Columbia Pacific CCO™

Regional Health Assessment and Improvement Plan

Including outreach, evidence-informed strategies and more

Contents

Introduction

Since its early days, Columbia Pacific CCO (CPCCO) has worked to increase opportunities for our members and the communities we serve to inform and participate in our strategic-planning efforts. Our Regional Health Assessment (RHA) and resulting Regional Health Improvement Plan (RHIP) are key opportunities to listen to the communities we serve to understand their health-related needs and commit to action in partnership.

We take pride in our unique approach in which our Community Advisory Councils and broader communities impact every step of our process and share in ownership of the results. We believe this process builds a firm foundation for our work and a clear vision of how best to leverage community investments and shared priorities.

In this document, you will see the result of two years of community-led work to learn from our partners' community health needs assessments, to gather and share experiences using a method that includes stories and numerical data, and to work together to make meaning of what we've learned. The in-depth process has made the mandate from our communities very clear.

To create a healthier Northwest Oregon, we must work together with a focus on the basics:

- Investing in more-equitable food systems
- Focusing deeply on the needs of children and youth
- Increasing housing stability and services for our houseless community members

Our Community Advisory Councils

The heart of our Regional Health Assessment and Improvement Plan

Columbia Pacific facilitates four Community Advisory Councils. There's a council in each of the three counties we serve. We also have a Regional Advisory Council whose members are the chairs and co-chairs of our three county-level Advisory Councils. Each council — much like the communities they represent — has its own culture, its own perspectives and its own needs. Since the formation of our Advisory Councils nearly 12 years ago, we've worked together to build Councils and spaces that reflect their feedback as well as their co-ownership of our work in the community.

In the same spirit, each of our Regional Health Assessments and Improvement Plans have incorporated more and more of our Councils' perspectives and feedback. For the assessment and improvement plan that follows, our Advisory Councils were actively involved in a variety of ways:

- **Pre-planning**: Our Advisory Councils adopted health-equity impact statements at the end of our previous Regional Health Improvement Plan cycle that became the starting place of the goal statements in this new plan.
- **Process input**: Each council received monthly updates on how the process had progressed and what work was upcoming, including opportunities for council participation.
- **Planning**: During the planning process, there were two main ways that our advisory councils were involved.
    - Community-inclusive workgroup (details in Methods and Processes): A voting Advisory Council member and multiple prospective members were among the regular attendees in this small group.
    - Instrument design workshop (details in Methods and Processes): Voting Advisory Council members made up the majority of participants.
- **Story Collection**: Advisory Council members who work for partner agencies hosted collection events, in addition to each Council member having multiple in-meeting opportunities to access the story-collection instrument. Members also encouraged their networks to participate.
- **Data interpretation:** (details in Methods and Processes): Voting Advisory Council members made up the majority of participants in this set of workshops.
- **Prioritization**: Each county-level Advisory Council hosted a community-input session in place of a normal meeting in February 2024. The sessions also offered an opportunity for Advisory Council members to weigh in as part of the community-voting process for priority selection.
- **Affirmation**: At all four Advisory Council annual meetings in March 2024, members were given time to review the outcome of the community-voting process. During this time,

members discussed and affirmed that the top-three priorities to receive votes resonated with them. They also discussed and affirmed that their existing health-equity impact statements related to each chosen priority reflect their vision for long-term improvement.

- **Adoption**: While all four Advisory Councils were presented with a high-level presentation of the resulting Regional Health Improvement Plan, our Regional Advisory Council formally adopted the plan in September 2024 on behalf of the county-level Councils they represent.

From here, our Advisory Councils will continue to be engaged in the regular updates to the Oregon Health Authority (OHA). They will also continue to play an important role in directing community investments in programs that align with the priorities and strategies laid out in this Regional Health Improvement Plan.

Our partners

Columbia Pacific is fortunate to have a region full of community-minded partners. The organizations listed below not only endorsed this plan but also participated in our process in any number of meaningful ways including: sending representative staff to our Regional Health Assessment Workgroup, hosting and collecting stories, hosting and participating in community-input sessions, and/or agreeing to partner around the strategies of the final Regional Health Improvement Plan.

A look at our region

Our geography

Northwestern Oregon – comprising Columbia, Clatsop, and Tillamook counties – is bound by the Columbia River to the north and the Pacific Ocean to the west. Yamhill County, Washington County and Multnomah County border the region to the south and east. The coast range runs through the region, with elevation reaching 1,794 feet at Saddle Mountain. The coast range is dominated by coniferous temperate rainforest. To the west, beaches with sandy dunes and steep mountain slopes meet the Pacific Ocean. To the east of the coast range lie foothills and farmland.[i,ii]

Our first stewards

Before European settlement, many Indigenous Tribes stewarded the land we now know as Columbia, Clatsop, and Tillamook counties. The Chinooks lived on the north bank of the Columbia River estuary in present-day Washington, and the Clatsops on the south bank, in what is now Clatsop County.[iii] The Tillamook Tribe resided a little to the south, in today's Tillamook County, and was comprised of bands including the Nehalem, the Tillamook proper, the Nestucca, the Salmon River, and the Siletz.[iv] The Tlatskanai (Clatskanie) Tribe lived farther east near the Clatskanie River in today's Columbia County, having migrated south from Washington near the Chehalis River.[v] Southeast Columbia County, near the Portland metro area, was home to the Kalapuya, Multnomah, and Cowlitz, among other Tribes.[vi]

All these Tribes were exposed to epidemic disease and experienced violent displacement at the hands of white European settlers. In 1792, at the time of Robert Gray's navigation of the Columbia River, the largest Clatsop settlement was located at Point Adams, or today's Fort Stevens State Park.[vii] An unratified 1851 treaty secured the primary Clatsop settlement at Point Adams. However, Fort Stevens was built several years later, forcibly displacing the Tribal community that was already in a precarious position.[viii] Many of the refugees from Point Adams moved to "Indian Place" in present-day Seaside: a settlement comprised of both Nehalem-Tillamook and Clatsop Tribal members, and a stopping point between the Native settlements of Bay Center, Washington (Chinook) and Garibaldi (Nehalem-Tillamook).[ix]

According to scholar Douglas Deur, "Indian Place became a prominent nineteenth-century hub of social, ceremonial, and economic activity linked to an increasingly diffuse constellation of displaced tribal refugees."[x] Residents of "Indian Place" made and sold baskets in the burgeoning tourist economy and caught and sold fish and shellfish to local markets. But by the early twentieth century, "Indian Place" residents dispersed as non-Native settlers encroached on their land and built the town of Seaside.[xi]

Farther to east, the Tlatskanai Tribe drastically decreased in number due to a smallpox outbreak following the Donation Land Law of 1850, which incentivized white European settlers to homestead in Oregon.[xii] To the south, Sauvie Island — known by the Multnomah Band of

Chinook as Wapato — was home to several Indigenous villages. White settlers introduced malaria in 1829, which killed most Indigenous peoples on Wapato over the next few years.[xiii]

Today, none of the Tribes of the North Coast region is federally recognized on its own, though the Confederated Tribes of Siletz Indians includes Clatsop, Chinook, and Tillamook among its members, and the Confederated Tribes of Grand Ronde includes Tillamook and Chinook among its members.[xiv] In 1954, the Western Oregon Termination Act stripped the Confederated Tribes of Siletz Indians and the Confederated Tribes of Grand Ronde of their federal recognition.[xv] Congress restored federal recognition for the Siletz in 1977 and in 1983 for the Grand Ronde.[xvi] The Chinook Tribe received federal recognition in 2001, and it was rescinded one year later. The Chinook Tribe's federal recognition remains unrestored.[xvii]

We acknowledge and honor the resilience of the Indigenous communities in the Columbia Pacific region and across the United States. Through preservation of culture, language and ways of life, and through continuing to fight for recognition, countless Indigenous Tribes and communities continue to resist the ongoing impacts of genocide, colonization and displacement. We also acknowledge that we are working in a context in which the U.S. government holds power to decide the terms of its relationships to Tribes as sovereign nations. That said, while many Tribes may not be recognized at the state or federal level, the sovereignty of Tribal governments is determined by their people and connection to ancestral land. It cannot be granted by an external government.[xviii]

In conducting our Regional Health Assessment, it has been important for us to include not only the experience of Indigenous members whose Tribes are federally recognized in our service area, but all Tribal members who live in the Columbia Pacific region. We acknowledge that we are not experts, and that like all data, our data has gaps. We welcome input and engagement on what we present here and will continue to seek input and engagement from Tribal members.

The people we serve

Demographics of Columbia Pacific service region

Much of the demographic data available for our region is from the U.S. Census Bureau, specifically from the 2020 Census and 2022 American Community Survey. This data source has flaws, as all do. How questions are asked, the methods of asking them, and the surrounding politics at the time the Census was taken can result in gaps in our understanding.[xix] This particularly comes into play when considering that the 2020 Census and 2022 American Community Survey were taken during the COVID-19 pandemic, with a shortened response window, and with questions around whether citizenship would be included as a question. Notably, the Census Bureau currently does not ask about sexual orientation. The data that we use from the Census Bureau remains the most-recent data we have for the most people. Columbia Pacific continues to be transparent in how we communicate our data sources to the communities we serve.

Rural status

While the definition and concept of "rural" is complex and constantly changing, according to the Ford Family Foundation's Oregon Voices Survey in 2022,[xx] most respondents in all three Columbia Pacific counties describe their community as "rural."

Our service region has a total land area of 2,768.68 square miles with a total population of 121,051 people. [xxi, xxii, xxiii] It is much-less dense than neighboring Washington and Multnomah counties, which have a total population of 1,415,800 in an area that is 1,155.3 square miles.[xxiv, xxv]

Maintaining health and well-being in the Columbia Pacific region can be difficult given the long distances residents must often travel to service providers and the fact that all three of our counties are designated as Health Professional Shortage Areas.[xxvi] This is especially true for residents who face economic challenges and transportation barriers. The combination of provider shortages, distance to services and economic challenges exacerbate any additional barriers to health and social care, such as knowledge or mobility.

Income and financial hardship

While Columbia County has a higher median income ($73,909) than the state average ($70,084), Clatsop ($61,846) and Tillamook ($55,730)[xxvii] Counties' are lower, yet still in the middle third of all Oregon counties (six). In terms of the percentage of households who are in financial hardship, however, the outlook is worse. Tillamook County has one of the highest percentages of households with annual incomes below what is needed to cover the basic costs of living at 49%.[xxviii] Columbia County has a financial-hardship rate of 47%, and Clatsop County has a rate of 45%.[xxix] The percentage of financial hardship for rural Oregon overall is 46% and 44%[xxx] for Oregon as a whole.

Additionally, Clatsop and Tillamook Counties have higher food-insecurity rates[xxxi] than Oregon on average, and Tillamook County has a high rate of child poverty[xxxii] compared to other Oregon counties.

Age

All three of our counties' median ages are older than the state as a whole and have a disproportionate number of people over the age of 65.[xxxiii] This is noteworthy given the barriers to care in rural areas described above and considering that the process of aging entails an increasing risk of poor health. Additionally, age discrimination and age-related stigma can be barriers to care for aging populations, resulting in poorer quality of care.[xxxiv]

Age	Median Age	Under 5	18+	65+
Clatsop (41,072)	44.5	4.7%	81.4%	22.5%
Columbia (52,589)	43.3	5.3%	79.1%	18.9%
Tillamook (27,390)	47.7	4.5%	81.1%	25.8%
Oregon (4,237,256)	40.1	5.0%	79.8%	18.6%

Figure 1. Source: 2022 American Community Survey, 5-Year Estimates

Race and ethnicity

As Oregon becomes an increasingly diverse state, it's important to understand the distribution of racial and ethnic groups in order to better serve communities facing contemporary and historical injustices.

According to the Ford Family Foundation, "Federal and state policies and economic forces have shaped Oregon's demographics since the state's founding. From Black exclusion laws enacted in the 1800s to immigration and labor policy to tribal termination, the racial and ethnic makeup of our state has a complicated history worthy of further learning and exploration."[xxxv] And with greater understanding, we aim to better serve our communities of color whose lives have been impacted by unjust laws and policies throughout history.

Communities that have grown in our service region between the 2010 and 2020 census include people who identify as American Indian and Alaska Native in all three counties, people who identify as Hispanic or Latino (of any race) in Clatsop County, and people who identified with two or more races in all three counties.[xxxvi] Our communities of color are growing, though unevenly. In the same span of time, the amount of people who identified as Black and the amount of people who identified as Native Hawaiian and Pacific Islander communities are smaller regionwide as compared to 2010.[xxxvii]

Compared to Oregon as a whole, there is a higher percentage of people who identify as American Indian and Alaska Native in both Columbia and Tillamook counties. Tillamook and Columbia Counties also have a higher percentage of people who identify as two or more races as compared to Oregon overall.[xxxviii] Tillamook has a higher percentage of people who did not identify with any of the racial categories on the U.S. Census (i.e., selected "some other race") as compared to Oregon overall.[xxxix] All three counties in Columbia Pacific's service area have a higher percentage of people who identify as white as compared to Oregon as a whole.[xl]

Race and Ethnicity	American Indian & Alaska Native	Asian	Black or African American	Hispanic or Latino (Of any race)	Native Hawaiian and Pacific Islander	Some Other Race	Two or More Races	White
Clatsop (41,072)	**1.1%**	1.4%	0.6%	**9.4%**	0.3%	4.0%	**8.8%**	84.1%
Columbia (52,589)	**1.4%**	1.1%	0.6%	5.8%	0.2%	1.9%	**8.7%**	86.0%
Tillamook (27,390)	**1.1%**	1.0%	0.3%	10.8%	0.3%	5.1%	**9.6%**	82.6%
Oregon (4,237,256)	1.5%	4.6%	2.0%	13.9%	0.5%	6.3%	10.5%	74.8%

Figure 2. Source: 2020 Decennial Census.

Language

According to the 2020 Census, the Columbia Pacific service region has become less linguistically diverse. English-only households grew in all three counties, while fewer households reported speaking Spanish in Clatsop and Columbia counties.[xli] The same is true of the other languages spoken in most counties. We do suspect that this is an undercount, but without further study we cannot find more accurate data. It's important to note that the number of Spanish-speaking households, as well as those who speak a language from Asia or the Pacific Islands, grew in Tillamook County when compared to the 2010 Census. Households speaking "Other Indo-European Languages" increased in Columbia and Tillamook counties.

Language	Asian and Pacific Islander Languages	English Only	Spanish	Other Indo-European Languages	Other Languages
Clatsop (41,072)	0.6%	**93.6%**	4.4%	1.2%	0.2%
Columbia (52,589)	0.6%	**96.7%**	2.0%	**0.6%**	0.1%
Tillamook (27,390)	**0.6%**	91.2%	**7.4%**	**0.6%**	0.3%
Oregon (4,237,256)	3.2%	84.8%	8.7%	2.6%	0.7%

Figure 3. Source: 2022 American Community Survey, 5-Year Estimates

Functional diversity

Our region's community members are more likely to report experiencing any form of functional need, when compared to the state as a whole.[xlii] This includes a higher rate of those under 65 years of age being more likely to experience a functional difficulty as compared to Oregon overall. All three counties have a higher percentage of people reporting themselves as "disabled" compared to Oregon overall, as well as people reporting hearing, cognitive, ambulatory, self-care, and independent-living difficulties. Clatsop and Tillamook counties had a higher percentage of people who reported vision difficulties compared to the state as a whole.

Functional Diversity*	Disabled Population*	Hearing Difficulty	Vision Difficulty	Cognitive Difficulty	Ambulatory Difficulty	Self-care difficulty	Independent living difficulty	Under 65 years
Clatsop (41,072)	18.7%	6.5%	2.9%	**7.5%**	**10.6%**	**4.2%**	8.0%	12.8%
Columbia (52,589)	16.2%	**5.6%**	2.1%	7.2%	8.1%	3.4%	7.2%	12.1%
Tillamook (27,390)	**20.3%**	6.1%	**3.7%**	**8.8%**	**10.2%**	**3.7%**	8.1%	17.5%
Oregon (4,237,256)	**15.1%**	4.4%	**2.5%**	**6.8%**	7.0%	**2.9%**	**6.7%**	10.2%

Figure 4.Source: 2022 American Community Survey, 5-Year Estimate

Health disparities in the Columbia Pacific region

Root causes of disparities and data gaps

The disparities that exist in our region are tied to structural violence and the oppression and marginalization of groups. This has manifested over the years nationally, regionally and locally, and continues to be perpetuated through economies and policies tied to cultural norms, distribution of resources and rules.

The structures of power that contribute to manifestations of privilege and marginalization include: racism/white supremacy, ableism, sexism, homophobia and transphobia, classism and nativism/xenophobia. These forms of oppression are also compounded by ensuing experiences of individual and intergenerational trauma. The legacy of the root causes and structures can be seen and are reflected in the data we see from community narratives and in population-health data. However, the data that is missing also says a lot because these structures of oppression limit what data is collected, how we can access it and who even lives in the community.

Columbia Pacific's three-county region shares much of Oregon's history of the oppression of groups based on identity and lived experiences. This history has had a myriad of impacts on the trajectory of our region's history, many of which come back to the long-term and systematic encouragement of homogeneity at the expense of our Indigenous and Black populations acutely, as well as people of color generally, and other groups who historically experience systemic oppression. This history has included white settlement and displacement of Tribes who were caretakers of our region,[xliii] Black-exclusion laws,[xlivxlv] Chinese-exclusion laws,[xlvi] and white-supremacy group ties to systems of power in the 1920s in the region, such as newspapers, schools and local governments.[xlvii]

This history and homogeneity are seen and felt in our health care and social care systems by natural extension. Power imbalances are far-reaching and very slow to shift, including when it comes to health care, social drivers of health and health outcomes. For example, struggles to access linguistically and culturally appropriate care in all settings of our region is an extension of long-term xenophobia and consolidation of power and leadership to mostly white, English-speaking residents. Unmitigated, historical and generational trauma can cause a variety of disparate impacts on health and well-being.

While there are many quantitative data gaps on health disparities in our region due to the causes mentioned above, we do have some disaggregated, quantitative population-health data within the region and seek regularly to access as much as we can. Below are some of the group specific disparities we see in our region.

Population- and member-specific health disparities

From claims data, we can observe some member-level opportunities to address disparities among specific populations. When looking at distribution of diabetes among age groups and race/ethnicity, there is an opportunity to address the disproportionate impact of diabetes on people who identify as Hispanic (with 16.8% accounting for 23% of the diagnosis).[xlviii] When we look at diabetes diagnosis by zip code, the Garibaldi (97118) area of Tillamook County is disproportionately impacted.

In terms of asthma diagnosis, a larger proportion of pediatric members who identify as American Indian/Alaska Native, Black/African American and Hispanic are diagnosed, with the disparity being most pronounced in the Hispanic population.[xlix] When looking at diagnosis by zip code, the Arch Cape (97102) area on both sides of the border between Tillamook and Clatsop counties are disproportionately impacted.

Health disparities by region (as compared to Oregon)

When looking at available-population data for all three counties in our service region, we see region-specific disparities as compared to Oregon overall. Please note that error margins can be high for much of this population data, so it is difficult to confidently generalize. However, the data does give insight into potential disparities in our region and important issues to address.

Housing

The Point-in-Time (PIT) count of people experiencing homelessness happens once every two years and is designed to count the number of people living in facilities for people who are unhoused and on the streets. It does not generally count people who are staying a few nights with a relative, youth who are "couch surfing" temporarily, or those being put up in a garage or a barn. While the PIT count is certainly far from perfect, it serves as a marker for the number of people experiencing homelessness, whether sheltered or not. From the last count in 2021, Clatsop had the highest rate per capita in Oregon, while Tillamook has the second-highest rate in the region, and eight-highest rate in Oregon.[l]

Maternal and child health

Low birthweight can be an indicator of mother's access to nutrition, rest, adequate prenatal care and a clean environment.[li] Relative to Oregon as a whole, all three counties in our service region had higher rates of low-birthweight babies born in 2022, the last year for which there is final data.[lii]

Children and youth

All three counties have seen a slow, mostly steady decline in the rate of children in foster care. However, the rates for Clatsop and Columbia counties remain higher than the statewide rate. [liii]

It is important to continually assess data around children who enter care, including demographics, living arrangements, where they go when they exit care, and the experiences of youth who never leave and age out of the system. These factors can flag areas to advance policy and practices to improve outcomes for children, youth and families.[liv]

The percentage of disconnected youth in all three counties is higher than that for Oregon overall.[lv] Disconnected youth are teens and young adults (ages 16-19) who are neither working nor in school and are at an increased risk of engaging in unhealthy behaviors and may need more support.

Juvenile-arrest rates are another indicator of youth health and are worse in Clatsop and Tillamook counties as compared to Oregon overall.[lvi] According to the Robert Wood Johnson Foundation, "juvenile arrests are the result of many factors such as policing strategies, local laws, community and family support, and individual behaviors. Youth who are arrested face disproportionately higher morbidity and mortality. Those who are arrested and incarcerated experience lower self-reported health, higher rates of infectious disease and stress-related illnesses, and higher body mass indices."[lvii]

Adult mental and physical health indicators and access to care/support

Our service region has additional health indicators that are worse than their corresponding statewide averages. Adult obesity, a chronic condition that puts individuals at an increased risk of other health issues, is higher in Columbia and Tillamook counties as compared to Oregon overall.[lviii] Access to exercise opportunities is relatively lower in these two counties, and physical inactivity is relatively higher.[lixlx] Columbia County also has higher rates of driving alone to work with a long commute, which can increase the risk of a variety of poor health outcomes.[lxi]

Adult smoking, which is a cause of many adverse health outcomes, is higher in all three counties compared to Oregon overall, as is excessive drinking.[lxii, lxiii]

Clatsop County fares worse on its food-environment index compared to the state as a whole. The index takes into account a combination of lack of access to healthy foods and food insecurity.[lxiv]

The difficulties of being rurally located and in a provider-shortage area are a reality for our region. Our region fares worse than the state as a whole in the ratio of primary care physicians to the population, as well as the ratio of mental health providers to the population.[lxv, lxvi] The rate of preventable hospital stays is also higher in each of the counties we serve compared to the state as a whole.[lxvii]

Suicide rates are higher in our region. The latest compilation of five-year data (2016-2020), shows that both Clatsop and Columbia counties have higher rates than Oregon overall, and that Tillamook County has a similar rate to that of Oregon, whose rate is higher than the national rate.[lxviii] Firearm fatalities are worse in all three counties as compared to Oregon overall.[lxix]

Drug-overdose deaths are another important factor to look at, given the rise in Oregon and nationally. Clatsop County had a higher drug-overdose death rate as compared to Oregon overall in the most-recent compilation of three-year data (2018-2020).[lxx]

Population data

Our narrative story collection and community-inclusive data review led to the identification of **seven key health concerns for the Columbia Pacific region**. The key concerns were treated as potential priority areas that our community later voted to prioritize. The data below is organized by which key health concern it most relates to, and whether it is health-status data and leading cause-of-death data, or data related to the social drivers of health.

