2022

COMMUNITY HEALTH NEEDS ASSESSMENT

EXECUTIVE SUMMARY

Providence Seaside Hospital

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UNDERSTANDING AND RESPONDING TO COMMUNITY NEEDS

The Community Health Needs Assessment (CHNA) is an opportunity for Providence Seaside Hospital (PSH) to engage with the community every three years to better understand community strengths and needs. At Providence, this process informs our partnerships, programs, and investments. Improving the health of our communities is foundational to our Mission and is a commitment deeply rooted in our heritage and purpose. Our Mission states, "As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable."

In the North Coast region, PSH partnered with Clatsop County Department of Public Health, Columbia County Public Health, Columbia Pacific CCO and Columbia Memorial Hospital to produce a comprehensive assessment of our communities' most pressing needs, share our findings with the broader public and develop new relationships leading to a healthier community. Our collaborative is dedicated to advancing health equity in the North Coast region, serving as a platform for collaboration around health improvement plans and activities that leverage collective resources to improve the health and well-being of local communities.

Based on geographic location relative to other hospitals in the area and patient demographics, Clatsop County is PSH's primary service area. Our 25-bed critical access hospital provides an array of services including primary care and specialty care, a birth center with family suites, general surgery, radiology, diagnostic imaging, pathology and 24/7 emergency care. The 2022 CHNA was approved by Providence's North Coast Service Area Advisory Council on November 16th, 2022 and made publicly available on December 19th, 2022.

The collaborative CHNA report is available in Appendix 1.

GATHERING COMMUNITY HEALTH DATA AND COMMUNITY INPUT

Through a mixed-methods approach and using quantitative and qualitative data, the CHNA team collected information from the following sources: American Community Survey, Behavioral Risk Factor Surveillance System (BRFSS), Centers for Disease Control and Prevention (CDC), County Health Rankings & Roadmaps, ESRi Updated Demographics, Oregon Health Authority, Oregon Student Wellness Survey, and the U.S. Census (such as public health data regarding health behaviors, morbidity and mortality, and hospital-level data).

We conducted six listening sessions with 36 individuals who are from diverse communities, have lower incomes, and/or are medically underserved. We conducted 10 stakeholder interviews with 11 representatives from organizations that serve these populations, specifically seeking to gain a deeper understanding of community strengths and opportunities. In addition, we conducted a community health survey in English and Spanish that engaged 616 individuals. Below is a short list of highlights from our quantitative and qualitative data collection:

- 19% of community health survey respondents did not have access to primary care, and 33% did not get all the health care they needed in the past year.
- 61% of community health survey respondents did not get all the counseling or mental health care they needed in the last year.
- In 2019, Clatsop County had the highest rate of homelessness in Oregon, with 23 out of every 1,000 people experiencing homelessness.

While care was taken to select and gather data that would tell the story of the hospital's service area, it is important to recognize the limitations and gaps in information that naturally occur. A full accounting of data limitations can be found starting on page 16 of the CHNA report. Complete information related to the CHNA methods and processes can be found on page 15 of the CHNA report.

IDENTIFYING COLLABORATIVE HEALTH PRIORITIES

Our collaborative used a Health Equity Framework and a modified Mobilizing for Action through Planning and Partnerships (MAPP) model to create the CHNA. The modified MAPP model is a strategic planning process that relies on collaborative partnership and includes five assessment components to inform planning: (1) Population Health Status Assessment, (2) Community Engagement, (3) Internal Utilization Data, (4) Community Strengths and Assets, and (5) Prioritization Protocol. Through this collaborative model, the following priority areas were agreed upon: Access to Health Care Services, Behavioral Health Challenges and Access to Care, Homelessness and Housing Instability, Affordable Childcare and Preschools, Economic Insecurity, Access to Dental Care, and Chronic Health Conditions. For a complete description of significant health needs, see page 22. A list of potential resources to address these needs can be found at the end of each "key themes" section.

PROVIDENCE SEASIDE HOSPITAL: 2022 PRIORITY NEEDS

Our collaborative identified a wide spectrum of significant health needs, some of which are most appropriately addressed by other community organizations. Providence's North Coast Service Area Advisory Council reviewed the collaborative health priorities and associated data. Considering PSH's unique capabilities, community partnerships and potential areas of community impact, we are committed to addressing the following priorities as aligned with the collaborative priority areas:

Mental Health and Substance Use Disorder: Focus on prevention and treatment, social isolation, and community building related to safe spaces and recreation. This priority area refers to the growing challenges of accessing care due to workforce shortages, a lack of culturally responsive care, and affordability.

Health Related Social Needs: Focus on housing stability, navigation of supportive services, food insecurity, and transportation. This priority area refers to the unmet social needs that exacerbate poor health and quality-of-life outcomes.

Economic Security: Focus on affordable childcare, education, and workforce development. This priority area affects nearly every aspect of a person's life and refers to the challenge of affording basic living expenses and obtaining affordable education.

Access to Care and Services: Focus on chronic disease management and prevention, oral health, and virtual care. This priority area refers to the lack of timely access to care and services due to physical, geographic, and systemic limitations, among others.

Three consistent cross-cutting themes surfaced during the assessment process and analysis, affecting all four priority areas:

- Racism, discrimination, and inclusion
- Culturally responsive care and services
- Trauma-informed care and services

PSH will develop a three-year Community Health Improvement Plan (CHIP) to respond to these prioritized needs, in collaboration with community partners, to make the best use of resources and community strengths and capacity. The 2023-2025 CHIP will be approved and made publicly available no later than May 15th, 2023.

MEASURING OUR SUCCESS: RESULTS FROM THE 2019 CHNA AND 2020-2022 CHIP

This report evaluates the impact of the 2020-2022 CHIP. PSH responded to community needs by making investments of direct funding, time, and resources to internal and external programs dedicated to addressing the previously prioritized needs using evidence-based and leading practices. This summary highlights several community health initiatives across PSH's service area. In addition, we invited written comments on the 2019 CHNA and 2020-2022 CHIP, made widely available to the public. No written comments were received on the 2019 CHNA and 2020-2022 CHIP.

The 2019 CHNA priorities were social determinants of health resulting from poverty and inequity, chronic health conditions, community mental health/ well-being and substance use disorders, and access to health services The table below is a summary of the strategies and outcomes for each priority identified in PSH's 2020-2022 CHIP.

Outcomes from the 2020-2022 CHIP

Table 1. Outcome Measures for Addressing Oral Health Needs

Outcome Measure	Baseline	2020	2021	2022
1. Increase access to oral health treatment services	250 individuals	225 individuals *(Due to COVID-19)*	214 individuals	195 individuals
2. Enhance oral health education and awareness	1,218 individuals	759 individuals *(Due to COVID-19)*	630 individuals	1,378 individuals

Table 2. Strategies and Strategy Measures for Addressing Oral Health Needs

Strategy	Strategy Measure	Baseline	2020	2021	2022
Offer mobile dental van services in partnership with Medical Teams International	# clinics offered # individuals served	18 clinics 196 patients	15 clinics 150 patients *(Due to COVID-19)*	29 clinics 214 patients	31 clinics 195 patients
Locate a mobile dental van on the	# clinics offered during	0 clinics offered	Paused due to van reallocation to	Continuing conversations with MTI	Strategy concluded

Oregon Coast during winter months	winter months		COVID testing and vaccinations		
Provide oral health education and screenings in classrooms with Providence Healthy Smiles program	# students educated # students screened	1,134 students educated 646 students screened *(Based on 2018-2019 academic school year)*	670 students educated 342 students screened *(Based on 2019-2020 academic school year; due to COVID-19)*	674 students educated 674 students screened *(Based on 2020-2021 academic school year)*	1342 students educated 1342 students screened *(Based on 2021-2022 academic school year)*
Increase dental access for people with Medicaid	# dental providers who take Medicaid insurance	1 dental provider	2 dental providers and 1 denturist	2 dental providers and 1 denturist	2 dental providers and 1 denturist

Table 3. Outcome Measures for Addressing Food Security

Outcome Measure	Baseline	2020	2021	2022
1. Reduce the number of households who experience food insecurity in Clatsop County	11.8% *(Feeding America, 2019)*	16% projected overall food insecurity rate *(Feeding America)*	Data not available	Data not available

Table 4. Strategies and Strategy Measures for Addressing Food Security

Strategy	Strategy Measure	Baseline	2020	2021	2022
Partner with Clatsop Community Action Regional Food Bank to offer their Food Bank Fresh Mobile Produce Pantry.	Pounds of food provided # people served	500,113 pounds 9,524 households	650,000 pounds 11,428 households	Grant concluded in 2020	Grant concluded in 2020
Develop Food Farmacy program	Program implementation landmarks	N/A	Develop program parameters	Program did not happen	N/A
Explore opportunities to partner with food-focused agencies to support food home	Program implementation landmarks	Discuss opportunities for intervention	Providence Community Connections transportation program	Program implemented	N/A

delivery initiatives serving older adults			partnered with CCA Food Bank to deliver 553 food boxes		

Table 5. Outcome Measures for Addressing Transportation Needs

Outcome Measure	Baseline	2020	2021	2022
1. Improve access to transportation	128 households served	116 households served (*Due to COVID-19)*	80 households served	118 households served

Table 6. Strategies and Strategy Measures for Addressing Transportation Needs

Strategy	Strategy Measure	Baseline	2020	2021	2022
Provide rides with Providence Community Connections program	# rides offered # miles driven	1,798 rides 71,167 miles driven	2,205 rides 42,963 miles driven	1,343 rides 27,880 miles driven	1,281 rides 37,599 miles driven
Connect with transportation services through the Community Resource Desk	# service referrals	146 service referrals	32 service referrals (*Due to COVID-19)*	23 service referrals *(Due to COVID-19)*	90 service referrals

Table 7. Outcome Measures for Addressing Culturally Responsive Supportive Services

Outcome Measure	Baseline	2020	2021	2022
1. Increase percentage of Latinx living in Clatsop County (with access to bilingual and culturally responsive services)	8.45% (2018)	8.6% (2019)	9.2% (2021)	Data not available

Table 8. Strategies and Strategy Measures for Addressing Culturally Responsive Supportive Services

Strategy	Strategy Measure	Baseline	2020	2021	2022
Support community-based organizations offering culturally responsive services	# agencies awarded who offer bilingual culturally responsive services	3 agencies	4 agencies	4 agencies	5 agencies
Co-develop a Healthcare Diversity Scholarship for students of color at Clatsop Community College	# scholarship awards given # of students awarded	N/A N/A	4 scholarships 4 students awarded for Fall 2020 term	10 scholarships 10 students	10 scholarships 10 students
Explore opportunities to improve Spanish-speaking culturally specific behavioral health services available in Clatsop County	# of trained resources/services available (may include trained traditional health workers and/or mobile services)	N/A	0 trained resources	Strategy changed	Strategy changed

Table 9. Outcome Measures for Addressing Culturally Responsive Supportive Services

Outcome Measure	Baseline	2020	2021	2022
Decrease number of unsheltered individuals living in Clatsop County	876 unsheltered people (2019 Point in Time Count)	650 unsheltered people (HUD Point in Time Report)	Data not available	Data not available

Table 10. Strategies and Strategy Measures for Addressing Culturally Responsive Supportive Services

Strategy	Strategy Measure	Baseline	2020	2021	2022
Fund organizations providing housing services and supports	# of organizations funded for housing work Community benefit $ amount contributed	4 organizations $96,415	5 organizations $181,415 *(largely for COVID rapid response)*	4 organizations $80,000	5 organizations $113,000
Assist individuals and families navigate housing resources through the Community Resource Desk	# housing needs identified % clients who are chronically homeless	85 housing needs identified 6% clients chronically homeless	190 housing needs identified 10% clients chronically homeless	139 housing needs identified 6% clients chronically homeless	156 housing needs identified 9% clients chronically homeless
Support affordable housing opportunities across Clatsop County	Development and implementation landmarks	N/A	Discussed joint funding opportunities with CCO and CBO partners	Discussed joint funding opportunities with CCO and CBO partners	Potential funding going towards affordable housing project

2022 CHNA Governance Approval

Rebecca Coplin 11-17-2022

Rebecca Coplin — Date
Chief Executive, North Coast Service Area

William Olson 11/22/2022

William Olson — Date
Chief Executive, Oregon Region

Louis Libby 11/22/2022

Louis Libby M.D. — Date
Chair, Oregon Community Ministry Board

12/15/2022

Joel Gilbertson — Date
Chief Executive, Central Division

CHNA/CHIP Contact:

Joseph Ichter, DrPH
Senior Director, Community Health Investment
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To request a copy free of charge, provide comments, or view electronic copies of current and previous Community Health Needs Assessments, please email CHI@providence.org.

Appendices

APPENDIX 1. 2022 NORTH COAST OREGON SERVICE AREA COMMUNITY HEALTH NEEDS ASSESSMENT

2022

COMMUNITY HEALTH NEEDS ASSESSMENT

North Coast Oregon Service Area

Clatsop County Oregon 1844

Columbia Memorial Hospital

PROVIDENCE Health & Services

Columbia County Oregon 1854

Columbia Pacific CCO™

Part of the CareOregon Family

CONTENTS

MESSAGE TO THE COMMUNITY + ACKNOWLEDGEMENTS

To our community members:

Community Health Needs Assessments (CHNAs) have long been used as a tool by hospitals, public health departments, and other social service agencies to identify key community health concerns. A CHNA is a systematic process involving the community to identify and analyze community health needs and assets, prioritize those needs, and implement a plan to address significant unmet needs. The CNHA process and findings allow Collaborative Partners to leverage resources toward programs, services, policies, and strategic initiatives that have the greatest positive impact on service areas.

This year, a collaborative group, including Columbia Memorial Hospital (CMH), Providence Seaside Hospital (PSH), the Clatsop County Health Department, the Columbia County Health Department, and the Columbia Pacific Coordinated Care Organization (CCO), or North Coast Service Area Collaborative Partners, came together to complete one CHNA for the region. During the COVID-19 pandemic, the collaborating organizations developed stronger ties, resulting in improved community health partnerships. Another outcome was the desire to find other opportunities for coordination, producing this latest CHNA in an effort to continue advancing population health through collaboration. It is the Collaborative Partners' hope that by working together, Collaborative Partners have enhanced the quality of the assessment that will serve as the basis for developing a cohesive improvement plan for the community.

Community engagement is a central component of the CHNA. Collaborative Partners worked to distribute and collect online and paper surveys, conduct virtual listening sessions, and conduct virtual interviews. Collaborative Partners also shared data between Collaborative Partners to establish an accurate picture of needs in the region. The region has many strengths and working together to meet big challenges is one of them. There are certainly many large challenges identified in this assessment, but continued collaboration will allow Collaborative Partners to address them.

Thank you to the additional organizations who helped collect data for the assessment:

- Clatsop Behavioral Health
- Clatsop Community Action
- Clatsop County Sheriff's Office
- Columbia Health Services
- Columbia Community Mental Health
- Columbia Pacific Food Bank
- Consejo Hispano
- The Harbor
- Head Start
- Helping Hands Reentry Outreach Centers
- The Lower Columbia Q Center
- Northwest Early Learning Hub
- Northwest Parenting Hub
- Northwest Regional Education Service District
- Northwest Senior and Disability Services
- Restoration House
- Seaside School District
- Scappoose School District
- St. Helens Parks and Recreation Program
- Sunset Empire Park and Recreation District
- Warrenton School District

Sincerely,
The North Coast Service Area Collaborative Partners Team

LAND ACKNOWLEDGEMENT

The place we have come to know today as Columbia, Clatsop, and Tillamook counties is the ancestral territory of the Clatsop, Tillamook, Nehalem, Chinook, Siletz, Klickitat, Cowlitz, Clatskanie, Wahkiakum, Cathlamet, and other Indigenous peoples. With this acknowledgment, the Collaborative Partners aspire to reflect on the practices, languages, innovation, and wisdom that this land has held for generations, and to honor the inextricable commitment together as the earth's present and future custodians. Recognizing the original people of the land is a start toward restoring visibility and ending the erasure of Native communities. However, this gesture alone, without meaningful engagement, becomes merely an empty performance. As such, the Collaborative Partners hope to engage in work to build relationships and cultivate trust with Tribal leaders, organizations, and communities, and to seek guidance on how Collaborative Partners can alter the trajectory of, and collectively heal from, ongoing colonization.

EXECUTIVE SUMMARY

Understanding + Responding to Community Needs

The Community Health Needs Assessment (CHNA) is an opportunity for North Coast Service Area Collaborative Partners (Collaborative Partners) in Oregon's north coast region, comprising Clatsop and Columbia counties, to engage the community every three years with the goal of better understanding community strengths and needs. This process informs partnerships, programs, and investments. Improving the health of communities is fundamental to Collaborative Partners' work and deeply rooted in partners' shared heritage and purpose. This year, the Collaborative Partners contracted with Rede Group to conduct listening sessions, stakeholder interviews, and write the CHNA. For a full list of listening session and stakeholder interviewee participants, see the table on pages 73-75.

Gathering Community Health Data + Community Input

Through a mixed-methods approach, using quantitative and qualitative data, Collaborative Partners and Rede Group collected information from both primary and secondary data sources. This CHNA incorporated quantitative and qualitative data on health conditions, health behaviors, and social determinants of health through primary data that included a community health survey, community listening sessions, and stakeholder interviews. Secondary data was pulled from local, state, and national sources to identify how health trends have changed over time.

To actively engage the community, Rede Group conducted six virtual listening sessions that included a total of 37 participants who were considered low-income, were from diverse communities, were older adults, were parents, and/or were medically underserved. The sessions took place between February 8 and March 21, 2022. Rede Group conducted 10 virtual stakeholder interviews, including 11 representatives from organizations that served the populations mentioned above and other community members, specifically seeking to gain a deeper understanding of community strengths and opportunities. Finally, a survey was distributed in English and Spanish, with Collaborative Partners receiving completed surveys from more than 600 community members.

Key Themes

The key themes described below are the highest priority needs determined through an analysis of qualitative data (key stakeholder interviews, listening sessions), community health survey results, and population-level data. The key themes below are listed in order of highest priority as identified by community participants.

ACCESS TO HEALTHCARE SERVICES

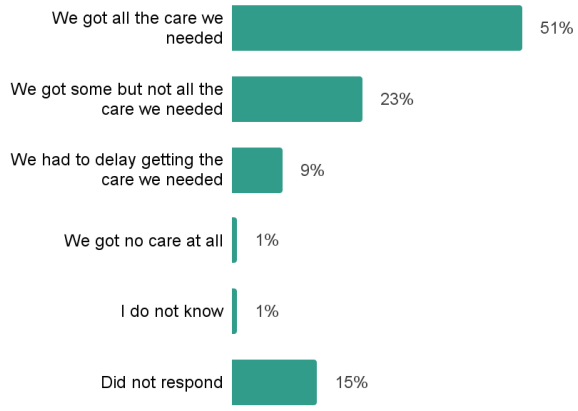
Community members and interviewees discussed a high need for access to adequate medical providers and facilities in the community, including services for the Latino/a/x community, those without insurance, and unhoused individuals and families.

"Most institutions that I work with, I've seen schedules get delayed and pushed back, and then it creates more demands [for healthcare services] when you do try to catch up."

—Stakeholder Interviewee

Interviewees shared that for those without health insurance, those who were unhoused, and those identifying as lesbian, gay, transgender, queer, two-spirit, intersex, asexual (LGBTQ2SIA+) it can be difficult to find care. Survey results showed that 33% of respondents did not get all the healthcare they needed in the past year and nineteen percent (19%) said they did not have a primary care provider.

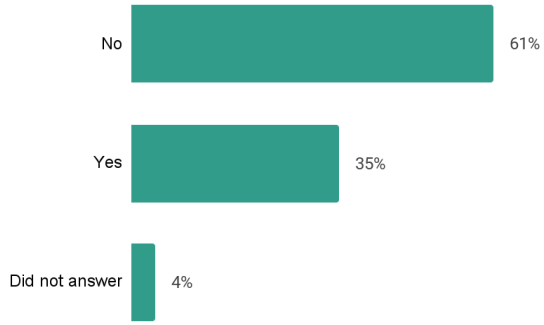
Did you get all the healthcare you needed?



BEHAVIORAL HEALTH CHALLENGES AND ACCESS TO CARE

Listening session participants and interviewees shared a high need for affordable health services and professionals, including outpatient mental health services. They discussed a need to reduce barriers to care, such as transportation, access to technology, and workforce challenges (including retaining providers). Thirty-five percent of survey respondents reported needing counseling or mental health support or care in the last year (see chart to the right), and 17% of those respondents shared that they did not get all the counseling or mental healthcare they needed.

In the last year, did you need counseling or mental health support or care?



Seventeen percent of survey respondents indicated that they or someone in their household had concerns about alcohol, tobacco, or substance use in the past year. Community members also shared that substance abuse and mental health disorders in the community are seen as co-occurring. Additionally, youth mental health had potentially been impacted by the social distancing required by COVID-19 public health measures.

"We've seen a big increase in people with severe mental health issues and substance abuse. Mental health is difficult enough to treat on its own, when you have co-occurring disorders, it becomes exponentially difficult to treat."

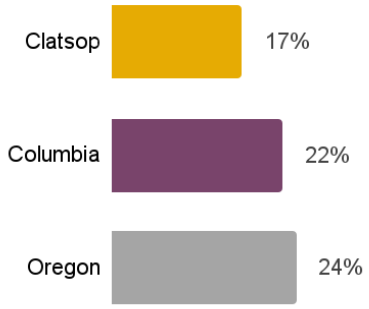
—Stakeholder Interviewee

HOUSELESSNESS AND HOUSING INSTABILITY

While the rate among Columbia County was higher than the statewide rate of houselessness (6.5 of every 1,000 in Columbia County and 3.7 of every 1,000 in Oregon), the number of those experiencing houselessness was higher in Clatsop County. Clatsop County had the highest rate in Oregon, with nearly 23 out of every 1,000 people experiencing houselessness[1]. Listening session participants and interviewees shared a high need for more safe and affordable housing options and highlighted the importance of stable housing on overall health. The high cost of housing, the housing cost burden on renters (see chart to the right), increased vacation rentals, and lack of housing stock contributed to the current lack of safe and affordable housing. Nearly a quarter of renters in Oregon experience a severe housing cost burden, spending 50% or more of their income on housing costs, with Columbia (22%) and Clatsop (17%) not far behind. Twelve percent (12%) of survey respondents who had housing were worried about losing it.

Severe Housing Cost[3]

Measure: Renter households experiencing severe housing cost burden are households spending 50% or more of their income on housing costs.



"The lack of inventory housing for low-income is absolutely zero, non-existent. That's a huge impact to our community."

—Stakeholder Interviewee

AFFORDABLE CHILDCARE AND PRESCHOOLS

Stakeholders were very concerned about access to affordable childcare and preschools in the community. They described a childcare and preschool crisis in Oregon and locally. Secondary data showed that Clatsop and Columbia Counties were considered childcare deserts[2].

"Affordable childcare and preschool, the whole state, the nation is in a crisis mode around that."

