

COMMUNITY HEALTH IMPROVEMENT PLAN

2020 - 2022

Providence Hood River Memorial Hospital

Hood River County, Oregon



To provide feedback about this CHIP or obtain a printed copy free of charge, please email Joseph Ichter, DrPH at Joseph.Ichter@providence.org



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EXECUTIVE SUMMARY

Improving the health of our communities is a fundamental commitment rooted deeply in our heritage and purpose. As expressions of God’s healing love, witnessed through the ministry of Jesus, our Mission calls us to be steadfast in serving all with a special focus on our most poor and vulnerable neighbors. This core belief drives the programs we build, investments we make, and strategies we implement.

Knowing where to focus our resources starts with our Community Health Needs Assessment (CHNA), an opportunity in which we engage the community every three years to help us identify and prioritize the most pressing needs, assets and opportunities. In the Columbia Gorge region, Providence Hood River Memorial Hospital (PHRMH) and 16 other regional community organizations, coordinated by the Columbia Gorge Health Council (CGHC) are learning and working together to improve the health and health care resources of Columbia Gorge residents. The collaborative brings together four hospitals, seven counties, three coordinated care organizations, and several social service agencies to produce a shared regional needs assessment.

PHRMH serves several counties in the Columbia River Gorge with its primary service area being Hood River County, Oregon. The facility is a 25-bed critical access hospital offering primary and specialty care, birth center with family suites, general surgery, radiology, diagnostic imaging, pathology and 24/7 emergency medicine. The surrounding six counties represented in the collaborative CHNA are primarily served by other area hospitals. PHRMH provided nearly \$20 million¹ in Community Benefit in 2019.

PHRMH Community Health Improvement Plan Priorities

As a result of the findings of our 2019 Community Health Needs Assessment (CHNA) and through a prioritization process aligned with our mission, resources, and hospital strategic plan, PHRMH will focus on the bolded areas within the four priorities specified below for its 2020-2022 Community Benefit efforts²:

PRIORITY 1: SOCIAL DETERMINANTS OF HEALTH AND WELL-BEING

Focus areas in **housing**, transportation, and **food security**; includes coordination of supportive services.

PRIORITY 2: CHRONIC CONDITIONS

Focus on prevention of obesity, diabetes, hypertension, and depression.

PRIORITY 3: BEHAVIORAL HEALTH/WELL-BEING AND SUBSTANCE USE DISORDERS

Focus on prevention (particularly for youth), **culturally responsive care and health education, social isolation, and community building.**

PRIORITY 4: ACCESS TO CARE

Focus on services navigation and coordination, culturally responsive care and oral health.

Responding to the COVID-19 Pandemic

In addition to the aforementioned, priority areas, the 2020 community health improvement process was disrupted by the SARS-CoV-2 virus and COVID-19, which has impacted all of our communities. While we have

¹ Unpaid costs of Medicare are included in this Community Benefit reporting

² These broad descriptions of priorities are consistent across Providence’s ministries. The language used in this report is not identical to the descriptions of priorities identified in the Columbia Gorge through the local collaborative process. However, the concepts are equivalent. A cross-walk between the priorities of the collaborative Gorge CHIP and the PHMRH CHIP is noted in the appendix.

focused on crisis response, it has required a significant re-direction of resources and reduced community engagement in the CHIP process.

This CHIP is currently designed to address the needs identified and prioritized through the 2019 CHNA, though COVID-19 will have substantial impacts on our community needs. These impacts are likely to exacerbate some of the needs identified, and cause others to rise in level of priority. While this is a dynamic situation, we recognize the greatest needs of our community will change in the coming months, and it is important that we adapt our efforts to respond accordingly. Additionally, the data projections included were crafted based on data collection and project forecasting done prior to the COVID-19 pandemic, so may be modified as we understand adjusted resources and priorities within our communities in the aftermath of the pandemic.

This CHIP will be updated by March 2021 to better document the impact of and our response to COVID-19 in our community. We are committed to supporting, strengthening, and serving our community in ways that align with our mission, engage our expertise, and leverage our community benefit dollars in the most impactful ways.

MISSION, VISION, AND VALUES

<i>Our Mission</i>	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.
<i>Our Vision</i>	Health for a Better World.
<i>Our Values</i>	Compassion — Dignity — Justice — Excellence — Integrity

INTRODUCTION

Who We Are

PHRMH is an acute-care hospital located in Hood River, Oregon serving nine counties in Oregon and Washington State. The facility is a 25-bed critical access hospital offering primary and specialty care, birth center with family suites, general surgery, radiology, diagnostic imaging, pathology, orthopedic surgery, 24/7 emergency medicine and 14 outpatient and clinics. PHRMH employees 550 caregivers, which includes 386 medical staff, and 84 volunteers.

Our Commitment to Community

PHRMH dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of the economically poor and vulnerable. During 2019, PHRMH provided nearly \$20 million in community benefit^{3,4} in response to unmet needs and improve the health and well-being of those we serve in the Columbia River Gorge area.

Community Benefit Governance and Management Structure

PHRMH further demonstrates organizational commitment to the community benefit process through the allocation of staff time, financial resources, participation and collaboration with community partners. The PHRMH hospital administration is ultimately responsible for coordinating implementation of State and Federal 501r requirements as well as providing the opportunity for community leaders and internal hospital Executive Management Team members, physicians and other staff to work together in planning and implementing the Providence Hood River Memorial Hospital Community Health Improvement Plan. However, the Service Area Advisory Council (SAAC) is the group that is charged with developing policies and programs that address identified needs in the service area, particularly for underserved populations, overseeing development and implementation of the Community Health Needs Assessment and Community Health Improvement Plan Reports, and overseeing and directing the Community Benefit activities.

As previously referenced, PHRMH's CEO is seated as a board member of The Columbia Gorge Health Council (CGHC). The Columbia Gorge Health Council works to elevate the well-being of everyone living in the Columbia Gorge. One of its main functions is producing The Columbia Gorge Community Health Assessment. This work is led by the Community Advisory Council (CAC) of CGHC through a collaborative approach focused on the region overall and which replaces independently conducted health assessments by hospitals, counties, health departments, hospitals, FQHC's, Coordinated Care Organizations and county mental health agencies. Because at least 50 percent of the seated CAC members are themselves low income Medicaid beneficiaries, the CAC

³ A community benefit is an initiative, program or activity that provides treatment or promotes health and healing as a response to identified community needs and meets at least one of the following community benefit objectives: a. Improves access to health services; b. Enhances public health; c. Advances increased general knowledge; and/or d. Relieves government burden to improve health. Note: Community benefit includes both services to the economically poor and broader community.

⁴ To be reported as a community benefit initiative or program, community need must be demonstrated. Community need can be demonstrated through the following: 1) community health needs assessment developed by the ministry or in partnership with other community organizations; 2) documentation that demonstrates community need and/or a request from a public agency or community group was the basis for initiating or continuing the activity or program; 3) or the involvement of unrelated, collaborative tax-exempt or government organizations as partners in the community benefit initiative or program.

serves as a powerful method for including community voice and lived experience at every level of the CHNA and CHIP. PHRMH's SAAC incorporates the CGHC CHNA and CHIP into Providence Hood River's CHNA and CHIP.

The SAAC has a minimum of 15 members including members of the hospital administration. Current membership includes six members of the hospital administration and 11 community members. A majority of members have knowledge and experience with the populations most likely to have disproportionate unmet health needs. The SAAC meets six times annually, with an additional four to six education and workshop sessions focused on community health.

Planning for the Uninsured and Underinsured

Our mission is to provide quality care to all our patients, regardless of ability to pay. We believe that no one should delay seeking needed medical care because they lack health insurance. That is why PHRMH has a Financial Assistance Program (FAP) that provides free or discounted services to eligible patients. Services must be medically necessary as defined by the Providence Financial Assistance Policy. Patients receiving emergency or medically necessary care at Providence hospitals and clinics may receive the following discounts based upon the following eligibility:

- 100% financial assistance is provided for households making up to 300% FPL
- 75% financial assistance for households between 301% and 400% FPL
- Financial assistance applies to self-pay balances and patient responsibility balances after insurance pays.

One way PHRMH informs the public of FAP is by posting notices. Notices are posted in high volume inpatient and outpatient service areas. Notices are also posted at locations where a patient may pay their bill. Notices include contact information on how a patient can obtain more information on financial assistance as well as where to apply for assistance. These notices are posted in English and Spanish and any other languages that are representative of 5% or greater of patients in the hospital's service area. Additionally, on-line publicly available resources include plain language FAP summaries in 25 different languages. All patients who demonstrate lack of financial coverage by third party insurers are offered an opportunity to complete the Patient Financial Assistance Application and are offered information, assistance, and referral as appropriate to government sponsored programs for which they may be eligible. Find more information on PHRMH Financial Assistance Program here <https://www.providence.org/obp/or/financial-assistance>.

OUR COMMUNITY

Description of Community Served

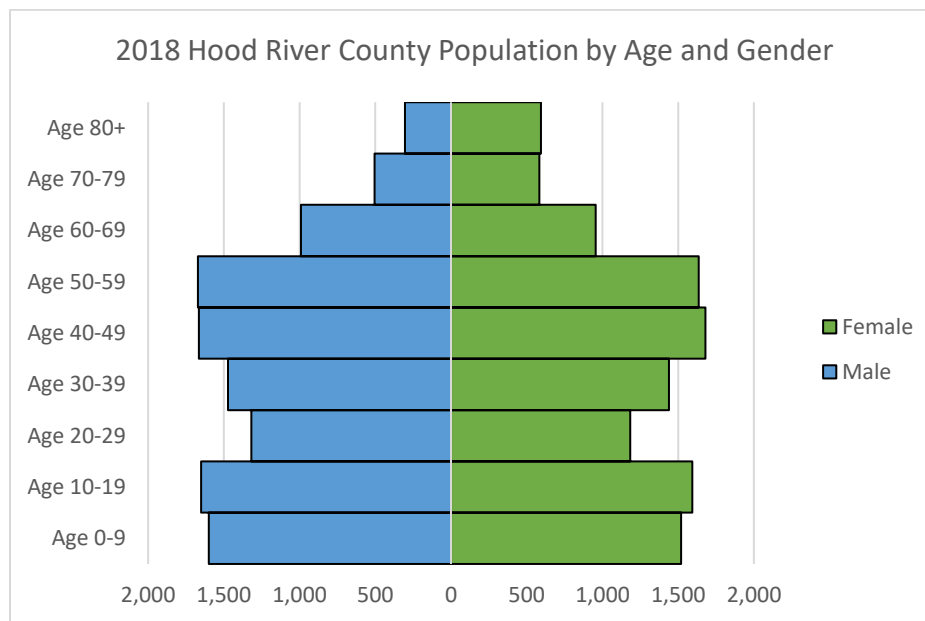
Based on geographic location relative to other hospitals in the area and patient demographics, Hood River County (in red) is PHRMH's primary service area. Klickitat and Skamania counties from Washington State are surrounding secondary counties that are primarily served by other area hospitals.



