceremonies that we have across this land, no matter where it might be, the traditional ceremonies our people have carried on for a long, long*

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<sup>22</sup>University of Minnesota, Center for Advanced Research on Language Acquisition. What is culture?

*time are a big part of our healing. I feel the more we believe in that healing, and the power of that healing from that ceremony, the better it will be for us in the long run."*

Community members often invoked the importance of having a **connection to the environment** as a community strength. Environment, not only as a source of healing and health, but also the ways in which environment impacts health. One participant noted *"health, healing, and wellness are related to our connection to land's capacity to grow, harvest, hunt our traditional foods and utilize the medicine available to us."* Additionally, physical being or presence in the environment or in nature impacts health, as one community member noted, *"I think about getting outside and the sunshine, fresh air, and water, and similar to a ceremony. This [activity] is healing".*

Many community members noted **connectedness among community members with a shared history of trauma** as a community strength. One stated, *"a strength [is] that we all have similar experiences together."*

In addition to the concept of connectedness, **another common theme of community strength was community capacity for resilience, despite adversity.** One aspect of resiliency expressed by community members was the idea of "problem solving" or "being good problem solvers." For example, community members said:

- *"One strength of the community is that we're really good problem solvers because we have to be. I think because we aren't often served well and we're often overlooked, we've gotten very good at adapting and problem solving and finding work arounds."*
- *"We need to change it ourselves and show them [government] what we can do. And then there would be a way to show them how to go about making that change."*

Lastly, a community strength commonly noted among participants was **intergenerational knowledge and compassion.** Adult community members' discussions reflected a deep respect and awareness of the need to support youth and children and to find space for youth to understand the ways in which their cultural practices can support health and healing. One community member noted their role or responsibility *"as a native woman to reach out to younger people who are struggling and offer [ceremony, practices, etc.] as opportunity for healing."* Another noted, *"we've had elders in our community that have been organizing for over 25 years to create spaces for our young ones to be able to come in."* Several community members specifically reported an increase in awareness and attention to mental health issues among youth and adults and an effort to reduce the stigma of discussing and addressing poor mental health. Some specific resources noted are peer supports and recovery as well as community partnerships. For example, one participant noted, *"we've done well at making connections with other native serving organizations to build those partnerships, to really bring in the healing and wellness."*

**Essential Community Resources and Services** includes a focus on:

Education  
Employment opportunities  
Unlivable wages  
Food Access  
Access to technology  
Language accessibility  
Supports for physical and visual accessibility  
Access to pro-bono or low-cost legal services  
Access to reliable transportation

## ESSENTIAL COMMUNITY RESOURCES AND SERVICES

Across the CE Sessions, community members identified a diverse set of non-clinical resources that were supportive to social drivers of health as being critical to improving the health of their communities. These resources ranged from supports to meet basic needs such as **access to healthy and culturally relevant foods** and **employment opportunities** to components of the physical and community environment that impact **access to needed resources**. Importantly, community members highlighted vital mechanisms of **community support** that they believed were key to their health and well-

being.

### Access to Healthy and Culturally Relevant Foods

Access to healthy and diverse foods was a core theme when community members identified essential community resources. Community members noted the presence of food deserts and highlighted that, even when grocery stores open in neighborhoods where they are most needed, stores are less likely to offer high quality fresh foods, and sometimes healthy options are out of reach financially. Community members also highlighted the importance of access to culturally relevant foods, which many found lacking amongst current resources.

- *“People don't realize that it's not just the cost of health care. It's the cost of maintaining health and how expensive that is. There's a lack of understanding that to have good health, it's pointless to go to the doctor and take whatever pills they give you, whether it's antidepressants or whatever, if you can't eat properly - because those pills are basically a band-aid that will eventually stop working.”*
- *“When you're not able to get fresh produce, you're not going to be as healthy as you can be...And I know for a lot of people...in my community, we have to rely on a lot of pre-made really unhealthy foods like cereal and a lot of other stuff like that.”*
- *“The food is very important. Yes. And that food, you know, those sacred foods, those traditional foods, you know, that is what keeps us healthy. If we go back to that traditional diet, we reverse our diabetes and high blood pressure and heart disease.”*
- *“Thinking about where all those farmer's markets and Whole Foods and Trader Joe's are in the city and where they're concentrated, it's the areas that are gentrified versus like where a lot of immigrant and refugee communities may still live and all that. So, you know, just more access to fresh foods, cultural foods, not just an aisle. There are plenty of us here. We deserve more than an aisle.”*

## **Employment and Career Development Opportunities**

Community members described the value of career development training and employment pipeline opportunities that bring more individuals into the formal workforce and provide them with opportunities for a living wage and professional development and advancement. Notable quotes included:

- *"We need to create new enterprise and we need to get our own people in health care. And if they start out as a [community health worker], then, you know, maybe they're going to get interested in nursing. We need nurses. We need doctors."*
- *"One thing is a pipeline for training into work that pays well. A lot of times, if there are trainings of this kind of nature, they're pretty sparse grants that actually don't connect folks to actual work.... Folks don't even know how they can tap into resources to be connected...into a network."*

In addition, community members noted a few barriers related to employment, including loss of benefits, challenges with background checks due to prior criminal justice involvement, and the accessibility of training in trades in addition to education received at a two- and four-year college.

- *"I can get a job, you know, and I have a master's degree. The problem is being able to figure out how to make enough money to balance out losing those benefits while being able to work. And quite frankly, you know, I would need at least like 50 grand a year starting out to be able to provide for my medical and health needs, as well as my financial needs."*
- *"The background checks keep us from serving our communities. So that's a problem that really, I think, needs to be addressed because otherwise it's a whole vicious circle."*
- *"Well, in terms of jobs...I really think that we need to be more supportive of...training in the trades because not everybody wants to go to community college or to university. And it's a really difficult place to be as a native person or as a person of color or culture."*

## **Access to Needed Resources**

Community members identified a variety of challenges to their being able to access essential resources and support services. They reported being concerned about the lack of access to adequate transportation and they acknowledged both the benefits and challenges to increased use of telehealth. In addition, several community members described medical facilities, community spaces (e.g., parks), and equipment where lack of accessibility for people with physical and/or intellectual disabilities limit their capacity to utilize needed resources, even when the resources or services are theoretically "available." One community member mentioned how education and a broader understanding of accessibility could help advance and improve access to care for community members experiencing those challenges:

- *"We need education both of the public and the community and the chronic illness committee and of health care professionals about even just basic things, such as what disability means and what accessibility means. Accessibility is not a one size fits all, and we need to stop pretending that for example, a public toilet is accessible if it has scented hand soap. Disability is anything that impairs a person's bodily functions or life functions, including ability to perform, self-care, get an education, perform a job."*

Community members described that some services and supports they utilize are designed to be inclusive, while others are not:

- *"I'm really surprised to go into any medical facility at this time. I mean, 2020, 2021 and still find their intake forms do not use inclusive language. They're totally male or female. Those are your only options. And even in big organizations, you know, that in my opinion should know better."*
- *"She took a picture of a sign outside of her hospital door, a laminated checklist of triggers for symptoms, including light, sound, and scent, so that the provider could indicate that scent or light or sound would trigger symptoms in the patient inside. And everybody could be mindful of not making the patient feel worse while they were recovering from spine surgery. It was one of the most humane interventions I've seen in the medical setting. I know people who avoid going to the doctor, not because they don't need care, but because they can't be upright enough to go in, or there will be so many triggers that make them feel worse and little chance of a positive outcome from an ignorant doctor."*

**Community members reported that access to transportation** presents a day-to-day challenge for many, both because of limitations to the medical transportation system, as well as limitations in public transportation. Community members provided several examples in which a lack of access to transportation impacted their capacity to receive adequate care:

- *"For example, I know that some people will have a hard cutoff at 30 visits a year for transportation difficulties. I just heard from a community member tonight actually that she is scheduled for an MRI, but Ride to Care canceled all rides that were not life-threatening because they're slammed. So, she's unable to get the care that she needs in a timely fashion."*
- *"Access to medical transportation has been a real difficult problem lately with Ride to Care...When COVID first happened, any of the transportation options were so easy because nobody was using it. So, they didn't overbook like they're doing now."*
- *"Some days my doctors will call me and say, we need you to go and get this done or that done. And I don't have a way there and transportation, I have ride connection, but you must make it so far in advance that when the doctor calls and says do it, or if people call and say do it, I can't."*

**Technology** was the focus of several CE Sessions and community members highlighted the opportunities that have been created by providing more virtual care (easier access to a broad range of providers). Community members also shared concerns about accessibility for those who might have less comfort with navigating virtual spaces and/or don't have reliable access to broadband internet and Wi-Fi connections:

- *"...there's a lot of resources and a lot of services that have gone online, especially because of COVID...I worry about people like seniors, who may not even have computers or the literacy or ability to access them. I worry about communities who, you know, there are language barriers. How are you going to even navigate a website that's not in your language? And then also people who don't even have electricity, how are they going to access this information and these amazing resources that are there for them, but they don't even know about it."*

## ACCESS TO CULTURAL AND LINGUISTIC RESPONSIVE CARE

### ***Access to Cultural and Linguistic***

***Responsive Care*** includes a focus on:

- Mental health services and support
- Access to culturally specific clinics and/or community centers
- Access to health care workers that reflect and represent our communities
- Access to health workers that speak and understand our communities' languages
- Access to disaggregated data from health systems

Overarchingly, community members' input illuminated the fact that access to health care should not solely focus on meeting communities' clinical needs, but should consider holistic, person-centered, and community-centered needs that are much broader and often dependent upon social and cultural factors that influence the ways people seek to take care of themselves and their loved ones. Further, community members' feedback suggests that communities within the Quad Counties clearly offer culturally and linguistically specific strengths and values that can and should be recognized and supported by the

health care system at large. In doing so, this could result in shifting the "access to care" paradigm from focusing only on clinical and physical health needs, to addressing other aspects of a person's life—the behavioral health (mental health and substance use disorder) and social factors (social drivers of health). This could support them in addressing and improving their general well-being and health and, in turn, may increase their access to care.

Throughout the CE Sessions, **community members' feedback shed light on the multiple, complex, and often interrelated challenges they have had and still experience in accessing the clinical care that they feel they need and want.** Community members across all priority populations echoed each other in describing their desire for clinical care that attends to the whole-person and their communities at large. They argued that clinical care treating symptoms and diseases was insufficient, even when they could get it. **Instead, community members reported wanting health care that is attentive to healing marginalized communities' experiences, past traumas, and historical inequities.**

- *"[I]t would be super important to have not just like a health care system that cares about...the surface level things, but also below that...with healing...communities and allowing a safe... and welcoming space for that."*
- *"[S]eeing your elders not really get the support that they need is really difficult to see, you know? And it like makes you kind of sometimes lose faith in the system when...you know how much they've gone through to come to this country and then seeing them not really get the support when it comes to...interpretation, like...having an interpreter there to kind of translate or just...then sometimes just no compassion..."*

**Past experiences and trauma with care that is not culturally, and linguistically responsive poses continued challenges to community members' willingness and ability to access care.**

Some community members referred to their own experience, and that of their ancestors and

family members, of not receiving clinical care that considered their personal and/or culturally informed ways of being. This resulted in being traumatized by the care they did receive, which they referenced as a reason they were wary of the existing health care system, places of care, and providers. Community members recalled experiences when they did seek care from the health care system, they often felt **traumatized, dismissed, and discriminated against**.

- *“Like when we do take that chance and go to the doctor, we're not heard. So, if we are told to value our health and listen to our bodies and all those things, and then when we do that, we're then dismissed or brushed off or invalidated. Then that makes you not want to do that [go to the doctor]. And then you end up negatively affecting your health.”*
- *“What I do know about health care for Micronesian Islanders especially, well, at least when we come from a Western medicine sense is that there's no access. And when you do have access, the physicians who are mostly white, don't think you know what you're talking about with your own health care. They don't listen to patients.”*
- *“I'm not confident that health care providers listen to immigrants.”*
- *“I've had a really hard time in this last, probably two years just trying to find a doctor or anything that could really understand where I'm coming from and respect...what I want for myself and my body. It's really turned me off from going to the doctor.”*
- *“It can be really hard to get the right kind of care from a doctor who doesn't quite understand you. Elaborating on that more, a huge issue with black women or black people who are assigned female at birth, is our health being undermined, I guess. And we're pretty much always passed off as being overdramatic and a lot of the time our health concerns aren't taken seriously. To me that seems like a farfetched, impossible thing until I experienced it.”*
- *“I feel like the power dynamic in that room is not really equal. And it's hard to tell the doctor what you want and have them listen. And if for some reason they don't listen or they don't treat you with the respect that you wanted or think you deserve, there's not really anyone else there to step in and defend you. And so, you're kind of just left. I've had good doctor appointments too but sometimes, I'm just like, [they] leave you with this bad feeling and you don't really know who to talk to about it or anything like that. So, you just avoid going to the doctor then unless you really need to.”*

Many community members reported wanting to be cared for by health care providers **with shared experiences, cultures and language, i.e., providers who are representative of the community members they cared for**. Some community members mentioned that just training providers in cultural competency is not enough, nor is having interpreters because they may or may not share the same linguistic dialect or experience or are not competent in medical translation. For one community member, shared experience could be valued by health care systems enough to take precedence over historically valued educational background and would result in hiring more providers who are represent the communities they care for. This person said, *“We also need our coordinated care organizations to look like us, to hire people who are from the community to hire people who have these, you know, educational background that are not education and background here [i.e., the person's home country where they received education], but it gives you a background out of there. So basically, respecting and valuing the past experiences and best degrees of*



our own community, that has not been happening because of the hiring process of the bureaucracies, like, you must have a high school degree and things like that. We need to get beyond that and actually...value the cultural and lived experiences.”

Other community member comments reflected this as well.

