COMMUNITY HEALTH NEEDS ASSESSMENT EXECUTIVE SUMMARY

PROVIDENCE MILWAUKIE HOSPITAL (MILWAUKIE, OREGON)

Understanding and Responding to Community Needs

The Community Health Needs Assessment (CHNA) is an opportunity for Providence Milwaukie Hospital (PMH) 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.

In the Portland metro area, PMH is a member of the Healthy Columbia Willamette Collaborative (HCWC). The collaborative is a unique public-private partnership of 12 organizations in Washington, Clackamas, and Multnomah Counties in Oregon and Clark County in Washington State. HCWC is dedicated to advancing health equity in the four-county region, serving as a platform for collaboration around health improvement plans and activities that leverage collective resources to improve the health and well-being of local communities.

Based on geographic location relative to other hospitals in the area and patient demographics, Clackamas County is PMH's primary service area. Multnomah, Washington, and Clark (WA) counties are surrounding secondary counties that are primarily served by other area hospitals. The facility is a 77-bed acute-care hospital offering primary and specialty care, general and specialty surgery, radiology, diagnostic imaging, pathology, and 24/7 emergency medicine. We are recognized for excellence in patient care and research in areas such as cancer, heart, orthopedics, women's health, rehabilitation services, and behavioral health.

This is a "joint CHNA report," within the meaning of Treas. Reg. § 1.501(r)-3(b)(6)(v), by and for Providence including Providence Milwaukie Hospital. 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. The collaborative CHNA report is available in Appendix 1.

The 2025 CHNA was approved by the Providence Oregon Community Ministry Board on November 14, 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

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:

- US Census American Survey: tracks individual and household characteristics
- US Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System: tracks health behaviors and risk factors
- CDC Wonder: includes birth, death, fetal death, and infant death rate
- Oregon Student Health Survey and Washington Healthy Youth Survey: assesses youth health behaviors and attitudes
- Oregon and Washington Department of Education: educational achievement and enrollment data for public school students

To actively engage the community, we conducted 37 listening sessions with people who have chronic conditions, are from diverse communities, have low-incomes, and are medically underserved. We also conducted a community health survey which was available in 19 languages and completed by 2,128 people. Some key findings include the following:

- The top three most important health diseases and conditions identified by survey respondents were chronic disease, mental health and dental/oral health.
- Community members expressed concerns about affordable housing, high rent costs, and a lack of housing options.
- Economic opportunities are essential to help people obtain living wages that provide a safety net for people to access healthcare and healthy lifestyle choices.

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. A full accounting of data limitations can be found starting on page 15 of the full CHNA report. For more information related to the CHNA methods and process please see page 11 of the full CHNA document in Appendix 1.

Identifying Collaborative Health Priorities

Through a collaborative process, HCWC used a modified version of the Mobilizing for Action through Planning and Partnerships (MAPP) model to create the CHNA. The modified MAPP model is an iterative process combining health data and community input to identify and prioritize community health needs. Results were distilled through discussions with the Community Advisory Group (CAG) to ensure the stories and information collected and presented in this report are aligned with our communities' experiences Through this community-informed approach, the following priority areas were identified: Safe and Affordable Housing, Physical Safety in Community, Access to Affordable Health Care, Educational Opportunity, Trust of the Health Care System, Culturally and Linguistically Responsive Health Care, Economic Opportunity, Reliable and Affordable Transportation, Trauma-Informed Care, Culturally-Specific and Healthy Foods, Social Connection, Cultural Displacement Due to Gentrification, and Virtual Resources. For a rank order list and a description of significant health needs, see page 29. For a list of potential resources available to address the identified needs, see page 57 of the collaborative CHNA report.

PMH 2025 Priority Needs

A wide spectrum of community needs were identified, some of which are most appropriately addressed by other community organizations. Providence's Portland Service Area Advisory Council reviewed the community needs and associated data. Considering PMH'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

PMH 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

PMH 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/or substance use disorder, access to care and services, health related social needs, and economic security.

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	BOB Program ED Outreach	Identifies BH patients with frequent ED visits who may need additional support after discharge	38 patients supported in 2024
Mental Health and Substance Use Disorder	Grant to Raices de Bienestar	Expand bilingual clinical services to Latine low-income community members	Expanded services to telehealth and mobile units, serving 218 individuals, with 67% remaining in clinical treatment in 2023
Mental Health and Substance Use Disorder	Grant to Adelante Mujeres	Serve Latine families and children with access to low-cost mental health services	Opened a culturally and linguistically responsive mental health and wellness clinic, serving 839 individuals in their first year, 2023
Access to Health Care and Services	EyeVan Mobile Vision Program	Partner with Pacific University to increase access to vision screening and prescription glasses	579 patients served across the Portland Metro area

Access to Health Care and Services	Mobile Dental Hygiene and Therapy Clinics	Partner with Pacific University to increase access to preventive oral health services	1,060 patients served across the Portland Metro service area
Access to Health Care and Services	Medical Teams International Mobile Dental Clinics	Provide free emergency dental services to uninsured and underinsured community members	246 community members served
Access to Health Care and Services	Grant to Volunteers of America	Provide services to health clinic patients impacts by domestic and sexual violence	68 women were served with 502 services in 2023, exceeding the anticipated impact of 50
Health Related Social Needs	Patient Support Program	Increase access to supportive services	1,856 individuals were served with 3,100 vouchers
Health Related Social Needs	Community Resource Desk	Support individuals and families with unmet social needs connect to essential community resources	1,962 individuals were provided with 3,250 essential resources, reaching 5,719 people living in those households from January '23 – June '25
Health Related Social Needs	Grant to Homeless Solutions Coalition of Clackamas County to develop a service "hub"	Develop a service "hub" that provides housing and supportive services	Have full-time staff and have become a resource and training hub for housing and social service providers. Their physical hub "Caring Place" is slated to open in February 2027
Economic Security	Grant to Serendipity Center	Expand student job skills and teacher incentives	85 students served during 2023, increasing the average attendance rate to 84%, surpassing Oregon's average by 20 points
Economic Security	Grant to ASSIST	Optimize client enrollment for Social Security benefits (SSD/SSDI) among adults with severe physical or mental disabilities who are unable to work	Between 2023-2024, ASSIST screened 1,529 people and enrolled 231 new applicants with SSI benefits. Over these 2 years, 82% of those enrolled secured approval for SSI/SSDI, exceeding the national average of 33%

This is not an exhaustive list.

Providence

2025 CHNA GOVERNANCE APPROVAL

This Community Health Needs Assessment was adopted by the Providence Oregon Community Ministry Board of the hospital on November 14, 2025. The final report was made widely available by December 28, 2025.

12/5/2025

Brad Henry — Date
Chief Executive, Providence Milwaukie Hospital
Providence

11/25/2025

Eric Stark — Date
Chair, Oregon Community Ministry Board

12/8/25

Jennifer Burrows — Date
Chief Executive, Oregon
Providence

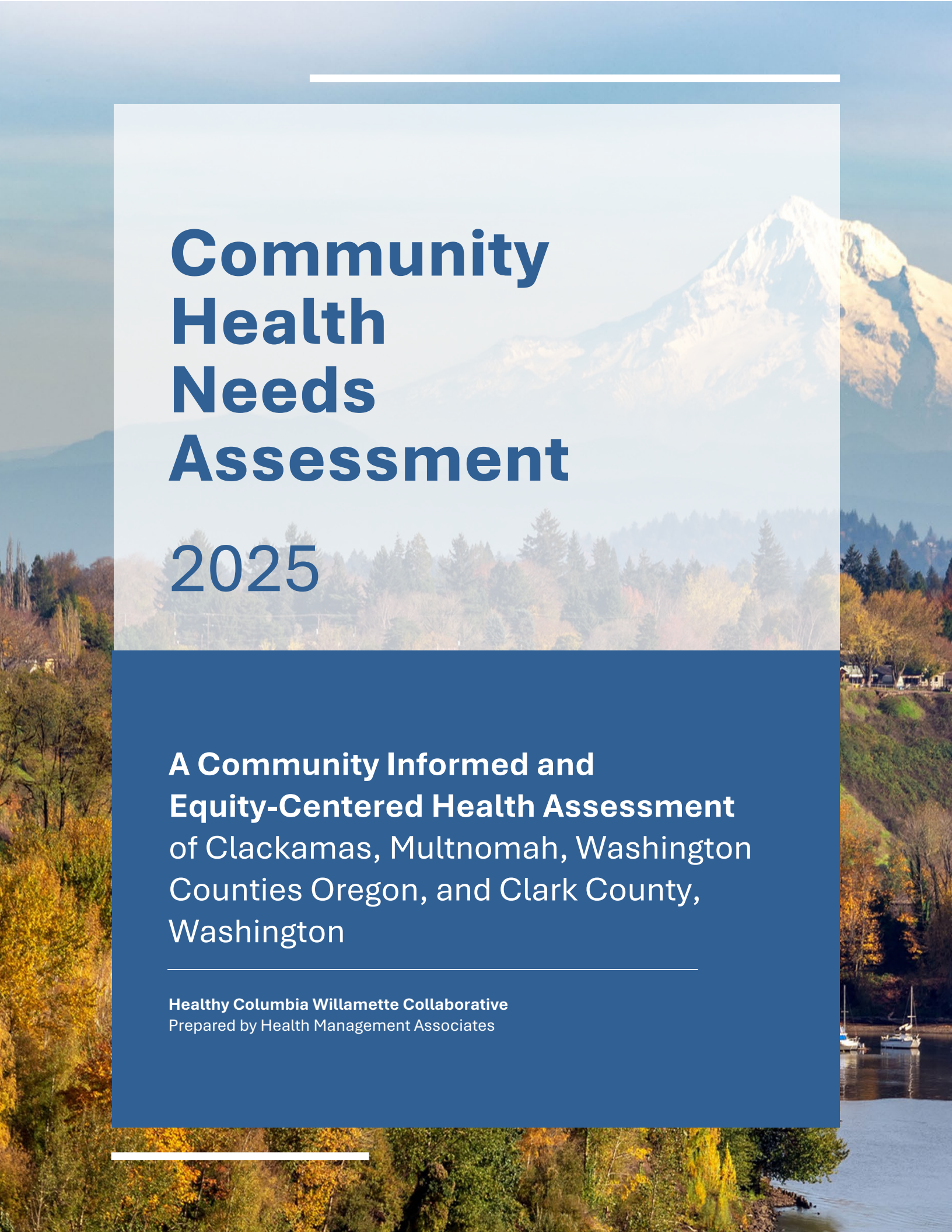
CHNA/CHIP Contact:

Sonya Kauffman Smith
Manager, Community Health – Oregon
Sonya.kauffmansmith@providence.org

Contact CHI@providence.org to provide feedback about this CHNA or to request a free printed copy.

APPENDICES

Appendix 1. Healthy Columbia Willamette Collaborative Community Health Needs Assessment



Community Health Needs Assessment

2025

A Community Informed and Equity-Centered Health Assessment of Clackamas, Multnomah, Washington Counties Oregon, and Clark County, Washington

Healthy Columbia Willamette Collaborative
Prepared by Health Management Associates

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LAND ACKNOWLEDGEMENT

The quad-county region, comprised of Clackamas, Multnomah, and Washington counties in Oregon and Clark County in Washington, is unceded indigenous land, now colonized, that rests on traditional village sites of the Multnomah, Wasco, Cowlitz, Cathlamet, Clackamas, Bands of Chinook, Tualatin, Kalapuya, Molalla, and many other tribes that made their homes along the Columbia River. We want to express our deep appreciation and respect to these peoples and all indigenous communities who hold ancestral ties to this land and acknowledge that the policies and actions of the United States systematically harm and oppress these communities. While this land acknowledgment cannot fix the harm done to these tribal communities, it serves as an invitation to recognize and respect the deep ties tribal communities have to the land, demonstrate the role stories play in honoring the experiences of our communities, and connecting those stories and experiences to practices of healing for today and future days.[1]

LETTER FROM THE COMMUNITY ADVISORY GROUP

The Community Advisory Group (CAG) represents a diverse group of community organizations from Clackamas, Multnomah, and Washington counties in Oregon. In partnership with Multnomah County Health Department, Health Management Associates, the Healthy Columbia Willamette Collaborative (HCWC), and Health Share of Oregon, the CAG collaborated from April 2024 to October 2025 to develop the HCWC's 2025 Community Health Needs Assessment (CHNA, also referred to as CHA), aiming to update the 2022 CHNA. This includes updating qualitative and quantitative data and adding additional context for what has changed in our communities since the last CHNA. This project was funded by the HCWC, a regional partnership between health systems, public health, and coordinated care organizations who serve our communities.

Many communities, especially Black, Indigenous, and People of Color communities, as well as individuals who hold multiple identities that are targeted by structural racism and systemic oppression, have often been excluded from these kinds of conversations. Therefore, the CAG intentionally had representation from 11 different cultural and population groups to ensure diverse voices were included. We wanted to amplify our communities' voices and have meaningful conversations to identify community needs.

Meeting on a monthly basis, we used popular education as our guiding values and methodology to create space for the members to share their own lived experiences as well as the communities that they serve. We guided all of the steps of the CHNA process, including the design of the focus groups and survey, to the data collection, analysis and meaning-making. The focus groups were conducted in nine languages and the survey was available in 20 languages, including English.

Our hope is that the 2025 CHNA will shine a light on the lived realities of our communities, identify the strengths and gaps in our current systems, and shape the strategies and programs that are culturally responsive, accessible, and effective. We hope that the report has the impact of demonstrating to our community that what they say matters - that in lifting their voices and raising their concerns, they can be active agents of change in the world around us.

In community,
Community Advisory Group

COMMUNITY ADVISORY GROUP MEMBER ORGANIZATIONS

4D Recovery
A Recovery Community Organization 4 Young People

Slavic Community Center of NW

AFHHO
African Family Holistic Health Organization

Black Parent Initiative

street roots

Living Islands

LatinoNetwork

Clackamas County

Legacy Health

Asian Health & Service Center
華人服務中心
아시안 보건 복지 센터
Trung Tâm Y Tế & Dịch Vụ Châu Á

IRCO
Greater Middle East Center
Serving communities from North Africa, Middle East & South Asia

NAYA Family Center

Oregon Spinal Cord Injury Connection

LETTER FROM THE HEALTHY COLUMBIA WILLAMETTE COLLABORATIVE

The Healthy Columbia Willamette Collaborative (HCWC) was founded on a shared vision: to improve the health and well-being of our region, collectively building towards community-driven strategies. This is done through alignment, community engagement, and gathering relevant, actionable data. Our partnership—comprising seven hospital systems, three county health departments, and two Coordinated Care Organizations—exists to reduce redundancy, foster equitable investment, and ensure our collective work reflects the priorities and lived experiences of the communities we serve. At the center of this vision is a single, regional Community Health Needs Assessment (CHNA) collaboratively conducted to minimize the burden on community partners while maximizing our ability to act together.

The 2022 CHNA was instrumental in guiding our collective efforts to improve health in the region. It provided a regional snapshot of community priorities, identified gaps and barriers to health, and illuminated structural and social determinants impacting well-being. HCWC partners have used this assessment to inform community benefit investments, strengthen strategic planning efforts, and align across public health, health care, and community systems. The CHNA continues to serve as a tool for engagement, shared learning, and strategic accountability.

Throughout this work, HCWC is guided by a growth mindset and a strong commitment to community accountability. We acknowledge that addressing health inequities is an ongoing process that requires humility, transparency, and sustained partnership. We are actively working to ensure continuity between CHNA cycles, learning from the past while building toward a more coordinated and impactful future. Our aim is to strengthen not only the systems that serve our communities, but also the trust between those systems and the people they are meant to support.

Looking ahead to the next CHNA, we are shifting to a regional backbone structure, designed to foster coordinated, equitable action among our partners. This cross-sector approach, with Health Share of Oregon as convener, will promote collaboration, align priorities, and ensure our efforts remain responsive to community health goals.

We are grateful for the continued collaboration, commitment, and leadership of our community partners. Together, we remain steadfast in our pursuit of a healthier, more equitable region for all.

Warm regards,

The Healthy Columbia Willamette Collaborative Partners

ABBREVIATIONS

BIPOC: Black, Indigenous, and People of Color
BRFSS: Behavioral Risk Factor Surveillance System
HCWC: Healthy Columbia Willamette Collaborative
IDD: People with Cognitive, Intellectual, and Developmental Disabilities

GLOSSARY

Community Advisory Group (CAG) – Composed of community members and stakeholders who provide critical input throughout the CHNA process. Their responsibilities include: 1) reviewing and providing feedback on draft recommendations; 2) participating in prioritization surveys to identify top community health needs; 3) offering insights based on personal experience and community engagement; and 4) helping ensure that the CHNA reflects the needs and priorities of diverse populations, especially those experiencing health disparities.

Community – Group of people with diverse characteristics who are linked by social ties, common perspectives, and who may be engaged in joint action in geographical locations or settings. This is but one definition. Community can be defined in multiple ways depending on the people asked and what groups have in common.

Community Health Needs Assessment (CHNA) / Community Health Assessment (CHA) – For the purpose of this report, the acronym CHNA is used. CHNAs and CHAs share several core similarities, even though they are conducted by different entities (hospitals vs. public health agencies) and serve slightly different purposes:

- Nonprofit hospitals: CHNAs are required for non-profit hospitals to maintain tax-exempt status under IRS rule and must be conducted every three years.
- Coordinated Care Organizations (CCOs): CCOs are required, per Oregon Revised Statue, Oregon Administrative Rule and CCO contract, to complete a Community Health Improvement Plan (CHIP), based on a CHA, at least every five years.
- Local Public Health Authorities (LPHAs): CHAs are used by state, tribal, local, or territorial health departments to guide public health planning and improve population health. While not required, most LPHAs develop and implement CHAs as a requirement of Public Health Accreditation. CHAs completed to meet accreditation standards must be completed at least every 5 years.

Community Investment – Refers to goods, services, and resources that hospitals and health plans provide to improve health outcomes and access to care—especially for populations with unmet needs/limited services—based on community-identified needs.

Community Served – Used interchangeably with service area. This area is defined as the geographic boundaries of a hospital's patient service area or market.

Health Behaviors – Actions individuals take that affect their health.

Health Outcomes – A change in the health status of an individual or a group that can be attributed to the intervention.

Focus Population – Group identified for support or analysis within a program, policy, or research effort. These groups share characteristics—such as age, race/ethnicity, location, health status, or socioeconomic background—that affect their access to resources or outcomes. In health and social services, focus populations often face disparities and are prioritized to promote fairness and improve service delivery.

LGBTQ2IA+ – An inclusive acronym used to include people of all gender identities and gender modalities that stands for lesbian, gay, bisexual, transgender, questioning/queer, intersex, asexual plus others such as pansexual

Social Determinants of Health – The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes.

Qualitative Data – Information that cannot be measured or expressed in terms of numbers but instead is narrative and gives a feel of the community.

Quantitative Data – Information that can be expressed in terms of numbers.

OVERVIEW

Many factors within a community determine community health. A Community Health Needs Assessment (CHNA) is a series of planning and data collection, analysis, and interpretation activities that are summarized in a report that describes a community's perception of their population's well-being. It involves hearing from community members about their strengths, resources, gaps, and health needs as well as the analysis of secondary quantitative data collected by external entities. Hospitals, public health entities, community-based organizations, and others use the CHNA to create programs and services to improve the health of a community.

This report includes a description of:

- The community demographics and population served.
- The process and methods used to obtain, analyze and synthesize primary and secondary data.
- The significant health needs in the community, taking into account the needs the identified focus populations.
- The process and criteria used in identifying certain health needs as significant community needs.

The Healthy Columbia Willamette Collaborative (HCWC) is a formal, charter-bound partnership to fund and guide a regional CHNA. This is the group's fifth CHNA used by the partners to inform community-level investments in health and well-being.

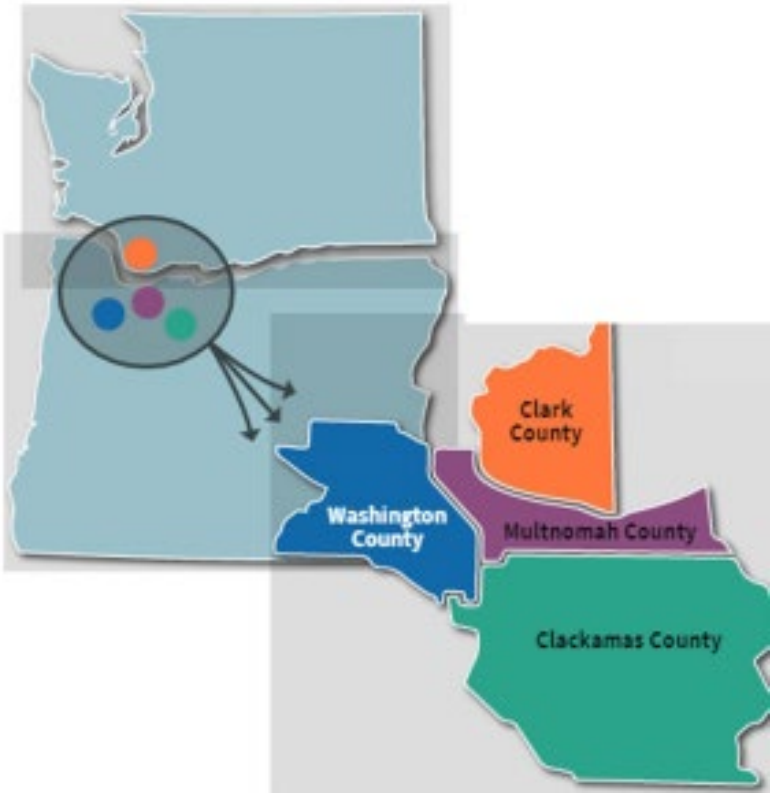
HCWC Partners include:

- CareOregon
- Clackamas County Health, Housing and Human Services
- Health Share of Oregon
- Hillsboro Medical Center
- Kaiser Permanente
- Legacy Health
- Multnomah County Health Department
- Oregon Health & Science University
- Portland Adventist Medical Center
- Providence Health & Services
- Trillium Community Health Plan
- Washington County Public Health

The purpose of HCWC is to align efforts of hospitals, public health, CCOs, and the residents of the communities they serve to develop a shared community health assessment across the four-county region of Clackamas, Multnomah, and Washington Counties, Oregon and Clark County, Washington.

The HCWC has not yet jointly addressed health challenges. Individual partners (not the HCWC as an entity) are serving communities with impactful solutions (but not always by leveraging shared resources and coordinated care.)

Figure 1. HCWC Regional Map



To meet the requirements of the IRS regulations 501(r) for charitable hospitals, hospitals are required to make the CHNA and Implementation Strategy (IS) available publicly through print copies and on the internet. Public comment is also solicited and documented. In keeping with these regulations, HCWC partners made the 2022 CHNA report available to community members to read online. No written comments had been received at the time this report was written.

APPROACH TO THE CHNA

The CHNA is a community-informed process that:

- Deepens community partnerships
- Centers community wisdom
- Tells a story that reflects lived experience
- Informs and influences critical community decision making

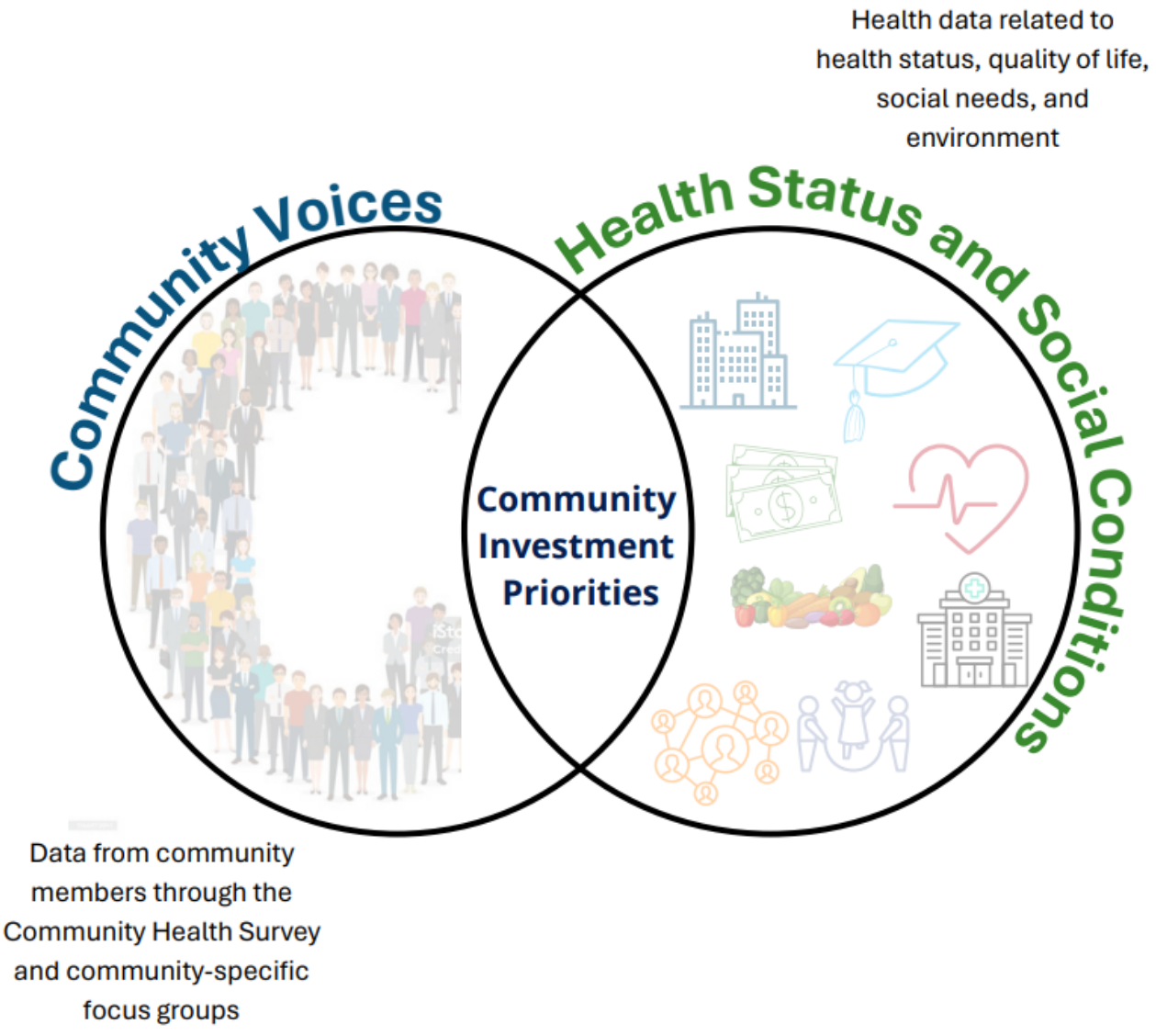
This approach relied upon the input of a Community Advisory Group (CAG) originating from HCWC's desire to increase the role of communities in developing these needs assessments and commitment to advancing health for all. Read **Appendix A** to learn more about each CAG member.

This 2025 CHNA serves as an update to the 2022 CHNA. To ensure the CHNA remains a responsive and actionable tool, the update process involved monitoring of health trends and disparities through timely data collection, community engagement, and cross-sector collaboration. This included integrating new quantitative data from public health surveillance and qualitative insights from community partners and residents. Regular check-ins with affected parties helped validate findings, identified emerging issues, and refined priorities. The updated CHNA serves as a strategic guide to inform equitable community investments, align resources with evolving needs, and drive measurable improvements in population health.

HCWC partners reviewed and provided feedback on the 2025 CHNA report outline and were given two opportunities to provide feedback on the report itself. For CCOs, this also included opportunities for their own Communtiy Advisory Councils to provide feedback.

Findings presented in this CHNA are the result of analyzing multiple data sources. Data include information from community voices (primary data collected first-hand through CAG engagement, surveys, and focus groups) and health indicators and outcomes (secondary data collected by another entity or for another purpose). This is described in **Figure 2**.

Figure 2. HCWC CHNA Approach and Data Sources



Community Voices

The CHNA relied on community voices and stories to identify and define the root causes of poor health outcomes that should be addressed through community improvement efforts. More than 350 people participated in community-specific focus groups, and 2,128 completed an online survey.

Community Specific Focus Groups

37 community-specific focus groups were led by members of the CAG and other community-specific partners in the fall of 2025. Nine focus groups were conducted in a language other than English (Arabic, Cantonese, Dari, Farsi, Mandarin, Russian, Spanish, Swahili, and Ukrainian), engaging over 350 community members. Three quarters of the participants identified as people of color and 60 percent of the community members preferred to speak a language other than English. See **Appendix B** for more information on the community engagement session protocol and **Appendix C** for participant demographics.

Community Health Survey

The HCWC Community Health Survey launched on October 7, 2024 and was open to the public through December 31, 2024. It was available in 19 languages. 2,128 individuals completed the survey. Most respondents were English speaking (72%), White (57%), women (70%), and between the ages of 26 and 55 years (75%). This was a convenience sample, which is the process of choosing people to participate in the CHNA simply because they are easy to reach. Instead of picking people randomly, they select those who are nearby, available, or willing to help. Therefore, the results may not represent everyone, but reflect generally held feelings and beliefs. See **Appendix D for survey methodology, Appendix E** for the survey instrument and **Appendix F** for survey respondent demographics.

Focus Populations

Individuals from groups that are often socially marginalized and underrepresented in community needs assessments were recruitment priorities for the community-specific focus groups and survey. The following groups comprise some, but not all, of the socially marginalized and underrepresented populations that were a priority for recruitment.

- People with mental health conditions and/or substance use disorder
- People with disabilities
- People of varying race and ethnic groups, including African immigrant and refugee, African American/Black, Asian, Indigenous/Native American/Alaskan Native, Latine/o/a/x, Middle Eastern, Native Hawaiian and Pacific Islander, and Slavic and Eastern European, and Rural dwellers
- LGBTQIA2+ (Lesbian, Gay, Bisexual, Transgender, Questioning/Queer, Intersex, Asexual plus others such as Pansexual)
- Unhoused/unsheltered

It is important to note that findings from each data source reflect the demographics of their participants. Community-specific focus groups results represent a highly diverse population aligned with the communities prioritized for engagement by the CAG, while the survey was distributed regionally regardless of the prioritized communities, reflects largely a majority white and female population.

Health Status and Social Conditions

In a CHNA, secondary data sources are collected, analyzed, and reported to provide a comprehensive understanding of the health status and social conditions affecting a community. These data—such as public health surveillance, census information, and state or national datasets—offer valuable insights into trends, disparities, and priority health issues without the need for new data collection. By leveraging existing, validated sources, CHNAs can efficiently identify areas of concern, support evidence-based decision-making, and compare local outcomes to broader benchmarks. Secondary data sources used in this CHNA include:

- **U.S. Census American Survey: Tracks individual and household characteristics**
- **U.S. Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS): Tracks health behaviors and risk factors.**
- **CDC WONDER: Includes birth, death, fetal death, and infant death data.**
- **Oregon Student Health Survey and Washinton Healthy Youth Survey: Assesses youth health behaviors and attitudes.**
- **Oregon and Washington Department of Education: Educational achievement and enrollment data for public school students**

CHNA Methodology Limitations

In CHNAs, both primary and secondary data collection methods have important roles but also come with limitations. Primary data, such as the Community Health Survey and focus groups, provided rich, community-specific insights, but was limited by resource constraints, small sample sizes, potential bias in responses or recruitment, and lack of representation of all the communities in the four counties. On the other hand, secondary data—including public health databases, census data, and hospital records—are more cost-effective and allowed for trend analysis and benchmarking, but were outdated, incomplete, or not specific enough to reflect the unique needs of certain populations. Additionally, secondary data do not capture emerging issues or community perceptions. Together, these limitations highlight the importance of using both data types in a complementary way to ensure a more accurate and inclusive understanding of community health.

ABOUT THE 2022 CHNA

A similar approach was used for the 2022 CHNA. The voices of community members in the region informed and defined the root causes of good and poor health. Secondary data was used to understand the region's health outcomes. More than 300 people participated in community meetings and over 500 people responded to an online survey. The community survey found that people living in the region were satisfied with getting the medical care needed and with their own health. However, getting help during stressful times, and related, getting the mental health or substance use care needed was found to be less satisfactory.

Four priorities areas for creating a healthier community emerged, and have been central to guiding the approach for the CHNA 2025 update:

Neighborhood for All: All people should have access to safe and affordable neighborhoods and housing.

Essential Community Services and Resources: All people should have access to opportunities for education, employment, nutritious food, and getting where they need to go.

Access to Culturally and Linguistically Responsive Health Care: All people should have access to health care that aligns with their cultural, behavioral, and communication needs.

Support for Family and Community Ways: All people should have access to culturally relevant food, healing practices, land for physical activity and connection to the natural world, and opportunities for ceremonial, religious, cultural, educational, and celebratory community gatherings.

FORCES OF CHANGE

In May 2025, members of the HCWC leadership group revisited the previous Forces of Change Assessment completed in 2022 during an in-person meeting May 12, 2025. During this time together, the partners reflected on evolving challenges and contextual shifts impacting the quad-county region. The partners noted that while many of the forces persist as described in the graphic to the right, the context and impact may have changed. For example, while the COVID-19 pandemic has ended, the long-term impacts of COVID-19 are still being felt and identified. The updated assessment captures both persistent and emerging forces shaping health for all.

New Trends and Factors

- Worsening financial conditions are increasing vulnerability across communities.
- Concerns about health misinformation - refers to false, misleading, or incomplete information about health topics that is presented as fact - have grown in recent years, particularly as the region grapples with overlapping public health crises like drug overdoses, vaccine hesitancy, and mental health challenges.
- A growing crisis that intersects with behavioral health, housing, and public safety systems through increased emergency service use, unhoused populations, and community tensions.
- Passage of major cuts to critical social safety net programs like Supplemental Nutrition Assistance Program and Medicaid is creating anxiety and instability in vulnerable populations, as well as the community-based organizations who serve them.
- The rollback of federal vaccine requirements and support is feared by some to contribute to a rise in infectious diseases, and a weakening of public messaging and resources around vaccines, possibly reducing confidence in their safety and effectiveness and lead to lower vaccination rates.
- Increased federal immigration enforcement is creating fear and distrust of systems, thereby leading to fewer immigrants and refugees accessing health and social services and greater social isolation.

Contextual Changes

- Many previously identified issues remain relevant but have intensified or shifted in nature.
- Economic pressures have deepened, exacerbating disparities.
- Backlash against racial justice movements has created new roadblocks to equity-focused work.

Specific Issues Identified

- Federal Diversity, Equity, and Inclusion (DEI) Policy Changes: Since early 2025, federal actions on DEI have shifted with the new administration. The Biden administration expanded DEI through executive orders (EO) like EO 13985, promoting fairness across agencies. In January 2025, the Trump administration's EO 14148 revoked many DEI orders, sparking debate: supporters say it restores neutrality, while critics warn it may reduce the variety of perspectives in the workplace and hinder efforts to address disparities in health care and education.[2]
- Oregon's Measure 110 (Drug Addiction Treatment and Recovery Act), passed in 2020, made Oregon the first state to decriminalize small amounts of all illicit drugs. While intended to reduce incarceration and improve treatment access, it received mixed reviews—supporters cite reduced stigma and a public health focus, while critics highlight implementation challenges and public safety concerns. In 2024, House Bill 4002 rolled back key elements, reintroducing a misdemeanor for simple possession.[3]
- Oregon Drug Overdose Trends: In the 12 months ending April 2024, Oregon saw a 22 percent increase in drug overdose deaths—one of the highest in the U.S.—while national deaths declined by 10 percent. Synthetic opioids like fentanyl caused over half of Oregon's overdose deaths in 2023. Methamphetamine, often combined with fentanyl, remains a major contributor to polysubstance overdoses.[4]

Forces of Change

COVID-19 PANDEMIC

ECONOMY

RACIAL JUSTICE MOVEMENT AND UPRISINGS

ENVIRONMENTAL EVENTS (WILDFIRES AND EXTREME HEAT)

POLITICAL UNREST/DIVISIVE ENVIRONMENT

CHANGING WHITE HOUSE ADMINISTRATION

CHALLENGES

Data are not current enough to truly understand the impact of the pandemic on the prevalence of violence, mental health issues, academic achievement, and employment.

Mental health issues continue to increase and have been exacerbated by COVID-19.

School districts struggle to meet the demand of mental health concerns among students.

Balancing working from home and online school during a pandemic.

Mental health workforce issues and getting individuals the appropriate level of care.

Lack of political will to support increased transportation access, particularly in rural areas.

Increased prevalence of unhoused individuals.

OPPORTUNITIES

Greater awareness of the social and health inequities and the contribution of racism to the disparities.

COVID-19 has heightened awareness of the effect of social isolation on health.

Desire to have greater cultural competency in the way health care is delivered.

New conversations are taking place on economic justice issues, including minimum wage increases.

Businesses and other organizations are looking to understand the contribution of their policies and procedures to perpetuate racism and discrimination.

The political will to improve access to housing and increase initiatives and research on strategies to shelter individuals experiencing houselessness.

HCWC Demographic Regional Profile

The demographic characteristics of a population are important in understanding the health risks, challenges, strengths, and opportunities of a region. Aspects such as race and ethnicity, age, and gender are closely linked to health outcomes. Socio-economic factors such as income and education are likewise associated with health risk and protective factors and outcomes. This section displays select demographics for the region. Key takeaways include:

- The region is becoming more racially and ethnically diverse, with notable growth in the Hispanic/Latino population and individuals identifying as two or more races.
- A growing number of households speak languages other than English, especially Spanish and Asian/Pacific Island languages.
- High school graduation rates have improved overall, but disparities remain —especially among individuals identifying as "some other race" and those with multiple racial identities.
- Overall poverty rates have declined, but certain groups—like older adults, people with disabilities, and foreign-born residents—continue to face higher levels of economic hardship.
- Nearly one-third of households struggle to meet basic needs despite earning above the federal poverty level.

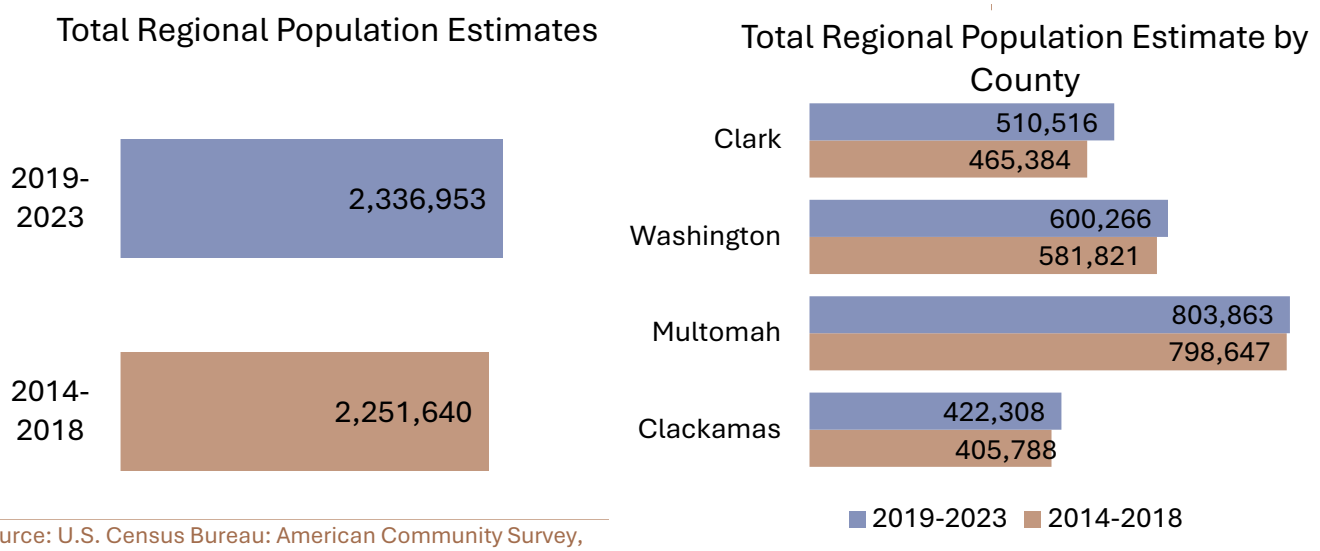
HCWC DEMOGRAPHIC REGIONAL PROFILE

Demographic data tables, including a breakdown of the data by county, are in **Appendix G**.

Total Population

Population estimates grew by about 4% between 2014–2018 and 2019–2023, adding approximately 85,000 residents. All counties in the region experienced population increases (**Figure 3**)

Figure 3. Total Regional Population, 2014-2018 to 2019-2023

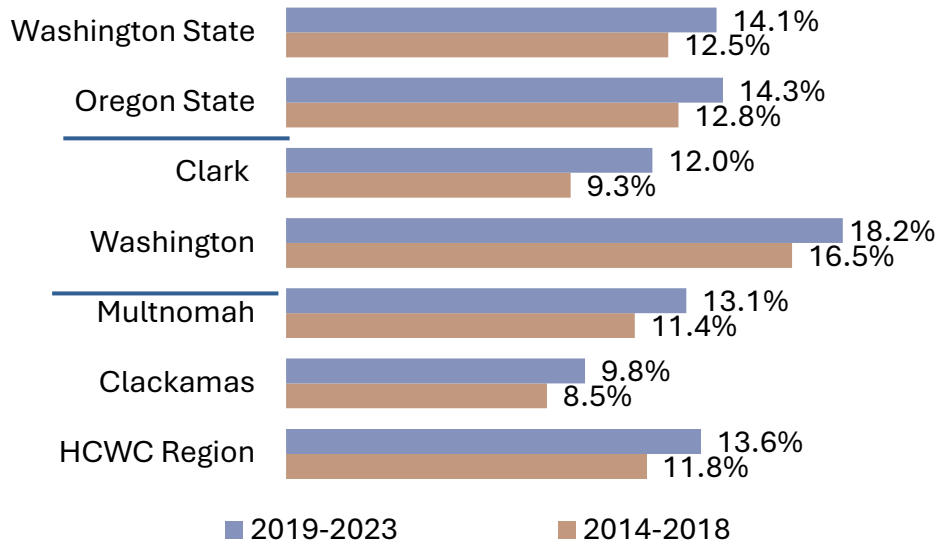


Source: U.S. Census Bureau: American Community Survey, Table B01001; Decennial Census: Table P012

The median age in the region was 39.1 years in 2019-2023. During this same time, the median age in Multnomah and Washington counties was significantly younger than the region at 38.5 and 37.8 years, respectively. The median age in Clackamas was significantly higher than the region at 42.1 years. Clark was similar to the regional median age at 38.9 years.[5] The population is fairly evenly distributed across working-age groups, including ages 40-64 years (32.7%) and ages 18–39 (30.9%), together making up nearly two-thirds of the regional population. Children and adolescents (ages 0–17) account for 20.6 percent of the population, while 15.7 percent were 65 and older.

Race and Ethnicity`

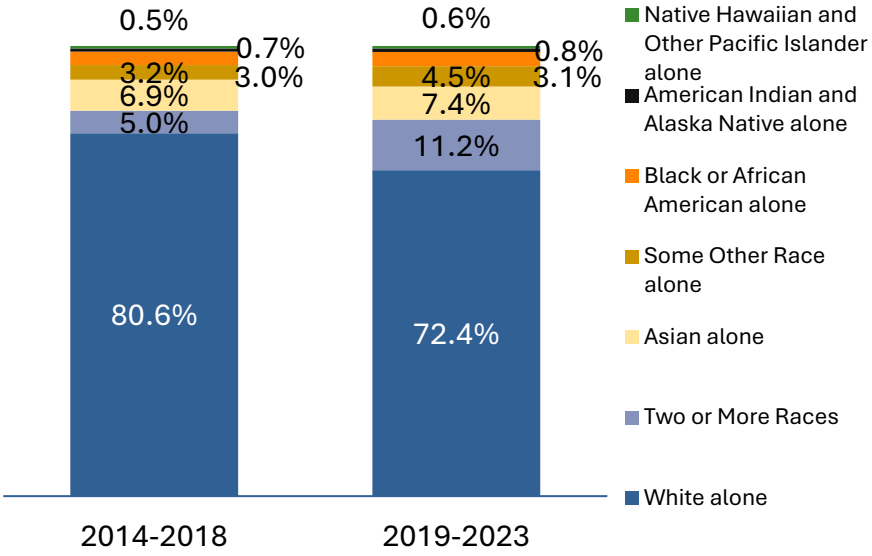
Figure 4. Percent of Population with Hispanic or Latino Origin, 2014-2018 and 2019-2023



Regionally, the Hispanic or Latino population grew from 11.8% to 13.6%, with the largest share in Washington County (**Figure 4**).

Source: U.S. Census Bureau, American Community Survey, 2018 and 2023 Five-Year Estimates Detailed B03002

Figure 5. Percent of the Regional Population by Race, 2014-2018 and 2019-2023



The region has also experienced notable shifts in the population by race (**Figure 5**). The White population declined from 80.6% to 72.4%, reflecting increasing representation from other race and ethnicity groups.

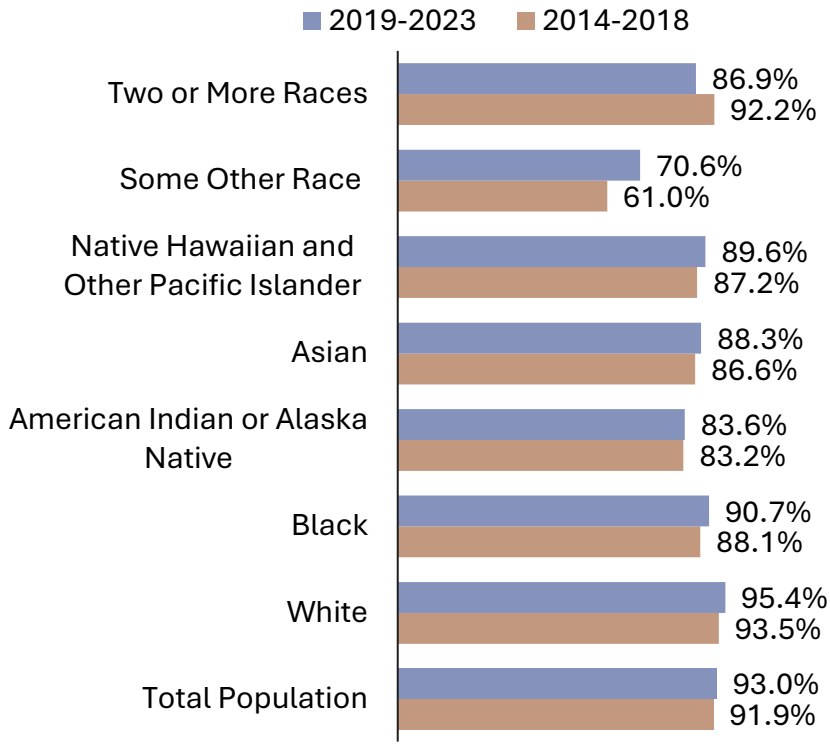
The share of people identifying as two or more races more than doubled, from 5.0% to 11.2%.

Source: U.S. Census Bureau, American Community Survey, 2018 and 2023 Five-Year Estimates Detailed B02001

High School Diploma or Equivalent

High school graduation rate is a critical demographic indicator that reflects both current and future community well-being. High school graduation rates help identify inequities in educational attainment that often correlate with health, economic stability, and civic engagement.[6]

Figure 6. Percent of Adults (Older than 25 years) with at least a High School Diploma or Equivalent, by Race, 2014-2018 and 2019-2023



High school graduation rates improved across the region, rising from 91.9% to 93.0%.
The largest gains were among individuals identifying as Some Other Race, Black, and Native Hawaiian or Pacific Islander. The only group to see a decline was those identifying as Two or More Races (**Figure 6**).

Source: U.S. Census Bureau, American Community Survey (ACS), 2018 and 2023 Five-Year Estimates Detailed Table S1501

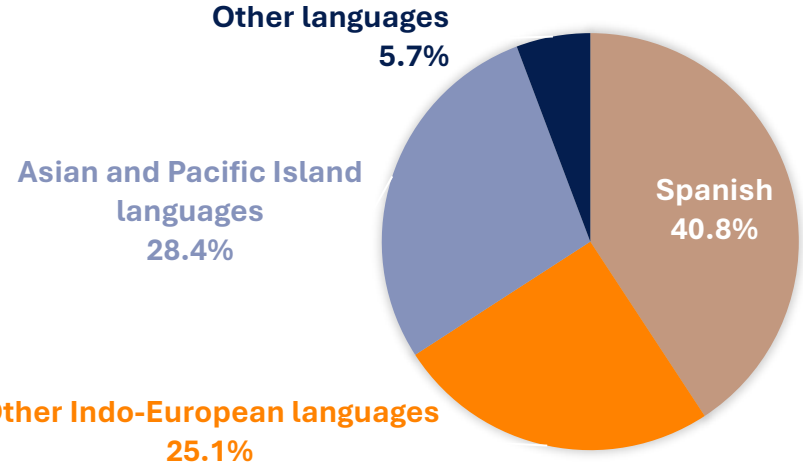
Languages Spoken other than English

Understanding the languages spoken in the HCWC region is important to identify potential obstacles to health access and communication. Reporting on language use helps ensure that health services, outreach, and materials are culturally and linguistically appropriate for the communities they serve.

The number of households speaking a language other than English increased in the region, from 163,000 households (18.8%) in 2014-0218 to 188,727 households (20.2%) in 2019-2023. The most common language spoken was Spanish (40.8%), followed by Asian and Pacific Island Languages (28.4%), and other Indo-European languages (e.g., Germanic, Slavic, Romance, Celtic Greek, Indic (indo-aryan), Iranian, Armenian and Albanian) (25.1%) (**Figure 7**).

Non-English-speaking populations grew since 2014-2018, with the largest percentage increases seen in households speaking other languages (+30.7%) and Asian and Pacific Island languages (+20.5%), reflecting a trend toward greater language representation in the region. The region had approximately 747,180 English-only households between 2019-2023, making up much of the population (79.8%).

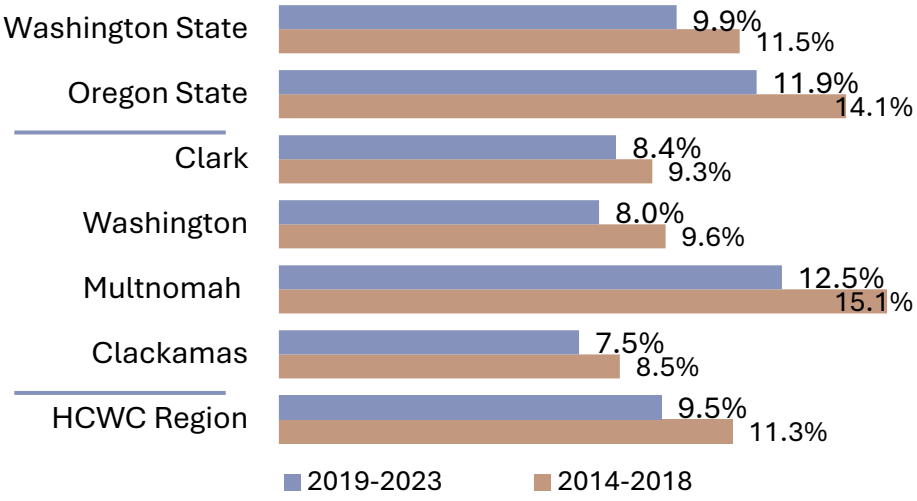
Figure 7. Percentage of Non-English-Speaking Households (n=188,727) in the HCWC Region, 2019-2023



Source: U.S. Census Bureau, American Community Survey (ACS) 2023 Five-Year Estimates Detailed Table C16002

Poverty Status

Figure 8. Percent of Individuals (all ages) Living at or Below Poverty Level, 2014-2018 and 2019-2023



The poverty rate in the region dropped from 11.3% (251,239 people) in 2014-2018 to 9.5% (220,311 people) in 2019-2023 (**Figure 8**).

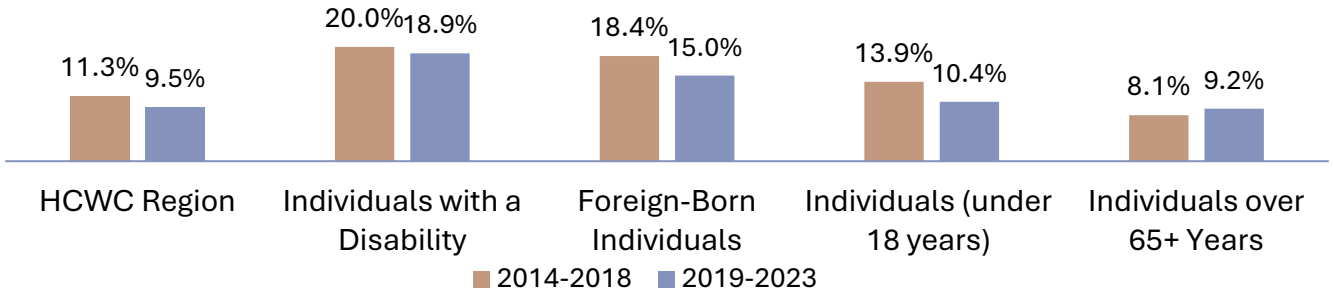
This matches the trend seen in Washington and Oregon States. The region's poverty rate is lower than the state averages, though Multnomah had higher rates than the region and both states during this period.

Source: U.S. Census Bureau, American Community Survey (ACS) 2018 and 2023 Five-Year Estimates Detailed Table S1701

Poverty rates for older adults (65+) went up from 8.1% to 9.2%. At the same time, their numbers grew by 18%, from 310,608 to 366,361 people, which means more older adults are experiencing poverty in the region (**Figure 9**).

Although overall poverty rates in the HCWC Region went down, some groups still have higher poverty rates than others. People with disabilities, immigrants, and children saw their poverty rates drop, but these rates are still higher than the average for everyone.

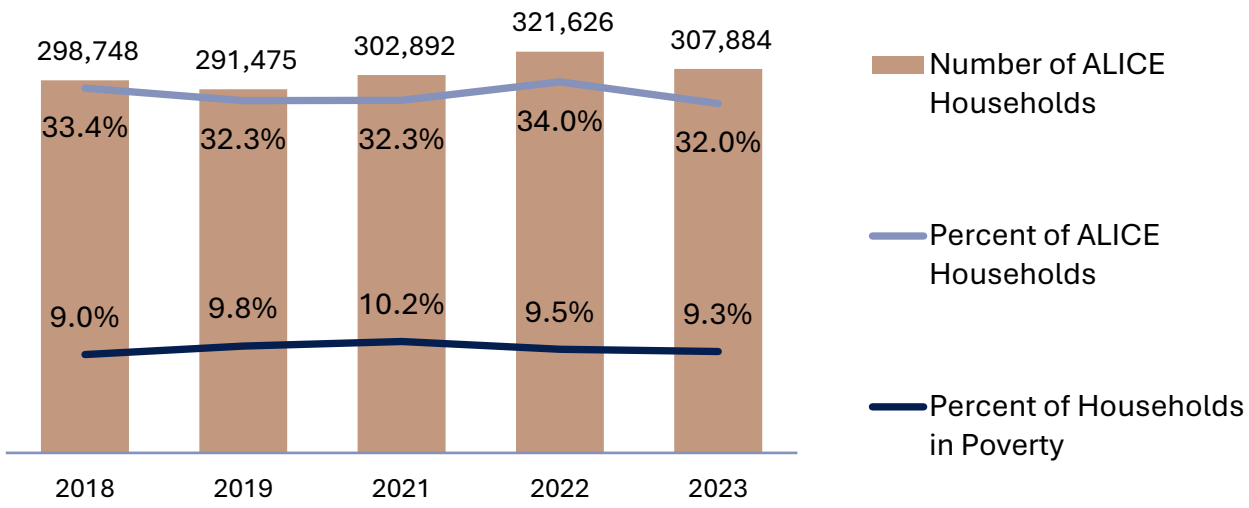
Figure 9. Percent of Individuals living in Poverty by Demographic Characteristic



More recent research efforts have established alternative methods for determining a more accurate understanding of what it costs to live in specific geographic areas and who within those areas do not have enough income to meet their basic human needs. The measure Asset-Limited, Income Constrained, Employed (ALICE) is available to understand who is struggling to meet their basic needs in the region.[7] In setting the minimum income needed to meet basic needs, ALICE includes the costs of housing, utilities, food, transportation, health care and a basic smartphone plan.

In 2023, about 32% of households in the region didn't earn enough to cover basic expenses like food, housing, health care, and transportation or about households. The number of these households went up from 298,748 in 2018 to a high of 321,626 in 2022, then dropped slightly to 307,884 in 2023 **(Figure 10).**

Figure 10. Number and Percent of ALICE Households and Poverty Rate in the Region, 2018 to 2023



Source: United for ALICE, data available at https://www.unitedforalice.org/county-reports.