Behavioral health is a broad term that refers to how behavior impacts the health and well-being of the body, mind and spirit. This includes what we often call mental health, substance use, suicide prevention, crisis intervention, sense of belonging and more. Behavioral health care can include prevention of deaths of despair, activities that build belonging and self-determination, as well as promotion of healthy self-care and much more. The data below give us a broad sense of the behavioral health in our region.

Health status and leading causes

The data below reflects regional health-status data as well as data on the leading causes of chronic disease, injury and death related to behavioral health.

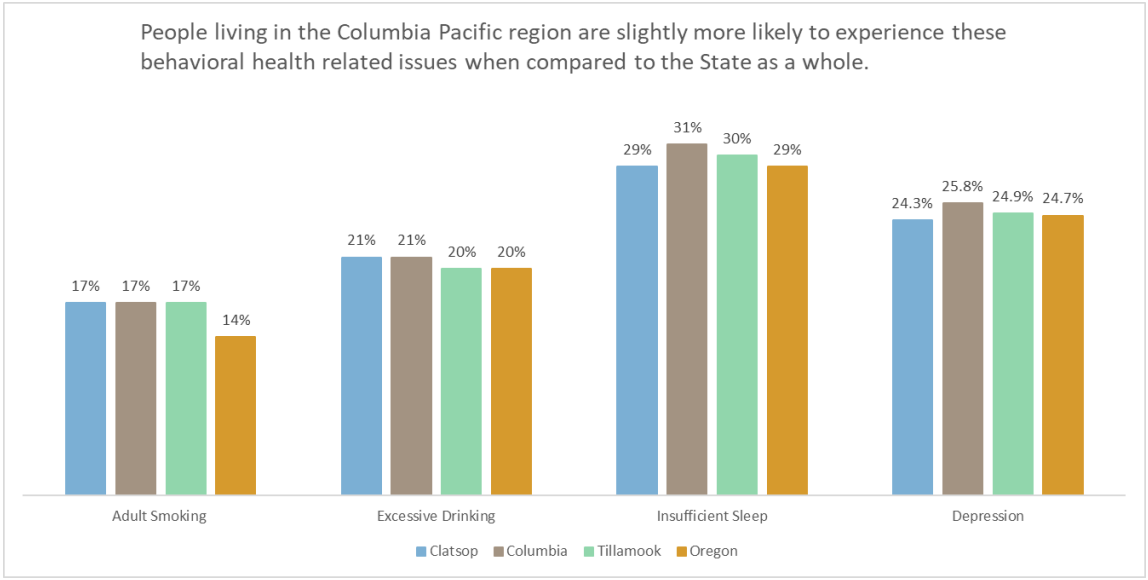


Figure 5. Source: 2021 Behavioral Risk Factor Surveillance Survey

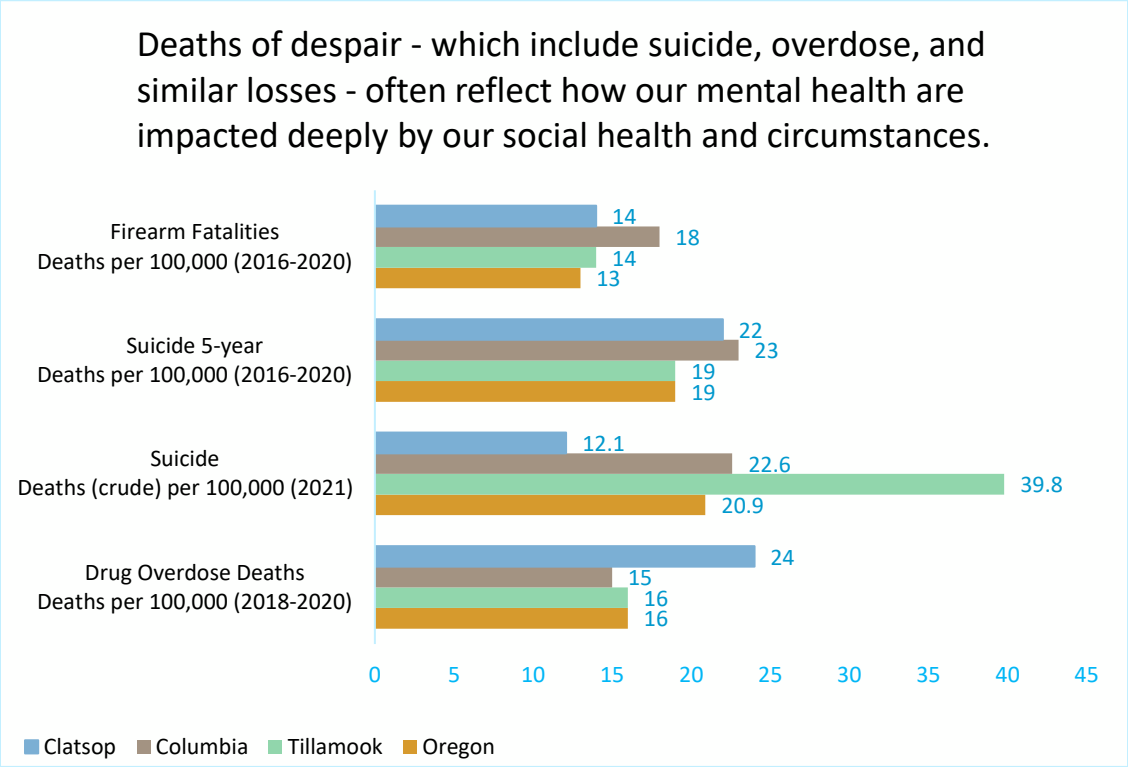


Figure 5. Source: Oregon Health Authority, Center for Health Statistics

Social drivers of health

The data below reflects the ways that place, access to services, community and economics can impact our behavioral health.

Behavioral Health Social Data	Clatsop	Columbia	Tillamook	Oregon
Mental Health Providers **(Ratio population to providers)**	280:1	250:1	330:1	160:1

Figure 6. Source: RWJF 2023 County Health Rankings

Community empowerment is an area of health that was called out quite clearly in our primary data as a connection between health, justice, community organizing and opportunities for self- and community-determination. Measures of community empowerment include: indicators of bias crimes, economic opportunity, access to equity-focused programs and organizations, and more. We interpret these data as signs of whether all our communities have an equitable opportunity to drive community health.

Health status and leading causes

The data below reflects regional health-status data as well as data on the leading causes of chronic disease, injury and death related to community empowerment.

Please see Health Disparities section.

Social drivers of health

The data below reflects the ways that place, access to services, community and economics can impact our communities' sense of empowerment and self-determination.

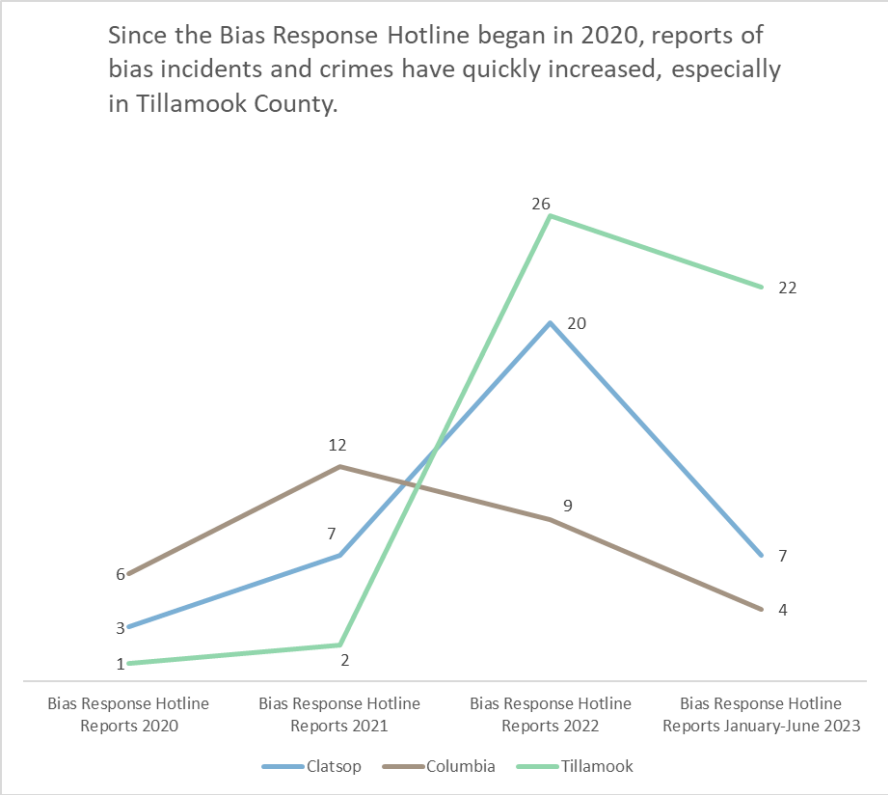


Figure 7. Source: Oregon Department of Justice

When looking at data about bias incidents and crime reports made to the state from all three counties combined, the types of bias and hate expressed are incredibly concerning but important to look at in context. For example, the Department of Justice determined that of the

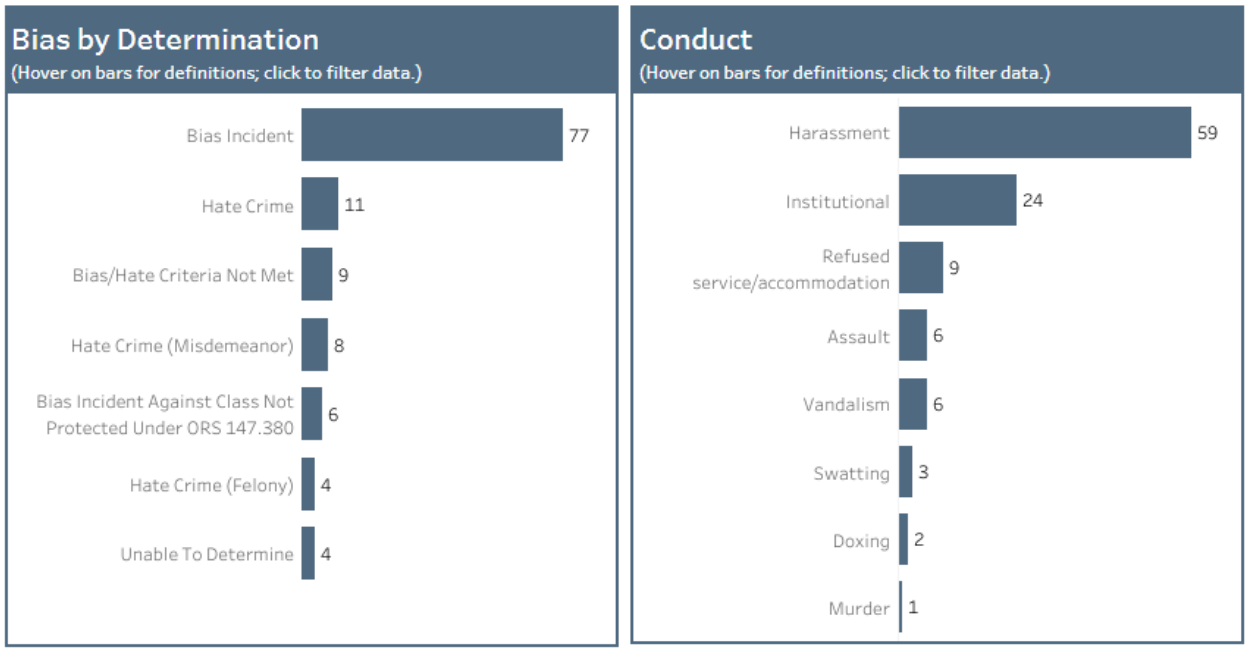


Figure 8. Source: Oregon Department of Justice

region's calls, there were 77 bias incidents (excluding crimes), which is a regional rate of **63.6 per 100,000 residents** in just six months.

When looking at the protected classes that the victims belonged to that may have been related to the bias incident or crime across our region, the incidents again span each class, with race, multiple, and sexual orientation leading the potential motivations.

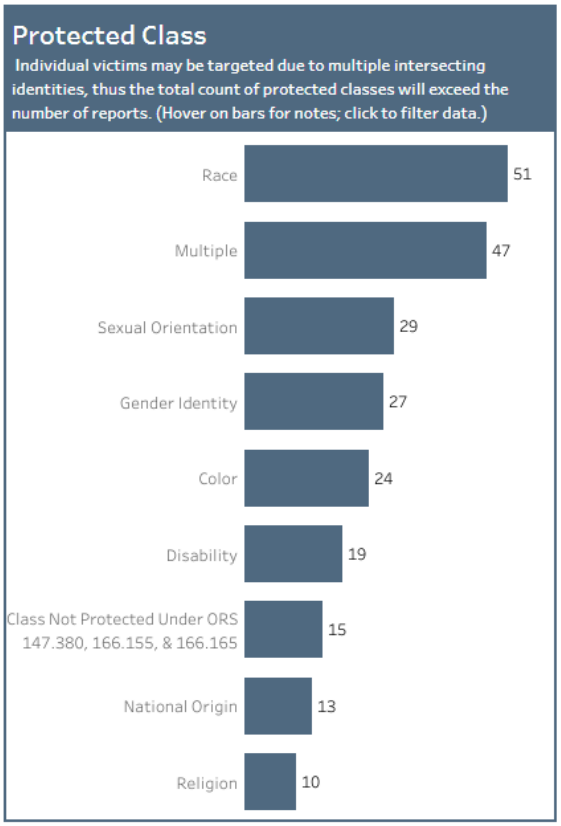


Figure 9. Source: Oregon Department of Justice

One important connection between Oregon's health care model and the idea of community empowerment is access to certified peers and navigators. Peers and navigators are traditional health workers who are trained and certified to walk alongside people who belong to communities of health, such as youth or people with substance use disorders and/or in recovery. They bring an expertise in the experiences of these communities as well as knowledge of how to work with people to build self-sufficiency when navigating complex health needs and complex health-related systems.

Figure 10. Source: CPCCO Traditional Health Worker Liaison Report

Culturally responsive care refers to the intentional and consistent delivery of care in ways that both recognizes and honors the role that culture plays in health and access to health and social systems. This can be measured by looking at health disparities as well as by access to certified medical interpreters and promotoras, access to culturally diverse providers of all kinds, and access to educational and licensing supports for future providers who are culturally diverse.

Health status and leading causes

The data below reflects regional health-status data as well as data on the leading causes of chronic disease, injury and death related to Culturally Responsive Care.

Please see Health Disparities section.

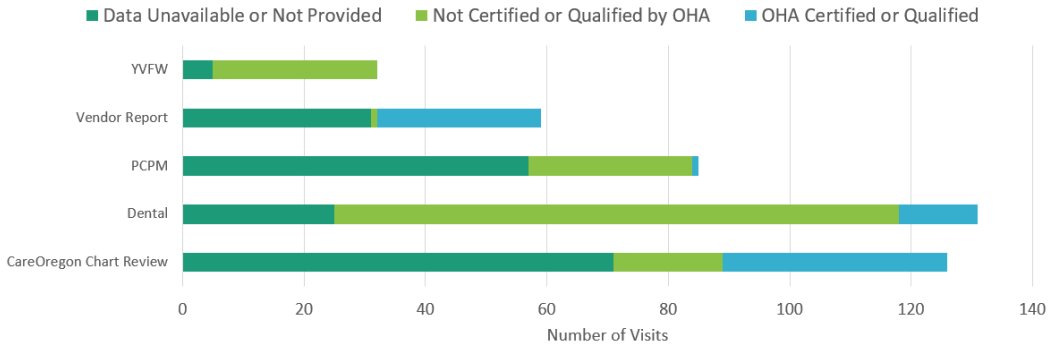
Social drivers of health

The data below reflects the ways that place, access to services, community and economics can impact our communities' sense of empowerment and self-determination.

As the data below makes clear, the health care system struggles to use data to identify who *needs* language-interpretation services. The following two graphs are of data specific to Oregon Health Plan members in our region but speak to gaps that exist among people regardless of health insurance. The first graph shows that of all the potential data sources about each patient's language, we still lack any information on the language the overwhelming majority of our members need their care in.

Figure 11. Source: CPCCO Language Interpretation Data Review (2023)

When we do have data, we find that most visits where someone needed interpretation still have limited available documentation or are interpreted by individuals without OHA certification.



Language interpretation data sources and interpreter certification/qualification status for Q2 2021 – Q3 2022 visits for members who indicated they need language interpretation on their OHP application.

Figure 12. CPCCO Language Interpretation Data Review (2023)

Food is a basic need that is tied directly to our health. Having access to foods that support our health, and that are informed by cultures and customs, is an important way to ensure that every family can be healthy. The COVID-19 pandemic made clear that our food systems are both vital to our communities and fragile in challenging times, in ways that impact some groups more than others. Data that helps us understand our food systems includes: health conditions which may include food as part of management and treatment, food insecurity data and more. Possible work in this area could include increasing access to culturally specific foods and medically tailored meals, as well as culturally inclusive nutrition education.

Health status and leading causes

The data below reflects regional health-status data as well as data on the leading causes of chronic disease, injury and death related to food and nutrition.

Please note: These conditions are complex and <u>are not necessarily</u> caused by food access issues or nutrition. Importantly though, the following conditions include food and nutrition as a core part of management and treatment.

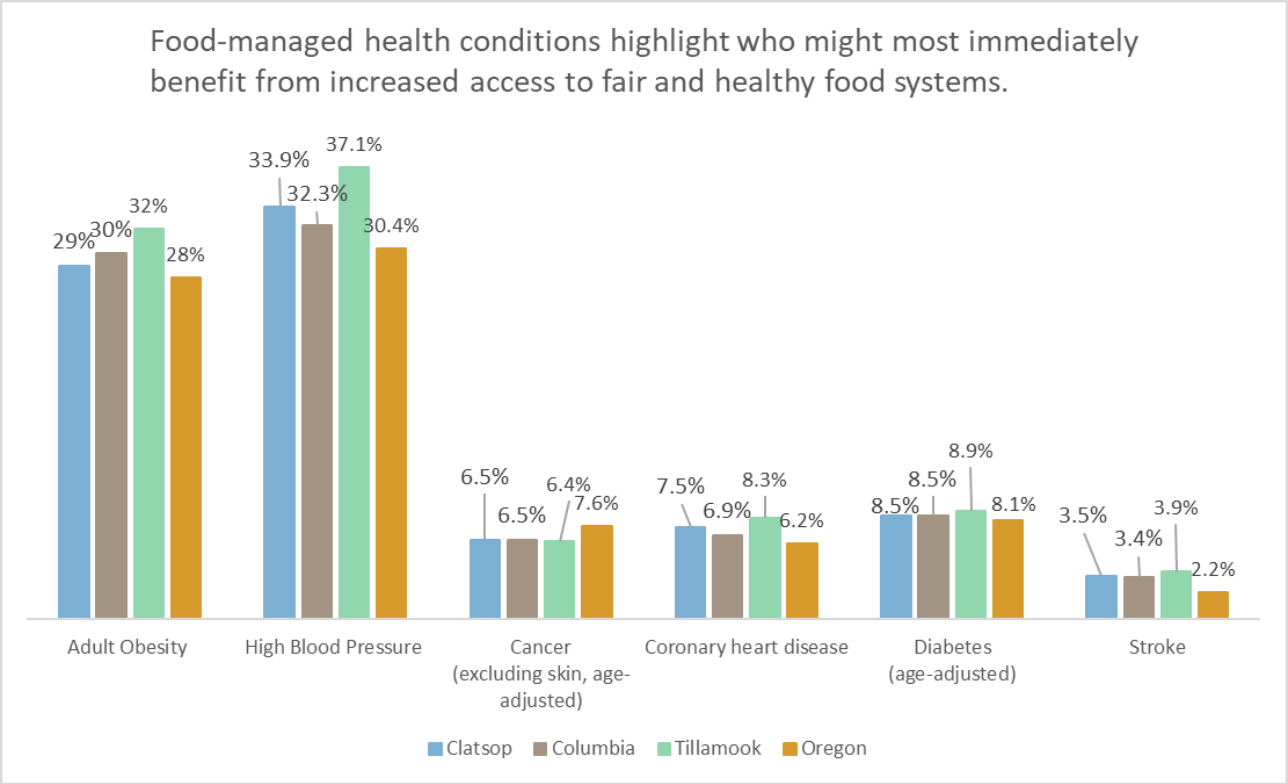


Figure 13. Sources: RWJF 2023 County Health Rankings; Centers for Disease Control and Prevention PLACES Local Data for Local Health

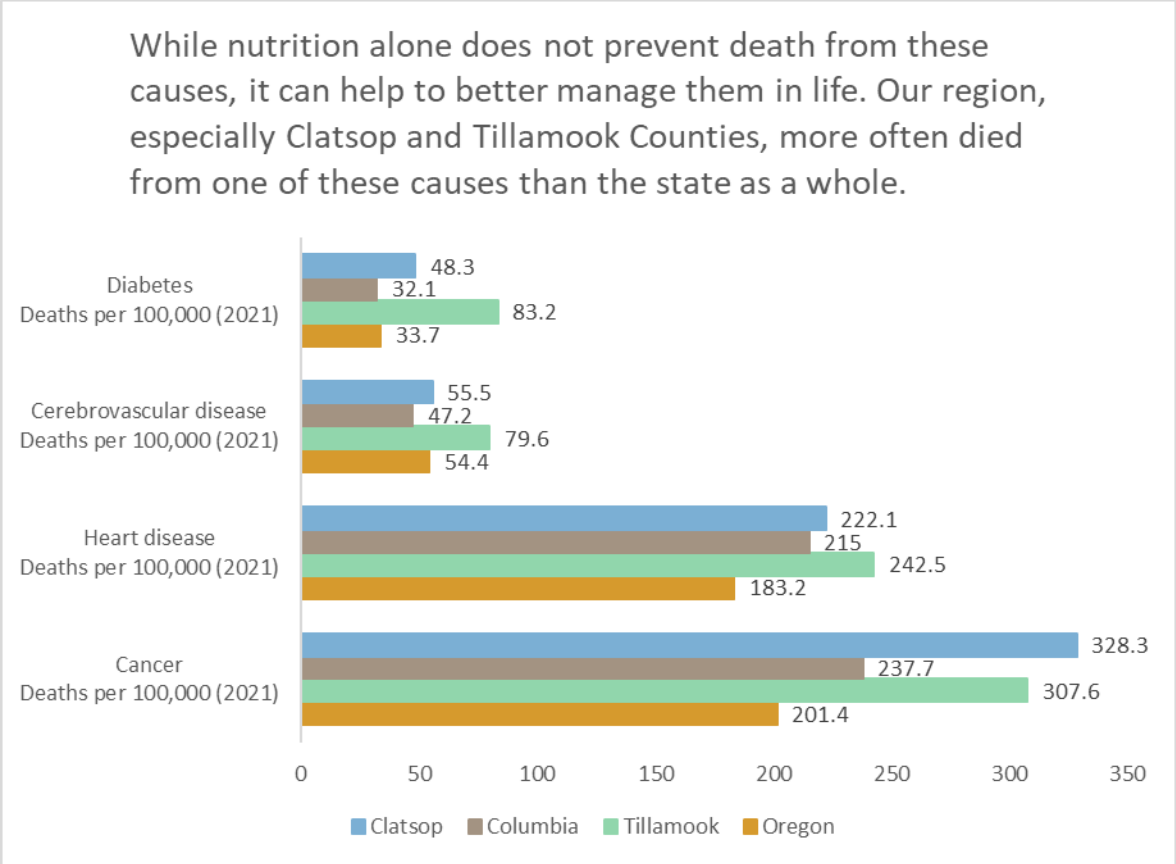


Figure 14. Source: Oregon Health Authority, Center for Health Statistics

Social drivers of health

The data below reflects the ways that place, access to services, community and economics can impact our access to food and nutrition.