- *“I think that if we had more Arab American doctors who truly understand our community, understand the background, that is something that can help.”*
- *“...[W]e've all talked about needing therapists of color, needing therapists that have similar backgrounds to us, and that aren't white, that aren't men, whatever it may be.”*
- *“We don't have providers who speak our language, who share our own experiences, who have our lived experiences. And at the end of the day, when we go to the doctor and, and we have an interpreter there, the interpreter does everything they can in their hand and in their power to translate, to interpret what we are feeling, but it's not, it's never like having a provider who speaks your own language and can deliver that.”*
- *“Interpretation is not just around language, you know, but around differences in the English language between the medical community and the native community.”*
- *“It's important to actually make the doctor understand that the interpretation is not a literal interpretation. You must make both sides, understand each other, and become comfortable with each other. So, they interact in a better way and that would save his time as a doctor and make the patient really take the medication and understand how this medication benefits him.”*

Some community members described being **burdened by having to explain their experience and the shared experience they had being part of a historically marginalized community.**

While they felt it is critical to being cared for, some described it as a challenge to their being able to get appropriate care they needed.

- *“So, it's like finding a therapist that can understand you, where you don't have to explain your entire existence and systems of oppression to...so you don't have to explain your whole existence to them.”*
- *“It can be really hard to get the right kind of care from a doctor who doesn't quite understand you. Elaborating on that more, a huge issue with black women or black people who are assigned female at birth is our health being undermined, I guess. And we're pretty much always passed off as being overdramatic and, a lot of the time, our health concerns aren't taken seriously. And to me that seemed like a farfetched, impossible thing until I experienced it.”*
- *“I think the notion of cultural competency, was a really great start, but [it] really screwed some folks up because you can't know black people...If you're willing to sit for long enough to hear it, you can know their pains, their successes, or accomplishments, all the stuff that that is concerning that person... even though there are some similarities across our community, even though there are symptoms that impact across community, it really is about health care provider [and an] awareness of the individual.”*

Some community members noted that the health care system and providers should have **different expectations and approaches when caring for communities most impacted by systemic oppression.** One member, who identified as Black, pointed out that even the treatment

model for mental health was not responsive and did not resonate with her or Black community in general.

- *“What I would say is there has to be an understanding that if you really want to do work with marginalized communities, specifically the black community, you have to understand that the work is not going to look the same. You must understand that there needs to be more, there's going to have to be more resources put towards it. And the expectations, the blanket expectations that are typically put on community to perform in a certain way to get funding or to get the service has to be addressed as well.”*
- *“[The] therapy model two is just a little bit... and I feel like this way for me, it is a little impersonal just because you're going to be like in a room with someone else who is not going to be sharing with you. I've heard that for some people it's beneficial for them and that's great...but I feel like for a lot of black folks, we're a very connected people. We like to share things, and I think that like just being in a circle and communicating that way is...better. I think that if we're going to be creating or rolling out programming, that we should use models that we know work or are more culturally geared.”*
- *“I know that when the doctor asks me at the beginning of the appointment, “how are you doing today?” and you have struggled to shower and put on your best clothes and comb your hair, and people have helped you get there. And when they [the doctors] document the fact that you are well-groomed, that you said you are feeling good, that those things hurt me in getting specialty care and hurt me and getting social security disability, because the doctor's note said that I was doing good and that I was able to care for myself because I showed up well-groomed and I showed up on time.”*
- *“I see a lot of people with disabilities that need help, like in support. We have a lot of people that are falling through the cracks that aren't necessarily getting help.”*
- *“So, if you are blind and need health care information or needing to fill a form before you go to an MRI, or before you go to the next room and you need to fill a form that literally the answers that you put in this form is going to affect your life in the next minute, you don't have that form interpreted in your own language.... So, in addition to the language [translation], we [need] also like an...accessibility aware system that literally engages everybody and [attends to] everybody's needs.”*

Community members noted challenges related to **insurance and affordability of health care** were constants in their lives and had a real impact on the understanding of what should be considered whole-person care. Even community members with insurance reported the numerous obstacles they face daily in getting the care they wanted. For some, the increase of telemedicine, which is typically considered by the dominant health care system as an affordable method of increasing access to care, was not a viable solution to accessing care because many of them and their community members did not have access to reliable internet services or, as they noted, their senior populations did not know how to use online services.

- *“I have insurance, but because I'm a grad TA, it's like a step up. But even so, navigating the insurance, I had a huge problem with the eyeglass place. I spent an hour and a half on the phone with the insurance company to make, to figure out exactly what they cover. And then I called the, you know, around not everybody takes that insurance. So, I found a place. I had four*

*conversations before my appointment to make sure they were going to call and make sure [they would accept my insurance]."*

- *"Even though they give you an advocate, that's the insurance advocate, whose side do you think they are on? They're not advocating for me in the most part."*
- *"[I]t would be nice to be able to have a referral, you know... To have possibly other doctors besides just a few. So that kind of gets frustrating, when you're referred to see another doctor, but then...there's only limited ones that will see you or won't accept your insurance."*
- *"A lot of our elders don't have that capability to get online or, if you're looking at [that] community that might be remote, [they] might not even have internet access."*
- *"How has technology been a barrier? No Wi-Fi. To rely on Wi-Fi and not have it has been really stressful; To make appointments you have to use one or four computers."*

Community members' access to care is challenged by **lack of linguistically responsive health care services and supports**, including the lack of translation of written materials in needed languages or provision of materials for persons with visual or audio support needs. This also includes lack of an assurance of confidential interpretation services, lack of interpretation services in dialects or from persons with lived experiences, like the community members.

- *"Look, there's no written materials that are allowing the person to be independent and pursuing their own health. The other thing is, and this is a problem for English speakers and it's like bigger for like non-English speakers. And our community is part of it is if you are a visually impaired or hearing impaired or disabled in any way, this scarcity of materials and ability to get access to the health needs that you need is becoming non-existent."*
- *"At the end of the day, when we go to the doctor and we have an interpreter there, the interpreter does everything they can in their hand and in their power to translate, to interpret what we are feeling, but it's not, it's never like having a provider who speaks your own language and can deliver that."*
- *"I want the doctors to speak more simply, [to make it] easier to understand for people who aren't in that field. We need more that are bilingual but also know more languages."*
- *"[L]istening to my elders as I was growing up, my grandparents, my uncles, my aunts, my parents, they instructed me, I guess you could say, in the traditional way of my people. And a lot of it was taught to me in my language. I understand my language. Sometimes it's hard to translate my language, the English and English into my language. Basically, they put it in simple terms. The English language is basically backwards compared to our traditional language."*

Community members relayed that their distrust of the health care system, particularly because it is not culturally or linguistically responsive, has often resulted in **delaying or avoiding seeking out health care** altogether. While access to care may not have been an obstacle, their past experiences or understanding of the system resulted in them making decisions about whether to utilize the system.

- *"I try not to go in for any little thing. And so, I will wait and wait and wait. And it'd been like three weeks since my back had been hurting. And, uh, I finally called NARA about it. I thought about going into urgent care, cause they're easy going at Emmanuel or whatever. But, um, I don't like*

*the bias of health care providers when you go in and you know, you might be red flagged because you're an addict or whatever it is."*

- *"I've had a really hard time in this last, probably two years just trying to find a doctor or anything that could really understand where I'm coming from and respect what I want for myself and my body."*
- *"I just haven't found anybody that is willing to listen to what I really have to say, you know? And so, I think that's been the hardest for me is just trying to communicate that. And I really feel like I can advocate for myself and communicate for myself, but there's a lot of people out there my age, or there's a lot of native people out there that cannot do that. And so, you know, then they don't get the health care that they need."*
- *"A lot of the services that are available are just too difficult to navigate. So, um, I just, I try not to mess with Western doctors as much as possible. I've been seeing a naturopath for years and they do everything in house. Like I can do my lab work and my therapy, like everything just there."*

## CIVIC HEALTH

**Civic Health focused on building political awareness, power, and infrastructure to shape and improve community health, and includes a focus on:**

- Civic representation
- Civic education
- Civic engagement
- Racial justice and equity education

One of the core themes that emerged from the CE Sessions regarding civic health was community members' reporting of their **need for additional education focused on health care rights and pathways for advocacy**. For example, many community members noted a need for education and outreach to recent immigrants and refugees about civic engagement and resources for understanding systems of care. For example, one community member noted, *"They don't know to whom they can reach out to help them with an application for a green card or application for health insurance and, or like if they want rent assistance."*

In addition to educational needs, several community members described larger **systems and policy issues, including historical trauma and oppression, that impact civic health**. These needs included honoring the treaty rights of indigenous communities, as well as a greater response to missing and murdered women and children in these communities. Participants described opportunities to advocate for their needs in a variety of governmental forums, primarily around issues of race and racism. One policy change identified was the need for improved data collection with respect to race and ethnicity to guide policy making and allocation of resources (for example, distinguishing between Alaska natives and other indigenous communities in the Pacific Northwest).

## SUPPORT FAMILY AND COMMUNITY WAYS

### Support Family and Community Ways includes a focus on:

- Access to peer education services
- Non-academic youth development programs
- Provision/funding for peer mentorship programs
- Language accessibility

During the community engagement sessions, some community members noted a **specific desire to have more peer support and a desire for agencies to employ more people who have lived experience** as peers, counselors, and providers, expressing that this would be an excellent way to support both family and communities. Community members desired agencies that were run and managed by people with lived experience. Several community

members expressed the lack of sufficient access to peer education services as a barrier, including lack of sufficient numbers of peers employed by agencies to assist with this effort. In addition, members of the community mentioned the need for a **way to exchange information and educational resources** among community members.

- *"I have not been seeing that much Arabic specific [resources]. Most of the time it's other cultures and yes, other cultures also need it, but our Arabic community does not have these services..."*
- *"My vision was that our people would be on the other end of that line, you know, like there would be native person talking to a native person and saying, 'Hey, here's a resource, a viable resource that I think might work for you. Or maybe you could look at, or maybe I could help you call them, or maybe I could help you fill out the form. But, you know, we're talking to our own people about these things, not just that there's a phone number of a resource, here or call them. I really am envisioning our community coming together to help each other and create or develop these resources for our people, for our communities."*

In addition to formal methods of supporting families and communities, community members acknowledged **informal methods which included spiritual gatherings, sharing ceremonies, conferences, and cultural events** to discuss past traumas as a community and to work toward healing together. Across the sessions, community members spoke to the importance of holistic care and various methods of self-care as well as the meaning of community wellness and the specific supports needed to achieve this. One community member described the need for a **shared physical space in the community**, where people can meet to discuss recipes, harvest, and cook traditional foods together and educate each other on traditional medicine. Other members spoke to the importance of spreading awareness on health issues that affect marginalized communities such as Lesbian, Gay, Bisexual, Transgender, Queer, Intersectional, and more (LGBTQIA+) and Black and Indigenous people of color (BIPOC) youth. Younger members of the community reported needing **peer education** in their high school community about these topics and shared that inclusivity has been a great barrier to accessing these services. They expressed the desire for specific health committees or creation of community youth groups to support family and community ways.

- *"I know that there is a church. I'm not sure which specific one, but they put on a young life youth group. And I am aware of probably over a dozen Sandy high school students who do attend that. Other than that, there's not many options for community."*
- *"...a coffee shop does have a youth program and my stepbrother was involved in it a few years back. And I'm not sure exactly what they do. I've been trying to keep up with their activities, but I know they work on a community garden and do a lot of community service acts and it was a very inclusive environment. I have talked with and worked with a lot of the administrators of that program over the years."*

**Neighborhood for All includes a focus on:**

- Housing Access
- Forced Displacement/Gentrification
- Community Safety including police profiling

**NEIGHBORHOOD FOR ALL**

Across the CE Sessions, community members expressed great concern regarding the safety of environments in their neighborhoods, access to safe and affordable housing, as well as community safety concerns.

**Healthy Environments**

Many community members discussed the need for a healthier environment and living spaces, which directly and indirectly impact their health and wellbeing. Community members wanted **safe, healthy, and supportive environments** which, for them, included access to clean air, safe drinking water, nutritious foods, and safe places to live. Several people reported environmental hazards that have increased their risk to certain diseases including cancer, heart disease and asthma.

- *"You're just surrounded by trash and, um, the air quality is terrible and you usually find that for low-income and I don't think that's fair because if they can't afford it, that takes a major toll on their health and that's going to lead to greater problems in the future"*
- *"Design of the neighborhoods in my experience, there is no sidewalks. So, we need to walk on the roads, to just walk to the nearest park, which can be discouraging to go and walk outside."*

**Housing Access**

As an important determinant of health, community members recognized the range of ways in which **lack of housing negatively affected their health and wellbeing**. Many living in poverty spoke about the community need for more affordable housing options, while others spoke about their concerns related to housing accessibility in their communities. Community members described home ownership as a privilege and many alluded to the meaning and benefits of "home," including feeling a sense of control over their own lives, autonomy, empowerment, and security related to having a home. Several community members shared stories and recollection of past hardships as well as current experiences with affordable and accessible housing options. Another shared theme was the need for more awareness among community about housing and shelter options.

- *"The supports that would probably be the most helpful for my community's health and wellness would be housing assistance, utility assistance, and paid work that meets Portland's more expensive standards of living."*
- *"I would definitely say affordable housing. [It] is very expensive to live, in Portland or find something that you can afford, especially if they're going to school and trying to work."*
- *"I think housing that is not stable, there is not a lot of affordable housing in Portland. There's a lot of housing, but the question is, is it affordable? And oftentimes it is not affordable."*
- *"I think there's a need for like more affordable housing. What I have noticed is that it seems that Black people from Portland [are] getting pushed out more and more like to Gresham and further and further."*
- *"I have enough money to pay rent, but then I got to go way far out of my way to get to somewhere that is good quality."*
- *"There are many, many programs for housing here, but nobody knows about it. We need to educate people or make a workshop for them... They have like many, many programs for housing, but nobody knows this is a bigger problem."*
- *"I know I lost the ability to live in my own home when I became wheelchair bound and I couldn't believe how difficult it was to find accessible housing. I can't walk up and down stairs and it has really limited where I'm able to live and what communities I'm able to participate in. It feels really difficult applying to rent somewhere and then not being sure about whether or how I'll be able to get support for modifications. [It] is really anxiety inducing, and I've called around for legal aid..."*

## **Community Safety**

Community members reflected on the importance of community safety as it related to their health. For most, **safety included being protected from violent acts in their neighborhoods and homes, as well as safety from injuries.** Several community members discussed ways in which they felt unsafe and the negative impact this has had on their well-being, such as the chronic stress associated with living in an unsafe neighborhood. A few community members spoke about their fear of violence and how it has kept them indoors. For example, for those who felt the need to stay inside to keep safe, there were many issues with accessing services (such as going to get groceries), enjoying the neighborhood by taking walks and participating in outdoor activities, or getting the care they need. Community members reported wanting policies and programs to be implemented that would protect residents from accidents and violence in their neighborhoods.

