Healthy Columbia Willamette Collaborative

2022 Joint Community Health Needs Assessment reviewed and approved by the Tuality Healthcare (dba Hillsboro Medical Center) Board of Directors June 23, 2022.

Community Health Needs Assessment

2022

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

Reader's Guide

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

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

This report is divided into nine sections:

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

Reading the first part of the report—from the Overview and Approach to the CHNA —will provide context for the rest of the report. The CAT defined what a healthier community is and defined the priority areas, using their own experience together with larger community member data collection. Each priority area has its own section. Priority areas describe the drivers of the health behaviors and outcomes in the region. This section is then followed by the three priority health outcomes identified by the CHNA.

The CHNA concludes with recommendations for HCWC partners and other community members for their health improvement planning efforts.

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

Table of Contents

Land Acknowledgement

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

Letter from the Community Action Team

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

Our team, the Community Action Team (CAT), met monthly to guide the process and ensure the stories and information collected and presented here reflect and align with our communities' experiences. We are committed to seeing a change in our communities and know that change must begin with community-informed approaches that elevate and honor our communities' lived experiences, wisdom, strengths, and decisions. To that end, we have adopted a storytelling model for this CHNA and within our CAT meetings. Our meetings were opportunities for storytelling, where we learned from each other and each other's cultures and centered our health and well-being through the stories we shared.

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

We hope that people reading this report find the information useful, easy to access, and representative of our diverse communities in the region. We hope that it serves as a catalyst for change and improvement so our communities get the services and supports needed to thrive.

Be well,
THE COMMUNITY ACTION TEAM

Letter from the HCWC Partners

The Healthy Columbia Willamette Collaborative (HCWC) partnership is committed to responding to identified needs within our shared communities. Our partnership, which includes seven hospital systems, four County health departments, and two Coordinated Care Organizations, is uniquely positioned to assess and strengthen the health of our region. We 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 returning to stable, affordable housing.

Investments to Address Health Inequities

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

COVID Response

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

EXECUTIVE SUMMARY

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

The CHNA was designed to be a community-informed process, one that:

- Deepens community partnerships
- Centers and emphasizes community wisdom
- Tells a story that reflects lived experience
- Has community informing and influencing critical decision making

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

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

FIGURE 1 PRIORITY AREAS

A Neighborhood for All

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

Access to Culturally and Linguistically Responsive Health Care

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

Essential Community Services and Resources

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

Support for Family and Community Ways

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

FIGURE 2

OVERVIEW

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

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

HCWC Partners

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

"Health is all about understanding the needs of not only yourself but those close to you and your community. And when you understand your needs and your community needs, then that's when things can start to change". –

BIPOC Youth Community Session Participant

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

APPROACH TO THE CHNA

The CHNA was designed to be a community-informed process, one that:

- Deepens community partnerships
- Centers and emphasizes community wisdom
- Tells a story that reflects lived experience
- Has community informing and influencing critical decision making

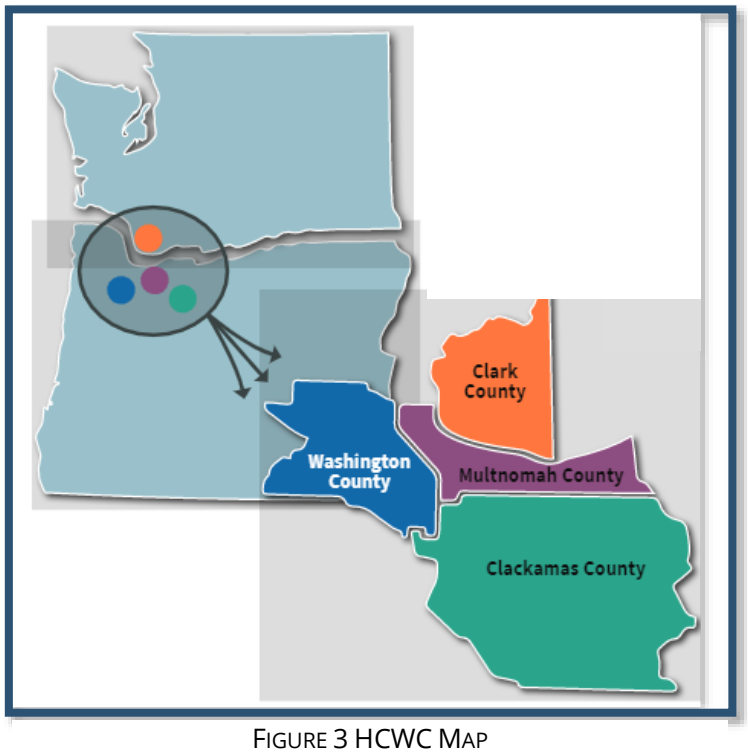


FIGURE 3 HCWC MAP

This approach, one that relied upon the input of a Community Action Team (CAT), originated from HCWC's desire to increase the role of communities in developing these needs assessments and committing to advancing health equity.

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

When people consider what most impacts a person's health, they often think only about an individual's choices, such as whether or how often they exercise and go to a doctor. But focusing *only* on individual behavior makes it hard to see structural causes of health inequities. Community members engaged in the CHNA process spoke to types of structural causes.

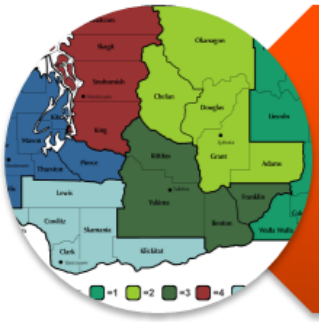
These health inequities result from a history of unjust, inequitable resource allocation, systematic bias, institutional racism, classism, and ableism that contribute to poorer health outcomes for some.[1]

Health inequities show up in individual's lives and community stories in the following ways:

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

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

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



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

FIGURE 4

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

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

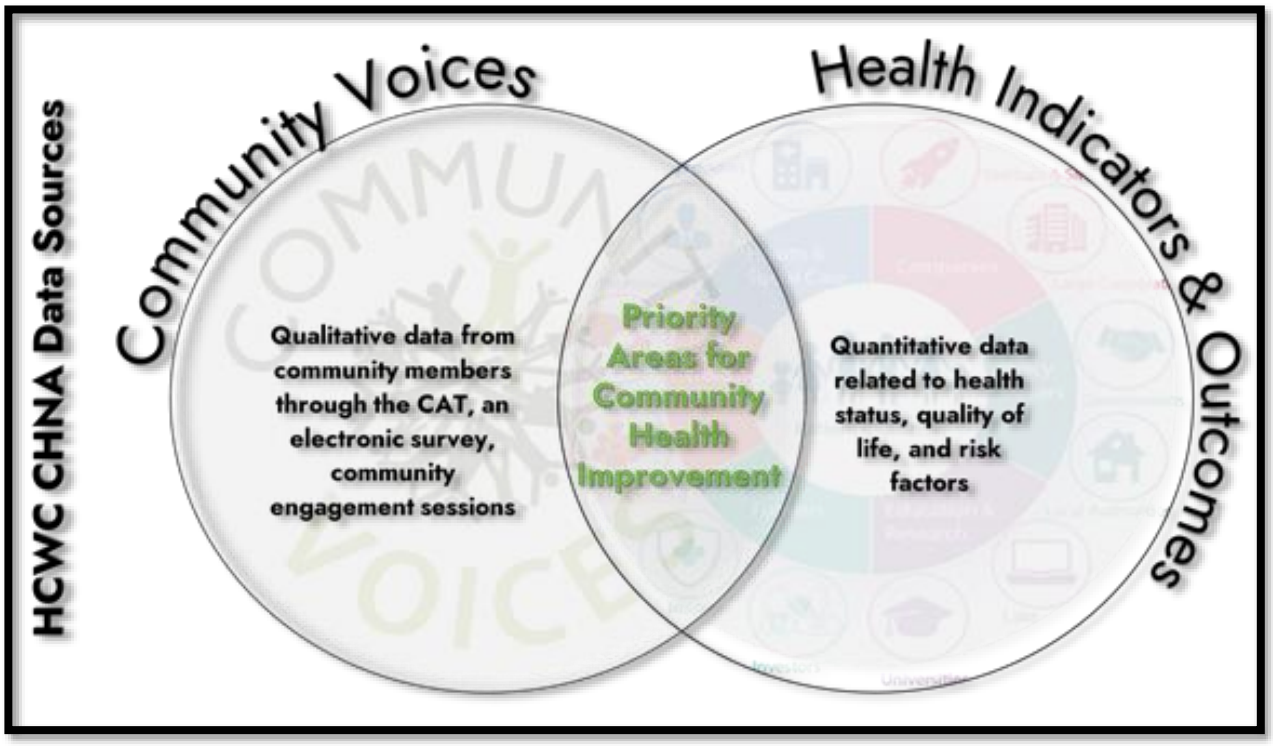


FIGURE 5 HCWC CHNA PROCESS

Community Voices

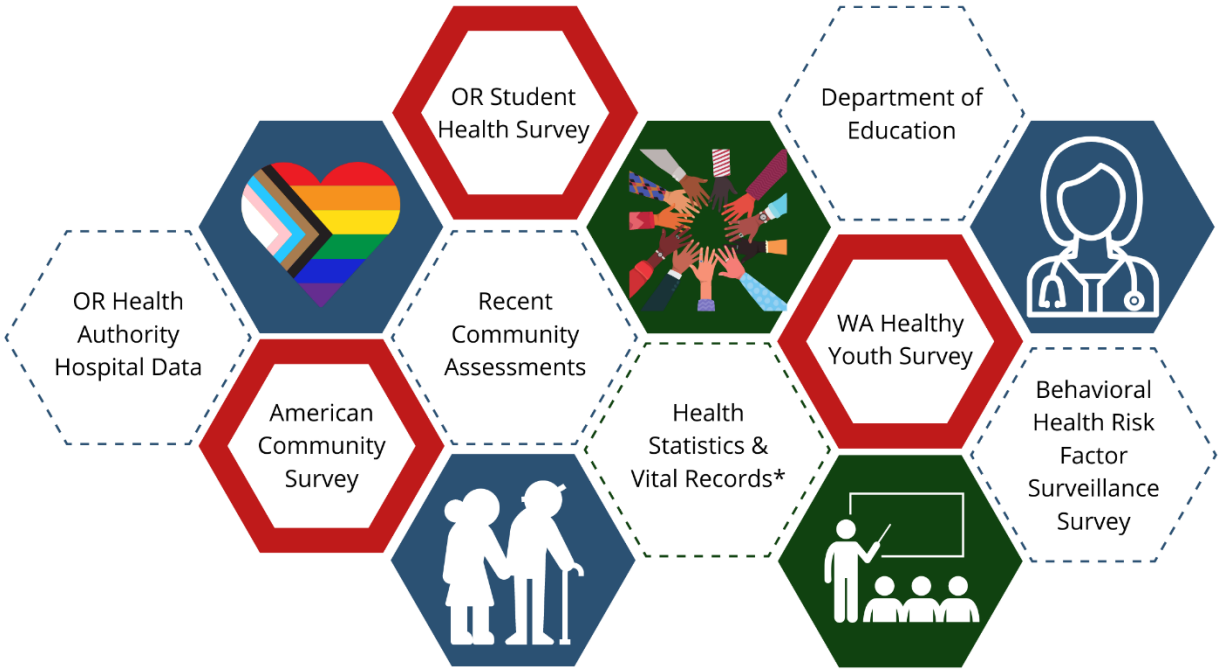
The CHNA relied on community voices and stories to identify and define the root causes of poor health outcomes that should be addressed through community improvement efforts. More than 300 people participated in community meetings, and over 500 responded to an online survey.

- Completed 37 community engagement sessions, seven conducted in a language other than English, engaging 311 community members. The top three race and ethnicity groups represented were Hispanic/Latinx, Black/African American, and White community members. Half of the community members spoke a language other than English. **See Appendix C for CE session protocol and Appendix F for participant demographics.**
- Launched the community survey on September 30, 2021, which was open to the public for three weeks. It was available in ten languages. Five hundred three people completed the survey. **See Appendix C for the survey instrument and Appendix G for survey respondent demographics.**

Health Indicators and Outcomes

Quantitative data was used in the CHNA to compare and identify health trends by looking at how an indicator has changed over time. This helps to understand the changing needs of communities to plan and prioritize ways to approach disease prevention and health promotion. The data sources[ii] used in the CHNA are described in Figure 6.

FIGURE 6 DATA SOURCES



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

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

Forces of Change

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

Populations of Focus

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

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

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

FIGURE 7 FORCES OF CHANGE

The list of prioritized communities included:

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

THE HCWC REGIONAL PROFILE

The demographic characteristics of a population are important in understanding the health risks, challenges, strengths, and opportunities of a region. Aspects such as race and ethnicity, age, and gender are closely linked to health outcomes. Socio-economic factors such as income and education are likewise associated with health risk and protective factors and outcomes.