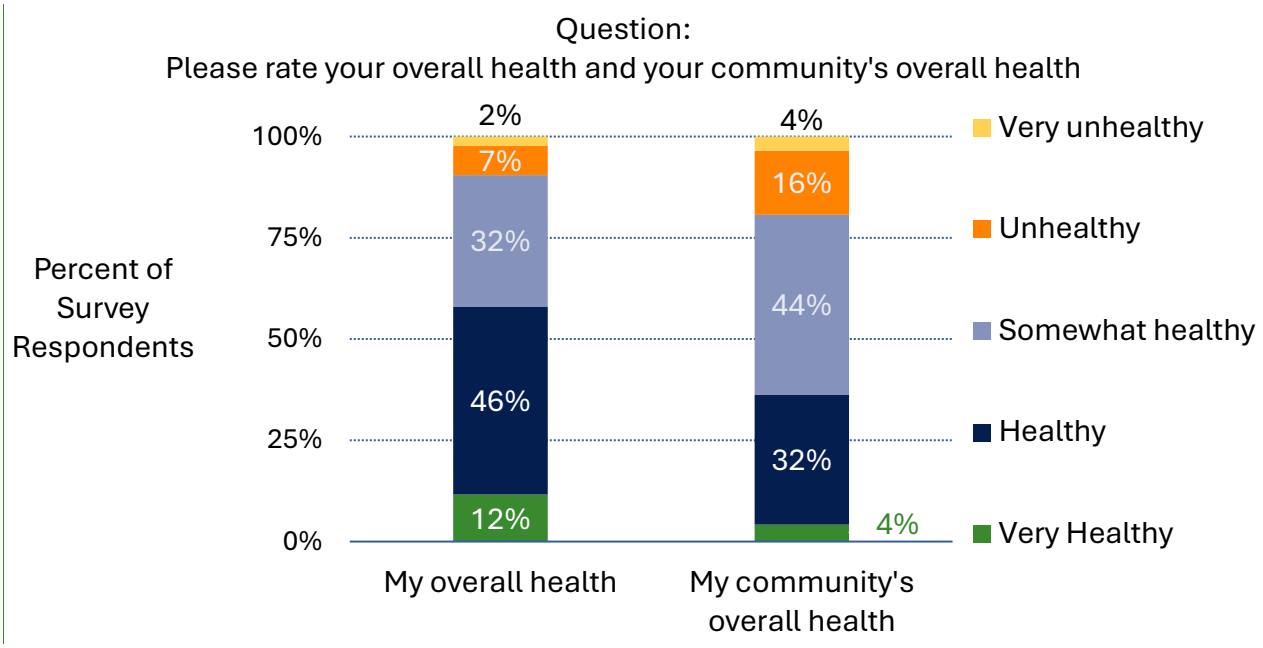
State of the Region: Health Status and Priorities

Social and community factors significantly influence health. The findings presented in this CHNA are derived from an assessment of community health, incorporating insights from focus groups and the Community Health Survey. This multifaceted approach allowed for a deep dive into the experiences, perceptions, and priorities of the HCWC region's residents.

STATE OF THE REGION: HEALTH STATUS AND PRIORITIES

Survey respondents were more likely to rate their own health more positively than their community's health. Among all respondents, most felt that their own overall health was "healthy" (46%), and their community's overall health was "somewhat healthy" (44%) (**Figure 11**). This may reflect a disconnect between how individuals perceive their own well-being versus the broader health of their community, which could reflect concerns about systemic issues, access to care, or social determinants of health.

Figure 11. Individual and Community Health Status



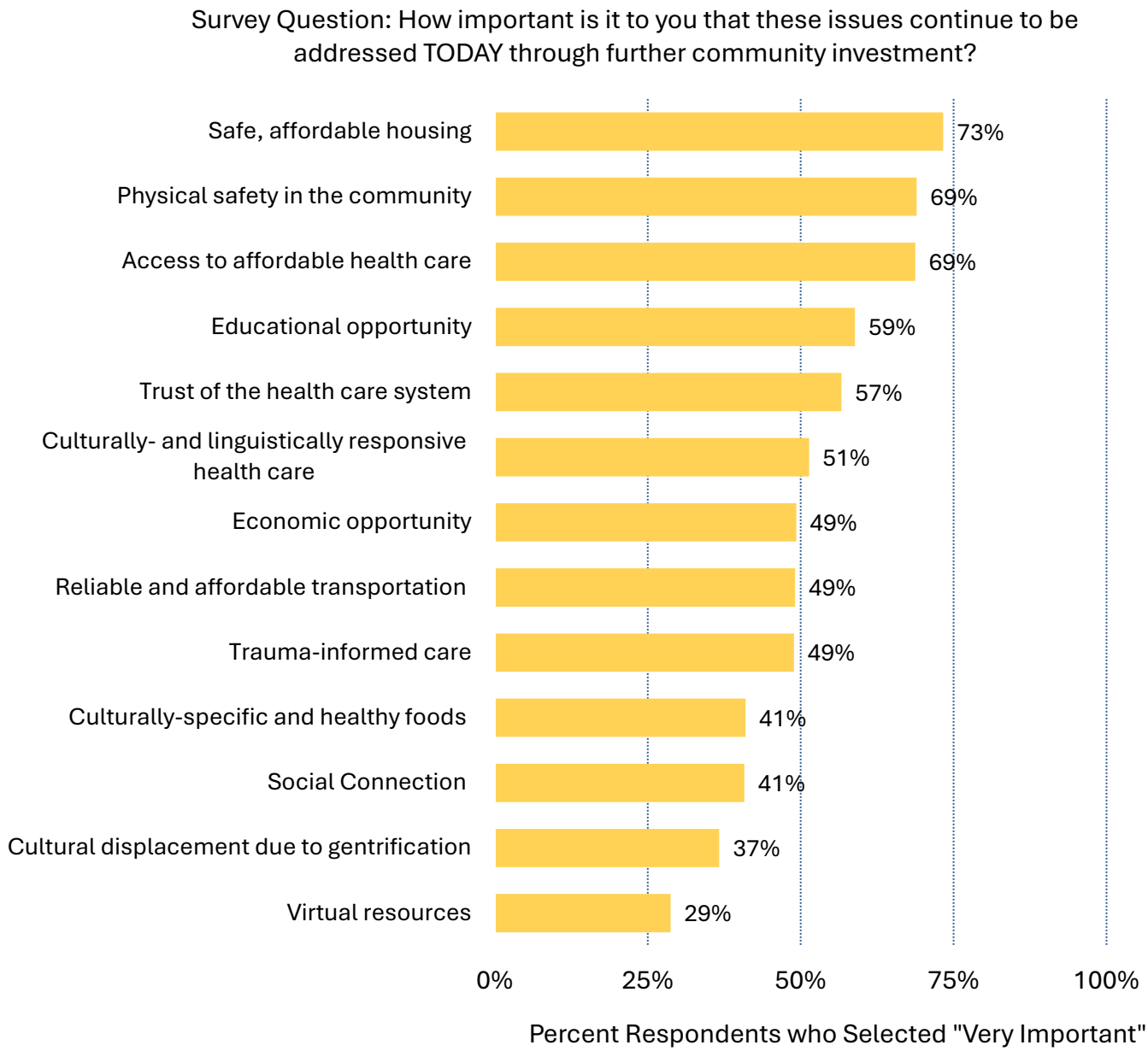
Source: HCWC Community Health Survey, 2024 (n=2,128)

The 2022 CHNA identified several areas for improvement in health, health care, and determinants of health. Survey respondents in 2024 were asked to share how important it is to them that these issues continue to be addressed ***TODAY*** through further community investment on a scale of one (Very Important) to five (Not Important).

Today, survey respondents prioritize basic needs and safety, followed by trust, inclusivity, and access. Safe, affordable housing is the top community priority, with 73 percent of respondents rating it as very important. Physical safety and access to affordable health care are also highly valued, each selected by 69 percent of respondents. Educational opportunity (59%) and trust in the health care system (57%) are important but slightly lower in priority.

Culturally- and linguistically responsive care was considered very important by 51 percent of survey respondents, highlighting the need for inclusive services (**Figure 12**).

Figure 12. Issue Prioritization for Community Investment Among All Survey Respondents

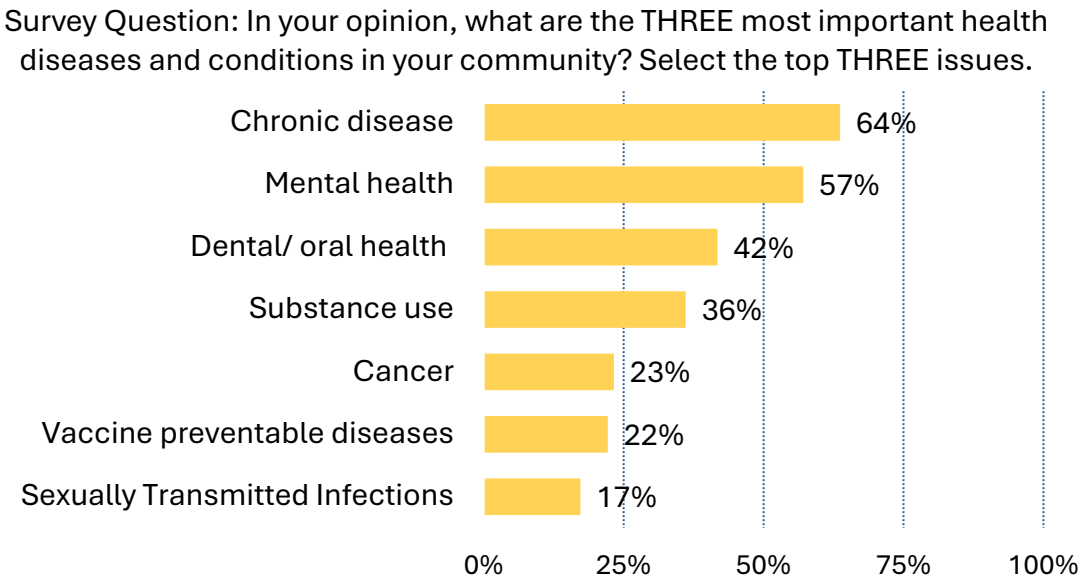


Source: HCWC CHNA Community Survey, 2024. n=2,128

Community Health Priorities

Survey respondents identified chronic disease (64%) and mental health (57%) as their top health concerns, followed by dental/oral health (42%) (**Figure 13**).

Figure 13. Top Three Most Important Health Diseases and Conditions Among All Survey Respondents



Source: HCWC CHNA Community Health Survey, 2024, n=2,128

PRIORITY RECOMMENDATIONS

To guide the prioritization of the recommendations presented in the 2022 CHNA, the HCWC engaged the CAG in a structured process. On June 3, 2025, CAG members reviewed the draft recommendations and provided feedback with the general community engagement findings in mind, including from both the Community Health Survey and community-specific focus groups. The updated recommendations were then shared with CAG members, who were invited to participate in an online prioritization survey conducted from July 16 to 31, 2025. See **Appendix H** for the survey. 10 of 11 (91%) CAG members completed the survey, selecting up to two recommendations within each priority area they believe should be prioritized for community investment over the next three to five years. Results are presented in **Figure 14**.

Figure 14. Priority Recommendations

A Neighborhood For All

Community Engagement Themes: Ease of Access and Transportation; Affordable Housing and Homelessness; Community and Safety Support

Top Priority

- Engage local politicians to advocate for safe, healthy neighborhoods

Other Recommendations

- Support civic engagement for immigrant/refugee communities
- Invest in equity-centered crime prevention

Support for Family and Community Ways

Community Engagement Themes: Community Connections & Support; Social Engagement & Inclusivity; Challenges in Accessing Community Resources

Top Priority

- Build awareness and engagement through community partnerships

Other Recommendations

- Invest in youth development and peer mentorship
- Offer culturally specific community spaces
- Improve demographic data collection

Essential Community Services & Resources

Community Engagement Themes: Financial Literacy & Stability; Access to Healthy & Culturally Appropriate Food; Education & Job Training

Top Priorities:

- Invest in service infrastructure and sustainability
- Eliminate education disparities through early childhood access

Other Recommendations

- Expand workforce development for living wages
- Invest in tech infrastructure for virtual access
- Improve food access in underserved areas

Access to Culturally & Linguistically Appropriate Services

Community Engagement Themes: Communication barriers; Navigating the health care system; Frustrations with quality of care; Gaps in mental health services

Top Priorities:

- Support more culturally specific trauma-informed health services
- Expand investments in traditional health workers

Other Recommendations

- Increase diverse workforce pipelines
- Invest in trust-building with focus populations
- Address insurance gaps
- Improve language accessibility

Across all focus areas, **Figure 15** below reflects the prioritization of the recommendations by the CAG members who voted.

Figure 15. Recommendations by CAG Member Votes

	RECOMMENDATIONS	PERCENTAGE OF CAG MEMBERS WHO VOTED (n=10)
1.	Support more trauma-informed physical and mental health services and supports, clinics and/or community centers.	50%
2.	Invest in ways to support not just the delivery of services but the infrastructure and capacity to sustain those services.	40%
3.	Expand investments in traditional health workers to increase community representation in the workforce.	40%
4.	Ensure adequate resources for language accessibility in services and education and invest in health literacy efforts.	40%
5.	Create more opportunities and capacity for workforce development programs that support individuals to earn a living wage.	40%
6.	Work to eliminate education disparities, starting with equitable access to affordable and quality child care and preschools	30%
7.	Build awareness and engagement of health resource and supports through supporting and leveraging existing collaborative efforts with community organizations to reach those in need.	30%
8.	Support sustainable civic engagement and education programs, particularly for immigrant and refugee communities.	20%
9.	Invest proactively rather than reactively in equity-centered and community-informed solutions to rising violent crime rates.	20%
10.	Invest in non-academic youth development programs as well as for peer mentorship programs and access to peer education services.	20%
11.	Invest in building/repairing trust between the healthcare system and priority populations.	20%
12.	Increase workforce development pipelines to health care workers that reflect and represent the region's diversity in language, ability, culture, sexual orientation, and gender.	20%
13.	Engage local politicians, including city councils and commissioners, as necessary advocates for creating a neighborhood where members of the community are safe, have access to quality housing, and have healthier living environments.	20%
14.	Offer culturally specific community spaces for community and educational events to take place.	10%
15.	Invest in addressing areas with limited grocery store options and ensuring culturally relevant and healthy food access to communities most impacted by these geographic disparities.	10%

STRATEGIC DIRECTION

The strategic direction for HCWC will be guided by both the identified needs and issues identified in this CHNA and the Oregon's and Washington's most recent State Health Assessments (SHA) and State Improvement Plans (SHIPs). Below is a table that aligns the CHNA recommendations with the SHA/SHIPs.[8] The CHNA was intended to catalyze data-informed dialogue, strategic alignment, and collective action across sectors and geographies. HCWC and its partners are committed to:

- Advancing population health solutions centered on fairness and personal experience.
- Implementing a regional backbone structure to support cross-sector collaboration, data integration, and shared accountability.

This report is one of many steps toward improving health outcomes across the HCWC region. It is anticipated that organizations, networks, and residents will be galvanized to act collectively on the priority issues identified. The CHNA will serve as a foundational resource for ongoing community health improvement efforts.

Prioritized Recommendations for the 2025 CHNA Update	Oregon SHP Priority Areas 2025-2029				Washington SHP Priority Areas 2014-2018				
	Healthy Environments	Individual, Family, and Community Wellbeing	Health Promotion and Disease Prevention	Emergency Preparedness and Response	Nutrition, physical activity and obesity	Access to care	Invest in the health and well-being of our youngest	Support development of healthy neighborhoods and communities	Broaden health care to promote health outside the medical system
1. Support more trauma-informed physical and mental health services and supports, clinics and/or community centers.		■	■			■			
2. Invest in ways to support not just the delivery of services but the infrastructure and capacity to sustain those services.		■	■			■	■		■
3. Expand investments in traditional health workers to increase community representation in the workforce.		■	■			■			■
4. Ensure adequate resources for language accessibility in services and education and invest in health literacy efforts.	■	■	■		■	■			
5. Create more opportunities and capacity for workforce development programs that support individuals to earn a living wage.	■	■					■	■	
6. Work to eliminate education disparities, starting with equitable access to affordable and quality child care and preschools.	■	■					■	■	
7. Build awareness and engagement of health resource and supports through supporting and leveraging existing collaborative efforts with community organizations to reach those in need.	■	■	■	■	■	■		■	■
8. Support sustainable civic engagement and education programs, particularly for immigrant and refugee communities.	■	■					■	■	
9. Invest proactively rather than reactively in equity-centered and community-informed solutions to rising violent crime rates.	■	■		■			■	■	

Prioritized Recommendations for the 2025 CHNA Update (continued)	Oregon SHP Priority Areas 2025-2029				Washington SHP Priority Areas 2014-2018				
	Healthy Environments	Individual, Family, and Community Wellbeing	Health Promotion and Disease Prevention	Emergency Preparedness and Response	Nutrition, physical activity and obesity	Access to care	Invest in the health and well-being of our youngest	Support development of healthy neighborhoods and communities	Broaden health care to promote health outside the medical system
10. Invest in non-academic youth development programs as well as for peer mentorship programs and access to peer education services.	■	■					■	■	
11. Invest in building/repairing trust between the healthcare system and priority populations.	■	■				■			
12. Increase workforce development pipelines to health care workers that reflect and represent the region's diversity in language, ability, culture, sexual orientation, and gender.	■	■					■		■
13. Engage local politicians, including city councils and commissioners, as necessary advocates for creating a neighborhood where members of the community are safe, have access to quality housing, and have healthier living environments.	■	■				■		■	
14. Offer culturally specific community spaces for community and educational events to take place.	■	■				■		■	
15. Invest in addressing areas with limited grocery store options and ensuring culturally relevant and healthy food access to communities most impacted by these geographic disparities.	■	■				■		■	

PRIORITY AREA FINDINGS

Each priority area includes areas of focus based on the shared community stories, responses to the Community Health Survey, and other data.

- A Neighborhood for All
- Essential Community Services & Resources
- Support for Family and Community Ways
- Access to Culturally and Linguistically Responsive Health Care

More in-depth information on each priority area is provided in this section.

A Neighborhood for All

2025 Update

All People

should have access to safe and affordable neighborhoods and housing.

A NEIGHBORHOOD FOR ALL UPDATE

All people should have access to safe and affordable neighborhoods and housing. Yet, for many people, especially in communities of color, such access is difficult or impossible due to obstacles in public health, social and public service, and private development systems.

A *neighborhood for all* refers to the built environment where we live, work, and play and the extent to which it is safe, affordable, and accessible. It includes our homes, buildings, streets, and open spaces. A neighborhood influences a person's ability to make positive choices for their health. This may consist of eating healthy, having cultural foods available, and being physically active. Neighborhoods also influence access to support systems for connection, involvement, and resources.

Figure 16 summarizes the key findings from both the community voices and health indicators and outcomes data related to a *Neighborhood for All*.

Figure 16. 2025 Update on Neighborhood for All Priority Issues

Safe and Affordable Housing

Insecure housing was rising across the region, especially cities in Multnomah County. At the same time, housing costs were going up faster than most people's incomes, making it harder for families to afford a place to live.

In 2023, Black, Indigenous, and People of Color (BIPOC) had a harder time getting approved for home loans. Native American, Hispanic/Latino, and Black applicants were approved at lower rates than the regional average, showing ongoing racial and ethnic gaps in access to homeownership.

Physical Safety in the Community

About two-thirds of people said they feel safe in their neighborhood. However, safety perceptions vary by county—Multnomah had the lowest number of people who felt safe, while Clackamas had the highest.

Violent crime in the region went up slightly between 2021 and 2023, and deaths from homicide nearly doubled over the past decade.

Accidents became the third leading cause of death in the region, with a sharp increase in recent years. A major reason for this rise was unintentional drug overdose.

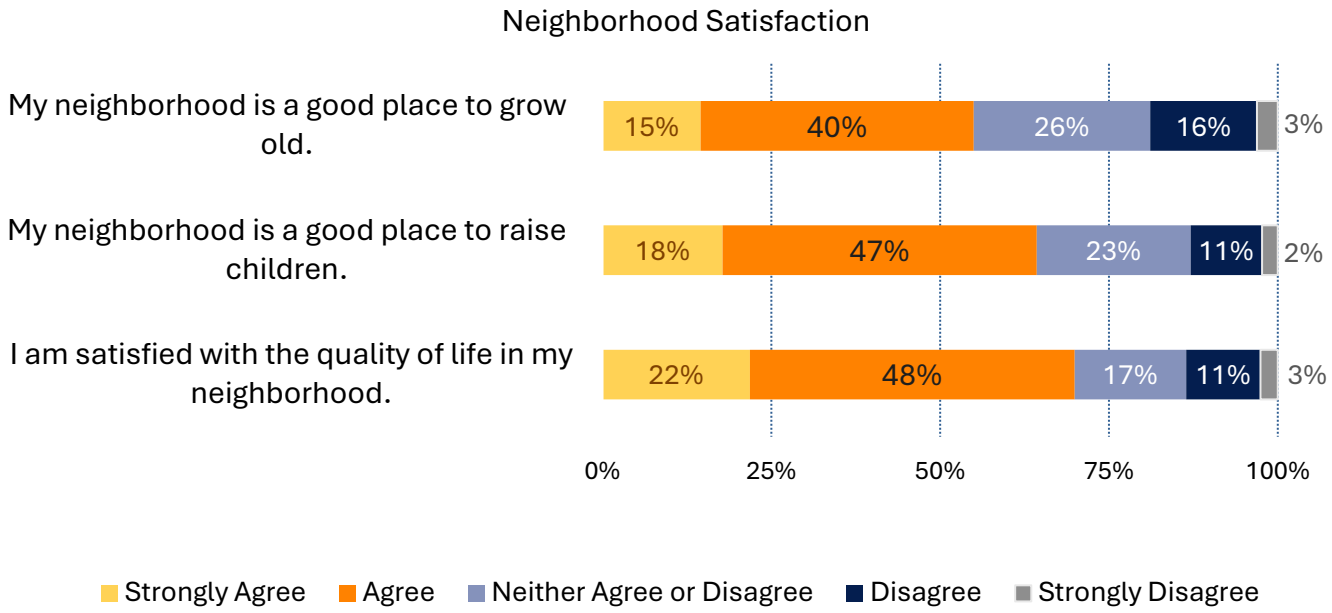
Cultural Displacement Due to Gentrification

About 4 in 10 survey respondents said that gentrification and cultural displacement were very important issues that need more community investment. Concern was even higher among young adults (18-24 years), people with disabilities, and LGBTQ2IA+ individuals.

BIPOC respondents and immigrant and refugee communities also showed above-average concern about cultural displacement.

The Community Health Survey indicated that generally community members were satisfied (responded that they 'strongly agree' or 'agree') with their neighborhood as a good place to grow old (55%), good place to raise children (65%), and their quality of life in their neighborhood (60%) (**Figure 17**).

Figure 17. Neighborhood Satisfaction



Source: HCWC CHNA Community Health Survey, 2024. (n=1,748-2,071)

Brief 1: Safe and Affordable Housing

Community members expressed concerns about affordable housing, high rent costs, and a lack of housing options. They discussed the long waitlists for rent assistance, the high cost of living, and the impact of housing instability on their overall well-being. They expressed a desire for housing loans for first-time homebuyers that don't require repayment. Community members reported that housing insecurity was also a major concern for them and called for increased resources and support to get people into the housing they need to feel safe and well.

Specifically, issues raised included:

- Paperwork to apply for loans, subsidies, and/or temporary shelter is overwhelming, and the wording used in housing services is difficult to understand, especially for those with limited literacy or language proficiency.
- There is a greater need for affordable housing than what is available. Rent assistance waitlists are long, and people often just miss eligibility due to small income differences.
- Understanding rental requirements, such as credit scores, is a challenge.
- There's a need for education and support around navigating rental systems and financial qualifications.
- Rent assistance programs are helpful, but not sufficient to meet the broader need for affordable housing.

The focus group participant quotes illustrate how complexity, limited availability, and financial obstacles make it difficult for many to access stable housing — even when support services exist:

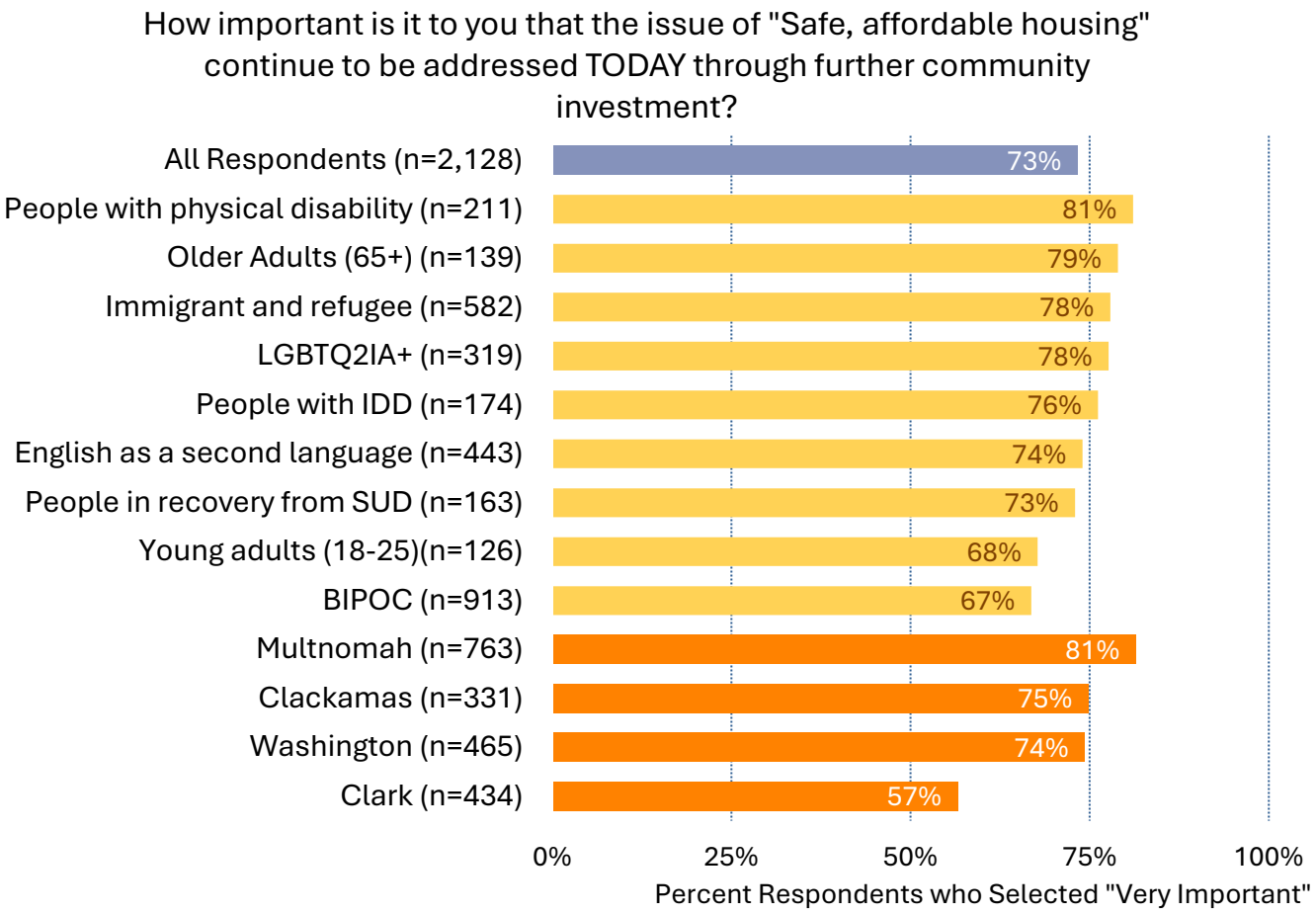
"Services like housing require so much paperwork and language is complicated."

"Rent assistance has helped. More affordable housing would help. The need though is more than the availability. Waitlists are long. The eligibility requirements are tough – sometimes you don't qualify by just a couple of hundred of dollars."

"Affordable rents or resources to help with understanding the rental structures is needed. For example, what it means to have a good credit rating."

Nearly three out of four people surveyed (73%) said that “safe, affordable housing” should remain a top priority for community investment (**Figure 18**). Out of 13 important issues, it was ranked number one.

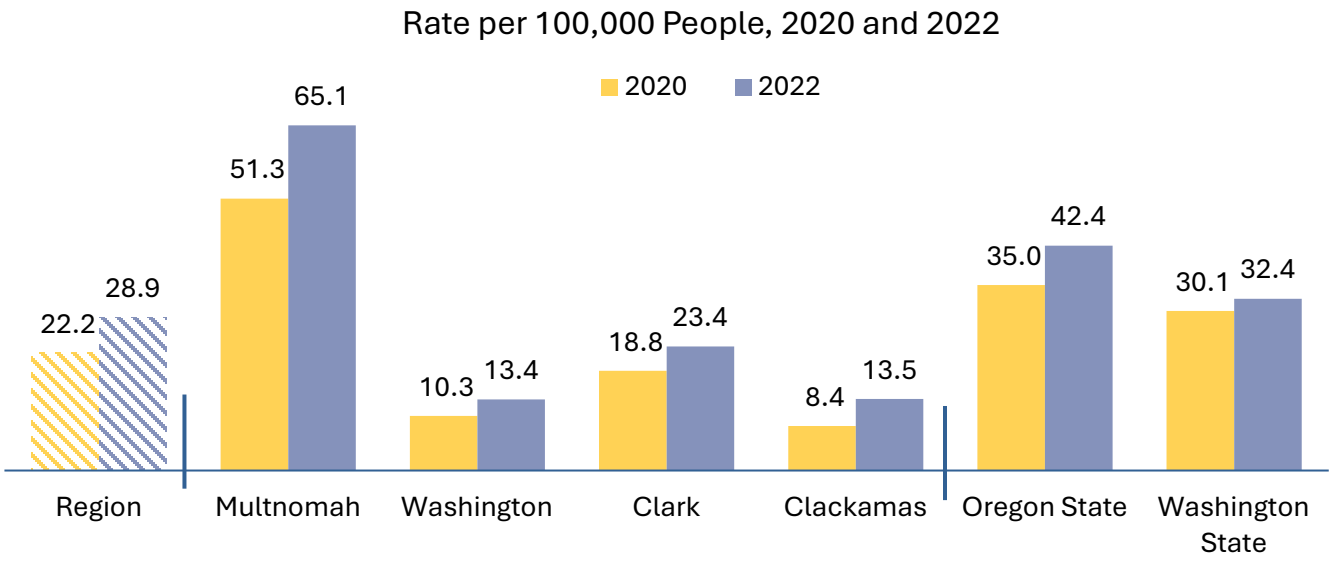
Figure 18. Safe, Affordable Housing as a Priority Issue for Investment by Focus Population



Source: HCWC CHNA Community Survey, 2025

Between 2020 and 2022, regional homelessness increased from 22.2 to 28.9 per 100,000 people (**Figure 19**). Oregon State increased from 35.0 to 42.4, Washington State from 30.1 to 32.4, and Multnomah County had the highest rates, jumping from 51.3 to 65.1. Clackamas, Clark, and Washington counties also saw steady increases. Overall, homelessness was on the rise throughout the region.

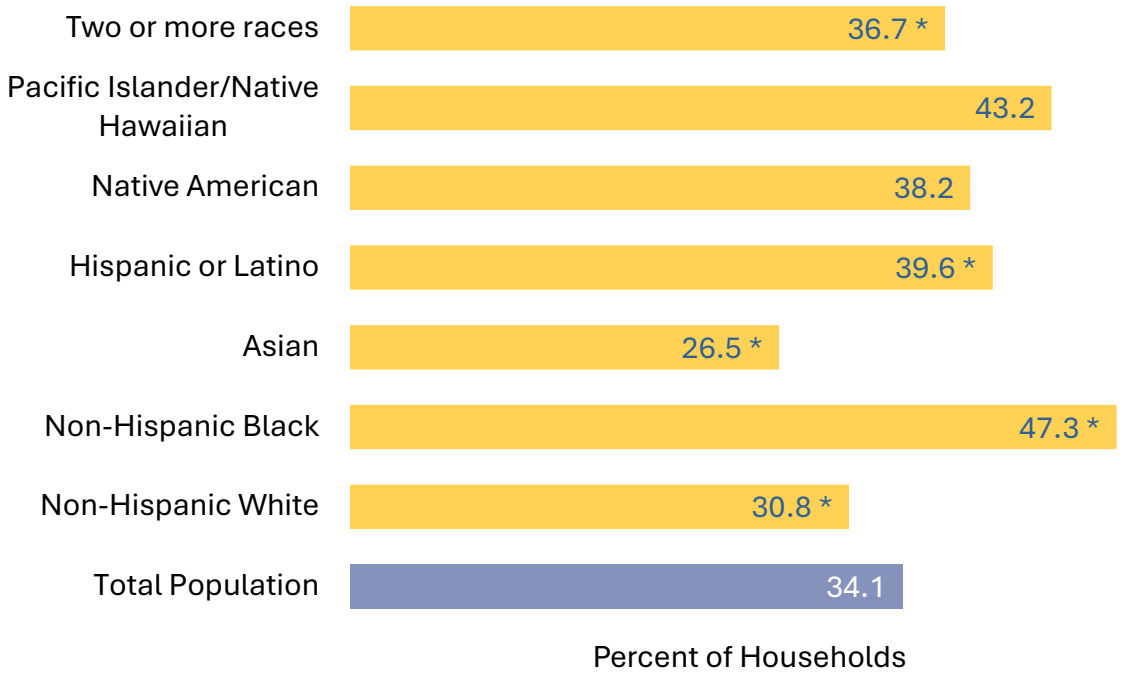
Figure 19. People Experiencing Homelessness, 2020 and 2022



Source: State of Homelessness Report, 2020 and 2022

The percentage of households spending over 30% of income on housing increased from 32.8 percent in 2018 to 35.2 percent in 2023, mainly due to increases in Multnomah (36.1% to 39.3%). Housing cost burden was highest among Non-Hispanic Black households (47.3%), followed by Pacific Islander/Native Hawaiian (43.2%) and Hispanic/Latino households (39.6%) (**Figure 20**).

Figure 20. Regional Housing Cost Burden by Race and Ethnicity, 2019-2023



***Significantly different compared to the full regional population. Note: Housing cost burden is defined as households spending more than 30% of income on housing and includes both renters (rent) and owners (mortgage and other owner costs). For renters, costs include any utilities or fees that the renter must pay, but do not include insurance or building fees Source: U.S. Census Bureau, American Community Survey (ACS), Tables B25070/B25091**

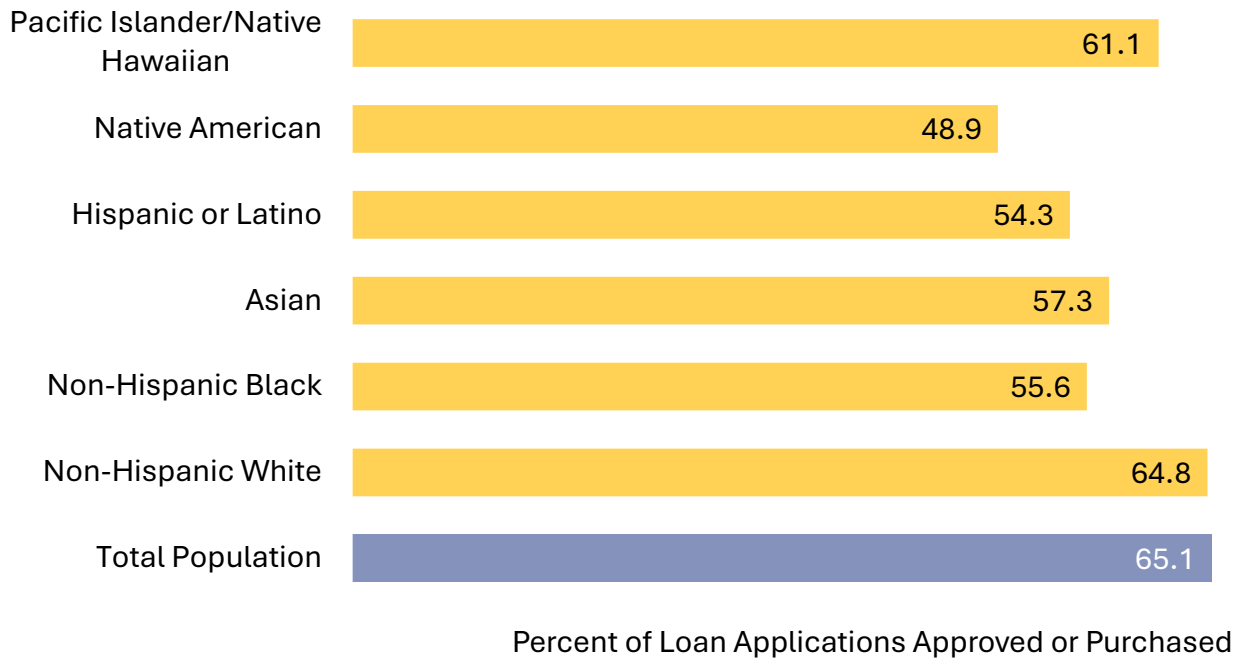
The monthly median rent was $1,685 in the region in 2023, significantly up 3.9 percent from $1,622 in 2019.[9] The average regional home sale price was $486,113 in 2019, increasing 3.6 percent to $536,708 in 2024 10 while the median household income increased less than one percent (0.6%, from $94,288 in 2019 to $94,855 in 2022).[11]

High rates of homeownership are often used as a proxy for housing stability. Homeownership is often linked to wealth-building and long-term investment in the community. However, homeowners can still face instability due to foreclosure risks, job loss, or rising property taxes. The data on mortgage loan approval rates in the region reveal notable disparities by race and ethnicity.

The overall approval rate for the total population is 65.1 percent (**Figure 21**). However, when broken down by race and ethnicity group, gaps emerge:

- Non-Hispanic White applicants have an approval rate of 64.8 percent, closely aligning with the regional average.
- Native American applicants have the lowest approval rate at 48.9 percent.
- Hispanic or Latino and Non-Hispanic Black applicants have lower approval rates than the regional average (54.3% and 55.6%, respectively).

Figure 21. Regional Mortgage Approval Rate by Race and Ethnicity, 2023



Source: HMDA Data Browser, Federal Financial Institutions Examination Council

In 2023, three percent (3.0%) of households in the region were considered crowded (e.g., housing units with more than one occupant per room such as three occupants in a one-bedroom apartment). There was no variation in the crowded housing rate by county; however, there were significantly more BIPOC communities and Hispanic/Latino households experiencing crowded housing. Hispanic/Latino (10.4%) and Pacific Islander/Native Hawaiian (12.9%) households had the highest rate, followed by Native American (8.9%) households.

Brief 2: Physical Safety in Community

Physical safety in a community is closely linked to health behaviors and outcomes, influencing both individual well-being and broader public health. When people feel physically safe in their neighborhoods—free from threats like violence, theft, injury, or unsafe infrastructure—they are more likely to engage in positive health behaviors and experience reduced stress and improved mental health.[12]

Safety emerged as a concern across three specific focus populations, including Slavic Eastern European, Greater Middle Eastern/North African (MENA), and Asian communities. It is important to note that different populations may have differing ideas about how ensure physical safety, which are informed by individual and community-level experience and historical context. While some may view increased law enforcement or police presence as a positive means to ensure or improve their physical safety, others have negative personal and historical experience that influences their perceptions of safety and law enforcement. Our community discussions did highlight some nuances to take note. Participants from Slavic Eastern European, Greater Middle Eastern/North African (MENA), and Asian communities shared their perspectives on crime, safety, and the need for stronger systems of protection and support.

- Participants emphasized a strong desire to live in safe, welcoming neighborhoods where they and their families feel protected. Several participants described fear stemming from gun violence in their neighborhoods, reinforcing a call for improved safety measures, visible law enforcement presence, and culturally sensitive responses to bias and discrimination.
- Certain participants expressed a strong need for culturally competent first responders, especially in crisis situations. Some noted that trauma-informed mental health and medical services are lacking, making it difficult to recover from incidents of violence or crime.
- Participants shared fears about both personal security and the well-being of older family members, citing recent incidents of bias-motivated attacks. Additionally, participants emphasized that property crimes such as car theft and home break-ins have become more common since the COVID-19 pandemic, leading to heightened anxiety about neighborhood safety.

Across the three groups, there was a call for community-based safety initiatives, such as self-defense classes, trauma counseling, and culturally sensitive crisis intervention services to prevent and respond to violence. The focus group participant quotes illustrate how safety concerns were not just about crime statistics—they reflect personal experiences of fear, loss of trust in public systems, and the emotional toll of feeling unprotected in one's own neighborhood:

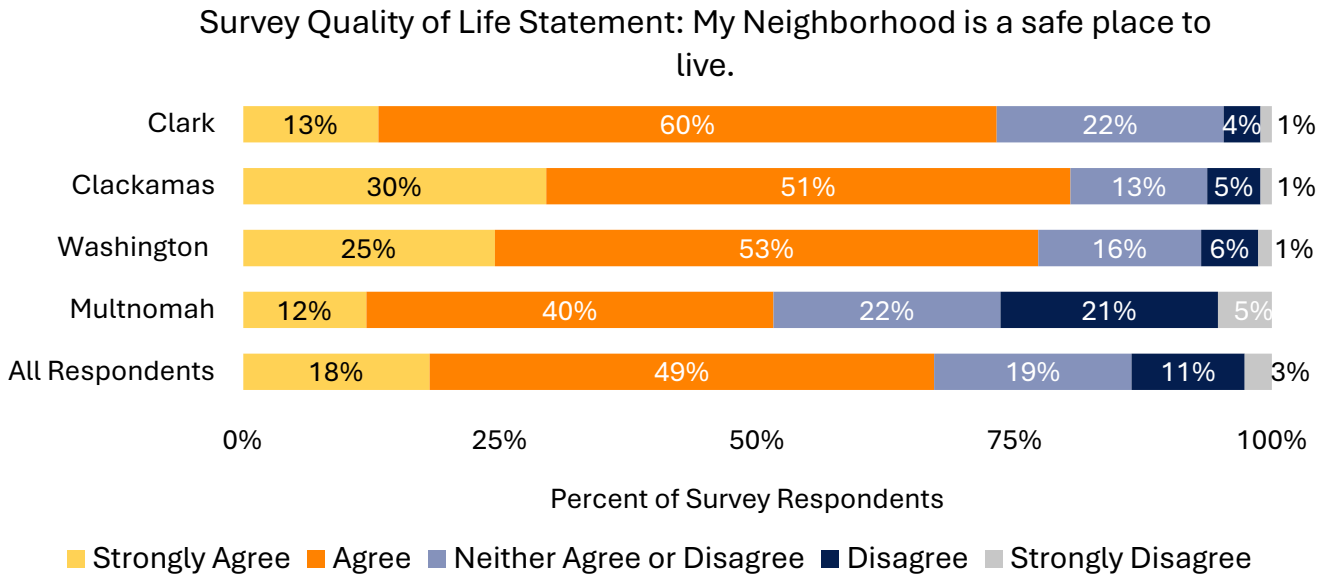
"I worry about break-ins at my house. I no longer feel safe parking my car on the street. As an Asian minority, I've heard many tragic stories about the Asian community, including elderly Asians being bullied in the city center."

"It was much safer earlier when we used to have the police patrol the territory, night and day, they would walk around, and across the home. There were no strangers or trespassers then on campus – they were afraid of the police who showed up suddenly. We were very grateful when police kept our building under its control, would come and check on it at night, walking across all of it, and would leave."

"I live in constant fear of gun violence every day."

Survey respondents rated neighborhood safety, considering areas like homes, workplaces, schools, and public spaces. Overall, 67 percent agreed their neighborhood was safe (**Figure 22**). By county: Multnomah had the lowest agreement at 52 percent (strongly agree/agree), Clackamas the highest at 81 percent, with Washington at 78 percent and Clark at 73 percent.

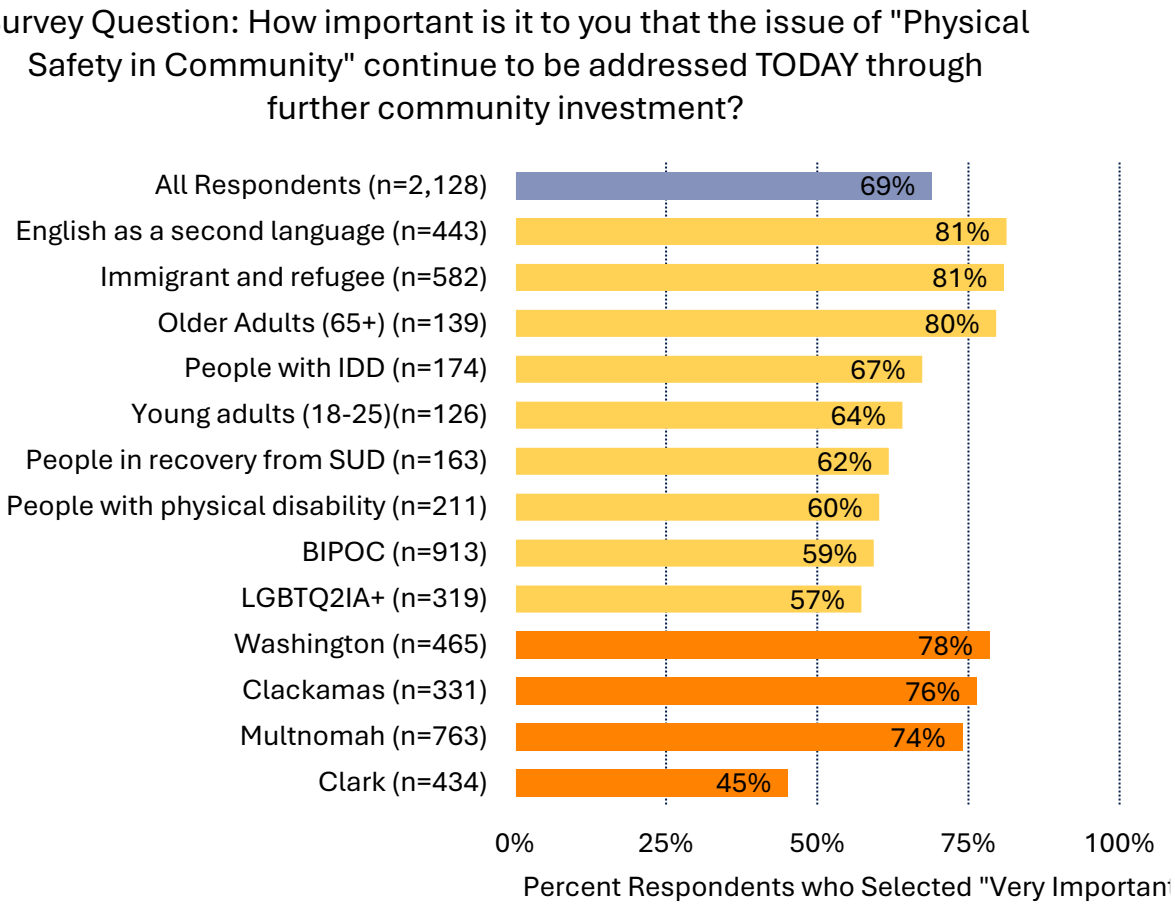
Figure 22. Satisfaction with Neighborhood Safety



Source: HCWC Community Health Survey, 2024. (n=1,747)

Sixty-nine percent of survey respondents said that “physical safety in community” remains a top priority for further investment (**Figure 23**), ranking it second among 13 issues.

Figure 23. Physical Safety in Community as a Priority Issue for Investment by Focus Population

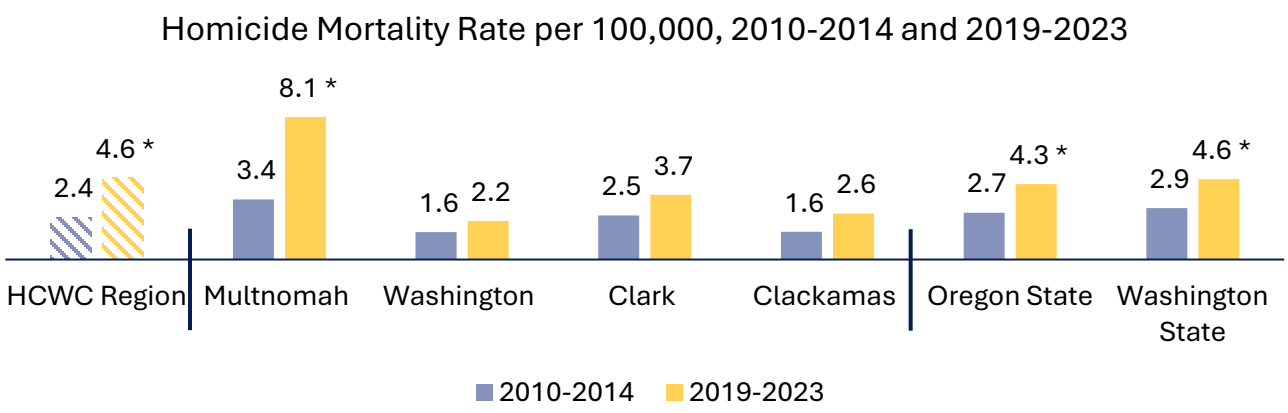


Source HCWC CHNA Community Health Survey, 2025

Violent crime rate in the region increased slightly between 2021 and 2023, from 246.6 crimes per 100,000 people to 260.8 crimes per 100,000. The crime rate includes homicide, criminal sexual assault, robbery, aggravated assault, and aggravated battery. Reported violent crime rates were higher in Washington and Clackamas counties compared to the region, while Multnomah had lower rates during this period.[13] Rates should be interpreted with caution as agency-level participation varies.

Homicide mortality in the region rose from 2.4 deaths per 100,000 (2010-2014) to 4.6 deaths per 100,000 (2019-2023), as shown in **Figure 24.** Multnomah saw an increase from 3.4 to 8.1 deaths per 100,000 in these periods. In 2019-2023, the regional rate matched Washington State (4.6) and was similar to Oregon State's 4.3 per 100,000.

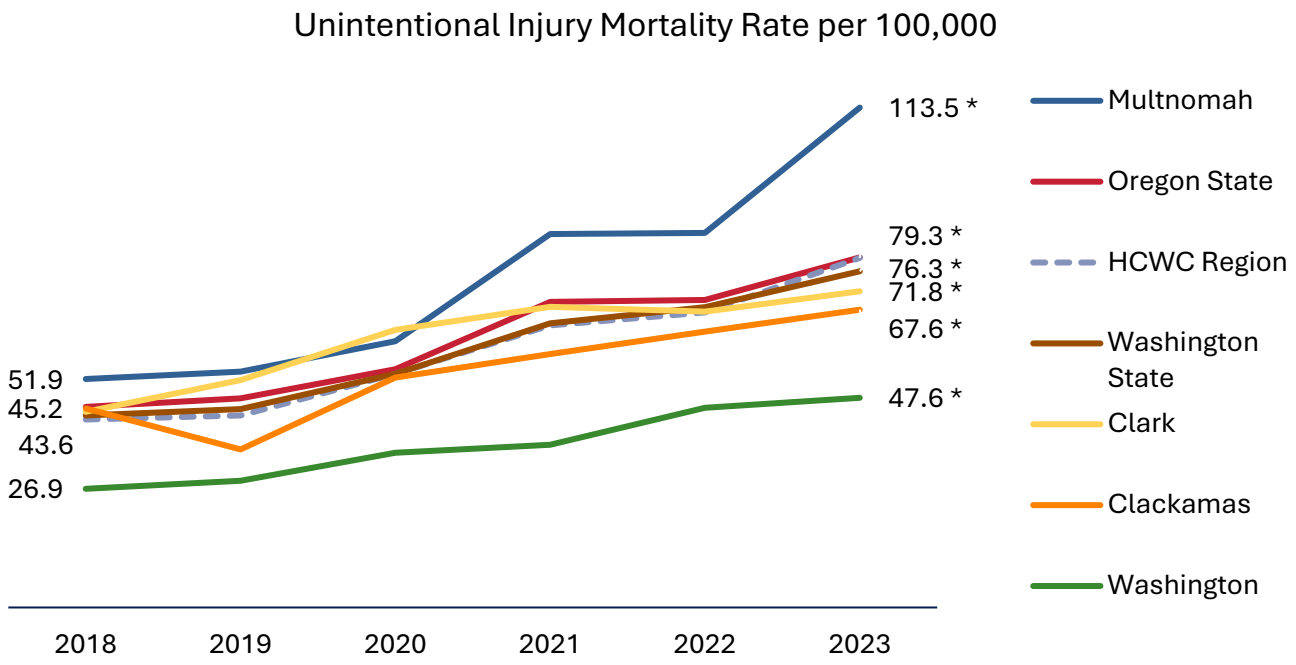
Figure 24. Homicide Mortality



***Significantly different in 2019-2023 compared to 2010-2014. Source. National Vital Statistics System-Mortality (NVSS-M) Centers for Disease Control and Prevention (CDC) Via Metopio**

The third leading cause of death in the region was unintentional injury (accidents including falls, drowning, poisonings, burns, motor vehicle), and this rate was significantly increasing in the region between 2018 and 2023 (**Figure 25**). All areas experienced a steady rise in unintentional injury rates over the six-year period. Multnomah consistently had the highest rates, escalating sharply from 51.9 deaths per 100,000 in 2018 to 113.5 deaths per 100,000 in 2023—more than doubling in five years. Washington County had the lowest rates throughout the period but still saw a notable increase from 26.9 to 47.6 deaths per 100,000.

Figure 25. Unintentional Injury Mortality Rate

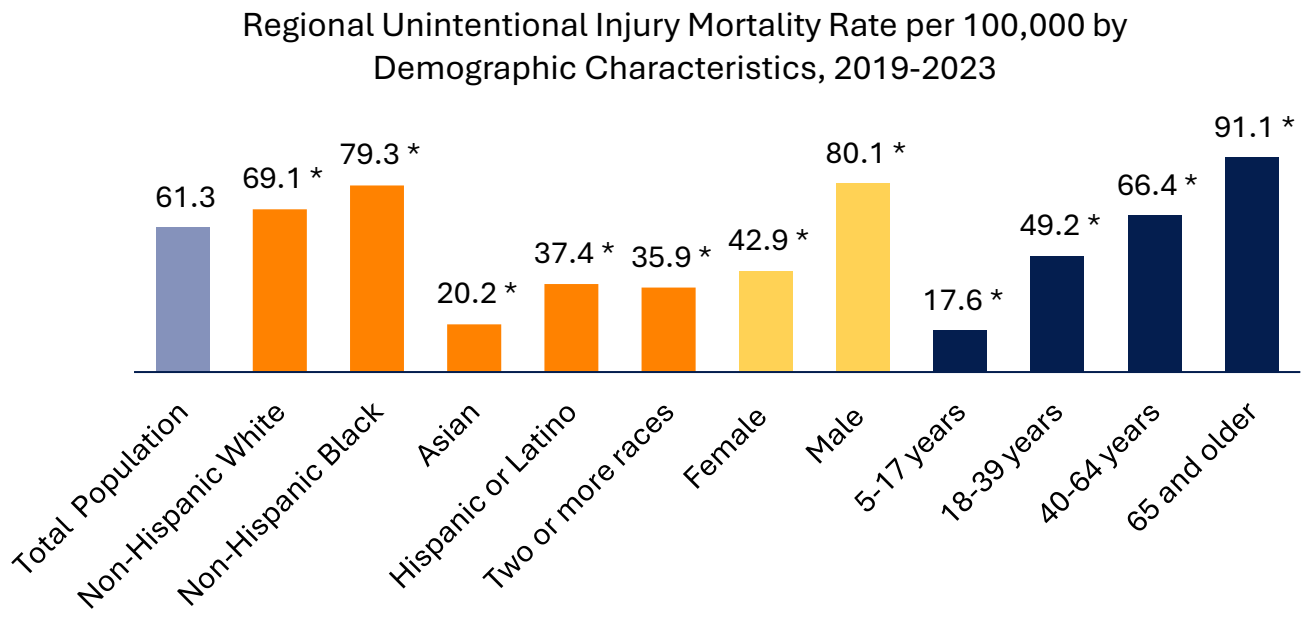


***Significantly different in 2023 compared to 2018. Source. National Vital Statistics System-Mortality (NVSS-M) Centers for Disease Control and Prevention (CDC) Via Metopio**

Disparities in unintentional injury regional rates (per 100,000 people) highlight the need for targeted injury prevention strategies that consider age, gender, and racial/ethnic differences (**Figure 26**).

- The highest mortality rate was among individuals aged 65 and older (91.1), followed by those aged 40–64 (66.4). The lowest rate was among youth aged 5–17 (17.6).
- Males had nearly double the mortality rate (80.1) compared to females (42.9).
- Non-Hispanic Black individuals had the highest rate among racial/ethnic groups (79.3), followed by Non-Hispanic White (69.1).
- Asian individuals had the lowest rate (20.2), significantly below the regional average (61.3).
- Hispanic or Latino and individuals of two or more races had moderate rates (37.4 and 35.9, respectively).