—Stakeholder Interviewee

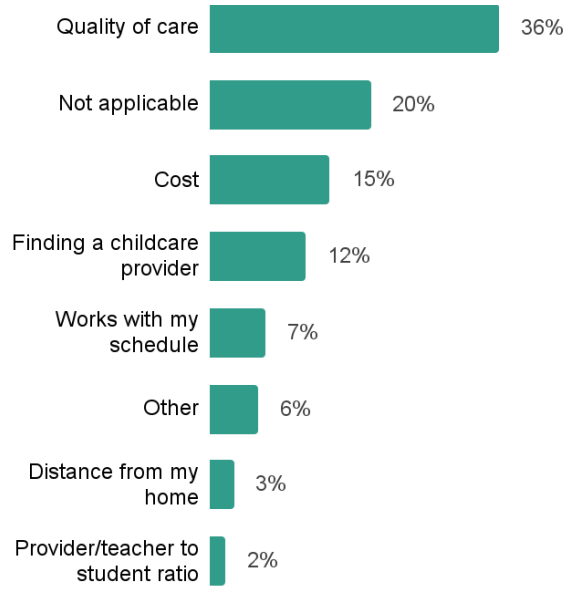
[1] Source:2019 American Community Survey, 5-year estimate https://experience.arcgis.com/experience/dbbfa53916ea40fc8dfb734a8d7b669d/page/Housing-Cost/

[2] Source:Oregon State University, Collect of Public Health and Human Sciences, Oregon Child Care Research Partnership, Oregon's Child Care Deserts 2020: Mapping Supply by Age Group and Percentage of Publicly Funded Slots https://health.oregonstate.edu/sites/health.oregonstate.edu/files/early-learners/pdf/research/oregons-child-care-deserts-2020.pdf

[3] Source:2019 American Community Survey, 5-year estimate https://experience.arcgis.com/experience/dbbfa53916ea40fc8dfb734a8d7b669d/page/Housing-Cost/

Many stakeholders with families shared that they had difficulty finding availability at childcare facilities and resorted to leaving their child with an acquaintance who cared for children in their home, which may have not always met regulatory standards, despite survey respondents sharing that quality of care was one of the most important factors when choosing childcare (see chart to the right). Additional factors that survey respondents found important included cost and the ability to find a childcare provider.

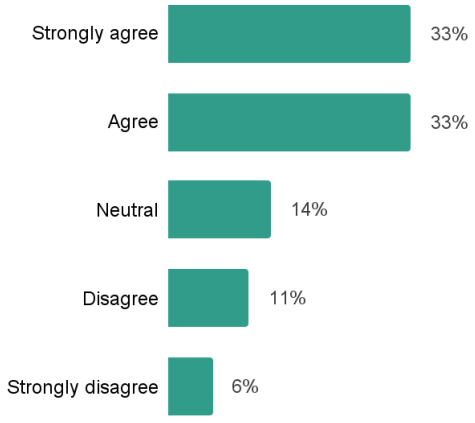
What are the two most important factors when choosing childcare or preschool for your child(ren)?



ECONOMIC INSECURITY

Listening session participants prioritized economic insecurity because, despite job growth, many jobs in the community did not pay well. While wages had increased, they had not increased at the rate of housing costs. The 2020 median income of individuals living in Clatsop County was $63,200 and $73,000 in Columbia County, compared to $67,800 in Oregon. These wages were below the livable wage for each county, which is $39/hr or $81,120 for those living in Clatsop County and $46/hr or $95,680 for those in Columbia County.[4,5] Over 65% of survey respondents shared they agreed or strongly agreed that they had enough financial resources to meet their needs, while 17% disagreed or strongly disagreed. While this may seem like a small percentage of survey respondents, 17% of the population of Clatsop and Columbia Counties equals nearly 16,000 people.

I have enough financial resources to meet my basic needs.



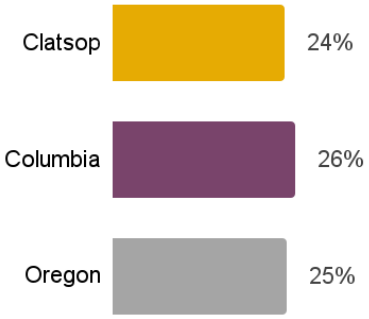
[4]Source: County Health Rankings and Roadmaps, US Census Bureau, Small Area Income and Poverty Estimates, 2020
[5]Source: County Health Rankings and Roadmaps, US Census Bureau, Small Area Income and Poverty Estimates, 2020

ACCESS TO DENTAL CARE

Stakeholders noted the importance of oral health on physical health, sharing that people in the community either did not have dental insurance through their employer or did not qualify, particularly workers in the hospitality and tourism industries. Additionally, the community lacked dental care options, particularly providers that accepted OHP for dental care. The ratio of population to dentists in both Clatsop and Columbia Counties was higher than in Oregon (Clatsop 1390:1, Columbia 1650:1, Oregon 1210:1). In Clatsop County, the percentage of individuals aged 18 and older who reported going to a dental clinic in the past year (24%) was slightly lower than Oregon (25%) in 2019, while Columba County was slightly higher (26%).

Dental Visits[6]

Measure: Respondents aged 18 years and older who report having been to the dentist or dental clinic in the past year.



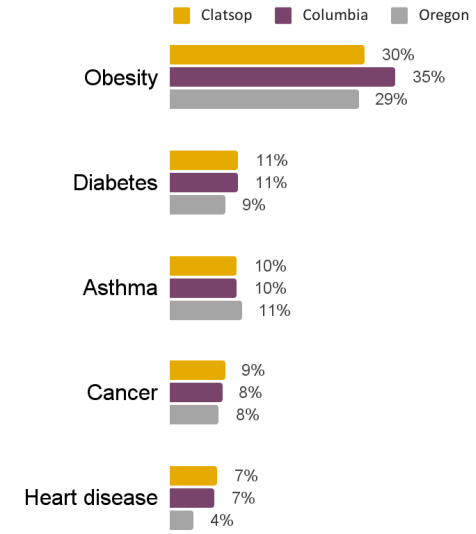
CHRONIC HEALTH CONDITIONS

In Clatsop and Columbia Counties, the prevalence of chronic conditions was comparable to that of Oregon. As of 2019, the top five leading chronic conditions across the two counties and the state were obesity, diabetes, asthma, cancer, and heart disease[7].

Of survey respondents, 5% ranked their health as 'excellent', 69% as 'very good' or 'good', and 34% as 'fair' or 'poor'.

Chronic Conditions[7]

Measure: Respondents aged 18 years and older who report ever been told by a doctor, nurse, or other health professional that they have a chronic condition.



[6]Source: https://experience.arcgis.com/experience/dbbfa53916ea40fc8dfb734a8d7b669d/page/Dental/ BRFSS, 2019
[7] Source: https://experience.arcgis.com/experience/dbbfa53916ea40fc8dfb734a8d7b669d/page/Cancer/

NEXT STEPS

This assessment lays the foundation for the Community Health Improvement Plans (CHIPs) that will be developed by each Collaborative Partner. The quantitative and qualitative data presented in this report and the key themes identified will guide the development of goals, objectives, strategies, and performance measures. After the publication of this CHNA, each partner in the Collaborative will engage in an independent prioritization process, reviewing key themes and prioritizing community needs they have the skills and expertise to address. Each organization's CHIP will describe the actions each organization intends to take, the anticipated impact of these actions, and the resources the organization plans to commit to address the community need. The CHIP will also describe any planned collaboration between organizations in addressing the prioritized needs.

INTRODUCTION

Who We Are

The Collaborative Partners are a group of public sector organizations, including Clatsop County Public Health, Columbia County Public Health, Columbia Pacific CCO, Columbia Memorial Hospital, and Providence Seaside Hospital. These organizations serve community members in Clatsop, Columbia, and Tillamook counties in northwest Oregon. Major programs and services offered to the community include the following: community-based services and outreach, health promotion and chronic disease prevention, and transportation services. Collaborative Partners also provide medical services, including physical and behavioral health, dental care, and navigation to community resources. The following paragraphs provide more detailed information about each of the Collaborative Partners' organizations.

COLUMBIA COUNTY PUBLIC HEALTH

Columbia County Public Health (CCPH) is the local public health authority for Columbia County. CCPH is committed to improving the quality of life and protecting the health and well-being of all residents by improving social, economic, and environmental conditions. CCPH wants to ensure that all people in Columbia County have the opportunity for a healthy life. CCPH protects the community's health by preventing disease and responding to health threats. CCPH influences conditions that promote health, such as access to healthy and affordable foods, clean water, healthcare, and neighborhoods that are safe for walking and biking. CCPH minimizes the impact of disease outbreaks through vaccination efforts, early detection, and swift responses.

COLUMBIA PACIFIC CCO

Columbia Pacific CCO is a nonprofit community benefit company, serving more than 31,000 Oregon Health Plan members in Clatsop, Columbia, and Tillamook counties. Columbia Pacific CCO's vision for the communities Columbia Pacific serves is to help those in need reach their highest potential by providing services that support their social, emotional, and physical health.

COLUMBIA MEMORIAL HOSPITAL

CMH is a full-service, 25-bed, critical access, not-for-profit, Level IV trauma center located in Astoria, Oregon. CMH has been serving the healthcare needs of the north coast community for more than 140 years. Collectively, CMH's hospital and clinics employ over 650 caregivers and a diverse professional medical staff, including specialists ranging from oncology to obstetrics. CMH clinics are now located in Astoria, Warrenton, and Seaside, as CMH has grown to meet the needs of the community. CMH is accredited by the Healthcare Facilities Accreditation Program (HFAP) and a Planetree Designated Patient-Centered health system.

PROVIDENCE SEASIDE HOSPITAL

Providence Seaside Hospital is a 25-bed critical access hospital with full accreditation by the Joint Commission that offers primary and specialty care, a birth center with family suites, general surgery, radiology, diagnostic imaging, pathology, and emergency medicine 24 hours a day, seven days a week. Residents along the north

Oregon coast have access to family practice and internal medicine with PSH's full roster of doctors and primary care providers at clinics in Seaside, Warrenton, Cannon Beach, heart clinics in Astoria and Seaside, and a full continuum of therapy, rehabilitation, and home health services.

CLATSOP COUNTY DEPARTMENT OF PUBLIC HEALTH

Clatsop County Department of Public Health (CCDPH) is the local public health authority for Clatsop County. CCDPH's core mission is to protect individuals and communities against the spread of disease, injuries, and environmental hazards, promote and encourage healthy behaviors, respond to disasters, and assure the quality and accessibility of health services through collaboration with community members to impact policy, systems, and environmental change.

TILLAMOOK COUNTY PARTNERS AND ORGANIZATIONS

While Collaborative Partners serve Tillamook County residents, a collaborative group of Tillamook County organizations produces a Tillamook County-specific CHNA. To view this CHNA, click here or visit https://www.adventisthealth.org.

State and Federal Requirements

CMH and PSH are required by section 501(r) of the Internal Revenue Service Code, as a tax-exempt 501(c)(3) organization that operates one or more hospital facilities, to conduct a CHNA at least once every three years for each hospital.

Clatsop County Public Health and Columbia County Public Health are accredited local public health departments. Accreditation is granted by the nationally recognized non-profit, Public Health Accreditation Board (PHAB), and is valid for 5 years. The accreditation process involves a comprehensive and rigorous evaluation of the public health department and involves the development of a CHNA and CHIP every five years.

As a CCO managing Medicaid for its region, Columbia Pacific CCO is required by its contract with Oregon Health Authority and OAR 410-141-4730 to conduct a CHNA and create a CHIP every five years.

Our Commitment to Community

The Collaborative Partners dedicate resources to improve the health and quality of life for the communities they serve. During 2021, hospitals which were a part of the Collaborative Partners collectively provided $26.5 million in Community Benefit[8] in response to unmet needs and to improve the health and well-being of those they serve in the north coast Oregon region. To learn about Columbia Pacific CCO's contributions, click here.

Collaborative Partners further demonstrated organizational commitment to community health through the allocation of staff time, participation, and collaboration to address community identified needs. They also ensured community and hospital leaders, physicians, and others worked together to plan and implement the resulting CHIP.

[8] Per federal reporting and guidelines from the Catholic Health Association. All hospitals and coordinated care organizations are required to report Community Benefit. Public health departments do not provide Community Benefit.

OVERVIEW OF CHNA FRAMEWORK AND PROCESS

The CHNA process is based on the understanding that health and wellness are influenced by factors within communities, not only within medical facilities. In gathering information on the communities served by partners, Collaborative Partners looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, and health behaviors. Additionally, Collaborative Partners invited key stakeholders and community members to provide additional context to the quantitative data through qualitative data in the form of interviews and listening sessions. Equity is at the forefront of Collaborative Partners' conversations and presentation of the data, which often have biases based on collection methodology.

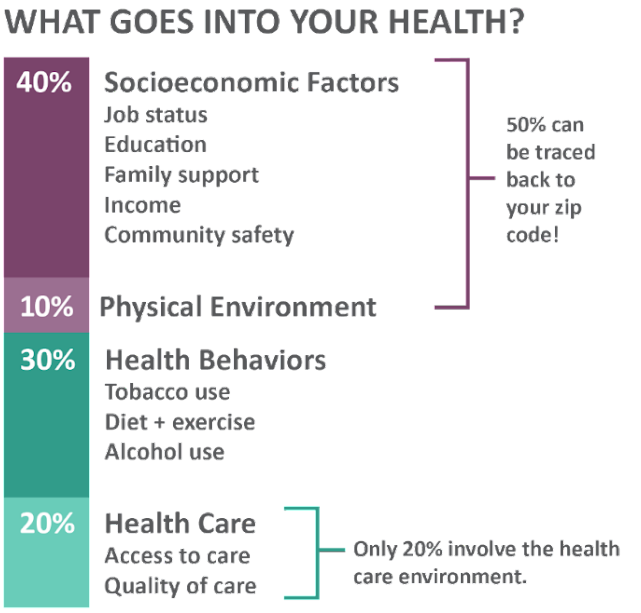
In addition, Collaborative Partners recognize that there are often geographic areas where the conditions for supporting health are substantially poorer than nearby areas. Whenever possible and reliable, data were reported at the zip code or census tract level. These smaller geographic areas allow Collaborative Partners to better understand the neighborhood-level needs of communities and better address inequities within and across communities.

To achieve this, Collaborative Partners reviewed data from the American Community Survey and local public health authorities. In addition, Collaborative Partners included hospital utilization data to identify disparities in utilization by income and insurance, geography, and race/ethnicity when reliably collected.

Health Equity Framework

The Collaborative Partners acknowledge that all people do not have equal opportunities and access to living their fullest, healthiest lives due to systems of oppression and inequities. Collaborative Partners are committed to ensuring health equity for all by addressing the underlying causes of racial and economic inequities and health disparities.

The CHNA is an important tool used to better understand strengths and assets in a community, as well as identify inequities and disparities. Collaborative Partners know that racism and discrimination have detrimental effects on community health and well-being. Collaborative Partners recognize that racism and discrimination prevent equitable access to opportunities and the ability of all community members to thrive. Collaborative Partners name racism as contributing to the inequitable access to all the determinants of health that help people live their best lives, such as safe housing, nutritious food, responsive healthcare, and more.



Adapted from: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

To ensure that equity is foundational to this CHNA, Collaborative Partners developed an equity framework that outlines the best practices that each of the Collaborative Partners will implement when completing a CHNA. These practices include, but are not limited to the following:

Approach

- Explicitly name commitment to equity
- Take an asset-based approach, highlighting community strengths
- Use people-first and non-stigmatizing language

Community Engagement

- Actively seek input from the communities served using multiple methods
- Implement equitable practices for community participation
- Report findings back to communities

Quantitative Data

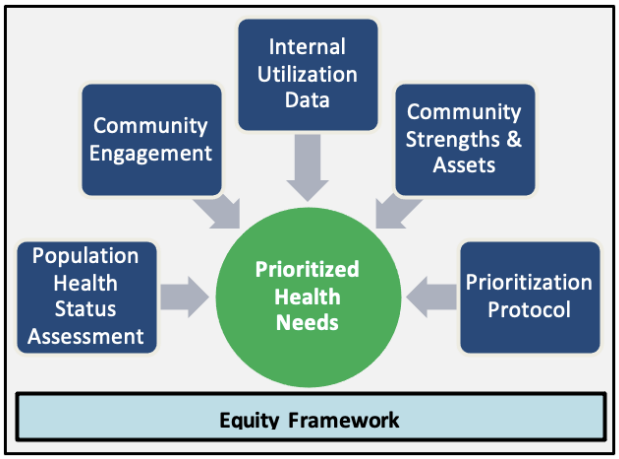
- Report data at the block group level to address masking of needs at a county level
- Disaggregate data when responsible and appropriate
- Acknowledge inherent bias in data and screening tools

Through community engagement, equity was centered in this CHNA by first determining which populations in the north coast region were most underrepresented in traditional data sources. Prioritizing these populations in the process allowed Collaborative Partners to elevate some of those voices via listening sessions, stakeholder interviews, and a community health survey. Although just a small subset of people were engaged, some of the populations of focus included people with low income or experiencing houselessness, people with behavioral health challenges, individuals and parents identifying as Latino/a/x, and older adults above the age of 65. To inclusively engage the Latino/a/x population, the CHNA community health survey was offered in Spanish and two community focus groups were conducted in Spanish. Additionally, the Collaborative Partners sourced input from community-based organizations (CBOs) that served additional underrepresented populations in the north coast region with the goal of engaging social service agencies, healthcare, education, housing, and government, among others, to ensure a wide range of perspectives.

Modified Mobilizing for Action through Planning and Partnerships (MAPP) Framework

Collaborative Partners used a modified version of the Mobilizing for Action through Planning and Partnerships (MAPP) model as a framework to guide the CHNA process. Using a mixed-methods approach allowed us to consider several key elements necessary to determine prioritized health needs including:

- Population health data (gathered through publicly-available resources, in addition to information only available to our community partners). Community engagement (completed through stakeholder interviews and listening sessions)
- Utilization data (accessed from hospital- and clinic-level reports)
- Community strengths & assets (solicited via the community health survey, stakeholder interviews, and listening sessions)
- Prioritization protocol (based on rigorous analysis of the data, looking for patterns and differences between and across groups)



Data Collection Methods

STAKEHOLDER INTERVIEWS AND COMMUNITY LISTENING SESSIONS

Collaborative Partners contracted with Rede Group to conduct stakeholder interviews and community listening sessions. Listening to and engaging with people who live and work in the community is a crucial component of the CHNA, as these individuals have firsthand knowledge of the needs and strengths of their community. Rede Group conducted 10 virtual stakeholder interviews with 11 leaders who are invested in the well-being of the community. Rede Group also conducted six virtual listening sessions with a total of 37 community members, each hosted in partnership with a community organization.

The goal of the stakeholder interviews and listening sessions was to identify the existing strengths of the community, what health needs are currently not being met, and what assets could be leveraged to address these needs.

Rede Group conducted stakeholder interviews and listening sessions in February and March of 2022. Stakeholders were selected by the collaborative based on their knowledge of the community and engagement in work that directly serves people who are economically disenfranchised. The collaborative aimed to engage stakeholders from social service agencies, health care, education, housing, education, and government to ensure a wide range of perspectives.

COMMUNITY HEALTH SURVEY

The community health survey was open from March 16th to May 15th, was distributed in both paper and electronic formats, and was available in English and Spanish. The survey captured key information about access to healthcare and behavioral health services, health and lifestyle, community strengths and gaps, and general demographics. The full survey and results can be found in Appendix 1. The survey was conducted electively and while efforts were made to engage the diverse populations of our primary service area, survey results were not representative of demographics in the general population.

A total of 622 surveys were submitted, 562 English surveys and 60 Spanish surveys, and 616 were deemed valid. Among the participants that included a zip code, 579 were within the primary service area or surrounding counties. A total of 37 surveys did not have a zip code provided but were still included in the analyses. Six surveys were excluded from the analyses because they were completed in zip codes outside the state of Oregon or in zip codes from other Oregon counties not surrounding the primary service area.

SECONDARY DATA

Quantitative secondary data was collected and added to the CHNA to supplement the qualitative data, as well as to add additional data points. Secondary data was collected through online sources between July and October 2022. Data points were chosen based on previous CHNA data points, interest from community members or stakeholders, and other public health issues. Data sources in this CHNA include:

- American Community Survey
- Behavioral Risk Factor Surveillance System (BRFSS)
- Centers for Disease Control and Prevention
- County Health Rankings & Roadmaps
- Oregon Health Authority's Student Health Survey (2020)
- U.S. Census Bureau

Data Limitations and Information Gaps

While care was taken to select and gather data that would tell the story of the partners' service areas, it is important to recognize the limitations and gaps in information that naturally occur, including the following:

- Not all desired data were readily available, so sometimes Collaborative Partners had to rely on tangential or proxy measures or not have any data at all. For example, there was little community-level data on the incidence of mental health or substance use.
- While most indicators were relatively consistent from year to year, other indicators were changing quickly (such as the percentage of people uninsured). This meant the most recent data available were not a good reflection of the current state of health.
- Reporting data at the county level can mask inequities within communities. This can also be true when reporting data by race, which can mask what is happening within racial and ethnic subgroups. Therefore, when appropriate and available, data was disaggregated by geography and race.
- During listening sessions, while video conferencing does facilitate information sharing, there were challenges creating the level of dialogue that would take place in person.

- The virtual nature of listening sessions may have created barriers for some people to participate, particularly those without access to technology.
- Multiple facilitators conducted listening sessions, which may have affected the consistency in how questions were asked. Multiple note-takers affected the consistency of notes across the listening sessions.
- While listening sessions participants and interviewee stakeholders were intentionally recruited from a variety of types of organizations, there may have been some selection bias as to who was selected as a stakeholder due to existing relationships and availability of stakeholders.
- Due to many community organizations engaged in COVID-19 response, some organizations had limited capacity and were not able to participate in interviews.
- Data gathered through interviews and surveys may have been biased depending on who was willing to respond to the questions and whether they were representative of the population.
- The accuracy of data gathered through interviews and surveys depended on how consistently the questions were interpreted across respondents and how honest people were in providing their answers.
- COVID-19 may have limited the number of individuals who completed the survey in person.
- Virtual surveys were not monetarily incentivized, while paper surveys were. Not compensating individuals for time spent completing surveys has been proven to decrease survey attrition; not providing incentives may have resulted in a lower number of completed virtual survey responses.
- No marketing or mailings were distributed to advertise surveys, which may have limited the demographic variety and/or number of survey responses, particularly those without access to technology.
- Parts of the analysis were completed by only one analyst and is therefore subject to influence by the analyst's unique identities and experiences.

Process for Gathering Comments on Previous CHNA and Summary of Comments Received

Written comments were solicited on the 2019 CHNA and 2020-2022 CHIP reports, which were made widely available to the public via posting on the internet in December 2019 (CHNA) and May 2020 (CHIP), as well as through various channels with Collaborative Partners community-based organization partners. No comments were received for these reports.