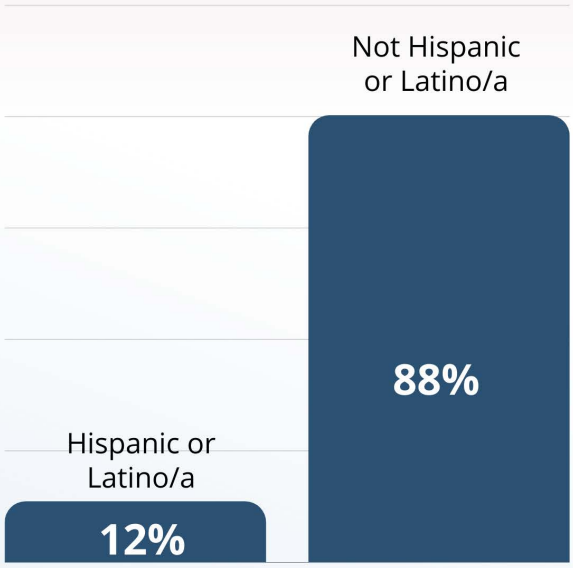
Subsequent sections of the CHNA help explain with specificity in context *why* there is variation in characteristics described below among different demographic groups. In short, this variation reflects the impacts of structural and systemic barriers and oppression such as racism, colonialism, ableism, sexism, and other determinants of health and equity. This section displays important demographics for the region. Appendix E includes demographic profiles by county.

Demographics
Quad County Region

Total Population: 2,277,802

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

Increase from 2009: 13%
Not Hispanic or Latino: 88.0%
Hispanic or Latino (of any race): 12.0%



Race and Ethnicity

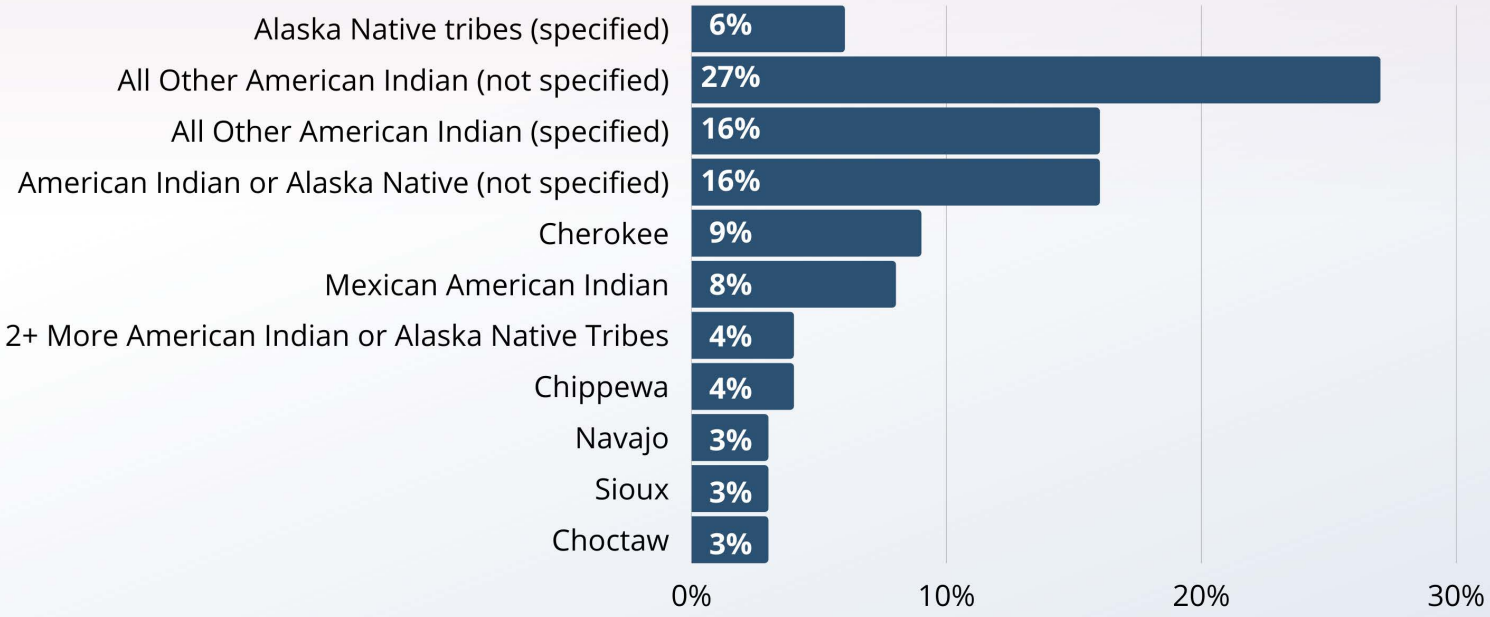
Count of individuals by racial group

Data source: American Community Survey, 2015-2019

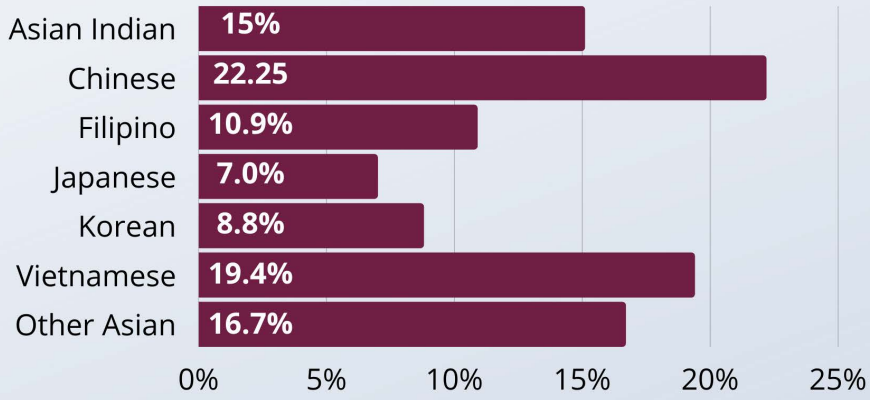
Racial Subsets

Quad County Region

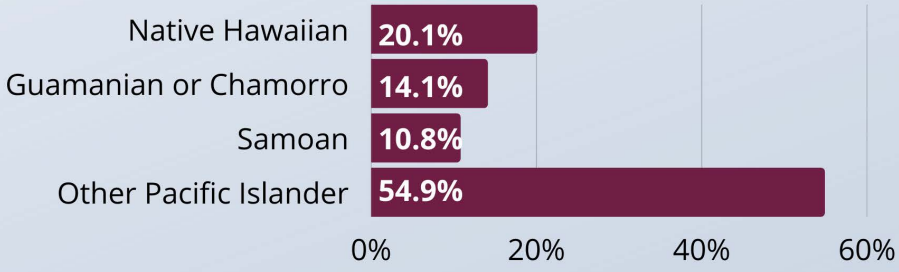
American Indian & Alaska Native 0.7%



Asian 9.7%



Native Hawaiian & Other Pacific Islander 0.7%



Data source: American Community Survey, 2015-2019

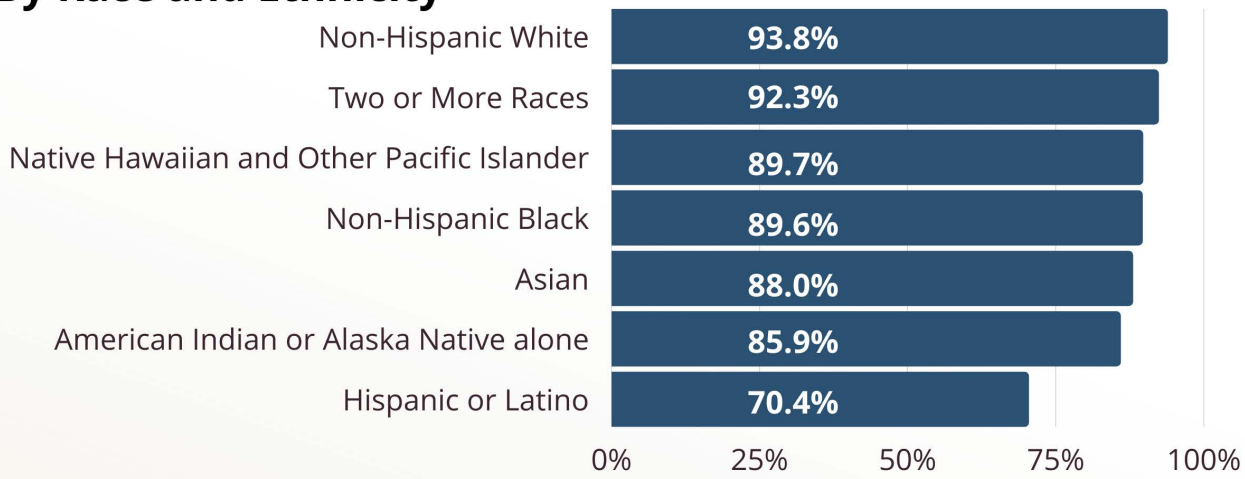
Educational Attainment

Quad County Region

Highschool Diploma or Equivalent

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

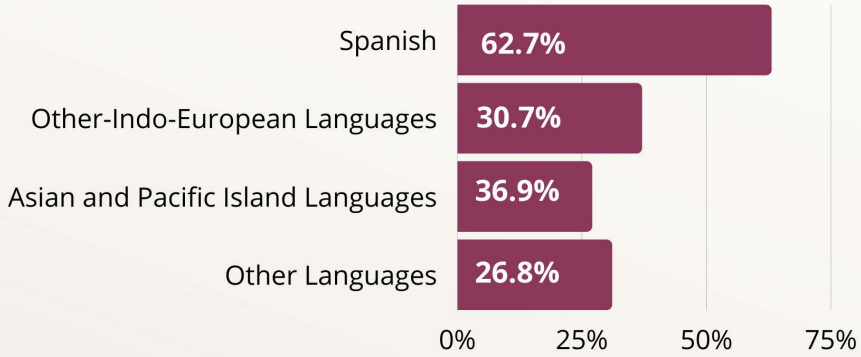
By Race and Ethnicity



Languages Spoken Other than English

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

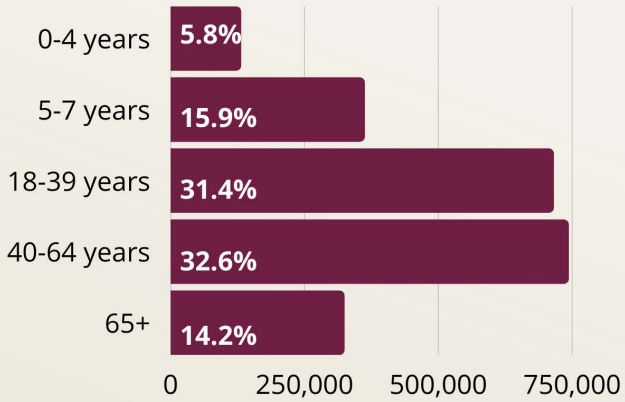
Linguistically Isolated Households (No member of the household 14 years or older speaks English "very well") (2019): 3.2% or 72,890 individuals



Languages Spoken by Age

Language and literacy are central to understanding health information and navigation. In the region, 21% or 500,000 people speak a language other than English

Residents Five years+ who speak a language other than English: 21% or 500,000 individuals



Data source: National Low Income Housing Coalition (Out of Reach 2020) - minimum wage
Data Source: American Community Survey, 2015-2019 - Linguistic

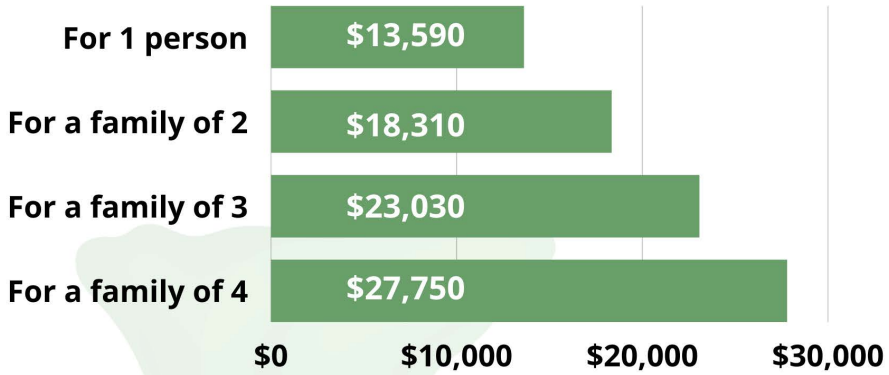
Financial Security

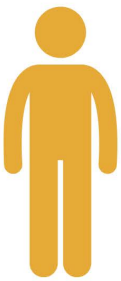
Quad County Region

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

2020 Minimum Wage: $13.30

2022 Federal Poverty Guidelines
Maximum Annual Household Income





= 50,000 people

Individuals Living at or Below the Poverty Level

10.5% or 240,047 individuals

Individuals in families whose income is below the federal poverty level.

