2022 Community Health Improvement Plan (CHIP)

2022-2024 Implementation Strategy

OHSUHealth
Hillsboro Medical Center

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Executive Summary/Message from the President & CEO

Tuality Healthcare, doing business as Hillsboro Medical Center, is pleased to share our 2022-2024 Community Health Improvement Plan (CHIP). Reflective of our mission, vision, and values, we are committed to provide the best health care available for the citizens of Washington County. Since 2016, our clinical affiliation with OHSU has resulted in improved access for the community, bringing more providers and services to the community and thereby improving access to both primary care and specialty care.

At Hillsboro Medical Center, improving the health of our community is a fundamental role of our organization. Doing so includes the programs we build, the investments we make, and the strategies we implement. Knowing where to focus our resources begins with the 2022 Community Health Needs Assessment (CHNA). Hillsboro Medical Center partners with other organizations in the Portland-metropolitan area, comprising the Healthy Columbia Willamette Collaborative (HCWC). HCWC is committed to advancing equity in our communities, identifying priorities for our CHIP, and identifying activities that leverage collective resources to improve the health and well-being of our communities.

Hillsboro Medical Center prioritized the following areas where we can affect the most significant change. During the 2022-2024 time period, our focus areas are as follows:

- Focus Area #1: Access to Care/Equity/Culturally Responsive Care
- Focus Area #2: Mental Health and Substance Abuse
- Focus Area #3: Chronic Conditions/Preventive Health
- Focus Area #4: Prenatal/Parenting Education

The Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP) are conducted in accordance with the Patient Protection and Affordable Care Act (ACA), IRS Section 501(r)(3), which requires tax-exempt hospitals to conduct a CHNA and create a CHIP every three years. The 2022 CHNA and 2022-2024 CHIP were approved by the Hillsboro Medical Center Board of Directors on June 23, 2022 and were made widely available to the public through posting on the hospital website on June 30, 2022: https://tuality.org/about/community_benefit_report/. Printed copies are available at no charge, upon request.

As we resume operations closer to "normal," the Executive Leadership Team of Hillsboro Medical Center looks forward to focusing on these updated priority areas of improvement and reporting results at the end of the 2022-2024 CHIP process. We invite you to explore these documents and how we intend to address health concerns in our community and partner to achieve improvements in overall community health.

Lori James-Melsen

Lori James-Nielsen, RN, BSN, MHA
President and Chief Executive Officer
Hillsboro Medical Center and Clinics

Introduction/About Hillsboro Medical Center

Hillsboro Medical Center's Commitment to the Community

Established in 1918, Hillsboro Medical Center is a not-for-profit, community-based health care organization in Washington County, Oregon. With over 100 years of history in the community, we operate as an independent organization, governed by community board members. Aimed at providing for the health care needs of local community members, the organization provides significant funding to benefit our patients through community education, investment in community health, and support of our community partners.

As our population in Washington County continues to lead the Portland-metro area in growth, Hillsboro Medical Center is prepared to continue to provide excellent health care and a positive patient experience as we transform the delivery of health care.

Service Area

Western Washington County, from Aloha and Beaverton west to the Coast Range, including Hillsboro, Cornelius, North Plains and Forest Grove; roughly 250,000 people and growing.

Hillsboro Medical Center Locations

- Hillsboro Medical Center: 167 beds with state-of-the-art acute care and level 2 NICU
- Community Health Education Center
- Tuality 7th Avenue Medical Plaza
- Tuality 8th Avenue Medical Plaza
- Over 20 primary care and specialty clinics serving the residents of western Washington County
- ¡Salud! Services outreach program for vineyard workers

Medical Staff

Over 400 doctors and other healthcare providers.

Workforce

One of the region's largest employers, with approximately 1,300 employees.

Mission, Vision and Values

Our Mission

Using skill and compassion, we are building a healthier community by bringing quality clinical care and unparalleled service to our region, in partnership with our patients, physicians and health care professionals.

Our Vision

To be the health system of choice for our region, our patients, our providers, and our employees, by delivering the highest quality care at an exceptional level of service.