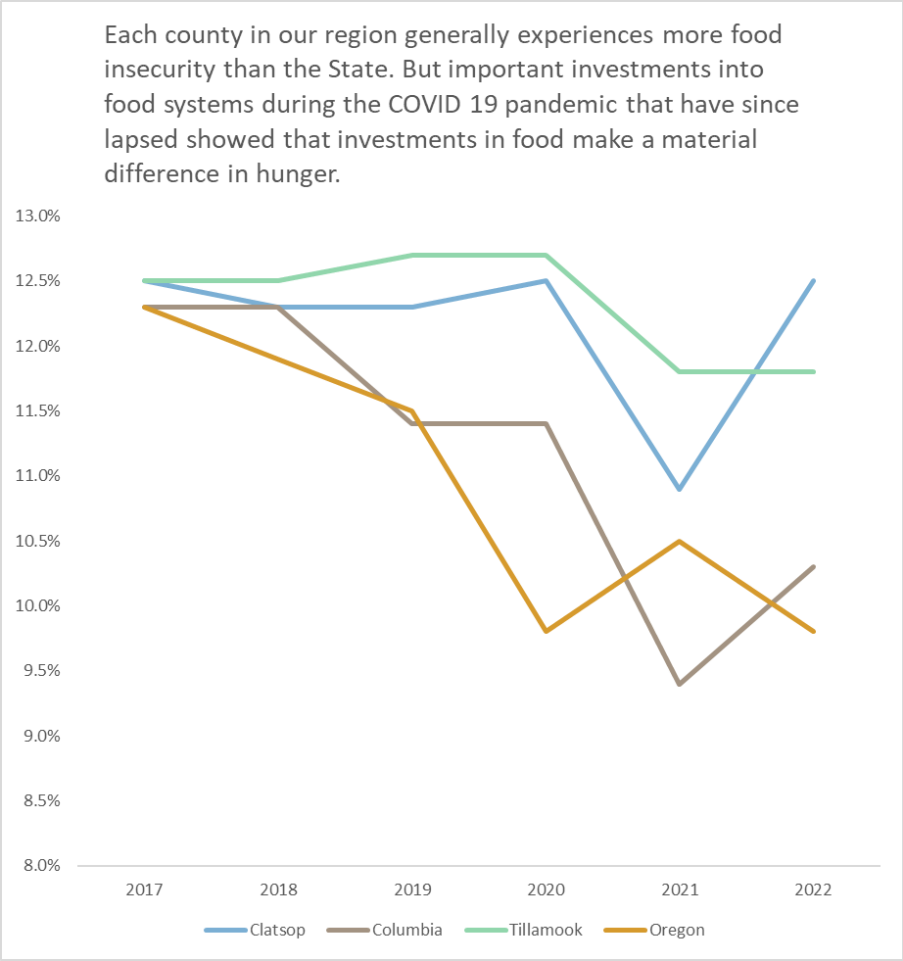


Figure 15. Source: Feeding America and Oregon Hunger Taskforce

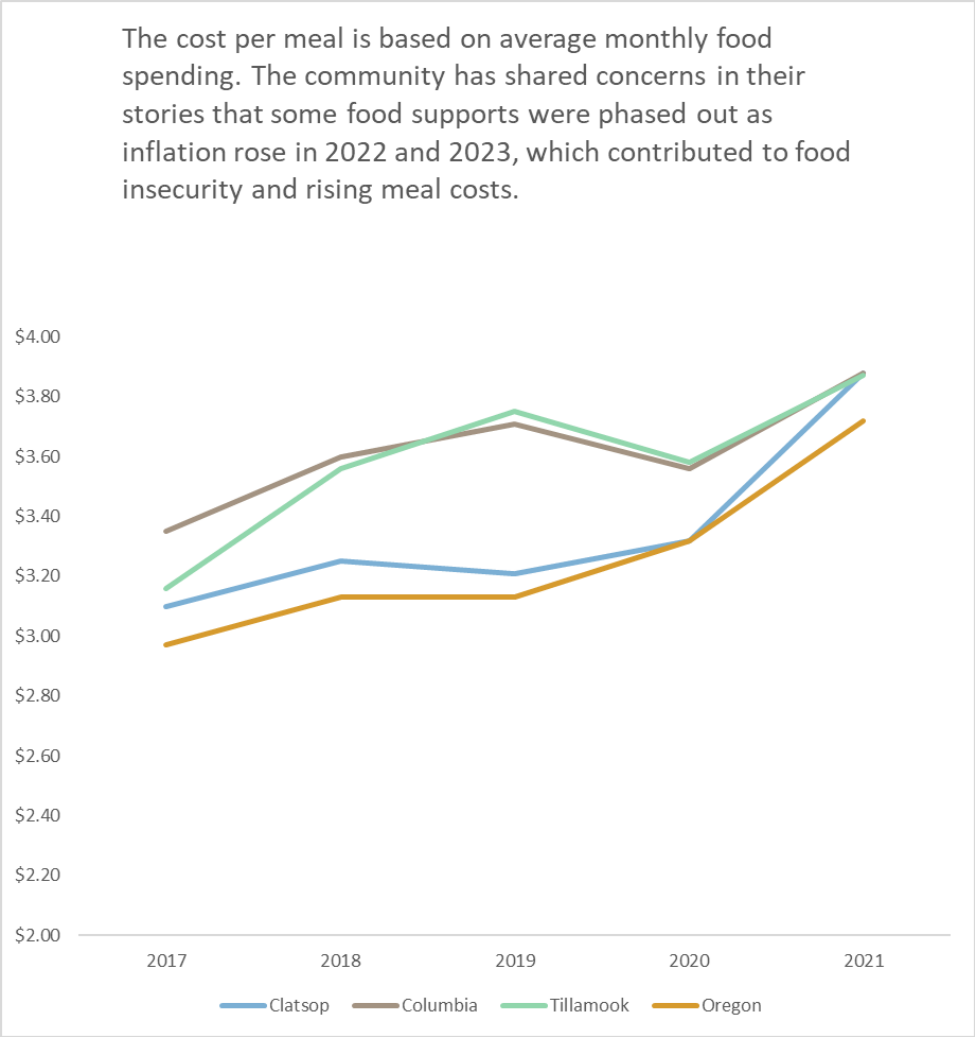


Figure 16. Source: Feeding America

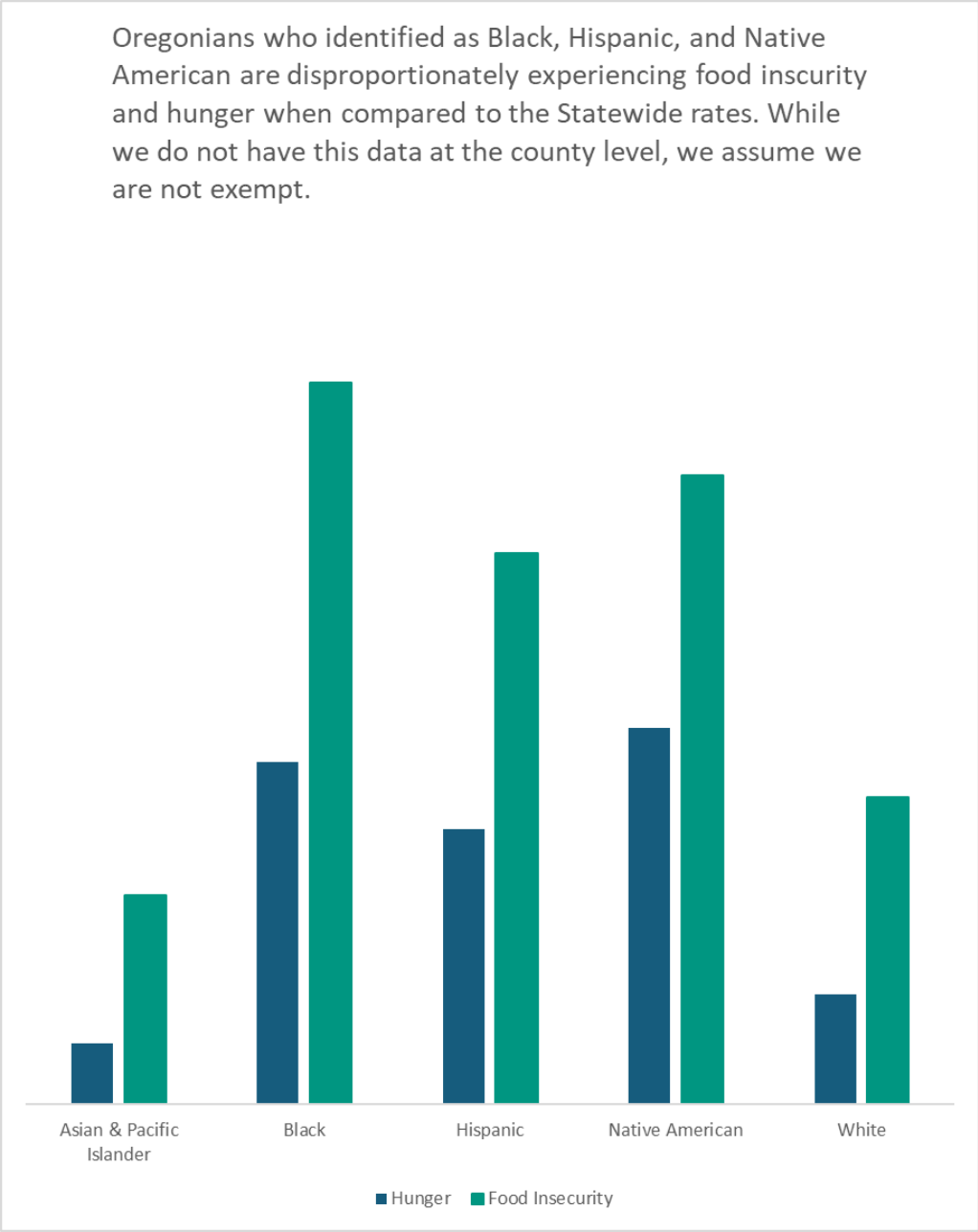


Figure 17. Source: Oregon Hunger Taskforce

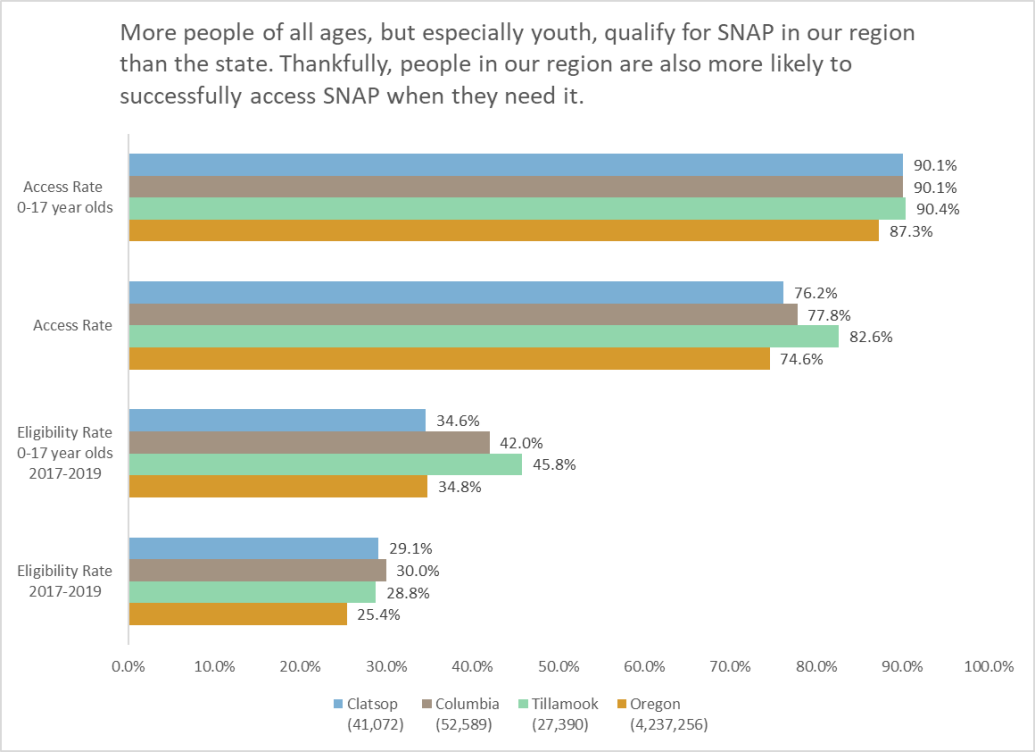


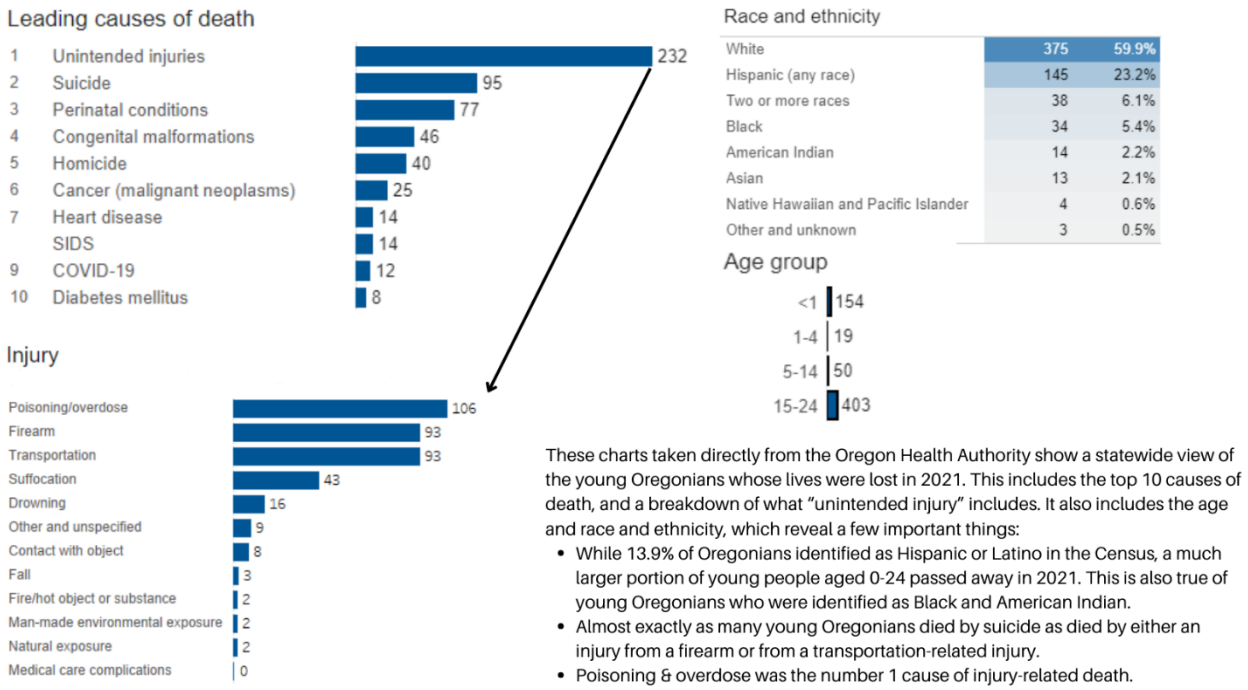
Figure 18. Source: U.S. Census Bureau's American Community Survey Administrative Records

Healthy children and youth

The health and success of our children and teens is essential to a healthy region. Whether talking about behavioral health, academic success, healthy skill building, child-care access, or supports for children and families who are engaged with state family services, children and youth have their own needs and their own voice that can be very distinct from the adults in their lives. In the post-pandemic era, there have been national and statewide conversations about the unique and disproportionate impacts to our kids, such as decreased access to childcare, learning loss, isolation, delayed milestones and poor access to trusted adults and systems.

Health status and leading causes

The data below reflects regional health-status data as well as data on the leading causes of chronic disease, injury and death related to children and youth.



These charts taken directly from the Oregon Health Authority show a statewide view of the young Oregonians whose lives were lost in 2021. This includes the top 10 causes of death, and a breakdown of what "unintended injury" includes. It also includes the age and race and ethnicity, which reveal a few important things:

- While 13.9% of Oregonians identified as Hispanic or Latino in the Census, a much larger portion of young people aged 0-24 passed away in 2021. This is also true of young Oregonians who were identified as Black and American Indian.
- Almost exactly as many young Oregonians died by suicide as died by either an injury from a firearm or from a transportation-related injury.
- Poisoning & overdose was the number 1 cause of injury-related death.

Figure 19. Source: Oregon Health Authority Center for Health Statistics

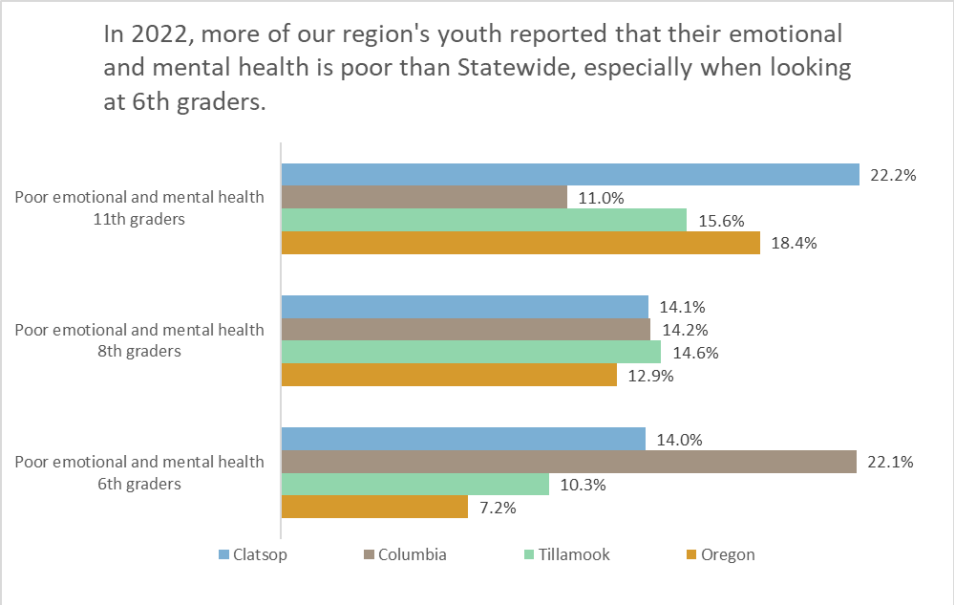


Figure 20. Source: Oregon Student Health Survey 2022

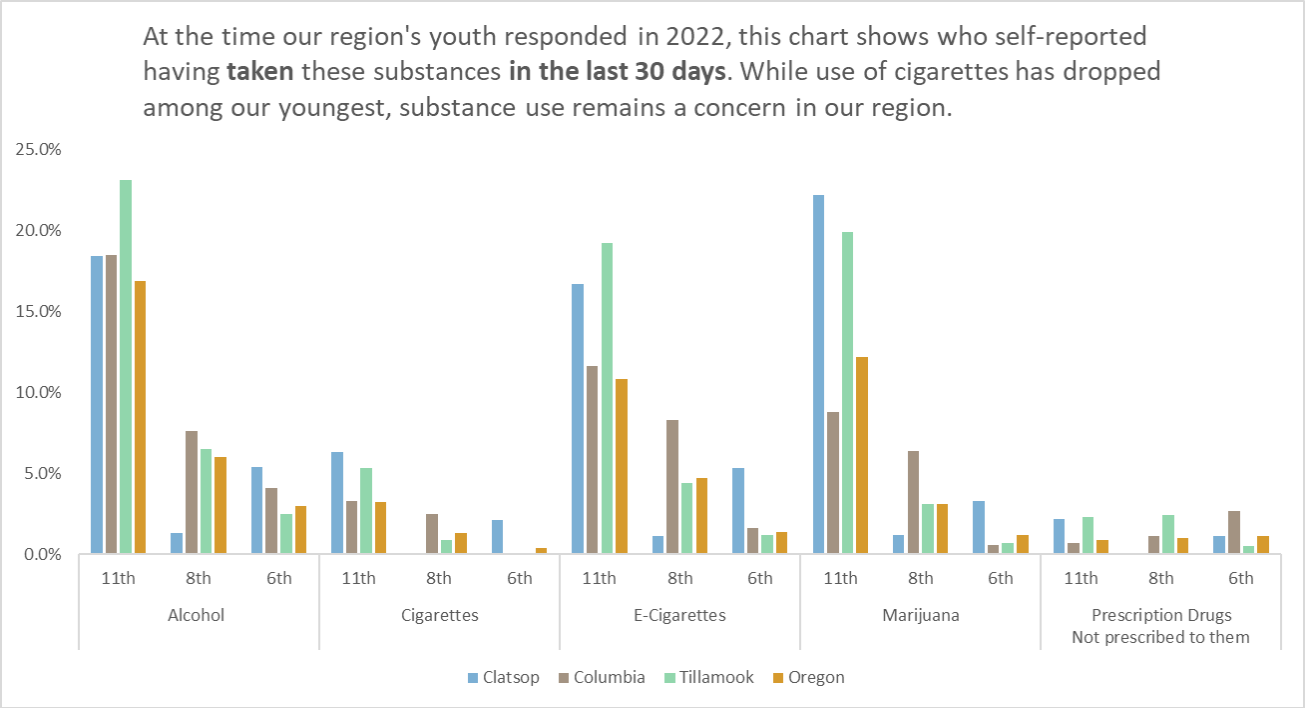


Figure 21. Oregon Student Health Survey 2022

Social drivers of health

The data below reflects the ways that place, access to services, community and economics can impact our children and youth.