Population and Demographics

The Regional Community Health Assessment covered Hood River, Wasco, Sherman, Gilliam, and Wheeler counties in Oregon as well as Klickitat and Skamania counties in Washington. As of June 2016, the total population of Hood River County was 24,146.

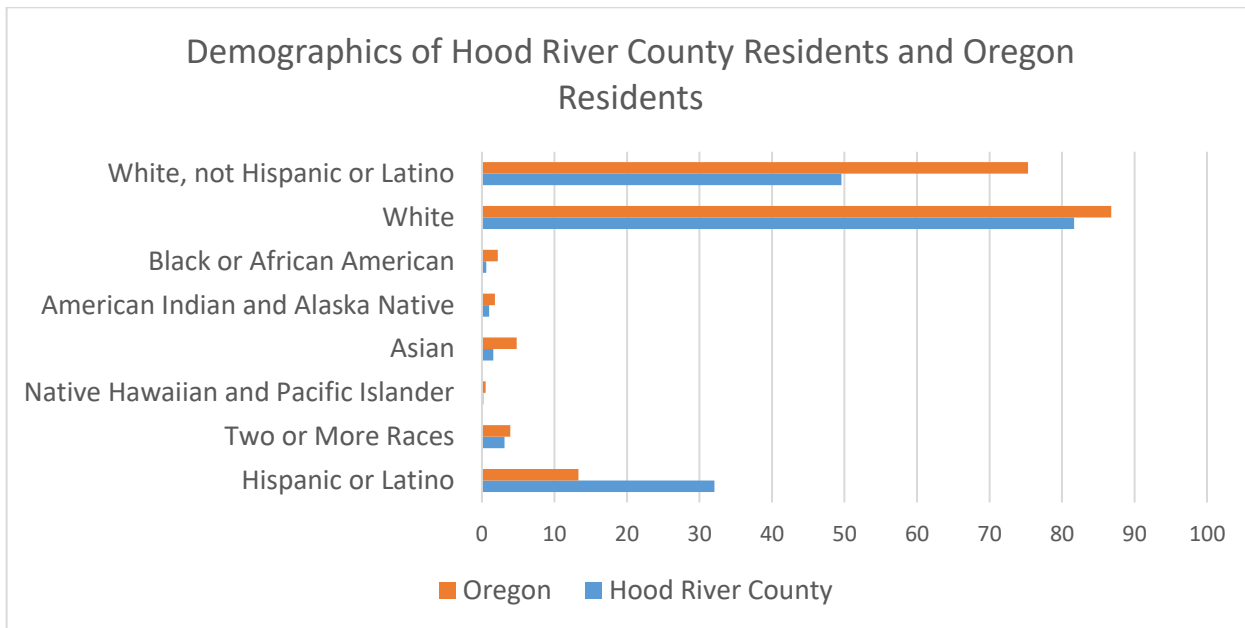
Figure 1: 2018 Hood River County by Age and Gender



Ethnicity

According to 2019 US Census data, Hood River County had smaller Black, Asian, and Native Hawaiian and Pacific Islander populations than the state as a whole, but a larger proportion of people who identify as Hispanic or Latino at nearly 31 percent of the total population. Because of this relatively large Latino population, Hood River County has a significantly smaller white (not Hispanic or Latino) population than Oregon as a whole. The following table shows the self-reported race and ethnicity for residents in Hood River County compared to Oregon overall.

Figure 2: 2019 Race and Ethnicity Demographics of Hood River County and Oregon Residents by Percentage of Total Population



Income

In 2018, the median household income for Hood River County was \$62,935, and 10.9 percent of residents lived at or below the Federal Poverty Guideline according to US Census data. This is slightly higher than the median income for the state of Oregon at \$59,393, and lower than percent of the population living in poverty in Oregon (12.6 percent).

Health and Well-being

In Hood River County, the combined 2014-2017 Oregon Behavioral Risk Factor Surveillance System (BRFSS) results found that 26.7 percent of adults are considered obese, slightly lower than the state average of 28.6 percent. Dental access is the greatest unmet healthcare need and of those surveyed, six in ten of the CORE survey respondents had an unmet dental need in the last year. Binge drinking is a challenge amongst adults as over 29 percent have three or more drinks on the days they do drink, over ten percent higher than the state average of 18.3 percent according to combined 2014-2017 Oregon BRFFS data.

COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs Assessment Process and Results

In the Columbia Gorge region, PHRMH and 16 other regional community organizations, coordinated by the Columbia Gorge Health Council (CGHC) are learning and working together to improve the health and health care resources of Columbia Gorge residents. The collaborative brings together four hospitals, seven counties, three coordinated care organizations, and several social service agencies to produce a shared regional needs assessment.

As part of the collaborative CHNA, public health data sources accessed for this report include the U.S. Census, Oregon and Washington Healthy Teen Survey, Oregon Health Authority (OHA) Immunization Program Data, and Hood River and Klickitat County Public Health, the Robert Wood Johnson County Health Rankings, the OHA 2018 Mental Health Survey, among others. An online and mailed Community Health Survey reached out to 2,500 residents in the spring of 2019, using an address-based random-sampling of residents in the Columbia Gorge service area, yielding 373 responses. Another 448 surveys were hand-fielded at a variety of community events and locations throughout the survey period with the intent of accessing responses from specific populations at higher risk of disparities.

Identification and Selection of Significant Health Needs

The prioritized needs were chosen based on various community health data and identifiable gaps in available care and services. These health needs were those that had worsened over time, are worse than the state or national average, or have a disproportionate impact on those who are low-income, communities of color, or otherwise marginalized populations.

Community Health Needs Prioritized

The prioritized needs were chosen based on community health data and identifiable gaps in available care and services. In the course of our work, we determined that emphasis on these needs would have the greatest impact on the community's overall health with significant opportunities for collaboration. These interventions were prioritized based upon relative needs and opportunities, particularly those that serve identified high needs ZIP codes and neighborhoods including low-income and minority populations.

SOCIAL DETERMINANTS OF HEALTH AND WELL-BEING

- **Affordable housing** (or housing accessibility) is a major challenge for low and moderate income families in the area, particularly for those in recovery. 27 percent of households are considered cost-burdened, meaning they spent more than 30 percent or more of their monthly income on rent. Another 10 percent are worried about losing their housing.
- A key barrier for many of Oregon's families continues to be **healthy food access**. 27 percent of households worried about running out of food, and 10 percent went without food. Furthermore, 30.1 percent of individuals consume 7 or more sodas in a week, a higher proportion than any other county in Oregon according to BRFSS data. Improvements in nutrition can further improve oral health and chronic

conditions.

- Economic development and **living-wage jobs** are key opportunities to improve the health and well-being of our communities. Adverse experiences and trauma are more likely in low-income households, particularly those in which the parents are stressed about resources. This also speaks to the challenge in Oregon of the “benefits cliff,” whereby families lose many of their social service benefits at the same point.
- **Transportation** is a challenge for some populations, particularly for the elderly and those living in rural areas. 13 percent of all households report going without needed transportation; that number jumps up to 19 percent for diverse communities.

CHRONIC CONDITIONS

- **Diabetes** continues to be one of the top reasons uninsured adults seek care in an Emergency Department, though the condition is likely better managed in a primary care setting. This suggests opportunities regarding prevention, education, and nutrition support. Diabetes is more common in Medicare recipients than in those who are privately insured.
- **Obesity** is a public health challenge, for both youth and adults. 26.7 percent of Hood River County’s adult population is obese, just slightly lower than Oregon’s overall percentage of 28.6 percent according to 2017 BRFSS. The current generation of youth may be the first to have a shorter life expectancy than their parents due to complications from obesity and its associated conditions.

COMMUNITY MENTAL HEALTH/WELL-BEING AND SUBSTANCE USE DISORDERS

- **Behavioral health** disparities exist by family income, with survey respondents at 200 percent or below FPL having significantly higher rates of depression and anxiety (39.1%) than those above 200 percent the FPL (18.4%). 1 in five (20.3%) reported particular concerns with social isolation.
- Access to **substance use treatment** continues to be a challenge for many. This includes alcohol and drug addiction services, both residential and outpatient treatment options. Oregon has relatively high rates of death from drug overdose, drug use (heroin, methamphetamines, and narcotics), and binge drinking.
- As we continue to learn about adverse childhood experiences (ACES) and the impacts of trauma on health later in life (i.e. child abuse, neglect, domestic violence, sexual assault, etc.), increasing **community resilience** and preventing exposure to these events in the first place has become increasingly important.

ACCESS TO CARE

- Timely and consistent access to **primary care** remains a challenge, particularly for those on the Oregon Health Plan (Medicaid) and the remaining uninsured. 14 percent of adults did not have medical insurance for part of the last year or at all, and another 9 percent did not get all the healthcare that they needed in the last year. For those without insurance, nearly half (47%) did not get needed medical care.
- Nearly 6 in 10 (58.4%) survey respondents reported experiencing an unmet dental need in the last year, suggesting access to **dental care** may be a key challenge in the Columbia Gorge. Dental conditions are among the top preventable reasons uninsured individuals access the Emergency Department, which is rarely the best point of care for these conditions. This presents an opportunity for prevention education and increasing access to preventive services.
- As the population is diversifying, it is increasingly important that community members feel welcome, safe, and respected in healthcare settings. One of the greatest opportunities to improve health amongst low-income and minority communities is to increase access by working for health equity. PHRM is

engaged in a dialogue with the local health departments, PacificSource Community Solutions, and regional to improve the collection of demographic information that will facilitate better disaggregation by race, ethnicity, and language. Further, over thirty local agencies are participating in health equity coalition and engaging in health equity trainings offering by a local community based organization, The Next Door, Inc.

Needs Beyond the Hospital's Service Program

No hospital facility can address all of the health needs present in its community. We are committed to continuing our Mission through Community Benefit grant-making and ongoing partnerships in our community. However, due to the strength of the partnerships in our community we believe these needs will not be overlooked community-wide. We see the interconnectedness of community needs across our community.

As previously described, the Community Health Needs Assessment process was a collaborative. All of the community needs were identified and prioritized together. However, PHRMH was the first of the cohort of organizations to complete its Community Health Improvement Plan; therefore, the first to declare the focus of its initiatives. This action clearly defines which needs remain unaddressed, so that our partner organizations can allocate their energy and resources accordingly. The other organizations could then join in PHRMH efforts, or spread out to address other needs surfaced through the collaborative CHNA.

COMMUNITY HEALTH IMPROVEMENT PLAN

Summary of Community Health Improvement Planning Process

The Columbia Gorge is a tight-knit and collaborative community. These assets have been leveraged to create a unique Community Health Improvement Plan (CHIP) process. The CHIP was built upon a joint Community Health Needs Assessment (CHA) referenced above. The CHIP process is also led by Columbia Gorge Health Council, for the third cycle. Community partners, including Providence, who contributed to the collaboration all agreed to adopt the CHA as their organization’s CHA and subsequently their CHIP. However, before beginning the CHIP process the Columbia Gorge Health Council took extraordinary efforts to develop a facilitated process, which brought together numerous groups throughout the region, to collect input and identify priorities through dot voting.