A Culture of Service to Our Community

Our mission and values statement implies a role for Hillsboro Medical Center that goes beyond providing services to patients. As an integral component of our community, Hillsboro Medical Center's employees, physicians and volunteers help comprise the very fabric of that community. Hillsboro Medical Center encourages each person to search for ways to give back to the community—in time, energy, and resources—that are personally meaningful, rewarding, and enjoyable.

A Culture of Service to Each Other

Serving our patients and our community begins with how we treat and interact with each other in the workplace. The building blocks of our working relationships are:

• People • Service • Quality • Stewardship

These four values, as expressed in our Mission and Values Statement, also shape how we care for our patients and customers, and how we sustain the health of our community.

A Culture of Service to Our Patients

People. We will care for our patients, their families and each other with understanding, concern, and helpfulness because we respect the right and dignity of all individuals. We will follow through as promised, deal honestly and consistently with patients and one another, behave in a professional manner and encourage open communication so that we maintain credibility and respectability.

Service. We will demonstrate quality, compassion, integrity and commitment to our patients, physicians, fellow employees, and the community. We will help patients achieve their best state of health. We will respond to changes in the community by designing and offering needed programs and services. We will offer our staff a positive and enriching

work experience, support and assist each other and reward excellence among staff members.

Quality. We believe that quality means exceeding our customers' needs, recognizing that customers include patients, their families, physicians, and fellow employees. We understand safety is a top priority which directly impacts the quality of patient outcomes.

Stewardship. We will be stewards to our community by maintaining a well-managed, efficient facility and return those resources in the form of high-quality, cost-effective healthcare services.

Annual Community Benefit Provided by Hillsboro Medical Center

Hillsboro Medical Center makes significant contributions to the community each year. Community Benefit includes the cost of free care provided to low-income community members, cost of free community-sponsored programs, and unpaid cost of providing care for government-insured community members.

Total community benefit spending by Hillsboro Medical Center in the most recent years included:

- FY18 $14,152,943
- FY19 $13,639,719
- FY20 $17,762,869
- FY21 $20,969,087

Financial Assistance/Planning for the Uninsured and Underinsured

Hillsboro Medical Center provides care for all patients, regardless of ability to pay. A financial assistance policy is in place to provide free or discounted services based on financial eligibility.

Financial Assistance Levels

- 100% financial assistance usually will be provided for households with gross family income at or below 300% of the Federal Poverty Level (FPL).
- 65% financial assistance usually will be provided for households with gross family income between 300% and 400% of the Federal Poverty Level (FPL). The 65% discount is applied to charges less the 35% self-pay discount.
- *Uninsured Patients*—for emergency and medically necessary care:
  - 100% financial assistance if gross family income is at or below 300% of the Federal Poverty Level (FPL).
  - 65% financial discount less the 35% self-pay discount.
- *Commercially insured patients*—for emergency and medically necessary care:
  - 100% financial assistance if gross family income is at or below 300% of the Federal Poverty Level (FPL).
  - 65% financial assistance if gross family income is between 300% and 400% of the Federal Poverty Level (FPL).

Applying for Financial Assistance

- Information about the financial assistance program is posted in the lobby areas of the hospital and in the 7th Avenue Medical Plaza. Financial Assistance information is also found online and on billing statements.

- Requests for financial assistance may be made verbally or in writing at any point before, during or after the provision of care.
- Information about the financial assistance policy may be obtained free of charge by phone, in person, or in writing.
- Financial assistance requests may be proposed by sources other than the patient, such as the patient's physician, family members, community or religious groups, social services or hospital personnel. Staff will reach out to the patient/responsible person in order to complete a screening.
- Anyone requesting financial assistance will be screened for eligible medical programs prior to being given a Financial Assistance Application, which includes instructions on how to apply.
- Consideration for financial assistance will occur once the applicant has completed Financial Assistance Screening and/or supplies a completed Financial Assistance Application with supporting documents, including verification of income.
- Dedicated staff screen all patients for financial ability to pay and assist them with insurance applications and preparing financial assistance documents.

Summary of the CHNA and CHIP Planning Process

Since community health is impacted by so many different factors within a community, the CHNA describes the current state of health of a specific community. It involves hearing from community members about their community strengths, resources, gaps, and health needs. CHNAs are used by hospitals, public health, and community-based organizations to create programs and services to improve the health of the community.