- *"I think security and safety is a big issue... I've lived in Oregon for 30 years and I've never quite been comfortable here. And what that does is it causes mental stress, which causes physical stress."*
- *"I can name at least three times in the past couple of years that there has been caution tape taping off that intersection. And you must do a detour because someone got shot in broad daylight. I know there's a shooting down on Halsy like a month or so ago in broad daylight. I don't know what we need to fix that, but I think it's an area thing, honestly. Like I feel like there's more areas that shootings happen more than others."*

- *“I think that a lot of black men grow up with PTSD, you know, based upon the fact that you walk around in fear from the time you're able to realize that it's not safe out there for you, for that reason, not because of your own, but because of uncontrollable circumstances like the police.”*



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## **Appendix G: HCWC Community Survey Demographics and Results**

## Appendix G: HCWC Community Survey Demographics and Results

This appendix includes three sections reporting the community survey demographics and results:

Section 1: Survey Respondent Demographics

Section 2: Regional Analysis

Section 3: Equity Analysis

### Section 1: Survey Respondent Demographics

**FIGURE 8 PERCENT RESPONDENTS BY COUNTY OF RESIDENCE**

County	Number	Percent
Clark	72	14%
Multnomah	87	17%
Washington	87	17%
<b>Clackamas</b>	<b>259</b>	<b>51%</b>
Other	5	1%

**FIGURE 9 PERCENT RESPONDENTS FOR HOW OFTEN IS WHERE YOU LIVE ALSO WHERE YOU GET SERVICES AND RESOURCES**

How often is where you live also where you get services and resources?	Number	Percent
Always	138	27%
<b>Usually</b>	<b>233</b>	<b>46%</b>
About half the time that I need something	83	16%
Seldom	38	7%
Never	15	3%
Don't know	2	0%
I don't know what this question is asking	2	0%
I don't want to answer	1	0%

**FIGURE 10 PERCENT RESPONDENTS BY "SATISFACTION WITH QUALITY LIFE"**

Selection	Number	Percent
Very Satisfied	90	18%
<b>Satisfied</b>	<b>229</b>	<b>47%</b>
Neutral	101	21%
Unsatisfied	48	10%
Very Unsatisfied	22	4%
Not applicable	1	0%

**FIGURE 11 PERCENT RESPONDENTS BY AGE**

Selection	Number	Percent
18 to 25 years	11	2%
26 to 35 years	53	11%
36 to 45 years	78	15%
46 to 55 years	109	22%
56 to 65 years	95	19%
<b>Over 65 years</b>	<b>149</b>	<b>30%</b>
I don't want to answer	9	2%

**FIGURE 12 PERCENT RESPONDENTS BY RACE/ETHNICITY**

Selection	Number	Percent
Asian ( <i>includes: Cambodian, Chinese, Filipino/a, Japanese, Korean, Laotian, South Asian, Vietnamese, and other Asian</i> )	30	6%
Biracial/Multiracial	12	2%
Black and African American: African-American	13	2%
Don't know/Unknown	1	<1%
Don't want to answer/Decline	20	3%
Hispanic and Latino/a/x ( <i>includes: Central American, South American, and other Hispanic and Latino/a/x</i> )	19	3%
Mexican	40	6%
Middle Eastern/North African: Middle Eastern	2	<1%
Native American and Alaska Native: Indigenous Mexican, Central American, or South American	8	1%
Native American and Alaska Native: Native American	10	1%
Native Hawaiian and Pacific Islander ( <i>includes: Chamoru (Chamorro), Marshallese, Native Hawaiian, and other Pacific Islanders</i> )	11	2%
Other	2	<1%
Other White	15	2%
Samoan	10	1%
<b>White</b>	<b>387</b>	<b>54%</b>
White: Eastern European	23	5%
White: Slavic	6	1%
White: Western European	74	10%

**FIGURE 13 PERCENT RESPONDENTS BY LANGUAGE USED MOST OFTEN AT HOME**

Selection	Number	Percent excluding blanks
<b>English</b>	<b>416</b>	<b>89%</b>
Spanish	32	7%
Samoan	8	2%
<b>Aggregated Results:</b>	14	3%
Arabic (1)	Romanian (1)	
Thai (1)	Russian (2)	
Hawaiian (1)	French (1)	
Lao (1)	Portuguese (1)	
Haitian Creole (1)	Cantonese (1)	
Marshallese (1)	German (1)	
	Chinese (1)	

**FIGURE 14 PERCENT RESPONDENTS BY LANGUAGE WOULD YOU PREFER TO USE WHEN COMMUNICATING (IN PERSON, PHONE, VIRTUALLY) WITH SOMEONE OUTSIDE THE HOME**

Selection	Number	Percent
<b>English</b>	<b>415</b>	<b>78%</b>
Spanish	24	5%
<b>Aggregated Results:</b>	<b>12</b>	<b>3%</b>
Samoan	3	
Hawaiian	1	
Lao	1	
Russian	1	
German	1	
Same, see above, primary language	4	
In person	1	

**FIGURE 15 PERCENT RESPONDENTS BY LANGUAGE WOULD YOU PREFER TO USE TO READ IMPORTANT WRITTEN INFORMATION SUCH AS MEDICAL, LEGAL, OR HEALTH INFORMATION**

Selection	Number	Percent
<b>English</b>	<b>408</b>	<b>76%</b>
Spanish	26	5%
<b>Aggregated Results:</b>	<b>11</b>	<b>2%</b>
Samoan	2	
Hawaiian	1	
Lao	1	
Russian	1	
German	1	
Same, see above, primary language	5	

**FIGURE 16 PERCENT RESPONDENTS BY HOUSING STATUS**

Selection	Number	Percent
<b>Owns or shares own home, condominium, or apartment</b>	<b>362</b>	<b>72%</b>
Rents or shares own home or apartment	95	19%
Lives with parent or family member	17	3%
Some other arrangement, please describe. See responses below	16	3%
Lives in public housing	6	1%
I don't want to answer	3	1%
Homeless and sharing housing	0	0%
Homeless and living in emergency shelter or transitional housing	0	0%
Don't know	1	0%
I don't know what this question is asking	1	0%

**FIGURE 17 PERCENT RESPONDENTS BY HOUSEHOLD INCOME AND NUMBER OF PEOPLE INCOME SUPPORT**

Selection - Income	Number	Percent
Less than \$15,000	18	4%
\$15,000 to \$24,999	33	7%
\$25,000 to 49,999	58	12%
<b>\$50,000 to \$74,999</b>	<b>86</b>	<b>17%</b>
\$75,000 to \$99,999	72	14%
\$100,000 to \$124,999	53	11%
\$125,000 or greater	80	16%
Not employed, student, retired, homemaker	21	4%
Don't know	4	1%
I don't know what this question is asking	1	0%
I don't want to answer	74	15%

**FIGURE 18 AVERAGE NUMBER OF PEOPLE SUPPORTED PER HOUSEHOLD INCOME**

Selection - Income	Number	Percent	Average Number of People this Income Supports
Less than \$15,000	18	4%	1.2
\$15,000 to \$24,999	33	7%	1.8
\$25,000 to 49,999	58	12%	2.2
\$50,000 to \$74,999	86	17%	2.2
\$75,000 to \$99,999	72	14%	2.6
\$100,000 to \$124,999	53	11%	2.7
\$125,000 or greater	80	16%	2.9
Not employed, student, retired, homemaker	21	4%	1.0
Don't know	4	1%	0.8
I don't know what this question is asking	1	0%	0.0
I don't want to answer	74	15%	1.5

**FIGURE 19 PERCENT RESPONDENTS BY PRIMARY SOURCE OF HEALTH INSURANCE**

Health Insurance Type	Number	Percent
Private	<b>296</b>	<b>56%</b>
Public	160	30%
No insurance	12	2%
Other	34	6%
Blank/No response	28	5%

**FIGURE 20 PERCENT RESPONDENTS BY PRIMARY SOURCE OF HEALTH INSURANCE TYPE**

Selection	Number	Percent
<b>A plan purchased through an employer or union (includes plans purchased through another person's employer)</b>	<b>268</b>	<b>53%</b>
Medicare	119	24%
Medicaid (Health Share of Oregon, Trillium Community Care, or Apple Health) or other state program	37	7%
Other	34	7%
A plan that you or another family member buys on your own	28	6%
I have no health care insurance	9	2%
Veterans' Administration	4	1%
I have no health care insurance and pay cash for health care	3	1%
I don't want to answer	2	0%
Don't know	1	0%
Alaska Native, Indian Health Service, Tribal Health Services	0	0%
I don't know what this question is asking	0	0%

**FIGURE 21 PERCENT RESPONDENTS BY GENDER PRONOUNS**

Selection	Number	Percent
<b>She/Her</b>	<b>326</b>	<b>59%</b>
He/Him	77	14%
No pronouns, use my name	59	11%
They/Them	30	5%
I don't want to answer	21	4%
Not listed, Please Specify	16	3%
Don't know	10	2%
I don't know what this question is asking	9	2%

## Section 2: Regional Analysis

**FIGURE 22 HOW OFTEN IS WHERE YOU LIVE ALSO WHERE YOU GET SERVICES AND RESOURCES?**

	Always/Usually	50% or less of the time	Don't know/ No response
Region	73%	26%	1%
Clackamas (n=259)	66%	33%	1%
Clark (n=72)	82%	18%	0%
Multnomah (87)	75%	23%	2%
Washington (n=87)	84%	15%	1%

**FIGURE 23 PERCENT RESPONDENTS WHO ARE VERY SATISFIED/SATISFIED WITH...**

	All Respondents (n=530)	Clackamas County (n=259)	Clark County (n=72)	Multnomah County (n=87)	Washington County (n=87)
Your own health	65%	71%	68%	53%	72%
The quality of life in your community	60%	66%	67%	39%	70%
The safety in your community	53%	59%	58%	32%	63%
Getting the medical care you need	66%	73%	75%	47%	69%
Getting the mental health or substance use care you need	39%	38%	51%	37%	40%
Getting help during stressful times	40%	38%	51%	40%	44%

### COMMUNITY STRENGTHS AND GAPS

**FIGURE 24 NUMBER AND PERCENT OF SOCIAL DETERMINANT OF HEALTH CATEGORY SELECTED AS A COMMUNITY STRENGTH AND GAP AMONG ALL RESPONDENTS**

**Q: Think about the times over the past year that you needed support to improve and/or maintain your health and wellness and received the support you needed. What support did you get? *Please select the one that was most impactful.***

Rank	Strength	Number of times selected
1	Health care supports (i.e., specialty health care, mental health care, doctors, clinics, hospitals)	361
2	Economic supports (i.e., safe workplace, job stability, good paying job)	233
3	Supports to feel safe or well in my neighborhood (i.e., community safety, housing, grocery stores, parks, transportation, internet, etc.)	195
4	Social and community connection supports (i.e., opportunities for involvement in public decision-making, arts and cultural centers and events, faith-based centers and/or organizations, summer youth programs)	156
5	Education supports (i.e., childcare, good schools, school-based resources)	83

**FIGURE 25 Q: THINK ABOUT THE TIMES OVER THE PAST YEAR YOU NEEDED SUPPORT TO IMPROVE AND MAINTAIN YOUR HEALTH AND WELLNESS AND DID NOT RECEIVE THE SUPPORT YOU NEEDED. WHAT DID YOU NOT GET? PLEASE SELECT THE ONE THAT WAS THE MOST IMPACTFUL.**

Rank	Gap	Number of times selected
1	Health care supports	188
2	Supports to feel safe or well in my neighborhood	177
3	Social and community connection supports	129
4	Economic supports	83
5	Education supports	74

**FIGURE 26 BY SOCIAL DETERMINANT OF HEALTH CATEGORY, THE PERCENT OF RESPONSES WHO FELT THE HELP/ SUPPORT/ SERVICE RECEIVED WAS ... (SELECT ALL THAT APPLY)**

	# of people who chose this	In my opinion, the help/ support/ service I received was (please select all that apply):
Health care supports	361	22% Affirming 40% Affordable <b>54% Easy to Access</b> 51% High Quality
Economic Support	233	23% Affirming 16% Affordable <b>33% Easy to Access</b> 31% High Quality
Supports to feel safe	195	25% Affirming 27% Affordable <b>53% Easy to Access</b> 41% High Quality
Social and Community connection	156	48% Affirming 35% Affordable <b>55% Easy to Access</b> 42% High Quality
Education Supports	83	19% Affirming 27% Affordable <b>46% Easy to Access</b> 39% High Quality

**FIGURE 27 BY SOCIAL DETERMINANT OF HEALTH CATEGORY, THE PERCENT OF RESPONSES WHO DID NOT RECEIVE THE HELP/ SUPPORT/ SERVICES NEEDED BECAUSE ... (SELECT ALL THAT APPLY)**

	# of people who chose this	In my opinion, I DID NOT receive the help/ support/ services I needed because they were (please select all that apply):
Health care supports	188	11% Not Affirming 28% Not Affordable <b>59% Not Easy to Access</b> 16% Not High Quality
Supports to feel safe	177	20% Not Affirming 18% Not Affordable <b>41% Not Easy to Access</b> <b>12% Not High Quality</b>
Social and Community connection	129	25% Not Affirming <b>7% Not Affordable</b> <b>47% Not Easy to Access</b> 8% Not High Quality
Economic Support	83	14% Not Affirming 22% Not Affordable <b>43% Not Easy to Access</b> <b>11% Not High Quality</b>
Education Supports	74	14% Not Affirming 38% Not Affordable <b>46% Not Easy to Access</b> 39% Not High Quality



Key themes from an analysis of “In your own words” responses, which was an opportunity for respondents to write in their own response, for avoiding getting health care, for which illustrative quotes are included:

### **COVID-related**

- Concerns about getting a COVID vaccine.
- I delayed because I was worried about COVID.
- Hospitals and clinic very busy during COVID & wild fire season in PDX.
- Didn't schedule dentist or doctor wellness visits due to avoiding covid exposure. There is a lack of available vaccine and covid testing sites with available appointments in the Gresham, Sandy area.