A second facilitated process was held with a sub-group of Providence’s Service Area Advisory Council (SAAC) where priority areas were identified. The sub-group then presented those priorities to the full SAAC. The full SAAC reviewed the CHA, approved the priorities, validated the selected priorities against what they saw as the most pressing community needs and compared them to the Columbia Health Council’s CHA selected priorities. The SAAC discussed the rationale of the priorities as well as the reasoning other identified areas would not be focused upon.

The identified priorities drove the creation of the initiatives found below. PHRMH anticipates that implementation strategies may change and therefore, a flexible approach is best suited for the development of its response to the CHNA. For example, certain community health needs may become more pronounced and require changes to the initiatives identified by PHRMH in the enclosed CHIP.

Addressing the Needs of the Community: 2020- 2022 Key Community Benefit Initiatives and Evaluation Plan

INITIATIVE #1: SOCIAL DETERMINANTS OF HEALTH RESULTING FROM POVERTY AND INEQUITY

Community Need Addressed

Access to affordable housing

Goal (Anticipated Impact)

Increase access to safe shelter and supports for individuals who are experiencing homelessness

Scope (Target Population)

Individuals experiencing homelessness in Hood River County

Table 1. Outcome Measures for Addressing Access to affordable housing

Outcome Measure	Baseline	FY20 Target	FY22 Target
Decrease the number of those experiencing homelessness in Hood River County	90 individuals experienced (2019 Point-In-Time Count)	5% decrease from baseline	10% decrease from baseline

Table 2. Strategies and Strategy Measures for Addressing Access to Affordable Housing

Strategy(ies)	Strategy Measure	Baseline	FY20 Target	FY22 Target
Develop local coalition to address homelessness	Develop charter, governance, and identification of goals and strategies	N/A	Finalize charter, governance, goals and strategies. Coalition actively meeting and documenting progress toward goals	Coalition reporting completion of one or more goals
Shelter people experiencing homeless during COVID-19 pandemic	Number of days individuals without a home were sheltered in hotel room	0	100 bed nights	Continue the program as COVID-19 prevalence requires; scale as appropriate
Implement Pathways Community Hub to address housing insecurity	# of housing pathways closed complete	135 Housing pathways in 2019	10% increase from baseline	15% increase from baseline
Develop Day Shelter	# of shelter service days provided	0	100 shelter service days provided	125 shelter service days provided

Evidence Based Sources

<https://endhomelessness.org/>

<https://www.cbpp.org/research/housing/supportive-housing-helps-vulnerable-people-live-and-thrive-in-the-community>

<https://community.solutions/our-solutions/built-for-zero/>

Resource Commitment

PHRMH will contribute staffing to current efforts to develop a Hood River County Homelessness Coalition. Further investment, to support facilitation, project management or identified goals of the coalition will follow as developed.

Key Community Partners

Mid-Columbia Center for Living, Mid-Columbia Housing Authority, the City of Hood River, the County of Hood River, Law enforcement, Columbia Gorge Health Council/Pacific Source CCO, Hood River County Library District, Hood River Shelter Services and the Mid-Columbia Community Action Council

INITIATIVE #2: SOCIAL DETERMINANTS OF HEALTH RESULTING FROM POVERTY AND INEQUITY

Community Need Addressed

Access to Healthy Food

Goal (Anticipated Impact)

Increase the access to nutritional food for those who are homebound

Scope (Target Population)

Older adults living in Hood River County who are homebound and shut in

Table 3. Outcome Measures for Addressing Access to Healthy Food

Outcome Measure	Baseline	FY20 Target	FY22 Target
Increase access to healthy food options for vulnerable and low-income older adults systems of home delivery.	24,000 people served annually	26,500 people	10% increase from 2020

Table 4. Strategies and Strategy Measures for Addressing Access to Healthy Food

Strategy(ies)	Strategy Measure	Baseline	FY20 Target	FY22 Target
Establish Store to Door food delivery system	Volume of grocery home deliveries for those who need it.	0	Grocery delivery active for 75% of Volunteers in Action clients requesting this service	TBD
Increase capacity of Meals on Wheels program	Number of meals delivered	24,000 meals delivered	10% increase from baseline	15% increase from baseline

Evidence Based Sources

<https://www.mealsonwheelsamerica.org/learn-more/research/more-than-a-meal/medicare-claims-analyses>

Resource Commitment

PHRMH has committed funding, administrative oversight and both professional and volunteer staffing for the Store to Door initiative, and is prepared to continue and/or expand this according to emerging community needs. PHRMH is also prepared to invest in expanded capacity for Meals on Wheels, depending on needs identified from that program, in light of state and federal funding possibilities.

Key Community Partners

Hood River Valley Adult Center, The Next Door, Inc., Meals on Wheels, Rosauer’s Grocery Store, Store to Door (in Portland, whose model we are replicating)

Initiative #3: BEHAVIORAL HEALTH/WELL-BEING

Community Need Addressed

Behavioral Health and Well-being

Goal (Anticipated Impact)

Increase access to mental health promotion program

Scope (Target Population)

Spanish speaking population in Hood River County

Table 5. Outcome Measures for Addressing Behavioral Health and Well-being

Outcome Measure	Baseline	FY20 Target	FY22 Target
Increase number of forums to facilitate mental health promotion.	0 participants	250 participants	300 participants
Improve “sense of community” and the understanding of the root causes of good and poor health	4 half-day Health Equity workshops in 2019 70 participants	4 full-day Health Equity workshops 70 new participants (Due to COVID-19)	4 full-day Health Equity workshops 70 new participants (Due to COVID-19)

Table 6. Strategies and Strategy Measures for Addressing Behavioral Health and Well-being

Strategy(ies)	Strategy Measure	Baseline	FY20 Target	FY22 Target
Offer Constructivist Listening Dyads framework as a tool for emotional discharge and stress management	Number of sessions and participants	0	15 sessions of 20 participants per session	20 sessions of 20 participants per session
Host Health Equity workshops	Number of sessions and participants	4 half-day sessions 35 participants	4 all-day sessions 35 participants	4 all-day sessions
Spanish Mental Health Promotion for Community Health Worker’s	Number of people trained	0	TBD	TBD

Evidence Based Sources

Becerra, A. & Weisglass, J. (2004). Take It Up: Leading for Educational Equity, Patient Educ Couns. 2011 Santa Barbara: The National Coalition for Equity and Education.

Resource Commitment

PHRMH is prepared to make cash and in-kind investments to advance the development of all three programs, according to the determination of priorities by community partners.

Key Community Partners

The Next Door, Inc.

Other Community Benefit Programs and Evaluation Plan

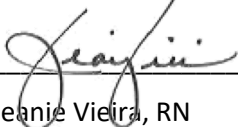
Table 7. Other Community Benefit Programs in Response to Community Needs

Initiative (Community Need Addressed)	Program Name	Description	Target Population (Low Income, Vulnerable or Broader Community)
Social Determinants of Health	The Next Door and Immigration Counseling Service	Assists immigrants relocating in the Gorge.	Immigrant population
Social Determinants of Health	Gorge Ecumenical Ministries/ Hood River County Government	Developed an ID card to enable vulnerable community members to access vital services, enhance public safety and increase the sense of belonging in the community.	Immigrant population
Access to Care	Hood River Family Medicine Residency Program	Four full-time primary care residents providing health care services at the local Federally Qualified Health Center.	Low income
Chronic Conditions	North Central Public Health District	The Youth Fit 4 Life Program offered at Mid Valley Elementary School in Odell, OR with an estimated 150-200 student participants benefitting.	Low income and Children
Chronic Conditions	Oregon Food Bank (OFB)	In 2017/2018 opened two school-based	Low income and Children

		food pantries at local elementary schools.	
Chronic Conditions	Gorge Grown Food Network – Veggie Rx Program	Provides fresh fruit and vegetables to 50 low income mothers and their families enrolled in the Hood River Health Department WIC program.	Low income
Chronic Conditions	One Community Health (OCH)	Supported 12-week community-based health education courses in English and Spanish facilitated by Community Health Workers.	Immigrants

2020-2022 CHIP GOVERNANCE APPROVAL


This Community Health Improvement Plan was adopted by the Service Area Advisory Council of the hospital on April 14th, 2020. The final report was made widely available⁵ by May 15, 2020.



Jeanje Vieira, RN
Chief Executive, Columbia Gorge Service Area

May 5, 2020

Date



Lisa Vance
Chief Executive, Oregon Region

May 8, 2020


Date



Joanne Warner
Chair, Oregon Community Ministry Boards

May 8, 2020

Date



Joel Gilbertson
Senior Vice President, Community Partnerships
Providence St. Joseph Health

May 11, 2020

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To request a copy free of charge, provide comments, or view electronic copies of current and previous Community Health Improvement Plans please email CommunityBenefit@providence.org.

⁵ Per § 1.501(r)-3 IRS Requirements, posted on hospital website

APPENDICES

Appendix 1: Definition of Terms

Community Benefit: An initiative, program or activity that provides treatment or promotes health and healing as a response to identified community needs and meets at least one of the following community benefit objectives:

- a. Improves access to health services;
- b. Enhances public health;
- c. Advances increased general knowledge; and/or
- d. Relieves government burden to improve health.

Community benefit includes services to persons living in poverty, persons who are vulnerable, and the broader community.

To be reported as a community benefit initiative or program, community need must be demonstrated. Community need can be demonstrated through the following:

- a. Community health needs assessment developed by the ministry or in partnership with other community organizations;
- b. Documentation that demonstrates community need and/or a request from a public agency or community group was the basis for initiating or continuing the activity or program; or
- c. The involvement of unrelated, collaborative tax-exempt or government organizations as partners in the community benefit initiative or program.

Health Equity: Healthy People 2020 defines *health equity* as the “attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.”

Social Determinants of Health: Powerful, complex relationships exist between health and biology, genetics, and individual behavior, and between health and health services, socioeconomic status, the physical environment, discrimination, racism, literacy levels, and legislative policies. These factors, which influence an individual’s or population’s health, are known as *determinants of health*. *Social determinants of health* are conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Initiative: An initiative is an umbrella category under which a ministry organizes its key priority efforts. Each effort should be entered as a program in CBISA Online (Lyon Software). Please be sure to report on all your Key Community Benefit initiatives. If a ministry reports at the initiative level, the goal (anticipated impact), outcome measure, strategy and strategy measure are reported at the initiative

level. Be sure to list all the programs that are under the initiative. Note: All Community Benefit initiatives must submit financial and programmatic data in CBISA Online.

Program: A program is defined as a program or service provided to benefit the community (in alignment with guidelines) and entered in CBISA Online (Lyon Software). Please be sure to report on all community benefit programs. Note: All community benefit programs, defined as “programs”, are required to include financial and programmatic data into CBISA Online.

