2025

COMMUNITY HEALTH NEEDS ASSESSMENT EXECUTIVE SUMMARY

PROVIDENCE HOOD RIVER MEMORIAL HOSPITAL (HOOD RIVER, OREGON)

Understanding and Responding to Community Needs

The Community Health Needs Assessment (CHNA) is an opportunity for Providence Hood River Memorial Hospital (PHRMH) to engage the community every three years with the goal of better understanding community strengths and needs. At Providence, this process informs our partnerships, programs, and investments. Improving the health of our communities is fundamental to our Mission and deeply rooted in our heritage and purpose.

Led by the Columbia Gorge Health Council, the core partners for this collaborative CHNA were Adventist Health Columbia Gorge, Hood River County Public Health, North Central Public Health District, PacificSource Community Solutions, and Providence Hood River Memorial Hospital. Insight for Health was contracted to facilitate this CHNA process.

This is a "joint CHNA report," within the meaning of Treas. Reg. § 1.501(r)-3(b)(6)(v), by and for Providence including PHRMH. This report reflects the hospitals' collaborative efforts to identify the significant health-related needs in the community as well as the community strengths. The hospitals participating in this joint CHNA share a service area and community served. This CHNA engaged with and sought input from that community. Based on the availability of data, geographic access to the facility, and other hospitals in neighboring counties, Hood River and Wasco Counties serve as the boundary for the shared CHNA service area. The collaborative CHNA report is available in Appendix 1.

The 2025 CHNA was approved by the Providence Hood River Service Area Advisory Council on October 22, 2025, and made publicly available by December 28, 2025.

Who We Are

Our Mission	As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.
Our Vision	Health for a Better World.
Our Values	Compassion — Dignity — Justice — Excellence — Integrity

PHRMH is a 25-bed critical access hospital offering primary and specialty care, birth center with family suites, general surgery, radiology, diagnostic imaging, pathology and 24/7 emergency medicine.

For more information on the resources invested to improve the health and quality of life for the communities we serve, please refer to our Annual Report to our Communities: https://www.providence.org/about/annual-report.

Gathering Community Health Data and Community Input

Through a mixed-methods approach, using quantitative and qualitative data, we collected information from the following sources: American Community Survey, Behavioral Risk Factor Surveillance System, Environmental Justice Index, Oregon Health Authority, National Center for Health Statistics, US Census Bureau, local public health data, and more. To actively engage the community, we conducted 34 listening sessions with people who have chronic conditions, are from diverse communities, have low-incomes, and are medically underserved. The 34 listening sessions included 321 community partners and community members. Community partners that participated in listening sessions have a deep understanding of the community's strengths and needs. In addition to listening sessions, the core group conducted a community survey during the spring of 2024. Approximately 1,100 people who most likely lived or worked in Hood River or Wasco counties completed the survey. Some key findings include the following:

- There is a lack of affordable housing
- There is a lack of access to services for behavioral health, mental health, and substance use disorders
- There is a lack of access to medical care, especially for primary care, oral health and specialty care
- There is a lack of workforce development opportunities. This issue was raised across several social determinants of health domains for behavioral health services, early childhood, education, economic development, and medical care.
- There is a need for more diverse, bicultural, and bilingual services and providers

For more information related to the CHNA methods and process please see page 1 of the full CHNA document in Appendix 1.

Data Limitations and Information Gaps

While care was taken to select and gather data that would tell the story of the hospital's service area, it is important to recognize the limitations and gaps in information that naturally occur, including the following:

- Not all desired data were readily available, so sometimes we had to rely on tangential or proxy measures or not have any data at all.
- While most indicators are relatively consistent from year to year, other indicators are changing quickly and the most recent data available are not a good reflection of the current state.

- Reporting data at the county level can mask inequities within communities. This can also be true when reporting data by race, which can mask what is happening within racial and ethnic subgroups. Therefore, when appropriate and available, we disaggregated the data by geography and race.
- Data that are gathered through interviews and surveys may be biased depending on who is willing to respond to the questions and whether they are representative of the population as a whole.
- The accuracy of data gathered through interviews and surveys depends on how consistently the questions are interpreted across all respondents and how honest people are in providing their answers.

Identifying Collaborative Health Priorities

The core group identified a wide spectrum of significant health priorities, some of which are most appropriately addressed by other community organizations. The Providence Columbia Gorge Service Area Advisory Council reviewed and the collaborative health priorities and associated data and voted on the priorities they committed to addressing.

For a list and a description of significant health needs, see page 12 of the full report in appendix 1. For a list of potential resources available to address the identified needs, visit the Hood River County Health Department Resource Guide.

Providence Hood River Memorial Hospital 2025 Priority Needs

A wide spectrum of community needs were identified, some of which are most appropriately addressed by other community organizations. Providence's Hood River Service Area Advisory Council reviewed the community needs and associated data. Considering PHRMH's unique capabilities, community partnerships and potential areas of community impact, we are committed to addressing the following priorities as aligned with the full list of community needs identified:

ACCESS TO CARE AND SERVICES: Focus on primary care and preventative health, chronic health conditions, and oral health. This priority area refers to the lack of timely access to care and services due to physical, geographic, and systemic limitations, among others.

ECONOMIC SECURITY: Focus on affordable childcare, education, and workforce development. This priority area affects nearly every aspect of a person's life and refers to the challenge of affordable basic living expenses and obtaining affordable education.

HEALTH RELATED SOCIAL NEEDS: Focus on housing stability, navigation of supportive services, food security, and transportation. This priority area refers to the unmet social needs that exacerbate poor health and quality of life outcomes.

MENTAL HEALTH & SUBSTANCE USE DISORDER: Focus on access, capacity, prevention, and treatment. This priority area refers to the growing challenges of accessing care due to workforce shortages, a lack of culturally responsive care, and affordability.

Three consistent cross-cutting themes surfaced during the assessment process and analysis, affecting all four priority areas:

- Culturally responsive care and services
- Racism, discrimination, and inclusion
- Trauma-informed care and services

PHRMH will develop a three-year Community Health Improvement Plan (CHIP) to respond to these prioritized needs in collaboration with community partners considering resources and community strengths and capacity. The 2026-2028 CHIP will be approved and made publicly available no later than May 15, 2026.

Measuring Our Success: Results from the 2022 CHNA and 2023-2025 CHIP

PHRMH responded to community needs by making investments of direct funding, time, and resources to internal and external programs dedicated to addressing the previously prioritized needs using evidence-based and leading practices. In addition, we invited written comments on the 2022 CHNA and 2023-2025 CHIP, made widely available to the public through posting on our website and distribution to community partners. No written comments were received on the most recent CHNA and CHIP. The 2022 CHNA and 2023-2025 CHIP priorities were the following: Mental Health and Substance Use Disorder, Health Related Social Needs, Economic Security, and Access to Care and Services.

Below is a summary of the outcomes for each priority:

Table 1. Outcomes from 2023-2025 CHIP

This table identifies key initiatives Providence supported to address the 2023-2025 CHIP priorities; however, it is not an exhaustive list. The results below reflect data over a three-year period from 2023 to 2025 unless otherwise noted.

Priority Need	Program or Service Name	Program or Service Description	Results/Outcomes
Mental Health and Substance Use Disorder Services	Next Door Inc	Provide mental health services to Spanish speaking community members	37 people were served during the one-year 2023 grant period
Mental Health and Substance Use Disorder Services	Better Outcomes Through Bridges Emergency Department Outreach	Peer Support Specialists identify patients who frequently visit the emergency department, and connect them with resources to address unmet needs while providing trusted support and advocacy	105 patients supported in 2024

Homelessness and Housing Instability	Mid-Columbia Community Action Council (MCCAC)	Strengthen coordinated services for unstably housed and houseless communities in the Mid-Columbia Region	64 people were served during a one-year 2022-2023 grant period
Access to Care and Services	Patient Support Program	Providing patients with resources necessary for a safe and secure discharge from the hospital	269 patients served and 761 resource vouchers provided
Food Insecurity	Hood River Valley Adult Center	Providing seniors with meals via Meals on Wheels program and meals at the congregate meal site	145 people were served during the one-year 2025 grant period
Food Insecurity	Fish Food Bank	Providing funds to purchase food to be distributed through the food bank	4,871 people were served during a one-year 2025 grant period

This is not an exhaustive list.

Providence

2025 CHNA GOVERNANCE APPROVAL

This Community Health Needs Assessment was adopted by the Columbia Gorge Service Area Advisory Council on October 22, 2025. The final report was made widely available by December 28, 2025.

Rebecca Coplin 11-24-2025

Rebecca Coplin **Date**
Chief Administrative Officer, Providence Hood River Memorial Hospital
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APPENDICES

Appendix 1. 2024 Community Health Assessment for Hood River and Wasco Counties

2024 Community Health Assessment for Hood River and Wasco Counties

COLUMBIA GORGE HEALTH COUNCIL

December 2024

ACKNOWLEDGEMENTS

We thank all the community partners, members, and patients who gave feedback and participated in the Community Health Improvement (CHA) process. We are grateful to the Community Advisory Council members for providing feedback on the CHA process, engaging in sense-making around the data, and recommending the CHA priorities.

We appreciate our core partners - Adventist Health Columbia Gorge, Hood River County Public Health, North Central Public Health District, PacificSource Community Solutions, and Providence Hood River Memorial Hospital – for creating and sharing in ownership of the 2024 CHA. Lastly, we thank Insight for Action for facilitating the CHA process.

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EXECUTIVE SUMMARY

BACKGROUND and PURPOSE

The Columbia Gorge Health Council (CGHC) has a **vision** of community health and well-being for all people in the Gorge region. Our **mission** is to address barriers to health and well-being by:

- Working with partners to generate community-driven solutions
- Lifting patient and provider voices
- Bringing partners together to invest funds and support collective efforts to improve health quality, access, and equity

Every five years, the CGHC facilitates the development of the community health assessment (CHA) on behalf of PacificSource Community Solutions (PacificSource) Columbia Gorge Coordinated Care Organization (CCO). The last Regional Columbia Gorge CHA was developed in 2019 and focused on seven counties along the Columbia River in Oregon (Hood River, Wasco, Sherman, Gilliam, and Wheeler) and Washington (Klickitat, Skamania). This 2024 CHA focuses on two Oregon counties—Hood River and Wasco—as these counties form the PacificSource Columbia Gorge CCO geographic footprint.

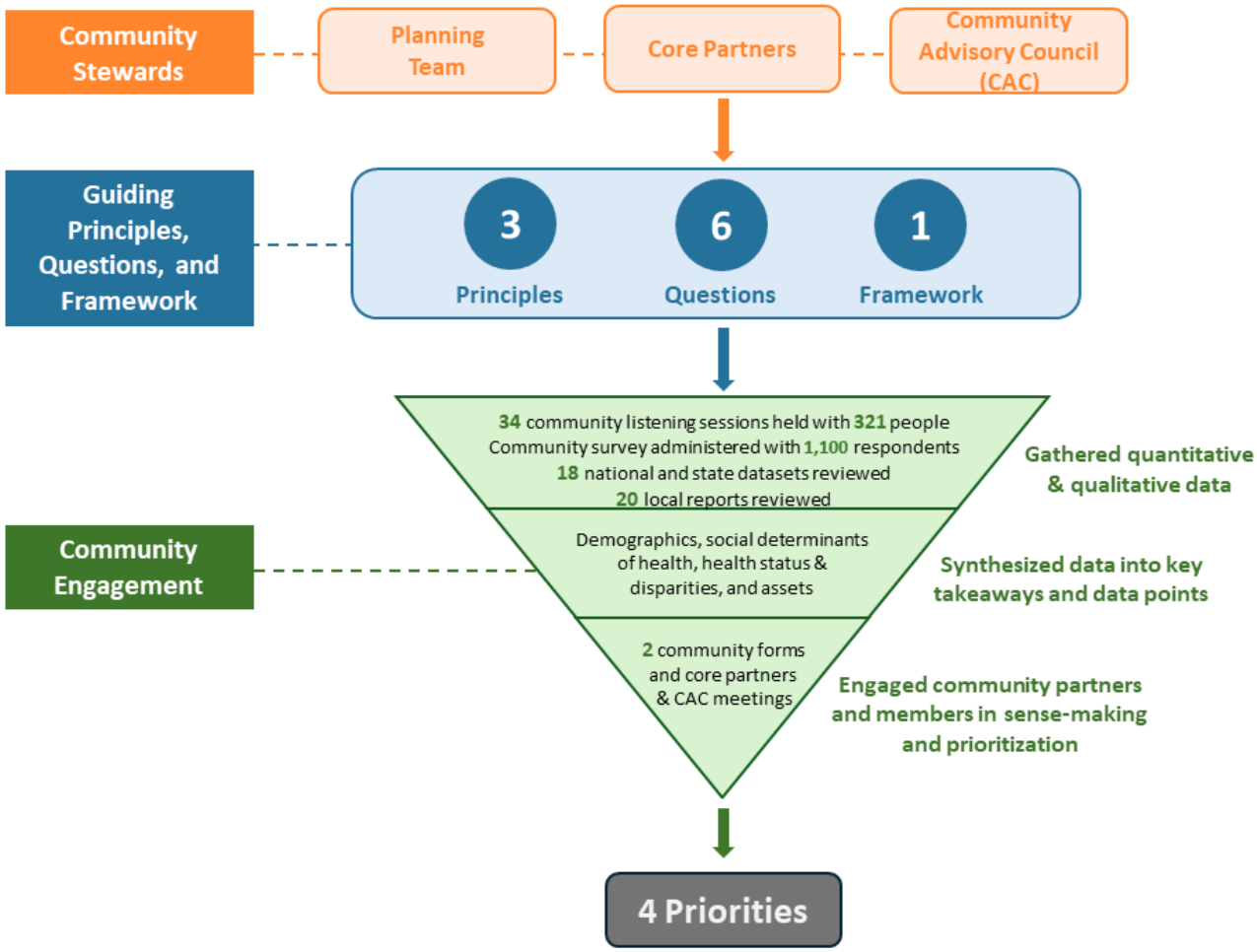
The **purposes** of the 2024 CHA are to:

- Identify critical health-related conditions that calls for community action to inform the 2025 Community Health Improvement Plan (CHIP)
- Inform the CGHC funding priorities.

COMMUNITY-DRIVEN PROCESS

The 2024 CHA was developed through a community-driven process to document and prioritize critical health-related issues. Three groups stewarded the process—a planning team, a set of core partners, and the Community Advisory Council (CAC). Three principles, six questions, and a health equity framework guided the process. Qualitative and quantitative data were gathered from four data sources. Data were synthesized into key takeaways to answer the guiding questions. Community partners (i.e., agencies) and community members (i.e., residents) were engaged in sense making of the key takeaways and recommended priorities through two community forums. The CAC also engaged in sense-making, reviewed priorities identified by the community, and recommended four priorities for the CHA.

Overview of the CHA Community-Driven Process



PRIORITIES

The community identified four social determinants of health priorities for action.

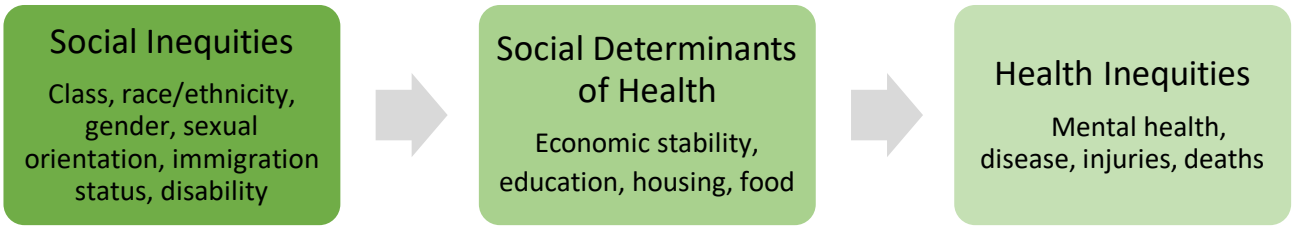
1. Lack of affordable housing
2. Lack of access to services for behavioral health, mental health, substance use disorders
3. Lack of access to medical care, especially for primary care, oral health, and specialty care
4. Lack of workforce development opportunities. This issue was raised across several social determinants of health domains for behavior health services, early childhood, education, economic development, and medical care.

A common theme identified across all four priorities was the need for more diverse, bicultural, and bilingual services and providers.

KEY TAKEAWAYS

We used the Bay Area Regional Health Inequities Initiative (BARHII), a nationally recognized framework for health equity to make sense of the interconnected relationships amongst the data points of demographics, social determinants of health, and health inequities. Social determinants of health are the conditions in which people are born, live, learn, work, and play that influence our well-being. Understanding these conditions helps explain why some people are less healthy than others, as indicated in the BARHII framework.

Bay Area Regional Health Inequities Initiative (BARHII) Framework (Modified)



The community-driven process revealed the following takeaways for demographics, social determinants of health, health status and inequities, unique community assets, and strengths and gaps for early intervention and treatment services for children and adolescents.

Demographics

- ✓ Taken together, Hood River and Wasco counties' total population is around 50,000 with **similar** sizes—Hood River around 24,000 and Wasco around 26,000.
- ✓ Hood River County, Wasco County, and the State of Oregon have **similar** patterns of younger and older age groups, and people who identify as male, female, and white, have a disability, or are veterans.
- ✓ Compared to Wasco County and the State of Oregon, **Hood River County** has more people who identify as Hispanic/Latino, were born outside of the USA; and live in a home where a language other than English is spoken.
- ✓ A **data gap** exists for county residents' sexual orientation and gender identity (SOGI), as the US Census data does not report these data. Although SOGI data are collected by the Oregon Health Authority and shared with PacificSource for CCO Oregon Health Plan (OHP) members, the current level of percentage collected for these Medicaid members are not statistically relevant at this point in time. OHP members are not required to report SOGI data. Although SOGI questions were asked in the 2024 Community Survey, those who completed the survey were considered a "convenience sample" as only two percent of Hood River and Wasco counties' residents do so. This precludes using the survey data for population estimates.

Social Determinants of Health

- ✓ Hood River County, Wasco County, and the State of Oregon have **similar** indicators of food insecurity, social connection, and transportation. Hood River and Wasco counties also have **similar** climate issues (i.e., days of extreme heat and poor air quality from wildfire smoke).
- ✓ Compared to Hood River County and the State of Oregon, **Wasco County** has more favorable housing indicators (i.e., fewer renters spend 30% of income on rent, lower median rent) and more unhoused people.
- ✓ Compared to Wasco County and the State of Oregon, **Hood River County** has more favorable access to mental health providers, primary care providers and dentists; education indicators (K-12 students meeting benchmarks and people with bachelor's degrees); and economic stability indicators (higher median household income, lower poverty rate, higher employment and job growth rate).