### **Gender**

- Gender (as a woman, I feel I am sometimes dismissed).
- My health problems are often dismissed and I think this is because I am female and have pain. Doctors are programmed not to care if someone is in pain anymore because they think the person is seeking pain medications. This blanket approach is leaving people who do not have addiction issues in pain and without treatment.
- In the past, I've found that some male doctors did not listen to me and also tried to prescribe antidepressants for fatigue. I prefer female doctors for this reason.
- I am often dismissed due to my gender being female by providers and community members of both sexes.
- I do not give personal answers to a male doctor.

### **Cultural Competency and Sensitivity**

- My health beliefs (about diet, alternative medicine, etc..) do not always align with mainstream medical thinking; some providers can be dismissive of these ideas. Also, I have found the being a post-menopausal woman seems to lead to assumptions about me that may or may not be accurate.
- I have avoided or delayed health care because I was worried that my concerns would not be taken seriously, or I would not be treated fairly because of the lack of awareness & understanding of how brain injury impacts a person's life.
- My beliefs do not align with the "dominant" culture. Many of my peers are avoiding going to the doctor for this reason.
- Because the provider had a language barrier and would not listen to me.

### **Lack of Whole Person Care**

- Going to a health care provider is getting more difficult all the time. They will only treat 1 problem at a time and then want you to reschedule to talk about something else. Then you must wait for another appointment.
- My desire to find a root cause and treat that rather than just take meds to control the symptoms is not welcomed. My use of natural treatments and birthing has been judged. I once had a very public argument with an OB Doc where I was being yelled at and told I was putting my child in danger. I left and did not return. When I did need to come back on another birth where I tore I was stitched up without any local anesthesia or any pain killers. These may have happened years ago but they impact my level of trust with western health care. I often wait to be seen until I must.

- I value an approach that supports healthy aging and proactive practices. Most health care is focused on treatment once a condition exists. Would like to see more ability to use Medicare for alternative medicine (e.g., massage and acupuncture).

### Judgement from doctor

- My weight is often seen as the problem
- Not getting help sooner

### Not enough time or attention from health care providers

- A huge concern for me in this area is simply laziness on the part of health care providers. Many health care professionals are stressed and overworked, and this creates a cookie cutter approach to care that I do not trust to properly identify and address my individual issues and health concerns.
- Too many patients for one doctor to concentrate on. In 15-20 min the doctor can't understand the whole picture of the problem.
- In the last year, my health system "forgot" or "lost" critical appointments (Breast Cancer detection). I felt numerous times the displeasure of some of the staff towards my care
- Health care providers don't seem to have the time to listen nor read your chart before you see them

## Section 3: Equity Analysis

**FIGURE 28 PERCENT RESPONDENTS WHO ARE VERY SATISFIED/SATISFIED WITH...**

	All Respondents (n=530)	BIPOC (n=97)	LGBTQ2I (n=93)	Respondents with a Disability (n=141)	Older Adults (65+ years)
Your own health	65%	59%	55%	45%	81%
The quality of life in your community	60%	40%	47%	47%	77%
The safety in your community	53%	35%	44%	42%	64%
Getting the medical care you need	66%	46%	49%	51%	85%
Getting the mental health or substance use care you need	39%	31%	31%	34%	43%
Getting help during stressful times	40%	33%	33%	38%	51%

**FIGURE 29 PERCENT OF RESPONDENTS WHO LIVE WHERE THEY GET SERVICES AND RESOURCES 50% OR LESS OF THE TIME BIPOC**

Race/Ethnicity Status	Overall number of respondents who live where they get services and resources 50% or less of the time	Percent	% of this demographic that responded
White	97	71%	25%
BIPOC	30	22%	31%
Unknown	9	7%	20%
	136	100%	

## LGBTQ2IA

**FIGURE 30 NUMBER AND PERCENT OF RESPONDENTS WHO LIVE WHERE THEY GET SERVICES AND RESOURCES 50% OR LESS OF THE TIME**

Sexual Orientation	Overall number of respondents who live where they get services and resources 50% or less of the time	Percent	% of this demographic that responded
Non-LGBTQ2IA	84	62%	24%
LGBTQ2IA	31	23%	33%
Unknown	21	15%	24%
	136	100%	

## Respondents with a Disability

**FIGURE 31**

Race/Ethnicity Status	Overall number of respondents who live where they get services and resources 50% or less of the time	Percent	% of this demographic that responded
Disabled	39	29%	28%
Not Disabled	97	71%	25%
	136	100%	

**FIGURE 32 WHAT HAVE BEEN SOME OF THE CHALLENGES FACED IN GETTING THE CARE YOU NEEDED OR WANTED?**

Percent of Respondents by Group Who Selected The Challenge	All Respondents (n=530)	BIPOC (n=97)	Non LGBTQ2IA Sexual Orientation n (n=93)	Respondents with a Disability (n=141)	Older Adults (65+ Years)
I have not experienced any barriers	36%	25%	23%	26%	37%
Poor physical access (i.e., handicap accessibility)	4%	6%	10%	10%	3%
Do not know what services and resources were available	15%	28%	25%	23%	6%
Language barriers	4%	14%	4%	5%	1%
Needed evening and/or weekend hours of service	16%	23%	29%	21%	7%
Needed services not offered in my area	12%	12%	20%	22%	5%
Not easy to travel to/lacked transportation	11%	14%	18%	23%	8%
Not eligible for services	12%	24%	20%	23%	5%
Application forms were too complicated	6%	10%	9%	9%	3%
Did not feel safe	6%	9%	5%	7%	2%
Could not find services that understood, valued, and respected my culture	5%	14%	9%	7%	2%

Percent of Respondents by Group Who Selected The Challenge	All Respondents (n=530)	BIPOC (n=97)	Non LGBTQ2IA Sexual Orientation (n=93)	Respondents with a Disability (n=141)	Older Adults (65+ Years)
Could not find providers that looked like me	0%	0%	5%	6%	1%
No health insurance	4%	10%	4%	4%	1%
High out-of-pocket costs	15%	21%	28%	20%	8%
Felt embarrassed about getting services	5%	5%	9%	10%	2%
Don't know	2%	6%	4%	1%	2%
I don't know what this question is asking	0%	1%	0%	1%	0%
I don't want to answer	1%	1%	0%	1%	1%
In your own words:	17%	16%	20%	21%	11%
Blanks	8%	4%	2%	5%	37%

### Challenges faced in getting care

Key themes from an analysis of “In your own words”, which was an opportunity for survey respondents to write in their own response, indicated challenges faced in getting care, for which illustrative quotes are included:

#### COVID-related

- Need to "justify" needing a COVID test
- In-person services were canceled by COVID restrictions
- Was denied access due to covid mandated restrictions. Covid fear porn usurped all access but government approved means
- I need to get a Covid test prior to a medical procedure. The closest location is Providence on NE 42nd (too scary). Next closest is in Tigard (too far).
- Services were delayed due to covid restrictions
- fear of going to any health care center due to covid
- Not able to access because of mask mandates
- Standing in line is very hard on my back, my daughter got me a wheelchair for the Covid shots lines
- Government lock downs were the biggest obstacle with the vaccine mandates
- Should have had much better vaccine clinics right away in our County - had to wait in line in airport in PDX for hours to get vaccinated when vaccines were available. Should have had better access in our county.
- Services not available due to high volume of covid patients - clinics for non-emergency care shut down

#### Cost

- Life supporting drug prices are too high. Health care costs are too high
- Again, after paying the premiums for ACA, no money left to actually use the services

- Because I support myself financially I am ineligible for many services. My out-of-pocket costs are very high and a barrier to quality of life. I would be screwed if I lost my job. Finding helpful providers is difficult and travel is often required which is a barrier to getting some treatments
- Shingle shots need to be free to seniors, not \$180 each, even with Medicare
- *Perdí mi trabajo ya hace más de dos meses y me quede sin aseguranza medica y hace dos semanas tuve que pagar de mi bolsa la consulta y el medicamento muy caro por cierto un botecito de 5ml a 160 dólares. lost my job more than two months ago and I was left without medical insurance and two weeks ago I had to pay out of pocket for the consultation and the very expensive medicine, by the way, a 5ml bottle at 160 dollars.*

### **Cultural and Linguistic Competency**

- The language used to access certain things are too complicated which allows people to feel not capable of filling out paperwork not capable of understanding what they're feeling out.
- I have been flat out refused services by more than one medical provider/clinic because I'm HIV+
- Could not get providers that looked like me
- Providers did not understand LGBTQ health and had stigma against my identities
- Sent in circles to find the resources I needed. Online has inaccessible language to English speakers.
- In the past, it's been hard to find medical providers that I have felt trust with. Some of that is based on my identity, and some of it is having trusted medical providers before but then not being taken seriously or getting the care I need. This history makes it hard for me to reach out, and I often wait to reach out until I'm really sure I need help.

### **Insurance**

- Providers in my area do not take my health insurance plan
- My insurance is through Kaiser - Added Choice, which means that I can use my own PCP. However, Vancouver Clinic and Kaiser do not communicate well for scheduling medical procedures.
- No vision insurance
- I do not experience this now but I lacked health insurance for most of my 20s and I still have long term health conditions that were harmed by this lack. This is one of many reasons poor people in America have a lower life expectancy than the general public.
- Change in insurance resulting in different practices/providers
- I would say that the difficulties we've experienced were in finding services for family members including health insurance and high out-of-pocket costs. I fully support and advocate for Universal Health care.
- Insufficient providers, especially in mental health
- Had to stop seeing my therapist after I changed insurance plan and her out of pocket is \$150/apt. It's hard to know who covers what these days

### **Service or doctor needed not available**

- Long wait times to see the provider of my choice.
- Provider availability. We must wait a long time for the next available appointment
- Health care overloaded/understaffed
- Hospital accessibility for surgery
- I have had to wait a long time for specialists appointments. Mental-health concerns still seem to have some stigma attached, even among health-care workers

- No in-home services
- Mental health care providers who were not seeing new patients. An extreme backlog of patients needing services, waitlists for appointments. Providers refusing to see children
- Availability of services
- Long wait list for services
- Providers were inaccessible due to over booking and lack of employees
- Access has been seriously impacted. It is impossible/very difficult to get some specialty services. I had to force pediatrics to provide appointments for both my young children on the same day/same hours. They wanted to only see the child where a CCO incentive was being met and not the child who actually needed to be seen for a condition. Other parents who are not as savvy or have the tenacity of myself would have had to come back twice and miss additional work, which means the child that needed to be seen would have been greatly impacted because the likelihood of a busy parent who may not have the resources to return would not have come back for quite some time.
- Doctor office is booked way out, hard to get appointment
- I work odd hours, so I guess hours of operation is a factor for me
- Unless you're an emergency, you usually cannot see someone today
- Health care organizations should not be able to reduce services to telehealth when the patient is asking for in person care with good reason. I had an injury continue a year longer than it should have because Kaiser would not allow me to access in person physical therapy when remote physical therapy was failing
- PT and OT should always be in-person appointments

### Transportation / Distance

- Better transportation for all and better health care as well that insurance doesn't needing to be one particular health insurance
- When my husband was very sick we had to travel to Vancouver frequently for treatments. We didn't qualify for things such as handicap housing or for assistance getting in home caregiving because we were "over income".
- No bus service in our rural areas
- Heavy traffic especially trying to go to West from the eastside, makes it very difficult
- I have had to drive 3 1/2 hours to go to a specialist in another town because none were available in my city. I have also had to have a consult with a specialist in another state because none were available in my state.
- Long distances to travel for health care - worry about wear on old car
- I get mental health care and am appreciative of it, but the provider is 15 miles away. If I had no car, I would be totally unable to get there
- Health care provider is 35 minutes away, rough to take that much time out of your day when need an appointment

### Other

- I have had negative experiences with medical professionals in the past.
- Everyone should have coverage and easy access. I feel for those that do not, as I have experienced this myself
- Such as kids received 4 month delay in getting needed dental care
- Health system is a very interesting topic to talk about. I have a lot to say but I am grateful for what I receive.
- There are times that I feel some age discrimination in a couple of local doctors offices.