The 2022 CHNA was conducted as a rigorous process with other health care organizations in the four-county Portland-metropolitan area as part of the Healthy Columbia Willamette Collaborative (HCWC). HCWC is a unique public-private partnership that includes 14 hospitals, four health departments, and two coordinated care organizations (CCOs). HCWC is responsible for facilitating the alignment of efforts to develop a shared CHNA across the four-county region of Clackamas, Multnomah, and Washington Counties in Oregon and Clark County in Washington.

This unified and comprehensive approach assesses the overall health needs of the larger community, with a heightened focus on the social determinants of health as they impact marginalized and underserved communities. The CHNA aims to prioritize needs, eliminate duplicate efforts, leverage resources, and enable collaborative efforts in implementing and tracking improvement activities. This collaborative approach enables the creation of an effective, sustainable process with stronger community relationships.

Community health needs were identified through a comprehensive study of population, hospital, Medicaid, and community data specific to Washington County, Oregon. The findings in the CHNA are utilized to create the CHIP. The Director of Outreach and Engagement drafts the CHIP with input from the hospital leadership team and community subject matter experts including leaders from the Health Department and local community-based organizations. Identified needs that the hospital is best suited to address are prioritized, analyzed and assigned implementation strategies. The final draft is then presented to the hospital Board of Directors for review and approval.

Implementation strategies are monitored throughout the three-year time period to verify improvements are achieved. In the rapidly changing health care environment, Hillsboro Medical Center anticipates some strategies may change throughout the three-year process and will make necessary updates to the priorities.

Summary of the Community Survey Process—Equity and Community Voice

The 2022-2024 Community Health Improvement Plan (CHIP) presents results of the fourth community health needs assessment (CHNA) conducted by the Healthy Columbia Willamette Collaborative (HCWC). The CHNA relied on community voices and stories to identify and define the root causes of poor health outcomes that should be addressed through community improvement efforts. More than 300 people participated in community meetings and over 500 responded to an online survey. The process included:

37 community engagement sessions, seven of which were conducted in a language other than English. The top three race and ethnicity groups represented were Hispanic/Latinx, Black/African American, and White community members. Half of the community members spoke a language other than English. 311 community members participated in these sessions.

Community survey launched on September 30, 2021, which was open to the public for three weeks. It was available in ten languages. 503 people completed the survey.

The CHNA relied on the regional community voice to identify and define the root causes of poor health and utilized secondary data to understand the health outcomes within the community. The community shared ideas on how best to address these issues.

The goal of the survey was to identify health-related issues from the community's perspective and ultimately inform improvement processes and plans to create strategies to address the issues. The goal was to make the survey available to as many residents as possible during the timeframe. The survey was disseminated through both the Community Action Team (CAT) and HCWC partners, leveraging existing networks throughout the region, using contact lists and listservs to share a link to the electronic survey.

Summary of Key Data and Demographics from the 2020 Census

Health and Social Indicators

Economic disparities related to income, housing, and education impact the health of a community, particularly as they influence health literacy and access to services. Comparing demographic data from the 2010 and 2020 US Census, a number of statistics stand out within the Hillsboro Medical Center service area. Items likely to impact overall health within our community positively or negatively include (See Appendix C):

- Population growth in our service area leads the region
- Growth in the number of community members identifying as Hispanic/Latino in our service area is higher
- Percent of population born outside the United States in our service area is higher
- Percent of population speaking a language other than English at home is higher
- The poverty rate in our service area is lower
- Broadband internet subscriptions in our service area are higher
- Percent of population without insurance in our service area is lower
- Percent of population with a bachelor's degree in our service area is higher
- Homelessness in our community is significantly lower
- Prenatal care during the first trimester in our community is higher
- Food insecurity among children in our community is lower

Alignment with Oregon Health Authority and Washington County Public Health

The Oregon Health Authority assesses overall state health status regularly, creating a state-wide plan referred to as the Healthier Together Oregon PartnerSHIP. Public health needs are prioritized and may receive additional state funding appropriations to improve community health.