Community Demographics

The tables and graphs below provide basic demographic and socioeconomic information for Clatsop and Columbia counties.

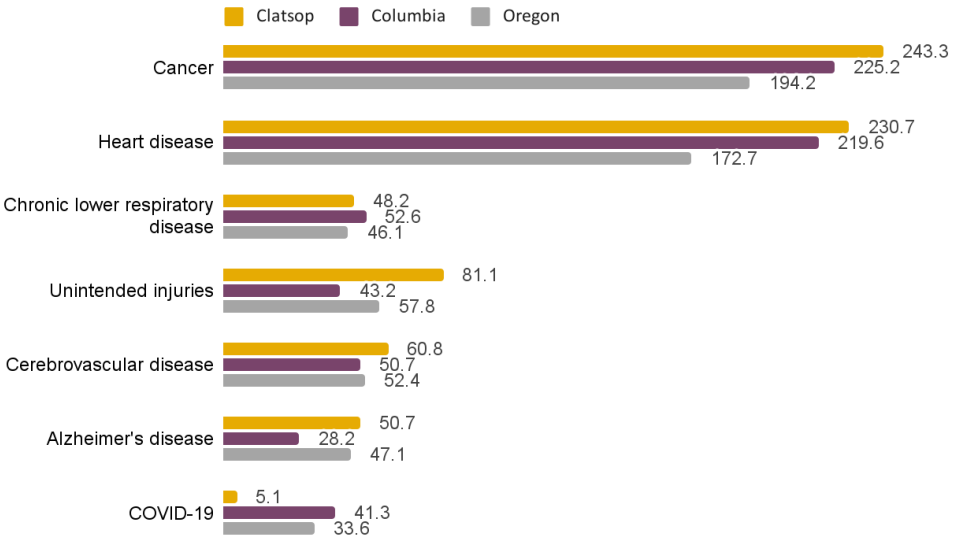
Providence Seaside Hospital developed a dashboard that maps different indicators at the census tract level. The dashboard shows the service area and how the high-need area compares to the broader service area. The high-need area includes census tracts identified based upon lower life expectancy at birth, a lower percentage of the population with at least a high school diploma, more households that are linguistically isolated, and more households at or below 200% of the Federal Poverty Level (FPL) compared to county averages. For reference, in 2019, 200% FPL represents an annual household income of $51,500 or less for a family of four. The dashboard can be found here: https://experience.arcgis.com/experience/dbbfa53916ea40fc8dfb734a8d7b669d/

The following population demographics are from the U.S. Census Bureau, Population Estimates Program (PEP), updated annually, 2021. Population and Housing Unit Estimates (census.gov).

Indicator	Clatsop County		Columbia County	
Population by Age Groups	Population	Percentage of Population	Population	Percentage of Population
Total population	41,810	-	53,074	-
Persons under 5 years	1,840	4.4%	2,601	4.9%
Persons under 18 years	7,651	18.3%	10,827	20.4%
Persons 18 to 64 years	22,201	53.1%	29,085	54.8%
Persons 65 years and over	10,118	24.2%	10,562	19.9%
Population by Gender				
Female population	20,989	50.2%	26,378	49.7%
Male population	20,821	49.8%	26,696	50.3%
Population by Race				
White alone	38,549	92.2%	48,881	92.1%
Black or African American alone	418	1.0%	425	0.8%
American Indian and Alaska Native alone	585	1.4%	849	1.6%
Asian alone	711	1.7%	584	1.1%
Native Hawaiian and Other Pacific Islander alone	167	0.4%	159	0.3%
Two or more races	1,422	3.4%	2,176	4.1%
Hispanic or Latino	3,847	9.2%	3,291	6.2%
White alone, not Hispanic or Latino	35,288	84.4%	46,174	87.0%

Mortality

Leading Causes of Death by County, deaths per 100,000 population[9]



In 2020, the top two leading causes of death in Clatsop and Columbia counties, as well as Oregon, were cancer and heart disease. Additional leading causes of death varied by county and included chronic lower respiratory disease, unintended injuries, cerebrovascular disease, and Alzheimer's disease. COVID-19 was the 6th leading cause of death in Columbia county.

Health Professional Shortage Area

The Federal Health Resources and Services Administration (HRSA) designates Health Professional Shortage Areas (HPSAs) as areas with a shortage of primary medical care, dental care, or mental health providers. They are designated according to geography (i.e., service area), demographics (i.e., low-income population), or institutions (i.e., comprehensive health centers). Clatsop and Columbia Counties are both located in a HPSA due to geographic or income-related circumstances.

Medically Underserved Area/Medical Professional Shortage Area

Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs) are defined by the Federal Government to include areas or populations that demonstrate a shortage of healthcare services. This designation process was originally established to assist the government in allocating the Community Health Center Fund to the areas of greatest need. MUAs are identified by calculating a composite index of need indicators compiled with national averages to determine an area's level of medical "under service." MUPs are identified based on documentation of unusual local conditions that result in access barriers to medical services. MUAs and MUPs are permanently set, and no renewal process is necessary. Columbia County is designated as an MUP, and portions of Clatsop County are designated as a MUA.

[9]Source:https://visual-data.dhsoha.state.or.us/t/OHA/views/CountyDash/CountyDash_cause?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n

Summary of Community Input

To better understand the unique perspectives, opinions, experiences, and knowledge of community members, Collaborative Partners, in partnership with Rede Group, conducted 10 interviews with 11 representatives from community-based organizations and six listening sessions with a total of 36 community members. During these interviews and listening sessions, community members and nonprofit and government stakeholders discussed the issues and opportunities of the people, neighborhoods, and cities of the service area. In addition, a community health survey was distributed in English and Spanish, receiving completed surveys from more than 600 community members.

Below is a high-level summary of the findings of the stakeholder interviews and listening sessions. Full details on the protocols, findings, and attendees are available in Appendix 2.

LISTENING SESSIONS AND STAKEHOLDER INTERVIEWS

Vision for a Healthy Community

Listening session participants were asked to describe their vision of a healthy community. This question was important for understanding what matters to community members and how they define health and wellness for themselves, their families, and their communities. The primary theme shared was "opportunities for recreation and a healthy lifestyle" and participants noted this as especially important to ensure kids can play in safe spaces and learn how to be healthy. Also mentioned were easy access to affordable healthcare and mental health supports, centralized resources and support for all people, diversity, inclusion, and respect, and economic security, including affordable housing and childcare.

Community Strengths

While a CHNA is primarily used to identify gaps in services and challenges in the community, Collaborative Partners wanted to ensure community strengths that already existed were highlighted and leveraged, including the following identified by stakeholders: community engagement and helping one another, community knowledge and wisdom, and stakeholder collaboration and commitment.

Stakeholders shared community members were aware of community needs and were actively engaging in solutions through conversation and volunteerism. They noted people rallied together for events and stepped up to help others when they saw someone in need. They also emphasized community members had a lot of knowledge about how to address needs and how to support one another and generally described a sense of accountability and commitment from local stakeholders.

Additionally, listening session participants were asked to describe community strengths. Participants generally described a sense of accountability and commitment from local stakeholders. They shared that local organizations collaborated well and had a shared sense of responsibility. Because of the size of the community, many people knew each other, creating a sense of accountability to one another.

Community Needs

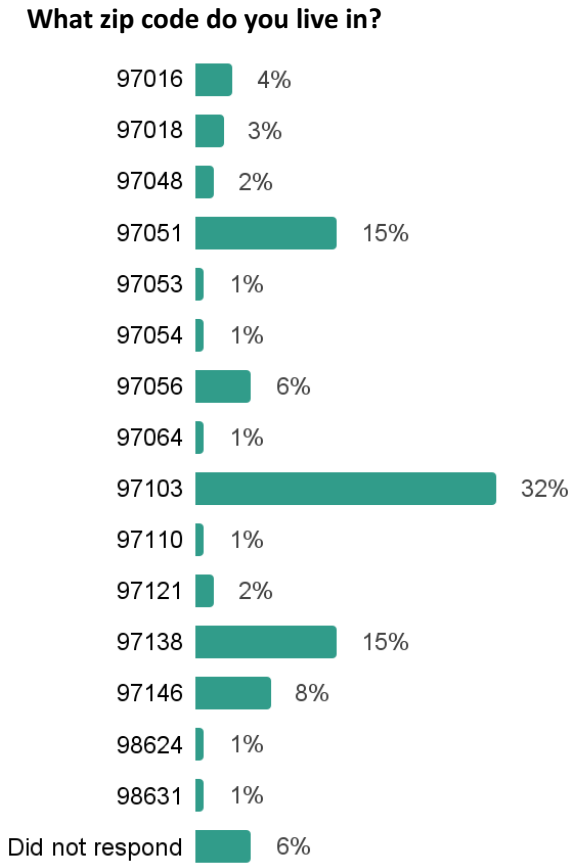
Stakeholder interviewees were asked to identify their top five health-related needs in the community. Three needs were prioritized by most stakeholders and with high priority. Therefore, they were designated as high-priority health-related needs and included access to healthcare services, behavioral health challenges (including mental health and substance use/misuse), and houselessness and housing instability. Medium priority needs discussed by stakeholders included affordable childcare and preschools, economic insecurity, access to dental care, and addressing the prevalence of chronic conditions.

Listening session participants discussed a variety of needs, but the most common were access to healthcare services and behavioral health challenges and access to care. Community members were particularly concerned about having sufficient access to healthcare and mental health appointments, noting long wait times and few options for people with Oregon Health Plan (OHP) or without insurance. Community members emphasized the need for in-person interpretation for Spanish-speaking patients during healthcare and mental health visits. Transportation barriers could be a challenge for the community, particularly for older adults.

Other needs discussed in detail by listening session participants included houselessness and housing instability, access to dental care, access to community resources, community safety, racism and discrimination, and transportation. Community members emphasized the importance of having more play and exercise opportunities available for families. This included more parks, covered and indoor play areas, and recreation opportunities for all ages. The information that these groups and individuals shared was supplemented with community health survey data and secondary data from state and national sources.

COMMUNITY HEALTH SURVEY

Over 600 surveys were collected from respondents in Clatsop, Columbia, and Tillamook counties from 15 unique zip codes (see chart on the right). While survey respondents were not specifically asked to identify community strengths or community needs like listening session and interview participants were, the survey collected critical feedback and health information from community members. General highlights from the survey included:



- A need for additional healthcare and behavioral healthcare services
- Barriers to care, including appointment availability
- Self-reported health conditions such as diabetes were higher than government-collected county-level data
- Feeling safe within their community and availability of places to be physically active

KEY THEMES

This key themes section describes the high and medium priority needs determined through an analysis of qualitative data, which included key stakeholder interviews and listening sessions, and quantitative data, which included community health survey data and publicly available population-level data.

Access to Healthcare Services

Community members and interviewees discussed a need for more medical providers and facilities in the community. They shared it can be very challenging to get an appointment to see a provider, which often schedule out weeks in advance. This may have been due to a lack of providers; Clatsop and Columbia County's ratio of population to primary care providers was lower than that of Oregon.

Ratio of Population to Primary Care Providers (2019)[10]

Clatsop	Columbia	Oregon
1490:1	2910:1	1060:1

Specific issues called out in listening sessions and interviews included healthcare setting staffing and interpretation services. Oftentimes providers' offices were understaffed and interpretation services were offered via telephone, which frequently dropped during visits. They also shared Black, Brown, Indigenous, and Persons of Color (BBIPOC) patients were not always treated well by White providers, and placed an emphasis on a need for more BBIPOC providers.

"There's a lot of obstacles in the way between being able to provide adequate healthcare to the homeless population, and they need a lot more than we're capable of giving them right now."

—Stakeholder Interviewee

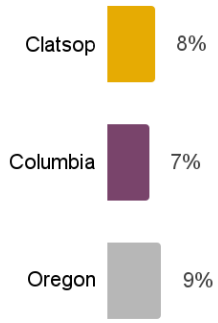
Other needs included more medical services for the unhoused population, more health education (particularly sex education) for young people, and improved transportation services to appointments (particularly for older adults). Safe and inclusive providers for those seeking care from the LGBTQ2SIA+ community was also called out, with an emphasis on people identifying as LGBTQ2SIA+ not feeling safe visiting providers because of provider homophobia and intolerance in the region.

Stakeholders shared it could be challenging to retain providers in a small community and some were concerned that there may not have been enough providers to meet the needs of the aging population. In Columbia County specifically, there was no hospital, meaning residents traveled further to get care. About nineteen percent (19%) of survey respondents said they did not have a primary care provider. Additionally, 23% of respondents who needed healthcare in the past year received "some care but not all". Despite this, the percentage of the population under age 65 without health insurance in 2022 was lower than that of Oregon, albeit close with Clatsop County at 8% uninsured, Columbia County at 7%, and Oregon at 9%.

[10]Source: County Health Rankings and Roadmaps, Area Health Resource File
https://www.countyhealthrankings.org/app/oregon/2022/measure/factors/4/map

Percent of the Population Uninsured[11]

Measure: Percentage of the population under age 65 without health insurance.



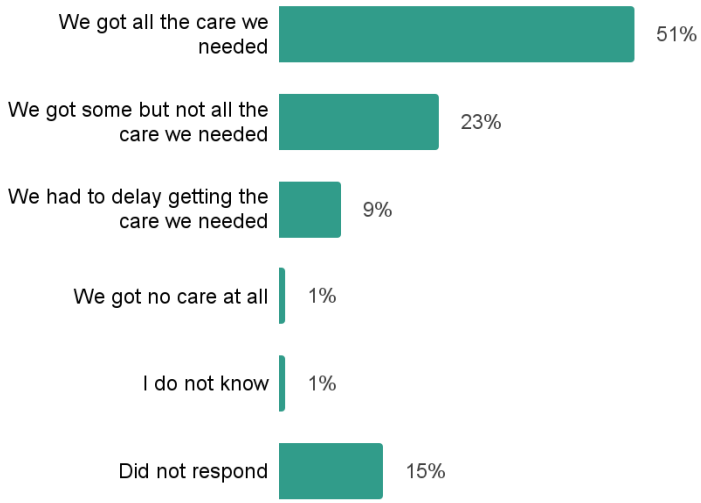
"Most institutions that I work with, I've seen schedules get delayed and pushed back, and then it creates more demands [to healthcare services] when you do try to catch up."

—Stakeholder Interviewee

The COVID-19 pandemic had only made accessing appointments more challenging, with delays in primary and specialty care appointments. The pandemic also highlighted and exacerbated inequities that already existed. During the pandemic, there was more reliance on technology for scheduling appointments and telehealth visits. Stakeholders shared they saw vaccine hesitancy in the Latino/a/x community, noting the need to address fear around vaccine safety and build trust.

Did you get all the healthcare you needed?

When survey respondents were asked if they received all the healthcare they needed, 51% responded they did, while 33% got some but not all the care they needed, had to delay getting care, or got no care at all (see chart opposite).



Collaborative Partners' hospitals can provide timely information regarding access to care and disease burden across the service areas. Collaborative Partners were particularly interested in studying potentially avoidable emergency department visits. Avoidable emergency department (AED) use is reported as a percentage of all Emergency Department visits over a given period, which are identified based on an algorithm developed by PSH's Population Healthcare Management team

[11]Source: County Health Rankings and Roadmaps, US Census Bureau's Small Area Health Insurance Estimates https://www.countyhealthrankings.org/app/oregon/2022/measure/factors/85/map

based on NYU and Medi-Cal's definitions. AED discharges typically contain primary diagnoses that are deemed non-emergent, primary care treatable or preventable/avoidable with better managed care. AED use serves as proxies for inadequate access to or engagement in primary care. When possible, we look at the data for total utilization, frequency of diagnosis and demographics to identify disparities. Hospital utilization data is included for Providence Seaside Hospital and Columbia Memorial Hospital in Astoria. See Appendix 5 for data.

The table below is a snapshot of the top diagnosis groups for AED visits in 2021.

Top 5 Diagnosis Groups for AED Visits – 2021	
Columbia Memorial Hospital	**Providence Seaside Hospital**
Urinary Tract Infection	Urinary Tract Infection
Nonspecific Back and Neck Pain	Substance Use Disorders (SUDs)
Bronchitis and Other Upper Respiratory Disease	Skin Infection
Tonsillitis	Anxiety and Personality Disorders
Screenings and Follow-Up Encounters	Nonspecific Back and Neck Pain

The following table shows an overview of populations experiencing challenges discussed in this section, top barriers, and frequently mentioned gaps.

Populations Experiencing Challenges to Accessing Care	Top Barriers to Accessing Care	Frequently Mentioned Gaps in Accessing Care
• People without insurance • People experiencing houselessness • Latino/a/x community • LGBTQ2SIA+ population	• Transportation • Cost of care • Staffing shortages/provider retention • Interpretation services • COVID-19 related issues	• Bilingual and bicultural workforce • Services for children with special needs • Reproductive healthcare services

Existing assets and resources to address access to healthcare services:

- Columbia Memorial Hospital
- Columbia Pacific CCO
- Lower Columbia Hispanic Council
- Medical Teams International
- Northwest Senior and Disability Services
- Providence Seaside Hospital
- Yakima Valley Farm Workers Clinic

Behavioral Health Challenges and Access to Care
(Mental Health and Substance Use/Misuse)

Listening session participants spoke to a need for more affordable mental health services and professionals in the community. They were concerned that there were not enough mental health provider options in the community, particularly for people with Oregon Health Plan (OHP) and without insurance. Older adults may not have been able to get the mental healthcare they needed due to transportation barriers and the cost of care, particularly because it was not a service covered by Medicare. Stakeholders shared that the Latino/a/x community could not access mental health services in Spanish. Participants also spoke to a need for more support for parents and their children, including parent groups and places for children to connect socially.

"We've seen a big increase in people with severe mental health issues and substance abuse. Mental health is difficult enough to treat on its own, when you have co-occurring disorders, it becomes exponentially difficult to treat."

—Stakeholder Interviewee

Participants spoke of needing more outpatient mental health services, outreach for mental health, harm reduction programs for people with SUDs, and more SUD treatment programs. This was especially important because COVID-19 had contributed to higher anxiety and depression for community members. Interviewees shared that meeting with patients in person is important, a service that has changed with COVID-19.

Interviewees shared that accessing behavioral health services could be a challenge for some people, particularly those living in Columbia County who had to travel to other communities to get care. They noted a need for more mental health providers in general. They also noted it could be challenging when people were not ready to receive help, with 17% of all survey respondents indicating they did not receive the counseling or mental healthcare they needed.

Stakeholders spoke of seeing behavioral health needs increase over the past two years during the COVID-19 pandemic, as well as an increase in the complexity of cases. There had also been a high number of opioid overdoses in the last two years, which had been challenging for the workforce trying to address SUD needs. Additionally, the ratio of population to mental health providers was greater for both Clatsop (270:1) and Columbia (240:1) counties than Oregon (170:1) (see table below).

Mental Health Providers (2021)[12]

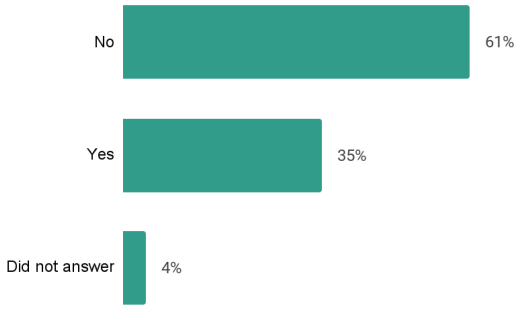
Measure: Ratio of population to mental health providers.

Clatsop	Columbia	Oregon
270:1	240:1	170:1

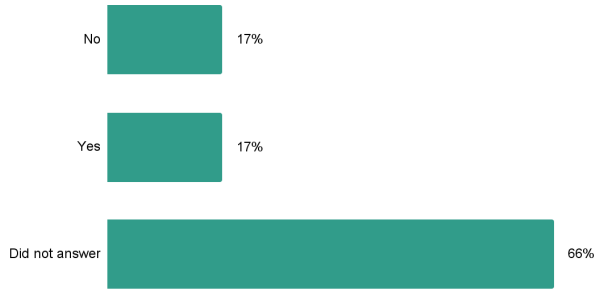
Survey respondents were asked to rate their overall mental health with 30% reporting fair or poor mental health (see chart to the right). Thirty-five percent (35%) of survey respondents said that they had a need for behavioral health counseling or mental health support/care in the past year and of those respondents, only 17% selected that they received the care they needed while a majority (66%) left this question (blank see charts below).

How would you rate your overall mental health?

In the last year, did you need counseling or mental health support or care?



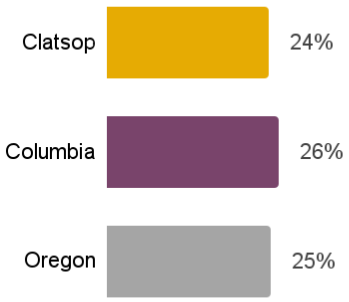
Did you get all the counseling or mental healthcare you needed?



[12]Source: County Health Rankings and Roadmaps, National Provider Identification Registry https://www.countyhealthrankings.org/app/oregon/2022/measure/factors/4/map

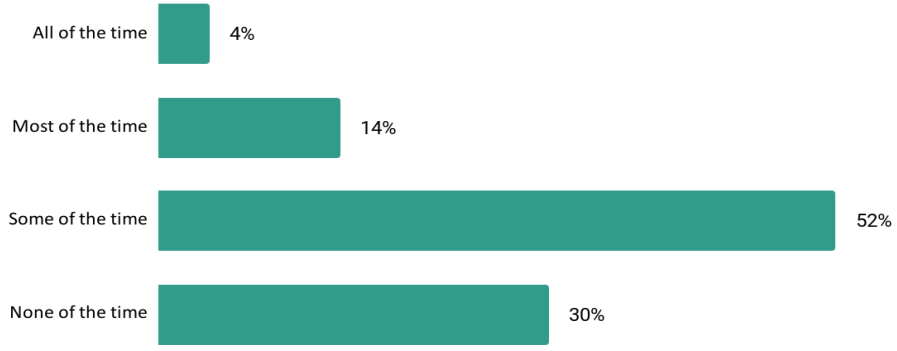
Depression[13]

Measure: Respondents aged 18 years and older who report having been told by a doctor, nurse, or other health professional that they had depressive disorder.