Health Status and Inequities

- ✓ The **leading two causes of death** in Hood River and Wasco counties are heart disease and cancer. The third top cause of death in Hood River County is cerebrovascular disease, while unintended injuries is the Wasco County's third cause of death.
- ✓ Relative to other counties and the State of Oregon, the **top three diseases and injuries** in Hood River County are cancers, mental health disorders, and infectious diseases. For Wasco County, they are injury deaths, tobacco use, and infectious and respiratory diseases.
- ✓ Compared to Wasco County and the State of Oregon, people (on average) in **Hood River County** experience better health in terms of life expectancy, premature death, disease, and injury.
- ✓ As noted in the *Social Determinants of Health* section of this report, **Hood River County** has more favorable social determinants of health indicators around economic stability, education, and access to medical care providers. According to our guiding equity framework (BARII), these more favorable social determinants may explain some of the health inequities between the two counties.
- ✓ A **data gap** exists for documenting health disparities race/ethnicity, gender, disability, and sexual orientation at the county level. The CGHC's Columbia Gorge Healthy Community Data Dashboard contains over 30 indicators of health status (i.e., adults with current asthma) at the county level. Only one of the indicators was available by race/ethnicity – all cancer incidence rate. The 2024 Community Survey asked about people's demographics (i.e., race/ethnicity, sexual orientation, disabilities), yet few people in this convenience sample identified as not heterosexual, non-binary or having a disability.

Unique Assets for Community Action

- ✓ The Columbia Gorge region is rich in assets dedicated to enhancing community health and well-being, characterized by unique public-private collaboratives that address critical issues such as houselessness, food insecurity, substance use, and health equity across county and state lines.
- ✓ The majority of these assets fall within categories that span multiple social determinants of health and equity issues specifically designed to meet the unique needs of Hood River County and Wasco County residents.
- ✓ The **44** unique assets that support community health in Hood River and Wasco counties are organized into four categories: 1) collaboratives 2) informational resources 3) physical facilities /infrastructure and 4) programs.

Assets and gaps for early intervention and treatment for children and adolescents

- ✓ Hood River and Wasco counties face significant gaps in preventive and treatment services for children (0-12) and adolescents (13-18), particularly access to medical and mental health care.
- ✓ A shortage of qualified providers and limited funding further exacerbate these challenges, making it difficult to address the region's needs.
- ✓ High needs, combined with limited infrastructure and resources, result in unmet health needs for both children and adolescents.
- ✓ Despite these obstacles, both counties benefit from strong early learning programs and school-based health centers in Hood River and Dufur that provide essential support to local families.

PART I: OVERVIEW & PRIORITIES

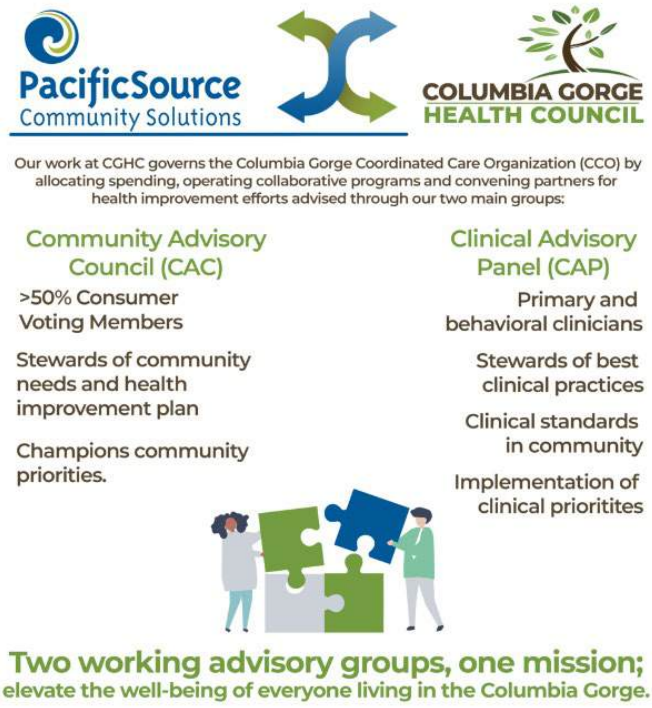
BACKGROUND and PURPOSE

The Columbia Gorge Health Council (CGHC) has a **vision** of community health and well-being for all people in the Gorge region. Our **mission** is to address barriers to health and well-being by:

- Working with partners to bring generate community-driven solutions
- Lifting patient and provider voices
- Bringing partners together, investing funds and supporting collective efforts to improve health quality, access, and equity

The CGHC works in partnership with PacificSource Community Solutions (PacificSource) Columbia Gorge Coordinated Care Organization (CCO) and is governed by a board of directors and supports two committees:

- **The Community Advisory Council (CAC)** champions community priorities by serving as stewards of community needs and health improvement plans. Over half of its members are Oregon Health Plan members.
- **The Clinical Advisory Panel (CAP)** champions best clinical practices and priorities. Most members



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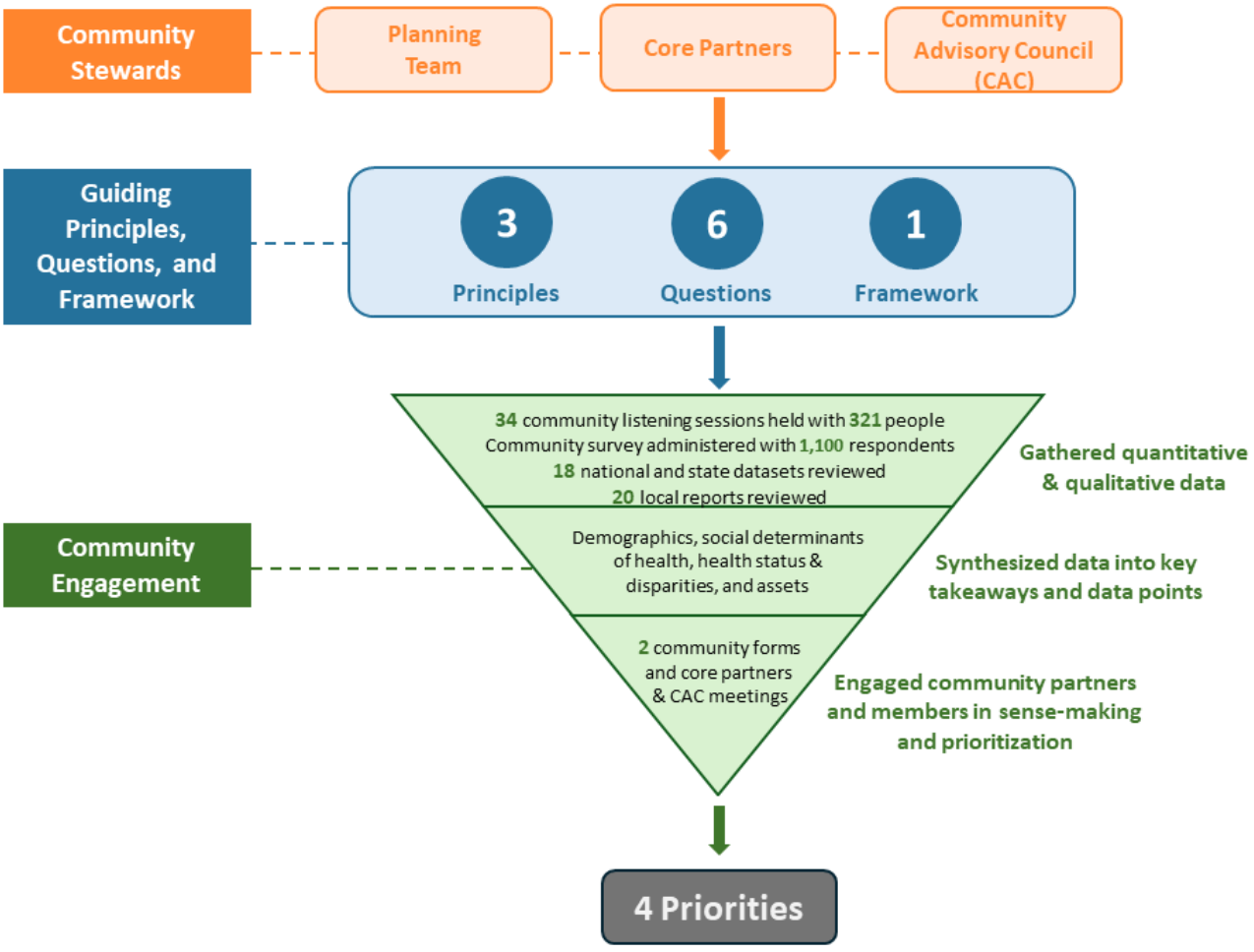
- Inform the CGHC funding priorities.

COMMUNITY-DRIVEN PROCESS

Overview

As illustrated in **Figure 1**, the CHA was developed through a community-driven process to document and prioritize critical health-related issues. Three groups stewarded the process—a planning team, a set of core partners, and the Community Advisory Council (CAC). They developed three principles, six questions, and used an equity framework to guide the process. Qualitative and quantitative data were gathered from four data sources. Data were synthesized into key takeaways to answer the guiding questions. Community partners (i.e., agencies) and community members (i.e., residents) were engaged in sense-making of the key takeaways and recommended priorities through two community forums. The CAC also engaged in sense-making, reviewed priorities identified by the community, and recommended the final priorities.

Figure 1: Overview of community-driven CHA process



Community Stewards

Three groups comprised of community partners (i.e., agencies) and community members (i.e., residents) stewarded the CHA process.

❶ The **planning team** was responsible for designing, implementing, and drafting the CHA. The team, which met monthly from May 2023 through December 2024, was comprised of Jenny Anglin and Amy Scholze (Columbia Gorge Health Council), Lexi Stickel (PacificSource), Sara Hoover (CAC Chair), and Maya Crone and Ronda Zakocs (Insight for Action).

❷The **core partners** shared ownership of the CHA by providing feedback on the CHA process, supporting data collection and recommending priorities for the CHA. The core partners met five times between January and October 2024. Core partners included representatives from Hood River and Wasco counties' **two hospitals** (Adventist Health Columbia Gorge and Providence Hood River Memorial Hospital), **two public health departments** (Hood River County Health Department and North Central Public Health District), and PacificSource Columbia Gorge **CCO's Tribal Liaison**. Providence administered and analyzed the 2024 Community Survey of Hood River and Wasco counties' residents. Refer to **Appendix 1** for Memoranda of Understanding (MOUs) from Adventist Health, Providence, Hood River County Health Department, and North Central Public Health District.

Figure 2: Core partners meetings

Meeting Date	Topics
January 17, 2024	▪ Described overview of OHA CHA requirements ▪ Solicited feedback on the CHA process ▪ Agreed upon their roles within the CHA ▪ Discussed pros and cons of a community survey
March 20, 2024	▪ Reviewed draft of community survey and discussed survey promotion
June 17, 2024	▪ Facilitated listening session on perceived health priorities and inequities
July 1, 2024	▪ Reviewed community survey progress and distribution strategies
October 14, 2024	▪ Shared community engagement process. ▪ Solicited feedback on priorities for the CHA

❸ The **Community Advisory Council** (CAC) was responsible for providing feedback on the CHA process, engaging community members in CHA participation, and recommending priorities for the CHA. Refer to **Appendix 2** for the CAC membership roster and demographics. The CAC discussed the CHA during seven of its monthly meetings from May 2023–November 2024 as detailed in **Figure 3**.

Figure 3: CAC meetings with CHA-related topics

Meeting Date	CHA-related Topic
May 22, 2023	▪ Shared OHA CHA requirements ▪ Agreed upon steward roles for the CHA—planning team, core partners and the CAC
October 23, 2023	▪ Agreed upon geographic scope of Hood River and Wasco counties. ▪ Agreed upon six guiding questions and three principles ▪ Agreed upon process for community engagement and data collection
January 22, 2024	▪ Engaged in sense-making around quantitative data points by county demographics and social determinants of health
May 20, 2024	▪ Provided update on process ▪ Solicited input on community partner and member listening sessions
October 28, 2024	▪ Engaged in sense-making on county resident health disparities and social determinants of health
November 11, 2024	▪ Provided update on community engagement process and priorities identified by the community during two community forums. ▪ Recommended priorities for the CHA
November 25, 2024	▪ Approved content of the CHA

Guiding principles

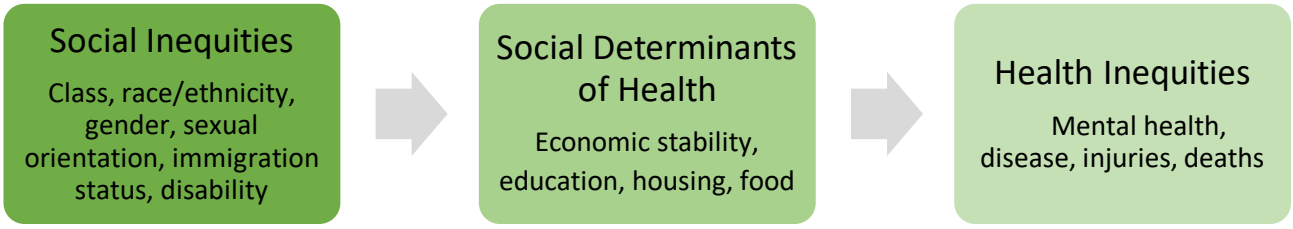
Three principles guided the CHA process:

1) Listen to and act upon community partner input without placing undue time burden
2) Use high quality, accessible, and regularly updated data sources, where available
3) Center equity in gathering, analyzing and reporting data

Guiding framework

The Bay Area Regional health Inequities Initiative (BARHII), a nationally recognized framework for health equity, served as a frame for sense-making around the relationships among demographics, social determinants of health, and health inequities. As depicted in **Figure 4**, the BARHII framework suggests that social inequities influence social determinants of health, which in turn, influence health inequities.

Figure 4: Modified BARHII framework



Guiding questions

Six questions guided the CHA's data collection efforts:

❶ What are the **demographics** of residents in Hood River and Wasco counties in terms of race, ethnicity, languages spoken, disability, age, gender, and sexual orientation?
❷ What is the **health status** of residents in Hood River and Wasco counties in terms of leading causes of death, life expectancy, top diseases and injuries, and self-reported health?
❸ What are the biggest **health disparities** between Hood River & Wasco counties around, race, ethnicity, disability, age, gender, and sexual orientation?
❹ What are the critical **social determinants of health** and how may they contribute to health disparities?
❺ What are the strengths and gaps in preventive and treatment services for **children and youth**?
❻ What are the unique **assets** in Hood River and Wasco counties that support community health improvement?

Community engagement

As displayed in **Figure 5**, the planning team engaged numerous types of community partners and members to meaningfully solicit their perspectives around the CHA's six guiding questions and recommend CHA priorities. Refer to **Appendix 3** for dates of these engagements.

Figure 5: Community partner and community member engagement

Type	Name
County & city government representatives	Dan Richardson, City Councilor, The Dalles Gladys Rivera, City Councilor, Hood River
CCO Tribal Liaison	Buffy Hurtado, PacificSource Tribal Liaison
Culturally specific organizations	Gorge Native American Collective* Mid-Columbia Health Equity Advocates The Next Door Inc.*
Federally recognized tribes	The Confederated Tribes of Warm Springs (CTWS) did not engage in this CHA cycle. CGHC is working with Buffy Hurtado, the CCO Tribal Liaison, and member of CTWS to plan a long-term tribal engagement strategy that centers tribal sovereignty and self-determination.
Federally qualified health center	One Community Health
Indian Health Care Providers	N/A: There are no Indian Health Care Providers as defined by health care program operated by IHS, Indian Tribe, or Tribal Organization in Hood River or Wasco County.
Local mental health authorities and community mental health partners	Columbia Gorge Health Council Clinical Advisory Panel Mid-Columbia Center for the Living
Physical, behavioral, oral health providers	Adventist Health Columbia Gorge Behavioral Health Advisory Committee Providence Hood River Memorial Hospital Hood River Public Health Department North Central Public Health District Oral Health Working Group
Representatives from populations experiencing health and health care disparities	Community member listening sessions with: ▪ People in recovery for substance use ▪ People accessing mental health services ▪ Seniors ▪ Spanish speakers
School nurses, school mental health providers & others representing child & adolescent health services	Columbia Gorge Educational Service District, Superintendent Columbia Gorge ESD, Early Intervention Four Rivers Parenting and Early Learning One Community Health, School-based Health Center Director North Wasco Schools, School Nurse South Wasco Schools, Assistant School Counselor Wasco County YouthThink, Program Director
Social determinants of health partners	Bridges to Health Columbia Gorge Food Security Coalition Mid-Columbia Community Action Council Mid-Columbia Houseless Collaborative Gorge Resource Huddle
Traditional health workers	Bridges to Health Community Health Worker Collaborative

*Identify as social determinants of health partners as well

The planning team engaged community partners and community members in 34 listening sessions held from March through August 2024 and two community forums held in September and October 2024. The next section on *Data Gathering* provides more details on listening sessions and community forums.

The CHA development process was transparent and inclusive. Information flyers were drafted in English and Spanish and distributed to community partners for outreach efforts for the community member listening sessions, the community forums, and the community survey. Refer to **Appendix 4** for outreach flyers.

Data gathering

The planning team gathered quantitative and qualitative data from the four sources described below to answer the CHA's six guiding questions:

❶ **Listening sessions.** The planning team held **34** listening sessions with approximately **321** community partners and community members from March to August 2024. Refer to **Appendix 5** for names of organizations or people, number participants per session, and session dates. A majority of the listening sessions (n=29) were held during regularly scheduled coalition or agency meetings as well one-on-one interviews with agency representatives. During these meetings and interviews, participants were queried about their perspectives on health inequities, social determinants of health, and assets in Hood River and Wasco counties. Five listening sessions were held with community members—seniors, people accessing mental health and substance use disorder services, and Spanish-speaking residents. During these sessions, participants were asked about their experiences, barriers to service or program access, and the assets they use. These conversations were recorded and transcribed along with notes written during the conversations.

❷ **Community survey.** Providence Health & Services designed and administered a web-based survey for Hood River and Wasco counties' residents during spring/summer 2024. The survey queried community members about their demographics, health care coverage, access to medical, mental health, and oral health care, self-reported health, and social connection. Approximately **1,100** people who most likely lived or worked in Hood River or Wasco counties completed the survey. See **Appendix 6** for a description of the methods, questions and participant demographics.

❸ **Existing datasets.** The CGHC's Columbia Gorge Healthy Community Data Dashboard compiles numerous state and national databases, which report 202 indicators of health for Hood River and Wasco counties. Insight for Action accessed this dashboard to document demographic, health conditions, and social determinants of health data. Data points were identified and verified from **18** state and national datasets. Refer to **Appendix 7** for list of datasets accessed.

❹ **Local reports.** Insight for Action reviewed **20** local reports commissioned or drafted by Hood River and Wasco counties' agencies around climate, healthcare, housing, and transportation. Key themes were documented in a spreadsheet. Refer to **Appendix 8** for list of local reports.