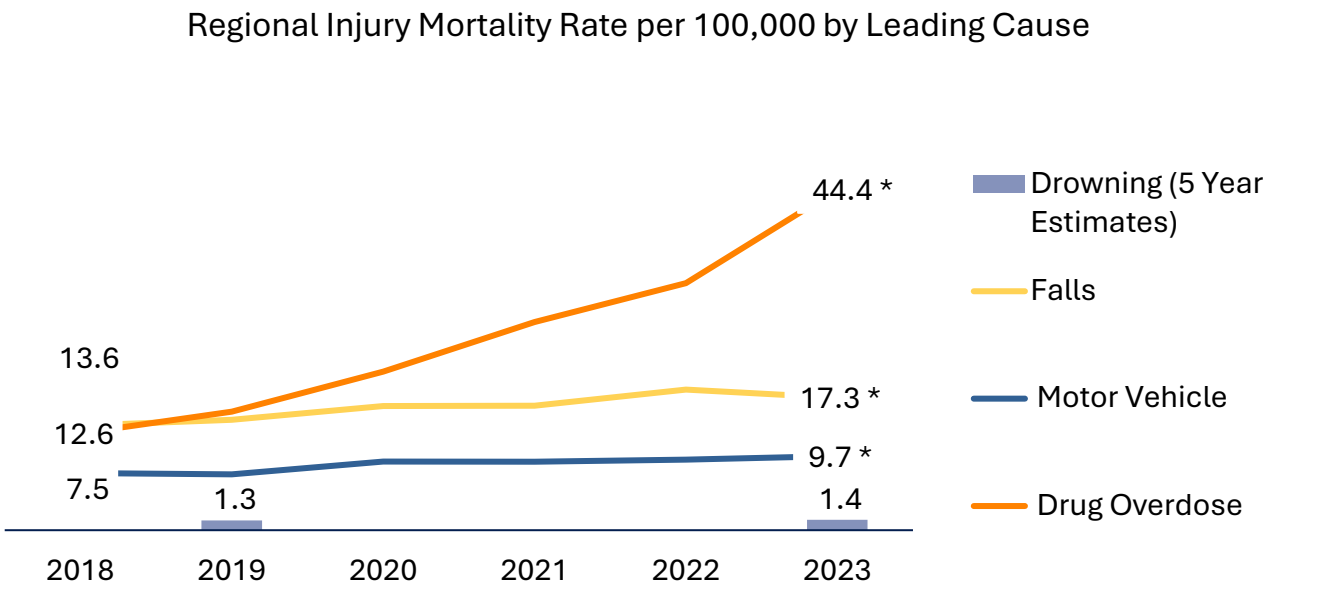
Figure 26. Regional Unintentional Injury Mortality by Demographics, 2019-2023



***Significantly different compared to the regional population estimate. Source. National Vital Statistics System-Mortality (NVSS-M) Centers for Disease Control and Prevention (CDC) Via Metopio**

Unintentional drug overdose was a significant contributor to the increased regional rates during this period. Among the four more prevalent causes of unintentional injury, drug overdose increased 252% from 12.5 deaths per 100,000 in 2018 to 44.4 deaths per 100,000 in 2023 (**Figure 27**).

Figure 27. Regional Injury Mortality Regional Rate by Leading Cause



***Significantly different in 2023 compared to 2018. Source. National Vital Statistics System-Mortality (NVSS-M) Centers for Disease Control and Prevention (CDC) Via Metopio**

Brief 3: Cultural Displacement due to Gentrification

Gentrification is the process whereby the character of a poor urban area is changed by wealthier people moving in, improving housing, and attracting new businesses, typically displacing current inhabitants in the process.[14] Some areas of the region are seeing investments from local and federal programs to "revitalize" them. The focus group findings revealed concerns of cultural displacement and the erosion of community identity. Specific issues raised include:

- The Black community in Northeast Portland feels its presence has diminished due to gentrification, leading to a loss of cultural and social identity within the neighborhood.
- Gentrification has resulted in increased living costs, making it difficult for returning residents to afford housing and everyday expenses in their former neighborhoods.
- There is an urgent need for development programs that prioritize affordable housing and local businesses to ensure long-term residents can remain in their communities.
- Efforts to bring back displaced populations face obstacles, such as offering unsuitable housing options like expensive apartments and condos, which do not meet the original community's needs.

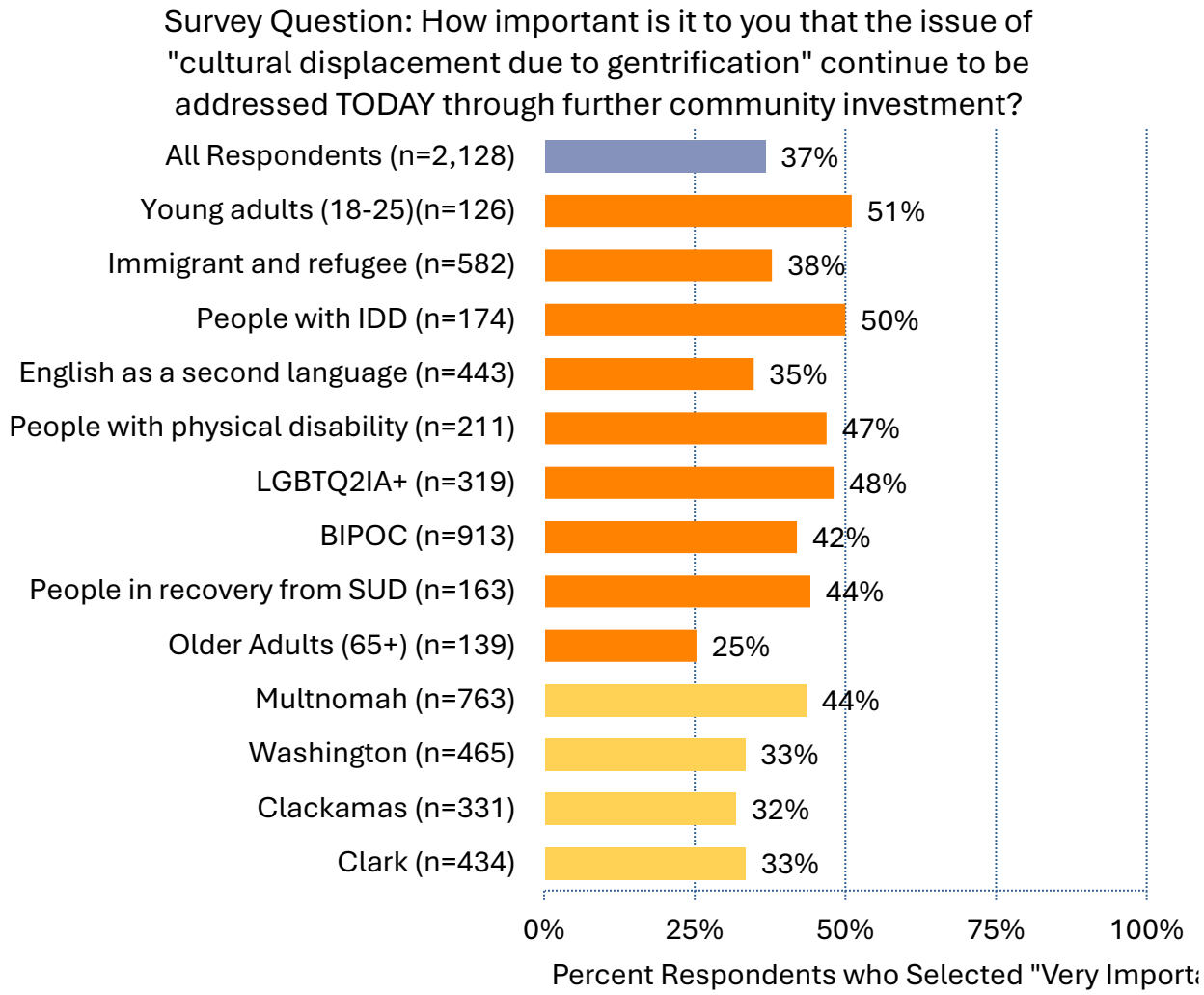
These focus group participant quotes illustrate these issues:

> **"I often feel like the Black community doesn't really exist anymore in North East Portland because of gentrification."**

> **"Tell people we need to work [on] where we are at right now, try to come together some kind of way. I tell people about the gentrification we left homes and with these agencies/programs trying to bring back Blacks into NE, but what they offer is apartment/condos. The stores around these areas are expensive. It's not for us anymore."**

Nearly 40 percent of survey respondents consider cultural displacement from gentrification a critical issue needing continued community investment. Concern was highest among young adults (51%), the LGBTQ2IA+ community (48%), BIPOC (42%), and immigrants/refugees (38%), compared to an average of 37 percent. In Multnomah, 44 percent of survey respondents flagged this as a priority (**Figure 28**).

Figure 28. Cultural Displacement due to Gentrification as a Priority Issue for Investment by Focus Population



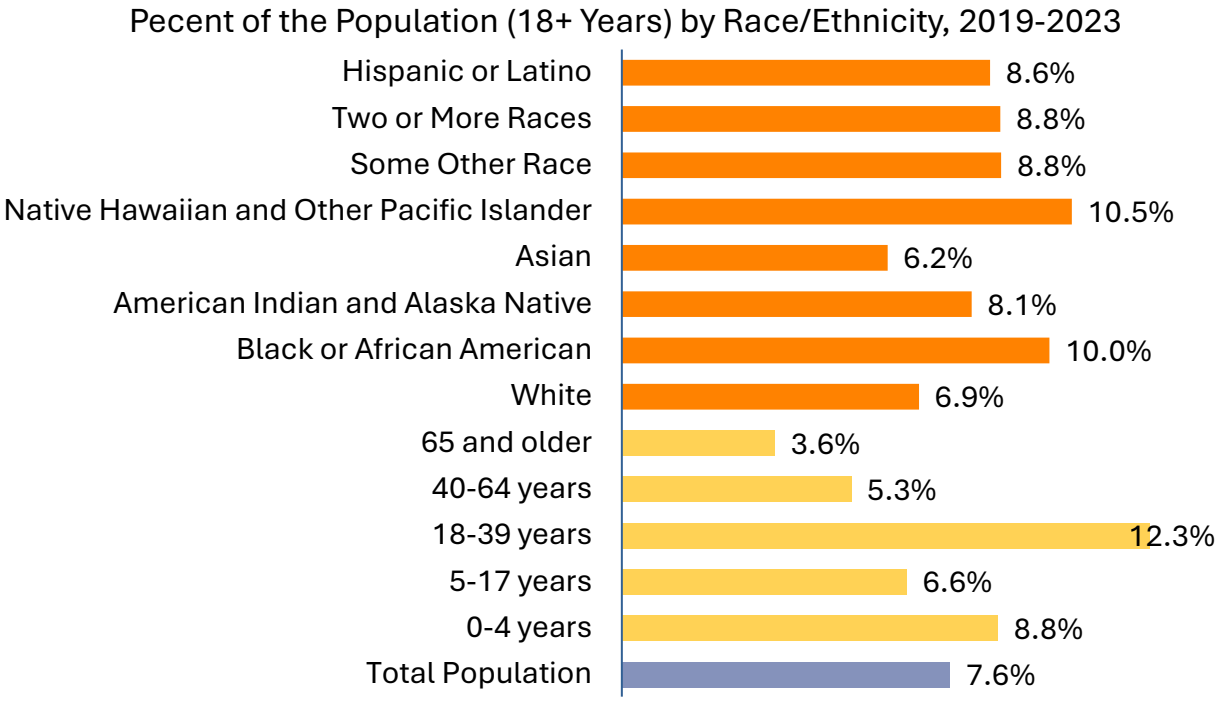
Source: HCWC Community Health Survey, 2024

The U.S. Census Bureau's metric "moved within county in the past year" can indicate housing instability and gentrification.[15] High rates suggest instability and displacement, especially when paired with other indicators like eviction rates and demographic shifts. Although it is not a direct measure, it provides useful context alongside other data. Regionally, this mobility rate decreased significantly from 9.8 percent in 2018 to 7.1 percent of residents in 2023.

In 2019-2023, 7.6 percent of residents in the region moved within their county of residence in the past year, significantly lower than 9.6 percent in 2014-2018. This significant decrease was experienced in all counties. From 2019 to 2023, Multnomah had higher mobility rates (9.4%) than the regional average, while Washington (5.5%) and Clackamas (4.8%) were lower. In 2019-2023, young adults (18–39 years) living in the region had the highest mobility rate at 12.3 percent, indicating greater residential movement likely due to life transitions such as education, employment, or housing changes (**Figure 29**).

By race and ethnicity, in 2019-2023, Native Hawaiian or Other Pacific Islander and Black or African American populations had the highest mobility rates at 10.5 percent and 10.0 percent, respectively, suggesting higher levels of housing instability or displacement. Asian and White alone, not Hispanic or Latino populations had the lowest rates at 6.2 percent and 6.8 percent, respectively. Hispanic or Latino origin (any race) had a mobility rate of 8.6 percent, above the overall average (**Figure 29**).

Figure 29. Moved Within County in Past Year, Regional Rate by Age Group, 2019-2023



Defined as the percentage of residents one year and older who moved into current residence from within the same county in the past year. This can be used to proxy for evictions, especially when looking at vulnerable populations (infants, seniors) for whom frequent moving can be disruptive. Source: U.S. Census, American Community Survey, Five-year Estimates, 2019-2023, Table B0700

Emerging Issues in A Neighborhood For All

Issues emerged out of both the primary and secondary data collected and analyzed:

- Community members expressed worries about gun violence, changes in police presence, and the need for trauma-informed medics and mental health responders.
- Finding safe and affordable housing was becoming increasingly difficult, with housing insecurity on the rise and housing costs outpacing income growth, especially in areas like Multnomah.
- Notable gaps in mortgage approvals persist across racial and ethnic groups, highlighting inequities in access to homeownership, which is a key pathway to stability and wealth-building.
- Most survey respondents (67%) think their neighborhoods were safe, but this varied a lot by county. Multnomah had the lowest feeling of safety (52%), while Clackamas had the highest (80%).
- Violent crime rate, including homicides, increased in the region between 2021 and 2023.
- The issue of cultural displacement due to gentrification was a priority area of community investment for most focus populations, and residents of Multnomah.
- Accidents were the third leading cause of death and have been rising since 2018—largely driven by a rise in accidental drug overdoses.

Esssential Community Services and Resources

2025 Update

All people should be afforded access to opportunities for education, employment, nutritious food, and transportation.

ESSENTIAL COMMUNITY SERVICES AND RESOURCES UPDATE

Access to essential community services and resources provides a foundation for a healthier community. Economic opportunity, social connection, and geography drive the services and resources available to a community. Having a living wage, secure employment, and education can strengthen access to health care. Increased choice in housing, education, health care, child care, food, and transportation also impact individual and community health.

Figure 30 summarizes the key findings of the data reported in this section on an *Essential Community Services and Resources*.

Figure 30. Update on Essential Community Services and Resources

Economic Opportunity

People in community focus groups said they need more job opportunities, better pay, and help finding work. They especially want more support for people with disabilities to get meaningful jobs. More than half of the people who took the Community Health Survey said they agree there were job opportunities for them and their families.

In 2023, the region recorded its lowest unemployment rate in a decade at 3.6 percent. However, household income demonstrated minimal growth, increasing from $92,831 in 2018 to $94,855 in 2023.

The poverty rate stayed about the same: 9.5 percent in 2019 and 9.2 percent in 2023. Young children were more affected—11 percent of kids ages 0–4 and 10.5 percent of kids ages 5–17 live in poverty, showing that families with young children were especially vulnerable.

Cultural and Healthy Foods

Healthy and culturally specific food should be a top priority for investment according to 41 percent of the Community Health Survey respondents. Young adults (56%), immigrants and refugees (55%), and people with disabilities (51%) felt this was more important than other groups did.

Focus group participants said healthy food costs too much and it's hard to find food that fits their culture. They strongly supported ideas like community gardens and programs that offer fresh, culturally appropriate food.

Transportation is a big challenge driving food insecurity—especially for seniors, people with disabilities, and people without cars—making it hard to get to grocery stores or specialty markets.

Rules in transitional housing can make it harder for people to get food or find work, which keeps them stuck in food insecurity.

Food insecurity in the region went up between 2020 and 2023. Multnomah and Oregon had the highest rates in the region, while Clark jumped the most during this time period.

More people were using SNAP (food assistance) by 2023, with Multnomah having the highest SNAP participation in the region and Clackamas the lower.

In 2023, over half of households living in poverty did not get SNAP benefits – but this was less households than in 2019 so it was improving.

Virtual Resources

More people in the region now have internet access with the greatest improvement in Multnomah.

Only 16 percent of Community Health Survey respondents said they used online groups or social media when they're sick or looking for health advice. That number goes up slightly to 23 percent when survey respondents were looking for help with things like food, housing, or jobs.

Five percent of survey respondents who had trouble getting health care said it was because they did not have internet or a device.

Educational Opportunity

People in focus groups said education and jobs were key to improving their lives. They want more affordable and easy-to-access options like short-term certificate programs and job training.

From 2018 to 2023, about seven percent of youth aged 16–19 was not working or in school. These young people are often called "opportunity youth."

Preschool enrollment increased to nearly half of three- to four-year-olds by 2020 but has since decreased —likely because of the COVID-19 pandemic.

Childcare was still hard to find, especially in Clark and Clackamas counties. Even though Multnomah had the best ratio of kids to child care spots, it's losing centers. Clackamas was adding more centers but still has one of the highest ratios—14.8 kids per spot.

In Oregon, more students missed school regularly. Chronic absenteeism nearly doubled between the 2018/2019 and 2022/2023 school years. In Clark, absenteeism among students in Grades 3–8 went down from 2022 to 2023 but was still higher than before the pandemic.

Transportation

In 2023, the region had 93.3 vehicles per 100 adults, lower than Oregon (97.0) and Washington (97.5) states. Multnomah had the lowest vehicle access, with only 81.9 vehicles per 100 adults.

People in the region spend less time and money on transportation than in Oregon or Washington states. Clackamas and Clark counties had the highest transportation burden, while Washington and Multnomah counties had the lowest.

Nearly half of survey respondents said reliable and affordable transportation was very important. It was ranked 8th out of 13 issues and was especially important to people with disabilities, young adults, and Multnomah residents.

Transportation problems make it hard for 11 percent of survey respondents to get health care. Community members said public transportation is often unreliable, infrequent, unsafe, or hard to use—especially in rural areas and for people with disabilities. These issues make it harder to get to health care, food banks, and jobs.

Most people drive themselves, especially in Clackamas. Clark was different—where a higher percentage of adults reported using public transportation.

Brief #1: Economic Opportunity

Economic opportunity refers to the belief in upward mobility for everyone. Diverse jobs with living wages within a community result in better health. Income allows for the purchase of health insurance and medical care and provides options for healthy lifestyle choices such as nutritious food and safe housing.

Community-specific focus group participants highlighted the need for more job opportunities, better wages, and resources to help connect people to jobs. They would like more resources to support people with disabilities to find meaningful employment. Specifically:

- People are actively searching for work but report that job opportunities are scarce.
- There's a strong desire for more resources to help connect people to employment, such as job placement services or career support programs.
- Connections to community leaders, Community Health Workers, and other trusted figures are seen as valuable pathways to accessing economic, social, and educational resources.

The focus group participant quotes illustrate that improving economic opportunity requires not just job creation, but also stronger support systems and community-based connections to help people access and navigate those opportunities.

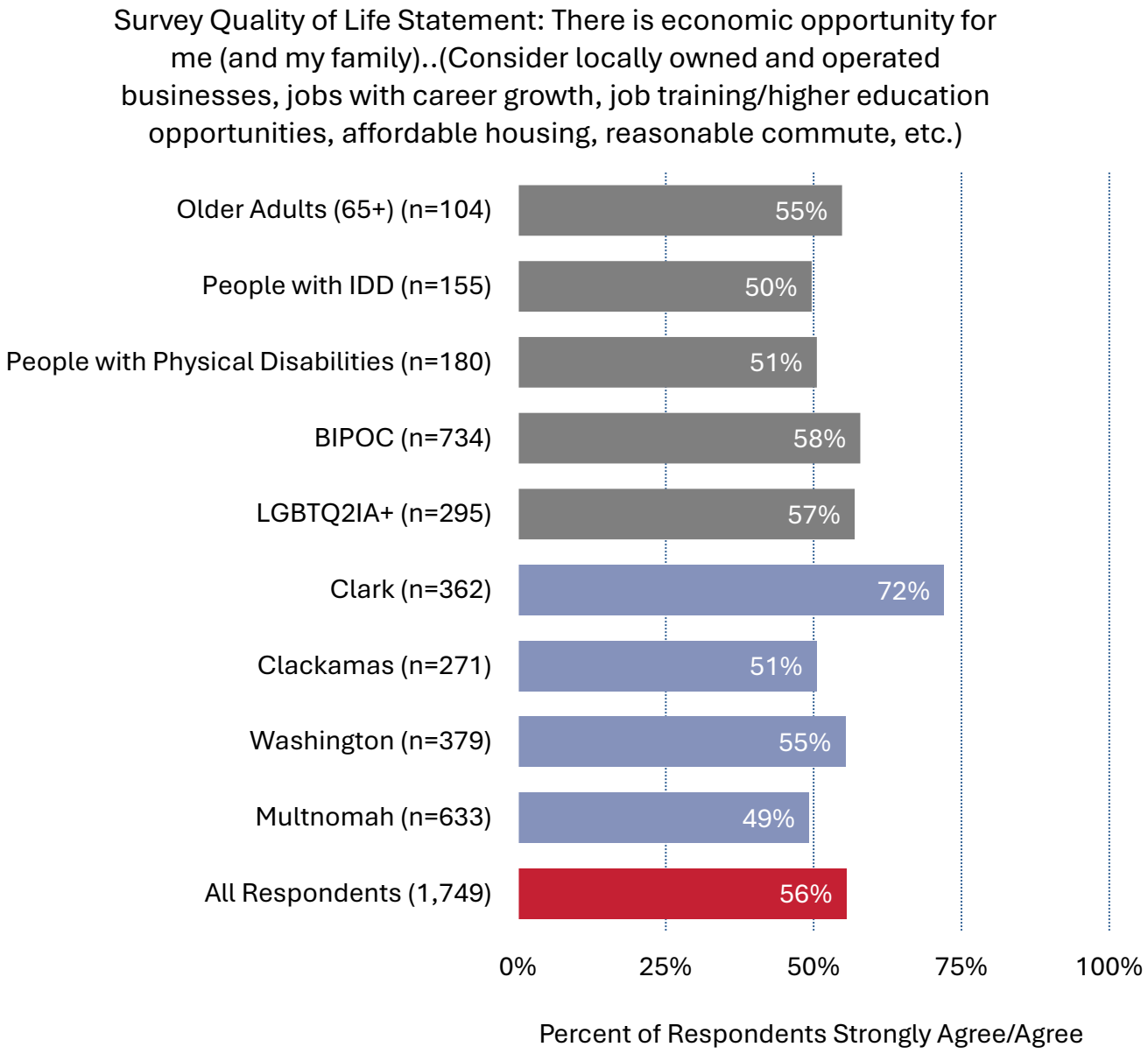
"I know a number of people that would benefit from some more resources here to help connect them to jobs"

"There would be more jobs. Right now, we have been looking for work here in Canby and there's nothing."

"Having connections to community leaders or health workers with connections to economic, social, and education resources."

More than half of the community survey respondents reported they strongly agreed/agreed with the statement that there was economic opportunity for them (and their family) (**Figure 31**). Clark respondents reported the highest agreement (72%) with the statement about economic opportunity. Multnomah had the lowest agreement at 49 percent. There was little variation among other focus populations.

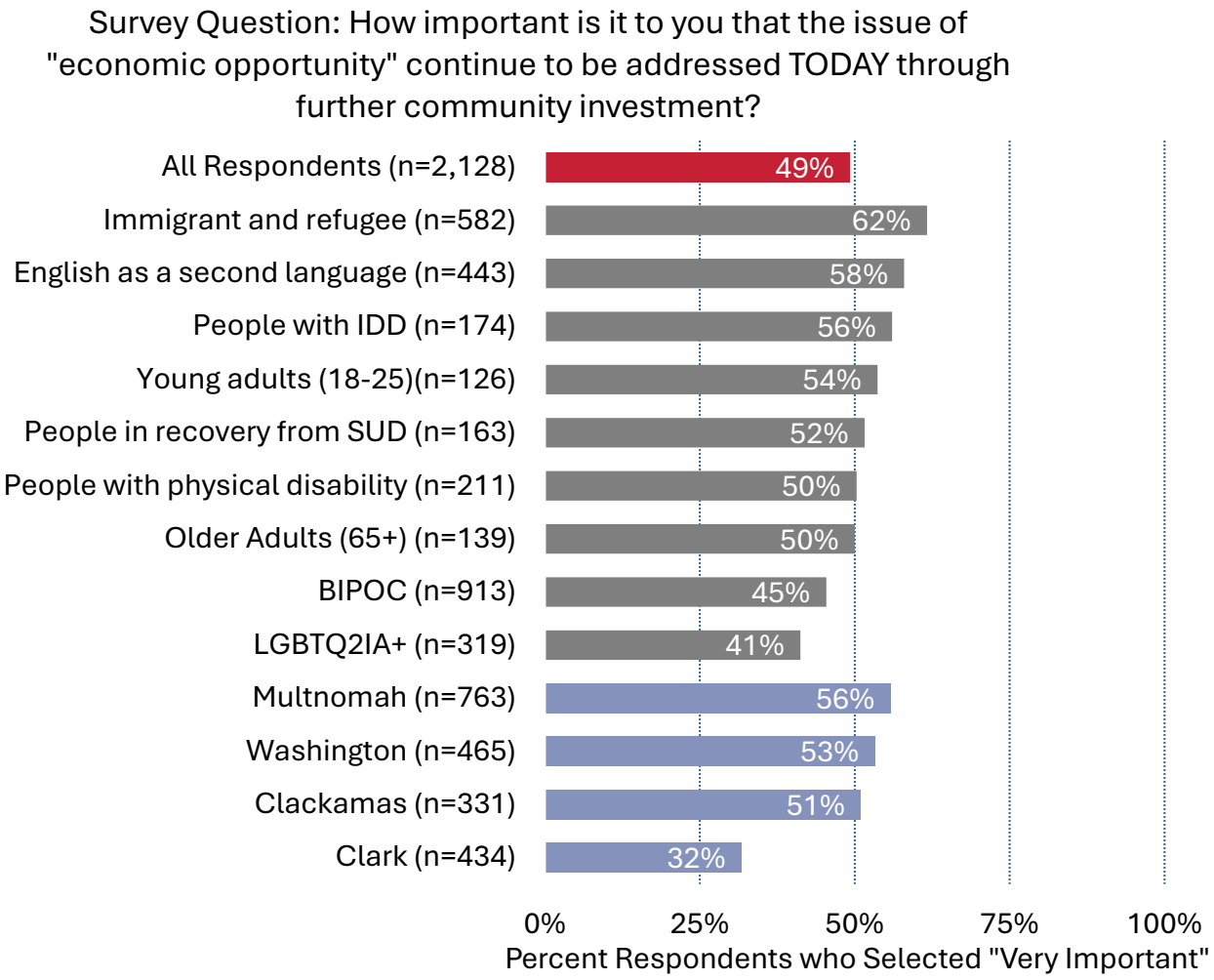
Figure 31. Satisfaction with Economic Opportunity by Focus Population



Source: HCWC CHNA Community Health Survey, 2025

Forty-nine percent of survey respondents considered "Economic Opportunity" a key issue for ongoing investment, ranking it seventh out of thirteen priorities (**Figure 32**).

Figure 32 Economic Opportunity as a Priority Issue for Investment by Focus Population



Source: HCWC CHNA Community Health Survey, 2025

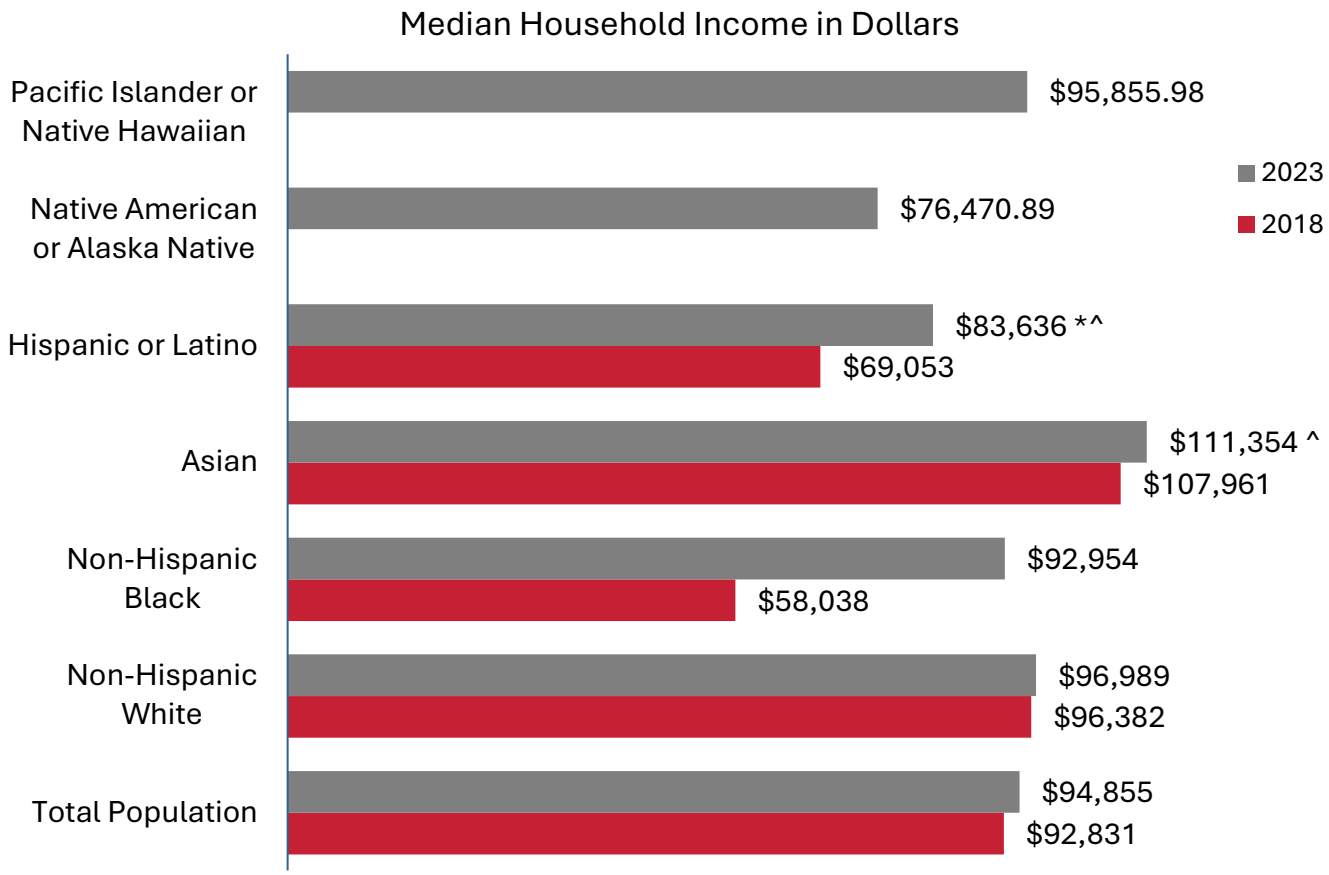
In 2023, the unemployment rate in the region was the lowest in 10 years in 2023 at 3.6 percent, with significantly lower unemployment rate in Clackamas (2.6%).16 Washington (3.6%), Multnomah (3.8%) and Clark (3.4%) counties' unemployment rates were similar to the regional rate.

The median household income in the region did not significantly change between 2018 and 2023, being $92,831 in 2018 to $94,855 in 2023. Clark was the only county within the region who had a significantly higher median housing income in 2023 at $97,678 (up from $89,671 in 2018). Compared to the 2023 regional estimate, Washington and Clackamas counties had higher median household incomes at $103,713 and $100,675, respectively. In contrast, Multnomah had a significantly lower household income at $83,583.

Trends in regional median household income by race and ethnicity reflect persistent income disparities, with Asian households maintaining the highest earnings and Native American or Alaska Native households experiencing more volatility. This volatility may in part be due to smaller population size of Native American or Alaska Native households in the region. The sharp rise in income for Non-Hispanic Black households was a notable sign of progress, though gaps remain (**Figure 33**). Specifically:

- Non-Hispanic Black households started with the lowest income in 2018 ($58,038) but saw a significant increase to $92,954 by 2023.
- Asian households consistently had the highest income, peaking at $121,108 in 2021 before a slight decline to $111,354 in 2023.
- Hispanic or Latino households showed steady growth, increasing significantly from $69,053 to $83,636; however, it remains lower than the regional median household income.
- Native American or Alaska Native households had a median household income in 2023 of $76,471 and Pacific Islander or Native Hawaiian households saw strong growth, from $73,423 in 2021 to $95,856 in 2023. (data available from 2021). These incomes were not significantly different compared to the region in 2023.

Figure 33. Regional Median Household Income by Race/Ethnicity, 2018 and 2023

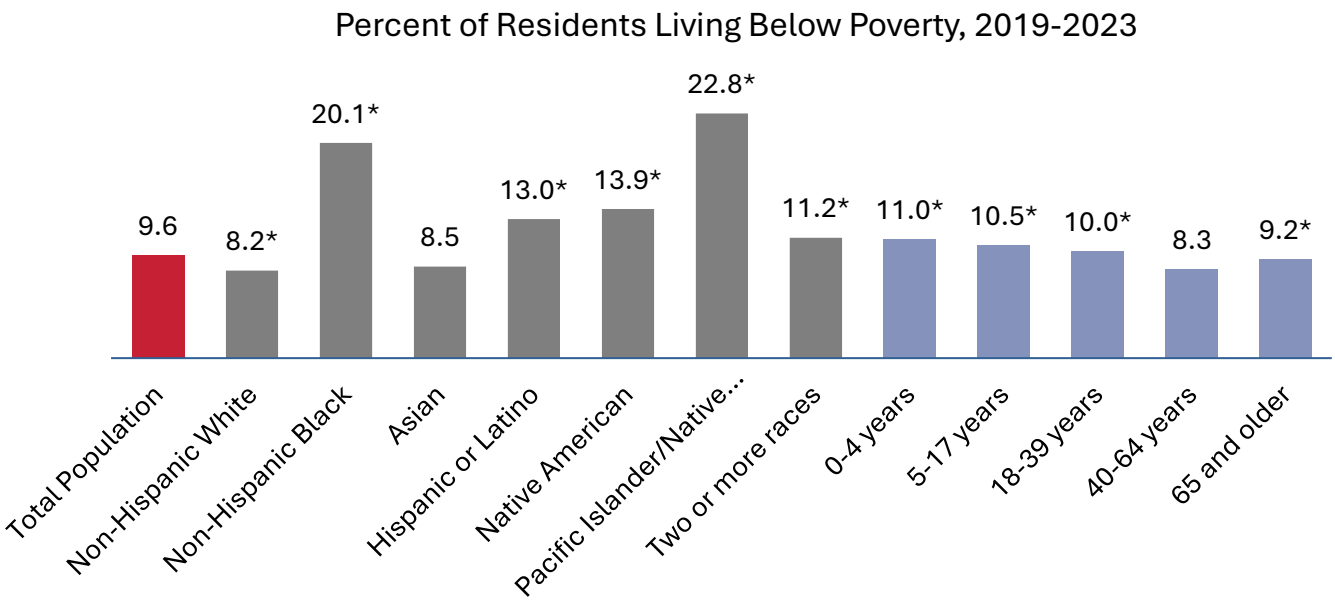


***Significantly different in 2023 compared to 2018. ^Significantly different compared to total population estimate in 2023. Source: U.S. Census Bureau, American Community Survey (ACS) Table B19013**

The region's poverty rate stayed steady from 2019 (9.5%) to 2023 (9.2%), averaging 9.6 percent over the period (**Figure 34**). Pacific Islander or Native Hawaiian (22.8%) and Non-Hispanic Black (20.1%) groups had rates more than twice the overall average, while Asian (8.5%) and Non-Hispanic White (8.2%) were below average.

Children aged 0–4 (11.0%) and 5–17 (10.5%) experienced higher poverty rates, showed greater vulnerability among families with young children. Young adults (aged 18–39) also exceeded the average at 10.0 percent, whereas middle-aged (aged 40–64, 8.3%) and older adults (aged 65+, 9.2%) matched or fell below the average.

Figure 34. Regional Poverty Rate, 2019-2023



***Significantly different compared to total population estimate in 2023. Source: U.S. Census Bureau, American Community Survey (ACS) Table B19013.**

Brief #2: Educational Opportunity

Educational opportunity refers to the belief in quality education for everyone. Education benefits individuals and society, with more schooling linked to higher incomes, better employment options, and increased social support. Historical and ongoing unfair treatment, discrimination, and exclusion prevent a quality educational opportunity for all.[17]

Focus group participants expressed that education and jobs were crucial for improving their quality of life. They reported needing more affordable and accessible educational opportunities, including short-term certification programs and vocational training. Community members also mentioned the need for job training programs that cater to specific communities and provide practical life skills. Community members emphasized the importance of financial literacy and stability, sharing the need for more financial literacy resources, such as budgeting classes and credit counseling. Additionally, community members relayed wanting more educational support and assistance with legal and immigration services. They discussed the challenges of navigating the legal system, the high cost of legal services, and the need for culturally specific legal assistance.

Lastly focus group participants highlighted the need for greater support for children of immigrant families such as affordable child care and improved educational resources. Specifically:

- Need for Farsi-speaking educators and peer support to help young students succeed.
- Early education and youth programs seen as key to promoting health and preventing drug use.
- Community members want practical life skills training, like personal finance.
- Strong support for short-term job certification programs (e.g., nursing).
- Employer-led technical training valued for improving job qualifications.
- Immigrants need programs to navigate health care and civic systems, fostering community participation.

The quotes of focus group participants illustrate that educational opportunity is not just about traditional schooling—it includes language access, life skills, career pathways, and early childhood support, all of which contribute to long-term community well-being.

"More educational opportunities, [I] would love to learn how to administer our finances so that we don't feel like we're coming up short at the end of each month."

"Education... I believe there is a need for short-term certification programs that can lead directly to employment, such as nursing programs."

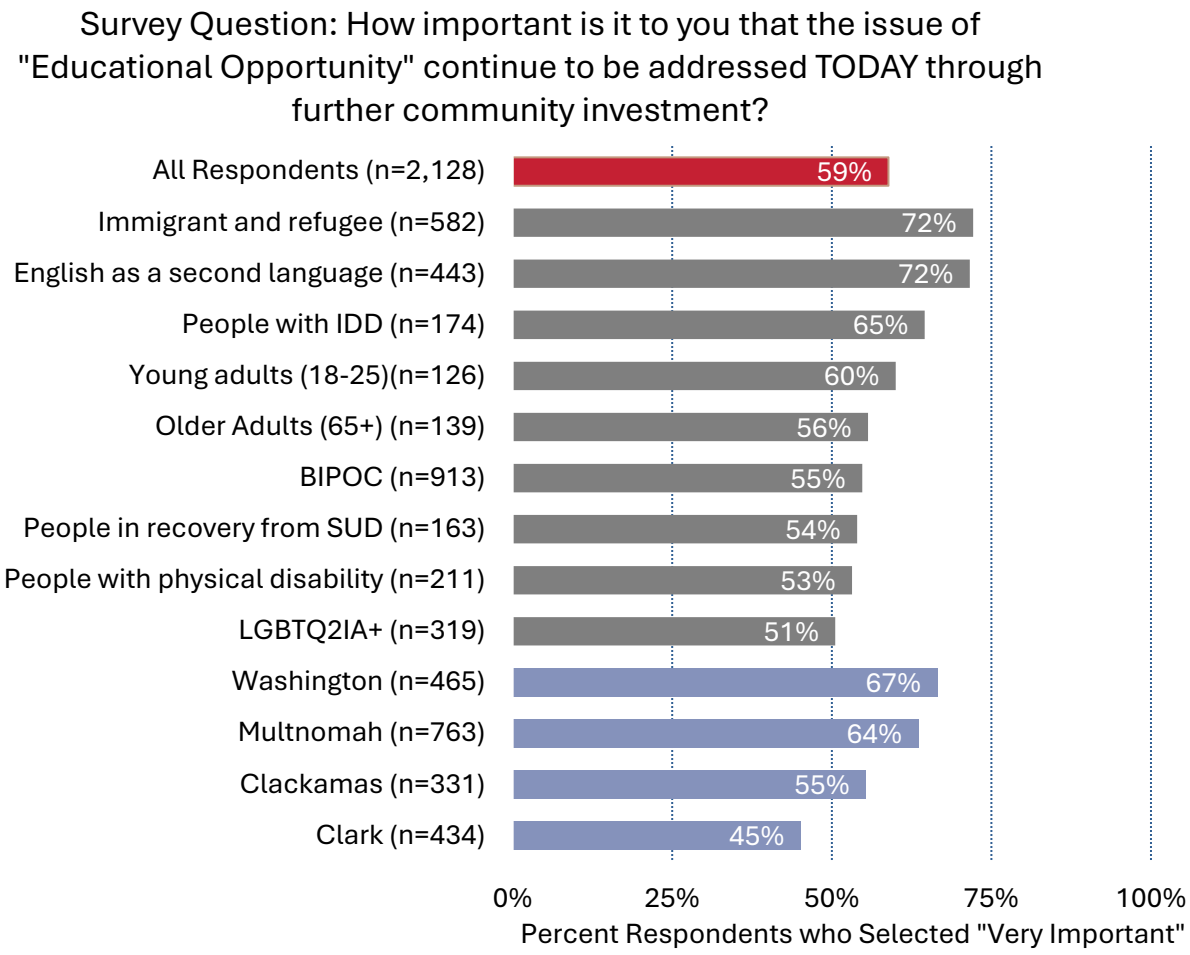
"Prioritizing youth education and community programs is vital for instilling healthy lifestyles and preventing issues such as drug use. Initiatives should focus on early education to cultivate a positive societal mindset."

"Definitely need more, like support or assistance for immigration. Sometimes right now, with all the changes going on in that area, a lot of people might not know what to do or it becomes very expensive to try to seek help filing for your residence card or a work permit."

"We need classes and orientations when it comes to financial literacy, how to save, get loans (house, auto, business)."

Over half of survey respondents (59%) rated “Educational Opportunity” as very important for continued community investment, ranking it fourth among 13 priority issues. Respondents who speak English as a second language and immigrant or refugee respondents both reported 72 percent levels of importance. Washington (67%) and Multnomah (64%) also indicated substantial support. Young adults aged 18–25 (60%) and individuals with cognitive, intellectual, or developmental disabilities (IDD) (65%) expressed need slightly above the regional average of 59 percent, as shown in **Figure 35**.

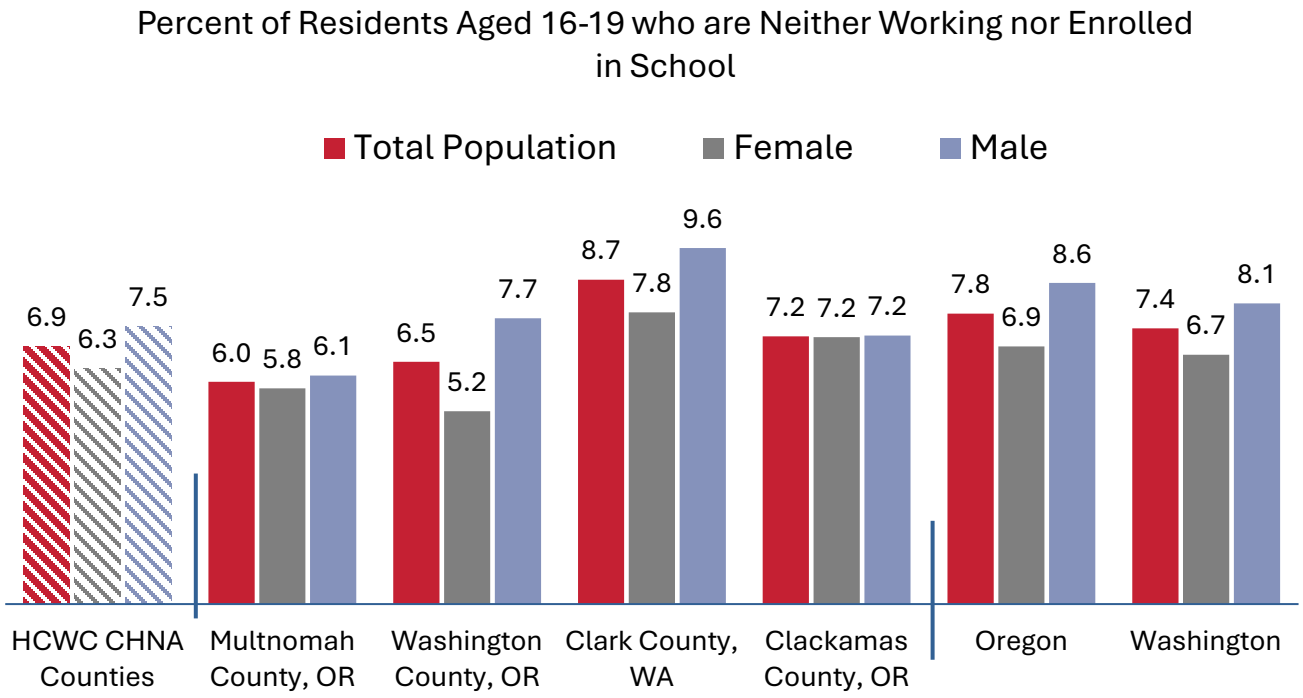
Figure 35. Educational Opportunity as a Priority Issue for Investment



Source: HCWC Community Health Survey, 2024

High-quality, inclusive education helps prevent youth disconnection. Access to engaging curriculum, caring educators, culturally responsive teaching, and pathways to higher education or vocational training encourages young people to remain enrolled, graduate, and transition successfully into the workforce. In the region, between 2018 and 2023, there remained approximately 7.0 percent of youth 16-19 years who were neither working nor enrolled in school – a group often referred to as "opportunity youth". Gender disparities are evident in most regions, with females generally showing higher opportunity youth rates—except in Clark, where males were more affected. Clark stands out with the highest rate of opportunity youth (8.7%), particularly among males (9.6%). Multnomah and Washington counties have lower-than-average rates, suggesting stronger youth engagement (**Figure 36**).

Figure 36. Opportunity Youth by Sex, 2019-2023

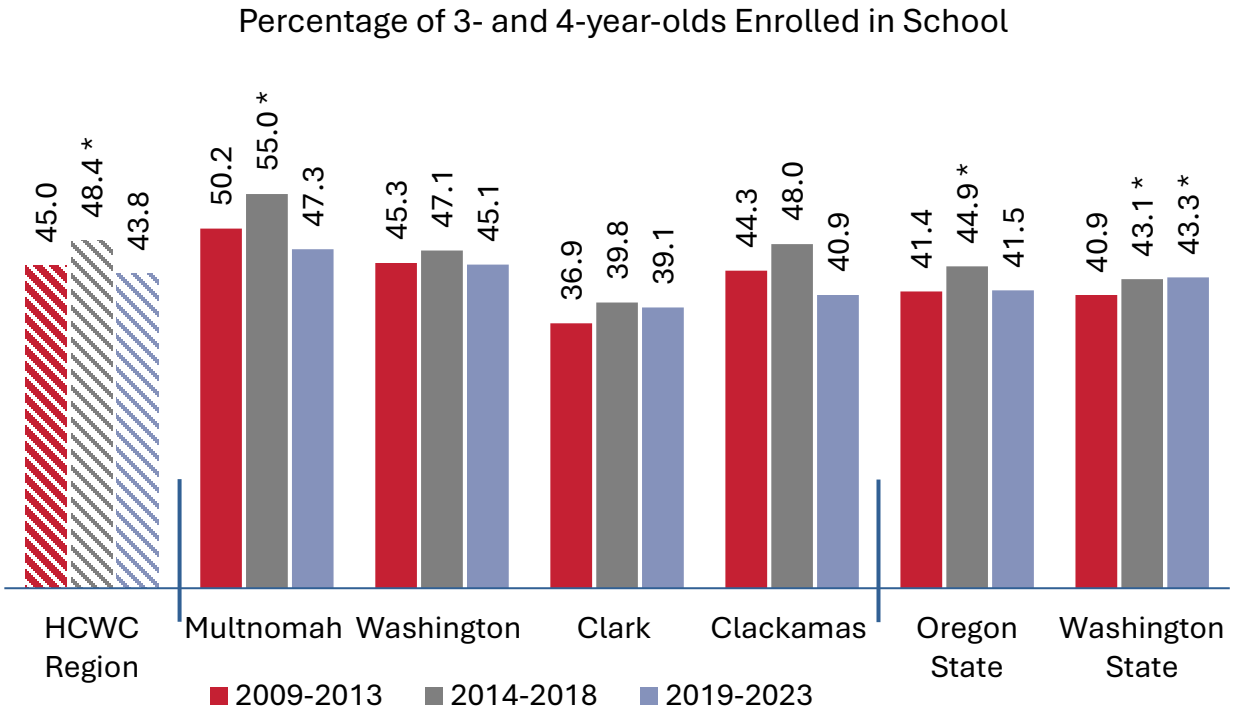


No significant differences between counties or genders. Source: U.S. Census Bureau, American Community Survey (ACS) Table B14005

This difference in having a high school degree begins, in part, with access to early childhood education. Child care is critical for young children's early development and supports caregivers with their education, work, or health care needs. It also improves kindergarten readiness. Children who enter school with early skills are more likely than their peers without such skills to have academic success, attain higher levels of education, and secure employment.[18]

Preschool enrollment trends were improving in the region prior to 2020, in part due to increasing trends in Multnomah. The regional preschool enrollment increased significantly from 45.0 percent of three- and four-year-olds in 2009-2013 to nearly half (48.4%) in 2014-2018. However, likely due to COVID-19 pandemic, preschool enrollment decreased between 2019-2023, returning to levels seen in 2009-2013 (**Figure 37**).

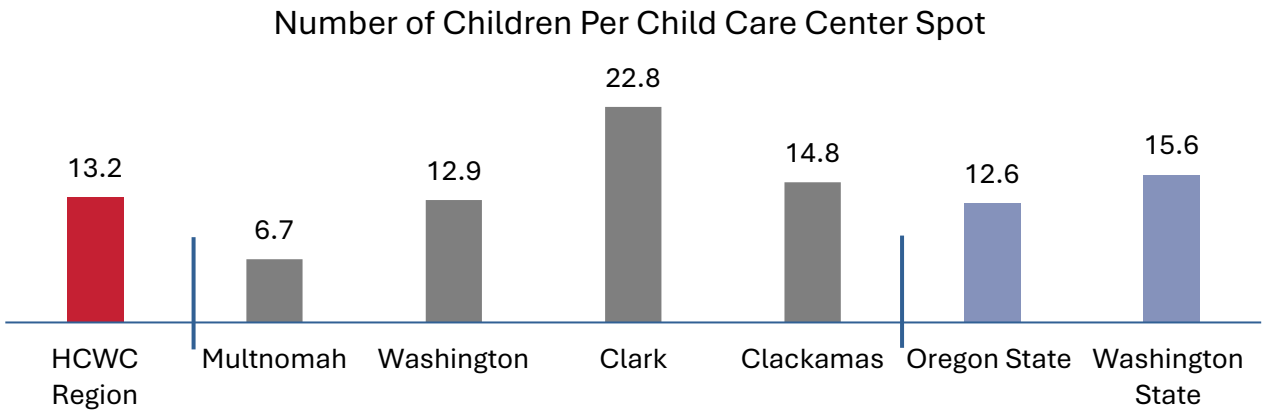
Figure 37. Preschool Enrollment, 2009-2013 to 2019-2023



***Significantly different compared to 2009-2013 estimate for the region or county. Source: U.S. Census Bureau, American Community Survey (ACS) Table B14003**

Access to child care remains a challenge, especially in Clark and Clackamas counties, where demand far exceeds supply. Multnomah, despite having the best (lowest) ratio of children per spot in a local child care center, was losing centers—potentially threatening future access. Clackamas was improving availability of centers but still had the second highest ratio (14.8) in the region. **Figure 38** shows the number of children per available child care center spot. A higher number indicates greater strain on child care resources. The region overall had a ratio of 13.2, higher than Oregon State (12.6) but lower than Washington State (15.6). Clark has the highest ratio at 22.8, meaning there were nearly 23 children for every one child care spot—indicating a severe shortage. Multnomah had the lowest ratio at 6.7, suggesting relatively better access.

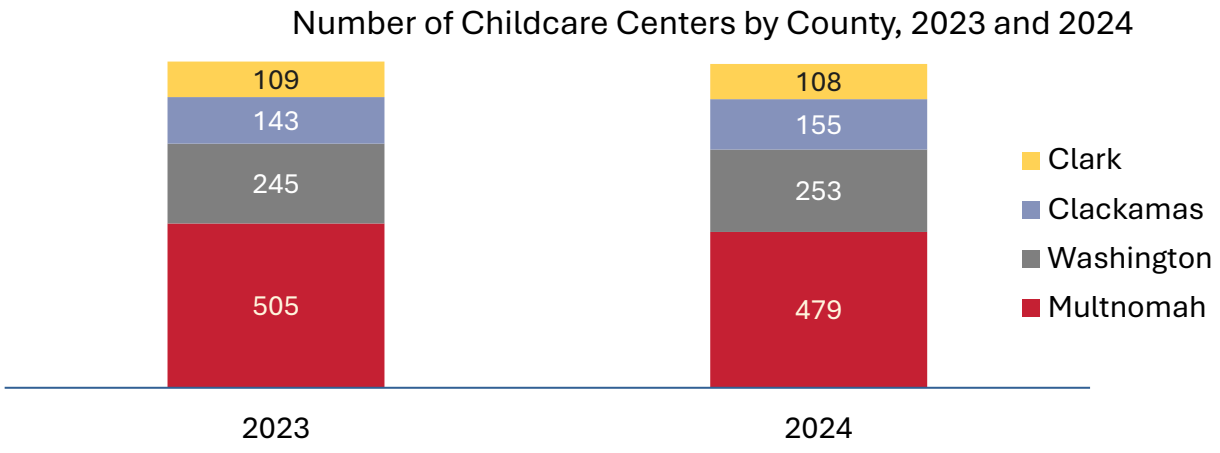
Figure 38. Child Care Center Ratio, 2023



Note: The number indicates the number of children for every one spot in a local child care center. For example, a value of 10 means that an area has 10 children for every one spot in local child care centers. Source: Department of Homeland Security (DHS), HIFLD Open Data, Childcare center dataset

Between 2023 and 2024, the region lost seven centers (a 0.7% decrease from 1,002 to 995 centers). Multnomah experienced the largest decline, losing 26 centers (a 5.1% decrease from 505 to 479 centers). The largest growth was in Clackamas, adding 12 centers (an 8.5% increase from 143 to 155 centers) (**Figure 39**).

Figure 39. Number of Childcare Centers by County, 2023 and 2024

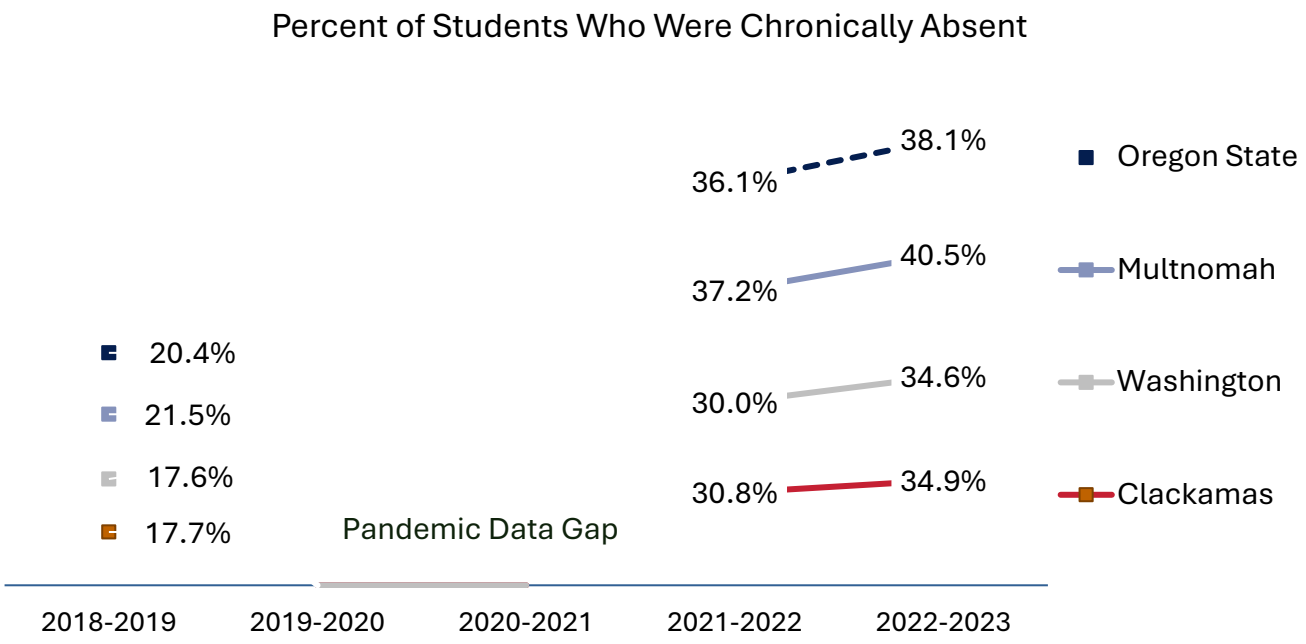


Source: Department of Homeland Security (DHS), HIFLD Open Data, Child Care Center Dataset

School attendance is a fundamental component of student learning, as engagement in educational activities requires physical presence. It serves as an important indicator of fairness, identifying students who may require additional support and highlighting areas for system and school enhancement. Chronic absenteeism affects students across all age groups. Students that miss just two days a month for any reason are more likely to not read at grade level, and more likely to not graduate. Absenteeism refers to the number of chronically absent students who miss more than 10 percent of a school year.

In Oregon, chronic absenteeism rates (for all students) trended upwards between School Year (SY) 2018/2019 and SY2022/2023. Oregon counties in the region experienced a dramatic rise in chronic absenteeism, nearly doubling in most cases (**Figure 40**). Multnomah consistently reported the highest chronic absenteeism rates, climbing from 21.5 percent to 40.5 percent. Clackamas increased from 17.7 percent in 2018–2019 to 34.9 percent in 2022–2023; Washington increased from 17.6 percent to 34.6 percent over the same period.