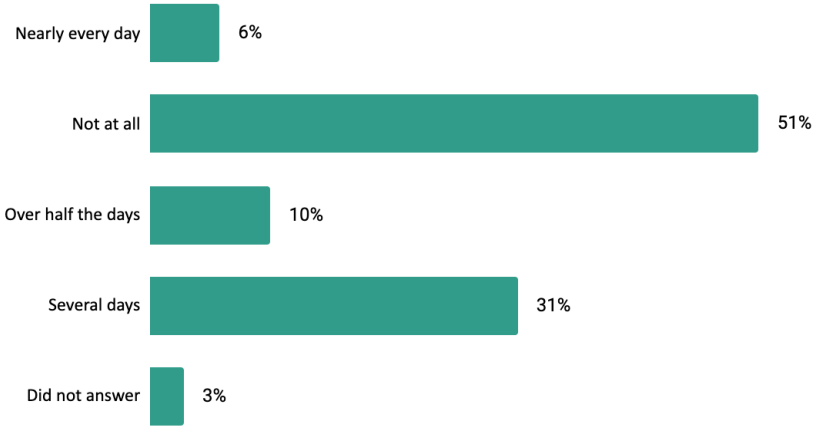


State available data showed that the rate of adults 18 or older depression mirrors that of the state, hovering around 25% (see chart to the left). Eighteen percent (18%) of survey respondents felt socially isolated "all or most of the time" and nearly half of survey respondents felt down, depressed, or hopeless several or more days a week. When asked how frequently they felt down, depressed or hopeless, 6% of respondents said they do "every day", 10% of respondents said they do "over half of the days", and 31% said "several days".

In the last year, how often did you feel socially isolated or experience loneliness?



During the last two weeks, how often have you felt down, depressed, or hopeless?

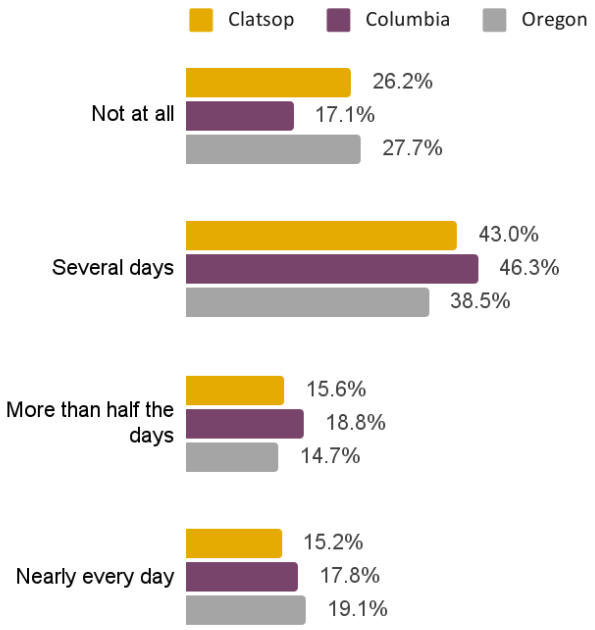


[13]Source: Behavioral Risk Factor Surveillance System Survey (BRFSS), 2019
https://experience.arcgis.com/experience/dbbfa53916ea40fc8dfb734a8d7b669d/page/Depression/

Secondary data showed that youth depressive symptoms hovered around that of the state (see two charts below), with a slightly higher percentage of 11th graders in Columbia County feeling sad or hopeless for two or more weeks in a row than 11th graders across Oregon, while a slightly lower percentage in Clatsop County as compared to Oregon.

Youth Mental Health[14]

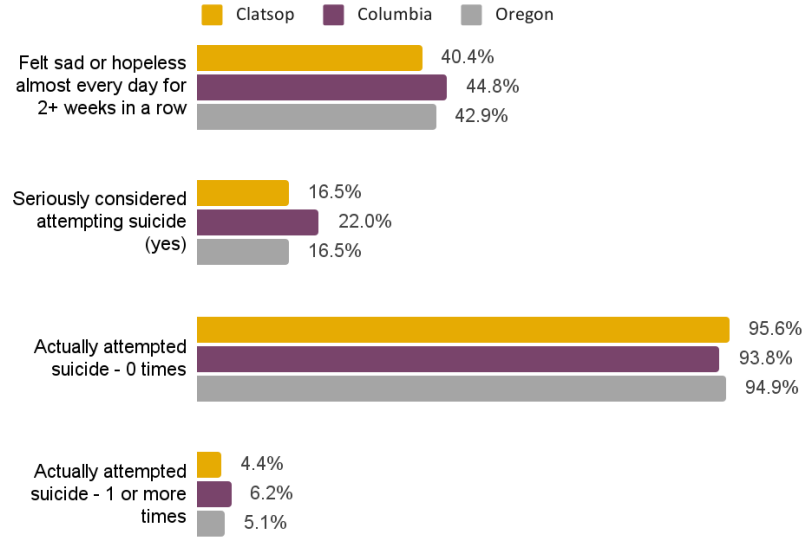
During the past 30 days, how often have you been bothered by feeling nervous, anxious or on edge? (11th graders)



"There's a lot of mental health and just social interaction needs that we've spent almost a year in distance learning and kids didn't get their needs met like they normally do when they're in the school system."

—Listening Session Participant

Depressive Symptoms - felt sad or hopeless almost every day for 2+ weeks in a row (11th graders)



[14]Source: 2020 Oregon Student Health Survey https://digital.osl.state.or.us/islandora/object/osl%3A82219

The following table shows an overview of populations experiencing challenges discussed in this section, top barriers, and frequently mentioned gaps.

Populations Experiencing Behavioral Health Challenges and Access to Care	Top Barriers to Behavioral Health Challenges and Access to Care	Frequently Mentioned Gaps in Behavioral Health Challenges and Access to Care
• Those with OHP • Those without insurance • Older adults • LGBTQ2SIA+ population • Unhoused population • Young people	• Lack of providers • Transportation + travel • Cost of care • Broadband access and technology	• Linguistically appropriate Spanish services • Support for parents and children • Mental health and SUD resources

Existing assets and resources to address behavioral health challenges:

- Beacon Clubhouse
- Clatsop Behavioral Health
- CoDependents Anonymous (CODA) Inc
- Columbia Community Mental Health
- National Alliance on Mental Illness (NAMI) Oregon

Houselessness and Housing Instability

In 2019, the north coast service area had a much higher rate of houselessness than the state of Oregon - with nine of every 1,000 Oregonians experiencing houselessness compared to three of every 1,000 statewide. Clatsop County had a rate of almost 23 of every 1,000 people - nearly six times the statewide rate[15].

As is true throughout the state, data from the three north coast counties showed that the rate of houselessness by race and ethnicity was experienced more by individuals who identified as American Indian/Alaska Natives (21.1 per 1,000) and Black/African American (12.1 per 1,000)[15].

The Point-in-Time Count, which provides a snapshot of people experiencing homelessness in a designated area on any given night, has been a bit challenging to gather with the same accuracy as pre-pandemic but based on the past two years of reported data, in 2019 there were 876 unsheltered people living in Clatsop County, and 1,000+ unsheltered people in 2020[16].

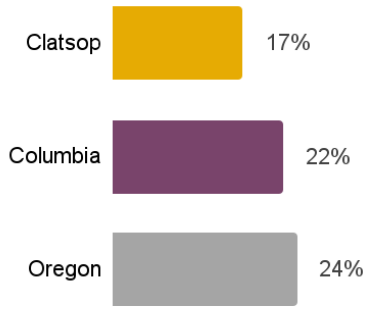
During data collection, community members shared a need for more safe and affordable housing options. Due to increased vacation rentals, they had seen many people unable to afford rent or spent most of their income on rent. In Clatsop County, 17% of renter households experienced severe housing cost burden

[15] Source: Rede Group, Regional Health Equity Report, Slatsop, Columbia, Tillamook. November 2020.
[16] Source: https://friendsoftheunsheltered.org/2021/02/16/research-pit/#:~:text=The%20following%20are%20recent%20PIT%20counts%20for%20Clatsop,in%20the%20county%20for%20the%202020%20PIT%20count.

(spending 50% or more of their income on housing costs) and 22% of Columbia County renter households experienced this (see chart below).

Severe Housing Cost[17]

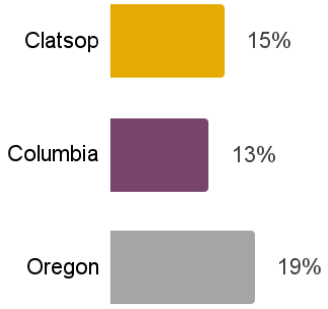
Measure: Renter households experiencing severe housing cost burden are households spending 50% or more of their income on housing costs.



Additionally, 15% of Clatsop County and 13% of Columbia County households experienced severe housing problems (percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities). Community also spoke to the importance of providing support for people completing housing applications, such as a peer navigator. Community members shared they would like to see more services for people experiencing houselessness, including shelters and emergency housing.

Severe Housing Problems[18]

Measure: Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.



Interviewees prioritized houselessness and housing instability because of its importance to overall health and stability. They shared it was hard to address other needs, like mental health or substance use/misuse challenges, without a safe place to live. It could also be challenging to stay housed with a mental health condition; a lack of support and case management could have contributed to this.

"The lack of inventory housing for low-income is absolutely zero, non-existent. That's a huge impact to our community."

—Listening Session Participant

[17]Source:2019 American Community Survey, 5-year estimate https://experience.arcgis.com/experience/dbbfa53916ea40fc8dfb734a8d7b669d/page/Housing-Cost/

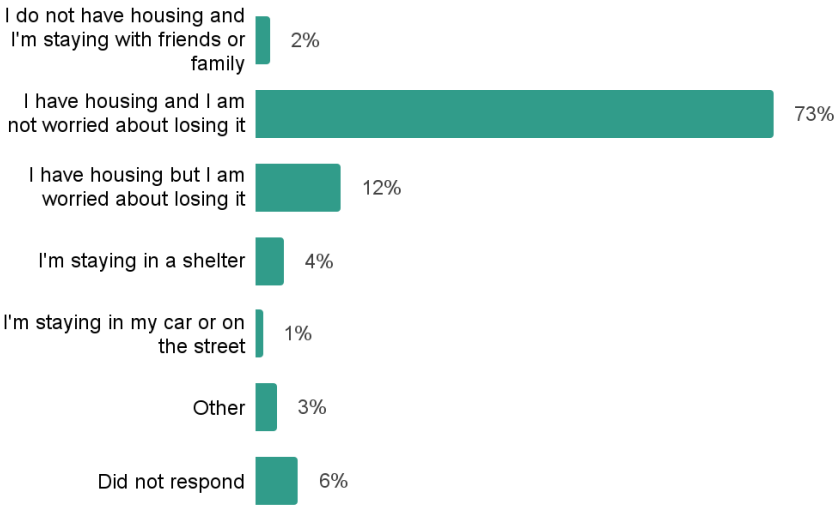
[18]Source: County Health Rankings and Roadmaps, US Department of Housing and Urban Development (HUD), 2014-2018 https://www.countyhealthrankings.org/app/oregon/2022/measure/factors/136/map

Stakeholders described the housing challenges in the community as a complicated need, one requiring strong collaboration and creative solutions. While there were efforts to build low-income housing, there was still a need for more. The lack of housing stock particularly affected workers, making it challenging for organizations to recruit and retain staff. This had implications for healthcare, education, and other sectors seeking qualified employees. Despite housing challenges, the owner-occupied rate of Oregon is 63%, while Clatsop and Columbia Counties are 61% and 76%, respectively, showing the region is better or nearly equal with the state.

Owner-occupied Rate[19]

Measure: A housing unit is owner-occupied if the owner or co-owner lives in the unit, even if it is mortgaged or not fully paid for.

Which of the following best describes your housing situation today?



Most survey respondents (73%) felt secure in their housing situation but some shared that they were afraid of losing their housing, with 12% indicating that they had housing but were afraid of losing it (see chart to the left).

[19]Source: US Census Bureau, Quick Facts
https://www.census.gov/quickfacts/fact/table/clatsopcountyoregon,columbiacountyoregon,OR,US/HSG445220#HSG445220

The following table shows an overview of populations experiencing challenges discussed in this section, top barriers, and frequently mentioned gaps.

Populations Experiencing Houselessness and Housing Instability	Top Barriers to Houselessness and Housing Instability	Frequently Mentioned Gaps for Houselessness and Housing Instability
• Latino/a/x community • People working in tourism or hospitality • People with a mental health condition	• High cost of housing • Lack of housing stock	• Completing housing applications • Ability to address other needs

Existing assets and resources to address houselessness and housing insecurity:

- Clatsop Community Action
- Community Action Team/Head Start
- The Harbor
- Helping Hands Reentry
- Restoration House

Affordable Childcare and Preschools

Stakeholders were very concerned about access to affordable childcare and preschools in the community. They described a childcare and preschool crisis in the state of Oregon with very little childcare availability locally, but especially for infants and toddlers from zero to three years. Both Clatsop and Columbia counties were considered childcare deserts[20] because less than 33% (far less for ages zero to two) of children had access to childcare slots (see chart on the following page.).

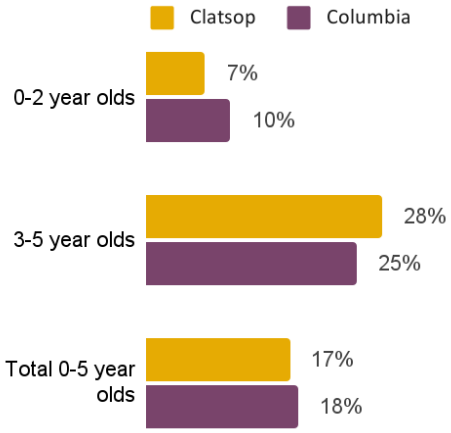
"Affordable childcare and preschool, the whole state, the nation is in a crisis mode around that."

—Stakeholder Interviewee

[20]Source:Oregon State University, Collect of Public Health and Human Sciences, Oregon Child Care Research Partnership, Oregon's Child Care Deserts 2020: Mapping Supply by Age Group and Percentage of Publicly Funded Slots https://health.oregonstate.edu/sites/health.oregonstate.edu/files/early-learners/pdf/research/oregons-child-care-deserts-2020.pdf

Percent of Children by County with Potential Access to a Regulated Slot by Age Group, 2020

Measure: Percent of children in the county with potential access to a regulated slot by age group. A county is considered a childcare desert if fewer than 33% of the county's children have access to a slot.

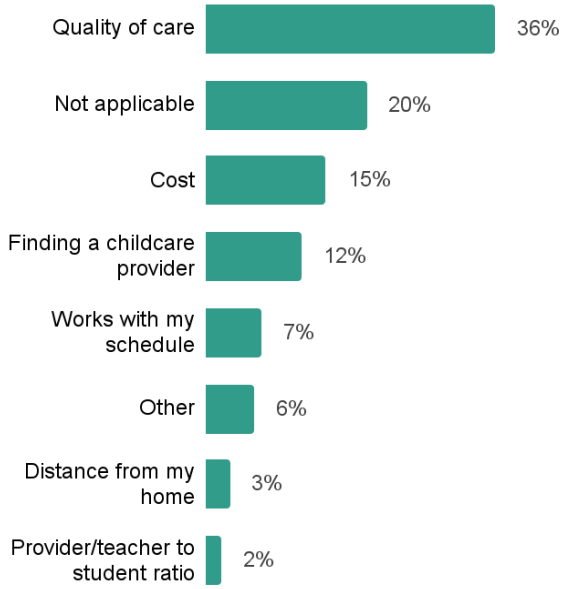


"Usually, [childcare is] not up to the standard… Because the families don't have any other options, they have to take their kid there even though it might not be the safest place for the kid."

—Listening Session Participant

Many stakeholders with families shared that they had difficulty finding availability at childcare facilities and resorted to leaving their child with an acquaintance who cared for children in their home, which may not have always met regulatory standards. Lack of childcare made some families feel that they had no other option but to leave their child somewhere that was not the safest option. Out of seven response options, quality of childcare was chosen most frequently as one of the most important factors when choosing childcare or preschool.

What are the two most important factors when choosing childcare or preschool for your child(ren)?

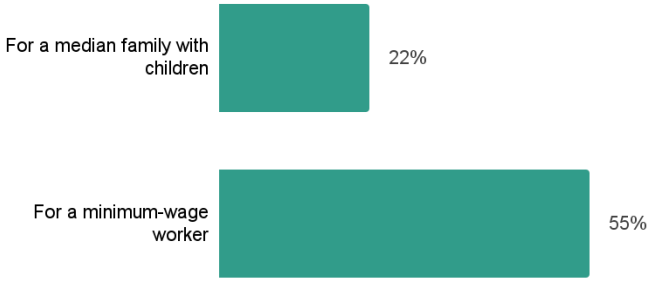


Many stakeholders shared families could not afford the cost of childcare and preschool. The high cost of childcare, along with the high cost of housing, meant that many families contributed a large portion of their income to meet these two needs. As a comparison, the average cost of college in Oregon is nearly the same cost of care for a four-year-old, while infant care was more expensive than college, housing, and four-year-old care in 2020 (see chart on the following page).

Average Annual Costs of Childcare Compared to Housing and College in Oregon, 2020[21]

Additionally, for Oregon families in 2020 with a median income, childcare costs were 22% as a share of income. For a minimum wage worker, this increased to 54.6%, showing the burden of childcare for lower-income families was much greater than median income families (see chart below).

Infant Care Costs as a Share of Income in Oregon, 2020[22]



"You work, never see your kid, and barely make your mortgage or rent payment. It's a tough dilemma for a lot of people."

—Stakeholder Interviewee

Stakeholders also discussed that there was very little workforce development happening in early childhood. People working in early childhood were often not paid sufficiently. There was a lack of providers, with many early childhood job openings that were hard to fill in the community, potentially due to lack of qualified professionals or lack of competitive salaries. Having conversations about investing in early learning had been more challenging for organizations during the pandemic as focus has shifted to addressing pandemic-related needs.

The pandemic had been challenging for childcare facilities as they have had to adapt to the pandemic. Many closed for periods of time at the beginning of the pandemic and continued to have temporary closures related to COVID-19 exposure. Families were doing their best to support their children and their socialization, but childcare closures had been very hard on them, affecting the mental health of the family and parents.

[21] Data Source: Economic Policy Institute, Child Care Costs in the United States, 2020

[22] Data Source: Economic Policy Institute, Child Care Costs in the United States, 2020

The following table shows an overview of populations experiencing challenges discussed in this section, top barriers, and frequently mentioned gaps.

Populations Experiencing lack of Affordable Childcare and Preschool	Top Barriers to Affordable Childcare and Preschool	Frequently Mentioned Gaps in Affordable Childcare and Preschool
• Parents and families	• Lack of availability at safe childcare facilities • Facility closures due to COVID-19	• Lack of workforce development • Maintaining focus on affordable childcare and preschool during COVID-19

Existing assets and resources to address affordable childcare and preschool:

- Columbia Pacific Economic Development District (ColPac)
- Northwest Early Learning Hub

Economic Insecurity

Stakeholders prioritized economic insecurity because many jobs in the community were in hospitality or tourism and may not have paid what community members considered a living wage. Many workers had shifts in seasonal work hours because of tourism activities. While wages had increased, they had not matched the increasing rate of housing costs. Stakeholders talked about workers lacking benefits, paid time off, flexible vacation, and a flexible work schedule, which impacted their quality of life.

"A lot of the times families get an apartment, but they prefer a house just because they're a bigger family. When they find a house its $2,800 and that's expensive on top of their bills that they have."

—Stakeholder Interviewee

Median Household Income[23]

Description: Median household income is the income where half of households in a county earn more and half of households earn less.

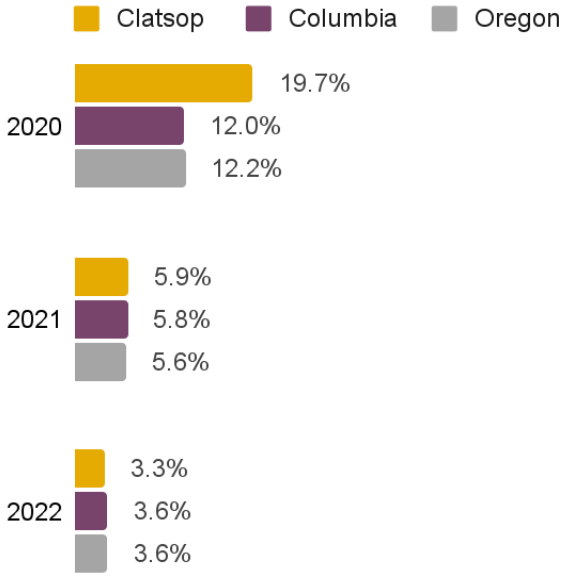
The 2020 median household income of individuals living in Clatsop County was $63,200 and $73,000 in Columbia County, compared to $67,800 in Oregon. This is below the livable wage for each county, which is $39/hr or $81,120 for those living in Clatsop County and $46/hr or $95,680 for those in Columbia County (see chart on the following page).

[23]Source: County Health Rankings and Roadmaps, US Census Bureau, Small Area Income and Poverty Estimates, 2020

Living Wage[24]

Description: The hourly wage needed to cover basic household expenses plus all relevant taxes for a household of one adult and two children.

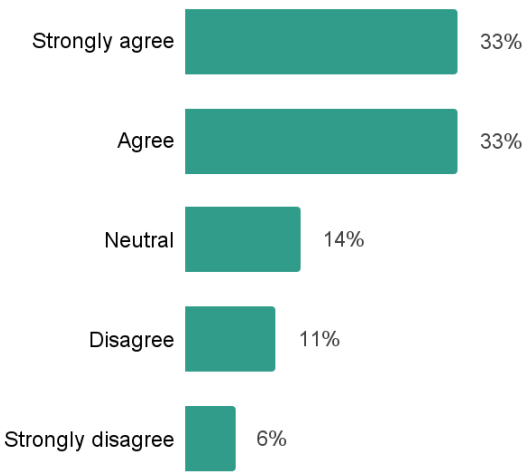
Unemployment Rate[25]



Unemployment in both counties, as well as the state, has decreased from 2020 to 2022. Clatsop and Columbia Counties' unemployment rates hover near or match Oregon's in 2022, at 3.3% and 3.6% respectively, compared to Oregon state at 3.6%.

[24]Source: County Health Rankings and Roadmaps, US Census Bureau, Small Area Income and Poverty Estimates, 2020
[25] Source: Bureau of Labor Statistics

I have enough financial resources to meet my basic needs.



Additionally, stakeholders shared that community members experiencing houselessness may have had a particularly hard time accessing job opportunities without a permanent address and safe place to keep their belongings. They also shared that the economy had shifted over the past couple of decades with decreased demand for certain industries like logging. It may have been difficult for young people to find jobs that paid a living wage in the community without an advanced degree. With the high cost of housing people found that they were spending a higher percentage of their income on housing, particularly the Latino/a/x population. Over 65% of survey respondents shared they agreed or strongly agreed that they had enough financial resources to meet their needs, while 17% disagreed or strongly disagreed.

Additionally, the COVID-19 pandemic had exacerbated economic inequities. People with low incomes and those lacking benefits and paid time off had a harder time meeting their needs. Stakeholders shared that people with mental health and substance use/misuse challenges may have also had challenges remaining stably employed and housed.

The following table shows an overview of populations experiencing challenges discussed in this section, top barriers, and frequently mentioned gaps.

