Executive Summary

2022 CHNA for Adventist Health Columbia Gorge, formerly known as Mid-Columbia Medical Center (MCMC):

1. Background of MCMC: A nonprofit, 49-bed community hospital serving the Columbia River Gorge region with various services including emergency care, cancer care, surgery, and more.
2. CHNA Partnership: MCMC collaborated with six other community health organizations to conduct a comprehensive regional health assessment following agreed principles of collaboration.
3. Data Collection Methods:
    - Quantitative data from sources like American Community Survey, CDC, and Oregon Health Authority
    - Qualitative data from 8 listening sessions with 66 community members
    - 11 stakeholder interviews with 16 representatives
    - Community health survey with 1,279 respondents in English and Spanish
4. Key Findings:
    - Strong collaboration between local organizations
    - Desperate need for affordable housing
    - Only 30% of survey respondents received all needed mental health services
    - 65% felt socially isolated or lonely at least some of the time
5. Priority Needs Identified by MCMC:
    - Homelessness and Housing Instability
    - Access to Health Care Services
    - Chronic Conditions
6. Next Steps: Development of a three-year Community Health Improvement Plan (CHIP) by May 31, 2023, to address these priority needs.

Biggest Gaps in Service

1. Mental health services - Only 30% of community health survey respondents stated that they received all the mental health services they needed in the past year, indicating a significant gap in mental health care access.
2. Culturally and linguistically centered care - The report identifies a shortage of providers that offer culturally and linguistically appropriate care, which impacts access to services.
3. Primary care and specialist access - The document mentions that Gorge residents are experiencing unmanaged chronic conditions partly due to "limited access there is to primary care providers and specialists."
4. Behavioral health services - Although MCMC attempted to reduce internal mental health referral wait times, the pandemic exacerbated mental health conditions, and they were unable to meet their target of reducing wait times from 10 days to 2 days.
5. Transportation services - Transportation is specifically mentioned as a social determinant of health that has impacted people's ability to access care.

Greatest Barriers to Care

1. Housing instability and homelessness - Rising housing costs are creating a "housing-burden" for community members, making it difficult to prioritize healthcare needs when struggling with basic shelter.
2. Transportation challenges - The report specifically mentions transportation as a social determinant of health that impacts people's ability to access care.

3. Shortage of healthcare providers - Particularly those offering culturally and linguistically appropriate care, creating access barriers for diverse populations.
4. Economic insecurity - When people focus on covering basic needs, they're less likely to seek care for chronic conditions or preventive services.
5. Mental health service limitations - With only 30% of survey respondents receiving all needed mental health services, there appears to be significant barriers to behavioral health care.
6. Social isolation - 65% of respondents reported feeling socially isolated or lonely at least some of the time, with 6% feeling isolated "all of the time," which can impact healthcare-seeking behaviors.
7. Food insecurity - The report mentions food insecurity as an issue, as evidenced by MCMC's initiatives to distribute food boxes to vulnerable populations including low-income and migrant/seasonal farmworkers.

The Unique Needs of the Community

1. Affordable housing solutions - The report emphasizes a "desperate need for affordable housing" as costs continue to increase, creating housing instability that directly impacts health outcomes.
2. Mental health services - With only 30% of survey respondents receiving all needed mental health services, there's a significant need for expanded behavioral health care access.
3. Culturally and linguistically appropriate care - The community needs more providers who can offer care that's culturally relevant and language-accessible, particularly for Spanish-speaking residents (as evidenced by MCMC's efforts to increase Spanish signage and materials).
4. Support for isolated individuals - 65% of community members reported feeling socially isolated or lonely at least some of the time, indicating a need for social connection programs.
5. Services for migrant and seasonal farmworkers - The report specifically mentions this population as requiring targeted support, including food assistance.
6. Chronic condition management resources - The community faces challenges with unmanaged chronic conditions, requiring better access to preventive care and management programs.
7. Food security initiatives - Food insecurity is identified as a concern, with MCMC implementing programs like food box distribution and the VeggieRx program.
8. Transportation assistance - This is highlighted as a social determinant of health affecting access to care in the region.

What the Hospital or CCO is Doing Well

1. Community collaboration - The primary strength identified by stakeholders was "the collaboration and relationships between local organizations," including programs like Bridges to Health Pathways, the local Coordinated Care Organization (CCO), and the Natives Along the Big River collaborative.
2. Expanded access to immediate care - MCMC opened an Immediate Care center in April 2020 and exceeded their target capacity, now offering 660 appointments per month (compared to their goal of 550).
3. Increased Medicaid assignment - They successfully increased the number of Medicaid-assigned individuals from 3,400 to 4,820, exceeding their target of 4,500 by 2022.

4. Food insecurity initiatives - MCMC's Community Health Workers distributed hundreds of food boxes to vulnerable populations, including 505 food boxes to migrant and seasonal farmworkers in 2022.
5. Bilingual communication - All public-facing signage is now printed in both Spanish and English, and they've translated patient materials including "8 Zone Tools" into Spanish.
6. Education programs - They've developed several successful patient education initiatives:
    - Persistent Pain Education program (benefiting 43 individuals)
    - PREVENT wellness program (benefiting 22 individuals)
    - Mommy & Baby Wellness Program (benefiting 8 individuals)
7. Telehealth implementation - During the pandemic, they implemented telemedicine appointments to maintain access for patients uncomfortable with in-person visits.
8. Behavioral health integration - They hired 1-2 new full-time staff to offer behavioral health services at their primary care clinics.

Strengths of the Community

1. The Bridges to Health Pathways program
2. The local Coordinated Care Organization (CCO)
3. The Natives Along the Big River collaborative
4. COVID-19 response services
5. Community-wide trauma-informed practices

Priorities

1. Homelessness and Housing Instability
    - Addressing the challenges of increased housing costs and the "housing-burden" experienced by community members
2. Access to Health Care Services
    - Focusing on social determinants of health such as transportation
    - Addressing the shortage of providers offering culturally and linguistically centered care
3. Chronic Conditions
    - Addressing unmanaged chronic conditions resulting from community members prioritizing basic needs
    - Improving limited access to primary care providers and specialists