- I have pulled back from some medical services in the Portland City vicinity due to the obvious (transients camping on public walkways, feces, usual panhandling related issues, lack of faith in police support if something should arise.
- In this last year, people, even in institutions have felt that they have permission to be blatantly disrespectful and negate services (like emergency transportation) because of race, gender
- All I wanted was to be able to choose between a few female PCPs in Kaiser at Sunnyside. In the search results I got loads of specialists including pediatricians but not just general practitioners at Sunnyside. It took me a few months of checking intermittently ("Find a Doctor" on the KP app) before I selected someone; then a few weeks later when I was ready to book I had to end up going to North Portland to see her
- My doctor chooses not to be all she can be so that's on her.
- Too busy with more pressing needs

**FIGURE 33 I HAVE AVOIDED OR DELAYED HEALTH CARE BECAUSE I WAS WORRIED THAT MY CONCERNS WOULD NOT BE TAKEN SERIOUSLY, OR I WOULD NOT BE TREATED FAIRLY DUE TO MY:**

	All Respondents (n=141)	BIPOC (n=42)	LGBTQ2I (n=46)	Respondents with a Disability (n=68)	Older Adults (n=21)
Age	30%	26%	33%	44%	43%
In your own words:	30%	19%	33%	28%	57%
Specific health condition (i.e., HIV/AIDS or excess weight, etc.)	29%	24%	26%	34%	14%
Disability (physical, mental, behavioral)	26%	19%	48%	43%	10%
Insurance status	23%	29%	28%	19%	19%
Gender identity	18%	12%	28%	24%	0%
Income	17%	19%	22%	24%*	14%
Race (discrimination based on physical characteristics or qualities attributed to one's race, including Black, American Indian, Pacific Islander, Asian, etc.)	16%	40%	4%	15%	0%
Ethnicity (discrimination based on cultural identity of a person, including culture, religion, nationality, ancestry, dress, and customs such as Hispanic, Latino/a, Spanish)	14%	36%	7%	13%	0%
Substance use	11%	10%	15%	10%	0%
Sexual orientation	11%	10%	28%	19%	5%
Religion or Spiritual beliefs	9%	10%	11%	9%	0%
Preferred language (i.e., I'm worried the doctor won't understand me)	6%	14%	4%	7%	10%
Immigration status	4%	10%	0%	4%	5%
Don't know	4%	2%	2%	1%	0%
I don't know what this question is asking	1%	0%	0%	0%	0%
I don't want to answer	1%	0%	4%	0%	0%

**FIGURE 34 IN YOUR OPINION, WHAT ARE THE THREE MOST IMPORTANT HEALTH DISEASES AND CONDITIONS IN YOUR COMMUNITY?**

	All Respondents (n=530)	BIPOC (n=97)	LGBTQ2I (n=93)	Respondents with a Disability (n=141)	Older Adults (n=149)
Mental health (i.e., stress, anxiety, depression, grieving, etc.)	71%	70%	78%	72%	57%
Chronic disease (i.e., diabetes, heart disease and stroke, high blood pressure)	60%	69%	53%	59%	63%
Vaccine preventable diseases (i.e., COVID-19, measles, influenza, mumps, pertussis, etc.)	41%	33%	42%	48%	52%
Substance use (i.e., alcohol, marijuana, heroin, cocaine, etc.)	38%	28%	39%	35%	38%
Dental/oral health	24%	32%	30%	30%	19%
Cancer	19%	31%	14%	14%	21%
In your own words	10%	10%	14%	16%	13%
Unintentional injuries (i.e., motor vehicle accidents, drowning)	7%	10%	6%	9%	6%
Rape/sexual assault/sex trafficking	5%	5%	12%	6%	2%
Sexually Transmitted Infections (STIs), HIV/AIDS, and other infectious diseases	4%	13%	9%	4%	1%
Don't know	4%	3%	3%	4%	8%
Blanks	4%	1%	1%	0%	0%
Respiratory/lung disease (i.e., asthma)	4%	9%	3%	2%	3%
I don't know what this question is asking	0%	0%	0%	0%	0%
I don't want to answer	0%	0%	0%	0%	0%

Key themes from an analysis of “in your own words” responses, which were opportunities for respondents to write in their own response, concerned the following health issues or topics, for which illustrative quotes are include:

**Mental health and substance use:**

- Walking through pdx - we need better support for substance use. where are the safe consumption sites? where are the street outreach workers? where are the crisis response teams?
- The mental health needs of people living in Oregon are not being adequately addressed. People living on the street need more medical services.

**Violence and Injury**

- Workplace injuries that are ‘chronic’.
- Brain Injury, #1 disability in our country.
- Domestic Violence.
- Rape/sexual assault/sex trafficking are also important, but I figure they actually fall under the mental health category.
- I would add that BIPOC people are being killed by police here and this is not properly known and addressed.
- Gun violence



- Public violence and lack of law enforcement

### **Social Determinants of Health**

- Many people do not have access to social determinants of health such as affordable housing, jobs, parks, and transportation.
- Social determinants of good health and education.
- Lack of housing, poverty.

### **General public health:**

- Living here is chaotic and deserves better humane, public health response to the issues plaguing our homeless, neighborhoods, and downtown.
- Help people take care of themselves so they stay healthy instead of spending more money and time after they become unhealthy

### **Access to care**

- There are not enough treatment facilities. There are virtually no treatment facilities that address mental health and addiction together - for youth - there are also no treatment facilities for male youth with eating disorders.
- I use my own money to get the alternative care I need.

### **Chronic diseases and risk behaviors**

- Diabetes
- Obesity.
- People with the same or similar chronic illness have poor quality of life, inability to access knowledgeable doctors, and thus often have stress/anxiety and depression.
- Being 71 little injuries (knees and hand pain) that may be chronic and slows down my active lifestyle.
- Rare, genetic, abnormally presenting and complex conditions needing to be treated by a care team of doctors. Treat the pain/comorbidities FIRST and the mental health will improve. Take it from a patient in over 70 support groups.
- Connective tissue disorders and how they are comorbid with often poorly understood and often stigmatized disorders such as: ME/CFS, migraine, autoimmune disease, spinal instability where there are only specialists on the east coast that have expertise in spinal instability as related to connective tissue disease, anaphylaxis from mast cell disease, even parents of kids with connective tissue disorders who are accused of child abuse. Critically ill patients with mobility issues are not able to access appropriate wheelchairs.

### **Environmental Quality**

- Air quality in parts of Hillsboro could be better, sometimes the sewage treatment plants stink, they say to report it when it occurs, but still they do nothing.
- Chronic genetic diseases are the biggest and chronic disease due to environmental toxin exposure.

### **Dental Care**

- People can't afford dental care. Everyone I know is constantly in a state of extreme emotional stress. Many people I know have issues with overuse of alcohol/other drugs due to mental health and stress of poverty.
- Dental care is exceptionally expensive even with insurance. Not universally available despite lots of providers.
- I'm on Medicare and must finance my own dental care.

- My Medicare supplement does not adequately cover dental care. COVID-19 is a horror story and not being adequately addressed. I do not need mental health care but many others do and can't find it.

**Other Comments:**

- En mi cultura lo consideran tabú. No es fácil hablar de estos temas. *In my culture they consider it taboo. It is not easy to talk about these issues.*
- Marijuana is not a substance in the ways that others are listed. Please stop incorporating this medicine in this description. It is a form of coopting patriarchal approaches to research, benefits and more. And who is doing the research, for how long and what are the measured outcomes and what do the measurement questions include?

**FIGURE 35 PERCENT OF RESPONDENTS BY INSURANCE TYPE WHO ARE VERY SATISFIED OR SATISFIED WITH HEALTH CARE RECEIVED AND HEALTH, BY INSURANCE STATUS**

Percent of respondents by insurance type who are very satisfied or satisfied with...	Private Insurance (n=296)	Public Insurance (n=160)	No Insurance (n=12)
Your own health	70%	70%	33%
Getting the medical care you need	71%	71%	17%
Getting the mental health or substance care you need	45%	38%	25%

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## Appendix H: Health Priority Area Supporting Data

## Appendix H: Health Priority Area Supporting Data

### A Neighborhood for All

**FIGURE 36 PEOPLE EXPERIENCING HOMELESSNESS OR HOUSELESSNESS**

	Washington State	Oregon State	Region	Clackamas	Clark	Washington	Multnomah
Rate per 10,000 people	30.1	35.0	22.2	8.4	18.8	10.3	51.3
# on One Night	22,923	14,476	6,059	352	916	618	4,173

Source: State of Homelessness Report, January 2020.

### Housing Cost Burden

**FIGURE 37 PERCENT OF HOUSEHOLDS PAYING 35% OR MORE OF THEIR HOUSEHOLD**

	Region	Clackamas	Clark	Multnomah	Washington
2010-2014	38.6	37.2	36.2	41.9	36.6
2011-2015	37.3	35.6	34.7	40.9	35.2
2012-2016	35.9	33.7	33.3	39.5	33.9
2013-2017	35.1	32.6	31.9	39.2	33.0
2014-2018	34.2	31.8	31.1	38.2	32.4
2015-2019	33.4*	31.6*	30.9*	36.8*	31.6*

\*Statistically different compared to 2010-2014. Source: American Community Survey, Table B25070.

**FIGURE 38 HOUSEHOLDS SPENDING MORE THAN 50% OF INCOME ON RENT ARE CONSIDERED SEVERELY RENT-BURDENED. RENT COSTS DO NOT INCLUDE UTILITIES, INSURANCE, OR BUILDING FEES.**

	Region	Clackamas	Clark	Multnomah	Washington
2010-2014	24.6	23.0	21.7	28.0	23.2
2011-2015	24.4	22.4	21.3	23.6	27.6
2012-2016	24.1	22.4	21.0	22.8	27.3
2013-2017	24.1	22.2	21.0	22.5	27.6
2014-2018	23.7	23.1	20.9	22.4	26.4
2015-2019	23.4*	25.3	20.9	21.1*	25.3

\*Statistically different compared to 2010-2014. Source: American Community Survey, Table B25070.

**FIGURE 39 PERCENT OF HOUSEHOLDS PAYING MORE THAN 50% OF INCOME ON HOUSING ARE CONSIDERED SEVERELY HOUSING COST-BURDENED.**

	Region	Clackamas	Clark	Multnomah	Washington
2010-2014	16.9	15.8	14.3	19.6	15.5
2011-2015	16.4	15.0	13.8	19.3	15.2
2012-2016	15.8	14.1	13.2	18.7	14.5
2013-2017	15.5	13.8	12.8	18.7	14.2
2014-2018	15.1	13.7	12.5	18.0	13.9
2015-2019	14.6*	14.1*	12.2*	17.0*	13.4*

\*Statistically different compared to 2010-2014. Source: American Community Survey, Table B25070.

**FIGURE 40 MEDIAN HOUSEHOLD INCOME, INCOME IN THE PAST 12 MONTHS, IN INFLATION-ADJUSTED 2017 DOLLARS.**

	Region	Clackamas	Clark	Multnomah	Washington
2010-2014	\$ 67,916	\$ 73,754	\$ 67,884	\$ 60,240	\$ 74,406
2011-2015	\$ 69,318	\$ 75,103	\$ 69,172	\$ 61,596	\$ 76,001
2012-2016	\$ 71,937	\$ 77,686	\$ 70,882	\$ 64,761	\$ 78,620
2013-2017	\$ 74,993	\$ 80,312	\$ 75,237	\$ 66,959	\$ 82,115
2014-2018	\$ 77,187	\$ 82,587	\$ 77,238	\$ 69,369	\$ 84,111
2015-2019	\$ 80,467*	\$ 85,371*	\$ 79,822*	\$ 73,376*	\$ 87,207*

\*Statistically different compared to 2010-2014. Source: American Community Survey, Table B19013.

**FIGURE 41 MEDIAN HOUSEHOLD INCOME BY RACE AND ETHNICITY, INCOME IN THE PAST 12 MONTHS, IN INFLATION-ADJUSTED 2017 DOLLARS.**

	Full population	Non-Hispanic White	Non-Hispanic Black	Asian or Pacific Islander	Hispanic or Latino
2010-2014	\$ 67,916	\$ 71,157	\$ 51,690	\$ 77,852	\$46,987
2011-2015	\$ 69,318	\$ 72,919	\$ 49,797	\$ 78,689	\$ 48,624
2012-2016	\$ 71,937	\$ 75,499	\$ 49,144	\$ 82,477	\$ 51,607
2013-2017	\$ 74,993	\$ 78,536	\$ 54,324	\$ 88,603	\$ 54,446
2014-2018	\$ 77,187	\$ 80,703	\$ 51,304	\$ 90,620	\$ 58,134
2015-2019	\$ 80,467*	\$ 83,918*	\$ 52,171	\$ 92,038*	\$ 61,526*

\*Statistically different compared to 2010-2014. NOTE: As reported by National Low Income Housing Coalition (Out of Reach 2020), fair market rent for two bedroom (HUD, 2020) is \$1,1441 per month. Annual income needed to afford a two bedroom at fair market rent (2020) was \$63,024. Source: American Community Survey, Table S1903.

## Violent Crime

**FIGURE 42 VIOLENT CRIME RATE PER 100,000**

	Region	Clackamas	Clark	Multnomah	Washington
2010-2014	263.6	86.4	212.5	472.0	147.8
2011-2015	232.8	68.6	216.9	407.0	125.0
2012-2016	241.5	81.4	222.3	414.1	135.5
2013-2017	249.4	96.0	228.4	420.1	142.7
2014-2018	265.0	117.9	241.2	432.7	160.6
2015-2019	282.0	145.6	255.4	450.4	171.1
2016-2020	326.9	179.6	265.8	529.1	206.7

Source: FBI Crime Data Explorer

## Essential Resources and Services

### Economic Opportunity

**FIGURE 43 PERCENT OF RESIDENTS IN FAMILIES THAT ARE IN POVERTY (BELOW THE FEDERAL POVERTY LEVEL).**

	Region	Multnomah	Washington	Clark	Clackamas
2010-2014	9.6	9.8	8.8	10.1	9.6
2011-2015	13.5	18.1	11.8	11.2	9.5
2012-2016	12.7	17.1	11.1	10.2	9.2
2013-2017	12.2	16.4	10.3	10.3	9.0
2014-2018	11.3	15.1	9.6	9.3	8.5
2015-2019	10.5*	13.8*	8.9*	9.3*	8.0*

\*Statistically different compared to 2010-2014. Source: American Community Survey (Table B17001).

**FIGURE 44 DEEP POVERTY: INDIVIDUALS IN FAMILIES WHOSE INCOME IS LESS THAN HALF OF THE FEDERAL POVERTY LEVEL, IN PAST 12 MONTHS INCOME.**

	Region	Multnomah	Washington	Clark	Clackamas
2010-2014	6.1	8.5	4.9	4.9	4.3
2011-2015	5.9	8.3	4.8	4.6	4.4
2012-2016	5.7	8.1	4.6	4.3	4.1
2013-2017	5.4	7.7	4.2	4.6	3.8
2014-2018	5.1	7.0	4.0	4.2	3.8
2015-2019	4.8*	6.3*	4.0*	4.2	3.6

\*Statistically different compared to 2010-2014. Source: American Community Survey (Table C17002).

**FIGURE 45 PERCENT OF RESIDENTS IN FAMILIES THAT ARE IN POVERTY (BELOW THE FEDERAL POVERTY LEVEL), BY AGE GROUP**

	Full population	Infants (0-4 years)	Juveniles (5-17 years)	Young Adults (18-39 years)	Middle-Aged Adults (40-64 years)	Seniors (65 and older)
2010-2014	13.8	19.3	17.9	15.5	10.1	8.3
2011-2015	13.5	18.2	17.3	15.3	10.1	8.0
2012-2016	12.7	17.3	16.1	14.3	9.5	7.8
2013-2017	12.2	16.2	15.4	13.7	9.1	8.3
2014-2018	11.3	14.8	14.0	12.5	8.8	8.1
2015-2019	10.5*	13.3*	13.1*	11.5*	8.3*	7.8

\*Significantly different compared to 2010-2014. Source: American Community Survey (Table C17002).

