Executive Summary

Major Demographics Findings:

- Since previous CHNAs, there has been a substantial increase in charity care and Medicaid patients in multiple zip codes both within and outside the service area
- Significant racial and ethnic health disparities exist, with Black/African Americans experiencing the greatest number of disparities
- The aging population has increased significantly and is projected to continue growing

Primary Data (Community Input) Shows Key Concerns Around:

1. Behavioral/Mental Health
- Need for community support to maintain cultural values and address depression/mental health
- Significant stress due to racism, discrimination, and feelings of exclusion
- Cultural/social isolation issues

2. Access to Affordable Healthcare
- Lack of access due to financial and cultural barriers
- Difficulty affording medical costs and medications
- Language barriers and lack of translators

3. Lifestyle Concerns
- Drug and alcohol abuse
- Safety concerns
- Obesity
- Lack of exercise

4. Social Determinants of Health
- Housing affordability and homelessness
- Food access/hunger
- Transportation needs

Secondary Data Shows Key Health Issues:

- Chronic diseases (heart disease, stroke, cancer, diabetes, etc.) are among the most common and preventable health problems
- Diabetes has doubled over 20 years in Oregon with significant racial disparities
- Obesity is the second leading cause of preventable death
- Mental health issues, particularly anxiety and depression, are increasing
- Substance abuse and addiction remain major challenges
- Health disparities persist across racial/ethnic groups

The executive summary indicates these findings will guide the hospital's implementation plans to direct resources toward improving community health needs, with a focus on equity and addressing disparities.

Biggest Gaps in Service

1. Mental/Behavioral Health Services:
- Anxiety disorders affect 40 million adults but only 36.9% receive treatment
- Lack of mental health counseling for families, including children whose parents lack insurance
- Need for more substance abuse treatment programs

- Oregon ranked 48th for mental illness prevalence and 12th for access to mental health care

2. Cultural and Language Access:
- Insufficient number of interpreters and translators
- Lack of culturally competent care providers
- Language barriers preventing access to medical services
- Need for more bilingual/bicultural healthcare workers
- Limited number of Spanish-speaking providers

3. Affordable Care Options:
- Many individuals earn too much for low-income clinics but cannot afford regular medical care
- High costs of dental care and lack of affordable dental services
- Limited low-income clinic options in certain geographic areas
- Difficulty affording medications and treatments
- High costs preventing preventive care visits

4. Geographic Access:
- Limited healthcare services in rural areas
- Transportation barriers to reaching medical facilities
- Lack of specialty care in outlying areas
- Need to travel long distances for certain medical services
- Limited emergency services in some areas, particularly with language access

5. Preventive Care:
- Insufficient preventive screening services
- Limited health education resources
- Lack of programs focused on chronic disease prevention
- Need for more community-based preventive health initiatives
- Gaps in vaccination and immunization coverage

The report particularly emphasizes how these gaps disproportionately affect communities of color, low-income populations, and those who face language barriers or live in more remote geographic areas.

Greatest Barriers to Care
1. Financial Barriers:
- High medical costs and medications
- Lack of insurance coverage
- Inability to afford copays and deductibles
- Many earn too much for low-income clinics but too little to afford regular care

2. Cultural and Language Barriers:
- Insufficient interpreters and translators
- Lack of culturally competent care
- Language barriers preventing effective communication with providers
- Cultural stigma around certain health issues, particularly mental health
- Fear of discrimination in healthcare settings

3. Transportation & Geographic Access:
- Limited access to healthcare facilities in rural areas
- Insufficient public transportation options
- Distance to specialty care providers
- Need to travel long distances for certain medical services
- Geographic isolation from healthcare resources

4. Social Determinants:
- Housing insecurity and homelessness
- Food insecurity
- Poverty
- Lack of job security/livable wages
- Limited access to healthy food options

5. System Navigation:
- Difficulty understanding the healthcare system
- Challenges navigating insurance coverage
- Limited knowledge about available resources
- Confusion about eligibility for services
- Lack of care coordination

The report emphasizes that these barriers particularly impact communities of color, low-income populations, elderly individuals, and those in rural areas, creating significant disparities in healthcare access and outcomes.