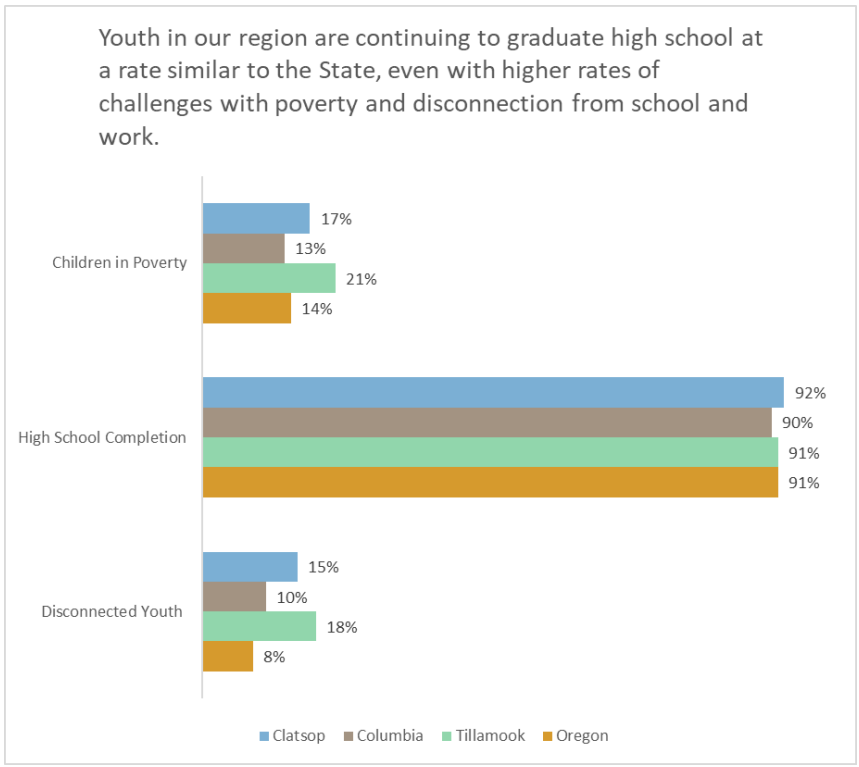


Figure 22. RWJF 2023 County Health Rankings

In both Clatsop and Tillamook counties, the rate of juvenile arrests for every 1,000 juveniles is roughly equivalent or more than double the rate of the state overall. Juvenile arrests can often be indicators of a history of trauma and behavioral health needs that have gone

Figure 23. Source: RWJF 2023 County Health Rankings

Figure 24. Source: RWJF 2023 County Health Rankings

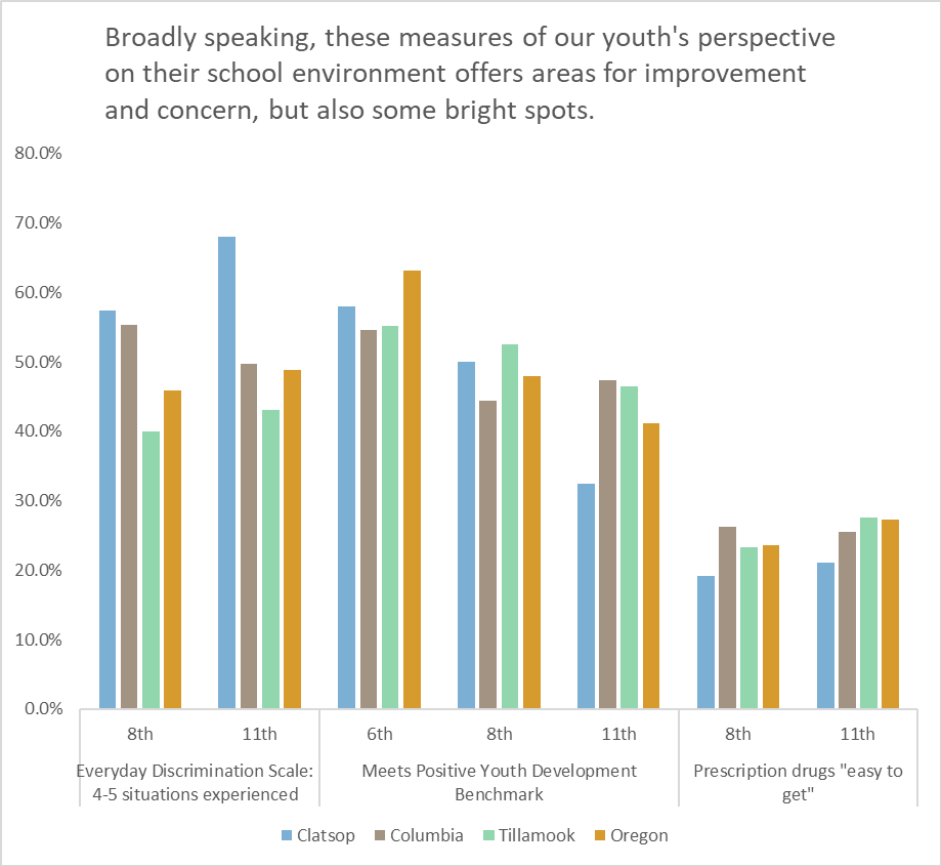


Figure 25. Source: Oregon Healthy Student Survey 2022

Housing is a long-term frustration in our region in ways that differ from much of the rest of the state. The entire continuum of housing is greatly constrained by our region's geography, landscape, economic constraints, program constraints, waitlists, language-accessibility needs and pure availability of stock and services. Continuing the work of addressing these needs will include regional creativity: increasing housing stock in creative ways, adding housing-support programs to fill gaps, increasing access to shelter and services for unhoused community members, and funding innovative solutions.

Health status and leading causes

The data below reflects regional health-status data as well as data on the leading causes of chronic disease, injury and death related to housing.

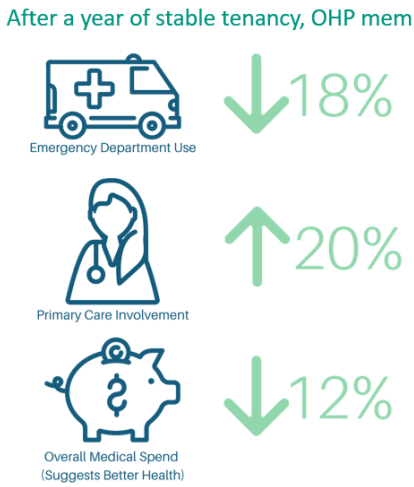


Figure 26. Source: Oregon Health Authority

While it can be challenging to gather population-level data that directly speaks to the connection between health status and housing, we have access to two data sources that help provide clues.

The Oregon Health Authority did a study of Oregon Health Plan members, previously experiencing unstable housing, who had tenancy supports for a full year. They found that stable tenancy has a positive impact on these three indicators of how well someone can manage their health.

Columbia Pacific has also evaluated the self-reported health impacts of receiving housing-preservation services. In 2023, through our partnership with Community Action Team's Healthy Homes team, we found that addressing housing-preservation needs – such as roofing, water access, mold remediation and more – can greatly improve the health of those who otherwise don't currently qualify for other forms of assistance.

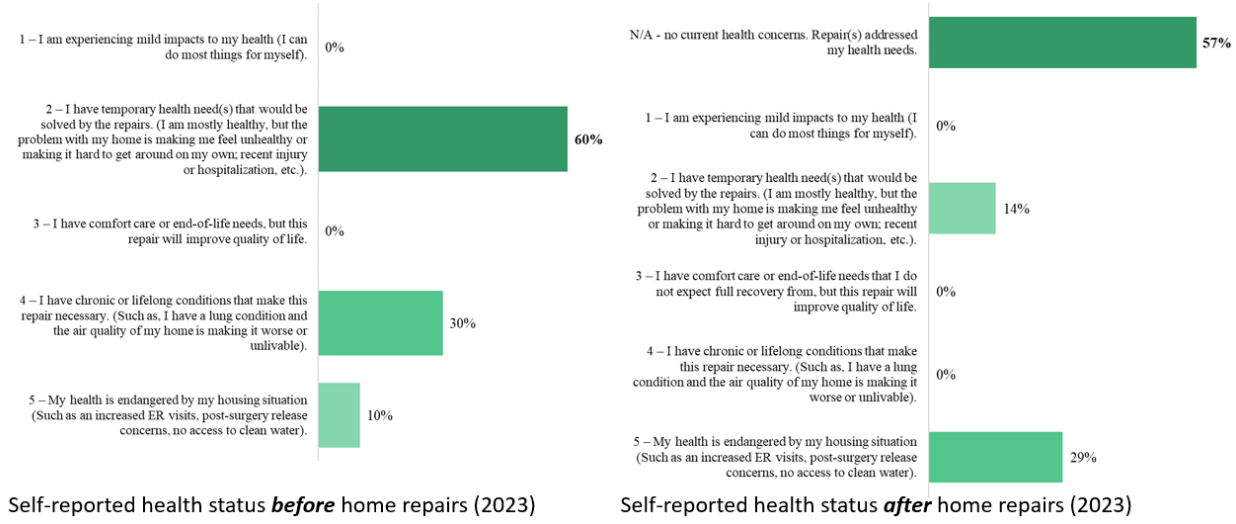


Figure 27. Source: CPCCO and Community Action Teams

Social drivers of health

The data below reflects the ways that place, access to services, community and economics can impact our housing access and health.

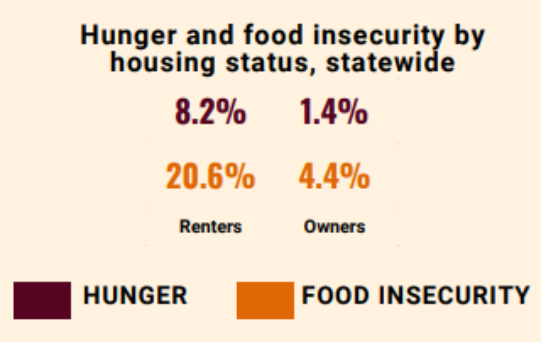


Figure 28. Source: Oregon Hunger Taskforce

From a statewide lens, renters are more likely to experience food insecurity than homeowners. This relationship is likely due to economic advantage and the stability that homeownership more often provides.

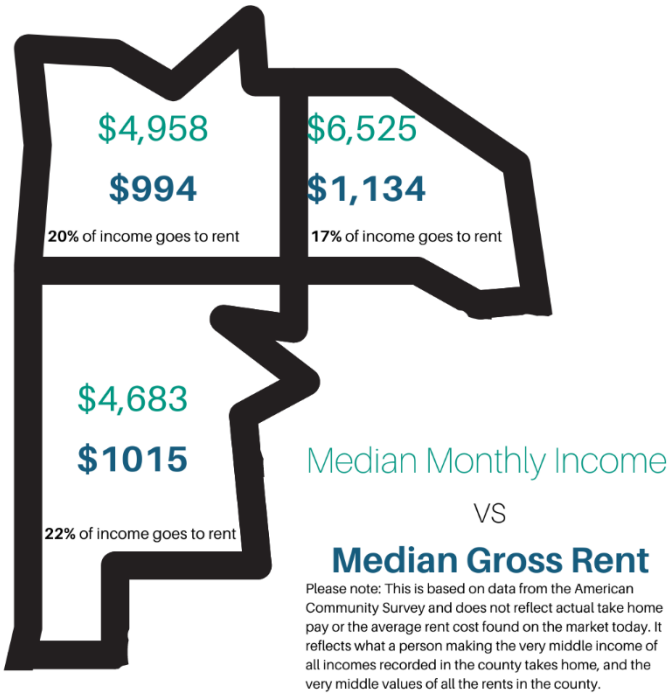


Figure 29. Source: U.S. Census Bureau

When looking solely at median monthly gross income versus median gross rent, the middle-income earner in any given county in our region would be on pace with the rest of the state, which, for comparison purposes, has a 21% median rent burden. However, experiential data collected this year suggests that the median gross rent is likely *incredibly optimistic.*

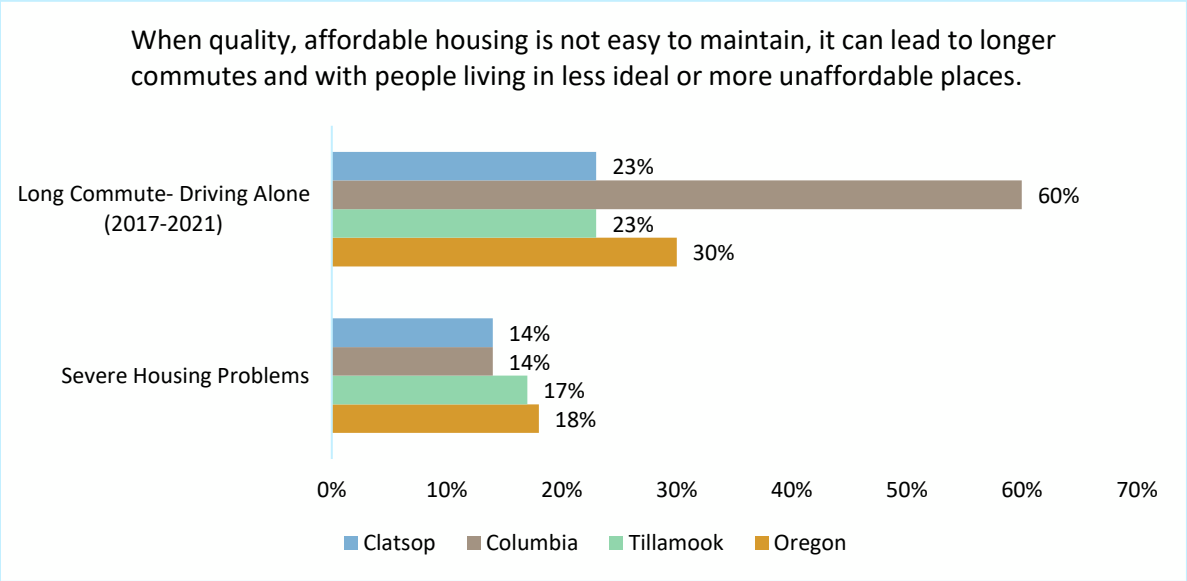


Figure 30.2022 American Community Survey 5-year Estimates; RWJF 2023 County Health Rankings

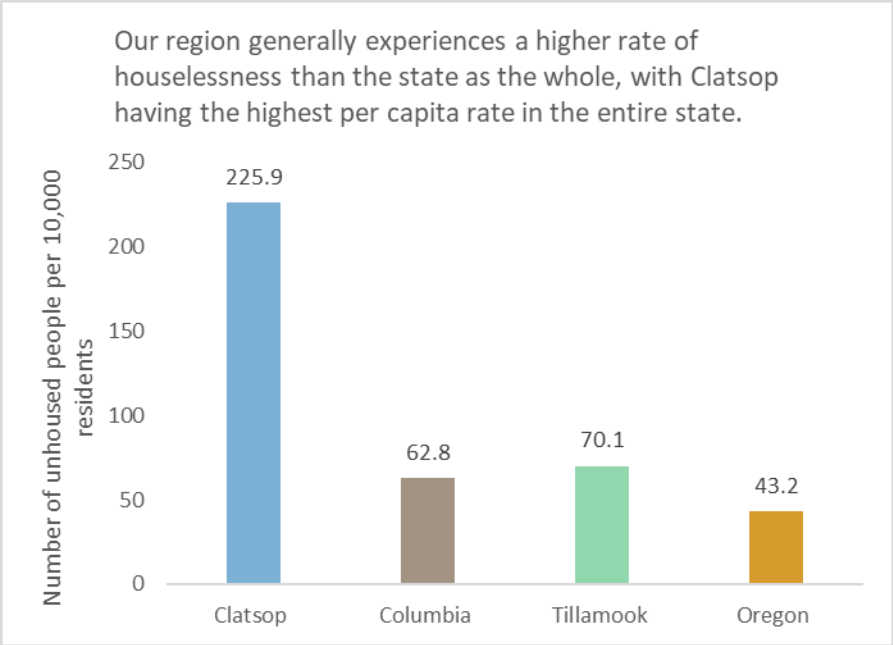


Figure 31. Source: Oregon Point-in-Time Count 2021

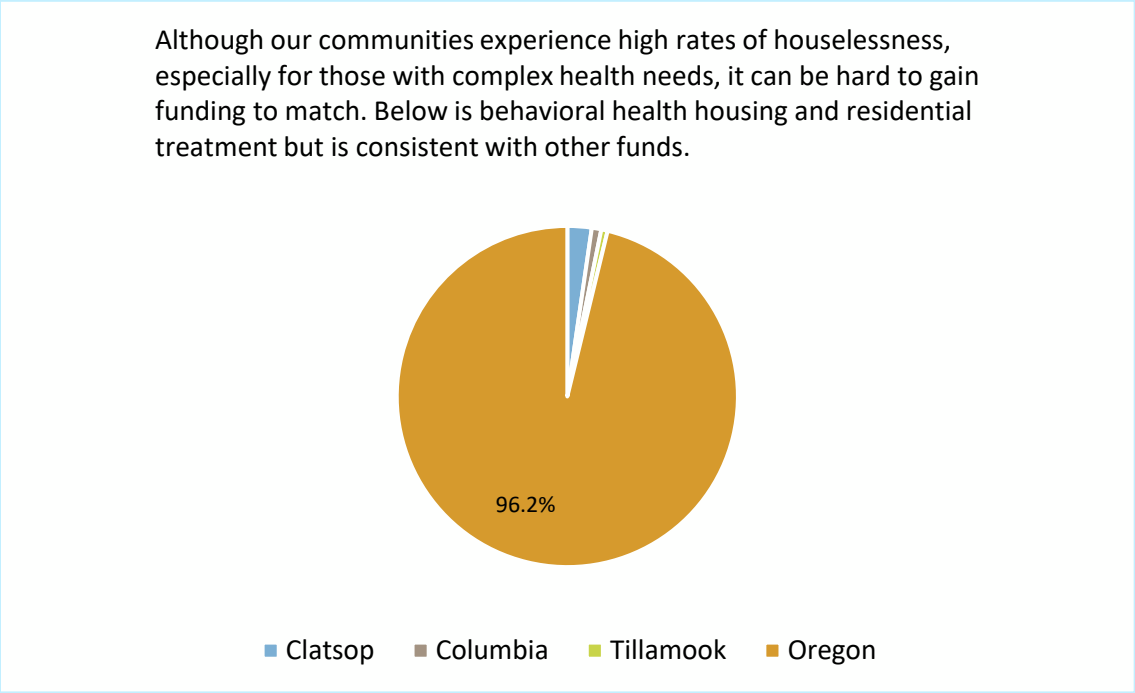


Figure 32. Oregon Health Authority, Behavioral Health Housing Fund Dashboard, accessed 2023

Whole person care is an evolution of the idea of accessing care, in which our communities are focused on a few related needs: connecting health and social care, the presence of traditional health workers in all appropriate settings and support for low-barrier-to-entry health career pathways to address provider shortages and improve patient-provider relationships.

Health status and leading causes

The data below reflects regional health-status data as well as data on the leading causes of chronic disease, injury and death related to whole person care.

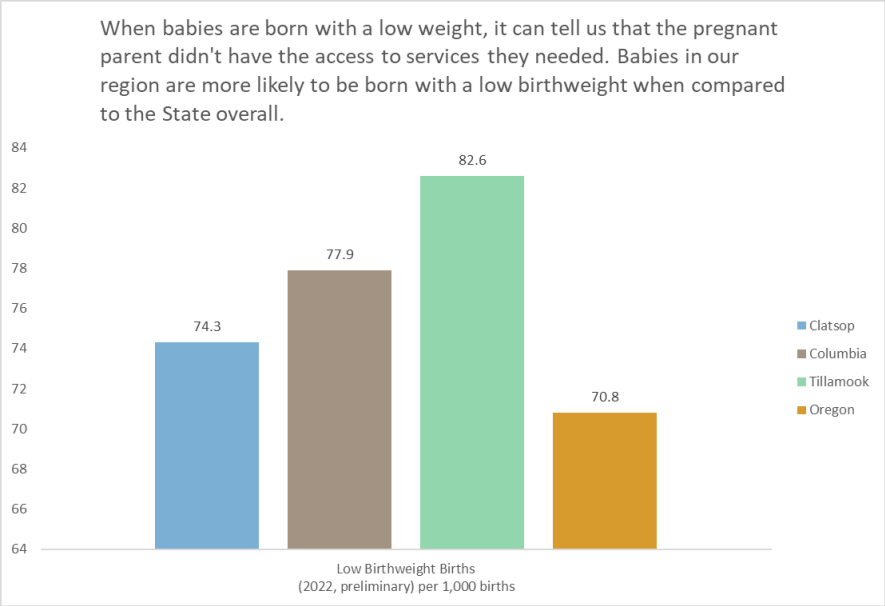


Figure 33. Source: Oregon Birth Data 2022, preliminary

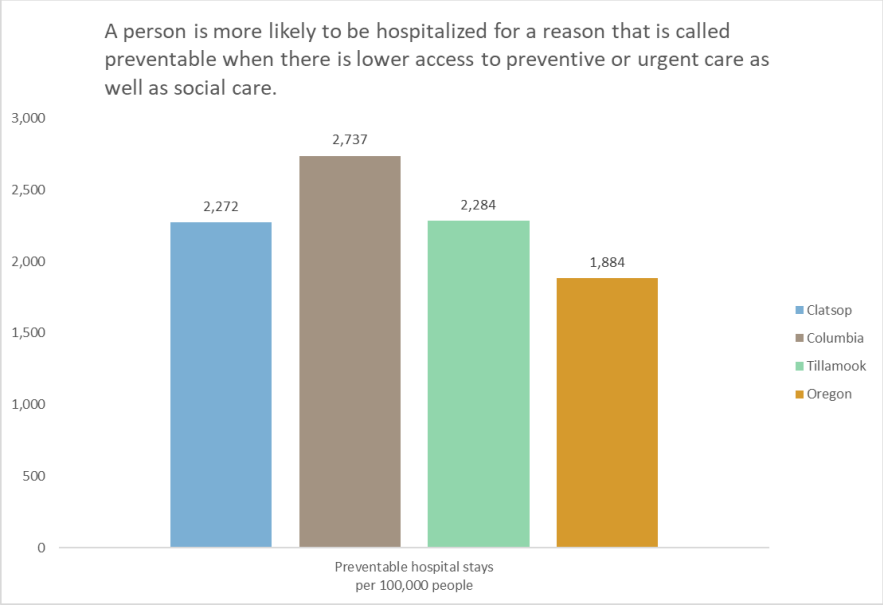


Figure 34. Source: RWJF 2023 County Health Rankings

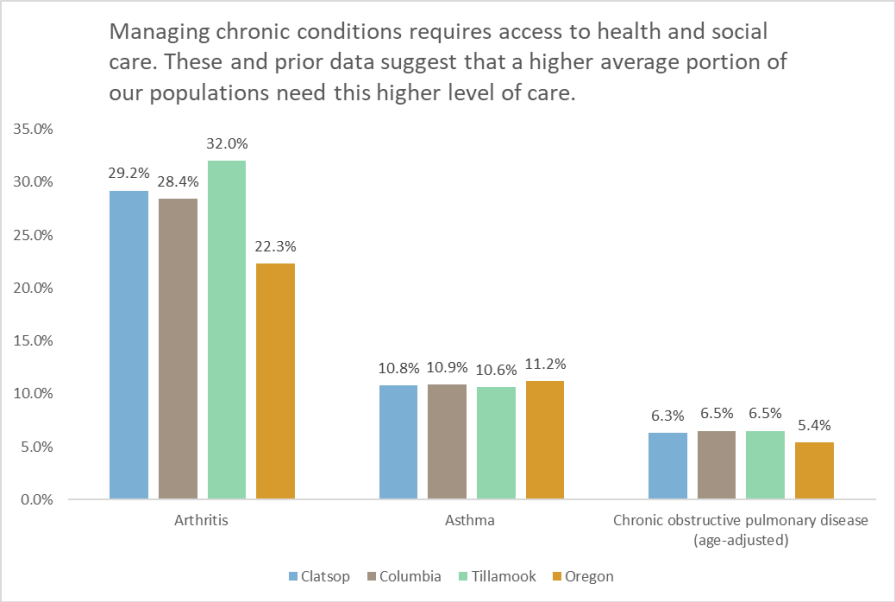


Figure 35. Source: Oregon Health Authority Center for Health Statistics, accessed 2023

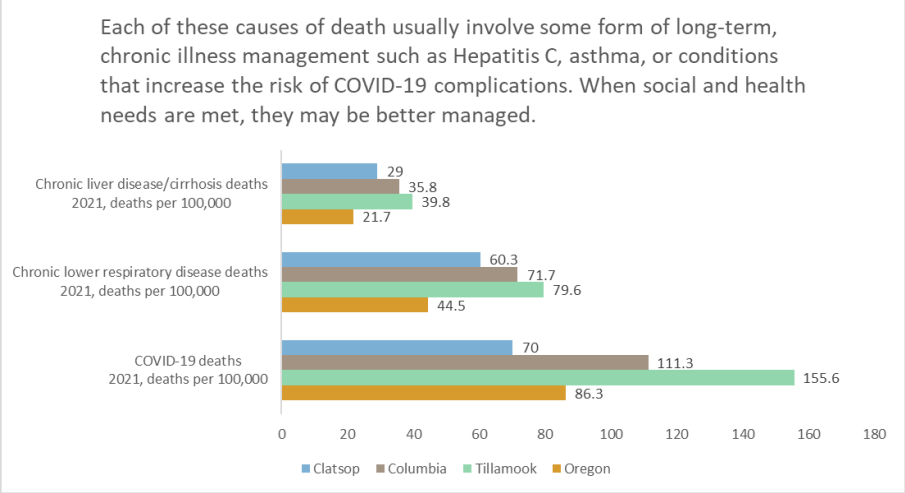


Figure 36. Source: Oregon Health Authority Center for Health Statistics, accessed 2023

Social drivers of health

The data below reflects the ways that place, access to services, community and economics can impact our housing access and health.