Populations Experiencing Economic Insecurity	Top Barriers to Economic Security	Frequently Mentioned Gaps for Economic Insecurity
• Those working in hospitality and tourism • Houseless population • Those without an advanced degree • Latino/a/x population	• High cost of housing • High cost of childcare	• Lack of comprehensive job benefits

Existing assets and resources to address economic insecurity:

- Clatsop Community Action
- Consejo Hispano
- Columbia Economic Team

Access to Dental Care

Stakeholders noted the importance of oral health on overall physical health. Many community members either did not have dental insurance through their employer or did not qualify, particularly those employed in the hospitality and tourism industries. In Clatsop County, the percentage of individuals aged 18 and older who reported going to a dental clinic in the past year (24%) was slightly lower than Oregon in 2019 (25%), while Columba County was slightly higher (26%).

Dental Visits[26]

Measure: Respondents aged 18 years and older who report having been to the dentist or dental clinic in the past year.

Additionally, the community lacked dental care options, particularly providers that accepted OHP for dental care. This created the need to travel outside of the community to Portland or other areas. Stakeholders shared that sometimes people cannot get a dental appointment for a few months. Additionally, both the ratio of population to dentists for Clatsop and Columbia counties was higher than that of Oregon in 2020, meaning there were fewer dental providers for individuals to receive care from than in Oregon as a whole.

Ratio of Population to Dentists[27]

Description: The ratio represents the population served by one dentist if the entire population of a county was distributed equally across all practicing dentists.

Clatsop	Columbia	Oregon
1390:1	1650:1	1210:1

The following table shows an overview of populations experiencing challenges discussed in this section, top barriers, and frequently mentioned gaps.

Populations Experiencing a Lack of Access to Dental Care	Top Barriers to Accessing Dental Care	Frequently Mentioned Gaps for Accessing Dental Care
• Those without employer provided dental • OHP members	• Travel for care	• Lack of providers • Lack of appointment availability

[26]Source: https://experience.arcgis.com/experience/dbbfa53916ea40fc8dfb734a8d7b669d/page/Dental/ BRFSS, 2019
[27]Source: County Health Rankings and Roadmaps, Area Health Resource File
https://www.countyhealthrankings.org/app/oregon/2022/measure/factors/88/map

Existing assets and resources to address access to dental care:

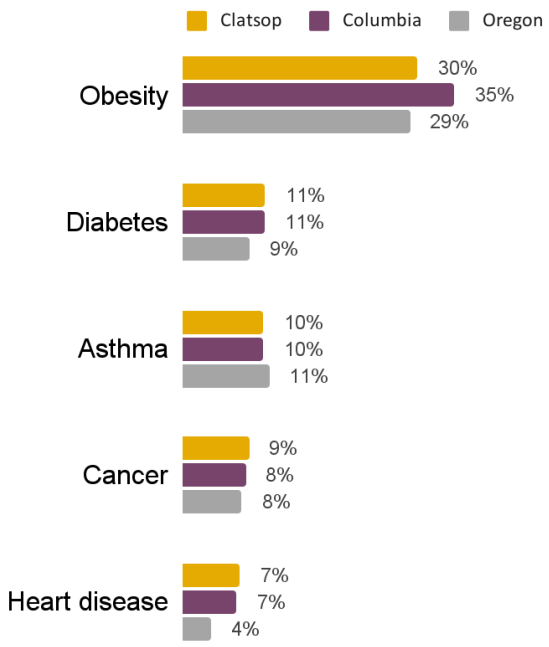
- Advantage Dental
- Columbia Pacific CCO

Chronic Health Conditions

In Clatsop and Columbia counties, the prevalence of chronic conditions was comparable to that of Oregon, with obesity, diabetes, asthma, cancer, and heart disease matching that of the state or falling within +/- six percentage points (see chart on the following page). The top five leading causes of death per 100,000 varied between county and state slightly and included cancer, heart disease, CLRD, unintended injuries, cerebrovascular disease, and Alzheimer's disease.

Stakeholders and interviewees spoke peripherally of chronic health conditions in the community and a need to address those conditions. They shared that there were gaps in services for people experiencing houselessness, particularly not receiving regular care for their chronic conditions due to a lack of insurance and challenges getting to appointments. Stakeholders also shared that patient needs may not be addressed holistically (whole-body), in part due to organizations focusing on one aspect of a patient's care because that was the organization's health focus. They suggested that when addressing chronic conditions, it could be beneficial to provide holistic care through wraparound support.

Chronic Conditions[28]

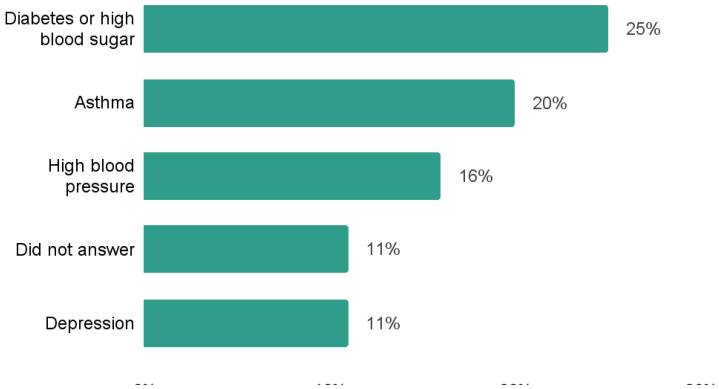


Of survey respondents, 36% rated their overall physical health as excellent or very good, while 38% ranked it as good, and 24% ranked it as fair or poor.

[28]Source: https://experience.arcgis.com/experience/dbbfa53916ea40fc8dfb734a8d7b669d/page/Cancer/ Behavioral Risk Factor, Surveillance System Survey (BRFSS), 201

How would you rate your overall physical health?

Have you ever been told by any healthcare professional that you have any of the following?



Additionally, survey respondents shared if they had been told by a healthcare professional if they had a chronic condition. The top three conditions that respondents shared were diabetes or high blood sugar (25%), asthma (20%), and high blood pressure (16%).

Existing assets and resources to address chronic health conditions:

- City of Seaside
- Coastal Family Health Center
- Columbia Memorial Hospital
- Columbia Pacific CCO
- Providence Seaside Hospital
- Sunset Empire Parks and Recreation District

APPENDICES

Appendix 1: Quantitative Data

POPULATION LEVEL DATA

PSH developed an interactive data dashboard that includes different health and health-related indicators at the census tract level. Please visit this link to explore data for Clatsop and Columbia counties: https://experience.arcgis.com/experience/dbbfa53916ea40fc8dfb734a8d7b669d/

PRIMARY DATA COLLECTION SURVEY RESULTS

Survey Instrument (Questions)

2022 Community Health Needs Assessment (CHNA) Survey

Clatsop County Public Health, Columbia Memorial Hospital, Columbia Pacific CCO, Columbia County Public Health, Providence Seaside Hospital, and Tillamook County Public Health would like to hear from you.

Please fill out this survey to let us know what is most important to you and your family. Your responses will also help us understand how we can support the community we serve.

Please answer each question as best you can and feel free to skip questions you do not want to answer. Your answers will be kept private and anonymous.

Thank you.

Healthcare

1. Do you have health coverage or insurance?

- Yes
- No (If no, skip to question 3)

2. What kind of health coverage or insurance do you have? Check all that apply.

- Medicaid
- Medicare
- VA, TRICARE or other military healthcare
- Indian Health Service (IHS)
- I have private coverage through an employer or family member's employer
- A private plan that I pay for myself
- Other
- I do not have any health insurance now
- I do not know

3. If you do not have health coverage or insurance, what are the main reasons why? Check all that apply.

- It costs too much
- I do not think I need insurance

- I am waiting to get coverage through a job
- Signing up for insurance is too confusing
- I have not had time to do it
- Other

4. Have you or anyone in your household needed healthcare in the last year?

- Yes
- No (If no, skip to question 6)

5. Did you get all the healthcare you needed? Check all that apply.

- We got all the care we needed
- We got some but not all the care we needed
- We had to delay getting the care we needed
- We got no care at all
- I do not know

6. For the most recent time you or anyone in your household put off or went without primary medical care, what were the reasons? Check all that apply.

- Cost
- Not having a healthcare provider
- Not having a healthcare provider who looks like me
- Not having a healthcare provider who understands my gender identity
- Not having a healthcare provider who speaks my language
- Not knowing where to go
- An appointment was not available when I needed one
- Not having childcare
- Not having transportation
- COVID-19 (coronavirus): appointment cancellation, concern of infection, or other related concerns
- Other reasons:
- Not applicable

7. A primary healthcare provider, including a naturopathic provider, is the person you see if you need a health check-up, want advice about a health problem, or get sick or hurt. Do you have a primary care provider?

- Yes
- No

8. Have you ever been told by any healthcare professional that you have any of the following? Check all that apply.

- Diabetes or high blood sugar
- Asthma
- High blood pressure
- High cholesterol

- Heart disease
- Cancer
- Depression
- Post-traumatic stress disorder (PTSD)
- Anxiety
- Substance use disorder
- Another ongoing health condition _____

9. In the last year, did you receive care using any of the following?

- Naturopathic
- Acupuncture
- Chiropractic
- Nutrition
- Ayurvedic
- Other _____

10. In the last year, did you receive care using any of the following?

- Urgent care
- Emergency room
- Telemedicine (video visit)

11. In the last year, did you need counseling or mental health support or care?

- Yes
- No (If no, skip to question 13)

12. Did you get all the counseling or mental healthcare you needed?

- Yes
- No (Please check all the types of counseling or mental healthcare you did not receive)
    - Support for a personal problem
    - Treatment for a mental health condition like PTSD, depression, or anxiety
    - Counseling to quit tobacco, alcohol, or drug use
    - Other kinds of care

13. In the last year, have you or anyone in your household had concerns about alcohol, tobacco, or substance use?

- Yes
- No (If no, skip to question 15)

14. In the last year, were you able to get the help you needed with alcohol, tobacco, or substance use?

Health service	Yes	No	Not applicable
Smoking cessation program			
Alcohol treatment program			
Medication-assisted treatment program (for example Suboxone)			
Substance use disorder counseling and treatment (not including alcohol)			

Health & Lifestyle

15. How would you rate your overall physical health?

- Excellent
- Very good
- Good
- Fair
- Poor

16. How would you rate your overall mental health?

- Excellent
- Very good
- Good
- Fair
- Poor

17. In the last year, how often did you feel socially isolated or experience loneliness?

- All of the time
- Most of the time
- Some of the time
- None of the time

18. How often do you have someone available to do each of the following?

Love you and make you feel wanted

- All of the time
- Most of the time
- Some of the time

- None of the time

Confide in or talk to about your problems

- All of the time
- Most of the time
- Some of the time
- None of the time

Help you if you became suddenly ill or disabled

- All of the time
- Most of the time
- Some of the time
- None of the time

19. In the last year, did you participate in a religious community? (Check all that apply)

- Christianity
- Islam
- Buddhism
- Judaism
- Other: _____
- No
- No, I am atheist or agnostic
- No, but I am religious or spiritual

20. During the last two weeks, how often have you felt the following:

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

21. Have you had any of these hard times or traumatic events in your life? (Check all that apply)

- Life changing illness or injury
- Neglect of any kind
- Lived with someone with mental illness

- Lived with someone with substance abuse issues
- Witnessed or experienced violence
- Made to do something sexual that you did not want to do
- Physically hurt or threatened by an intimate partner or parent/caregiver
- Abuse of any kind
- Parents were separated or divorced during your childhood (ages newborn to 18)
- A personal suicide attempt
- A suicide or suicide attempt by a close friend or family member
- Unexpected death of a loved one
- Another traumatic event

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

- Yes
- No (If no, skip to question 26)

23. Have you ever been told by a healthcare professional that any of your children have the following? Check all that apply.

- Diabetes or high blood sugar
- Asthma
- A behavioral or mental health diagnosis (such as depression, anxiety, or ADHD)
- A developmental delay or a learning disability (such as autism or dyslexia)
- Post-traumatic stress disorder (PTSD)
- Another ongoing health condition: _____

24. Before, during, or after your pregnancy, did any of these statements apply to you?

	Yes	**No**	**Not applicable**
I had enough support during my pregnancy			
My health provider addressed mental health and substance abuse concerns with me			
I experienced post-partum depression, either diagnosed or undiagnosed			
I was provided information o n home visiting programs			
I was provided information on birthing support options			

25. What are the two most important factors when choosing childcare or preschool for your child(ren)?

- Finding a childcare provider
- Cost
- Distance from my home
- Works with my schedule
- Quality of care
- Provider/teach to student ratio
- Other _____
- Not applicable

26. The following questions are about where you live. Please choose the number that best represents your opinion of each statement.

If you do not know, please respond "DK"

Statements	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Do not know
My community has healthcare options available. Think about the cost and quality of care, distance you need to travel, and availability of appointments.	1	2	3	4	5	DK
My community is a good place to raise children. Think about the quality and safety of school and childcare, after-school programs, and places to play in your neighborhood.	1	2	3	4	5	DK
My community is a good place to grow older. Think about senior housing, transportation to medical services, access to shopping centers and businesses, recreation, and services for seniors.	1	2	3	4	5	DK
I feel safe in my home.	1	2	3	4	5	DK

Think about everything that makes you feel safe, such as neighbors, presence of law enforcement, etc. and everything that could make you feel unsafe at home, including family violence, robbery, or housing conditions.						
My community feels safe. Think about how safe you feel in and around your neighborhood, schools, playgrounds, parks, businesses, and shopping centers.	1	2	3	4	5	DK
I feel prepared for an emergency. Think about everything that makes you feel prepared, such as toolkits, smoke alarms, fire extinguishers, etc.	1	2	3	4	5	DK
People of all races, ethnicities, backgrounds, and beliefs in my community are treated fairly. Think about discrimination and programs that work to increase diversity.	1	2	3	4	5	DK
Healthy food is available in my community. Think about restaurants, grocery stores, supermarkets, corner stores, and farmers' markets that sell fresh fruits, vegetables, lean proteins/meats and other healthy options.	1	2	3	4	5	DK
There are places to be physically active near my home. Think about parks, trails, places to walk and playgrounds.	1	2	3	4	5	DK
I have enough financial resources to	1	2	3	4	5	DK

meet my basic needs.						
Think about income for purchasing food, clothing, housing, and utilities.						

Adapted from Lake County Community Health Assessment, 2018

Would you like to tell us more about any of your responses above?

_____

_____

_____

End of Life Questions

27. Have you completed or considered completing the following documents/forms? Check all that apply.

- Advanced Directive
- Power of Attorney for Healthcare
- Physicians Orders for Life Sustaining Treatment (POLST)
- Five Wishes
- A Living Trust or Will

28. I feel that it is important to discuss end of life concerns or wishes with a confidant, significant other, or a healthcare provider.

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

29. I am aware of resources to facilitate a conversation about living well, death, and dying well?

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

30. I understand what palliative care means.

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

31. I know how to access hospice for myself, a friend or family member

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

About You and Your Family

Answering the next 13 questions helps us know we are getting the best picture of our community. You may skip any questions you prefer not to answer, but all answers are combined so you will not be linked to your answers.

32. What ZIP code do you live in? _____

33. What year were you born? _____

34. Are you Hispanic or Latino/Latina/Latinx?

- Yes
- No

35. What is your race? Check all that apply.

- White
- Black or African American
- Asian
- Native Hawaiian or other Pacific Islander
- American Indian or Alaska Native
- Middle Eastern/North African
- Do not know/not sure
- Prefer not to answer

36. What is your current gender?

- Female
- Male
- Transgender
- Gender non-binary
- Gender non-conforming
- Choose not to answer
- Other _____

37. What is your current sexual orientation?

- Asexual
- Bisexual
- Gay

- Heterosexual or straight
- Lesbian
- Pansexual
- Queer
- Choose not to answer
- Other _____

38. How many people currently live in your home? Count adults, seniors, and children under 18?

- Number of adults (18 to 65 years) _____
- Number of seniors (over age 65) _____
- Number of children (birth to 18) _____

39. What is your gross household income (the amount before taxes and deductions are taken out) for last year (2021)? Your best guess is fine.

- $0
- $1 to $10,000
- $10,001 to $20,000
- $20,001 to $30,000
- $30,001 to $40,000
- $40,001 to $50,000
- $50,001 to $60,000
- $60,001 to $70,000
- $70,001 to $80,000
- $80,001 to $90,000
- $90,001 to $100,000
- $100,001 or more

40. What is your current employment status?

- Employed full time (40 hours per week)
- Employed part time
- Seasonal, service industry, gig economy
- Self-employed
- Retired
- Unable to work due to illness, injury, or disability
- Homemaker or stay-at-home parent
- Student
- Unemployed

41. Do you work more than one job?

- Yes
- No (If no, skip to question 40)

42. Do you **have to** work more than one job to afford your living expenses?

- Yes
- No

43. Have you or someone in your household lost a job or hours due to COVID-19?

- Yes
- No

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

- I have housing and I am not worried about losing it
- I have housing, but I am worried about losing it
- I do not have housing, and I am staying with friends or family
- I am staying in a shelter
- I am living in a tent or camping
- I am staying in my car or on the street
- Other (tell us):

45. Have you or someone in your household lost your housing due to COVID-19 or wildfires?

- COVID-19
- Wildfires
- Not applicable

46. In the last year, have you or anyone in your household had to go without anything from this list because you couldn't afford it?

	Yes	**No**	**Not applicable**
Food			
Utilities (water, electricity, heat)			
Transportation			
Clothing			
Personal hygiene items (soap, shampoo, toilet paper, feminine products, etc.)			
Stable housing or shelter			
Medical care			
Medicine			
Childcare			

Dental care			

47. What health services are needed but are not available near where you live?

_____

_____

48. What one thing could be done to improve the health and quality of life for your family?

_____

_____

49. What one thing could be done to improve the overall health and quality of life in your community?

_____

_____

Thank you for completing the 2022 Community Health Needs Assessment survey!

Survey Responses

1. Do you have health coverage or insurance?

Response Option	Percentage
No	5%
Yes	95%

2. What kind of health coverage or insurance do you have?

Response Option	Percentage
Medicare	15%
Medicaid	12%
I have private coverage through	54%
A private plan that I pay for	4%
VA TRICARE or other military health care	2%
Indian Health Service (IHS)	0%
I do not have any health insurance	3%

other	4%
I do not know	1%
(blank)	5%

3. If you do not have health coverage or insurance, what are the main reasons why?

Response Option	Percentage
I am waiting to get coverage through a job	0%
I have not had time to do it	0%
It costs too much	2%
It costs too much, I am waiting to get coverage t	0%
other	1%
(blank)	97%

4. Have you or anyone in your household needed healthcare in the last year?

Response Option	Percentage
No	14%
Yes	85%

5. Did you get all the health care you needed?

Response Option	Percentage
We got all the care we needed	51%
We got some but not all the care we needed	23%
We had to delay getting the care we needed	9%
We got no care at all	1%
I do not know	1%
Did not respond	15%

6. For the most recent time you or anyone in your household put off or went without primary medical care, what were the reasons?

Response Option	Percentage
Not applicable	20%
An appointment was not available when I needed one	19%
Cost	16%
COVID-19 (appointment cancellation, concern of infection)	10%
Not having a health care provider	10%
Other reasons	7%
Not knowing where to go	5%
Not having childcare	3%
Not having transportation	3%
Not having a health care provider who speaks my language	3%
Not having a health care provider who looks like me	3%
Not having a healthcare provider who understand my gender identity	0%

7. A primary health care provider, including a naturopathic provider, is the person you see if you need a health check-up, want advice about a health problem, or get sick or hurt. Do you have a primary care provider?

Response Option	Percentage
No	19%
Yes	81%

8. Have you ever been told by any health care professional that you have any of the following?

Response Option	Percentage
Diabetes or high blood sugar	25%
Asthma	20%

High blood pressure	16%
Did not answer	11%
Depression	11%
High cholesterol	5%
Other	3%
Cancer	3%
Anxiety	2%
Post-traumatic stress disorder	2%
Heart disease	1%
Asthma	1%
Substance use disorder	0%
Asthma, Depression, Anxiety	0%

9. In the last year, did you receive care using any of the following?

Response Option	Percentage
Chiropractic	33%
Other	24%
Naturopathic	16%
Acupuncture	14%
Nutrition	11%
Ayurvedic	1%

10. In the last year, did you receive care using any of the following?

Response Option	Percentage
Urgent Care	52%
Did not answer	23%
Telehealth	15%
Emergency room	9%

11. In the last year, did you need counseling or mental health support or care?

Response Option	Percentage
No	61%
Yes	35%
Did not answer	4%

12. Did you get all the counseling or mental health care you needed?

Response Option	Percentage
No	17%
Yes	17%
(blank)	66%

13. In the last year, have you or anyone in your household had concerns about alcohol, tobacco, or substance use?

Response Option	Percentage
No	81%
Yes	17%
Did not answer	2%

14. Were you able to get the help you needed with alcohol, tobacco, or substance use?

Smoking Cessation	
Response Option	Percentage
No	5%
Not Applicable	7%
Yes	3%
(blank)	86%
Alcohol Treatment Program	
Response Option	Percentage
No	3%
Not Applicable	6%
Yes	5%
(blank)	85%
MAT	
Response Option	Percentage
No	2%

Not Applicable	8%
Yes	4%
(blank)	86%

SUD Treatment/Counseling	
Response Option	Percentage
No	3%
Not Applicable	6%
Yes	5%
(blank)	86%

15. How would you rate your overall physical health?

Response Option	Percentage
Excellent	5%
Very Good	31%
Good	38%
Fair	19%
Poor	5%

16. How would you rate your overall mental health?

Response Option	Percentage
Excellent	13%
Very Good	21%
Good	36%
Fair	23%
Poor	7%

17. In the last year, how often did you feel socially isolated or experience loneliness?

Response Option	Percentage
All of the time	4%
Most of the time	14%
Some of the time	52%

None of the time	30%

18. How often do you have someone available to do each of the following?

Love you and make you feel wanted	
Response Option	Percentage
All of the time	47%
Most of the time	27%
None of the time	5%
Not at all	0%
Some of the time	20%
(blank)	1%

Confide in or talk to you about your problems	
Response Option	Percentage
All of the time	41%
Most of the time	28%
None of the time	7%
Not at all	0%
Some of the time	23%
(blank)	1%

Help you if you became suddenly ill or disabled	
Response Option	Percentage
All of the time	50%
Most of the time	21%
None of the time	9%
Not at all	0%
Some of the time	19%
(blank)	1%

19. In the last year, did you participate in a religious community?

Response Option	Percentage
Christianity	30%
Islam	0%
Buddhism	1%
Judaism	0%

Other	6%
No	29%
No, I am atheist or agnostic	11%
No, but I am religious or spiritual	23%

20. During the last two weeks, how often have you felt the following?

Little interest or pleasure in doing things	
Response Option	Percentage
Nearly every day	7%
Not at all	50%
Over half the days	11%
Several days	29%
(blank)	3%

Feeling down, depressed or hopeless	
Response Option	Percentage
Nearly every day	6%
Not at all	51%
Over half the days	10%
Several days	31%
(blank)	3%

Feeling nervous, anxious, or on edge	
Response Option	Percentage
Nearly every day	10%
Over half the days	15%
Several days	34%
Not at all	38%
(blank)	3%

Not being able to stop worrying	
Response Option	Percentage
Nearly every day	11%
Not at all	44%
Over half the days	14%
Several days	28%
(blank)	3%

21. Have you had any of these hard times or traumatic events in your life?

Response Option	Percentage
Life changing illness or injury	9%
Neglect of any kind	5%
Lived with someone with mental illness	10%
Lived with someone with substance abuse issues	10%
Witnessed or experienced violence	9%
Made to do something sexual that you did not want to do	6%
Physically hurt or threatened by an intimate partner or parent/caregiver	6%
Abuse of any kind	7%
Parents were separated or divorced during your childhood (ages newborn to 18)	8%
A personal suicide attempt	2%
A suicide or suicide attempt by a close friend or family member	7%
Unexpected death of a loved one	13%
Another traumatic event	8%

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

Response Option	Percentage
Yes	59%
No	39%
Did not answer	2%

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

Response Option	Percentage
Diabetes or high blood sugar	1%
Asthma	4%
A behavioral or mental health diagnosis (such as depression, anxiety, or ADHD)	10%
A developmental delay or a learning disability (such as autism or dyslexia)	5%

Post-traumatic stress disorder (PTSD)	0%
Another ongoing health condition	0%
Blank	79%

24. Before, during, or after your pregnancy, did any of these statements apply to you?

I had enough support during my pregnancy	
Response Option	Percentage
Yes	65%
No	17%
Not applicable	17%

My health provider addressed mental health and substance use concerns with me	
Response Option	Percentage
Yes	41%
No	25%
Not applicable	34%

I experienced post-partum depression, either diagnosed or undiagnosed	
Response Option	Percentage
Yes	41%
No	35%
Not applicable	25%

I was provided information on home visiting programs	
Response Option	Percentage
Yes	27%
No	50%
Not applicable	23%

I was provided information on birthing support options	
Response Option	Percentage
Yes	38%
No	38%
Not applicable	23%

25. What are the two most important factors when choosing childcare or preschool for your child(ren)?

Response Option	Percentage
Quality of care	36%
No applicable	20%
Cost	15%
Finding a childcare provider	12%
Works with my schedule	7%
Other	6%
Distance from my home	3%
Provider/teacher to student ratio	2%

26. The following questions are about where you live. Please choose the number that best represents your opinion of each statement.