The Unique Needs of the Community
Latino Population:
- More Spanish-speaking providers and interpreters
- Culturally specific healthcare resources
- Support for families, including parenting classes and childcare
- Mental health services that address immigration-related stress
- Programs to help youth avoid substance abuse
- Protection from discrimination and racial profiling

African American Community:
- Community-led resources and black-owned businesses
- More black healthcare providers and leaders
- Mental health services addressing racism and discrimination
- Programs to strengthen community connections
- Solutions to address displacement from gentrification
- Resources to address higher rates of chronic diseases

Pacific Islander Community:
- More Community Health Workers from their community
- Improved translations and language services
- Cultural competency in healthcare delivery
- Education about preventive care and U.S. healthcare system
- Support maintaining cultural traditions and values

Elderly Rural Population:
- Better transportation options to medical services
- More local healthcare providers and services
- Support for caregivers
- Programs to reduce social isolation
- Assistance with technology and system navigation

Veterans:
- Comprehensive support for addiction and homelessness
- Mental health services
- Better access to ongoing care, especially for older veterans
- Community support and connection
- Advocacy in the healthcare system

Low-Income/Affordable Housing Residents:
- Affordable healthcare options
- Transportation assistance
- Access to healthy food
- Safe community spaces
- Mental health support
- Assistance with utility costs

Arabic Population:
- Female-only healthcare spaces
- Arabic-speaking providers
- Mental health support addressing immigration stress
- Help transferring professional credentials
- Support maintaining cultural and religious values

The report emphasizes that addressing these unique community needs requires culturally specific approaches and involvement of the communities themselves in developing solutions.

What the Hospital or CCO is Doing Well
Chronic Disease Management:
- Increased mammography screenings for uninsured (47 screenings in 2018)
- Significantly increased smoker CT scans (537 in 2018)
- Provided 160 skin cancer screenings and education
- Distributed 19 home radon testing kits
- Supported cancer patients through navigator services (189 families served)
- Provided transport for 200 cancer patients

Access to Care:
- Partnered with Compassion Connect to provide free medical/dental clinics (3,373 people served)
- Hosted Impact Your Health Portland free clinic (674 guests served by 650 volunteers)
- Assisted approximately 1,100 patients with enrollment in means-tested programs
- Helped fund Project Access NOW to connect uninsured people to care
- Provided medical transport services for cancer and behavioral health patients (200+ served)

- Hired more Russian-speaking staff (7 new hires) to better serve that community

Behavioral Health:
- Continued funding and leadership support for UNITY Center for Behavioral Health
- Expanded outpatient emotional wellness clinic (402 patients served in 2018)
- Provided grief support and emotional/spiritual programs (767 served)
- Developed weekly grief recovery and Bible study groups (814 encounters)

Cultural Responsiveness:
- Increased engagement with Russian community
- Enhanced training for chaplains from diverse backgrounds
- Developed Student Healthcare Leaders Program for high school students
- Improved multilingual staffing in Emergency Department and clinics

The report indicates these were positive steps, though ongoing needs still exist in all these areas.

Strengths of the Community
Strong Community Leadership & Support:
- Latino communities described strong community leaders, particularly seniors helping others with transportation and assistance
- Community members taking care of each other and looking out for neighbors
- Churches and cultural centers providing food assistance and support
- Resilience of communities despite challenges and changes

Cultural Resources & Organizations:
- Active community organizations like APANO, Utopia PDX (for LGBTQ+ Pacific Islanders)
- Cultural centers providing services and gathering spaces
- Community Health Workers serving as bridges between communities and healthcare system
- Certified interpreters providing language assistance

Community Programs & Services:
- School systems connecting children to services and programs
- Food assistance through churches, cultural centers, and food banks
- Programs like Adelante Mujeres and Virginia Garcia offering health classes
- Local businesses serving community needs

Community Engagement:
- Partnerships between organizations like Sandy AntFarm Youth and AmeriCorps
- Free community meals hosted by churches to engage diverse groups
- Community center outreach programs
- Native council meetings bringing people together to solve issues
- Local action centers providing resources

Resilience:
- The Black community was specifically noted for being "incredibly resilient" in withstanding community changes
- Pacific Islander communities maintaining cultural traditions
- Communities supporting each other despite challenges

- Strong family values and intergenerational support in many cultural communities

The report suggests these community strengths could be built upon to help address identified health needs and challenges.

Priorities
Priority Areas:
1. Chronic Disease
- Racial disparities
- Heart Disease and Stroke
- Cancer
- Diabetes
- Obesity

2. Access to Care
- Access to care and resources
- Cultural and Language Barriers
- Racism and Prejudice

3. Behavioral Health
- Suicide
- Anxiety/Stress
- Depression
- Alcohol & Drug Misuse
- Alzheimer's

4. Social Determinants
- Housing/Homelessness
- Hunger/Food Access
- Transportation
- Safety

The organization's goals as stated in their mission and values are:

Mission:
"Living God's love by inspiring health, wholeness and hope."

Vision:
"We will transform the health experience of our communities by improving health, enhancing interactions and making care more accessible."

Values:
- Integrity
- Compassion
- Respect
- Excellence

The report indicates these priorities were determined based on:

- Input from community stakeholders
- Primary and secondary data analysis
- Severity and magnitude of needs
- Opportunity for partnerships
- Existing resources
- Mission alignment
- Resources of hospital
- Importance to community