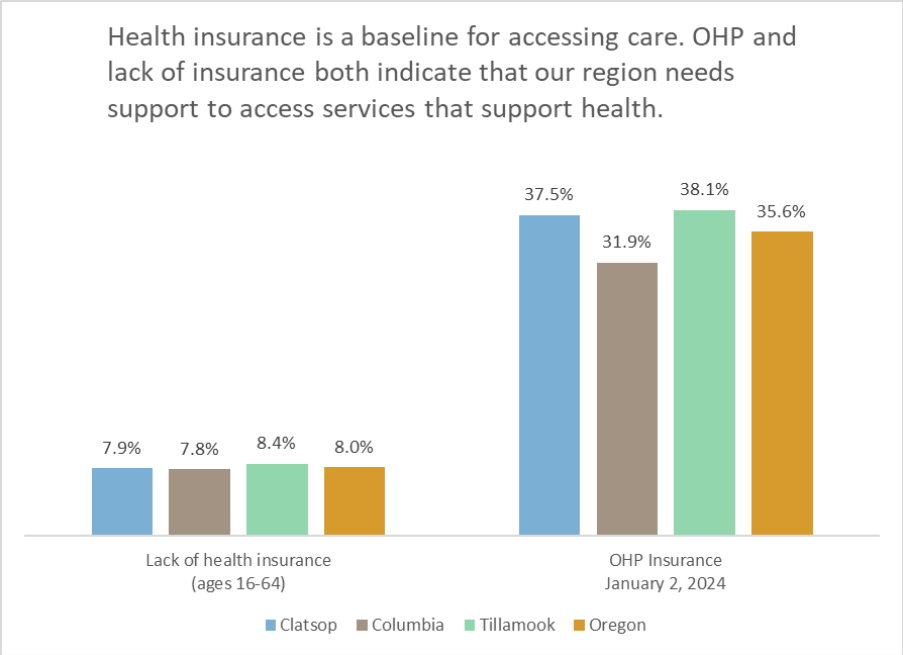


Figure 37. Source: 2021 Behavioral Risk Factor Surveillance Survey; Oregon Health Authority Monthly Enrollment Report

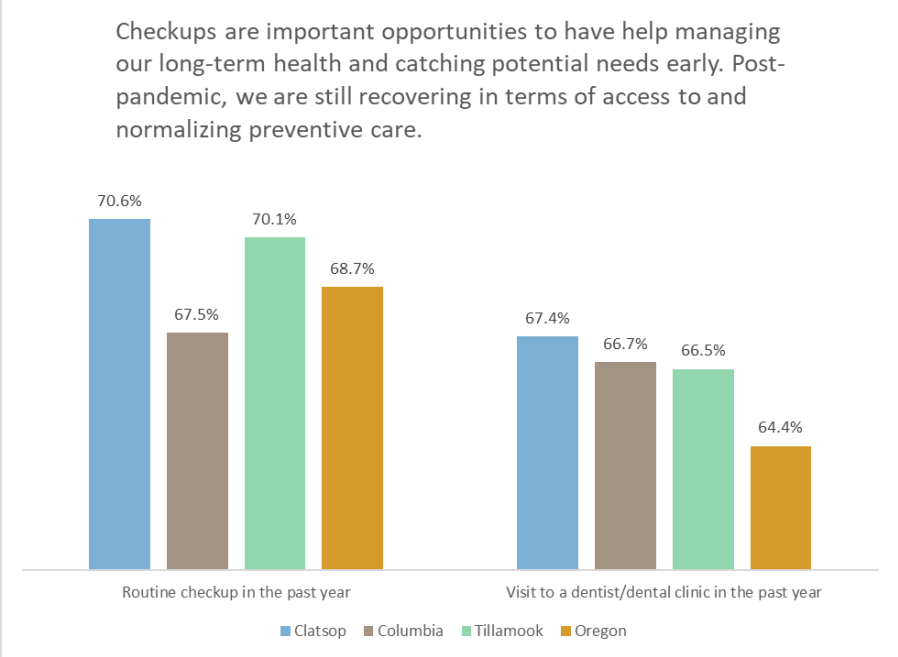


Figure 38. Source: 2021 Behavioral Risk Factor Surveillance Survey

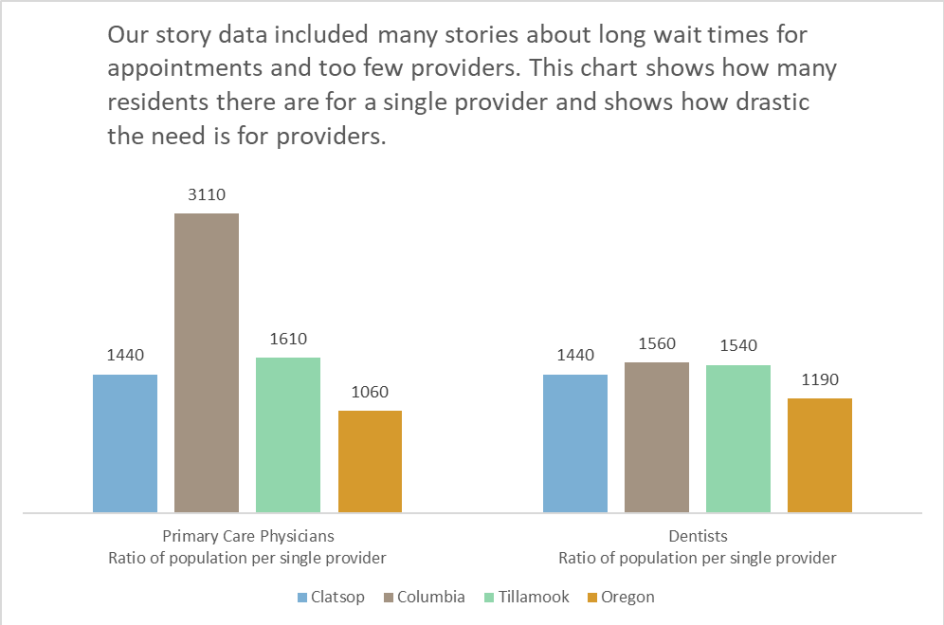


Figure 39. Source: RWJF 2023 County Health Rankings

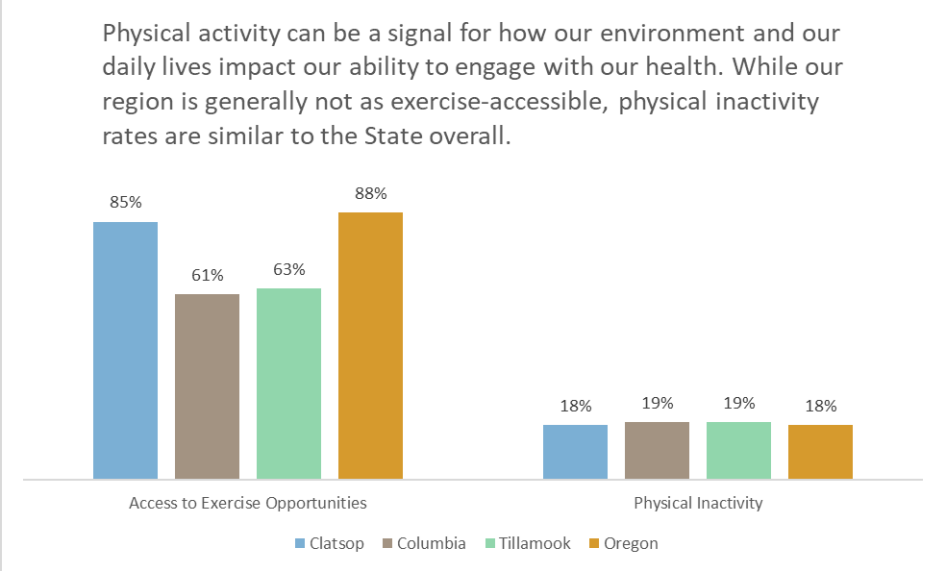


Figure 40. Source: RWJF 2023 County Health Rankings

Income inequality is a measure that compares the income of the 20% who earned the most in the county against the income of the 20% who earned the least.

From 2017-2021, the 20% who earned the most earned...

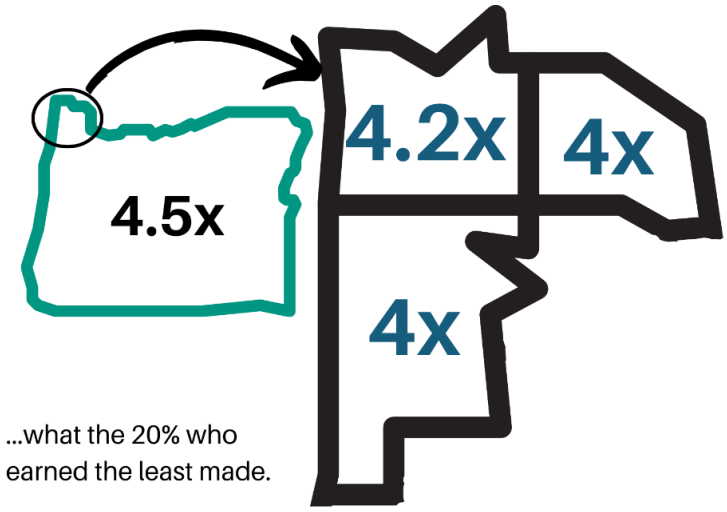


Figure 41. Source: 2022 American Community Survey, 5-Year estimates

Regional Average Living Wage: $48.77/hr

The hourly wage someone would need to cover basic expenses for **one adult and two children** while being **financially independent** from all tax benefits or public programs varies in our region. The living wages in our region are not reflected in the minimum wage **of most of the state in 2024:**

$14.20/hr.

Making it hard, if not impossible, for many single-parent families to meet all their social and health-related needs without support.

Figure 42. Source: Massachusetts Institute of Technology; RWJF 2023 County Health Rankings

Our priority populations

Pairing both equity and clinical perspectives to maximize impact

Who this plan serves

Columbia Pacific's Regional Health Assessment and resulting Improvement Plan are built to broadly benefit all communities within our three-county region, whether members of our health plan or not. At the same time, we believe that when we focus our investments on the needs, barriers and empowerment of people who may otherwise "fall through the cracks" of our systems, we are helping everyone have more opportunity to be healthy. For our purposes, there are two overlapping ways to think about which groups we must practically focus on, both within our own health plan members, and more broadly.

Our equity-focused priority populations

When thinking purely about what it means to have a healthier and more-just region, there are a few communities within our communities who must be kept at the center of our planning:

- Tribal communities, inclusive of members of Tribes whose federal recognition remains unrestored or Tribes outside our region
- Black, Indigenous, and people of color (BIPOC) communities
- English language learners
- Lesbian, gay, bisexual, transgender, queer, intersex, asexual, two-spirit (LGBTQIA2S+) communities
- Children and youth ages 0-21
- Functionally diverse communities, including those who identify as disabled and those who use other terminology

Clinical priority populations

Our Quality Health and Outcomes teams have additionally looked at what *health conditions* are more likely to impact the communities outlined above and may contribute to someone falling through the cracks of our health and social systems:

- People with complex or acute behavioral health needs
- People with uncontrolled chronic conditions or advanced illnesses
- Children and youth, with extra focus on ages 0-6 or youth with specific health needs
- Pregnant parents, especially if they need behavioral health supports

Methods and processes

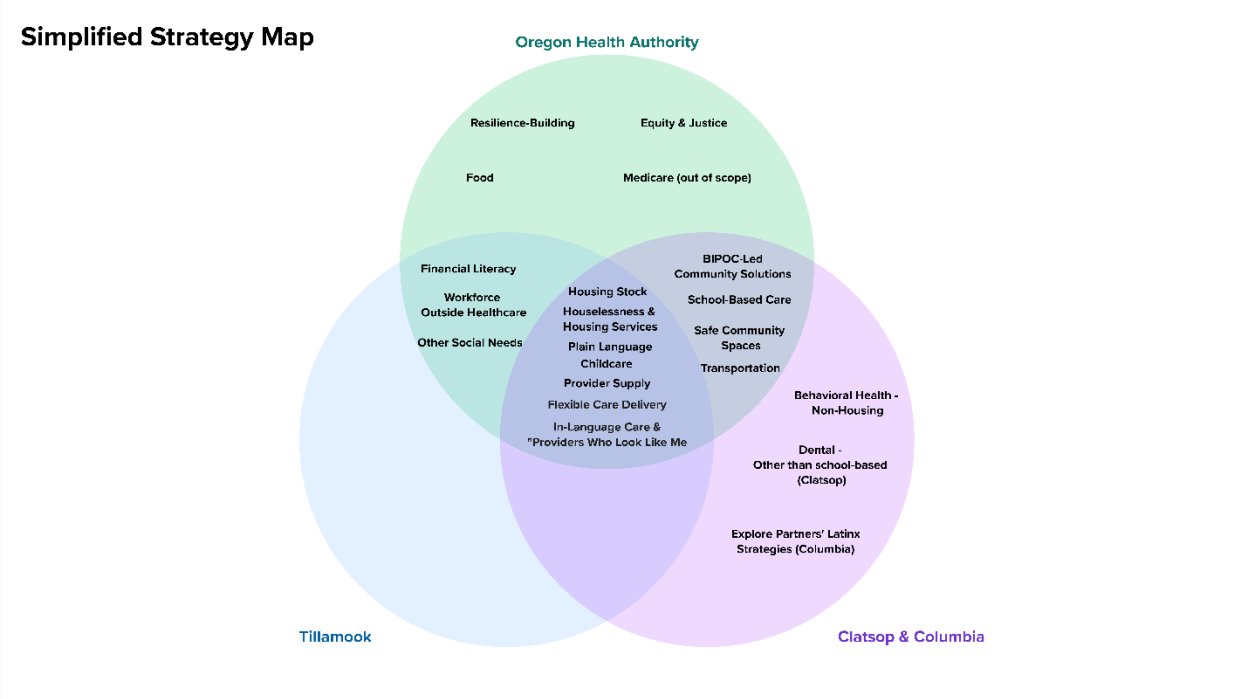
Regional participation prior to formal assessment

Community health needs assessments

Within our three-county region, there are two formal community health needs assessments (CHNAs) that partner hospitals, public health authorities, local mental health authorities and community partners complete collaboratively. They are:

- Clatsop and Columbia Counties' joint CHNA, which in 2021-2022 included an additional survey focusing on Columbia County's Latin/a/o/x community. From this CHNA, Providence Seaside and Columbia Memorial Hospital complete formal community health improvement plans.
- Tillamook County's CHNA, which results in Adventist Health's Community Health Improvement Plan for its Tillamook County footprint.

While Columbia Pacific is a formal partner to these assessments and the outcomes inform our process, our Regional Health Assessment process is separate at the request of our hospital partners. We participate in local CHNA steering committees, and we agree to a data- and information-sharing process to avoid duplicating efforts for our region-wide approach. From this, we compile the data and resulting priorities from each process and fold them into our population data and as considerations for which strategies are chosen once our priorities are selected by the community. Below is an image of shared concepts from the two in-region assessments as well as the State Health Improvement Plan.



Initiating the Story Collection process

Convening our community-inclusive workgroup

From September 2022 to January 2023, we convened a workgroup to plan our Regional Health Assessment, which we call our Story Collection process. A consistent focus of the workgroup was to be low barrier and based on trust. Our non-staff workgroup members included people from all three counties, and diverse perspectives based on background and lived experiences.

This workgroup was empowered to provide actional feedback that impacted a variety of key areas that would increase safe community participation. Areas of oversight included communication planning, incentive planning and planning for the workshops that would help guide our story-collection tool and review resulting data.

Staff members were then accountable to report on their activities between meetings and how the decisions made in meetings were acted on.

Developing the survey

A community-first approach to design

In January 2023, we worked with our consultant at QED Insight to hold a survey-design workshop that included a mix of staff, Community Advisory Council members and community-inclusive workgroup members. This workshop led participants through activities that identified areas of community concern, experiences that may impact health, values that influence how people interpret the world around them, and more.

QED Insight took the learnings of the workshop and developed the initial tool with the aim of allowing us to capture the ideas and "front of mind" concerns that arose as patterns in the workshops. This tool was then put through two forms of testing. The first is a "cognitive review" which asks a very small group of people to consider whether they *could* recall a story and answer the coding questions as presented in either English or Spanish. The second is a formal pilot which asks a slightly larger pool of people to complete the tool and note any points of confusing words or meanings.

The tool is built to be a practical application of the Cynefin Framework.[lxxi] This framework is a school of thought and tools to visualize how issues exist in different types of contexts that require different approaches to understanding and responding. Coordinated care organizations work in a very *complex* context, and community health is also *complex,* and so our approach to understanding what communities need of us must be able to hold onto that complexity.

The tool itself consists of three sections:

- **Storytelling:** This section offers three prompts or "idea starters." Participants were directed to choose one prompt, then write or relay a specific experience or story based on that prompt and give it a title that is meaningful to how they sum up the story.

- **Self-Coding:** This section asks people to then think about the story they told and answer a series of questions that help clarify how the participant sees the different values, needs and interactions with people or systems within their story. These questions are asked in the form of triangle questions and slider questions which ask people to balance potentially competing ideas. The final part of self-coding includes multiple-choice questions that provide insight into the topics and feelings the participant feels are most important to understanding their story.
- **Demographics:** This section asks that participants tell us more about themselves. Questions are adapted from the REAL-D (Race, Ethnicity, Age, Language, Disability) Questionnaire and SOGI (Sexual Orientation & Gender Identity) guidance from the Oregon Health Authority. This section also includes questions around location and health insurance. This section included input and adaptation work from staff and workgroup members around how to ask sensitive questions in a trauma-informed and inclusive way.

Story Collection and Sensemaking

A community-first approach to data

From May through July 2023, Columbia Pacific staff and partners went into communities across the region to collect stories. Collection events were especially focused on places or events where people belonging to priority populations would be found – such as food pantries and other community based organizations – and the region's Pride events.

QED Insight then completed an initial data analysis to create the numerical visuals and to remove any potential Protected Health Information (PHI) from the text of stories. QED Insight staff then led the participants from the initial workshops through a data workshop designed to help the community-inclusive group make meaning of the numerical and textual data by looking for patterns and themes. This process is called Sensemaking. Sensemaking "refers generally to those processes by which people seek plausibly to understand ambiguous … or confusing issues or events"[lxxii] and in this process it specifically refers to the use of "the wisdom of the crowd"[lxxiii] to look for *patterns* that point to a general, complex understanding of what is going on in our communities.

These learnings informed the list of potential Columbia Pacific priorities that were presented at community-input sessions.

After the workshops, Columbia Pacific staff did a focused look at the numerical data for focus populations to look for patterns, nuances and potential disparities when comparing smaller groups to all respondents.

Community-input sessions

A community-first approach to setting priorities

Workshop participants informed the seven potential priority options that were shared at the community-input sessions. These options included: behavioral health, community empowerment, culturally responsive care, equitable food systems, healthy children and youth, housing and houselessness and whole person care.

The options provided the structure and organization of the story and population data that was presented across our region in February 2024 and as our Regional Health Assessment. presentations were given at all three county-level Community Advisory Council meetings, as well as at least one youth-focused and a health coalition event, which included all required clinical partners. At each event, staff shared the findings of data, and then asked participants to order each option from top priority to lowest priority. The total results were then combined for a weighted final vote. The priorities that received the highest weight of votes were then selected to be the priorities that follow in the Regional Health Improvement Plan.