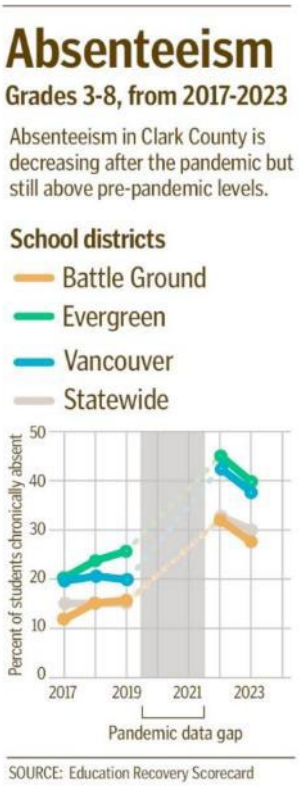
Figure 40. Chronic Absenteeism for All Students



Note: Chart excludes Clark Couty and Washington State. Source: Oregon Department of Education

In Clark, the Education Recovery Scorecard obtained data from the American Enterprise Institute that shows absenteeism in Clark schools among students Grades 3-8 decreased from 2022 to 2023 but remains above pre-pandemic levels (**Figure 41**).[19] Washington State's chronic absenteeism increased from 15 percent of students in 2019 to 30 percent in 2023, according to the scorecard.

Figure 41. Clark County Absenteeism Rate, Grades 3-8



Brief #3: Culturally Specific and Healthy Food

Access to healthy and culturally appropriate food was a common theme across community member focus groups. Concerns were raised about the high cost of healthy food and the lack of culturally specific foods in food banks and grocery stores. Community members also emphasized the importance of community gardens and food programs providing fresh, culturally appropriate foods. They highlighted the need for more affordable and accessible food options. Specifically:

- While ethnic food options have increased, they are often only available at specialty stores that may be far away or inaccessible without transportation.
- Food banks and food boxes typically offer generic items that don't reflect the cultural dietary needs of communities like Latinos or Asians.
- Many individuals, especially old adults or those without cars, struggle to get to grocery stores.
- There is interest in having ethnic foods available through delivery services like Instacart or Amazon Fresh, though affordability remains a concern.
- Some food boxes contain expired or low-nutrition items, leading to health risks like food poisoning.
- People in transitional housing face restrictions that make it hard to access both employment and food assistance, trapping them in cycles of food insecurity.

The focus group quotes illustrate that food access is not just about quantity—it is about cultural relevance, safety, and usability for all.

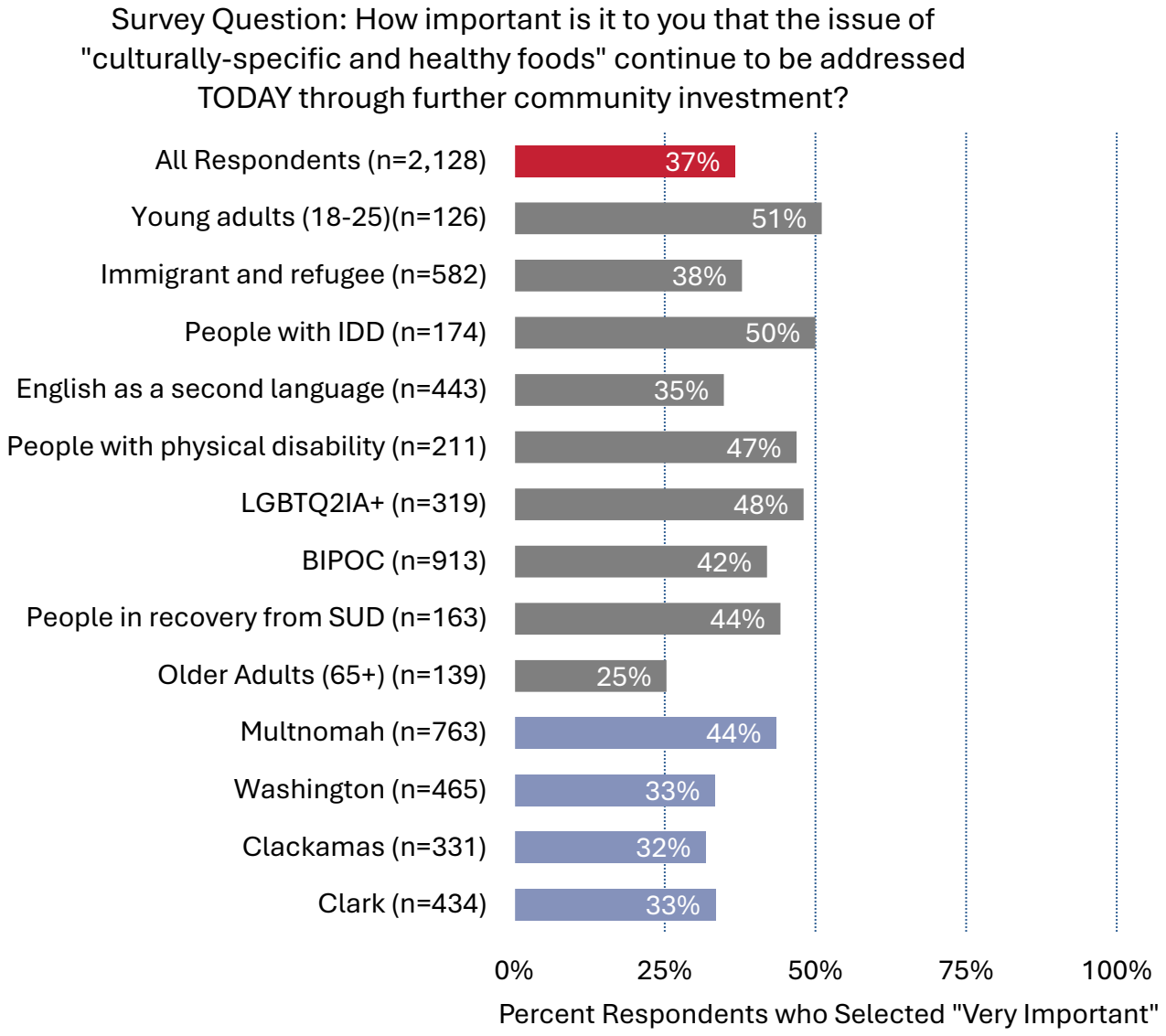
"Next door, they have a bus - I think it's once a week or every other week - that take people to the grocery store so they can get groceries. There is a lot of us around here that do not drive anymore and to get to the grocery store is hard for some."

"Food boxes do not [always] provide nutritious food. In transitional housing, you cannot have a job and be on food stamps. I was stuck in a cycle where this is where I am and this is where I will stay."

"I know family members and friends that go to food banks and have [little for] Latinos. It's a little hard to get our culture's foods from food banks. It's usually just general stuff and we get creative to incorporate [food items] into what our family is used to eating."

Culturally specific and healthy food is a top priority for further community investment today by 41 survey respondents (**Figure 42**), ranking it tenth out of 13 issues. Young adults (ages 18–25) reported the highest levels of importance at 56 percent, followed by immigrant and refugee respondents at 55 percent, and individuals with cognitive, intellectual, or developmental disabilities at 51 percent. Regionally, Multnomah recorded the highest level of county support at 52 percent, while Clark reported the lowest at 26 percent. These findings indicate that culturally specific and healthy food access was considered a priority among younger people and immigrant and refugee groups.

Figure 42. Culturally-Specific and Healthy Food as a Priority Issue for Investment by Focus Population

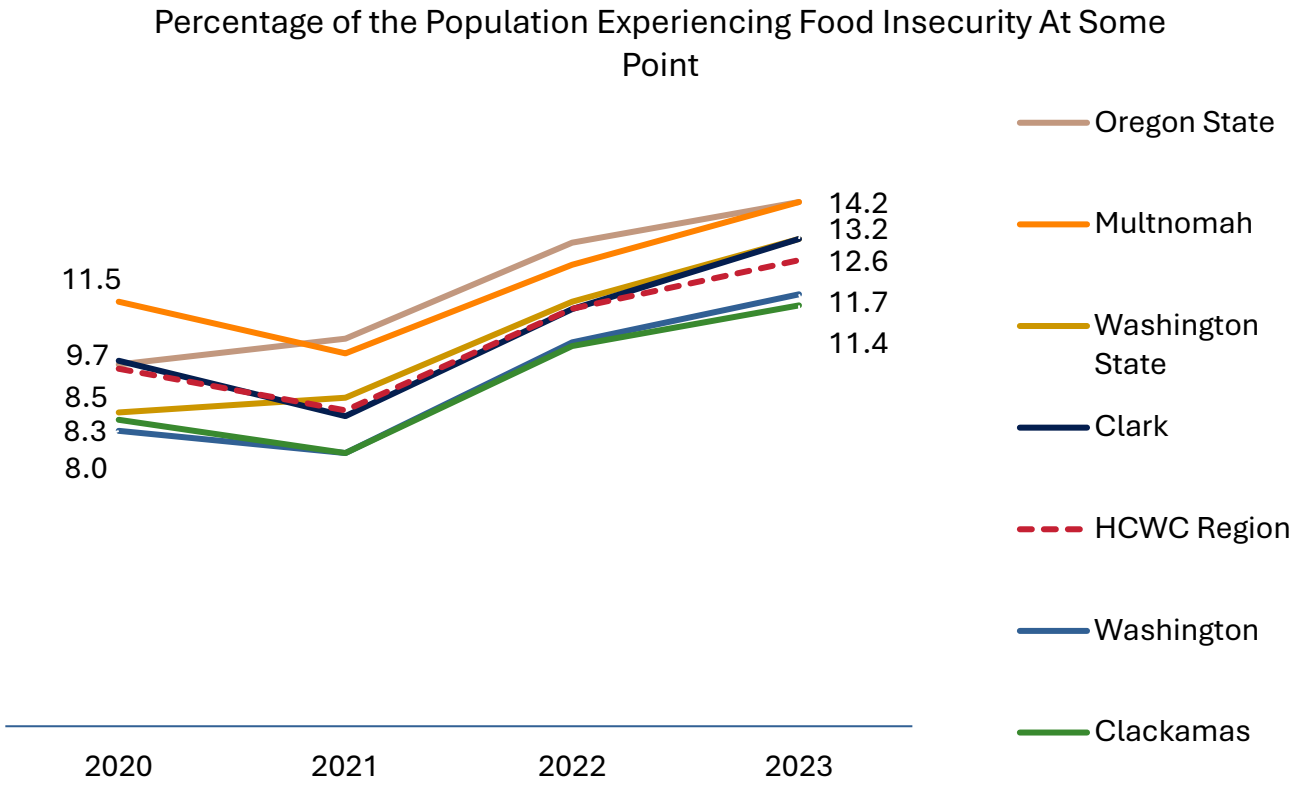


Source: HCWC Community Health Survey, 2024

Nearly 20 percent of children across the country were experiencing food insecurity and in some rural counties child food insecurity rates were estimated to be as high as 50 percent, according to Feeding America's annual Map the Meal Gap study.[20] While most children in the U.S. live in urban metropolitan areas, over 80 percent of U.S. counties with the highest estimated rates of child food insecurity (top 10% of all counties) were rural.

The region, and each county, experienced rising food insecurity over the four-year period between 2020 and 2023 (**Figure 43**). Overall, the regional rate increased from 9.7 percent to 12.6 percent. Multnomah and Oregon State had the highest rates in 2023, both reaching 14.2 percent. Clark also saw a sharp increase, from 9.9 percent in 2020 to 13.2 percent in 2023. Washington County increased from 8.0 percent to 11.7 percent, and Clackamas from 8.3 percent to 11.4 percent. Washington State followed a similar trend, rising from 8.5 percent to 13.2 percent. These trends reflect a growing challenge in food access and affordability.

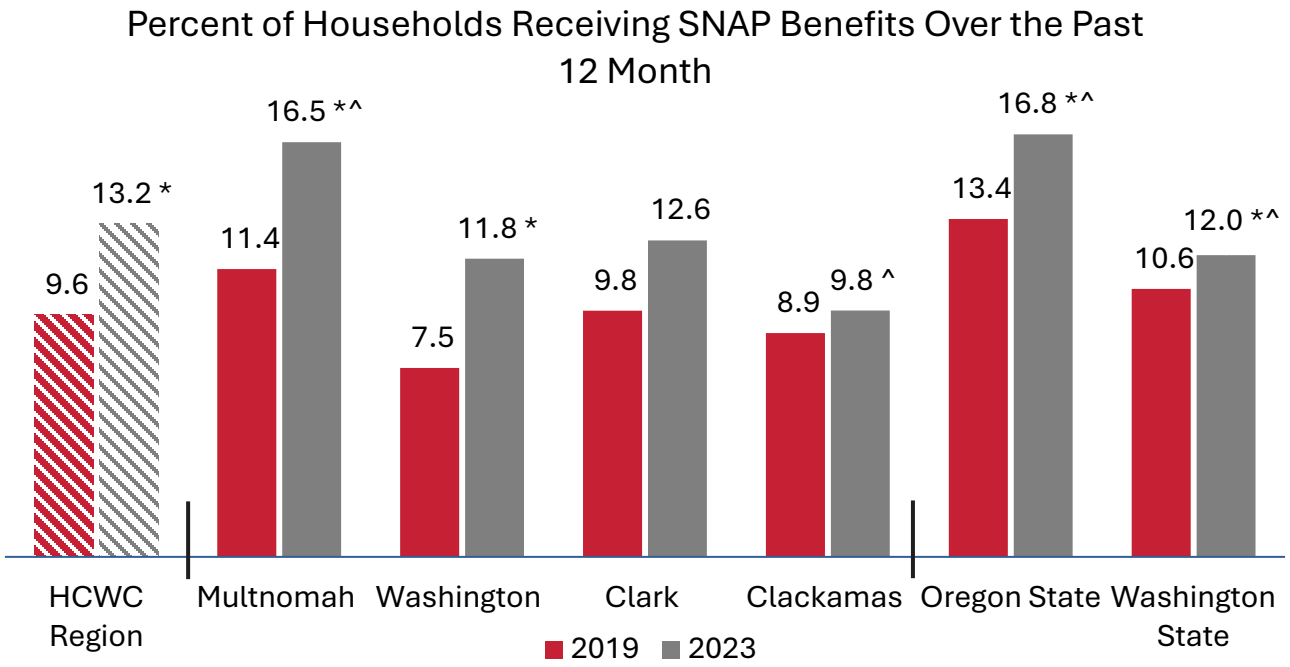
Figure 43. Food Insecurity, 2020 to 2023



Source: USDA, Map the Meal Gap, Feeding America

The percent of households receiving Supplemental Nutrition Assistance Program (SNAP) benefits, formerly known as food stamps, over the past 12 months significantly increased between 2019 and 2023, from 9.6 percent of households in 2019 to 13.2 percent of households in 2023 (**Figure 44**). The increase occurred in all four counties. In 2023, Multnomah had significantly more households receiving SNAP compared to the region at 16.5 percent, while Clackamas was significantly lower (9.8%).

Figure 44. SNAP Benefits by Year

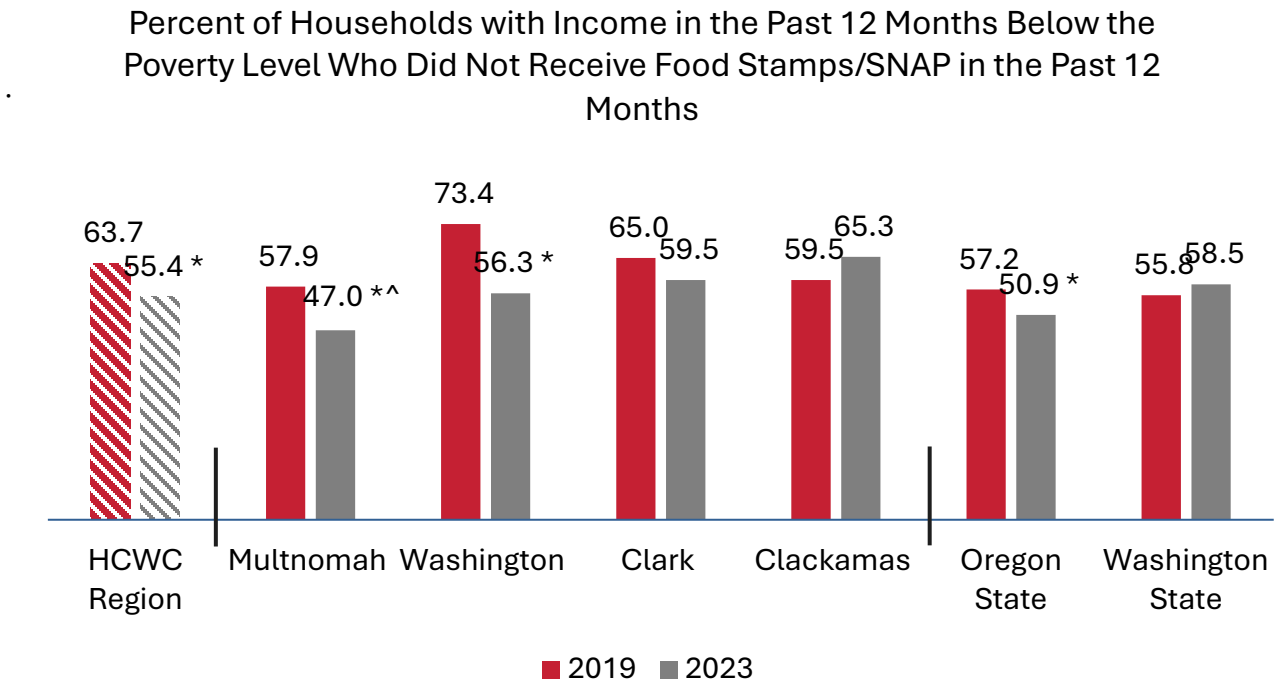


***Significantly different in 2023 compared to 2019. ^Significantly different compared to HCWC region in 2023. Source: U.S. Census Bureau, American Community Survey (ACS) Tables B22003, B22005, and S2201**

In the region, 55.4% of households below the poverty line did not receive SNAP in the past year, down from 63.7% in 2019 (**Figure 44**). Most counties in the region had fewer households in poverty who were not receiving SNAP, suggesting better access or outreach. Washington dropped from 73.4 percent in 2019 to 56.3 percent in 2023 — a significant improvement. Clackamas was an exception, where the percentage increased from 59.5 percent to 65.3 percent. Reasons why people in poverty might not receive food stamps, other than not realizing they are eligible or not signing up, include[21, 22]:

- Having resources over a certain limit, such as money in a bank account or vehicles, even if their income puts them below the poverty line
- Not meeting work requirements
- Immigrants who lack documentation or legal status
- Workers on strike
- Adults without children are often eligible only for limited periods, such as three months every three years

Figure 44. Households in Poverty Not Receiving SNAP, 2019 and 2023



***Significantly different in 2023 compared to 2019. ^Significantly different compared to HCWC region in 2023. Source: U.S. Census Bureau, American Community Survey (ACS), Table B22003**

Brief #4: Getting Where One Needs To Go (Transportation)

Focus group participants frequently mentioned the difficulties they face with transportation. They reported relying on public transportation that is often unreliable, infrequent, or inaccessible, especially for those with disabilities or those living in rural areas. As a result of this, focus group participants relayed they had difficulties accessing essential services, such as health care, food banks, and employment opportunities. Additionally, focus group participants emphasized the need for better usability for all and transportation, citing issues like inadequate sidewalks, a lack of ramps, and insufficient ADA-compliant signage. They also raised concerns about the affordability and capacity of public transportation, advocating for free and more frequent bus services. Specifically:

- Restricted schedules (e.g., no service after 7 PM or on Sundays) make it difficult or impossible to attend essential appointments or meetings.
- Lack of transportation leads to missed job opportunities and difficulty commuting to work.
- Having to negotiate work hours around unreliable transit can be embarrassing and stressful.
- Public transportation is described as unsafe, especially for women and parents with children.
- Long travel times and unsafe bus stops add to the burden.
- The experience of navigating transportation without a car is described as anxiety-inducing and fearful, especially when relying on public transit.

The focus group participant quotes illustrate how transportation challenges are not just logistical, but deeply impact economic opportunity, personal safety, and mental well-being:

"Transportation is crucial. It is anxiety inducing. I have a lot of fear trying to utilize public transportation and telling a boss you have to get off work at a certain time is embarrassing."

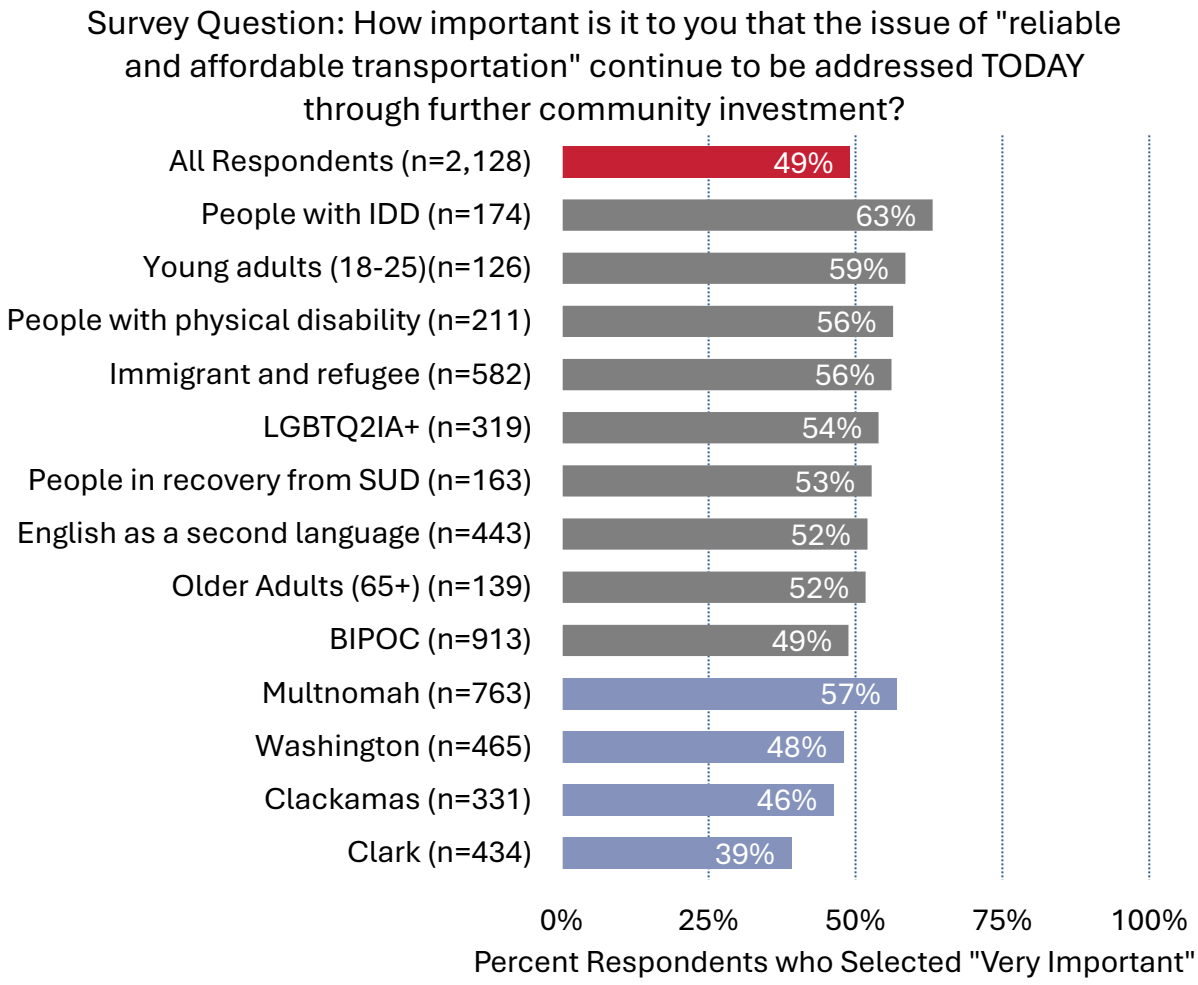
"Public transportation with a child takes hours even to just get the basics and essentials done. We are spending more time trying to find transportation. It is also very dangerous at the bus stops, with a child or as a female."

"I don't have a car and have been denied many jobs because of that. I can't get home from food pantries via the bus."

"I didn't have a license. The buses don't run past seven or on Sundays. It was hard to get to meetings, it was impossible to get where I needed to go."

Almost half of survey respondents (49%) said "reliable and affordable transportation" is a top priority for current community investment (**Figure 45**), ranking it eighth among 13 issues. People with IDD (63%), young adults aged 18–25 (59%), and Multnomah residents (57%) were most likely to rate this as "Very Important".

Figure 45. Reliable and affordable transportation as a Priority Issue for Investment by Focus Population



Source: HCWC CHNA Community Health Needs Survey, 2024

Regionally, in 2023, there were 93.3 vehicles per 100 adult residents (18+ years), which was lower than both Oregon (97.0) and Washington (97.5) states. 23 Multnomah had a significantly lower rate of 81.9 vehicles per 100 adult residents compared to the region. In contrast, Clark and Clackamas had significantly higher rates at 102.8 and 103.5 vehicles per 100 residents, respectively.

In 2023, almost eight percent of households in the region did not own a vehicle.[24] This rate remained stable. Multnomah's rate was 13.1 percent, while Washington, Clark, and Clackamas counties have rates of 5.1 percent, 4.9 percent, and 3.8 percent respectively.

Survey respondents were asked to share how they usually get to your medical appointments (physical health, mental health, oral health, etc.). Driving oneself is the most common method overall, especially in Clackamas (81%), Washington (77%), and Multnomah (72%) (**Figure 46**). Clark stands out: only 41 percent drive themselves, while 45 percent rely on public transportation — significantly higher than other counties. Public transportation was used by 17 percent of all survey respondents, but usage varied widely by region.

Telehealth, rides from friends or relatives, and community or insurance-provided transport are used by smaller percentages across all counties. This data highlights regional differences in transportation access and reliance, especially the unique reliance on public transportation among Clark County residents

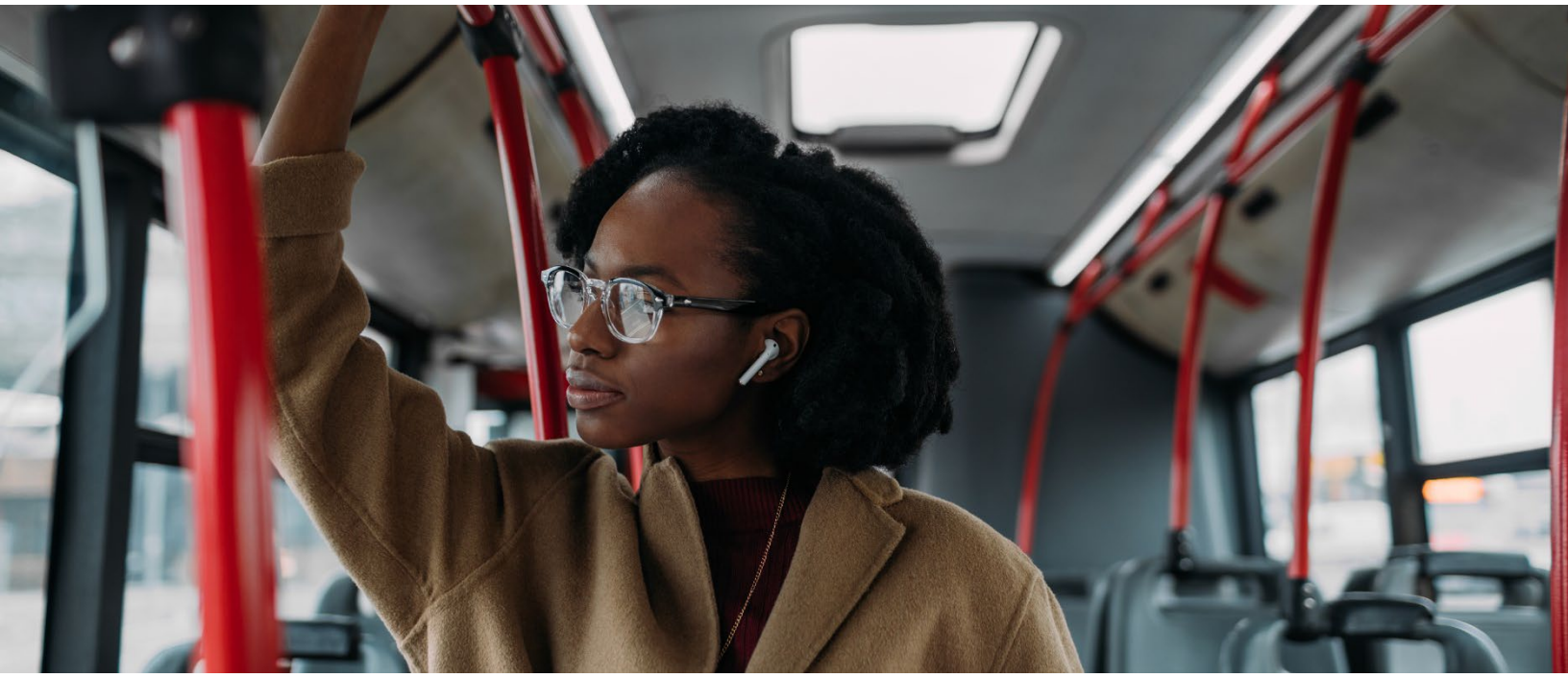
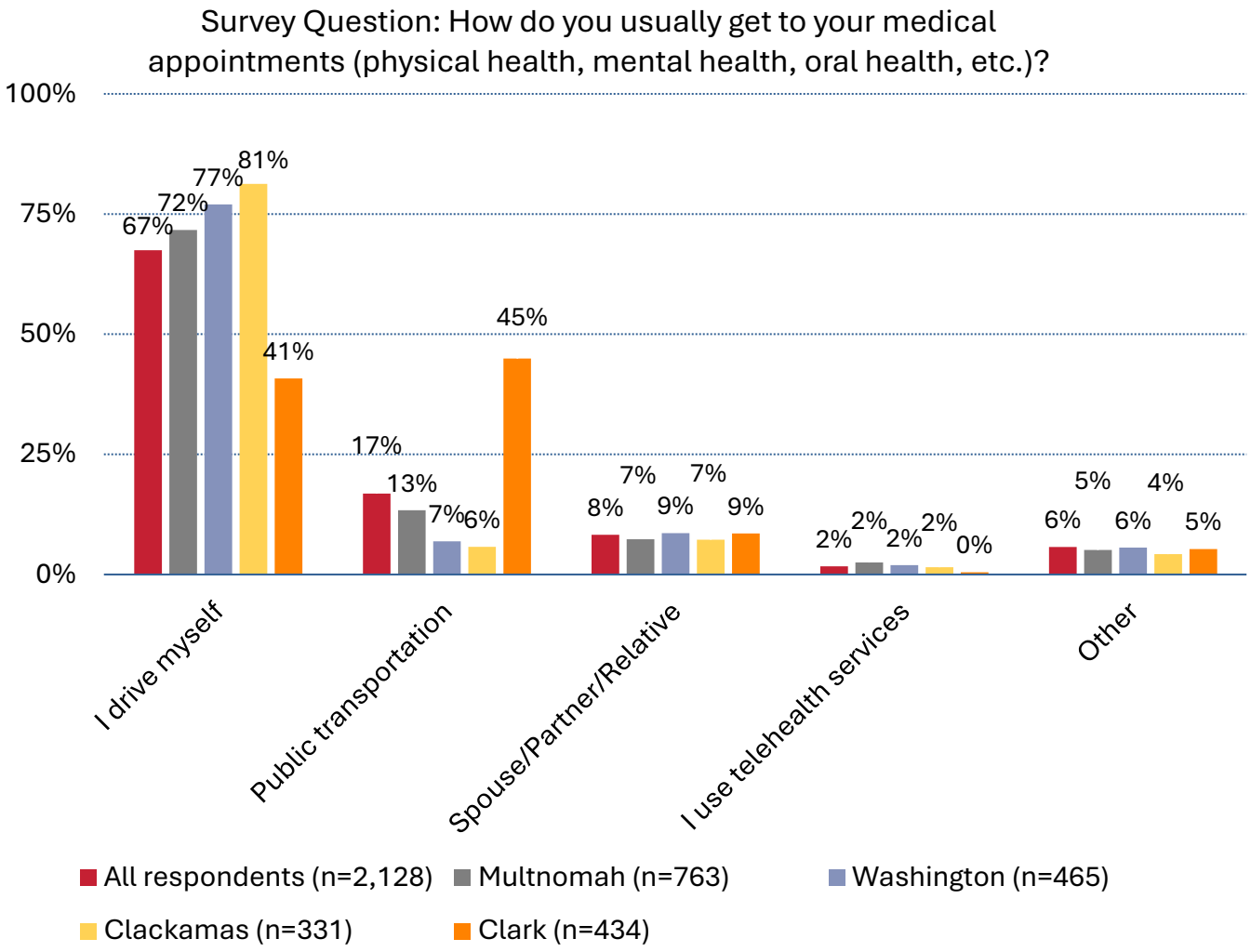


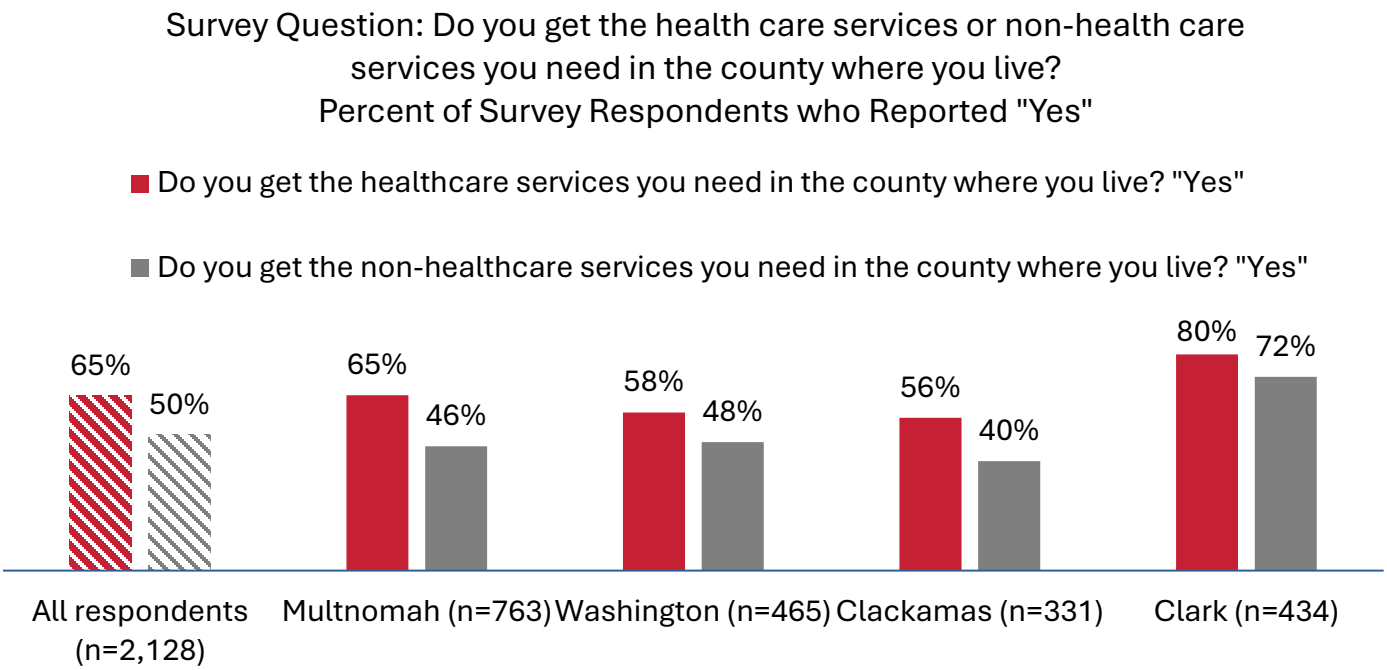
Figure 46. How do you usually get to your medical appointments (physical health, mental health, oral health, etc.)?



Note: "Other" includes friend or neighbor (2%), Transportation provided by my health insurance (2%), Cab/Uber/Lyft not covered by my health insurance (1%), and Transportation provided by a community group (1%). Source: HCWC CHNA Community Health Survey, 2024

Access to services often depends on proximity. This assessment focused on whether individuals can access nearby services. Overall, 65 percent of all respondents get health care services locally, but only 50 percent get non-health care services in their county (**Figure 47**). Clark stands out with the highest access to both health care (80%) and non-health care services (72%) locally. Clackamas had the lowest access to non-health care services (40%) and relatively low health care access (56%). Multnomah and Washington counties showed moderate access, with health care access higher than non-health care.

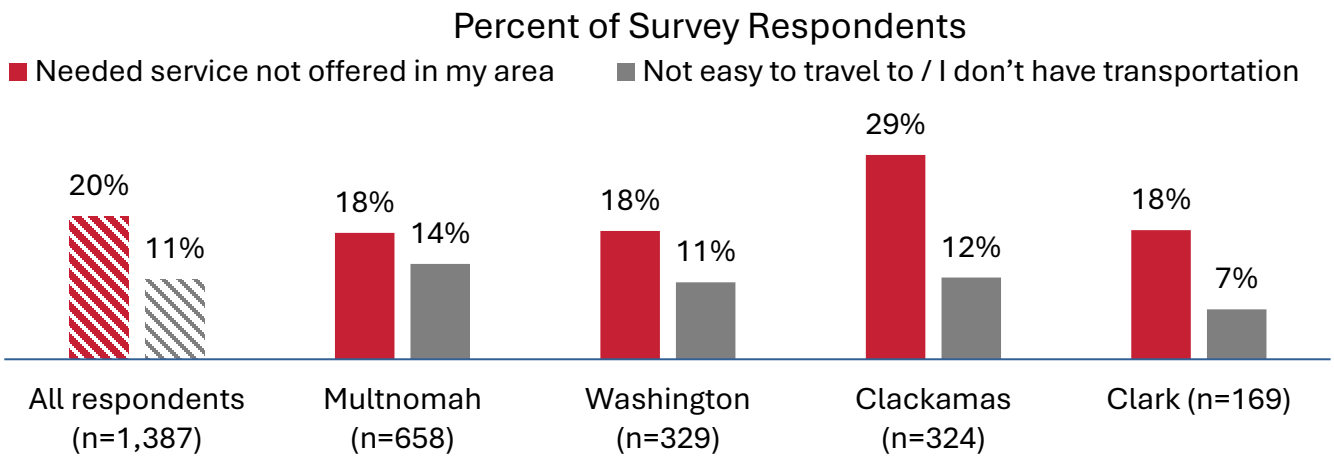
Figure 47. Do you get the health care services or non-health care services you need in the county where you live? "Yes"



Source: HCWC CHNA Community Health Needs Survey, 2024

The community health survey identified "needed services not available locally" as a potential barrier. One in five respondents (20%) noted this as an issue (**Figure 48**). One in 10 survey respondents (11%, n=1,387) who experienced obstacles in accessing health care services noted their challenges as “not easy to travel to / I don’t have transportation”. There was little variation by county within the region. Multnomah survey respondents reported transportation as an obstacle to accessing health care services (14%), followed by Clackamas (12%), Washington (11%) and Clark (7%) counties. Clackamas stood out with nearly one in three respondents (29%) saying the services they need were not available in their area.

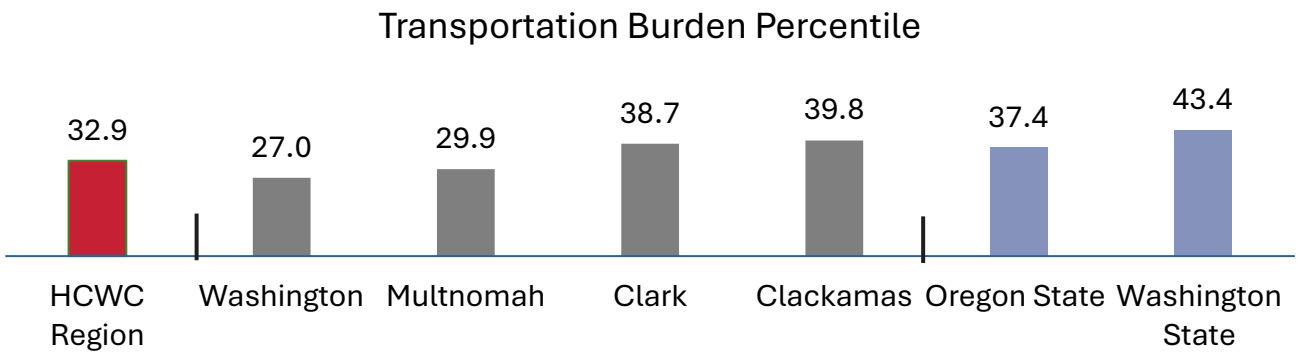
Figure 48. Transportation Challenges



Source: HCWC CHNA Community Health Needs Survey, 2024

Transportation burden is defined as the average relative cost and time spent on transportation relative to all other census tracts. A higher score indicates greater transportation insecurity—people in that area spend more time and/or money on transportation than most others.[25] The transportation burden for the region was 32.9 which indicates that residents experience less transportation insecurity than most of the country—specifically, their burden was lower than about two-thirds of other areas (**Figure 49**). Clackamas (39.8) and Clark (38.7) counties have the highest transportation burden in the region.

Figure 49. Transportation Burden



Source: Department of Transportation via Council of Environmental Quality's Climate and Environmental Justice Screening Tool

Brief #5: Virtual Resources

In the last 2022 CHNA, community members spoke of the opportunities created by providing more virtual health and/or social care services (more access to a broad range of providers). However, they also noted concerns about ease of access for those who might have less comfort navigating virtual spaces and do not have reliable access to broadband internet.

Twenty-three percent of respondents use the internet to find non-health care resources like jobs, food, child care, or housing. Just five percent of survey respondents facing health care access challenges cited lack of internet or a device as a reason for not using telehealth services. Households with internet access in the region increased between 2014-2018 and 2019-2023 from 91.0 percent to 95.9 percent of households in 2019-2023).

Emerging Issues in Essential Community Services and Resources Update

Issues emerged out of both the primary and secondary data collected and analyzed:

- Focus group participants have highlighted a need for financial literacy and stability resources. This includes more budgeting classes, credit counseling, and job training programs, particularly for positions that do not require a college degree. The community's emphasis on financial education and practical financial skills underscores the importance of supporting long-term economic stability and informed decision-making.
- There is a pronounced demand for more support and assistance with legal and immigration services. Focus group participants face challenges such as navigating the legal system and the high cost of legal services. There is a specific call for culturally competent legal aid.
- Unemployment dropped in the region, but median income and poverty rates were unchanged. Families with young children were particularly vulnerable, with higher poverty rates among children aged 0-4 (11.0%) and 5-17 (10.5%).
- Access to culturally specific and healthy foods was a growing concern, particularly for young adults, immigrants, refugees, and people with disabilities, exacerbated by high costs and transportation challenges.
- There was a need for affordable and accessible educational opportunities, including short-term certifications and vocational training. The COVID-19 pandemic led to a decrease in preschool enrollment, and access to child care remains a challenge. Rising chronic absenteeism rates and a high percentage of youth not engaged in work or education were trends to monitor and address.
- Reliable and affordable transportation was essential for many focus group participants, especially those with disabilities, young adults, and residents of Multnomah. Transportation challenges (such as unreliable, infrequent, unsafe, or inaccessible public transport) limit access to health care, food banks, and employment opportunities.
- Despite increased internet access in the region, virtual tools remain underutilized for health and social support. Only a small percentage of individuals facing health care access challenges cited lack of internet or a device as a reason.

Support for Family and Community Ways

2025 Update

All people

people should be afforded access to foods and healing medicines or practices specific to their communities of origin.

SUPPORT FOR FAMILY AND COMMUNITY WAYS UPDATE

All people should be able to access foods, healing medicines, and practices specific to their communities of origin. In addition, all people should have access to land, which supports physical activity and connection to the natural world, as well as to opportunities for ceremonial, religious, cultural, educational, and celebratory community gatherings. These gatherings foster community cohesion and share the necessary life skills or teachings necessary for youth to grow up in a good and healthy way. "Ways" refers to, but is not limited to, the traditions, practices, histories, customs, and rites that support community connectedness and wellness.

Figure 50 summarizes the key findings of the data reported in this section on *Support for Family and Community Ways*

Figure 50. Support for Family and Community Ways

Social Connection

Social connection matters deeply to many, especially young adults and people with cognitive or developmental disabilities. While less than half of all survey respondents ranked it as a top investment priority, those in Multnomah and vulnerable groups showed stronger support.

Most people feel they have support networks during tough times—especially in Clark, among older adults, and BIPOC communities—highlighting both the value and uneven access to social connection across the region.

Brief #1: Social Connection

The absence of social connections can profoundly affect our overall health.[26] Strong communities are critical, serving as a central source of social connection and belonging. Social support involves having family, friends, and other people to turn to in times of need or crisis. Social support also enhances the quality of life and helps whenever people experience unfortunate life events.[27] Communities with strong social support help to decrease an individual's level of stress, increase motivation, and encourage healthy behaviors.[28] Therefore, offering support of family and community connections is an essential strategy for improving health and wellness. It is about facilitating opportunities for people to come together to solve problems and celebrate the good moments of their lives. This includes space for families and friends, cohesion in one's local community, as well as space to encourage cultural connection and understanding.

Focus group participants emphasized that community connections are vital for emotional survival and resilience, especially during crises like sweeps of unhoused encampments. These connections provide comfort, reduce isolation, and offer a sense of belonging. Events such as Independent Living Skills meetings, holiday gatherings, and other social activities were seen as effective ways to build relationships, share resources, and develop life skills. These engagements fostered both individual growth and collective support.

Community connectedness was repeatedly linked to improved mental, emotional, and even physical health. Focus group participants noted that knowing others share similar experiences helps reduce stress and promotes mental wellness.

While community support was praised, focus group participants also highlighted challenges in accessing social services. Some interactions with providers were described as transactional or unfeeling, underscoring the need for more compassionate, trauma-informed care.

Focus group participants valued the reciprocal nature of community—offering and receiving help, sharing lived experiences, and learning from one another. This mutual aid was especially important for navigating systems and accessing basic needs.

The focus group participant quotes illustrate several interwoven themes around *connectedness*, particularly in the context of community well-being, engagement, and resilience:

“Social engagement with specific communities, special events, or holiday events, allow us an opportunity to link up, share the experiences we go through, and share like resources that I might know [and that] another person might not know.”

"Community has saved my life this year.”

"Connections can help expedite access to social supports especially if one is new to the area."

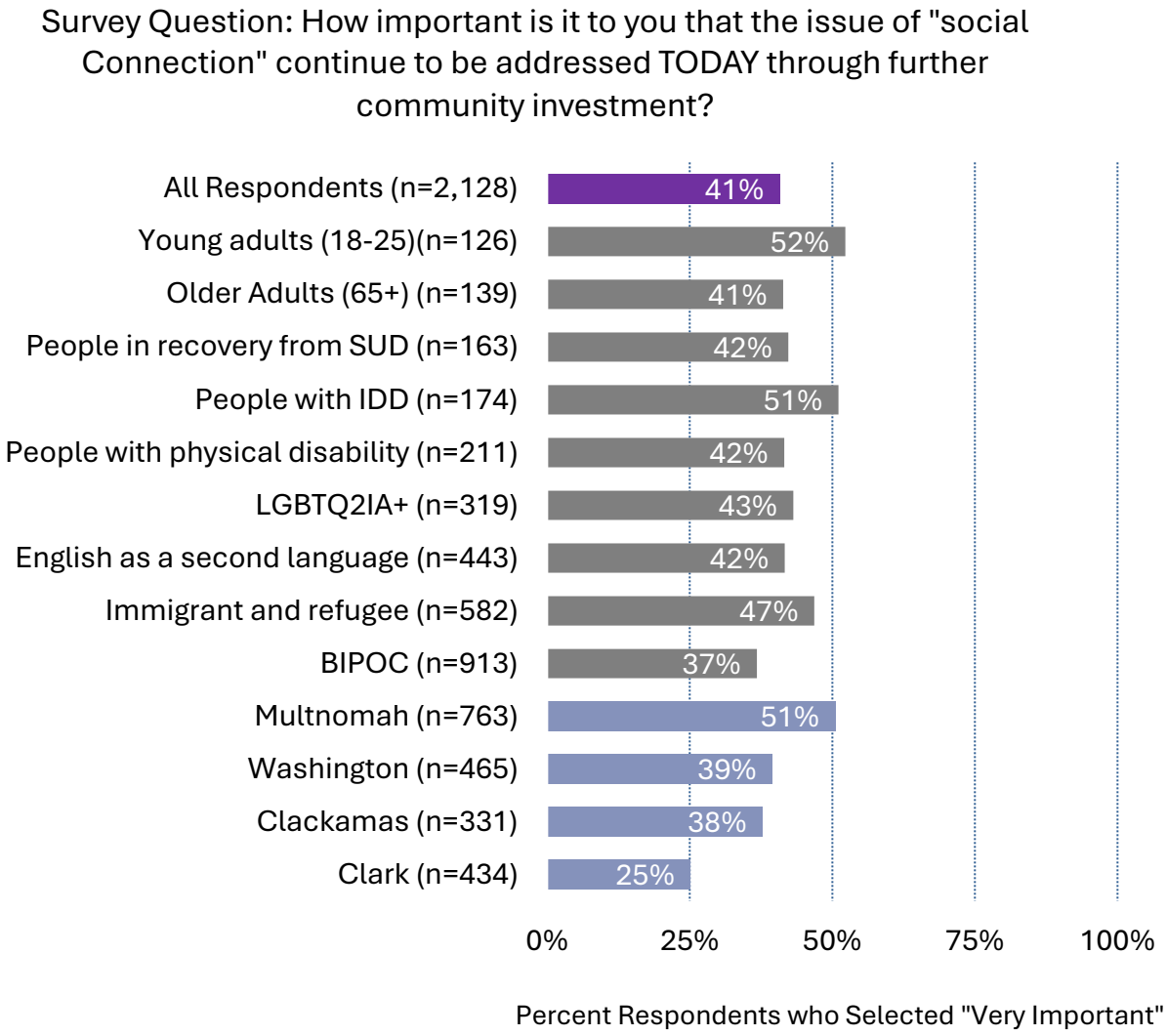
"Loneliness is a serious concern in our community [and] that is why social spaces like this [focus group] are helpful in helping people come together and share stories."

"It is important to gather like in this instance at this focus group. In-person gatherings like this help people open up more to share stories, seek support, learn about opportunities in the community but also strengthen unity. These social spaces also help with mental wellness because people lead very busy lives which can be very isolating."

"...one main thing I can think of is [that social connections have] impacted mental health and physical health and then emotional health as well in a positive way. Knowing that as a minority and young adult, you're not alone in any situation, and that there is someone out there or a community out there that has gone through some of your similar experiences. It is comforting when going out."

According to the survey, 41 percent of respondents indicated that "Social Connection" should continue to be addressed through additional community investment (**Figure 51**). Out of 13 priority issues, it was ranked eleventh. Young adults (18–25) and people with cognitive intellectual or development disabilities had the highest percentage of respondents rating social connection as "very important" at 52 percent and 51 percent, respectively. Survey respondents living in Multnomah were more likely to prioritize social connection (51%) than respondents living in other counties.

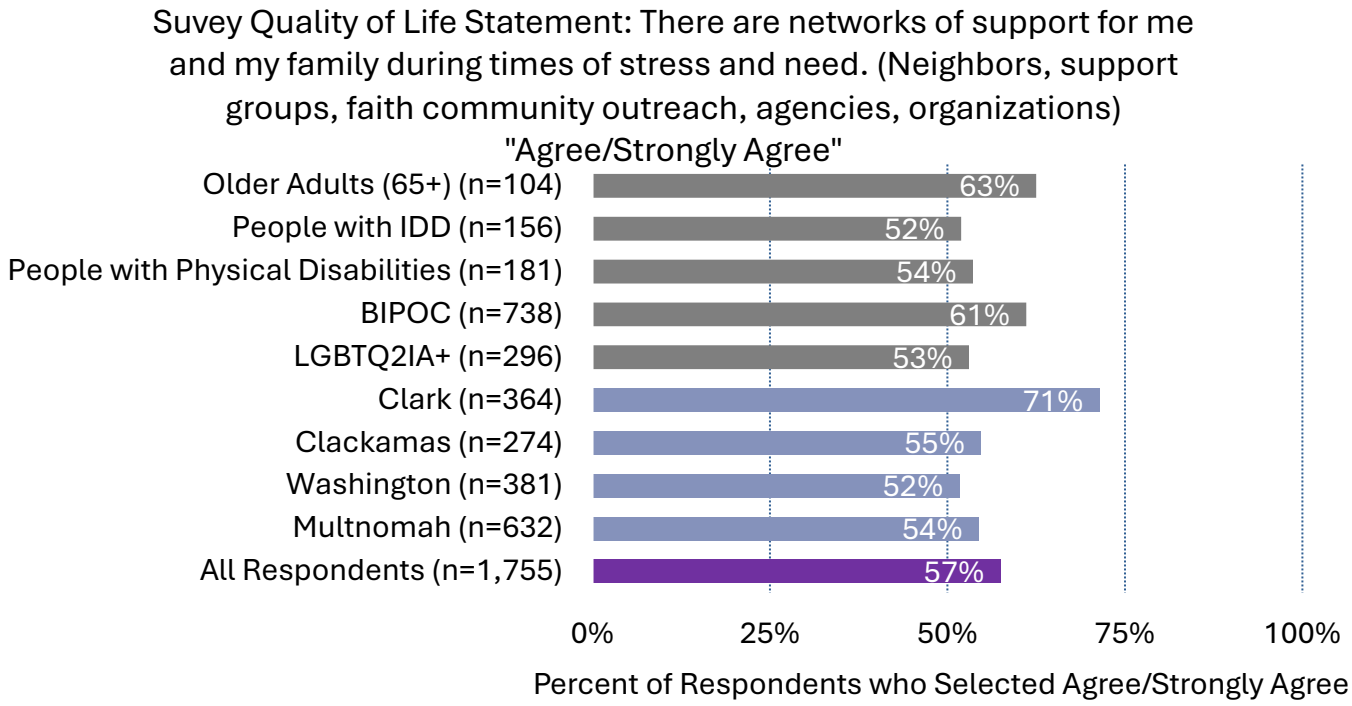
Figure 51. Social Connection as a Priority Issue for Investment by Focus Population



Source: HCWC Community Health Survey, 2024

More than half (57%) of the community survey respondents reported they strongly agreed/agreed with the statement that there are networks of support for them and their family during times of stress and need (**Figure 52**). Respondents from Clark showed the highest level of agreement, with 71 percent indicating that support networks are available. Agreement levels among BIPOC respondents were 61 percent, while older adult respondents reported a 63 percent agreement, both of which were higher than the overall respondent group.

Figure 52. Satisfaction with Networks of Support



Source: HCWC Community Health Survey, 2024

Emerging Issues in Support for Family and Community Ways

Issues emerged out of both the primary and secondary data collected and analyzed. Strong community connections were noted as critical for emotional and mental health, and resilience, especially during crises.

- Community events help build relationships, share resources, and develop life skills.
- Community focus group participants link their mental, emotional, and physical health to community connectedness.
- Challenges in accessing social services highlight the need for more compassionate, trauma-informed care.
- Mutual support within communities is crucial for navigating systems and accessing basic needs.
- Clark respondents show high satisfaction with support networks, and BIPOC and older adult respondents report higher agreement levels with their support networks than the overall respondent group.

Access to Culturally- and Linguistically-Responsive Health Care

Update 2025

All people

should be afforded access to health care that aligns with their cultural, behavioral, and communication needs.

ACCESS TO CULTURALLY AND LINGUISTICALLY RESPONSIVE HEALTH CARE UPDATE

All people should have access to health care that aligns with their cultural, behavioral, and communication needs. Community members described wanting to receive health care that does not solely focus on clinical needs but that is holistic, and person- and community-centered. Social, economic, and cultural factors shape how people access care. A health care system that considers these at individual, community, and population levels may enhance health, well-being, and access.

Figure 53 summarizes the key findings of the data reported in this section on *Access to Culturally and Linguistically Responsive Health Care*.

Figure 53. 2025 Update to Access to Culturally and Linguistically Responsive Health Care Priority Issues

Access to Affordable Health Care

In 2025, nearly 7 out of 10 survey respondents said affordable health care was one of the most important things to invest in. This was especially true for older adults, immigrants, and people with disabilities.

More than half of the people said high out-of-pocket costs make it hard to get care. LGBTQ2IA+ individuals and people recovering from substance use disorders were self-reportedly hit hardest.

Many people said expensive health care was one reason they don't trust the system.

Public insurance (like Medicare, Medicaid, and VA) went up from about 25% to 35% across the region. Medicaid coverage increased in Clackamas, while Multnomah saw a small decline.

Fewer people were uninsured in most places, but Clark County saw a small increase between 2022 and 2023.

Linguistically and Culturally Responsive Health Care

Just over half of people (51%) said it was important to have health care that respects their culture and language. This was especially important to people with disabilities and immigrant or refugee communities.