The Washington County Department of Health and Human Services utilizes the state data to identify priorities for improvement within the county. In the current 2020-2024 CHIP document, Washington County identified the public health priorities as:

- Improve access to health care, including primary care, behavioral health and oral health services
- Improve behavioral health outcomes, including mental health, suicide and substance use
- Build systems to improve well-being
- Attention to the county-level priorities is achieved through the CHIP Steering Committee and a complex structure of committees and councils assigned with improving their respective areas of responsibility for each area. Individual committees include:
- Healthy Communities Committee
- Access to Care Committee
- Older Adult Behavioral Health Committee
- Adverse Childhood Experiences (ACES) Collaborative
- Suicide Prevention Council
- Cross-Sector Navigation Committee

Hillsboro Medical Center works collaboratively with the Washington County Department of Health and Human Services and dozens of other local community-based organizations to create the implementation plan and also participates in the individual committees.

Summary of Priority Focus Areas

Community Health Improvement Plan (CHIP) Priorities

Priorities identified by the Oregon Health Authority and the Washington County Department of Health and Human Services guide the CHIP priorities. The CHIP identified the following four key priorities:

Identified priorities will be addressed through health service delivery, collaboration with other community agencies, community investments, and implementation of evidence-based programs and services. Hillsboro Medical Center adopted this CHNA as the basis for creating a CHIP and corresponding Implementation Strategies.

Hillsboro Medical Center will measure improvements through the identified Measurements/ Metrics identified within each identified focus area. These will be monitored regularly to assure improvements are achieved and sustained. Hillsboro Medical Center prioritized the following areas of focus according to where we can affect the most significant change. During the 2022-2024 time period, our focus areas are as follows:

- Focus Area #1: Access to Care/Equity/Culturally Responsive Care
- Focus Area #2: Mental Health and Substance Abuse
- Focus Area #3: Chronic Conditions/Preventive Health
- Focus Area #4: Prenatal/Parenting Education

Responsible departments and measurements/metrics have been identified to ensure focus and follow-through.

Health Needs Identified but not Addressed

The HCWC completed a crosswalk comparing the identified priorities with the Oregon Health Authority PartnerSHIP priorities. The crosswalk assures coordination of efforts across the state. The table below shows the alignment with Oregon's most recent State Health Improvement Plans and the CHNA's four priority areas. Check marks indicate areas of overlap:

State Health Improvement Plan Priority Areas		HCWC CHNA Priority Areas			
		A Neighborhood for All	Essential Community Services and Resources	Access to Culturally and Linguistically Responsive Health Care	Support for Family and Community Ways
Oregon PartnerSHIP 2020-2024	Institutional bias			✓	
	Adversity, trauma, and toxic stress		✓	✓	✓
	Behavioral health	✓	✓	✓	✓
	Economic drivers of health, such as housing, transportation and living wage jobs	✓	✓		
	Access to equitable preventive health care			✓	

Given other organizational priorities and the restraints of time, money, and expertise, Hillsboro Medical Center categorized interventions into four priority strategies. No single organization can address all the issues present in the community single-handedly. Through our partnerships, though, we are confident the other identified needs will be addressed by the community-based organizations.

During the 2022-2024 implementation period, Hillsboro Medical Center will not be addressing the priorities identified under "A Neighborhood for All" but will support community-based improvements in the areas of safe and affordable housing, physical safety in the community, and cultural displacement due to gentrification. These areas are more aligned with the roles of our partnering community-based organizations.

Implementation Strategies

Focus Area #1: Access to Care/Equity/Culturally Responsive Care

Objective: Improve access to primary care, with special emphasis on those covered by the Oregon Health Plan (Medicaid)

Interventions/Actions

Improve access to Spanish translations of website materials, patient documents, and MyChart electronic health record

Communicate availability of virtual visits, particularly to rural communities, seniors, etc.