Results

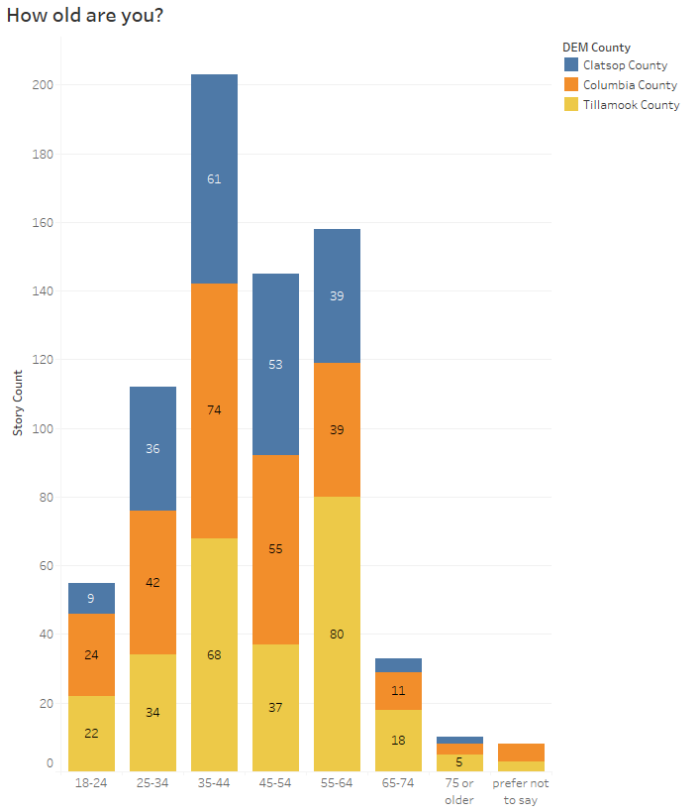
Story Collection

In all, 25 Columbia Pacific staff members gave nearly 600 person-hours across 155 events, collecting 1,344 stories. After review, there were 1,308 usable surveys.

Respondents

Please note that limits of the U.S. Census Bureau's data prevent us from determining if we have adequately sampled, let alone oversampled, some focus communities in our region.

Age



Most respondents identified their age as being between 35-44, followed by 55-64 and then 45-54. Notably, we also had 55 respondents under the age of 25. When compared to census data, we oversampled all age groups under the age of 65.

Figure 44. CPCCO. RHA respondents by age and county

When broken down by county, Tillamook had a disproportionately high number of respondents aged between 55-64, while the other two counties combined skewed a bit younger (between 35 and 54).

Gender

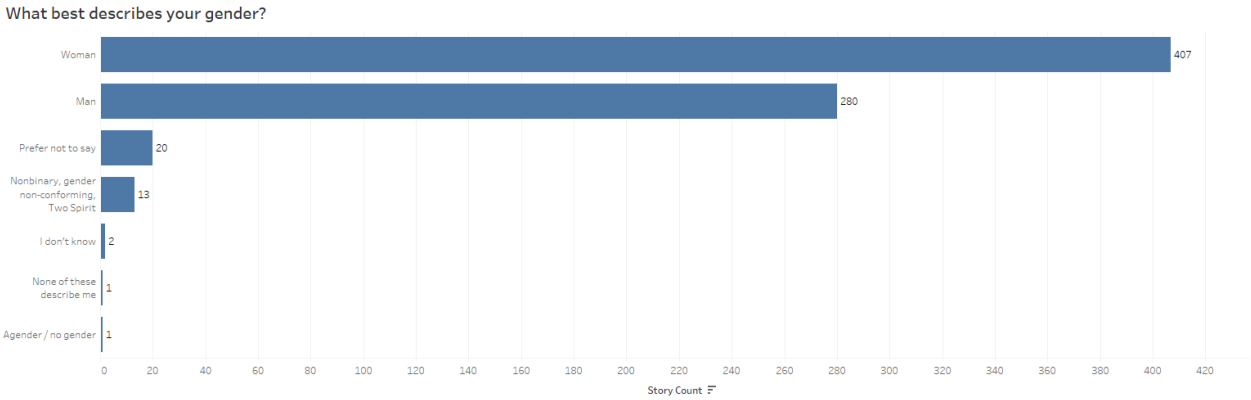


Figure 43. CPCCO. RHA respondents by gender

Most of our respondents (407, an oversample) identify as women, followed by men (280). Importantly, this is the first time we have had guidance that helped us ask more expansively about gender, serving as a new baseline. In these more-expansive options, 13 respondents identified as nonbinary, gender non-conforming, or two-spirit, one identified as agender/no gender, and one identified as "none of these describe me." Until the census offers more expansive data about gender, we can't know if we have proportionately sampled, let alone oversampled, these groups.

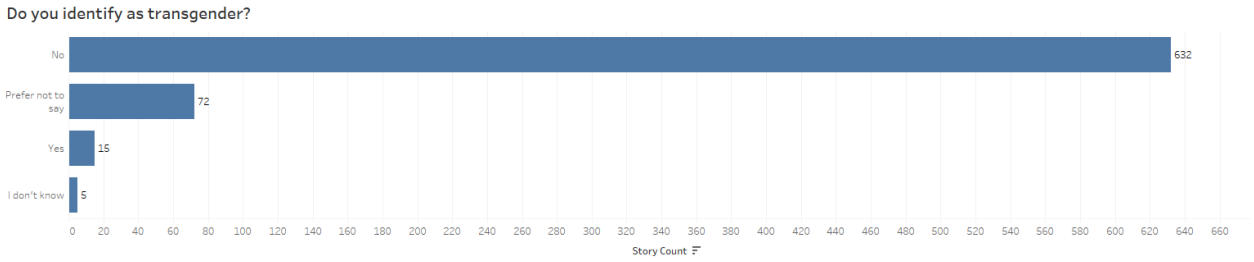


Figure 44. CPCCO. RHA respondents by transgender identification

Additionally, this was the first Story Collection where we explicitly asked respondents if they identify as transgender. In response, 15 people identified as transgender, while five said "I don't know." We cannot know if we have proportionately sampled or oversampled our transgender population either.

Sexual identity

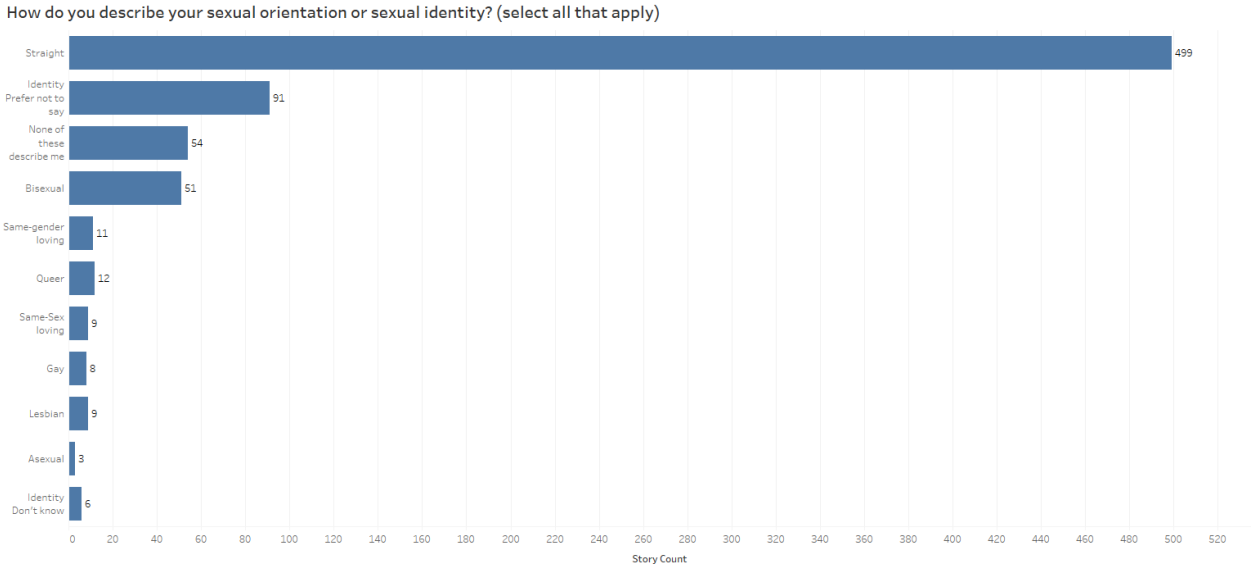


Figure 45. CPCCO. RHA respondents by sexual orientation

This was the first Story Collection since receiving guidance on asking about sexual identity in a trauma-informed, adequately expansive way. Altogether, 109 responses came from people who identify as LGBTQIA2S+. We cannot know if we have proportionately sampled or oversampled our LGBTQIA2S+ communities.

Race and ethnicity

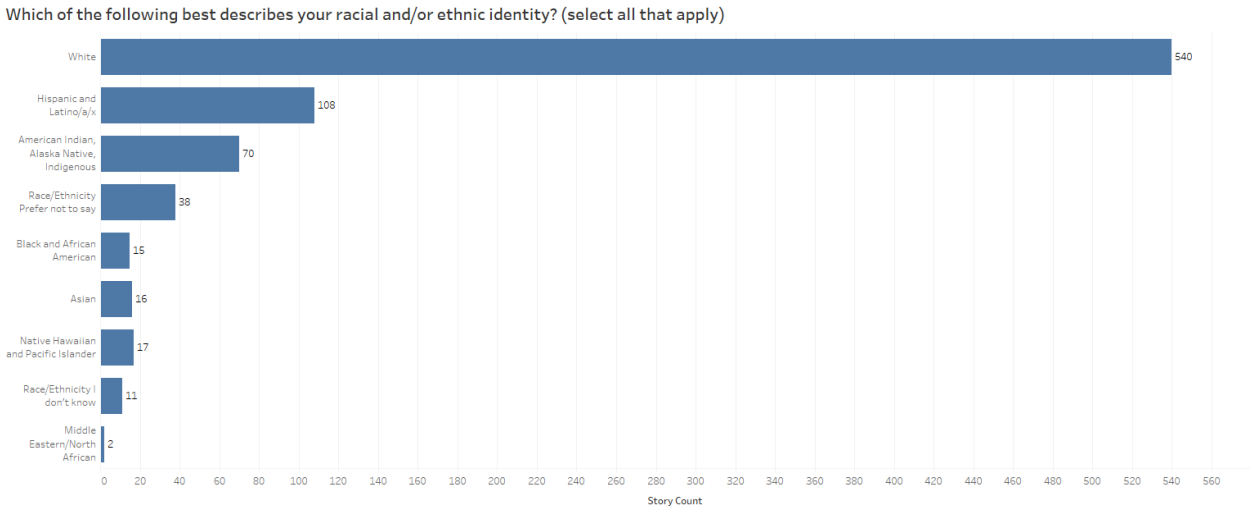


Figure 46. CPCCO. RHA respondents by race and ethnicity

Our respondents are racially diverse, with both our collective BIPOC representation and our representation by specific BIPOC identity groups being oversampled. We were additionally able to reach the ability to draw generalized observations for most groups. This required a minimum of 15 stories, which would contain at least 1,500 individual data points (100 per story).

Functional diversity

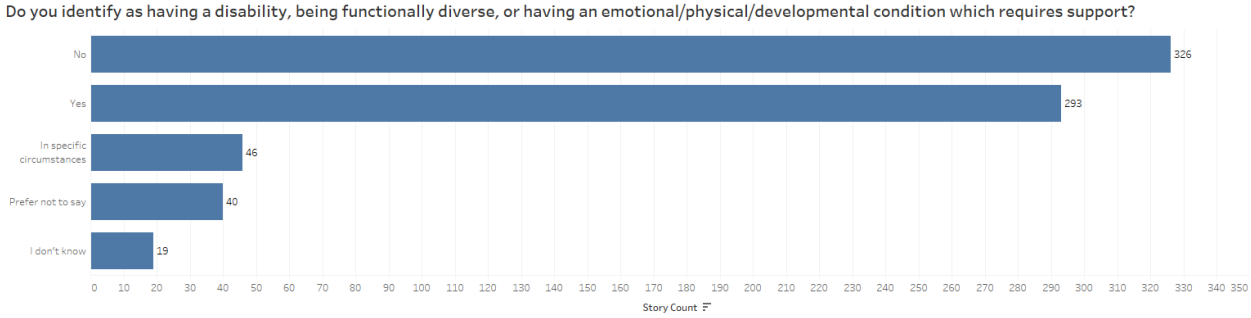


Figure 47. CPCCO. RHA respondents by functional diversity identification

This was the first time we asked about functional diversity in an inclusive way during a Regional Health Assessment. This question was crafted based on OHA's REAL-D guidance but adapted with input from our Community Advisory Councils and the use of cognitive testing on the question to check for understandability. This question is intentionally far more inclusive than census data and therefore cannot be *directly* compared. However, both sets of data affirm that people in our region are generally more likely to have needs for functional supports regardless of age when compared to statewide data. We suspect that we oversampled our functionally diverse communities but cannot directly confirm.

County

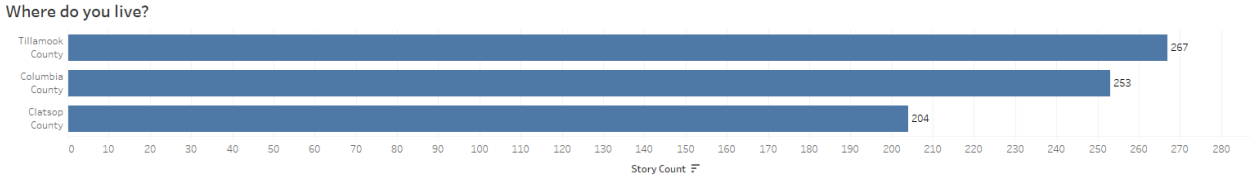


Figure 48. CPCCO. RHA respondents by county of residence

Our region's counties from most to least populous are: Columbia County, Clatsop County, and Tillamook County. While at least 200 respondents came from each county, more came from Tillamook County than the others, and fewer than would be proportional came from Clatsop County in particular.

Sample results

Please note, these results are not meant to be representative of all findings.

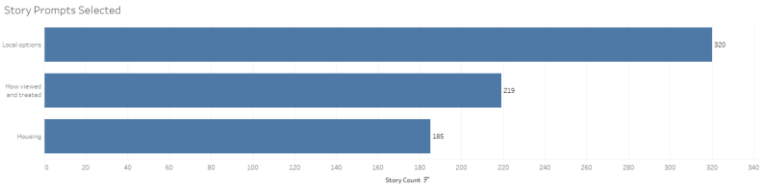


Figure 49. CPCCO. RHA story prompts selected

Before telling their stories, respondents chose a prompting sentence to respond to with an experience.

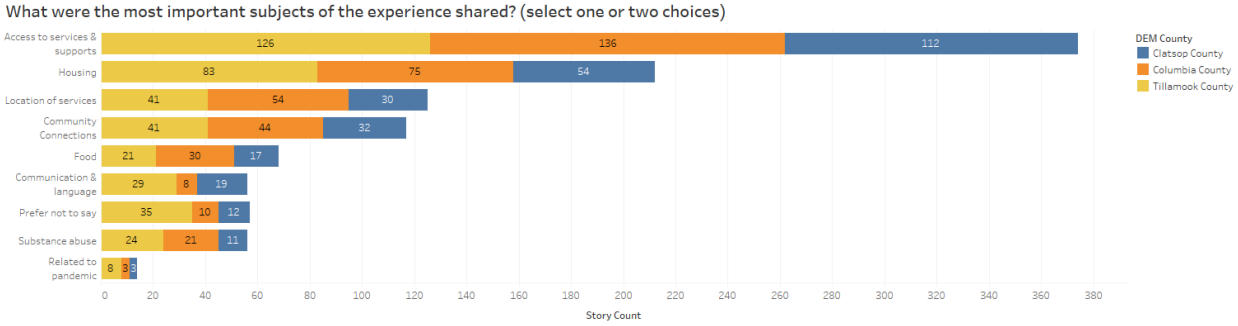


Figure 50. CPCCO. RHA story topics by county

When asked to choose one or two "most important subjects" from a multiple-choice list, the top subjects in all three counties were: Access to Services and Supports, Housing, Location of Services, and Community Connections.

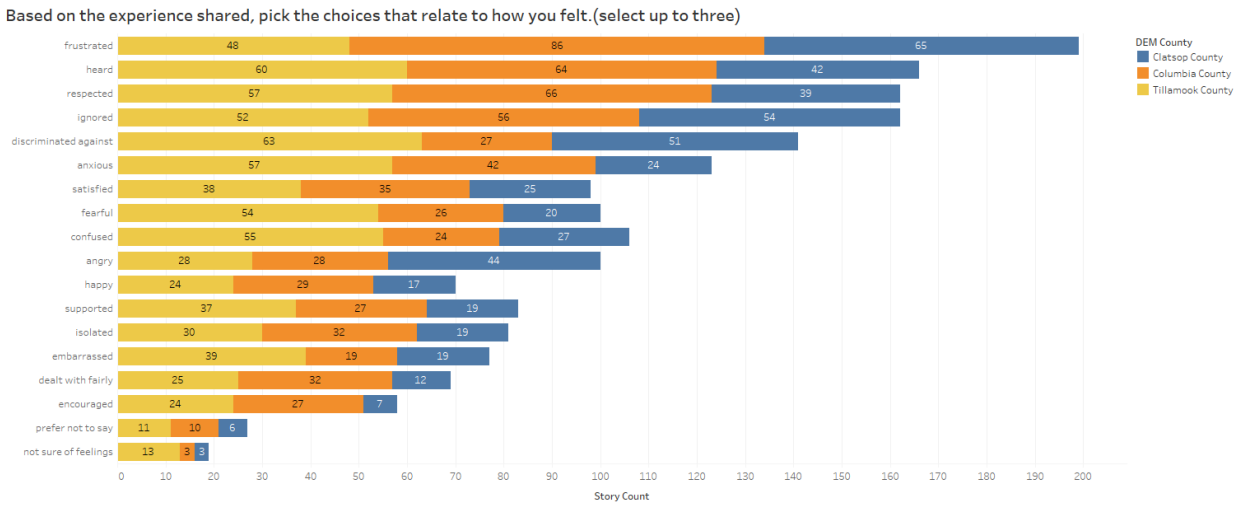


Figure 51. CPCCO. RHA feelings experienced by county

When asked how their story made them feel, the top results may seem discordant, but reflect the complexity of human experience: frustrated, heard, respected, ignored, discriminated against, and anxious.

Sensemaking

The community-involved workshop to find patterns among groups of stories and numerical data led to the following crowd-sourced observations:

Figure 52. CPCCO. RHA community observations of data

Additional work by staff using a different sensemaking approach for our equity-focus populations led to additional observations:

- BIPOC respondents' perspectives are best represented when looked at by individual identities rather than as one large group, as there are a lot of nuances to be seen that could guide approaches.
- The same is true of our LGBTQIA2S+ respondents. For example, sexual identity-diverse storytellers answered differently as a group from gender-diverse storytellers as a group much of the time, even while understanding that the groups are not wholly separate.
- In a high-level generality, those who belong to groups that have historically been oppressed are the most likely to have to "fend for themselves" today.
- In a high-level generality, those who belong to groups that have historically been oppressed look to community more strongly than others, though autonomy must also be respected.
- County of residence has a clear influence on how diverse groups navigate their experiences.
- Younger responses (under age 35) generally have stronger senses of how they see their experiences than their elders do.
- Broadly speaking, the negative impact of rules and the need for getting needs met are disproportionately strong among these members of our communities.

Community-input sessions

Staff presented summaries of story data and health-indicator data, followed by reflections on opportunities and priority-ranking votes at eight community events. Three were at Columbia Pacific Community Advisory Council meetings, three were at county-level health coalition meetings, and the last two were at youth-specific gatherings. Over **150 people attended**, with approximately 55 being under the age of 18. Of the attendees, 121 logged into the online voting platform. Of those who logged into the platform, **101 submitted their priority rankings**. Four voters voted in Spanish, and 28 were under the age of 18.

Reflections on opportunities

We asked community members to submit small phrases to answer the question "What are our greatest opportunities?" Below are the responses given by all people who responded to this question.

Figure 53. CPCCO. Community-input session responses to "What Are Our Greatest Opportunities?" English and Spanish

We then asked people to put all seven of the top community needs into their order of priority. Their placement correlated with a weighted score, with the most points being given to top place votes. Weighted scores were tracked by looking at the group as a whole, those who participated in Spanish, and those who attended a youth-specific event. Had there been close ties or discordance among the top-three priorities between groups, we would have proposed a resolution based on equity. The top three, no matter how we calculated it, were: **Equitable food systems, Healthy children and youth, and Housing and houselessness**. Ultimately, no matter the form of equity-focused weighting, the top among all groups remained the same.

Community input session vote tabs

Final rankings

Equitable food systems
Healthy children and youth
Housing and houselessness

Ranks	1st pl (8pts)	2nd pl (6pts)	3rd pl (5pts)	4th pl (4pts)	5th pl (3pts)	6th pl (2pts)	7th pl (1pts)	Weighted pts	Final rank
Behavioral health	10	15	17	13	15	12	6	382	4
Community empowerment	4	8	8	6	7	20	33	238	7
Culturally responsive care	3	9	11	15	11	17	20	280	6
Equitable food systems	10	18	20	10	18	12	7	413	3
Healthy children and youth	28	13	17	12	11	7	5	487	2
Housing and houselessness	36	20	10	13	6	5	3	541	1
Whole person care	14	9	6	17	18	12	12	354	5

Figure 54. CPCCO. Community-input sessions responses to "How Would You Rank These Priorities?"

Regional Health Improvement Plan

Figure 55. CPCCO. Community-identified priorities

Equitable food systems

Vision of health equity

We envision a future where the whole community has access to food, information and wellness opportunities which are culturally relevant, individually appropriate and meet people's needs. Our food systems are an important part of building a community where everyone's humanity and dignity are respected.

SMARTIE Goal 1

Aim

By December 31, 2029, improve food security among families with children under age 18 by improving coordination and increasing investments in food-systems partners and family-serving agencies, as informed by our communities and their stories.

Strategies

1. Increase CCO investments into food-systems partners and family-serving agencies with food-related programs. This will be done through grants and covered services with a focus on increasing people's options and autonomy regarding food access.
2. Improve coordination and integration between health and social systems to increase connections to food-related services. This will be done through closed-loop referral pathways and grantee reports on partnerships.

Measures

1. **Any average decrease** in childhood food insecurity rates as reported by the Oregon Hunger Taskforce and Feeding America from the rates contained in this assessment.
2. **A 10% increase** from baseline (2024) in referrals for food services via closed-loop pathways.
3. **A 5% increase** from baseline (2024) in options people have when accessing food by way of increased:
    a. **Programs**
    b. **Contracts**
    c. **Sites/times for access points**
    d. **Agencies**

SMARTIE Goal 2

Aim

By December 31, 2029, increase the cultural responsiveness and inclusivity of our food systems by increasing programs and services that are equity oriented as informed by our communities and their stories, especially those who belong to focus populations.

Strategies

1. Increase CCO investments into food programs and services in all three counties that explicitly focus on Tribal members, communities of color, English language learners, LGBTQIA2S+ communities, functionally diverse communities and/or our clinical priority populations. This will be done through grants and covered services.
2. Improve navigation to food services for English language learners by increasing access to in-language supports.

Measures

1. **An increase by 5** in the number of evidence-informed, culturally specific food programs across sectors from baseline (2024).
2. **An increase by five food systems organizations** in the number who provide in-language support such as:
    a. **Translated forms and websites**
    b. **Support by bilingual staff or volunteers**
    c. **Formal agreements that connect people to bilingual traditional health workers**
    d. **Provision of professional interpreters by phone or other means**

Healthy children and youth

Vision of health equity

We envision a future where children and youth are supported, empowered and thriving. We are committed to creating a trauma-informed community where children and youth have a safe environment to get the right kind of care, which meets their needs in ways that support their identities and lived experience, and that promotes family and community resilience.