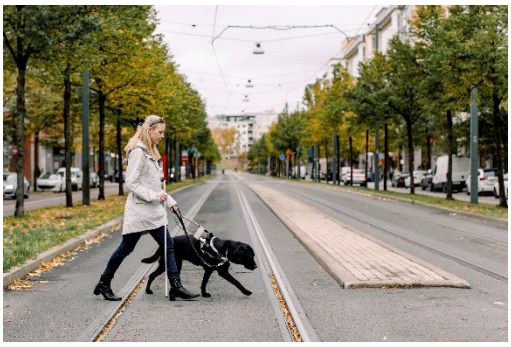
Nearly 1 in 5 survey respondents who had trouble getting care said they could not find a provider who respected their culture. Community focus group participants discussed language barriers, disconnected care, and not enough broad representation among providers as ongoing problems.

In both Oregon and Washington states, most health care professionals were still non-Hispanic White, and broad representation in the field has not improved much.

Trauma-informed Care

Nearly half of the people surveyed (49%) said trauma-informed care should be a priority. It ranked 7th out of 13 issues. Support was especially strong among people with disabilities, LGBTQ2IA+ individuals, and immigrant or refugee communities.

Focus groups highlighted issues like provider turnover, lack of follow-up, and judgmental care as barriers to trauma-informed services.



Trust in the Health Care System

Nearly half (45%) of survey respondents reported **trusting the health care system.**

Almost half of the respondents said they delayed or skipped care because they felt afraid or uncomfortable. This was especially true for people recovering from substance use and those with cognitive, intellectual, or developmental disabilities.

Common reasons included their age, insurance status, and religion. Focus groups also pointed to discrimination and systemic issues as major reasons people don't seek care when they need it.

Health Care Availability and Navigation (Emerging)

People said it was hard to access care because of long wait times, transportation problems, and confusing referral processes.

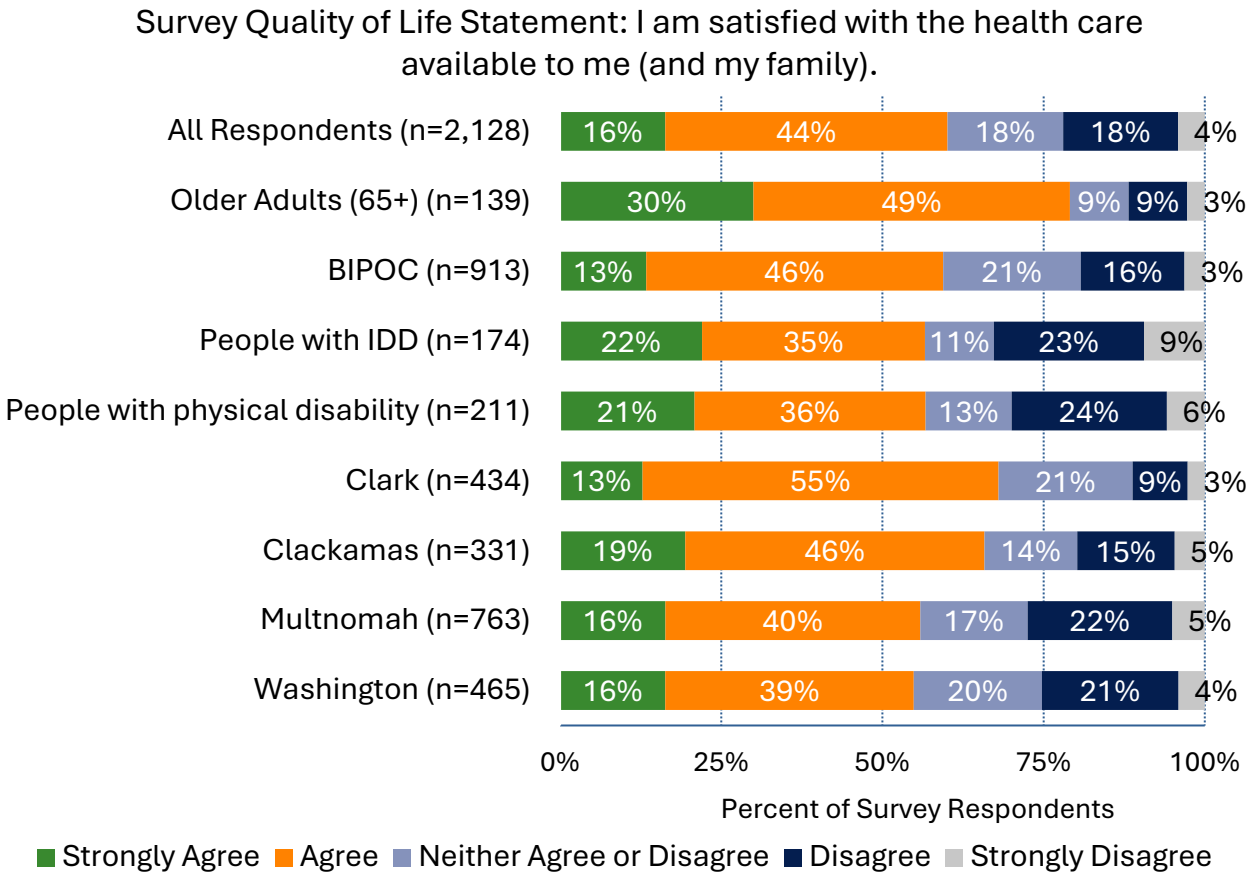
There were not enough dental, mental health, and primary care providers in the region. This means:

- Over 172,000 people could not get the dental care they needed.
- About 139,000 missed out on mental health care.
- Around 102,000 could not get primary care.

Survey results show that 60 percent of respondents were satisfied with their health care. Satisfaction varied by group (**Figure 54**): 79 percent of adults older than 65 were satisfied, while only 57 percent of those with cognitive or physical disabilities reported satisfaction.

Satisfaction with health care availability varied by region: Clark had the highest rate at 68 percent, followed by Clackamas at 65 percent. Multnomah and Washington were lower, with 56 percent and 55 percent agreement, respectively.

Figure 54. Health Care Satisfaction

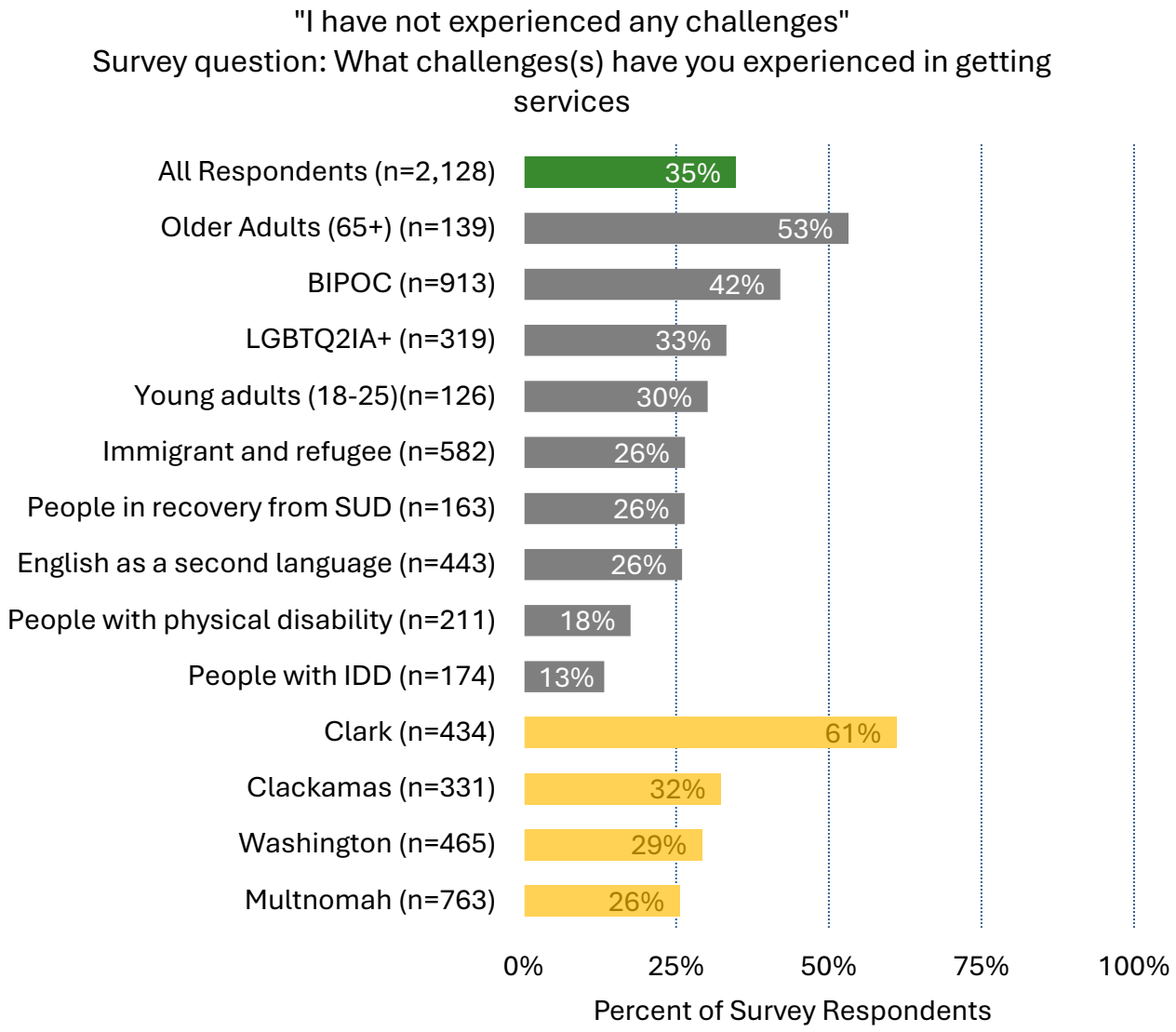


Source: HCWC CHNA Community Health Survey, 2025

Identifying and understanding the barriers that prevent people from accessing health care is a foundational step in improving community health. More than one third of survey respondents (35%, n=741) reported they had not experienced barriers when accessing health care services. (**Figure 55**). Older adults (65+) reported the easiest access (53%). In contrast, only 26 to 33

percent of LGBTIQ2IA+ people, young adults, immigrants/refugees, and those recovering from substance use reported no challenges to accessing health care. Difficulties were greatest for those with disabilities: just 18 percent of respondents with physical and 13 percent with IDD had none. Clark exceeded all others, with 61 percent reporting no challenges.

Figure 55. Did Not Experience Challenges Accessing Health Care

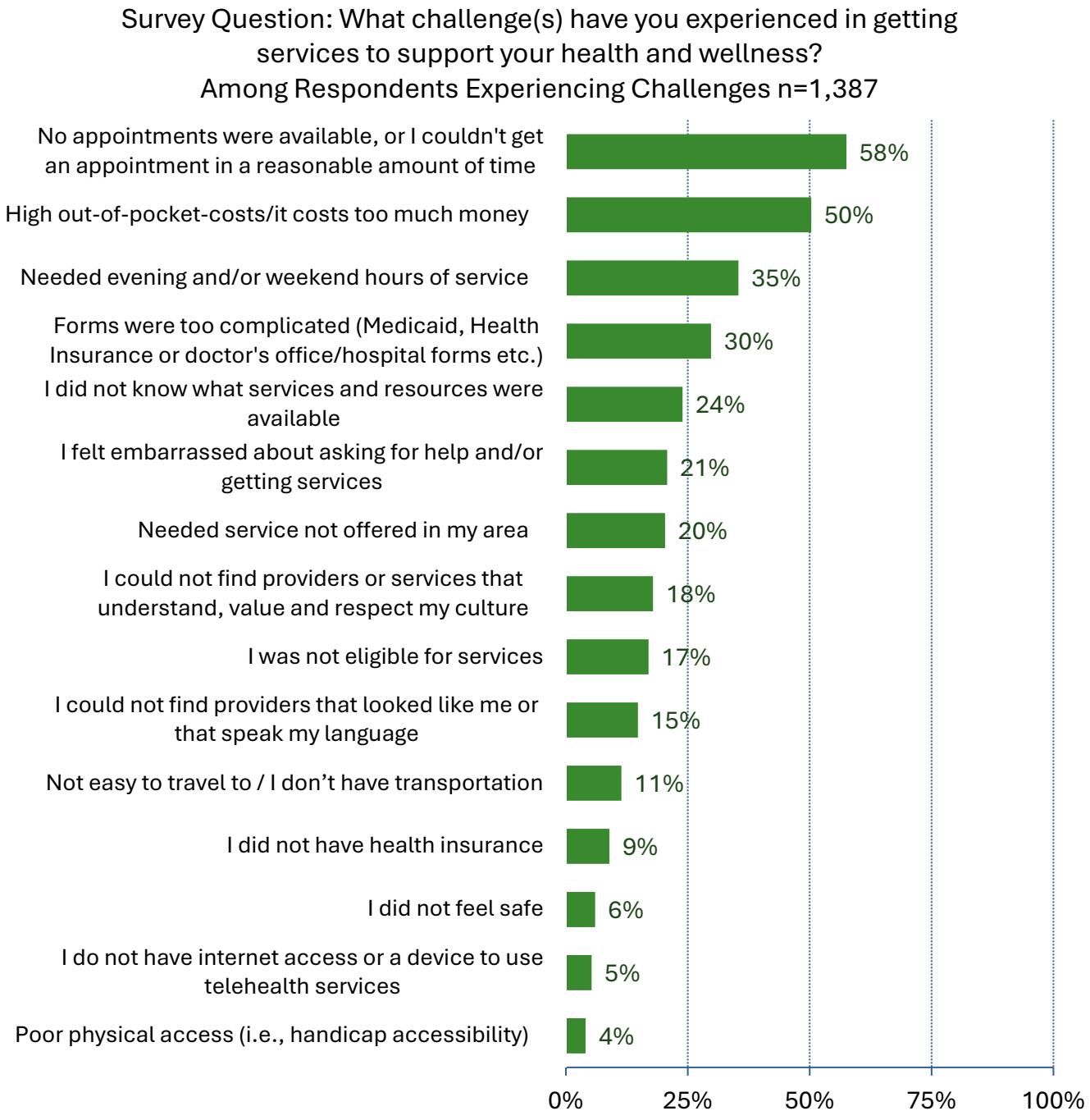


Source: HCWC CHNA Community Health Survey, 2025

The biggest barrier to health care among survey respondents was appointment unavailability (58%), followed by high out-of-pocket costs (50%), highlighting affordability as a persistent concern (**Figure 56**). Other frequently reported barriers included:

- Limited-service hours (needing evening and/or weekend hours) (35%)
- Complicated forms / paperwork (30%)
- Lack of awareness of available services (24%)
- Feeling embarrassed about asking for help or services (21%)

Figure 56. Barriers Experienced When Accessing Health Care Service



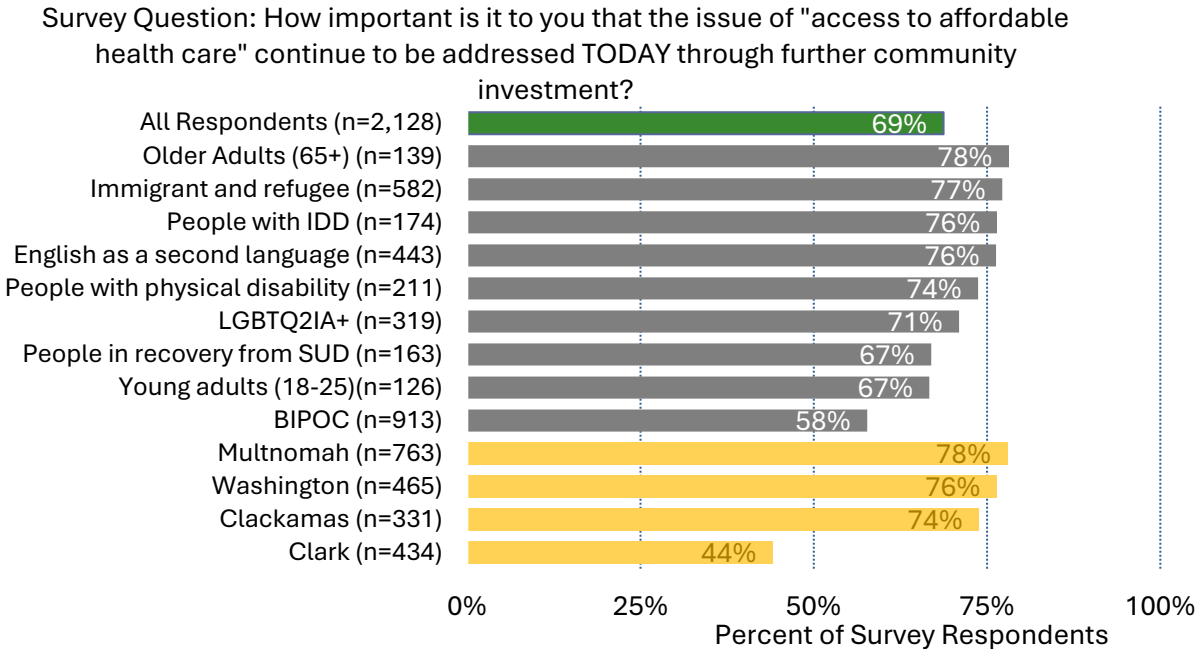
Source: HCWC CHNA Community Health Survey, 2025

Brief 1: Access to Affordable Health Care

Focus group participants expressed frustration with being uninsured or having insurance that did not cover the services they needed. Many also shared that, even when insured, the out-of-pocket costs for uncovered care made it unaffordable and inaccessible. Participants said health care providers focused more on profit than on patient care, resulting in reactive rather than preventive treatment.

Sixty-nine percent of survey respondents identified affordable health care as a top community investment priority (**Figure 57**), ranking it second out of 13 priority issues. Older adults (78%) and immigrants or refugees (77%) prioritized this issue most, followed by respondents with IDD (76%) and English language learners (76% each), and people with physical disabilities (74%). BIPOC respondents ranked it lowest at 58 percent, highlighting disparities in perceived access. Regionally, Multnomah respondents expressed the strongest support for continued investment in access to affordable health care (78%), followed closely by Washington (76%) and Clackamas (74%) counties. In contrast, only 44 percent of respondents in Clark rates this issue as very important, indicating a significant regional difference that may reflect differing local experiences or priorities.

Figure 57. Access to Affordable Health Care as a Priority Issue for Investment

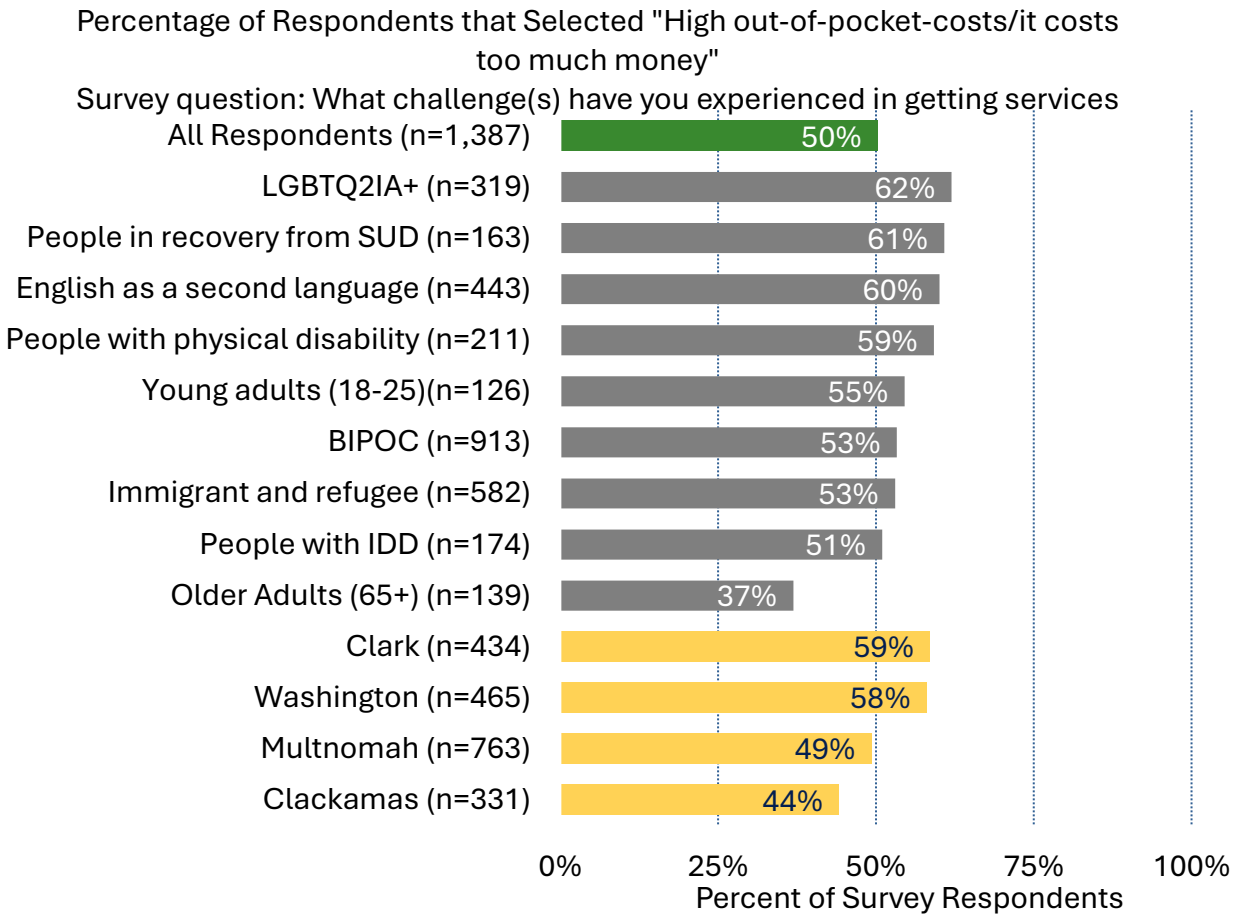


Source: HCWC CHNA Community Health Survey, 2025

When survey respondents were asked to identify challenges in getting services to support their health and wellness, of the respondents that have experienced challenges, half (50%) selected "high out-of-pocket costs/it costs too much money" as a barrier. This made it the second most frequently reported challenge.

High costs affected respondents unevenly, with some groups facing greater challenges affording care (**Figure 58**). Specifically, LGBTQ2IA+ individuals (62%), people in recovery from SUD (61%), people who speak English as a second language (60%), and people with a physical disability (59%) cited high out-of-pocket costs as a barrier. In contrast, only 37 percent of older adults (65+) reported cost as a significant barrier. Clark and Washington counties had the highest concern about high out-of-pocket costs (59% and 58%), while Multnomah and Clackamas were lower at 49% and 44%.

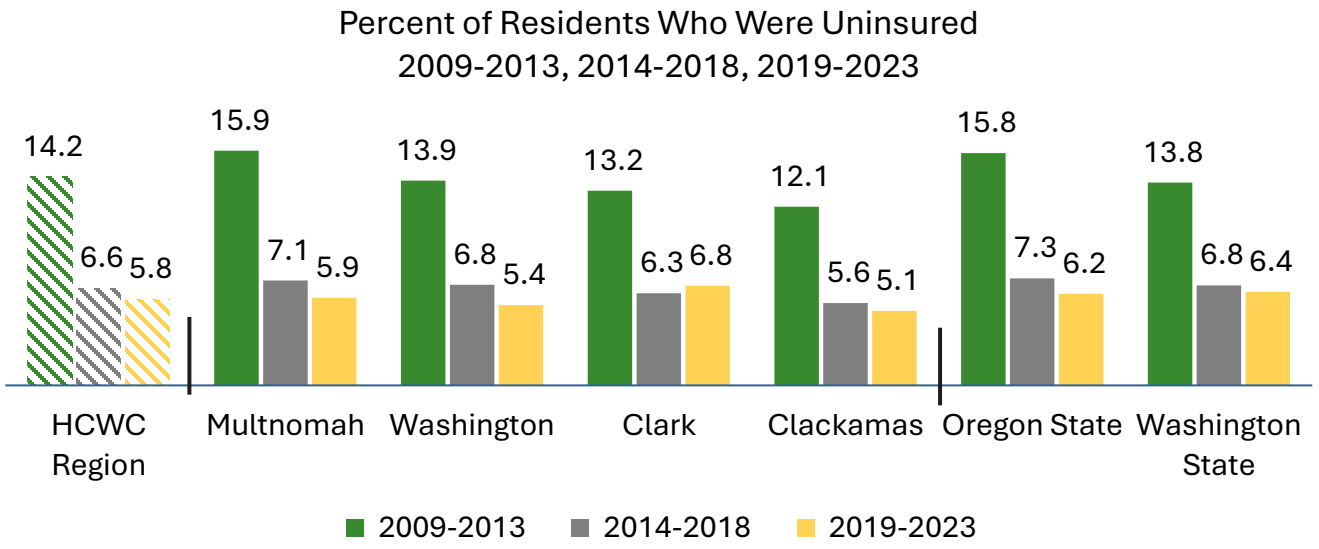
Figure 58. Challenges, High Costs, by Respondent Group



Source: HCWC CHNA Community Health Survey, 2025

Over the past fifteen years, 2009 to 2023, uninsured rates in the region fell from 14.2 percent (295,636 residents) to 5.8 percent (135,628 residents) (**Figure 59**). All counties saw declines except Clark, which rose from 6.3 percent (28,926 residents) to 6.8 percent (34,353 residents).

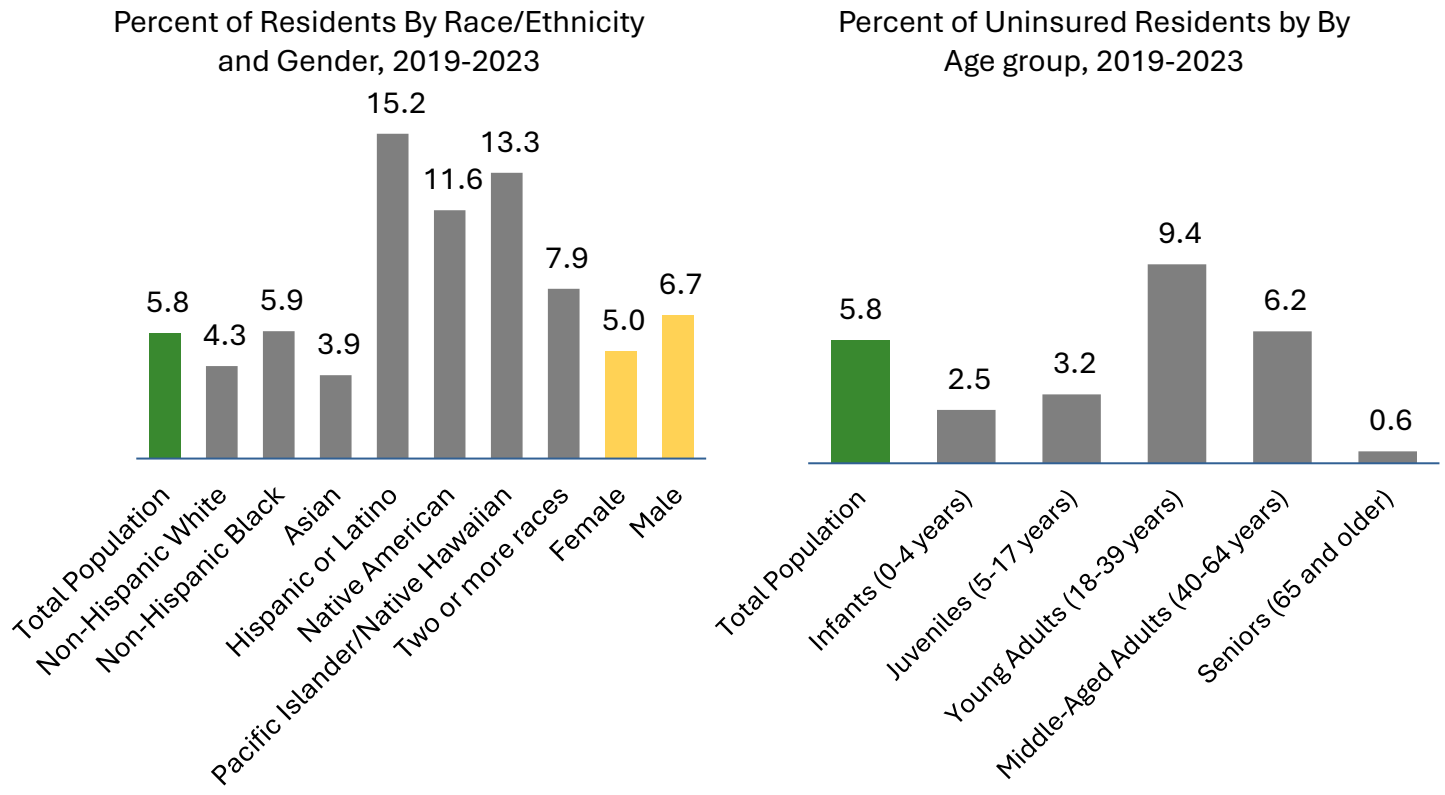
Figure 59. Percentage of Uninsured Residents



Source: U.S. Census Bureau, American Community Survey (ACS) Tables B27001/C27001 via Metopio

Regionally, Hispanic/Latino, Pacific Islander/Native Hawaiian, and Native American individuals have higher rates of being uninsured. Males were slightly more likely to be uninsured compared to females as shown in **Figure 60**. Adults (aged 18-39) had higher rates of being uninsured compared to other ages.

Figure 60. Regional Uninsured Rates by Race/Ethnicity, Gender, and Age, 2019-2023

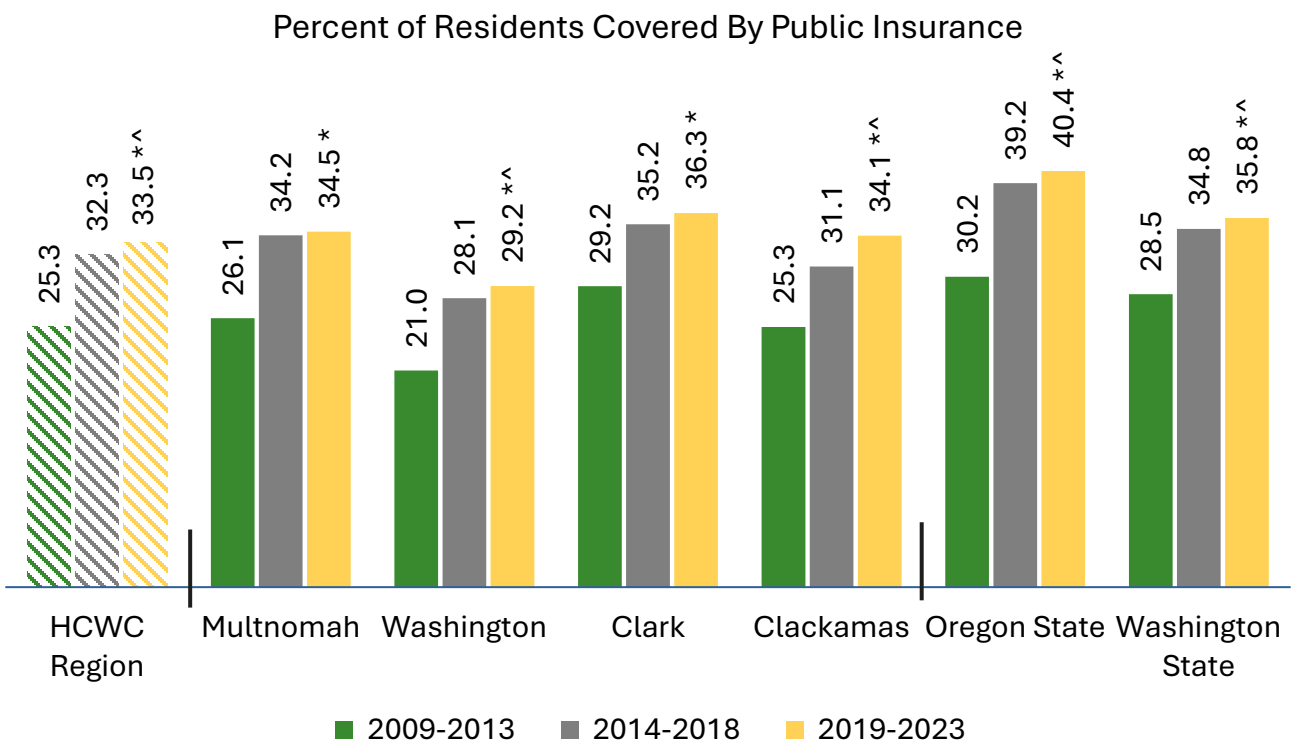


Source: U.S. Census Bureau, American Community Survey (ACS) Tables B27001/C27001 via Metopio

Public insurance coverage—Medicare, Medicaid, or Veteran Affairs Health Care—in the HCWC region rose from 25.3 percent (2009-2013) to 35.3 percent (2019-2023), as shown in **Figure 61.** Every county saw growth in public insurance access during this period.

- Clark had one of the highest public coverage rates, growing from 29.3 percent to 36.3 percent.
- Washington increased from 21.0 percent to 29.2 percent, though it consistently had the lowest public coverage rates in the region and remained significantly below the regional and state public coverage rate in 2019-2023.

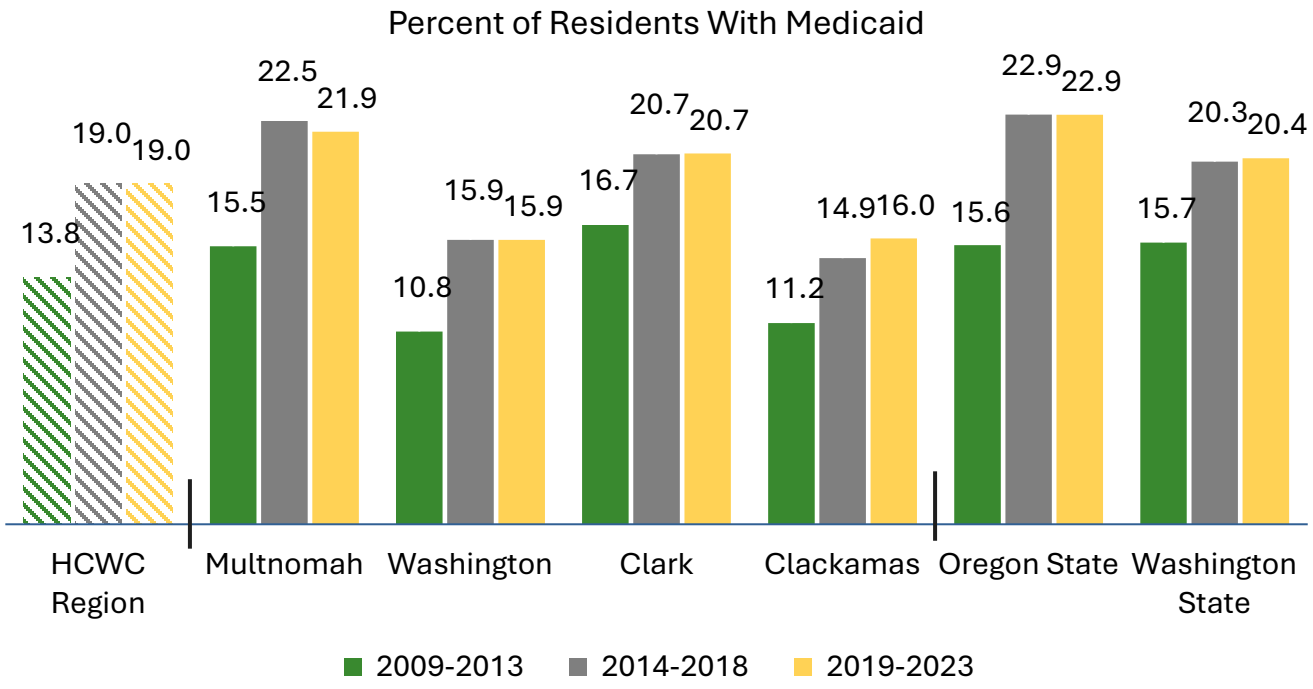
Figure 61. Publicly Insured Rate by Year



***Significant difference between 2009-2013 and 2019-2023. ^Significant difference between 2014-2018 and 2019-2023. Source: U.S. Census Bureau, American Community Survey (ACS), Tables S2704, S2701, and B27010 via Metopio**

Expanded Medicaid enrollment, especially after the Affordable Care Act in 2014, drove regional growth in public insurance coverage. Medicaid coverage rose from 13.8 percent (2009-2013) to 19.0 percent (2014-2018), then held steady throughout 2019-2023. Washington and Clark counties followed this pattern. Clackamas saw continuous increases: coverage jumped from 11.2 percent to 14.6 percent (2009-2018), then grew further to 16.0 percent by 2019-2023 (**Figure 62**).

Figure 62. Medicaid Insurance Rate, 2009 to 2023



Source: U.S. Census Bureau, American Community Survey (ACS), Tables S2704, S2701, and B27010 via Metopio

Brief 2: Linguistically and Culturally Responsive Health Care

Linguistically and culturally responsive health care refers to the delivery of services that are respectful of and tailored to the cultural beliefs, preferred languages, and communication needs of diverse populations. According to the U.S. Department of Health and Human Services' Office of Minority Health, this approach ensures that, "patients receive effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language."[29]

Focus group participants shared a range of experiences and challenges related to accessing culturally and linguistically responsive health care:

- Participants frequently described difficulties accessing care due to language challenges, including limited availability of interpreters (i.e., American Sign Language) and lack of culturally relevant health information in languages other than English. These challenges reportedly lead to misunderstandings and emotional exhaustion from having to repeatedly self-advocate.
- Many participants emphasized the need for providers who understand and respect their cultural background.

These quotes from focus group participants illustrate how language challenges and cultural disconnects may erode trust and create emotional and logistical burdens for some individuals in the region:

"There is a language barrier because most things are in English. Some people don't know how to ask for what they need because of a language barrier. The doctors aren't taking the time. Even if we help someone with a language barrier, the next person we send them to isn't as willing to do so and we end up seeing them a week later in the same spot."

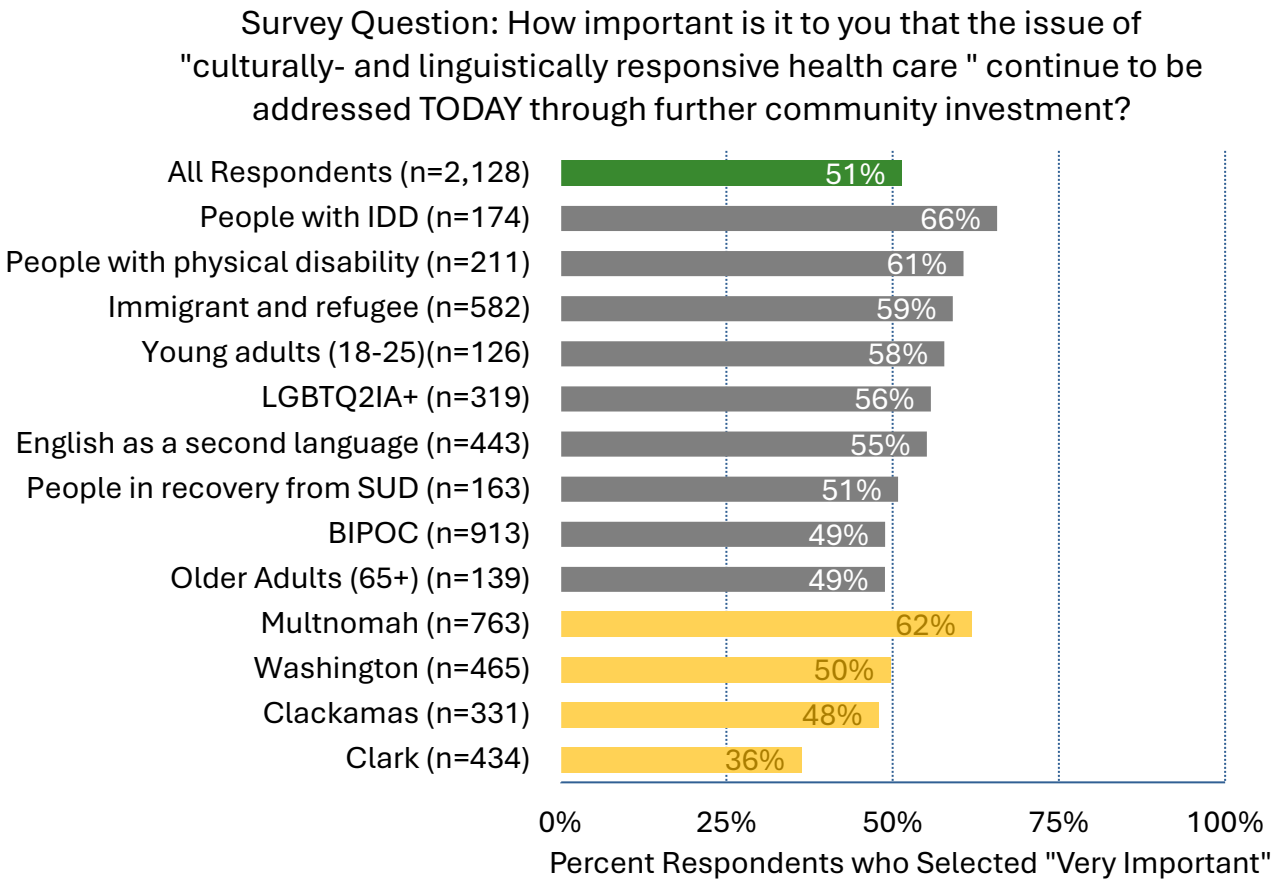
"Where we come from, they [doctors] start at the end – they see what has been going on with you. Here, every time you go [to the doctor], it's like you are starting from the beginning."

"I always wanted a doctor that looked like me, but they didn't have cultural competency, I felt like because of my past incarceration I was given the basics and then kicked out, [and received] no aftercare."

Of all survey respondents, 51 percent indicated that "culturally and linguistically responsive health care" was very important to address through additional community investment. Out of 13 priority issues, it was ranked fifth. Prioritization of this issue varied across population groups and counties (**Figure 63**):

- People with IDD (66%), people with physical disabilities (61%) and immigrant and refugee communities (59%) prioritize "culturally and linguistically responsive health care" more so than other respondents.
- Geographically, Multnomah respondents prioritized "culturally and linguistically responsive health care" the most (62%), while Clark reported the lowest prioritization (36%).

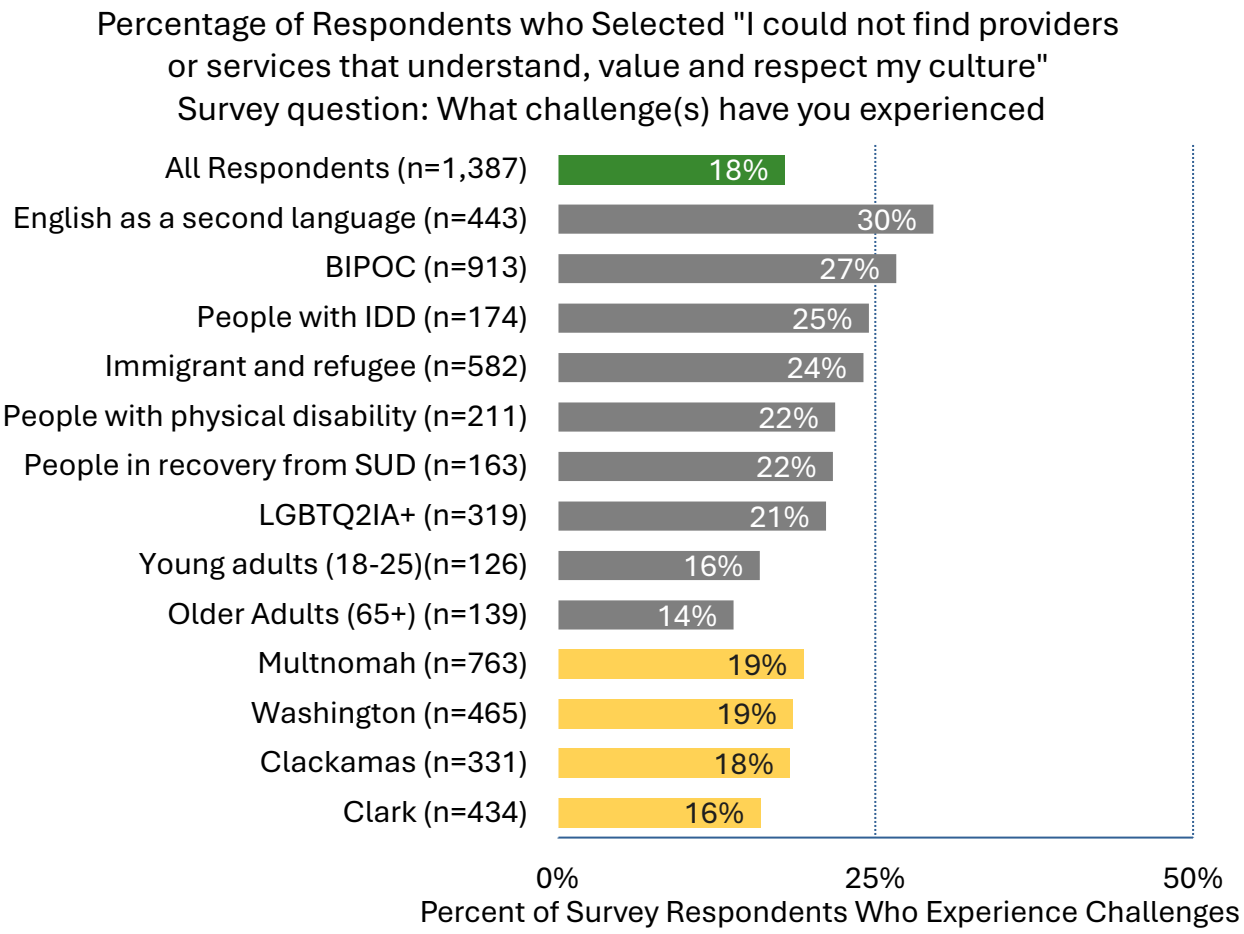
Figure 63. Culturally and Linguistically Responsive Health Care as a Priority Issue for Investment



Source: HCWC CHNA Community Health Survey, 2025

In the survey, 18 percent (n=248) of respondents who faced obstacles said they could not find culturally respectful providers or services, ranking this seventh among 14 options. This obstacle had a notable effect on certain population (**Figure 64**). Nearly 30 percent of respondents who speak English as a second language reported this barrier, followed closely by BIPOC respondents (27%), individuals with IDD (25%), and immigrant and refugee communities (24%). There was little variation geographically.

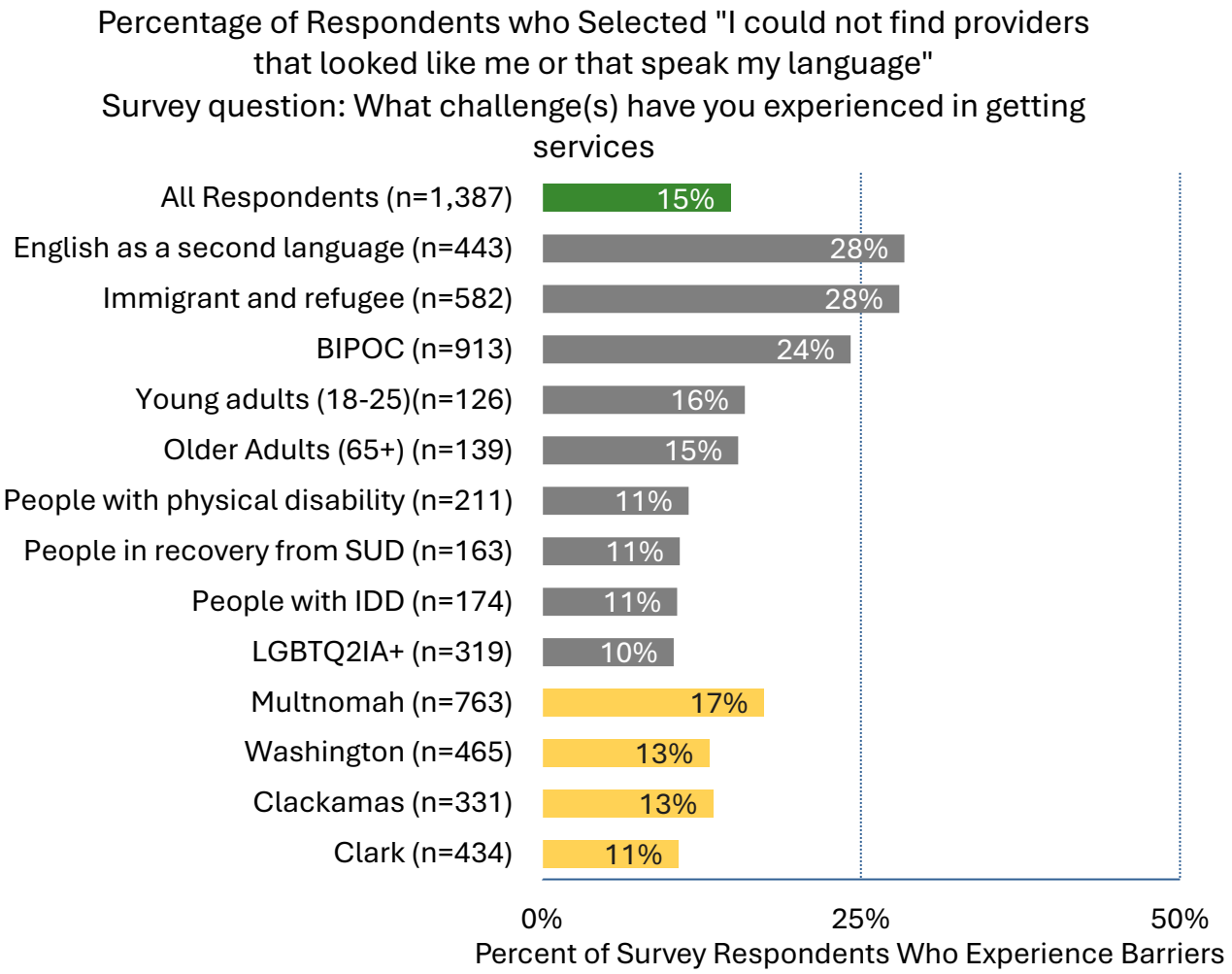
Figure 64. Challenges, Culturally Relevant Care, by Respondent Groups



Source: HCWC CHNA Community Health Survey, 2025

Of those who faced challenges, 15 percent (n=205) could not find a provider matching their language (**Figure 65**). Though this was the ninth most common of 14 challenges. One in five households (188,727 households or 20.2%) in the region speak a language other than English. The most common languages spoken were Spanish followed by Asian and Pacific Islander languages.

Figure 65. Challenges, Provider Representation and Language, by Respondent Groups



Source: HCWC CHNA Community Health Survey, 2025

Workforce representation among health care providers in Oregon and Washington states remains limited across key professions, including mental health professionals (psychologists and social workers), dentists, and physicians (**Figures 66, 67, and 68**). In both states, most providers identify as non-Hispanic White, with relatively low representation from Hispanic/Latino, Black, and individuals identifying as other or multiple races. Asian providers were more represented in Washington State than in Oregon State across all three provider types.

Figure 66. Race/Ethnicity of Psychologist and Social Workers (combined), Washington & Oregon, 2018-2022

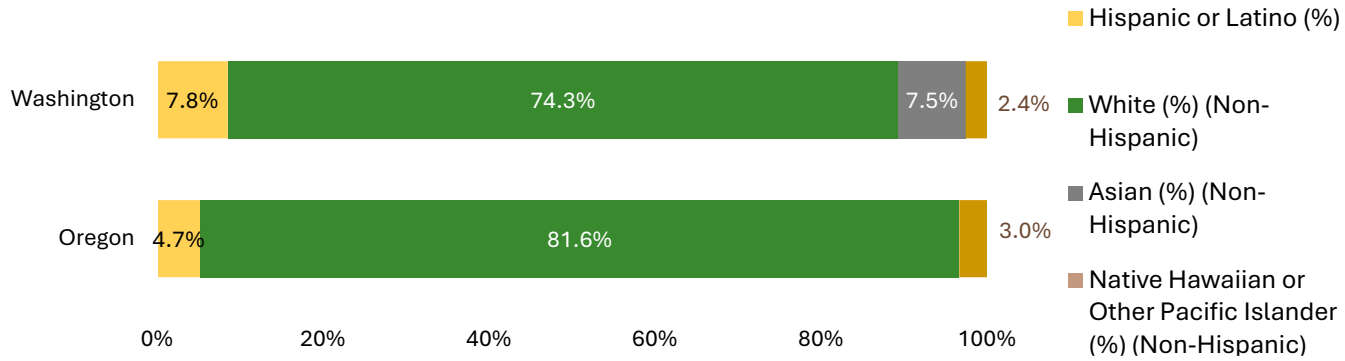


Figure 67. Race/Ethnicity of Dentist, Washington & Oregon, 2018-2022

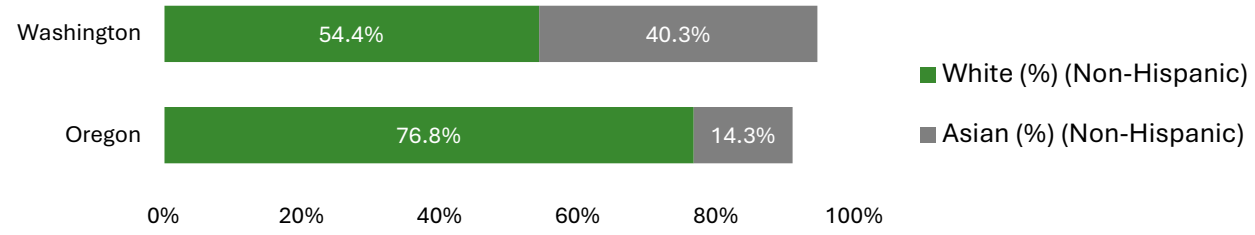
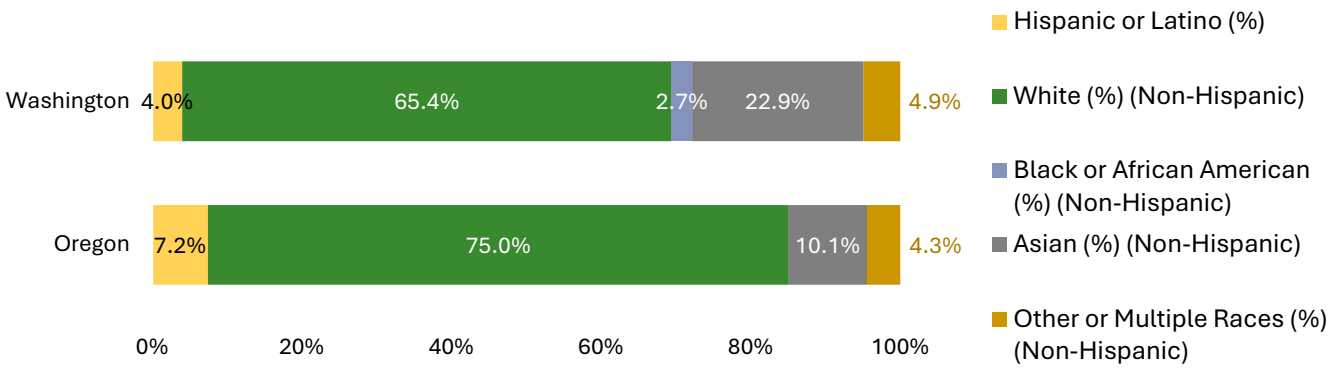


Figure 68. Race/Ethnicity of Physicians, Washington & Oregon, 2018-2022



Note: Race and ethnicity groups with no rates was suppressed due to small numbers.
Source: American Community Survey PUMS 2018-22. Retrieved from Department of Health and Human Services, Health Resources and Services Administration, Health Workforce Demographics Dashboard.

Brief 3: Trauma-informed Care

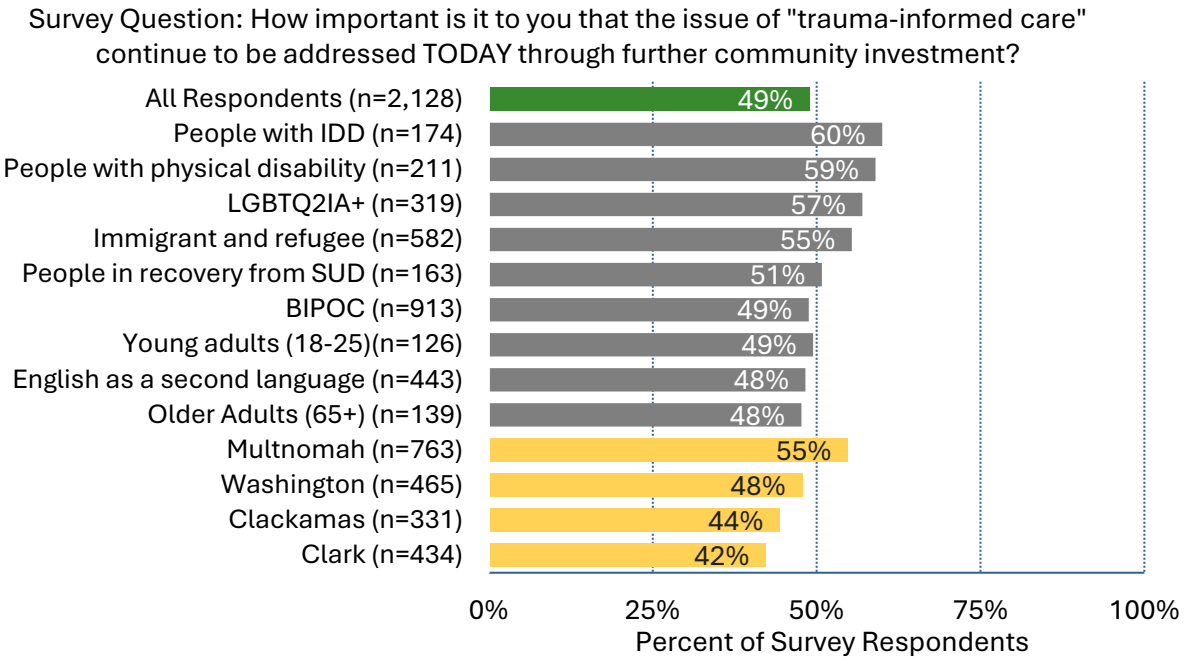
Focus group participants expressed concerns about insufficient mental health services, specifically the difficulty of finding culturally competent and trauma-informed support as illustrated by the following quotes:

"How frustrating it is for people with serious mental health issues to keep having to change [doctors]. It's like rehashing your trauma and your story."