Goal (Anticipated Impact): The goal is the desired ultimate result for the initiative’s or program’s efforts. This result may take years to achieve and may require other interventions as well as this program. (E.g. increase immunization rates; reduce obesity prevalence.).

Scope (Target Population): Definition of group being addressed in this initiative: specific description of group or population included (or not included, if relevant) for whom outcomes will be measured and work is focused. Identify if this initiative is primarily for persons living in poverty or primarily for the broader community.

Outcome measure: An outcome measure is a quantitative statement of the goal and should answer the following question: “How will you know if you’re making progress on goal?” It should be quantitative, objective, meaningful, and not yet a “target” level.



Columbia Gorge Regional COMMUNITY HEALTH IMPROVEMENT PLAN 2020

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ABOUT THE REGION

The Columbia Gorge Region includes seven counties along the Columbia River. The region includes Hood River, Wasco, Gilliam, Sherman, and Wheeler counties in Oregon plus Skamania and Klickitat counties in Washington.

Combined, these counties cover 10,284 square miles and are home to a population of approximately 84,000.

The Columbia River Gorge has been home to the Indian people since “time immemorial” and is

home to four major tribes that share similar languages, cultures, religions, and diets: the Nez Perce Tribe, the Confederated Tribes of the Umatilla Indian Reservation, the Confederated Tribes of the Warm Springs Reservation of Oregon, and the Confederated Tribes and Bands of the Yakama Nation. These four tribes have a long history of interaction, including intermarriage, shared use of common resources like Celilo Falls, and extensive trade. In the treaties of 1855, the Tribes ceded lands to the federal government but retained rights for fishing and to some lands. We acknowledge them as the past, present and future caretakers of the land and it is on their traditional land where we partner to improve the health and well-being of all who live here.

The Columbia Gorge Region is now a mostly rural area with only a few towns that are larger than 1,000 people. Agriculture is a large industry in almost every county. Tourism, healthcare, forestry, and growing technology firms also drive the economy. Many of our industries rely on seasonal employment. Therefore, we experience a large influx of workers, especially migrant and seasonal farmworkers.

Because many of our local organizations are required to conduct a community health assessment and a Community Health Improvement Plan, we chose to do this work collaboratively. The seventeen organizations highlighted on the cover page are part of the 2019 Regional Community Health Assessment cohort. Cohort partners include:

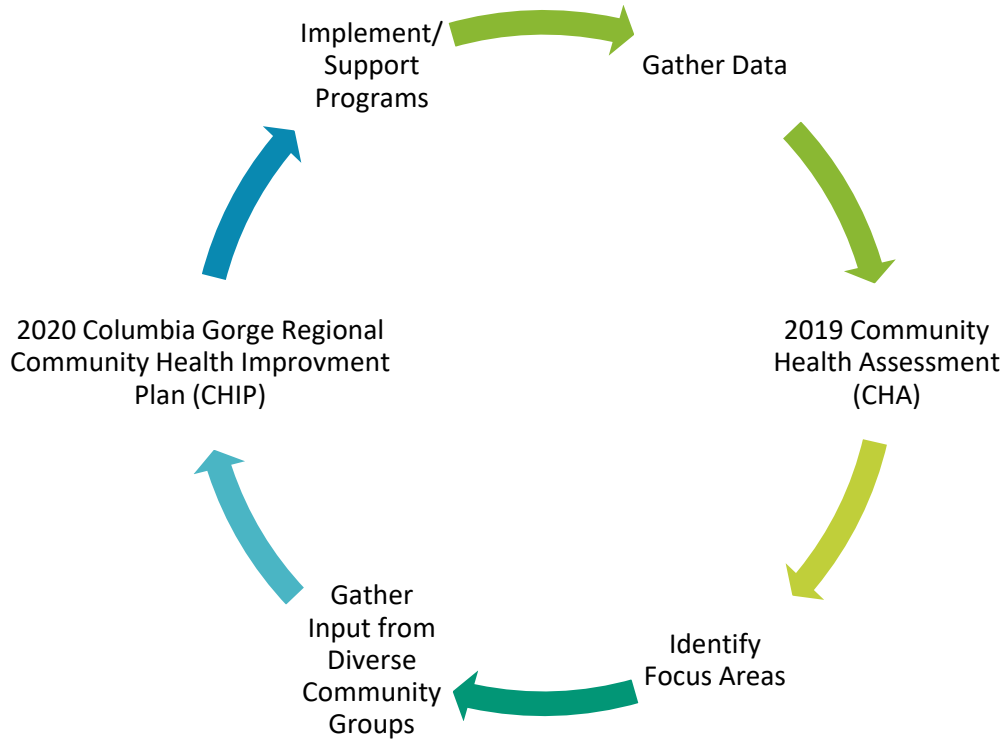
- Hospital systems
- Primary Care, Dental and Behavioral Health Clinics



Figure 3-Map of Columbia Gorge Region

- Government Representatives
- Community Mental Health Provider
- Early Learning HUB
- Other Coordinated Care Organizations (OR) and Accountable Communities of Health (WA)

The role of the cohort is to collaboratively work together and agree to adapt the Regional Columbia Gorge Health Improvement Plan as the Improvement plan for their individual organization. Organizations may add additional information or data to either the Community Health Assessment (CHA) or the Community Health Improvement Plan (CHIP) but agree to not take anything away. The cohort typically has a representative in attendance at the Community Advisory Council meetings where the work of the creation and implementation of the CHA and the CHIP happens.



2020 COMMUNITY HEALTH IMPROVEMENT PLAN PROCESS OVERVIEW

Every three years, organizations come together to develop a regional Community Health Assessment (CHA) in the Columbia Gorge and based on that assessment, a Community Health Improvement Plan (CHIP). The Columbia Gorge Community Advisory Council oversees and helps facilitate that process.

The Community Advisory Council

The Community Advisory Council, or CAC is comprised of Medicaid consumers, community members, and representatives from local social and human service providers, public health, healthcare, community health workers, and government partners. The CAC is supported by the Columbia Gorge Health Council, or CGHC, who partners with PacificSource Community Solutions as the Columbia Gorge Coordinated Care Organization. In the role as facilitator, CGHC bring partners together to lead the

regional Community Health Improvement Plan process. The Community Advisory Council oversees the process from start to finish.

CAC Mission: To identify needs, barriers, and opportunities in the Columbia Gorge. At the same time, to advocate for solutions that support health and well-being in the region.

CAC Vision: A region of communities where all people enjoy improved health through equitable access to and engagement with coordinated resources. Coordinated resources are when agencies work together to make sure services are available and appropriate for all members of our community.

CAC Values

- Engage
- Collaborate
- Be transparent
- Be inclusive
- Ensure equity
- Ensure diversity
- Empower

Strategies Used by the Columbia Gorge Community Advisory Council:

The Columbia Gorge Community Advisory Council (CAC) works very hard to create authentic meaningful engagement within our CAC. We believe that the ingredients for meaningful engagement are trust, relationship building and leadership. We also believe that in our meetings, held monthly, we are all teachers and we are all learners and we provide as many varied opportunities for people to learn and share with each other and from each other as possible. In order to do this, we employ Popular Education Techniques, a social justice tool that comes out of the work of Paulo Freire, a Brazilian educator and philosopher.

Some examples of our techniques we utilize:

Meaningful Community Engagement:

- The room is arranged in a large circle so everyone can see each other
- CAC members are involved in agenda planning
- Healthy and nourishing food is offered at meetings
- Stipends are offered
- Simultaneous interpretation in Spanish is offered
- Meeting materials and invitations are sent out via email or on paper if needed and are posted on our websites
- Often the meeting begins with a live music bi-lingual song with words for people to join in if interested
- Materials are written in plain language, at a sixth-grade reading level, and limit the use of acronyms as much as possible
- Topics discussed at the CAC where input is requested come back to the group for follow up
- Every meeting has opportunities for public sharing and comments
- Meeting space is ADA accessible

- Stipends support members not affiliated with an organization and additional support is offered for transportation and childcare as needed
- Attendees are asked for feedback at the end of meetings to ensure needs and expectations are being met
- Discussion formats are held in small groups, café style input and discussions, individual input in writing or via brainstorming

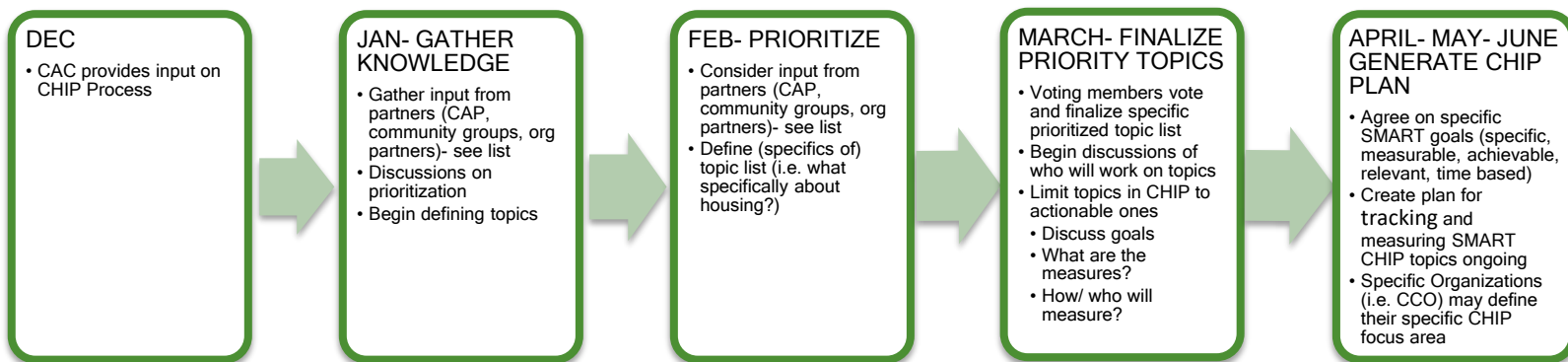
The Community Health Improvement Plan 2020 Process:

The CAC played an integral role in reviewing, refining and crafting questions for the community survey as part of the 2019 Community Health Assessment. The full description for the 2019 Community Health Assessment can be found at: <http://cghealthcouncil.org/documents/>

The Community Health Assessment process, in 2016, was recognized in when the Columbia Gorge Region was awarded the Robert Wood Johnson Foundation (RWJF) Culture of Health Prize. This prestigious recognition further engaged the community in a conversation on what defines health and measurements for monitoring progress towards health.



For the 2020 Community Health Improvement Plan process, the Community Advisory Council set out to gather more input from groups in the community about the new 2019 Community Health Assessment data and determine if the previous 2017 CHIP priorities may have changed over time.



The CAC began with group discussions, reviewing the 2019 CHA data and discussing the relevance of the priorities from the previous CHIP completed in 2017. Although there are often 35 + people in the room at the CAC meetings, the group determined that input from our larger community was needed. The CAC listed specific populations that they felt needed representation to be able to define the 2020 CHIP priorities of our large region.