My community has health care options available.	
Response Option	Percentage
Strongly Agree	15%
Agree	33%
Neutral	16%
Disagree	20%
Strongly Disagree	9%
My community is a good place to raise children	
Response Option	Percentage
Strongly Agree	17%
Agree	35%
Neutral	26%
Disagree	9%
Strongly Disagree	3%
My community is a good place to grow older.	
Response Option	Percentage
Strongly Agree	16%
Agree	35%

Neutral	24%
Disagree	14%
Strongly Disagree	3%
I feel safe in my home	
Response Option	Percentage
Strongly Agree	46%
Agree	31%
Neutral	12%
Disagree	6%
Strongly Disagree	1%
My community feels safe	
Response Option	Percentage
Strongly Agree	20%
Agree	42%
Neutral	20%
Disagree	11%
Strongly Disagree	3%
I feel prepared for an emergency.	
Response Option	Percentage
Strongly Agree	19%
Agree	42%
Neutral	20%
Disagree	13%
Strongly Disagree	3%
People of all races, ethnicities, backgrounds, and beliefs in my community are treated fairly.	
Response Option	Percentage
Strongly Agree	10%
Agree	23%
Neutral	21%
Disagree	24%
Strongly Disagree	10%
Healthy food is available in my community.	
Response Option	Percentage

Strongly Agree	27%
Agree	40%
Neutral	17%
Disagree	10%
Strongly Disagree	3%

There are places to be physically active near my home	
Response Option	Percentage
Strongly Agree	40%
Agree	37%
Neutral	13%
Disagree	6%
Strongly Disagree	2%

I have enough financial resources to meet my basic needs.	
Response Option	Percentage
Strongly Agree	33%
Agree	33%
Neutral	14%
Disagree	11%
Strongly Disagree	6%

27. Have you completed or considered completing the following/forms?

Response Option	Percentage
Advanced Directive	34%
Power of Attorney	20%
Physicians Orders for Life Sustaining Treatment (POLST)	10%
Five Wishes	2%
A living Trust or Will	34%

28. I feel that it is important to discuss end of life concerns or wishes with a confidant, significant other, or a health care provider.

Response Option	Percentage
Strongly Agree	50%

Agree	32%
Neutral	10%
Disagree	0%
Strongly Disagree	1%
Did not respond	6%

29. I am aware of resources to facilitate a conversation about living well, death, and dying well.

Response Option	Percentage
Strongly Agree	19%
Agree	25%
Neutral	26%
Disagree	21%
Strongly Disagree	1%
Did not respond	8%

30. I understand what palliative care means.

Response Option	Percentage
Strongly Agree	33%
Agree	32%
Neutral	13%
Disagree	13%
Strongly Disagree	2%
Did not respond	7%

31. I know how to access hospice for myself, a friend or a family member.

Response Option	Percentage
Strongly Agree	33%
Agree	32%
Neutral	13%
Disagree	13%
Strongly Disagree	2%
Did not respond	7%

32. What zip code do you live in?

Response Option	Percentage
97016	4%
97018	3%
97048	2%
97051	15%
97053	1%
97054	1%
97056	6%
97064	1%
97103	32%
97110	1%
97121	2%
97138	15%
97146	8%
98624	1%
98631	1%
Did not respond	6%

33. What is your age?

Response Option	Percentage
65 and over	14%
35-64	61%
18-34	15%
17 and under	1%
Did not answer	9%

34. Are you Hispanic or Latino/Latina/Latinx?

Response Option	Percentage
No	87%
Yes	6%
(blank)	6%

35. What is your race?

Response Option	Percentage
American Indian or Alaska Native	1%
Asian	1%
Black or African American	1%
Multiracial	1%
White	80%
Do not know/not sure	2%
Prefer not to answer	8%
other	1%
(blank)	6%

36. What is your current gender?

Response Option	Percentage
Female	69%
Male	22%
Gender non binary	0%
Gender non conforming	0%
Two-Spirit	0%
other	1%
Choose not to answer	0%
Choose not to answer	3%
(blank)	4%

37. What is your current sexual orientation?

Response Option	Percentage
Heterosexual or straight	71%
Bisexual	4%
Asexual	4%
Heterosexual	0%
Gay	1%
Lesbian	2%

Pansexual	1%
Queer	1%
other	1%
Choose not to answer	10%
(blank)	5%

38. How many people currently live in your home?

Response Option	Percentage
Number of adults	Data not available
Number of seniors (over age 65)	Data not available
Number of children (birth to 18)	Data not available

39. What is your gross household income?

Percentage	Percentage
$0	4%
$1 to 10 000	4%
$10 001 to 20 000	6%
$20 001 to 30 000	9%
$30 001 to 40 000	8%
$40 001 to 50 000	6%
$50 001 to 60 000	6%
$60 001 to 70 000	6%
$70 001 to 80 000	7%
$80 001 to 90 000	6%
$90 001 to 100 000	6%
$100 001 or more	28%

40. What is your current employment status?

Response Option	Percentage
Employed full time 40 hours per week	52%
Employed part time	10%
Self employed	6%
Family Caregiver	0%
Retired	14%
Student	3%
Unemployed	6%
Seasonal service industry gig	1%
Homemaker or stay at home pare	3%
Unable to work due to illness	4%
(blank)	2%

41. Do you work more than one job?

Response Option	Percentage
No	81%
Yes	13%
Did not answer	6%

42. Do you have to work more than one job?

Response Option	Percentage
No	5%
Yes	7%
Did not answer	87%

43. Have you or someone in your household lost a job or hours due to COVID-19?

Response Option	Percentage
No	66%
Yes	29%
Did not answer	5%

44. Which of the following best describes your housing situation today?

Response Option	Percentage
I do not have housing and I'm staying with friends or family	2%
I have housing and I am not worried about losing it	73%
I have housing but I am worried about losing it	12%
I'm staying in a shelter	4%
I'm staying in my car or on the street	1%
Other	3%
Did not respond	6%

45. Have you or someone in your household lost your housing due to COVID-19 or wildfires?

Response Option	Percentage
COVID-19	2%
Wildfires	0%
Not applicable	90%
Did not answer	8%

46. In the last year, have you or anyone in your household had to go without anything from this list because you couldn't afford it?

Response Option	No	Yes	Not Applicable	Did not answer
Food	78%	8%	4%	9%
Utilities (water, electricity, heat)	79%	6%	4%	11%
Transportation	76%	11%	3%	10%
Clothing	77%	11%	3%	9%
Personal hygiene items	80%	7%	4%	9%
Stable housing or shelter	80%	7%	4%	9%
Medical care	73%	16%	3%	7%
Medicine	75%	13%	4%	9%
Childcare	58%	8%	23%	11%
Dental care	67%	22%	4%	8%

Appendix 2: Community Input

INTRODUCTION

The North Coast CHNA Collaborative Partners contracted with Rede Group to conduct stakeholder interviews and community listening sessions. Listening to and engaging with the people who live and work in the community is a crucial component of the CHNA, as these individuals have firsthand knowledge of the needs and strengths of the community. Rede Group conducted 10 stakeholder interviews including 11 participants who were invested in the well-being of the community and had first-hand knowledge of community needs and strengths. They also conducted 6 listening sessions. The goal of the interviews and listening sessions was to identify what needs are currently not being met in the community and what assets could be leveraged to address these needs.

METHODOLOGY

Selection

The Rede Group completed 6 listening sessions that included a total of 37 participants. The sessions took place between February 8 and March 21, 2022. The CHNA Collaborative included organizations representing Clatsop, Columbia, and Tillamook counties in Northwestern Oregon. Listening session participants were recruited with the help of (CBOs).

Table 1_Apx 2. Key Community Stakeholder Participants

Community Input Type and Population	Location of Session	Listening Session Date	Language
Listening session with individuals with low income or experiencing houselessness	Clatsop Community Action via Zoom	2/8/2022	English
Listening session with individuals with behavioral health conditions	Columbia Community Mental Health via Zoom	2/22/2022	English
Listening session with individuals identifying as Latino/a/x	Consejo Hispano via Zoom	3/2/2022	Spanish
Listening session with parents identifying as Latino/a/x	Northwest Early Learning Hub via Zoom	3/10/2022	Spanish
Listening session with parents	Northwest Early Learning Hub via Zoom	3/1/2022	English

Listening session with older adults (65 years or older)	Zoom (Rede online recruitment the tri county area)	3/21/2022	English

Rede Group conducted 10 stakeholder interviews including 11 participants overall between January and March 2022. Stakeholders were selected based on their knowledge of the community and engagement in work that directly serves people who are economically poor and vulnerable. The collaborative aimed to engage stakeholders from social service agencies, healthcare, education, housing, and government, among others, to ensure a wide range of perspectives.

Table 2_Apx 2. Key Community Stakeholder Participants

Organization	Name	Title	Sector
Clatsop Behavioral Healthcare	Amy Baker	Executive Director	Behavioral health
Clatsop Community Action	Viviana Matthews	Executive Director	Housing, food, energy assistance, and basic needs
Clatsop County Sheriff's Office	Matthew D. Phillips	Sheriff	Law enforcement
Columbia Community Mental Health	Todd Jacobson	Executive Director	Behavioral health
Consejo Hispano	Kayla Slovak-Perez	Community Health Worker	Programs and services that focus on education, health, financial empowerment, and advocacy and civic engagement for the Latinx community
Helping Hands Reentry Outreach Centers	Alan Evans	Founder and CEO	houselessness

	Benedetto DeFrancisco	Program Coordinator	
Lower Columbia Q Center	Tessa James Scheller	Chairperson for the Community Outreach and Education Committee	Advocacy, outreach, and education for the LGBTQ2SIA+ community
Northwest Parenting Hub and Northwest Early Learning Hub	Elena Barreto	Regional Coordinator	Parenting education, family engagement, child development, early learning, childcare and preschool
Scappoose School District	Tim Porter	Superintendent	Education
Sunset Empire Park & Recreation District	Skyler Archibald	Executive Director	Healthy lifestyle, recreation, community-building, childcare and preschool

Facilitation Guides

For the listening sessions, participants were asked an icebreaker and three questions:

- Community members' definitions of health and well-being
- The community needs
- The community strengths

For the stakeholder interviews, PSH developed a facilitation guide that was used across all hospitals completing their 2022 CHNAs:

- The community served by the stakeholder's organization
- The community strengths
- Prioritization of unmet health related needs in the community, including social determinants of health
- The COVID-19 pandemic's effects on community needs
- Suggestions for how to leverage community strengths to address community needs
- Successful community health initiatives and programs
- Opportunities for collaboration between organizations

Full facilitation guides are included at the end of this appendix.

Training

The facilitation guides provided instructions on how to conduct a stakeholder interview and listening session, including basic language on framing the purpose of the sessions. Facilitators were trained, professional facilitators in community listening sessions and stakeholder interviews and were provided guides.

Data Collection

Stakeholder interviews were conducted virtually and recorded with the participant's permission. Listening sessions were conducted either completely virtual, with each participant joining via their own device, or hybrid, with the facilitators joining virtually and participants joining from an in-person setting. Two note takers documented the listening session conversations.

Analysis

Qualitative data analysis was conducted by PSH using Atlas.ti, a qualitative data analysis software. The data were coded into themes, which allows the grouping of similar ideas across the interviews, while preserving the individual voice.

The recorded interviews were sent to a third party for transcription. The analyst listened to all audio files to ensure accurate transcription. The stakeholder names were removed from the files and assigned a number to reduce the potential for coding bias. The files were imported into Atlas.ti. The analyst read through the notes and developed a preliminary list of codes, or common topics that were mentioned multiple times. These codes represent themes from the dataset and help organize the notes into smaller pieces of information that can be rearranged to tell a story. The analyst developed a definition for each code which explained what information would be included in that code. The analyst coded eight domains relating to the topics of the questions: 1) name, title, and organization of stakeholder, 2) population served by organization, 3) greatest community strength and opportunities to leverage these strengths 4) unmet health-related needs, 5) disproportionately affected population, 6) effects of COVID-19, 7) successful programs and initiatives, and 8) opportunities to work together.

The analyst then coded the information line by line. All information was coded, and new codes were created as necessary. All quotations, or other discrete information from the notes, were coded with a domain and a theme. Codes were then refined to better represent the information. Codes with only one or two quotations were coded as "other," and similar codes were grouped together into the same category. The analyst reviewed the code definitions and revised as necessary to best represent the information included in the code.

The analyst determined the frequency each code was applied to the dataset, highlighting which codes were mentioned most frequently. The analyst used the query tool and the co-occurrence table to better understand which codes were used frequently together. For example, the code "food insecurity" can occur often with the code "obesity." Codes for unmet health-related needs were cross-referenced with the domains to better understand the populations most affected by a certain unmet health-related need. The analyst documented patterns from the dataset related to the frequency of codes and codes that were typically used together.

This process was repeated for the listening sessions, although rather than recordings, notes were used. The analyst coded three domains related to the topics of the questions: 1) vision, 2) needs, and 3) strengths.

FINDINGS FROM COMMUNITY LISTENING SESSIONS

Vision of a Health Community

Listening session participants were asked to share their vision of a health community. The following themes emerged:

- **Opportunities for recreation and a healthy lifestyle**: Listening session participants described healthy communities as having lots of parks and activities for children and adults to stay active and play safely outside. They also spoke to there being organized community activities, like community runs, that get people moving together. They spoke to these kinds of activities being particularly important for building a healthy lifestyle for families and also opportunities for socialization amongst kids.
- **Easy access to affordable healthcare and mental health supports:** In a healthy community there are sufficient mental health supports, particularly for people with low incomes and children. There is also easy access to healthcare services that are close by.
- **Centralized resources and support for all people:** Listening sessions participants described a healthy community as one where everyone can easily get the support they need. They spoke to having easy access to resources, like a resource hub, with support services related to accessing healthy food and shelter. People are available to support one another, and people can get the help they need.
- **Diversity, inclusion, and respect:** In a healthy community there is diversity of races, ethnicities, ages, and abilities and all people are welcome and respected. They shared a healthy community is one where people with disabilities, the Latino/a/x community, and people with low incomes are treated with respect and included.
- **Economic security, including affordable housing and childcare**: In a healthy community, people can afford their basic needs, like housing and childcare. Participants described a community where people are working and participating in the community and have their basic needs met.

Community Strengths

The following table includes programs, initiatives, or other resources that members noted are working well for them.

Area of Need	Program, Initiative, or Other Resource
Access to healthcare	CCO Community Advisory Council: community input for people on OHP Clatsop County Public Health Department: multiple programs that help people access healthcare services, including a women's health program
Behavioral health	Clatsop Behavioral Healthcare's Rapid Access Clinic

	Columbia Community Mental Health: LGBTQ2SIA+ program
Community resources and information	Buy Nothing group Churches that provide clothing Clatsop Community Action Clatsop County DHS Office Community radio Libraries: Information and resources in the community, as well as classes that meet regularly that help build community Social media for connecting to resources in the community, including the Shared Needs Facebook group
Dental care	School dental programs that provide free fillings and dental care
Education	Early Head Start Head Start Local schools provide a lot of communication and outreach, including food, shoes, clothes, and more.
Food security	The farmer's market Churches providing sack lunches and community meals Food banks WIC
Housing and houselessness	Clatsop Community Action Helping Hands Reentry Outreach Centers Local women's shelters
Latino/a/x services	Abriendo Puertas: Abuela, Mamá y Yo Consejo Hispano Programa Inmigrante
Recreation	Beaches Community parks Gyms with classes
Safety/ Emergency Preparedness	Everbridge Public Warning platform Map Your Neighborhood program

Community Needs

High priority community needs identified from listening sessions

- **Access to healthcare services:** Community members discussed a need for more medical providers and facilities in the community. They shared it can be very challenging to get an appointment to see

a provider, oftentimes scheduling out weeks. Part of the issue may be staffing. They discussed that many providers are not accepting new patients and it can be hard to attract healthcare providers to the community. They were particularly concerned about people without insurance and folks on Oregon Health Plan (OHP), noting there are few healthcare provider options for these groups.
They also shared they do not think the Latino/a/x population is being well served. Interpretation services are often offered through a phone, which frequently drops during the visit. They emphasized needing in-person interpretation and more services in Spanish. They also shared Black, Brown, Indigenous, and Persons of Color (BBIPOC) patients are not always treated well by white providers, noting a need for more BBIPOC providers.
Other needs include more medical services for the houseless population, more health education (particularly sex education) for young people, and improved transportation services to appointments (particularly for older adults).

- **Behavioral health challenges and access to care:** Participants spoke to a need for more affordable mental health services and professionals in the community. They were concerned that there are not enough mental health options in the community, particularly for people with OHP and without insurance. Older adults may not be able to get the mental healthcare they need due to transportation barriers and cost of care, particularly because it is not a service covered by Medicare. The Latino/a/x community cannot access mental health services in Spanish. Participants also spoke to a need for more support for parents and their children, including parent groups and places for children to connect socially.
  Participants spoke of needing more outpatient mental health services, outreach for mental health, harm reduction programs for folks with a substance use disorder (SUD), and more SUD treatment programs. This is especially important because COVID-19 has contributed to more anxiety and depression.
- **Safe and accessible parks and recreation:** Community members spoke to the importance of having play and exercise opportunities available for families. They spoke to a need for more parks in the community, programs for teens, and more socialization opportunities for children after school. This could include sports teams, activities for parents and children to do together, walking tracks, and music programs. They also spoke to needing covered park areas and indoor play areas. Parents saw this need as especially relevant in light of the pandemic and many children missing out on critical socialization and physical activity opportunities.

Medium priority community needs identified from listening sessions

- **Houselessness and housing instability:** Community members shared a need for more safe and affordable housing options. Due to increased vacation rentals, they have seen many people unable to afford their rent or spending most of their income on rent. They also spoke to the importance of providing support for folks in completing housing applications, such as a peer navigator.
  Community members shared they would like to see more services for people experiencing houselessness, including shelters and emergency housing. Participants were also concerned about increasing levels of houselessness and camping, affecting people's feeling of safety.

- **Access to dental care:** Accessing dental care can be very challenging, particularly for people with OHP and without insurance. They shared needing more dentists in Clatsop County for people with OHP, without insurance, and for children. They also shared that there are no dental services in Spanish and very few dental options across the board in the community.
- **Access to community resources**: Community members spoke to wanting to see a resource hub to help people know what resources are available in the community. They would also like to see more outreach and communication through posters, newspapers, and other channels. They would particularly like to see more resources for families with low incomes and Spanish-speaking community members.
  Accessing resources can be overwhelming for people. Making the process to apply for services as easy as possible, including support filling out forms and persistent outreach from organizations, would be beneficial.
- **Community safety**: Community members were concerned about increases in crime and encampments. They noted more car break-ins that make people feel anxious. They were concerned about their children leaving school events or activities after dark.
- **Racism and discrimination:** Participants shared that BBIPOC communities can feel unwelcome in the community. Latino/a/x community members spoke to receiving rude looks out in public and experiencing racism. They spoke of wanting there to be more education around inclusion and unity, particularly in schools, to promote more acceptance of all people.
- **Transportation**: Participants spoke to a need for improved public transportation. This is important for job security and getting to healthcare appointments. They particularly need transportation to Portland for certain healthcare needs. Older adults and people living in rural areas may experience more challenges with transportation. Participants shared the Columbia County Rider cut many lines making transportation harder.

FINDINGS FROM STAKEHOLDER INTERVIEWS

Community Strengths

The interviewer asked stakeholders to share one of the strengths they see in the community and discuss how we can leverage these community strengths to address community needs. This is an important question because all communities have strengths. While a CHNA is primarily used to identify gaps in services and challenges, we also want to ensure that we highlight and leverage the community strengths that already exist. The following strengths emerged as themes:

Community engagement and helping one another

Stakeholders shared community members are aware of community needs and are actively engaging in solutions through conversation and volunteerism. They noted people rally together for events and step up to help others when they see someone in need.

In particular, community members are engaging in solutions related to houselessness and housing challenges. They are also engaged in supporting children and young people, through creating access to sports and recreation opportunities. There is generally a lot of support for schools and children.

Stakeholders shared this strength can be leveraged to create more conversation around and understanding of mental health challenges and disabilities to spur more support of families experiencing these challenges.

Community knowledge and wisdom

Stakeholders emphasized community members have a lot of knowledge about how to address needs and how to support one another. For example, the LGBTQ2SIA+ community shares information about affirming, respectful, and supportive healthcare providers with one another. This is especially useful for folks new to the area seeking care. Within the Latino/a/x community, there is a lot of trust and wisdom to be shared. This strength has been beneficial during COVID-19 vaccination events when trusted community members share information about the events and vaccine safety.

Honoring community knowledge and wisdom means trusting that communities know what they need and letting them inform program and initiative development. The state provided funding for housing and allowed communities to determine the type of housing needed. A workgroup identified a need for LGBTQ2SIA+ housing. This is an example of community knowledge being leveraged to meet a need.