**FIGURE 46 PERCENT OF CURRENTLY EMPLOYED RESIDENTS 16 AND OVER WHO ARE IN POVERTY.**

	Region	Clackamas	Clark	Multnomah	Washington
2010-2014	7.2	4.8	5.3	9.8	6.7
2011-2015	7.2	4.8	5.2	9.8	6.8
2012-2016	6.7	5.0	4.8	9.0	6.3
2013-2017	6.4	4.8	4.8	8.6	5.8
2014-2018	5.8	4.3	4.3	7.8	5.5
2015-2019	5.3*	4.0*	4.1*	7.1*	4.9*

Source: American Community Survey (Table B17005)

**FIGURE 47 ECONOMIC CHARACTERISTICS AMONG PEOPLE WITH A DISABILITY, 2015-2019**

	Region	Clackamas	Clark	Multnomah	Washington
Total Population Age 16 Over	1,826,437	330,486	369,305	662,120	464,526
Total Population with a Disability	248,046	45,563	54,010	94,497	53,976
% Population with a Disability	13.6%	13.8%	14.6%	14.3%	11.6%
% Population Employed	64.1%	62.0%	61.5%	66.5%	66.5%
% Population with Disability and Employed	27.5%	26.3%	26.4%	28.1%	29.0%
% Total Population and Less than High School Graduate	7.6%	6.6%	7.3%	8.5%	7.8%
% Population with Disability and Less than High School Graduate	13.1%	12.5%	11.8%	16.2%	11.7%
Median Earnings in past month among Total Population	\$40,126.50	\$41,647.00	\$40,093.00	\$37,658.00	\$41,108.00

Median Earnings in past month among Population with a Disability	\$27,595.50	\$29,771.00	\$30,036.00	\$23,235.00	\$27,340.00
% Total Population At or above 150% of Poverty Level	84.6%	87.5%	85.1%	79.6%	86.1%
% Total Population with Disability At or above 150% of Poverty Level	72.3%	75.9%	73.7%	63.2%	76.2%

Note: Regional estimates are unweighted averages. Source: American Community Survey (Table S1811)

**FIGURE 48 UNEMPLOYMENT RATE BY RACE AND ETHNICITY AND DISABILITY STATUS, 2015-2019**

	Region	Clackamas	Clark	Washington	Multnomah
With any disability (of any race/ethnicity)	10.8	10.0	11.1	11.3	10.9
White alone	4.3	4.5	4.2	4.2	4.4
Some other race alone	6.4	6.3	5.8	8.2	5.3
Multiracial	7.4	6.5	6.9	8.3	8.0
Native Hawaiian/Other Pacific Islander alone	4.6	6.7	1.4	6.4	3.7
Hispanic or Latino origin (of any race)	5.3	5.7	4.2	6.2	5.2
Black/African American alone	8.6	9.4	5.2	9.1	10.6
Asian alone	4.3	5.4	3.7	3.4	4.5
American Indian/Alaska Native alone	8.1	8.0	7.9	6.0	10.5
Total Population Age 16 and over	4.7	4.8	4.4	4.5	4.9

Note: Regional estimates are unweighted averages. Source: American Community Survey (Table S2301)

### Education Opportunity

**FIGURE 49 RESIDENTS 25 OR OLDER WITH AT LEAST A HIGH SCHOOL DEGREE: INCLUDING GED AND ANY HIGHER EDUCATION**

	Region	Clackamas	Clark	Washington	Multnomah
2010-2014	90.9	92.8	91.2	90.6	90.0
2011-2015	91.1	93.1	91.4	90.7	90.3
2012-2016	91.4	93.3	91.7	90.8	90.7
2013-2017	91.7	93.2	92.0	91.3	91.0
2014-2018	91.9	93.3	92.3	91.6	91.3
2015-2019	92.2*	93.4	92.7	92.2	91.5

\*Significantly different compared to 2010-2014. Source: American Community Survey (Table B15002)



**FIGURE 50 RESIDENTS 25 OR OLDER WITH AT LEAST A HIGH SCHOOL DEGREE: INCLUDING GED AND ANY HIGHER EDUCATION, BY RACE AND ETHNICITY**

	Full population	Non-Hispanic White	Non-Hispanic Black	Asian or Pacific Islander	Hispanic or Latino
2010-2014	90.9	94.5	88.4	84.6	63.9
2011-2015	91.1	94.6	89.1	84.9	65.5
2012-2016	91.4	94.9	89.3	85.0	66.4
2013-2017	91.7	95.0	89.7	86.1	68.2
2014-2018	91.9	95.3	89.4	86.6	69.2
2015-2019	92.2*	95.6*	89.3	86.5	69.9

\*Significantly different compared to 2010-2014. Source: American Community Survey (Table B15002).

**FIGURE 51 PERCENTAGE OF 3- AND 4-YEAR-OLDS ENROLLED IN SCHOOL**

Region	Clackamas	Clark	Washington	Multnomah
2010-2014	45.5	44.9	39.1	49.5
2011-2015	47.1	47.7	39.1	50.7
2012-2016	47.4	48.1	37.8	52.5
2013-2017	47.9	48.2	38.5	53.4
2014-2018	48.5	48.0	39.8	55.0
2015-2019	49.4*	49.0	39.2	56.4*

\*Significantly different compared to 2010-2014. Source: American Community Survey (Table C17002).

### Access to Culturally Specific and Healthy Foods

**FIGURE 52 ADDITIONAL MONEY THAT WOULD BE NEEDED FOR RESIDENTS THAT ARE FOOD-INSECURE TO BUY ENOUGH FOOD FOR THEIR HOUSEHOLD.**

	Annual food budget shortfall
Region	\$ 140,638,164.29
Clackamas	\$ 22,305,789.04
Multnomah	\$ 59,185,810.87
Washington	\$ 30,296,159.90
Clark	\$ 28,850,404.49

Note: Calculated using the weekly food budget shortfall of people reporting food insecurity, weighted by the time spent food-insecure. This number can be interpreted as the amount of food benefits that would be needed to ensure nobody goes to bed hungry.

Source: Feeding America (Map the Meal Gap 2020)

**FIGURE 53 PERCENT RESIDENTS WHO HAVE LOW TO VERY LOW FOOD ACCESS**

	Very low food access	Low food access
Region	14.1	35.0
Clackamas	17.6	34.4
Multnomah	7.5	33.8
Washington	14.2	40.1
Clark	22.0	31.4

Note: Percent of residents who have low access to food, defined solely by distance: further than 1/2 mile (low) or 1 mile (very low) from the nearest supermarket in an urban area, or further than 10 miles in a rural area. Source: USDA (Food Access Research Atlas).

### Access to Virtual Resources

**FIGURE 54 NUMBER AND PERCENT OF HOUSEHOLDS WITH NO ACCESS TO THE INTERNET THROUGH SUBSCRIPTION BROADBAND, DIAL-UP, SATELLITE, CELLULAR DATA, OR ANY OTHER SERVICE**

Year	Region	Clackamas	Clark	Washington	Multnomah
2013-2017	10.4%	10.7%	9.8%	8.4%	12.0%
2014-2018	9.0%	9.2%	8.4%	7.0%	10.6%
2015-2019	7.8%	8.6%*	7.2%	6.0%*	9.2%*
Total Households (2015-2019)	902,937	161,295	180,862	222,877	337,903
% of Households (2015-2019)	70,429	13,871	13,022	13,373	31,087

\*Significantly different compared to the region. Note: Regional estimates are unweighted averages. Source: American Community Survey (Table B28002).

## Access to Culturally and Linguistically Responsive health Care

### Affordable Health Care For All

**FIGURE 55 PERCENT OF RESIDENTS WITHOUT HEALTH INSURANCE**

	Region	Washington	Multnomah	Clackamas	Clark
2010-2014	13.1	13.0	14.6	11.1	12.4
2011-2015	11.3	11.3	12.4	9.6	11.0
2012-2016	9.5	9.5	10.4	8.1	9.3
2013-2017	8.1	8.1	8.9	6.8	7.7
2014-2018	6.6	6.8	7.1	5.6	6.3
2015-2019	6.0*	5.9*	6.7*	5.3*	5.8*

\*Significantly different compared to 2010-2014. American Community Survey, Tables B27001/C27001.

**FIGURE 56 PERCENT OF RESIDENTS WITHOUT HEALTH INSURANCE BY AGE, 2015-2019**

	Region	Clackamas	Clark	Washington	Multnomah
Full population	6.0	5.3*	5.8	5.9	6.7*
Infants (0-4 years)	2.5*	2.9	2.3	3.3	2.0
Juveniles (5-17 years)	3.0*	3.2	2.7	3.1	3.0
Young Adults (18-39 years)	10.0*	9.0*	10.8	9.3	10.5
Middle-Aged Adults (40-64 years)	6.0	5.8	5.5	6.2	6.3
Seniors (65 and older)	0.8*	0.6	0.7	0.6	1.0

\*Significantly different from the region for that age group. Source: American Community Survey, Tables B27001/C27001.

**FIGURE 57 PERCENT OF RESIDENTS WITHOUT HEALTH INSURANCE BY SEX, 2015-2019**

Sex	Region	Clackamas	Multnomah	Washington	Clark
Full population	6.0	5.3	6.7	5.9	5.8
Females	5.3*	4.5	5.8	5.2	5.2
Males	6.8*	6.2	7.5	6.6	6.4

\*Significantly different from the region for that age group. Source: American Community Survey, Tables B27001/C27001.

**FIGURE 58 ACCESS TO PREVENTATIVE CARE**

	Visited doctor for routine checkup (2019) <sup>1</sup>	Visited dentist (2018) <sup>2</sup>	Taking medicine for high blood pressure control among adults aged >=18 years with high blood pressure (2019)	Cholesterol screening among adults aged >=18 years (2019)
Region (unweighted average)	69.6	68.8	50.3	85.5
Clackamas	69.1	70.1	49.1	86.0
Multnomah	71.9*	67.5	49.1	86.6
Washington	71.0	66.5	51.8	87.8
Clark	66.3*	71.6	51.3	81.7*

\*Significantly different compared to the region 1. Percent of resident adults aged 18 and older who report having been to a doctor for a routine checkup (e.g., a general physical exam, not an exam for a specific injury, illness, condition) in the previous year (Age-adjusted prevalence). 2. Percent of resident adults aged 18 and older who report having been to the dentist or dental clinic in the previous year (Age-adjusted prevalence). Source: PLACES, Behavioral Risk Factor Surveillance System (BRFSS).

**FIGURE 59 ACCESS TO PREVENTATIVE CARE (CONTINUED)**

	Mammography use among women aged 50–74 years (2018)	Cervical cancer screening among adult women aged 21–65 years (2018)	Older adult men aged ≥65 years who are up to date on a core set of clinical preventive services: Flu shot past year, PPV shot ever, Colorectal cancer screening (2018)	Older adult women aged ≥65 years who are up to date on a core set of clinical preventive services: Flu shot past year, PPV shot ever, Colorectal cancer screening, and Mammogram past 2 years (2018)
Region (unweighted average)	74.0	86.3	23.6	26.2
Clackamas	72.7	87.7	23.0	23.6
Multnomah	75.5	86.4	23.3	26.3
Washington	78.6	85.3	22.0	27.9
Clark	69.1	85.7	25.9	27.0

Source: PLACES, Behavioral Risk Factor Surveillance System (BRFSS).

## Support Family And Community Ways

### Social support and connection

**FIGURE 60 DISCONNECTED YOUTH: PERCENT OF RESIDENTS AGES 16-19 YEARS WHO ARE NEITHER WORKING NOR ENROLLED IN SCHOOL, 2015-2019**

	Region	Clackamas	Clark	Multnomah	Washington
2010-2014	8.8	8.1	9.5	9.5	7.9
2011-2015	7.9	8.0	7.6	8.8	6.8
2012-2016	7.1	6.9	7.1	7.9	6.3
2013-2017	6.4	6.5	6.2	7.1	5.4
2014-2018	6.2	6.3	6.5	6.4	5.6
2015-2019	6.0*	6.1*	6.7	6.0*	5.1*

\*Significantly different compared to 2010-2014. Source: American Community Survey (Table B14005).

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# Appendix I: Health Behaviors and Outcomes Supporting Data

**FIGURE 61 SENIORS LIVING ALONE: PERCENT OF RESIDENTS AGE 65 AND OLDER WHO LIVE ALONE.**

	Region	Clackamas	Multnomah	Washington	Clark
2010-2014	28.4	25.0	31.6	28.8	25.5
2011-2015	27.9	24.7	31.7	27.4	25.2
2012-2016	27.6	24.5	31.5	27.1	24.4
2013-2017	27.6	24.5	31.4	26.7	24.8
2014-2018	27.7	24.6	31.8	26.6	25.1
2015-2019	27.4	25.0	31.1	26.5*	24.4

Note: Does not include those living in group homes such as nursing homes. \*Significantly different compared to 2010-2014. Source: American Community Survey (Table B09020)

## Appendix I: Health Behaviors and Outcomes Supporting Data

Visit

<https://docs.google.com/spreadsheets/d/1ziGYOfw3eNoReJieqN9pnXpg3O02pmQI/edit?usp=sharing&ouid=115656647515966616299&rtpof=true&sd=true>

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## Appendix J: CHNA Data Limitations

## Appendix J: CHNA Data Limitations

Qualitative data is ideal for capturing rich descriptions of lived experiences. Despite efforts to speak to a broad range of community members, limitations to the qualitative data remain:

- ▶ Community-based organizations (CBOs) helped to recruit community members for focus groups. Communication materials, including electronic and paper flyers, social media posts, and newsletters were used to recruit participants. CBOs leverage their existing networks and communication channels. This strategy is necessary for contacting community members and for securing spaces where participants feel safe. However, it inherently excludes disconnected individuals (i.e., those not engaged in services).
- ▶ CBOs limited capacity and the ability to prioritize these sessions given the additional services and supports they are offering due to the needs exacerbated by COVID-19 and Oregon's wildfires.
- ▶ Many of the CE sessions were conducted via Zoom in a virtual setting. The virtual sessions required technology to work and for participants to have access to and to be comfortable with that technology.