Improve awareness of services through increases in social media followers: FB, Instagram, Twitter

Improve awareness of the availability of OHP insurance and HMC financial assistance program

Improve appointment scheduling process, Odeza and reminder texts/calls; show progress toward 60% *new patient* appointment scheduling within 10 days in ambulatory clinics

Support diversity in hiring of employees, providers, and residents

Promote activities and efforts of the HMC Diversity, Equity and Inclusion Committee

Continue Patient and Family Advisory Council to access patient input with diverse representation

Support HMC Residency program with diverse outreach opportunities

Hire Community Health Workers (CHW) to support patients in women's and children's services at HMC

Continue to expand Home Health services

<u>Community Partnerships</u>
Participate in Washington County Health Literacy grant to increase role of community health workers (CHWs) at HMC:

- Build CHW network capacity
- Provide insight to barriers related to accessing COVID-19 vaccines and education
- Adopt health literacy training tools

Improve referral process to community agencies, e.g., Community Action, county services, etc.

Fully implement automated Connect Oregon "Unite Us" social service referral platform in Epic for Medicaid patients

<u>Measurements/Metrics</u>
%Non-white employees
%Non-white residents
Sponsorships – financial support of non-profit community organizations
Scholarships – financial support for education
#High school students served with mentorship, education, internships
Trend: Virtual visits (primary care)
Trend: Social media followers
Trend: Billing screenings/referrals/support
Trend: Appointments scheduled within 10 days (primary care)
Trend: % referral appointments made
Trend: # patients served by Home Health

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

"Oregon's licensed health care workforce Is less racially and ethnically diverse than the population being served. 20% of Oregon's health care professionals reported speaking languages other than English; however, only 11.3% report advanced skills or being a native speaker of another language. Of this group, 9.4% report using a language other than English with a patient."

Focus Area #2: Mental Health and Substance Abuse

Objective: Participate in expansion of treatment programs in Washington County

Interventions/Actions
Promote availability of Improving Addiction Care Team (IMPACT) services at HMC Provide training for designated providers and staff in trauma-informed care Support awareness of Behavioral Health Consultant services integrated within HMC primary care clinics Community Partnerships Support expansion of supportive housing and affordable housing within the community Participate in "One Pill Can Kill" public fentanyl campaign Align with Washington County on the expansion of local mental health services: • Improved access to community programs • Expansion of Mental Health Resource Team (police/sheriff) • Reduced number of substance abuse patients brought to Emergency Department • Implementation of Center for Addictions Triage and Treatment (CATT) 2023 • Implementation of Substance abuse treatment center (sobering center) 2023 Measurements/Metrics Trend: #Hospitalized/ED patients who could have received care at CATT/sobering center #Staff and providers receiving training in trauma informed care #Clinic patients accessing BHC services #Inpatients referred to services through HMC IMPACT program

Focus Area #3: Chronic Conditions/Preventive Health

Objective: Improve access to preventive care and community education related to chronic conditions

Interventions/Actions

Provide community education to support community health:

- Diabetes: Diabetes Management, support group, outpatient consultations
- Cardiovascular disease: hypertension screening, CPR/AED/First Aid classes
- Stroke: BE FAST stroke awareness campaign
- Parkinson's and Alzheimer's Disease: Support group referrals
- Cancer: support group
- Advance Directives

Implement cancer screening campaign in concert with OHSU and Adventist: Colorectal cancer, Breast cancer, Prostate cancer. Lung cancer, Skin cancer

Community Partnerships

Promote community-wide availability of mobile units eg Breast Health Mobile Unit, ¡Salud!, Pacific, Virginia Garcia, Lions Club, Dental vans, etc.

Support growth of Hillsboro Food Co-op and new grocery stores in Forest Grove, North Plains, Aloha, Hillsboro

Provide healthy eating/nutrition information to the community

Participate in community events such as Farmer's Markets to provide health screening, wellness/nutrition information, and referral information

Participate in 10th Avenue visioning process to improve livability and connectedness for area residents and businesses

Support installation of internet access for low-income and rural residents, thereby making virtual medical appointments and education more readily available to the entire population

Support growth of a diverse health care workforce through collaboration with the Health & Education District partners, Hillsboro School District, and the Chamber of Commerce School-to-Career program

Support expansion of public transportation eg TriMet, MAX, bus/taxi passes, Council Creek Trail