Key takeaways

Insight for Action analyzed the quantitative data from the national/state datasets by comparing data points for Hood River County, Wasco County, and the State of Oregon. Providence analyzed quantitative data from the 2024 Community Survey using frequency distributions and bi-variate analyses. Insight for Action analyzed the qualitative data from the listening sessions and local reports by coding into themes via spreadsheets. Lastly, Insight for Action synthesized the quantitative data points and qualitative themes into key takeaways organized around the CHA's guiding questions.

- **Demographics**. Sixteen data points were identified for Hood River and Wasco counties' residents and Oregon Health Plan members served by PacificSource Columbia Gorge CCO. Refer to the *Demographic section* of this report for key takeaways and data points.
- **Social determinants of health**: Ten social determinants of health domains and 196 issues emerged from the community-driven process. Domains are broad categories, such as housing, and are listed in **Figure 6.** Issues are specific barriers or challenges within the domains such as lack of affordable housing. See **Appendix 9** for the full list of 196 issues identified. Forty-two data points for social determinants of health were identified from data and national datasets. Refer to the *Social Determinants of Health* section of this report for data points.
- **Health status & disparities**: Eleven data points were identified from national and state datasets. Refer to the *Health Status & Disparities* section of this report for key takeaways and data points.
- **Unique assets**: Forty-four assets unique to Hood River and Wasco counties were identified from listening sessions (and more were subsequently added from the community forums). Refer to *Assets & Gaps* section of this report for key takeaways.

Figure 6: Ten social determinants of health domains identified by community members and partners

1. **Behavioral & mental health services |** *Access to affordable, quality, and culturally appropriate treatment services for substance abuse and mental conditions like anxiety, depression, and PTSD*
2. **Climate change/natural disasters** | *Access to services to address drought, extreme heat and wildfires*
3. **Early childhood development** | *Access to childcare and early learning programs like Head Start*
4. **Economic stability** | *Access to living wage jobs and government assistance programs like SNAP or TANF*
5. **Education** | *Access to quality K-12 schools, community colleges, and workforce training programs*
6. **Food security** | *Access to affordable, nutritious, culturally appropriate food*
7. **Housing** |*Access to affordable, stable, safe housing*
8. **Medical care services** | *Access to affordable, quality, culturally appropriate, necessary services*
9. **Public transportation** [*Access to affordable and quality public transport*
10. **Social connection** |*Access to opportunities for social connection and community engagement*

Sense-making and prioritizing

Community partners and members, core partners, and the CAC engaged in sense-making around the key takeaways and recommended priorities through community forums and meetings.

Community forums. The planning team invited community partners and members who participated in the CHA listening sessions to attend one of two **community forums** held in The Dalles on September 25, 2024, and in the City of Hood River on October 1, 2024. Forty people attended these community events. Refer to **Appendix 10** for community forum rosters.

The forums were designed to engage community partners and community members in sense-making around the social determinants of health and to recommend priorities. During the forums, participants were invited to:

- Read the key takeaway summary (provided in English and Spanish) on social determinants of health domains and issues. Refer to **Appendix 9** for full list.
- Pair up with another attendee to reflect on the key takeaways (e.g., What surprised you? What disappointed you? What resonated with you?)
- Participate in a World Café activity. Small groups moved across stations presenting posters with key takeaways where participants shared their perspectives on 1) important assets or barriers around the social determinants of health that may be missing and 2) which social determinants of health and issues should be prioritized in the CHA.
- Complete an anonymous survey rating which social determinants of health domains (i.e., housing) were most important for the CHA to prioritize and what specific issues within each domain were most important (i.e., affordable housing).

After the community forums, Insight for Action analyzed the survey data to identify the most important social determinants of health domains and issues. These were summarized into a one-page document. Community members and partners prioritized two domains—Housing and Access to Behavioral/Mental Health Services—and 21 issues. Refer to **Appendix 11** for a narrowed one-page summary.

Core partners. The planning team invited representatives of the core partners to provide feedback on the one-page summary of priority social determinants of health domains and issues in a meeting on October 14, 2024. Those present concurred with the prioritized domains (Housing and Access to Behavioral/Mental Health Services) and the 21 issues. One additional issue was added to the list.

Community Advisory Council (CAC). In meetings held on October 28 and November 4, 2024, CAC members:

- Engaged in sense-making with demographic, health inequity, and social determinants of health data points.
- Reviewed the one-page summary of recommendations made by community partners and members and endorsed by the core partners.
- Recommended which social determinants of health issues should be prioritized.

PRIORITY ISSUES

This community-driven process identified four social determinants of health to prioritize for community action in this CHA:

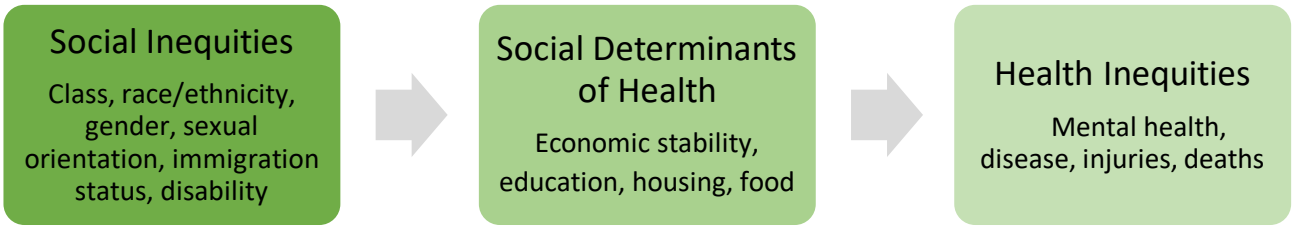
1. Lack of affordable housing
2. Lack of access to services for behavioral health, mental health, substance use disorders
3. Lack of access to medical care, especially for primary care, oral health, and specialty care
4. Lack of workforce development opportunities. This issue was raised across several social determinants of health domains for behavior health services, early childhood, education, economic development, and medical care.

A common theme identified across all four priorities was the need for more diverse, bicultural, and bilingual services and providers.

PART II: KEY TAKEAWAYS & DATA POINTS

Part II displays key takeaways and data points for demographics, social determinants of health, and health status and inequities. The Bay Area Regional Health Inequities Initiative (BARHII), a nationally recognized framework for health equity, served as a frame for community sense-making around the relationships among demographics, social determinants of health, and health inequities. As reflected in **Figure 7**, the BARHII framework suggests that social inequities (i.e., demographics) influence social determinants of health and then influence health inequities.

Figure 7: Modified BARHII framework



DEMOGRAPHICS

This section describes key takeaways and data points for demographics of Hood River and Wasco counties' residents from US Census data, and Oregon Health Plan (OHP) members served by PacificSource Columbia Gorge CCO in those two counties.

Key Takeaways for Hood River and Wasco Counties Demographics

- ✓ Taken together, Hood River and Wasco counties total population is around 50,000 with **similar** sizes - Hood River around 24,000 and Wasco around 26,000.
- ✓ Hood River County, Wasco County, and the State of Oregon have **similar** patterns of younger and older age groups, and people who identify as male, female, and white, have a disability, or are veterans.
- ✓ Compared to Wasco County and the State of Oregon, **Hood River County** has more people who identify as Hispanic/Latino, were born outside of the USA, and live in homes where a language other than English is spoken.
- ✓ A **data gap** exists for county residents' sexual orientation and gender identify (SOGI), as the US Census data does not report these data. Although SOGI data are collected by the Oregon Health Authority and shared with PacificSource for CCO Oregon Health Plan (OHP) members, the current level of percentage collected for these Medicaid members are not statistically relevant at this point in time. OHP members are not required to report SOGI data. Although SOGI questions were asked in the 2024 Community Survey, it is considered a "convenience sample" as only two percent of Hood River and Wasco counties' residents completed the survey. This precludes using the survey data for population estimates.

Data Points for Hood River and Wasco Counties' Residents

Figures 8 – 12 display data points from the US Census Bureau for age, gender, race/ethnicity, foreign born, languages other than English spoken at home, rurality, disability, and veterans.

Figure 8: Age

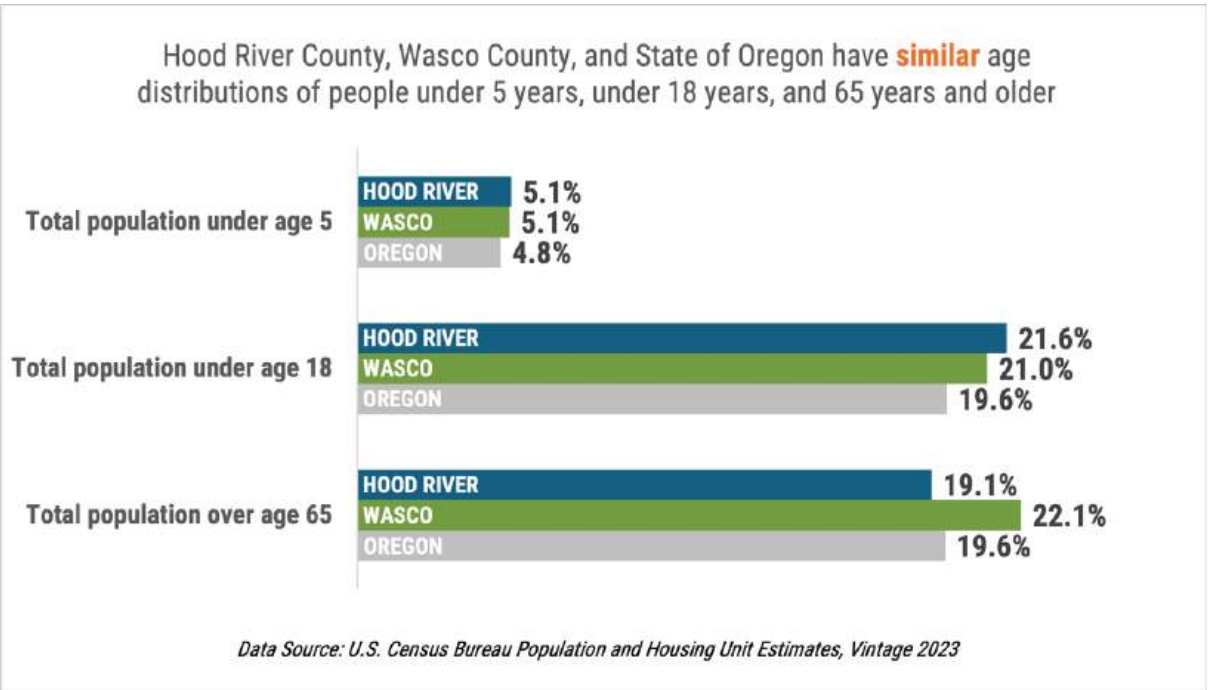


Figure 9: Sex

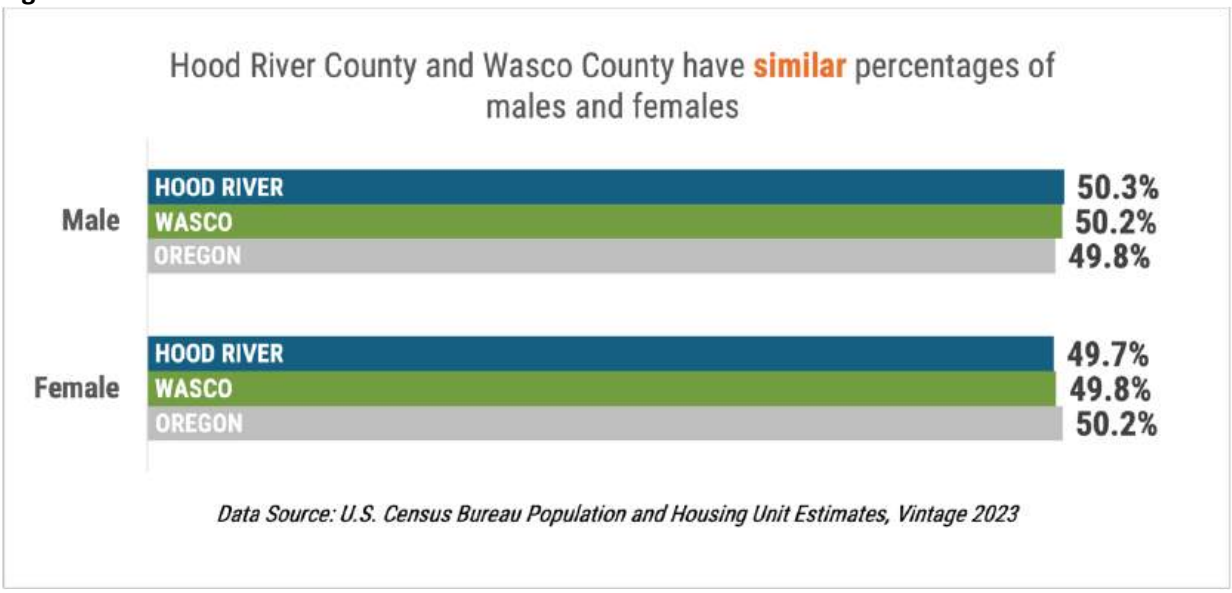


Figure 10: Race/ethnicity

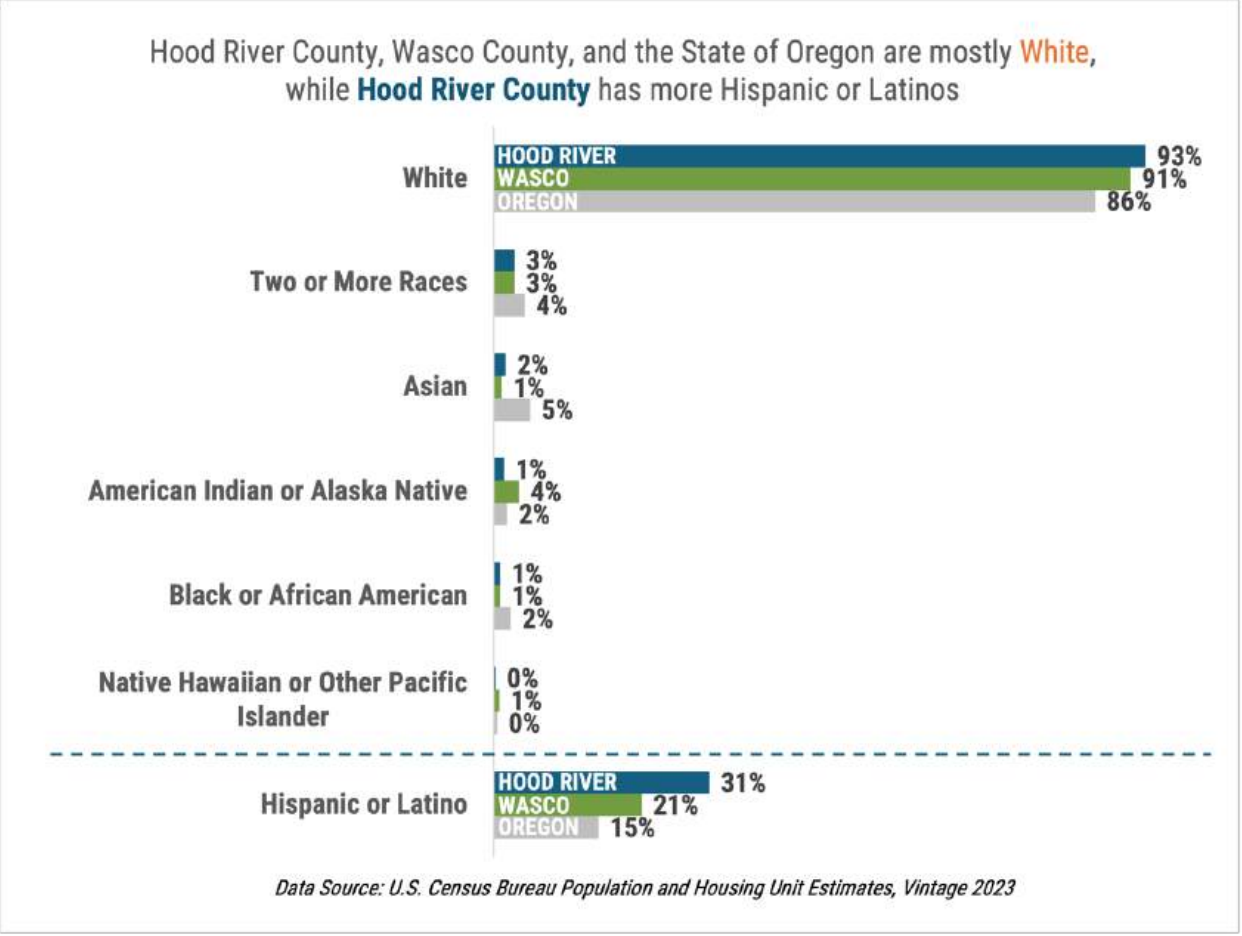


Figure 11: Foreign born and language other than English spoken at home

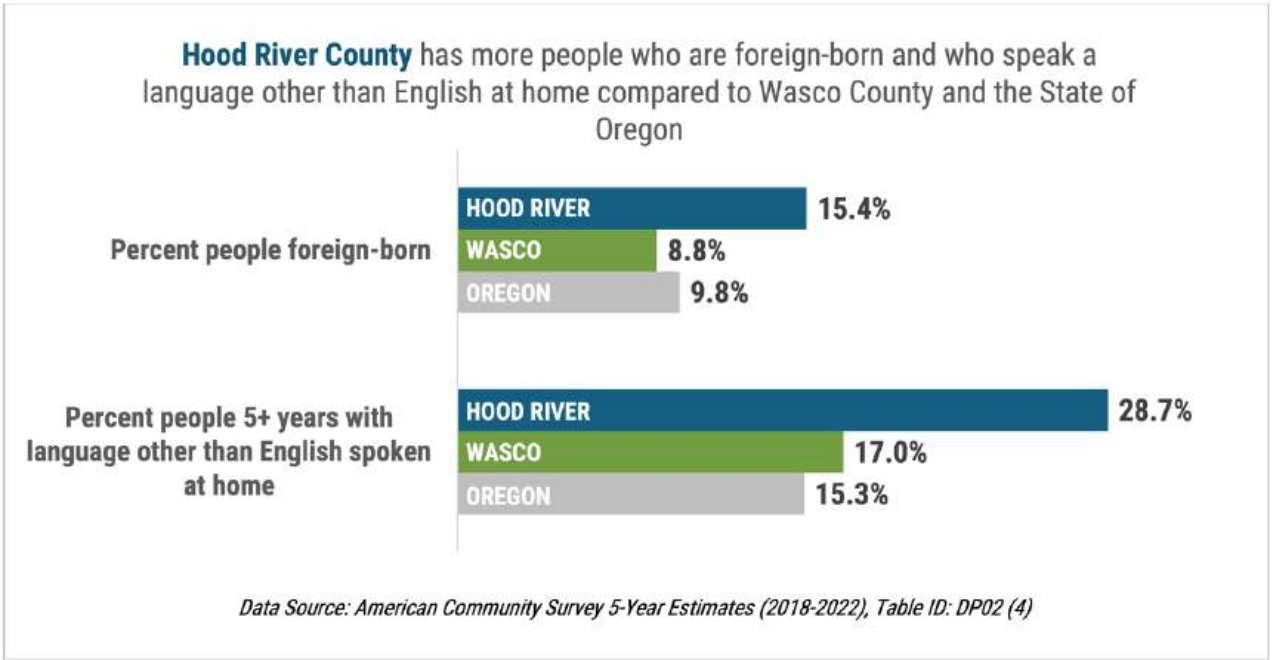
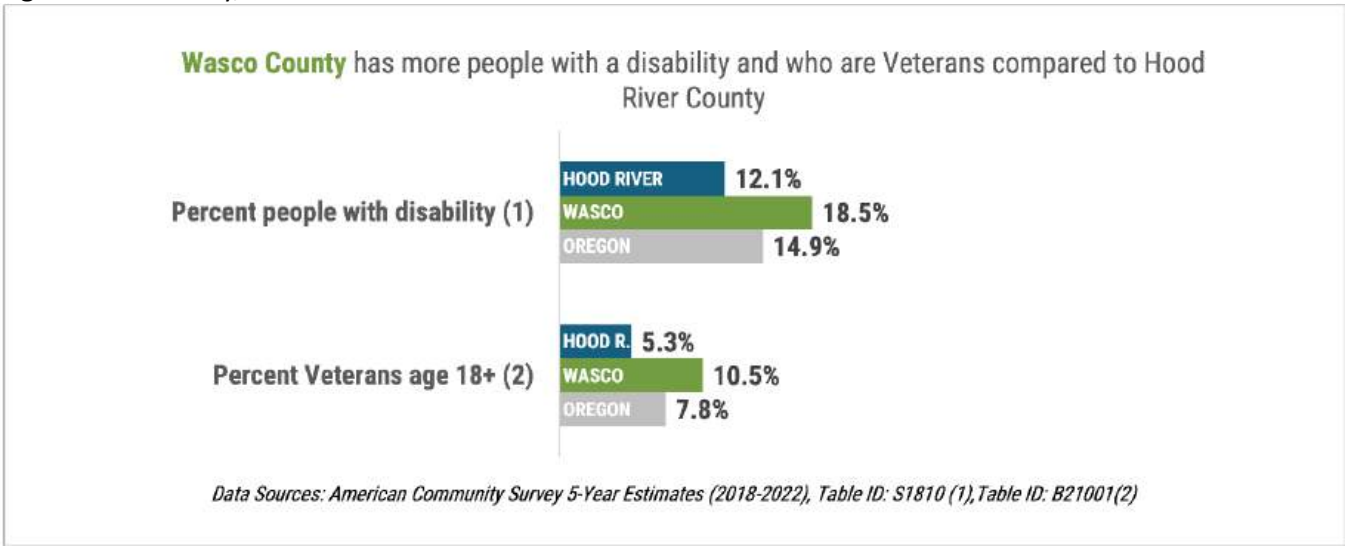