**Limits to the quantitative data included a lack of sufficiently granular data.** Many of the health indicators and outcomes do not allow for analysis by subgroup such as race, ethnicity, or county. For some indicators, the data collection process does not encompass these and other subgroups. For example, it is difficult to capture health information about migrant workers or incarcerated populations. Without this individual and community representation in the data, the ability to understand the nuances of the health issues and socioeconomic factors is challenged. One example of this is the 2020 Census. The 2020 Census was an important opportunity to achieve a fair and equitable count so that all community members are represented in population data. This is vital because:

- ▶ It determines how resources are allocated.
- ▶ It informs representation in government.

Each county in the region was above the national census return rate (the number of people who return a completed census survey). This means the rate at which people responded to the census in each county in the region was higher than the rate of return in United States.<sup>23</sup> However, this was not true for all populations within each county. Figures 1 and 2

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<sup>23</sup> A county's census self-response rate is one of 84 metrics used to assess community health and well-being in the 2020 Healthiest Communities rankings. The metrics fall into 10 broad health and health-related categories,



below reveal that this is true for the region too. **Figure 62 shows the percent of communities within the region by the percent of the population who are BIPOC and census return rates.**

**FIGURE 62**

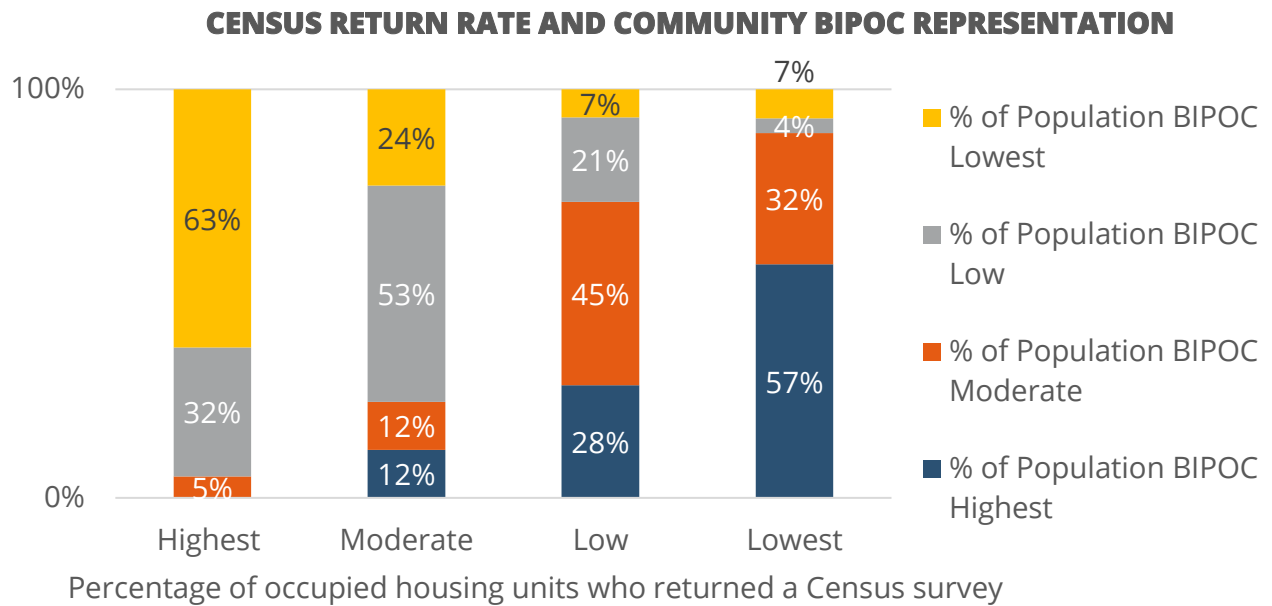
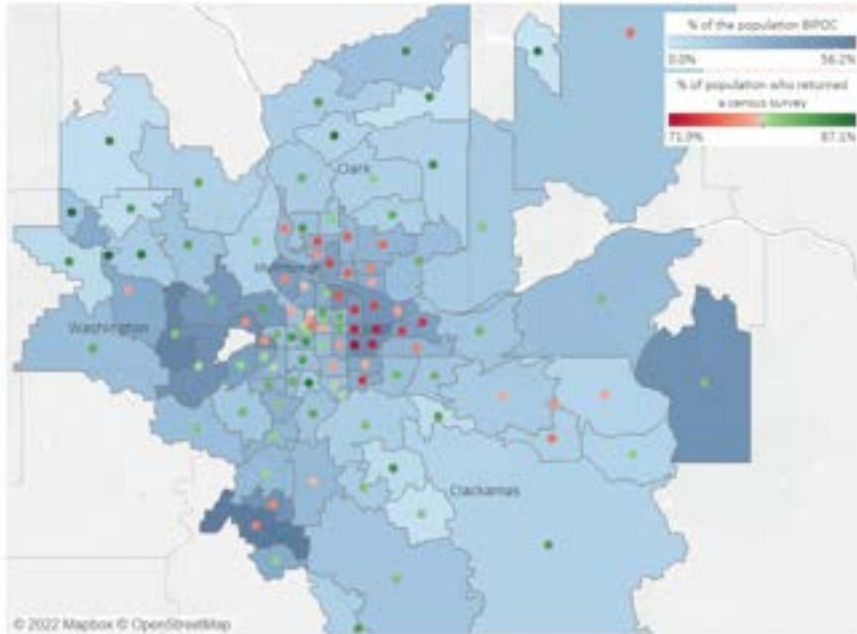


Figure 63 provides a geographic illustration. Dark blue areas in the map reflect areas with higher BIPOC populations. Red circles indicate areas with the lowest Census return rate. Together, dark blue areas and red circles were areas with low census return rates within large BIPOC resident communities.

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from equity and housing to public safety and population health. The rate is part of the community vitality category, which also includes measures of voter participation and the share of nonprofits per capita within a community.

**FIGURE 63**



Percentage of occupied housing units that complete and return the decennial Census form. Source: Decennial Census, 2010.

**All data sets used in the CHNA have limitations. There are both technical and political issues to consider:**

- ▶ The raw data that is collected, in addition to the stories that the data tells, generally reflects the values of the entity that is collecting the data.
- ▶ Databases reflect individual, legal, and societal decisions about what information are open to making public.
- ▶ Data are often categorized in ways that reflect dominant cultural norms and practices. And, even when these norms are changing (as in the case of acknowledging multi-racial identities or a spectrum of gender identities), public databases may lag years behind how researchers and activists are reconfiguring identity groups and other classifications.
- ▶ Data has and continues to “erase” various communities in its collection, analysis and reporting processes which are often rooted in dominant structure frameworks. Identifying health disparities requires data on health status and individual determinants of health for subgroups of the population, at the national, state, and community levels—

Peer Review Group Members

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- ▶ Carla Edith Jimena

data that are frequently difficult to obtain. Problems include small sample sizes, missing data, and measurement errors.<sup>24</sup>

Recognizing that anti-racist data approach is still an emerging practice, the CHNA partners recognized the limitations of our own experience in this space and the tension between dominant culture data practices and community-centered approaches. Local experts were from these communities who have dedicated their field of practice and study to these topics.

The Peer Review Group reviewed the proposed CHNA process, indicators, and data sources to make recommendations for how to elevate anti-racist, Indigenous practices of data collection, analysis, and reporting. These materials were reviewed by the CAT members over several in-depth discussions from March 2021 to July 2021 with a framework and the list of recommendations were developed in July 2021. These recommendations were used to shape subsequent data analysis and reporting processes as well as serve as an accountability tool for the partners of this project.

Through this process, this CHNA seeks to name the continued challenges with data that perpetuates racism and white supremacy culture. More data in the future is needed to emphasize community strengths and center racial justice – as this CHNA strives to do. Lastly, future CHNA and data efforts should be done in relationship with community members, be intentional about power-sharing, and center community member stories and wisdom.

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<sup>24</sup> Bilheimer, L. T., & Klein, R. J. (2010). Data and measurement issues in the analysis of health disparities. *Health services research, 45*(5 Pt 2), 1489–1507. <https://doi.org/10.1111/j.1475-6773.2010.01143.x>

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## Appendix K: Reflections for Future CHNAs

## Appendix K: Reflections for Future CHNAs

Developing a community-informed and equity-centered community health assessment is a complex and daunting task that takes considerable time and resources. Developing one amid a pandemic, unprecedented environmental events (wildfires and extreme heatwaves), and extreme political and civil unrests is even more challenging. Here are some reflections on this CHNA that are intended to help inform future efforts.

### **DATA SOURCES AND ASSESSMENTS**

Data sources and assessments that are grounded in anti-racist data practices, uplift community wisdom and experience, and allow data stratification by race, ethnicity, language, disability, and more are few and far between. Having comparable data sources between regions is another limitation. These pose challenges to developing regional comparisons, understanding disparities by populations, and understanding and addressing the challenges faced by the region's communities. Efforts and investments to support data collection and assessments that leverage emerging anti-racist data collection practices and are community-driven are needed in the region.

### **ROLE OF THE CAT AND COMMUNITY**

This cycle of the HCWC CHNA pushed the role of community further into the forefront than previous cycles. The CAT was a critical piece of this project. The CAT identified the priority areas, priority populations, community engagement efforts, and made meaning out of the data. Their knowledge of what is going on in the community and the relationships they bring were vital. However, time and budget constraints posed challenges to advancing this community-led effort, meaning that the bulk of the work conducting this CHNA, collecting and analyzing the data, and writing this report fell to the paid staff doing this assessment. Additionally, and perhaps the most significant barrier to community engagement this past cycle, was the time constraint created by the timeline. Conducting a community-driven and equity-centered CHNA takes significant resources and the two-year period created challenges in allowing the CAT the time necessary to meaningfully engage in all aspects of the CHNA. Many significant events over the last two years not only impacted the health of communities, but also their availability to participate in this CHNA. The impact of the pandemic as many CAT members expressed mental and emotional exhaustion due to the realities of living in a pandemic and managing rising racism and race-based hate crimes. Many of the community-based organizations and community members engaged reported similar concerns.

Future CHNAs could continue to advance community-driven efforts by funding organizations closer to communities to conduct the assessments themselves. These assessments could then become the data sources for the HCWC CHNA, rather than HCWC CHNA doing their own data collection. Additionally, we'd recommend going back to a three-year cycle and leveraging the CAT relationships and capacity by engaging members interested in the next cycle.

## **DATA ANALYSIS AND DEPICT MODEL**

To pursue a more community-led and anti-racist data approach, various collaborative data analysis models were researched and shared with the CAT. The DEPICT model was selected which would allow the CAT to engage in every aspect of the assessment methods, including data analysis and reporting.<sup>25</sup> While the DEPICT model aligned with the desires of the CAT, ultimately, the process lacked the budget or time necessary to implement it fully. The CHNA adopted a modified DEPICT approach. Future cycles should consider the necessary resources and time to use the full DEPICT.

## **TRANSLATION AND INTERPRETATION**

Increased support and forward-thinking intention at the beginning of this process is needed around hosting a bilingual project and subsequent bilingual meetings. CHNA staff should be prepared to engage with a multilingual audience, including how to use interpreters and plan projects around the needs of translation and interpretation. Moreover, ensuring project activities and plans don't create gaps in participation for non-English speaking participants is needed.

One of the barriers in this cycle was the costs associated with translating materials into other languages and for interpretation to ensure full participation and access to community engagement opportunities. This includes serving on the CAT. Additionally, with centering equity and engaging more diverse communities – it is imperative that efforts are taken to ensure the final product is accessible to those very communities being represented. This means having a more robust budget for translation and interpretation including making the completed CHNA available in multiple languages.

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<sup>25</sup> <https://www.semanticscholar.org/paper/The-DEPICT-model-for-participatory-qualitative-in-Flicker-Nixon/c25d631d54ee6f70a2e5ace24dcdd5b25c7884d4>

## **PEER REVIEW GROUP RECOMMENDATIONS**

Upon review of the data available and the start of analysis, it became clear that a better understanding of the emerging decolonized data and community-centered research and data practices was needed. This led to the convening of the Peer Review Group. The group's recommendations should continue to inform future HCWC cycles as the collaborative continues to move closer to a community-led and equity-centered CHNA and process.

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# Appendix L: Peer Review Group Recommendations and Action Steps



## Appendix L: Peer Review Group Recommendations and Action Steps.

The following are considerations recommended by the Peer Review Group. Upon final review, OHEA sorted these considerations by partners within the HCWC CHNA project (CAT, HMA, OHEA). For each consideration we have provided a suggested next step and action.

**Summary of Consideration/Implications:** Documents offer good language for drafting the CHNA, including how to describe our approach. For example, the CHNA should:

- ▶ Include introductory language framing our approach to the CHNA, and how it is similar and different from previous processes, including a section on how we centered community/communities in our CHNA
- ▶ Make sure the CHNA is developed and written from a strengths-based approach/perspective
- ▶ Reflect the story and narrative the CAT is trying to build
- ▶ Include context for the CHNA that names historical and contemporary injustices, oppressions, etc, and acknowledges the impacts on community outcomes
- ▶ Explicitly name racism, colonialism, white supremacy culture, and white superiority as determinants of health that must be acknowledge and addressed - these are the drivers of the outcomes we see
- ▶ Describe who this CHNA is for, how we hope it is used, and explicitly state how we don't want it used (as weapons against our communities)
- ▶ Offer an expansive definition of "data" that we used in this CHNA, and the limitations of different data sources used
- ▶ Be explicit and clear on how we stratified data and what the categories mean/how they are defined.