Stakeholders shared this strength can be leveraged by ensuring there are opportunities to actively listen to people and understand where there are community gaps and opportunities for improvement. Additionally, the community should call on leaders, people with lived experience, and trusted community organization to provide education and insight.

> *"I think the biggest suggestion I can give is to truly sit down and listen to everybody and see exactly where we're missing things and what we can do better as a community to make sure people can live a healthy lifestyle."—Community Stakeholder*

Stakeholder collaboration and commitment

Participants generally described a sense of accountability and commitment from local stakeholders. They shared that local organizations collaborate well and have a shared sense of responsibility. They spoke to healthcare, mental health, law enforcement, businesses, non-profits, and more working together towards common goals. Because of the size of the community, many people know each other, creating a sense of accountability to one another.

> *"I think there is no anonymity in Clatsop County. It's not a thing. It doesn't exist… That creates a different level of accountability that we have, I think, to each other around trying to come up with common solutions."—Community Stakeholder*

This strength can be leveraged to address complex and challenging community needs, including mental health challenges. Current collaboration could be improved upon by ensuring current efforts are well coordinated. Particularly when funding is available, organizations should collaborate to develop programs and initiatives.

> *"I think what makes it good is people are genuinely committed to their field and making a difference in people's lives."—Community Stakeholder*

Community Needs

Stakeholders were asked to identify their top five health-related needs in the community. Two needs were prioritized by most stakeholders and with high priority. Four additional needs were categorized as medium priority. The effects of the COVID-19 pandemic will be woven throughout the following sections on health-related needs.

High Priority Health Needs

Stakeholders were most concerned about the following health-related needs:

1. houselessness and housing instability
2. Access to healthcare services

Houselessness and housing instability

Stakeholders prioritized houselessness and housing instability because of its importance to overall health and stability. They shared it is hard to address other needs, like mental health or substance use/misuse challenges, without a safe place to live. It can also be challenging to stay housed with a mental health condition; a lack of support and case management can contribute to this.

Stakeholders shared houselessness is a problem in Clatsop County. Stakeholders discussed the following challenges contributing to houselessness and housing instability in Clatsop County:

- High cost of housing: The high cost of housing was identified as the primary challenge to stable housing. Parts of Clatsop County are desirable places for second homes and vacation rentals, making the current housing stock unaffordable for many people who live there. While wages have increased a bit, not at the rate of housing costs. With the high cost of housing and childcare, many families are not able to afford housing that meets their needs. To afford housing, sometimes multiple families will live together to share the cost, leading to overcrowding.

  "A lot of the times families get an apartment, but they prefer a house just because they're a bigger family. When they find a house its $2,800 and that's expensive on top of their bills that they have. What happens too is sometimes they find other families or friends to live with them so they can afford being there. Then when winter rolls around, work slows down, people's hours are cut, and it makes it even harder for them to pay their rent."—Community Stakeholder

  Families and young adults are priced out of purchasing a home, creating a sense of hopelessness.

- Lack of housing stock: Stakeholders emphasized there are very limited housing opportunities and limited housing stock. They described low-income housing as non-existent.

  "The lack of inventory housing for low-income is absolutely zero, non-existent. That's a huge impact to our community."—Community Stakeholder

The lack of housing stock particularly affects workers, making it challenging for organizations to recruit and retain staff. This has implications for healthcare, education, and other sectors seeking qualified employees.

"When it comes to workforce housing, there's a lot of entities that are considering that right now, trying to figure out what they need to do in order to remain viable. It's disheartening when you interview candidate after candidate and they look at the housing situation out here and they're like, 'No, can't afford to live there.'"—Community Stakeholder

Stakeholders identified the following populations as disproportionately affected by housing instability:

- Latino/a/x community: Stakeholders shared Latino/a/x households may be multi-generational, meaning they need a larger space to accommodate the whole family. Additionally, families may move in together to stay close to work or school, leading to overcrowding. Families that are in seasonal work may experience months of reduced hours and pay.
- People working in tourism or hospitality: Stakeholders described tourism and hospitality work as often not paying sufficient wages to meet the high cost of housing. Additionally, the seasonality of the work means some months there are fewer hours available.
- People with a mental health condition: A variety of factors can contribute to challenges remaining stably housed for folks with a mental health condition, including a lack of support and case management, not having the correct medication, and lack of understanding from landlords. People may end up paying more money for deposits if they are moving frequently. Wraparound support services are especially important for this population.

Stakeholders described the housing challenges in the community as a complicated need, one requiring strong collaboration and creative solutions. While there are efforts to build low-income housing, there is still a need for more.

Access to healthcare services

Stakeholders identified the following populations as having increased challenges to accessing appropriate and timely care:

- People without insurance: Stakeholders shared it can be more challenging for people to receive regular care without health insurance, meaning they may wait until needs are emergent and use the Emergency Department. This can especially be an issue for the houseless population, the Latino/a/x community, and people in the hospitality and tourism industries.
- People experiencing houselessness: Stakeholders shared there is a gap in services for people experiencing houselessness. They may not receive regular care for their chronic conditions due to a lack of insurance and challenges getting to appointments. Without an address, people may end up losing their insurance during the renewal process. Additionally, if folks have to carry their belongings with them to appointments to ensure they are not stolen, they may not be willing to

travel for care. This reinforces the need to bring services to people experiencing houselessness, providing care at shelters or other convenient locations.

"For our homeless community, them having to pack up their tents and their sleeping bag and all the stuff that goes with it to go to an appointment, because if they leave it, then its going to get rummaged through or stolen. There's a lot of obstacles in the way between being able to provide adequate healthcare to the homeless population, and they need a lot more than we're capable of giving them right now."—Community Stakeholder

- Latino/a/x community: Stakeholders shared many folks in the Latino/a/x community may work in roles that do not offer health insurance. They may also not be able to access insurance due to immigration status.
- LGBTQ2SIA+ population: Stakeholders noted it can be challenging to find an LGBTQ2SIA+ friendly provider that is knowledgeable and respectful of this group's healthcare needs.

  "I wouldn't recommend anybody be seeing healthcare providers that they can't be full and honest about their personal history, who they love, what their family's about. Those are elements of who we are."—Community Stakeholder

  It can be especially challenging to access hormone therapy or transition-related healthcare locally. Many people in the LGBTQ2SIA+ community leave the area to access these services. Stakeholders also shared that people may delay getting care for fear of not being treated well by providers or not being safe with a homophobic provider.

  "I can assure you that for LGBTQ+ people as elders, some of our concerns are who's treating us? Are we being treated by people with cultural competence and cultural respect, or are we going to be fearful about being treated by transphobic or homophobic folks, who we would then be vulnerable to? We've experienced discrimination all our lives, all our lives. We don't expect it to be any better because we're in a dependent position. For some of us, that can be really a fearful circumstance."—Community Stakeholder

Stakeholders discussed the following barriers to accessing care:

- Transportation: Transportation was frequently discussed as a challenge for many people, but especially people living in more rural parts of Columbia and Clatsop counties. Particularly in parts of Columbia County, folks may need to travel to Portland or Beaverton for primary care or to access a hospital. While Columbia Area Transit does help and can be beneficial, there is a need for more transportation services.
- Cost of care: Without insurance, people do not want to access care for fear of not being able to pay for the care. This can sometimes mean that people wait until they are very sick to get the care they need. For example, people may ignore warning signs of diabetes, waiting until the disease has progressed before receiving care and a diagnosis.

Stakeholders spoke to the following gaps in community services:

- Bilingual and bicultural workforce: Stakeholders shared many local organizations do not have the capacity to translate health-related information into Spanish or other languages. This points to a lack of investment in serving the Spanish-speaking community and is an equity issue. Stakeholders shared providing culturally responsive and linguistically appropriate care and health information is a crucial component of being inclusive of this community and undoing racism.
- Services for children with special needs: Stakeholders spoke to a lack of services for children with special needs, noting families often have to travel to other cities, like Portland, to get their specialized health needs addressed. Transportation can be a challenge for many families. There is a lack of speech and language pathology for children under 5 years and no Spanish-speaking Speech and Language Pathologists in the region, creating a large gap for this population.
- Reproductive healthcare services: Stakeholders shared it can be challenging to access full-service reproductive healthcare in the community. People with resources may opt to seek those services outside of the community. There is a need for more health education.

Stakeholders shared it can be challenging to retain providers in a small community and some were concerned that there may not be enough providers to meet the needs of the aging population. In Columbia County specifically, there is no hospital, meaning folks need to travel further to get needed care.

The COVID-19 pandemic has only made accessing appointments more challenging, with delays in primary and specialty care appointments. Stakeholders shared they have seen longer wait times for appointments and people feeling discouraged they cannot get the care they need as quickly. Elective surgeries were also delayed, leading to a backlog of surgery appointments.

> *"I think it's also led to delays in appointments with primary care or specialty clinics. Some hospitals, I'm not going to say for everyone, but most institutions that I work with, I have seen schedules get delayed and pushed back, and then, it creates more demands when you do try to catch up."—Community Stakeholder*

Staffing in healthcare has also been a challenge with more staff burnout.

The pandemic also highlighted and exacerbated inequities that already existed. Folks with the means to do so are able to travel to other areas to get needed and timely care, while others may not have that option. For folks who had challenges getting needed care before the pandemic, it only became more difficult.

> *"I think the other thing that it's done is it's really, for us, I can see this, it's separated the 'haves and the have nots.' People that have benefit jobs or jobs where they can take paid time off, or a little more financial means, they can still get the care that they might need. They can go to a different provider, or they can go to Portland or even Seattle for care, they can still get those services and those things. But folks that maybe were just on the cusp of being able to have their health needs be met, I think COVID has stretched those resources more thin (sic) and they are probably not as available to them or they aren't able to put those things first in terms of their means. I think it's created some disparity I think with meeting the basic health needs of our community."—Community Stakeholder*

During the pandemic there has been more reliance on technology for scheduling appointments and telehealth visits. Additionally, registering for vaccine appointments and getting health education information often required online access. Stakeholders shared that many of their clients needed help registering for vaccine appointments online, scheduling medical appointments, and accessing telehealth services. People may not have an email address or comfort using technology. Other folks may not be comfortable reading in English or Spanish.

> *"We've seen a lot of that is tech where they don't necessarily know much, or they have their kids, and they help them out but that only helps them out so much. Especially when they want to book an appointment or even look up housing, the basic stuff, they don't know how to do. We're trying to encourage the community, encourage them to use or open the e-mail account."—Community Stakeholder*

Stakeholders shared they particularly saw vaccine hesitancy in the Latino/a community, noting the need to address fear around vaccine safety and build trust.

Medium Priority Unmet Health-Related Needs

Four additional needs were often prioritized by stakeholders:

3. Affordable childcare and preschools
4. Economic insecurity
5. Access to dental care
6. Behavioral health challenges and access to care (mental health and substance use/misuse)

Affordable childcare and preschools

Stakeholders were very concerned about access to affordable childcare and preschools in the community. They described a childcare and preschool crisis in the state of Oregon overall.

> *"Affordable childcare and preschool, the whole state, the nation is in a crisis mode around that."—Community Stakeholder*

Investing in childcare is an important upstream intervention that affects the whole family. Affordable childcare allows parents and older siblings to access education and work opportunities, while ensuring children are safe and well cared for. A lot of families need to have both parents working, meaning childcare is essential. Additionally, for families in the tourism and hospitality sectors, they may work non-traditional hours, meaning they need childcare that meets their work schedule.

> *"I think [youth programs and childcare are] really important in our community because we have so many families that need to have multiple parents, both parents working and often work longer hours or different hours than traditional because of our hospitality and tourism region."—Community Stakeholder*

Investing in early learning also gives children access to positive social interactions, structure, and programs that help them develop. This is true for young children in preschool, as well as older children in after school care.

They described very little availability of childcare in general, but especially for infants and toddlers zero to three years. It is very expensive to offer childcare for children zero to three, meaning many organizations cannot afford to provide it.

Many families cannot find a spot in a childcare facility and may resort to leaving their child with an acquaintance who cares for children in their home, which may not meet regulatory standards. The lack of childcare spots puts families in the tough situation where they may have no option but to leave their child somewhere that is not the safest.

> *"A lot of the times it's 'oh, I know a lady who knows a lady who takes care of the kids.' Usually, it's not up to the standard. It's the one lady and she's taking care of eight, nine kids… Because the families don't have any other options, they have to take their kid there even though it might not be the safest place for the kid."—Community Stakeholder*

Finding a preschool spot is also challenging. There are very limited Head Start spaces available and preschool programs fill up fast. Families have to be diligent about registering their child for preschool or they may not get a spot.

A lot of families cannot afford the cost of childcare and preschool. There is a need for more scholarships and reduced tuition for families that qualify. The high cost of childcare, along with the high cost of housing, means that many families contribute a lot of their income to meeting these two needs.

> *"You work, never see your kid, and barely make your mortgage or rent payment. It's a tough dilemma for a lot of people."—Community Stakeholder*

Stakeholders discussed that there is very little workforce development happening in early childhood in general. Folks working in early childhood are often not paid sufficiently. There is a lack of providers, with many early childhood job openings that are hard to fill in the community.

> *"There's very little workforce development happening, and just in early childhood workforce in general. Part of that is because they're so low, like they're paid so little that it is not reasonable for someone to enter the field. It doesn't matter how much they love kids, if they can't pay their own bills at the end of the day, people aren't going to be able to do it."—Community Stakeholder*

Having conversations about investing in early learning has been more challenging during the pandemic as focus has shifted to addressing pandemic-related needs. There needs to be more conversations upstream to think about building the workforce in early childhood.

> *"We never get to the place where we can actually talk about what prevention would look like in this community because we're so busy putting out fires. How many of our family and kid problems are directly related to the fact that we really don't have childcare out here? What does that do to the workforce? Emotional well-being, what is it going to look like in this community if we ever get to the place where we can transition from providing sick care to wellness care?"—Community Stakeholder*

This need has been highlighted during the COVID-19 pandemic. Many families, particularly those with young children, are in crisis right now. Stakeholders shared it is challenging to even know the extent of the

issue, with many families with very young children not yet connected to any services and maybe not receiving any sort of support.

The pandemic has been challenging for childcare facilities as they have had to adapt to the pandemic. Many closed for periods of time at the beginning of the pandemic and continue to have temporary closures related to COVID-19 exposure. Families are doing their best to support their children and their socialization, but childcare closures have been very hard on them. This affects the mental health of the family and parents' abilities to work.

Economic insecurity

Stakeholders prioritized economic insecurity because a lot of the jobs in the community are in hospitality or tourism and may not pay particularly well. Many people have shifts in their work hours seasonally because of tourist-related activities. While wages have increased, not at the rate of housing costs. Therefore, people are working hard and working long hours, but still having difficulty making ends meet. They also may lack benefits, paid time off, flexible vacation, and a flexible work schedule, affecting their quality of life.

> *"There's a significant portion of our population that every day is really like struggling to get by and they're working hard, they're working long hours, especially during the peak tourism season."—Community Stakeholder*

Folks experiencing houselessness may have a particularly hard time accessing job opportunities without a permanent address and safe place to keep their belongings.

Stakeholders shared the economy has shifted over the past couple of decades with decreased demand for certain industries like logging. Young people may feel despair as it is challenging to access a job that pays a living wage in the community without an advanced degree.

Stakeholders emphasized economic insecurity is connected to many other needs:

- Housing: The cost of housing outpaces wages in the community. Families spend a high proportion of their income on housing, forcing many families to move in together, leading to overcrowding and poor living conditions. This may be particularly true for theLatino/a/x community.
- Childcare: Childcare is very expensive in the community. People may spend a substantial amount of their income on childcare. That, coupled with high housing costs, means families have little extra income to meet their other needs.
- Mental health and substance use/misuse: Economic insecurity can contribute to stress for families. People with mental health and substance use/misuse challenges may also have challenges remaining stably employed and housed.

The COVID-19 pandemic has exacerbated inequities. People with low incomes and lacking benefits and paid time off have only had a harder time meeting their needs.

Access to dental care

Stakeholders noted the importance of oral health on overall physical health. They shared that a lot of people in the community either do not have dental insurance through their employer or do not qualify, particularly folks in the hospitality and tourism industries.

There are also not a lot of dental options in the communities, particularly providers that accept Oregon Health Plan (OHP) for dental care. Folks on OHP may have to travel outside of the community to Portland or other areas, which can be a big barrier.

Stakeholders shared that sometimes people cannot get a dental appointment for a few months, which is really discouraging, particularly if they are in pain.

The Providence Seaside Hospital Dental Van helps bring dental services to the community for people who qualify. Stakeholders shared people are more likely to use this service if they have heard good things about it from a friend or family member who encourages them to go.

Behavioral health challenges and access to care (mental health and substance use/misuse)

Stakeholders described Clatsop County as having a significant substance use/misuse issue, noting they were concerned about methamphetamine use and young people using substances. Stakeholders were also concerned about an increase in mental health issues, which can be co-occurring with substance use/misuse.

> *"Certainly, hand in glove is the mental health issues. We've certainly seen a big increase in people with severe mental health issues and behaviors, and it's almost always tied with substance abuse. Mental health is difficult enough to treat on its own when you have co-occurring disorders, then it becomes especially difficult to treat. It's like almost exponentially difficult."—Community Stakeholder*

Stakeholders discussed access to behavioral health services can be a challenge for some people, particularly those living in Columbia County that have to travel to other communities to get that care. They noted a need for more mental health providers in general. They also noted it can be challenging when people are not ready to receive help.

Stakeholders identified the following barriers to addressing behavioral health challenges in the community:

- Transportation: Transportation can be particularly challenging for people in more rural parts of Clatsop and Columbia counties.
- Broadband access and technology: With a shift to more telehealth appointments, not all patients may have the broadband access or technology to effectively engage. Telehealth appointments have been positive for patients hesitant to engage in person, but not for others. Providers may also have a hard time evaluating the full scope of a patient's situation and needs over telehealth since it only provides a limited picture of what is happening.

  > *"That whole picture [during an appointment] is incredibly valuable to the honesty in which someone's saying, what they're saying, what they're presenting, whether they're leaving something out, whether they're concealing something or not because those little twitching movements give stuff away."—Community Stakeholder*

- Workforce challenges: Stakeholders were concerned there are not enough people seeking higher education related to therapy and social work, pointing to a general workforce shortage. Organizations have had difficulty filling clinical positions related to behavioral health.

  "What I do know is that people are no longer or appear to be no longer interested in getting their master's degree in social work or counseling or family practice. When I say family practice, I'm not talking about physicians, I'm talking about marriage and family, therapy. There is no longer interest in doing that. Of course, my big concern is if that is truly the case, then whatever we're experiencing right now is going to be at least a minimum four or five years in recovery making."—Community stakeholder

Stakeholders noted particular concern for the following populations:

- LGBTQ2SIA+ population: This population experiences discrimination for their sexual orientation and gender identity, harming their mental health.
- People experiencing houselessness: Stakeholders emphasized that people need to be stably housed and safe before they will be able to address their behavioral health needs. It can also be challenging to stay housed with a persistent mental illness, due to lack of case management, support, or medication. People with severe mental illness need wraparound support to address their needs.

  "Let me say first that housing is a stabilizing factor for anybody. That's also or maybe especially true for people with substance abuse or mental health disorder."—Community Stakeholder

- Young people: Stakeholders discussed a need to educate children more on the signs and symptoms of depression, anxiety, and suicide. They noted having these conversations early can help promote understanding of mental health needs and support young people in identifying when they or a friend need support.

Stakeholders spoke of seeing behavioral health needs increase over the past two years during the COVID-19 pandemic, as well as an increase in the complexity of cases. There have also been a high number of opioid overdoses in the last two years, which has been really challenging for the workforce trying to address these needs.

The pandemic has been particularly challenging for children and parents. There has been less opportunity for socialization for children over the last couple of years. Educators are seeing more behavioral challenges and delays in social-emotional learning. Some of these mental health and social needs result from lacking routine, not being at school, friends and teachers, and increased time at home.

"I think where we see it most being a school district is in the social-emotional needs of our students. There's a lot of mental health and just social interaction needs that we've spent almost a year in distance learning and kids didn't get their needs met like they normally do when they're in the school system. That's been a pretty big change in what we've seen for our students compared to what we've seen in the past."—Community Stakeholder

Families with low incomes may have had additional stress during the pandemic if they were unable to access affordable childcare or additional support. Parents have been navigating a lot of challenges during the pandemic and many have not had the time or capacity to address their own stress and self-care needs. Stakeholders spoke to seeing a lot of mental health and support needs for parents and a need to continue to connect families to support resources. This includes investing in counselors and family liaisons to reach out to those families that may be having an especially hard time.

> *"I feel like people know this, but I don't know how to emphasize it enough. I feel like families and especially families with young children are in crisis right now. I know that I can't fully express how hard it is for families to have young children right now, even people of higher incomes, it is particularly a challenging time to have littles."—Community Stakeholder*

The pandemic has been isolating for many people. Stakeholders noted the mental health benefits of people being in community and being included in social events. This can be especially important for folks experiencing racism and discrimination, including the LGBTQ2SIA+ community.

Addressing substance use/misuse challenges has also been difficult during the pandemic. For example, due to COVID-19 precautions, recovery allies were not allowed to visit folks in the jails to try to engage them in substance use disorder treatment services.

Identified Assets

Stakeholders were asked to identify one or two community initiatives or programs that they believe are currently meeting community needs.