Figure 12: Disability, veterans



Key Findings from PacificSource Columbia Gorge CCO Oregon Health Plan Members

- ✓ Majority of members are children 12 years younger and adults 19 to 35 years
- ✓ Members who identify as white (42%) and Hispanic/Latino (21%) are the largest racial/ethnic groups
- ✓ Majority of members speak English (81%); Spanish is spoken by 18%
- ✓ Around 10% of members need translation services
- ✓ Around 13% of members live with a disability of some kind
- ✓ Percentage level collected for Medicaid member SOGI data are not statistically relevant at this point in time

Data Points for Oregon Health Plan Members

Figures 13 – 19 display demographic data points for Oregon Health Plan members served by PacificSource Columbia Gorge CCO by age, race/ethnicity, language spoken, translation needs, disability, and gender identity and modality.

Figure 13-1: Age

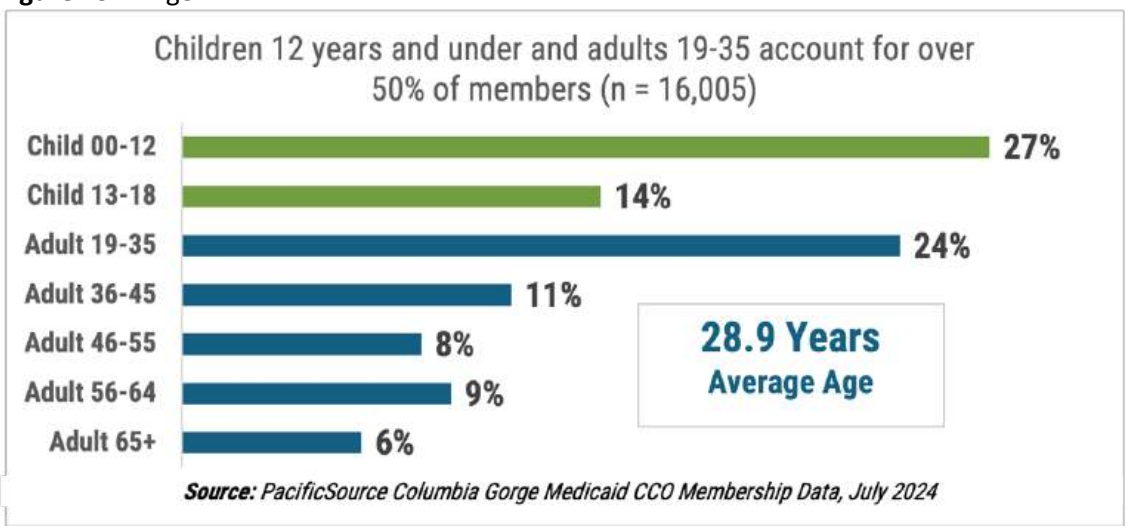


Figure 13-2: Age

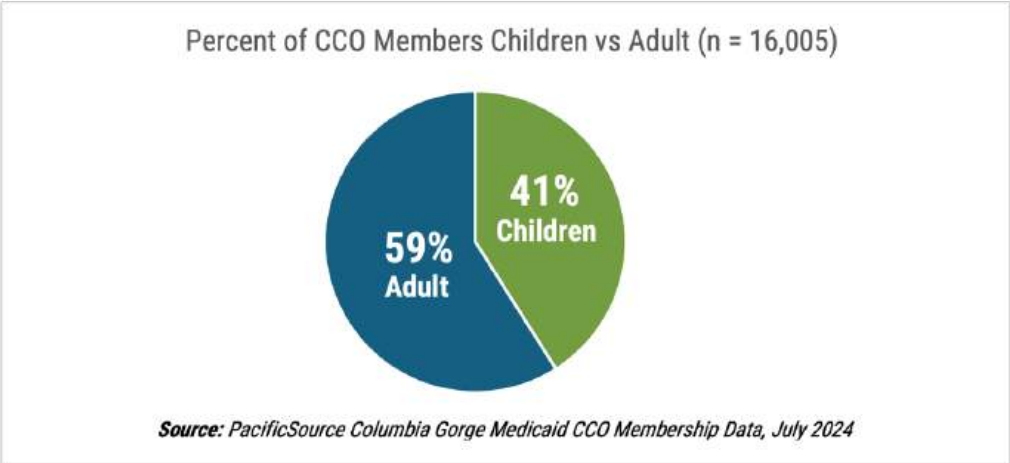


Figure 14: Race/ethnicity

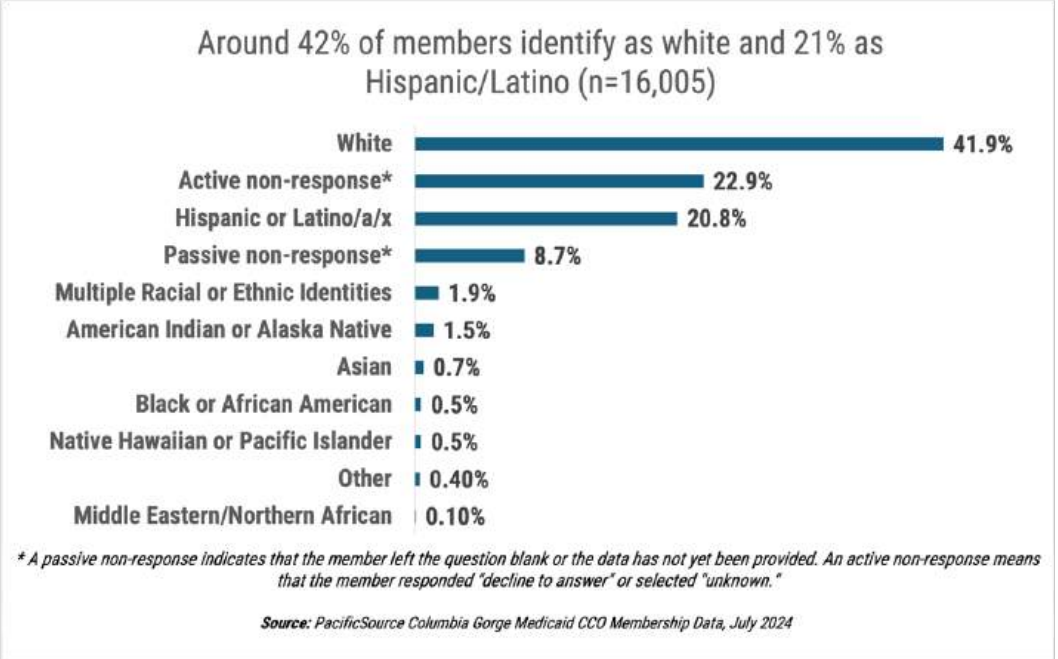


Figure 15: Top spoken languages

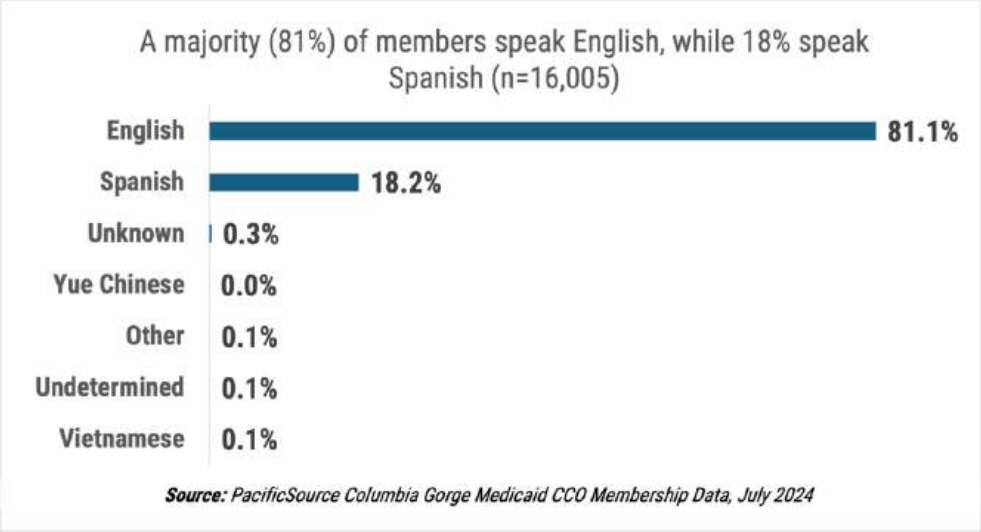


Figure 16: Interpretation needs

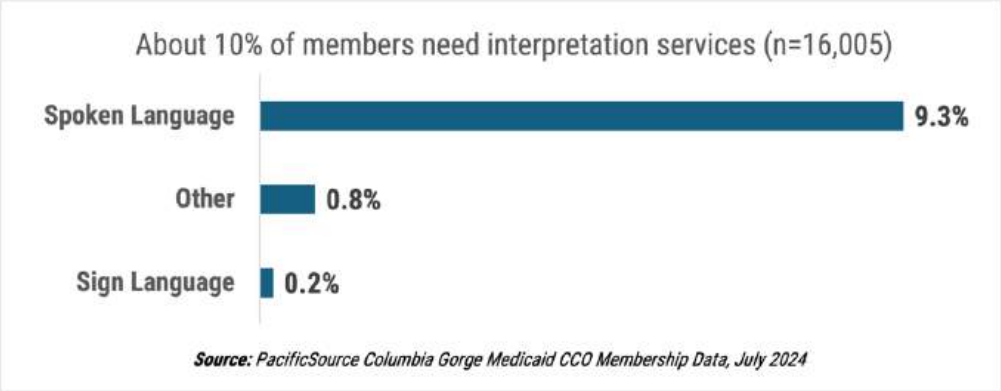


Figure 17: Disability status

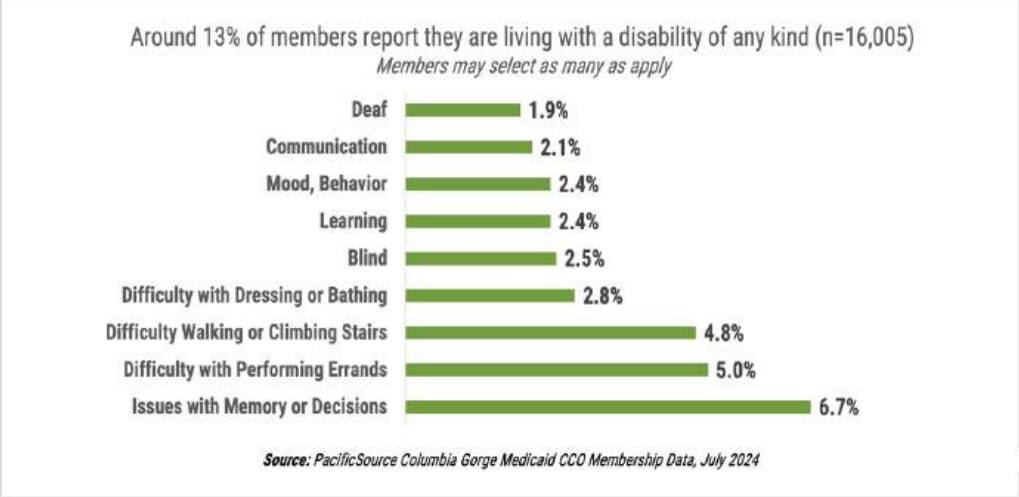


Figure 18: Gender identity

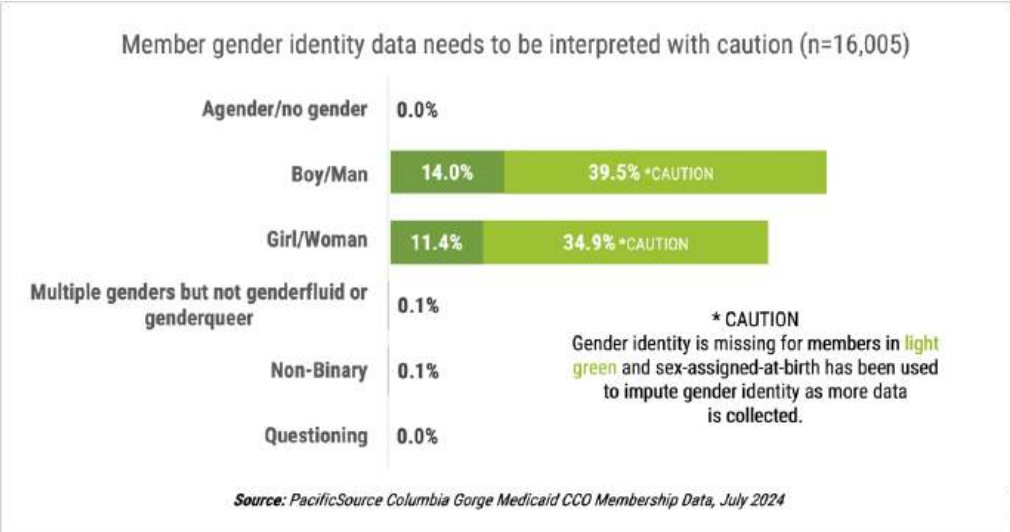
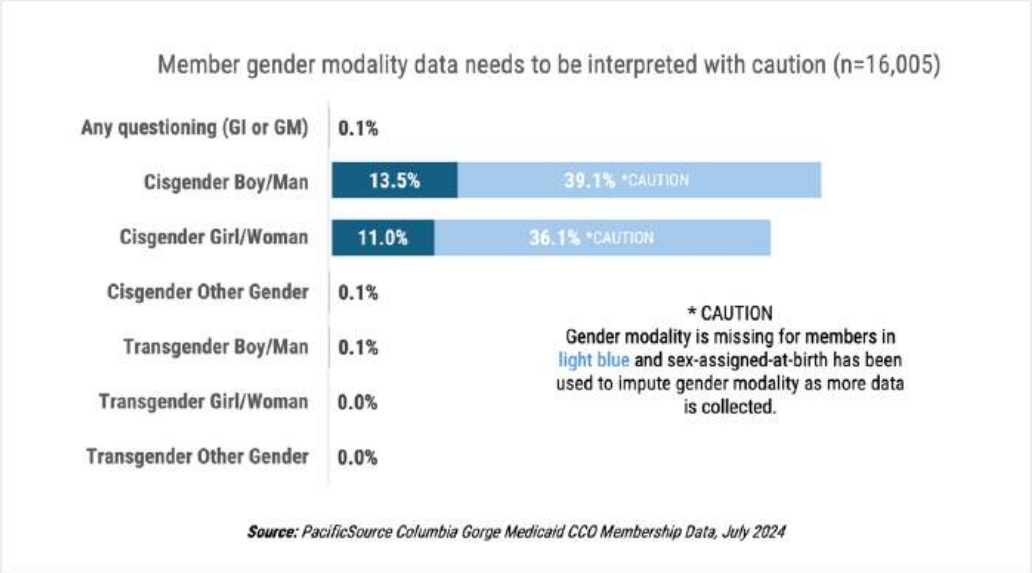


Figure 19: Gender modality



SOCIAL DETERMINANTS of HEALTH (SDoH)

Overview

Social determinants of health are the conditions in which people are born, live, learn, work, or play that influence our well-being. Understanding these conditions helps explain why some people are less healthy than others, as illustrated in the BARII framework (**Figure 20**). This section describes key takeaways and data points from existing state and national datasets.

Figure 20: Modified BARHII framework

Key Takeaways

- ✓ Hood River County, Wasco County, and the State of Oregon have **similar** indicators of food insecurity, social connection, and transportation. Hood River and Wasco counties also have **similar** climate issues (i.e., days of extreme heat and poor air quality from wildfire smoke.)
- ✓ Compared to Hood River County and the State of Oregon, **Wasco County** has more favorable housing indicators (i.e., fewer renters spending 30% of household income on rent).
- ✓ Compared to Wasco County and the State of Oregon, **Hood River County** has more favorable access to mental health providers, primary care providers and dentists; education indicators (K-12 students meeting benchmarks and people with bachelor's degrees); and economic stability indicators (Higher median household income, lower poverty rate, higher employment and job growth rate).

Data Points

Figures 21- 42 display indicators of access to behavioral/mental health services, access to medical care services, economic stability, education, neighborhood and built environment, and social and community health from national and state datasets and the 2024 Community Health Survey.