The CAC prioritized hearing from populations of individuals representing a diverse group of people and a diverse geographic area with a priority towards typically marginalized groups. In partnership with CAC leadership, consultants Lindsay Miller, Sandi Scheinberg and Jody O'Connor collected input regarding health-related priorities in the region from community groups selected by the CAC. The consultants attended already existing gatherings to and, in most cases, performed an interactive activity effective at gaining input on health improvement priorities. In some cases, some

of the affinity groups listed had already prioritized their needs, in which case, those priorities were incorporated into the larger list and specifics were recorded. The chart on the following page is the list of community groups from which information was gathered.

Of note, the gorge region has an active, relatively new and growing leadership group that is part of the Regional Health Equity Committee run by The Next Door, Inc. and supported by the Oregon State Office of Equity and Inclusion called Natives Along the Big River (NABR). Since this group had already prioritized their needs as a coalition, the consultants worked with the leadership from this group to incorporate their needs and specific input into the CHIP. The Columbia Gorge Coordinated Care Organization did not have a Tribal Liaison to the CAC appointed at the time of the creation of the 2020 CHIP.

Community Input on 2020 CHIP Priorities:

Engagement with Community Groups for CHIP Input:

#	Community Group	Representing										Geographic Area							
		Community at large	Families	Frontier communities	Latinx community	LGBTQIA+	Medicaid members	Native American community	Older adults	Providers	Youth	Gorge wide	Hood River	Gilliam	Klickitat	Sherman	Skamania	Wasco	Wheeler
1	Abogados de la Comunidad																		
2	Aging in the Gorge Alliance																		
3	Bridges to Change																		
4	CGCC Food Pantry																		
5	Clinical Advisory Panel (CAP)																		
6	Community Advisory Council (CAC)																		
7	Community Health Worker Collaborative																		
8	Familias Unidas (scheduled)																		
9	Fit in The Gorge																		
10	Four Rivers Early Learning HUB																		
11	Gilliam County CHIP																		
12	Gorge Food Security Coalition																		
13	Gorge Pride Alliance Health Committee																		
14	Hood River Shelter Services																		
15	Juntos (Latinx student club)																		
16	Latinos en Acción																		
17	NAMI Gorge																		
18	Natives Along the Big River																		
19	NORCOR Juvenile Detention Center																		
20	Online Respondants																		
21	Oral Health Coalition																		
22	Raices																		
23	Rufus Food Pantry																		
24	SAAC Providence																		
25	Senior Advisory Council (AAA/APD)																		
26	Sherman County CHIP																		
27	Sherman County LCAC																		
28	Skyline Hospital																		
29	Strong Women - Cascade Locks																		
30	The Cottage at MCCFL																		
31	Unidos Por Poder																		
32	Wasco County Youth Services																		
33	Washington Gorge Action Programs																		
34	Wheeler County CHIP																		
35	YES House																		
36	Youth Health Media Club																		
37	Youth Think																		

More than 180 individuals representing 37 community-based groups provided input to the CHIP process. Participants were asked to select their top five most important priorities from the 2017 CHIP

listed below. Participants were also invited to share why certain priorities matter most to them, and they had a chance to suggest new or different priorities for the CAC’s consideration.

2017 COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP) PRIORITIES

Built Environment	Housing affordability	Access	Access to Primary Care	Sense of Community
	Access to Healthy Food		Access to Mental Health Services	
	Transportation & Mobility		Access to Dental Care	
	Youth Safety		Stable Health Insurance	Social Support
	Equity in Physical Activity Opportunities		Collaboration & Info Sharing	Effective Referrals

Where possible, the consultants attended existing community meetings and facilitated in that group’s preferred language. Groups were also offered support to self-facilitate sessions, conduct individual sessions with community members, and/or provide input via an online survey. Some community groups had already established priorities, and so those priorities were incorporated with their permission.

The information below summarizes the community input the consultants received about health-related priorities for our region. The information gathered was extremely useful to the CAC as it developed the 2020 Community Health Improvement Plan.

What We Learned

The consultants spoke with people representing the interests of youth, families, low-income individuals, the Latino community, the Native American community, the LGBTQ+ community, people living in frontier communities, and older adults. In all of these interactions, it was clear that people care deeply about improving the conditions that affect health in our region.

Changes to the Priority List

Through these conversations about what matters to people, the consultants received important feedback about how the original CHIP categories should be changed to better represent the priorities of our communities. As a result, two changes to the priority topics were made:

1. Mental Health Services → Behavioral Health Services

Many participants highlighted Substance Use Services as a missing priority. In response, Mental Health Services has been changed to Behavioral Health Services and the definition broadened to include both Mental Health and Substance Use Services.

2. Sense of Community + Social Supports → Sense of Community

Many participants stated that Sense of Community and Social Supports seemed related or similar. In response, these categories were combined.

There Were Six Top Priorities

Based on the community feedback, ALL of the priorities were perceived as having an impact on health and wellness of Gorge residents, but some were perceived to be a higher priority or more urgent than others. Six priorities consistently emerged as the most important to the people and groups:

- **Housing**
- **Food**
- **Sense of Community**
- **Behavioral Health**
- **Youth Safety**
- **Transportation**

Details on the Top Priorities

Housing was consistently ranked as the most important factor for improving health in our communities. People reported that without safe and stable housing, it is impossible for people and families to focus on other areas of health. They also added that the cost of housing in our area makes it very hard for people to find affordable housing options. People perceive that homelessness and housing insecurity are growing problems in our communities. As well, people see a need for housing that meets the accessibility needs of older adults and people with disabilities.



- “We must address people's basic needs - again it plays a role in overall feeling of safety. You cannot sleep well if you don't feel safe. Lack of sleep can be a major health concern.” - Youth Services Provider, Wasco County
- “People need safe & dignified housing, not just affordable. This can boost a sense of community, social support, food access, and transportation & mobility.” - 22-year old Oregon Health Plan member in The Dalles
- “There is no affordable housing or none at all. I am seeing people spend 70-80% on their house payment.” - Latinx resident of Odell
- “There’s a lot of people who might not call themselves homeless, but they essentially are. They are staying on people’s couches, living out of cars, transient - they don’t have a permanent place to call home.” - Provider, Skyline Hospital
- “Homelessness keeps a person in crisis.” - Member, Strong Women Cascade Locks
- “Because people like me live in very unstable housing, and the house is too small for the amount of people that live in it and the house is falling apart.” - Latinx youth living in Hood River County
- “We need adequate, accessible housing for low-income seniors on a fixed income. If people lose their housing, the deposits required, the wait time, the application procedures to get into a new place are too much for most people.” - Medicare recipient in Hood River County

Food was ranked by groups as the second most important topic for supporting overall health. The high cost of healthy food and the challenges that low-income people face as a result was a common theme. Many stated that more than *healthy* food, people first need to have *enough* food. Transportation was also mentioned as an important barrier to accessing food. People must be able to get to the store or food pantry to get the food they need. Finally, comments included the need for more education about how to buy and cook healthy foods.



- “For some folks having NO food is more pressing than access to healthy foods. Access to culturally appropriate foods [is also important].” - The Dalles resident, Food Security Coalition

- “A healthy diet provides the physical and mental strength to address other needs.” - Older adult resident of Mosier
- “Not having healthy food options at the prices of unhealthy foods is a problem. If you can buy one apple - that is a snack; or 10 packages of ramen noodles - that is 10 meals.” - Resident of the Dalles
- “Food = Money. SNAP will not buy enough for just one person!” - Medicare recipient in Hood River County
- “Healthy food is very expensive and a lot of people aren't able to buy food that is good for our children.” - Latinx resident of The Dalles
- “[There is a] lack of education around how to prepare healthy fresh foods. Unfamiliarity = avoidance.” - Goldendale resident, Community Advisory Council

Sense of Community ranked third based on community input. Sense of Community was a broad category and people talked about feeling safe and welcome in the community. Others shared experiences of feeling unwelcome or discriminated against. People also talked about the importance of having providers and helpers in our community who speak the same language and understand the culture. Finally, people talked about how important connection and belonging is to overall health.



- “Sense of community can be interpreted differently depending on who's in charge. People will say they have a strong sense of community, but an outsider won't feel that way.” - Latinx mother living in The Dalles
- “I don't feel part of the community because business owners are always chasing me away, taking pictures of me when I stand near their store. It makes me feel unwanted here.” - The Dalles resident
- “Encourage agencies to hire bilingual, bicultural individuals that have a connection and resemble the Mid-Columbia Gorge area.” - Latinx service provider, The Dalles
- “When you're struggling financially or with your health, it's easy to feel alone and feel like you don't have any support.” - Latinx youth living in Hood River
- “People make assumptions about me all the time because I'm Native - they think I'm selfish or lazy.” - Native American youth living in NORCOR
- “I want to have people to talk to rather than being alone. I have self-abandonment. I need to find a way to work it out. It would help if I could socialize.” - Hood River Shelter Services participant
- “Social support is so important for all ages. Young and old need to be connected to others.” - Medicare recipient in Hood River County

Behavioral Health, a category that was expanded to include Mental Health and Substance Use Services, also ranked highly. Mental health and well-being is viewed by many as central to overall health. People talked about the barriers that keep folks from getting the support they need. This included cost, a lack of insurance coverage, a lack of bilingual and bicultural providers, and/or long wait times to get an appointment. Many people saw an urgent and critical need for mental health and substance use crisis intervention services in the region.



- “Very few mental health providers take insurance. Those that do are overloaded.” - Community Advisory Council member
- “We desperately need more providers - this is a workforce issue.” - Grass Valley resident
- “There is no place for people to go for mental health needs. You can arrest them and they're off the streets for one night. It's not a solution.” - Input from the Senior Advisory Council
- “[Mental health and suicide] can have wide reaching effects, on an entire family. It can lead to anger problems and PTSD. Sometimes my emotions control me.” Youth living in NORCOR
- “We want local services here in the Gorge for [mental health] crisis intervention and evaluation and at least some short-term treatment inpatient beds.” - Input from NAMI representative
- “We need to have more counselors for Spanish speakers. Drug addiction services should be bicultural.” - Latinx service provider in The Dalles
- “Depression is very common in teenagers. To protect everyone, having access to mental health services is important.” - Latinx youth living in Hood River

Youth Safety was also very important to the people engaged in the process. This broad category included the need to have safe activities and spaces and positive role models for youth in our communities. People talked about the need to address bullying in schools, and they noted that many youth are exposed to violence in their home, which impacts their overall sense of safety.