Table_Apx 3. Clatsop County Organizations and Initiatives Addressing Community Needs

Community Need	Community Organization/Initiative
Access to healthcare	Clatsop County Public Health COVID-19 vaccination events: Stakeholders spoke to the benefits of having county-wide efforts to stand up the vaccine clinics and provide outreach and education to the community to build trust in vaccine safety.
	Clatsop County Public Health Harm Reduction Program: This program includes the Syringe Service Program and provides Naloxone training and product. Stakeholders spoke to the Naloxone distribution as being successful in reversing overdoses in the community.
	Clatsop County Public Health HIV Counseling and Testing: Stakeholders shared there are good supports for people living with HIV/AIDS. Case management services are also available through the HIV Alliance.
	Columbia Pacific CCO: This coordinated care organization (CCO) supports communities in addressing their social needs, acknowledging these factors

	contribute to overall health. Stakeholders shared Columbia Pacific CCO looks at the whole person and strives to address their needs beyond just medical care. *"Columbia Pacific CCO is attempting to look at [health] in a different way and invites the community into seeing things differently than they've seen them before. They've really been putting forth the effort to bridge the gaps between the services and the needs of people. They've been doing a really good job at it."—Community Stakeholder*
	Regional Health Equity Coalition: This coalition is working to secure money through SB-70 to address health equity issues within the community.
Behavioral Health	Better Outcomes thru Bridges (BOB) Program: This program meets people where they are and provides mental health and substance use disorder peer support specialists. The program also provides street outreach, clinic outreach, and school-based outreach.
	Clatsop Behavioral Health: The Rapid Access Clinic (RAC) was identified as an important service that offers mental health and substance use drop-in services for adults.
	Columbia Community Mental Health: Stakeholders specifically spoke to the effectiveness of peer groups that visit people living unsheltered. These peers engage with folks experiencing houselessness, identifying mental health needs, and using harm reduction approaches. They are effective because they focus on building relationships and mutual trust. *"[Peer groups] are finding out if there's mental health needs, they're trying to slowly, through a harm reduction approach, get them into services by developing rapport in that relationship with them."—Community Stakeholder*
	Community Corrections Counselor: Stakeholders spoke to the benefits of having a full-time behavioral health counselor at the Clatsop County Sheriff's office to reduce barriers to access.
Health and Social Services	Healthy Families Program: Healthy Families is a voluntary family support and home visiting program. This program has adapted to the challenges of the pandemic by doing a lot of virtual visits and dropping off needed items. Stakeholders shared the program is built on relationships and mutual trust. *"I think part of it is it's built on the relationship that the home visitor develops with the family, so it's a trusted relationship that goes both ways. The family knows that they can reach out and be supported. They know who to reach out to and be supported, rather than finding someone out there they would need to call or whatever it may be."—Community Stakeholder*

Housing and houselessness	Clatsop Community Action: This organization provides multiple housing programs for the community. Stakeholders spoke to the benefits of the housing program under the Continuum of Care that houses individuals experiencing chronic houselessness. It is effective because it helps folks be self-sustainable. They also spoke to the houseless liaisons that bridge the gap between law enforcement and the unhoused population.
	Helping Hands Reentry Outreach Center: This organization provides houseless services to adults and children.
Latino/a/x services	Consejo Hispano: This is the only organization specifically serving the Latino/a/x community for a few counties. Stakeholders shared the staff have trusted relationships in the community and they do whatever is needed to meet needs. *"They have amazing staff that just, again, have that trusted relationship with Latinx community, and will do everything and anything in their power to meet the needs. There's no ceiling. There's nothing that they won't try."—Community Stakeholder* Consejo Hispano distributed air filters for folks affected by wildfire smoke. This was really beneficial for families with members with asthma or another respiratory disease.

Opportunities to Work Together

Participants were asked, "What suggestions do you have for organizations to work together to provide better services and improve the overall health of your community?" Stakeholders shared the following opportunities:

Bring services to people and co-locate services

Stakeholders emphasized the need for organizations to work together to co-locate services and bring services to where people are. For example, they shared a need to bring healthcare services to people experiencing houselessness staying in a shelter or somewhere else convenient.

Other examples include putting childcare in affordable housing communities to mitigate any transportation and childcare barriers for families. There are also opportunities to co-locate staff, meaning place CBO staff in schools or other places where families are. This person can serve as a bridge in understanding both systems and make it easier for families to navigate resources.

Additionally, stakeholders shared the importance of bringing information and resources to where people are. This means placing event fliers in local stores or popular community gathering spaces rather than just online. It can be especially helpful if information comes from a familiar face and is shared through trusted community members.

"We can connect the dots to make it easier for people to receive the basic healthcare needs they need to make healthy decisions in their life. I think that that's the biggest thing that's out

there. People have to go someplace to try to receive the assistance and the assistance needs to be brought to them."—Community Stakeholder

De-siloed and whole person care

Stakeholders shared the importance of considering all the factors that contribute to a person's health and well-being. This means all organizations need to take responsibility for taking care of the whole person, rather than assuming one problem is the responsibility of one organization and another problem is the responsibility of another organization. Too often people's needs are segmented to fit the different scope of the organization and the person is not seen in their entirety.

One way to better provide whole person care is to provide wraparound support for people's wellness needs, particularly when addressing chronic conditions and obesity. It can be important to provide individualized support including a team of folks that can address all the factors, including a physician and dietician, and other professionals. Additionally, there is room to improve collaboration between case managers and people who work directly with clients.

Opportunities for partnership and relationship building

Stakeholders discussed a variety of opportunities for partnerships between organizations and across sectors. They shared that funding streams create siloes that make organizations work against each other, rather than together. By competing for funding, organizations are missing partnership opportunities. This also makes it harder for patients to get whole person care as they have to move between many disjointed services.

"This competitive dollar that goes out there means that we have to compete against the organizations that we want to work with. I think that's something we need to change dramatically to get unity in community to work together."—Community Stakeholder

Stakeholders agreed that community change and improvement will require working together and creative solutions. Community challenges like houselessness have been deteriorating despite continued investments, signaling a need for innovative approaches. Addressing community housing needs is complicated and while many people are addressing the need, the approaches are not always aligned.

While organizations are often willing to partner, it is not always done in a strategic way or with all the right parties at the table. For example, there is a particular opportunity for better collaboration to serve families that do not speak English since not all organizations have the capability to serve folks in their primary language.

There is also an opportunity to collaborate to address substance use/misuse in the community, fostering more partnership between healthcare and community organizations.

Healthcare has the opportunity to connect families with community organizations that offer services. Healthcare providers may have relationships with families that are not engaged in other systems, such as families with children not yet enrolled in school. This could be an opportunity to build a support network for families with primary care providers as an entrance point.

Stakeholders also noted that organizations with trusted community relationships should be seen as key partners when trying to serve specific populations. This is especially true with theLatino/a/x community and

the LGBTQ2SIA+ community. For example, there are opportunities to partner to ensure healthcare intake forms are inclusive and safe.

Stakeholders discussed challenges knowing what services are available in the community, emphasizing people need to continue to talk to one another and build relationships. This can be especially challenging with frequent turnover in organizations. Having continuity of relationships can support partnerships and trust between organizations.

The stakeholders also noted a need for more cooperation within healthcare, ensuring systems are communicating with one another and collaborating.

LISTENING SESSION AND INTERVIEW GUIDES

Stakeholder Interview Questions

1. Please state your name, title, and organization as you would like them included in the report.
2. How would you define the community that your organization serves?
3. While a Community Health Needs Assessment is primarily used to identify gaps in services and challenges in the community, we want to ensure that we highlight and leverage the community strengths that already exist. Please briefly share the greatest strength you see in the community your organization serves.
4. Please identify and discuss specific unmet health-related needs in your community for the persons you serve. We are interested in hearing about needs related to not only health conditions, but also the social determinants of health.
5. Using the table, please identify the five most important "issues" that need to be addressed to make your community healthy (1 being most important). [see table below]
6. Has the COVID-19 pandemic influenced or changed the unmet health-related needs in your community? If yes, in what ways?
7. What suggestions do you have for how we can leverage community strengths to address these community needs?
8. Please identify one or two community health initiatives or programs that you see currently meeting the needs of the community.
9. What suggestions do you have for organizations to work together to provide better services and improve the overall health of your community?
10. Is there anything else you would like to share?

Question 5: Using the table below, please identify the five most important "issues" that need to be addressed to make your community healthy (1 being most important). Please note, these needs are listed in alphabetical order.			
	Access to healthcare services		Few community-building events (e.g., arts and cultural events)
	Access to dental care		Food insecurity

	Access to safe, reliable, affordable transportation		Gun violence
	Affordable childcare and preschools		HIV/AIDS
	Aging problems		Houselessness/lack of safe, affordable housing
	Behavioral health challenges and access to care (includes both mental health and substance use disorder)		Job skills training
	Bullying in schools		Lack of community involvement and engagement
	Community violence; lack of feeling of safety		Obesity and chronic conditions
	Disability inclusion		Opportunity gap in education (e.g., funding, staffing, support systems, etc. in schools)
	Domestic violence, child abuse/neglect		Racism and discrimination
	Economic insecurity (lack of living wage jobs and unemployment)		Safe and accessible parks/recreation
	Environmental concerns (e.g., climate change, fires/smoke, pollution)		Safe streets for all users (e.g., crosswalks, bike lanes, lighting, speed limits)
			Other:

Listening Session Questions

1. What makes a health community? How can you tell when your community is healthy?
2. What's needed? What more could be done to help your community be healthy?
3. What's working? What are the resources that currently help your community be healthy?
4. Is there anything else related to the topics we discussed today that you think I should know that I haven't asked or that you haven't shared?

Appendix 3: Community Resources Available to Address Significant Health Needs

The North Coast Area Collaborative Partners cannot address all of the significant community health needs by working alone. Improving community health requires collaboration across community stakeholders and with community engagement. Below outlines a list of community resources potentially available to address identified community needs, also included in each key themes section.

Additionally, the following websites offer further available resources:

- 211: https://www.211.org/
- Clatsop County Resource Directory: https://ccaservices.org/information-and-referral/resource-directory/
- Columbia County Resources Guide: https://www.scappooselibrary.org/e-resources/resource-guide.pdf
- Community Action Team: https://cat-team.org/about-us/

Organization or Program	Significant Health Need Addressed
Coastal Family Health Center	Access to healthcare services
Columbia Memorial Hospital	Access to healthcare services Chronic Health Conditions
Columbia Pacific CCO	Access to healthcare services Access to Dental Care Chronic Health Conditions
Lower Columbia Hispanic Council	Access to healthcare services
Medical Teams International	Access to healthcare services
Northwest Senior and Disability Services	Access to healthcare services
Providence Seaside Hospital	Access to healthcare services Chronic Health Conditions
Beacon Clubhouse	Behavioral health challenges and access to care
Clatsop Behavioral Health	Behavioral health challenges and access to care
CoDependents Anonymous Inc (CODA)	Behavioral health challenges and access to care

Columbia Community Mental Health	Behavioral health challenges and access to care
National Alliance on Mental Illness (NAMI) Oregon	Behavioral health challenges and access to care
Clatsop Community Action	Houselessness and housing instability Economic Insecurity
Community Action Team/Head Start	Houselessness and housing instability
The Harbor	Houselessness and housing instability
Helping Hands Reentry	Houselessness and housing instability
Restoration House	Houselessness and housing instability
Columbia Pacific Economic Development District (ColPac)	Affordable Childcare and Preschools
Northwest Early Learning Hub	Affordable Childcare and Preschools
Consejo Hispano	Economic Insecurity
Columbia Economic Team	Economic Insecurity
Advantage Dental	Access to Dental Care
City of Seaside	Chronic Health Conditions
Coastal Family Health Center	Chronic Health Conditions
Sunset Empire Parks and Recreation District	Chronic Health Conditions

Appendix 4: North Coast Area Collaborative Partners Community Health Needs Assessment Committee

Table_Apx 4. Community Health Needs Assessment Committee Members

Name	Title	Organization
Jiancheng Huang	Public Health Director	Clatsop County Health & Human Services
Nancy Knopf	Community Health Partnership Director	Columbia Pacific Coordinated Care Organization
Chris Laman	Vice President of Strategy	Columbia Memorial Hospital
Michael Paul	Director of Public Health	Columbia County Public Health
Jill Quackenbush	Deputy Director	Clatsop County Public Health
Kyle Roesler	Program Manager, Community Health Investment	Providence Health & Services

Appendix 5: Hospital Utilization Data

COLUMBIA MEMORIAL HOSPITAL, ASTORIA

Avoidable Emergency Department (AED) Visits

Facility and Year	AED %
Columbia Memorial Hospital 2020	7.0%
Columbia Memorial Hospital 2021	5.9%

2020 Facility and Top Patient ZIP Codes	Avoidable ED %	% of Total AED Cases	% of Total ED Cases
Columbia Memorial Hospital	**7.0%**	-	-
97103	7.2%	47.7%	46.5%
97146	6.4%	15.4%	16.8%
97138	6.6%	5.4%	5.7%
97121	6.6%	3.6%	3.8%
98640	8.9%	4.8%	3.8%
98631	8.8%	4.4%	3.5%
98638	6.9%	3.1%	3.1%
97016	8.8%	2.4%	1.9%
98624	9.3%	1.9%	1.4%

2021 Facility and Top Patient ZIP Codes	Avoidable ED %	% of Total AED Cases	% of Total ED Cases
Columbia Memorial Hospital	**5.9%**	-	-
97103	5.8%	46.0%	46.6%
97146	6.1%	17.0%	16.6%
97138	5.7%	5.3%	5.5%
98631	7.4%	4.5%	3.6%
98640	5.0%	2.9%	3.5%
97121	6.9%	4.0%	3.4%
98638	5.3%	2.5%	2.8%
97016	8.4%	3.1%	2.2%
98624	7.1%	1.5%	1.2%

Top Diagnosis Groups* for AED Visits	AED %
Columbia Memorial Hospital - 2020	-
Urinary Tract Infection	25.1%
Nonspecific Back and Neck Pain	24.0%
Headache/Migraine	12.3%
Bronchitis and Other Upper Respiratory Disease	8.2%
Acute Otitis Media and Sinusitis	6.8%
Screenings and Follow-Up Encounters	5.6%
Tonsillitis	5.0%
Conjunctivitis	2.7%
Preventative Wellness Visits	2.3%
Gynecologic Infectious Disease	1.7%
Skin Infection	1.3%

*Diagnoses are grouped by Care Family; method is Sg2 CARE Grouper

Top Diagnosis Groups* for AED Visits	AED %
Columbia Memorial Hospital - 2021	-
Urinary Tract Infection	35.7%
Nonspecific Back and Neck Pain	29.0%
Bronchitis and Other Upper Respiratory Disease	7.9%
Tonsillitis	7.2%
Screenings and Follow-Up Encounters	5.0%
Acute Otitis Media and Sinusitis	4.0%
Preventative Wellness Visits	2.2%
Conjunctivitis	1.9%

*Diagnoses are grouped by Care Family; method is Sg2 CARE Grouper

PROVIDENCE SEASIDE HOSPITAL

Avoidable Emergency Department (AED) Cases

Yearly Avoidable ED (Emergency Department) Cases, 2019-2021

Hospital ED Cases by Year	Year			
Providence Seaside Hospital	**2019**	**2020**	**2021**	**Total**
Avoidable ED %	31.1%	29.1%	27.8%	29.4%

2021 Hospital ED Cases and Patient Age Groups

2021 Hospital ED Cases and Patient Age Group	Avoidable ED %	% of Total AED Cases	% of Total ED Cases
Providence Seaside Hospital	**27.8%**	-	-
0 – 17 Years	27.2%	10.5%	10.7%
18 – 39 Years	31.8%	28.7%	25.1%
40 – 64 Years	29.1%	33.7%	32.2%
65+ Years	23.6%	27.2%	32.1%

2021 Hospital ED Cases and Top 10 Patient ZIP Codes

2021 Hospital ED Cases and Top Patient ZIP Codes	Avoidable ED %	% of Total AED Cases	% of Total ED Cases
Providence Seaside Hospital	**27.8%**	-	-
97138	30.0%	52.0%	48.2%
97146	28.2%	9.2%	9.1%
97103	32.1%	7.6%	6.6%
97131	22.2%	2.8%	3.5%
97110	22.3%	2.7%	3.4%
97130	20.5%	1.1%	1.4%
97121	22.3%	1.0%	1.2%
97147	33.3%	0.7%	0.6%
97136	34.2%	0.6%	0.5%
97145	25.0%	0.5%	0.5%

2021 Avoidable ED Cases by Diagnosis

2021 Hospital ED Cases and Top Diagnosis Care Families	% of Total AED Cases
Providence Seaside Hospital	-
Urinary Tract Infection	10.3%
Substance Use Disorders	9.0%
Skin Infection	8.3%
Anxiety and Personality Disorders	6.3%
Nonspecific Back and Neck Pain	5.4%
Bronchitis and Other Upper Respiratory Disease	4.4%
Oral and Dental Disease	4.0%
Dizziness	3.9%
Diabetes Mellitus	3.1%
Chronic Obstructive Pulmonary Disease	2.5%

Behavioral Health ED Cases

Yearly Behavioral Health ED Cases, 2019-2021

Behavioral Health ED Cases by Year	Year			
Providence Seaside Hospital	**2019**	**2020**	**2021**	**Total**
% Behavioral Health	6.5%	7.4%	6.5%	6.8%

2021 Behavioral Health ED Cases by Diagnosis Grouping

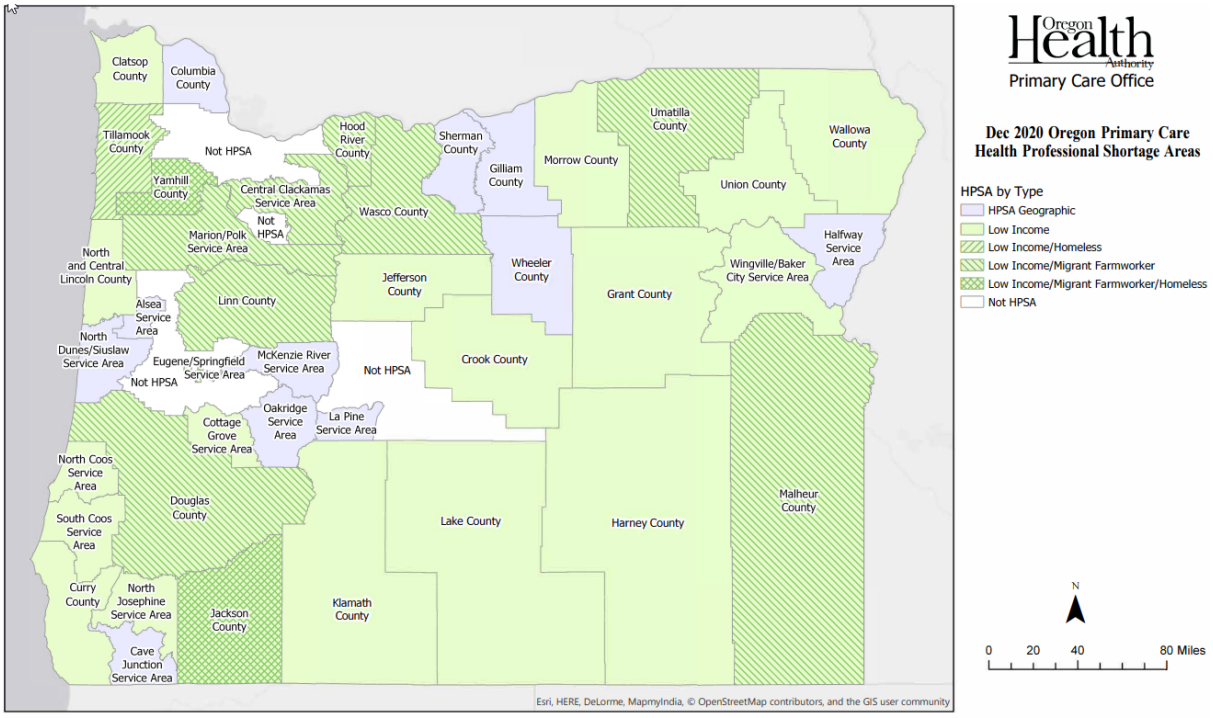
2021 Behavioral Health ED Cases by Diagnosis Groupings	% of Total Behavioral Health ED Cases
Providence Seaside Hospital	-
Substance Use Disorders	43.4%
Anxiety and Personality Disorders	27.4%
Mood Disorders, Episodic	12.1%
Psychosis	7.8%
Poisonings - Commonly Abused Drugs	4.7%
Bipolar Disorders	2.3%

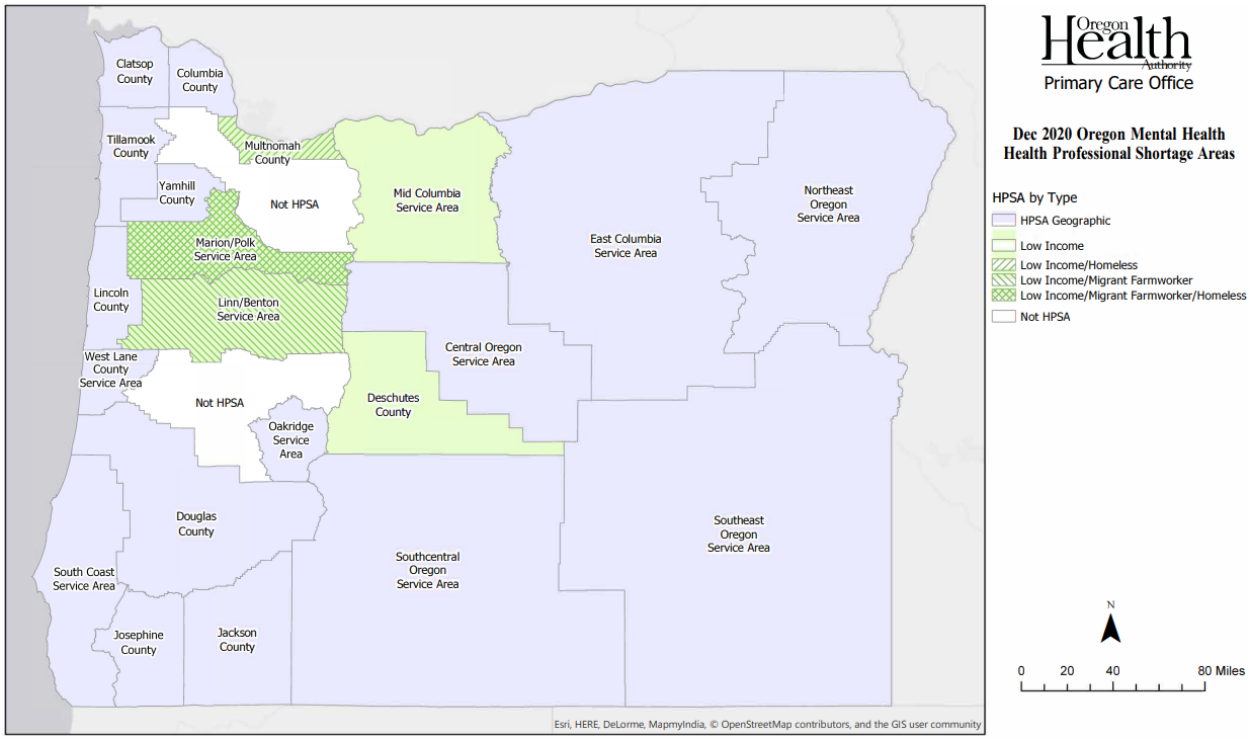
Appendix 6: Health and Medical Professional Shortage Areas

HEALTH PROFESSIONAL SHORTAGE AREA

The Federal Health Resources and Services Administration (HRSA) designates Health Professional Shortage Areas HPSAs) as areas with a shortage of primary medical care, dental care, or mental health providers. They are designated according to geography (i.e., service area), demographics (i.e., low-income population), or institutions (i.e., comprehensive health centers).

The maps below depict these shortage areas for dental health, primary care, and mental health professional shortage areas.





MEDICALLY UNDERSERVED AREA/ MEDICAL PROFESSIONAL SHORTAGE AREA

Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs) are defined by the Federal Government to include areas or populations that demonstrate a

shortage of healthcare services. This designation process was originally established to assist the government in allocating the Community Health Center Fund to the areas of greatest need. MUAs are identified by calculating a composite index of need indicators compiled and with national averages to determine an area's level of medical "under service." MUPs are identified based on documentation of unusual local conditions that result in access barriers to medical services. MUAs and MUPs are permanently set and no renewal process is necessary.

The following map depicts the Medically Underserved Areas and Medically Underserved Populations in Oregon State.