Access to Behavioral/Mental Health Services

Figure 21: Mental health providers

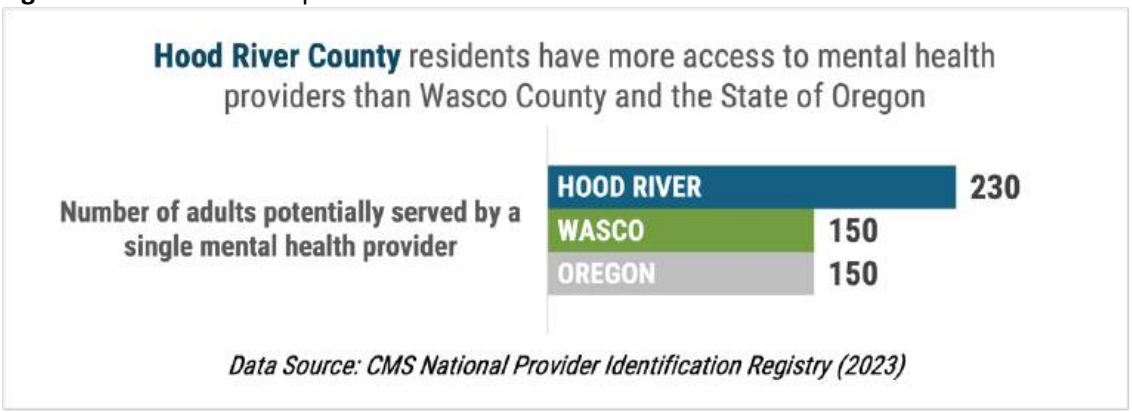


Figure 22: Student unmet mental health care needs

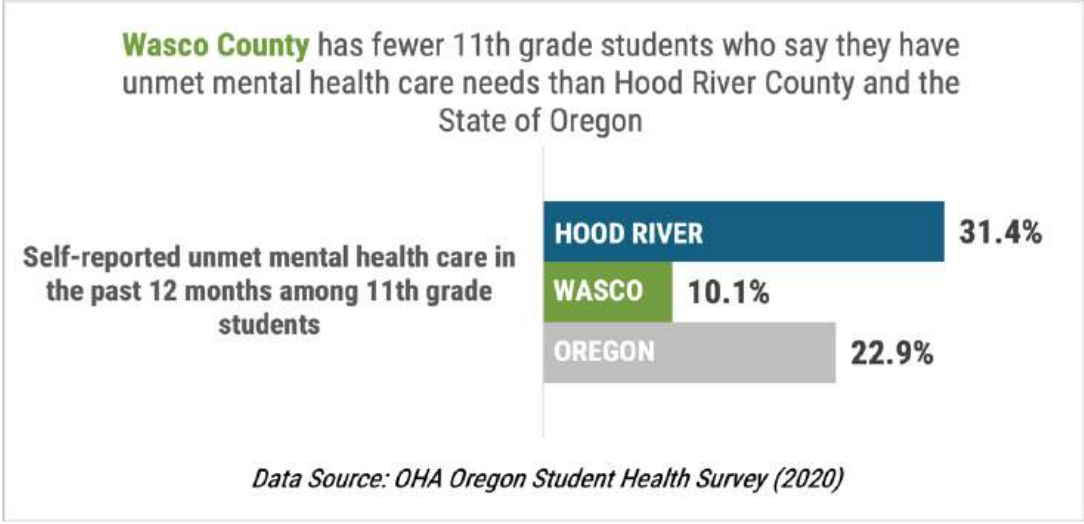
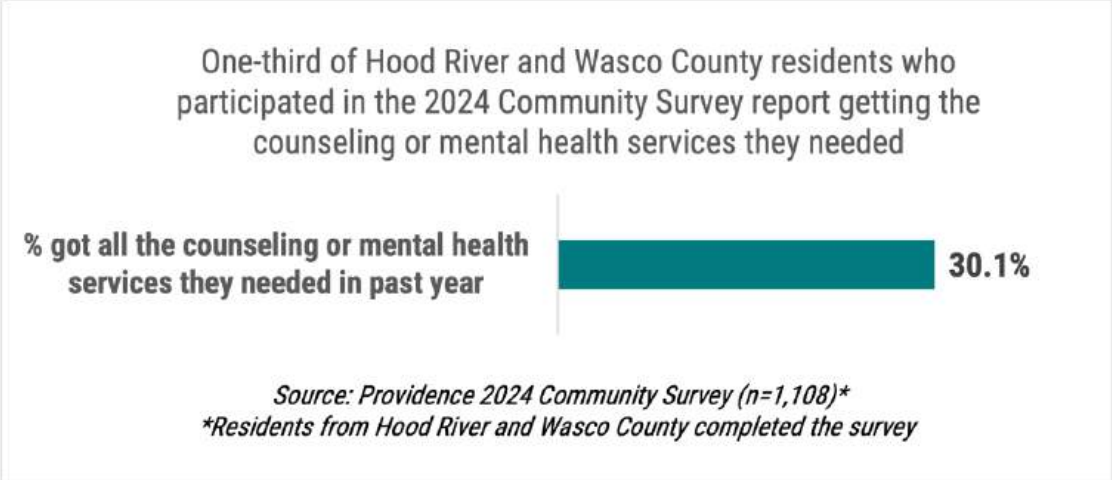


Figure 23: Mental health services (2024 Community Survey)



Access to Medical Care Services

Figure 24: Health insurance

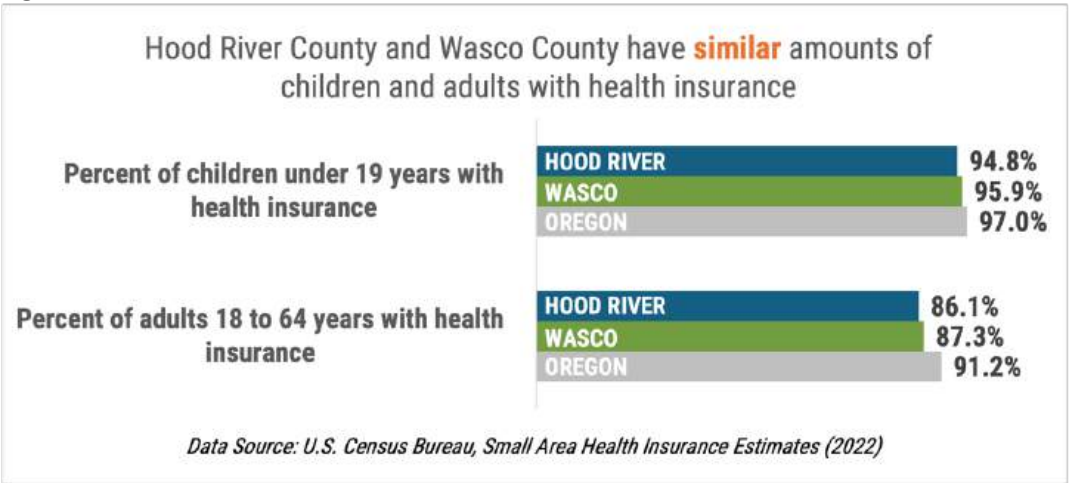


Figure 25: Medical care providers (national data set)

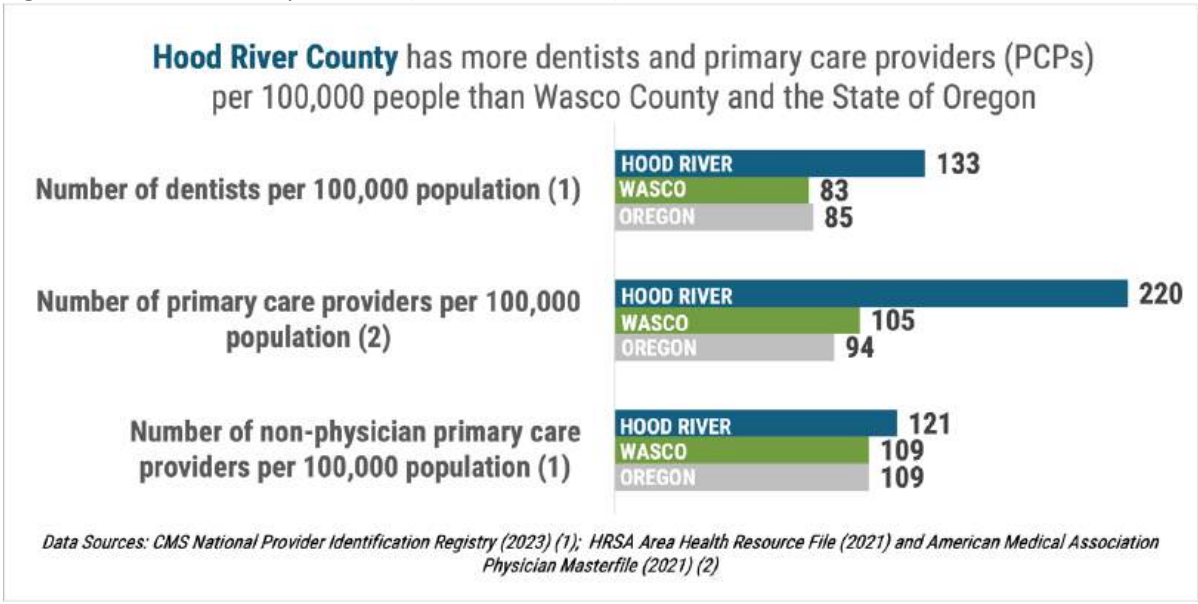
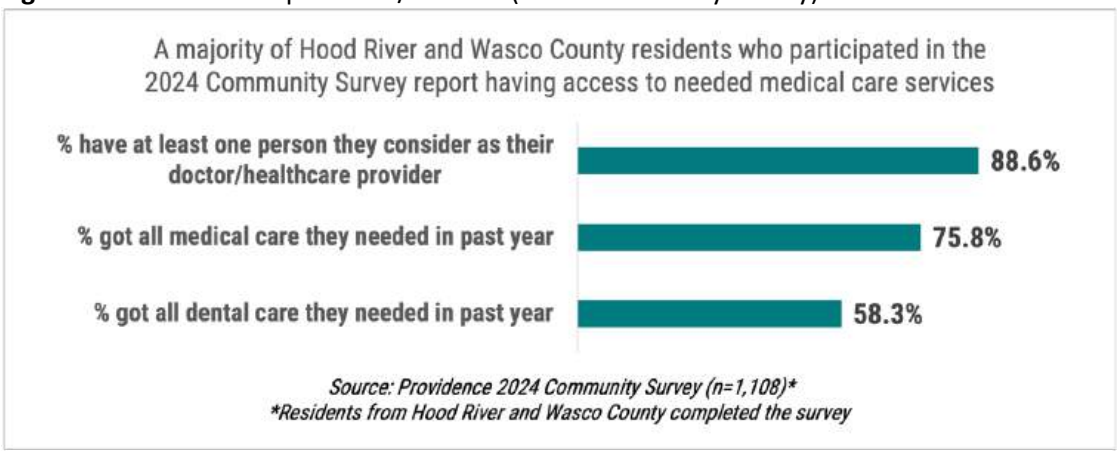


Figure 26: Medical care providers/services (2024 Community Survey)



Economic Stability

Figure 27: Household income

Figure 28: Financial need

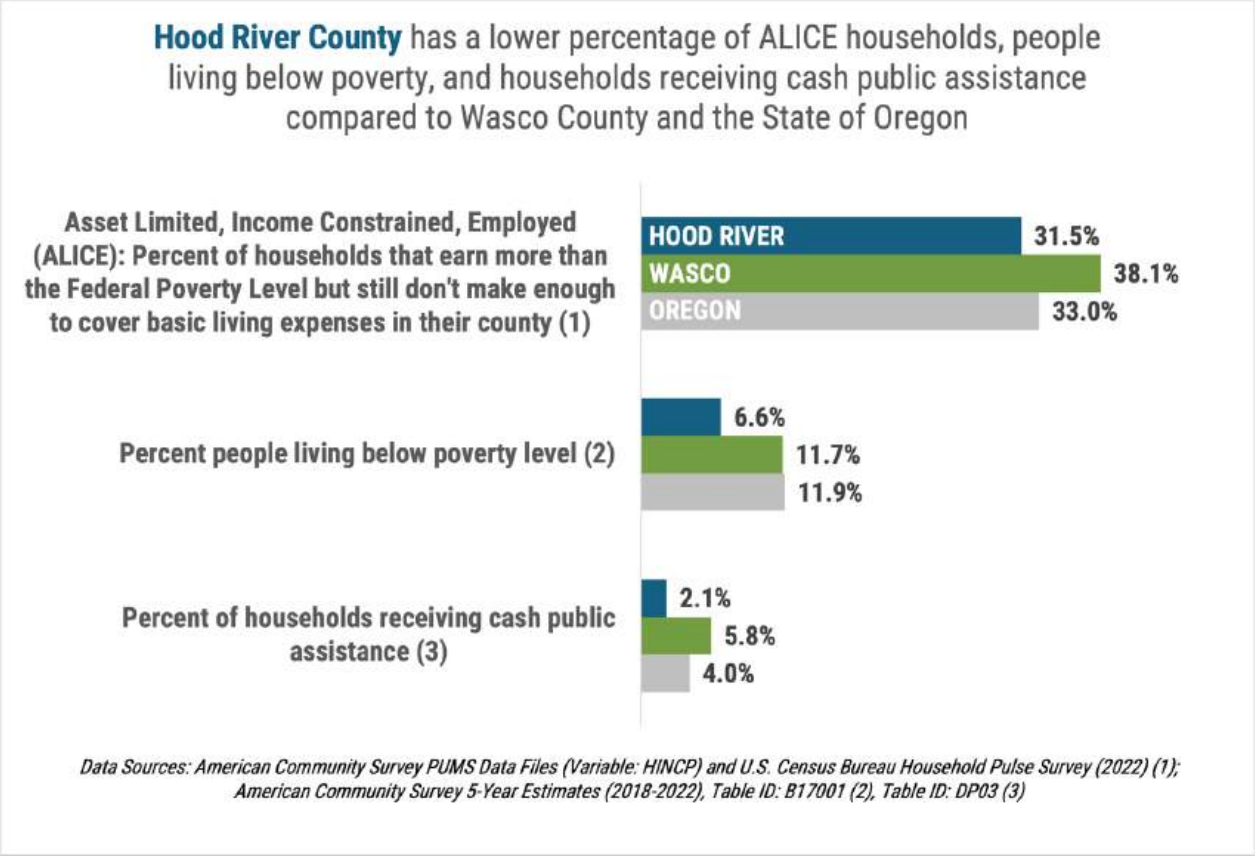


Figure 29: Income inequality

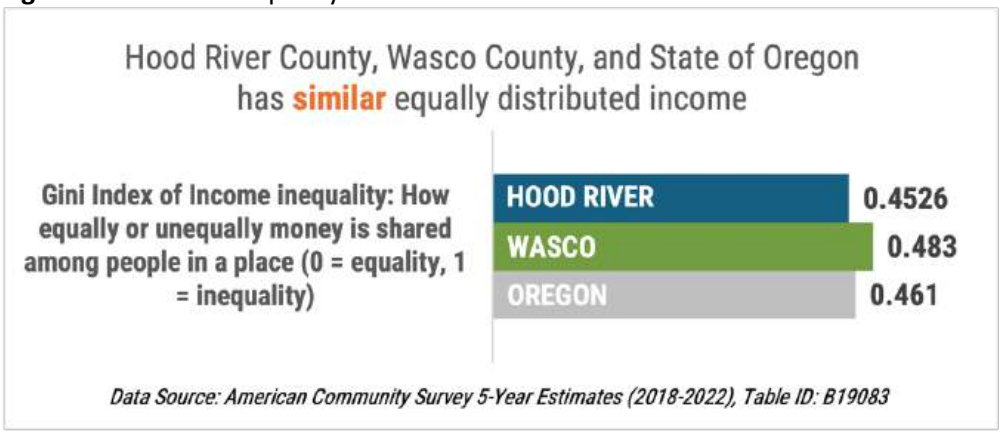


Figure 30: Employment

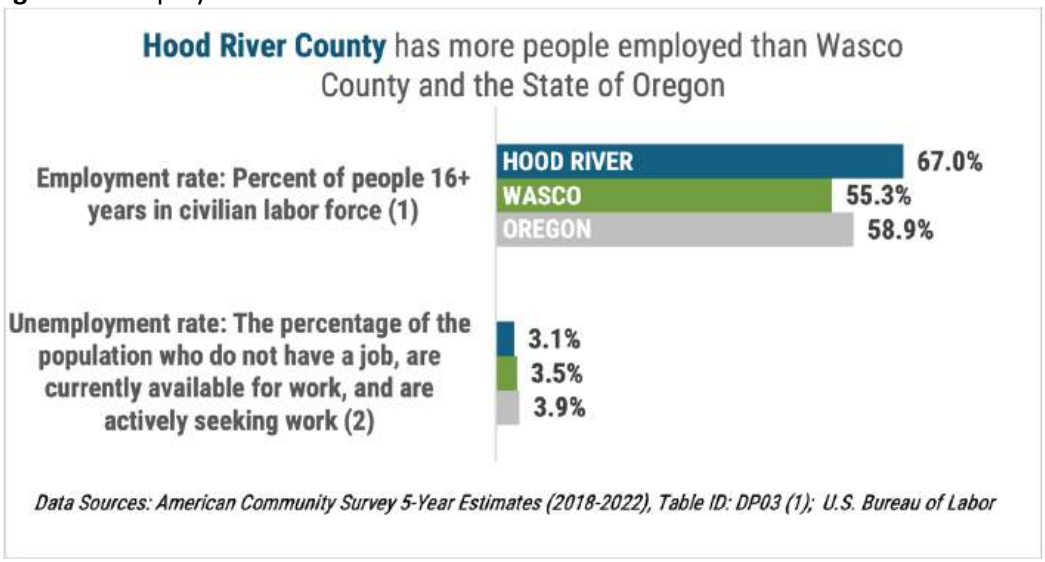
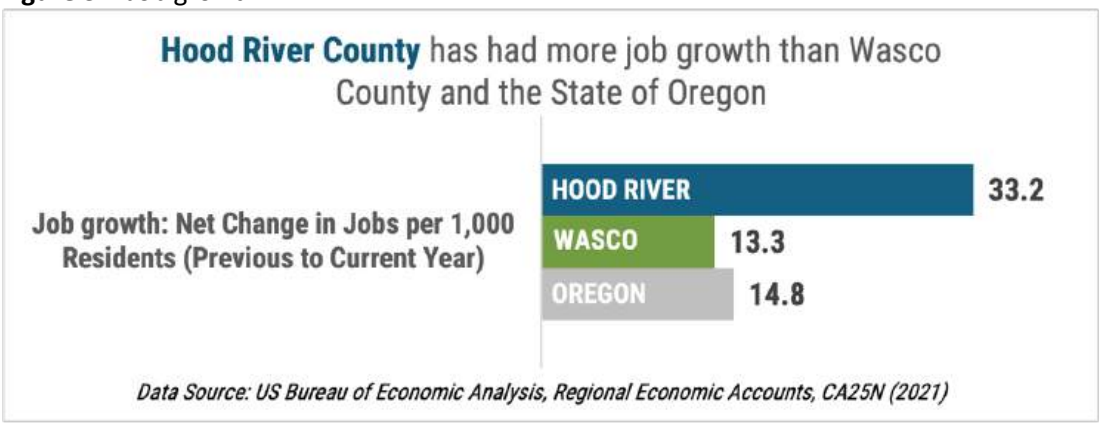