Individuals Living in Deep Poverty

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

Children 17 Years or Younger Living in Poverty

26.4% or 64,963 children

People living with at least one disability who are at or Below the Poverty Level

11.6% or 265,224 individuals

People born outside of the US who are living at or Below the Poverty Level

13.1% or 298,392 individuals

Priority Areas in Creating a Healthier Community

A healthy community is one where all citizens have what they need to be as healthy as possible – like access to social and economic resources, quality education, clean environments, quality and culturally responsive health care, clean environments, and safe and inclusive neighborhoods.[2] These conditions are connected and impact the health outcomes for the community members of the HCWC region. This CHNA explored these conditions, or drivers of health, to better understand how we might take steps to improve the health and well-being of all who live in the region.

Across the priority populations, a key factor identified in protecting, supporting, sustaining, and advancing health, healing, and wellness for their communities was a sense of connection or community connectedness. Many community members stated that they relied on their social networks when they did not want to or could not access or use the health care system.

Research suggests that supportive relationships with family and friends and healthy behaviors, like engaging in physical activity and getting better sleep, appeared to protect against the harmful effects of the pandemic on both physical and mental health.[3] For many, the government-mandated social isolation requirements and lockdowns during the COVID-19 pandemic deprived people of social support from friends, family, and other community support systems.

Understanding the conditions and characteristics that promote or hinder health is necessary to create a healthier community. The CAT identified and prioritized needs and characteristics into four key priority areas (Figure 8) and assessed them in the CHNA.

Areas of Focus

Each priority area includes areas of focus based on the shared community stories and other data, as shown in Figure 8. More in-depth information on each priority area and focus area is provided in this report.

Areas of Focus

FIGURE 8 AREAS OF FOCUS

A NEIGHBORHOOD FOR ALL

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

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

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

Three priority issues emerged in A Neighborhood for All

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

A Neighborhood For All

Physical Safety in the Community

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

Cultural Displacement Due to Gentrification

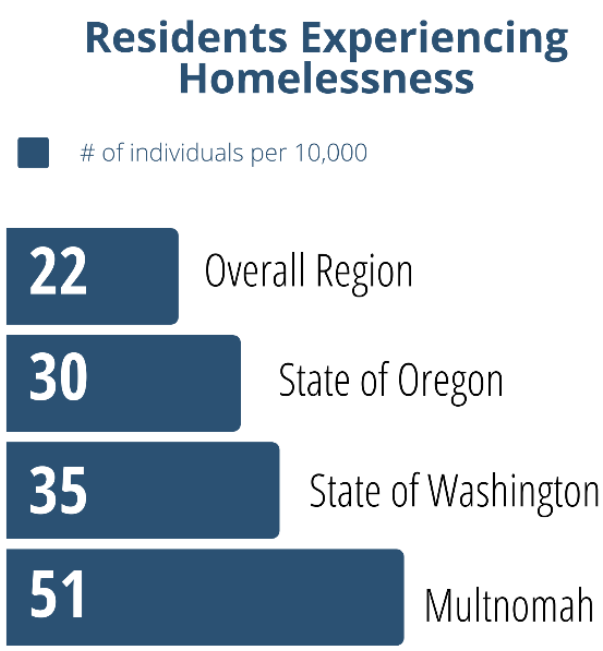
- Displacement due to gentrification disproportionately impacts people of color who are often pushed away before they could benefit from increased property values and opportunities in revitalized neighborhoods. (HCWC CHNA Community Engagement)
- Data suggests communities of color within the region are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

Safe & Affordable Housing

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

Safe and Affordable Housing

Safe and affordable housing can provide a safe place for families to live, learn, grow, and form social bonds**.** The average number and rate of people experiencing houselessness in the region are generally lower at 22.2 per 10,000 people compared to Oregon or Washington at 30.1 and 35.0, respectively.[4] This means that for every 10,000 people in the region, there were about 22 people experiencing houselessness. Multnomah has significantly higher unhoused rates than the region at 51.2 per 10,000 people.



INFOGRAPHIC 1

Since 2016, the total unhoused population in Oregon has increased 1.7 percentage points from 33.0 to 34.7 per 10,000 people. This was a 9.1% increase in the number of people unhoused, from 13,328 people in 2016 to 14,655 people in 2020.

Since 2016, the total unhoused population in Washington has increased 1.0 percentage points from 29.1 to 30.1 per 100,000 people. This was also a 10.0% increase in unhoused people, from 20,827 in 2016 to 22,923 in 2020.

Housing is often the single most significant expense for a family. When too much of a paycheck goes to paying the rent or mortgage, this housing cost burden can force people to choose between paying for other basic needs such as utilities, food, transportation, or medical care.

Among all households in the region, the severe housing cost burden[iii] had decreased two percentage points from 16.5% in 2015 to 14.6% in 2019, while dropping one percentage point among renting households, from 24.4% to 23.4%.[5]

While the median household income had increased 16.1% between 2015 and 2019, the change in average rent rose 18.9% over the same period (from $1,114 in 2015 to $1,360 in 2019).[6, 7]

[iii] Severe housing cost burden is defined as the percent of households spending more than 50% of income on housing.

Using data from the Rental Assistance Priority Index, Figure 9 shows the need for rental assistance by zip code. The level of need is based on how at-risk people are for unstable housing due to historical and COVID-19 risk factors.[iv]

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

"Neighbors and local businesses provided tremendous support during the challenges of this past year in COVID-19 pandemic". – Clackamas Community Survey Respondent

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

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

"The supports that would probably be the most helpful for my community's health and wellness would be housing assistance, utility assistance, and paid work that meets Portland's more expensive standards of living". –

Black LGBTQ2IA Community Session Participant

iv The index estimates the level of need in a census tract by measuring the prevalence of low-income renters who are at risk of experiencing housing instability and homelessness. To do this, it examines neighborhood conditions and demographics. For more information about the index, visit https://www.urban.org/sites/default/files/2020/08/24/where_to_prioritize_emergency_rental_assistance_to_keep_renters_in_their_homes_technical_appendix.pdf

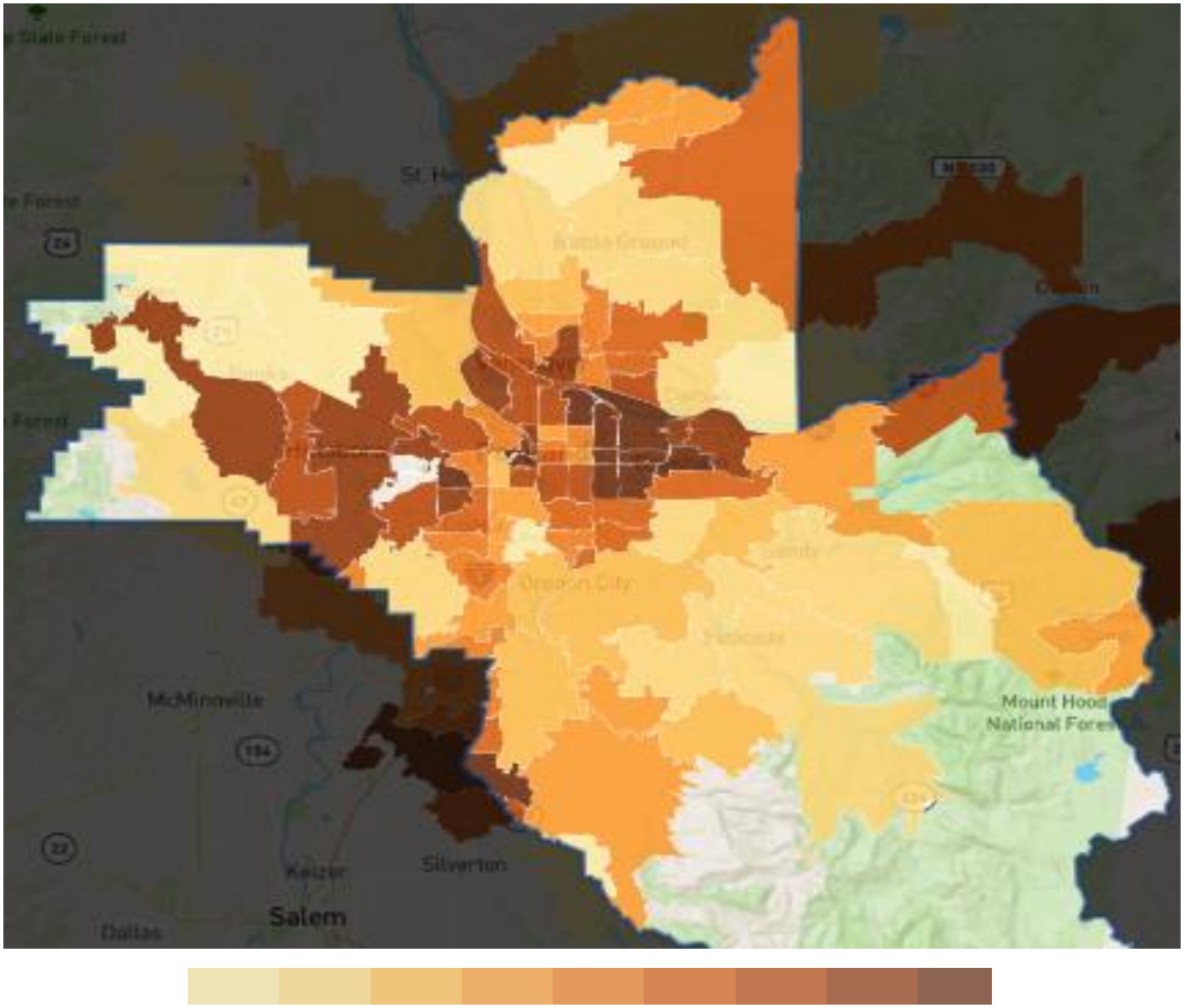


FIGURE 9 NEED FOR RENTAL ASSISTANCE

Dark brown areas on the map reflect areas with a greater need for rental assistance and most at risk for unstable housing.

Physical Safety in Community

When there is a lot of violent crime in a community, people may feel less safe. Higher crime rates can also stop residents from following healthy behaviors, such as exercising outdoors. Additionally, exposure to crime and violence has been shown to increase stress, worsening high blood pressure and other stress-related disorders.[8] These illnesses can include upper respiratory disease and asthma.[9]

Regionally, from 2016-to 2020, the violent crime rate was 342.7 crimes per 100,000 residents. This rate is higher than both Washington and Oregon States, at 291.9 and 293.7.[10]

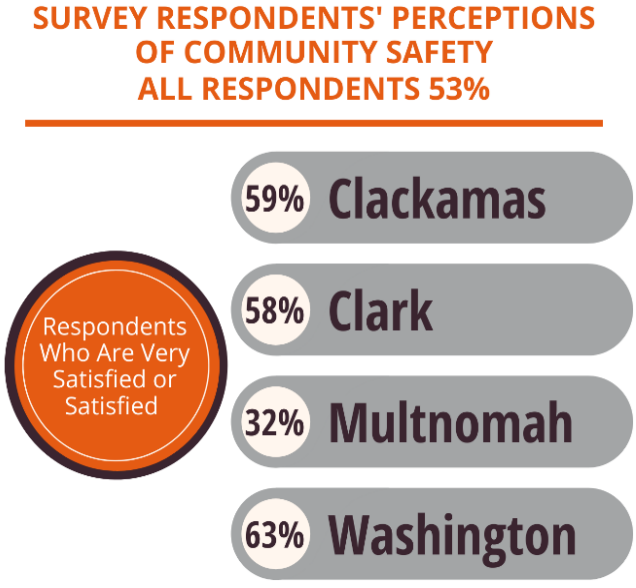
"I can walk freely without concern of being attacked. Can breathe fresh air. Can park my car without concerns of it being broken into or vandalized. Can get good groceries. Have access to a library and health care. Ability to walk through beautiful spaces with landscape and art". –
Clackamas Community Survey Respondent

The violent crime rate for the region has increased 13% in the last five years, from 302.8 to 342.7 crimes per 100,000 residents. The crime rate has not changed in the United States.

Multnomah experienced the highest rate at 541.0, Clark at 296.3, Washington at 222.6, and Clackamas at 185.4 crimes per 100,000 residents.