- “You got to keep kids busy. Once I started skipping school, I started doing stupid stuff and getting into trouble. Skipping school leads to bad behavior.” Latinx youth living in NORCOR
- “Bullying and racism in the schools and community affects youth and adults.” - Latinx resident of The Dalles
- “Youth safety is about poverty, neglect, drug use in the home, threat of harm in the home. If we don't put support into what is going on at home, these kids don't have a chance.” - Input from Wasco County Youth Services
- “There is not a lot of security for kids and youth in the schools or in the streets. Bullying is a big problem at school and when my child tries to tell a teacher about it they get ignored. Kids are afraid to tell the teachers.” - Latinx parent in The Dalles
- “[There has been an] increase in suicide attempts, harassment, and racial discrimination, [and] lack of behavioral health support in bilingual bicultural services. Doesn't matter if you have access at a school clinic or community clinic if there isn't a qualified person to deliver services.” - Odell resident
- “Sports used to be free. Kids at the poverty level don't have the opportunity to be involved. Poverty leads to drugs, then you just follow in your parent's footsteps. At least that's what happened to me.” - Bridges to Change participant living in The Dalles

Transportation was another category that consistently scored in the top. People said that transportation in the region is improving, and lots of people are using the medical transport services available. However, people still need more transportation options to get to work, do their shopping, and complete other day-to-day activities. Transportation options should be accessible for people with disabilities and older adults. Information about existing transportation resources should be communicated clearly.



- “Not having enough time to get to the bus, no shelter at the bus stop, no bus available for shopping specific.” - Resident of Parkdale
- “Need a real system with lots of stop times. If I have a doctor’s appointment at 3, I have to take a bus at 1 and wait 2 hours.” - Oregon Health Plan Member, The Dalles
- “Transportation is improving but those in rural areas still struggle. The bus doesn’t do you any good if you can’t get to town.” - White Salmon resident
- “[Information about public] transportation needs to be communicated well so that we can [find it and] use it.” - Input from Unidos Por Poder, The Dalles
- “Public transportation is improving!! But it’s still not adequate for a disabled person who can’t get to the curb by themselves.” - Medicare recipient in The Dalles
- “Especially to and from doctor appointments in Portland!” - Resident of The Dalles

Details on All Other Priorities

The other priorities (listed below) did not rank as consistently high according to the input we received. However, *every priority made the top 5 list of at least five different groups*, which suggests that they all matter to community members.

- **Access to Dental Care**
 - “Dental is very important for all. Teeth can cause a lot of pain.” - Member of the Senior Advisory Council
 - “Some clients have dentures and they are only covered once in every 5 or 10 years and don’t have coverage for repairs” - Parkdale resident
 - “There are 3 different dental insurance companies and each one has different rules. They are supposed to maintain an adequate referral network but they don’t. There are none in White Salmon. OCH supposedly accepts them, but they don’t seem to be very accessible. People end up having to go to Yakama.” - Provider, White Salmon
- **Access to Primary Care**
 - “We should have in-person interpreters and bilingual staff at all agencies so people feel like they can ask questions. Why even go if you can’t understand?” - Latinx service provider in The Dalles
 - “We do not have any emergency care in our county, we have to be transported 50 miles to the nearest ER for services. We have no after-hours care in our County.” - Arlington resident
 - “I usually just wait if I’m sick until I have to go to the ER.” - Youth living in NORCOR
- **Access to Health Insurance**
 - “There is still a large gap in those who qualify for OHP and those that can’t afford the insurance costs that don’t qualify.” - Sherman County resident

- “I live in The Dalles so there is a lot of access to care, but the stress of not knowing how much and what will be covered and when is overwhelming.”
- Oregon Health Plan recipient
- “Lots of people get Medicare but to get a supplement is very expensive and inaccessible for most. Medicare doesn't cover vision, hearing, or dental - most people have no idea. And, if you don't have a supplement, you're still on the hook for 20% of every charge. If you end up in the hospital one time, that's enough to bankrupt some people.” - Aging in the Gorge Alliance representative
- **Collaboration & Information Sharing**
 - “People don't know where to go for various questions, both social, physical and mental.” - Aging in the Gorge Alliance representative
 - “There is no HUB for info. Need a central place to go to find out what is available. Resource Hub. Community Center. Medical home that treats the whole person, and connects to the variety of services out there.” - Gorge Pride Alliance
 - “We really need a paper resource guide. I used one when I was in Seattle. It saved me. It told me everything I needed to go, where to find help and get support. Directions for how to get places. Portland Street Roots has a really good one.” - Oregon Health Plan recipient living in The Dalles
- **Equitable Access to Physical Activity Opportunities**
 - “It's important for older adults to stay strong, active - it prevents falls and injuries. Our population is aging. Coming to Strong Women helped me come back from a major health setback. It saved my life and made it so I could still live on my own.” - Strong Women exercise group participant
 - “We lack activities in the community to improve our health [especially in winter]. Doctors should give referrals [that can be covered by] insurance to make physical activity accessible, like gym memberships, etc.” - Input from Unidos Por Poder, The Dalles
 - “For meaningful quality of life, health and well-being, people need to feel safe in their environment and have the ability to access enjoyable physical activities.”
- The Dalles resident
- **Effective Referrals**
 - “Too many people come through our doors who've already gone 5 different places without receiving answers.” - WAGAP representative
 - “It's nice to go in for something and have it taken care of immediately.” - YES House youth participant
 - “Confusion exists in all communities about available resources and how to access those resources.” - Providence Hood River SAAC representative

New Priorities to Consider

Participants were also asked to suggest new or different priorities that they felt were important to improving overall health and that weren't captured in the priorities above. The following topics were mentioned by multiple individuals and groups:

- **Health Education, Prevention & Promotion**
 - “We need to be able to provide families with alternative options than a referral to MCCFL. There should be school counselors, parenting classes, support groups, or other services available. We need to be able to divert folks from the MH system just like we divert from the JJ system.” - Wasco County Youth Services representative

- “There is so much that I wish someone had taught me about - puberty, sexually transmitted diseases. Parents should know about that stuff and teach their children.” - Latinx youth living in NORCOR
- **Childcare**
 - “If people can't work [because they can't access child care], they can't access health care, pay for food, housing and transportation.” - Hood River resident
 - “We need more affordable daycare for working parents.” - Latinx resident of The Dalles
- **Services for Older Adults**
 - “Long term care is a huge need. Long wait lists - people have to move out of the area to get into long-term care. Hood River only has ONE assisted living facility that accepts Medicaid.” - Senior Advisory Council
 - “Legal aid and financial planning support are really needed. We hear this all the time, it's the most requested topic for discussion. Older people are really looking for help in this area.” - Gorge Ecumenical Ministries volunteer
- **Early Childhood Development**
 - “We need to work on trauma informed care; childhood obesity; and developmental screening. Our children's health is important and we need to catch issues early on to take corrective actions. We also need to realize that the more adverse childhood experiences that a child has, the more health issues that they will have as they grow older. we need to try to increase the protective factors of children so that they can grow both physically and mentally, more healthy.” - Condon resident
- **Living Wage Jobs**
 - “Money is a huge determinant of health & wellness. Housing, food, transportation all stem from income.” - Hood River resident
 - “Our area is expensive. Not all families can afford healthcare, childcare, social and recreational activities in this area.” - WAGAP representative

Additional quotes related to these new priorities, as well as a list of all new priorities mentioned can be found in Appendix A and B

2020 CHIP PRIORITIES

Community Health Improvement Plan (CHIP) Main Goal:

We will work together to make sure that ALL members of our community have equitable access to supports that address the priority needs listed below. This is regardless of race, ethnicity, religious affiliation, sexual orientation, gender identity, age, location, ability, or income level.

We commit to making sure we measure our improvement through an equity lens. We also commit to making sure that services are provided in a way that is equitable and trauma informed.

We recognize the work ahead will include program and systems level change. This can include policy recommendations and support of living wages that would help create a more equitable and just community where all people can thrive.

Priorities:

- ❖ HOUSING
- ❖ FOOD
- ❖ TRANSPORTATION AND MOBILITY
- ❖ IMPROVED ACCESS TO EQUITABLE HEALTH CARE SERVICES
- ❖ IMPROVED ACCESS TO EQUITABLE PHYSICAL ACTIVITY AND THE OUTDOORS
- ❖ IMPROVED SOCIAL CONNECTION AND COMMUNICATION
- ❖ CHILDREN AND YOUTH



PRIORITY: Housing

- People can gain access and afford safe housing.
- People do not worry about losing their housing.
- People spend less than 30% of their income on housing.

PRIORITY: Food

- All people can access and afford healthy food.
- People do not worry about running out of food for themselves or the people they live with.

PRIORITY: Transportation and Mobility

- Public and private transportation is available and convenient for all activities that support and encourage health, daily living, physical activity and well-being.
- Public and private transportation is safe and meets the needs of each person.
- Communities have safe transportation and infrastructure that supports walking, biking and wheelchair or walker rolling.

PRIORITY: Improved access to equitable health care services

Dental Care:

- People get the dental services they need when they need them.
- Dental care is equitable, affordable and inclusive and is offered in a respectful and trauma informed manner.

Primary Care:

- People get the primary care they need when they need it.
- Primary care is equitable and inclusive and is offered in a respectful and trauma informed manner.
- Health care is offered in diverse settings which supports health and wellness at every stage of life

Behavioral Health Care:

- People get the behavioral services and supports they need when they need them, including:
 - Mental health
 - Substance abuse services
 - Crisis intervention
 - Inpatient treatment
 - Outpatient treatment
- Behavioral health care is equitable and inclusive. It is offered in a respectful and trauma informed manner.
- Behavioral is offered in diverse settings which supports mental health and wellness at every stage of life.

Health Insurance:

- People have stable insurance they can afford and when they use it, it does not cause financial distress.
- Insurance covers the services people need, which include physical, dental and behavioral health.

- People who are not documented can get insurance that covers physical, behavioral and dental healthcare.

Prevention and Promotion:

- The information that people need to support healthy choices is available to all.
- Information and education on wellness, health promotion and disease prevention are available and offered in an equitable and trauma informed way.
- Prevention and control of current and emerging health care issues are addressed in the community.
- Prevention of interpersonal violence is addressed through the promoting health, safety, communication, equity, and respect.

PRIORITY: Improved Access to Equitable Physical Activity and the Outdoors

- All people have opportunities for physical activity that supports their health and well-being. This is regardless of their race, ethnicity, physical limitation or where they live.
- It is easy for people to access parks, trails and natural areas for both exercise and social activities.

PRIORITY: Improved Social Connection and Communication

Sense of Community:

- People feel a sense of connection, security, belonging, and trust in their community.
- People receive social support from family, friends, and other community members.
- People feel a sense of community through access to parks, nature and recreation.
- People and groups get support in growing as leaders. They feel they have a voice and can contribute to their community.

Collaboration and Information Sharing:

- People get the language appropriate information they need or want on paper, online, or video to be able to access the services they need.
- Organizations coordinate intake and exchange information for shared patients or clients.
- Referrals are coordinated and people get their needs met in a timely manner.