SMARTIE Goal 1

Aim

By December 31, 2029, increase the programs and supports that build resilience and protective factors for youth and their families by adapting our community investments to better serve the community based organizations who do this work, and by working to align the measures and visions of the Trauma Informed Networks (TINs) and trauma-responsive partners.

Strategies

1. Complete adaptations to community investment programs to best support community based organizations delivering programs and providing resources. Partners include but are not limited to: the NW Regional Educational Services District, Early Learning Hubs, Youth Era's Youth Advisory Councils and School Based Health Centers.
2. Successful agreement among Trauma Informed Networks in strategic-plan goals, measures and investments.

Measures

1. A **30% increase** in the number of trauma-informed, evidence-informed or best-practice programs for children, youth and families when compared to the 2020-2024 period.
2. **Increase by 10** in the number of partners documenting trauma-informed services and practices **per county** when compared to the 2020-2024 period.

SMARTIE Goal 2

Aim

By December 31, 2029, increase access to traditional health workers (THW) that are family- and youth-facing by focusing on both increasing respite and increasing access to THW training.

Strategies

1. Regionwide adoption of a focus on respite between system of care practice-level workgroups.
2. Improvement in availability of THW trainings and THW-to-other-program supports.
3. Structure community investments to ask for reporting on prevention activities.

Measures

1. **Any increase** in peer-driven respite programs.
2. An **increase by 1 per county** in post/peri-partum THWs and youth peers.

SMARTIE Goal 3

Aim

By December 31, 2029, increase connection to existing supports for healthy child and youth development by improving closed-loop referral system use, increasing capacity for covered services and assessing scope of services related to Social Emotional Health.

Strategies

1. Complete environmental scans and additional needs assessments for SEH-support services.
2. Increase contracted, community-based capacity for covered services.
3. Increase use of closed-loop referrals for youth and child-facing programs.

Measures

1. **Any increase** in telehealth options for children.
2. **Any increase** in combined SEH-related assessments and services.
3. A **10% increase** in successful referrals for youth/child-facing programs.

SMARTIE Goal 4

Aim

By December 31, 2029, increase supports for families with children with developmental disabilities by investing in partners who provide supports, increasing the number of THWs with lived experience working in the region, and increasing developmental screenings for members ages 0-5.

Strategies

1. Complete adaptations to investment programs to best support community based organizations delivering programs and providing resources.
2. Continue engagement with partners and families through SEH metric and ongoing SEH-related work.

Measures

1. **Any increase** in programming that supports families with children with developmental disabilities.
2. An **increase to 3** in THWs who explicitly focus on children and families with developmental disabilities.
3. **Increase to 6%** the rate of developmental screenings provided by contracted providers in each county.

Housing and houselessness

Vision of health equity

Housing is health: prevention and improvement when people are housed, and harmful when they are not. We envision a future where secure and affordable housing is available to everyone regardless of documentation status, income, functional need, culture or background, criminal record and mental health needs. A variety of housing options should be available, including transitional housing, population-specific housing and supportive housing. Supports to apply for and maintain housing should be available and provided to meet the needs of our communities, including in-language and/or peer support.

SMARTIE Goal 1

Aim

By December 31, 2029, increase affordable housing stock by expanding our housing investment portfolio in terms of who we fund and how we fund them.

Strategies

1. Increase CCO investments in affordable housing stock, including types of programs and populations served. This will be done through our Regional Housing Impact Fund and Supporting Health for All Through Reinvestment (SHARE) Initiatives.

Measure

1. **A 15% increase from baseline (2020-2024)** in the number of units funded for affordable, workforce and intergenerational housing.

SMARTIE Goal 2

Aim

By December 31, 2029, increase transitional and recovery housing by expanding our housing investment portfolio in terms of who we fund and how we fund them.

Strategies

1. Increase the number of CCO investments in transitional and recovery housing, including the expansion of the investment portfolio to include innovative programs and alternative funding strategies.

Measure

1. **A 15% increase from baseline (2020-2024)** in the number of beds funded for both transitional and recovery housing.

SMARTIE Goal 3

Aim

By December 31, 2029, show an improvement in members' connection to housing and services by training health and social care partners, including traditional health workers, to navigate housing systems and benefits and support a more-equitable and holistic approach to housing services.

Strategies

1. Support housing-specific continuing education opportunities for traditional health workers, where they can provide communication and education on housing across the social ecology (individual, community, systemic).
2. Successfully implement and continuously improve the Health Related Social Needs (HRSN) housing-specific benefit and housing-specific Health Related Services-Flex (HRS-Flex) claims.

Measures

1. **Any increase** in traditional health workers trained in housing navigation, education and/or advocacy.
2. **A 5% increase each year from baseline** (2025) in HRSN and HRS-Flex housing-related request **approvals** between 2026-2029.

SMARTIE Goal 4

Aim

By December 31, 2029, successfully implement a sustainable funding model for housing by successfully braiding various types of funding together for housing-related partners.

Strategies

1. Build an onboarding model for community based organizations to contract successfully for multiple funding types, using a combination of capacity-building funds, technical assistance, and HRSN and HRS-Flex supports.
2. Ensure payment processes are completed, with continual quality improvement for both housing-specific HRSN and HRS-Flex.

Measures

1. **Increase by 5** the number of contracts with housing-related partners using a braided-funding mechanism.
2. **A 10% increase each year** when compared to baseline (2025) of successful, on-time HRSN and HRS-Flex service **payments** between 2026-2029.

Assets, sufficiency, effectiveness and gaps

While rurality and geography can impact what assets are available in our region or how effective they can be, community and clinical organizations in our region also partner ***deeply*** to address people's needs the best they can. Below is a color-coded summary of the assets in our region:

Key

Multiple	Clatsop	Columbia	Tillamook	Relevant programs	Comments regarding sufficiency	Comments regarding gaps

Equitable food system assets				
Clatsop Regional Food Bank - CCA	Mobile markets in summer	Strong volunteer base	No income/other requirements	
North Coast Food Web	Online farmers market with home delivery	Farm and food business support	Commitment to equity	Free home delivery for low-income shoppers
	Commercial kitchen and storage rental	Kitchen education	Online market takes SNAP and Farm Direct Nutrition Program	
Columbia Pacific Food Bank	Cooking classes/ kitchen space	Turning Point, HOPE of Rainier and Vernonia Food Pantry are affiliates		No volunteer training programs
	Culturally specific food boxes			
Oregon Food Bank Tillamook County	Meal programs	Direct connect to all the county's food pantries and senior meals	They are a key connect in Tillamook regarding food access	All the county's food pantries and meal sites are affiliated but not managed
	Advocacy regarding food policy			

Food Roots	Farm to School education	Mobile pickup sites	Their programs take SNAP and offer special prices/free delivery to drop-off sites		
		CSAs			
Familias en Accion	Abuela, Mama, y Yo	Some of their programs are virtual and/or can travel statewide	Post-pandemic many programs aren't delivered in person outside of Metro due to staffing		
	Spanish language traditional health worker program				
Community Meals St. Helens	Community gathering place and meals		Used to have an outreach nurse pre-pandemic		
El Centro NW	Tax education and financial literacy	ESOL	Cultural Center: dance classes, cultural workshops and events incl. health	Works to encourage people to engage in school boards, local government, etc., and increase community voice/visibility	"Seek out other social assistance agencies ... establish collaboration agreements to help the Hispanic community"
	Spanish literacy	GED prep			
Nestucca Pass It On	Food pantry	Informal navigation services	Doing a lot with very little		
Senior Centers	Meals	Some are directly supported by Area Agencies on Aging (AAAs), some aren't	Various programs, almost always volunteer or peer led		
Consejo Hispanio	Economic empowerment programs	Culturally specific food bags	Trusted, only culturally specific organization in region	Focus is outside health care scope	
				Not actively partnering with us	
Contracted Language Service Providers (6)	Certified Medical Interpreters	Data regarding language service adequacy	They cover all CareOregon regions but are mostly in Metro, which limits in-person options		
	Contracts with network		Capacity		

Healthy children and youth assets					
YMCA Tillamook	Youth-focused program with traditional health workers	Diabetes Prevention Program	Tillamook Early Learning Center is connected	Deeply invested in youth and health programming	
	Bowling alley - expansion to youth programs	Youth sports at schools and onsite		Long history of partnership	
Amani Center	Forensic assessment and services		Trained traditional health workers		
	Multidisciplinary Team		Victim Advocates		
Youth Era	Peers, general support and connection for "at risk" youth	Youth Advisory Council SOC also give empowerment component	Rural outreach means a lot of geography to cover	No drop-in center yet	
Sunset Empire Park + Recreation	Swim lessons	After-school programs		Summer camps	
NW Regional Education Service District	NW Parenting	Dolly Parton Imagination Library	Migrant Education and parent advisory groups	Long history of grants including current trauma informed care grant	
	Early Learning Hubs (3)	Child Care Resource and Referral (CCR&R)			
Resilient Clatsop County	Comprehensive strategic framework	Broad work scope and partnerships affects capacity	Committed network members		
Columbia County Childhood Trauma Informed Network (CTIN)	Comprehensive strategic framework	Broad work scope and partnerships affects capacity	Missing some sector representation		

The Playground Skate Park	Open skate	Lessons	Building capacity for programming	
St. Helens Parks and Recreation	After-school programs	Summer camps	Leverages partnerships well	Probably need more funding support to better serve low-income families
Wildflower Play Collective	Community co-op play space (0-6 years)	Co-op is primary, but some support group programming	Haven't found sustainable way to fund scholarships outside of CCO grants	
	Post-partum groups		No full-time staff – 1 very part-time person	
Columbia Health Services	School-Based Health Centers	Some integrated care and traditional health workers	Some behavioral health services, have to refer to CCMH	
	Prevention programs	WIC	Assuming have to refer out a lot since small clinics	
Court Appointed Special Advocates (CASA)	CASA Multnomah, Washington, Columbia, and Tillamook counties	Clatsop CASA	Systemic limits to model	Sustainable funding
			Volunteer-based model	
First Steps	Camps	Peer groups for parents, adults, youth and children	Only organization in the region that solely focuses on kids/families with autism and developmental disabilities	
	Tutoring	Resource walk-ins with open play	Traditional health worker-run	
Oregon Family Support Network	Family navigators with lived experience for children and youth with special needs		CareOregon grantee	Working with CPCCO
Job Corps - Tongue Point	Job training	GED support	Beginning to partner	Solely focuses on low-income youth

Libraries	Variety of programs depending on location and leadership		Some involvement in trauma informed care networks		Dispersed capacity, rather than systemic capacity
Suicide Prevention Task Force	Potential for safe storage work with public health			Sustainable funding	
Suicide Prevention Coalition	Strong, newer reconvened group attached to state community of practice now			Sustainable funding	
Tillamook Family Counseling Center	Prevention Specialist	Long history of partnership on behavioral health			Provider shortage at all levels and for people of all backgrounds
Folk Time	Traditional health worker training programs (soon) Traditional health worker supports	Just received a large CareOregon grant to expand traditional health worker training access cross-regionally		Currently in process of state approval for trainings; not done yet	
Tillamook Early Learning Center (TELC)	Repeat grantee related to increasing trauma informed care practices				
Lower Columbia Q Center	Queer recovery support with Clatsop Behavioral Healthcare	Variety of peer groups		Partnerships with the Harbor and Clatsop Behavioral Healthcare	Is in a leadership transition

Housing and houselessness assets					
Tides of Change	Emergency shelter	Several traditional health workers who are IPV advocates Health leadership council	Bilingual advocates	When contracting, they cannot provide member-level data due to important privacy laws	
Helping Hands	Re-entry program	Peer-run recovery supports	Several locations throughout region	Higher barrier; positive for families but harder for some adults	

CARE	Utility Assistance	Houselessness services	Bus lottery	Long history of partnership with CPCCO	Strong community partnerships	
	Low-barrier shelter	Microshelters	Housing assistance		High degree of restrictions based on federal and state funding	
Community Action Team	Meals on Wheels	Utility Assistance	Healthy Families	Both local and regional programming	Strong community partnerships	Programs and applications not integrated
	Healthy Homes	Housing assistance	Head Start	Working towards contractability	Long history of partnership with CPCCO	High degree of restrictions based on federal and state funding
Clatsop Community Action	Hilltop Apartments	Rapid Rehousing Program	Strong community partnerships	Long history of partnership with CPCCO	High degree of restrictions based on federal and state funding	
	Utility Assistance					
SAFE (Columbia County IPV)	Emergency shelter	When contracting, they cannot provide member-level data due to important privacy laws			Capacity to partner	
The Harbor (Clatsop IPV)	Traditional health workers	Bilingual advocates	Resilient Clatsop County member and active participant	When contracting, they cannot provide member-level data due to important privacy laws		
	Emergency shelter	Strong Latine/x advocacy				
LiFEBoat Services	Feeding Empty Bellies (food program)	Beacon Clubhouse (peer-run, non-clinical program)		Low barrier	Capacity to partner	
Adventist Community Services Herald Center	Food, clothing, and "basics" pantry	Safe park with porta-potties		Low barrier	Very open to innovation or expansion, dependent on support	
	Day center with showers and laundry			Doing a lot with very little	Doing a lot with very little	

Oregon Housing and Community Services	Multiple grant and funding programs	Funds many Regional Housing Impact Fund projects-high leverage value	Very competitive statewide	Funding isn't on a rolling basis No longer hosts Point-in-time count data — that is shifting to Portland State University
Clatsop County Risk Share	RHIF Partner	Funds many Regional Housing Impact Fund projects		
Tillamook County Risk Share	Has funded its first Regional Housing Impact Fund project			
Northwest Oregon Housing Authority	HUD housing provider	Section 8 voucher authority	Has received grants from CPCCO	Waitlist: Demand far exceeds supply
Regional Housing Impact Fund Grantee Developers	Daryn Murphy (NDC LLC)	Engage NW	Innovative Housing Solutions	GreenLight

Most or all			
Clatsop County and Public Health	Child Care Advisory Committee	CHART convener	Provider shortage at all levels and for people of all backgrounds
	Harm reduction programs	Bilingual bicultural staff (PH)	
Columbia County and Public Health	Harm reduction programs	Still building out programs and defining scope	No Community Health Improvement Plan to provide direction	Provider shortage at all levels and for people of all backgrounds

Tillamook County and CHC	Housing Commission	Clinics - physical, behavioral health, dental	Harm reduction programs	Truly a Patient-centered Primary Care Home	Provider shortage at all levels and for people of all backgrounds
	Tillamook County Wellness	Nurse home visiting programs	Mobile clinic	Is the backbone for Tillamook County Wellness but also now for a Rural Health Grant at the federal level	
Clatsop County's School Districts (5)	Involvement in Resilient Clatsop County; commitment to trauma informed care			Varied success at partnering, but continuing to make efforts (e.g. Jewell School SBHC)	
Columbia County's School Districts	School-Based Health Centers are run by Columbia Health Services			Some districts very involved in Columbia County Childhood Trauma Informed Network	
Tillamook County's School Districts (3)	School-Based Health Centers: Neahkahnie has one, Nestucca is working in that direction.		Varied successes partnering, and hoping to work towards consistency	Tillamook School District 9 (TSD9) has no School-Based Health Center	
	TSD9's Family Support program				
ColPac Economic Development District	Food systems support	Childcare resource and referral		Transportation	No history of partnering with CPCCO
211	Coordination Center	CBO Outreach		Are a go-to resource regarding childcare specifically	Are still building visibility in our region/ low uptake regarding coordination center

Latinx Collaborative	Raised specific potential projects that reflect Latinx priorities in the region	Ideas they've raised: English-Spanish co-teaching; OHP & Me in person; regular community convos about things like mental health, youth health needs, substance use, suicide prevention		Needs connection to a 501c3 for grants
OSU Extension	Food and nutrition education programs	Behavioral health studies and projects	High-quality traditional health worker training; has been very responsive to our region	Demand for traditional health worker training exceeds capacity
	Traditional health worker trainings and CEUs	Expertise of gaps in food systems by community		
Clatsop Behavioral Health	School-based staff	Drop-in programs	Long history of partnership on behavioral health and housing	
	Permanent supportive housing	Early intervention	Provider shortage at all levels and for people of all backgrounds	
United Way	Funds many of the same partners for Food and Children and Youth			
Connect Oregon (background)	Connect Oregon (Oregon+SW WA) network and platform	Tillamook County is engaging in a community-based strategy of expanding the network	Low uptake in our region due to barriers	
Nehalem Bay Health Center	Social health program	Diabetes management and prevention program	Bilingual promotoras lead the social health work	Provider shortage at all levels and for people of all backgrounds
		Operates the Neahkahnie SD's School-Based Health Center	Strong history of partnership and innovation work	

Providence Seaside	BOB Program	Clinics - physical, behavioral health	Strong partnership with Medical Teams International for dental	Provider shortage at all levels and for people of all backgrounds
	Community Help Desk		Bilingual navigator	Low access to specialties in-region
Oregon Community Health Workers Association (ORCHWA)	Community Health Worker training	Region 3 Network	Region 3 is geographically large and dispersed	More demand for training than supply
	Policy advocacy	Annual conference	Statewide focus	
Mental Health & Addiction Association of Oregon (MHAAO)	Peer Wellness Specialist training, others as well		Annual Peerpocalypse Conference	Statewide focus

Missing/Gaps

Local supports for interpreters	**Regional Health Equity Coalition**	**Ed programs for childcare providers**	**RV repair/replace programs**	**More low-barrier shelter/housing**
Suicide Prevention Coalition	Not a strong call for it at the moment but could be a future behavioral health-related investment if interest turned up			
Tillamook County Trauma Informed Network (future)	Recently increased staff capacity to lay the groundwork	General interest in trauma informed care and commitment of organizations/individuals in Tillamook County	Has not launched	

Conclusion

As we think ahead to the next five years and as we work towards the goals of each priority that our community has named for us, we also reflect on the challenges and opportunities we've encountered in the past few years. The past reminds us to be humble in what we promise, because we don't know what the next five years may bring. At the same time, we see that our communities still dream of a more-equitable, healthy region and are inspired to act boldly.

What's next?

At Columbia Pacific, we value transparency, accountability, honesty, respect and commitment. We plan to carry out this Regional Health Improvement Plan with these values at the core.

- **Transparency**: As we complete the work of this plan, there will be many opportunities to invite our region in to see what we and our partners have done. This includes updates to our Community Advisory Councils and other governing bodies, and communication efforts to celebrate the victories and share how we try to address community needs.
- **Accountability**: The stories our community shared with us will not sit on a shelf collecting dust. This means consulting individual stories and the patterns among groups of stories as we do the work of our strategies. It also means providing regular updates to this plan, which will be made available on our website and on the Oregon Health Authority website.
- **Honesty and respect**: We respect and honor the diverse points of view that we've been trusted with as we've asked for community feedback and stories. We will continue to engage with our partners and Community Advisory Councils to advance the priorities of our region collaboratively and in good faith.
- **Commitment**: This plan now becomes the foundation of Columbia Pacific's work. The plan will guide where we commit our time, partnership, staffing and funds for the next five years.

Final thoughts

It is incredibly exciting to share this Regional Health Improvement Plan with you. And we hope you will join us in our shared efforts to build a healthier region together. Whether you are one of our amazing health plan members, serve on one of our Community Advisory Councils, work for a community based organization, are a passionate advocate, or provide care, we can't move forward together without you.

Thank you for every way that you have participated in this effort to better understand where we can have the biggest impact. For telling your stories, voting on our priorities, helping with the process, reading this final product, and for taking part in the work ahead.

Onward!

Appendices

Including outreach, evidence-informed strategies and more

Appendix A:

Outreach to Tribal organizations

Our service region overlaps with two federally recognized Tribal Nation service areas. Both the Confederated Tribes of Grand Ronde and the Confederated Tribes of Siletz Indians include Tillamook County in their service area, and each has a health clinic. Native American Rehabilitation Association of the Northwest (NARA Northwest) has an adult residential treatment center just outside of Columbia County near Burlington. Medicine Wheel Recovery Services Inc. in St. Helens provides outpatient treatment for substance use disorders.

Below is our summary of Tribal outreach by phone and email, including health care providers, recognized Tribe, and Tribes who have a connection to our region. We would like to particularly thank Troy Montserrat-Gonzales, Director of Tribal Affairs at CareOregon, for her generous consultation.

			Outreach Attempt Type				
Tribal Entity	Type	Response	Initiation	Story Collection	Data Review & Share	Community Input Sessions	Draft Review
Director, Tribal Affairs	CCO Tribal Liaison	Yes: Consult	☑	☑	☑	☐	☑
Confederated Tribes of Grand Ronde	Tribal Government and Healthcare Provider	None	☐	☐	☑	☑	☑
Confederated Tribes of Siletz Indians	Tribal Government and Healthcare Provider	None	☐	☐	☑	☑	☑
Medicine Wheel	Healthcare Provider	Yes: Collect Stories	☐	☑	☑	☑	☑
NARA NW	Healthcare Provider	Decline	☐	☐	☑	☐	☑
Chinook Indian Nation	Tribal Government and Healthcare Provider	None	☐	☐	☑	☑	☑

Confederated Tribes of Warm Springs	Tribal Government and Healthcare Provider	None	☐	☐	☑	☑	☑
Cowlitz Indian Tribe	Tribal Government and Healthcare Provider	None	☐	☐	☑	☑	☐

Appendix B:

Examples of evidence-based practice for chosen strategies

Equitable food systems

Practices for equitable food systems have a largely documented evidence base to the improvement of health outcomes, particularly when it comes to healthy food access for children and making healthy choices an easier choice. It is important to note that capacity to assess for evidence in community-based settings and among all populations is limited. Thus, it is important to support innovative solutions, documenting improvements though evaluation and practiced-based evidence. Culturally and linguistically appropriate services and initiatives that decrease barriers to care have a large evidence base in health care, which can be translated to other sectors of care (such as food systems and social services). Where resources for whole programs may not exist or be practical, components of evidence-based practices can be implemented to make an impact on measures for this priority area.