The rate in Clark increased by 22% between 2016 and 2020 while increasing by 13% in the region.

Due to systemic racism and other structural oppressions, racial and ethnic minorities and people with low incomes are more likely to live in neighborhoods with a higher risk of violence or other safety risks.[11] While over half of the CHNA community survey participants (53%) reported they were satisfied or very satisfied with the safety of their community, people of color, LGBTQ2IA, and people with disabilities were less likely to feel the same way. Protection from violence and safety as pedestrians were the main drivers for these community members.



Source: HCWC CHNA Community Survey
INFOGRAPHIC 2

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

Community members reflected on the importance of community safety related to their health. Not feeling safe keeps them from getting services, such as going to get groceries, participating in outdoor activities, or getting the care they needed. The health burden of living in constant stress was associated with living in an unsafe neighborhood for other community members.

Cultural Displacement due to Gentrification

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

One such program, such as the 2017 Federal Opportunity Zones, continues to promote the renewal of areas that have faced lost investment.[12] While investments can improve neighborhood conditions, reduce crime rates, and increase property value, there is a debate over who will benefit from these investments and who will be harmed. It can equally foster adverse conditions associated with poorer health outcomes, such as breaking up social groups, loss of cultural organizations and neighborhood businesses, and increases in stress.[13]

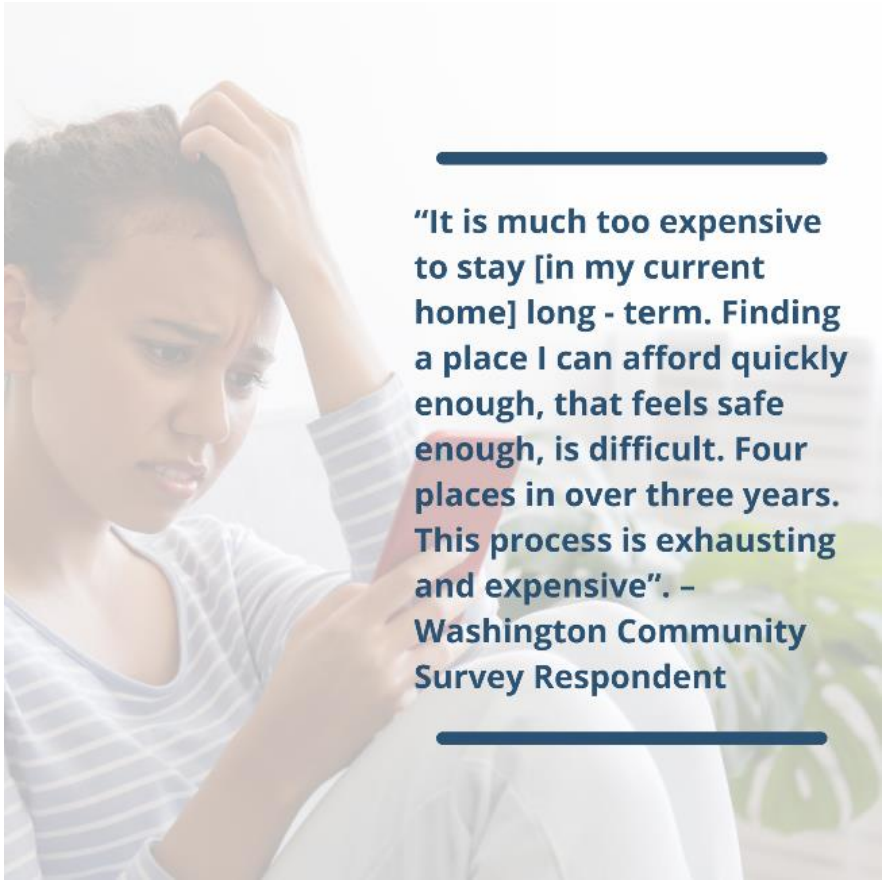
Displacement disproportionately impacts people of color, who are often pushed away before they could benefit from increased property values and opportunities in revitalized neighborhoods, as shown in Table 1.[14] In both Oregon and Washington, the proportion of Black and Hispanic/Latinx populations are higher in the designated opportunity zones than in all other regions. For example, in Oregon, the Hispanic/Latinx population represents 17.6% of the people living in designated opportunity zones, higher than all of Oregon's tracts at 11.6%. These populations have the potential to benefit from programs such as the Opportunity Zones if they have the resources to stay.

TABLE 1

Average Percent of the White, Black, and Hispanic/Latinx Population				
	Oregon		Washington	
Demographic (average %)	Designated Opportunity Zones	All state census tracts	Designated Opportunity Zones	All state census tracts
White alone	70.3%	78.2%	62.6%	71.6%
Black alone	2.1%	1.7%	5.3%	3.4%
Hispanic/Latinx	17.6%	11.6%	15.4%	11.3%

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

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



ESSENTIAL COMMUNITY SERVICES AND RESOURCES

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

Access to essential community services and resources provides a foundation for a healthier community. Economic opportunity, social connection, and geography drive the services or resources available to a community. Having a living wage, secure employment, and education can strengthen access to health care. Increased choice in housing, education, health care, childcare, and food also impact individual and community health.

Five priority issues emerged in the area of Essential Community Services and Resources:

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

Essential Community Services & Resources

Economic Opportunity

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

Educational Opportunity

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

Cultural & Healthy Foods

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

Economic Opportunity

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

The ongoing stress and challenges linked with having a low income can lead to numerous impacts on both physical and mental health. For example:

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

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

Note: County data by race and ethnicity are not yet available for 2021. Source: Bureau of Labor Statistics. Geographic

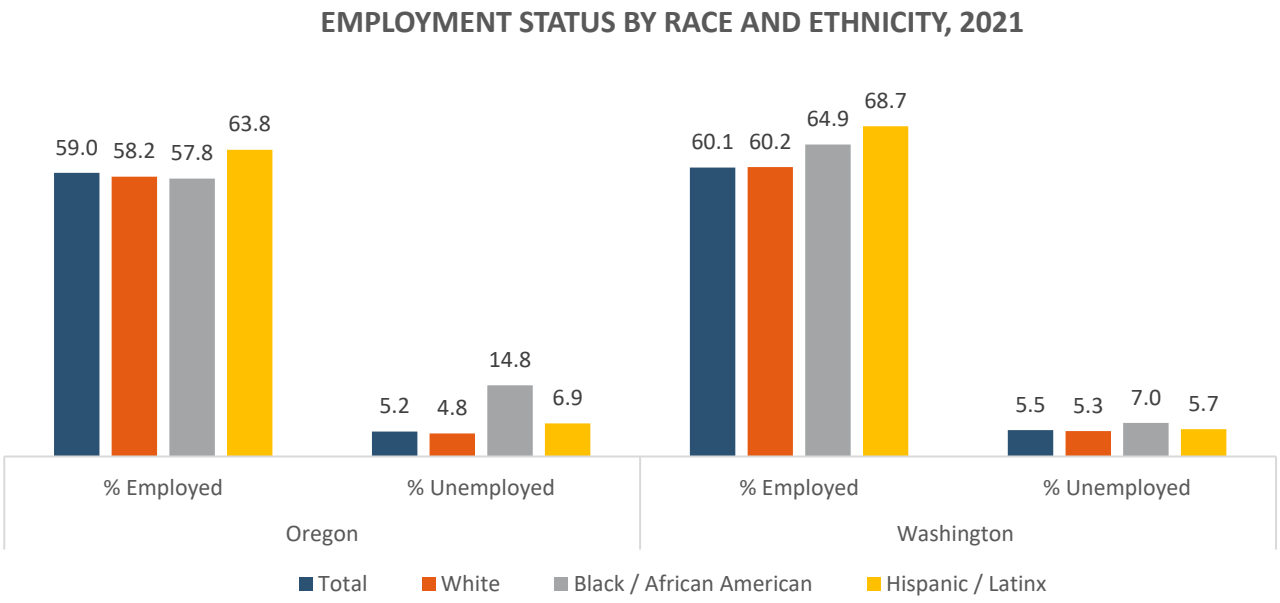


FIGURE 10 EMPLOYMENT STATUS, 2021

Profile of Employment and Unemployment, 2021. Retrieved on 2/9/2022.

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

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

[v] Percent of residents 16 and older in the civilian labor force who are actively seeking employment. Regional estimates are unweighted averages. Source: American Community Survey, 2015-2019 Combined Estimates, Table S2301

[vi] Percent of residents 16 and older in the civilian labor force who are actively seeking employment. Regional estimates are unweighted averages. Source: American Community Survey, 2015-2019 Combined Estimates, Table S2301

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

From 2015-to 2019, 5.3% of residents in the region had employment yet remained in poverty.[18] The average minimum wage in the area is $13.30. According to the Center for Women's Welfare Self-Sufficiency Standard[19,] the minimum wage to be a single self-sufficient adult in the region is higher at $16.22. This increases to $31.90 if that adult is caring for an infant. The current minimum wage is inadequate economic support for the region's residents.

[vii] Hispanic/Latinx workers represent the largest nonwhite racial group in the workforce but are the most underrepresented group across the state workforce (8% of the state's workforce but 13% of Oregon's population).

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

INFOGRAPHIC 3

Community members described the value of career development training and employment pipeline opportunities. These opportunities were thought to help bring more individuals into the formal workforce and provide a living wage and professional advancement opportunities. There was a sense that there were not enough of these kinds of options.

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

Community Session Participant with a Physical Disability

Educational Opportunity

Educational opportunity refers to the belief in quality education for everyone. Education benefits individuals and society, with more schooling linked to higher incomes, better employment options, and increased social support.[20] Historical and ongoing racism, discrimination, and exclusion prevent a quality educational opportunity for all.[21] As shown in Figure 11, the likelihood of having at least a high school degree is more significant for some race and ethnicity groups, including White and multiracial groups. Some other race and Hispanic/Latinx groups were least likely.

Source: American Community Survey, 2015-2019, Table S1501.

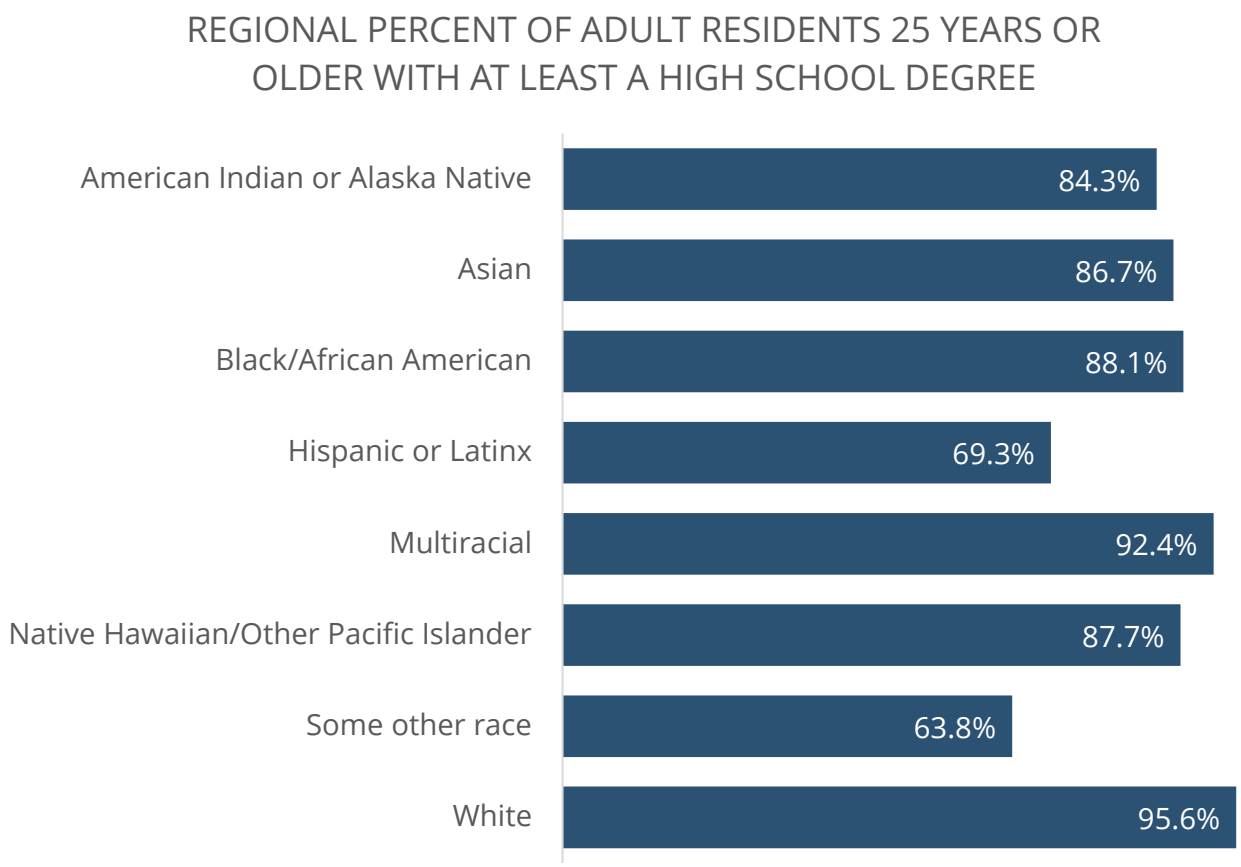


FIGURE 11 HIGH SCHOOL GRADUATE BY RACE & ETHNICITY

This disparity in having a high school degree begins, in part, with access to early childhood education. Childcare is critical for young children's early development and supports caregivers with their education, work, or health care needs. It also improves kindergarten readiness. Children who enter school with early skills are more likely than their peers without such skills to have academic success, attain higher levels of education, and secure employment.[22]

"I had a very difficult time finding child care. Without safe child care facilities, I cannot work. If I cannot work, I cannot afford my home, food, preventative care". – Clackamas Community Survey Respondent

From 2015-to 2019, before the pandemic, 49.4% of the region's three and four-year-old children were enrolled in school.viii While this reflected a (non-significant) increase from 45.5% in 2010-2014, enrollment dropped for the first time in 11 years to 46.6% in 2016-2020.[ix]

In 2015-2019, before the pandemic, 49.4% of the region's three and four-year-old children were enrolled in school. While this reflected a (non-significant) increase from 45.5% in 2010-2014, enrollment dropped for the first time in 11 years to 46.6% in 2016-2020.