### Considerations/Next Steps for the CAT

Consideration/Recommendation	OHEA Response	HMA Response
<p>1. Focus on what power and strengths the community has versus what they need; demonstrate appreciation and value(ing) of those contributions to the</p>	<p>We recommend that this consideration be used as a guide during upcoming data analysis and communication planning. It should be revisited as a guiding framework for both sections.</p>	<p>Agree – CE sessions, survey, and CAT activities are structured to gather data to this end, HMA will have this front of mind as overarching goal of analysis and CHNA overall all. Outline for CHNA included this in</p>

Consideration/Recommendation	OHEA Response	HMA Response
<p>greater good and also to the very community they emerge from</p>		<p>framework.</p>
<p>2. The indicators are heavily focused on deficits instead of strengths, and tell a narrative of challenges and deficits of a community “at risk” and lacks self-determination.</p> <p>a. Does the community want to tell a story of deficits? Or do they want to tell a story of strengths and resistance and of thriving futures? Were they given a choice?</p> <p>b. How are community members disrupting the structural inequities, historical violence, and trauma underlying the outcomes represented by the indicators? This data is critical to the assessment</p> <p>c. How is power being exercised and manifested in this community? Who has agency?</p>	<p>We recommend the CAT play a role in assessing if the final indicator list developed by HMA exhibits what is said to the left.</p> <p>We recommend that this consideration be used as a guide during upcoming data analysis and communication planning. It should be revisited as a guiding framework for both sections.</p> <p>Ensure the initial framing (logic model) of indicators is revisited throughout the process.</p>	<p>Agree – Most indicators pulled from previous HCWC CHNAs. Intend to conduct an assessment of each indicator, example questions to assess each indicator include:</p> <ul style="list-style-type: none"> <li>• Is it strengths-based or deficit based</li> <li>• How was community engagement in the data source</li> <li>• Is it a trusted source by BIPOC communities</li> <li>• How has the data been used - historical impacts of that data?</li> </ul> <p>HMA recognizes that indicators/outcomes just part of story, all indicators are driven by structural / systemic factors. HMA can 1) look at different ways to link data indicators (risk/protective factors versus how is connected to structures, 2) code for mentions of structural inequities, historical violence, and trauma in CE session and survey data</p> <p>E.g. Have data about youth suicide, put side by side with data about protective factors related to youth suicide. Put deficit up with community capacity to address (school connectedness? Others?). Present</p>

Consideration/Recommendation	OHEA Response	HMA Response
		<p>structural solutions to problem, not community deficits, problem lies in structures not individual/community behaviors.</p> <p>Consider an approach such as the “5 Whys” – 3 issues we prioritize, can CHNA structured around 5 whys?</p>
<p>3. Begin with the vision of the future the group would like to see its community in; that will be the guide</p>	<p>We recommend this serve as a guiding framework for final report creation and communications plan.</p>	<p>Agree</p>
<p>4. Focus on upstream processes and structural/institutional origins of the outcomes instead of focusing on the outcomes at the individual level - the outcomes represented by the indicators will not change unless the upstream causes shift</p>	<p>We recommend that this be used as a guide during data analysis and communication planning.</p> <p>We recommend this be used as a guiding framework when coding and theming transcripts as well as capacity building with CAT that ties structural forces named in data to outcomes. These efforts should be noted in the final report as a part of this process.</p> <p>We recommend ensuring transparency about the flaws of this process i.e. use of ACS data</p>	<p>Agree.</p> <p>Clarification: HMA is not focusing on outcomes at the individual level, CHNA is community level. Understand concerns of breaking up community by categories. We will connect outcomes to structures/systems.</p>

Consideration/Recommendation	OHEA Response	HMA Response
<p><b>5.</b> Many of the indicators selected are from datasets that BIPOC communities do not trust due to colonial and imperialist methodologies.</p>	<p>We recommend including a note on datasets in the beginning of the CHNA that acknowledges specific issues with data sources and what efforts were made to adjust to this.</p> <p>We recommend mentioning that PRG in the final report and why.</p>	<p>Agree. Agree.</p> <p>We need to think through what this mean for us in regards to 1) how to educate community the limitations of the data sources 2) if and how to use the indicators to tell the community story.</p>
<p><b>6.</b> Public health data and CHNA methodologies are rooted in implicit and explicit colonization and white supremacy</p>	<p>We recommend defining elements of community-centered approach that were taken in this project in order to address problematic methodologies in final report. We recommend highlighting our use of community facilitators as a way to demonstrate community-led processes. If possible, facilitators can be invited to note what it was like facilitating the focus groups.</p> <p>If possible, we recommend including recommendations that have come from CAT conversations about how this can be mitigated for in future assessments.</p>	<p>Agree. Agree.</p> <p>Agree – can include lessons learned? We need to ensure CAT perspective and recommendations are being collected / captured.</p> <p>HMA will be sure to recognize why we used Peer Review Group as part of process.</p>
<p><b>7.</b> Adverse health outcomes are the result of historical and intergenerational trauma, and other structural and institutional factors - the unit of analysis should be community, not the individual (e.g. access might be</p>	<p>We recommend that we explicitly name an SDOH framework that includes naming racism, colonization, and colonialism as fundamental SDOH as part of the data analysis and the report.</p> <p>We recommend using this as a guiding framework for the codebook development</p>	<p>Agree.</p> <p>Consider frameworks such as the Political determinants of health or Sum of Us <a href="#">Heather McGhee</a> Framework for codebook is CAT-driven logic model – HMA will include codes to address structural/institutional factors,</p>

Consideration/Recommendation	OHEA Response	HMA Response
experienced individually but the origins of inequitable access are structural)	and development of themes.	racism,
<p>8. Access is not enough - can have access but the experience engaging with institutions can be harmful; need to understand how institutions fail to serve community members. Need to understand why institutions refuse to take action to dismantle and abolish embedded institutional racism. Need to understand the models for taking such action</p>	<p>Looking to the next CHNA, we recommend using this as a core consideration when considering project timelines to challenge false parameters of the project (HMA as project management, for HCWC Exec Team to consider/reflect on). In what ways did we render parts of this process inaccessible due to timelines?</p> <p>We recommend considering how the survey responses acknowledge this recommendation/framework (ex. Do folks select that something is physically accessible but that it is not culturally responsive?)</p>	<p>Debrief/lessons learned – not include in CHNA, but can conduct and report to OHEA, HCWC, other</p>
<p>9. The focus on outcomes is not enough -- we must also examine the processes, context, and history of these outcomes</p> <p>10. -AND-</p> <p>11. The indicators are heavily focused on deficits instead of strengths, and tell a narrative of challenges and deficits of a community “at risk” and lacks self-determination.</p>	<p>We recommend considering this as a guiding framework for the codebook development and that final reporting is done with this framework in mind</p> <ul style="list-style-type: none"> <li>• OHEA can support ensuring this is done</li> </ul>	<p>Agree – HMA goal is to always connect outcomes to processes, context, and history of these outcomes</p> <p>An assessment should be done of the existing indicator list for 1) where we can “reverse” the indicators to be strengths based 2) identify the data that are needed to examine the underlying/root causes of the outcome that any one indicator suggests</p>

Consideration/Recommendation	OHEA Response	HMA Response
<p>12. Does the community want to tell a story of deficits? Or do they want to tell a story of strengths and resistance and of thriving futures? Were they given a choice?</p> <p>13. How are community members disrupting the structural inequities, historical violence, and trauma underlying the outcomes represented by the indicators? This data is critical to the assessment</p> <p>14. How is power being exercised and manifested in this community? Who has agency?</p>		
<p>15. Reject dominant hierarchies of knowledge; everything can be data, not just quantitative/numeric data</p>	<p>We recommend including stories (including from CAT members) as section leads, as a way to contextualize quant in qualitative setting.</p>	<p>Agree. Any coding of CE sessions and survey data will include one for stories. Consider also to identify stories that highlight disruption, or programs being run in ways that have grown out of community</p>
<p>16. Data should be community centered and community collected/analyzed using principles of data justice</p>	<p>We recommend naming the PRG was a necessary partner in the data analysis portion of the work in the final report</p>	<p>Agree.</p>
<p>17. The purpose of administrative data (Census, ACS, Vital Stats, Immunization, etc.) is surveillance, not the equitable</p>	<p>We recommend that folks analyzing the datasets mentioned gain understanding about the racist foundations of these data sources. This will require personal capacity</p>	<p>Agree. Include in CHNA section on data source limitations See below for a list of references HMA is</p>

Consideration/Recommendation	OHEA Response	HMA Response
distribution of resources or the assessment of needs. This kind of data continually erases communities. This data must be interpreted within this context.	building work. Limitations of this data should also be named to the CAT and in the final report.	using to inform approach to the CHNA
18. More data is not necessarily better, and the use of multiple datasets that are collected by disparate institutions will lead to a lack of harmonization (especially with regard to definitions and categories of data collected)	<p>We recommend this as a consideration for the HCWC Exec team, in support of future RFP's and CHNA/CHIP processes.</p> <p>ZJ: Can we pull some of these HCWC Exec points and share as recs for the next process(es) for CHNA and CHIP?</p>	<p>Agree!</p> <p>HMA is committed to a prioritization process to ensure data included is meaningful</p>
19. Use community stories and other qualitative data as a primary source for indicators; focus on knowledge, lessen reliance on quantitative data	<b>(REPEAT)</b> We recommend including stories (including from CAT members) as section leads, as a way to contextualize quant in a qualitative setting.	Agree.
20. Make distinction between primary, secondary, tertiary data sources and make sure to thoroughly vet and critique primary sources, explicitly name primary sources	Recommendation as is: Make distinction between primary, secondary, tertiary data sources and make sure to thoroughly vet and critique primary sources, explicitly name primary sources	<p>Agree.</p> <p>CHNA should include a description of these types of data sources, and the prioritization/assessment process conducted to vet whether any data source is included in the CHNA. For example, some criteria might be:</p> <ul style="list-style-type: none"> <li>• How was community engagement in the data source</li> <li>• Is it a trusted source by BIPOC communities</li> </ul>

Consideration/Recommendation	OHEA Response	HMA Response
		<ul style="list-style-type: none"> <li>How has the data been used - historical impacts of that data</li> </ul>
21. If data is stratified by demographics, need to be explicit as to how these are defined (racial categories, sexual orientation and gender identity categories)	Recommendation as is: We recommend including stories (including from CAT members) as section leads, as a way to contextualize quant in qualitative setting.	Agree
22. Need to critically evaluate data quality and <b>make explicit</b> the limitations (e.g. Medicaid data is often missing race/ethnicity data)	We recommend limitations of this data should be named in the final report as we become aware of them.	Agree. Include in the data limitations section reference to how data often drives invisibility
23. See detailed critique of data sources ( <a href="#">link to matrix</a> )	Recommendation as is: See detailed critique of data sources ( <a href="#">link to matrix</a> )	Agree. Consider include matrix as an appendix to the CHNA, and referenced during the data limitations sections

Consideration/Recommendation	OHEA Response	HMA Response
24. Consider and identify the level of community engagement in the data - was it meaningful, was there transfer of power, or was it performative?	<p>We plan to continue to review the data analysis processes and ensure capacity building and co-learning opportunities are integrated into each step of the process for the CAT</p> <p>We plan to create a timeline of the project that reflects steps of community engagement for final report</p>	



	<p>We plan to include a critique about our community engagement process via focus groups</p> <p>What role we played in fostering harmful spaces via our questions</p> <p>Focus group questions were high reading level</p>	
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<b>Consideration/Recommendation</b>	<b>OHEA Response</b>	<b>HMA Response</b>
<p><b>25.</b> In addition to working in partnership with the CAT, it is critical to be in relationship with community members who are engaged in critiquing dominant forms of data collection and developing community-based, community-centered, and decolonizing data. They can be guides as to what data is trusted or invalid, and provide other sources of data or suggest decolonized methodologies</p>	<p>We recommend noting this to HCWC as a rec for next RFP and highlight what had to be done here re: PRG creation</p>	<p>Agree. This will be important to understand the scope better and have a realistic expectation of cost.</p>
<p><b>26.</b> Important to consider how this data can be weaponized against the community, especially if it was collected without centering, engaging, and power sharing with community</p>	<p>We recommend this as a consideration and discussion point for the final report creation and communications planning</p> <p>We recommend that folks analyzing the datasets mentioned gain understanding about the racist foundations of these data sources. This will require personal capacity building work. Limitations of this data</p>	<p>Agree</p>

Consideration/Recommendation	OHEA Response	HMA Response
	should also be named to the CAT and in the final report.	
<p><b>27.</b> Important to consider how communities are erased in the data</p>	<p>We recommend including the distribution of folks engaged in focus group and surveys, highlight gaps</p> <p>We recommend including the distribution of folks engaged in on the CAT, highlight gaps</p>	<p>Agree.</p> <p>HMA also views the recommendation as more than just who physically was included in the CAT, surveys, and community engagement sessions but rather ensuring we discuss the role that data plays in dehumanization/invisibilizing</p>
<p><b>28.</b> Identify racism, colonialism, white supremacy culture and white superiority as the determinants of health that must be acknowledged and addressed. If BIPOC lives are shaped by these determinants, then they must be central to the determinants and indicators.</p>	<p>We recommend including a section in the CHNA report that defines racism, colonialism, white supremacy culture and white superiority as the determinants of health that must be acknowledged and addressed</p>	<p>Agree</p> <p>Would we refer to Shared Definitions file Racial Equity Glossary of Terms – SP HCWC CHNA <a href="#">HERE</a></p>
<p><b>29.</b> Focus on community strengths, how community expresses and wields agency and power, include this data</p>	<p>See related recommendations on community strength</p> <p>We recommend highlighting efforts with question selection to do this work</p>	<p>Agree</p>
<p><b>30.</b> Cultivate partnerships and be in relationship with community members who are experts in and engaged in data work about their communities</p>	<ul style="list-style-type: none"> <li>● Identify 1-2 CAT members (Waddah and Joannie) who can serve in additional advisory roles</li> <li>● Consideration for next CHNA to not start again and learn from relationships and groups convened.</li> </ul>	<p>Agree.</p>

Consideration/Recommendation	OHEA Response	HMA Response
	<ul style="list-style-type: none"> <li data-bbox="877 240 1381 349">Cultivate relationship with groups like BIPOC data group in prep for next CHNA cycle</li> </ul>	
<p data-bbox="201 362 800 573">31. Identify the framework that will guide the health indicators; which ones center BIPOC and community strengths (e.g. data justice) and which ones are deficit based (dominant frameworks)?</p>	<p data-bbox="821 362 1419 475">We recommend reviewing initial CAT framework and editing to center community strengths with CAT.</p>	<p data-bbox="1440 362 1535 394">Agree.</p>
<p data-bbox="201 589 800 711">32. Specific recommendations for Peer Review Group members (see <a href="#">comments on document</a>)</p>	<p data-bbox="821 589 1136 621">Recommendation as is</p>	