"More so than [being given] a prescription, she would like the doctor to follow up on how she is doing."

Half of survey respondents (49%) considered ongoing community investment in trauma-informed care very important, ranking it seventh among 13 priorities. Support for trauma-informed care was highest among people with IDD (60%), followed by those with physical disabilities (59%), LGBTQ2IA+ individuals (57%), immigrants and refugees (55%), and people in recovery from SUD (51%). Support ranged from 55 percent in Multnomah to 42 percent in Clark (**Figure 69**).

Figure 69. Trauma-Informed Care as a Priority Issue for Investment



Source: HCWC CHNA Community Health Survey, 2025

Brief 4: Trust in the Health Care System

Focus group participants reported delaying or avoiding health care because of discrimination related to race, gender, sexual orientation, socioeconomic status, appearance, and insurance, as illustrated by the following quotes:

> **"Medical professionals make assumptions about folks who 'look homeless'."**

> **"Hospitals tended to be very judgmental based on being an addict and abscesses, [giving me the] basic level of care and then booting me out the door immediately."**

Trust in the health care system is a foundational component of community health. When individuals feel confident that health care providers and institutions will meet their needs and support their well-being, they are more likely to seek care, follow medical advice, and engage in preventive health behaviors.[30]

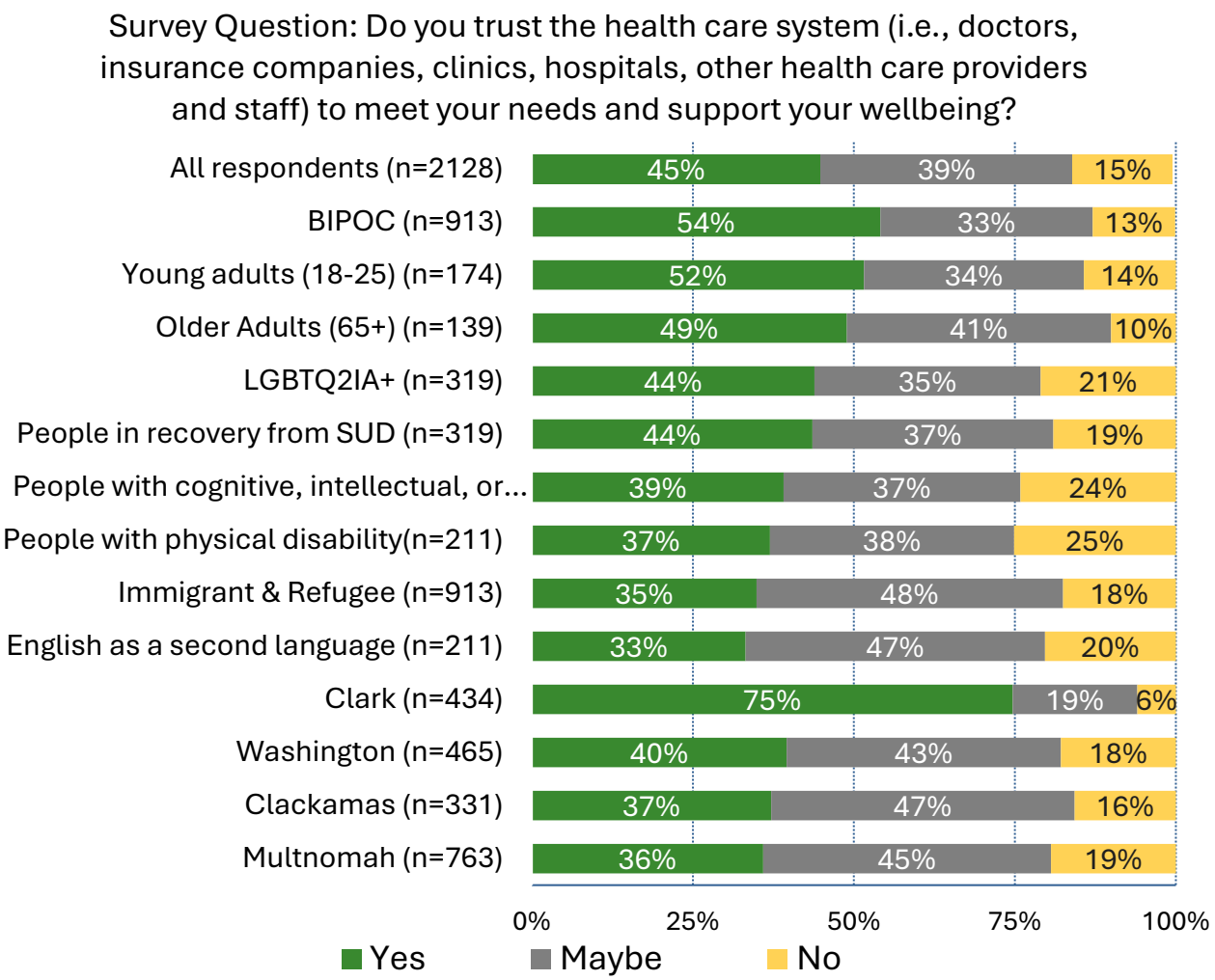
Among all survey respondents, fewer than half (45%) reported that they trust the health care system. A substantial portion (39%) responded "maybe," indicating uncertainty or conditional trust, while 16 percent explicitly stated that they do not trust the system. These findings suggest that while many community members were open to trusting health care institutions, some remained hesitant (**Figure 70**).

Trust levels varied notably across counties. Clark stood out with the highest level of trust, where nearly 75 percent of respondents responded "yes" that they trusted the health care system. This contrast sharply with the Oregon counties, where most respondents selected "maybe" or "no".

The survey responses also revealed disparities in trust across demographic groups:

- BIPOC respondents, young adults (18-25), and older adults (65 years or older) reported relatively higher trust, with 54 percent, 52 percent, and 49 percent respectively answering "yes".
- Groups that reported the most distrust or highest percentage of respondents selecting "no" were people with physical disabilities (25%), people with IDD (24%), and those who spoke English as a second language (20%).

Figure 70. Survey Respondents Trust in Health Care System



Source: HCWC CHNA Community Health Survey, 2025

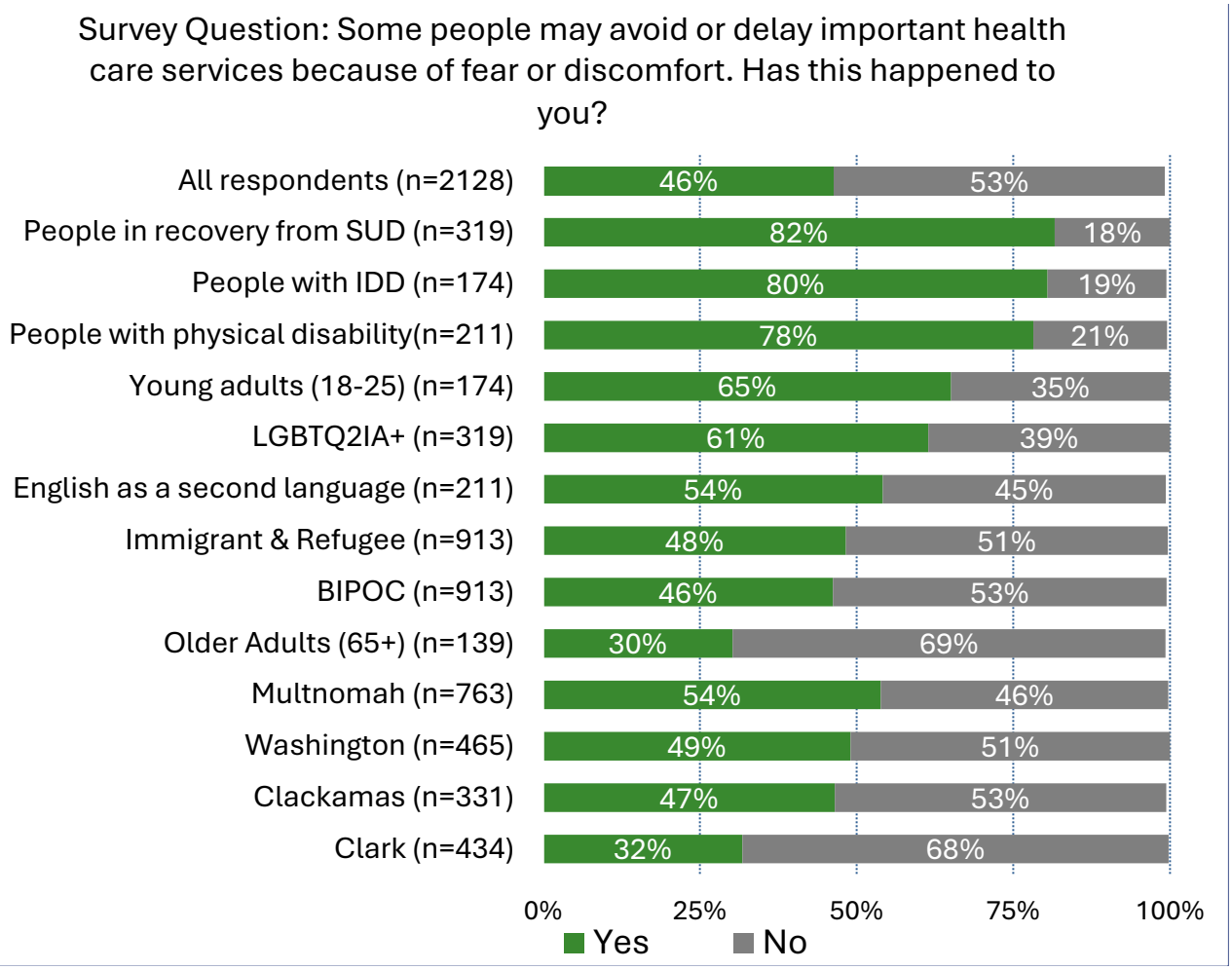
The follow-up survey question, which invited respondents to explain their answers about trust in the health care system, revealed several key themes highlighting both systemic and personal obstacles to trust. 1,110 respondents wrote a response. Themes of these responses include:

- **Access and availability:** Respondents cited long wait times for appointments, difficulty accessing specialists, and delays in diagnosis testing. These obstacles were especially pronounced for individuals with chronic conditions. Many reported resorting to urgent care due to the unavailability of primary care providers.
- **Insurance and financial burden**: Distrust of insurance companies was a prominent theme. Respondents described high premiums, coverage denials for necessary treatments, and nontransparent billing practices. Many felt the system prioritizes profit over patient care, with insurance companies acting as gatekeepers to essential services.
- **Quality of care and provider relationships:** Experiences with health care providers varied widely. While some respondents praised individual doctors for their professionalism and empathy, others described rushed appointments, misdiagnoses, and a lack of follow-through. A recurring concern was that providers often failed to listen to patients or take their concerns seriously.
- **Cultural competence and language obstacles**: Respondents from diverse cultural and linguistic backgrounds reported feeling misunderstood. Language challenges, inadequate interpreter services, and a lack of culturally responsive care contributed to feelings of exclusion or mistrust.
- **Systemic and structural issues**: Many respondents viewed the health care system as bureaucratic, profit-driven, and reactive rather than preventative. They expressed frustration with a system that emphasizes medication over holistic or root-cause approaches and that often fails to coordinate care effectively.
- **Discrimination and bias**: Several respondents shared experiences of discrimination based on race, gender, weight, or sexual orientation. These experiences contributed to a sense of isolation and reinforced distrust in the system.

Despite widespread concerns, some respondents reported positive relationships with individual providers. Trust was often built over time through consistent, respectful, and attentive care.

Nearly half of the survey respondents (46%) reported delaying or avoiding health care due to fear or discomfort. The highest rates of avoidance were reported by people in recovery from SUD (82%), people with IDD (81%), and people with physical disabilities (78%) (**Figure 71**). Other groups who reported elevated rates of avoidance included young adults (18-25) (65%), LGBTQ2IA+ individuals (61%), people who speak English as a second language (54%), and individuals who identify as an immigrant or refugee (48%). In contrast, older adults (65+) reported the lowest rates of avoidance (30%). Geographically, Multnomah had the highest rate of avoidance among the counties (54%).

Figure 71. Survey Respondents Delay or Avoided Care



Source: HCWC CHNA Community Health Survey, 2025

In the community survey, respondents were asked to identify the factors contributed to their decision to delay or avoid care, and the most reported reasons were:

- Age (32%)
- Insurance status (30%)
- A factor not listed (23%)
- Religion or spiritual beliefs (26%)
- Ethnicity (22%)

Emerging Issues in Access to Culturally and Linguistically Responsive Health Care

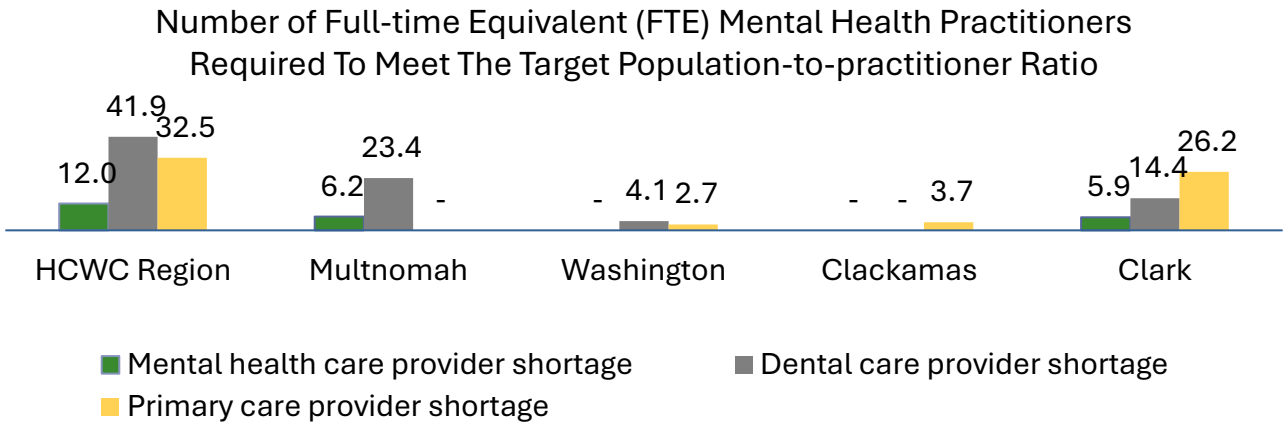
Primary and secondary data revealed concerns about health care availability and system navigation. Focus group participants reported frustration with limited access to specialists, geographic challenges, and delays in treatment, highlighting ongoing systemic challenges, as illustrated by these quotes:

> **"Now it took me probably eight months to find nephrologist and we don't have a nephrologist for so long with medical issues. It can lead to some pretty serious consequences."**

> **"Along with like not enough appointments. I've also noticed that there's not that many offices. There's not like a big quantity of offices here in Clark County. I have a friend who has a different provider, and their office is all the way in Salmon Creek and that became an issue when they didn't have transportation, and so it ended up piling on top of that [individual's health need], transportation was something stressful."**

According to 2024 data from Health Resources and Services Administration (HRSA), the region continues to experience notable shortages in dental, mental health, and primary care providers. These shortages are measured in full-time equivalent (FTE) practitioners needed to meet the recommended population-to-provider ratios as shown in **Figure 72.** The HCWC region faces the most acute shortages in dental care (deficit of 41.9 FTEs), followed by primary care providers (shortage of 32.5 FTEs), then mental health care (gap of 12.0 FTEs).

Figure 72. Provider Shortage in HCWC Region, 2024



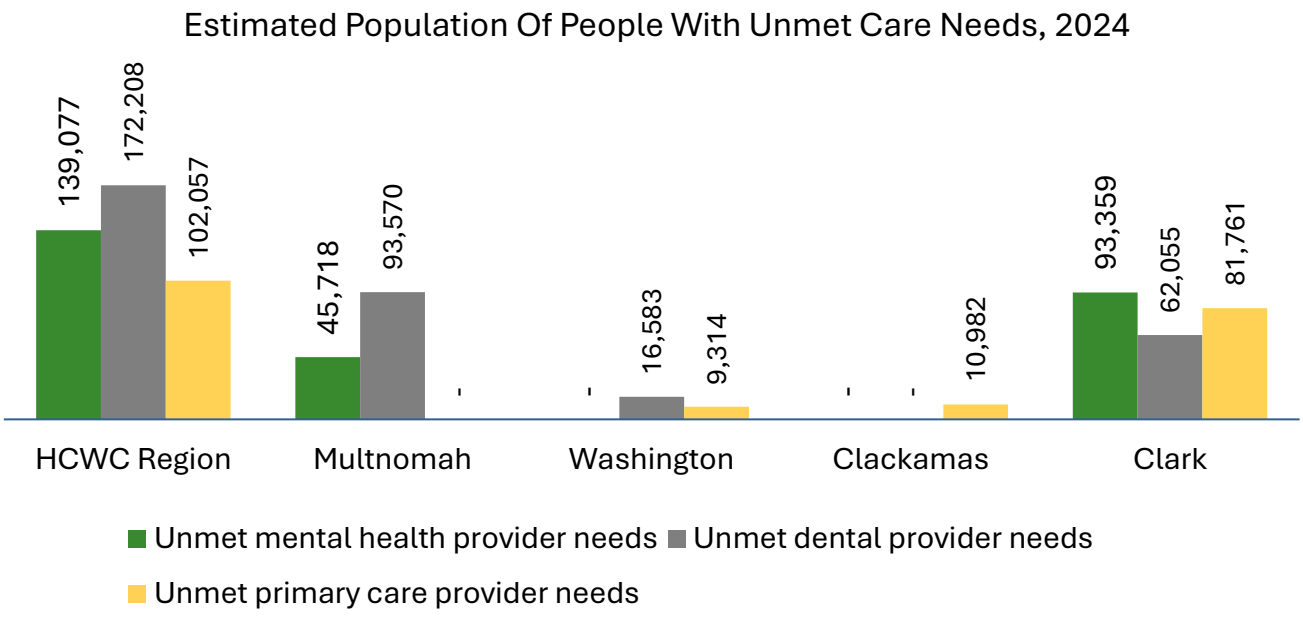
Source: Health Resources and Services Administration, Health Professional Shortage Area

Provider shortages are not just a workforce issue -- they directly affect the health of thousands of residents across the region. According to the HRSA Health Professional Shortage Area (HPSA) data, the HCWC region faces substantial unmet care needs across all major service areas (**Figure 73**).

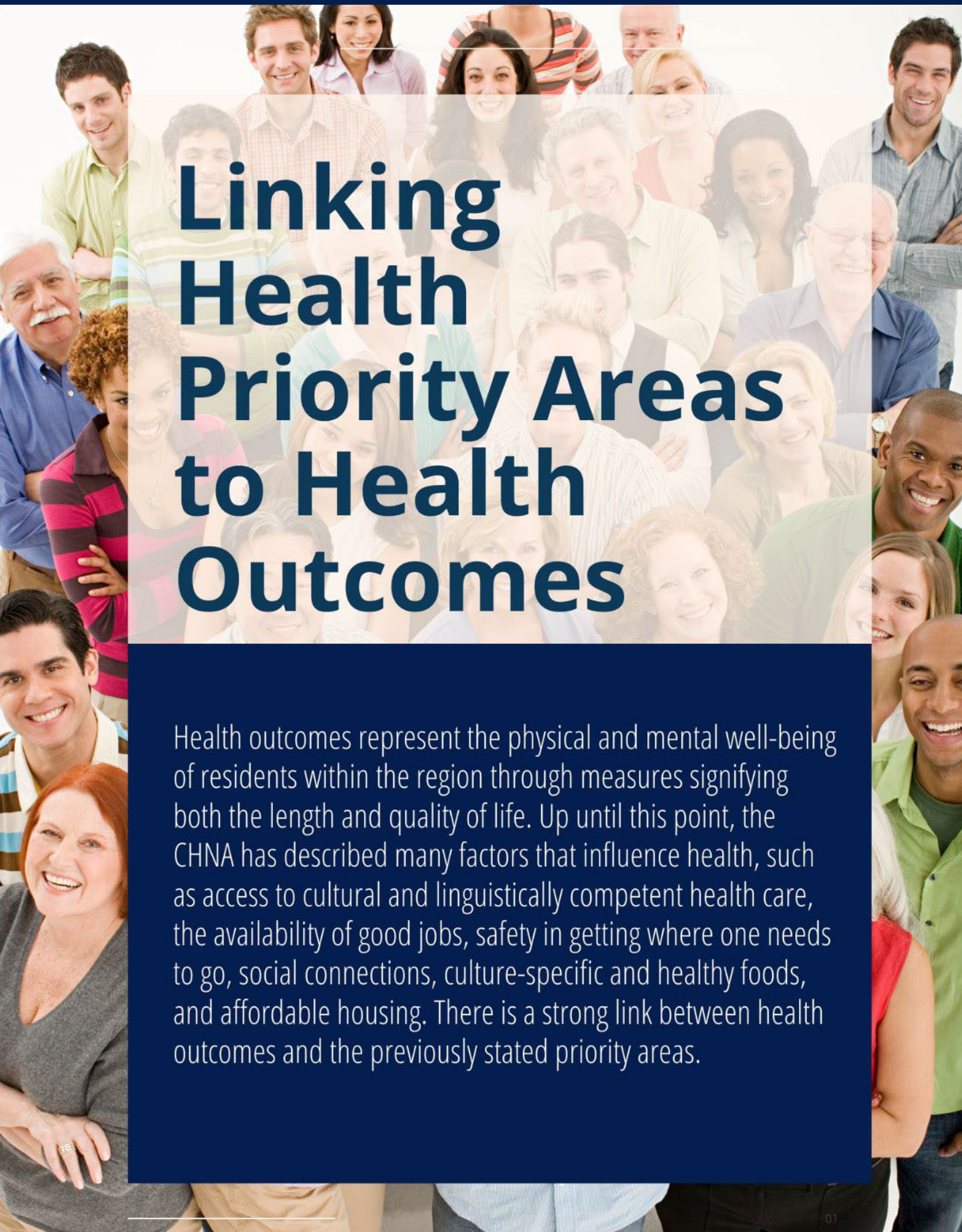
- Dental care: Approximately 172,208 people have unmet dental care needs
- Mental health: An estimated 139,077 people are not receiving needed mental health services.
- Primary care: Over 102,000 people are estimated to lack access to adequate primary care.

When provider capacity is stretched, it becomes more difficult to ensure that services are linguistically accessible and culturally responsive, especially for populations with limited English proficiency and BIPOC communities. Too few providers who reflect or understand the cultural backgrounds of the community they serve can lead to delays in care, miscommunication, and lower satisfaction.[31]

Figure 73. HCWC Region Count of the Population with Unmet Care Needs, 2024



Source: Health Resources and Services Administration, Health Professional Shortage Area



Linking Health Priority Areas to Health Outcomes

Health outcomes represent the physical and mental well-being of residents within the region through measures signifying both the length and quality of life. Up until this point, the CHNA has described many factors that influence health, such as access to cultural and linguistically competent health care, the availability of good jobs, safety in getting where one needs to go, social connections, culture-specific and healthy foods, and affordable housing. There is a strong link between health outcomes and the previously stated priority areas.

LINKING HEALTH PRIORITY AREAS TO HEALTH OUTCOMES

This section identifies the trends in key health behaviors and health outcomes since the 2022 CHNA.

Health Issue	Key Health Concerns
Lower life expectancy	• Regionally, life expectancy dropped significantly between 2016–2018 and 2020–2022. • Non-Hispanic Black residents had the lowest life expectancy; Asian residents had the highest.
Rising mortality rates	• Age-adjusted mortality increased across all counties from 2018 to 2023, from 655.0 deaths per 100,000 people to 846.7 deaths per 100,000. • Regionally, the top five causes of death remained the same since 2019, including cancer, diseases of the heart, stroke, accidents (unintentional injury) and chronic lower respiratory disease. • Increases were driven by cancer, heart disease, and injuries (unintentional), homicide, motor vehicle, diabetes, and alcohol. Firearm related mortality increased in the region between 2014 and 2023.

Declining physical health	• The percentage of adults (18+ years) reporting poor physical health declined from 12.1% in 2018 to a low of 8.5% in 2020, before increasing significantly to 10.9% by 2022.
	• Chronic disease conditions among adults in the region were stable from 2018 to 2022, indicating persistent health concern.
	  ○ Asthma affected nearly one in four adults (23%) by 2022.
	  ○ Diabetes was prevalent among 8.5% of adults by 2022.
	  ○ Approximately, one in 20 adults were affected by heart disease (5.3%) and/or COPD (5.0%) in 2022.

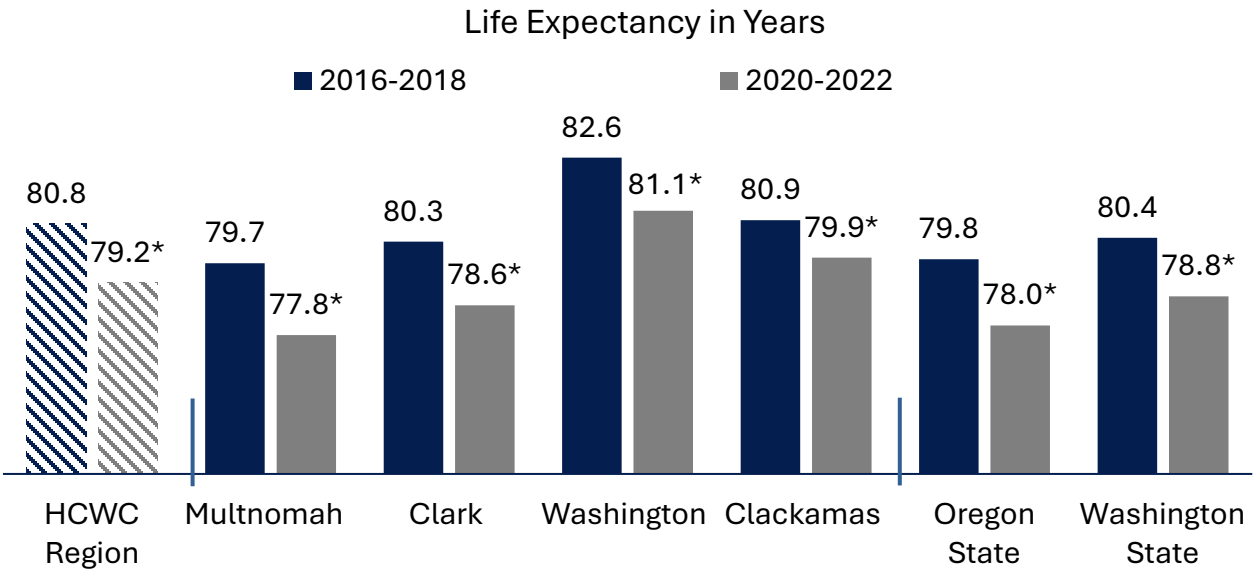
Substance use	• Binge drinking remained high (~20%) in the HCWC region. • Drug overdose mortality in the region increased significantly between 2018 and 2023, from 12.6 deaths per 100,000 in 2018 to 44.4 deaths per 100,000 in 2023.

Health Issue	Key Health Concerns
Mental health challenges	• Between 2018 and 2022, self-reported poor mental health and depression among adults (18+ years) in the region increased. • Youth depression increased, especially among grade 11 students. • Suicidality rates among both grades 8 and 11 students peaked around 2019 and then declined by 2022. Grade 11 students consistently reported higher rates than grade 8 students, though the gap narrowed in 2022. • Suicide mortality increased in the region between 2010-2014 to 2019-2023, particularly in Multnomah, among White adults and adults aged 18–39.
Maternal and child health risks	• Birth and teen birth rates declined, while maternal risk factors (e.g., hypertension, diabetes, tobacco use) increased between 2016-2020 and 2019-2023. • Native American/Alaskan Native and Pacific Islander/Native Hawaiian populations had the highest maternal risk rates in 2019-2023. • Prenatal care utilization remained stable, with approximately eight in 10 pregnant individuals receiving care during both 2017–2019 and 2020–2022. However, Clark County and Washington State reported lower rates, falling below 80%. • Black infants had higher rates of preterm and low birth weight births regionally.
Dental care access	• Nearly seven in 10 adults visited a dentist in 2022, which remained stable between 2018 and 2022
Communicable disease burden	• Consistently, between 2019 and 2022, sexually transmitted infection (STI) rates in the HCWC region were higher than state averages. • Multnomah had the highest STI incidence, Clackamas had the lowest. • Syphilis rates nearly doubled in the region from 2018 to 2022. • In 2022, non-Hispanic Black residents in the region had the highest STI rates.
Childhood immunization rates	• In Oregon, immunization coverage peaked in 2020 but declined slightly afterward. • Washington County maintained the highest rates.

Length of Life

Life expectancy describes the average number of years people are expected to live. Life expectancy has significantly decreased between 2016-2018 and 2020-2022 across all counties in the HCWC region, as well as in Oregon and Washington states (**Figure 74**).

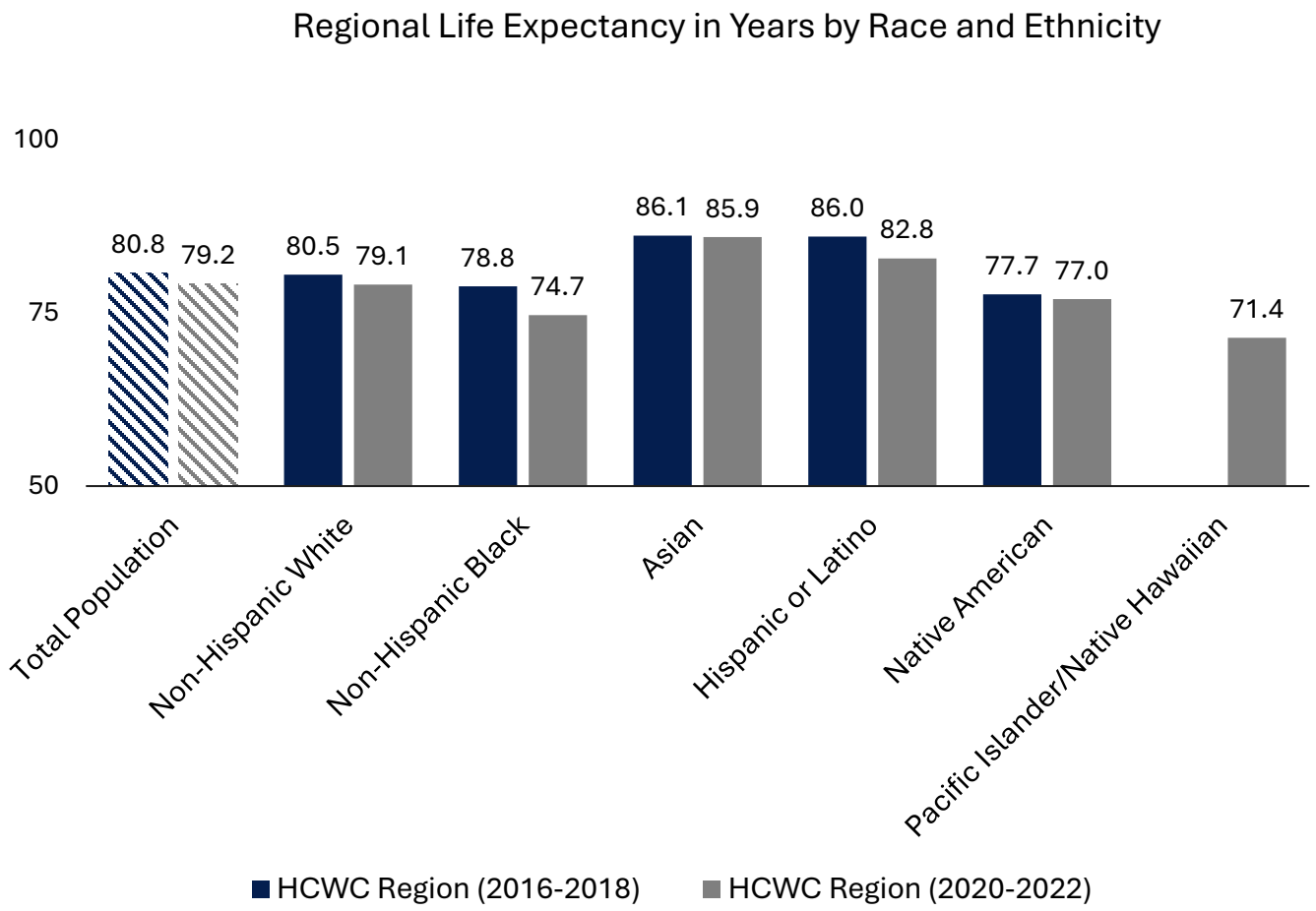
Figure 74. Life Expectancy, 2016-2018 and 2020-2022



***Significantly lower in 2020-2022 compared to 2016-2018. Source: National Center for Health Statistics via County Health Rankings (Metopio)**

Life expectancy significantly decreased for all race ethnicity groups except Asian and Native American/Alaskan Native groups. Since 2016, non-Hispanic Black individuals had the lowest life expectancy while Asian individuals had the highest life expectancy (**Figure 75**).

Figure 75. HCWC Region Life Expectancy by Race and Ethnicity

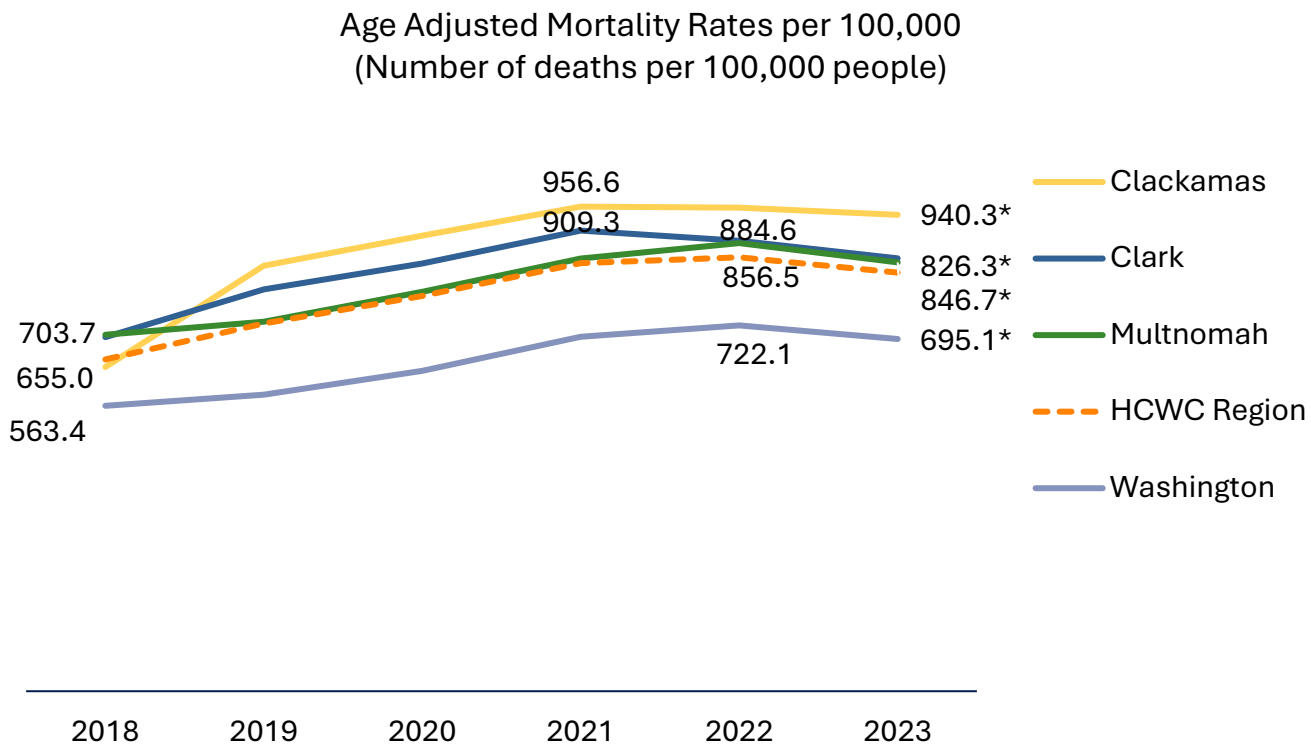


Note: Asian in 2016-2018 is an estimate that includes Pacific Islander/Native Hawaiian. In 2020-2022, the race and ethnicity group was separated, reporting an Asian alone and a Pacific Island/Native Hawaiian alone rate. *Significantly lower in 2020-2022 compared to 2016-2018. Source: National Center for Health Statistics via County Health Rankings (Metopio)

Mortality Rate

Mortality rates have increased significantly in all counties of the HCWC region since 2018, from 655.0 deaths per 100,000 people in 2018 to 846.7 deaths per 100,000 in 2023. All counties in the region experienced a significantly higher mortality rate in 2023 compared to 2018; Clackamas had the highest mortality rate in the region since 2019 (**Figure 76**).

Figure 76. Age Adjusted Mortality Rates per 100,000

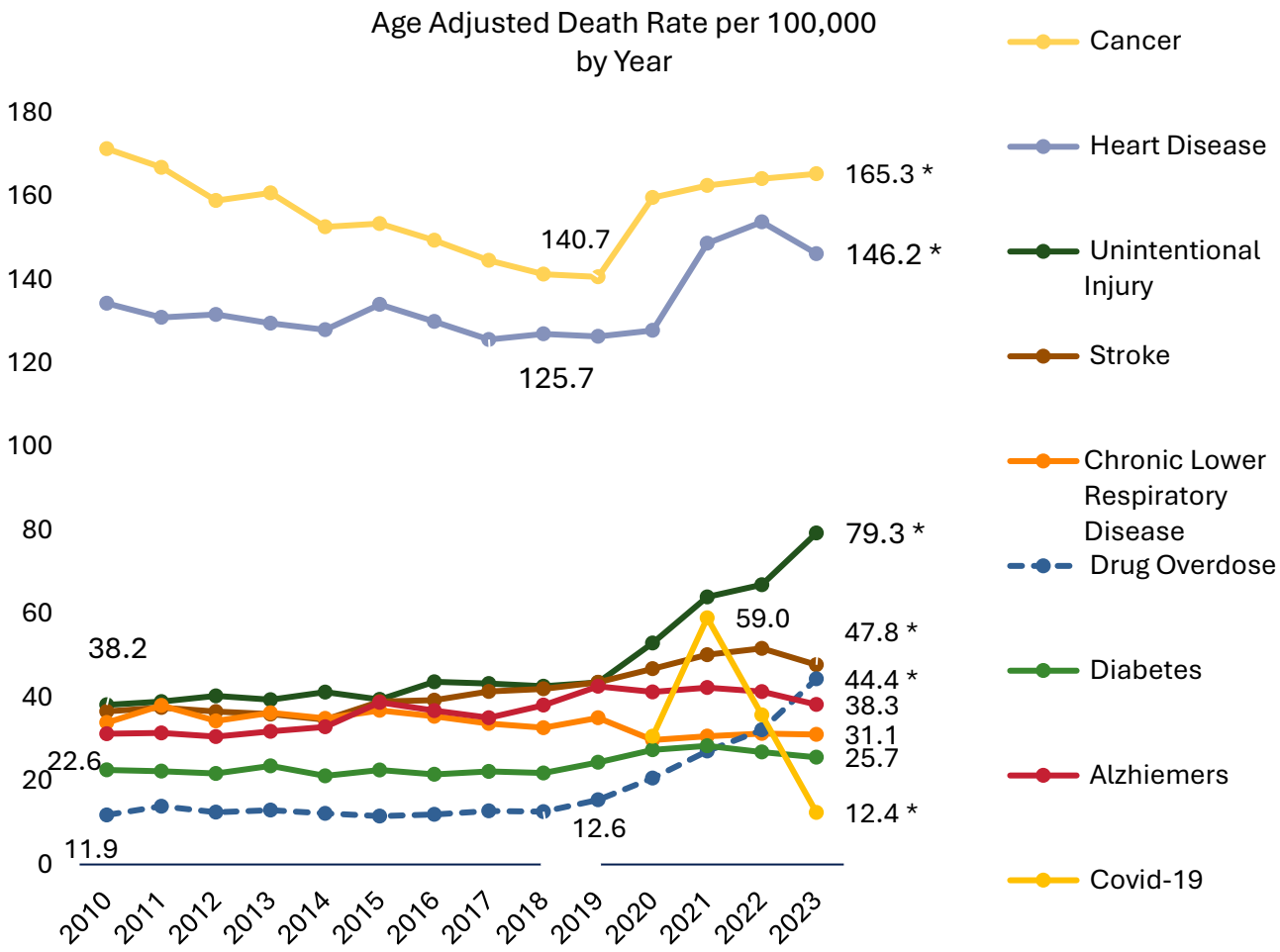


***Significantly higher in 2023 compared to 2018. Source: CDC Wonder via Metopio**

Regionally, the top five causes of death remained the same since 2019, including cancer, diseases of the heart, stroke, accidents (unintentional injury) and chronic lower respiratory disease (**Figure 77**). The increase in mortality rate was driven in part by a significant increase in the following causes of death:

- Cancer was significantly higher from a low of 140.7 deaths per 100,000 in 2019. However, this rate was similar in 2023 to the rate 10 years ago.
- Heart disease was significantly higher in 2023 than it was at its lowest in 2017, at 125.7 deaths per 100,000.
- Unintentional injury increased significantly to 79.3 deaths per 100,000 in 2023.
- COVID-19 was the 4th leading cause of death in 2021, surpassing stroke. COVID-19 as a significant cause of death has decreased since 2021.

Figure 77. Region Top Causes of Death by Year



***Significantly different than the 10-year low or high, or since 2010. Source: National Vital Statistics System-Mortality (NVSS-M) Centers for Disease Control and Prevention (CDC) via Metopio**

While reflecting a lower mortality rate, deaths due to the following causes significantly increased between 2014 and 2023: diabetes (21.2 to 25.7), alcohol (10.7 to 21.6), motor vehicle (6.9 to 9.7), and homicide (3.7 to 6.2). Mortality due to firearms also increased (9.3 to 12.5). Mortality due to influenza and pneumonia decreased, from 8.3 deaths per 100,000 in 2014 to 5.7 deaths per 100,000 in 2023. [32]

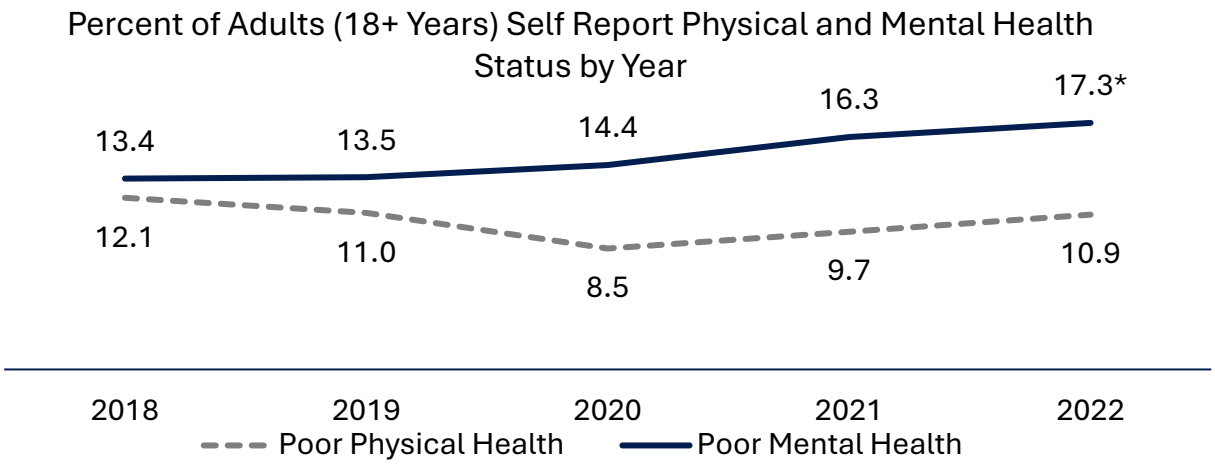
Self-Reported Health Status

Health status is a measure of people's perceptions of their overall health, typically categorized as excellent, very good, good, fair, or poor.[33] It encompasses various aspects of health, including physical, mental, emotional, and functional well-being and is a strong predictor of important health outcomes, including mortality, morbidity, and functional status.

Between 2018 and 2022, self-reported poor mental health among adults in the region increased from 13.4 percent to 17.3 percent, with a notable increase between 2020 (14.4%) and 2021 (16.3%). However, rates in 2021 and 2022 did not differ significantly. In 2022, the percentage of adults (18+ years) reporting poor physical health declined from 12.1 percent in 2018 to a low of 8.5 percent in 2020, before increasing significantly to 10.9 percent by 2022.

- By county, in 2022, there was little difference in self-reported physical health and mental health status compared to the region.
- In 2022, the regional self-reported poor health status was significantly lower than Oregon State (12.4%); while similar to Washington State (11.5%). Similarly, the regional self-reported poor mental health status was significantly lower than Oregon State (19.0%); while similar to Washington State (16.7%).

Figure 78. Self-Reported Poor Physical and Mental Health



***Significantly higher in 2022 compared to 2018. Defined as the percentage of residents aged 18 and older who report 14 or more days during the past 30 days during which their physical health or mental health was not good. Source: BRFSS via Metopio**

Morbidity

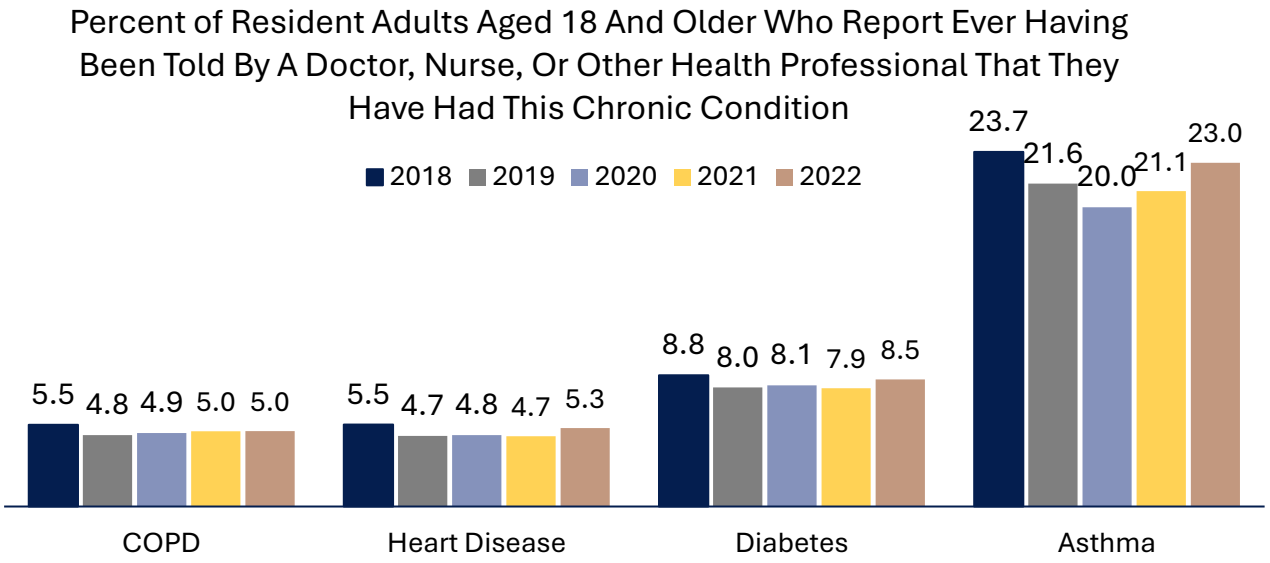
Morbidity refers to the state having a disease or health condition and often is used to describe the presence of a disease or health condition within a population. Morbidity can encompass a range of health issues, including infectious diseases, chronic conditions, injuries, mental health disorders, and more. By measuring the morbidity, public health officials can make informed decisions about vaccination campaigns, screening programs, treatment guidelines, and health education initiatives to promote overall well-being and reduce the burden of illness within a community or society. This section examines chronic conditions and cancer incidence.

Chronic Disease

Data from the Centers for Disease Control and Prevention (CDC) suggest that chronic diseases such as heart disease, cancer, and diabetes are the leading causes of death and disability in the United States. Chronic diseases are defined broadly as conditions that last at least one year and require ongoing medical attention, limit activities of daily living, or both.

In the HCWC region, the prevalence of chronic disease conditions among adults remained stable between 2018 and 2022. Specifically, in 2022, asthma affected nearly one in four adults (23%). Diabetes was also prevalent, with 8.5 percent of adults reporting being diagnosed with the condition. Approximately, one in 20 adults (18+ years) were affected by heart disease (5.3%) and COPD (5.0%) in 2022 (**Figure 79**).

Figure 79. Chronic Disease Prevalence Among Adults 18+ Years, HCWC Region by Year



Note: Percent of resident adults aged 18 and older who report ever having been told by a doctor, nurse, or other health professional that they have had this chronic condition. Source: Behavioral Risk Factor Surveillance System (BRFSS) via Metopio

Mental Health

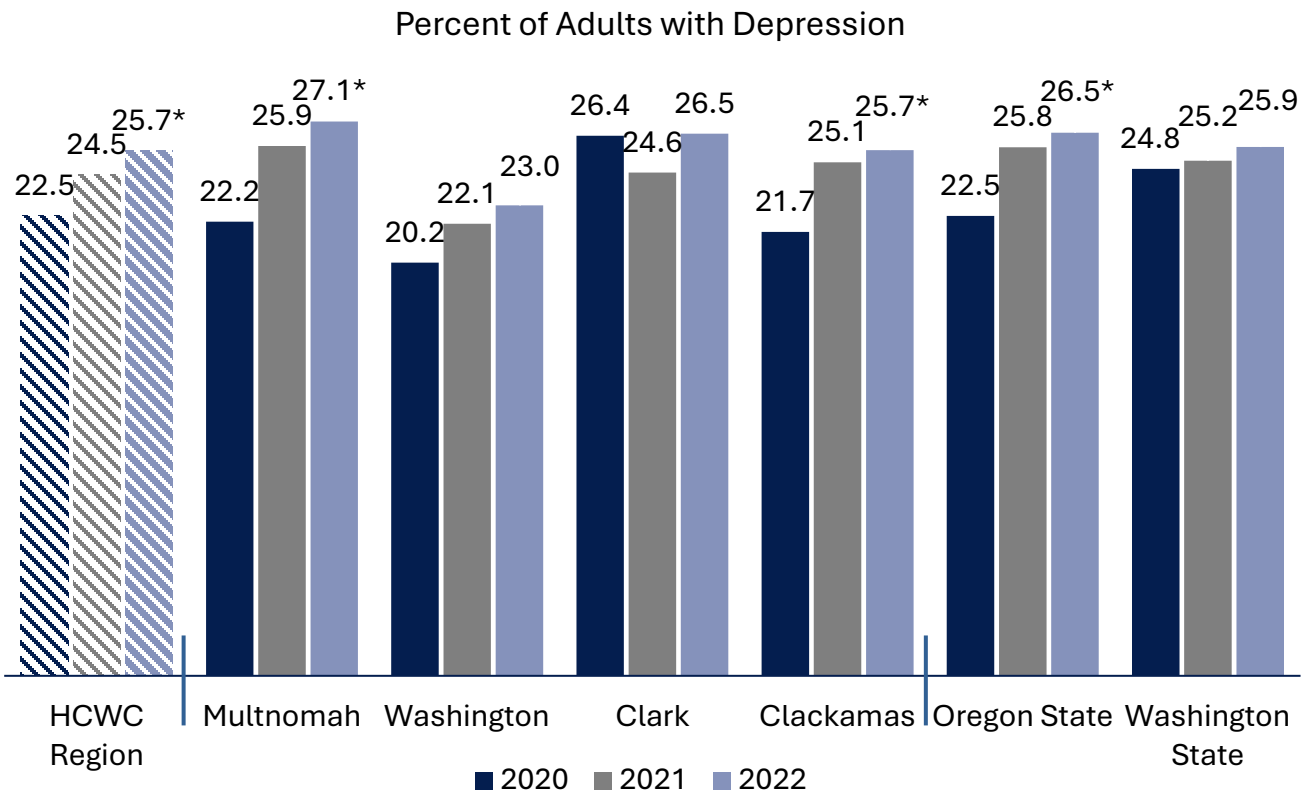
According to the World Health Organization (WHO), "There is no health without mental health".[34] Mental health encompasses three key aspects of a person's well-being:

- Emotional well-being: Understanding and managing one's own emotions
- Psychological well-being: The process of thinking, learning, and remembering
- Social well-being: Interacting with others and forming relationships

Depression

In the region, depression rates among adults (18 years and older) increased from 22.5 percent in 2020 to 25.7 percent in 2022. Multnomah and Clackamas counties experienced some of the largest increases. In 2022, Multnomah's rate was 27.1 percent, compared to 22.2 percent in 2020. Clackamas followed a similar pattern to the region overall, with a rate of 25.7 percent in 2022, up from 21.7 percent in 2020 (**Figure 78**).

Figure 78. Prevalence of Depression among Adults (18+ Years)



***Significantly higher in 2022 compared to 2020/ Source: National Vital Statistics System-Mortality (NVSS-M). Centers for Disease Control and Prevention (CDC) (via Metopio)**

The data on the prevalence of depression symptoms among grade 8 and grade 11 students from 2015 to 2022 across Clackamas, Multnomah, and Washington counties reveals several key trends. Depression symptoms have generally increased over time among both grade levels, with grade 11 students consistently reporting higher rates than grade 8 students. Multnomah grade 11 students had the highest reported prevalence in 2022 at 41.2 percent. Specifically, the following describes trends by grade level (**Figure 79**).

Among Grade 8 Students:

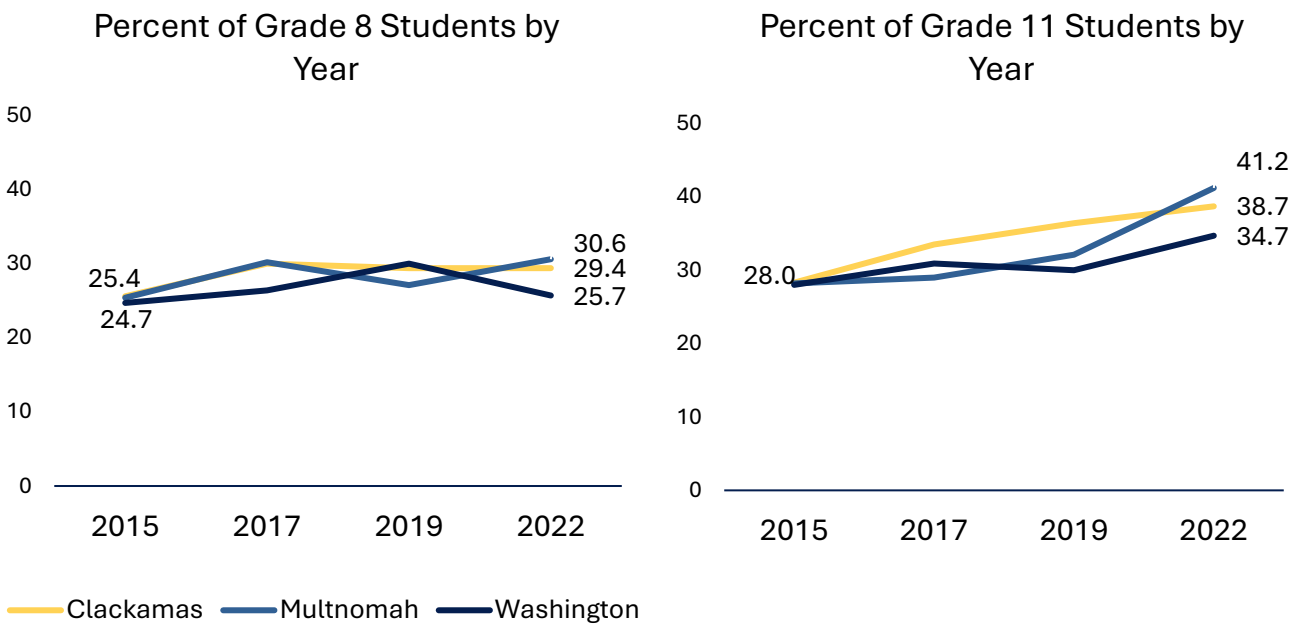
- Clackamas saw an increase from 25.6 percent in 2015 to 30.0 percent in 2017, followed by a slight decline and stabilization at 29.4 percent in both 2019 and 2022.

- Multnomah showed a similar pattern, rising from 25.4 percent in 2015 to 30.2 percent in 2017, dipping to 27.1 percent in 2019, and then increasing again to 30.6 percent in 2022.
- Washington experienced an increase from 24.7 percent in 2015 to 30.0 percent in 2019, but then a notable drop to 25.7 percent in 2022.