Measurements/Metrics

#Attendee hours at community education classes/support groups
#Community contacts in screening campaigns
#Patients served by mobile mammography unit
#Patients served by ¡Salud! Services mobile unit
%County residents with internet access

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

25%	Nearly 25% of adults (18 years or older) reported being diagnosed with depression in 2019. This is higher than the United States at 19%.[48]
36% to 42%	Among high school students in the region (10th and 11th grade), 36% to 42% reported they felt so sad or hopeless they stopped doing usual activities almost every day for 2+ consecutive weeks over the past year (2018, 2019).[49]
62%	In 2020, 7% of preventable hospital stays were due to a primary mental health diagnosis. This rate increased to 62% when more than one diagnosis was included as a reason for the stay.[50] The age group 15 to 24 years, while representing only 5% of 2020 preventable hospital stays, accounted for: ‣ 23% of all suicide, ‣ 28% of depression, and ‣ 22% of all other mental illness-related inpatient stays.
1,197	There were 1,197 suicide deaths in the region (2018-2020) for an (unweighted) average rate of 16.3 suicide deaths per 100,000 people. The number of deaths had increased from 1,057 in 2014-2016 to 1,197 deaths.[51]

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

Focus Area #4: Pre-Natal/Parenting

Objective: Expand awareness of supportive services available to women and children

Interventions/Actions
Provide *Help Me Grow*, *Healthy Beginnings, and Braner Family Safety Resource Center* outreach and information to OB/GYN and family practice clinics to improve access to early pre-natal care Provide pre-natal/parenting classes in English and Spanish; offer in-person and virtual options Increase awareness of the OHSU providers (physicians and nurse midwives) in the OB/GYN Clinic Increase community awareness of the Doernbecher NICU/Pediatric Unit at HMC Increase community awareness of the Braner Family Safety Resource Center at HMC including infant safety, locking cabinets for medications, locking cabinets for guns, etc. Provide Car Seat Education Station at HMC to provide car seat education and resources to the community Provide outreach to pediatric clinics to increase awareness of HMC pediatric services, Braner Family Safety Resource Center, and pediatric specialty services coming to Orenco Station <u>Community Partnerships</u> Improve provider/staff awareness of patient eligibility for Washington County programs for families: Family Connects, Nurse-Family Partnership, Help Me Grow, Healthy Families, and WIC Participate in Baby Steps support group awareness campaign with OHSU Implement partnership between OHSU Doernbecher Injury Prevention Program and Washington County District Attorney's Office to distribute safe sleep kits to families <u>Measurements/Metrics</u> Full-time Washington County community health worker implemented to support HMC and Virginia Garcia patients. #Patients referred to Washington County women's and children's programs #Served by HMC Braner Family Safety Resource Center

Conclusions and Next Steps

Hillsboro Medical Center and the Healthy Columbia Willamette Collaborative (HCWC) demonstrated significant improvement since the previous Community Health Needs Assessment period. Implemented strategies can be found on the Hillsboro Medical Center website. Examples of HCWC accomplishments are included in Appendix A within this document.

The Executive Leadership Team of Hillsboro Medical Center looks forward to reporting additional results at the end of the 2022-2024 CHIP process.

For more information, to request a copy, provide comments or view electronic copies of current and previous community health needs assessments or improvement plans, visit About Us on our website at https://tuality.org/about/community_benefit_report/.

> "I was able to connect to neighbors through little neighborhood get-togethers, go to COVID-safe outdoor events center trans and queer people, collaborate with other disabled people online, and pool resources to buy things that none of us could afford alone."
>
> —Transgender Community Survey Respondent

Who to Contact for Questions or More Information

CHNA/CHIP Contact:

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Appendix A: Letter from the HCWC Partners – 2019-2022 Accomplishments

Letter from the HCWC Partners

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

Supportive Housing

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

Investments to Address Health Inequities

Since 2017, the region's major health providers have collectively invested in Project Access NOW, non-profit focused on improving community health and equity by providing access to care, services, and resources for the underserved and uninsured. To date, the regional health systems have invested more than $40 million to support health services for Project Access NOW's clients who are largely low-income, non-native English speaking, and identify as Black, Indigenous, or people of color. Project Access NOW has become a critical link for health access and education, particularly for underserved communities. Over the next three years, partners have pledged to contribute a total of $7.85 million, increasing their annual investment by over 55%.