In 2015-2019, there were differences in preschool enrollment by county, with Multnomah having a significantly higher rate at 56.4% compared to the region and Clark having a substantially lower rate at 39.2%.

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

This means that childcare costs create a large gap between families who can access subsidies versus families who can pay out of pocket. Challenges in the availability of high-quality care intensify this cost. Before the pandemic, the task force estimated four children under the age of

viii Preschool enrollment includes home school and licensed private preschool, as well as 4-year-olds enrolled in kindergarten (which usually begins at age 5).

ix Opportunity Zones were created under the Tax Cuts and Jobs Act of 2017 (Public Law No. 115-97). Thousands of low-income communities in all 50 states, the District of Columbia and five U.S. territories are designated as Qualified Opportunity Zones. Taxpayers can invest in these zones through Qualified Opportunity Funds.

12 for every childcare slot. A quarter of childcare facilities in Washington closed by August 2020. As of March 2020, there were seven infants and toddlers for each childcare slot in Oregon.

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

Culturally Specific and Healthy foods

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

In 2019, as shown in Figure 12, 2.5% of all residents, or 50,387 people, were low-income and experienced living far away from a grocery store. Socioeconomic barriers that come with living in poverty, such as lack of reliable transportation to get to the grocery store, make getting food for this population harder.

"People don't realize that it's not only the cost of health care. It's the cost of maintaining health. There's lack of understanding that to have good health, it's pointless to go to the doctor and take whatever pills that they give you, if you can't eat properly. Those pills are basically a band-aid that will eventually even stop working". – Washington BIPOC Community Session Participant

FIGURE 12 FOOD ACCESS

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

Food insecurity means that a person may lack access, at times, to enough food for an active, healthy life and have limited or uncertain availability of healthy foods.[23] The COVID-19 pandemic has impacted food insecurity in the region. As shown in Figure 13, data suggest:

- Children experienced greater food insecurity compared to adults.
- There was geographic variation in the rates of food insecurity.[33]
- Food insecurity was returning to pre-pandemic levels, as shown in 2021 projected data. [33]

The Supplemental Nutrition Assistance Program (SNAP) is one way to alleviate food insecurity. However. in the region, the percentage of households with income in the past 12 months below the poverty level who did not receive SNAP significantly increased between 2010-2014 and 2015-2019, from 44.4% to 54.8%. In 2015-2019, as shown in Figure 14, Washington was significantly higher while Multnomah was considerably lower compared to the region.

Community members highlighted that, even when grocery stores open in neighborhoods where they are most needed, stores are less likely to offer high-quality and affordable fresh foods.

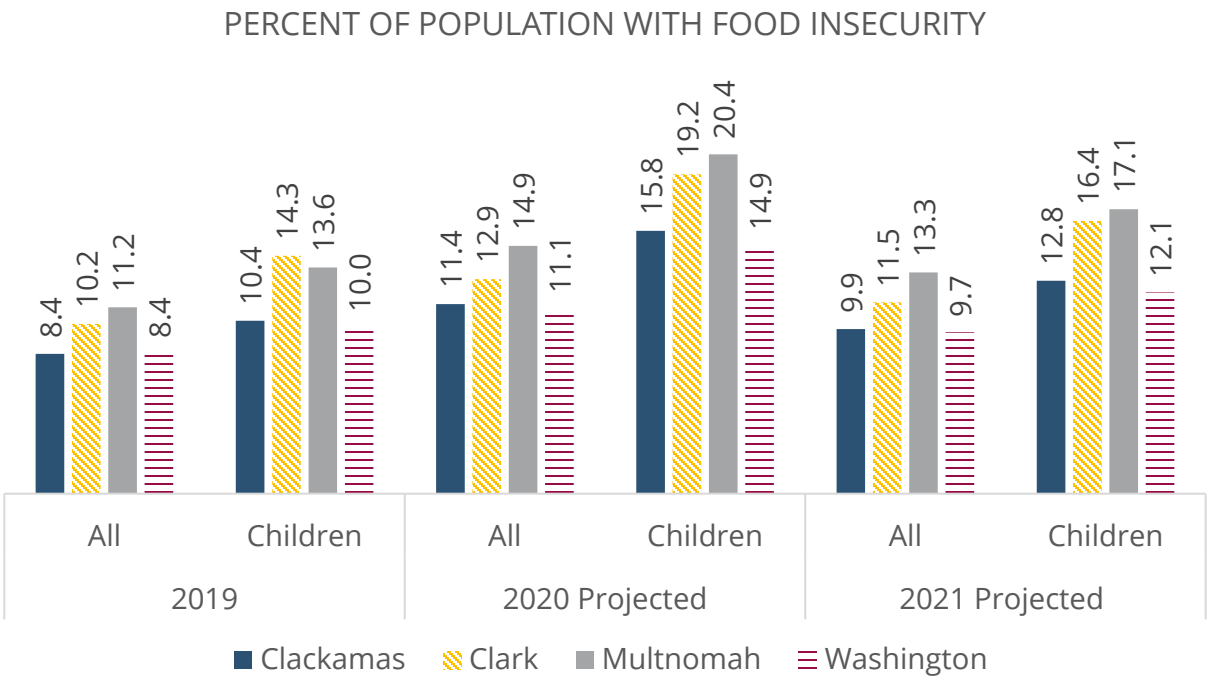


FIGURE 13 POPULATION EXPERIENCING FOOD INSECURITY

Note: Definition of food insecurity is 1) lack of access, at times, to enough food for an active, healthy life for all household members and 2) limited or uncertain availability of nutritionally adequate foods. Source: USDA Feeding America.

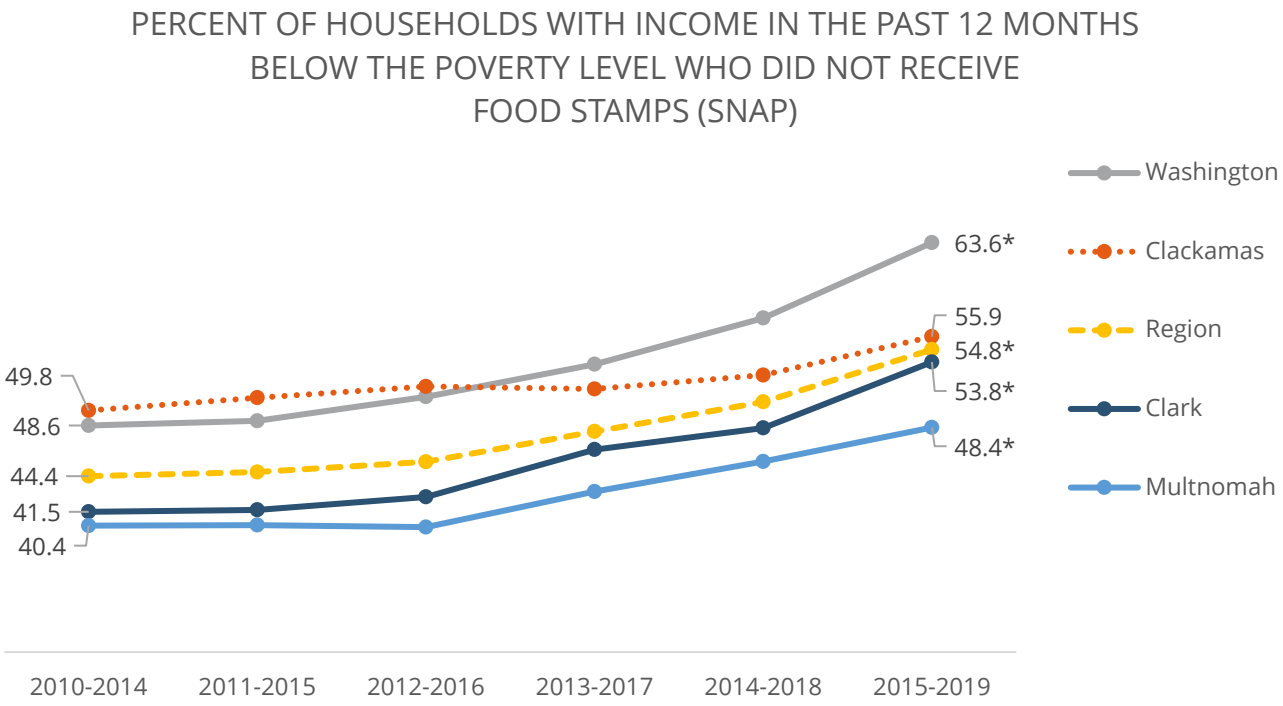


FIGURE 14 HOUSEHOLDS ELIGIBLE FOR SNAP THAT DID NOT RECEIVE BENEFITS

*Significantly higher rate in 2015-2019 compared to 2010-2014. Source: American Community Survey (Table B22003).

Transportation

Walking, biking, and public transportation in neighborhoods safe for pedestrians (i.e., sidewalks, crosswalks) and with access to outdoor spaces for recreation allow people to get where they need to go. It can also reduce their exposure to air and noise pollution, minimize the risk and severity of crashes, and improve access to various resources that contribute to health, including parks, trails, medical and social services, jobs, and schools.[24]

"Neighborhood design is a factor of health. There are no sidewalks. So, we need to walk on the roads, to walk to the nearest park, which can be discouraging to go and walk outside". –
BIPOC Youth Community Session Participant

Community members shared they lacked transportation options, including opportunities to walk or bike, due to pedestrian and neighborhood safety concerns. Specifically, the lack of transportation to access non-emergency health care was a central theme among community members. This was particularly true among people living with a disability. Figure 15 shows the percent of people who have self-reported living difficulty or self-care difficulty who needed non-emergency medical transportation. In summary, 25% of the region has a significant need for non-emergency transport. This need was highest in Multnomah at 45%.

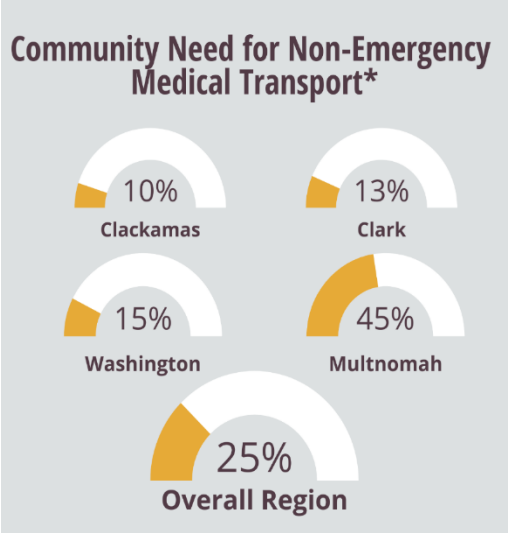
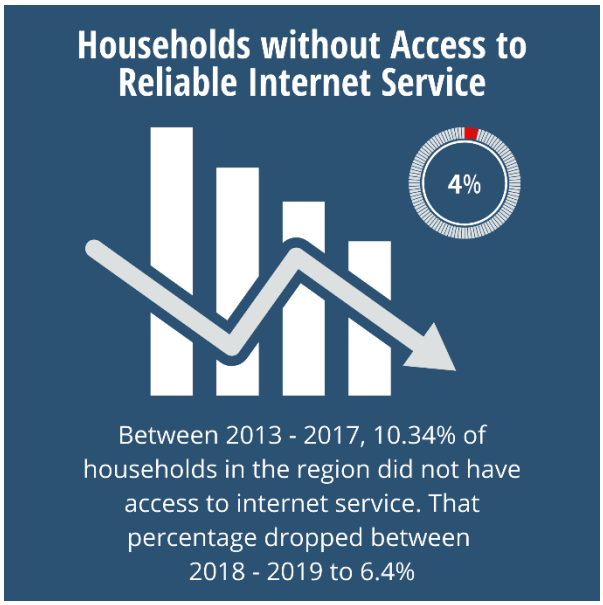


FIGURE 15 NEED FOR NEMT

Virtual Resources

Community members spoke of the opportunities created by providing more virtual care (e.g., more access to a broad range of providers). However, they also noted concerns about accessibility for those who might have less comfort navigating virtual spaces and do not have reliable access to broadband internet.