Figure 31: Job growth



Education

Figure 32: K-12 education benchmarks

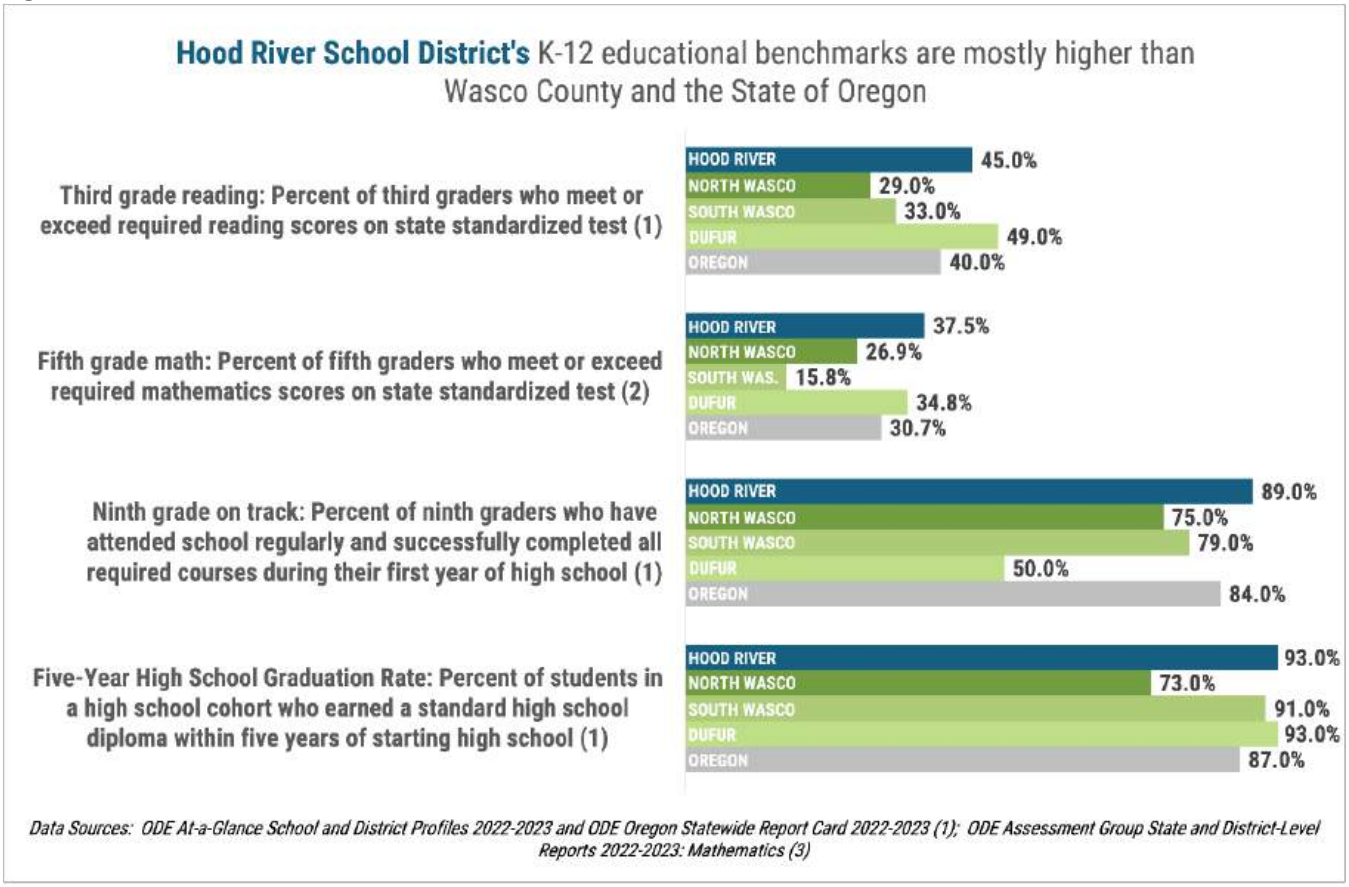
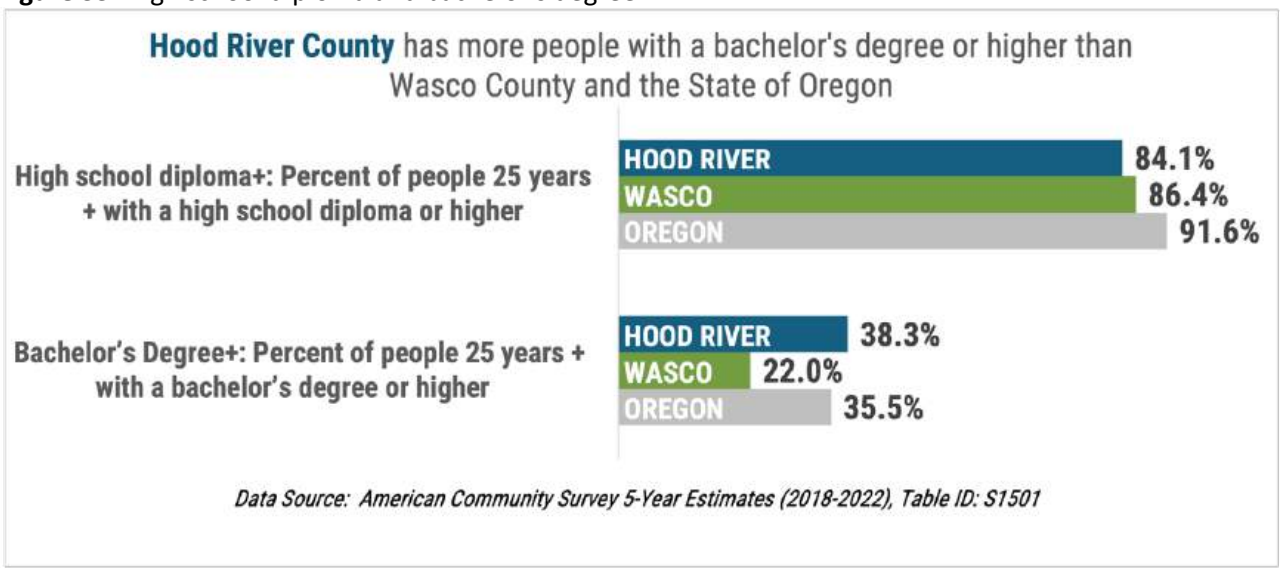