COVID Response

Over the last two years regional Public Health Authorities, Health Systems, and Coordinated Care Organizations partnered with dozens of Community-Based Organizations to directly support their communities with essential resources and education. Together, hundreds of vaccine and testing clinics were held and reached people who may have been missed by a more conventional approach. The foundational partnership work we do throughout the CHNA and CHIP processes enables us to respond faster together when emergencies arise.

Appendix B: Participants in the CHNA/CHIP Process

Healthy Columbia Willamette Collaborative Members

Health System Members

- CareOregon
- Portland Adventist Medical Center dba Adventist Health Portland
- Hillsboro Medical Center (formerly Tuality Healthcare)
- Kaiser Permanente (Sunnyside Medical Center, Westside Medical Center)
- Legacy Health (Emanuel, Good Samaritan, Meridian Park, Mt Hood, Salmon Creek)
- Oregon Health & Science University
- Providence Health Services (Milwaukie Hospital, Portland Medical Center, St. Vincent Medical Center, Willamette Falls Medical Center)

Public Health Members

- Clackamas County Public Health Division
- Clark County Public Health
- Multnomah County Health Department
- Washington County Department of Health and Human Services

CCO Members

- Health Share of Oregon
- Trillium Community Health Plan

In addition to Hillsboro Medical Center's internal departments and leadership, community partners who reviewed and commented on the CHNA and CHIP include:

- Washington County Department of Health and Human Services
- Washington County Sheriff's Department
- Virginia Garcia Memorial Health Center
- Adelante Mujeres
- Centro Cultural
- Community Action Organization
- Aging and Veteran Services; DHS Aging and People with Disabilities
- City of Hillsboro, City of Forest Grove, City of Cornelius
- Hillsboro School District, Forest Grove School District
- Hillsboro Police Department
- HealthShare of Oregon
- Lifeworks Northwest/Hawthorn Crisis Center
- Neighborhood Health Center
- OSU Extension Services
- Pacific University
- Hillsboro Senior Center
- Parkinson's Resources of Oregon
- Alzheimer's Association

Appendix C: Key Census Data

2020 Census Data

U.S.	Oregon	WashCo	Hillsboro	Forest Grove	
331,893,745	4,237,256	600,811	106,447	26,225	Population, 2020 Census
308,745,538	3,831,074	529,710	91,611	21,083	Population, 2010 Census
7.5%	10.6%	13.4%	16.2%	24.4%	Percent Population Growth 2010-2020
76.30%	86.70%	79.60%	66.70%	81.60%	Percent White
18.50%	13.40%	17.10%	24.40%	23.80%	Percent Hispanic/LatinX
$64,994	$65,667	$86,626	$85,586	$69,513	Household Income
$35,384	$35,393	$41,015	$38,162	$30,180	Per Capita Income
11.4%	11.0%	7.5%	9.3%	10.7%	Poverty Rate
88.5%	91.1%	92.6%	90.4%	91.4%	High school graduation rate
85.2%	88.1%	92.5%	93.1%	86.9%	Broadband Internet Subscriptions
21.5%	15.3%	24.8%	30.8%	18.6%	Households, language other than English at home
10.2%	8.6%	6.9%	7.0%	5.2%	Percent of population without insurance
NA	NA	11.0%	NA	NA	Percent of population with Medicaid/CHIP
13.5%	9.8%	17.9%	20.5%	9.8%	Foreign-born
32.9%	34.4%	44.9%	41.4%	31.0%	Bachelor degree or higher
8.7%	9.9%	6.9%	7.2%	9.2%	Disability
		83.9%			Adequate prenatal care (baseline 72.9 in 2008)
		78.0%			Childhood Immunizations (baseline 69% in 2014)
		808			Homeless (227 unsheltered, 496 shelter, 85 transitional)
		12.1%			Percent of children with food insecurity
	15%	8.8%			Percent receiving SNAP assistance (40% working families)

Cover photo acknowledgment: Andrea Johnson