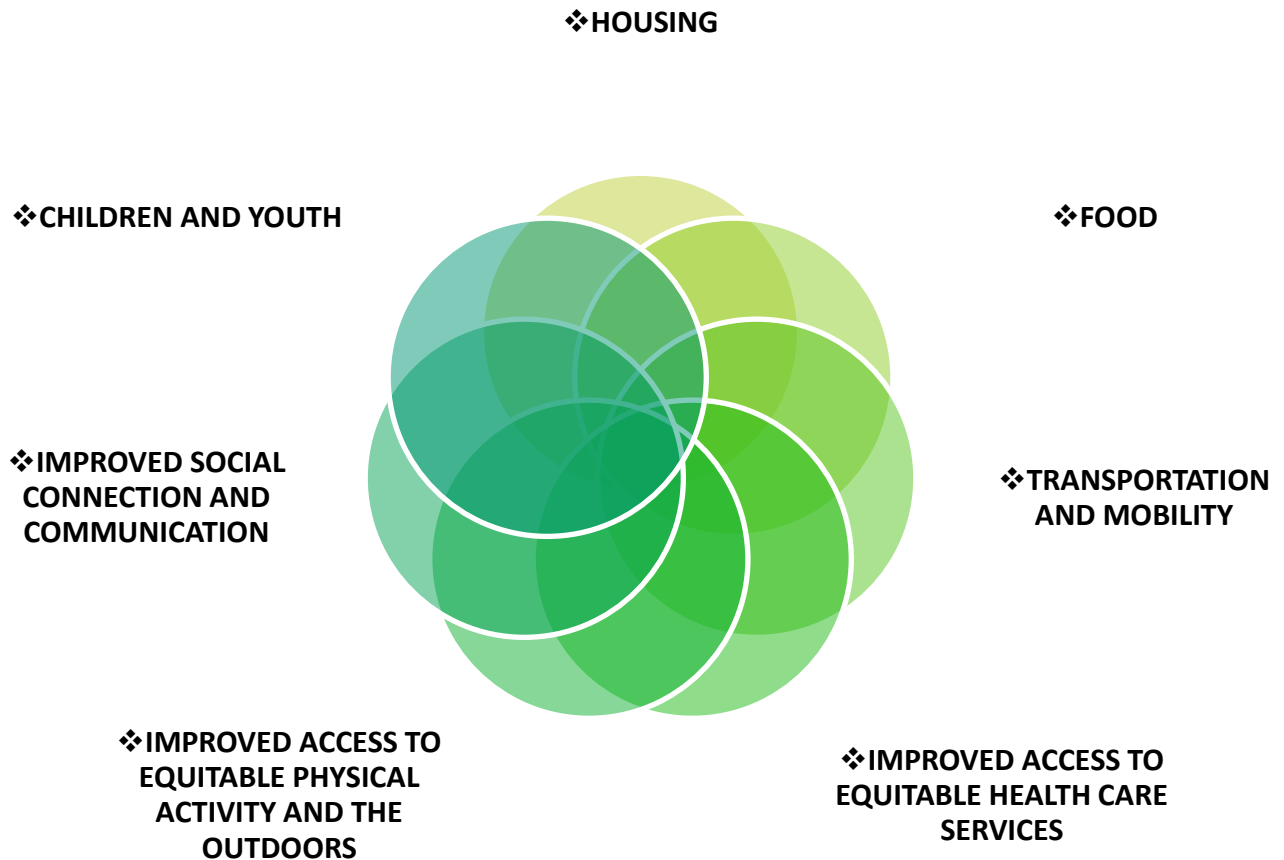
PRIORITY: Children and Youth

Youth Safety:

- Youth (ages 0 to 18) feel respected, safe and supported:
 - In their homes
 - Getting to and from school
 - In school
 - In community activities
- Youth have equitable access to activities to play, learn and grow outside of school that their families can afford.
- There is infrastructure and there are opportunities so that youth of all ages, abilities and interests have a variety of physical and other activity options that are offered in an equitable way.
- Youth who experience bullying or suffer violence, whether in person or online, are supported and have access to the help they need.

Early Childhood Development and Child Care:

- People can access cultural and language appropriate, high-quality, affordable childcare when and where they need it.
- People can access and afford early childhood development supports and opportunities, such as early intervention, home visiting, group socialization, preschool and activities.



APPENDICES

Appendix A: Quotes related to CHIP topics:

HOUSING

- “I think this is a critical need and must continue to be elevated in order to make sustained change. Housing affects the majority of people in the region and their ability to thrive or barely survive.” - Hood River resident, Food Security Coalition
- “If you’re unable to afford housing, you can’t access services. Without an address you cannot focus on finding work, eating healthy foods, etc.” - The Dalles resident, Oregon Health Plan member
- “It’s really difficult for someone with a history [of drug use, prison time] to rent a place. Everything is run by property management. They have too many stipulations.” - The Dalles resident, Bridges to Change

- “Working in a clinic, I know that several of my patients worry daily about where they live or if they’ll have a place to live in the next month.” - Provider, Klickitat County Health Department
- “It’s not just a low-income issue. We’ve tried to recruit professionals to the hospital, and as soon as they learn about the cost of housing, and compare it with elsewhere, they say, ‘no thank you.’” - Provider, Skyline Hospital
- “People need to know that there are a lot of different ways to live, different perspectives and different cultures. I lived on a reservation and didn’t have electricity, but that’s normal for where I come from.” - Native American youth living in NORCOR
- “There’s a Not In My Back Yard mentality - it’s becoming difficult to site low income housing facilities in our communities.” - Input from the Senior Advisory Council (SAC)
- “HUD does not respect pronouns, and is not respectful for non-cis-gender individuals.” - Gorge Pride Alliance
- “People looking for housing [can’t] go through all the HUD paperwork (40 pages long application). What about a housing advocate to help people navigate? Columbia Gorge Housing Authority is difficult to navigate. People lose their HUD vouchers because of lack of clarity in navigating.” - Gorge Pride Alliance
- “It’s hard to have a sense of community when you don’t have a home.” Bridges to Change participant in The Dalles
- “I’m shocked by the degree of homelessness over here. Klickitat County is worse than anywhere in the Gorge. It’s a disaster and it’s getting worse. We have a trailer park that’s being sold, and it’s resulting in 36 families getting evicted. There’s literally nowhere for them to go.” - Provider, White Salmon

FOOD

- “There are increasing health issues around eating healthy and this is due to how hard it is for families with low wages to be able to afford healthy foods.” - Latinx resident of Hood River
- “Nutrition and your diet are crucial to your physical, emotional and mental health.” - Input from Fit in the Gorge representative
- “The low income and homeless community we serve at Community Meal would benefit greatly if access to healthy food was easier and faster.” - Social Service Provider, The Dalles
- “The poverty in this area is often invisible to the rest of the public because of the rural nature of our area. Demand at the food bank is growing.” - Aging in the Gorge representative living in Hood River
- “People give a lot to food banks, but sometimes they don’t give you good food. You get a bunch of stuff you don’t need.” - Latinx youth living in NORCOR
- “You can buy beer and chips at the front [of a market] but have to go to the back for produce. The fact you can get drunk at a store before you can buy veggies is backward. Make people walk by veggies before they can buy booze. What about food stamps only for healthier food, or not including the worst food?” - Gorge Pride Alliance

- “Kids going hungry in school is a big problem in educational outcomes. Access to healthy foods is a basic building block to children's futures.” - Input from a Providence SAAC representative
- “We are currently involved with Frontier Veggie Rx Program and this is amazing and we feel like it is making such a big difference in our communities. People are able to be more secure in their food opportunities; become healthier and the whole community benefits from the stores carrying more and better fruits and vegetables.” – Condon resident

SENSE OF COMMUNITY

- “Giving back makes me feel a part of the community. I help the homeless, bring them food, act as a representative between them and other groups. I've been there, so they know me and listen to me.” - Person in recovery, The Dalles
- “If we are not together, what are we? You see people in the snow. It's hard to see that.” - Visitor to the Hood River Warming Shelter
- “Too many issues arise—physical and mental—that are related to feelings of isolation, a lack of inclusion and belonging. People are overwhelmed and can't advocate for themselves. It leaves them feeling isolated. If they could connect, they could support each other.” - White Salmon resident
- “I feel that there are some groups (non-white, non-affluent, rural, etc.) who struggle to participate in many of the activities which make our community attractive and welcoming. This is probably due to access. Firewalls like financial ability, language barriers and lack of transportation from affordable, outlying areas have fairly segregated this community.” - WAGAP respondent
- “There is lots of prejudice in our communities. It's mostly racial, but I also experience agism. Younger people will call me 'honey' or 'dear'. I just let it go, but I do notice it.” - Older adult living in Hood River County
- “Strength and support for all within the community is vital!” - Cascade Locks resident
- “[We need] open and accepting community activities with an emphasis on ensuring safe, trauma supportive messaging.” - Youth service provider in Wasco County
- “People at some employers are not allowed to share their gender, or correct people when they get mis-gendered. They are told they cannot share their gender because it will be confusing to people, and that it will disrespect the company. We need to model policies and procedures for businesses to use to be gender inclusive and supportive.” - Gorge Pride Alliance
- ““We are older and aging, and home alone, and really hard for us to take care of ourselves.’ Working age adults must leave elders at home so that they can keep their jobs.” - Input from Natives Along the Big River

BEHAVIORAL HEALTH

- “We need an in-patient substance use disorder treatment facility. [We have the] highest number of opioid prescriptions/frequent users cycling in and out of jail and not getting the rehab they really need.” - The Dalles resident, Fit in the Gorge

- “Calls to police related to people who are mentally ill have significantly increased in recent years. It shows great and increasing unmet need.” - The Dalles resident, Community Advisory Council
- “I should be able to get counseling if suicide is on my mind.” - Latinx youth on the Oregon Health Plan
- “Parents need help for their children with special needs and it almost seems as if this service is hiding.” - Latinx resident, Parkdale
- “Two of my children have been referred to local mental health counselors by our family's general practitioner. Unfortunately, the waitlist for pediatric mental health is currently closed to new patients or has a year-long wait list; our only recourse under our insurance policy is a drive into Vancouver or Portland. For regular weekly sessions for two growing children, this is an untenable situation. It is clear that our community faces many hurdles with mental health, but access to practitioners (especially pediatric providers covered by insurance) is at a crisis level.” - Medicaid recipient
- “So many older adults who are dealing with isolation, depression, or other mental health issues turn to alcohol or drugs to cope. It becomes a downward spiral and can affect all aspects of life.” - Input from the Aging in the Gorge Alliance
- “In Cascade Locks, there is a great need for substance abuse services - especially because we do not have 24/7 police coverage.” Resident of Cascade Locks
- “Current wait is 3 weeks to get into substance abuse clinic. I have a patient who cannot get clean without support, and I’m pretty certain that meth is going to kill him. He wants to get help and is willing to leave the Gorge and leaving his family to do it, if necessary, but there are no good options. The requirements for getting help at Lifeline in Vancouver are insurmountable for him.” - Provider, Skyline Hospital