Among Grade 11 Students:

- Clackamas exhibited a steady increase in depression symptoms, from 28.3 percent in 2015 to 38.7 percent in 2022.
- Multnomah showed a consistent upward trend, starting at 28.2 percent in 2015 and reaching 41.2 percent in 2022.
- Washington data shows a rise from 28.0% in 2015 to 34.7% in 2019.

Figure 79. Depressive Symptoms Among Students

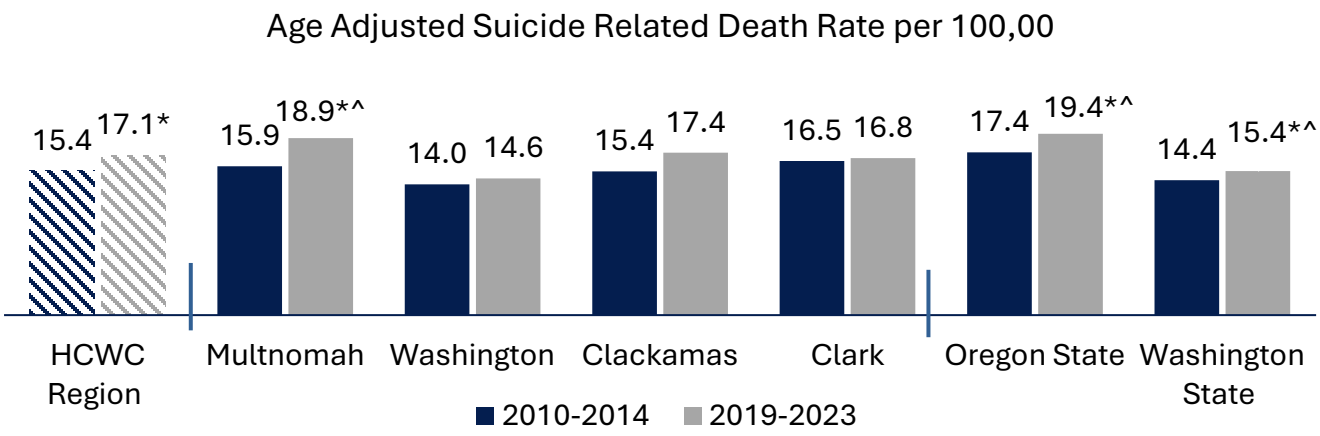


Source: Oregon Student Health Survey

Suicide Mortality

The suicide mortality rate in the region increased from 15.4 per 100,000 (2010–2014) to 17.1 per 100,000 (2019–2023). Multnomah experienced a significant increase to 18.9 per 100,000, exceeding the regional average. Other counties remained below or near the regional rate. During this period, Oregon's suicide mortality rates were significantly higher than the regional average, while Washington State's were lower; however, both states experienced significant increases in suicide mortality, mirroring the regional trend (**Figure 80**).

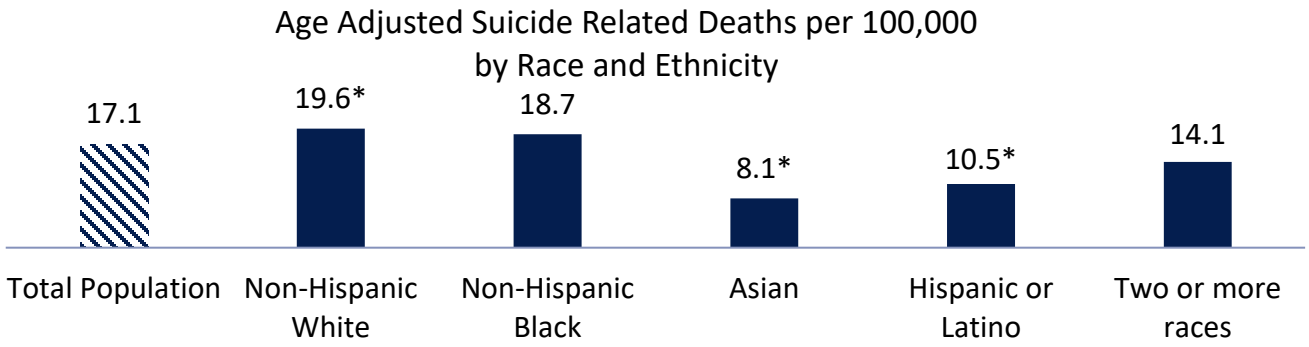
Figure 80. Suicide Mortality by County and Year



***Significant difference between 2010-2014 and 2019-2023. ^Significantly different compared to HCWC regional rate in 2019-2023. Source: National Vital Statistics System-Mortality (NVSS-M). Centers for Disease Control and Prevention (CDC) (via Metopio)**

Between 2019-2023, racial and ethnic disparities exist with respect to suicide mortality; non-Hispanic White individuals had the highest rate at 19.6 per 100,000, significantly above the regional average (**Figure 81**). Asian and Hispanic/Latino populations had significantly lower rates at 8.1 and 10.5 per 100,000, respectively. Non-Hispanic Black and multiracial groups had rates close to or slightly below the regional average.

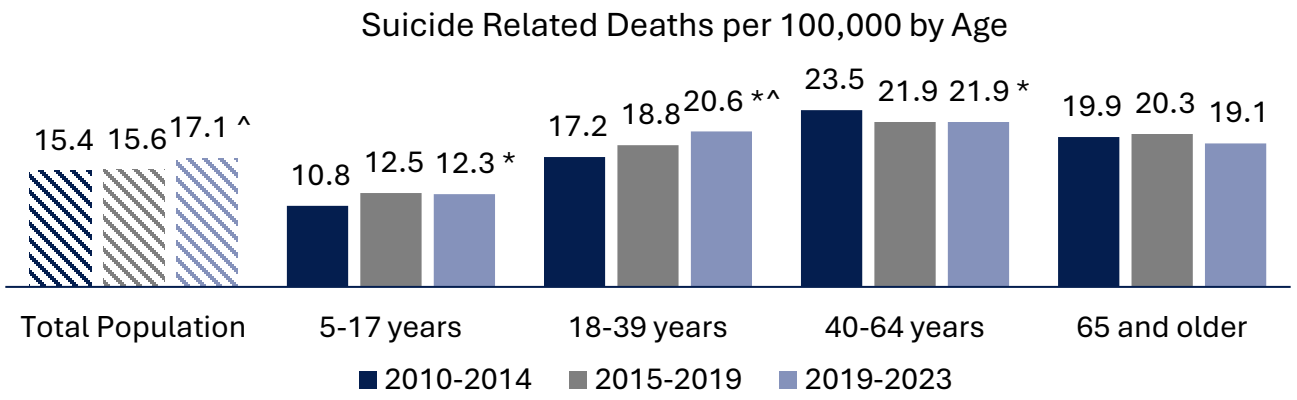
Figure 81. Regional Suicide Mortality Rate by Race/Ethnicity, 2019-2023



***Significantly different compared to HCWC regional rate. Source: National Vital Statistics System-Mortality (NVSS-M). Source: Centers for Disease Control and Prevention (CDC) (via Metopio)**

Between 2010 and 2023, suicide mortality rates in the region showed notable variation across age groups and time periods (**Figure 82**). Among youth aged 10–17, the rate increased (not significantly) from 10.8 to 12.3 deaths per 100,000 between 2010-2014 and 2019-2023 and remained the lowest across all age groups. Young adults aged 18–39 experienced a consistent significant increase, from 17.2 in 2010-2014 to 20.6 deaths per 100,000 in 2019-2023. Adults aged 40–64 had the highest rate in 2010–2014 at 23.5, which then stabilized at 21.9 in the following periods. Meanwhile, the rate for those 65 and older fluctuated slightly, peaking at 20.3 in 2015–2019 before declining to 19.1 deaths per 100,000 in 2019-2023.

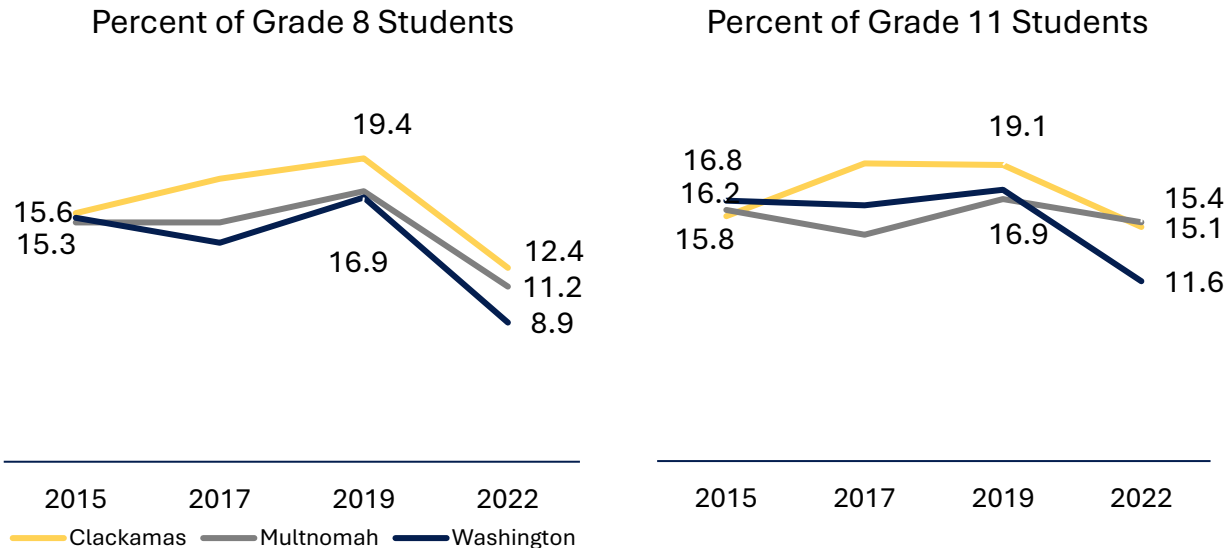
Figure 82. Regional Suicide Mortality Rate by Year and Age



***Significantly different compared to HCWC regional rate in 2019-2023. ^Significantly different in 2019-2023 compared to 2010-2014. Source: National Vital Statistics System-Mortality (NVSS-M). Centers for Disease Control and Prevention (CDC) (via Metopio)**

The data on the prevalence of suicidality among grade 8 and grade 11 students across three counties—Clackamas, Multnomah, and Washington—reveals several important trends between 2015 to 2022 (Figure 83). Suicidality rates among both grade levels generally peaked around 2019 and then declined by 2022 across all counties. Grade 11 students consistently reported higher rates than grade 8 students, though the gap narrowed in 2022. The most significant reductions in 2022 were observed in Washington County, particularly among grade 8 students, decreasing from 16.9 percent in 2019 to 8.9 percent of students in 2022.

Figure 83. Suicidality Among Students (Oregon Counties only)



Source: Oregon Student Health Survey

Alcohol Use

In 2022, 19.6 percent or approximately 1 in 5 adults living in the HCWC region binge drank in the past 30 days. This regional rate remained stable between 2018 and 2022, despite binge drinking significantly increasing in both Oregon and Washington states. There was not significant differences between the counties.[35]

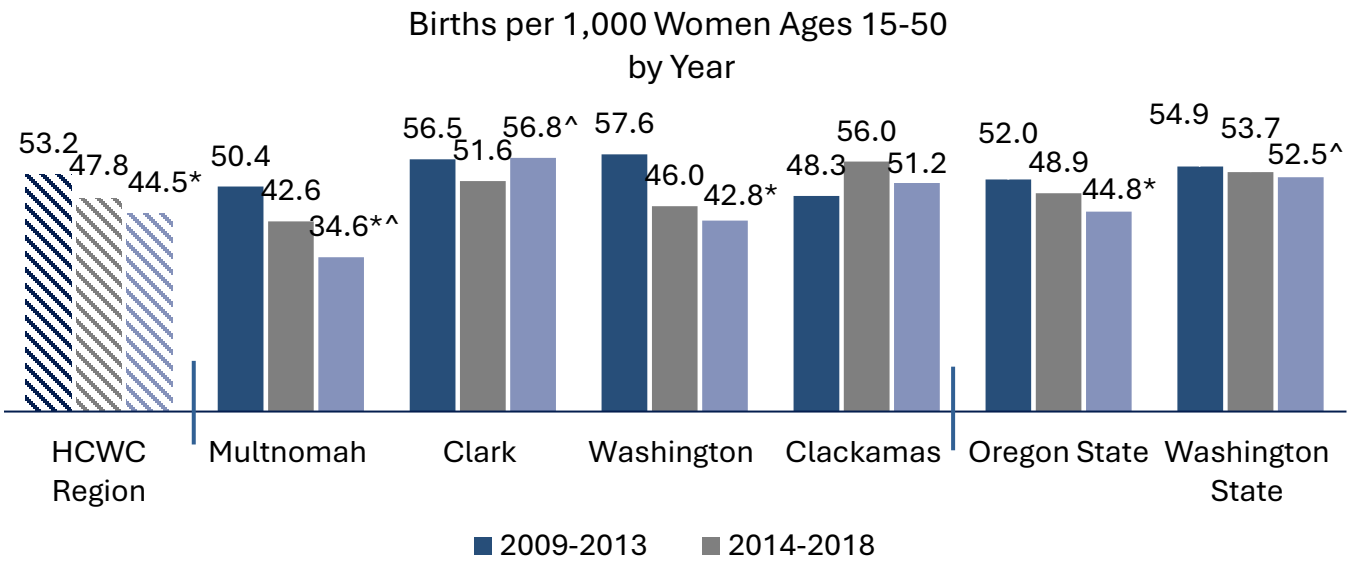
MATERNAL AND CHILD HEALTH

Understanding maternal and child health (MCH) indicators is essential for identifying health disparities, guiding resource allocation, and shaping effective public health interventions. This section summarizes key MCH trends in the region, highlighting areas of progress and concern that are critical for community planning and support.

Birth Rates

Birth rates in the region have declined significantly over the past decade, dropping from 53.2 births per 1,000 women aged 15–50 in 2009–2013 to 44.5 in 2019–2023. This trend was consistent across most counties and states, with Multnomah reporting a significantly lower rate than the regional average, while Washington State reported a higher one (**Figure 84**). Although birth rates varied by race and ethnicity, no statistically significant differences were found in the most recent period. Monitoring birth rates helps communities anticipate future needs for services such as child care, education, and maternal health support.

Figure 84. Birth Rate by Year

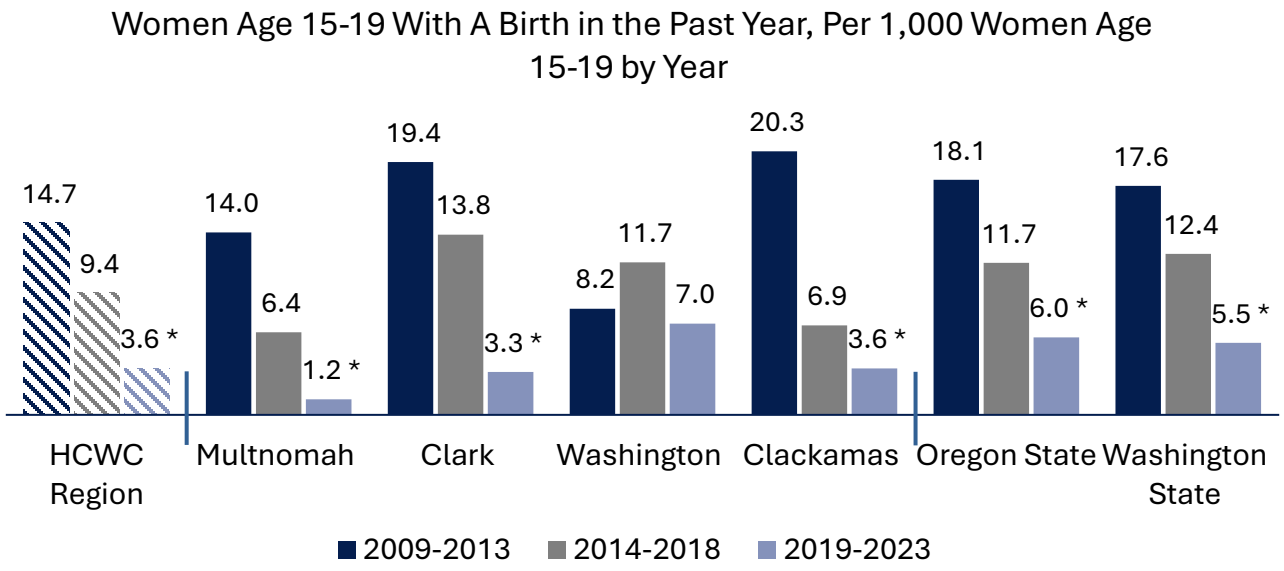


***Significant difference between 2010-2014 and 2019-2023. ^Significantly different compared to HCWC regional rate in 2019-2023. Source: American Community Survey, Table B13002**

Teen Birth Rates

Regionally, the teen birth rate also saw a dramatic decline, falling from 14.7 births per 1,000 females aged 15–19 in 2009–2013 to just 3.6 in 2019–2023. This decline was observed across nearly all counties, with the exception of Washington County where the rate of teen births increased in 2014-2018 before decreasing in 2019-2023 (**Figure 85**). The reduction in teen births is a positive public health outcome, as early childbearing is associated with increased health risks for both mother and child, as well as long-term socioeconomic challenges.

Figure 85. Teen Birth Rate by Year



***Significant difference between 2010-2014 and 2019-2023. Source: American Community Survey, Table B13002**

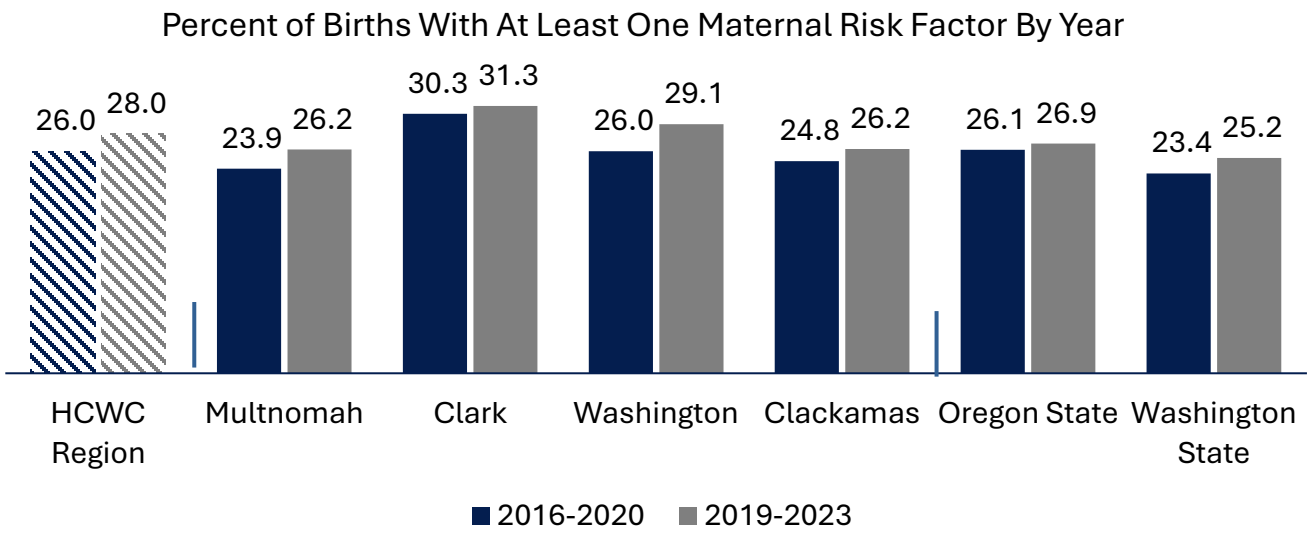
Infant Mortality

Infant mortality, a key indicator of overall population health, remained relatively stable in the region. The rate decreased slightly from 4.5 per 1,000 live births in 2017–2019 to 3.9 in 2020–2022. Rates in each county were not significantly different compared to the region.[36]

Prevalence of Maternal Risk Factors

The proportion of births with at least one maternal risk factor (such as hypertension, diabetes, tobacco use) increased from 26 percent in 2016–2020 to 28 percent in 2019–2023. These risks are linked to negative outcomes for mothers and infants (**Figure 86**).

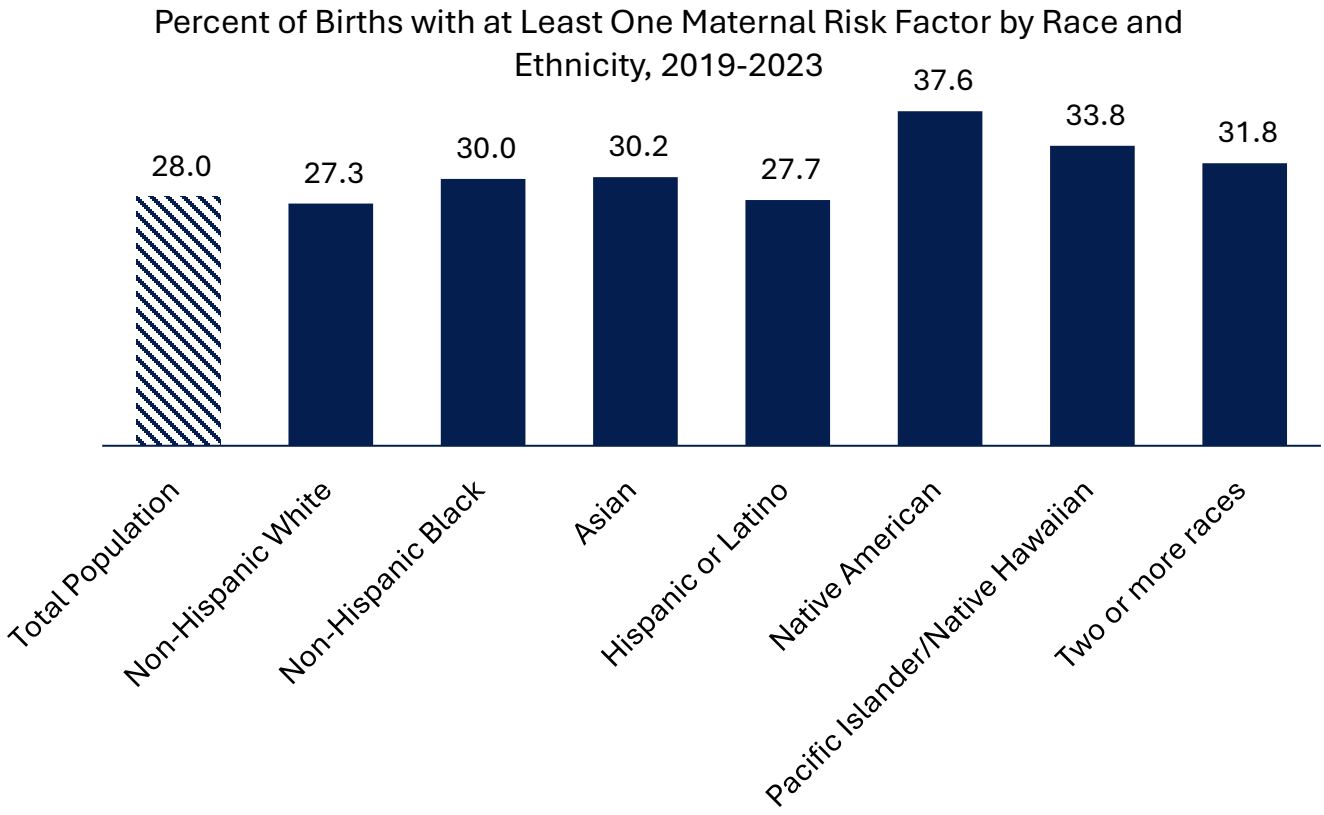
Figure 86. Births With At Least One Maternal Risk Factor by Year



Note: Births where the mother has at least one of the following conditions: Chronic Hypertension, Eclampsia, Diabetes, Tobacco use, or Pregnancy-associated hypertension.
Source: National Vital Statistics System-Natality (NVSS-N), Centers for Disease Control and Prevention (CDC) Wonder, five- year data via Metopio

Notably, in 2019-2023, Native American/Alaskan Native and Pacific Islander/Native Hawaiian populations had the highest rates of maternal risk factors (**Figure 87**).

Figure 87. Regional Rate of Births with at Least One Maternal Risk Factor by Race and Ethnicity, 2019-2023

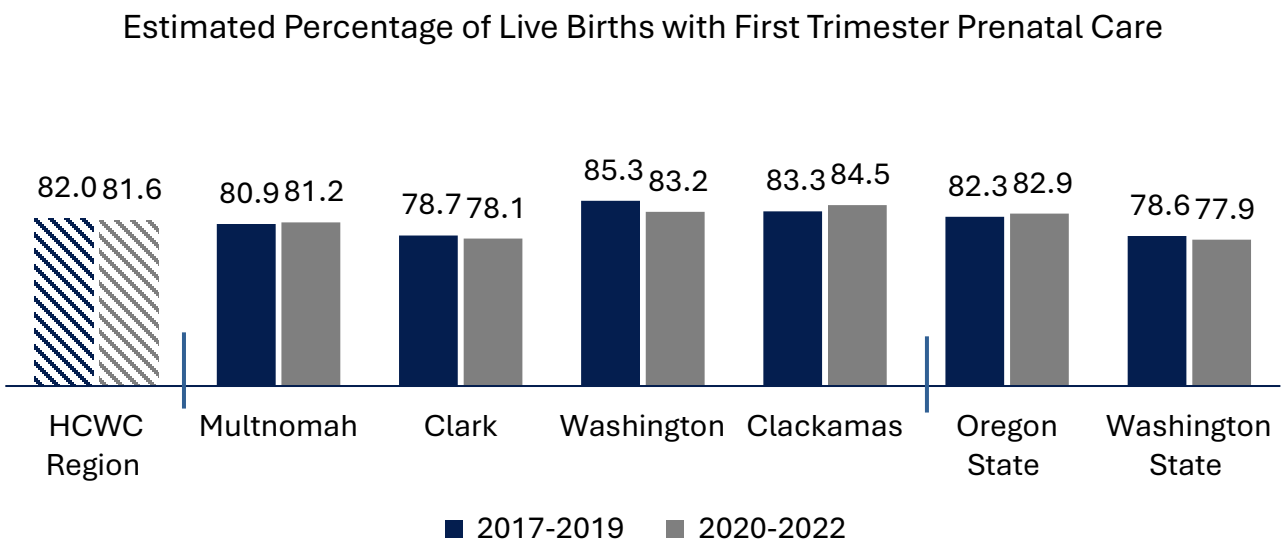


Note: Births where the mother has at least one of the following conditions: Chronic Hypertension, Eclampsia, Diabetes, Tobacco use, or Pregnancy-associated hypertension. Source: National Vital Statistics System-Natality (NVSS-N), Centers for Disease Control and Prevention (CDC) Wonder, five- year data via Metopio

Prenatal Care Utilization

Prenatal care utilization remained stable, with approximately 82 percent of pregnant individuals receiving care during both 2017–2019 and 2020–2022. Notably, Clark County and Washington State reported lower rates, falling below 80 percent (**Figure 88**). Early and consistent prenatal care is vital for detecting complications, promoting healthy behaviors, and improving outcomes for mothers and babies.

Figure 88. Prenatal Care in the First Trimester

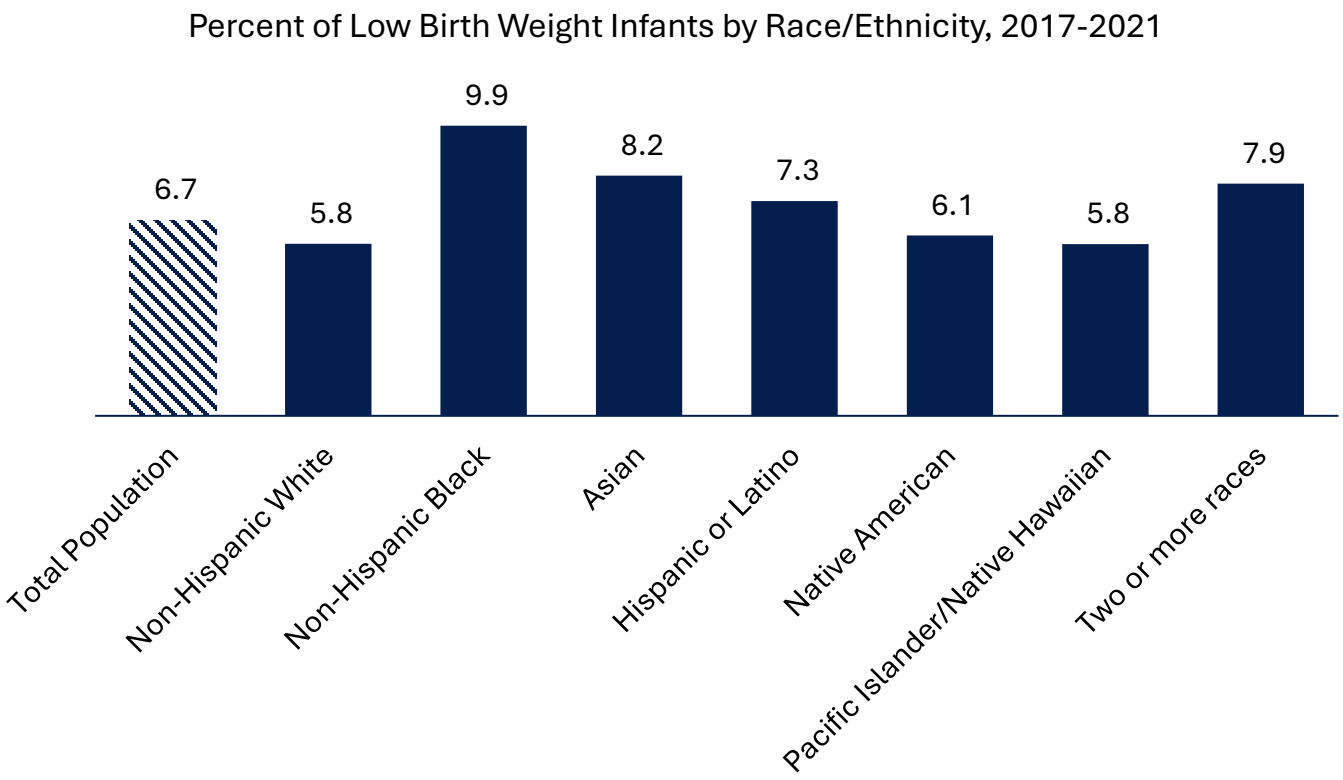


Source: Maternal and Child Health Bureau (MCHB) Health Resources & Services Administration via Metopio

Low Birth Weight Infants

The rate of low birth weight—a predictor of infant morbidity and mortality—was 6.8 percent in 2020–2022, similar to 2017-2019 at 6.7 percent. In 2017-2021, Non-Hispanic Black infants had the highest rate at 9.9 percent of live births, while Pacific Islander/Native Hawaiian (5.8%) and Non-Hispanic White (5.8%) infants had the lowest (**Figure 89**).

Figure 89. HCWC Region Estimate of Low Birth Weight Infants by Race/ Ethnicity, 2017-2021

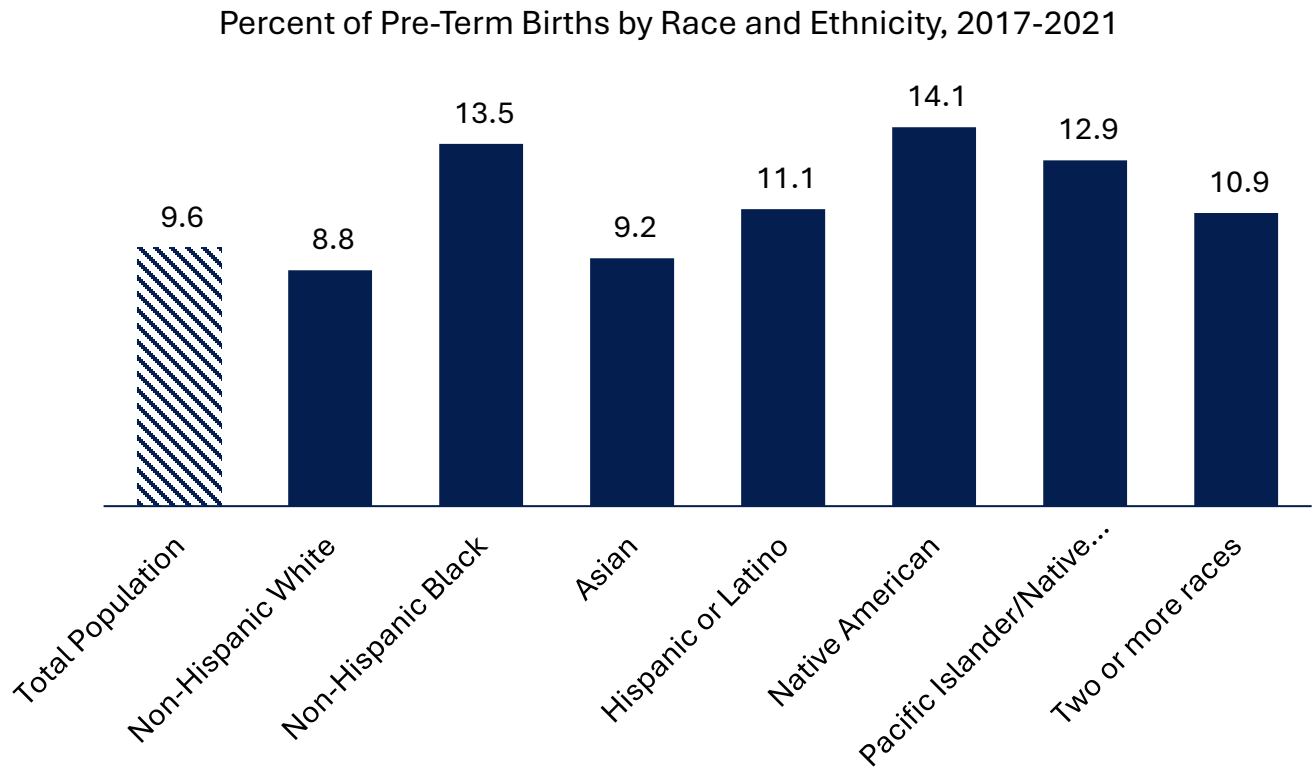


Source National Vital Statistics System-Natality (NVSS-N) Centers for Disease Control and Prevention (CDC) Via CDC Wonder (Metopio)

Preterm Births

Preterm birth is the leading cause of infant death in the U.S. and is associated with long-term developmental challenges. Nationally, in 2022, preterm birth and low birth weight together accounted for approximately 14 percent of infant deaths.[37] Regionally, 9.6 percent of live births were preterm in 2017-2021. Non-Hispanic White individuals report a slightly lower rate at 8.8 percent, below the regional average while all other race and ethnicities were slightly higher (except Asian, which is also lower than the region at 9.2) (**Figure 90**).

Figure 90. Regional Pre-Term Births by Race and Ethnicity, 2017-2021

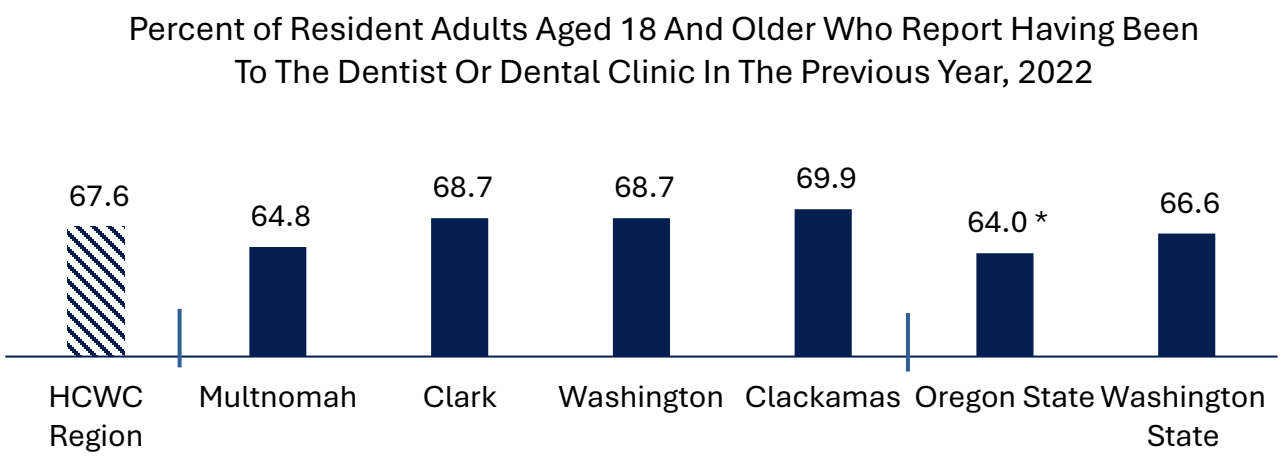


Source National Vital Statistics System-Natality (NVSS-N) Centers for Disease Control and Prevention (CDC) Via CDC Wonder (Metopio)

Dental/Oral Health

From 2018 to 2022, 67.6 percent of adults in the region visited a dentist annually—a stable rate that was higher than Washington State (66.6%) and Oregon (64.0%) averages. Among counties**,** Multnomah had the lowest rate at 64.8 percent, while Clackamas led with 69.9 percent; Washington and Clark counties both reported 68.7 percent (**Figure 91**).

Figure 91. Percent of Resident Adults Aged 18 And Older Who Report Having Been to the Dentist or Dental Clinic In The Previous Year, 2022



***Significantly different rate compared to the region. Source: CDC Places, BRFSS, 2022 via Metopio**

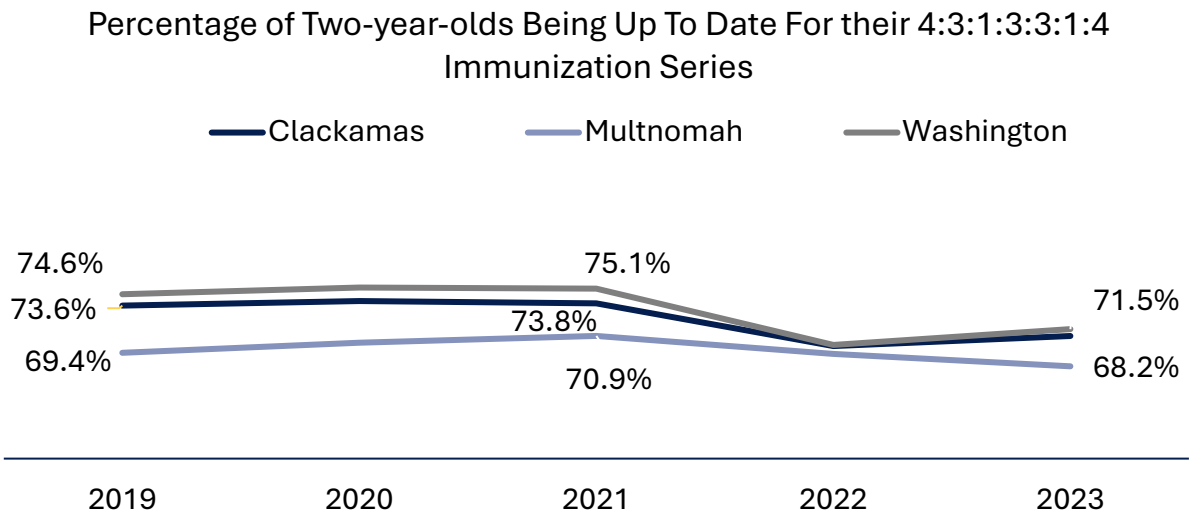
Communicable Diseases

Communicable diseases—such as sexually transmitted infections (STIs), tuberculosis, hepatitis, and respiratory illnesses—can spread rapidly and affect large segments of the population. Understanding their incidence helps identify urgent health threats and prioritize interventions.

Vaccine Preventable Diseases

This indicator looks at the proportion of children who, by their second birthday, have received all the recommended doses in a specific vaccine schedule. Immunization rates in young children increase from 2016 to 2021, then declined (**Figure 92**). In 2022–2023, Clackamas and Washington counties saw some improvement, while Multnomah County continued its downward trend.

Figure 92. Percentage of Two-Year-Olds Being Up To Date for Their 4:3:1:3:3:1:4 Immunization Series



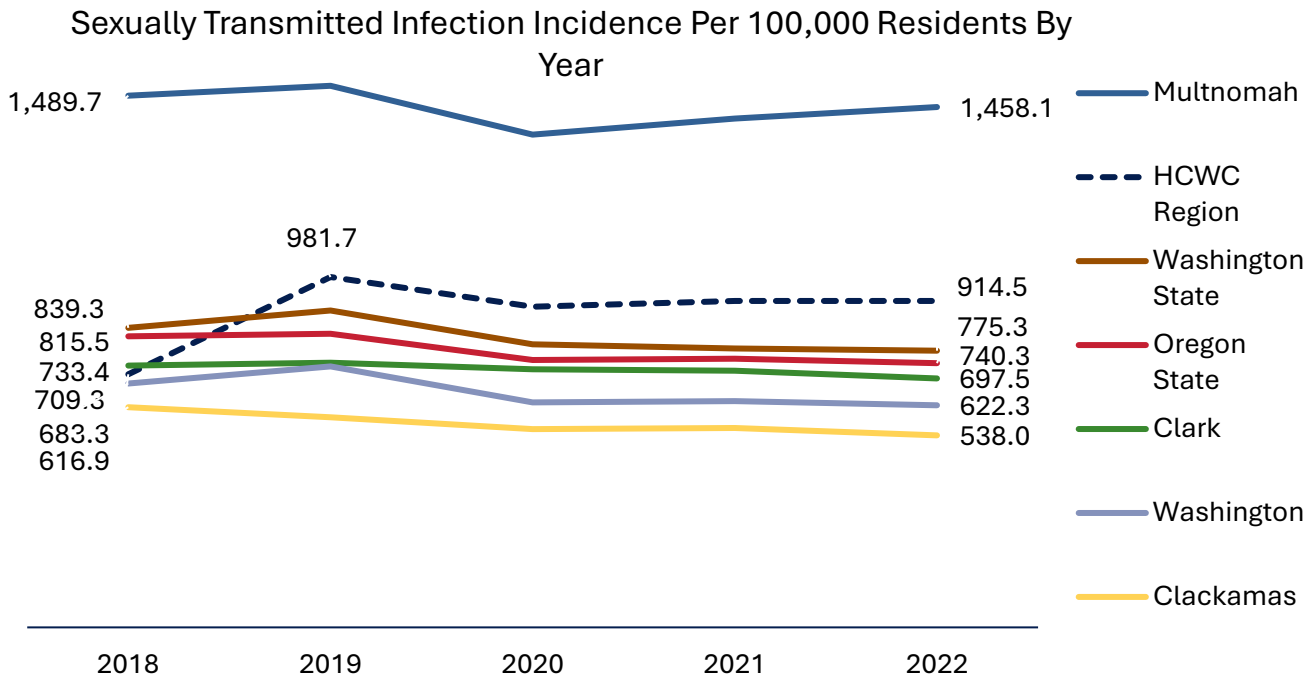
Note: "Percentage of two-year-olds being up to date for their 4:3:1:3:3:1:4 immunization series" refers to the proportion of children who, by their second birthday, have received all the recommended doses in a specific vaccine schedule. Source: Oregon Health Authority, Office of Public Health

Sexually Transmitted Infection Incidence

Between 2018 and 2022, the HCWC region reported higher STI rates than Washington and Oregon (**Figure 93**). HCWC's rate rose sharply from 709.3 to 981.7 per 100,000 residents in 2019, then stabilized at about 914.5 by 2022. Meanwhile, STI rates declined in Oregon (815.5 to 740.3) and Washington (839.3 to 775.3)

Multnomah reported the highest STI incidence rates in the region, reaching 1,517.5 per 100,000 in 2019 and staying above 1,400 through 2022. Clark, Washington, and Clackamas counties all experienced gradual declines during this period, with Clackamas recording the lowest rate by 2022 at 538.0 per 100,000.

Figure 93. Sexually Transmitted Infection Incidence by Year



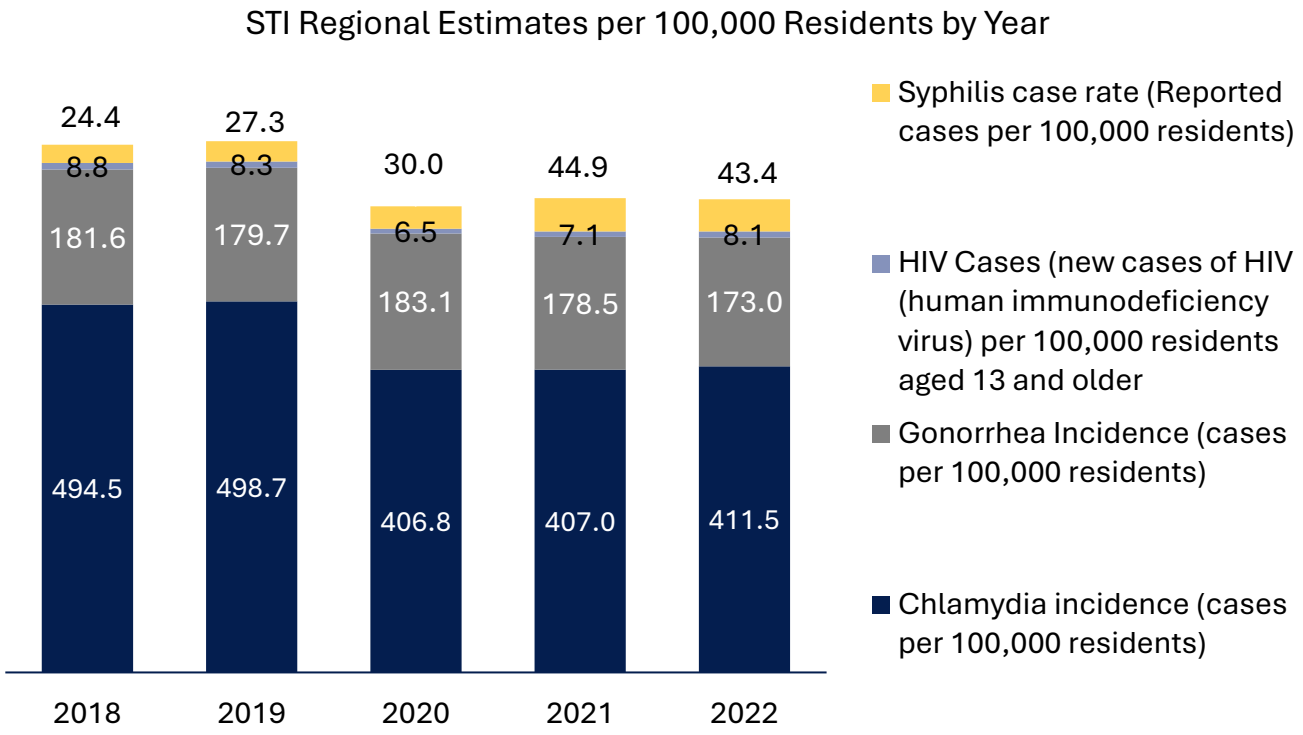
Note: The number of sexually transmitted infections per 100,000 residents. Includes chlamydia, gonorrhea, syphilis, and HIV/AIDS cases. More than half of these cases are from chlamydia alone. Source: CDC National Center for HIV/AID, Virl Hepatitis, STD, and TB Prevention: Atlas Plus via Metopio

Chlamydia was the most prevalent STI relative to gonorrhea, HIV, and syphilis. Between 2018 and 2022, chlamydia and gonorrhea incidence rates generally improved in the region while syphilis increased from 24.4 reported cases per 100,000 in 2018 to 43.4 reported cases per 100,000 in 2022 (**Figure 94)**. Specifically:

- **Chlamydia** rates were decreasing, starting at 494.5 in 2018 and ending at 411.5 in 2022. There was a slight dip in 2020 (406.8).
- **Gonorrhea** incidence showed minor fluctuations, peaking at 183.1 in 2020 before gradually declining to 173.0 by 2022.
- **HIV** case numbers varied slightly year over year. The lowest number of new cases was recorded in 2020 (6.5), with a return to 8.0 cases in 2022, matching the 2018 level.

- **Syphilis** rates, however, increased over the five-year period. From 24.4 in 2018, the rate nearly doubled to 44.9 in 2021, before slightly decreasing to 43.0 incidents per 100,000 in 2022.

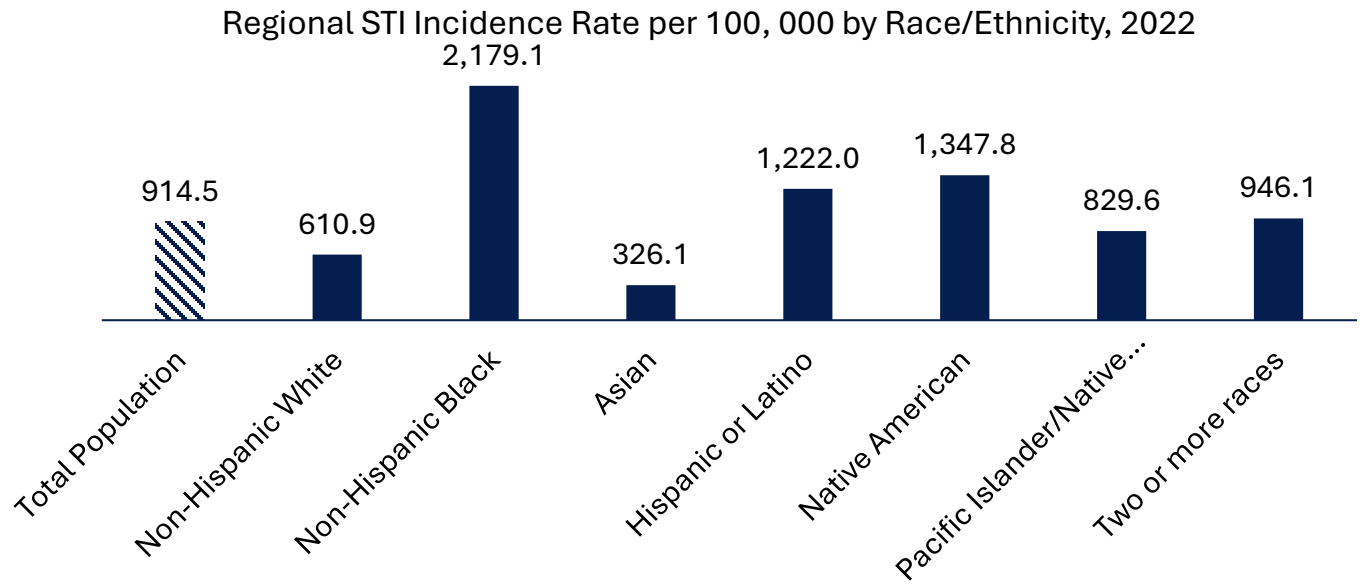
Figure 94. STI Regional Estimates by Year



Note: The number of sexually transmitted infections per 100,000 residents. Includes chlamydia, gonorrhea, syphilis, and HIV/AIDS cases. More than half of these cases were from chlamydia alone. Source: CDC National Center for HIV/AID, Virl Hepatitis, STD, and TB Prevention: Atlas Plus via Metopio

In 2022, the overall STI incidence rate in the HCWC Region was 914.5 cases per 100,000 residents. However, this average masked significant disparities across racial and ethnic groups (**Figure 95**). Non-Hispanic Black residents had the highest incidence rate at 2,179.1, over twice the regional average. Native American/Alaskan Native and Hispanic/Latino populations followed with rates of 1,347.8 and 1,222.0 per 100,000, respectively. Those identifying as two or more races were at 946.1, Pacific Islander/Native Hawaiian at 829.6, both above some groups but below average. Non-Hispanic White residents had a lower rate of 610.9, and Asian residents recorded the lowest at 326.1.

Figure 95. Regional STI Incidence Rate per 100, 000 by Race/Ethnicity, 2022



Note: The number of sexually transmitted infections per 100,000 residents. Includes chlamydia, gonorrhea, syphilis, and HIV/AIDS cases. More than half of these cases were from chlamydia alone. Source: CDC National Center for HIV/AID, Virl Hepatitis, STD, and TB Prevention: Atlas Plus via Metopio

CONCLUSION AND NEXT STEPS

The purpose of the 2025 CHNA process was to update the findings from the 2022 CHNA, and document and elevate the health and well-being priorities of residents across the HCWC region—including Clackamas, Multnomah, and Washington counties in Oregon and Clark County in Washington. While the region benefits from strong community assets and cross-sector partnerships, the data reveal persistent challenges in behavioral health, access to culturally and linguistically responsive and affordable care, and the social conditions that shape health—such as housing, education, and economic stability.

These challenges are compounded by structural inequities and systemic obstacles that more significantly affect BIPOC communities, immigrants and refugees, people who are low-income, LGBTQ2IA+ individuals, people who are unhoused, people with substance use and/or mental health conditions, and people living with disabilities. The CHNA was intended to catalyze data-informed dialogue, strategic alignment, and collective action across sectors and geographies.

HCWC and its partners are committed to:

- Advancing population health solutions centered on fairness and lived experience.
- Implementing a regional backbone structure to support cross-sector collaboration, data integration, shared accountability, and future community planning efforts and assessments.

This report was one of many steps toward improving health outcomes across the HCWC region. It is anticipated that organizations, networks, and residents will be galvanized to act collectively on the priority issues identified. The CHNA will serve as a foundational resource for ongoing community health improvement efforts.

The HCWC welcomes input and remarks from members of the community and partners. Kindly direct any feedback or comments to Christine Kan, HCWC Convener, at kanc@healthshareoregon.org.

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[24] U.S. Census Bureau. (2024). B25044: Gross rent as a percentage of household income in the past 12 months [2023 ACS One-Year Estimates Detailed Tables]. American Community Survey.

[25] The transportation burden index measures how much time and money residents spend on transportation compared to people in other areas. This score is expressed as a percentile—a higher percentile means people in that region dedicate more time or income to transportation than most others. For instance, if an area scores in the 80th percentile, it means that residents there have a transportation burden higher than 80% of all other census tracts in the country. Conversely, a score in the 30th percentile means that only 30% of census tracts have a lower burden, while the majority—70%—have more transportation insecurity.

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APPENDIX A: PRIMARY DATA METHODS & ANALYSIS - FOCUS GROUP PROTOCOL

Community input for the HCWC CHNA was collected to expand on and/or inform the information and analysis of secondary data collection efforts. Primary data used in this assessment was collected through a Community Health Survey and community-specific focus groups. This appendix describes in detail the focus group protocol, data analysis and reporting methods used in the CHNA.

CAG members recruited, hosted, and/or facilitated 37 community engagement sessions (focus groups), nine of which were conducted in a language other than English (e.g., Arabic, Cantonese, Dari, Farsi, Mandarin, Russian, Spanish, Swahili, and Ukrainian). Participants were recruited using multiple recruitment mechanisms: direct recruitment by partner community-based organizations, emailed invitations, flyers, newspaper and social media postings. Persons that identified with the following groups or descriptive categories, which are more likely to be socially marginalized and underrepresented in data collection efforts for community needs assessments, were specifically recruited for participation in the focus groups:

- People with mental health conditions and/or substance use disorders
- People with disabilities
- People of varying race and ethnic groups, including African immigrant and refugee, African American/Black, Asian, Indigenous/Native American/Alaskan Native, Latine/o/a/x, Middle Eastern, Native Hawaiian and Pacific Islander, and Slavic and Eastern European, and Rural dwellers
- LGBTQ2IA+
- Unhoused/unsheltered

Together these sessions engaged over 350 community members. Three quarters of the participants identified as BIPOC and 60 percent of the community members preferred to speak a language other than English. A $50 incentive was provided to each consenting participant.

To support the CAG members in this effort, Multnomah County Health Department offered in-person and virtual facilitator training in August 2024 with the following objectives for CAG members and additional focus group facilitators:

- Understand the goals and scope of the Healthy Columbia Willamette Collaborative's 2025 Community Health Assessment update

- Use the Focus Group Facilitator Guide to conduct a focus group
- Identify best practices for facilitating focus groups
- Draft a plan for how to set up their focus groups (invitations, food, note taking, gift cards, etc.)

A facilitator's guide was created, available here. The facilitator's guide provides details on the supports and incentives made available to participants and facilitators. Focus group objectives outlined in the guide were for participants to:

- Understand the purpose of the 2025 CHNA process
- Share their experiences and understanding of what affects their community's health and wellbeing
- Identify the strengths and needs of their community as it relates to health and wellbeing

The CAG updated the 2022 CHNA focus group questions to reflect the present-day reality of their communities. Eight questions were developed in collaboration with the CAG that explored the priority areas identified in the results of the 2022 CHNA and allowed for an opportunity for 2025 participants to identify persistent challenges and/or new and emerging issues or opportunities. The list of the questions directed to participants during the focus groups include:

1. What has been your experience with being able to find and use health and wellness services that match your culture, language and physical needs?
   a. Probe: How has that experience affected your health & wellbeing?

2. How do people in your community connect with each other?
   a. Probe: What has made it difficult for people to connect?
   b. Probe: What does connection mean to you?

3. How do your connections with your community help you to take care of yourself?
   a. Probe: In what ways has connecting with your community impacted your health?

4. Imagine your ideal community. What would it look like?
   a. Probe: What specific resources, services, or changes would need to happen for you to have access to healthy, safe, affordable, and accessible places to live, work, and play?