Figure 33: High school diploma and bachelor's degree



Neighborhood & Built Environment

Figure 34: Home ownership

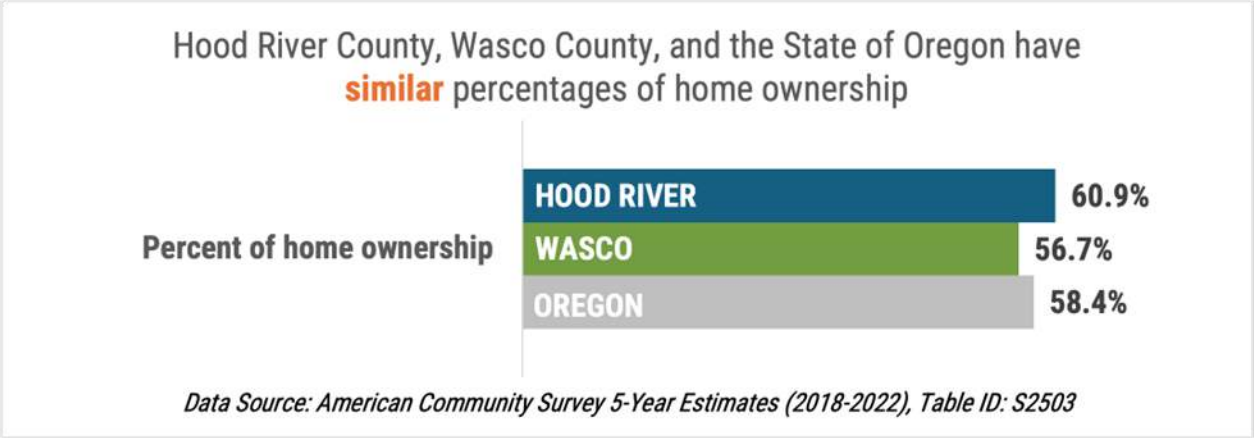


Figure 35: Rental costs

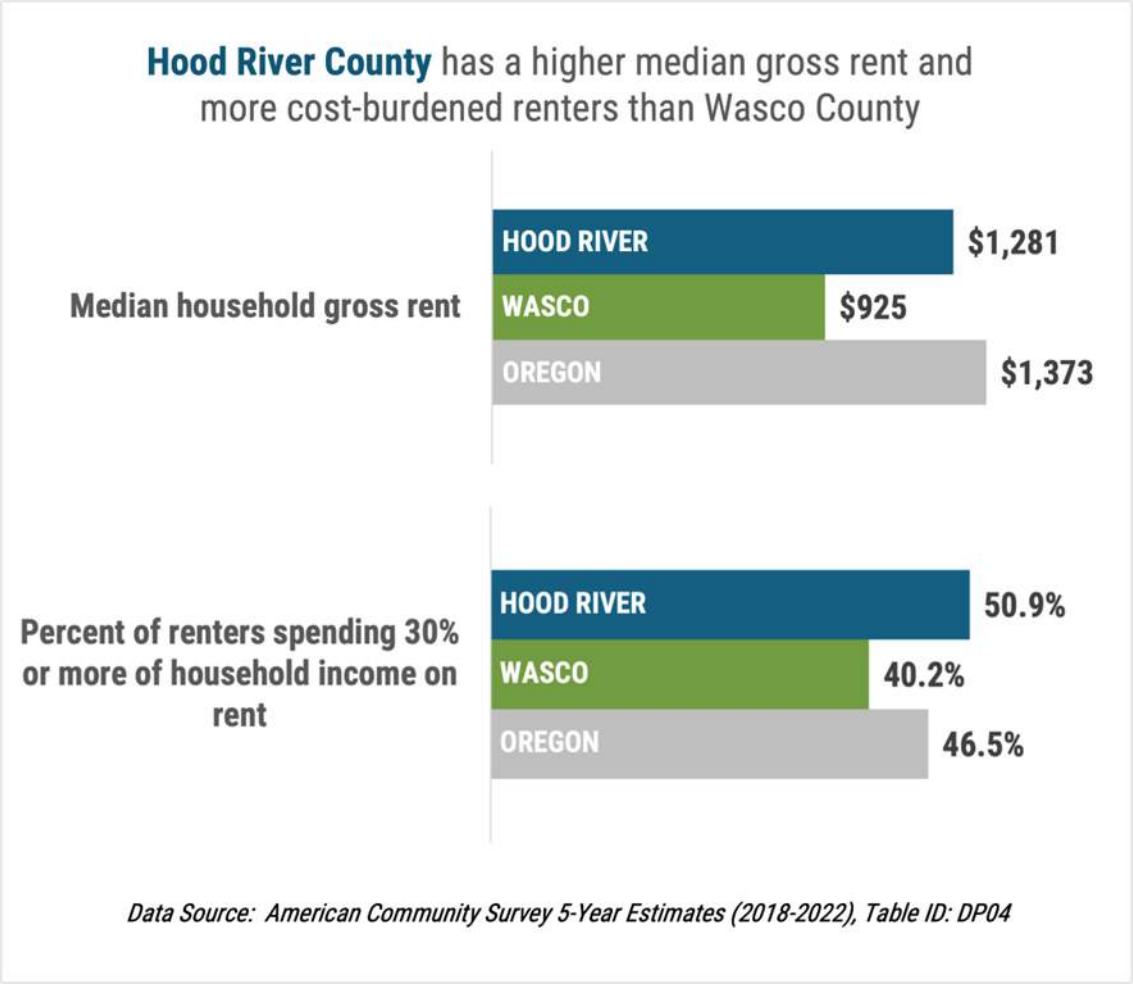


Figure 36: Houselessness

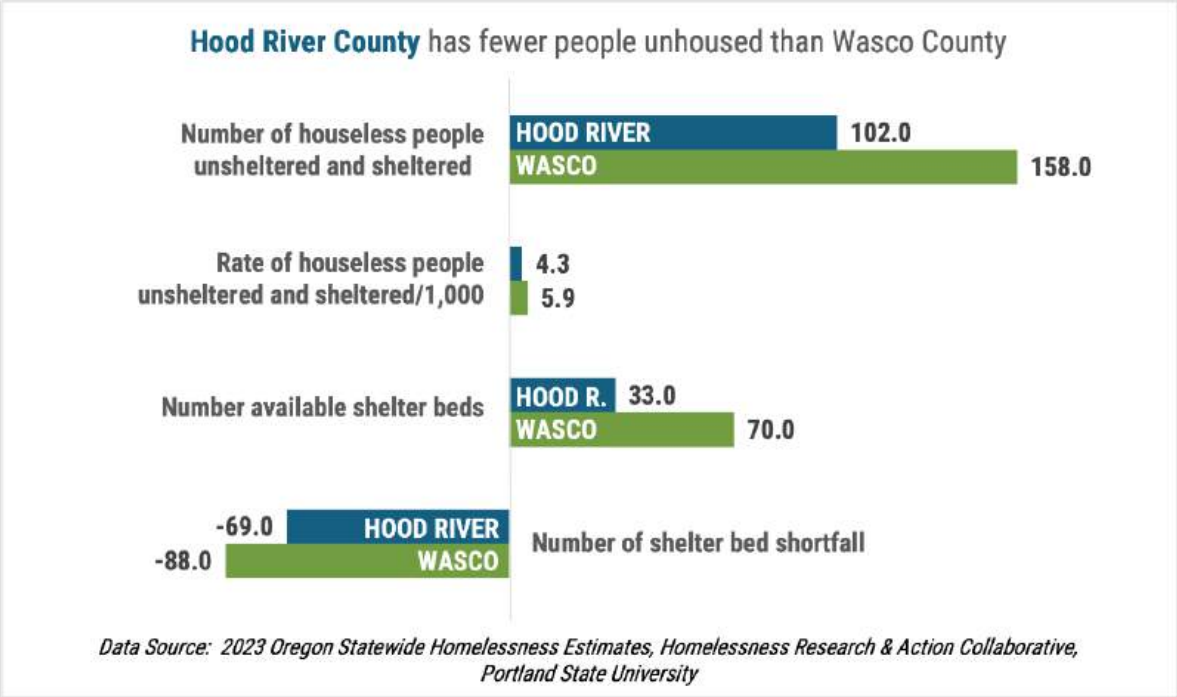


Figure 37: Food insecurity

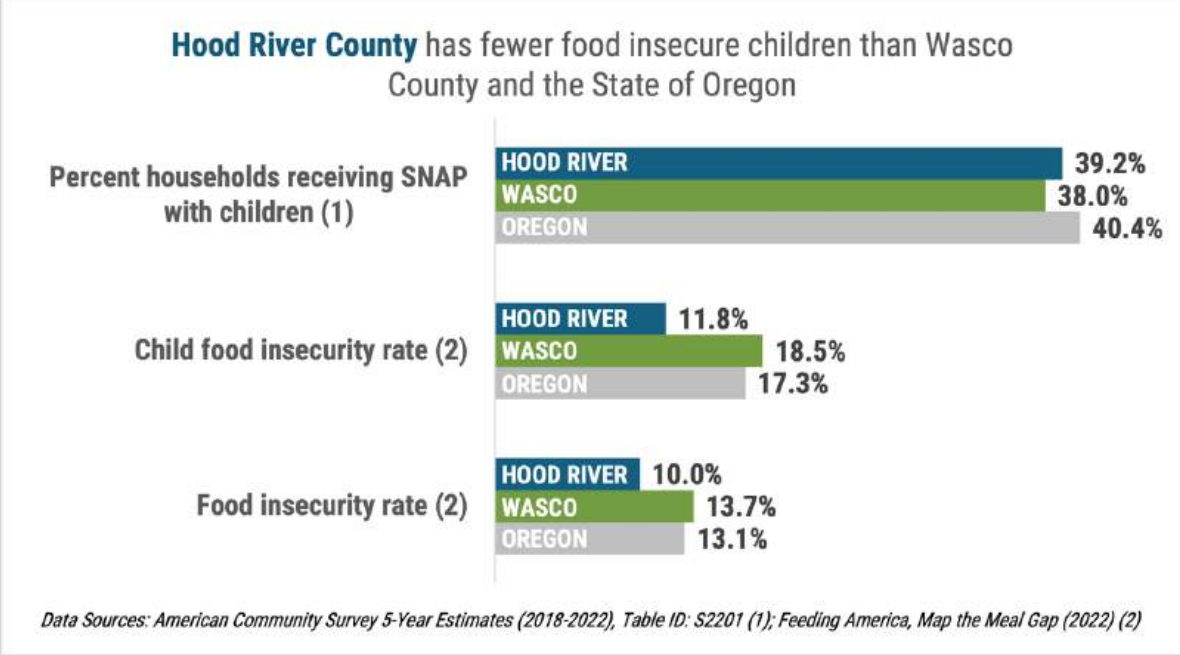


Figure 38: Transportation

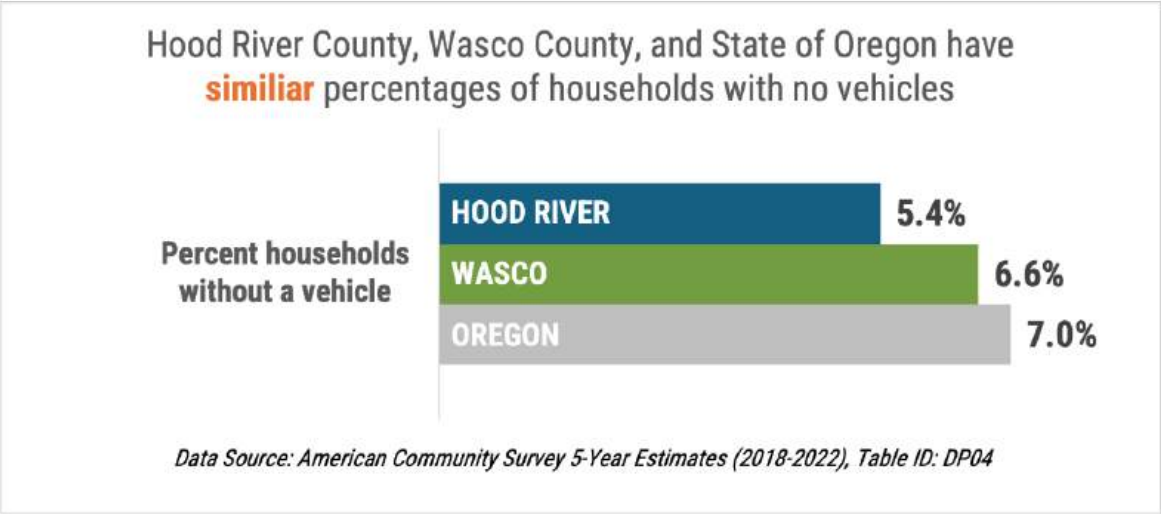


Figure 39: Extreme heat

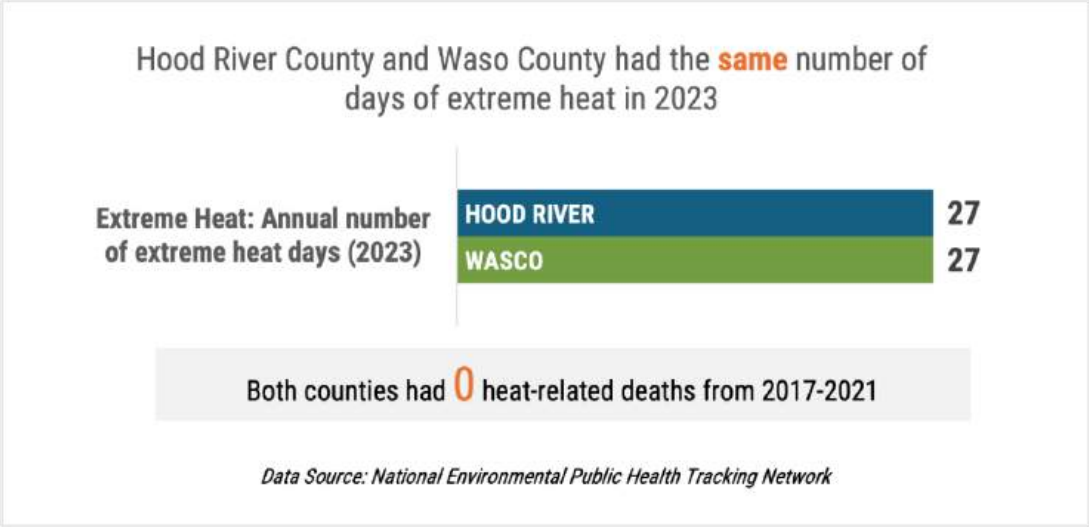


Figure 40: Air quality

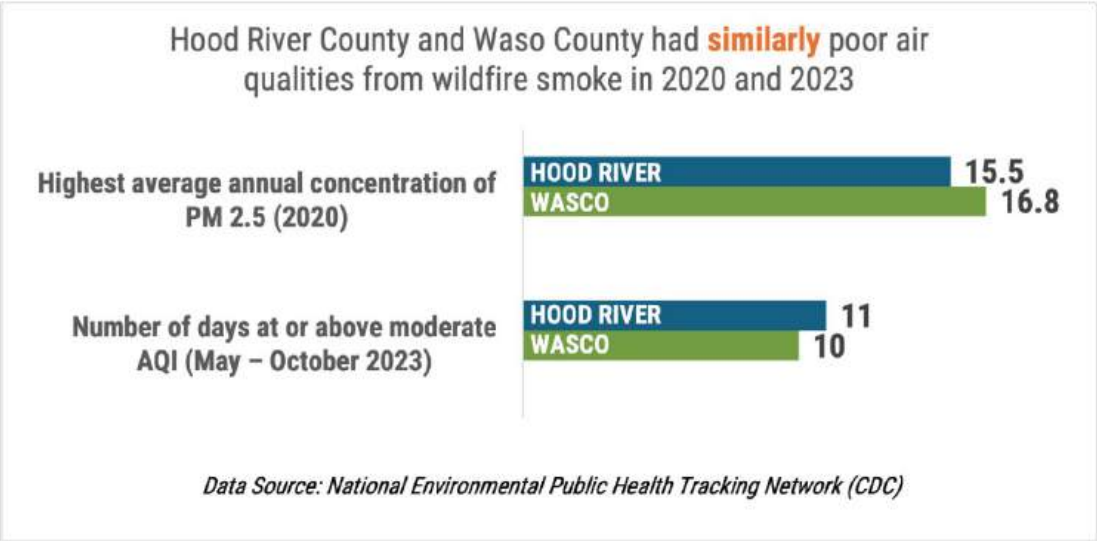
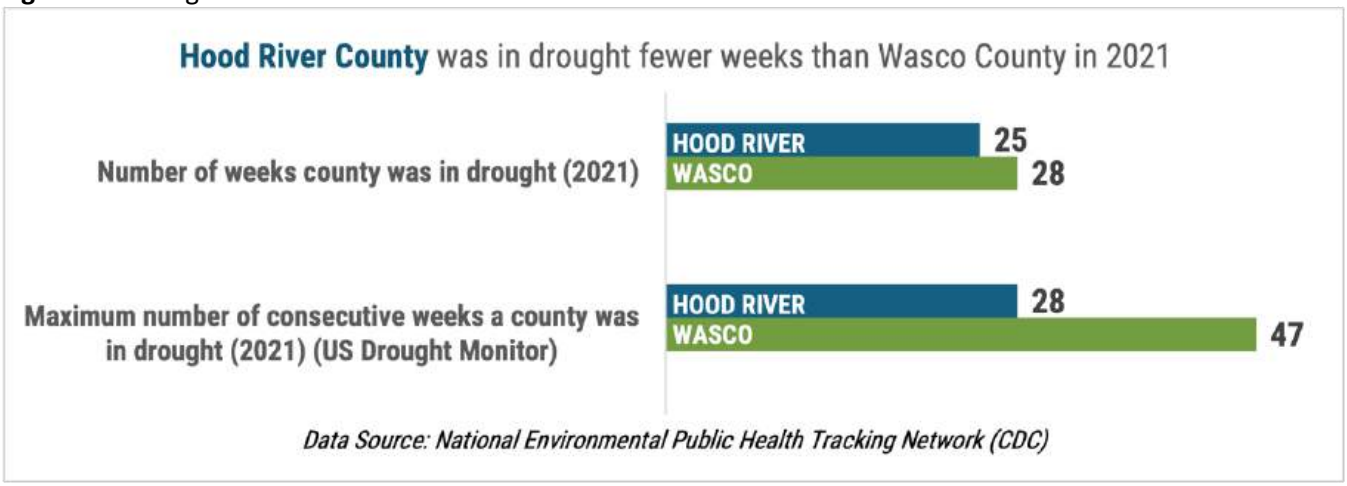


Figure 41: Drought



Social & Community Health

Figure 42: Social organization membership

Figure 43: Voter participation

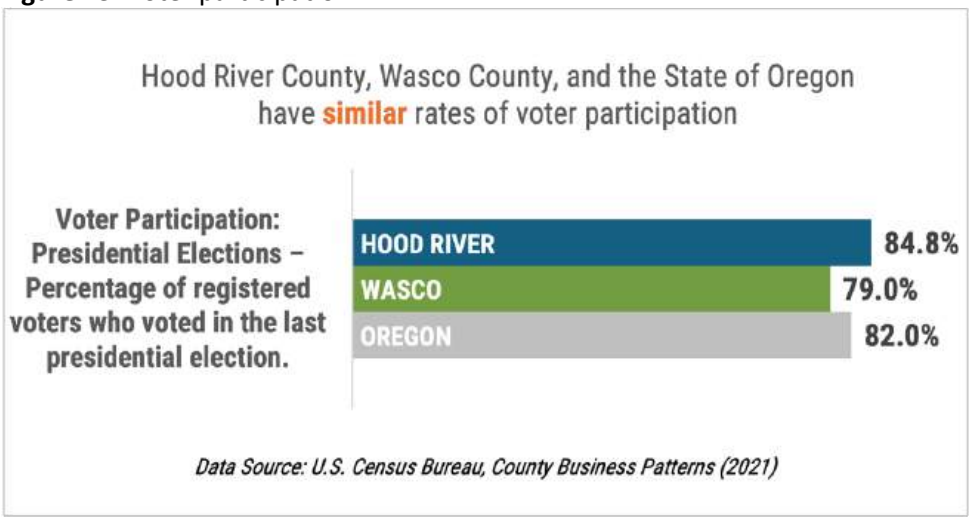
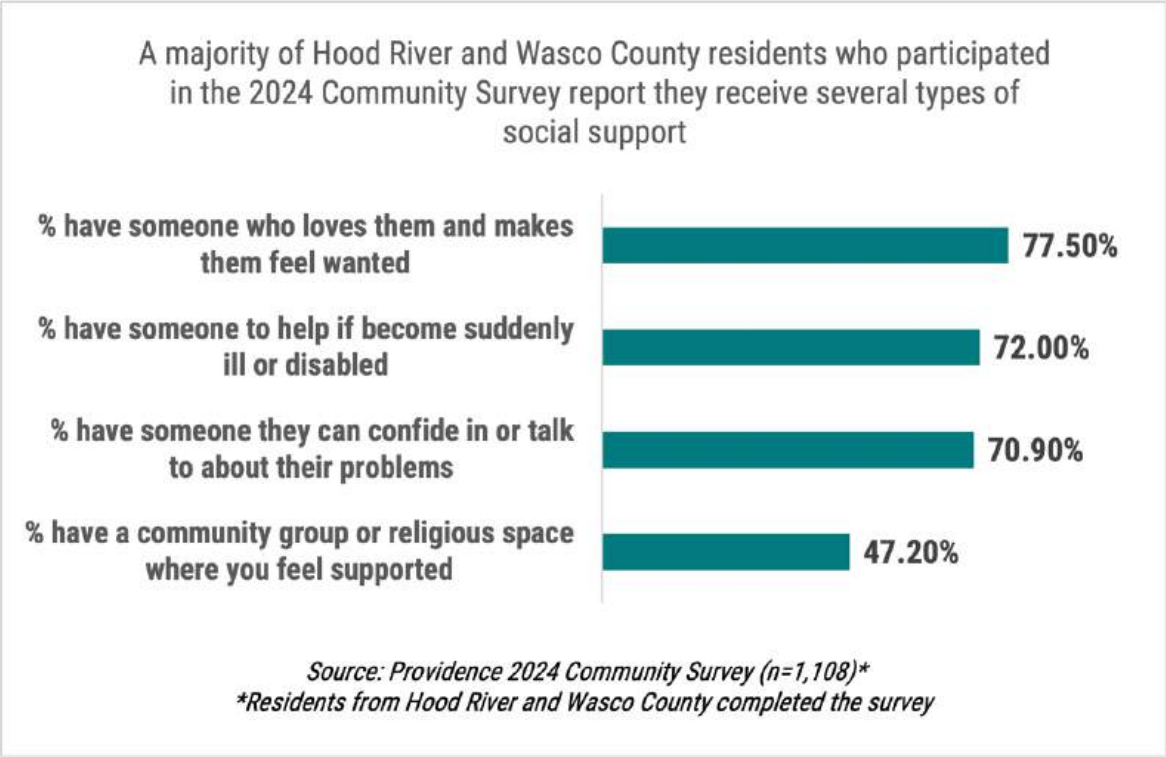


Figure 44: Social support (2024 Community Survey)



HEALTH STATUS & HEALTH INEQUITIES

Overview

This section describes the **health status and disparities** for life expectancy, premature death, leading causes of death, infant low birthweight rate, top diseases and injuries, and self-related health for residents of Hood River County, Wasco County, and the State of Oregon documented in a variety of state and national datasets. Self-reported health status indicators are reported by race/ethnicity from the 2024 Community Health Survey.

Key Takeaways

- ✓ The **leading two causes of death** in Hood River and Wasco counties are heart disease and cancer. The third top cause of death in Hood River county is cerebrovascular disease; unintended injuries is Wasco County's third cause of death.
- ✓ The **top three diseases and injuries** in Hood River County are cancers, mental health disorders, and infectious diseases. For Wasco County, the top three are injury deaths, tobacco use, and infectious and respiratory diseases.
- ✓ Compared to Wasco County and the State of Oregon, people (on average) in **Hood River County** experience better health in terms of life expectancy, premature deaths, diseases, and injuries.
- ✓ As described in the *Social Determinants of Health* section in this report, **Hood River County** has more favorable social determinants of health indicators around economic stability, education, and access to medical care providers. According to our guiding equity framework (BARII), these more favorable social determinants of health may explain some of the health inequities between the two counties.
- ✓ A **data gap** exists for documenting health disparities around age, disabilities, race/ethnicity, gender, and sexual orientation at the county level. The CGHC's Columbia Gorge Healthy Community Data Dashboard contains over 30 indicators of health status (i.e., adults with current asthma) at the county level. Only the all cancer incidence rate was available by race/ethnicity. The 2024 Community Survey asked about people's demographics (i.e., race/ethnicity, sexual orientation, disabilities), yet few people in this convenience sample identified as not heterosexual, non-binary or having a disability.

Data Points

Figures 45 – 53 display data points for life expectancy, premature deaths, opioid-related deaths, top causes of deaths, leading diseases and injuries, and self-reported health.

Figure 45: Life expectancy

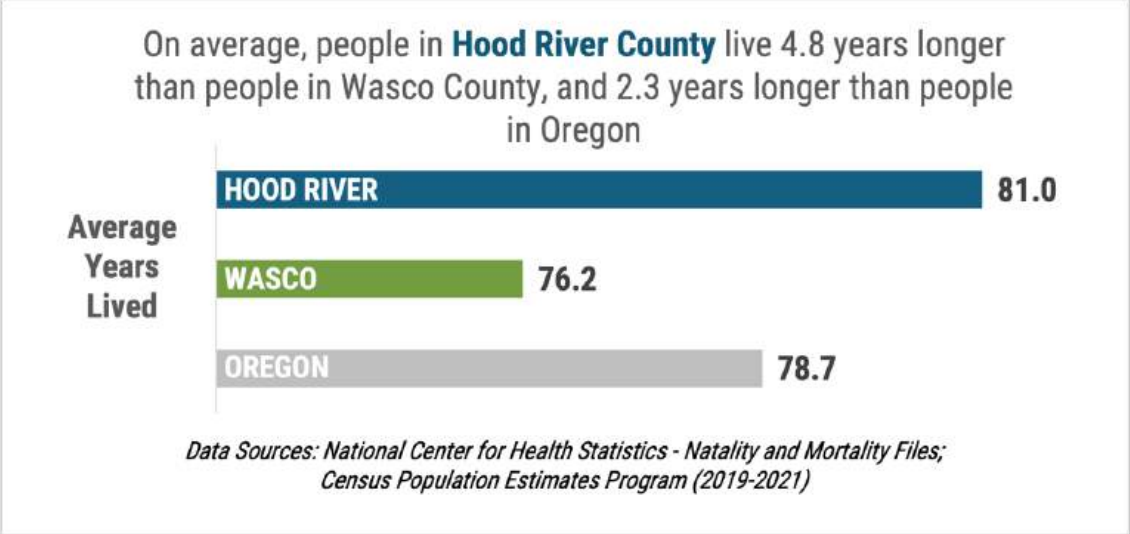


Figure 46: Life expectancy by Hispanics or Latinos, whites (not Hispanic or Latino) and overall (all race/ethnicities combined)

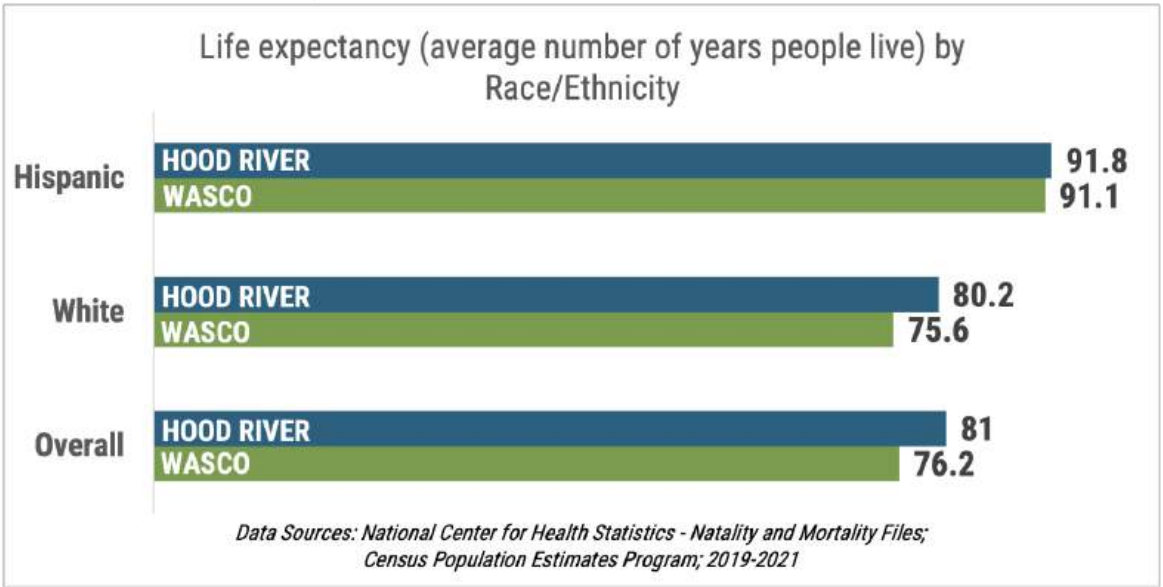


Figure 47: Premature deaths

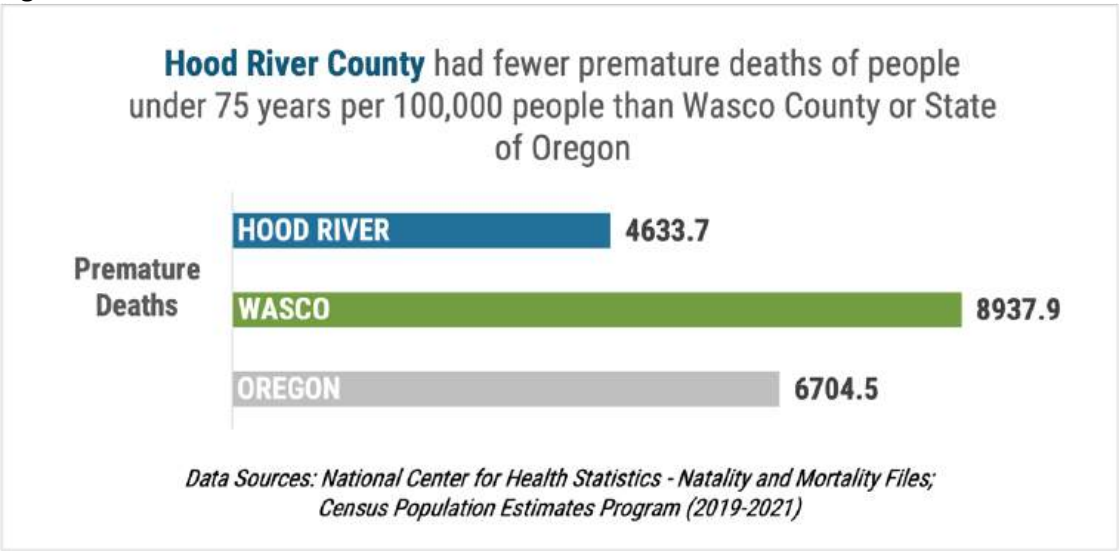


Figure 48: Top causes of deaths

Rank	Oregon	Hood River County	Wasco County
1	Cancer (malignant neoplasms)	Heart disease	Heart disease
2	Heart disease	Cancer (malignant neoplasms)	Cancer (malignant neoplasms)
3	Unintended injuries	Cerebrovascular disease	Unintended injuries
4	Cerebrovascular disease	Alzheimer's disease	Chronic lower respiratory disease
5	Alzheimer's disease	Chronic lower respiratory disease	COVID-19
6	Chronic lower respiratory disease	Unintended injuries	Cerebrovascular disease
7	COVID-19	Diabetes mellitus	Diabetes mellitus
8	Diabetes mellitus	COVID-19	Alzheimer's disease
9	Chronic liver disease/cirrhosis	Influenza and Pneumonia	Suicide
10	Suicide	Suicide; Parkinson's Disease; Neoplasms not known to be malignant	Chronic liver disease/cirrhosis