YOUTH SAFETY

- “Youth suicide attempts and bullying [affect] Sense of Community.” - The Dalles resident
- “Having safe spaces for youth to hangout and learn new activities [is important].” Latinx resident of Hood River
- “The skate park is dangerous. It's a very unsavory situation. Drug dealers are all around. We need more after school programs; things kids can do.” - Oregon Health Plan recipient living in The Dalles
- “The youth are our future. We need to make sure everyone is stable.” - Native American resident of Hood River
- “As a parent, youth safety is important to me. I have a high school age child who sees vaping prolifically both in and out of school, including students vaping in bathrooms during class.” - Parent in The Dalles
- “Bullying is on the rise - time to stop it now.” - Resident of Home Valley, WA
- “Our children are our future. If they don't feel safe in their own community, this has a ripple effect on their health in the future.” - Latinx resident of Hood River
- “I do not feel that our youth are a priority in our community. They are an afterthought - not nearly enough upstream efforts. Links into sense of community. Lots of "Adult"

businesses (alcohol, vapes, marijuana) but where do we as a community support our youth? Lack positive adult role models.” - Youth service provider in The Dalles

TRANSPORTATION

- “People need the ability to navigate the community and especially for needed appointments and activities - beyond healthy appointments. [Lack of access to cycling and walking is a] public health issue and equity issue.” - The Dalles resident
- “There's no coverage to go shopping and they should provide more coverage on weekends. [There should be] more wait time available for disabled to get out to the bus or van.” - Disabled resident in The Dalles
- “We need a system with routes and lots of useful stops, as opposed to buses that just go to destinations. You can get a bus up to the college, but the buses skip all the places I need to go.” - Native American resident in The Dalles
- “Transportation can be a real safety issue - the train often stops on the only access road into the village - in an emergency, people cannot evacuate, and emergency vehicles cannot enter the village.” - Input from Natives Along the Big River
- “Sidewalks are nonexistent in The Dalles.” - Input from CAC representative
- “It's hard to get a job without transportation and without an income you can't find stable housing.” - Latinx youth living in White Salmon
- “Housing Affordability & Transportation and Mobility: These are two faces of the same problem. As housing near the commercial hubs in the Gorge grows unaffordable to households with even median incomes, housing that IS attainable becomes pushed into more rural areas. Rising gas prices and cost of vehicle ownership means that having more than one personal vehicle per household becomes at best burdensome, and at worst impossible, greatly complicating commutes to work, school and basic necessities.” - Input from WAGAP representative

DENTAL CARE

- “People should be aware of what all is available and the process to get a referral to dental. Dental issues can affect overall health.” - Oregon Health Plan recipient living in The Dalles
- “Dental health is important and minority groups don't always know proper dental care.” - Latinx youth living in Hood River
- “It's part of people's health and will give people more confidence and people need to be able to attend a dentist appointment.” - Latinx resident of Hood River
- “We have only one dental provider in our community for one day a week for many years. They also have not accepted OHP until very recently. We will now have to see if he will have the capacity to take on more clients that are on OHP. We have also started a pilot project this last year in tele-dentistry. We have an expanded practice dental hygienist who has started seeing patients in Arlington. She can provide a full dental exam and transfer all of that information virtually, then a dentist will look at the information and determine if there is further work required for that client and they can then be referred to go and

see the dentist to get those things fixed. This is a truly amazing program to have in our Frontier Rural county.” - Condon resident

- “Address the reality and prevalence of Dental Trauma as a barrier to dental health; people are afraid of the dentist, need anti-anxiety meds, so they put it off. So, what can the dentists do to ask if that exists, take it seriously, and offer tools and options to address it, in order to help patients come and actually USE the dentist?” - Gorge Pride Alliance

PRIMARY CARE

- “Very important to have access to an advocate to help find a PCP and where to go for assistance.” - Oregon Health Plan recipient living in The Dalles
- “I should be able to get a doctor and not die with medical bills.” - Oregon Health Plan recipient living in Hood River
- “There is no School Based Health Center in Wasco County.” - Medicare recipient living in The Dalles
- “Every practitioner should take an LGBTQ training. How to treat people, bathrooms you need, issues particular to trans people. Also, we need training on how to be ‘present’ with the actual human being that is there, instead of just entering data into a computer. Because trans folks are getting asked to do that training, to be on the advisory boards, to educate the providers. There should be a system-level support for this. And it should be mandatory.” - Gorge Pride Alliance
- “[We need] cultural competency and discrimination reduction among medical providers.” - Provider, Skyline Hospital
- “Some of us choose to live in rural areas and know that we will do without what larger areas have. Yet, people still grumble when they don't have the same services as the larger areas.” - Fossil resident
- “In a small town, it would be nice to have a local provider!” - Cascade Locks resident
- “There is a reluctance among many older adults to seek out preventative care. People don't want to go see the doctor because of the money, fear that it might be something awful or fear of immigration issues, or because they're ashamed for some reason. Instead, they'll just wait until it becomes an emergency.” - Aging in the Gorge Alliance representative
- “Older adults, especially those with early stage dementia, need to have the same provider each time, to build up that relationship. That's why the Community Health Workers are such a godsend. We need more of them.” - Medicare recipient in Hood River County
- “Primary care, behavioral health, and dental care are basic needs and should be considered (and provided) together.” - Hood River resident
- In The Dalles in particular we have seen high turnover of providers, a lack of affordable dental, and limited resources for mental health care outside of MCCFL. Our family left The Dalles to seek care in Hood River due to the constant turnover and lack of available appointments with providers in The Dalles. I recently had to book an appointment for physical therapy and availability was 3-4 weeks out. In my professional work with low-

income families, we also see families struggling to get the appointments they need with either long waits or unavailability with their PCP.” - Parent in The Dalles

HEALTH INSURANCE

- “Treatment options are limited if you don't have insurance.” - Lyle resident
- “Without health insurance it's very difficult to be a part of the healthcare system.” - Mosier resident
- “My insurance will no longer cover me once I turn 18. If I get sick or break something, I'll be screwed.” - Latinx youth living in Hood River
- “People are more apt to seek care if they have insurance and understand it.” - Lyle resident
- “Many people earn too much to qualify for Oregon insurance but still can't afford other insurance options.” - Latinx resident of The Dalles
- “I really don't have anything bad to say. I've always been on OHP and it's really helped me. I had a back injury and it paid for x rays, everything. My sister has epilepsy and OHP has paid for her seizure meds for 9 years.” - Latinx youth living in NORCOR
- “Just ‘Medicare’ doesn't suggest that a person has good coverage.” - Medicare recipient in The Dalles
- “Need health insurance for undocumented.” - Latinx youth living in Hood River

COLLABORATION & INFORMATION SHARING

- “When more people know what's going on there can be more help.” – Y.E.S. House youth participant
- “Consensual, informed info exchange - patients need to be a part of this process and have readily available transparent decision-making power on what is shared and with whom.” - Uninsured resident of Hood River
- “This is connected to Social Support and Effective Referrals. If we have a supportive group of doctors and specialists who can see our comprehensive care in its totality, it makes the patient feel listened to and helps them realize that perhaps one issue affects another.” - Latinx resident of The Dalles
- “Collaboration and information sharing for me relate to efficiency and quality of service. As an example, I see layers of agencies performing developmental screening and a lack of information sharing so children and families are going through repeated screenings. This can be seen in other ways too. When resources are limited, collaboration and information sharing allow us to maximize service delivery and patient convenience.” - Four Rivers Early Learning Hub representative
- “This can be good and bad - if you're talking to a counselor and they tell your doctor something without your permission, you won't want to talk to them anymore.” - Youth living in NORCOR

PHYSICAL ACTIVITY

- “Proven, equitable health outcomes.” - Mosier resident

- “Physical health is important. Folks need to feel empowered and educated on where to go.” - Latinx resident of Hood River
- “There's no gym in town, or a pool.” - Cascade Locks resident
- “We don't have enough economic earnings [to access] this.” - Latinx resident of Hood River
- “Exercising can make you feel better - like endorphins or something. You can exercise any time, you don't need special access or money, you can make it happen if you need to.” - Youth living in NORCOR

EFFECTIVE REFERRALS

- “I hear of providers not asking about food security because there isn't a referral process.” - Odell resident

Appendix B: New Priorities Mentioned and Select Quotes

The following topics were mentioned by individuals and/or community groups:*

New Topic	Unique Mentions
Health Education, Prevention & Promotion	13
Childcare	7
Services for Older Adults	6
Early Childhood Development	5
Living Wage Jobs	4
Access to Nature	2
Domestic Violence	2
Education	2
Leadership Development	2
Emergency Preparedness	1
Environmental Health	1
Support for Criminal Justice Involved	1
Workforce Development	1

Health Education, Prevention & Promotion

- “This allows people to stay well and have tools to work toward well-being.” - CAC member
- “What about wellness services? To help you maintain when you feel ok, and to even help people thrive? What if we could move not just from illness to wellness, but from wellness into thriving? Such as fitness classes covered, discussion about lack of access or knowledge about preventive health. Preventive health is so much cheaper than treating conditions.” - Gorge Pride Alliance

Childcare

- “If people can't work [because they can't access child care], they can't access health care, pay for food, housing and transportation.” - Hood River resident
- “Too few, too expensive, really distressing for parents.” - Youth Think representative
- “We need more affordable daycare for working parents.” - Latinx resident of The Dalles

Services for Older Adults

- “Medically fragile older adults often fall through the cracks, aren't getting social support when needed, do poorly, and become unsafe, unhappy, and/or unhealthy.” - Aging in the Gorge Alliance representative

- “Short term memory loss and dementia in older adults is growing rapidly as our population ages. It presents a huge burden on individuals experiencing dementia, and on their families and caregivers.” - Senior Advisory Council representative
- “In Gilliam County, there are a lot of seniors who want to stay in their homes, no help even for cleaning or people to check in on them. No Meals on Wheels out there.” - Senior Advisory Council representative

Early Childhood Development

- “[Need] more social emotional emphasis in care - schools & hospitals. Also pay attention to influence of screen/media.” - Input from Youth Think representative

Living Wage Jobs

- “Money is a huge determinant of health & wellness. Housing, food, transportation all stem from income.” - Hood River resident
- “Our area is expensive. Not all families can afford healthcare, childcare, social and recreational activities in this area.” - WAGAP representative

Access to Nature

- “Lots of impact on both physical and mental health. Create equitable accessibility.” - The Dalles resident
- “Proven health benefits.” - Mosier resident

Domestic Violence

- “Family. Healthy relationships. Work with prevention.” - Latinx resident of Odell
- “Families (and more importantly) kids will live with less stress.” - Latinx resident of Hood River

Emergency Preparedness

- “Food, water, shelter may be extremely limited in a disaster.” - CAC representative

Environmental Health

- “The Columbia River should be cleaner.” - Latinx youth living in Hood River County

Support for Criminal Justice Involved

- “Need for rehabilitation services for people transitioning out of incarceration.” - Input from Natives Along the Big River

Workforce Development

- “It's really hard to retain staff in the mental health field.” - Wasco Youth Services representative