5. What resources or education has or would assist you and/or individuals in your community become financially stable? [Economic Stability; Educational opportunities]

6. How does transportation influence your ability to find and maintain employment, as well as access essential services like health care, food banks, and shelters? [Transportation]

7. What is your experience with getting nutritious food that aligns with your cultural beliefs and attitudes? [Culturally specific and healthy foods]

8. What is your and someone you know experience with seeking and/or getting mental health and/or substance use support? [Mental health and Substance Use support]

CAG members were encouraged to host focus groups at easily accessible locations, offer transportation support and $50 participant incentives. The process included informed consent activities, facilitator/note taker, recording, and recommended duration of sessions. Each focus group included a facilitator and a note taker to capture the conversation. Additionally, when possible, focus groups were recorded and transcribed and, when needed, translated into English.

HMA analysts used qualitative research methods to analyze the written transcripts of the focus groups and focus group notes. They used Dedoose, a secure, online qualitative analysis software platform. The focus group transcripts and notes were analyzed qualitatively by HMA to code the transcripts with the initial set of codes derived from the major health and quality of life topics during the 2022 CHNA activities. HMA analysts leveraged new analytical tools to support their qualitative analysis, including a HIPAA/HITECH secure, proprietary version of the artificial intelligence platform, Copilot. With Copilot, HMA ensured the security of focus group data within a controlled environment and with additional safeguards for privacy including the removal personal identifiers before using Copilot to conduct an initial thematic analysis of the coded transcripts. Copilot, and any AI system, has the capacity to rapidly analyze large amounts of data and is:

- Efficient – can process large volumes of data very quickly
- Consistent – consistency reduces human error and bias
- Enhanced insights – can identify patterns and theme that might be overlooked by human analysts
- Cost effective – automates costs related to human labor

To highlight cultural specificity and perspectives of focus populations, HMA tagged focus group transcripts with population-specific descriptors to compare themes between populations. Additionally, HMA analysts reviewed and conducted multiple analyses with periodic peer review check-ins to discuss the results. HMA took the following steps in analyzing the focus group data:

1. Pulled excerpts from Dedoose that HMA coded with the parent and child codes (Error! Reference source not found.).
2. Conducted coding confidence check with Copilot
3. Conducted a thematic analysis of excerpts with Copilot by each parent code
4. Conducted a thematic analysis of excerpts with Copilot comparing and contrasting emerging themes from focus populations
5. Reviewed the analysis results and query Copilot, if necessary for clarification
6. Asked Copilot to pull excerpts to support the themes it produced
7. Reviewed results from Copilot's analysis
8. Discussed and came to agreement with the results
9. Shared and discussed results with CAG to collect resonance checks with CAG members who are representatives of the community members that participated in the focus groups
10. Input from the CAG informed and prioritized what information was shared in the CHNA.

An analysis of each focus population as a separate group was not reported on in the CHNA for the following reasons.

- With qualitative research, the goal is to reach *saturation* of repeated patterns and themes so one can be confident that the results are representative of any particular population under scrutiny. Saturation– seeing the same finding or theme over and over again-helps researchers be confident in making the conclusions they make.
- As a research method, focus groups are useful in understanding nuances about topics for any specific population. However, focus group findings are typically not generalizable to the population as a whole. Generalizability is dependent upon the total number of participants and upon the attainment of saturation of emergent themes.
- Focus populations that participated in the focus groups did not have the same number of participants. For example, there may have been 4 participants that identified with one focus population, and 30 participants that identified with a different focus population.

This difference in the total number of participants for any focus population means two things:

1. The findings from any one focus population are not necessarily generalizable to a specific focus population. In some case, the total number of participants in some focus populations was so small, there would be a risk of the analysis including information that may be identifiable or tied to a particular individual. Confidentiality was promised to the focus group participants and by analyzing the data across all groups, the risk of breaking confidentiality was mitigated, if not avoided all together.
2. By comparing the themes that emerged *among* the groups, the CHNA process can make general conclusions about *differences* among focus populations, while maintaining confidentiality

Figure A. 2024 Current Codes – Expanded on 2022 Codes

2024 Current Codes – Expanded on 2022 Codes

- Access to Ling & Cult Responsive Health Care
  - Experience with services aligning to needs
    - Negative experiences
      - Cost of care
      - Inability to properly serve persons with disabilities
      - Lack of cultural competency/ humility
      - Cultural Considerations
      - Lack of diversity of providers
      - Language Barriers
      - Mistrust of Providers
      - Navigating the healthcare system
      - Need for TIC
      - Non-traditional medicine and care
      - Racism
      - Stigma
    - Positive experiences

- Essential Community Services & Resources
  - Culturally specific and healthy foods
    - Access to healthy and nutritious food
  - Mental health and Substance Use support
    - Access to mental health support
    - Cost of services and supoprts
    - Cultural considerations
    - Mental Health Stigma
    - Substance abuse & addiction
  - Resources & Education for Financial Stability
    - Access to Food
    - Civic education classes about American culture
    - Educational opportunities
    - Financial counseling and/or classes
    - Jobs - placement, training, better jobs, etc.
    - Rent and Housing assistance
  - Transportation

- Neighborhood for All
  - Ideal community resources and services
    - Accessible and Affordable healthcare
    - access to community & recreational activities
    - Access to healthy food
    - Affordable childcare
    - Affordable/ Safe Neighborhoods & Housing Options
    - Communities that share racial/ethnic identity
    - Disability friendly communities
    - Friendly and sociable communities
    - Job opportunities
    - More SUD and MH treatment options
    - Reproductive health
    - Safe and Affordable Transportation

- Support for Family & Community Ways
  - Community Connections
    - Forming community connections
    - Impact on health
    - Meaning of connection
    - What makes it difficult to connect
      - Activities and conversation outside of recovery
      - Cost/ Price of activities
      - Homelessness
      - Lack of meeting and hangout spaces
      - Lack of transportation
      - Need for childcare
      - Social isolation
      - Stigma
      - Work obligations/ time constraints

Green = Root/Parent code

Blue = Child code

Yellow =Child sub code

APPENDIX B: COMMUNITY ADVISORY GROUP BIOGRAPHIES

Sara Barger

4D Recovery

Sara Barger is the Public Affairs and Relations Director at 4D Recovery, with a Master's degree in Conflict Resolution and Peace Studies and over a decade of experience in nonprofit and advocacy work. While earning her degree, she held several student leadership roles and completed an internship with local government, where she developed an equity plan for the Center for Mediation and Dialogue in the Beaverton Mayor's Office. Over the past four years, Sara has worked to expand access to recovery and treatment services across Oregon and Washington—focusing on youth, young adults, and families. She collaborates with stakeholders and local and statewide government to address critical gaps in behavioral health care, particularly related to substance use. A person in long-term recovery, Sara is committed to centering lived experience in systems change and is honored to support the CHNA process in lifting up community voices.

Joy Mulumba

African Family Holistic Health Organization

Joy Mulumba is a community-centered leader, educator, and advocate with deep roots in the Black and African diaspora in the Portland Metro area. He is the co-founder and director of a nonprofit organization, African Family Holistic Health Organization (AFHHO) dedicated to advancing maternal and family health, intergenerational well-being, and culturally grounded healing practices. With a background in medical health, English literature and community organizing, Mulumba brings a culturally responsive, equity-driven lens to systems change and community voice. His work centers Black Refugees and Immigrant families historically excluded from health planning and policy.

Chenya Chiu
Asian Health & Service Center

Chenya Chiu serves as the Community Program Manager at the Asian Health & Service Center (AHSC), where she brings years of experience supporting Chinese, Vietnamese, and Korean immigrant communities. A Taiwanese immigrant and graduate of Portland State University with a degree in Public Health, Chenya combines cultural insight with a deep commitment to health equity. Through her work, Chenya has helped countless individuals and families overcome barriers to accessing care, navigate complex healthcare systems, receive culturally responsive health education, and find emotional support. In addition to her direct service work, she plays a key role in program management and team supervision, ensuring effective coordination and delivery of community-based services. A dedicated public health practitioner, Chenya is passionate about health education and community empowerment. She joined the Community Advisory Group (CAG) on behalf of AHSC to deepen her impact and continue advocating for improved services for the communities she serves.

Jamie Zenter
Clackamas County Public Health Division

Jamie Zentner (she/her) leads the Health Equity and Partnerships team at Clackamas County Public Health Division. Her team oversees the Community Health Improvement Plan, supports the Public Health Advisory Council, and changes policy and systems to improve environments where we live, work, play and pray. Jamie is a member of the Clackamas County IDEA (Inclusion, Diversity, Equity, Action) workgroup to implement organizational policies and practices that center the communities we serve. Jamie launched her public health career in the Peace Corps Guatemala where she worked in rural communities to develop small businesses and implement sanitation projects. Returning to the United States, Jamie committed to addressing a variety of health inequities - agricultural injury prevention among farm workers, supporting individuals with limited resources to manage chronic health conditions, and improving the County's emergency response to focus more on marginalized communities. Jamie has contributed to the Healthy Columbia Willamette Collaborative Community Health Assessment for over 10 years. It has been an honor and privilege to participate in the Community Advisory Group.

Bianca Bermejo & Magali Perez

Latino Network

Bianca Bermejo and Magali Perez, serving the Latino Network is a nonprofit agency that is a Latine-led education organization, grounded in culturally-specific practices and services, that lifts up youth and families to reach their full potential. Their work springs from the core belief in Latino community self-determination —that is, the ability of community members to participate meaningfully in the decisions that affect their lives and the lives of their families. Promotoras de Salud, such as Magali Perez and Bianca Bermejo, are dedicated to uplifting the Latine community they live in and represent through individual and family health education, advocacy and access to care.

Alicia Evan

Native American Youth & Family Center

Alicia Evan (she/her) is Central Yup'ik from the Napaskiak Tribe located in rural Southwest Alaska. She graduated with a degree in Public Health and Psychological Development. In the fall of 2022, she moved to Portland, Oregon from California. In her free time, she loves to go on walks, watch sports, and try new foods.

Maximiliano Jimenez-Sutton

Street Roots

Maximiliano Jimenez-Sutton is the Ambassador Program Coordinator at Street Roots and an Outreach Specialist at Janus Youth Programs, Yellow Brick Road Street Outreach. Maximiliano began working with Street Roots as an intern in 2021 while finishing his BA at Pacific University. The Ambassador Program is a street outreach and advocacy team comprised of people who have years of lived experience with housing instability. Offering people with lived experience a platform and job is vital in our ability to advocate and grow a relationship of trust and understanding with people living unhoused in our community.

West Livaudais
Oregon Spinal Cord Injury Connection

West Livaudais, MPH, is a dedicated advocate and the founder of Oregon Spinal Cord Injury Connection (OSCI), an organization he established in 2014, just one year after sustaining a spinal cord injury (SCI). Recognizing a critical void in community support for people affected by SCI in Oregon and SW Washington, West took the initiative to create a champion for this underserved population.

As the leader of OSCI, West guides the team in expanding the organization's reach, enhancing its impact, and increasing vital awareness about spinal cord injury. His commitment to health equity is underscored by years of service to this community and a Master of Public Health degree from Oregon Health and Science University (2018). West also holds a Master of Theological Studies from Regis College at the University of Toronto (2010) and a Bachelor of Science from Gonzaga University (2000), providing him with a unique interdisciplinary perspective that informs his impactful work in the non-profit sector.

Jessica Waller
Oregon Spinal Cord Injury Connection

Jessica Waller serves as the Operations Manager at Oregon Spinal Cord Injury Connection (OSCI), a nonprofit organization committed to supporting
individuals affected by spinal cord injuries in Oregon. OSCI's mission is to ensure all Oregonians with a spinal cord injury have the care, community, and resources they need to thrive. The organization provides community health worker support, educational forums, wheelchair maintenance workshops, and inclusive recreational opportunities to help individuals with spinal cord injuries live a life they love. She is also a dedicated caregiver to her mother, who sustained a C4/C5 spinal cord injury in 2018—an experience that fuels her passion for improving services and support for the spinal cord injury community specifically and physical disability community at large. In addition to her work at OSCI, Jessica has supported small nonprofits through consultant roles focused on improving internal processes and communication strategies. She also previously served as a nonprofit executive director, bringing valuable leadership experience to her nonprofit work. Jessica's personal and professional experiences inform her commitment to fostering equity, accessibility, and connection for all Oregonians.

Mouna Jbali brings substantial experience working with a variety of stakeholders in government entities and community-based organizations around the world. Her areas of expertise include management, budgeting and contracts, conference coordination and event planning, translation and interpretation, research, teaching, and more. A skilled and natural leader, she completed the City of Portland's ENGAGE Leadership Program, the City of Beaverton BOLD program and was a U.S. Department of State Leadership Trainee. Mouna also has extensive experience working with families from the Greater Middle East. She's trilingual in English, Arabic, and French.

Andrea Preisz, Program Coordinator at the Immigrant and Refugee Community Organization (IRCO)'s Greater Middle East Center (GMEC), brings a deep commitment to community organizing, cultural heritage, and intercultural collaboration to her work. Raised in Washington County, Andrea pursued a career at the intersection of archaeology, cultural heritage management, and public engagement, living and working for over a decade in Egypt and Sudan. Across all projects, she has worked to center community voice and prioritized socio-economic benefit to the people directly impacted by project implementation. In her role at GMEC, Andrea applies this interdisciplinary background and international experience to support immigrant and refugee communities through culturally grounded, people-first programming. She is committed to immigration rights, environmental sustainability, and inclusive community building.

Anna Yelsukova is a dedicated community advocate who serves as a lead program coordinator at the Slavic Community Center of NW (SCC of NW), a culturally specific nonprofit organization supporting Slavic and Eastern European immigrants and refugees in Oregon. Anna moved to the United States from Ukraine in 2010 and earned her bachelor's degree in Biological Sciences from City University of New York. With a strong background in healthcare, she has worked and volunteered in psychiatric research, nursing homes, and emergency departments, and since 2020 has been a part of community health and outreach efforts through SCC of NW.

Anna brings both professional expertise and lived experience to her work. She understands firsthand the challenges immigrants face navigating systems in a new country and is passionate about helping others find their path. At SCC of NW, she supports programs focused on health equity, behavioral health, refugee support, youth engagement, emergency preparedness, and culturally responsive services for Russian-, Ukrainian-, and Romanian-speaking communities. Her efforts are rooted in a deep love for the community and a commitment to improving the wellbeing of underserved populations. Anna believes in building bridges between communities and institutions, advocating for equitable access, and creating opportunities where immigrants and refugees can thrive and lead.

Cruzko Ward
Living Islands

Cruzko Ward was born and raised in Salem, Oregon. He is a bilingual Marshallese who is second generation. He has a background in social services, workforce development, and mental health. Cruzko experienced the difficulties of adjusting to American society firsthand as a result of his upbringing here in the United States; he frequently had to serve as the primary source for relatives who had difficulty blending two cultures. He brings four years of social services experience and ten years of experience in mental health and workforce development. Cruzko was able to help guide many people into long and secure careers while also addressing the issues of the work/life balance throughout his work as a Job Developer and Career Coach for those who have been diagnosed with Mental Health illnesses and also adults from marginalized communities. Cruzko is now the current Health Director for Living Islands Organization. He has always been in the business of serving people but has always been most passionate about being able to make an impact on his own community

Timur Holove
Slavic Community Center of Northwest

Timur Holove is a passionate Project Manager at the Slavic Community Center of Northwest, where he leads initiatives that support immigrant and refugee families from Eastern Europe. Originally from Central Asia, Timur immigrated to the United States in 1998 and has since dedicated himself to uplifting immigrant communities through culturally responsive programs and impactful storytelling. With a strong background in media production and community outreach, he manages cross-sector partnerships and coordinates projects that highlight the voices of underserved populations. His work reflects a deep commitment to equity, empowerment, and inclusive community building in the Portland area.

Thijs Kleinpaste
Street Roots

Thijs Kleinpaste is the Education and Civic Engagement Coordinator at Street Roots. Thijs started working at Street Roots while finishing his Ph.D. in Political Theory at Georgetown University. At Street Roots, he creates opportunities for vendor self-advocacy through town halls, community forums, focus groups and civic circles, and serves as the liaison between local government, schools and universities, civic groups and other community partners and the Street Roots vendors. Thijs works together with Maximiliano Jimenez-Sutton on the Ambassador Program.


Leigh Bohannon
Black Parent Initiative
Natasha Davy
Multnomah County Health Department
(CAG Convenor)
Natasha Davy is a Program Specialist Senior with Multnomah County's Health Department who serves as the lead staff for Multnomah County's Community Health Improvement Plan's (CHIP). The CHIP describes the priorities, goals, solutions, and resources for health improvement. She also sits on HealthShare's Community Advisory Council (CAC); this council has been instrumental in the creation of HealthShare's regional Community Health Improvement Plan. Natasha has experience making an impact in the community through participation in several organizations that help to build community and influence change and sustainable impacts such as the Pan African Cultural Foundation, the National Forum for Black Public Administrators (NFPBA), Urban League of Portland Young Professionals (ULPDXYP), and Women of Color Empowerment Series (WOCES).Mrs. Davy has a Master's degree in Public Health (MPH) from the University of South Florida and has worked for the Health Department since 2015.
Beth Poteet
Multnomah County Health Department
(CAG Convenor)
Beth Poteet has 25+ years of experience as a community organizer working on a range of issues including immigrant rights, peacemaking, and racial, climate, and economic justice in Latin America and the United States.Since 2010, she has created and facilitated training for Community Health Workers and diverse nonprofit and public sector leaders using popular education through the Multnomah County Health Department. With degrees in Peace Studies and Social Work, she has taught social work courses on social justice, diversity, and community-based practice. She speaks intermediate Spanish and beginning French. Beth is passionate about supporting the community-based workforce to improve community health and believes in the power of popular education to transform people and systems.

APPENDIX C: FOCUS GROUP PARTICIPANT DEMOGRAPHICS

Table 1 County of Residence

	Count	Percent
Multnomah	146	42%
Clackamas	110	32%
Washington	60	17%
Clark	10	3%
Other	17	5%
Did not answer	4	1%
Total	**347**	**100%**

Table 2. Age

Age Groups	Count	Percent
36 to 45 years	86	25%
Over 65 years	59	17%
26 to 35 years	56	16%
56 to 65 years	52	15%
46 to 55 years	49	14%
18 to 25 years	35	10%
I don't want to answer	10	3%
Total	**347**	**100%**

Table 3. Gender

Gender	Count	Percent
Woman/Girl (or Woman or Girl)	228	66%
Man/Boy (or Man or Boy)	89	26%
Did not answer	5	1%
I don't want to answer	3	1%
Selected more than one gender	22	6%
Total	**347**	**100%**

Table 4. Sexual Orientation

Sexual Orientation	Count	Percent
Straight (attracted mainly to or only to other gender[s])	255	73%
I don't want to answer	21	6%
Mor than one sexual orientation selected	18	5%
Did not answer	15	4%
Bisexual	11	3%
Gay	6	2%
Queer	5	1%
Lesbian	5	1%
Pansexual	4	1%
I don't know what this question is asking	3	1%
I don’t know	2	1%
Asexual	2	1%
Total	347	100%

Table 5. Preferred Language Spoken

Language	Count	Percent
English	150	43%
Spanish	62	18%
Russian	21	6%
Ukrainian	15	4%
Swahili	14	4%
Dari	13	4%
Arabic	9	3%
Burmese	9	3%
Kiswahili	9	3%
Cantonese	8	2%
Did not answer	6	2%
Chinese	5	1%
Tigrija	5	1%
Tongan	5	1%
Kachin	4	1%
Farsi/Dari/Persian	3	1%
Marshallese	3	1%
Refaluwaasch	3	1%
Karen	2	1%
Lingala	2	1%
Mandarin	2	1%
Pohnpeian	2	1%
Vietnamese	2	1%

Table 6. Preferred Language Spoken (continued)

Language	Count	Percent
ASL	1	0.3%
Azeri	1	0.3%
Carolinian	1	0.3%
Chagga	1	0.3%
French	1	0.3%
Italian	1	0/3%
Pashto	1	0.3%
Zomi	1	0.3%

Table 7. Race

Race	Count	Percent
Asian: Asian Indian	3	1%
Asian: Chinese	14	4%
Asian: Communities of Myanmar	8	2%
Asian: Japanese	1	0%
Asian: Other Asian	27	8%
Asian: South Asian	5	1%
Asian: Taiwan	2	1%
Asian: Vietnamese	3	1%
Biracial/Multiracial	5	1%
Black and African American: African-American	19	5%
Black and African-American: Other African (Black)	21	6%
Black and African-American: Other Black	8	2%
Black and African-American: Somali	1	0%
Hispanic and Latino/a/x: Central American	8	2%
Hispanic and Latino/a/x: Mexican	50	14%
Hispanic and Latino/a/x: Other Hispanic or Latino/a/x	7	2%
Hispanic and Latino/a/x: South American	9	3%
Indian	1	0%
Kachin (Myanmar)	1	0%
Middle Eastern/North African: Middle Eastern	9	3%
Native American	1	0%
Native American and Alaska Native: Alaska Native	1	0%
Native American and Alaska Native: Indigenous Mexican	2	1%
Native American and Alaska Native: Native American	20	6%
Native Hawaiian and Pacific Islander: CHamoru (Chamorro)	1	0%
Native Hawaiian and Pacific Islander: Communities of the Micronesian Region	6	2%
Native Hawaiian and Pacific Islander: Marshallese	3	1%

Table 8. Race (Continued)

Native Hawaiian and Pacific Islander: Native Hawaiian	**2**	**1%**
Native Hawaiian and Pacific Islander: Other Pacific Islander	9	3%
Native Hawaiian and Pacific Islander: Samoan	1	0%
Refaluwasch	3	1%
White: Eastern European	51	15%
White: Other White	50	14%
White: Slavic	21	6%
White: Western European	41	12%
I don't know	2	1%
Did not answer	3	1%
I don't want to answer	1	0%

APPENDIX D: COMMUNITY HEALTH SURVEY METHODS & DEMOGRAPHICS

Since one of the most valuable ways to learn about the health of a community is by reaching out to the different constituents in the community, including residents, HCWC prioritized local participation for this community health needs assessment cycle. In partnership with HMA and Multnomah County as the CAG convener, the CAG updated the 2022 survey questions to reflect the current needs of the community. The community health survey was distributed online through Qualtrics from October 7, 2024 to December 31, 2024 through the CAG, HCWC, and their partner organizations. The survey was made available in the following 18 languages, with 70 percent of survey respondents selecting English, followed by Russian (12%) and Chinese (7%) **(**Error! Reference source not found.**)**. CAG members provided $50 gift cards to 15 survey participants from their communities to ensure diverse representation in survey respondents. Additional survey respondents were entered into a raffle for $50 gift cards for their participation.

Table 9. Languages Survey Was Taken In

	Count	Percent
Total	**2,128**	
English	1488	70%
Russian	247	12%
Chinese	144	7%
Spanish	112	5%
Ukrainian	99	5%
Korean	14	1%
Myanmar/Burmese	6	0.3%
Arabic	4	0.2%
Persian	4	0.2%
Dari	3	0.1%
Vietnamese	3	0.1%
Swahili	2	0.1%
Chuukese	1	0.1%
Karen	1	0.1%
Kurdish	0	0%
Marshallese	0	0%
Pashto	0	0%
Romanian	0	0%
Samoan	0	0%

The survey's areas of inquiry included the following:

- Most important community health factors and issues
- Access to care, including experiences with discrimination
- Quality of life
- Demographics, using REALD methodology

The CAG added a new demographic question to the survey in 2024 to permit an opportunity for respondent to self-identify with a CHNA's focus populations. The question was: ***Identifying with a Community.*** *Identifying with a community means feeling a strong sense of belonging, connection, and shared identity with a group of people. It's about recognizing yourself as part of a larger whole and sharing common experiences, values, or goals. From the following list, please select the communities with whom you identify.* Responses to this question were then used to stratify the survey data by focus populations (Error! Reference source not found.).

Table 10. Identifying with a community. From the following list, please select the communities with whom you identify:

	Count	Percent
Total respondents	**2,128**	
I do not identify with any of the listed communities	620	29%
Immigrant and Refugee	582	27%
English as a Second Language	443	21%
LGBTQIA2+	319	15%
People with physical disabilities	211	10%
People with cognitive, intellectual, or developmental disabilities	174	8%
Prefer not to answer	170	8%
Another community not listed, please describe.	165	8%
People in recovery from substance use disorder	163	8%
No response/blank	25	1%

APPENDIX E: COMMUNITY HEALTH SURVEY INSTRUMENT

HCWC Community Health Survey

Welcome to the Healthy Columbia Willamette Collaborative (HCWC) Community Health Survey. This survey is a chance for you to tell us firsthand the issues you, your family, and your community are experiencing that lead to health problems. We are inviting you to share your opinions about community health issues and the experiences impacting your quality of life in Clackamas, Multnomah and Washington counties of Oregon as well as Clark County, Washington. Information from this survey will be used to inform community health improvement plans and how money is invested in community health and well-being. Therefore, this survey is an important opportunity to hear from communities what they would want to see in place to support health for everyone. The Community Health Needs Assessment (CHNA) report will be available and accessible to the community upon completion of the project in Fall 2025. To learn more about the HCWC CHNA, click here. Filling out the survey is your choice – it is completely voluntary. Although we do ask for some basic demographic information to help us understand the different experiences in the various communities in our county, this survey is anonymous. No one will know what your answers are. We value your time and input. You will be offered an opportunity to enter yourself into a drawing to win a $50.00 Visa Gift Card. Thank you for your time and interest in helping us identify our region's most critical problems! If you have any questions regarding the survey, please contact Berkley Powell at bpowell@healthmanagement.com

Introduction: The American Planning Association (APA) defines "healthy communities" as places where all individuals have access to a healthy built, social, economic, and natural environment that gives them the opportunity to live up to their fullest potential, regardless of their race, ethnicity, gender identity, income, age, abilities, sexual orientation, or other socially defined circumstance. For the survey, please answer the questions based on the ***place you live in***, as defined by the county.

In which county do you live

- Clark County, Washington
- Multnomah County, Oregon
- Washington County, Oregon
- Clackamas County, Oregon
- None of the above

The 2022 CHNA identified key health and well-being issues that were characterized by limited ease of access, high costs, poor quality, and/or a lack of cultural and linguistic responsiveness. These issues were recommended for community investment. How important is it to you that

these issues continue to be addressed TODAY through further community investment? Rate each issue on a scale of 1 (Very Important) to 5 (Not Important).

- Safe, affordable housing (refers to stable and healthy living environment that is affordable to a wide range of people)
- Physical safety in the community (refers to the state of being protected from physical harm, injury, or violence within a specific geographical area. It includes the freedom from threats, accidents, and other hazards that could endanger one's well-being.)
- Cultural displacement due to gentrification (refers to the process of wealthier individuals moving into a historically lower-income neighborhood, leading to increased property values and changes in the area's character
- Economic opportunity (Refers to the chances or prospects individuals or groups have to improve their financial status, access resources, and engage in economic activities.)
- Educational opportunity (Refers to the access and availability of educational resources and experiences for individuals. It includes the idea of equal access to education for all, regardless of social or economic background).
- Culturally-specific and healthy foods (Refers to food both rooted in a particular culture's traditions and dietary practices and also provide essential nutrients for good health. These foods often reflect a community's history, values, and taste preferences)
- Reliable and affordable transportation (refers to public transit, ride sharing, sidewalks, cross walks, bike lanes)
- Virtual resources (refers to the ability to interact with and utilize digital assets (e.g. telehealth) that exist within a virtual or online environment)
- Trauma-informed care (refers to any care that acknowledges that many individuals have experienced traumatic events that can significantly affect their mental health and well-being).
- Access to affordable health care (refers to the ability of individuals and families to obtain necessary medical treatment and services without causing financial hardship)
- Culturally- and linguistically responsive health care (Refers to a health care approach that recognizes and values the cultural beliefs, practices, and needs of patients from diverse backgrounds)
- Trust of the health care system (refers to refers to the public's belief in the competence, integrity, and reliability of health care providers, institutions, and systems)
- Social Connection (refers to the experience of feeling close and connected to others).

In your opinion, what are the THREE most important health diseases and conditions in your community? Select the top THREE issues.

- Dental/ oral health
- Chronic disease (i.e., diabetes, heart disease and stroke, high blood pressure)
- Sexually Transmitted Infections (STIs), HIV / AIDS, and other infectious diseases
- Vaccine preventable diseases (i.e., COVID-19, measles, influenza, mumps, pertussis, etc)
- Cancer
- Unintentional injuries (i.e., motor vehicle accidents, drowning)
- Mental health (i.e., stress, anxiety, depression, grieving, etc.)
- Substance use (i.e., alcohol, marijuana, heroin, cocaine, etc)
- Rape / sexual assault / sex trafficking
- Respiratory / lung disease (i.e., asthma)
- Don’t know
- I don't want to answer

Feeling like you belong is one of the main drivers of health and quality of life. Following are statements about the quality of life where you live. Please think about each statement from the neighborhood where you live and tell us if you agree, are neutral, or disagree with each statement.

○ Strongly Agree (4)	○ Agree (6)	○ Neither Agree or Disagree (9)	○ Disagree (10)	○ Strongly Disagree (11)

- 1 of 7. I am satisfied with the quality of life in my neighborhood. (Consider your sense of safety, wellbeing, participation in community life and associations, etc.)
- 2 of 7. I am satisfied with the health care available to me (and my family). (Consider access, cost, availability, quality, and options to see a provider who understands my culture, race, sexual orientation, gender identity, or disability as it relates to health care)
- 3 of 7. My neighborhood is a good place to raise children. (Consider school quality, day care, after school programs, recreation, etc.)
- 4 of 7. My neighborhood is a good place to grow old. (Consider elder-friendly housing, transportation to medical services, churches, shopping; elder day care, social support for the elderly living alone, meals on wheels, etc.)
- 5 of 7. There is economic opportunity for me (and my family)..(Consider locally owned and operated businesses, jobs with career growth, job training/higher education opportunities, affordable housing, reasonable commute, etc.)
- 6 of 7. My neighborhood is a safe place to live.(Consider residents' perceptions of safety in the home, the workplace, schools, playgrounds, parks, and the mall. Do neighbors know and trust one another? Do they look out for one another?)
- 7 of 7. There are networks of support for me and my family during times of stress and need. (Neighbors, support groups, faith community outreach, agencies, organizations)

Access to care and services means you can get health care and other services when you need them. It also means you have a usual source of care and get regular screening and prevention services so you can stay healthy. There are many reasons why people do not have access to care and services. The questions in this section of the survey will help us understand your experience with getting care from a doctor's office, clinic, or other organizations where you live.

Please rate your overall health and your community's overall health.

	Very unhealthy (1)	Unhealthy (2)	Somewhat healthy (3)	Healthy (4)	Very healthy (5)
My overall health (1)	•	•	•	•	•
My community's overall health (2)	•	•	•	•	•

Do you get the health care services you need in the county where you live?

- Yes
- No
- Sometimes
- I don't know
- Prefer not to say

Do you get the non-health care services you need in the county where you live?

- Yes
- No
- Sometimes
- I don't know
- Prefer not to say

How do you usually get to your medical appointments (physical health, mental health, oral health, etc.)?

- I drive myself
- Spouse/Partner/Relative
- Friend or Neighbor
- Public transportation
- Cab/Uber/Lyft not covered by my health insurance
- Transportation provided my health insurance
- Transportation provided by a community group
- I use telehealth services

Some people may experience barriers when accessing health care services. For example, long-distance travel can make it hard to get health care services. What barrier(s) have you experienced in getting services to support your health and wellness? Select all that apply.

- I have not experienced any barriers.
- Forms were too complicated (Medicaid, Health Insurance or doctor's office/hospital forms etc.)
- High out-of-pocket-costs/it costs too much money
- I was not eligible for services
- I could not find providers or services that understand, value and respect my culture
- I could not find providers that looked like me or that speak my language
- I did not feel safe
- I did not have health insurance
- I did not know what services and resources were available
- I do not have internet access or a device to use telehealth services
- I felt embarrassed about asking for help and/or getting services
- Needed evening and/or weekend hours of service
- Needed service not offered in my area
- No appointments were available, or I couldn't get an appointment in a reasonable amount of time
- Not easy to travel to / I don’t have transportation
- Poor physical access (i.e., handicap accessibility)

When you are sick or need health advice, where or who do you usually go? Select up to three (3) places or people.

- Doctor's office
- Hospital
- Community health center
- Retail store or minute health clinic
- Faith-based organizations
- Community based organizations
- Cultural centers
- Community health workers
- Peer health support
- Advocacy organizations
- Schools
- Government agencies (Women, Infants and Children [WIC], local health departments, etc.) (74)
- Virtual/internet groups/ social media
- Libraries
- Family member
- Friend or community member
- 211
- None
- Don't know
- I don't want to answer

If you need help getting non-health care resources, such as jobs, food, child care, or housing, where or who do you usually go? Select up to three (3) places or people

- Doctor's office
- Hospital
- Community health center
- Retail store or minute health clinic
- Faith-based organizations
- Community based organizations
- Cultural centers
- Community health workers
- Peer health support

- Advocacy organizations
- Schools
- Government agencies (Women, Infants and Children [WIC], local health departments, etc.) (74)
- Virtual/internet groups/ social media
- Libraries
- Family member
- Friend or community member
- 211
- None
- Don't know
- I don't want to answer

Do you trust the health care system (i.e., doctors, insurance companies, clinics, hospitals, other health care providers and staff) to meet your needs and support your wellbeing?

- Yes
- Maybe
- No

Please explain your response. _____

Some people may avoid or delay important health care services because of fear or discomfort. For example, a person may avoid getting health care services if they feel their health care provider (doctors, nurses, dentists, pharmacists, midwives, clinical social workers, etc.) will not listen to their concerns due to who they are. Has this happened to you?

- Yes
- No

Skip To: End of Block If Some people may avoid or delay important health care services because of fear or discomfort. For... = No

I have avoided or delayed heath care because I was worried that my concerns would not be taken seriously, or I would not be treated fairly due to my…. Select all that apply

- Race (discrimination based on physical characteristics or qualities attributed to one's race, including Black, American Indian, Pacific Islander, Asian, etc.)
- Ethnicity (discrimination based on cultural identity of a person, including culture, religion, nationality, ancestry, dress, and customs such as Hispanic, Latino/a, Spanish)
- Insurance status
- Gender identity
- Sexual orientation
- Religion or Spiritual beliefs
- Substance use
- Disability (physical, mental, behavioral)
- Specific health condition (i.e., HIV/AIDS or excess weight, etc.)
- Age
- Language
- A factor not listed
- Don't know

Tell Us About You The questions below ask for demographic information, such as your age, marital status, employment, and more. Why do we ask these questions? Your answers will help us understand the issues you have experienced and provide information about where we need to find solutions to improve them. Your answers are anonymous, and no one will know who responded. Please know that your privacy is important to us and will remain confidential.

How old are you?

- 18 to 25 years
- 26 to 35 years
- 36 to 45 years
- 46 to 55 years
- 56 to 65 years
- Over 65 years
- I don't want to answer

What is your household income? This is the total income of all the people you live with.

- Less than $15,000
- $15,000 to $24,999
- $25,000 to $49,999
- $50,000 to $74,999
- $75,000 to $99,999
- $100,000 to $124,999
- $125,000 or greater
- Not employed, student, retired, homemaker
- I don't know
- I don’t want to answer

What is your housing situation? Choose only one.

- Own home, condominium, or apartment
- Rent home, condominium, or apartment
- Live in public housing
- Live with parent or family member who is the owner or renter
- Homeless and living in emergency shelter or transitional housing
- Some other arrangement, please describe:

  _____
- I don’t want to answer

What is your primary source of health insurance today?

- A plan purchased through an employer or union (includes plans purchased through another person’s employer)
- A plan that you or another family member buys on your own
- Medicaid (Health Share of Oregon, Trillium Community Care, or Apple Health) or other state program
- Medicare
- Veterans’ Administration
- Alaska Native, Indian Health Service, Tribal Health Services
- I don't know
- I have no health care insurance.
- I have no health care insurance and pay cash for health care.
- I don't want to answer

What is your gender? (Please select all that apply)

- Woman or Girl
- Man or Boy
- Agender/No gender
- Feminine-leaning
- Masculine-leaning
- Non-binary
- Questioning
- Transgender
- Not listed.
- I don't want to answer

How do you describe your sexual orientation or sexual identity? (Please select all that apply)

- Asexual
- Bisexual
- Gay
- Lesbian
- Pansexual
- Queer
- Questioning
- Same-gender loving
- Same-sex loving
- Straight (attracted mainly to or only to other gender[s]
- Not listed
- I don’t know
- I don't want to answer

Identifying with a Community Identifying with a community means feeling a strong sense of belonging, connection, and shared identity with a group of people. It's about recognizing yourself as part of a larger whole and sharing
common experiences, values, or goals. From the following list, please select the communities with whom you identify:

- LGBTQ2IA2+
- People in recovery from substance use disorder
- People with physical disabilities
- People with cognitive, intellectual, or developmental disabilities
- Immigrant and Refugee
- English as a Second Language
- Another community not listed, please describe.
- I do not identify with any of the listed communities
- Prefer not to answer

Race and Ethnic Identity In this section, we are going to ask you a few questions about race and ethnicity. It's OK to have more than one racial or ethnic identity. Please choose the category or categories that you relate more closely to. What is your racial and ethnic identity? (Please select all that apply)

- Asian
- Biracial or Multiracial
- Black or African American
- Hispanic or Latine
- Middle Eastern or North African
- Native American or Alaska Native
- Native Hawaiian and Pacific Islander
- White
- I do not want to answer

Display This Question:

If What is your racial and ethnic identity? (Please select all that apply) = Asian

You selected Asian. Which of the following best describes your Asian heritage:

- Asian Indian
- Cambodian
- Chinese
- Communities of Myanmar
- Filipino/a

- Hmong
- Japanese
- Korean
- Laotian
- South Asian
- Vietnamese
- Other Asian
- I don't want to answer

Display This Question:

If What is your racial and ethnic identity? (Please select all that apply) = Black or African American

You selected Black or African American. Which of the following best describes your Black or African American heritage:

- African-American
- African (Black)
- Afro-Caribbean
- Ethiopian
- Somali
- Other African (Black)
- I don't want to answer

Display This Question:

If What is your racial and ethnic identity? (Please select all that apply) = Hispanic or Latine

You selected Hispanic or Latine. Which of the following best describes your Hispanic or Latino heritage:

- Central American
- Mexican
- South American
- Other
- I don't want to answer

Display This Question:

If What is your racial and ethnic identity? (Please select all that apply) = Middle Eastern or North African

You selected Middle Eastern or North African. Which of the following best describes your Middle Eastern or North African:

- Middle Eastern
- North African
- I don't want to answer

Display This Question:

If What is your racial and ethnic identity? (Please select all that apply) = Native American or Alaska Native

You selected Native American or Alaskan Native. Which of the following best describes your Native American or Alaskan Native heritage:

- Native American
- Alaska Native
- Indigenous Mexican, Central American, or South American
- I don't want to answer

Display This Question:

If What is your racial and ethnic identity? (Please select all that apply) = Native Hawaiian and Pacific Islander

You selected Native Hawaiian or Pacific Islander. Which of the following best describes your Native Hawaiian or Pacific Islander heritage:

- CHamoru (CHamorro)
- Communities of the Micronesian Region
- Marshallese
- Native Hawaiian
- Samoan
- Other Pacific Islander
- I don't want to answer

Display This Question

If What is your racial and ethnic identity? (Please select all that apply) = White

You selected White. Which of the following best describes your White heritage:

- Eastern European
- Western European
- White
- Other White
- I don't want to answer

If you selected more than one racial or ethnic category, do you consider one of the categories you selected as your primary identity?

- Yes
- No
- I don't want to answer

Skip To: Q6.19 If If you selected more than one racial or ethnic category, do you consider one of the categories yo... = Yes

Skip To: Q6.20 If If you selected more than one racial or ethnic category, do you consider one of the categories yo... = No

Skip To: Q6.20 If If you selected more than one racial or ethnic category, do you consider one of the categories yo... = I don't want to answer

Please tell us the racial or ethnic identity that is your primary identity.

Languages We are collecting language data to understand better and serve the diverse populations of the people we serve. The next few questions will ask you about: Languages spoken in your home. The language you prefer to use when talking with people outside of your home. The language you prefer when you are reading. What language or languages do you use most often at home? (Please select all that apply.

What language would you prefer to use when communicating (in person, phone, virtually) with someone outside the home about important matters such as medical, legal, or health information? Select all that apply.

What language would you prefer to use to read important written information such as medical, legal, or health information? Select all that apply.

Response options for all Language Questions were:

- Arabic
- Burmese
- Chinese
- Chuukese
- Dari
- English
- Farsi
- Karen
- Korean
- Kurdish
- Marshallese
- Pashto
- Romanian
- Russian
- Samoan
- Spanish
- Ukrainian
- Vietnamese
- Zomi
- Other

Functional Limitations Collecting information about functional limitations can help us plan for the health care and social needs of the people we serve. This section will ask you about the need for accessible facilities, assistive devices, and specialized care.

Please answer the following five questions about mental, emotional, and cognitive limitations

	Yes	No	I don't know	I don't want to answer

- 1 of 5. Because of a physical, mental or emotional condition, do you have serious difficulty concentrating, remembering or making decisions?
- 2 of 5. Do you have serious difficulty learning how to do things most people your age can learn?
- 3 of 5. Using your usual (customary) language, do you have serious difficulty communicating (for example understanding or being understood by others)?
- 4 of 5. Because of a physical, mental or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?
- 5 of 5. Do you have serious difficulty with the following: mood, intense feelings, controlling your behavior, or experiencing delusions or hallucinations?

Thank you for participating in the 2025 HCWC Community Health Survey. Please choose from the following:

- Yes, I would like to be entered into a lottery to win a $50 gift card.
- No, I would not like to be entered into a lottery to win a $50 gift card.

Skip To: Q7.2 If Thank you for participating in the 2025 HCWC Community Health Survey. Please choose from the foll... = Yes, I would like to be entered into a lottery to win a $50 gift card.

Skip To: Q7.3 If Thank you for participating in the 2025 HCWC Community Health Survey. Please choose from the foll... = No, I would not like to be entered into a lottery to win a $50 gift card

The gift card will be delivered virtually, so you must provide a valid email address to receive it. HMA will not use your email address for any purpose other than delivering the gift card should you win the lottery. If you do not have a valid email address please provide a valid phone number that can receive calls and text messages. HMA will work with you to make arrangements to mail or deliver your gift card

- First and last name _____
- Email address _____
- Phone number _____

Please click the box below if you are not a robot.

APPENDIX F: SURVEY RESPONDENT DEMOGRAPHICS

Table 11. County of Residence

In which county do you live:		
	Count	**Percent**
Multnomah County, Oregon	763	36%
Washington County, Oregon	465	22%
Clackamas County, Oregon	331	16%
Clark County, Washington	434	20%
None of the above	122	6%
No response/blank	13	1%
Total respondents	2128	

Table 12. Age

How old are you?		
	Count	**Percent**
18 to 25 years	126	6%
26 to 35 years	556	26%
36 to 45 years	537	25%
46 to 55 years	503	24%
56 to 65 years	244	11%
Over 65 years	139	7%
I don't want to answer	10	0%
No response/blank	13	1%
Total respondents	2128	

Table 13. Household Income

What is your household income? This is the total income of all the people you live with.		
	Count	**Percent**
Less than $15,000	182	9%
$15,000 to $24,999	162	8%
$25,000 to $49,999	290	14%
$50,000 to $74,999	380	18%
$75,000 to $99,999	306	14%
$100,000 to $124,999	237	11%
$125,000 or greater	338	16%

Not employed, student, retired, homemaker	60	3%
I don't know	41	2%
I don't want to answer	118	6%
No response/blank	14	1%
Total respondents	2128	

Table 14. Housing Situation

What is your housing situation? Choose only one.		
	Count	**Percent**
Own home, condominium, or apartment	1009	47%
Rent home, condominium, or apartment	811	38%
Live in public housing	69	3%
Live with parent or family member who is the owner or renter	125	6%
Homeless and living in emergency shelter or transitional housing	12	1%
Some other arrangement, please describe:	54	3%
I don't want to answer	34	2%
No response/blank	14	1%
Total respondents	2128	

Table 15. Health Insurance Coverage

What is your primary source of health insurance today?		
	Count	**Percent**
A plan purchased through an employer or union (includes plans purchased through another person's employer)	1133	53%
A plan that you or another family member buys on your own	235	11%
Medicaid (Health Share of Oregon, Trillium Community Care, or Apple Health) or other state program	395	19%
Medicare	187	9%
Veterans' Administration	16	1%
Alaska Native, Indian Health Service, Tribal Health Services	8	0%
I don't know	36	2%
I have no health care insurance.	65	3%
I have no health care insurance and pay cash for health care.	12	1%
I don't want to answer	26	1%
No response/blank	13	1%
Total respondents	2128	

Table 16. Gender

What is your gender? Select all that apply.		
	Count	Percent
Woman or Girl	1493	70%
Man or Boy	515	24%
Agender/No gender	17	1%
Feminine-leaning	28	1%
Masculine-leaning	43	2%
Non-binary	62	3%
Questioning	7	0%
Transgender	33	2%
Not listed.	9	0%
I don't want to answer	24	1%
No response/blank	13	1%
Total respondents	2128	

Table 17. Sexual Orientation or Sexual Identity

How do you describe your sexual orientation or sexual identity? Select all that apply.		
	Count	Percent
Asexual	94	4%
Bisexual	144	7%
Gay	41	2%
Lesbian	35	2%
Pansexual	42	2%
Queer	92	4%
Questioning	13	1%
Same-gender loving	21	1%
Same-sex loving	18	1%
Straight (attracted mainly to or only to other gender[s])	1478	69%
Not listed	23	1%
I don't know	21	1%
I don't want to answer	210	10%
No response/blank	28	1%
Total respondents	2128	

Table 18. Self-Identified Community/ Focus Population

Identifying with a community. From the following list, please select the communities with whom you identify:		
	Count	**Percent**
LGBTQIA2+	319	15%
People in recovery from substance use disorder	163	8%
People with physical disabilities	211	10%
People with cognitive, intellectual, or developmental disabilities	174	8%
Immigrant and Refugee	582	27%
English as a Second Language	443	21%
Another community not listed, please describe.	165	8%
I do not identify with any of the listed communities	620	29%
Prefer not to answer	170	8%
No response/blank	25	1%
Total respondents	2128	

Table 19. Race and Ethnicity

What is your racial and ethnic identity? Select all that apply.		
	Count	**Percent**
Asian	202	9%
Biracial or Multiracial	85	4%
Black or African American	97	5%
Hispanic or Latine	267	13%
Middle Eastern or North African	31	1%
Native American or Alaska Native	280	13%
Native Hawaiian and Pacific Islander	35	2%
White	1218	57%
I do not want to answer	78	4%
No response/blank	16	1%
Total respondents	2128	

Table 20. Race and Ethnicity (continued)

You selected Asian. Which of the following best describes your Asian heritage:		
	Count	Percent
Asian Indian	11	5%
Cambodian	1	0%
Chinese	59	29%
Communities of Myanmar	17	8%
Filipino/a	12	6%
Hmong	3	1%
Japanese	12	6%
Korean	29	14%
Laotian	1	0%
South Asian	8	4%
Vietnamese	27	13%
Other Asian	31	15%
I don't want to answer	5	2%
Total that selected Asian	202	
Total choices selected	216	

You selected Black or African American. Which of the following best describes your Black or African American heritage:		
	Count	Percent
African-American	44	45%
African (Black)	32	33%
Afro	0	0%
Afro-Caribbean	9	9%
Ethiopian	5	5%
Somali	9	9%
Other African (Black)	3	3%
I don't want to answer	3	3%
Total that selected Black or African American	97	
Total choices selected	105	

Table 21. Race and Ethnicity (continued)

You selected Hispanic or Latine. Which of the following best describes your Hispanic or Latino heritage:		
	Count	**Percent**
Central American	18	7%
Mexican	191	72%
South American	28	10%
Other	31	12%
I don't want to answer	3	1%
Total that selected Hispanic or Latine	267	
Total choices selected	271	

You selected Middle Eastern or North African. Which of the following best describes your Middle Eastern or North African:		
	Count	**Percent**
Middle Eastern	24	77%
North African	6	19%
I don't want to answer	1	3%
Total that selected Middle Eastern or North African	31	
Total choices selected	31	

You selected Native American or Alaskan Native. Which of the following best describes your Native American or Alaskan Native heritage:		
	Count	**Percent**
Native American	256	91%
Alaska Native	20	7%
Indigenous Mexican, Central American, or South American	11	4%
I don't want to answer	1	0%
Total that selected Native American or Alaskan Native	280	
Total choices selected	288	

Table 22. Race and Ethnicity (continued)

You selected Native Hawaiian or Pacific Islander. Which of the following best describes your Native Hawaiian or Pacific Islander heritage:		
	Count	**Percent**
CHamoru (CHamorro)	4	11%
Communities of the Micronesian Region	9	26%
Marshallese	1	3%
Native Hawaiian	4	11%
Samoan	5	14%
Other Pacific Islander	11	31%
I don't want to answer	2	6%
Total that selected Native Hawaiian or Pacific Islander	35	
Total choices selected	36	

You selected White. Which of the following best describes your White heritage:		
	Count	**Percent**
Eastern European	345	28%
Western European	345	28%
White	505	41%
Other white	99	8%
I don't want to answer	32	3%
Total that selected White	1218	
Total choices selected	1326	

Table 23. Language most often used at home

What language or languages do you use most often at home? Select all that apply.		
	Count	**Percent**
Arabic	30	1%
Burmese	13	1%
Chinese	62	3%
Chuukese	1	0%
Dari	10	0%
English	1532	72%
Farsi	15	1%
Karen	15	1%

Table 24. Language most often used at home (continued)

What language or languages do you use most often at home? Select all that apply.		
	Count	Percent
Korean	26	1%
Kurdish	2	0%
Marshallese	4	0%
Pashto	6	0%
Romanian	24	1%
Russian	361	17%
Samoan	6	0%
Spanish	261	12%
Ukrainian	191	9%
Vietnamese	22	1%
Zomi	4	0%
Other	127	6%
Blank/no response	24	1%
Total respondents	2128	

Table 25. Preferred Language for Communications

What language would you prefer to use when communicating (in person, phone, virtually) with someone outside the home about important matters such as medical, legal, or health information? Select all that apply.		
	Count	Percent
Arabic	18	1%
Burmese	10	0%
Chinese	40	2%
Chuukese	3	0%
Dari	6	0%
English	1656	78%
Farsi	16	1%
Karen	12	1%
Korean	17	1%
Kurdish	1	0%
Marshallese	4	0%
Pashto	7	0%
Romanian	17	1%

Russian	311	15%
Samoan	5	0%
Spanish	166	8%
Ukrainian	151	7%
Vietnamese	12	1%
Zomi	3	0%
Other	43	2%
Blank/no response	24	1%
Total respondents	2128	

Table 26. Preferred Language for Written Information

What language would you prefer to use to read important written information such as medical, legal, or health information? Select all that apply.

	Count	Percent
Arabic	18	1%
Burmese	8	0%
Chinese	41	2%
Chuukese	1	0%
Dari	6	0%
English	1621	76%
Farsi	14	1%
Karen	11	1%
Korean	17	1%
Kurdish	3	0%
Marshallese	3	0%
Pashto	4	0%
Romanian	14	1%
Russian	290	14%
Samoan	6	0%
Spanish	166	8%
Ukrainian	152	7%
Vietnamese	9	0%
Zomi	3	0%
Other	37	2%
Blank/no response	45	2%
Total respondents	2128	

APPENDIX G: SUPPORTING DATA FOR REGIONAL DEMOGRAPHIC PROFILE, HEALTH PRIORITY AREAS, HEALTH BEHAVIORS, AND OUTCOMES

Click here

APPENDIX H: COMMUNTIY ADVISORY GROUP RECOMMENDATION PRIORITIZATION SURVEY

The following recommendations were developed through the 2022 Community Health Needs Assessment (CHNA) process and further refined by the Community Advisory Group in 2025. This survey offers you an opportunity to share your perspective by prioritizing these recommendations based on what you've learned from the findings of the 2025 CHNA.

Please keep in mind the following criteria in your assessment of each recommendation:

- Impact on Health Outcomes: Will the recommendation significantly improve health outcomes for the community? Does it address a major health issue identified in the CHNA?
- Feasibility: Is the recommendation realistic given current resources, infrastructure, and capacity?
- Community Support: Is there strong support or demand from community members or stakeholders?

Please reach out to Robyn Odendahl, with HMA at rodendhal@healthmanagement.com, if you have questions about this survey. Please respond by July 31st. The results will be shared with you for your feedback by August 4th.

Access to Culturally & Linguistically Appropriate Services Recommendations. Please select up to **THREE [3]** recommendations you would prioritize for HCWC investment over the next 3 to 5 years

- Support more culturally-specific trauma-informed physical and mental health services and supports, clinics and/or community centers.
- Increase workforce development pipelines to healthcare and behavioral health workers that reflect and represent the region's diversity in language, ability, culture, sexual orientation, and gender.
- Expand investments in traditional health workers to increase community representation in the workforce.
- Invest in building/repairing trust between the healthcare system and priority populations.
- Invest in efforts to address gaps in insurance eligibility for Hispanic/Latinx, Pacific Islander and multi-racial populations.
- Invest in and ensure adequate resources for language accessibility in services.
- Other (14) _____

Neighborhood for All. Please select up to **TWO [2]** recommendations you would prioritize for HCWC investment over the next 3 to 5 years

- Engage local politicians, including city councils and commissioners, as necessary advocates for creating a neighborhood where members of the community are safe, have access to affordable and accessible quality housing and transportation, and have healthier living environments.
- Invest proactively rather than reactively in equity-centered and community-informed solutions to rising violent crime rates.
- Support sustainable civic engagement and education programs, particularly for immigrant and refugee communities.
- Other, please describe _____

Support for Family and Community Ways. Please select up to **TWO [2]** recommendations you would prioritize for HCWC investment over the next 3 to 5 years

- Offer culturally specific community spaces for community and educational events to take place and foster relationship building.
- Build awareness and engagement of health resource and supports through supporting and leveraging existing collaborative efforts with community organizations to reach those in need.
- Invest in non-academic youth development programs as well as for peer mentorship programs and access to peer education services.
- Invest in and prioritize data collection with respect to race and ethnicity, sexual orientation, ability, and gender to guide policy making and allocation of resources.
- Recognize the role of traditional health workers (THW) in providing social support and community cohesion by expanding investments in the THW workforce.
- Other, please describe _____

Essential Community Services and Resources. Please select up to THREE [3] recommendations you would prioritize for HCWC investment over the next 3 to 5 years

- Create more opportunities and capacity for workforce development and community education programs that support individuals to earn a living wage, including non-English speaking community members.
- Invest in ways to support not just the delivery of services but the infrastructure and capacity to sustain those services.
- Invest in addressing geographic areas with limited grocery store options and ensure culturally relevant and affordable healthy food access to communities in all grocery stores.
- Work to eliminate education disparities, starting with equitable access to affordable and quality child care and preschools.

- Invest in technology infrastructure to increase access to virtual resources and ensure any community engagement efforts in the region include resources to address internet access barriers.
- Other, please describe__

Below is the list of ALL recommendations provided across the four focus areas. Please select up to **FIVE [5]** recommendations you would prioritize for HCWC investment over the next 3 to 5 years.

- Support more trauma-informed physical and mental health services and supports, clinics and/or community centers.
- Increase workforce development pipelines to health care workers that reflect and represent the region's diversity in language, ability, culture, sexual orientation, and gender.
- Expand investments in traditional health workers to increase community representation in the workforce.
- Invest in building/repairing trust between the healthcare system and priority populations.
- Invest in efforts to address gaps in insurance eligibility for Hispanic/Latinx and multi-racial populations.
- Ensure adequate resources for language accessibility in services and education and invest in health literacy efforts.
- Engage local politicians, including city councils and commissioners, as necessary advocates for creating a neighborhood where members of the community are safe, have access to quality housing, and have healthier living environments.
- Invest proactively rather than reactively in equity-centered and community-informed solutions to rising violent crime rates.
- Support sustainable civic engagement and education programs, particularly for immigrant and refugee communities.
- Offer culturally specific community spaces for community and educational events to take place.
- Build awareness and engagement of health resource and supports through supporting and leveraging existing collaborative efforts with community organizations to reach those in need.
- Invest in non-academic youth development programs as well as for peer mentorship programs and access to peer education services.
- Invest in and prioritize data collection with respect to race and ethnicity, sexual orientation, ability, and gender to guide policy making and allocation of resources.
- Create more opportunities and capacity for workforce development programs that support individuals to earn a living wage.
- Invest in ways to support not just the delivery of services but the infrastructure and capacity to sustain those services.

- Invest in addressing areas with limited grocery store options and ensuring culturally relevant and healthy food access to communities most impacted by these geographic disparities.
- Work to eliminate education disparities, starting with equitable access to affordable and quality child care and preschools.
- Invest in technology infrastructure to increase access to virtual resources.
- Ensure any community engagement efforts in the region include resources to address internet access barriers.
- Other, please describe _____

(Optional) Please share any additional feedback and/or considerations we should know regarding your prioritization.

_____

_____

APPENDIX I: FOCUS GROUP THEMATIC FINDINGS

Click here

APPENDIX J: COMMUNITY HEALTH SURVEY ANALYSIS AND DETAILED FINDINGS

Click here