INFOGRAPHIC 4

The percentage of households in the region without access to the internet is decreasing. In 2013-17, 10.4% or 88,897 households did not have access to the internet. In 2015-2019, it was 6.4% or 69,136 households. There was a significant geographic disparity. In 2015-2019, Clackamas and Multnomah had significantly more households with no access to the internet compared to the region.[35] Washington had substantially less.[35]

"There's a lot of resources and a lot of services that have gone online, especially because of COVID-19. I worry about people who like seniors, may not even have computers or the literacy or ability to access them. I worry about communities with language barriers. How are you going to even navigate a website that's not in your language? And then also people who don't even have electricity, how are they going to access this information and these amazing resources, but they don't even know about it". –
Washington BIPOC Community Session Participant

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

ACCESS TO CULTURALLY AND LINGUISTICALLY RESPONSIVE HEALTH CARE

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

Four priority issues emerged in Access to Culturally and Linguistically Responsive Health Care:

- Access to affordable health care
- Linguistically and culturally responsive health care
- Trauma-informed care
- Delayed or avoided health care

Access to Culturally & Linguistically Responsive Healthcare

Access to Affordable Healthcare

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

Trauma Informed Care

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

Linguistically and Culturally Responsive Healthcare

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

Access to Culturally & Linguistically Responsive Health Care

Delayed or Avoided Healthcare

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

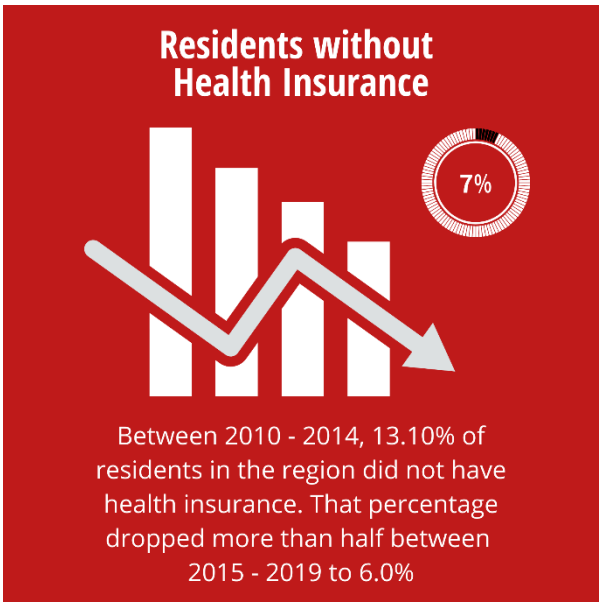
Affordable Health care

Health insurance makes it easier to get preventive services for chronic conditions like diabetes, heart disease, or cancer. Health insurance makes it easier for children to get care for conditions like asthma or preventive dental care, immunizations, and well-child visits.[25]

In the region, residents without health insurance dropped by nearly half from 13.1% or 277,194 residents in 2010-2014 to 6.0%, or 136,662 residents, in 2015-2019.[26] This drop was primarily due to the Affordable Care Act and the expansion of Medicaid.[27]

Despite this improvement, gaps include:

- Multnomah residents had a significantly higher uninsured rate of 6.7% than the region.[28]



INFOGRAPHIC 5

- Community members lacking health insurance had lower median household incomes and less education than residents with insurance.[40]

As shown in Figure 16, regionally, people of color (except for Asian populations) were disproportionately represented in the uninsured population compared to the general population. This was particularly true for the Hispanic/Latinx populations. This is likely due to structural barriers regarding Medicaid eligibility and citizenship status.[29]

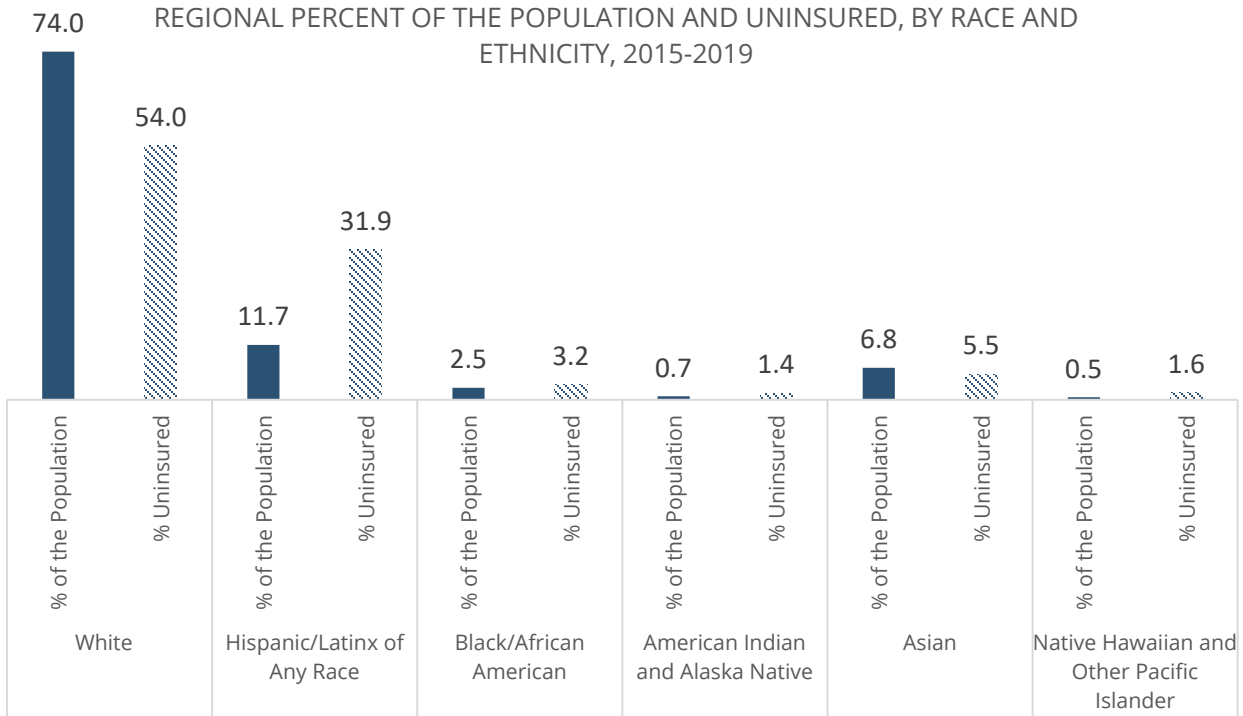


FIGURE 16 RESIDENTS WITHOUT HEALTH INSURANCE
Source: American Community Survey, Table S2702, 2015-2019.

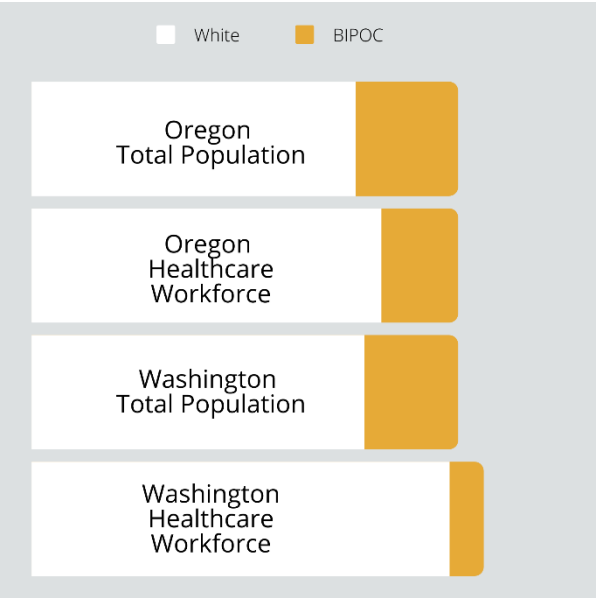
Linguistically And Culturally Responsive Health Care

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

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

Oregon and Washington state data show that linguistic and cultural representation in the workforce does not reflect the region's residents. Oregon's licensed health care workforce in 2020 was less racially and ethnically diverse than the population being served.[30]

People of color, except for providers of Asian descent, tended to be underrepresented relative to Oregon's and Washington's populations among primary care, behavioral health, and oral health care professionals.[42,31] For example, while 76% of Oregon's population was White, the health care workforce was 82% white in 2020. In Washington, 8% of Washington's providers were BIPOC (not including Asian descent), while 22% of Washington's population were BIPOC in 2018. [43, 32]



INFOGRAPHIC 6

Regarding language, 20.0% of Oregon's health care professionals reported speaking languages other than English; however, only 11.3% said advanced skills or being a native speaker of another language. Of this group, 9.4% reported using a language other than English with a patient.

Community members felt that underrepresentation was in part due to the barriers experienced by BIPOC students to finishing their studies, including less economic and social support to continue a career and obtain a doctorate.

Language and literacy are central to understanding health information and navigation. 21% or 500,000 people speak a language other than English in the region. Figure 17 below shows that 68% of people speak a language other than English and speak English well. This suggests great diversity in the language spoken within the region and the bilingual capacity for English. However, only 31% (137,867) of people felt they could speak English very well among people who speak a language other than English or Spanish. Simplifying health information for people with limited English is one approach to address this language gap and improve access to linguistically and culturally responsive health care.

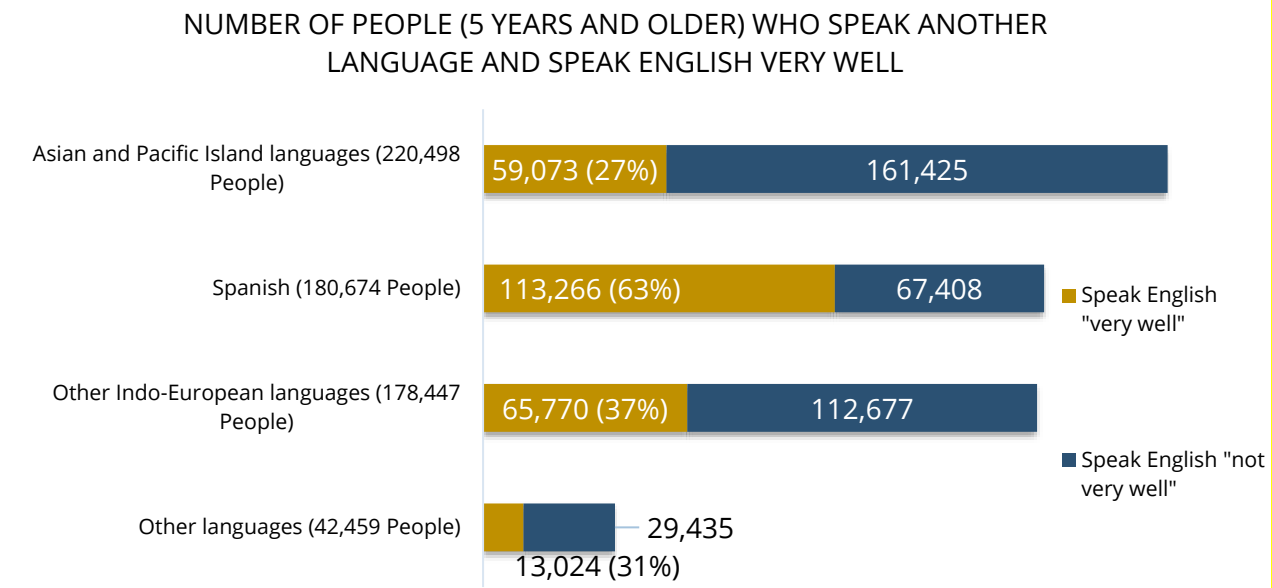


FIGURE 17 MULTILINGUAL RESIDENTS

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

Trauma-Informed Care

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

Community members shared that health care should focus on the whole person. This includes mental, spiritual, economic, and social needs–not only clinical or physical needs. These needs are often dependent upon shared historical traumas and experiences that affect how people seek and receive care.

