Executive Summary

The Community Health Improvement Partnership (CHIP) of Morrow County conducted a comprehensive health needs assessment to identify gaps in healthcare access and evaluate the health status of county residents. This assessment builds on previous reports from 2012, 2015, 2018, and 2021.

Key Findings

Population Demographics:

- County population: 12,300 (2022), with significant growth in Boardman
- Highest Hispanic/Latino population in Oregon: 39.6% county-wide, with Boardman at 67%
- Designated as a frontier county with Health Professional Shortage Areas for medical, dental, and mental health services

Areas of Concern by Category:

Population Groups:

1. Low-income residents
2. Latinx community
3. Maternal and family populations
4. Older adults

Health Conditions:

1. Behavioral health issues
2. Substance abuse
3. Chronic conditions with modifiable health behaviors
4. Oral health problems

System Challenges:

1. Maintaining access to local healthcare system
2. Communication and coordination gaps
3. Workforce shortages
4. Health equity disparities
5. Social determinants of health barriers

Emerging Trends

- Declining vaccination rates for seasonal influenza and COVID-19
- Increasing sexually transmitted infections/diseases
- Growing older adult needs and community social support requirements
- Rising obesity rates (45% of adults, up from 32% in 2012-15)

Major Health Indicators

Leading Causes of Death: Cancer, heart disease, chronic lower respiratory disease, and cerebrovascular disease remain consistent with previous assessments.

Economic Challenges:

- Median household income ($64,975) below state and national levels
- 44% of households in some areas living below 200% of federal poverty level
- Increasing ALICE (Asset Limited, Income Constrained, Employed) households

Healthcare Access:

- 8.2% of population lacks health insurance
- 45% of population (5,630 people) enrolled in Medicaid
- Geographic barriers to specialized care, with nearest comprehensive services 45-88 miles away

The assessment concludes that while overall health status has remained relatively stable, significant challenges persist in healthcare access, health equity, and addressing the needs of vulnerable populations, particularly the growing Hispanic/Latino community and older adults.

Biggest Gaps in Service

Geographic and Access Gaps

Remote Location Challenges:

- Entire county classified as "frontier" with majority area classified as "remote"
- 45-88 miles to nearest comprehensive health services (Hermiston, Pendleton, Tri-Cities)
- 45+ miles to nearest emergency department for southern county residents
- Over one hour driving time through mountainous terrain on narrow rural roads

Professional Shortage Areas

Designated shortages in:

- Primary medical care
- Dental care
- Mental health care
- Services for low-income populations
- Services for migrant/seasonal farmworker populations

Specific Service Gaps

Specialized Care:

- Obstetrical/prenatal care (must travel to Hermiston or Pendleton)
- Emergency medical services in southern areas
- Specialty medical services requiring referral to distant locations

Behavioral Health:

- Mental health services, particularly for youth
- Substance abuse treatment
- Crisis intervention services

Dental Care:

- Only 43% of adults ages 50-75 had recommended colorectal cancer screening (vs. 72% statewide)
- Limited access to preventive dental care
- Many dental clinics don't accept Medicaid patients
- Less than 45% of Oregonians 20 and under with Medicaid/CHIP visited dentist in past year

Workforce Challenges

Provider Shortages:

- Limited number of healthcare professionals
- Surrounding counties also have shortage designations, making recruitment difficult
- Cultural and linguistic barriers (28% of Boardman population speaks English less than "very well")

Transportation Barriers

Limited Mobility:

- Difficulty reaching medical services reported as "concerning" for ages 18-24 and 55+
- Transportation challenges for low-income households
- New public transit system (The Loop) began in 2024 but still developing

Population-Specific Gaps

Underserved Populations:

- Farmworkers facing language, cultural, and legal status barriers
- Hispanic/Latino community needing culturally appropriate services
- Older adults requiring long-term care and specialized services
- Veterans needing VA-specific services

The report emphasizes that these gaps are compounded by the county's rural, frontier designation, making it challenging to recruit and retain healthcare professionals while serving a diverse population with significant economic and cultural barriers to care.

The Unique Needs of the Community

Demographic-Driven Unique Needs

Highest Hispanic/Latino Population in Oregon (39.6% county-wide):

- Boardman specifically at 67% Hispanic population
- Need for bilingual services and cultural competency
- Specialized services for multiple indigenous languages (Mam, Mixteco, Q'anjob'al/Kanjobal, Quiche)
- Culturally appropriate maternal and family health services

Agricultural Community Needs

Significant Farmworker Population:

- Estimated 6,074 migrant workers plus 2,130 seasonal worker dependents
- 92% of farmworker population is Latinx
- Seasonal employment creating gaps in healthcare continuity
- Occupational health and safety needs
- Housing challenges (inadequate or unsafe conditions)
- Fear of using healthcare due to immigration status concerns

Frontier Geography Challenges

Remote, Mountainous Terrain:

- Entire county classified as "frontier"
- 2,032 square miles with elevation varying from 250 feet to nearly one mile
- Emergency response challenges over difficult terrain
- Weather-related access issues

Economic Structure Needs

Agricultural Economy Impacts:

- Second largest agricultural producer in Oregon
- Seasonal economic fluctuations
- Need for flexible healthcare scheduling around farming seasons
- Occupational health services for cattle ranches, dairies, potato and onion farming

Multi-Generational Community Needs

Aging Population (18% are 65+):

- 2,163 people aged 65 and older
- Need for long-term care services
- Medicare/Medicaid dual enrollment challenges (480 people)
- Rural aging-in-place support services

Educational and Workforce Development

High English Language Learner Population:

- 43% of Morrow County School District students are Ever English Language Learners
- 19% of Ione School District students are Ever English Language Learners
- Need for educational support bridging language and cultural gaps

Environmental and Infrastructure Needs

Water Quality Concerns:

- Ongoing water quality issues requiring multi-agency coordination
- LUBGWMA (Lower Umatilla Basin Groundwater Management Area) involvement
- Complex environmental health challenges

Social Support System Needs
Community Integration Challenges:

- High rates of grandparents raising grandchildren (50.1% responsible for basic needs)
- Need for "wraparound" services through CARE Team and Wellness Hub
- Social isolation in rural areas
- Transportation for social and community engagement

Specialized Healthcare Delivery
Innovative Service Models:

- School-based health centers (Ione Community Clinic)
- Telehealth services (VA Primary Care Telehealth Outreach Clinic)
- Mobile and outreach services
- Community health worker (Promotoras) programs

Emergency Preparedness
Unique Geographic Challenges:

- Remote location complicating emergency response
- Need for disaster preparedness in agricultural community
- Coordination across multiple small communities spread over large area

Veterans Services
Rural Veterans Population (923 veterans, 7.5% of adults):

- Higher percentage than state average (6.2%)
- Need for specialized rural veterans services
- Distance to VA facilities creating access challenges

What the Hospital or CCO is Doing Well
Morrow County Health District

- Comprehensive local network: Operates multiple facilities (Pioneer Memorial Hospital, Irrigon Medical Clinic, Boardman Immediate Care, Ione Community Clinic)
- Critical Access Hospital funding: Enhanced funding to support other healthcare services
- Home health and hospice services across Morrow and Gilliam counties
- Swing bed program for skilled nursing care

Eastern Oregon Coordinated Care Organization (EOCCO)

- Large Medicaid coverage: Serving 5,630 people (45% of county population)
- Collaborative ownership structure with diverse providers and hospital systems
- Community partnerships with local hospitals, public health, and county governments
- Integrated approach focusing on better health, better care, and lower costs
- Community engagement: Conducting surveys and focus groups to assess community needs

Columbia River Health

- Comprehensive integrated services: Physical health, behavioral health, dental, pharmacy all in one location
- Community outreach: Promotoras program and translation services
- 340B pharmacy program: Discounted medications for patients
- Transportation services: Free rides for patients in service area
- Telemedicine capabilities: Improving access despite geographic barriers

Strengths of the Community
Strong Collaborative Infrastructure

- Community Health Improvement Partnership (CHIP): Multi-disciplinary partnership operating since 2010
- Cross-sector collaboration: Health care providers, human services, government, education, faith communities, agri-business, chambers of commerce working together
- CARE Team and Wellness Hub: Providing "wraparound" services through coordinated partnerships

Economic Foundation

- Strong agricultural economy: Second largest agricultural producer in Oregon
- Diverse agricultural base: Cattle ranches, dairies, potato and onion farming
- Employment stability: 531,000 jobs connected to Oregon agriculture, contributing $42 billion annually
- Lower unemployment: 3.5% seasonally adjusted rate, slightly below state and national averages

Community Support Systems

- Extensive food assistance network: Food banks in Heppner, Irrigon, and Boardman plus independent groups providing food boxes to students
- Senior meal programs: Multiple senior centers and meal sites
- Transportation services: New "Loop" public transit system launched in 2024
- Emergency assistance programs: Rent, utilities, and household support services

Educational Resources

- Early childhood programs: Oregon Child Development Coalition, Head Start, multiple preschool options
- Community partnerships: Blue Mountain Early Learning Hub
- Cultural support: Programs specifically designed for farmworker families and Hispanic/Latino students

Healthcare Innovation

- Creative service delivery models: School-based health centers, telehealth clinics, mobile services
- Community health workers: Promotoras program providing culturally appropriate outreach
- Preventive care initiatives: In-school dental screening and treatment programs

Cultural Diversity as Strength

- Bilingual workforce: Spanish-English bilingual staff in multiple agencies
- Cultural organizations: Euvalcree, Doulas Latinas International, Oregon Rural Action
- Community integration programs: Organizations working specifically with Latino and farmworker populations

Civic Engagement

- Long history of collaboration: Community health assessments conducted regularly since 2010
- Public participation: Community forums, focus groups, and public presentations
- Multi-generational involvement: Services spanning from early childhood through older adults

Geographic Advantages

- Close-knit communities: Small town environments fostering strong relationships
- Agricultural heritage: Deep community knowledge and experience in farming and ranching
- Natural beauty: Location between Columbia River and Blue Mountains

Priorities

Identified Priority Areas of Concern

Population Groups:

1. Low-income populations
2. Latinx community
3. Maternal and family populations
4. Older adults

Health Conditions:

1. Behavioral health
2. Substance abuse
3. Chronic conditions with modifiable health behaviors
4. Oral health

System Priorities:

1. Maintain access to local system of care
2. Communication and coordination
3. Workforce development
4. Health equity
5. Social determinants of health

Broader Organizational Mission:

- Collect information to identify gaps in access to health care services
- Assess health status of county residents
- Form a rural health network for collaborative community-driven health needs assessment
- Create strategic plans to address identified needs using cost-effective strategies
- Support the Advisory Council to EOCCO for local input on health planning

Focus on Prevention:

- Programs supporting chronic disease management
- Health promotion and disease prevention
- Early intervention and screening programs

Community-Driven Solutions:

- Grant communities ability to identify local needs
- Plan strategically to address needs
- Utilize cost-effective strategies
- Build on community strengths and partnerships

Equity and Access:

- Address health disparities
- Improve access for vulnerable populations
- Strengthen cultural competency in service delivery