

Executive Summary

Assessment Overview Marion and Polk Counties in Oregon's Mid-Willamette Valley conducted a collaborative community health needs assessment covering a population of approximately 494,000 residents. The assessment utilized quantitative data analysis, community surveys (n=1,164), focus groups, and stakeholder interviews to identify priority health needs.

Priority Health Needs Identified The assessment identified five priority areas: mental health and substance use disorders, access to health care services, chronic disease prevention and management, social determinants of health (housing, food security, economic stability), and healthy growth and development for children and families.

Key Health Indicators The region faces significant challenges including higher rates of substance use disorders, mental health conditions, and chronic diseases compared to state averages. Marion County shows elevated rates of diabetes, heart disease, and obesity. Both counties experience disparities in health outcomes among Latino/Hispanic populations, low-income residents, and rural communities.

Access Barriers Major barriers include provider shortages (particularly in mental health and primary care), insurance coverage gaps, language and cultural barriers for Spanish-speaking populations, transportation challenges in rural areas, and affordability concerns. Long wait times for mental and behavioral health services were consistently reported.

Community Strengths Strengths include strong collaborative networks among health care providers and community organizations, committed safety net providers, culturally specific organizations serving diverse populations, community health workers and promotores, and established referral systems connecting residents to resources.

Implementation Priorities Hospitals and community partners will focus on expanding behavioral health services, improving health care access through workforce development and care coordination, addressing social determinants through housing and food security initiatives, preventing chronic disease through community-based programs, and supporting child and family well-being through early intervention services.

Biggest Gaps in Service and Barriers to Care

Mental and Behavioral Health Service Gaps Insufficient mental health providers and counselors, particularly for children and adolescents. Long wait times (3-6 months or more) for psychiatric appointments and therapy services. Limited crisis intervention services and psychiatric beds. Shortage of substance use disorder treatment programs, including detox facilities and medication-assisted treatment providers.

Primary and Specialty Care Shortages Inadequate number of primary care providers accepting new patients, especially those with Medicaid. Limited availability of specialists including neurologists, endocrinologists, cardiologists, and rheumatologists. Few providers accepting Oregon Health Plan (Medicaid). Rural areas particularly underserved.

Dental Care Gaps Severe shortage of dental providers accepting Medicaid. Limited pediatric dental services. Long wait times for appointments.

Insurance and Coverage Barriers Gaps in insurance coverage, particularly among undocumented populations. High deductibles and out-of-pocket costs. Confusion about insurance eligibility and enrollment processes. Medicaid coverage limitations restricting access to certain services and providers.

Language and Cultural Barriers Insufficient Spanish-speaking providers and bilingual staff. Lack of interpretation services. Cultural differences affecting communication and trust. Limited culturally appropriate health education materials.

Transportation Barriers Long distances to specialty care and services in rural areas. Limited public transportation options. Transportation costs prohibitive for low-income residents. Difficulty attending multiple appointments due to travel requirements.

Financial Barriers Cost of services, medications, and medical equipment. Inability to take time off work for appointments. Fear of medical debt. Lack of awareness about financial assistance programs.

System Navigation Challenges Complex referral processes and fragmented care systems. Difficulty understanding how to access services. Limited care coordination between providers. Lack of awareness about available community resources and services.

The Unique Needs of the Community

Latino/Hispanic Population Needs Language-appropriate services and Spanish-speaking providers. Culturally responsive care and health education. Support for undocumented residents who lack insurance access. Addressing fear and distrust of health care systems. Immigration-related stress and trauma services.

Agricultural Worker Needs Services accommodating work schedules and seasonal employment patterns. Addressing occupational health hazards and injuries. Understanding of migratory lifestyle affecting continuity of care. Support for families with unstable housing and income.

Rural Community Needs Addressing geographic isolation and long distances to services. Local access to specialty care and behavioral health services. Reliable broadband internet for telehealth access. Transportation solutions for medical appointments.

Low-Income and Uninsured Population Needs Affordable health care options and sliding fee scale services. Assistance navigating insurance enrollment and financial aid programs. Access to safety net providers and community health centers. Support for social determinants including housing, food security, and employment.

Children and Family Needs Early childhood mental health services and trauma-informed care. Developmental screening and early intervention programs. Parenting education and family support services. School-based health services. Pediatric behavioral health providers.

Ageing Population Needs Chronic disease management and prevention programs. Home-based care and aging-in-place support. Fall prevention and mobility services. Dementia and Alzheimer's support for families. Affordable senior housing options.

Substance Use Disorder Population Needs Low-barrier access to treatment and harm reduction services. Medication-assisted treatment availability. Peer support and recovery services. Integration of substance use treatment with mental health and primary care. Addressing stigma affecting treatment-seeking.

Mental Health Crisis Needs Immediate crisis intervention and stabilization services. Alternatives to emergency department care for mental health crises. Mobile crisis response teams. Short-term psychiatric beds and residential treatment options.

Strengths of the Community

Collaborative Networks and Partnerships Strong collaboration among health care providers, hospitals, public health agencies, and community-based organizations. Established coalitions

focused on specific health priorities. Regional coordination through Community Health Improvement Plans. Active participation in assessment and planning processes.

Safety Net Providers Committed Federally Qualified Health Centers (FQHCs) and community health centers providing affordable primary care. Sliding fee scale programs for low-income residents. Providers accepting Medicaid and serving uninsured populations. School-based health centers expanding access for children.

Culturally Specific Organizations Organizations serving Latino/Hispanic communities with culturally responsive programs. Community health workers (promotores) providing outreach and navigation. Bilingual staff and interpretation services at key agencies. Cultural brokers connecting community members to resources.

Community Health Workers and Peer Support Promotores and community health workers embedded in communities. Peer support specialists for mental health and substance use recovery. Trusted community members providing education and navigation. Bridging cultural and language gaps between providers and residents.

Resource Navigation and Coordination 2-1-1 information and referral services. Care coordination programs connecting patients to services. Community resource guides and directories. Systems for warm handoffs between providers and social services.

Prevention and Education Programs Community-based chronic disease prevention initiatives. Health education programs targeting specific populations. Wellness and physical activity opportunities. Nutrition assistance and food programs.

Hospital and Health System Commitment Hospitals' dedication to community benefit and addressing priority needs. Investment in community health improvement initiatives. Support for vulnerable populations through charity care and financial assistance. Partnership with community organizations on health equity efforts.

Public Health Infrastructure County public health departments providing essential services. Immunization and communicable disease programs. Maternal and child health services. Environmental health monitoring and protection.