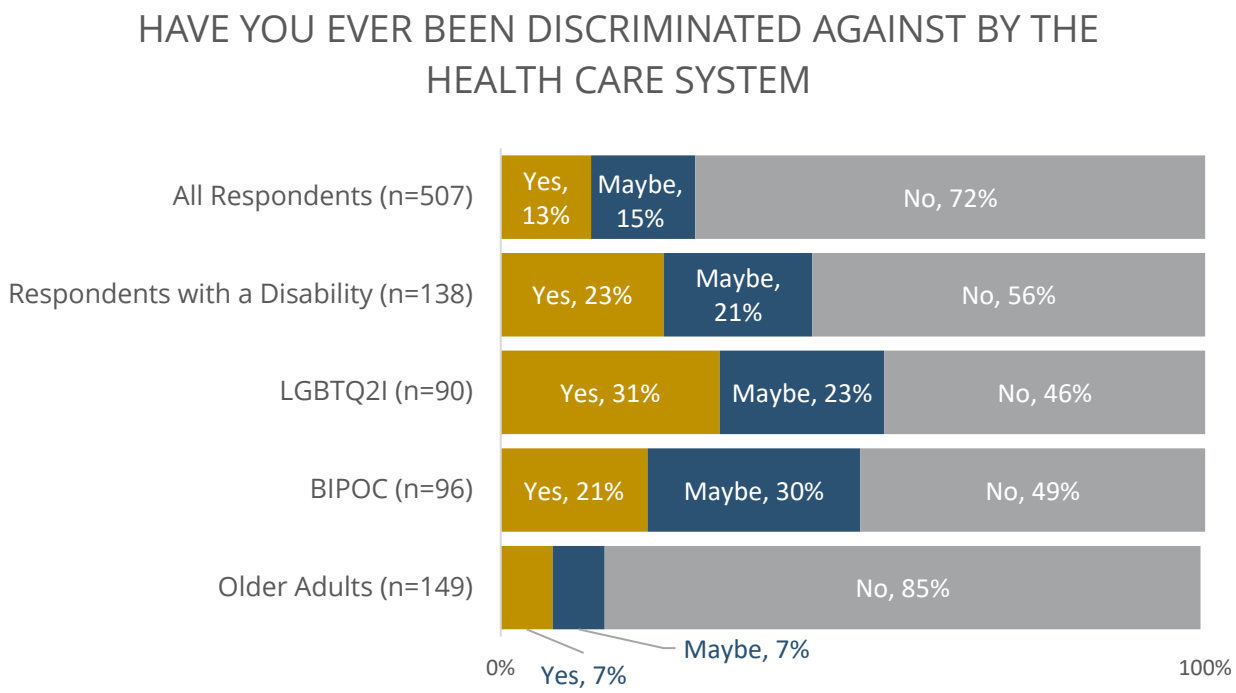


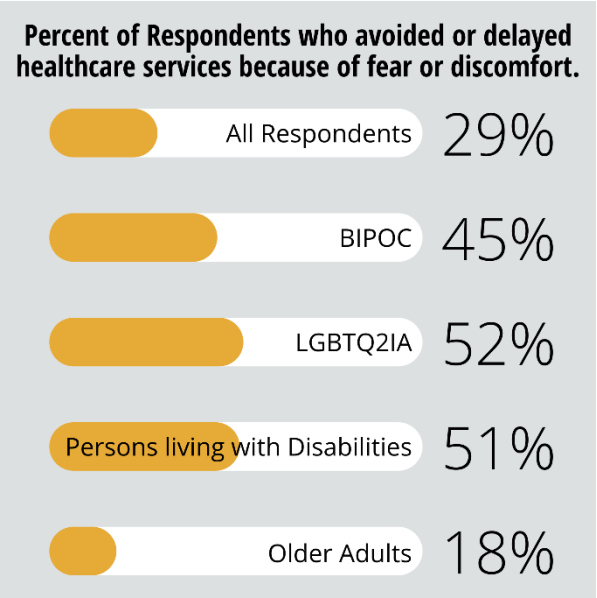
FIGURE 18 RESIDENTS EXPERIENCING DISCRIMINATION

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

Delayed Or Avoided Health Care

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

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



INFOGRAPHIC 7

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

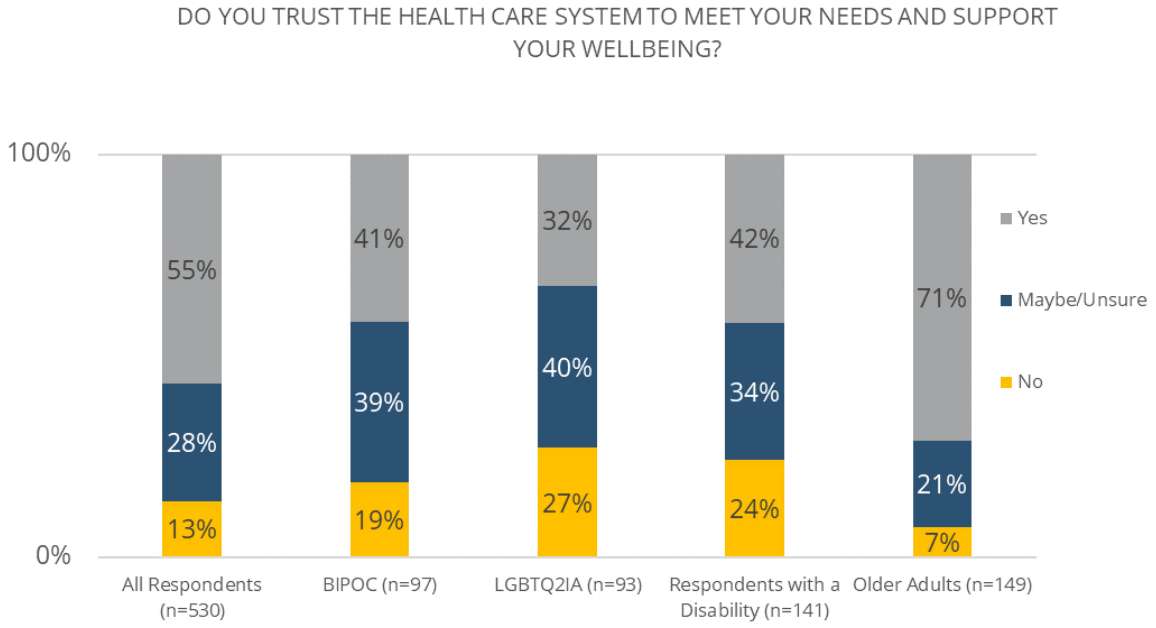


FIGURE 19 RESIDENTS EXPERIENCING DISTRUST

Source: HCWC CHNA Community Survey

SUPPORT FOR FAMILY AND COMMUNITY WAYS

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

One priority issue emerged in Support for Family and Community Ways:

- Social connection

The absence of social connections can have profound effects on our overall health.[33] Strong communities are critical they are an important source of social connection and belonging. Social support involves having friends and other people, including family, to turn to in times of need or crisis to give one a broader focus and positive self-image.

Social support also enhances quality of life and helps when people experience unfortunate life events.[34] When communities have strong social support, it helps decrease an individual's level of stress, increases motivation, and encourages healthy behaviors.[35] Therefore, offering support of family and community connection is an essential strategy to improving health and wellness. It is about creating opportunities for people to come together to solve problems and to celebrate the good moments of their lives. This includes not only space for families and friends but also space to encourage cultural connection and understanding.

Social Connection

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

Social Connection

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

Social & Community Connection

Community members shared 156 stories of receiving social and community connections over the past year.

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

Social & Community Connection

Community members shared 129 stories of struggling to receive the needed support to improve and maintain their health and wellness to align with who they were.

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

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

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

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

Community members commonly noted that spiritual gatherings, sharing ceremonies, conferences, and cultural events were important to discuss past traumas and work toward healing together. Additionally, community members shared the following:

- The importance of holistic care and various methods of self-care.
- There was a need for a shared physical space in the community, where people could meet to discuss recipes, harvest, and cook traditional foods together and learn traditional medicine.
- Community members spoke of the importance of building awareness on health issues that affect marginalized communities such as LGBTQ2IA and BIPOC youth.
- Young adults reported needing peer education in their high schools to share and learn about these topics with other youth who have similar background and experiences. They expressed the desire for specific health committees or the creation of community youth groups.

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

Community Session Participant Impacted by the Incarceration

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

Rural Communtiy Session Participant

LINKING HEALTH PRIORITY AREAS TO HEALTH OUTCOMES

Health outcomes represent the physical and mental well-being of residents within the HCWC region through measures signifying not only the length of life but quality of life as well. Up until this point, the CHNA has described many factors that influence health, such as access to culturally and linguistically competent health care to the availability of good jobs, safety in getting where one needs to go, social connections, culture-specific and healthy foods, and affordable housing. In addition to these factors, are the challenges faced when seeking care.

There is a strong link between health outcomes and access to quality care.[37] Regular prevention-focused health care can reduce rates of disease, death, and emergencies that require hospital stays. This includes regular health screenings, tests, treatment, and vaccinations. However, as shown in Figure 20, 60% community members responded that they experience challenges getting the care they needed or wanted. Among the CHNA's priority populations, this ranged higher from 63% to 76%.

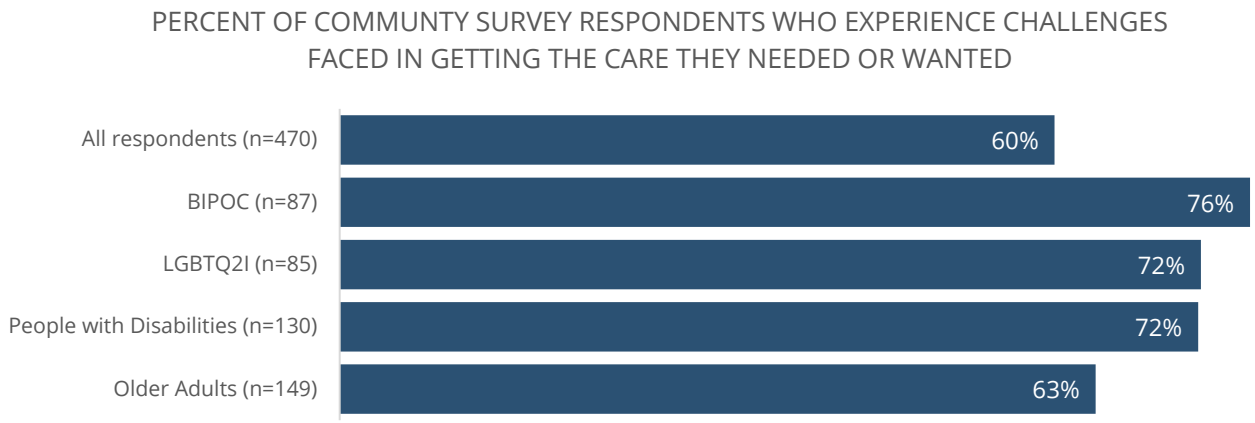


FIGURE 20 CHALLENGES ACCESSING CARE
Source: HCWC CHNA Community Survey

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

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

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

TABLE 2

Source: HCWC CHNA Community Survey

COMMUNITY VOICE: IMPORTANT DISEASES AND CONDITIONS

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

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

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

The Most Important Health Diseases and Conditions, By County

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

TABLE 3

Source: HCWC CHNA Community Survey

The four priority populations responded similarly to all respondents except ranking higher the need for improved dental/oral health. BIPOC respondents ranked cancer and STIs as a health disease or condition as important more so than all respondents. LGBTQ2IA ranked rape/sexual assault/sex trafficking as important more so than all respondents.