Equitable Food Systems (access- and education-focused practices) *Strategy:* *-Increased food security*	Healthy School Meals for All[lxxiv] Increase Access to Healthy Food Options[lxxv] • Fruit and Vegetable Incentive Programs • Healthy School Lunch Initiatives • Healthy Vending Machine Options • School Fruit and Vegetable Gardens • School Breakfast Programs • Water Availability and Promotion Interventions Promote Healthy Eating[lxxvi] • Breast Feeding Promotion Programs • School Nutrition Standards Reduce Access to Unhealthy Foods[lxxvii] • Competitive Pricing for Healthy Foods
Equitable Food Systems (quality-of-care focused practices) *Strategy:*	Provide Culturally Competent Care[lxxviii] • Patient Navigators • Cultural Competence Training • Culturally Adapted Healthcare • Professionally Trained Interpreters

-Culturally responsive and inclusive food systems	Increase Coordination of Care[lxxix] • Chronic Disease Management Programs
Equitable Food Systems (promising or innovative practices) *Strategies:* *-Increasing food security* *-Culturally responsive and inclusive food systems*	Raices Cooperative Farm[lxxx] • Supports Latino entrepreneurs and small businesses by increasing organic produce available to project members, food banks and local farmers markets and providing education and community connection Double Up Food Bucks[lxxxi] • Increases access to fresh fruits and vegetables by matching SNAP on dollars spent at select locations Veggie Rx[lxxxii] • Improves access to fresh produce through provider prescriptions for free produce from local stores or farmers markets Food Bank Fresh and Produce Boxes[lxxxiii] • A summer mobile food pantry that focuses on distributing produce and other fresh products Seed to Supper/Siembra La Cena[lxxxiv] • Beginning gardening course focused on reducing food insecurity

Healthy children and youth

According to the Robert Wood Johnson Foundation, the evidence base for the significance of early childhood interventions on health can be difficult to compile because of lack of investment in research as a barrier in meeting the need for large-scale longitudinal studies.[lxxxv] Despite this, "the evidence is clear that we need systematic national, state, and local investments and policies to give all children the chance to reach their full potential for health and well-being."[lxxxvi] These investments and policies should focus not just on programs but also on equity in socioeconomic factors. Although there are many examples of promising interventions globally, the availability of such interventions is limited, particularly for the most "socioeconomically disadvantaged families whose children would benefit most."[lxxxvii] Thus, it is important to acknowledge the breadth of practices that are not only evidence-based, but promising and innovative, addressing health inequities among children and youth in a way that meets the particular needs of communities.

Healthy Children & Youth (community safety-focused practices) *Strategies:*	Assist Youth Involved with the Justice System[lxxxviii] • Functional Family Therapy (FFT) • Multisystemic Therapy (MST) for juvenile offenders • Treatment Foster Care Oregon Prevent Child Maltreatment[lxxxix]

-Increase programs and supports that build resilience and protective factors	• Early childhood home-visiting programs • Family treatment drug courts • Kinship foster care for children in the child welfare system Prevent Neighborhood Crime & Violence[xc] • Mentoring programs to prevent youth delinquency • Restorative justice in the criminal justice system
Healthy Children & Youth (education-based practices) *Columbia Pacific strategies:* *-All for priority area*	Create Environments that Support Learning[xci] • Community schools • Positive Behavioral Interventions and Supports (PBIS) Tier 1 • School breakfast programs • Summer youth employment programs • School-based health centers • School-based social and emotional instruction • School-based violence and bullying prevention programs Improve Quality of K-12 Education[xcii] • Attendance interventions for chronically absent students • Knowledge is Power Program (KIPP) in middle schools • Summer learning programs Increase Early Childhood Education[xciii] • Early Head Start (EHS) • Preschool education programs • Preschool education programs with family support services Increase Education Beyond High School[xciv] • College access programs • Health career recruitment for minority students Increase High School Completion Rates[xcv] • Career & technical education for high school completion • Career academies • Dropout prevention programs • Mentoring programs for high school graduation Parent Education Programs[xcvi] • Families and Schools Together • Incredible Years • Reach Out and Read School-based Suicide Prevention Programs[xcvii] • Good Behavior Game (GBG) • Sources of Strength • Signs of Suicide (SOS)
Healthy Children & Youth (promising or innovative practices)	Family Hui[xcviii] • Resilience-Focused Peer-led Parenting Program

Columbia Pacific strategies: *-All for priority area*	Nurse-Family Partnerships[xcix] • Uses nurses to conduct ongoing home visits with low-income, first-time mothers from pregnancy to age 2, addressing social and psychological needs Promote Social Norms that Protect Against Violence and Adversity[c] • Public Education Campaigns • Bystander Approaches and Efforts to Mobilize Men and Boys in Allies in Prevention Teach Skills such as Social Emotional Learning, Safe Dating and Healthy-Relationship Skill Programs, Parenting Skills and Family Relationship Approaches[ci] • Life Skills Training • Dating Matters • The Incredible Years Connect Youth to Caring Adults and Activities[cii] • Big Brothers, Big Sisters (One-on-One Mentoring) • After School Matters • Powerful Voices Interventions to Lessen Immediate and Long-Term Harms[ciii] • Enhanced Primary Care to Identify and Address Adverse Childhood Experiences (ACES) • Victim-Centered Services • Treatments to Lessen the Harms of ACES • Treatment to Prevent Program Behavior and Future Involvement in Violence • Family-Centered Treatment Approaches for Substance Use Disorder Positive Youth Development[civ] • Works to strengthen protective factors, including skills, competencies and supportive relationships among youth Inclusive Sexual Health Education[cv] • Sex education that is relevant to LGBTQIA2S+ youth Gay-Straight Alliances[cvi] • Provide a safe place for students to support each other around issues related to sexual orientation and gender identity The Family Acceptance Project[cvii] • Resources to strengthen family support of LGBTQIA2S+ youth Mama Sana/Vibrant Woman[cviii] • Pregnancy, birth, and post-partum support for families of color • Collective founded by Black and Hispanic moms

	Abuelo, Mama, Y Yo[cix] • Nutrition and healthy eating program for Latinx/e families • Based on Developmental Origins of Health and Disease (DOHaD) research Evidence-Supported and Culturally Relevant Behavioral Health Interventions for Youth and Families[cx] • Achieving Whole Health • Familia Adelante • Motivational Interviewing

Housing and houselessness

There is extensive evidence that shows stable and affordable housing has a positive impact on health outcomes and results in efficient use of health care dollars. In compiling the following list of evidence-based practices and promising practices, we reviewed the University of Wisconsin Population Health Institute's County Health Rankings & Roadmaps, the National Alliance to End Homelessness Center for Evidence Based Solutions to Homelessness, and the Oregon Statewide Shelter Study, among other sources. This list is not exhaustive. It is important to acknowledge that while many evidence-based and promising practices exist and have been studied, the cultural and political landscape determines whether and to what degree these strategies are implemented, and how successful they are. Our role in increasing affordable housing generally supports local developers, leverages other sources of state funding, and works in a context of financial and policy supports, such as the Housing Choice Voucher Program (Section 8) and Low-Income Housing Tax Credits (LIHTCs) program.

Strategy: Increase CCO investments in affordable housing stock, including types of programs and populations served. This will be done through our Regional Housing Impact Fund and Supporting Health for All Through Reinvestment (SHARE) Initiatives.	Housing First[cxi] • Provides housing to people without barriers • Provides ongoing supports, including crisis intervention and case management Rapid Rehousing programs[cxii] • Supports families and individuals experiencing homelessness in finding permanent housing quickly, usually within 30 days Permanent Supportive Housing[cxiii] • Combines subsidized housing with other voluntary supports to help individuals with disabilities stay stably housed • Often focused on individuals who are chronically homeless or who have multiple barriers in finding housing
Strategy: Support housing-specific continuing education opportunities for traditional health workers, where they can provide communication and education on housing	Healthy home environment assessments[cxiv] • Works with community health workers to assess and reduce environmental health risks • Generally focused on asthma management Housing rehabilitation loan & grant programs[cxv] • Provide funding to repair homes and remove safety hazards

across the social ecology (individual, community, systemic). *Strategy: Successfully implement and continuously improve the Health Related Social Needs (HRSN) housing-specific benefit and housing-specific Health Related Services-Flex (HRS-Flex) claims.*	• Healthy Homes[cxvi] is an example at the federal level Integrated pest management for indoor use[cxvii] • Pest control that minimizes risks to people and environment • Adapted from agriculture for indoor use Lead paint abatement programs[cxviii] • Eliminate lead-based paint and contaminated dust Weatherization assistance program[cxix] • Supports low-income families in making their homes energy efficient • Reduces utility bills
Strategy: Increase the number of CCO investments in transitional and recovery housing, including the expansion of the investment portfolio to include innovative programs and alternative funding strategies.	Coordinated Entry[cxx] • System that matches individuals experiencing houselessness with available opportunities Diversion[cxxi] • A client-driven approach to immediately address the needs of an individual who just lost housing Recovery Housing[cxxii] • Short-term housing for individuals with substance use disorder and/or mental illness
Strategy: Build an onboarding model for community based organizations to contract successfully for multiple funding types, using a combination of capacity building funds, technical assistance, and HRSN and HRS-Flex supports. *Strategy: Ensure payment processes are completed, with continual quality improvement for both housing-specific HRSN and HRS-Flex.*	Quality improvement practices such as Awareness, Desire, Knowledge, Ability, Reinforcement (ADKAR), LEAN, and Plan, Do, Study, Act (PDSA) may use local data and evidence from literature to implement effective evidence-based practice.
Housing & Houselessness (promising and innovative practices)	Alternative Financing • Microloans to pay for housing. Homesharing[cxxiii] • Normalizes co-living as an affordable housing option • Increases direct services to seniors; fosters companionship

Appendix C:

Transparency and public process

We provided external communications throughout the entire process of conducting the Regional Health Assessment and writing the Regional Health Improvement Plan. We published communications in the form of press releases, website updates and Facebook posts. We created and shared content to encourage participation in Narrative Story Collection and community-input sessions, to thank the community for participating, and to keep the community informed about where we were in the process. Examples of our communication are included below.

Regional Health Improvement Plan web page: Regional Health Improvement Plan (colpachealth.org)

Press Release for RHA Story Collection: Columbia Pacific CCO launches new Regional Health Assessment, seeks input on community priorities (colpachealth.org)

Columbia Pacific CCO Facebook page: https://www.facebook.com/search/top?q=columbia%20pacific%20coordinated%20care%20organization

Example Facebook post content:

Jan 24, 2024
Want to make a positive impact on the health of your community? Please join us for a community-input session on Feb. 5, 6 or 7 to vote on the priorities of our next five-year Regional Health Improvement Plan.
Dates, times and locations:
§ Monday, Feb. 5, 3-5 p.m., Columbia Center, 375 S 18th St., St. Helens
§ Tuesday, Feb. 6, 4:30-6:30 p.m., Holiday Inn Express, 204 W Marine Drive, Astoria
§ Wednesday, Feb. 7, 1-3 p.m., Tillamook Community College, 4301 Third St., Tillamook
All residents of Clatsop, Columbia and Tillamook counties are welcome. Attendees will vote to prioritize community needs identified as a result of the extensive community feedback we collected for our Regional Health Assessment. Spanish interpretation and light snacks will be provided.
We look forward to seeing you!
#columbiapacificcco
#columbiacountyoregon
#tillamookcounty
#clatsopcounty
#publichealth

¿Quiere tener un impacto posivo en la salud de su comunidad? Únase a nosotros para una sesión de aportes comunitarios el 5, 6 o 7 de febrero para votar sobre las prioridades de nuestro Plan de Mejora de la Salud Regional para los próximos cinco años.

Fechas, horarios y lugares: - Lunes, 5 de febrero, de 3 a 5 p.m., Columbia Center, 375 S 18th St., St. Helens - Martes, 6 de febrero, de 4:30 a 6:30 p.m., Holiday Inn Express, 204 W Marine Drive, Astoria - Miércoles, 7 de febrero, de 1 a 3 p.m., Tillamook Community College, 4301 Third St., Tillamook
Todos los residentes de los condados de Clatsop, Columbia y Tillamook son bienvenidos. Los asistentes votarán para priorizar las necesidades comunitarias idenficadas como resultado de los extensos comentarios de la comunidad recopilados en nuestra Evaluación de Salud Regional. Se proporcionará interpretación en español y aperivos ligeros en cada sesión. ¡Esperamos verlo/a!
Conozca más sobre nuestro Plan de Mejora de la Salud Regional: https://bit.ly/48ANRZ6
#columbiapacificcco
#columbiacountyoregon
#tillamookcounty
#clatsopcounty
#publichealth

July 11, 2023
"Columbia Pacific really puts its money where its mouth is and uses the feedback they receive from the [Regional Health Assessment] story collection data to put their funding where the community wants it to go," said Angelica Godinez Garcia, a Tillamook native and chair of the Columbia Pacific Tillamook Community Advisory Council.
Watch the video below to learn more about Columbia Pacific's Regional Health Assessment and the people (like Godinez Garcia) who help make it happen.
All residents of Tillamook, Clatsop and Columbia counties are eligible to share a story for the Regional Health Assessment, and it's easy to do.
Visit the Columbia Pacific website to take the Regional Health Assessment survey (in English or Spanish): https://colpachealth.org/rha
We have also been collecting stories in person at food pantries, community events and many other locations in our three-county service region. Look for us at a location near you!
#columbiacountyoregon
#clatsopcountyoregon
#tillamookcounty
#columbiapacificcco
#healthequity
Nehalem Bay Health Center

Appendix D:

Partnerships requirements met

Partner	Engaged?	Name (if applicable)	What did engagement entail?	Notes
Community Advisory Council (4)	Yes	See Demographic Report for individual names	Creating & piloting RHA survey; prioritization process at community input sessions; adopting the CHP.	The CAC has been engaged throughout the entire RHA/RHIP process.
Local Public Health Authorities	Yes	Clatsop County Department of Public Health, Columbia Health Services, Tillamook County Community Health Centers	Engagement through collaborative CHNA and prioritization process at community input sessions.	
Federally Recognized Tribes of Oregon in CCO's service area	Yes	Confederated Tribes of Grand Ronde, Confederated Tribes of Siletz Indians, with additional outreach to Confederated Tribes Warm Springs, Chinook Indian Nation, and Cowlitz Indian Tribe.	Engagement through sharing stories; received direct outreach from our team and Tribal Liaison.	Reached out beyond those whose service area include CPCCO region to include a distinct local Tribe seeking Federal re-recognition and also a Tribe who many CPCCO members belong to.
Tribal organizations	Yes	Medicine Wheel	Through story collection and data sharing.	
Other CCOs	No	N/A	N/A	**CPCCO is the sole CCO serving this region's counties. This rule does not apply.**
County government	Yes	Representatives of all three counties	Through the collaborative CHNA process and the CACs as well as Board of Directors' update and Community Input Sessions.	Representatives (elected or employed) from different departments of each county have been engaged consistently, including county-level public health, first responders, elected judges, Housing Coordinator, Commissioners, etc.)
City government	Yes	St. Helens (Mayor & Councilmember), Scappoose (FD),	Through the collaborative CHNA process, the CACs, and and Community Input Sessions.	
SDOH-E partners	Yes	Regional and local food banks, senior centers, IPV advocacy organizations, affordable housing providers/locations, shelters & navigation centers, recovery support providers, LGBTQIA+ partners.	Engagement through story collection at these sites; staff of these organizations helped with community-inclusive workgroup, pilot survey and survey distribution and shared their stories. Also attended Community Input Sessions.	
Local Mental Health Authorities	Yes	Clatsop County Department of Public Health, Columbia Health Services, Tillamook County Community Health Centers	Engagement included collecting stories on site and at events; invitations to input sessions.	In our region, the LMHAs are the same as the LPHAs for several legal reasons. They then essentially appoint the CMHPs as their subcontractors.
Community Mental Health Programs	Yes	Clatsop Behavioral Health, Columbia Community Mental Health, Tillamook Family Counseling Center	Engagement included collecting stories on site and at events; invitations to input sessions.	
Physical, Behavioral, Oral health providers	Yes	Columbia Memorial Hospital, Clatsop Behavioral Health, Providence Seaside, Nehalem Bay Health Center & Pharmacy, Tillamook County Community Health Centers, OHSU, Medical Teams International dental van, Columbia Health Services, Adventist Health Tillamook, ODS Community Dental	Engagement included CHNAs, collecting stories on site and at events; invitations to input sessions. Board of Directors includes representatives of several of these providers and received an update mid-process.	Not all listed orgs participated in all engagement. Naming orgs only since multiple sites represented at different phases
FQHCs	Yes	Yakima Valley Farmworkers, Nehalem Bay Health Center & Pharmacy, Tillamook County Community Health Centers	Engagement included collecting stories on site and at events, invitations to input sessions.	Not all listed orgs participated in all engagement.

Indian Health Care Providers	Yes	Native American Rehabilitation Association	Received outreach from CCO Tribal Liaison.	Not interested in engaging.
CCO Tribal Liaison	Yes	Troy Montserrat-Gonzales, Director of Tribal Affairs	Conducted outreach to Tribal leaders and consulted.	Reached out to NARA. Offered general advice for staff RE opportunities for engagement.
THWs	Yes	Nehalem Bay Health Center & Pharmacy, Tides of Change, The Harbor(Stevi, Nayeli), First Steps Center for Autism & Developmental Disabilities, Youth Era, NorthWest Senior and Disability Services (Steven)	Representative in community-inclusive workgroup, creating & piloting RHA survey; CAC members, host organizations & supports, prioritization process at community input sessions.	Captured via the organizations they work at
School nurses, school mental health providers	Yes	Columbia Health Services, Nehalem Bay Health Center & Pharmacy	Representative of NBHC in community-inclusive workgroup and in CAC; invited to share stories and to attend community input sessions.	These two organizations oversee the operations of some of the Region's SBHCs. Related, the Family Navigator at TSD9 was included in invite to Tillamook CAC input session.
Culturally specific organizations, including RHECs	Yes	Clatsop Health Equity Group, Medicine Wheel.	Engagement through story collection and prioritization process at community input sessions.	We don't currently have an RHEC in the CPCCO region.
Representatives from populations who are experienicng health and health care disparities	Yes	Community Advisory Councils (4), Tongue Point Job Corps, Medicine Wheel clients, staff of SDOH-E partners and THWs.	Engagement through community-inclusive workgroup, sharing stories, and as CAC members supporting all phases of story collection, also Community Input Sessions.	Not all listed orgs participated in all engagement.

Appendix E:

SMARTIE Goal Measures: Baseline & Target Data

Equitable Food Systems

1.1.1. Any average decrease in childhood food insecurity rates as reported by the Oregon Hunger Taskforce and Feeding America from the rates contained in this assessment.

County	Baseline (2022)	RHIP Target
Clatsop	12.5%	12.4%
Columbia	10.3%	10.2%
Tillamook	11.8%	11.7%

1.1.2. A 10% increase from baseline (2024) in referrals for food services via closed-loop pathways

County	Baseline (2024)	RHIP Target
Region (Clatsop, Columbia, Tillamook Counties combined)	102	112.2

1.1.3. A 5% increase from baseline (2024) in options people have when accessing food by way of increased: programs; contracts; sites/times for access points; agencies.

County	Baseline Score (2024) Score determined by rubric	RHIP Target Score
Clatsop	220	231
Columbia	220	231
Tillamook	216	226.8

1.2.1. An increase by 5 in the number of evidence-informed, culturally responsive food programs across sectors from baseline (2024).

County	Baseline (2024)	RHIP Target
Clatsop	6	11
Columbia	4	9
Tillamook	4	9

1.2.2. An increase by 5 organizations in the number who provide in-language support such as translated forms and websites; support by bilingual staff or volunteers; formal agreements that connect people to bilingual THWs; provision of professional interpreters by phone or other means.

County	Baseline (2024)	RHIP Target
Region (Clatsop, Columbia, Tillamook Counties combined)	1	6

Healthy Children and Youth

2.1.1. A 30% increase in the number of trauma-informed, evidence-informed or best practice programs for children, youth, and families when compared to the period of 2020-2024.

County	Baseline (2020-2024)	RHIP Target
Clatsop	19	24.7
Columbia	26	33.8
Tillamook	15	19.5

2.1.2. An increase by 10 in the number of partners documenting trauma informed services and practices per county when compared to the period of 2020-2024.

County	Baseline (2020-2024)	RHIP Target
Clatsop	7	17
Columbia	7	17
Tillamook	7	17

2.2.1. Any increase in peer-driven respite programs.

County	Baseline (2024)	RHIP Target
Region (Clatsop, Columbia, Tillamook Counties combined)	0	1

2.2.2. An increase by 1 per county in post/peri-partum THWs and youth peers.

County	Baseline (2024)	RHIP Target
Clatsop	1	2
Columbia	2	3
Tillamook	1	2

2.3.1. Any increase in telehealth options for children.

County	Baseline (2024)	RHIP Target
Clatsop	6	7
Columbia	6	7
Tillamook	6	7

2.3.2. Any increase in combined SEH-related assessments and services.

County	Baseline (2024)	RHIP Target
Regional Assessments (Clatsop, Columbia, Tillamook Counties combined)	4.6%	4.7%
Regional Services (Clatsop, Columbia, Tillamook Counties combined)	2.7%	2.8%
Regional Combined Reach (Clatsop, Columbia, Tillamook Counties combined)	6.0%	6.1%

2.3.3. A 10% increase in successful referrals for youth/child-facing programs.

County	Baseline (2024)	RHIP Target
Region (Clatsop, Columbia, Tillamook Counties combined)	N/A	Baseline *1.1

2.4.1. Any increase in programming that supports families with children with developmental disabilities.

County	Baseline (2024)	RHIP Target
Clatsop	4	5
Columbia	2	3
Tillamook	2	3

2.4.2. An increase to 3 in THWs who explicitly focus on children and families with disabilities.

County	Baseline (2024)	RHIP Target
Clatsop	1	1.15
Columbia	0	0
Tillamook	0	0

2.4.3. Increase to 6% the rate of developmental screenings provided by contracted providers in each county.

County	Baseline (2024)	RHIP Target
Regional Assessments (Clatsop, Columbia, Tillamook Counties combined)	4.6%	4.7%

Housing and Houselessness

3.1.1. A 15% increase from baseline (2020-2024) in the number of units funded for affordable, workforce, and intergenerational housing.

County	Baseline (2020-2024)	RHIP Target
Region (Clatsop, Columbia, Tillamook Counties combined)	401	461.15

3.2.1. A 15% increase from baseline (2020-2024) in the number of beds funded for both transitional and recovery housing.

County	Baseline (2020-2024)	RHIP Target
Region (Clatsop, Columbia, Tillamook Counties combined)	56	64.4

3.3.1. Any increase in Traditional Health Workers trained in housing navigation, education, and/or advocacy.

County	Baseline (2024)	RHIP Target

Region (Clatsop, Columbia, Tillamook Counties combined)	0	1

3.3.2. A 5% increase each year from baseline (2025) in HRSN and HRS-Flex request approvals between 2026-2029.

County	Baseline (2020-2024)	RHIP Target
Region (Clatsop, Columbia, Tillamook Counties combined)	N/A	Baseline*1.05/year

3.4.1. Increase by 5 the number of contracts with housing-related partners using a braided-funding mechanism.

County	Baseline (2020-Q2 2024)	RHIP Target
Region (Clatsop, Columbia, Tillamook Counties combined)	0	5

3.4.2. A 5% increase each year from baseline (2025) of successful, on-time HRSN and HRS-Flex service payments between 2026-2029.

County	Baseline (2020-2024)	RHIP Target
Region (Clatsop, Columbia, Tillamook Counties combined)	N/A	Baseline*1.05/year

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