Data Source: Leading Causes of Death by County, Center for Health Statistics, Oregon Health Authority (2022)

Figure 49: Low birthweight

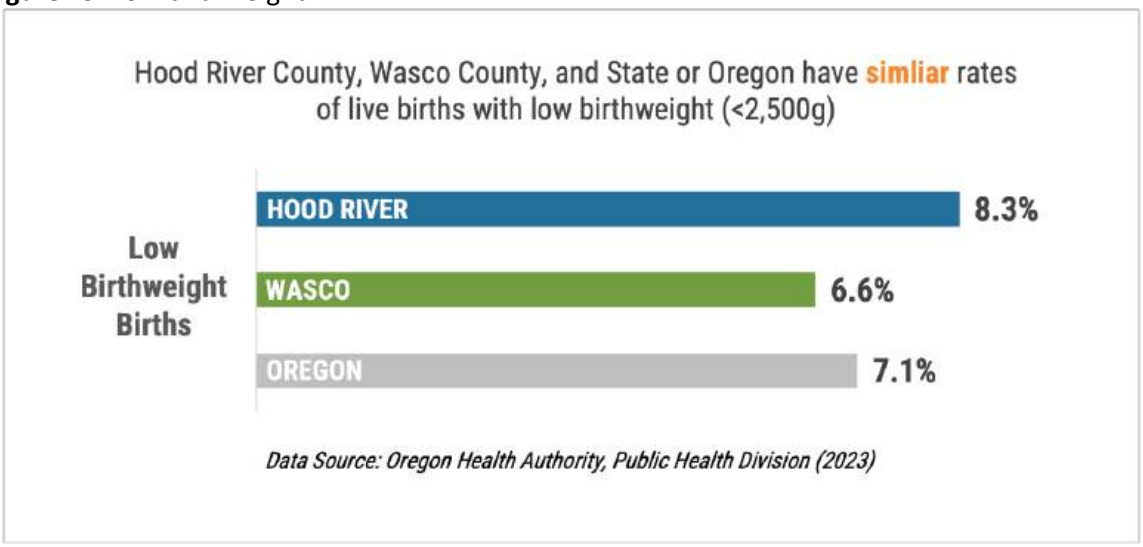
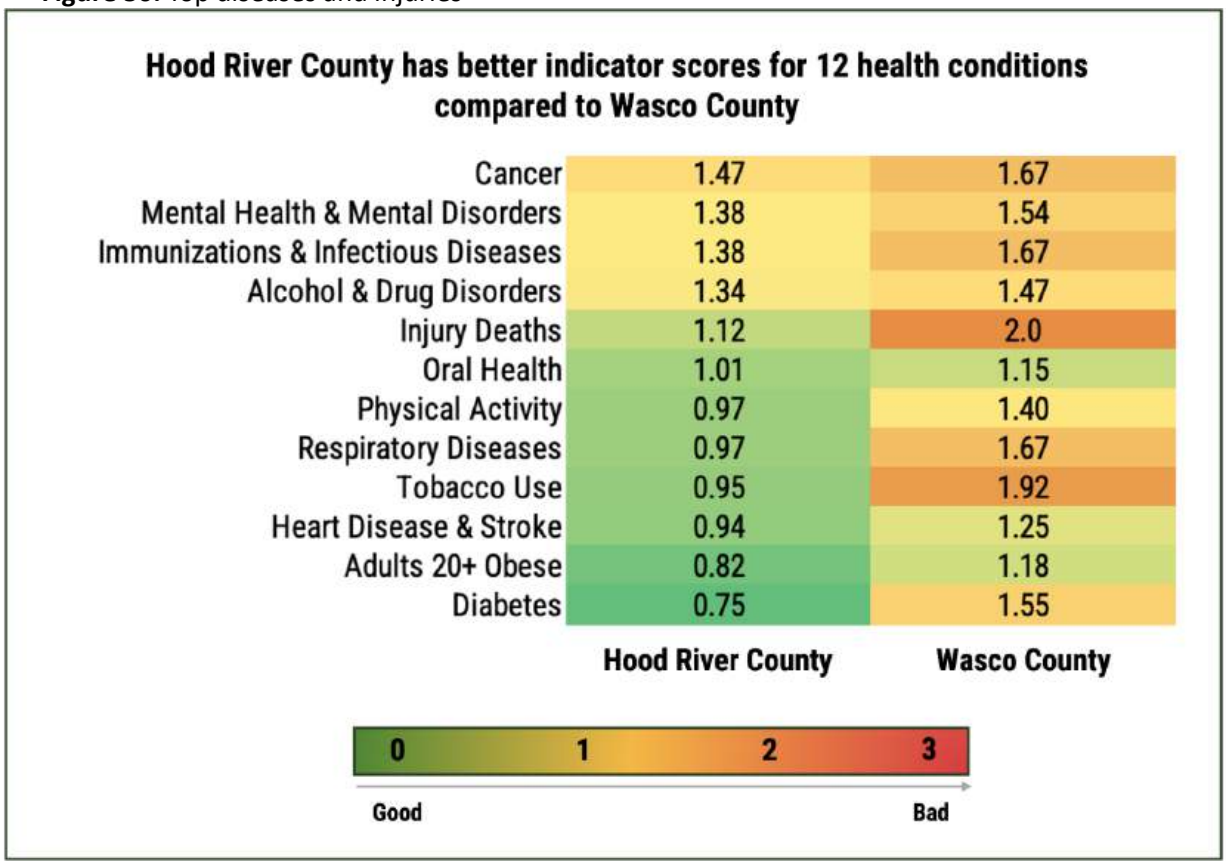


Figure 50: Top diseases and injuries



Data Source: Columbia Gorge Community Data Dashboard—Conduent Data Scoring tool that ranks and compares severity of health conditions. The methodology compares values of 202 individual health indicators (i.e., Adults 20+ years with diabetes) for each county to other Oregon counties, the State of Oregon, other counties in the US, and the US values to calculate an indicator score. Each indicator is scored from 0 (good) to 3 (bad). Conduent groups individual health indicator scores into Health Topics, where indicator scores that represent a health condition are averaged to create Topic Scores. The range of indicators averaged within a Health Topic score ranges from 3 to 24. For example, the Diabetes Topic Score includes the average of three indicators: Adults 20+ with diabetes, Death rate due to diabetes, and Medicare population with diabetes. Refer to table below for list of indicators that were combined into each of the 12 conditions.

Figure 51: Self-reported overall health (national dataset)

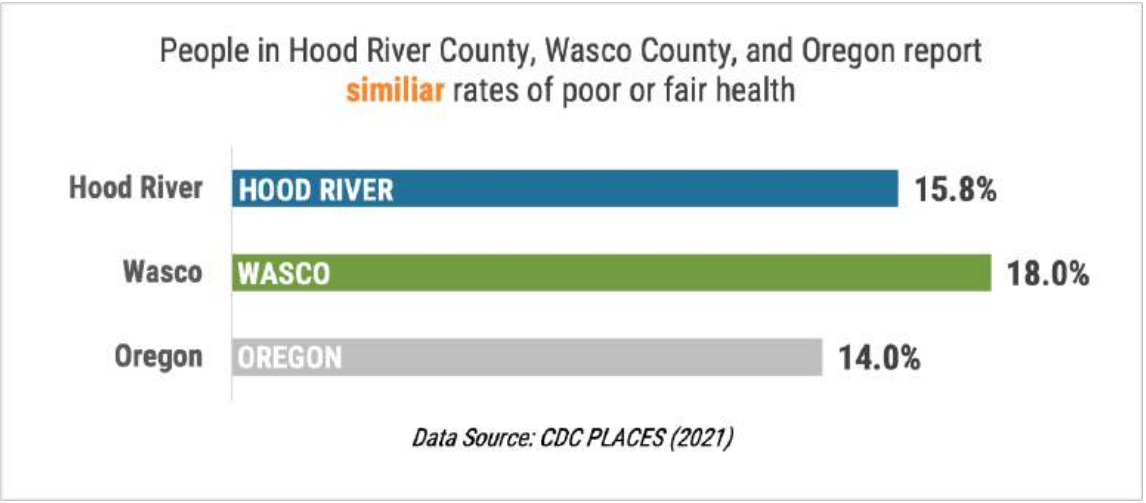


Figure 52: Self-reported physical health (state dataset)

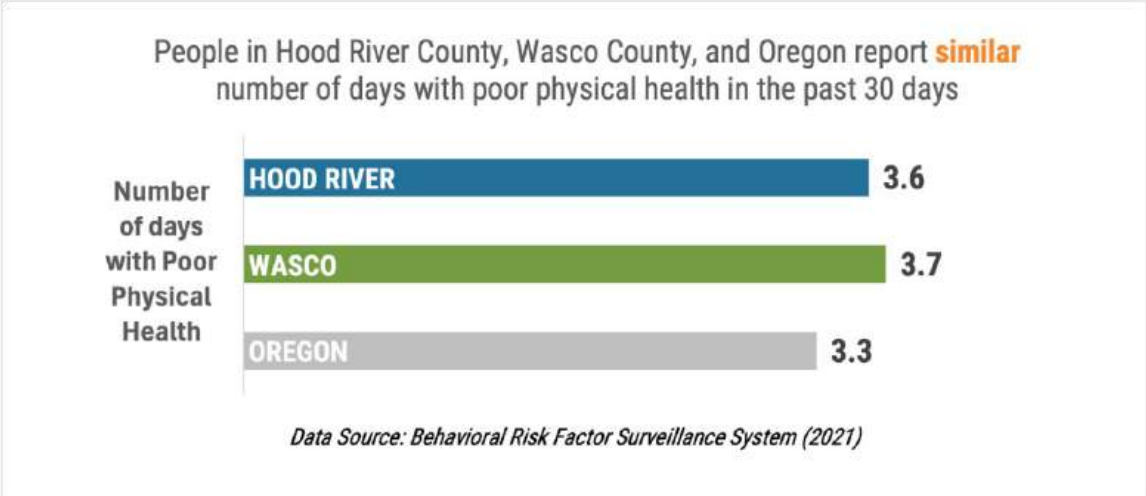


Figure 53: Self-reported health by race/ethnicity (2024 Community Survey)

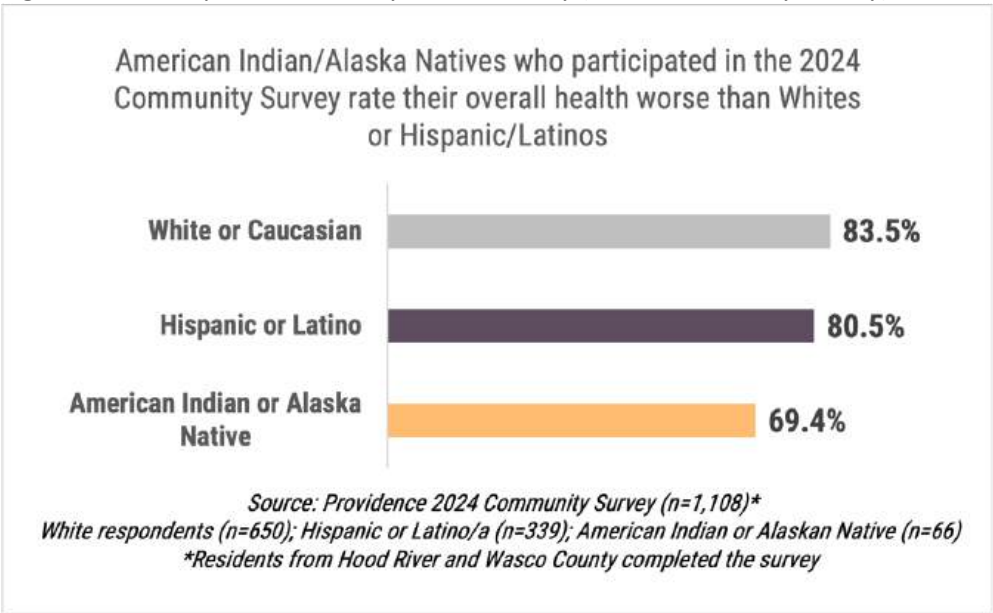


Figure 54: Self-reported mental health **(**state dataset)

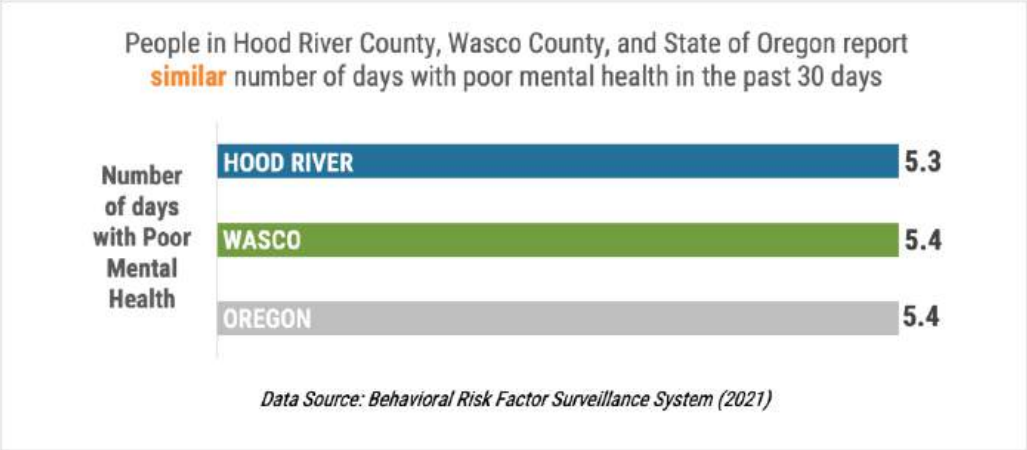
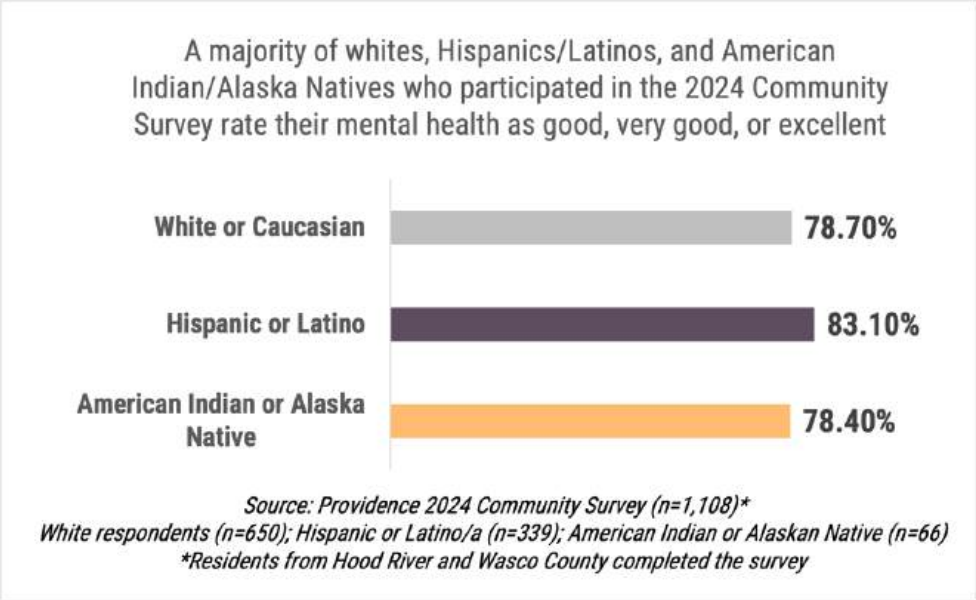


Figure 55: Self-reported mental health **(**2024 Community Survey)



ASSETS and GAPS

Overview

This section describes assets unique to Hood River and Wasco counties for community health improvement in general and specific assets and gaps for early intervention and treatment for children and adolescents. Unique assets for community health improvement were identified through 34 community partner and member listening sessions as well as two community forums described in the *Community-driven Process* section of this report. Participants in the community listening sessions who identified assets and gaps for children/adolescents included the following stakeholders:

- Director, Four Rivers Early Learning
- Director, YouthThink, Wasco County
- Superintendent, Columbia Gorge ESD
- Director, Early Intervention, Wasco County
- Director, School Based Health Centers, One Community Health
- Counselor, School Based Health Centers, One Community Health
- Assistant School Counselor South Wasco School District
- School Nurse, North Wasco School District

Key takeaways for assets unique to Hood River and Wasco counties

- ✓ The Columbia Gorge region is rich in assets dedicated to enhancing community health and well-being, characterized by unique public-private collaboratives that address critical issues such as houselessness, food insecurity, substance use, and health equity across county and state lines.
- ✓ The majority of these assets fall within programmatic categories that span multiple social determinants of health and equity issues, specifically designed to meet the unique needs of residents in Hood River and Wasco Counties.
- ✓ The **44** unique assets that support community health in Hood River and Wasco counties are organized by four categories: 1) collaboratives 2) informational resources 3) physical facilities/infrastructure and 4) programs. Refer to **Appendix 12** for a list of these assets.

Key takeaways for assets and gaps in early intervention and treatment for children and adolescents

- ✓ Hood River and Wasco counties face significant gaps in preventive services and treatment services for children (0-12) and adolescents (13-18), particularly in access to medical and mental health care.
- ✓ A shortage of qualified providers and limited funding further exacerbate these challenges, making it difficult to address the region's needs.
- ✓ High needs, combined with limited infrastructure and resources, result in unmet health needs for both children and adolescents.
- ✓ Despite these obstacles, both counties benefit from strong early learning programs and school-based health centers located in Hood River and Dufur, which provide essential support to local families.
- ✓ Refer to **Appendix 13** for a detailed list of assets and gaps.