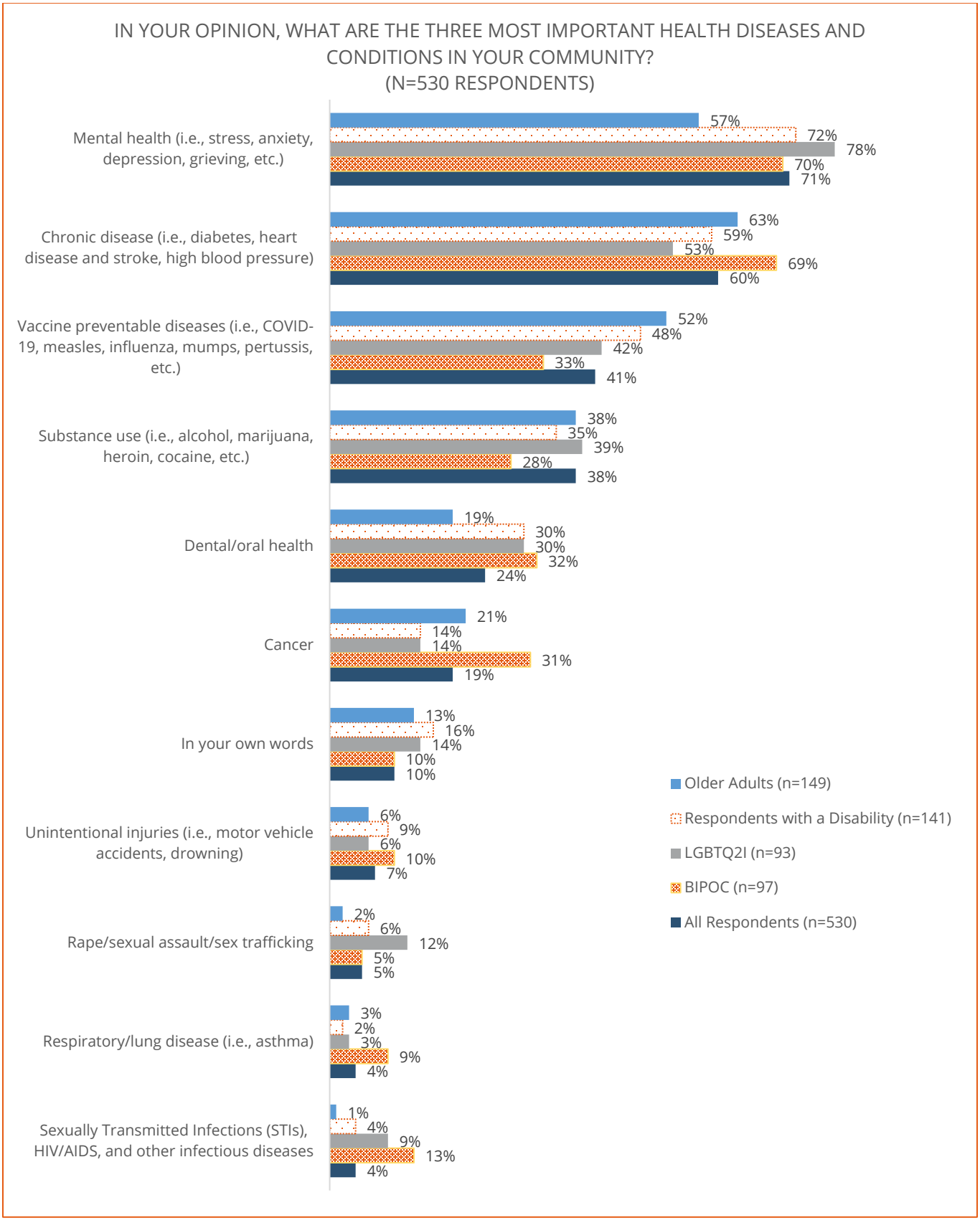


FIGURE 21

Source: HCWC CHNA Community Survey

By looking at these community data together with population health outcome data, the CHNA provides an understanding of the health of the community and what programs the community may need. For example, the expansion of language interpreters in health centers might impact access to primary care, leading to improved management of chronic diseases and lead to longer lives. Additionally, it is important to look at differences in health outcomes based on the presence of various community health factors and demographics. The CHNA describes three priority areas to focus that reflects both the community perspective and the population health data. For more data on health outcomes, including Maternal and Child Health, see Appendix I.

#1: MENTAL WELL-BEING

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

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%.[36]
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).[37]
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.[38] 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.[39]

#2: CHRONIC AND COMMUNICABLE DISEASE MANAGEMENT

Chronic disease is a health condition lasting three months or longer that generally cannot be prevented by vaccines and does not "get better" or disappear on its own.[40]

18.9%	Regionally, **18.9%** reported binge drinking in 2019 and this was significantly higher than the United States at 17.9%. Reported binge drinking among adults was higher in Multnomah and Clark.[41, x]
9.8%	Adults with asthma was significantly higher in the region at **9.8%** of adults compared to the United States at 8.9%. Other chronic diseases including high blood pressure (27.4% of adults) and high cholesterol (26.1% of adults), while the two most prevalent in the region, were significantly lower than rates in the United States.[53, xi]
37.3% **28.9%** **14.4%**	Among all avoidable hospital stays in 2020, the top three leading chronic disease-related causes include: ▪ Diabetes at **37.3%** ▪ Chronic heart failure at **28.9%,** and ▪ Chronic obstructive pulmonary disease (COPD) at **14.4%.**[50] It is important to note that this trend likely was affected by COVID-19 and the public being dissuaded from going to the hospital.
33,596 **11,681** **1,521**	The incidence of STIs chlamydia, gonorrhea, and syphilis increased in the region between 2016 and 2019. The number of cases in the region during 2019 was: ▪ Chlamydia: **33,596** cases, representing a 14.7% increase from 430.7 to 494.0 per 100,000 people. ▪ Gonorrhea: **11,681** cases, representing a 69.7% increase from 90.1 to 152.9 per 100,000 people. ▪ Syphilis: **1,521** cases, representing a 28.8% increase from 13.9 to 17.9 per 100,000 people (significantly higher only in Multnomah and Clark)[42]
11,065 **9,614**	Cancer and heart disease continue to be the top two causes of death in 2018-2020, representing: ▪ **11,065** deaths due to cancer 1. **9,614** deaths due to heart disease While deaths due to cancer and heart disease decreased between 2014-2016 and 2018-2020, cerebrovascular diseases, such as stroke, increased from 18.7 to 30.3 per 100,000 deaths.

[x] Regional estimates are unweighted averages.

[xi] Regional estimates are unweighted averages. County estimates were not significantly different compared to the region. High cholesterol is defined as the percent of adults >=18 years who have been screened in the past 5 years.

#3: ACCIDENTAL INJURY

Accidental injuries can be caused by events including falls, motor vehicle crashes, firearms, drug overdose, and suicide. Accidents are one of the top 15 killers of Americans of all ages and, according to the CDC, are the leading cause of death for Americans from birth to age 44.[43]

3,132	Over **3,132** deaths in the region were due to accidental injury, making it the third leading cause of death 2018-2020.[51]
88% **85%**	Children less than 1 year old and older adults 65 years and older were particularly vulnerable to experiencing an accidental death. Among injury-related deaths, 2. Among children less than 1 years old, **88%** were accidental (compared to 12% of injury deaths due to violence or suicide) 3. Among older adults 65 years and older, **85%** were accidental (compared to 15% of injury deaths due to violence or suicide)
49%	Age groups 15 to 24 years were particularly vulnerable to experiencing a violent or suicide-related injury death. 4. **49%** were accidental (compared to 51% of injury deaths due to violence or suicide)
13.7 per 100,000	Falls were the leading cause of accidental injury death in the region with an average (unweighted) rate of **13.7 per 100,000** people or 1,048 deaths in 2018-2020.[51] While the rate had increased for each county between 2014-2016 and 2018-2020, the change was not significant.
13.3 per 100,000	Drug overdose death was the second leading cause of accidental death in 2018-2020 at a regional (unweighted) rate of **13.3 per 100,000** people. Drug overdose had significantly increased in the region, from 9.8 in 2014-2016 to 13.3 per 100,000 in 2018-2020. This was in part due to the increase in Multnomah from 13.1 to 20.9 per 100,000 during the same period.[51]
8.1 per 100,000	Motor vehicle accidents were the third leading cause of accidental death in 2018-2020 at a regional (unweighted) rate of **8.1 per 100,000** people or 566 deaths. While the rate increased for each county between 2014-2016 and 2018-2020, the change was not significant.

RECOMMENDATIONS

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

A Neighborhood For All

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

Essential Community Services and Resources

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

Access to Culturally and Linguistically Responsive Health Care

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

Support for Family and Community Ways

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

These stories of the CHNA ring true beyond the region's borders. The table below shows the alignment between Oregon's and Washington's most recent State Health Improvement Plans and the CHNA's five priority areas. Note that checked boxes indicate areas of overlap:

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

About the CAT

A community action team (CAT), a team comprised of community leaders representing the diverse communities in the region, led the development of the CHNA with support from HCWC partners and subcontractors Health Management Associates and Oregon Health Equity Alliance. The partnership's approach was informed by a Peer Review Group, who was a group of data professionals of color who have expertise in engaging in decolonized, community-centered, data approaches and/or are deeply connected to an anti-racist, Indigenous practice of doing health equity work.

Biographies of each CAT member are shared below.

Jacinta S. Galea'i

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

Trish Jordan

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

Cheryl Carter

Mz. Cheryl Carter is a community leader representing HCAT/MCPHAB (Multnomah County Public Health Advisory Board) and PAC (focuses on the homeless community). She has been a part of these organizations for a couple of years and she is a part of the Oregon Health Authority (OHA) smoke-free campaign. She was the spokesperson for our voter's rights campaign as well as the chair of the Oregon Voters Community in 2004 which won the rights to increase wages as well as food service which is still in play (Snap). She has been apart of Home Forward's campaign to have residents be a part of the residential involvement committee. She is also a part of the Portland Lesbian Choir and Transition Projects (TPI). At TPI, she is involved in their community trainings for employees to improve participant care and their fundraising campaign. She also supported Multnomah County's interviewing candidates for their first-ever liaison position focused on the houseless community.

Waddah Sofan

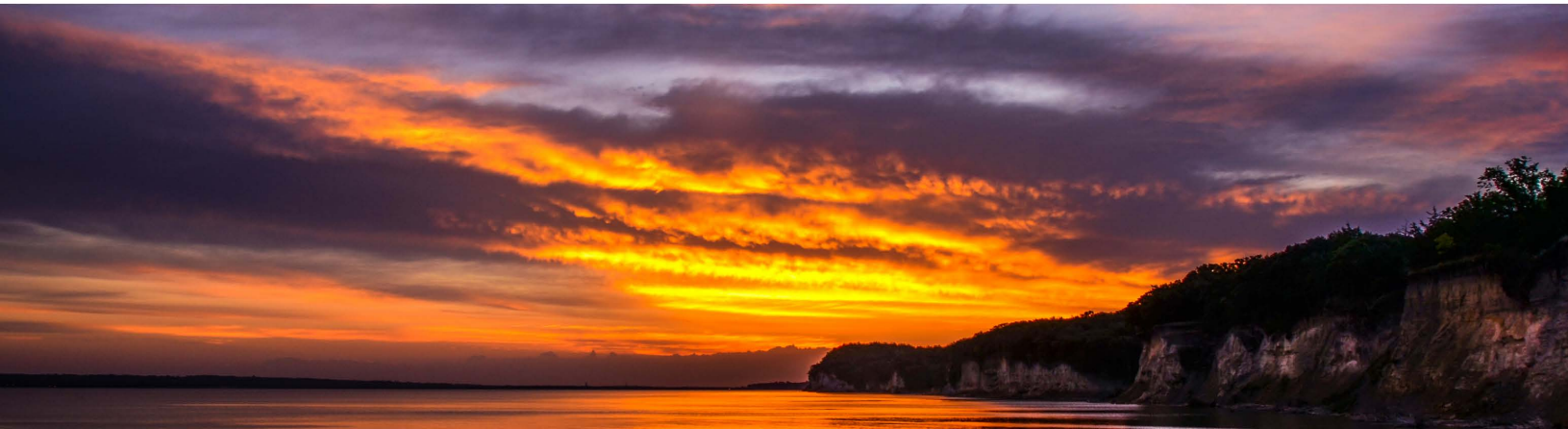
Waddah (He/Him) is the Community Outreach/Education Coordinator of Oregon Spinal Cord Injury Connection. Waddah is a trusted member and leader in the disability and immigrant community. He has extensive experience working with people with disabilities, people of color, immigrants, and refugees to overcome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

Kianna Juda-Angelo

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

Jaxon Mitchell

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



Benita Presley

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

Suzie Kuerchner

Suzie Kuerchner is a Fetal Alcohol Spectrum Disorder consultant and a child and family development specialist working from the contexts of Education and Behavioral Health to develop culturally congruent systems and strategies for trauma-informed, strength-based therapeutic support to children, families, and the systems serving them. Her work includes program development and delivery for over forty-five years, in which she has developed multiple Early Childhood Development Centers, Early Intervention, Interagency, and Family Resource programs within the context of state, county, tribal, and public schools and treatment settings; integrating federal, state, county, and tribal services. She has worked with Juvenile Justice and Adult Corrections in cognitively retailoring strategies and services within those settings and providing court and judicial assistance in designing appropriate sentencing for individuals impacted by an FASD.


Sisilia Afemui
Dominique Horn
Chenoa Landry

APPENDIX

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